Strategic Plan of Action for the Prevention and Conrol of Non-Communicable Diseases for countries of the Caribbean Commumnity 2011 - 2015

Pan American Health Organization/World Health Organization
Caribbean Community Secretariat

January 2011

Pan American Health Organization
Regional Office of the World Health Organization

CARICOM

STRATEGIC PLAN OF ACTION FOR THE PREVENTION AND CONTROL OF CHRONIC NON-COMMUNICABLE DISEASES (NCDs)

FOR COUNTRIES OF THE CARIBBEAN COMMUNITY (CARICOM)

2011 - 2015

Caribbean Community Secretariat/
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FOR COUNTRIES OF THE CARIBBEAN COMMUNITY (CARICOM)

2011 – 2015

EXECUTIVE SUMMARY

The Strategic Plan of Action for the Prevention and Control of Chronic Non-Communicable Diseases (NCDs) in the Countries of the Caribbean Community (CARICOM) is intended to form a road map for action and resource mobilisation at both the regional and country levels. The Plan also includes recommendations for country plans, and at the national level, countries need to own the Plan by adapting it according to their priorities, adopting it and identifying their own sustainable funding for NCDs, e.g., a National Health Fund. Regional funds can and may be injected.

This is not a Plan for donors. Individual projects requiring funding, which may be of interest to particular donors, have been identified in a Gap Analysis, a summary of which is set out in **Appendix VII.**

BURDEN OF DISEASE

The Caribbean epidemic of chronic non-communicable diseases (NCDs) – principally, cardiovascular disease including heart disease, stroke, hypertension, diabetes, cancer and asthma - is the worst in the region of the Americas, causing premature loss of life, lost productivity and spiralling health care costs.

This epidemic has the common root causes of unhealthy diets, physical inactivity, tobacco use and harmful use of alcohol, in turn, driven by social determinants and global influences

CARICOM SUMMIT SET THE DIRECTION

In response to the heavy burden of disease, and because of the multi-sectoral causes of the risk factors for these conditions, CARICOM Heads of Government convened a Summit on Non-Communicable Diseases (NCDs) in September 2007. This was a first-in-the world event in which Heads of Government took policy decisions to prevent and control the NCD epidemic. The 15-point Summit Declaration outlines a framework for policies and programmes across several government ministries, in collaboration with the private sector, civil society, the media, non-governmental organisations (NGOs), academia and the community, aimed at creating supportive environments *"to make the right choice the easy choice*."

NCD PLAN

This Plan responds to the *Declaration of Port-of-Spain* emanating from the 2007 CARICOM Summit on Chronic Non-Communicable Diseases, "Uniting to Stop The Epidemic of Chronic Non-Communicable Diseases"; forms part of the Caribbean Cooperation in Health Initiative Phase III (CCH-3); and is aligned with the Pan American Health Organisation/World Health Organisation (PAHO/WHO) strategies and plans for prevention and control of chronic diseases.

PRIORITY PROCESS AND OUTPUT INDICATORS FROM NCD PLAN LOG FRAME

PRIORITY ACTION #1: RISK FACTOR REDUCTION AND HEALTH PROMOTION

1. NO TOBACCO, NO HARMFUL USE OF ALCOHOL

1.1.1) World Health Organisation (WHO) Framework Convention on Tobacco Control (FCTC) ratified in all Caribbean countries by 2011
1.1.2) 100% smoke free public spaces (enclosed spaces) in at least eight (8) countries by 2013
1.1.3) 90% cigarettes sold in countries carry FCTC-compliant labels by 2012
1.1.4) Complete ban on tobacco ads, promotion and sponsorship in at least seven (7) countries by 2013
1.1.5) Smoking prevalence declines by 15% in at least two (2) countries by 2013

1.2.1) Reduction by 40% in the number of youths (< 18 years) consuming alcohol in six (6) countries by 2013
1.2.2) Reduction by 20% in motor vehicle and pedestrian fatalities associated with drunk driving in six (6) countries by 2013

2. HEALTHY EATING (INCLUDING TRANSFAT, FAT, SUGAR)

2.1.4) All imported and locally produced foods with required nutrition labels in at least three (3) countries by 2013
2.1.5) At least seven (7) countries have developed and implemented transfat- free policies and strategies by 2013 for 100% elimination of transfat from the food supply in at least three (3) countries by 2015
2.2.1) Model nutritional standards for schools, workplaces and institutions developed by 2013
2.2.2) At least six (6) countries adopt and implement food-based dietary guidelines in at least two (2) sectors by 2015

3. SALT REDUCTION

3.1.1) The CARICOM Regional Organisation for Standards and Quality (CROSQ) issues standards for salt by 2012
3.1.2) At least 80% of large food manufacturers following the Caribbean Association of Industry and Commerce (CAIC) pledge to reduce the salt and fat content of processed and prepared foods (including in schools, workplaces and fast-food outlets) by 2013

4. PHYSICAL ACTIVITY

4.2.1) At least five (5) countries with weekly car-free Sundays or some other ongoing mass-based, low cost physical activity event by 2013
4.2.2.) At least six (6) countries have new safe recreational spaces by 2012

4.3.2) Caribbean Wellness Day (CWD) celebrations in at least three (3) separate locations in each of 12 CARICOM countries by 2011
4.3.4) Sustained multi-sectoral physical activity programmes spawned by CWD in at least four (4) countries by 2013 and eight (8) countries by 2015

5. INTEGRATED PROGRAMMES, ESPECIALLY IN SCHOOLS, WORKPLACES AND FAITH-BASED SETTINGS

5.1.2) At least 20% increase in the number of schools with healthy meal choices and physical education programmes by 2013
5.1.3) At least 50% increase in the number of workplaces with healthy food choices and Wellness Programmes, including screening and management of those at high risk by 2013
5.1.4) Strategies for engaging with faith-based organisations (FBOs) in six (6) countries by 2012

PRIORITY ACTION #2: INTEGRATED DISEASE MANAGEMENTAND PATIENT SELF-MANAGEMENT EDUCATION

6. SCALING UP EVIDENCE-BASED TREATMENT

6.1.2) 80% of at risk populations screened and treated according to evidence-based guidelines from the Caribbean Health Research Council (CHRC) or other national Guidelines, including the risk chart approach, in at least two (2) countries by 2013

6.1.6) Countries and CARICOM develop and implement a proposal for shared tertiary treatment services that addresses technical, legal, economic and political realities

6.2.1) Ministry of Health senior personnel, NCD programme managers and at least 50% of primary health care (PHC) professionals trained in NCD programme quality improvement, based on national guidelines

PRIORITY ACTION #3: SURVEILLANCE, MONITORING AND EVALUATION

7. SURVEILLANCE, MONITORING AND EVALUATION

7.1.1) Health information policy and plan adopted in all countries by 2012

7.1.2) CARICOM countries collecting and reporting data at least annually on NCDs (risk factors, morbidity, mortality, determinants, health systems performance, including private sector data), using standardised methodologies, in at least 10 countries by 2011 and in 14 countries by the end of 2014

7.3.3) Risk factor and Burden of Disease data used to evaluate implementation of the *NCD Declaration* in at least eight (8) countries by 2013

PRIORITY ACTION #4: PUBLIC POLICY, ADVOCACY AND COMMUNICATIONS

8. ADVOCACY AND HEALTHY PUBLIC POLICY

In various countries, several policies, laws, and regulations adopted, such as tobacco taxation and the use of seat belts and helmets, have been successful in preventing or reducing the burden of disease and injury. . A substantial proportion of Caribbean countries still have no policies, plans or programmes to combat NCDs to support a reduction in behavioural and environmental risk factors. However, the NCD Summit in September 2007 delivered high-level support for multi-sectoral policies to combat NCDs.

8.1.2) Model regional guidelines for advocacy of NCD policy framework and legislation, identifying networking resources developed by end of 2012

8.1.3) Capacity built for health professionals, NGOs and Civil Society in networking, information-sharing and advocacy strategies to lobby for healthy public policies in five (5) countries by 2013

8.1.4) Priority government ministries and agencies review their policies that are relevant to NCD prevention and control by 2013

9. MEDIA AND SOCIAL COMMUNICATIONS

9.1.3) Capacity built for media (health journalists and reporters) to empower them to be more effective behaviour change and communication agents in four (4) countries by 2012 and 10 countries by 2015

9.1.4) Social Change Communication strategies, public education and information for preventive education and self-management, implemented in at least five (5) countries by 2013

PRIORITY ACTION # 5: PROGRAMME MANAGEMENT

10. PROGRAMME MANAGEMENT, PARTNERSHIPS AND COORDINATION

10.1.1) Inter-sectoral NCD Commissions or analogous bodies appointed and functioning in at least 10 countries by 2012, and in all countries by 2014

10.1.2) Model Terms of Reference (TOR) define multi-sectoral composition, mandates to make policy recommendations, and to evaluate NCD programmes, including public policies at the national level by 2012

10.1.5) Training in NCD prevention and control, partnerships, programme management and evaluation provided for Ministry of Health personnel and members of the national NCD Commissions in at least eight (8) countries by 2013

10.3.4) NCD Summit Secretariat develops, pilot tests and executes framework for coordination, monitoring and evaluation of *NCD Plan* and *NCD Summit Declaration* by 2012

10.3.6) External evaluation of implementation of the Regional *NCD Plan* and *Declaration* conducted by end 2013

11. RESOURCE MOBILISATION/ HEALTH FINANCING

11.1.1) Fundable projects identified from the Regional *Plan* presented to donors and funding secured for national NCD programmes, with regional support by Dec 2011

11.1.2) Joint training for stakeholders (public, private, civil society) in resource mobilisation and grant applications conducted in at least two (2) countries by 2012

11.4.1) Tobacco taxes funding NCD prevention and control activities in at least eight (8) countries by 2013

12. PHARMACEUTICALS

12.1.1) Common drug registration system agreed and implemented in at least eight (8) countries by 2014

12.1.2) Formularies for vital essential and necessary drugs established in at least 10 countries by 2013

12.2.1) Essential (accessible, affordable and high quality) generic drugs for NCD prevention and control available in eight (8) countries by 2012 – aspirin, beta-blocker, statin, thiazide diuretic, ACE inhibitor

TRANSLATION

The plans proposed in this document will need support at the regional level and dedicated resources at the national level. Earmarked funding will be required for its implementation.

EVALUATION

The Heads of Government have accepted the Evaluation Framework for assessing the implementation of the NCD Summit *Declaration* (Table 6 and Appendix IV). The data will come from national PANAM STEPS NCD Risk Factor Surveys in Member Countries, the Minimum Data Set and other sources.
A critical aspect of the evaluation will be the funding provided for implementation of this *Plan*.

PROJECTS

Project proposals requiring funding are set out in **Appendix VII** of this document.

