



Chronic Disease Research Centre: Technical Report Series
Technical Report 01



HEALTHY CARIBBEAN 2008

Caribbean Chronic Disease Conference

A Wellness Revolution Event



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Technical Report 01





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Published by

Miller Publishing Company,
Edgehill, St. Thomas, Barbados, West Indies.

Tel: (246) 421-6700 Fax: (246) 421-6707

E-mail: miller@caribsurf.com

Designed by Ashif Nakhuda

Printed in Barbados by Coles Printery Limited.

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ISBN 978-976-621-164-7

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Foreword

Professor Trevor A. Hassell
Conference Chairman and Co-ordinator

Chronic non-communicable diseases (CNCDs) have over the past several decades been a major cause of morbidity and mortality in the Caribbean as in most other regions and sub-regions of the world.

Several initiatives taken in the Caribbean at the regional, country, and organization level to slow the pandemic of chronic diseases culminated in September 2007 with the Summit of Heads of Governments of CARICOM which was held in Trinidad and Tobago at which the “Declaration of Port-of-Spain: Uniting to stop the epidemic of CNCDs” was issued. The declaration expressed conviction that “the burdens of CNCDs can be reduced by comprehensive and integrated preventive and control strategies at the individual, family, community, national and regional levels and through collaborative programmes, partnerships and policies supported by the governments, private sectors, NGOs and our other social, regional and international partners.”

Against this background and as a direct outcome of, and response to, the Heads of Governments of CARICOM Summit, a Caribbean Civil society-led chronic disease conference was convened in Barbados, 16-18 October 2008, titled “Healthy Caribbean 2008 – A Wellness Revolution Conference”.

The local host organization of the conference was the Heart & Stroke Foundation of Barbados (HSFB), and co-sponsors were the Caribbean Development Bank (CDB), Pan American Health Organization (PAHO), InterAmerican Heart Foundation (IAHF) and the Barbados Ministry of Health–National Chronic Non-communicable Diseases Commission.

The conference achieved its specific objectives of the provision of a forum for a cross-section of representatives from various sectors of Caribbean society to learn about CNCDs and consider how best to tackle them, build capacity in important elements of civil society, identify and promote evidence-based best practices for addressing the CNCD epidemic in the Caribbean, strengthen capacity of civil society to monitor implementation of the Port-of-Spain Summit Declaration, and consider resource mobilization.

Foremost among the outputs of the conference was a declaration titled “Caribbean Civil Society Bridgetown Declaration: Tackling the Caribbean Epidemic of Chronic Diseases”, and a “Caribbean Civil Society Action Plan for Tackling Chronic Non-communicable Diseases: 2008-2011”, both of which are reproduced in this Technical Report of the conference which it is my pleasure to recognize is a production of the Chronic Disease Research Centre, UWI, Cave Hill, and represents the first report of its kind to be produced by that organization.

Finally, I would like to recognize all those several persons who contributed in one way or another to making this unique Caribbean civil society conference the tremendous success that it was, and in the words of Sir George Alleyne during closing remarks at the conference, “Let us now go forward clothed in the armour of social justice and armed with the sword of information to bring about a wellness revolution in the Caribbean” that results in a significant slowing of the epidemic of chronic non-communicable diseases.



Message from the Principal, Cave Hill Campus, UWI

Professor Sir Hilary Beckles

I wish to take this opportunity to congratulate the Chronic Disease Research Centre, The University of the West Indies, on the successful production of the Report of the Caribbean Chronic Disease Conference: “A Healthy Caribbean 2008 – A Wellness Revolution Conference”. This document is the department’s first Technical Report, and represents another contribution aimed at providing information to promote health and wellbeing.

The University has long been aware of the emerging challenge of the chronic non-communicable diseases in the region, and these are now the leading causes of ill health and death in our communities. The early recognition of this impending ‘tsunami’ of disease, as titled by Sir George Alleyne, underpinned the development of the CDRC by Professor Henry Fraser in the early 1990s. The department has gone from strength to strength and is now the flagship medical research department at the Cave Hill Campus, significantly contributing to essential national health research needs, policies and national disease surveillance through the Barbados National Registry for Chronic non-Communicable Disease.

As a regional institution, the UWI fully supports this civil societal response to the CNDCs. This technical report provides the permanent record that pioneering representatives of Caribbean Civil Society and related organizations created in order that they would positively impact the legacy that would be left for future Caribbean generations. They advanced the cause outlined by the Caribbean Heads of Government at the Port-of-Spain Summit on CNCDs, September 2007, by resolving to contribute actively at personal, community, organizational, national, regional and global levels, to avoid, delay and reverse the further development of CNCDs through defined strategies. History has shown us time and again, that it is only through such efforts where men and women unite around a common goal, can change be effected. I therefore wish to congratulate the visionaries and leaders of this enterprise. We, the university community, therefore wish to reiterate our commitment to ameliorating the challenges caused by the CNCDs to the region. There are already many facets to our involvement, and these include community outreach, education and health promotion, medical research, policy and clinical intervention as we collaborate with our compatriots in achieving the goal of improving the wellbeing of all Caribbean communities.

These civil society efforts are indeed very timely. The Faculty of Medical Sciences at the Cave Hill Campus pioneered preclinical training in 2008 with the intake of its first cohort. This broadens the commitment to train clinical graduates which has been in place for the past 40 years. We will therefore continue to produce well-trained graduates, highly competent and knowledgeable in preventing the CNCDs, and able to optimally treat such diseases and their complications when they exist. The challenges will be great, but we will work collaboratively to ensure the best outcomes for our region, and are delighted to partner with civil society in this regard.



Declaration



Caribbean Civil Society Bridgetown Declaration: Tackling The Caribbean Epidemic Of Chronic Diseases

Prepared by participants at the Healthy Caribbean 2008 Conference, 13 October 2008.

We, the undersigned representatives of Caribbean Civil Society and related organizations, on the occasion of a special Caribbean Civil Society led conference titled “Healthy Caribbean 2008 – a wellness revolution conference”, held on the 16-18 October, 2008, at Bridgetown, Barbados;

Recognizing that chronic non-communicable diseases (CNCDs), which include heart diseases, stroke, diabetes, cancer, and lung diseases, are occurring in epidemic proportions in all countries of the region, resulting in the majority of ill health, suffering and premature death, producing excessive financial and personal burden on the people of the region, and requiring urgent, comprehensive intervention;

Aware that the above situation has occurred as a result of the increase in several common risk factors for CNCDs in the region, and an inadequate societal response to risk factor management, screening, prevention of these conditions, and treatment of persons already affected;

Recognizing that prevention of disease and promotion of good health are both affordable and effective and would prevent much suffering for the people of the Caribbean;

Mindful of the fact that CNCDs may be prevented and even reversed in an environment supportive of healthy lifestyles, based on regular physical activity, healthy eating and weight control, avoidance of alcohol abuse, tobacco consumption and exposure to tobacco smoke;

Conscious that healthy living, which prevents or delays the development of the CNCDs, requires the independent and collaborative efforts and contributions of all sectors of society including corporate and civil society, the private sector, policy makers, community planners, educators, media, health care providers and administrators, among others;

Aware that there is substantial scientific evidence regarding the magnitude of the CNCD problem, its causes and solutions to inform our actions to reduce risk factors for CNCDs and improve the management of these diseases throughout the age spectrum;

Acknowledging that many circumstances of daily living provide opportunities to pursue healthy living including workplace, school, places of worship, the community and the home;

Sensitive to the fact that civil society has at its disposal a variety of useful tools to mobilize society and drive change, such as advocacy, coalition building, service delivery programmes, and resource mobilization that can be applied effectively to address the CNCDs epidemic;

Noting that civil society organizations have a strong record of providing services and public education, and have traditional linkages with people in the community that can be harnessed to effect behaviour change; and

Recognizing the significant leadership given by the Heads of Government of CARICOM countries as demonstrated at the Port-of-Spain Summit on CNCDs in September 2007 and the Summit Declaration “Uniting to Stop the Epidemic of Chronic Non-communicable Diseases,” which recognized the role of civil society, private sector, and other social actors and international partners.

We declare our commitment to contribute actively, at the personal, family, organization, community, national, regional and global levels, to avoid, delay and reverse the further development of CNCDs through the following:

1. Support fully the CARICOM Heads of Government Declaration of Port-of-Spain: “Uniting to stop the epidemic of CNCDs”;
2. Establish a Caribbean Civil Society coalition for tackling CNCDs in the areas of advocacy and coalition building, public education and media campaigns, provision of services, and monitoring and evaluation, before, or as soon as possible after the 31 December 2008; support existing country level networks/coalitions where they exist, and promote their development by June 2009, where they do not; and encourage the establishment of National Commissions for Chronic Non Communicable Diseases in all countries of the Caribbean;
3. Advocate for and participate actively in partnerships between civil society, government and the business/ corporate sector in developing and implementing strategies for preventing and managing CNCDs nationally and regionally;



4. Advocate for policies and strategic targeted programmes to prevent and control CNCDs and risk factors, mindful of gender, youth and issues affecting the elderly;
5. Promote physical activity through population based actions and policy change to create environments that facilitate physical activity among all sectors of the population, including effective spatial planning and design, guidelines, daily school physical education, workplace programmes, among others;
6. Promote healthier diets by encouraging the availability of affordable and nutritious foods, preferably locally grown, banning trans fats, reducing salt, harmful fats and sugar in Caribbean diets, establishing regional standards for food labeling and services, encouraging breast feeding, and protecting children and society's other vulnerable groups, through legislative, educational, health promotional and other measures;
7. Seek the full implementation of the Framework Convention on Tobacco Control (FCTC), following the recommendations of the Conferences of the Parties, in those countries that have ratified this treaty, and support ratification in those that have not;
8. Promote reduction in harmful alcohol use through updated legislation, policy change and user awareness campaigns;
9. Foster and lead sustained and well-targeted Caribbean wide public education and media campaigns, including annual Caribbean Wellness Day, to promote prevention, screening and treatment of CNCDs;
10. Strengthen screening, early diagnosis, counseling, treatment, and care for people living with CNCDs and their families, and support development of such initiatives where they do not exist, considering the need to provide continuing health education to health professionals and de-medicalizing healthcare and education where appropriate;
11. Hold governments accountable for implementing the Port-of-Spain Declaration by encouraging and publicizing the monitoring and evaluation of efforts and results towards the prevention and control of CNCDs as well as promoting collaboration on risk factor surveillance and other research approaches; and
12. Commit to continued recruitment of civil society signatory organizations to this Declaration in an effort to enhance its implementation, strengthening the efficacy of individual member organizations, and hosting a biennial meeting to monitor and carry forward commitments made in this declaration.





A full-page background image of a man and a woman running on a blue athletic track. The woman is on the left, wearing a black sleeveless top and black shorts, running towards the camera with a smile. The man is on the right, wearing a black tank top and black leggings, also running towards the camera. The track has white lane markings, and the background shows a clear blue sky with some clouds and trees in the distance.

Action Plan



Caribbean Civil Society Action Plan for Tackling Chronic Non-Communicable Diseases (CNCDs): 2008-2011

1. Introduction

This plan has been produced to assist the development and functioning of a Caribbean Civil society CNCD network/coalition and as a guide for action for tackling CNCDs by Caribbean civil society. It aims to complement and support activities and programmes in countries and civil society organizations throughout the region. It is a holistic integrated plan for the years 2008-2011 developed in a participative manner by the invitees and attendees of the Caribbean Civil Society led CNCD conference titled "Healthy Caribbean 2008 – A Wellness Revolution Conference", 16-18 October 2008.

The plan has as its frame of reference, and supports, the Heads of Government of CARICOM Declaration of Port-of-Spain "Uniting to Stop the Epidemic of Chronic Non-communicable diseases" with a commitment of civil society to take necessary action to foster the mandates of that declaration. The plan recognizes that there has been considerable activity, and several successful projects and programmes initiated and led by civil society organizations throughout the Caribbean, for the past many years and aims to add to, enhance and strengthen, and bring a regional dimension to these efforts.

The Action Plan recognizes the Caribbean Association of Industry and Commerce declaration from the regional private sector, in support of the Declaration of Heads of Government of CARICOM on CNCDs, and appreciates the initiatives of the Caribbean Business Community.

The common vision and guiding principles of the Civil Society Declaration for tackling CNCDs in the Caribbean arising out of the Healthy Caribbean 2008 Conference are translated in this plan into concrete action lines. These action lines will be as specific and as practical as feasible, realistic and achievable, time-bound, and measurable. They will provide clear definition of roles, and responsibilities, and the plan will specify mechanisms for improved co-ordination of the focus and work of the many NGOs that are involved in health programmes.

2. The scope of the challenge presented by the CNCDs

CNCDs, including heart disease, diabetes, cancer and

respiratory diseases, are the major causes of ill-health in the Caribbean, an epidemiologic pattern seen in many other regions of the world. As a result, heart disease, cancer and stroke were the three principal causes of death in the Caribbean, between 1980 and 2000, and continue to be the leading causes of mortality. Of particular relevance is the observation that CNCDs are relatively more prevalent in the Caribbean than in the rest of the Americas. Data from the Pan American Health Organization (PAHO) indicate that the countries with the highest frequencies of diabetes mellitus in the Americas (in descending order) are Barbados, Trinidad and Tobago, Jamaica and Belize, respectively. The prevalence rate of diabetes in Barbados is 16.4%.

The prevalence rates of hypertension are similar among the Caribbean countries and are significantly higher than rates in North America. The adverse impact of the CNCDs are particularly apparent in Trinidad and Tobago, where the rates for ischemic heart disease approach those of North America, while the age adjusted mortality rates for diabetes are 17 times higher than in the USA. Other diabetes-related complications also have significant clinical and public health relevance. There have been almost 1000 diabetes-related amputations at the Queen Elizabeth Hospital in Barbados over the past six years.

The overall mortality attributable to the CNCDs in the Caribbean is twice as great as deaths due to the communicable diseases and injuries combined. The toll in human suffering caused by the CNCDs diseases in the Caribbean is enormous.

2.1. The risk factors in the Caribbean

There are limited risk factor data available in the region. Smoking rates among youth aged 13 - 15 years range from 3.6% in Antigua and Barbuda to 14.7% in Belize. Among the adult populations available data indicate smoking rates in Trinidad and Tobago and St. Lucia (21.4% and 18.9%, respectively).

Unhealthy diet, high blood pressure, obesity, physical inactivity and tobacco use and exposure are the major modifiable risk factors contributing to the CNCDs. About one



quarter of the Caribbean adult population is hypertensive, with approximately 50% of adults aged 40 years and older affected. The Caribbean Food and Nutrition Institute estimated a decade and a half ago, that almost 60% of females and 25% of men were obese or overweight. Age is a key non-modifiable risk factor that increases risk of CNCDs, and Caribbean populations are living longer. The Caribbean now demonstrates one of the highest rates of increase of its older populations among the developing countries of the world, which will clearly have implications for the CNCD epidemic, including the ability of the health services to provide health care and public health policies.

2.2. Prevention and control of CNCDs

Any systematic approach to prevent CNCDs must be based on primary prevention - reduction of the risk factors which are responsible for these diseases.

"Small shifts throughout the range and accompanying reductions in the mean population levels of several risk factors are likely to be more effective in reducing the incidence of disease. We should also identify, target and manage people with elevated levels of those risk factors or people who meet diagnostic criteria for hypercholesterolemia, hypertension, obesity or diabetes". (Epidemiology and prevention of cardiovascular disease in elderly people. Report of a WHO Study Group WHO Technical Report Series 853.)

The most cost-effective intervention for preventing cardiovascular disease is the control of tobacco use and exposure. This implies increasing tobacco taxes, banning advertising by tobacco companies, banning smoking in public places, health promotion and education through effective graphic messages on tobacco packages, and assisting smokers in their efforts to quit. Healthy eating and active living, and prevention of alcohol abuse are other cornerstones of effective health promotion programmes.

2.3. Caribbean public policy and CNCDs

The process through which appropriate public policies have developed in the region is of considerable relevance. In 2001 the CARICOM Heads of Government at their meeting in Nassau, Bahamas, declared that the "Health of the region is the wealth of the region". They identified the non-communicable diseases and HIV/AIDS as health problems of significant concern and a Task Force established at the time, and which subsequently evolved into a Caribbean Commission on Health and Development, substantiated the critical importance of CNCDs and HIV/AIDS to the region's health. This commission later added violence and injuries as areas of concern, and recommended steps to be taken to address these problems.

2.4. The CARICOM Summit on CNCDs

The recommendations mentioned earlier were presented to the Heads of Government of Caribbean countries who later met in a Summit to discuss CNCDs in Port-of-Spain, Trinidad, on 15 September, 2007. This was a seminal meeting which was the first

such gathering in the world by national leaders who recognized the importance of combating CNCDs in the wellbeing of their nations. The Summit declaration was titled "Uniting to Stop the Epidemic of Chronic Non-communicable diseases", and recognized the role of civil society, the private sector and other social actors and international partners. The Declaration of that Summit encapsulated the approaches the Caribbean intended to take to address the problem of CNCDs primarily through reduction of risk factors such as tobacco exposure, unhealthy diets, physical inactivity, and alcohol abuse, and the enhanced management of people with CNCDs e.g. through improved identification and control of hypertension and diabetes.

There was agreement for clear timelines and outputs to be achieved by the Ministries of Health in collaboration with other sectors. A goal was to establish by mid-2008 comprehensive plans for the screening and management of the CNCDs so that by 2012, 80% of people with CNCDs would be receiving best practice quality care and have access to preventive education based on regional guidelines.

3. The role of civil society in tackling chronic diseases

Civil society is that sphere of voluntary associations and informal networks where individuals and groups engage in activities of public consequence. It includes voluntary associations, nongovernmental health organizations, churches, neighbourhood organizations, cooperatives, charities, unions, parties, social movements, special interest groups and families.

3.1. The task of civil society

Civil society has several different roles. In very general terms, the associations of civil society reinforce the spirit of collaboration so vital for public affairs and political associations. Through these associations citizens are imbued with an ethic of "self interest, rightly understood" in which an "enlightened regard for themselves constantly prompts them to assist one another and inclines them willingly to sacrifice a portion of their time and property to the welfare of the state".

Civil society traditionally and conventionally has, and uses, several tools at its disposal. These include advocacy, coalition building, leadership, contributing to public policy, education via public information and media campaigns, and agitating for legislative changes.

3.2. Audit of civil society in the Caribbean

The post independence period, that is, the past 5 decades, has seen a significant growth and expansion of civil society in the form of voluntary associations and informal networks in the Caribbean region. A brief review of the website of the World Association of NGOs (WANGO) shows that more than 400 associations in the Caribbean are members of WANGO, while several civil society organizations exist that are not members of WANGO.

Several civil society organizations, though not having a chronic



disease or specific health care emphasis as their prime objective, nevertheless, contribute to the health of their members and of the nation state.

There are presently at least some 40 nongovernmental health organizations with a particular emphasis on chronic disease and some of these have established networks for tackling a particular area of concern as for example has been done by the Caribbean Diabetes Association, and a Tobacco Control Caribbean Network led by the InterAmerican Heart Foundation, Heart Foundation of Jamaica and the Jamaica Coalition for Control of Tobacco.

3.3. Civil society's contribution to meeting the challenge of the CNCDs

Civil society associations in the Caribbean have been involved for the past several years in many activities aimed at slowing the epidemic of chronic disease and encouraging and fostering healthy lifestyles.

In Barbados, the Cancer Society is credited with having played a major role in the continuing low prevalence of cigarette smoking with levels of around 9% in 2009. The Nation Group, publishers of the Nation Newspaper, has for the past decade and more held a Annual Healthy Lifestyle Extravaganza; the Barbados Workers Union has been actively involved for many years in chronic diseases programmes; the Eastern Conference of Seventh Day Adventists has a longstanding and well deserved reputation for its programmes in chronic disease prevention; the Barbados Diabetes Association has many programmes and the Heart & Stroke Foundation of Barbados has for the past 25 years been very active in public education, advocacy, cardiovascular rehabilitation, and emergency care programmes.

In Jamaica outstanding leadership and initiatives have been taken in the field of chronic diseases by the University Diabetes Outreach Program, the Diabetes Association of Jamaica, the Heart Foundation of Jamaica and the Jamaica Cancer Society. The National Health Fund of Jamaica has also been instrumental in supporting many CNCD activities at the national level.

3.4. Civil society challenges in the Caribbean

Despite the appreciable contributions civil society has made and is making in the Caribbean in tackling CNCDs, many challenges remain that need to be met and overcome.

The associations of civil society need to be better informed both with respect to the challenge posed by the CNCDs and the best evidence based steps and actions that they can take to tackle them. Many CNCD civil society organizations lack a sound appreciation of the tools available to them and the most effective means of employing these tools. Thus many organizations allocate significant effort to risk and disease detection and treatment, and very little to effective advocacy aimed for example at policy change when the latter approach may be more cost effective and strategic than the former.

A further challenge arises from many chronic disease oriented nongovernmental organizations not being well established with

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sufficiently strong governance, legal and financial systems in place. These shortcomings, together with the absence of Caribbean networks of nongovernmental CNCD organizations, restrict these associations to exerting their influence at the community, but not at the national or regional level. Civil society CNCD related NGOs do not for the most part take part in decision making at the regional level.

A final challenge to civil society in the Caribbean is the apparent competition among civil society associations as they seek to advance their respective agendas and causes, often not mindful of the fact that they are likely to be more effective by joining with other associations having similar goals and objectives.

4. Objective and target

The objective of the Action Plan 2009-2010, is to develop and execute a coordinated approach to prevent and control the CNCDs in the Caribbean, building on the several programmes and projects presently being undertaken throughout the region.

The ultimate target is the reduction of death and disability from CNCDs in the region through better prevention, detection and management of CNCDs.

5. Action lines

5.1. Establishment of a Caribbean Civil Society CNCD Coalition/Network

5.1.1. Activity

Establishment of a network/coalition guided by a small regional Organizing Task Force of key partners, principally from civil society. This Organizing Task Force, as was determined by acclamation at the conclusion of the Healthy Caribbean 2008 Civil Society led CNCD Conference held in Barbados October 2008, is led by the co-ordinator of that conference and Chairman of the CNCD Commission, Barbados, and includes 2-4 civil society regional organization representatives, 1-3 national civil society organization representatives, one academic representative, one PAHO or CARICOM observer, and one national government observer.

The coalition/network will be a grouping of all civil society organizations in the Caribbean, at the national and regional levels, that commit to advance the prevention and management of Chronic Non-communicable Diseases (CNCDs) in their jurisdiction, within the parameters of the Declaration of Bridgetown of 18 October 2008 to be established.

The Caribbean civil society CNCD coalition/network will assist civil society, in partnership with government, private enterprise, academia, and international partners, to focus its power in developing and implementing appropriate plans for the prevention and management of CNCDs in the Caribbean.

5.1.2. Strategic partner/lead agency

The Organizing Task Force is expected to establish the Caribbean Civil Society CNCD Coalition/Network with the InterAmerican Heart Foundation playing a lead coordinating role in the development process.

5.1.3. Timeline

30 March 2009.

5.1.4. Budget/resources

US\$5,000.00 annually.