POSITIVE ACTIONS

- The Regional NCD Secretariat has been established.
- The ***NCD Plan of Action*** has been completed.
- A **Model NCD Plan for countries** based on the regional Plan has been developed and has been circulated. Dominica and Suriname have used this Model Plan to develop their country NCD plans.
- Eight (8) countries report the establishment of **NCD Commissions**, though others are still seeking guidance on its composition, recommended terms of reference and function.
- The **Healthy Caribbean Coalition** has been established as the civil society umbrella organisation for the Region, to support implementation of the NCD Summit *Declaration of Port-of-Spain*.
    - Priority programmes to be implemented include advocacy, and coalition building, public education and media campaigns, monitoring and evaluation, support for existing country level networks and activities, and support for Caribbean Wellness Day (CWD).
    - Web site: www.healthycaribbean.org has been developed.
- The Caribbean Association of Industry and Commerce (CAIC) - the **regional umbrella private sector** organisation - has issued a Pledge in support of the NCD Summit *Declaration*.
    - The Pledge includes a commitment to Workplace Wellness Programmes, producing healthier products and support for CWD.
- Six (6) countries have completed risk factor surveys. Reporting on the Minimum Data Set began in early 2010.
- The Inter-American Development Bank (IDB)-funded **Regional NCD Surveillance Systems** Project is being executed by the University of the West Indies (UWI) with the participation of six (6) IDB countries - The Bahamas, Barbados, Belize, Guyana, Jamaica and Trinidad and Tobago - and with technical support from CAREC/PAHO. This Project audited country capacity in the collection and analysis of standardised valid data on NCDs and its risk factors, and developed a model system to guide the development of Health Information Systems throughout the Region.
- CARICOM and PAHO are planning to convene a **donors meeting** during 2011 to seek funding for the Caribbean Public Health Agency (CARPHA), the Caribbean Cooperation in Health Initiative, Phase 3 (CCH-3) and NCDs. 14 projects in the NCD *Plan* have been identified and elaborated to facilitate funding.
- All but two (2) countries have now ratified the **FCTC**. Trinidad and Tobago has passed its Tobacco Control Bill, which has been circulated to all CARICOM countries as a potential model for developing their own tobacco legislation.
- A **Caribbean Tobacco Control Project,** with funding from the **Bloomberg Global Initiative,** is supporting the packaging and labelling process in selected CARICOM countries. The images proposed as part of the CROSQ standard have been field-tested. The health warnings should be at least 50% of the principal display areas, should be on the top half, with rotating pictures or pictograms. These standards await adoption by the CARICOM Council for Trade and Economic Development (COTED).
- Caribbean Experts on control of Cardiovascular Disease (CVD) and Diabetes have recommended the adoption of the Total Risk Approach and the Chronic Care Model for the management of high-risk patients with cardiovascular disease. This initiative would be the most costly, but would yield the most lives saved. Since then, The Bahamas has decided to introduce CVD risk assessment in its services.
- Capacity-Building/Training: The Caribbean Chronic Care Collaborative: **Improving the Quality of Diabetes Care.** Teams from nine (9) countries have been trained in diabetes quality improvement initiatives.
- **Caribbean Wellness Day** (CWD) is now well established, with regional branding and products, and activities in multiple locations in 19 of the 20 CARICOM Members and Associate Members in 2010 to promote ongoing physical activities. The private and public sectors, with civil society partnerships in several communities, are sustaining these. Details on CWD may be accessed at www.paho.org/cwd09, at www.paho.org/cwd10 and at www.healthycaribbean.org.

BUDGET SUMMARY

Annual Budget for Regional Actions and Regional Support to Countries in US $

PRIORITY ACTION #1: RISK FACTOR REDUCTION AND HEALTH PROMOTION	
1. NO TOBACCO, NO HARMFUL USE OF ALCOHOL	**$100,000**
2. HEALTHY EATING (INCLUDING TRANSFAT, FAT, SUGAR)	**$75,000**
3. SALT REDUCTION	**$31,000**
4. PHYSICAL ACTIVITY	**$103,000**
5. INTEGRATED PROGRAMMES, ESPECIALLY IN SCHOOLS, WORKPLACES AND FAITH-BASED SETTINGS	**$195,000**
PRIORITY ACTION #2: INTEGRATED DISEASE MANAGEMENTAND PATIENT SELF-MANAGEMENT EDUCATION	
6. SCALING UP EVIDENCE-BASED TREATMENT	**$400,000**
PRIORITY ACTION #3: SURVEILLANCE, MONITORING AND EVALUATION	
7. SURVEILLANCE, MONITORING AND EVALUATION	**$492,000**
PRIORITY ACTION #4: PUBLIC POLICY, ADVOCACY AND COMMUNICATIONS	
8. ADVOCACY AND HEALTHY PUBLIC POLICY	**$85,000**
9. MEDIA AND SOCIAL COMMUNICATIONS	**$220,000**
PRIORITY ACTION # 5: PROGRAMME MANAGEMENT	
10. PROGRAMME MANAGEMENT, PARTNERSHIPS AND COORDINATION	**$135,000**
11. RESOURCE MOBILISATION / HEALTH FINANCING	**$235,000**
12. PHARMACEUTICALS	**$70,000**
Sub-total	**$2,141,000**
STAFF (1 AT CARICOM, 1 LONG TERM CONSULTANT, 2 SHORT TERM CONSULTANTS, TRAVEL AND PER DIEM)	**$250,000**
Total	**$2,391,000**
10% contingency	**$239,100**
Grand Total	**$2,630,100**

NOTE THAT THE PROJECT PROPOSALS REQUIRING FUNDING HAVE THEIR OWN BUDGETS SHOWN ON THE FOLLOWING PAGE

PROJECT PROPOSALS REQUIRING FUNDING (US$):

BUDGET SUMMARY	Budget for 3 Years	15% contingency	Total
CAPACITY-BUILDING			
1. CAPACITY-BUILDING FOR INTER-SECTORAL WORK IN SUPPORT OF NCD PREVENTION AND CONTROL a. SUPPORT FOR NCD NATIONAL COMMISSIONS b. CARIBBEAN AND NATIONAL PARTNERS FORUM c. STRENGTHENING CIVIL SOCIETY NETWORKS IN COUNTRIES	$565,000	$84,750	**$649,750**
2. BUILDING CAPACITY FOR LEGISLATION	$400,000	$60,000	**$460,000**
3. CURRICULUM DEVELOPMENT AND TRAINING	$2,410,000	$361,500	**$2,771,500**
RISK FACTOR REDUCTION			
4. BUILDING CAPACITY FOR IMPLEMENTING THE FCTC			-TBD-
5. CFNI TRANSFAT PROPOSAL			**$1,500,000**
6. REDUCE SALT CONSUMPTION	$1,675,000	$251,250	**$1,926,250**
7. CARIBBEAN WELLNESS DAY CELEBRATIONS AND ONGOING, MASS PHYSICAL ACTIVITY	$455,000	$68,250	**$523,250**
8. PUBLIC POLICY, ADVOCACY AND COMMUNICATIONS	$1,040,000	$156,000	**$1,196,000**
9. HEALTHY SCHOOLS, WORKPLACES, FBOs	$450,000	$67,500	**$517,500**
10. PREVENTING OBESITY AND NCDs IN CARIBBEAN ADOLESCENTS THROUGH BEHAVIOURAL INTERVENTION	**$160,855**		**$785,744**
DISEASE MANAGEMENT			
11. IMPLEMENTATION OF ENHANCED SURVEILLANCE SYSTEM DESIGNED BY IDB PROJECT			-TBD-
12. INTEGRATED MANAGEMENT OF NCDs:	$2,730,000	$409,500	**$3,139,500**
13. STRATEGIC PLAN FOR CANCER PREVENTION AND CONTROL IN THE CARIBBEAN: 2011-2015	$945,000	$141,750	**$1,086,750**
14. ESTABLISHMENT OF TWO REGIONAL CENTRES OF EXCELLENCE FOR KIDNEY TRANSPLANTATION; AND CONTROL IN DIALYSIS			-TBD-
GRAND TOTAL			**$14,556,244**

INTRODUCTION

The Caribbean epidemic of chronic non-communicable diseases (NCDs) – principally, cardiovascular disease including hypertension, diabetes, cancer and asthma - is the worst in the region of the Americas[1], causing much premature loss of life, lost productivity and spiralling health care costs. The CARICOM Summit[2] on Chronic Non-Communicable Diseases (NCDs), which was convened in September 2007, was a first-in-the world event in which Heads of Government took policy decisions to prevent and control the NCD epidemic. This epidemic has the common root causes of unhealthy diets, physical inactivity, tobacco use and harmful use of alcohol, in turn, driven by social determinants and global influences[3].

The Caribbean has a rich **history of cooperation in health[4].** This began in 1969 when Caribbean Ministers of Health began meeting annually under the aegis of the Caribbean Free Trade Area (CARIFTA). In 1974, the Treaty of Chaguaramas established the Caribbean Community (CARICOM) and Common Market, replacing CARIFTA. The Caribbean Cooperation in Health Initiative (CCH) was introduced in 1984 by the CARICOM Conference of Ministers responsible for Health (CMH) and approved by the Heads of Government in 1986 as a mechanism for health development through increasing collaboration and promoting technical cooperation among countries in the Caribbean. The successes of the Expanded Programme on Immunisation (**EPI**) in the elimination of indigenous poliomyelitis, measles and rubella in the Caribbean are perhaps the most notable achievements of the CCH. Inter-sectoral collaboration between the countries, the Caribbean Epidemiology Centre (CAREC), PAHO/WHO and other partners played a key role in these successes.

The **regional health institutions**, the Caribbean Epidemiology Centre (CAREC), Caribbean Food and Nutrition Institute (CFNI), Caribbean Health Research Centre (CHRC), Caribbean Environmental Health Institute (CEHI) and Caribbean Regional Drug Testing Laboratory (CRDTL) are expressions of CCH. The process of integrating these five regional bodies into a single body, the Caribbean Public Health Agency (CARPHA), has begun.

In 1996, the CARICOM Conference of Ministers responsible for Health (CMH) mandated a reformulation of the CCH for the period 1997-2001 (CCH-2). Eight (8) health priority areas were selected, with strategies for implementation in areas that required joint action. During CCH-2, in response to the epidemic of HIV and AIDS, the Pan-Caribbean Partnership against HIV and AIDS (PANCAP) was formed, and has been designated by the United Nations to be a best practice in the region of the Americas. This notwithstanding, the evaluation of CCH-2 showed that very few of the goals/targets for Chronic Diseases had been achieved and indeed, the problem had become much worse. The third re-formulation of CCH (CCH-3) has now been published.

The 2001 ***Nassau Declaration*** of CARICOM Heads of Government, *"The Health of the Region is the Wealth of the Region"* gave rise to the **Caribbean Commission on Health and Development** (**CCHD**). The Commission's Report showed that the major health problems of the Region were -

- Chronic Diseases,
- HIV and AIDS, and
- Injuries and Violence.

The CCHD also pointed to two critical issues:

- public health leadership and workforce capacity; and
- health information systems,

both of which need to be strengthened in order to successfully address any health issue.

A *Strategic Plan for the Prevention and Control of Chronic Non-Communicable Diseases* was developed and submitted for approval in 2002[5]. However, the *Plan* did not gain the traction that the seriousness of the problem warranted due, in part, to the unavailability of resources; lack of clarity as to its ownership; and lack of key implementation modalities, e.g., a Regional Task Force on chronic diseases.

CARICOM Summit on NCDs

The CCHD Report to CARICOM Heads in 2005 led to the decision taken by the Conference of Heads of Government to convene a Summit to deal with this huge and growing problem of chronic diseases and their risk factors, given that most of the actions to prevent NCDs and promote health lay outside of the health sector and thus required a mandate from Heads of Government. On 15 September 2007, the CARICOM Summit on Chronic Non-Communicable Diseases (NCDs), convened with joint support from the CARICOM Secretariat and PAHO/WHO, issued the *Declaration of Port-of-Spain* (POS), **"Uniting to Stop The Epidemic of Chronic Non-communicable Diseases",** compiling an overarching framework for an integrated, multi-sectoral, regional response to this epidemic (The *Declaration* is set out at **Appendix I** to this document). The 15-point Summit *Declaration* outlines a framework for policies and programmes across several government ministries, in collaboration with the private sector, civil society, the media, non-governmental organisations (NGOs), academia and the community, for creating supportive environments *"to make the right choice the easy choice*."

Partnerships

Since the NCD Summit, in keeping with the mandates in the *Declaration*, there has been increased engagement with the private sector and civil society. The Caribbean Association of Industry and Commerce (CAIC) has issued a *Private Sector Pledge* in support of the NCD Summit *Declaration* (as set out at **Appendix II** to this document) and a regional civil society umbrella organisation, the Healthy Caribbean Coalition was launched in October 2008, and its *Bridgetown Declaration* in support of the NCD Summit *Declaration* is set out at **Appendix III** to this document.

CARICOM Members and Associate Members

Members:

ANT	Antigua and Barbuda
BAH	The Bahamas
BAR	Barbados
BEL	Belize
DOM	Dominica
GRE	Grenada
GUY	Guyana
HAI	Haiti
JAM	Jamaica
MON	Montserrat
SKN	St Kitts and Nevis
STL	Saint Lucia
SVG	St. Vincent and the Grenadines
SUR	Suriname
TRT	Trinidad and Tobago

Associate Members

ANG	Anguilla
BER	Bermuda
BVI	British Virgin Islands
CAY	Cayman Islands
TCI	Turks and Caicos Islands

SITUATIONAL ANALYSIS

Global and Regional Trends

Globally, chronic diseases cause approximately 35 million deaths annually (about 60% of deaths)[6]. In Latin American and the Caribbean (LAC), the projections are that deaths from infectious diseases, perinatal conditions, and nutritional deficiencies will decline by 3% over the next 10 years, while deaths due to chronic diseases will increase by 17%. Predictions for the next two decades include a near tripling of ischemic heart disease and stroke mortality in LAC[7].

Figure 1 shows that the English Caribbean has the heaviest burden of cardiovascular disease and diabetes in the region of the Americas.

Figure 1:

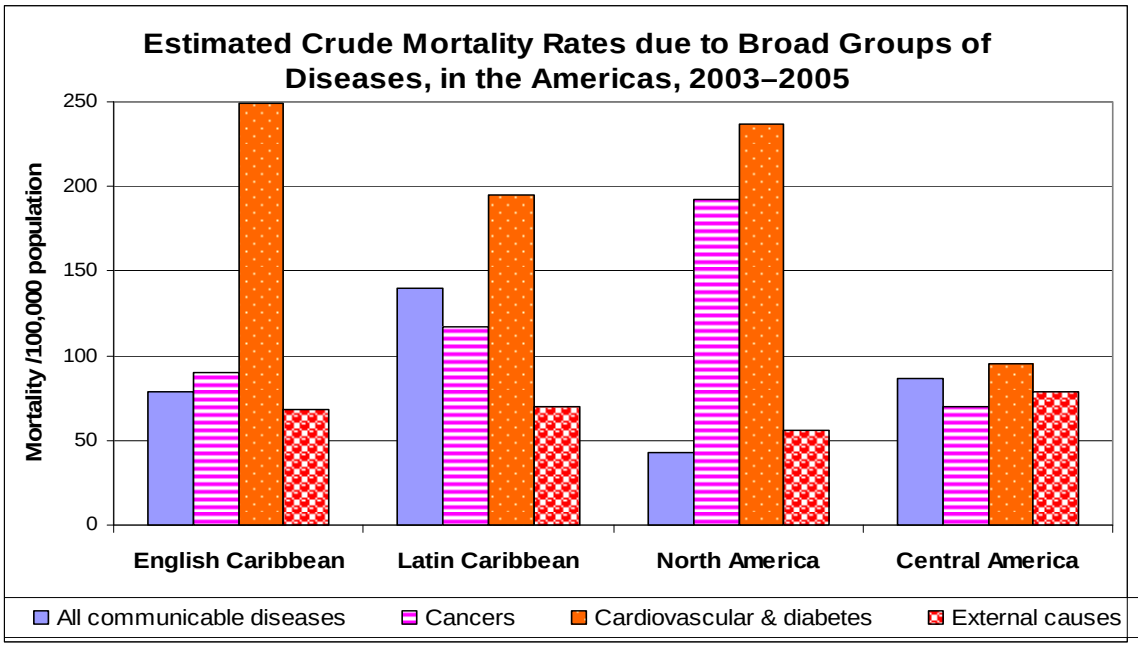


Fig 1 Source: PAHO Health Situation in the Americas. Basic Indicators 2008

Chronic diseases are devastating to individuals, families and communities, and they are a growing threat to economic development. Moreover, vulnerable populations such as the poor are more likely to develop chronic diseases, and low-income families are more likely to become impoverished from them. The aim must be to prevent and reduce the burden of chronic diseases and related risk factors [7].

In CARICOM countries, the leading causes of death in 2004 were heart disease, cancer, diabetes, stroke, injuries (intentional and unintentional), hypertensive disease, and HIV and AIDS - in that order (see Figure 2). The Caribbean has the highest death rates from heart disease and the top five countries for diabetes in the Americas[1].

Figure 2:

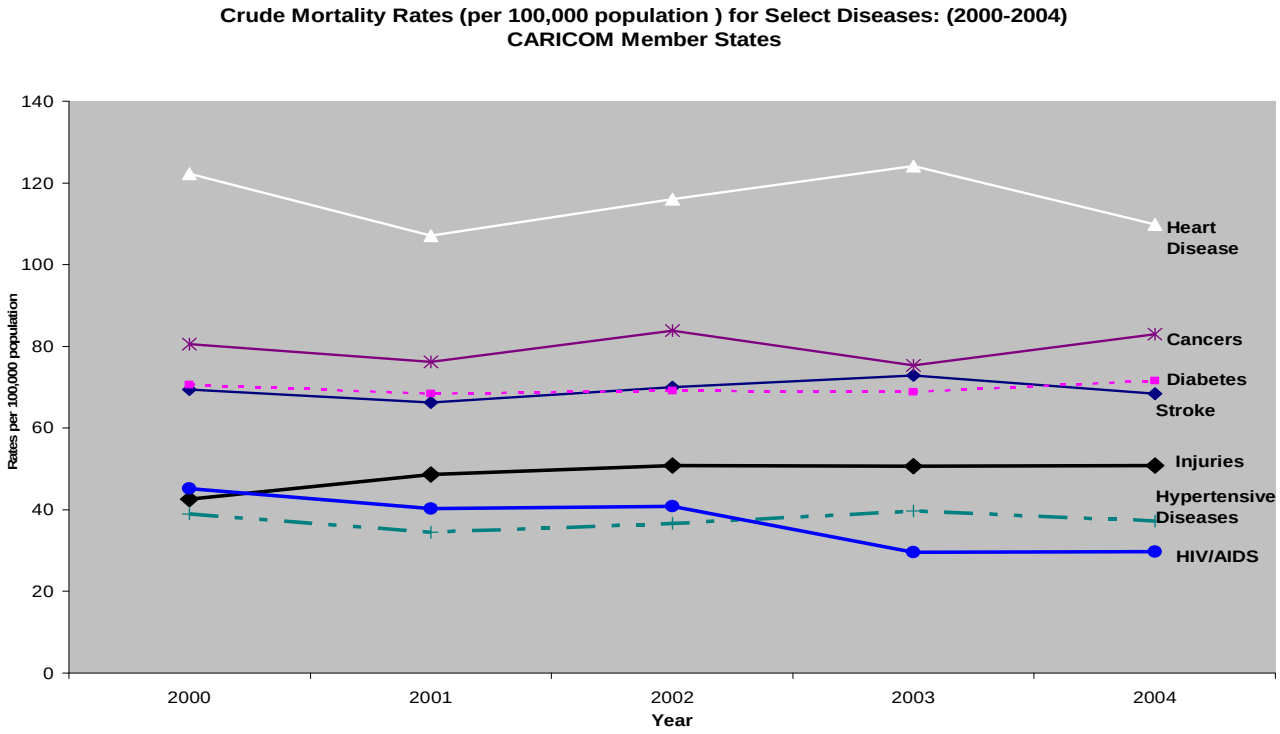


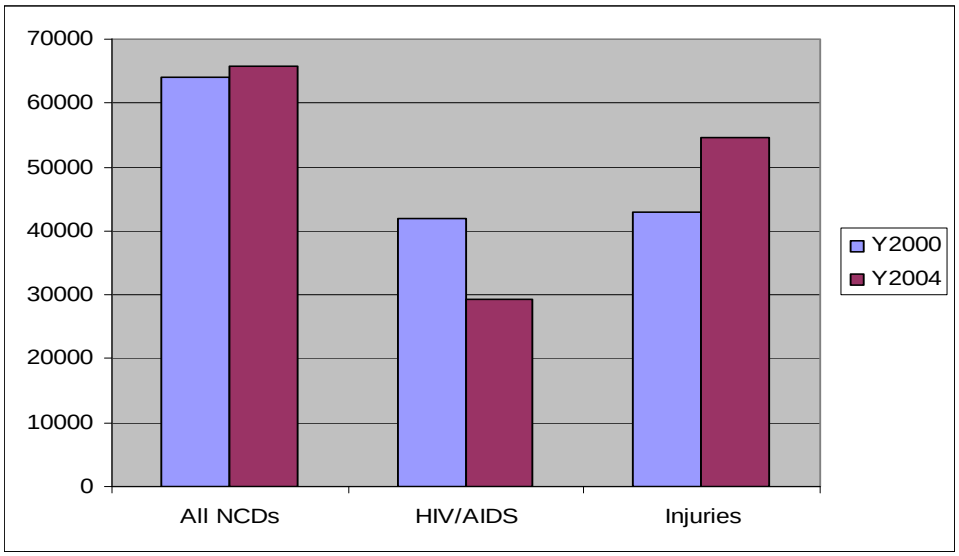
Fig 2 Source: CAREC 2007 based on country mortality reports (minus Jamaica

Approximately 80% of heart disease and diabetes, and 40% of cancers are preventable, and another 30% of cancers are treatable[8].

Premature Mortality, Morbidity and Disability

Figure 3 below shows the potential years of life lost (PYLL) before 65 years of age in CARICOM countries in 2000 and 2004. Chronic diseases were the largest cause of PYLL. This helps dispel the myth that chronic diseases are mainly a problem of the elderly. Over this period, PYLL due to injuries and violence increased by 27%, while PYLL due to AIDS decreased by 25%, probably due to expanded treatment for people living with HIV. Access to quality health services is critical to the management of chronic diseases and the prevention of expensive complications such as blindness, amputations, renal failure needing dialysis, and strokes.

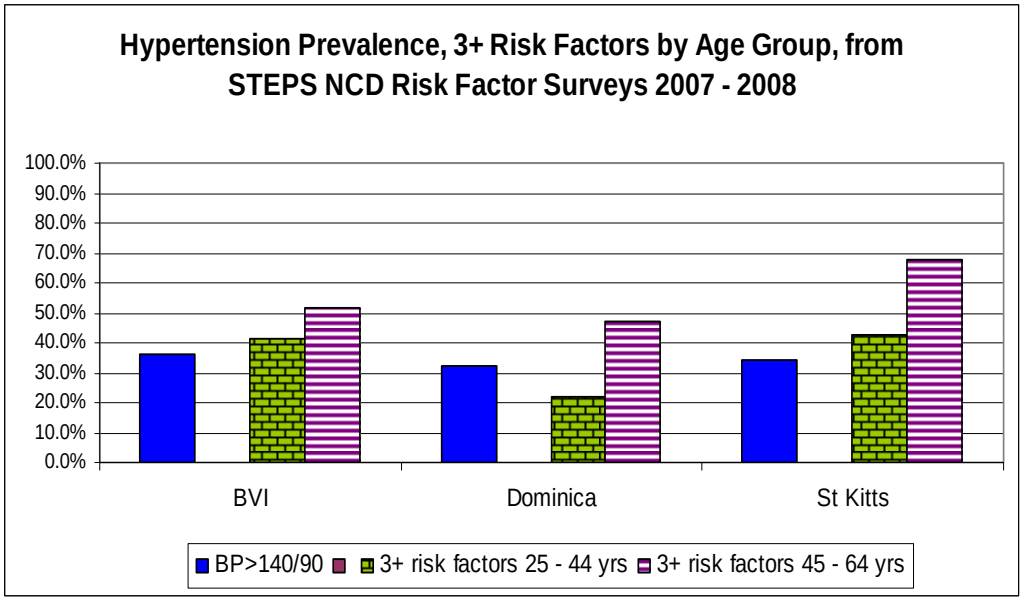
Figure 3: Potential Years of Life Lost before 65 yrs by cause, 2000 - 2004, in CARICOM countries, minus Jamaica



Cardiovascular Disease and Hypertension

Cardiovascular disease (stoke, coronary artery disease and diabetes) was the biggest cause of death in the Caribbean in 2006 [1]. Raised blood pressure is the biggest single cause of cardiovascular disease, accounting for 62% of strokes and 49% of coronary heart disease[9]. PANAM STEPS available data for 2007-2008 from the British Virgin Islands (BVI)[10], Dominica[11] and St. Kitts[12], show hypertensive rates of approximately 35%, with marked increases in prevalence with advancing age (see Figure 4). There is a 90% lifetime likelihood of developing hypertension[13].