5.2. Advocacy

5.2.1. Activities

- (a) The primary activity of the coalition/network is one of advocacy, undertaken directly and through members of the coalition/network, and targeted at lobbying Caribbean Governments to take the kinds of actions and policy decisions related to chronic diseases that only Governments can take.
- (b) Determination of a mechanism and formula which provides for Civil Society to be a partner with other major Caribbean institutions, such as PAHO, CARICOM, Caribbean Governments, other regional policy making institutions and groupings, and academia, in determining and contributing to the way forward in tackling CNCDs.
- (c) Support and lobby for national and sub-regional policy dialogues to establish CNCD National Commissions or analogous bodies in countries throughout the region, with representation by civil society on all CNCD National Commissions.

5.2.2. Strategic partner/lead agency

The above activities are to be led by the Healthy Caribbean Coalition, and relevant civil society organizations within each country.

5.2.3. Timeline

- (a) Demonstrable tangible progress in achieving partnership by the middle of 2009.
- (b) National CNCD Commissions or comparable bodies established in all Caribbean countries by 31 December 2010.

5.2.4. Budget/resources

US\$10,000.00 annually.

5.3. Development of a communications strategy for and among the Healthy Caribbean CNCD Coalition/Network

5.3.1. Activities

- (a) Development and management of a Caribbean civil society CNCD website as a source of information, a resource and an instrument for activity sharing.
- (b) Promotion and dissemination of the Caribbean Civil Society led CNCD Action Plan, including the preparation of an abridged version for public distribution.
- (c) Preparation of a popular brochure-style version of the Declaration of Port-of-Spain and of the Civil Society Declaration of Bridgetown for Caribbean wide distribution.
- (d) Distribution of the Technical report of the Healthy Caribbean 2008 Conference to all stakeholders by 30 March 2009.
- (e) Approval and implementation of national civil society action plans, based on the regional action plan.



5.3.2. Strategic partner/lead agency

The Organizing Task Force will lead on these activities on behalf of the Healthy Caribbean Network, and they will be developed and implemented with the assistance of the member organizations of the network.

5.3.3. Timeline

- Communication activities will be on-going, with evidence,
- (i) that by the third quarter of 2009 activities 5.3.1 (a) – (d) have been achieved,
 - (ii) and 40% of member states by 2010, 75% by 2013, and all countries by 2015 have achieved activity 5.3.1 (e), that is, national strategic civil society led CNCD Action Plans established based on the Regional Action Plan.

5.3.4. Budget/resources

US\$150,000.00.

5.4. Healthy Caribbean CNCD Public Education Programme

5.4.1. Activity

Development and implementation of a civil society led Caribbean wide strategy to inform and motivate the public about activities such as promotion of good health (diet, physical activity, no tobacco exposure), best practice care and management of CNCDs (including high blood pressure and the need for its control), recommended screening schedules for CNCDs, and the creation of library of videos for patient education.

5.4.2. Strategic partner/lead agency

The Organizing Task Force will be responsible for executing this item.

5.4.3. Timeline

The strategy to be finalized by 28 March 2009 with implementation on or before 1 May 2009.





5.4.4. Budget/Resources

US\$75,000.00

5.5. Support for Caribbean Wellness Day

5.5.1. Activity

Contribution to the further development and wider implementation of Caribbean Wellness Day, by among other things, ensuring that civil society is well represented on planning and management committees in those countries that actively participate in Caribbean Wellness Day. At the same time support for Caribbean Wellness Day will take the form of encouraging all countries in the Caribbean to actively support Caribbean Wellness Day through the very active participation of civil society. Types of activities that will be encouraged include:

- (a) Population-based screening during Caribbean Wellness Month (September)
- (b) A community sponsored and conducted beach activity
- (c) A civil society sponsored hike
- (d) Sponsorship for free or subsidized health screening during September
- (e) Promotion of CNCD risk factor screening in schools, workplaces, faith-based organization, trade unions, retail outlets during Caribbean Wellness month (September)

5.5.2. Strategic partners/lead agencies

Caribbean Business Community (Caribbean Association of Industry and Commerce), non-governmental and civil societies within countries, policy makers and national CNCD Commissions.

5.5.3. Timeline

An ongoing activity. Civil society will play its part in meeting a target date for all Caribbean countries to participate in Caribbean Wellness Day, by the 12 September 2010.

5.5.4. Budget/resources

None required by the Healthy Caribbean Network.

5.6. Advocacy and support for CNCD risk factor reduction:

I. Tobacco control and implementation of FCTC

5.6.1. Activities

Advocate a legislative agenda for passage of the legal provisions related to the International Framework Convention on Tobacco Control; urge its immediate ratification in all States which have not already done so; and support the immediate enactment of legislation to eliminate smoking in public places, ban the sale, advertising and promotion of tobacco products to children, require effective graphic warning labels, and introduce such fiscal measures (e.g. increased taxes) as will reduce accessibility of tobacco.

Advocate that public revenue derived from tobacco, alcohol or other such products should be employed, inter alia for preventing

CNCDs, promoting health and supporting the work of National CNCD Commissions.

Launch a major regional media campaign to educate the public about the health risks of smoking, including the effects of second hand smoke.

Conduct a "Caribbean No Tobacco" FCTC conference with widest possible representation by Caribbean Civil Society.

5.6.2. Strategic partner/lead agency

Activities to be led by the Bloomberg Caribbean group in association with the leadership of the Healthy Caribbean CNCD Coalition/network, the National CNCD Commissions, national civil society organizations and PAHO.

5.6.3. Timeline

Advocacy, with governments,

- (a) to achieve FCTC laws enacted in 95% countries in the Caribbean by the year 2012
- (b) for rotating pictorial warnings on cigarette packages by the year 2010, for 100% smoke free spaces, starting with all government buildings, and
- (c) collaboration with private sector for 100% smoke free workplaces by 2012
- (d) Caribbean No Tobacco Conference to be held in the fourth quarter of 2009.

5.6.4. Budget/resource

US\$100,000.00

5.7. Advocacy and support for CNCD risk factor reduction:

II. Increased physical activity

5.7.1. Activities

Conduct a Caribbean civil society led physical activity conference aimed at further sharing information, and producing a Caribbean action plan for increased physical activity among people of the Caribbean.

Seek to establish a relation with Agita Mundo.

Advocate and play a practical role where possible in increasing levels of physical activity in settings such as schools and workplaces.

5.7.2. Strategic partner/lead agency

Trade unions, educators, physical activity organizations throughout the Caribbean, and the Faculty of Medical Sciences, Cave Hill Campus, UWI, Barbados.

5.7.3. Timeline

Aim for conference and formal relationships established by at least 3 Caribbean organizations with Agita Mundo by the end of the first quarter of 2009. Advocate for and contribute to an increased numbers of Caribbean people engaged in regular physical activity in safe settings over the next several years.

**5.7.4. Budget/resources**

US\$10,000.00

5.8. Advocacy and support for CNCD risk factor reduction:**III. Improved dietary intake including reduction of trans fats and salt****5.8.1. Activities**

Support for Caribbean Food and Nutrition Institute (CFNI), and mobilization of consumer organizations and others towards reduction and ultimately the elimination of trans fats from the diet of our citizens, including capacity for testing for trans fats, promoting greater use of indigenous agricultural products and foods by our populations; mandating the labeling of foods or such measures as are necessary to indicate their nutritional content through the establishment of the appropriate regional capability; and public education showing people how to read food labels and prepare favourite foods less 'harmfully'.

Support for faith-based and workplace wellness programmes, in partnership with health insurance companies, trade unions, consumer organizations and others, and mobilize consumer groups, unions and others to encourage food manufacturers and restaurateurs to reduce fat, sugar and salt in prepared and processed foods.

Advocacy for revised user-friendly food content labeling standards to facilitate "making the right choice, the easy choice".

Support for, and contribution to national population salt reduction programmes.

5.8.2. Strategic partner/lead agency

Organizing Task Force and the Healthy Caribbean Network, and National CNCD Commissions.

5.8.3. Timeline

The network of civil society organizations will seek to inform the Caribbean population of the importance of consuming healthy diets that include, elimination of trans fats, and the reduction of salt and sugar intake from the food supply at the earliest possible date.

National policy statements made and programmes started on population salt reduction in at least four Caribbean countries by the second quarter of 2010.

5.8.4. Budget/resources

US\$5,000.00 and resources of individual countries.

5.9. Advocacy and support for CNCD risk factor reduction:**IV. Enhanced identification and management of CNCDs****5.9.1. Activities**

Advocate and encourage the strengthening of the capacity and competencies of the health system for the integrated management of chronic diseases and their risk factors. To this end assist our Ministries of Health, in collaboration with other sectors, in establishing comprehensive plans for the screening and management of chronic diseases and risk factors so that people with CNCDs would receive

quality care and have access to preventive education based on regional guidelines. In particular assist where possible in:

1. Improved screening for chronic diseases and their risk factors, including community based blood pressure measurements
2. Dissemination and utilization of Clinical Guidelines for the management of CNCDs
3. Improving competencies in the health work force, including those in civil society (e.g. church and health NGOs) to appropriately and effectively manage chronic disease prevention and control
4. Management structure implemented to support effective delivery of chronic disease management programmes including developing partnerships with professional organizations and other key stakeholders
5. Improvement of access to quality care for chronic diseases
6. Screening for blood sugar, cholesterol, HIV and blood pressure in most workplaces and churches (guarantee confidential results)
7. Train physicians and health workers about the risk charts and promote risk factor screening (fasting blood sugar, cholesterol and HIV), blood pressure, weight and height in healthcare settings
8. Create a coalition of health NGOs and in collaboration with private physicians, training in the chronic care model, risk factor prevention and control
9. Develop and maintain patient support groups for specific diseases (e.g. cancer, diabetes, asthma) or processes (e.g. going to another island for radiotherapy), and for terminal and hospice care
10. Documentation, evaluation, and support of the in-service training of health workers, including those in health NGOs and faith-based services, in evidence-based quality primary care for patients with chronic diseases, especially in diabetes care. Curricula for health workers to include total risk approach for CVD prevention and control
11. Contribute to the implementation of comprehensive plans for the screening and management of chronic diseases and risk factors

5.9.2. Strategic partner/lead agency

Implementation of the above achieved through efforts led by National Chronic Non Communicable Disease Commissions with the support of the Caribbean CNCD coalition/network in partnership with PAHO, CFNI, and CHRC.

5.9.3. Timeline

The foregoing aimed at Caribbean civil society assisting wherever possible in countries of the region, to achieve the following goals as stated in the Declaration of the Heads of Government of CARICOM Summit on CNCDs, and elsewhere:

- (a) 80% of at risk populations screened by 2012
- (b) Integrated, evidence-based guidelines, protocols for prevention and control of chronic diseases implemented with ongoing audit in all countries by 2010
- (c) Updated curricula, continuous training programmes and QI (management of high blood pressure, diabetes risk approach) for 80% care providers implemented in all countries by 2012



- (d) Chronic Care Model implemented in 50% of health facilities (public, private and NGO) in 50% of member states by 2010, and in 80% of health facilities in 80% of countries by 2012
- (i) 50% patients trained in self management by 2010
- (ii) At least one quality of care improvement project / CMI applying CCM in each member state, by 2010
- (iii) Prevalence of raised blood pressure and blood glucose among adults aged 25–64 years determined in all countries by 2011.

5.9.4. Budget/resources

Regional and national agencies.

5.10. Support of initiatives, plans and programmes at country and organization levels

5.10.1. Activities

Conduct and maintain audit records of the CNCD related civil society organizations and their principle activities and programmes.

Identify possible human and financial resources to be made available to member NGOs of the network to allow them to be more effective both in their specific programmes and in contributing to the deliverables of this Action Plan.

Encourage CNCD Health NGOs to initiate certain specific projects that were highlighted at the Healthy Caribbean 2008 Conference, e.g. measurement of weight, height and blood pressure in barber shops, distribution of “CNCD health passports”, population salt reduction programmes, etc.

Support for the many significant CNCD reduction activities taking place, often as a result of the committed leadership of civil society organizations within country, wherever and whenever possible.

This support will specifically take the form of, but will not be restricted to:

- Provision of a forum for exposure on the Healthy Caribbean CNCD website of CNCD activities at the national and organization level.
- Assistance with advocacy efforts of country programmes.
- Assistance with identification and provision of regional and international experts at faculty level for conferences as needed
- Provision of resources to assist with enhanced governance of local CNCD relevant civil society organizations.
- Sourcing of funds to allow for local CNCD NGOs to make more effective contributions to the Action Plan

5.10.2. Strategic Partner/lead agency

This activity is to be executed by the Organizing Task Force and the Healthy Caribbean Network in collaboration with member organizations of the network.

5.10.3. Timeline

An ongoing activity.

5.10.4. Budget/resources

US\$20,000.00 for the first year with further funding to be sourced as and when needed.

6. Implementation of Action Plan: Follow up and evaluation

The Action Plan evolved out of the Healthy Caribbean 2008 Civil Society conference held in Barbados, 16-18 October 2008. It reflects the inputs and considerations of the participants of that conference. A major decision taken at the conference was the need for the establishment of a CNCD Caribbean civil society network/coalition, and the Conference Coordinator was mandated to establish such a Task Force which will take the necessary steps to complete and distribute the Action Plan and establish a Healthy Caribbean CNCD network. Principles and positions and decisions taken thus far are as follows;

The Healthy Caribbean CNCD will comprise a group of all civil society organizations in the Caribbean, at the national and regional levels, that commit to advance the prevention and management of Chronic Non-communicable Diseases (CNCDs) in their jurisdiction, within the parameters of the Declaration of Bridgetown of 18 October 2008.

Objective

To harness the power of civil society, in partnership with government, private enterprise, academia, and international partners, to develop and implement a plan for the prevention and management of CNCDs in the Caribbean.

Suggested organization

A regional, small, Organizing Task Force of key partners, principally from civil society, be set up to advance the completion of the plan and organize the coalition. Members of the task force will include a Chairman, 2-4 civil society regional organization representatives, 1-3 national civil society organization representatives, one academic representative, one PAHO observer, and one national government observer.

The proposed membership of the Organizing Task Force is:

Chair of Task Force

1. Prof. Trevor Hassell, Chairman of the National CNCD Commission, Barbados.

Representatives of regional civil society organizations

2. Dr Beatriz Champagne, Executive Director, InterAmerican Heart Foundation.
3. Mr Owen Bernard, Secretary of the Diabetes Association of the Caribbean
4. Representative of faith based organizations in the Caribbean
5. Representative of Caribbean Youth Ambassadors, CARICOM Secretariat, Guyana

Representative of national civil Society organizations

6. Mr Orlando “Gabby” Scott, Barbados Workers Union

Representative of academia

7. Prof. Paul Teelucksingh, UWI, St. Augustine Campus

**Special observer**

8. Dr Alafia Samuels

Government observer

9. James Fletcher, PhD, Director, Social and Sustainable development, OECS

Functions

1. The Organizing Task Force is responsible for completing, distributing for public review and comment, and disseminating the Action Plan and Declaration arising from the Healthy Caribbean 2008 Conference, and the establishment of a coalition aimed at tackling the CNCDs in the Caribbean.
2. The Organizing Task Force is responsible for planning, organization, capacity building, providing support to national and local coalitions, and liaising with the public to identify national and local needs.
3. National Coalitions, through their secretariat, are responsible for planning, organizing and implementing actions at the national level.
4. Secretariats at the regional and national level will facilitate activities and provide administrative support.

Next steps

1. Complete plan and declaration, with public input, and prepare and implement a dissemination plan.
2. Determine criteria for invitation to Coalition and invite potential members to join the Coalition.
3. Review situation in each country to determine how best to advance a national civil society coalition at the national level. This process may vary in each country but should involve public discussion wherever possible.
4. Identify a few actions to support exchange of information among coalition members (website, internet list, regular information e-mails).
5. Consider setting up working groups to advance specific actions. For example, the tobacco area may be managed by the Bloomberg team that is already set up to do this. Other groups may be set up for physical activity, diet and nutrition, healthcare or other areas.

Target audience of the plan

The target audience of the plan and the technical conference report will include first the conference participants and the organizations that they represented. A draft of plan will be made available to those civil society associations that were not present at the meeting and to the wider public and they will be invited to make comment and give inputs into the plan before it is finalized.

Additionally, major funding and sponsoring organizations and companies will be provided with copies of the Action Plan, and copies will be provided to heads of Government of CARICOM and other senior Caribbean stakeholders and leaders.

Finally, a summarized version of the Action Plan will be produced and made available to the wider public of the Caribbean.

Monitoring of the actions emanating from the plan

The title of this plan reflects the approach taken at the conference from which it arose, and emphasizes “one of action”. A mechanism will therefore be established to determine and monitor the achievables of the plan in the years after the conference, and a system will be set up for regular reporting to relevant civil society stakeholders on the outputs measured against the projections. The process will make use of surveys via email, sharing of information in the civil society network that will be established, and the provision of electronically available reports. A further meeting of Caribbean CNCD Civil society will take place in 2010 to assess progress, and the leaders of the Healthy Caribbean CNCD Network will meet regularly via teleconference with at least two face-to-face meetings over the next 18 months.

Funding, financing and governance

A major need in the implementation of several actions of the plan, at the regional, national or country, and organization level, will be the provision of funds projected at US\$375,000.00 for the first year. Potential sources of funding will need to be identified.

A specific need recognized during the conference was for the development and strengthening of the chronic diseases nongovernmental organizations in the region, since they are expected to lead the charge for civil society as this segment of Caribbean society seeks to play its role in tackling the CNCDs. Strengthening of the NGOs will require funding support, but equally important assistance with governance, human resource development etc.. This will require the commitment and assistance of all, both individuals and organizations who seek to slow the epidemic of CNCDs in the region.

Finally, consideration will need to be given as to methods that will allow the Caribbean civil society CNCD coalition/network, once established, to become a more structured and formal entity.



A full-page photograph of an older African American couple walking and laughing in a park. The man is on the left, wearing a light-colored short-sleeved button-down shirt and jeans. The woman is on the right, wearing a white t-shirt and jeans. They are both smiling broadly. The background is a sun-drenched park with trees and a path. A dark blue banner with white text is overlaid on the left side of the image.

Conference Proceedings



1. Feature Address by the Hon. David Thompson, MP, Prime Minister of Barbados

Thank you for inviting me, as the Prime Minister of Barbados and the Head of Government with lead responsibility for the establishment of the CARICOM Single Market and Economy, to welcome you to this Conference on Chronic Non-Communicable Diseases (CNCDs).

I understand the stakeholders ranging from the Pan American Health Organization, the Inter American Heart Foundation, CARICOM Governments and several Caribbean Non-Governmental Organizations have responded to the call to be here.

I also thank and congratulate our Heart and Stroke Foundation of Barbados Inc. for taking a leadership role in organizing this Conference. The Foundation has given 23 years of excellent service in highlighting the dangers that heart disease and other chronic non-communicable diseases pose to our development. This is a time bomb which has been ticking away for decades. Today, the Foundation's untiring efforts and the enormous sacrifices its members have made have been vindicated. The prevention and treatment of chronic non-communicable diseases placed at the top of the national and regional priority list. I salute the Foundation as an exemplary Non-Governmental Organization whose members recognize the need to give something back to their community.

I crave this Conference's indulgence to seize this opportunity to publicly thank the first President of the Heart and Stroke Foundation of Barbados, Professor Trevor Hassell and the second President "Dru" Symmonds - who has just retired after 13 years of sterling service. New President Dr Stephen Moe has two enormous sets of shoes to fill.

Let us not underestimate the importance of this Civil Society Conference. For me, it does two things. One is that it clearly demonstrates the need for Partnerships, particularly with organizations that embrace and represent the people. If we want to bring about lasting social change, we have to mobilize our people. And there is no better way to do this than to seek the participation and win the support of civil society organizations.

The second point is that it shows beyond a shadow of a doubt that the best means of bringing about regional integration is by mobilizing the people around common interests and common

threats – one of the biggest being the high incidence of Chronic Non-Communicable Diseases (CNCD's) such as obesity, hypertension, high blood pressure, diabetes, stroke, heart attack and cancer.

Heads of Government of CARICOM held a Special Summit in Trinidad last year. The statistics revealed before and during the Summit were shocking. Dr the Hon. Denzil Douglas, the Prime Minister of St. Kitts and Nevis, who has lead responsibility for Health in the Quasi-Cabinet of CARICOM Heads of Government, said that chronic diseases had become "the poor world's greatest health problem". He further revealed that the incidence of CNCDs in the Caribbean region was the highest in the Americas.

In 2005, according to figures from the World Health Organization, heart disease, cancer, diabetes, and other CNCDs accounted for over 60% of all deaths in the region, compared with 29.2% from infectious diseases, such as HIV/AIDS, and 9.3% from injuries. While the popular media were pre-occupied with violent deaths and the HIV/AIDS pandemic, CNCDs were becoming mass killers.

The economic implications of the CNCD pandemic are serious. Take for example the case of Barbados, which is showing patterns that are very similar to those in other CARICOM jurisdictions. In 2001 the prevalence of diabetes among adults was 16.4%. Total amputations at the Queen Elizabeth Hospital between 2002 and 2006 were 995 for diabetics and 230 for non-diabetics.

The estimated cost related to diabetes in Barbados in 2001 was US\$37.8 million and hypertension US\$72.7 million. These costs alone accounted to over 5% of the island's Gross Domestic Product. Interestingly, the incidence of diabetes in Haiti, the poorest country in the Western hemisphere was found to be 7.3%. The correlation between increases in CNCDs and rising standards of living seems to suggest that if left to chance, all the gains achieved by countries of the Caribbean during the march from poverty to relative affluence since Independence can be wiped out by CNCDs. The irony is that since all CNCDs are lifestyle diseases, they are preventable. They have a causal relationship to physical inactivity, unhealthy diet, tobacco use, alcohol abuse, stress.



There are two factors emerging from the study of this pandemic which should cause us concern. One is the growing incidence of CNCDS among children. The Heart and Stroke Foundation of Barbados has been reporting an increasing number of cases of stroke among children. Similarly, the incidence of obesity among children is highly visible on our streets. Most recently, Dr Colin Alert, the Team Doctor for the Commonwealth Youth Games sounded the alarm about CNCDS; even among young athletes. That is not news to me, because this startling revelation was made to me many years ago by my wife Mara, who trained and spent many years as Physical Education Teacher and Coach.

The second cause for concern is the close association between stress and CNCDS. People in high status jobs working to deadlines in an environment where failure is publicly visible are prone to stress. Who could these people be? Politicians, lawyers, Prime Ministers, and so on. It is for these reasons that the CARICOM Summit was called in an effort to stem the epidemic. After careful consideration of the data, the Heads of Government drew up a Declaration to guide future action in preventing and controlling CNCDS.

It was agreed that the best approach was to address the causal risk factors of unhealthy diets, physical inactivity, tobacco use and alcohol abuse and strengthening our health services. It was further agreed that the most effective response through the individual, family, community, national and regional levels and collaborative programmes, partnerships and policies supported by governments, private sectors, NGOs and other social, regional and international partners.

The Declaration was very clear on what has to be done and should be used as a guide to action. The checklist includes the establishment of National Commissions on CNCDS, a legislative agenda, the establishment by mid-2008 of comprehensive plans for the screening and management of chronic diseases and risk factors so that by 2012, the re-introduction of physical education in our schools, ensuring that schools promote programmes of healthy eating, promoting increased physical activity in the entire population and among others. This Declaration acknowledges that all stakeholders have a role to play in solving this social problem. It is essentially about Good Governance. Basically good governance is too important to be left exclusively to Government.