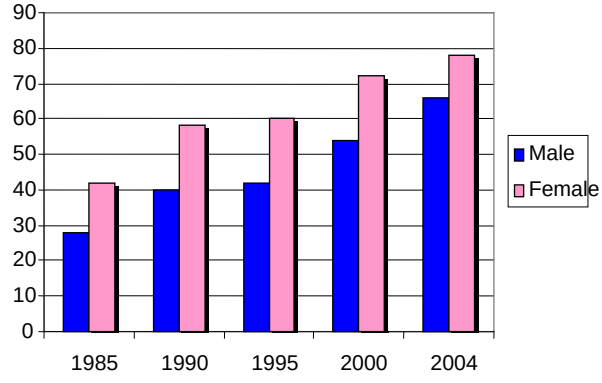
Figure 4:



Diabetes

Diabetes is a major cause of death and disability in the Caribbean and its prevalence has been increasing over time[14] (See Figure 5). Although 75% of deaths in diabetes cases are from cardiovascular disease, there is often poor adherence to evidence-based guidelines, and the blood pressure in many patients with diabetes is only lowered when the systolic level is ≥160 mmHg, although the guideline target is ≤ 129 mmHg.[15] The health and economic burden from diabetes, including morbidity and complications, is significant, both for the patient[16] and for society[17]. The cost of dialysis for diabetic nephropathy is significant, and uncontrolled diabetes is associated with blindness and amputations, which alter lives forever.

Figure 5: Caribbean Trends in Diabetes Mortality 1985 - 2004 (Rates/100,000)



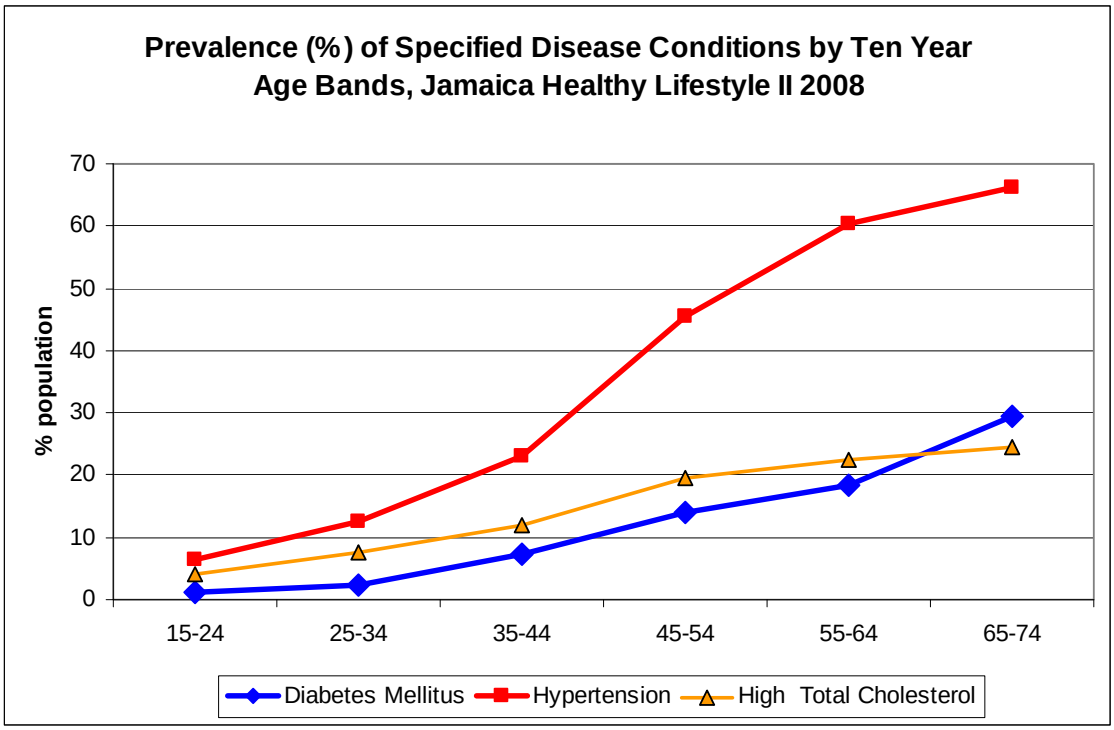
Source: CAREC

Jamaica Healthy Lifestyles Survey

Jamaica conducted two Healthy Lifestyle Surveys in 2000 and 2008, including NCD risk factors. The methodology was not identical to the STEPS, so its findings are reported separately.

Data from the Jamaica Healthy Lifestyles Survey (JHLS) 2008[18] of Jamaicans aged 15 – 74 years, indicate that the mean prevalence of hypertension is 25%, high cholesterol, 12% and diabetes, 8%, with marked increases with age, especially for hypertension (see Figure 6). Females had a higher prevalence of elevated cholesterol compared to males (12% vs. 8%). One in five persons was depressed, with twice as many women as men. The prevalence of chronic diseases varied with socioeconomic status, with more persons at the lower levels suffering from diabetes, hypertension and depression. Awareness, treatment and control of diabetes, hypertension and high cholesterol are shown in Figure 7.

Figure 6:

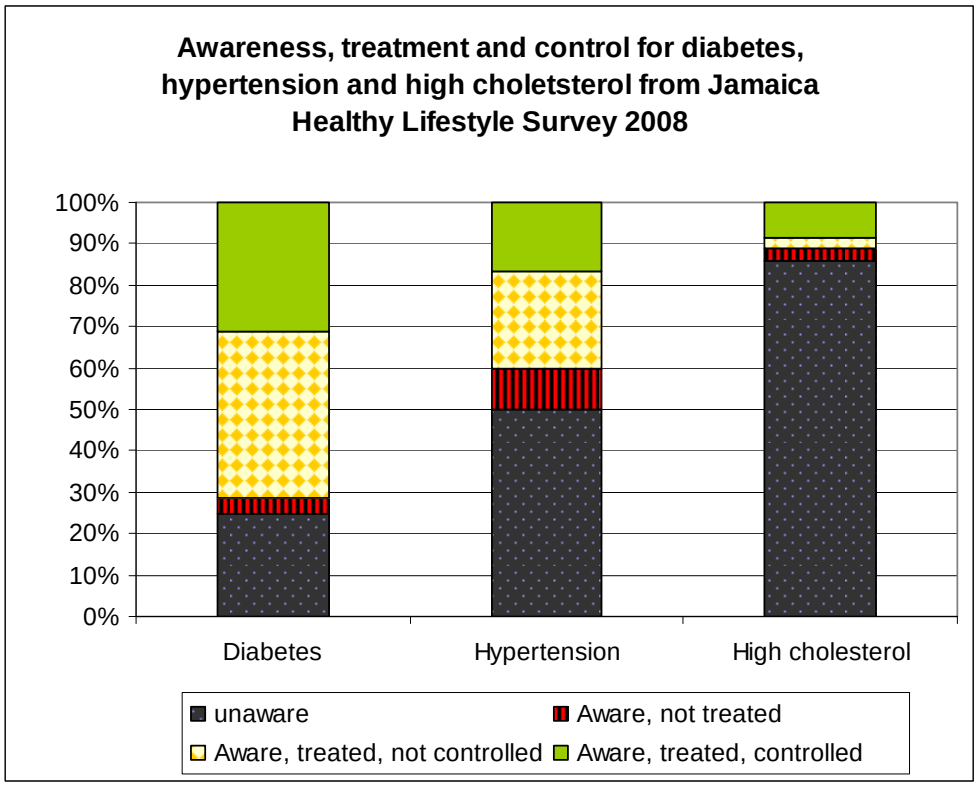


Figs. 6 and 7 Source: Jamaica Healthy Lifestyles Survey 2008

The JHLS data indicate that one in four persons with diabetes, 50% with hypertension and 85% with hypercholesterolemia were unaware of their diagnosis, while 30% of persons with diabetes, 18% with hypertension and 10% with hypercholesterolaemia were controlled to target.

The JHLS 2008 data also indicate that over 90% of Jamaicans who were obese and had high blood pressure and high cholesterol were not on a disease-specific diet.

Figure 7:



Cancer (Breast, Cervix, Prostate, Colon)

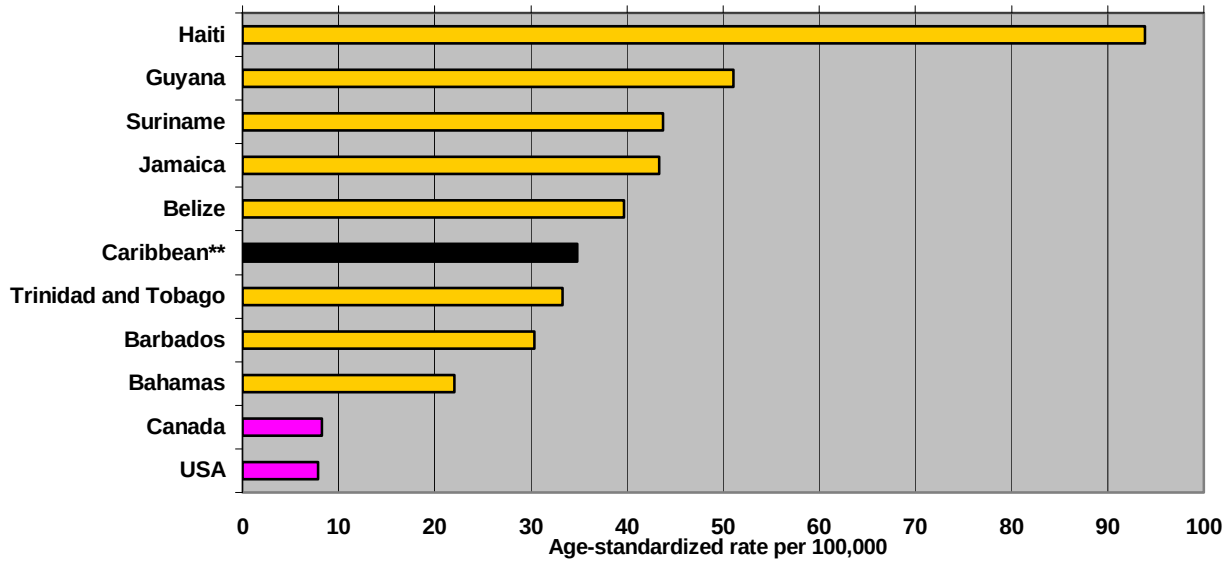
Breast Cancer

Breast cancer incidence has been increasing in the Region over the past 40 years, likely due to changing patterns of reproductive behaviour and diet[19]. Breast cancer has high mortality rates in women in the Caribbean. In 2002, Barbados had the highest recorded age-adjusted mortality from breast cancer in the region of the Americas (25.5 / 100,000) [14].

Cervical Cancer

The estimated incidence of cervical cancer in the Caribbean in 2000 was 35.8/100,000, which was among the top four sub-regions in the world. In most English- and Dutch-speaking Caribbean countries, these rates are at least three times higher than the prevailing rates in North America. French-speaking Haiti has the highest estimated incidence in the world (Figure 8).

Figure 8: Estimated Age-standardised* Cervical Cancer Incidence for Selected Caribbean and North American Countries, 2000



** Rates are standardised to the age distribution of the World Standard Population*
*** Includes Cuba, the Dominican Republic and Haiti. Does not include Belize, Guyana or Suriname*[20]

Cervical cancer was the second leading cause of cancer deaths among Caribbean women during the period 1991-95, and data from Trinidad and Tobago and Jamaica suggest that approximately half of the women diagnosed with cervical cancer die from the disease**.** Age-standardised cervical cancer mortality rates range between 6 and 53 per 100,000 women in Caribbean countries (see Figure 8). As with the incidence rates, cervical cancer mortality rates in the Caribbean are several magnitudes higher than in the USA (Table 1) where the mortality ASR (W) for the period 1996-2000 was 2.2 per 100,000. Cervical cancer deaths account for less than 3% of cancer deaths among women in the USA, but range from 8.8% in The Bahamas to 49.2% in Haiti.