In Barbados, we had the foresight and the good fortune to create a unique mechanism for the voluntary and rational resolution of conflict in the production process. This requires Government, Employers and Workers' Representatives to sit down at regular intervals and rationally discuss pressing issues in an effort to reach consensus. I am referring to the Social Partnership which was established in the early 1990s. Since then, it has served the function not only of preventing industrial conflict, but also to offer a platform for the collective solution to a range of social problems and the joint pursuit of national objectives.

We have tried, on several occasions, to involve a wider cross-section of civil society organizations in the process but with limited success. Perhaps this Conference will succeed in getting larger

numbers of such organizations to participate in the efforts to prevent CNCDS from further ravaging the Caribbean.

In the meantime, I can assure you that my Government will continue to play a leadership role and create the conditions for the success of the regional response to the CNCDS pandemic. You will therefore be pleased to hear that Barbados has been a leader in setting the agenda for the management of CNCDS by being the first English-speaking Caribbean country to establish a National Commission for CNCDS. This Commission has been mandated to formulate sound policies and programmes to address these diseases, with emphasis on prevention. Out of the work of this Commission will come recommendations for legislation to tackle the threat posed by CNCDS.

The Government of Barbados is firmly committed to responding positively to all the other aspects of the Port-of-Spain Declaration. This was evidenced in a very tangible way, during the Financial and Budgetary Statement presented in June of this year, through the increase in taxes on tobacco products by 100% and the removal of duty free concessions. With respect to the promotion of physical activity, the Government of Barbados celebrated Caribbean Wellness Day on 13th September. Broad Street was closed to vehicular traffic and several public activities were conducted related to physical exercise, good nutrition and wellness. Multiple activities occurred in the same space at the same time, with an underlying theme of promoting healthy lifestyles. In keeping with our policy of participation, several stakeholders were present in an effort to create synergies. For example, the Ministry of Agriculture was there, admonishing people to eat locally grown healthy foods. Naturally this would give Barbadian farmers a comparative advantage and give a boost to agriculture. Similarly, the Ministry of Sports was there because of the logical spin-offs for sports. This is in keeping with our Manifesto promise to make sports available to all Barbadians.

It was made abundantly clear that this was not just a one-off event. Participants were encouraged to get involved in or create continuous programmes of physical activities. Tentative plans for a "Barbados Wellness Day at the Beach" were revealed. This event is part of a strategy to draw attention to the fact that Barbados has more sea than land, and that we cannot afford to continue living in fear of this resource or ignoring it. If we continue to treat our maritime environment in this way we would be encouraging pollution and condemning dozens of young people to death each year simply because they never learned to swim. Moreover, I believe that it is only when we become aware of the Caribbean Sea as a bridge and not a barrier that true regional integration will begin. I feel very strongly about this. We must teach our people to appreciate the Caribbean Sea as an extension of our small islands and the gateway to our future.

The first step in this direction is to understand that spending time at the beach swimming – once we can get to it – is good for our personal health. There is also the need for private sector organizations to make a direct contribution to the campaign for developing healthy lifestyles among their workers. People spend most of their waking hours at work. Enlightened employers in the developed countries of the world are renowned for meeting the health



needs of their employees at the workplace. Gymnasias and other recreational facilities are often provided. Companies like Cadbury's in the UK and most Japanese conglomerates readily come to mind. Quality inputs into the human resources at the workplace invariably result in improved outputs. However, I am convinced that the people of Barbados and the other member states of the Caribbean are best empowered to solve their own problems through Civil Society Organizations.

I know, from bitter experience as a founder member of several community-based organizations, including "Families First", that voluntary community organizations are less effective and less efficient than expected, simply because of their isolation from the corridors of power.

Despite having the best intentions, they just have not got the capacity to deliver. Communities throughout the region are littered with the bones of voluntary organizations that emerged with idealistic zeal but soon wither and die for lack of resources. If Civil Society Organizations are to succeed and bring to the attention of Governments, the needs of vulnerable groups and the new needs of categories of people like returning nationals or those who have taken early retirement, then they must be fully resourced and have a direct channel of communication with Government.

I believe that this response to the CNCD pandemic runs the risk of failure unless Civil Society Organizations throughout the region are empowered. This is the challenge I want to lay down to my counterpart political leaders across the region. In Barbados we have agonized over this challenge, particularly during the long years when my Party was in the political wilderness. Hence we are currently experimenting with Constituency Councils as a means of addressing the issue of empowering people in communities. If you consider constituencies as comparable collections of actual or potential communities, then you can see why we are focussing on constituencies and not communities or parishes. Government is committed to establishing a Constituency Council in each of the 30 constituencies in Barbados. Members of these Councils will be drawn from local community organizations. Representation will be provided for (i) Faith Based Organizations; (ii) Political Parties with representation in the House of Assembly; (iii) Emergency Management Organizations; (iv) Youth Organizations; (v) Sports Organizations; (vi) Seniors Clubs/Retired Persons' Organizations; (vii) Women's Organizations; (viii) Men's Organizations; (ix) Recognized Community Leaders. These Constituency Councils will act as the link between Government and the people by offering a channel of communication between the people and Parliament. Along this two-way channel will flow information and other resources necessary for solving problems at the level at which they emerge including how best to respond to the CNCD pandemic.

I sincerely hope that the Action Plan which you draw up during this Conference will lead to the Wellness Revolution that is so desperately needed in the Caribbean. I wish you well in your deliberations and I look forward to the outputs from this Conference.

I hereby formally declare this Conference Open.

The estimated
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US\$72.7 million.



2. The InterAmerican Heart Foundation Science of Peace Award and Lecture “Peace, Pandemics and Pluralism”

Sir George AO Alleyne, Chancellor, University of the West Indies.

First I wish to thank the Inter-American Heart Foundation, President Schuleib and particularly my colleague, Professor Trevor Hassell for the double honour bestowed on me. You have seen fit to honour me with your prestigious Science of Peace Award and in addition have given me the opportunity to share my thoughts with you on an area of concern that is assuming greater and greater global significance as the years pass.

It gives me special pleasure to be honoured by an Inter-American institution as personal experience has led me to believe in and recognize the capacity of the countries and peoples of the Americas and their institutions to do great things when they collaborate among themselves. Over the centuries, in spite of the many variations on the theme, the vision of there being something special that binds together the peoples of this continent has always burned brightly. The fact of geographical contiguity is one of the bases for the concept of pan Americanism, while another has been the vestige of the romantic idea of Bolivar's grand American patria. This notion of a pan American ideal is one that increases in salience and relevance as the institutions that bear the name American grow and prosper to the benefit of the people of the Americas.

We in the Caribbean are proud of our American linkages and the role we play in the inter-American institutions. We also say, somewhat facetiously that we are responsible for the integrity of the continent as this chain of countries, stretching from Belize to Suriname can be regarded as that crucial lateral ligament of the major joint of the system.

The InterAmerican Heart Foundation is a child of that pan Americanism. Sixty years ago, at the same time the World Health Organization (WHO) was founded, the American Heart Association became a volunteer-led organization that united American efforts against cardiovascular disease. It was 46 years later that participants from 12 countries of the Americas met and formed the InterAmerican Heart Foundation with a mission that was as noble then as it is now-“to reduce disability and death from cardiovascular disease and stroke in the Americas”.

It pleases me enormously to see health workers concerned

about peace and the means to establish it. But let us not forget that after all Imhotep, recognized as the father of medicine was also known as the “Prince of Peace”. I also welcome an Inter-American institution's concern for peace, although this continent is now free from the wars and rumours of wars that consume many other parts of the world. However, in the decade of the eighties when much of Central America was convulsed by armed conflict, the notion of health as a bridge for peace and the programmatic efforts to sustain it occupied much of the work of the Pan American Health Organization.¹

This Award is dedicated to the science of peace and when I received the announcement, I reflected as to whether there is indeed some science, some corpus of knowledge that can contribute to peace. I have decided to explore that corpus and attempt to show that the concern for health is very relevant to there being peace and understanding and there is some knowledge to be gained from examining how different forms of societal organization contribute to the success of our efforts to secure health and peace.

This lecture honours the lives and work of two cardiologists Dr Paul Dudley White and Dr Rene Favorolo who were outstanding not only for their technical skills, but for their appreciation of the societal influences on heart disease, their social consciences and their persistent promotion of peace in our time.² Paul Dudley White – I have never heard reference to him by anything but his full name – was regarded as the doyen of cardiologists in his day and his textbook “Heart Disease” is a classic.³ He was the physician of the menial as well as of the mighty. He was President Eisenhower's cardiologist and perhaps he exceeded the bounds of medical advice in trying to persuade the President that physicians could be a powerful force in promoting peace. Their contribution would be through advocacy to those in power, especially those to whom they had access by virtue of their profession. They would be in an excellent position to draw in starkest form the pictures of the human suffering caused by war.

But Dr White was not very successful and after one of his visits, President Eisenhower wrote this letter.

"Dear Dr White:

*I have tried to test out my friends as frequently and thoroughly as I could on the idea we discussed on the sun porch at Gettysburg. It is astonishing how universally they have rejected the idea that an individual, no matter how well known in the world, could be reasonably effective in the promotion of a peace based on understanding, unless operating from an official position of great power. This point came up for discussion last evening with a group of my closest associates in the government and the conclusions were unanimous along the line I have indicated. Nevertheless, I am not completely convinced."*⁴

Dr White must have rejoiced in his grave when another Boston colleague of his, Dr Bernard Lown along with the Russian physician Dr Yevgeny Chazov received the Nobel Peace Prize in 1985 on behalf of the International Physicians for the Prevention of Nuclear War. He would have liked Dr Lown's peroration:

*"May we learn from the barbaric and bloody deeds of the twentieth century and bestow the gift of peace to the next millennium. Perhaps in that way we shall redeem some measure of respect from generations yet to come. Having achieved peace, in the sonorous phrase of Martin Luther King spoken here twenty-one years ago, human beings will then 'rise to the majestic heights of moral maturity'."*⁵

Nuclear war was avoided and with the end of the Cold War there was the hope that we would have arrived at that almost Utopian state of universal peace and prosperity. I even entertained a rather naïve notion about peace and prosperity on the fiftieth anniversary of the founding of the United Nations when there was optimism that at last the swords would be turned into ploughshares, since nations now had no reason for confrontation that could lead to war. I speculated that since

there was no need for war as the theatre in which they could play out the basic need of mankind to struggle, then perhaps that drive to struggle which Plato says is derived from the thymotic part of our souls could be directed toward a noble cause that would unite and not divide the peoples of the earth. Obviously my suggestion was that the combined efforts of nations could be directed to ensuring that the world's health inequities be reduced or eliminated.

But indeed, the end of the World War did see major efforts at creating and nurturing a culture of peace, particularly in the United Nations Scientific and Cultural Organization (UNESCO). UNESCO's constitution echoed the Dutch philosopher Spinoza in its concept of peace. UNESCO's constitution states "since wars begin in the minds of men, it is in the minds of men that the defense of peace must be constructed",⁶ and almost 400 years ago Baruch Spinoza had written:

*"Peace is not an absence of war; it is a virtue, a state of mind, a disposition for benevolence, confidence, and justice"*⁷

It is the notion of peace being related to justice, particularly social justice, which engages physicians and all health workers; it is the notion that it is possible to change the minds of men and women to address some of the more egregious manifestation of social injustice that must have energized Drs. White and Favorolo. It is not disciplinary bias which makes us claim that much of the world's disease is a manifestation of social injustice.

There is social injustice in the causation of much ill health; there is social injustice in the inequality of access to measures of prevention and treatment of disease. This was recognized by the famous German physician Rudolf Virchow 160 years ago when he pointed out that the cause of an epidemic lay in the social conditions of the people.⁸ It was the social injustice combined with the poor living conditions, including ill health and disease that detonated the Caribbean riots 70 years ago. The essence of the relation of this social injustice to health has been



captured brilliantly by the recent Report of the Commission on Social Determinants of Health which makes the bold statement that “social justice is a matter of life and death”.⁹ This surely brings back memories of the work of Paul Dudley White. The relation of social gradients to heart disease has been one of the seminal contributions of the Chair of the Commission, Sir Michael Marmot.¹⁰

Much of the interest in disease as related to social injustice and poverty has centered traditionally on the infectious diseases, as most of the developing world was stuck for a long time at the stage of pestilence and famine according to the divisions in the health or epidemiologic transition. But the situation is changing rapidly, as the chronic non-communicable diseases (NCDs) are assuming ever greater significance in all parts of the world and the efforts to prevent and treat them constitute one of the major development challenges of this century. WHO has pointed out that in 2005 there were 35 million deaths from NCDs, a figure which represented 60% of all deaths globally and 80% of these deaths occurred in low and middle income countries.¹¹ The latter category will include all of the Caribbean countries except Haiti. The cardiovascular diseases of heart disease, stroke, hypertension and diabetes make up the major fraction of the NCDs. Indeed they represent a genuine pandemic which is spreading rapidly as WHO projects a 17% increase in the deaths due to NCDs over the next 10 years.

Data from 23 countries responsible for 80% of the burden of NCDs in low and middle income countries were analyzed recently. By 2030 these diseases will account for 71% of all deaths, 53 % of deaths in persons younger than 70 years of age and 59 percent of the total burden of disease as measured by Disability Adjusted Life Years.¹² The fixation on other diseases in developing countries that contributes to a certain myopia as regards the NCDs is shown in a recent study from India which begins thus:¹³

Every year in India, complications during childbirth kill 100,000 women; tuberculosis kills 364,000 people; and pneumonia, diarrheal disease and other infections kill more than 2 million children. But none of these tops the list. Surprisingly the leading cause of death in India is an ailment generally associated with wealthy developed countries: heart disease. It kills 3 million people in India every year—a third of the country's total deaths.

This is a situation which I am sure is repeated in much of the developing world. In 2005 there were 4.8 million deaths from the NCDs in the Americas and it is estimated that over the succeeding 10 years 53 million will die from these diseases. We must ask Bob Marley's question:

How many more will have to suffer, how many more will have to die?

The situation of the pandemic in the Caribbean has been well described during this conference so I will summarize it briefly for

those who did not attend the scientific sessions.¹⁴ Of all the regions in the Americas, the Caribbean is the worst affected by the epidemic of NCDs. Heart disease is the number one killer of our citizens and the potential years of life lost from the chronic diseases are greater than those attributable to AIDS or injuries and violence. The prevalence of hypertension and diabetes is increasing to the extent where the age adjusted mortality rates for diabetes, at least in the larger Caribbean countries, are higher than those seen in North America. Caribbean countries occupy the first 4 places among the countries of the Americas in terms of prevalence of diabetes among adults.

It must be stressed over and over that these diseases are not restricted to the rich, but are increasingly of concern for the poor. There is good evidence that the poor suffer more, they have less access to the services needed to treat them and when the diseases do strike the poor with limited savings they are more likely to be thrust into poverty or struggle helplessly to escape from the poverty trap.¹⁵ The Caribbean does not see the grinding poverty that affects some other parts of the world, but there are significant numbers of the poor among us and there is evidence that income inequality which has repercussions in disease and ill health is actually increasing in several places. No country can afford to neglect this pandemic.

The risk factors are very clear and are practically the same all over the world. We know that this pandemic is fuelled by tobacco use, unhealthy diet and lack of physical activity and the cost effective interventions to address them have been well described.¹⁶ There is no mystery about the fact that 80 percent of premature deaths from heart disease, stroke and diabetes could be prevented through a healthy diet, regular physical activity and avoidance of tobacco products. We can project that a 2% annual reduction in chronic disease death rates over and above existing trends during the next 10 years would save 5 million lives in the Americas and over 2 million of these would be younger than 70 years. Obesity as a result of the combination of diet and lack of physical activity is especially troublesome. Approximately two thirds of males and females in the Americas are overweight and this figure is rising steadily in all age groups with the concomitant increase in diabetes.¹⁷⁻¹⁹ It is also now more and more common to see diabetes in children as a result of obesity.

There is no doubt that the NCDs represent a global pandemic and as is the case with most pandemics, the solution has to be a global one. In the case of pandemics that arise from infectious agents the solution lies in actions that are taken collectively. In the case of this pandemic, the solution lies in actions to be taken both collectively as well as universally. Many if not all of the global conquests of disease have started with well organized regional or sub regional collective initiatives. The Caribbean region was the first in the world to call for and succeed in the elimination of measles. Success in the Olympics is not the only lesson the Caribbean can give to the world, so let us examine the approach being taken or which must be taken in the Caribbean and its relevance to the regional and global solutions.

First, two aspects of an approach have become clear to us in the

Caribbean. Focusing attention only on the individual and his or her behaviour is necessary but not sufficient and there has to be modification of the enabling environment to facilitate that change. It is pointless enjoining citizens to walk more when there are no spaces in which they can walk or their personal safety is in jeopardy from violence if they venture out of their houses. It is pointless advising children about healthy diets and the need for exercise, when school vending machines promote the sale of sodas and physical activity gets short shrift in the formal curriculum.

Over the past few years I have become increasingly disenchanted with the standard reference to the chronic NCDs as life-style diseases and I would like to encourage the Inter American Heart Foundation to join me in arguing for removing that term as a descriptor for the NCDs. The very use of the expression gives the impression that all that is necessary is for the individual to assume some responsibility, without any consideration for those factors that predispose him or her to adopting the risk factors. I am not advocating a nanny-state in which all aspects of the individual's behaviour are ordered and regulated with the full power of the government available to ensure enforcement. What I am calling for is a more overt recognition of the reality of the forces that lead to adoption of the contributing risk factors. Indeed, if the accent is put exclusively on individual behaviour, then there must be few diseases which are not the product of the individual's way of life. So let us just say chronic non-communicable diseases. I am not proposing that the individual should be relieved of any responsibility, but I am emphatic that there has to be a major shift in emphasis and I propose that we begin here and now. Life styles, yes; lifestyle diseases, no!

Second, any successful approach to a change in the enabling environment has to involve all of the social partners and I use this expression deliberately rather than making the traditional call for inter-sectoral action. It is in this context that I refer to the growth of pluralism in global as well as local health matters. It is a pluralist approach that must be a feature of the new phenomenon of global health and it is a pluralist approach that is ideal for addressing the pandemic of NCDs at the population level.

We are observing a growing attention to pluralism in all spheres of activity. In the field of international relations it has become clear that the unique focus on the nation state as the sole negotiator in affairs of international concern is no longer tenable. In his book on the Post American World, Fareed Zakaria describes a situation in which it is not that the United States is faltering to the level of crisis economically and otherwise, but the other nations of the world are just progressing faster.^{20,21} He points out that the hegemony exercised by Britain and the USA for almost 200 years no longer exists, so the solution of the major global problems has to be based on dialogue between and among many states and here is a change with profound implications. The preeminence of the post Westphalian state and its identity with the constituted government is waning. There are now major non-government state actors who claim legitimacy in discussions and decisions that affect the lives and well being of citizens. There must be robust inter and intra-national pluralism.

The major actors in the pluralist state are the government itself, the private for profit sector, the private philanthropic sector, civil society, the media and the trade unions or organized labor. The duly constituted government has responsibility to provide the sanitary and social measures necessary to preserve the health of its citizens, as the American Declaration on the Rights and Duties of Man states. It must do this by employing the instruments it has at its disposal and which only the government can wield-legislation, regulation and taxation. No country or group of countries will tackle the pandemic successfully without judicious use of these instruments by governments. I have hope that opinion on government regulation and oversight will change soon and rapidly. In our love affair with the autonomy of the market we have tended to forget that even Adam Smith saw the need for government to play a critical role. In a pungent and perhaps prophetic comment the Economist wrote the following in 1776.

"Mr Smith's intellectual heirs may be less judicious than he is in seeking to keep government and the market in harmonious balance".²²

There are critical roles for the other major actors as well. The private sector must see itself as a partner and I believe that its most effective participation is through three mechanisms. First, in collaboration with organized labor it can focus on the work place as a locus for programme promotion. Thus the private sector should discourage or prohibit smoking in the workplace. Second as a good corporate citizen it can contribute with resources to the national plan. Finally it can contribute with the skills such as marketing and branding that are fundamental for the change of public opinion needed to alter the enabling environment. Let us not forget the wisdom of Abraham Lincoln who said;

"Public sentiment is everything. With public sentiment nothing can fail; without it, nothing can succeed".²³

In looking for examples of radical change in attitudes, I have been attracted to initiatives such as the Illinois methamphetamine programme which through brutally explicit and carefully researched advertising and marketing has changed the popular perception of methamphetamine use. The public sector in collaboration with the private sector, civil society and the media can make it socially undesirable to smoke or to be obese for example. This combination can be a major influence in changing the popular perception of obesity and is likely to be far more effective than pious exhortations to lose weight. To those who prate that it cannot be done, I invite them to look at the styles of dress being adopted by our youth-styles that are derived from the informational imperialism which rarely seems to be the purveyor of images and practices that make for our social progress. Fundamental cultural change is possible. But let me be clear about the relative roles of the social partners. Maximum effect will be achieved when the various actors work in concert and being



an advocate does not automatically mean being an opponent. Pluralism does not of necessity breed antagonism.

The term web would have conjured up images of a spider to Drs White or Faviolo and they would have been unaware of the power of the internet and the new information moguls. It is to them that I am also looking for help in changing the environment to stem the pandemic of chronic diseases. It is on the internet and the immense possibility of developments in fields such as social networking that I am pinning much hope. The internet has to be the most revolutionary development of our time. It must rank with the stirrup, the plough and gunpowder as agents of change. The speed and facility of its interconnectedness drives globalization ever faster, transforming the very belief systems that sustain societies.

The attention to pluralism within the state does not diminish the need for inter-sectoral action within the public sector. Thus, there has to be cooperation among education, health, agriculture and several other parts of the public sector if the risk factors that lead to NCDs are to be addressed conclusively. The education sector will be responsible for the programmes in schools that inculcate into children the practice of eating right, weighing right and exercising right. It was salutary to see the Caribbean Ministers of Agriculture

acknowledge their responsibility in addressing the problem of the quantity and quality of food made available to in the region.

The major effort at a collaborative approach that the Caribbean governments have adopted is a fine example of international pluralism. You have heard of the historic Summit of CARICOM Heads of Government which issued the Port-of-Spain Declaration that incorporated 15 policy elements that must be addressed in order to reduce the burden of the NCDs.²⁴ Indeed, that Declaration calls emphatically on the social actors to play their parts in addressing the pandemic. The emphasis on and the active participation of civil society in this conference augurs well for the prevention and control of these diseases. It was gratifying to see that the decision of the Summit to establish the second Saturday in September as Caribbean Wellness Day has been so well received throughout the Caribbean. I hope that this example of elevating consideration of this pandemic to the level of Heads of Government will have echo in other parts of the world.

But it is not only political pluralism that is needed. There must be disciplinary pluralism as well, a pluralism that is often referred to as a multidisciplinary or interdisciplinary approach. CP Snow lamented the schism between the two cultures—arts and the sciences although even now they have become further subdivided.²⁵ The really major problems of our time are resistant to the disciplinary reductionism that has characterized many efforts inside and outside of academia. We will understand the basic causes of the NCDs as well as the possible solutions at the individual and population level when many different disciplines become involved and the contributions of the engineers, the molecular biologists, the economists, the politician and yes the physicians are invited and respected. Contributions from several disciplines have now shown us that stress will lead to changes in markers of inflammation and changes in the control of chromosomal integrity which are associated with the occurrence of the NCDs.