Table 1: Estimated Cervical Cancer Mortality Rates for Selected Caribbean Countries, 2000

Country	IARC estimates[a] 2000		CAREC mortality database[b] circa 1997	
	Crude Rate	ASR[c]	Crude Rate	ASR
The Bahamas	8.23	9.27	7.07[d]	6.09[d]
Dominica	NA[h]	NA	18.97[e]	17.4[e]
Guyana	15.86	20.65	9.29[f]	7.2[f]
Haiti	31.68	53.49	NA	NA
Saint Lucia	NA	NA	17.18[e]	12.07[e]
St Vincent and the Grenadines	NA	NA	21.25[f]	15.58[f]
Trinidad and Tobago	14.82	15.05	9.95[g]	10.14[g]
The Caribbean[i]	16.40	16.84	NA	NA

a) Source: J. Ferlay, F. Bray, P. Pisani and D.M. Parkin. GLOBOCAN 2000: Cancer Incidence, Mortality and Prevalence Worldwide, Version 1.0. IARC CancerBase No. 5. Lyon, IARC Press, 2001.
b) Source: Deaths: CAREC Mortality Data Base from Country Reporting. Populations: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2002 Revision and World Urbanization Prospects: The 2001 Revision, http://esa.un.org/unpp, 31 August 2003; 5:37:23 PM.
c) Age-standardised rates to the World Standard Population
d) 1994-1998; e) 1996-2000; f) 1995-1999; g) 1995-1998 S
e) NA = Not Available
f) Includes Haiti, the Dominican Republic and Cuba. Does not include Belize, Guyana or Suriname.

Prostate and Colon Cancer[21]

The Caribbean has extremely high rates of prostate cancer, 28/100,000, with the highest mortality from prostate cancer occurring in Barbados (55/100,000) and Belize (35/100,000). High colon cancer death rates are related to low rates of colonoscopy in the Region.

Asthma

The prevalence of asthma in the Caribbean is high and rising, with significant morbidity and mortality, despite the existence of evidence-based protocols for its management and control[22]. Patient admissions have been increasing and mortality continues to rise. Self-reported wheezing in Caribbean children is among the highest in the world, likely due to reactivity to the house dust mite[23].

Data from population-based surveys of Caribbean adolescents reveal that over 13% of participants admitted to a past or present diagnosis of asthma[24]. Surveys of paediatric hospitals' emergency rooms report that as many as 23% of the cases were acute asthmatics[25]. At the Port-of-Spain General Hospital in Trinidad and Tobago, asthma reportedly accounted for 8-10% of emergency room admissions[26], and in Barbados, 13%[27]. These high rates are associated with the high cost of care for this disease.

Common Risk Factors and Social Determinants of the Chronic Disease Epidemic

Apart from genetic influences, two major factors drive the NCD epidemic: population ageing and the high level of preventable risk factors. The Caribbean now shows one of the highest rates of increase in the older populations among the developing countries of the world, with the percentage >50 years increasing, in part, due to the successes of earlier water, sanitation, nutrition, maternal and child health programmes[28].

Figure 9 below shows a model of causation for heart disease, in which the disease is the end result of a chain of interconnected physiological and behavioural risks, and environmental and social determinants. It serves as a general model for chronic disease causation and indicates levels of prevention and intervention to address the epidemic.

Risk Factors

Chronic diseases are caused by **physiological factors** such as high blood pressure, obesity, high blood sugar and cholesterol. The physiological risks that lead to the chronic diseases are caused mainly by lifestyle-related, **socially determined behavioural risk factors**, namely, unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol. Conversely, regular physical activity, which is declining in the Caribbean, promotes health and protects against all the NCDs. Just 30 minutes' walking per day or its equivalent significantly reduces the risk of heart attack[29]. But the environment and conditions of life are often not conducive to regular physical activity.

Figure 9: Social determinants of Health in Latin America and the Caribbean

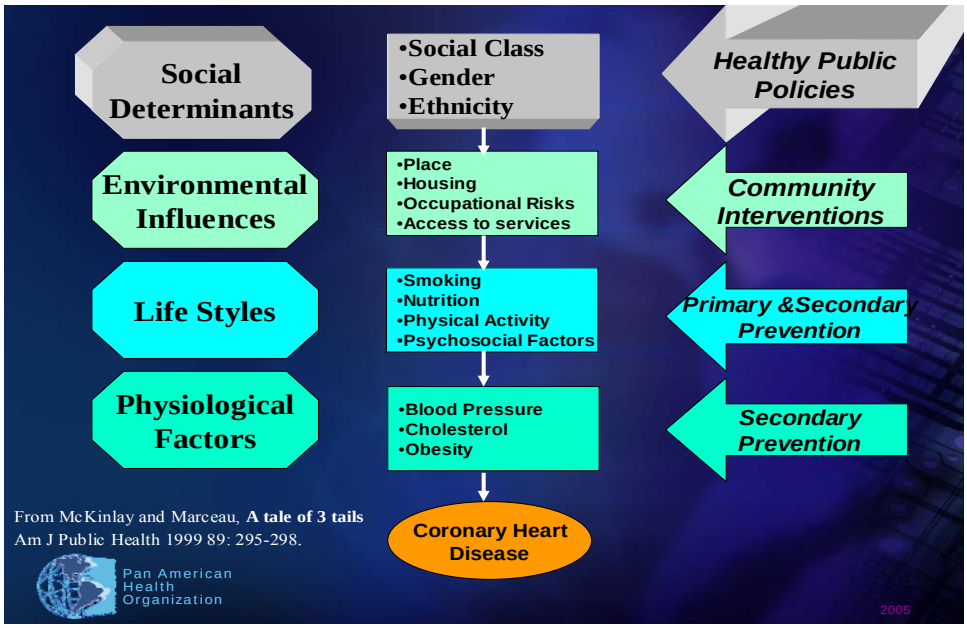


Figure 10 below[30] shows deaths attributable to various risk factors, by disease type in Latin America and the Caribbean. High blood pressure is the single most important cause, followed by overweight, alcohol and smoking.

Figure 10:

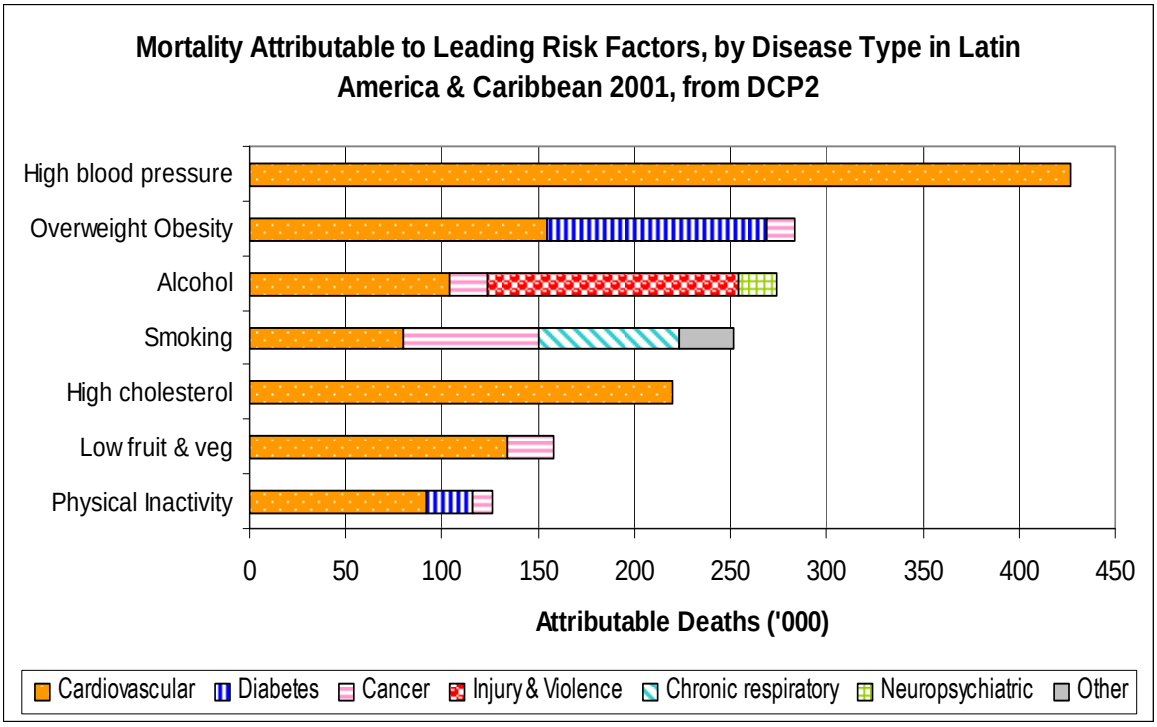
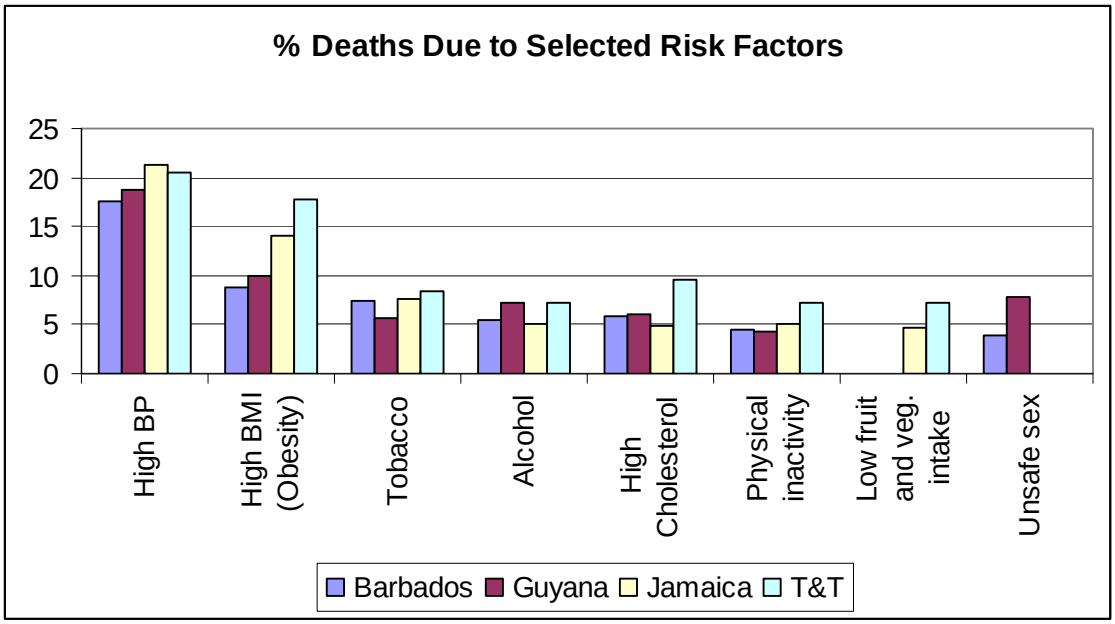


Figure 11 below shows the estimated percentage of deaths due to selected risk factors in four Caribbean countries. The significant contribution of unhealthy diets, smoking, alcohol and being sedentary is evident.

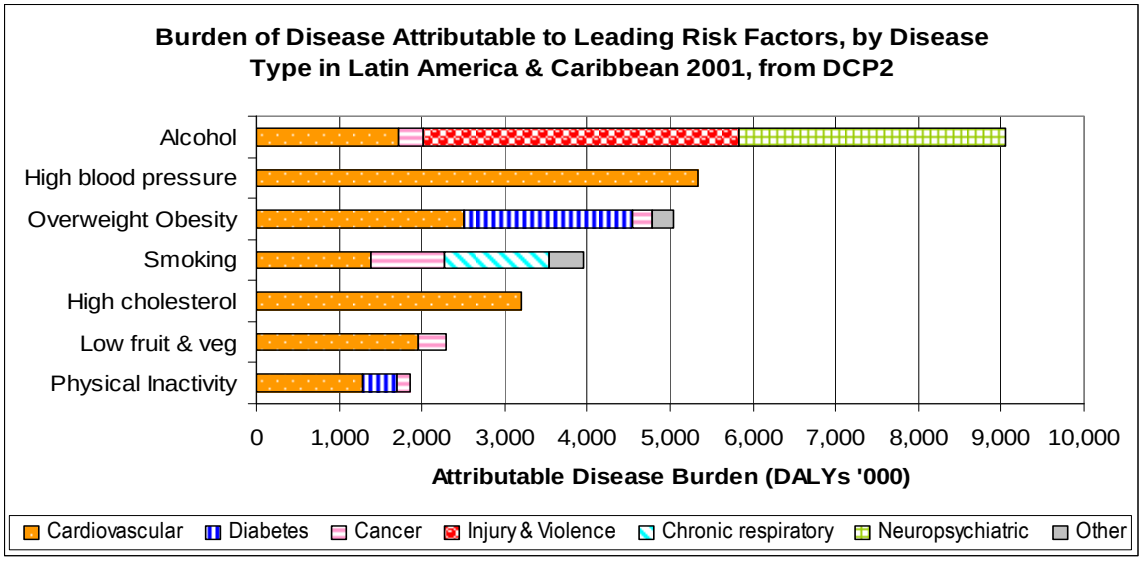
Figure 11: Percentage Deaths Due to Selected Risk Factors, in 4 CARICOM countries 2002



Source: Personal communication from C. Mathers to G. Alleyne, 2007

An internationally accepted method of calculating burden is Disability Adjusted Life Years (DALY), which includes premature deaths, impairment and disability. From this perspective, as shown in the Figure 12 below, alcohol becomes the main risk factor, followed by high blood pressure, overweight and smoking.

Figure 12:



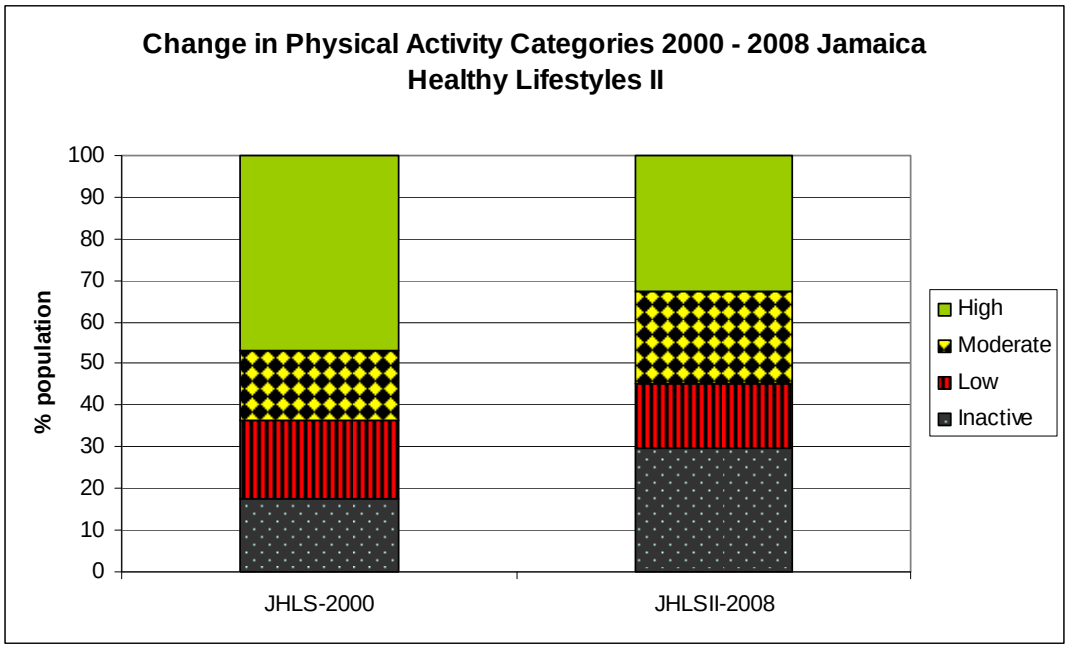
<u>Unhealthy diets</u> are a major contributor to the NCD epidemic. The diet in the Region is characterised by a relatively low, under-target consumption of fruits, vegetables, whole grains, cereals and legumes, coupled with an over-target, high intake of imported foods rich in saturated fat, sugars and salt, among them whole milk, meats, refined cereals and processed foods. Caribbean countries now ingest more calories per capita than needed (though still with small pockets of under-nutrition). The Region has >160 % of the average requirement for fats and >250% for sugars. Both global and local forces drive these excesses. This dietary pattern and less physical activity are the key factors in the rise of obesity[31].

NCD risk factor data from Barbados, the BVI, Dominica, Jamaica and St. Kitts are that 1–10% of the Region's populations eat the recommended five (5) servings of fruits and vegetables per day.

<u>Physical Inactivity</u>

In Caribbean countries, almost 50% of men and women, urban and rural, are physically inactive – performing less than 30 minutes-a-day of physical activity five days a week. Among persons over 60 years of age, physical inactivity is even higher, and it is this age group that has the highest prevalence of NCDs[32]. In Jamaica, inadequate physical activity (inactive + low levels) increased from 36% to 46% between the Jamaica Healthy Lifestyles Survey (JHLS) in 2000, and the second JHLS in 2008 (Figure 13).

Figure 13:

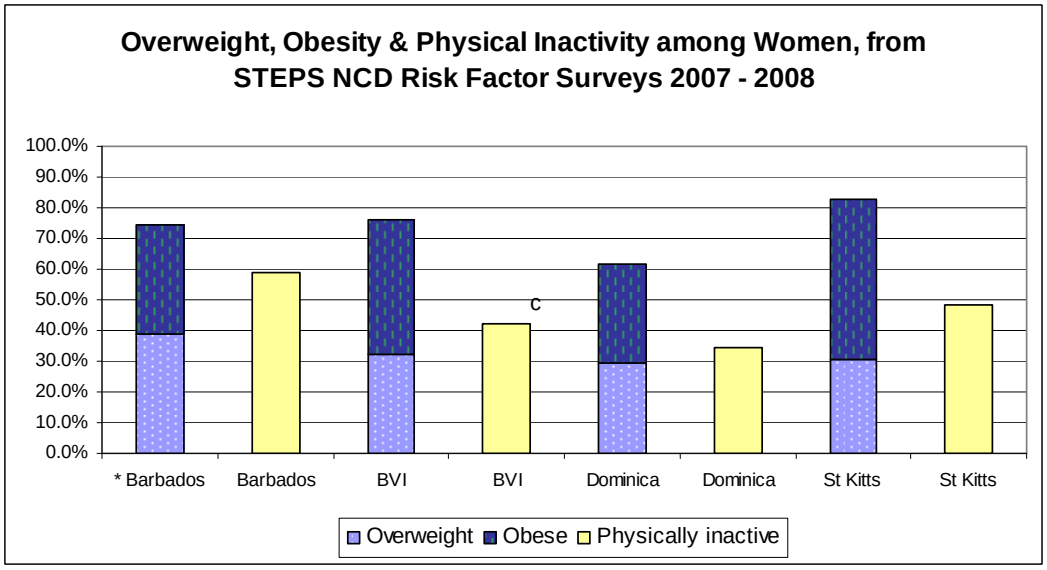


Obesity

The prevalence of obesity increases with age. Overweight (Body Mass Index (BMI) >25) and obesity (BMI >30) affects 60-85% of adult women according to recent STEPS data (see Figure 14). Obesity among women is approximately twice that of their male counterparts[33]. The JHLS 2008 finds 36% of Jamaican women obese, compared to 18% of men. There is a sharp increase in childhood obesity and the resultant occurrence of type 2 diabetes in adolescents, for which obesity is the major risk factor. Obesity is the single main cause of diabetes, in addition to its contribution to hypertension, arthritis, cancer and other diseases, thus, the rising level of diabetes and other NCDs, including type 2 diabetes in children, is not surprising.

However, even in overweight and obese persons, physical activity protects and helps reduce the risk of heart attacks, strokes and cancer[34].

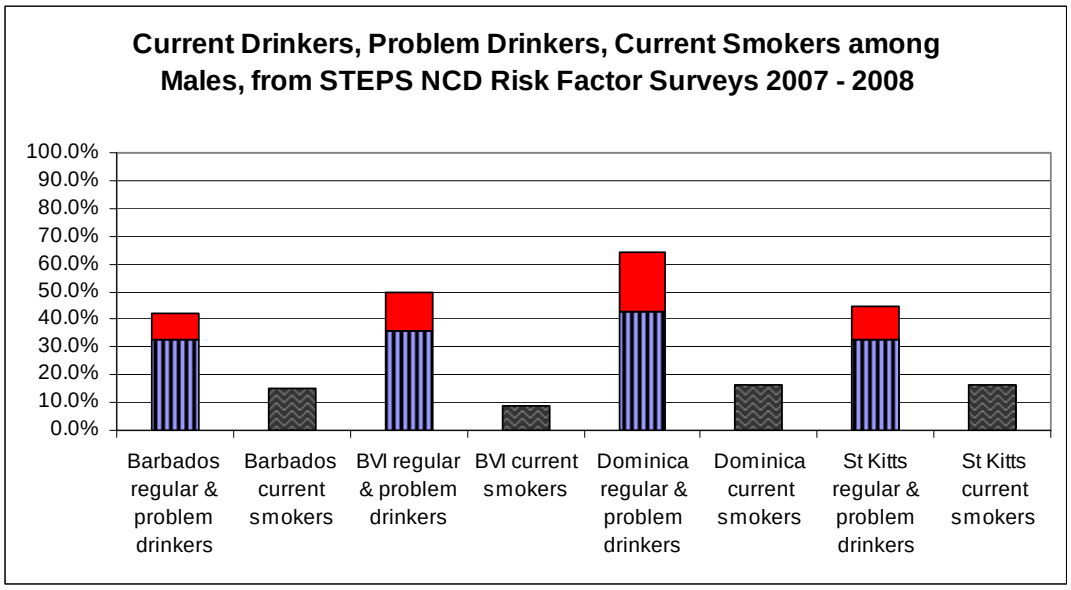
Figure 14:



*Barbados data not from representative sample [35]

Data from JHLS 2008[18] of Jamaicans aged 15 – 74 years show that 65% of the population currently use alcohol; 14.5%, cigarettes; 13.5%, marijuana; and less than 1%, hard drugs. Higher socio-economic levels are associated with lower prevalence of tobacco and marijuana use, but higher prevalence of alcohol use. STEPS data are shown below in Figure 15.

Figure 15:



Tobacco

Tobacco is the only legal product that kills when used as directed, and harmful in all its forms. It is the single greatest preventable killer in the world, playing a causal role in all the chronic diseases. In the Caribbean smoking prevalence ranges from 10-27% of adults and 10-25% of teens[36]. Table 2 below provides an estimate of smoking deaths in CARICOM countries.

Table 2: Smoking deaths in CARICOM (in thousands, indirect estimates)

Causes	Men		Women	
	Total	Due to smoking	Total	Due to smoking
Cancers	3	1.5	2.9	0.6
Vascular/diabetes	6.7	1.7	6.4	1
Respiratory	1.3	0.5	1.1	0.2
Other NCDs	2.7	0.5	2.3	0.2
Tuberculosis	0.4	0.1	0.2	0.1
TOTAL	14.1	4.4	13	2.1

30% of male & 15% female deaths are due to smoking

Source: Jha and Alleyne, 2007

The *WHO Framework Convention on Tobacco Control* (FCTC)[37] is a landmark in global public health, and implementing the recommendation on taxes could raise revenue for governments, while saving thousands of lives. (See Figure 16).

The MPOWER report is the first comprehensive worldwide analysis of tobacco use and control efforts as a roadmap to reverse the global tobacco epidemic that, if left unchecked, will kill one billion people by the end of this century. The MPOWER package (see below) is a set of six key tobacco control measures that reflect and build on the FCTC.