Ladies and gentlemen, will there be peace in our time? I doubt it. I fear that Jeffrey Sachs is correct in saying:

"The seemingly soft issues of the environment, public health, population growth and extreme poverty will become the hard issues of geopolitics in coming years. Indeed these issues will become the key determinants of war and peace" ²¹

Many of these issues are very much with us today. I will add that the social injustice that is inimical to peace has an expression in ill health and it can be reduced by addressing the causes of that ill health. Much of the ill health that will be upon the people will be in the nature of the chronic diseases and I also posit that our approach to their prevention and treatment has its best hope in the pluralism that will be increasingly the way in which we organize major societal efforts.

There may indeed be a science of peace!





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3. Outline Of Conference And Technical Report Procedure

The conference included three discussion formats: individual presentations, workshops and small group discussions. The Chronic Disease Research Centre (CDRC) was responsible for recording the conference proceedings. For each small group discussion and workshop, hand-written notes were collected from designated scribes. In addition, all individual presentations and plenary sessions were audio-recorded, most were video-recorded and all power point presentations were collected from presenters. The different discussion formats are reported in this report as outlined below.

3.1. Individual presentations

There were 18 individual presentations on a range on chronic disease topics, and a short summary of each presentation is given. Some presenters wrote their summaries and are listed as the summary authors. If no author is listed, the summary was compiled by the report editors from recorded conference proceedings.

3.2. Workshops

On the first day of the conference, there were three concurrent workshops on Advocacy and Coalition Building, Public Education and Media Campaigns, and Monitoring and Evaluation, each

comprising about 30 participants. The workshops were repeated that afternoon with new participants. Each workshop had two leaders, who provided written summary reports along with their presentations (where applicable). Notes taken during all six workshops, and the leaders' summary notes, are presented in this report.

3.3. Small group discussions

On each day of the conference, there were one or more small group discussion sessions involving about 10 groups, followed by a plenary session summarizing their findings. Written summaries of each group's discussion, along with editorial notes from the plenary, are provided.

3.4. Acknowledgements

The CDRC Editorial Team thanks Dr Tracey Carmichael, Ms Celia Greaves, Dr Selvi Jeyaseelan, Dr Kim Quimby, Dr Nastassia Rambarran, and Dr Lynda Williams for their hard work and professionalism involved in taking notes and recording the proceedings on the conference days. We also gratefully acknowledge Ms Stephanie McConney and Ms Karen Greene for secretarial support in preparing the typed report.



4. Summaries Of All Presentations, Workshops And Discussions

	Thursday 16 Oct	Friday 17 Oct	Saturday 18 Oct
08h30	4.1. Introduction	4.3. Strategic risk factor priorities	4.4 The disease management challenge
	4.1.1. Welcome & outline	4.3.1. Topic 1: Nutrition & diet	4.4.1. Diabetes prevention proposal
	4.1.2. Caribbean CNCD epidemic	(a) Caribbean dietary challenge	4.4.2. Hypertension & heart disease prevention proposal
	4.1.3. Civil society as agent for change	(b) Civil society's role in obesity control	4.4.3. Cancer prevention proposal
	4.1.4. Introduction to workshops	4.3.2. Topic 2: Physical activity	4.4.4. Lung disease prevention proposal
		(a) Wellness revolution	4.4.5. Question & answer session
		(b) Promoting physical activity	4.4.6. Review of presented proposals from Caribbean perspective (mixed group table work)
10h30	Concurrent workshops		
	4.1.5. Workshop 1: Advocacy & coalition building	4.3.3. Topic 3: Tobacco	4.4.7. Plenary discussion: Caribbean plan for CNCD management
	4.1.6. Workshop 2: Public education & media campaigns	(a) Strategic risk factors	4.4.8. Presentation of the 5th InterAmerican Journalism Contest Awards on Tobacco Control
		(b) Caribbean tobacco control	4.5. Partners in change: towards 2012
	4.1.7. Workshop 3: Monitoring & Evaluation	(c) Question & answer session	4.5.1. First Caribbean Wellness Day
12h00	Repeat workshops		4.5.2. Workshop report: Mobilizing private sector response
13h00	REPEAT Workshop 1	4.3.4. Introduction to small group work (by country) Country group work	4.5.3. Bloomberg: Graphic smoking warnings
	REPEAT Workshop 2		4.5.4. Question & answer session
	REPEAT Workshop 3		4.5.5. Regional CNCD surveillance system
14h30	4.2. Tools for a Wellness Revolution		4.5.6. Duke University and the Caribbean CNCDs
15h00	4.2.1. Introduction to small groups: Civil society and its toolkit	4.3.5. Plenary discussion: Report from country groups	4.5.7. PwC/Health Research Institute
	4.2.2. Plenary discussion: Report from small group work	4.3.6. Workshops on risk factor priorities	4.6. Civil society – meeting the challenge 4.6.1. What was heard
		4.3.7. Plenary summation: reports from risk factor workshops	4.6.2. Platform Working Group presentation 4.6.3. Closing comments
			4.6.4. Reflections on the way forward 4.6.5. Words of thanks
17h00	END	END	END



4.1. Part one: Introduction

4.1.1. Welcome and outline of conference programme, purpose and objectives

Chairperson: Trevor Hassell, Conference Co-ordinator

The purpose of this conference is to bring together a wide spectrum of CARICOM partners to plan civil society's response to the CNCD pandemic. Approximately 120 persons are registered to attend with participants from 16 Caribbean countries, spanning 19 disciplines. The main goal of the conference is to engage civil society to support the implementation of the "Heads of Government of CARICOM Port-of-Spain Declaration: Uniting to stop the epidemic of NCDs". This will be achieved through production of a Caribbean civil society declaration on CNCDs and by identification of priorities for development of a civil society action plan to combat these diseases. Specific objectives include provision of a forum for a cross-section of different sectors of society to learn about chronic diseases and consider ways to tackle them; identification and promotion of evidence-based best practice for addressing the Caribbean CNCD epidemic; and strengthening the capacity of Caribbean civil society to monitor the epidemic. The expected outcomes from this conference are (1) the Caribbean Civil Society Declaration; (2) the Caribbean Civil Society Action Plan to combat CNCDs for 2008-2012; (3) a conference report produced as a technical report by CDCR; (4) in collaboration with CaribVision, a broadcast of the conference for distribution in 2009; (5) the InterAmerican Heart Foundation's (IAHF) Science of Peace Award and Lecture by Sir George Alleyne; and (6) the 5th IAHF Journalism contest awards for tobacco control.

The agenda for the conference is as follows: after the introduction session, there will be sessions considering civil society and the tools or instruments it uses, the CNCD risk factors, chronic disease prevention and management, and reflections on previous successful Caribbean initiatives as well as consideration of our next steps: the action and the revolution.

The conference will comprise a limited number of short presentations followed by group discussions managed by content experts. A very preliminary draft action plan has been made available to all participants, and will be used as a frame of reference for presentations and group discussions, thus allowing for inputs into the final action plan by all. A small working group of participants will, over the course of the conference, continue to prepare and adapt the Declaration based on the reports from the group discussions.

The following Caribbean references and background documents were used in the preparation of the conference and the preliminary declaration: the Report of the Caribbean Commission on Health and Development; the Nassau Declaration, CARICOM Heads of Government (2001); the Caribbean Charter for Health Promotion; the Caribbean Co-operation in Health Initiative 1, 11, and now 111; the Caribbean Regional Plan for Prevention and Control of NCDs (2008-2012, PAHO); the Heads of Government of CARICOM Summit and Declaration against CNCDs (2007); the 20 Grand Challenges in CNCDs (Oxford Health Alliance); the Report of the Caribbean

Commission on Health and Development; the CD "Preventing Chronic Disease- a vital investment"(WHO); the Advocacy Toolkit for CNCDs (WHO/PAHO); PricewaterhouseCooper Health Research Institute documents; and various Caribbean Landmark documents.

The local team that assisted with the preparation and organization of this conference, included Adrian Randall, Pam Proverbs, Denise Carter-Taylor, Ena Harvey, Judy Best, Dr Shirley Alleyne, Andy Taitt, Ishanti Connell, Dr Joy St John, Magnus Whitehead, and Bernard Phillips. Conference supporters were Pfizer, Cable & Wireless, Servier Caribbean Ltd, Insurance Corporation of Barbados, Super Centre Ltd, National Insurance Office (Barbados), Inter American Institute for Cooperation on Agriculture, Peter Moore's Barbados Trust, Faculty of Medical Sciences, Cave Hill Campus, UWI, and the Barbados Tourism Authority.



4.1.2. Keynote Presentation 1:

James Hospedales
PAHO

The Caribbean Chronic Disease Epidemic: What We Know

Public health surveillance has been defined as "the ongoing, systematic collection, analysis, and interpretation of data" (Centers for Disease Control and Prevention). It is essential to the planning, implementation, and evaluation of public health practice, and is closely integrated with the timely dissemination of these data to those responsible for prevention and control.

There are complex interactions between risk factors of physical inactivity, unhealthy diets, and exposure to tobacco, and underlying socioeconomic, cultural, political and environmental determinants, together with common non-modifiable risk factors (such as age and sex) that lead to intermediate risk factors (such as raised blood pressure, high cholesterol, obesity, and high blood glucose levels). These in turn lead to the main chronic diseases (such as stroke, cancer, heart disease, diabetes and chronic respiratory illnesses). The chronic disease burden has increased over the past 50 years. In 1952 the Dean Emeritus at The University of the West Indies School of Medicine in Port-of-Spain, saw his first case of coronary artery disease – a full FOUR years after his arrival as a resident cardiologist in Kingston, Jamaica.

The World Health Organization's STEPwise approach to Surveillance (STEPS) is a simple, standardized method for collecting, analysing and disseminating data on risk factors for CNCDs in WHO member countries. By using the same standardized questions and protocols, all countries can use STEPS information not only for monitoring within-country trends, but also for making comparisons across countries. The approach encourages the collection of small amounts of useful information on a regular and continuing basis. Step 1 is a questionnaire on behavioural risks, Step 2 includes anthropometrical measurements and Step 3 adds biochemical measurements of glucose and cholesterol levels.

In the Caribbean, data (on mortality, morbidity, demographics, risk factors and costs of the epidemic) are present, but are scattered and not comprehensive. Mortality data especially are not up-to-date for a number of Caribbean countries. The leading causes of death in CAREC countries, for the latest 3 available years (around 2005), are for both men and women ischaemic heart disease, cerebrovascular disease and diabetes. In CARICOM countries (no data from Jamaica), for those <65 years old, the highest potential life years lost (PLYL) are from all CNCDs, followed by injuries and HIV/AIDS (data from 2000 and 2004). Taken separately, cancer and heart disease form the bulk of the PLYL within this category.

There are important regional variations. Age-adjusted death rates per 100 000 people for ischaemic heart disease in 2000 was less than 75 for the Bahamas, Barbados, Guyana and Jamaica but above 100 for Trinidad and Tobago. These rates compare to Canada and the USA, which also report rates in excess of 100 per 100,000.

There has been a notable increase in deaths due to diabetes throughout the Caribbean. Since the 1960s in the Caribbean, fat consumption has been above recommended levels, and continues to increase; while fruit and vegetable consumption has been below recommended levels.

Physical activity reduces the incidence of CNCDs and the subsequent impact of chronic disease on morbidity and mortality. Tobacco control has reduced morbidity and mortality and through taxation has the potential to generate a revenue stream that can be used for further CNCD prevention efforts.

The Caribbean has acknowledged its serious and increasing chronic

disease risk factor profile and CNCD burden. There is an urgent need for more and timely information on CNCD morbidity, mortality, and risk factors including social determinants. Health economics has an important role to play in quantifying the economic burden of CNCDs. Data from PAHO show that the estimated economic burden from diabetes and hypertension in 2001 was more than USD\$100 million for Barbados, more than USD\$450 million for Jamaica and more than USD\$750 million for Trinidad and Tobago. These diseases are largely avoidable, yet very expensive in both human and economic terms.

What is the Caribbean response? Although the region has a proud history of political commitment and co-operation in the health arena, it lacks capacity. Country responses must show that they are “walking the walk”. The CARICOM Heads of Government summit in 2007 with its resulting declaration outlined strategies needed to reduce the CNCD burden in the region – through “comprehensive and integrated preventive and control strategies at the individual, family, community, national and regional levels, through collaborative programmes, partnerships and policies supported by governments, private sectors, NGOs and our other social, regional and international partners”.

There are a range of proven prevention and control strategies and tools. Better monitoring of the extent to which these tools are being implemented is required. Finally, a key public health issue for health services and health NGOs is the percentage coverage and quality of care, and new systems are needed to measure this feature of healthcare. The way forward requires a rework of proven strategies and pressure on governments to implement them to the required extent.



photo courtesy of Andrew Hulsmeier



**4.1.3. Keynote Presentation 2:
Beatriz Champagne
InterAmerican Heart Foundation
Civil Society as the agent for
Change: What Works**

Governments of the Caribbean and PAHO are already working on the implementation of the Port-of-Spain Declaration, and civil society must be a major partner in this effort as it can make the difference between success and failure. Civil society should play its role forcefully, strengthening its present role and using all of the tools at its disposal. There have been many declarations produced throughout the world for tackling chronic diseases. Tackling chronic diseases requires complementary approaches including individual change but more importantly structural or systemic change. Once implemented, a plan such as the one arising from this conference will have the power to make the Caribbean the healthiest area in the world. The key component lacking in the region is "implementation and execution".

Civil society is the totality of voluntary civic and social organizations and institutions, forming the basis of a functioning democratic society, and is distinct from government or commercial organizations. It includes community groups, women's organizations, trade unions, self-help groups, business associations and social movements, and its

strengths lie in areas such as the provision of expert volunteers and the freedom from political obligations.

Civil society plays important roles by being an advocate, providing evidence-based information, acting as a "watch dog", and functioning as a service provider. Civil society frequently focuses on its service providing role to the detriment of other roles that would support policy change in their countries and communities.

Civil society might use a range of tools to achieve its aims including strategic planning, advocacy, coalition building, media and public information campaigns, and independent monitoring and evaluation. For example, civil society may influence government using advocacy campaigns such as letter writing or legislative briefings. It might use the media and public information campaigns to mobilize others. Further, it might conduct independent monitoring and evaluation through such means as report cards or shadow reporting.

Civil society has greater freedom to act since it is independent of government. With its many roles and tools, civil society can be a major contributor to CNCD prevention and control, working collaboratively with governments and industry or, when necessary, pressuring them to act. Civil society can be very effective in support of policy change such as indoor smoke free workplaces, warning labels on cigarette packaging, advocating for economic incentives to reduce sugar, fat and salt in the diet and make fruits and vegetables more available and affordable, or promoting daily school physical activity.



An important role is the translation of science for use by policy-makers, media and the public. An example of this might be for civil society to produce and distribute healthcare guidelines. Civil society might also enhance its traditional role as a service provider. For example it might perform screening and counseling for chronic disease risk factors, provide medications, or provide rehabilitation services.

There is much evidence that prevention works and that it can be simple, affordable and effective. The role of civil society is crucial in prevention. In Uruguay, for example, civil society has led an initiative on tobacco control, through promotion of smoke-free environments, lobbying for taxation of cigarettes, and effecting bans on publicity, sponsorship and promotion by tobacco companies. Civil society has also been behind successful effort to ban trans fats, reduce dietary salt and regulate food advertising to children. There are many more examples of the role civil society has played including reducing obesity and promoting physical activity. The tools used by civil society could be termed its “tool kit”.

This conference affords us enormous opportunity. We must emphasize the need for civil society to play its role forcefully, to strengthen its present role and to use the tools at its disposal, since it could make the difference between success and failure. Successful citizen action required “careful preparation, effective organization and stamina . . . lots and lots of stamina” (John Gardner, Common Cause).

4.1.4. Concurrent Workshops: Introduction and objectives

Chairpersons: Trevor Hassell and Oscar Jordan

The six leaders (two for each workshop) were introduced and the participants separated into groups for the concurrent workshops. Each workshop was run twice, back-to-back, to give each participant the possibility to attend two workshops. Participants examined what was available to civil society to assist them with their work in the Caribbean, by sharing information on available tools and approaches for bringing about change. The workshops began with a presentation by one of the leaders, in which topics were defined and effective use of tools and approaches were outlined. These were followed by moderated group discussions.

Workshop 1: Advocacy and coalition building

Leaders: Lorraine Fry and Deborah Chen

4.1.5. (a) Advocacy and coalition building workshop

Speaker: Lorraine Fry

Advocacy is defined as active support for a cause, policy or legislation, with the express goal of influencing opinion and mobilizing action. Its aim is to influence decision-makers. Advocacy can be performed at all levels (local, regional, nationwide, international) and can be either direct (asking in person) or indirect (influencing public opinion through the media). There are many different approaches through which the goals of advocacy may be achieved. These goals must be well defined (specific, realistic, achievable, timely), as must their targets (opinion leaders, decision-makers). Importantly, these

targets must hear core advocacy messages from trustworthy sources.

Strategies should be developed to achieve goals through alliances and coalition building (such as links with the media, politicians, and civil servants). Coalition is needed when resources and activities which an organization cannot manage alone are required for reaching a desired goal. Coalitions increase resources and create a common front with visible support for the goal. Flexibility is key; there may be difficulties in sharing control, and balancing the needs of the coalition and of each individual organization, and these must be carefully planned. Timelines and budgets should be set in advance, and there must be some way of measuring progress. In Canada, the coalition to campaign for effective warnings against tobacco use provides us with a model for successful coalition-building. Despite strong opposition from the tobacco industry, this health coalition was successful in reaching its goal: 16 rotating picture-based images, covering 50% of the top and back of a cigarette pack.

4.1.5. (b) Advocacy and coalition building – a Jamaican experience

Speaker: Deborah Chen

In the Caribbean, a successful example of coalition-building through advocacy and networking is the Framework Convention on Tobacco Control (FCTC) Caribbean Network. It was established under the auspices of the Inter American Heart Foundation. The FCTC Network aims to achieve in a timely manner the strongest possible implementation of the most effective tobacco control measures prescribed by the WHO FCTC (especially advertising prohibition, creation of smoke-free public places and work environments for all, packaging regulation and increased taxes on tobacco products). The FCTC Caribbean Network operates by promoting public awareness, and mobilizing civil society to join the network and build public support. It collaborates and partners directly with elected officials and government officers to overcome challenges.

The Jamaica Coalition for Tobacco Control is another example of advocacy and coalition-building in the Caribbean. The group comprises medical and nursing organizations which aim to further sensitize the public to smoking risks, promote tobacco control activities, and support rehabilitation of smokers.

4.1.5. (c) Key Points from discussions following presentations (Workshop 1)

The Chronic Disease Action Plan resulting from this conference could be a powerful advocacy and coalition-building tool, providing a needed mechanism for civil society involvement. The competitive aspect among health ministers in the region has provided some motivation for progress, in relation to the Port-of-Spain declaration, and this element can be similarly used to our advantage, for achieving change in the Caribbean. Effort must be put into building a new coalition, noting that challenges faced may include (1) turf wars (competition with NGOs for limited resources) and (2) governance issues relating to efficiency and accountability.



Recognition of the design and structure of our communities is very important as outcomes impact our public health; town planners are thus happy to see this link made between their work and health. Examples of unsatisfactory planning that adversely impacts health include the lack of “green spaces” or safe areas in which to walk and exercise, crowded streets that are unfriendly to pedestrians, and the nuisance of vicious dogs.

A big regional challenge is how to integrate different, perhaps competing, issues. Individual countries, especially those with smaller populations, may have different agendas and scarce resources, creating difficulty in deciding which goals to pursue. Further, transportation between the islands is a challenge to efficiency and an obstacle to trade, as seen with the limited Caribbean-wide trade in fruits and vegetables.

Problems and solutions concerning the chronic disease epidemic are multi-sectoral and require a huge collaborative effort, with input required from agriculture, regional transportation, business, education and the various offices of the public sector.

Suggestions/recommendations

Training in project administration, accountability, governance issues and project proposal writing is needed, if accountability and efficiency are to be achieved. As an example, in Jamaica, the Council of Voluntary Social Services offers a well-devised programme on training in NGO management.

The powerful, personal testimony of those affected by disease, employing theatre and humour, is needed to educate people. In addition, the tobacco intervention model from Jamaica could be adapted for use with other CNCD risk factors.

All Caribbean countries need to enact policies related to legal age for consumption of alcohol. It is important to follow-up on legislative or policy changes and civil society must be vigilant to ensure that proper implementation and roll out of such changes are affected. Post-conference follow-up is needed from Caribbean civil society and the NGOs.

Workshop 2: Public education and media campaigns

Leaders: Karen Gutierrez and Carol-Ann Senah

4.1.6. (a) The Global Dialogue for Effective Stop Smoking Campaigns

Speaker: Karen Gutierrez

The Global Dialogue for Effective Stop Smoking Campaigns (www.stopsmokingcampaigns.org) is an international collaboration of 17 organizations whose goal is to increase the impact of public education and mass media campaigns in reducing tobacco use and exposure to secondhand smoke. This is accomplished through training, individual consultation and resources to assist campaign managers, agency staff and researchers as they plan, implement and evaluate tobacco control campaigns. The international collaboration of organizations have developed many resources, which include a “campaign development tool kit” with 375 pages of guidance on the process of creating a campaign, with examples and case studies from

over 25 countries; and advertising exhibits with DVDs of advertisements to heighten awareness of campaign advertising and stimulate ideas. The toolkit comprises 12 chapters and is available in English and several other languages.

Mass media can be used to achieve advocacy goals, by building awareness of a campaign, or by providing information which builds relevant knowledge, or perhaps by changing key attitudes and beliefs and motivating individuals to change behaviour. Media campaigns can contribute to changing social norms and creating a positive environment for policy change.

For example, effective anti-smoking campaigns use a combination of “why to quit” and “how to quit” messages: “why to quit” messages jolt smokers, motivating them to “put quitting on today’s agenda”, while “how to quit” messages give them the hope and promise of resources to think they can successfully quit. Graphic messages can elicit strong negative emotions. In contrast the “how to quit” messages are helpful and supportive, and provide understanding of the aspect of addiction. Well-designed advertisements can appeal to all age-groups.

Some countries have opted to focus and emphasize the role and importance of increased physical activity in preventing chronic diseases. In Colombia every Sunday and public holiday the streets are closed, while people run, walk, skate, play, do aerobics, or dance in a programme and initiative sponsored and promoted by an organization known as “Ciclovía” (a Spanish term meaning “bike path”). The police ensure a safe environment while the activities not only provide physical exercise but also foster a sense of community.

4.1.6. (b) Public education and media campaigns in the Caribbean

Speaker: Carol-Ann Senah

The Caribbean Charter for Health Promotion (1993) has provided a framework for public education and media campaigns in the Caribbean for over 15 years. There have been past successes and failures and these previous campaigns can help us as we plan for future successes. Examples of successful campaigns include those for immunization (“Make measles history!”), cholera prevention, and clean-up campaigns, although challenges remain; e.g. in the government sector, it may be difficult to take issues through to completion due to shifting political focus. In addition there is a history of ‘outing of fires’, i.e. periodic big campaigns are necessary (e.g. dengue) and these channel resources from planned campaigns. In the Caribbean, a paternalistic “medical approach” still dominates: this leads to a prescription-based mentality of disease control over disease prevention, and there remains a simplistic interpretation of education and communication – process vs production. While posters and banners are often considered enough, a holistic approach to public education is needed. Past health promotion campaigns in the Caribbean could have benefited from wider involvement. During a measles, mumps, and rubella (MMR) vaccine campaign nurses in clinics were not involved, limiting the campaign’s effectiveness. In order to ensure workable future campaigns, before

implementing a programme, emphasis must be placed on why it is needed and how it is to be done. The best preventative tool is communication; well-designed advertisements can influence both young and old. Campaigns ought to be graphic, utilizing both humorous and “shock” methods to communicate messages. Civil Society should create a toolkit for developing programmes for the media. Further, use of the CNCD Charter, produced in 2005 in order to help develop health promotion programmes, is recommended. New strategies should build on old; campaigns should be part of bigger initiatives. For example, formulating healthy public policy by lobbying fast food chains to increase healthy-eating options, lobbying for canteen food planning policy and lobbying against carbonated drink dispensing machines in schools. Finally, an especially important role for NGOs lies in empowering communities to achieve well being, through development of increasing personal health skills (e.g. quitting smoking).

4.1.6. (c) Key Points from discussions following presentations (Workshop 2)

Suggestions and recommendations include the importance of (a) providing funds for evaluating programmes when budgeting for health promotion programmes; (b) research to inform actions of civil society, and improve the efficacy of future campaigns; (c) encouraging taxation increases, which can be used to finance other initiatives; (d) greater regional co-operation, including a regional approach to the availability of information.

Marketing seems to have no sustained effort and needs non-traditional initiatives as a simple and sustained means necessary for community change. For example, the Caribbean has a culture of music and storytelling which should be used to influence media campaigns. One way to make the health promotion messages stick is to use the SUCCESS acronym – simple, unexpected, concrete, credible, emotion-evoking and embedded in stories.

Workshop 3: Monitoring and Evaluation

Leaders: Ernesto Sebríe and Donald Simeon

4.1.7. (a) Monitoring and Evaluation workshop

Speaker: Donald Simeon

Monitoring is a routine process in which we collect data to measure programme efficiency and progress towards programme goals. In contrast, evaluation involves measurements over time in order to systematically investigate the effectiveness of a programme. The rationale for monitoring and evaluation can range from checking that administration and service delivery are proceeding as planned (monitoring) to financial accountability, measures of project effect or outcomes and quality control (evaluation). Evaluation results can lead to further funding being procured, improvements in processes, or cessation of a programme.

Indicators are specific measures which reflect a larger set of circumstances; i.e. they give a “slice” of reality but not the whole picture. They tend to have explicit measurement protocols. Data for

indicators could be gathered from a variety of primary or secondary sources. Examples of primary data sources include key interviews, specific surveys or evaluation reports. Examples of secondary data sources include surveillance reports, and routine statistics. Indicators must be clearly related to the programme goals and objectives and can be used at all programme stages, from process (e.g. ability to record hospital admissions), outcome (e.g. change in hospital admission numbers), through to impact (e.g. changes in hospital mortality rates). Indicators should additionally be expressed in terms of quantity (how much), quality (how well), population (for or on whom) and time (when). The selection of appropriate indicators (feasible, sensitive, affordable, relevant, measurable) is critical to programme success.

4.1.7. (b) Monitoring and Evaluation: Tools for civil society to advance effective tobacco control policies

Speaker: Ernesto Sebríe

Civil society could effectively use its several tools to advance policies for tobacco control. The policies concern (1) smoke-free zones (2) labeling/ packaging; and (3) bans on tobacco advertising and sponsorship. The monitoring and evaluation tools for these include behaviour monitoring (for the tobacco industry and government), and evaluation (for mass media and policymakers).

Civil tools which could be used to advance and enforce smoke-free zones, include public opinion surveys, and measures to draw attention to the pollution of the environment by cigarette smoke (e.g. through use of a personal aerosol monitor), which would generate media attention, and educate the public by quantifying risk.

A further tool that civil society could use in the realm of tobacco control is evaluation of tobacco labeling policies and this should be conducted in three phases: pre-implementation (pre-testing layout and content), during implementation (visual inspection or “environmental scan” to see whether labeling has been enforced) and post-implementation.

4.1.7. (c) Key Points from discussions following presentations (Workshop 3)

There is a need for collective capacity development in Caribbean Civil Society, in order to avoid repetition. Monitoring and evaluation should be implemented for all projects (but is often not completed). There should be (a) a national system to address monitoring and evaluation; (b) monitoring of food labels to ensure nutritional information on them is correct. A regional approach may be more appropriate for the Caribbean, as some islands are small and their capacity is limited.

Monitoring and evaluation should not be an afterthought but should be included in the initial project proposal and design phase, and for this to happen, resources must be assigned to monitoring and evaluation before the project starts. After the end of the project, data from monitoring and evaluation should be used to improve processes in the future. Regional, routine and well-established quantitative surveys should be utilized to collect relevant data. One successful example is the Survey of Living Conditions in Jamaica.



4.2. Part two: Tools for a wellness revolution

4.2.1. Small group discussions: Civil Society and its tool kit Chairpersons: Oscar Jordan and Trevor Hassell

Participants were divided into small groups, by country (or groups of countries), in order to discuss what civil society might already have in its “tool kit” in their country. Three main areas were addressed: (1) which tools were available; (2) what each country currently does well; (3) the general recommendations from the group. Responses to these were written down and summarized by group leaders in the plenary session; below is a summary of these responses.

4.2.2. Plenary discussion: Reports out of small group work

Chairpersons: Oscar Jordan and Trevor Hassell

Tools available

Many Caribbean countries have similar tools. These include good education infrastructure and training facilities (for example through group education in the workplace), a well developed media sector, access to screening for some chronic diseases in some countries, and fledgling attempts at influencing policy. There is general political support, and increasingly this is translating to legislative support from government departments (for example the introduction of smoke-free zones in some countries, and chronic disease surveillance in Barbados). The Caribbean has an active NGO sector. A range of civil society groups are already “on-the-ground” in various countries. Examples include a wide range of faith-based groups, health organizations such as cancer societies, heart foundations, and support groups supporting persons (for example) with diabetes, lupus and sickle cell disease.

What we are doing well

There are many examples of success stories, and there is a need for a central review and summary of all Caribbean health promotion programmes to help inform future campaigns. Particular examples mentioned included one country’s Cancer Society having monthly open-door symposia on particular medical conditions, regular education and screening provided by another country’s Heart Foundation, and the availability of free medication available in most Caribbean nations. In Jamaica in particular, there are strong links with the media, an annual conference by the Diabetes Association in collaboration with The University of the West Indies, and several health initiatives such as pharmacy-provided foot care clinics, and a cardiac resuscitation programme. The Cancer Society of Jamaica offers screening for three major cancers (breast cancer: mammograms; cervical cancer: pap smears; and colorectal cancer: colorectal exams). In Barbados, a commission for chronic non-communicable diseases has been initiated to oversee public-health campaigns. Some governments in the Caribbean have passed legislation on tobacco control, smoke-free public places (e.g. Barbados from 2010), or increased tobacco taxation, physical activity promotion, or the lowering of taxes on basic food items.

General recommendations from groups

The recommendations generally cover four main areas: (1) the need for improved collaboration; (2) health promotion and disease prevention; (3) involvement of youth and community; and (4) policy and advocacy.

Improved collaboration

Overall, groups within civil society must work together nationally and regionally, and foster links with Governments, the private sector, unions, and NGOs. This increased collaboration will allow greater sharing of information and resources, increase the visibility of the efforts, and generally bring economies of scale to the efforts. To this end, a “Caribbean civil society for health promotion” website is suggested as an information gateway for coalition partners and for target audiences.

A specific regional coalition partner of interest would be the University of the West Indies, to provide scientific rigour and monitoring and evaluation expertise to health promotion programmes. Monitoring and evaluation efforts were currently lacking in the region, and they should receive a high priority when developing programmes. The monitoring and evaluation process should aim to review programme structures, specifically how finances are allocated, and whether programmes are culturally relevant and meet the needs of the target groups.

Health promotion and disease prevention

Suggestions for health promotion and disease prevention range from very general community activities, to specific disease-targeted projects.

Examples of general campaigns include expansion of current national physical activities involving social mobilization, such as the “Family and Fitness Sundays” developed and implemented in Colombia; health fairs and fun runs (such as the well-known annual event in Barbados), and promoting use of village greens and savannahs for fitness events. Other themes include using a variety of media for health promotion messages, such as text messaging on cell phones, social websites on the internet, and television dramas addressing CNCDs.

Chronic disease surveillance should be promoted using surveillance results in the media to spread health promotion messages. Specific disease recommendations include the introduction of screening programmes when follow-up treatment is possible, and the use of evidence-based information already available, such as CVD risk charts, to assess the chance of cardiovascular disease. Annual conferences involving treatment clinics and specialty health organizations such as the Diabetes Association or Heart Foundation (in existence in several different countries) are needed. Free healthcare services are essential, and would be the core of any disease prevention infrastructure.

Caribbean countries currently have limited infrastructure for the safe enjoyment of physical activity, and access to safe spaces for walking and exercising. Appropriate facilities need to be developed and improved.

Dietary recommendations include a decrease in salt intake through gradual decreases in the salt content of processed foods, increased taxes on “junk foods”, and a ban on the sale of soft drinks and “junk foods” in schools.

Youth and community involvement

Societal norms and other aspects of culture (music, art, drama, and social icons) should be more frequently used to promote wellness. In the Caribbean, parents exert considerable influence over the behaviour patterns of the family. Consideration should be given to programmes specifically geared to parents, as well as a greater use of faith-based organizations. These must involve all the community (schools, churches, neighbours, artists etc.). There should be more emphasis on early education for a healthy lifestyle. Governments can introduce strategies to help young people to eat and live in a healthy way, so that it becomes a way of life.

Policy and advocacy

There is a need to use education and a strong evidence-base to influence policy through greater participation and dialogue with policymakers and other influential people - this can be done by targeting opinion leaders. Certain areas are highlighted for immediate advocacy efforts. These include screening for diabetes and hypertension, and government screening education programmes, legislation for tobacco control and the promotion of healthy eating, and “back-yard” gardening for domestic purposes.

The CARICOM Heads of Government Declaration of Port-of-Spain should be printed, distributed, and promoted to all health ministers and permanent secretaries of all Caribbean governments. All countries should utilize the World Health Organization (WHO) CNCD advocacy toolkit, and support the efforts of the WHO Framework Convention on Tobacco Control.

By agitating and negotiating for legislative change, everyone can contribute to public policy. Such negotiations are currently sporadic and must be more consistent, with subsequent policy enforcement. The best policies from across the Caribbean should be assembled and

made available to all in the region, and that all future strategic plans include advocacy.

4.2.3. Opening Ceremony;

Welcome:

Dr the Hon. David Estwick, MP
Minister of Health
National Insurance and Social Security

Greetings from key sponsoring organizations:

Caribbean Development Bank
Mr Frank Sampson
Director of Human Resources and Administration

Pan American Health Organization

Dr Gina Watson
PAHO/WHO Rep. for Barbados and the Eastern Caribbean

InterAmerican Heart Foundation

Dr Raphael Schuleib
President

Heart & Stroke Foundation of Barbados

Dr Stephen Moe
President

Feature address and opening of conference:

The Hon. David Thompson, MP
Prime Minister of Barbados
(Please see pages 21-23 for the feature address)

Vote of thanks:

Dr Joy St. John
Chief Medical Officer, Barbados.





4.3. Part three: Strategic risk factor priorities — CaribAction 2012

Chairpersons: Alafia Samuels and Rae Barrett

4.3.1. Topic 1: Nutrition and Diet

Speakers: Phil James and Fitzroy Henry

4.3.1. (a) The dietary challenge in the Caribbean

Speaker: Phil James

Nutritional problems can be explained by unhealthy diet and physical inactivity. Obesity amplifies disease, but if it were a simple problem, this would have been solved long ago. Although much money has been spent on healthy eating, obesity continues to increase – education is essential but additionally there is insufficient accountability. Various food marketing strategies exist to manipulate patterns of food intake for financial gain (such as increasing portion sizes); in fact the food business is more powerful than the alcohol or tobacco industries. Our policies are based on ancient concepts: it is an agricultural policy to overproduce fats/sugar/butter, and the cost for these has decreased. Food marketing is incredibly effective at influencing food purchasing behaviours and patterns, and supermarkets manipulate sales by 'strategic placement of items on supermarket shelves' (using eye-tracking technology). The British government says that the obesity epidemic represents a failure of the current free market world. Most Caribbean countries have a combination of foods for general consumption. Caribbean countries import substantial amounts of food – so we have to control the quality of these foods – perhaps through nutritional profiling. In the Caribbean it is not the people who control the food chain. The Caribbean should adopt food labeling - for example, we need to know the salt content in bought products (a high salt diet is linked to obesity and to hypertension) and marketing of unhealthy foods and drinks to children should be eliminated. Governments should allow only high quality food to be distributed to retailers. Civil society needs to think how to lobby government to change, while stressing that a focus on adults could provide positive results as well as that on children.

4.3.1. (b) Nutrition in obesity and CNCD control – the role of civil society

Speaker: Fitzroy Henry

Overall calorie consumption is on the increase in the Caribbean, as in many other regions of the world. This increase reflects an increasing pressure for consumption, a wider distribution of greater disposable income, and dietary changes leading to increased fat, salt and sugar content. Options are available by which civil society can help to combat obesity and NCDs through nutritional action: (i) advocate for fiscal change; (ii) force legislative changes; (iii) demand healthy meals; (iv) sustain media campaigns; (v) promote healthy foods and eating habits in the community; (vi) protest unacceptable nutrition policies and practices. A national, multi-sectoral approach is needed.

4.3.2. Topic 2: Physical Activity

Speakers: Becky Lankenau and Victor Matsudo

4.3.2. (a) First Caribbean Chronic Disease Conference:

A wellness revolution event

Speaker: Becky Lankenau

The burden of chronic disease in the Caribbean is directly related to the prevalence of physical inactivity in the Caribbean. The link between the lack of physical activity and chronic disease was established relatively recently compared to the role of nutrition as a chronic disease risk factor.

There are opportunities for initiatives to promote physical activity in the Caribbean. For example, physical activity can be achieved through activities for daily living (ADL), and marketing this is relatively easy as the message is simple and consistent (promotion of physical activity is exciting, positive, marketable and timely). Moreover, it is free of opposing lobbies or special interest groups and previous evaluations of physical activity programmes have shown that such interventions are cost-effective, and can reduce disease incidence. Some examples of promotion of physical activity include renovating or building sports facilities, having weight loss challenges, media campaigns, and encouragement by employers for employees to have exercise time. Benefits can be far-reaching - for example in the workplace there is a positive effect not just on health but on absenteeism and company morale.

4.3.2. (b) Promoting physical activity in the Americas and the rest of the world

Speaker: Victor Matsudo

Sedentarism and obesity represent the most dangerous combination in public health, and together have reached prevalence of between 60 and 70% of the world population, and high mortality (about two million deaths per year in the world). The consequences of sedentarism also contribute about 70% of world expenses in the health sector. Achieving enhanced physical activity is difficult - human behaviour is hard to change. Despite public-health campaigns, the population of Sao Paulo was 70% inactive throughout the 1990s. Science now provides a strong evidence base supporting the link between coronary artery disease and physical inactivity - there is a need for collaboration between governments, NGOs and the community.

People should have 30 minutes of daily physical activity, five days per week. Lack of time is the main challenge for persons to engage in physical activity, and most do not know that exercise may be split into shorter segments, since the accumulation of activity has the same effect as exercising for a longer duration, i.e. 3 x 10 minute walks have the same effect as a 1 x 30 minute walk.

Various levels of society should be targeted for the promotion of physical activity, i.e. men, women, families, the disabled, the young and the elderly. Cultural links are also very important; e.g. in Brazil, the Centro de Estudos do Laboratório de Aptidão Física de São Caetano

do Sul (CELAFICS) created a logo for each group in the community to encourage their buy-in. In Sao Paulo, the Agita Mundo (Move for Health) programme for physical activity was embraced and local government developed the city's infrastructure to include walkways for the half-hour of physical activity, thus creating an attractive city. The social perception of chronic diseases needs to be changed, as people need to be made aware of the indignities and suffering associated with chronic diseases.

4.3.3. Topic 3: Tobacco

Speakers: Lorraine Fry and Ernesto Sebr  

4.3.3. (a) Strategic risk factors: Tobacco

Speaker: Lorraine Fry

The tobacco industry had been unregulated for 40 years, and it wasn't until the 1950s that evidence emerged of the link between tobacco use and increases in lung cancer incidence. The tobacco industry refuted these epidemiological links for many years. Much of the public today remain unaware of the death and disease statistics linked to exposure to tobacco.

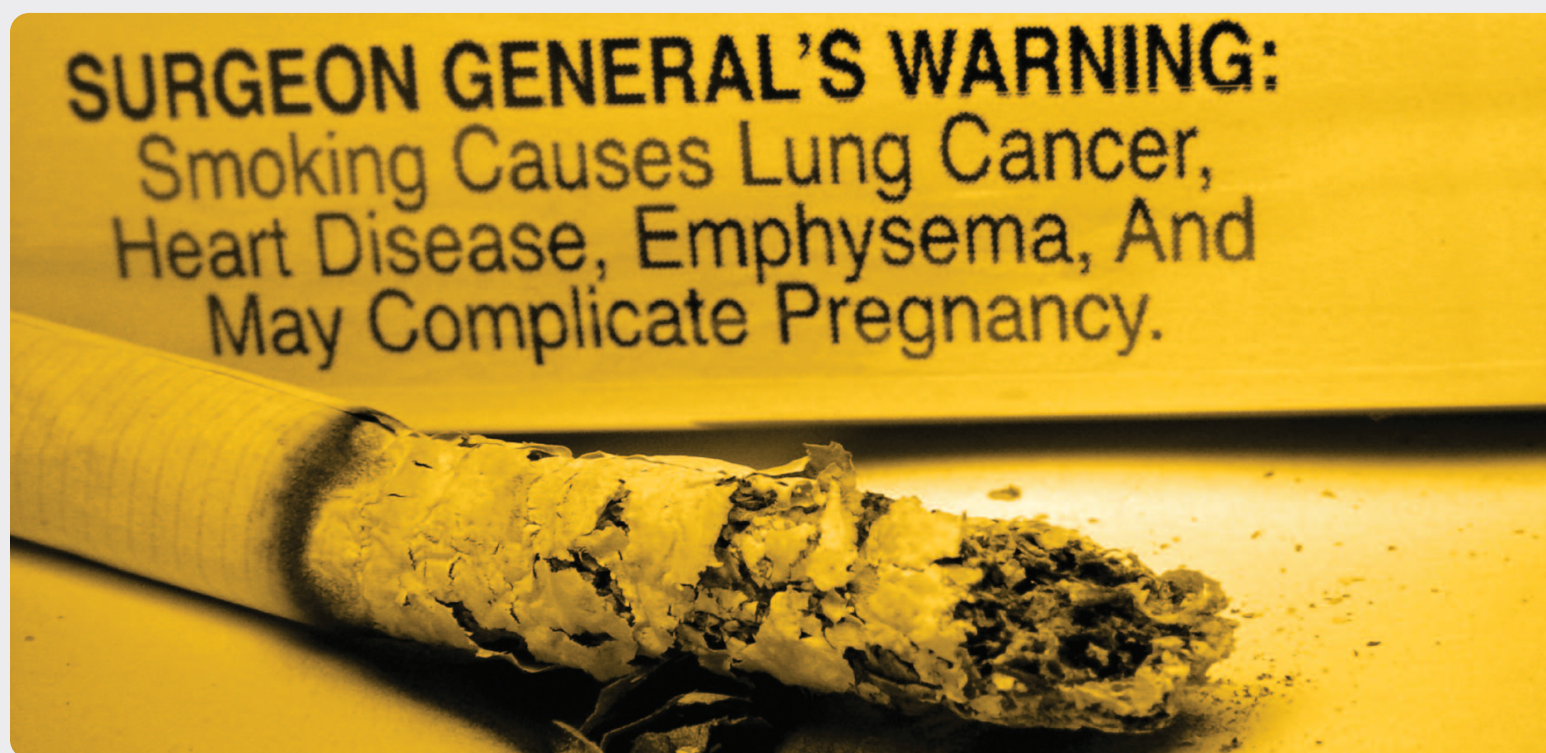
Tobacco use is increasing globally (currently there are more than 1 billion smokers worldwide). The industry is shifting its marketing to the developing world and countries that do not have the stringent tobacco controls now adopted by the developed nations. In the peoples Republic of China, the Government owns the tobacco industry, and this contributes to the difficulty of fighting the industry

in that country.

The link between smoking and lung cancer is well known. But tobacco use is also linked to other cancers. Breast cancer is linked to tobacco use in pre-menopausal women. Tobacco use is thought to be responsible for 30% of all cancers (disease and deaths), 30% of all heart disease and stroke morbidity and mortality, and 90% of all lung disease and deaths. In addition, smoking has a negative effect on almost all organs in the body and reduces overall health, for example tobacco use amplifies the complications of diabetes. 85% of smokers become addicted before age 19 years, and this is a driver for young people as an advertising focus for the tobacco industry.

The best measures for tobacco control are government regulations such as tax increases and smoking bans in public spaces. Educational programmes targeting children or adults are not as effective but should be utilized jointly. The Caribbean is now moving towards graphic images on cigarette packages showing the extent of the health detriment caused by exposure to cigarette smoke. All healthcare personnel should also be asking patients whether they smoke and in the event that they do so, provide them with resources to quit.

Canada is an example of a successful country-wide prevalence decrease: using a combination of increased taxes, bye-laws, advocacy initiatives, various acts of parliament and finally the ground-breaking warning labels and anti-smoking campaigns which have all contributed to reduction of smoking prevalence from 50% in 1965 to 19% in 2007.





4.3.3. (b) Tobacco control in the Caribbean:

Problem and response

Speaker: Ernesto Sebríe

A lack of national data on tobacco use is a major obstacle in the Caribbean, although it is known that males smoke more than females, e.g. smoking prevalence in Caribbean males ranges from 18% in St Vincent and the Grenadines to 36% in Trinidad & Tobago, while in women it ranges from 3% in Barbados to 11% in St Lucia.

The Framework Convention on Tobacco Control (FCTC) was established in 2003 as a global effort to combat the adverse effects produced by the tobacco industry. As yet, none of the Caribbean countries that ratified it have complied with Article 11 of the FCTC regarding pictorial labeling. The deadline for implementation was the end of 2008.

The constitution of some countries (such as Chile) does not allow cigarette advertising to be banned. An alternative is placing health warnings next to displayed advertising and warnings on packages. The Bloomberg initiative, based in Jamaica, works to assist the Caribbean in developing strong visual labels. Jamaica is currently developing labeling policies on behalf of the Caribbean region.

Tobacco taxing policies in over 80% of high-income countries is to tax tobacco by at least 50% of the retail price. Tobacco taxation varies across the Caribbean; Barbados has recently increased tobacco tax by 100% while Belize has just lowered tobacco tax. Comprehensive bills are under discussion in Trinidad & Tobago and St Lucia, and there is a possibility that Jamaica and Barbados may move towards smoke-free legislation. Meanwhile, the tobacco industry opposes strong warnings and undermines advertising bans, and attempts to block 100% smoke-free policies.

4.3.3. (c) Question & Answer session

Chairpersons: Alafia Samuels and Rae Barrett

Comments and suggestions from the floor are given below.