MPOWER

M – **Monitor** tobacco prevalence, impact of policies and tobacco industry marketing and lobbying

P – **Protect from second hand smoke**: 100% **smoke free public indoor spaces**, including bars and restaurants

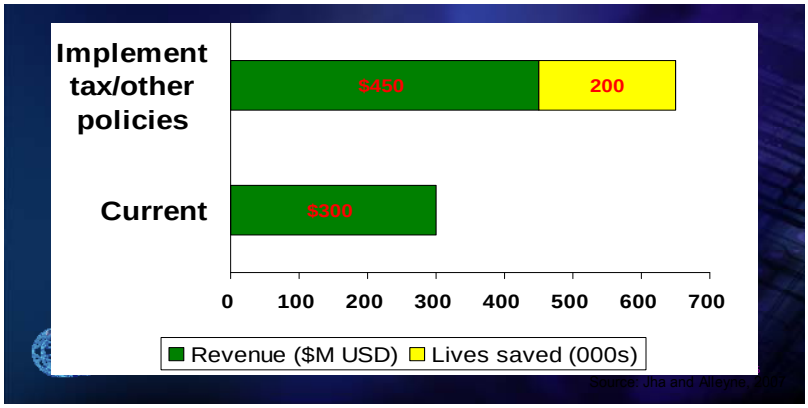
O – **Offer help to quit**. Develop tobacco cessation programme including medical advice, nicotine replacement therapy, telephone quit lines and counselling

W – **Warn of the dangers – Pictorial warnings on 50% of cigarette packages. Public education programmes** on the addictiveness of tobacco and dangers of its use

E – **Enforce ban on tobacco advertisement, promotion and sponsorship**

R – **Raise taxes** on tobacco to 75% of retail price. A 70% increase in price will prevent 25% of tobacco deaths. [38]

Figure 16: Tobacco Control could save Lives and raise Revenue in CARICOM over 10 years



Two CARICOM countries have not ratified the FCTC, a priority intervention for the Region.

WHO Framework Convention on Tobacco Control

SIGNED AND RATIFIED:
- Antigua and Barbuda
- The Bahamas
- Barbados
- Belize
- Dominica
- Grenada
- Guyana
- Jamaica
- Saint Lucia
- Saint Vincent and the Grenadines
- Suriname
- Trinidad and Tobago

SIGNED, NOT YET RATIFIED:
- Haiti
- St. Kitts and Nevis

Alcohol

Table 3: Alcohol exposure of selected countries in the Americas, 2002 [39]

Country (WHO classification)	[1] Per capita consumption	[2] Unrecorded consumption	[3] Drinking Patterns	% abstainers		[4] Per capita consumptn per drinker
				Males	Females	
Barbados	7.0	-0.5	2	29	70	14.1
Belize	8.6	2.0	4	24	44	13.0
Guyana	5.9	2.0	3	20	40	8.5
Haiti	7.5	0.0	2	58	62	18.8
Jamaica	3.9	2.0	2	38	61	7.8
Suriname	6.2	0.0	3	30	55	-
Trinidad and Tobago	4.3	0.0	2	29	70	8.7

1. in litres of pure alcohol including unrecorded consumption; 2. in litres of pure alcohol; 3. hazardous drinking score with 1 = least and 4 = most detrimental; 4. Per capita consumption per drinker in litres of pure alcohol, including unrecorded consumption

An estimated 5.4% of deaths in the Americas in 2002 were attributable to alcohol, compared to the world figure of 3.7%[40] (68% higher than the global average). Alcohol was responsible for nearly 10% of all Disability Adjusted Life Years (DALY) lost in the Region in 2002, compared to the global figure of 4.4%.

Excess alcohol intake (>1-2 drinks per day)[41] also contributes significantly to cancers, CVD, liver disease and neuro-psychiatric conditions, including alcohol dependence. 20-50% of road traffic fatalities in the Region are alcohol related, and 50.5% of alcohol-attributable deaths in the Americas in 2002 were due to injuries and violence[30]. Alcohol causes lost productivity[42], and social and economic problems to individuals, families and communities.

STEPS NCD Risk Factor Data from the BVI, Barbados, Dominica and St. Kitts show current drinkers among males ranging from 42 to 65%, with problem drinkers (more than 5 drinks at any one time) estimated at 10 – 21% of the male population.

Economic Burden and Costs

Hypertension is not only the most prevalent risk factor for death in the Region, it is also very expensive. The data in Table 4 show that diabetes and hypertension are a significant drain on the economies of the Region[43].

Table 4: Economic Burden (US$ Millions) of Diabetes & Hypertension in Selected Caribbean Countries (2001)

Cost Item	The Bahamas	Barbados	Jamaica	Trinidad & Tobago
DIABETES				
Direct Cost	16.7	34.9	170.4	128.7
Indirect Cost	10.5	2.9	38.4	355.7
Total Cost	27.3	37.8	208.8	484.4
Percentage of GDP (%)	0.50	1.83	2.66	5.21
HYPERTENSION				
Direct Cost	30.0	50.9	188.2	137.9
Indirect Cost	16.4	21.9	63.5	121.6
Total Cost	46.4	72.7	251.7	259.5
Percentage of GDP (%)	0.86	3.51	3.21	2.79
COMBINED % GDP IMPACT	**1.4**	**5.3**	**5.9**	**8.0**

REGIONAL RESPONSE

As members of PAHO and WHO, Caribbean countries have also approved the PAHO/WHO *"Regional Strategy on an Integrated Approach to the Prevention and Control of Chronic Diseases Including Diet, Physical Activity, and Health (September 2006)"*. A 2005 PAHO Survey found that the countries with the least developed NCD response in the Americas were those in the Caribbean, although the Caribbean has the highest burden of disease.

Regional Actions

Regional actions (see Table 5) would assist countries in implementing their respective NCD programmes.

Table 5: Regional Actions for NCD Mandates

Regional Actions for NCD mandates	Regional
Regional NCD Secretariat functional	√
Support for the definition, design and development of National Commissions to plan and coordinate the comprehensive prevention and control of NCDs - recommended membership, functions, secretariat, reporting	In process
Partners Forum: Healthy Caribbean Coalition, Caribbean Assoc of Industry and Commerce engaged	In process
Model plans, policies, programmes developed and disseminated	In process
Revision of regional policy and model of care for PHC and chronic care	In process
Model curricula	
Model legislation, e.g., tobacco legislation	
Tobacco pictorial warnings	In process
Food security – trade	
Labelling of foods	In process
Transfat policies	
Salt in manufactured products	
Regional branding and support for CWD	√
Identification, support and enhancement of "good practices"	
Chronic Care Model capacity-building and demonstration sites	In process
Regional, integrated approach to NCDs, generic drug procurement, mainstreaming surveillance, gender and other actions	In process
Capacity development for resource mobilisation, with emphasis on Grants	
Convening of annual NCD FP meeting for training and programme review	√

Country Capacity

Table 6 has been accepted as one metric to summarise NCD status in the Region. All countries, besides Haiti, have an NCD Focal Point, but a minority of countries has a NCD plan and dedicated resources. Less than half of the countries have appointed Inter-Sectoral NCD Commissions more than three (3) years after this was mandated by the Heads of Government in the NCD *Declaration*.

All independent countries, with the exception of Haiti, and St. Kitts and Nevis, have now ratified the FCTC. Caribbean Wellness Day (CWD) has been celebrated in all countries except Haiti, and many have, or are working towards ongoing physical activities in communities.

NCD risk factor surveillance, required for monitoring and evaluation of the NCD Summit *Declaration* and national plans, is improving, with seven (7) countries completing STEPS or equivalent surveys, four (4) countries planning to do so in 2011, and all countries committing to begin reporting the NCD Minimum Data Set in 2010.

Table 6: NCD Progress Indicator Status / Capacity by Country in Implementing NCD summit Declaration - Yellow indicated September 2010 update

POS NCD #	NCD Progress Indicator	ANG	ANT	BAH	BAR	BEL	BER	BVI	CAY	DOM	GRE	GUY	HAI	JAM	MON	SKN	STL	SVG	SUR	TRT	TCI
	COMMITMENT																				
1,14	NCD Plan	X	X	±	√	±	√	±	X	√	√	√	x	√		√	√	±	±	√	
4	NCD budget	X	X	X	√	±	X	X	X	±	X	±	x	X		X	√	X	X	√	
2	NCD Summit convened	X	X	X	√	X	√	√	X	√	±	√	x	√		X	√	X		√	
2	Multi-sectoral NCD Commission appointed and functional	X	X	X	√	±	√	√	X	x	√	√	x	±		X	√	X	±	√	
12	NCD Communications plan	X	X	±	±	X	√	X	X	±	±	√	x	±		X	±	X	X	√	
	TOBACCO																				
3	FCTC ratified	*	√	√	√	√	*	*	√	√	√	√	x	√	*	±	√	√	√	√	*
3	Tobacco taxes >50% sale price	X	X	X	√	X			±	X		√	x	√		±	X	X	√	X	
3	Smoke Free indoor public places	X	√	X	√	±	√	√	√		√	√	x	±		X	√	X	±	√	
3	Advertising, promotion & sponsorship bans	X	X	X	±	X	√	√	√		X	±	x	√		X	X	X	±	√	
	NUTRITION																				
7	Multi-sector Food & Nutrition plan implemented	√	√	√	±	±	X	√	X	√	√	√	x	√	√	±	X	√	X	±	√
7	Trans fat free food supply					X			X					±				X	X	X	
7	Policy & standards promoting healthy eating in schools implemented		√		√	±	√	X	±			±		√		±		X	X	±	
8	Trade agreements utilised to meet national food security & health goals					±			X			±		X				X	X	√	
9	Mandatory labelling of packaged foods for nutrition content		X			X	±		±			±		X				X	±	X	
	PHYSICAL ACTIVITY																				
6	Mandatory PA in all grades in schools				√	√	±		√			±		X				X	X	√	
10	Mandatory provision for PA in new housing developments				√	√			X			X		X				X	X		
10	Ongoing, mass Physical Activity or New public PA spaces	X	X	√	√	√	√	X	±		√	√		√		√	√	√	√	√	
	EDUCATION / PROMOTION																				
15	CWD multi-sectoral, multi-focal celebrations	√	√	√	√	√	√	√	√	√	√	√	x	√	√	√	√	√	√	√	√
10	≥50% of public and private institutions with physical activity and healthy eating programmes		X			X		X	X			±					±	X	X	X	
12	≥30 days media broadcasts on NCD control/yr (risk factors and treatment)		√		√	X	√	X	±			√		√		√	±	X	X	X	
	SURVEILLANCE																				
11, 13, 14	Surveillance: - STEPS or equivalent survey	X	X	√	√	√	±	√	X	√	±	±	x	√		√	±	X	±	±	
	- Minimum Data Set reporting	X	X	X	X	X	√	√	X	√	X	X	x	X	X	X	X	√	√	X	X
	- Global Youth Tobacco Survey	X	√	√	√	√	X	√	±	√	√	√	√	√		±	√	√	√	√	
	- Global School Health Survey	√	√	√	±	±		√	±		√	√	x	√		±	√	√	√	√	
	TREATMENT																				
5	Chronic Care Model / NCD treatment protocols in ≥ 50% PHC facilities	X	√	√	±	±	±	X	±	X	±	±	x	√		X	√	X	X	√	
5	QOC CVD or diabetes demonstration project	±		√	√	±	±	±	√	X	√	√	±	√		±	√	X	√	√	
		ANG	ANT	BAH	BAR	BEL	BER	BVI	CAY	DOM	GRE	GUY	HAI	JAM	MON	SKN	STL	SVG	SUR	TRT	TCI

√ **In place** **± In process/partially implemented** **X Not in place** *** Not applicable** **No information**

CARMEN

In November 2007, Caribbean countries decided to request Ministers of Health to all make application for their countries to join CARMEN, whose English translation is – "*Collaborative Action for Risk Factor Reduction and Effective Management of NCDs"*. The network seeks to:

- implement projects to support the Regional Strategy for Prevention and Control of Chronic Diseases;
- define tools/methodologies to support CARMEN initiatives at country level; and
- deepen the sense of joint collaborative commitment among PAHO, countries and partners towards implementing the Regional Strategy for Prevention and Control of Chronic Diseases.

At the CARMEN meeting of 2009, the Caribbean Sub-region met to discuss the issues facing the region and individual countries. The discussion primarily focused on the *Declaration of Port-of-Spain* that guides much of the work being done in the Region with regard to the prevention and control of NCDs. At the sub-regional (Caribbean) level, the following priorities were outlined:

1. Support for the design and development of National Commissions;
2. Support for development of Tobacco Legislation for implementation in countries;
3. Development of an integrated approach to NCDs, mainstreaming surveillance and other actions within the health care model; and
4. Capacity development for resource mobilisation, with emphasis on Grants.