Nutrition and diet

As healthy foods can be expensive in the Caribbean, civil society should lobby for manufactured products to show caloric, fat and sugar content. Perhaps in the Caribbean we should identify and emulate success stories e.g. in Finland, one piece of fruit per person is included in all meal prices in restaurants and canteens. Culturally, ground provisions are considered poor man's fare; however we should encourage all to eat them. The fast food industry is providing a low cost unhealthy food choice for families. Trade policy is important to encourage consumers to make better choices.

Tobacco

Canada pays its farmers to switch crops and stop producing tobacco. In the Caribbean, health promotion and education will only be effective if they are part of a national policy change.

4.3.4. Small group-work by country

Chairpersons: Alafia Samuels and Rae Barrett

Participants formed groups to discuss their country's strategic risk factor priorities, by considering three questions (outlined below). They then completed a table ranking current country responses to CNCD risk factors, with recommendations for civil society actions. The three questions:

1. Which risk factors (diet, physical activity, and tobacco exposure) are being tackled well in your country?
2. Which risk factor is the most neglected in terms of how it is being tackled in your country?
3. What are two significant changes or initiatives that could be taken at country and at regional level, which would have a positive impact or outcome in addressing risk factor priorities in your country?

4.3.5. Plenary discussion: Report from country groups

Chairpersons: Alafia Samuels and Rae Barrett

Below is a summary of the information provided on the tables produced by each country, for each of the risk factors.

(a) Diet: Proposed civil society actions

1. Country Level

Advocacy is required for both a food and nutrition policy and the implementation of a food and nutrition council. National nutritional dietary guidelines and appropriate food labels need to be required and food vendors and restaurant staff trained and educated on healthier cooking techniques. Taxation and legislation to reduce trans fats (both importation and local production) must be achieved, the selling of high salt, high fat and high sugar foods in schools prohibited and subsidies for farmers to produce organic fruit and vegetables afforded.

Backyard gardens should be promoted with the hope of encouraging both families and communities to produce more fruit and vegetables. Promotion should extend to the provision of healthy foods for food fairs, seminars and occasions such as conferences. Furthermore, local manufacturers and cottage industries should be nurtured, and encouraged together with local fast food restaurants to provide healthy and nutritious food.

Within the country, each parish/district should ensure the availability of a dietician and place more functioning nutritionists in each medical station and/or health centre. Finally, an umbrella organization of health-related NGOs needs to be formed and supported.

2. Regional Level

A heart-smart Caribbean diet that can be commercialized should be produced. Advocacy is needed for harmonized legislation, standards and adoption of dietary guidelines, education, culture and policy changes and the reduction in pre-production cost of foods.

Promotion through technically assisted development of attractive TV programmes, combined with support and interventions from CFNI, PAHO and WHO, can be used positively to address diet on a regional level. Relevant regional agencies need to assist in matters related to trade.

(b) Physical Activity: Proposed civil society actions

1. Country Level

Advocacy is needed for intersectoral partnership, creation of more green spaces and controlled motor vehicle importation to promote increased physical activity. The provision of safe spaces for the performance of organized physical activity within the workplace and schools, for example, need to be supported. Physical education at a pre-school, primary and secondary school level should be promoted and a school health policy, with particular intervention in teacher colleges, should be implemented. On the other hand, guidelines to encourage workplace programmes through private sector partnership for facilities should be provided.

Supportive environments and walking spaces should be provided to encourage the use of open spaces. These could include hiking and walking trails, the availability of parks and more user-friendly sidewalks. More community facilities, e.g. community gyms, and safe exercise spaces need to be created to facilitate increased physical activity.

Awareness programmes for healthy weight are needed to sensitize the population on the important link between physical activity and good health. Accordingly, initiatives which target poverty, nutrition and physical activity, such as backyard gardens and the most-active-village contest, should be encouraged. Children should be taught to swim and initiatives such as one titled “10,000 steps a day” which includes the provision of pedometers and was carried out in some Caribbean countries should be encouraged.

Development of stronger health promotion resource teams and partnership with media via use of existing programmes, e.g. “Morning Barbados”, can be used to impact positively.

2. Regional Level

CARICOM and OECS heads should contrive to place physical activity at the top of the political agenda. Financial resources for initiatives need to be provided and capacity building for physical activity programmes and Caribbean-wide physical activity promotion encouraged. The Fun Walk for the Caribbean on Caribbean Wellness Day is a prime example.

(c) Tobacco: Proposed civil society actions

1. Country Level

Advocacy is needed for the ratification of FCTC, laws to ban smoking in public places, and implementation of smoking cessation programmes and structures, such as the introduction of smoking cessation training for healthcare practitioners. Sensitization programmes on the dangers of tobacco use should be created, even as public education campaigns, pictorial labeling and plans for tobacco control activities, including passing the draft bill in our possession, are being implemented. Enactment and enforcement of appropriate legislation is critical to the reduction of exposure to tobacco within country as it is throughout the Caribbean.

2. Regional Level

On a regional level, not only are more campaigns and more advocates needed but FCTC support and finances will prove essential as well. Technical assistance to make appropriate modifications to legislation and the monitoring and evaluation of programmes is also required.

A regional response to smoking cessation needs to be coordinated. An example is the collaboration between Belize and its neighbours (Mexico and Guatemala) in the fight against tobacco use. Expansion and extension of the Bloomberg Caribbean initiative is needed.

(d) Schools – Diet & Physical Activity: Proposed civil society actions

1. Country Level

It is important to advocate for relevant government ministries to promote the importance of physical activity. It is essential that they incorporate comprehensive structured sports programmes in schools, mandate that physical activity be a core subject and increase the number of physical activity periods. Furthermore, advocacy for swim clubs, cycling clubs and athletic clubs, through the National CNCD Commissions is recommended and should be encouraged.

An intersectoral mechanism for healthy diet and physical activities is needed in schools to promote health education and inculcate healthy lifestyles at all levels. The “healthy snack diet”, which is a programme initiated in one of the Caribbean countries, should be increased from 1 to 5 days of the week and be expanded regionally, and the sponsorship of school interventions, e.g. fruit days in schools (Fruit a Day), should be encouraged.

Policies which improve nutrition, that is, the quality of food and drink available in schools including vending machines on the school compound, should be implemented and attention given to the



regulation of school canteens and surrounding vendors, to ensure healthy food choices (e.g. healthier food in school meals). Effective monitoring of the school feeding programmes with an aim of making the provision of healthy daily meals in all schools a reality should be commenced and school gardens promoted.

2. Regional Level

Caribbean Examination Council (CXC) should be encouraged to incorporate healthy lifestyles into schools' curricula. Financial resources and advice (CFNI) to support school-based interventions need be provided.

Programmes from regions that have been successfully implemented can be copied and used.

(e) Workplace Programmes: Proposed civil society actions

1. Country Level

Advocacy is needed for the implementation of a workplace health policy for physical activity, the establishment of workers' health council, and health screening for employees. Moreover, advocacy is needed for evidence-based practice and the inclusion of risk factor modification programmes in the Labour Code.

Government is encouraged to pass statutory instrument to enforce workplace programmes that emphasize health promotion whilst the corporate sector is encouraged to promote healthy lifestyles and increased physical activity among employees. Guidelines for establishment of programmes and facilities need to be provided, as well as recommendations for best practice for use by workers representatives as they lobby employers.

Seminars at the workplace educating on disease prevention, control of CNCs, risk factor reduction and complications are encouraged, in conjunction with training in First Aid/CPR.

Screening for CNC risk factors should be carried out in barbershops and hairdresser salons.

2. Regional Level

Model workplace policies should be developed and risk factors' modification programmes at the workplace included in labour legislation in all countries. Regional programmes on health and medical care should be encouraged for all workers.

(f) Screening and Disease Management: Proposed civil society actions

1. Country Level

Advocacy is needed for collection of baseline data for all risk factors, walk-in screening at physician offices, and the continuation of screening programmes at churches and workplaces, with PAHO/WHO support.

The use of data collected to inform policy, programmes and legislation should be promoted. On the other hand, promotion of workplace screening should expand to encompass screening across the board, with incentives to all parties involved. Not only is a

multidisciplinary approach to the management of chronic illnesses needed, but a more active role in disease management control and care must be assumed. In keeping with this effort, programmes to improve knowledge of the disease should be scheduled, symposia on self-care for persons with selected CNCs sponsored and professionals educated on screening and management. Furthermore, expansion of screening for CNCs and risk factors at health centres is recommended as is the development of screening programmes for height, weight and blood pressure at barbershops and hairdresser salons.

2. Regional Level

Funds to assist with procurement of equipment, e.g. blood pressure monitoring machines need to be more widely available throughout the region.

4.3.6. Workshops on risk factor priorities

Chairpersons: Alafia Samuels and Rae Barrett

Participants convened into groups in which each discussed one risk factor priority, highlighting the top three recommendations for civil society actions and considering available tools, activities, partners, opportunities and barriers. Each of these is summarized in the next section.

4.3.7. Plenary summation: Reports from risk factor workshops

Chairpersons: Alafia Samuels and Rae Barrett

(a) Physical activity: Recommendations for civil society actions

Prime Ministers should be encouraged to participate in appropriate activities. For example, at the next intercessional or full meeting, Heads of Governments could undertake one physical activity as a group; thereby leading by example. Secondly, there should be greater consultation between town planners, government and communities when planning the built environment. Perhaps they could consider health and wellness and the Wellness Revolution to be on their agenda during their next planning meeting. One of the participants is a Town Planner who will put this on the agenda for the next meeting (in November 2009 in Trinidad).

Thirdly, civil society should encourage the use of existing buildings and facilities, such as schools by people who wish to engage in physical activity between the hours of 3.00 and 10.00 pm when the facilities are not otherwise in use.

(b) Diet: Recommendations for civil society actions

Advocacy of the food manufacturers and public education has already been discussed. However there is a need to advocate for the elimination of marketing of unhealthy food products both in schools and in government institutions. There needs to be an enabling environment for breast-feeding in public places (e.g. a room set aside for working mothers to breast-feed). In addition, promotion of extension of maternity leave to encourage 6 months of breast-feeding is recommended. Nursery and childcare facilities should provide a diet within the framework of healthy eating for these age-groups.

Secondly, civil society needs to advocate for trade opportunities previously discussed. These should be made public so that civil society can take advantage of these 'flexibilities' in the trade agreements.

Thirdly, civil society needs to advocate for media partnership in terms of the monitoring and evaluation framework for efficiency and effectiveness. Within civil society itself, some form of monitoring and evaluation is also needed so that different countries can be followed up in terms of the various recommendations related to diet.

(c) Public education: Recommendations for civil society actions

Civil society should develop and implement a comprehensive public education programme on diet, physical activity and smoking in order to reduce the impact of CNCDs such as diabetes, hypertension, heart disease, cancer and lung disease. Public education aims to sensitize target groups, such as youth/children, health professionals, politicians and policy-makers, workers and their representatives, professionals and business leaders, social groups, faith-based organizations, clubs and societies, and patients and their families. These groups should all be sensitized to the risk factors of lifestyle practices in order to take action, dispel myths, and effect cultural change, among Caribbean people.

Based on data collected, we would identify key messages for target groups, i.e. on diet, physical activities and smoking. We would advocate for the training of various groups, partner with community and civil society groups to promote wellness, and promote health and family life education at schools, community health centres, in social groupings and at the workplace.

This should be done from a "bottom up" perspective: we want to educate people, politicians and policy makers of the economic and social costs of CNCDs. Civil society including social groups, coalitions and associations (e.g. breast cancer, heart association, etc. where we have 'champions'), should lobby governments so as to effect legislative changes e.g. banning of smoking in public places and change of school curricula, diet and physical activities.

Tools to be used include the media, TV, the internet, social networking websites (Facebook, Hi5), text messages, notice boards, entertainment (music, dance, drama and poetry). We should also utilize "icons" (popular persons), multimedia, pamphlets, brochures, and focus groups.

Opportunities include health fairs. We can use health professionals to educate civil society and other social groups. A type of chain reaction may develop from e.g. a single doctor educating a group which then goes on to educate further groups. We need to lobby our business leaders to create incentives for wellness and should include faith-based organizations and other social networks to get the message out.

Partners include health professionals, media houses, telecommunication companies, coalition groups, the private sector, education sector, and social groups such as the faith-based organizations. For resources we suggest obtaining information from websites such as WHO, PAHO, and seeking funding from NGOs (non-governmental organizations).

One of the main barriers we identified was culture, as well as myths. Political will is also an important challenge and we need politicians who will look after the welfare of society. Likewise the provision of technical and financial support represents important challenges that need to be met. Finally, we have to show them the benefits of the long-term action. Knowledge is power: the strength of public education.

(d) Activities of Caribbean Wellness Day (CWD) in 2008 throughout the islands: Recommendations for civil society actions

Activities throughout the Caribbean region included closed off circuits of streets in Trinidad and Barbados to encourage physical activity, the launch of a national wellness policy in St Vincent and the Grenadines, health fairs in Dominica (politicians even took part in a night cricket match), and a Wellness Symposium in St Kitts.

Some of the challenges the planning teams encountered when organizing the CWD '08 activities were firstly, funding. Secondly, there was not much support from civil society as the activities were perceived as government initiatives. There was limited time for preparation of the CWD and media buy-in was fairly limited.

Ideas for 2009 are as follows. Firstly we must aim to achieve private sector, the public and civil society involvement in CWD '09. Ministry campaigns must invite civil society to be actively involved on the planning teams. A request should be made for contributions from civil society and though some may not be able to give a financial contribution they must be asked to volunteer their services for the day. Some activities to be considered include song and poetry competitions, awards for the most active communities (parishes/regions), a 'best healthy dish' nation-wide competition geared towards primary school students so that they (with help from teachers), and their parents can work towards creating the best dishes. Prize-giving for this event would occur on CWD '09 so that parents are obliged to bring their children on the day and take part in the activities. There could also be 'jamercise' sessions where participants walk/chip to music of any type, physical activity demonstrations, and efforts made to highlight the Declaration of Port-of-Spain and the goals of future CWDs. Efforts must also be made to engage and involve local parliaments (as has been done in Dominica) and we need to incorporate the beaches in these programmes – e.g. exercise on the beach rather than inland. We can schedule some activities for the night-time, e.g. night football matches and other sporting activities for those who cannot make it during the day. Finally a theme for CWD '09 is suggested: Cooking Healthy 09!

(e) Healthy settings: Recommendations for civil society actions

In schools: Firstly, Caribbean civil society could lobby for swimming programmes in schools. A barrier would be lack of facilities. Mandatory physical activity is needed with some form of standard e.g. 30 minutes of physical exercise per day. It is recognized that there are barriers such as the academic examination schedule. Secondly, civil society could advocate for a ban on sale of "junk food" on school premises and the promotion of natural, healthy foods and



drinks. Barriers might include buy in from those preparing meals or commercial drink manufacturers. Finally, schools should be 100% smoke-free; legislation for this should be lobbied for, as mandated by the FCTC.

In the workplace: Firstly, there should be healthy food offerings available from workplace canteens and vendors, and this could be advocated for by civil society. Secondly, wellness programmes could also be offered by workplaces, and encouraged by the provision of special concessions for those workplaces. In addition there should be provision for peer counseling as a component of this programme, so that people could be counseled e.g. for diabetes, with the relevant disease associations taking charge of this aspect. Thirdly, the insurance industry could be pressured by civil society to offer health insurance policies that emphasize prevention in addition to disease treatment.

For faith-based organizations: Civil society could advocate for these groups to adopt and structure wellness programmes, again with a peer-counseling component.

For communities and cities: All civil society throughout the Caribbean should advocate for safe, healthy green spaces for physical activity, so that people in their communities can incorporate increased physical activity into their normal daily living.

(f) CNCD screening: Recommendations for civil society actions

In the past our predecessors were very good at screening for primarily infectious diseases, while CNCDs were rarely seen. We should ask 5 questions: (1) Who am I dealing with? (2) What am I dealing with? (3) Where am I going to do what I should be doing? (4) How frequently am I going to do it? and finally: (5) What am I going to do with these people whom I have screened for disease?

Firstly: everyone at risk should be screened; and everyone in the Caribbean is at risk, including schoolchildren. CNCDs are occurring a decade or two earlier in our population so we have to be careful of arbitrary targets. We should screen for diabetes, hypertension, dyslipidaemia and obesity, even in primary schools. Screening is now largely done in NGO offices and this is a great opportunity for us to partner with others e.g. employers, churches, schools (e.g. the successful eradication of hookworm in Trinidad was achieved through this kind of partnership) and universities. Doctors' offices are unfortunately often the places where screening for CNCDs and risk factors is least likely to occur since doctors often see themselves as being "too busy" treating disease. We should screen annually for CNCDs and risk factors. Finally, it is unethical to screen without having a treatment or management plan in place, so processes should be set up in advance. We suggest health care providers institute an objective, structured clinical evaluation rather than a random encounter with an arbitrary doctor in a clinic. A useful paradigm to consider is a 10-station encounter where at each station, something is being sought: e.g. for the diabetic, evaluation for microalbuminuria, foot sensitivity, ankle pulses, visual acuity, etc. This will bring efficiency and more focus to the process, improve note-taking and delivery.

Finally, we have been successful with immunization because of the use of vaccine cards that enable entry into schools, examinations etc... Why not create a similar "CNCD passport"?

(g) Tobacco control: Recommendations for civil society actions

Those involved in tobacco control must keep up to date on information knowledge and education so that we can remain a step ahead to counter the deception from the tobacco industry. We considered a variety of methods for tobacco control.

Firstly we considered advocacy for 100% smoke-free spaces, as well as lobbying for appropriate legislation. Also the production of educational materials including those tailored to the media, as media campaigns are very important. We also looked at the education of broader civil society, including the health sector, e.g. there is a need to educate nutritionists to include the question of whether the person they are seeing is a smoker. Doctors as a matter of routine need to check whether their patients are smokers and then to advise on the wider ill-effects of smoking. We need to continue to educate people about all the adverse effects of smoking on health.

For activities we need to identify spokespersons who are versed in the over 40-year deception of the tobacco industry. We also need to identify sub-spokespersons and Champions, both in terms of parliamentarians who are au fait with what is happening, persons who influence policy-makers, and people who work in NGOs who are interested in tobacco control.

With regard to achieving 100% smoke-free spaces, there are various opportunities that could be utilized, such as sharing expert data and using the expertise of tobacco control advocates. We also need to be aware of barriers to educating the wider society (apart from the machinations of the tobacco industry), such as societal apathy. Some people feel that smoking is one of the major ways they can relax or feel good about themselves, and smoking is culturally acceptable in some parts of the Caribbean. Unfortunately many of the ill-effects do not manifest until after 20 or 30 years of cigarette use, and smokers are really not aware of the potential implications for their health. For partners we should consider the private sector, trade unions, the Jamaica Coalition for Tobacco Control through the Heart Foundation of Jamaica, and other organizations that exist in other countries which are our Bloomberg partners (e.g. Trinidad and Barbados), faith-based organizations, the University of the West Indies, the media in general, and international partners.

The time-frame for this – because some Caribbean countries have not yet either ratified or signed the FCTC – would be more generous, e.g. 31 December 2010 would be a more appropriate target for everyone to come on board. Regional support will be sought from PAHO/WHO and the Bloomberg Initiative since it spans four Caribbean countries (Jamaica, Trinidad, Barbados and Guyana). With regard to banning tobacco advertising, sponsorship and promotion, the same considerations would hold as for 100% smoke-free spaces described above. However, our major barrier in this regard will be the virulent arguments from the tobacco industry, as well as lack of data or data discrepancies. This is balanced by the fact that we have solid

data from around the world establishing links between smoking and harm to health.

There is another opportunity in terms of banning tobacco promotion, sponsorship and advertising in the Port-of-Spain Declaration. We have to ensure that our parliamentarians translate words into action, and we must commit them over time to implement the goals of the declaration.

We also looked at advocacy for rotating picture-based advertising on cigarette packs. Much of our current activity is possible because Bloomberg has provided funding for the four participating Caribbean countries, and to our best knowledge, this is the first that money has been provided in this region for tobacco control – a major impetus and resource. As a result, there is ongoing lobbying to effect the FCTC and accompanying legislation. Focus group activities will be ongoing and we are awaiting WHO approval to guide the ethics of the picture-based warnings. A best-practice brochure has been produced using tobacco control experts worldwide.

A major barrier is that of educating the population. Apart from Bloomberg, other partners are CARICOM, the International American Heart Foundation, and the Non-Smokers' Rights Association of Canada. It is critical that civil society acts as a catalyst to remind governments that they have a moral commitment to these issues.

Considering taxation dedicated to prevention and control of CNCs: even though governments tend to promise that taxes will be directed to health-related issues, there are often contingencies and national emergencies which alter such intentions. We therefore need to provide strong justification through data obtained from hospitals and health facilities to show the burden of healthcare costs for tobacco-related illnesses. There are myths from the tobacco industry about the level of funding received from them through taxation. The fact is that every country can provide data to support that no amount of cigarette tax (as revenue) can ever pay for the healthcare costs for persons who smoke and have smoking-related illnesses.

There is therefore clear need for experts well versed in economics to be part of teams pressing for anti-smoking legislation, to provide a sound financial evidence base.

An ongoing barrier is also likely to be lack of political will; politicians need to maintain their popularity which is especially critical when there are imminent elections. We hope to show them that you can never lose by always promoting a healthy society. Other lobby activities would be aimed at engaging not only ministries of health, but also the ministries of finance and trade, and encouraging links with ministries of agriculture as well. These are all inter-related and their functions affect health and well being.

4.3.8. InterAmerican Heart Foundation Science of Peace Award and Lecture

Sponsored by: the Faculty of Medical Sciences, Cave Hill Campus, UWI

Welcome & Background:

Dr Raphael Schuleib, President, IAHF

Greetings & Welcome remarks:

Dr The Hon. David Estwick, Minister of Health

Lecture:

Sir George Alleyne, Director Emeritus, WHO/PAHO

Please see pages 24-29 for this lecture

Presentation of Award:

Dr Raphael Schuleib, President, IAHF

Vote of thanks:

Mr Adrian Randall, CEO, HSFB





4.4. Part four: The disease management challenge — CaribAction 2012

Chairpersons: Henry Fraser and Anselm Hennis

4.4.1. Diabetes mellitus: a grassroots intervention

Speaker: Errol Morrison

The Jamaican experience in the 1970s and early 1980s was that patients with diabetes were poorly compliant with treatment until they developed complications. An outreach project which used a radio programme to reach one-third of the entire Jamaican population (or 900,000 persons), led to improved knowledge about diabetes nationally.

In the early 1990s, Assal in Switzerland developed the model in which persons with diabetes were put at the centre of the health team, which had salutary effects on practice. Attempts to adopt this model in Jamaica through training physicians and nurses were unsuccessful. Proponents of this model then developed the “lay diabetes facilitator” (LDF) model. Potential leaders were selected from the community and trained as diabetes facilitators. Trainers administered baseline pre-tests followed by training sessions, which included members of the health team. Those achieving high post-test scores were selected and as LDFs followed the mantra “Each one teach one”.

Follow up evaluations of this programme indicated initial problems with access to medication, and follow-up care, which were addressed. Participants soon demonstrated improved glycaemic control compared to non-participants. Such improvements were estimated to translate into a 22% reduction in complications, equivalent to US \$37.5M savings annually to government.

Regional partnerships in diabetes care, involving the Diabetes Association of the Caribbean, the International Diabetes Federation, and the Pan American Health Organization, inclusive of the Declaration of the Americas on Diabetes, are necessary to prevent diabetes and improve care.

4.4.2. Proposal for revolutionizing the prevention and management of hypertension and heart disease

Speaker: Rainford Wilks

The chronic non-communicable epidemic in the region has been recognized since the 1960s but the policy and institutional response has lagged behind the academic efforts to respond to this epidemic. The sojourn of Bill Miall and his colleagues in the region (Lawrence Tavern, Jamaica etc.) and the seminal work of George Miller in Trinidad were all in recognition of this emerging epidemiological transition. There have been regional responses to this epidemic exemplified by the response led by PAHO, including the efforts of Knox Hagley and colleagues, and more recently the efforts of the CHRC. These responses included both standard approaches of prevention and the development of manuals and guidelines for improved management of those afflicted. Perhaps the major difference today is the apparent commitment of regional political leaders to the process.

There is good evidence that the regional burden of the CNCDs has increased as estimated by mortality and morbidity statistics. There are also valid data documenting an increase in the burden of risk factors in particular obesity and diabetes mellitus. Of the major risk factors fuelling these risk factors, the increase in available dietary energy has also been documented; and while secular trends in physical activity are less readily available, large proportions of the region’s populations are classified at low and moderate physical activity levels.

The regional response must essentially consist of the population approach to reduce risk factors (shifting the distribution to the left), complemented by better detection and management of those already afflicted. The weight of regional and international evidence suggests that nutritional (lifestyle) management (healthy eating and improved physical activity) is the mainstay of risk factor reduction. The efficacy of lifestyle management and available pharmacological agents is also well documented and it is the effectiveness and efficiency of these interventions which require testing and implementation in the regional response.

Improved lifestyle will require the ready availability of healthy options for diet and physical activity complemented by health education to assist the population in making these choices. Improved detection and management of hypertension and heart disease will require synergies between the health systems (private and public), the assistance of NGOs (especially in screening), improved health provider attitude especially in diligently “treating to goal”, increased patient involvement, including knowledge of goals and improved monitoring (e.g. subsidized home blood pressure monitoring machines). The health system must respond creatively and in this regard we recall the crucial role of public health nurses and inspectors in the eradication of the communicable diseases. We need to develop a similar cadre of health workers with similar reach into the community but with the required new skills to respond to the CNCD epidemic.

4.4.3. Revolutionizing the management of cancer: Prevention

Speaker: Anesa Ahamad

Cancer is predicted to become the number one cause of death within the next few years worldwide. It is a leading cause of death associated with pain and suffering, resulting in 7.6 million deaths worldwide in 2005 (i.e. exceeding total deaths from AIDS, TB and malaria combined), with more than 70% of cancer deaths occurring in low- and middle-income countries. The most feasible strategy for cancer prevention is through education and provision of evidence based information and resources for the general public and patients, health care providers, politicians and decision makers.

Most countries in the Caribbean can successfully implement the three basic components of cancer control: prevention, early detection with treatment for cure and care of people living with cancer. However health workers are desperately needed in the area of cancer care. The most efficient initiative is training of non medical staff to demedicalize education and prevention and collaboration to share

scarce and resource intense resources such as expensive equipment and experts. The strategy comprises (a) support for a network of Caribbean professionals both at home and abroad (Canada, USA and UK) with regional cooperation to provide shared specialized centres; (b) advocacy for healthcare agencies to mandate and pay for staff education and training of non medical educators and facilitators; and (c) use of available resources – e.g. use of WHO's six modules that guides programme managers on how to advocate, plan and implement effective cancer control programmes, especially in low- and middle-income countries (<http://www.who.int/topics/cancer/en>).

The International Union against Cancer (UICC) has outlined the following major targets by 2020:

1. Sustainable delivery systems in place to ensure effective cancer control programmes for all countries
2. Measurement of global cancer burden and impact of cancer control interventions to improve significantly
3. Global tobacco consumption, obesity and alcohol intake levels to fall significantly
4. Populations in areas affected by human papilloma virus (HPV) and hepatitis B virus (HBV) covered by universal vaccination
5. Public attitudes towards cancer to improve; damaging myths and misconceptions dispelled
6. Many more cancers diagnosed early through screening and early detection; high levels of public and professional awareness about important warning signs
7. Access to accurate cancer diagnosis, appropriate cancer treatments, supportive care, rehabilitation services and palliative care to improve for all patients worldwide
8. Effective pain control measures available universally to all cancer patients in pain
9. Training opportunities available for health professionals in different

- aspects of cancer control to improve significantly
10. Emigration of health workers with specialist training in cancer control to reduce dramatically
11. Major improvements in cancer survival rates in all countries

National development agendas must include cancer, which must be among political priorities. A country's investment in cancer management is an investment in national economic and social well-being. Training health care workers involved in cancer management, re-training and repatriating or importing such workers to the region are critical initiatives to develop cancer care and pain relief programmes. In summary, we should "toast cancer": Train the trainers and decision makers; Optimize use of existing staff; locate educators in clinic; Avoid cancer through prevention programmes; and STOP pain and suffering due to cancer by providing holistic care.

4.4.4. Proposal for revolutionizing the prevention and management of lung disease

Speaker: Tim Roach

The single most effective method for revolutionizing the prevention and management of chronic lung diseases is to reduce tobacco consumption. There is a paucity of local and regional data on the relationship between tobacco exposure and lung disease, and on lung diseases in general. The three lung diseases which provide the greatest challenges to prevention and control, and have the greatest global burden are chronic obstructive pulmonary disease (COPD), lung cancer and asthma.

Global COPD statistics indicate an overall prevalence of 10% (12% male, 9% female), with an estimated 600 million sufferers worldwide (WHO). It is the fourth leading cause of death in the USA, costing over US\$14 billion per year, while its prevalence continues to increase. COPD is caused by smoking and pollution.



photo courtesy of Andrew Hulsmeyer



Lung cancer is the principal malignancy leading to death in the USA, and smoking is the key risk factor. Urgent ratification by all countries signatory to the International Framework Convention on Tobacco Control will provide widespread enactment of legislation to limit or eliminate smoking in public places; ban the sale, advertising and promotion of tobacco products to children; and require effective warning labels on all cigarette packets. In addition, there is need to promote fiscal measures, i.e. increased taxes, to reduce tobacco consumption.

Asthma is the commonest chronic disease of childhood, and international prevalence rates vary enormously. The global International Study of Asthma and Allergies in Childhood (ISAAC) reported the highest prevalence of asthma ($\geq 25\%$ of schoolchildren affected) in New Zealand, Australia, UK and Ireland. Barbados, Jamaica and Trinidad reported prevalence rates between 17-20%. Exposure to cigarette smoke (including in utero and during infancy) and obesity are two of the main risk factors for asthma. Air quality is also a key risk factor for lung disease. So called "sick buildings" are increasingly recognized in the region, and air quality monitoring needs to be on national health agendas. We are yet to address the relevance of climate change in the region.

In conclusion, there needs to be political commitment at the highest level, and reduction of factors leading to lung disease through tobacco control measures, including legislation and taxation.

4.4.5. Question & Answer session

Chairpersons: Henry Fraser and Anselm Hennis

Prof. Wilks deemed it appropriate to suggest reduced salt intake as a major initiative to our leaders, with the compelling evidence for the benefits of such interventions being noted in support. The Consensus Action on Salt and Health (CASH), in the UK, where a group of specialists worked successfully to achieve consensus between the food industry and government in order to reduce salt levels in processed foods, was used as an example. In this instance, results had shown that reductions in blood pressure would be evident in 6 months.

A proposal to "de-medicalize" blood pressure measurement in the community, via introducing blood pressure monitors to barbershops for opportunistic screening, was suggested and supported by the initiative's possible success with only minimal training.

It was recommended that public education and healthcare provider education within communities be increased and worksite wellness programmes acknowledged as an important strategy. With regards to advocacy, it was recommended that there be ongoing systematic representation at the CARICOM level.

Despite the decision at the level of international agencies not to link marijuana use to the tobacco use, Prof. Hassell noted that the widespread use of marijuana within the Caribbean may require an unconventional approach, where the issue of exposure to tobacco smoke was linked to reducing marijuana use.

4.4.6. Mixed group table discussions in which the proposals presented are reviewed from a whole Caribbean perspective **Chairpersons:** Henry Fraser and Anselm Hennis

Participants were divided into groups comprising members from different countries, for discussion of the previous four presentations in terms of the potential approach from Caribbean perspective, with identification of likely barriers and support measures, using worksheets provided for guidance. Different groups selected aspects to be considered, with some groups focusing on different diseases (diabetes, hypertension and heart disease, cancer and lung disease) while others applied a concept (e.g. the lay facilitator model) to all diseases. The rapporteur from each group then provided a brief summary to all participants (see next section).

4.4.7. Plenary discussion, presentation of Caribbean plan for CNCD management and conclusions

Chairpersons: Henry Fraser and Anselm Hennis

a) Group 1: Physical activity and smoking control

Civil society should work with governments to achieve national targets for reduction of CNCDs in the following areas.

Physical activity

Civil society should be involved in influencing the review of town and country planning regulations for provision of recreational space in communities, developed to support community needs. There should be a move towards comprehensive physical activity programmes during and after work hours, and its accomplishment is suggested via collective agreement and provision of physical activity resources (taxation/duty free concessions). Civil society must promote the use of beaches and marine environments as physical activity resources so that, for example, certain beaches within the Caribbean could be designated to have lighting and security issues addressed, enabling them for use even after hours.

Smoking

Concerning smoking control, civil society should continue to advocate with constituents to support FCTC, encouraging embracement of framework convention on tobacco control and seeking to provide support for countries that have not yet ratified the FCTC. The identification and targeting of youth and teens is specifically emphasized, as smoking habits start in this age group. The media is a critical resource for information dissemination and its use is encouraged, along with the use of resources to implement tobacco cessation programmes. Civil society and NGOs should provide a framework for these programmes.

(b) Group 2: Lay facilitator model

Prof. Morrison's proposal should be applied to all four diseases. Owing to its feasibility, this lay facilitator programme should be expanded, with provision of specific funding. The programme would empower communities, enabling them to take more responsibility for their health. Messages need to be specifically targeted for certain

age and gender groups. More lay facilitators should be trained more generally in chronic diseases (not just diabetes) and their risk factors. Referral systems should be in place for chronic diseases and lay facilitators used for awareness-building and directing people who may not know about screening facilities.

Screening is generally integral to chronic disease and follow-up services need to be available for screening programmes. The government system is over-burdened and NGOs could be utilized to offer this service, perhaps by formalizing the situations where NGOs screen. In Barbados, for example, the Barbados Cancer Society annually screens for breast cancer during the month of October. A similar model could be used to identify cases of hypertension.

More research is needed to uncover reasons for non-compliance with anti-hypertension treatment; research which should be completed before measures to combat this practice are implemented. Screening is also important in the overall management of cancer and lung disease and NGOs could usefully be involved where possible.

The main barriers to the implementation of the Lay Facilitator model is the lack of funding, with special regard to the training of facilitators, the unavailability of qualified persons to conduct training and occasional resistance to co-operation with other agencies. A standardized system of training of Lay Facilitators is recommended for the entire region.

(c) Group 3: Lay facilitator model

Lay educators' programmes need to be established throughout the region. Persons would be trained by various foundations that deal especially with heightened awareness and non-compliance. One programme to cover all chronic diseases is required – not a separate diabetes lay facilitator, and a cancer lay facilitator, etc.. Tobacco interventions, cancer, and hypertension, should all be included in such a programme. Areas for training should include waist measurement and blood pressure monitoring, with added questions on tobacco use. Some form of training partnership is essential for a functional coalition between diabetes and heart foundations and tobacco control organizations. Furthermore, databases should be developed for these conditions in each country, to help us understand the scope of the problems in the region.

The plan of action must therefore incorporate legislation change and development and standardization of simple, easy-to-use questionnaires to provide additional information.

(d) Group 4: Lay facilitator, waistline measurement, reduction in salt intake and cancer education for health care professionals

All islands require a paid, full time programme of facilitators and educators deployed to every health facility and health centre, hospital and pharmacy with the aim of covering every interface with patients, i.e. one should always see the lay facilitator before seeing the doctor (unless in an emergency!). Internet access, videos, DVDs, audio and print are also vital; every form of media and contact person must be identified.

Civil society
can play a
leadership role
in promoting
NCD screening,
tobacco control
and dietary salt
reduction



Advocacy is needed for legislation to reduce salt in food, including bread. Regarding waist-line measurement, efforts to reduce obesity would be appropriate.

Funding is needed for a mandatory education programme for medical professionals and health workers, especially in cancer, so as to destroy existing myths and train on evidence-based guidelines for treating cancer and other CNCDs. These funds are also needed to allow health workers time off for training; to pay the trainers; and to provide all trainers' materials (print, audio, video, DVD).

Concerning lung disease, a plan must be prepared and implemented for the enforcement of tobacco legislation and consideration given to the way in which it would be policed. Enactment and enforcement of the occupational safety and health act, which all governments have been signatory to, is also needed – ILO convention.

A pain management programme needs to be implemented to combat myths about morphine and the common belief that cancer pain is not curable. The barrier to this is the availability of (very cheap) drugs.

(e) Group 5: the role of NGOs

There is a need for the legitimization, legislation and recognition of a definitive role for NGOs in the Caribbean and in enabling the environment. Technical and funding support from international bodies to collective NGO groups is more likely to be successful than to disparate groups of well-meaning individuals. A certified training programme for NGOs exists in Jamaica and in much of the West Indies. However, this is perhaps not the case in other territories in the Caribbean and should be encouraged by ensuring training is going on in concert throughout the region.

The Council for Voluntary Services (CVS), which used to exist in Barbados, is similar to the lay facilitator programme in Jamaica. The CDB (supporter of this conference) could play a leading role in funding the organization of other CVS across the Caribbean. Doctors have limited time to pass information to patients. Information needs to be provided in logical way and patients need to be aware of other information sources.

(f) Group 6: Screening and management, tobacco and diet *Screening and Management Programmes*

Annual comprehensive screening programmes should be implemented or, if already in existence, strengthened. For example, a question remains as to what is to be done with the information from screening in workplace and in schools at beginning of the school year. Barriers include human and financial resources and technical skills – especially relating to equipment.

Smoking

Smoking is a risk factor for all areas presented and advocacy is needed for legislation for 100% smoke-free environment. One of the major barriers will be lack of political will, especially where governments feel this will impinge on rights.

Diet

Advocacy is needed for comprehensive food-security policies to include breast-feeding, labelling of foods, school feeding and nutrition education re: nutritional value of foods (how much and what). There is also a need to advocate for involvement in trade negotiation as most of our foods are imported.

(g) Group 7: Lay facilitator model

There should be an increase in screening, using lay facilitators. For example, screening for CNCDs can be increased through the use of unconventional outlets: identified faith-based organizations, hairdressers, barbers and the workplace. Barriers include cost, confidentiality, laws, research (lack of data) and the need for behaviour change in medical practitioners to support this initiative.

(h) Group 8: Cancer, Lung disease, Diabetes, Hypertension

Cancer

Regarding cancer, prostate cancer proves most important with a need for early detection thorough screening (starting at 45 years), resources and corporate partnerships. Support can be achieved through the use of men as lay educators; men's clubs, NGO resources and polyclinics. This proposal, however, requires facilitation through government concessions, e.g. removal of taxes on PSA reagents to reduce cost. Barriers include male sensitivity, the need for a creative approach to clinic appointments (e.g. retired men in morning and workers in evening) and the cost of prostate cancer screening (e.g. the PSA test in Barbados is >\$100).

Colorectal cancer, second in significance, requires lot of screening or proactive activity. Routine colonoscopy is recommended every 5-7 years for people 60 years and older. Support involves empowering patients to know and to insist on educational provisions, creating awareness among the public and gaining the support of the government. Barriers include the cost (BB\$600), the attitude of certain doctors in referring, misinformation and the need to lobby government to get insurance companies to provide for screening.

Lung disease

Lung disease requires education of health providers, provision of affordable prices for medication and devices and policies in schools to recognize signals and act appropriately e.g. an attack in a child; to allow schoolchildren to use medication and to have smoke-free environments. Barriers include knowledge of healthcare professionals (additional training support needed) and the very high death toll in children with asthma which must be tackled.

Diabetes

Promotion of blood pressure control in diabetes is very important since 75% of deaths are from heart attack and stroke (not just high blood sugar). There is limited information from the Diabetes lay programme and a toolkit is needed which should then be shared throughout the region. Everyone must have opportunity to study and

implement it. Barriers include resources, human and financial, and motivation for participation. Government acceptance should lead to major support. Health professionals need reinforcement so that they are sold on the concept. They also need to share their information with lay educators, enabling and educating them for formation of peripheral groups, so that more people get on board to spread the message out at all levels.

De-medicalization of blood pressure

Opportunities need be provided for people to have blood pressure taken at the barber shop, beauty salon, pedicure facilities, etc.. Barriers include the cost of instruments needed to do this in so many areas, their maintenance, their calibration etc.. Community health professionals could be used to keep an eye on these programmes, to see that monitors are working properly and to maintain programmes with the support of proprietors of establishments.

Other

Programmes are needed to inform on numbers, risks and targets. Everyone should be aware of his or her BMI, height, weight, systolic

and diastolic blood pressure, food portion sizes. Barriers include food portion size and resistance to persons allowing knowledge/information on themselves to be held by others. Support requires willingness and growing interest of the private sector in trying to bring about better health. A prediction chart for self-assessment needs to be adapted for Caribbean and its circulation promoted.

Generally speaking, the goal is to enable people to become more supportive and knowledgeable of their own health in all of the above areas.

4.4.8. Presentation of the 5th InterAmerican Journalism Contest Awards on Tobacco Control

The “NO Tobacco” awardees were:

Cheryl Springer of Stabroek News,
Guyana

Fernanda Melfi D' Avila Andrade of Bandnews Brazil,
Brazil



Fernanda Melfi D' Avila Andrade, of Bandnews Brazil receives her award from Dr Raphael Schuleib



Dr Raphael Schuleib, president of the InterAmerican Heart Foundation presents an award to Cheryl Springer of Stabroek News, Guyana



4.5. Part five: Partners in change — toward 2012 Coming Together to Defeat the Caribbean epidemic of CNCDs

Chairpersons: Errol Morrison and James Hospedales

4.5.1. The First Caribbean Wellness Day

Speaker: Alafia Samuels

The first Caribbean Wellness Day (CWD) took place on 13 September 2008. The slogan adopted was “Love That Body”. A logo and posters were developed and circulated in the region. The main target audience was adults older than 40 years who are physically inactive. The main messages were: (a) No tobacco – Half of regular users will die from tobacco; (b) Exercise 30 minutes per day – Cut your heart attack risk in half; (c) Less salt, less fat – Don’t add salt at the table; and (d) Check your Blood Pressure – The Silent Killer.

To prepare for the CWD, representatives of 14 countries attended a PAHO-sponsored Physical Activity Workshop in May 2008, where plans were developed, followed by the dissemination of a summary and guidelines to participating countries. Countries identified a CWD “Focal Point” and established inter-sectoral committees, including representatives from the private sector and civil society, and established links with local media. Member states all had events, although these were limited in the Bahamas, Haiti, and the Turks & Caicos, which were recovering from damage caused by recent hurricanes. Prime Ministers and Ministers of Health made statements in support of CWD in most countries; the local media carried press releases, and there were health screenings among other health promotion activities. Essentially the CWD acted as a “launch-pad” to promote increased physical activity, healthy eating, and healthy lifestyle changes to stop the epidemic of CNCDs.

Proposals for 2009 are: to build on the experience of the successful 2008 CWD; to propose the expansion of the inter-sectoral CWD committees to become CNCD Commissions where these do not yet exist to source funding for CWD 2009 and to start work on the CWD 2009 immediately. Suggestions for CWD 2009 preparation include physical activity where countries who want to do CAR FREE spaces perhaps monthly or weekly, are trained. Collaboration with mayors, architects and town planners to create supportive environments will be necessary. Other proposals included finals of competitions for tasty healthy foods to encourage healthy eating as well as finals of school debating competition and song competition for health promotion. Screening for blood sugar, cholesterol, HIV and blood pressure in most workplaces and churches (guarantee confidential results) was also proposed.

4.5.2. Report on Workshop on mobilizing the Caribbean private sectors response to CNCDs, and the role of the private sector in tackling the chronic diseases

Speaker: Sue Springer

The CAIC/PAHO workshop was held in Trinidad in May 2008 with the primary aim of encouraging the Caribbean private sector to take a more active role in the reduction of chronic non-communicable

diseases, by implementing risk reduction measures among employees and the wider community. This would be facilitated by changing private sector policies and practices that reduce CNCDs, by adopting relevant strategies outlined in the Summit Declaration, through regular circulation of health information, by promotion of physical activities and healthy living such as implementing workplace health promotion programmes, and by increased partnership between the private sector and government.

At the workshop, participants identified a need for wellness programmes in all companies, and devised an action plan for implementation. The need for the highest political commitment was acknowledged, with establishment and strengthening of national policies and plans for the prevention of chronic diseases; as well as promotion of specific interventions to reduce the risk factors for, and conditions predisposing to, chronic diseases. Participants also concluded that partnerships should be promoted and systems established for monitoring and tracking chronic diseases, along with promotion of research for their prevention and control.

Employees who eat poorly, do not exercise and fail to schedule routine checkups are likely to miss more days of work, be less productive at work and incur higher medical costs. Provision of workplace wellness programmes is a sustainable approach to reduce absenteeism, which ideally should not exceed 3%. Most absences from work are due to illness, especially chronic diseases, and occur more frequently among the impoverished, among those performing dangerous, stressful work, or perceived workplace discrimination (leading to workplace angst). The workshop concluded that workplace wellness programmes should be part of a company’s comprehensive strategy, including provision of training, and health and safety legislation in place to provide the groundwork for such programmes. The steps involved in setting up such programmes were outlined, and included raising awareness, education and skill-building, environmental support, and development of clear, written policies. The basic idea is to foster a culture of wholesome wellness and enhanced lifestyle at the workplace.

In summary, health and wellness lifestyle programmes are critical, and companies are increasingly cognizant of their importance. They must cover ALL aspects of the wellbeing of workers (health, money matters, operations etc.), and have support services – such as other private sector entities. Those designing and implementing the programmes need to be aware of the need to be confidential, sensitive, patient and above all to make the process fun!

4.5.3. The Bloomberg Global Initiative to Reduce Tobacco Use – The Caribbean Project

Speaker: Debbie Chen

The Bloomberg Global Initiative was founded in 2005 with special focus on the 15 countries in the world with the highest prevalence of smokers. The project is administered by several agencies including the Campaign for Tobacco-Free Kids in the USA, CDC Atlanta, Johns Hopkins Bloomberg School of Public Health, the WHO, the World Lung Foundation and its partner the International Union against Tobacco and Lung Disease.

Tobacco is a risk factor for six of the eight leading causes of death worldwide and is the only product which kills when used exactly as the manufacturer recommends. The most effective control measures are higher taxation, elimination of advertising, promotion of smoke-free environments and strong graphic health warnings on packaging. The Bloomberg initiative in the Caribbean concerns the latter – to implement rotating picture-based warnings on cigarette packaging in four Caribbean countries.

4.5.4. Question & Answer session

Chairpersons: Errol Morrison and James Hospedales

The need for more gyms in new hotels across the region was expressed.

Dr Shirley Alleyne, PAHO, commented that it would be great to have more smoke-free hotels, noting that guests cannot smoke in hotels in their home countries. She also responded to the query about smoking, acknowledging hotels with ‘no smoking’ restaurants and ‘no smoking’ rooms which are becoming popular. Formal legislation was expected soon and the Barbados Tourism Association is in support of limiting smoking in bars. Dr Alleyne also mentioned a UWI study on absenteeism, which led to a discussion about why people stayed off work. It was suggested that flexibility was needed in the workplace to accommodate employees who found it difficult to eat properly or had challenges collecting children from school, etc. It was suggested that crèches be a possible solution.

Prof. Rainford Wilks commented on research funding: as international funds are very scarce and competitive, he suggested researchers consider more local funding. After recognizing the

contribution to the TMRI in Jamaica by the National Health Fund (e.g. the Lifestyle Survey), Prof. Wilks wondered whether other NGOs in the Caribbean could not be seen – or see themselves – as lobby organizations to support the funding of research, nationally, regionally and internationally. He pointed out that other local sources of funding in Jamaica include the Chase fund (lottery money), and funds from tobacco tax and he recommended that the Caribbean region should consider the Jamaica model. A further suggestion by Prof. Wilks concerned information and communication technology. The suggestion was that the Caribbean region move towards unique identification numbers for its population – to allow information from all sources to feed into a central database.

4.5.5. Regional NCDs Surveillance System – an IDB supported project

Speaker: Paul Teelucksingh (author)

Caribbean territories share a common heritage and it is not surprising that we experience health/wellness issues that are quite similar. Chronic non-communicable diseases (CNCD) e.g. diabetes, hypertension, lung disease, some cancers, cardiovascular diseases and obesity have emerged as a major burden to the region costing lives and productivity.

The University of the West Indies, which this year celebrates its 60th year as a regional institution, has received a technical assistance grant from the InterAmerican Development Bank to undertake a project to develop a research and surveillance system targeting CNCD. This project, to be conducted in six countries - Belize, Bahamas, Jamaica, Barbados, Trinidad & Tobago and Guyana – will





run over 3 years in which time the piloting and implementation of a regional CNCD surveillance system will be established using common, standardized methodologies and technology. Another important expectation of the project is to deliver policy guidance in respect of the "Declaration of Port-of-Spain" which emanated from the CARCIOM Summit of Heads of State and Government on CNCD (Port-of-Spain, 15th September, 2007).

The University of The West Indies in close collaboration with the ministries of health in the respective territories (through their Chief Medical Officers) will execute the project. CAREC will provide technical assistance and Steering Committees will align local needs and expectations towards the design of this region-wide operating system.

4.5.6. Duke U./PAHO/CARICOM – a collaborative effort: meeting the challenge of the CNCDs

Speaker: Dorothy Powell (author)

This presentation describes the process of building relationships and seeking areas of mutual interest for collaboration between the Duke University School of Nursing, nursing and other health professional counterparts in the Caribbean using a community engagement model. The Caribbean nursing community sought assistance in developing a model of evidence-based care and services, workforce development, and research to address aging and cardiovascular and other chronic diseases which could have relevance and application throughout the Caribbean. Duke University School of Nursing partnered with PAHO-CPC to address the concerns and regional priorities. In 2008, the partnership was extended to include the Regional Nursing Body of PAHO. These relationships led to a joint commitment to work with a broad network of nursing colleagues, other disciplines, and stakeholders to explore, refine, and recommend evidenced-based models, programmes, and strategies to manage chronic diseases among the elderly and to facilitate disease prevention and health promotion. The partners would collaborate on capacity building, research/scholarship, advocacy, and through the development and translation of research. A series of three invitational continuing education conferences, supported primarily by the US Centers for Disease Control and Prevention are/or will be planned to inform, promote and inspire leadership toward a preferred future for Caribbean elderly. The series of conferences, with representatives from throughout the Caribbean focuses on (1) Management of Cardiovascular Disease in the Elderly (October 2007, Barbados); (2) Community-based Prevention and Management of Cardiovascular and Other Chronic Diseases among Caribbean Elderly: A Focus on Nursing Leadership (October, 2008, Antigua); and (3) a yet, unnamed conference that will focus on policy (October 2010). The conferences serve as a launching pad for subsequent activities throughout the years. Spin off initiatives include the following: an evolving official relationship between Duke University and UWI with a focus on education and research; an agreement with UWI-Mona School of Nursing on faculty development in geriatrics and chronic diseases; consultation and technical assistance to nursing

and nursing education on other islands; and an expanding Duke presence through student experiences and exchanges.

4.5.7. PwC/Health Research Institute –

potential resource in tackling the chronic disease epidemic
Speaker: Karen Mitchell

The PricewaterhouseCoopers (PwC) Health Research Institute (HRI) provides dedicated global healthcare research through leading-edge intelligence, perspectives, and analysis. The HRI supports decision-making and strategy development for the private and public sector and leverages diverse PwC experience within the health industries. Their publications are used by policy makers, businesses, healthcare "thought-leaders" and the major media e.g. CNN. The HRI is a strategic partner with the World Economic Forum, and implements strategies to promote workplace wellness and stem the tide of chronic disease, with particular focus on developing countries.

There is economic rationale for health and wellness. For example, healthcare costs (in the USA, people with CNCDs account for more than 75% of the nation's US\$ 2 trillion in medical spending), productivity (losses associated with poor health risks are as much as 400% of the cost of treating chronic disease and include absenteeism, reduced effectiveness, increased accidents, etc.), human capital (organizations invest an average of \$290 in labour costs to generate \$1,000 in revenue), and sustainability (as the economic burden of chronic disease grows, it could consume monies needed to improve other critical areas such as education and infrastructure). There are potential gaps in information, such as the following: lack of incentives for "upstream" behaviour; lack of common definitions and standards; clinicians not viewed as partners; poor environmental factors; lack of consideration of genetics; lack of partnership between the private and public sector; and fragmentation of the current infrastructure. A number of solutions exist for these problems, based on global examples which have used PwC/HRI approaches, and these include investing in public health and education, empowering patients, creating information infrastructures. People are the cornerstone to a nation's success; building and sustaining a culture of health and wellness is key to reaping rewards for a country and its people.

4.6. Part six: Civil society meeting the challenge

Speakers: Conference Leaders

4.6.1. What was heard throughout the conference

Prof. Hassell defined "revolution" as a fundamental change in thinking, or a change of paradigm – and declared this to be our challenge in moving forward following this conference. He acknowledged the tremendous excitement of participants during the 3 days of the meeting, and their willingness to be involved in the Wellness Revolution. He expressed the commitment to continue to accommodate and support everyone's determination to be involved, especially in advocacy, which is the major role of civil society.

Dr Beatriz Champagne noted a great deal of enthusiasm (with

many exclaiming “It’s about time!”), and a sense of good timing – for the activities now taking place. In addition, she noted a willingness to be open – to learn, to change towards the revolution, and a desire to continue, not to drop the ball, with many participants asking questions about what events would come next, and how we could ensure that the revolution would continue.

Dr James Hospedales commented on the shared vision/passion now evident in the region, with increased numbers of people becoming active and participating at both country and regional level. He stressed that we must advocate and build the capacity to advocate; that we, in the Caribbean, should unite over things that are in everyone’s interest, especially at the risk factor level, and he emphasized the need to work together – especially concerning with this movement, which began last year together to realize and spur on the revolution.

Prof. Fraser spoke of his sense that there was a willingness to work together and stressed the need for partnership, partnership, partnership. He repeated the call for monitoring and evaluation, and pointed out that we need both CNCD surveillance and risk factor surveillance. In other words; action, action, action: urgent action – and he begged those present not to drop the ball. Prof. Fraser then proposed that a Caribbean civil society task force be established to take forward the decisions made during the conference. This task force would include a modest number of persons from civil society to advance the Action Plan, organize the network of civil society, and organize the revolution – e.g. academics, PAHO, CARICOM representatives, etc. They should complete and finesse the declaration and the Action Plan and in so doing we could guarantee the promotion of the meeting’s agenda. Prof. Fraser pointed out that the UWI had now committed to hosting a physical activity workshop in Barbados in the first quarter of 2009, as a direct outcome of this conference.

There was consensus with Prof. Fraser’s proposal for the establishment of a task force, he then formally proposed that Prof. Hassell, act as Chair. Prof. Hassell indicated his willingness to undertake the proposed task.

Other participants shared their views about the meeting.

Dr Oscar Jordan highlighted the view that the community has to deal with CNCDs both as a group and individually. He pointed out that there is a Diabetes Association of the Caribbean which has been functioning for many years and this conference has helped to re-invigorate the concept underpinning the organization and this would be an opportune time to forge partnerships both to raise the profile and reinvigorate the association. Dr Becky Lankenau thanked the organizers and noted that she had been to many meetings over several years, and had never seen such a specific follow-up action plan. She was excited that the idea of the Physical Activity Workshop already had legs.

Mrs Ena Harvey suggested promoting eating local foods, by proposing a ‘Healthy Cooking the Caribbean Way’ workshop, to which she would like to make a commitment and suggested a number of organizations which could participate.

The Wellness
Revolution
– requires a
fundamental
change in
paradigm
– this will be
our challenge
moving forward



A representative from the Seventh Day Adventist Church commended everyone noting that the church has a philosophy to promote health and wellness for all its members. The relevance of the conference to this goal was important and they look forward to being part of the coalition.

Dr Raphael Schuleib felt that this forum provided a great opportunity for those already working in the field of CNCDs.

The Chief Medical Officer of Barbados, Dr Joy St John, stated that there needs to be a clear recognition of NGOs and their work, in order to identify the support they needed as well as specific roles. There is also a need for government to work collaboratively with the NGOs. She hoped the Declaration would lead to very strong revolutionary statements about timelines so as not to lose the momentum started at this very successful workshop.

Dr Shirley Alleyne (PAHO) mentioned the power that civil society can have when members come together and act collectively. She noted the benefits of outstanding leadership, and suggested that it was also important to empower bodies to act collectively. Dr Alleyne emphasized how much could be done when we really believe in an ideal, citing the Caribbean Wellness Day as a successful example.

Prof. Philip James pointed out that several participants had referred to similar models in other countries and expressed his belief that we need to present a portfolio of all options which could be applied depending on a nation's needs. He felt that resources would be wasted and efforts could fail if we spent time merely duplicating everything.

Mr Orlando "Gaby" Scott (Barbadian Trade Unionist) stated that this conference was about getting civil society together with other players, noting that we cannot work alone and it is critical to build strong coalitions to push the agenda forward. He emphasized the need for all to be involved: doctors, researchers, NGOs etc. He also stressed the need for more interactions between countries.

Mrs Ena Harvey, noting that the Caribbean is the most tourism-dependent region in world, expressed the view that we needed to promote "health and wellness tourism".

Ms Vickie Peters mentioned having facilitated many meetings, especially planning for the American Heart Association, but stated that in 25 years of activities she had not seen as much focus and energy as at this meeting. Secondly, the poor individual has always been burdened – she concluded that we had put that aside and instead agreed to the need to build a world where every individual can enjoy good health.

4.6.2. Platform Working Group presents final

"Platform/Declaration" and describes how they included ideas from the entire conference

Dr. Champagne detailed the more significant changes made to the document point by point, and concluded by naming and thanking the members of the Working group. Debbie Chen then thanked Dr. Champagne for all her hard work and proposed that the participants endorse the Declaration subsequent to final editing by the Working Group.

Prof. Hassell concluded the meeting by thanking everyone for their many contributions to, and attendance at, a very successful conference, and noted that if anyone had additional inputs to the declaration post-conference they should provide them to the working group. He finally pointed out that an Action Plan arising out of the contributions and discussions at the conference will be produced within the next few months and circulated for inputs, comments and subsequent approval.

4.6.3. Closing comments by participants

There being no further closing comments by participants, Prof. Hassell invited Sir George Alleyne to present his reflections on the way forward.

4.6.4. Reflections on the conference and the way forward

Speaker: Sir George Alleyne

The phrase "Wellness Revolution" was perhaps first used in the region by the Hon. Ralph Gonsalves, Prime Minister of St. Lucia, who through lifestyle change has lost 45 lbs since the Port-of-Spain summit held in 2007. Successful revolutions rarely start from the base; people armed with the information are the prime movers to mobilize those who go to the barricades. Present conference attendees are therefore expected to lead the rest of the Caribbean to the barricades in the fight against CNCDs.

A key challenge with CNCDs is that treatment is not supply but is demand driven. Thus if one is to bring about change it needs to be driven by the potential sufferers from CNCDs who demand of their suppliers, namely health care providers a certain level of service. An example of the application of this approach might be that every Caribbean adult has a risk factor card which he/she then uses to obtain information from his/her health care provider about his/her risk of developing CNCD.

This conference demonstrates what can be achieved with passion; the conduct of the meeting was excellent, and the mixture of participants contributed to much of the success. A key message was that we are all healthcare workers, regardless of our 'job' – and all are committed to a common cause, which is 'to improve the health of the Caribbean people'.

The following are the most revolutionary points:

- (1) De-medicalizing the issue of CNCDs– the idea of using lay workers is a great one. With this we can genuinely create a revolution.
- (2) Use of barber shops and hairdressing salons as locations for self measurement of weight, height and possibly blood pressure by clients.
- (3) Use of risk factor chart/card as a simple and powerful tool in the hands of individuals.

All present should take account of institutions, e.g. the National Council of Voluntary Social Workers, and we must not forget the input of the private sector. We should remember and repeat the conference Declaration, and make reference to it often. The content and spirit in

which they were created should make these declarations/charters last and the feeling of togetherness which has permeated this meeting is a powerful augury for their continued relevance.

All of us have a responsibility – some collective, some individual – we all move in circles of influence, some bigger than others. There are many things which each of us can do in our respective circles, but each of us should do three things:

- (1) Each one promise to tell at least one person what happened here (“each one tell one”)
- (2) Each person find a national association that already exists – either join or re-join it and offer to help
- (3) On returning home, contact a friend in the media and have a press briefing to apprise communities of the meeting

In closing, let me thank all participants who are asked to leave here

“clothed in the armour of social justice and armed with the sword of information” to go forward with this Declaration.

4.6.5. Words of thanks

Speaker: Alafia Samuels

Thanks are given to conference organizers for their efforts, especially Professor Trevor Hassell, Mr Adrian Randall, Ms Pam Proverbs and conference staff. Additional thanks to Ms Vickie Peters (American Heart Association), Dr Beatriz Champagne, Professor Fraser, all presenters, the staff of Accra Hotel, Prof. Hennis and the CDRC team, in anticipation of the technical report; to the Barbados Ministry of Health, dignitaries, the InterAmerican Heart Foundation, the Barbados Tourism Association and special thanks to Sir George Alleyne and meeting participants for all ideas. Finally, thanks to the organizations in the home countries of participants, who will lead this revolution.



Annexes





1. List Of Attendees – Faculty And Resource Participants

Attendees	Affiliated organizations
Dr Victor Matsudo	Agito Mundo, Sao Paulo, Brazil
Vickie Peters	American Heart Association, Dallas
Dr Tim Roach	Barbados Cancer Society
Dr Oscar Jordan	Barbados Diabetes Foundation
Sue Springer	Barbados Hotel and Tourism Association
Dr Fitzroy Henry	Caribbean Food and Nutrition Institute
Dr Donald Simeon	Caribbean Health and Research Council
Dr Becky Lankenau	Centers for Disease Control and Prevention, Atlanta, USA
Prof. Anselm Hennis	Chronic Disease Research Centre, UWI, Barbados
Prof. Trevor Hassell	Chronic Non-Communicable Diseases Commission, Barbados
Dr Dorothy Powell	Duke University, Atlanta, USA
Prof. Henry Fraser	Faculty of Medical Sciences, UWI, Barbados
Karen Gutierrez	Global Dialogue for Effective Stop Smoking Campaigns, USA
Karen Mitchell	Global Human Resource Solutions Group, Pricewaterhouse Coopers, NY, USA
Prof. Phil James	Global Prevention Alliance for Combating Obesity and Chronic Disease, London, UK
Debbie Chen	Heart Foundation of Jamaica
Carol Ann Senah	ILO Sub-Regional Office for the Caribbean
Dr Beatriz Champagne	InterAmerican Heart Foundation, Dallas, USA
Dr Rafael Shuchleib	InterAmerican Heart Foundation, Mexico
Dr Anesa Ahamad	Medical School, UWI, Trinidad & Tobago
Sir George Alleyne	PAHO, Washington, USA
Dr James Hospedales	PAHO, Washington, USA
Dr Alafia Samuels	PAHO, Washington, USA
Dr Ernesto Sebríé	Roswell Park, USA
Lorraine Fry	Smoking and Health Action Foundation, Canada
Prof. Errol Morrison	Technical University of Jamaica
Prof. Rainford Wilks	Tropical Medicine Research Institute, UWI, Jamaica
Prof. Paul Teelucksingh	UWI, Trinidad and Tobago



2. List Of Attendees - General Conference Participants

Attendees	Affiliated organizations
Dana Ruan	Anguilla Diabetes Association
Vivian James	Antigua & Barbuda Diabetes Association
Bradley Cooper	Bahamas Diabetes Association
Dr Carlos Chase	Barbados Association of Medical Practitioners
Rosita Pollard	Barbados Asthma Association
Dr Dorothy Cooke-Johnson	Barbados Cancer Society
Yvonne Lewis	Barbados Cancer Support Services
Tessa Chaderton-Shaw	Barbados National Council on Substance Abuse
Jennifer Hunte	Barbados National Insurance Office
Richard Nunez	Barbados National Insurance Office
Donna Coppin-Forde	Barbados Tourism Association
Byron Jackman	Barbados Workers Union
Orlando Scott	Barbados Workers Union
Anthony Castillo	Belize Diabetes Association
Rhona Grant	BVI Diabetes Association
Pedro Scantlebury	Cable and Wireless, Barbados
Rhonda Bryan-Hutson	Cable and Wireless, Barbados
Patricia Comoss	Cardiac Rehabilitation, USA
Sharmaine Edwards	Caribbean Association of Dieticians & Nutritionists (CANDI)
Candice Lawrence	Caribbean Association of Industry and Commerce
Beverley Dinham Spencer	Caribbean Cardiac Society
Dr Martin Didier	Caribbean Cardiac Society
Dr Pauline Williams Green	Caribbean College of Family Physicians
Elizabeth Nicholas	Caribbean Conference of Churches
Basil Scantlebury	Caribbean Pharmacists Association
Audrey Gittens-Scott	Caribbean Regional Nursing Body
Kamesha Turner	Caribbean Youth Ambassadors, CARICOM
Dr Sandra Plummer	CARICOM Secretariat
Barton Clarke	Chief Agricultural Officer, Barbados
Dr Joy St John	Chief Medical Officer of Health, Barbados
Mitchell Clarke	Chief Nursing Officer, Barbados
Angela Rose	Chronic Disease Research Centre, UWI, Barbados
Celia Greaves	Chronic Disease Research Centre, UWI, Barbados



Attendees	Affiliated organizations
Dr Ian Hambleton	Chronic Disease Research Centre, UWI, Barbados
Dr Kim Quimby	Chronic Disease Research Centre, UWI, Barbados
Dr Lynda Williams	Chronic Disease Research Centre, UWI, Barbados
Dr Nastassia Rambarran	Chronic Disease Research Centre, UWI, Barbados
Dr Tracy Carmichael	Chronic Disease Research Centre, UWI, Barbados
Dr Selvi Jeyaseelan	Clinical Research Management Inc.
Denise Carter Taylor	CNCD Commission, Barbados
Dr Kenneth George	CNCD Commission, Barbados
Ivy George	CNCD Focal Point, Min of Health, BVI
Lynette Rogers	CNCD Focal Point, Ministry of Health, Anguilla
Larone Hyland	CNCD Focal Point, Ministry of Health, Barbados
Alestina Anthelia James	CNCD Focal Point, Ministry of Health, Dominica
Gillian Julien-St Paul	CNCD Focal Point, Ministry of Health, Grenada
Dr Hazel Williams-Roberts	CNCD Focal Point, Ministry of Health, St Kitts
Anne Margaret Henry	CNCD Focal Point, Ministry of Health, St Lucia
Claudia Monlouis	CNCD Focal Point, Ministry of Health, St Lucia
Dr Patsy Wyllie	CNCD Focal Point, Ministry of Health, St Vincent
Shenica Haynes	Commonwealth Youth Programme, CARICOM
Owen Bernard	Diabetes Association of Jamaica
John Grace	Diabetic Association of Barbados
Marvlyn Birmingham	Dominica Diabetes Association
David Clarke	Duke Of Edinburgh's Award International Association
Priscilla Prevost	Eastern Caribbean Conference of Seven Day Adventists
Chris Ragunath	Guyana Chest Society
Dr Moti Lall	Guyana Chest Society
Glynis Alonzo-Beaton	Guyana Diabetic Association
Lucy Anderson	Health Promotion Education Unit, MOH, Guyana
Adrian Randall	Heart & Stroke Foundation of Barbados
Dr Stephen Moe	Heart & Stroke Foundation of Barbados
Wayne Hunte	Heart & Stroke Foundation of Barbados
Dr Knox Hagley	Heart Foundation of Jamaica
Leah d'Auvergne	Heart, Blood And Lung Foundation, St Lucia
Shelley Weir	Hope Foundation of Barbados



Attendees	Affiliated organizations
Sharon Howell-Clarke	Insurance Corporation of Barbados Ltd
Ena Harvey	Inter American Institute for Cooperation in Agriculture
Ian Ho-A-Shu	InterAmerican Development Bank
Joeseeph Peltier	InterAmerican Institute for Cooperation in Agriculture
Michael Leslie	Jamaica Cancer Society
Barbara McGraw	Jamaican Coalition Tobacco Control
Dawn Williams	Jamaica Coalition Tobacco Control
Raphael Barrett	Jamaica National Health Foundation
Rosemarie Lee	Jamaica National Health Fund
Lennox Prescod	Kiwanis, Barbados
Margo Clarke	Lions Club of Barbados
Richard A Green	National Union of Public Workers, Barbados
Victor Roach	NCPAAD, Barbados
James Fletcher	Organization of Eastern Caribbean States
Andrel Griffith	Pfizer Barbados Limited
Anthony Bryan	Pfizer Barbados limited
Richard Thomas	PricewaterhouseCoopers, Barbados
Shirley Alleyne	Pwr-ECC PAHO Barbados
Michel Loustric	Servier Ltd
Cuthbert St Juste	St Lucia Diabetic and Hypertension Association
Delia Octave	St Lucia Heart Blood and Lung Foundation
Gloria Williams	St Vincent & The Grenadines Cancer Society
Curtis Parris	Stokes and Bynoe Limited, Barbados
David Neilands	Supercentre (B'dos) Ltd
Augusta St Louis	Trinidad & Tobago Cancer Society
Dominique Monteil	Trinidad & Tobago Cancer Society
Ancil Kirk	Trinidad & Tobago Society of Planners
Skye Hernandez	Trinidad Express Newspaper
Leonard St Hill	Urban Developer, Barbados
Joan Dennis Manager	Urban Developer, Jamaica
Jacinta Anthony Branday	UWI Health Services, Mona, Jamaica