Regional Institutions providing support to countries:

- Caribbean Epidemiological Research Centre (CAREC): Public Health Surveillance, applied research, training, information warehousing/databases; specific support to Cervical Cancer
- Caribbean Food and Nutrition Institute (CFNI): Regional, collaborative approaches to solving the nutrition challenges in the Caribbean - enhance, describe, manage and prevent the key nutritional problems and increase their capacity for food security and optimal nutritional health using nutritional surveillance, policy and intersectoral work with Agriculture, Education and others, information, training and applied research.
- Caribbean Health Research Centre (CHRC): Coordinating research, advocacy
- Caribbean Regional Drug Testing Laboratory (CRDTL): Monitoring the quality of pharmaceuticals
- Caribbean Environmental Health Institution (CEHI): Environmental Health and Policy Management, drinking and water analysis, industrial and sewage effluent testing, heavy metal testing and pesticide residue analysis

  (The five agencies above are being merged into the Caribbean Public Health Agency (CARPHA)
- Universities in countries of the Region
- Chronic Disease Research Centre (CDRC), UWI Barbados: conducting research, training, advocacy
- CARICOM Secretariat: policy, especially inter-sectoral approaches, e.g., trade policy currently negotiated by the CRNM, resource mobilisation, capacity-building, advocacy and programme support.
- PAHO/WHO: normative roles, surveillance, capacity-building, applied research, resource mobilisation, advocacy with other UN and international partners, CCH joint coordination with CARICOM

CARCICOM Summit on NCDs

CARICOM is in the unique position of having a mandate from its Heads of Government for inter-sectoral work to combat the NCD epidemic. Since the CARICOM Summit in September 2007, inter-sectoral NCD meetings have been held and national inter-sectoral commissions launched in several countries. Both the regional private sector (CAIC) and regional civil society (Healthy Caribbean Coalition) have been mobilised to support implementation of the NCD Summit *Declaration*.

Governments:

Heads of Government will continue to have the unique role of leading the policy initiatives related to the *Declaration* and to forge national inter-sectoral collaboration among sectors, where required, including the establishment of the inter-sectoral National Commissions, the leadership mechanism for the *POS Declaration*. The regional twice yearly reporting by the Lead Head of Government responsible for Health on the implementation of the *Declaration of Port-of-Spain* will certainly provide a stimulus for achieving the requisite regional public goods. Heads of Government should continue to lead by example and, recognising the multi-sectoral factors in the NCD epidemic, provide the various government ministries and agencies with clear objectives, priorities and time-tables for the actions required, and determine a reporting mechanism, with milestones.

Government-wide priorities in support of NCD prevention and control should include:

- Fiscal and tax policies;
- New legislation (especially tobacco legislation) and enforcing existing legislation;
- Review of policies and programmes to improve the built environment and mass transportation, which significantly impact the health risks of inactivity, pollution, stress and road traffic accidents;
- Review of policies and practices of all Government Ministries and Agencies to enhance the development and implementation of healthy public policies; and
- Strengthen coordination and management mechanisms between government agencies.

Partnerships

Addressing NCDs requires the collaboration of civil society, the private sector, governments, regional and international organisations, and individual community residents to bring action to bear on the broad determinants of these diseases. Since the CARICOM Summit on NCDs, partnerships have been enhanced.

Civil society:

In October 2008, 40 civil society organisations launched the ***Healthy Caribbean Coalition*** and issued their ***Declaration and Plan of Actio***n, [45] as the regional civil society component of the multi-sectoral response. Priority programmes include capacity-building for enhancing their advocacy or "watchdog" role through activation of a communications plan and social marketing programmes for public education, monitoring and evaluation. The public needs to be reminded of their Governments' commitments to NCD prevention and control, and to hold them accountable. Activities will include the establishment of a Caribbean civil society NCD Coalition/Network; enhancement of country level networks, improving collaboration with Health NGOs and support for Caribbean Wellness Day (see **Appendix II**).

Private Sector:

The CAIC/PAHO private sector workshop of May 2008 issued the CAIC ***Private Sector Pledge*** for combatting NCDs as their commitment to the multi-sectoral response to the *Declaration of Port-of-Spain*. Priority programmes include-

- examining and changing private sector policies and practices to favour wellness and the prevention of NCDs, Workplace Wellness initiatives, and the marketing of healthy products (e.g., less salt and fat);
- enhancing media involvement in comprehensive public education programmes; and
- mobilising resources and other partners and support for Caribbean Wellness Day (see **Appendix III**).

Activities will include national and regional inter-sectoral planning and action, including National NCD Commissions, support for laws, regulations and other measures in support of NCD prevention and control, and documenting and disseminating private sector best practices in NCD prevention and control.

Private and NGO Health Sector

In many countries of the Region, the majority of primary care is delivered through private medical practitioners and Health NGOs, including services provided by faith-based communities. Private pharmacies, laboratories and other health and wellness services form part of the network of the country's health system. Collaboration with these important partners needs to be developed and enhanced.

Alternative Medicine

Licensed and unlicensed alternative medicine practitioners, promoting and providing treatments to enhance wellness and treat chronic diseases, have increased significantly in the Region and are considered by many to be credible sources that assist in slowing the pandemic of NCDs. Efforts will need to be made to determine credible and effective ways to establish relationships with these groups.

International Agencies and Partners

CARICOM Secretariat/PAHO/WHO:

Regional institutions will focus on initiatives that are best undertaken collectively and/or those that can be adapted and adopted in countries. Technical cooperation between countries and the sharing of best practices are to be encouraged. The size of the population of some countries limits their potential for specialisation and, in these cases, the countries may request additional assistance in capacity-building or other external support.

Other requirements from the *Declaration* include: POS# 1: Strengthening regional health institutions; and POS# 14: Regional Secretariat established and functional in support of the Caribbean NCD Plan and programme; and technical cooperation with countries to provide technical advice about evidence-based interventions and assist with accessing support for their initiatives.

Much of the food consumed in the Region is imported either from other countries within the Region or from outside the Region, thus, POS# 7: Enhance food security and elimination of transfats; POS# 8: Fair trade policies in all international trade negotiations to mitigate the impact of globalisation on the food supply; and POS# 9: Labelling of foods products. The regional Bloomberg Project supports pictorial warnings on tobacco products as a regional public good.

Other International Partners:

Successful partnerships already exist with international organisations that provide technical and financial support. Through these partners, countries have access to initiatives to strengthen in-country programmes, capacity-building and re-orienting the primary health care systems towards prevention and control of chronic diseases. WHO/PAHO developed programmes for integrated management of illnesses through the life cycle approach such as the IMCI (Integrated Management of Childhood Illnesses), IMAI (Integrated Management of Adolescent and Adult Illness) and IMAN (Integrated Management of Adolescent and their Needs).

Other international partnerships include the Governments of Canada and the United States, through the Canadian International Development Agency (CIDA) and President's Emergency Plan for AIDS Relief (PEPFAR) projects, respectively. Funding partners also include the Government of Spain, the Inter-American Development Bank (IDB), Global Fund against AIDS, Tuberculosis and Malaria (Global Fund/GFATM), The World Bank, United Nations Food and Agriculture Organisation (FAO) and the World Development Foundation (WDF). Efforts should be made to advance partnerships with these and other agencies to maximise support for the strengthening of primary health care and building capacity, which are critical in the prevention and control of NCDs.

Regional Developments

The Sixteenth Meeting of the CARICOM Council of Ministers responsible for Human and Social Development (COHSOD), on Children and Development (April 2008) and Seventeenth Meeting of the COHSOD, on the Implementation Agenda on Education (October 2008) adopted relevant elements of the *Declaration of Port-of-Spain* for implementation by the respective sectors. In addition, the successful annual, region-wide, inter-sectoral celebrations of Caribbean Wellness Day (CWD) have set the stage for scaling up NCD activities. Sustaining these activities requires inter-sectoral support, a multi-agency approach, capacity-building and dedicated resources.

Ministers of Agriculture of CARICOM issued the ***Declaration of St. Ann*** on 9 October 2007, "Implementing Agriculture and Food Policies to prevent Obesity and NCDs in CARICOM" (see **Appendix IV**) with commitments to use regional and World Trade Organisation (WTO) agreements to ensure food security, support the Caribbean Regional Negotiating Machinery (CRNM) to pursue fair trade policies, the elimination of transfats from our food supply, using the CFNI as a focal point, the labelling of foods to indicate their nutritional content, and public education for increased consumption of fruits and vegetables.

In March 2009, PAHO hosted a preparatory meeting, then launched in November 2009, the ***NCD Partners Forum*** to address priority issues for establishing successful public, private and civil society partnerships at the regional, sub-regional and national levels to address the NCD epidemic.

Heath and Education Officials met in March 2009 to discuss the results of the Global School Health Survey (GSHS). There are disturbingly high rates of risk factors among 13–15-year-olds, with tobacco use, alcohol and other drug use, mental health and social isolation, physical inactivity, and violence and unintentional injury.

The **Fifth Summit of the Americas, held in Port-of-Spain, Trinidad and Tobago** in April 2009 reaffirmed the WHO/PAHO and CARICOM Plans and restated the need for universal access to quality comprehensive health care:

> *"We are convinced that we can reduce the burden of non-communicable diseases (NCDs) through the promotion of 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 governments, the private sector, the media, civil society organisations, communities and relevant regional and international partners. We therefore reiterate our support for the PAHO Regional Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases Including Diet, Physical Activity, and Health. We also commit to measures to reduce tobacco consumption, including, where applicable, within the World Health Organisation (WHO) Framework Convention on Tobacco Control and to incorporate the surveillance of NCDs and their risk factors into existing national health information reporting systems by 2014."*

The problem of the NCDs was presented to the **Commonwealth Heads of Government Meeting (CHOGM) held in Port-of-Spain, Trinidad and Tobago** in November 2009. There was agreement on a declaration which in the strongest language possible emphasised their importance, committed the Commonwealth countries to elevate the priority of NCDs and supported the call for a **United Nations High Level Meeting (UNHLM)** in September 2011 to deal with the NCDs as a major developmental problem. As a consequence of the call for a UNHLM on NCDs in 2011, the Caribbean has undertaken a systematic lobbying effort through its diplomatic contacts to make this possible. The expected outcomes of the UNHLM are -

- Increased awareness of development implications of NCDs; changed perception that there are no cost-effective interventions.
- Political Declaration of Commitment for coordinated, multi-sectoral, national and regional programmes for the prevention and control of NCDs
- International solidarity for policies in support of national plans including for universal access to services and medicines required
- Increased engagement by international partners and commitment to a significant increase in ODA and technical cooperation to assist countries to develop and implement national plans
- Establishment on UN agenda through a request for status reports from the UN Secretary General every two (2) years and reviews of the situation by high level review meetings every five (5) years.

CHARACTERISTICS OF THE SOLUTIONS

The Silence of Non-Communicable Diseases (NCDs) [44] These diseases can be referred to as silent in the sense that they have not awakened the kind of public emotion or concern they merit. First, by their very chronicity, they do not have an immediate impact and, in many cases, do not provide the kind of dramatic external manifestation that occurs in other diseases. There is the popular perception that NCDs are an inevitable consequence of the ageing process and every elderly person is expected to have high blood pressure, for example. This flies in the face of the evidence that at least half of the deaths from NCDs occur in persons less than 70-years-old.

According to the World Bank, *"the NCD deaths are expected to rise over the next 25 years essentially because declining age-specific death rates will not be rapid enough to offset the effects of an older population structure"*. This is a significant assertion, as it implies that the preventive actions that can be taken to reduce the age-specific death rates will not remove the task of treating an ever-increasing burden of NCDs from the health services of the future.

However, attention cannot be focused exclusively on mortality. Much of the future effort will be directed to the kinds of interventions which will delay the onset of NCDs and thus, compress the period of morbidity – which, in itself, is a highly desirable end, not only for the individual, who can be productive for a longer period of time, but also for the state, which has an interest in reducing this period of morbidity and thereby reducing the cost of treatment of these diseases.

Prevention and Control of NCDs

Thus, the solutions lie not only in measures to educate the population, to screen those at risk and treat those in need, but must also include attention to other sectoral policies to make the healthy choice the easy choice. Any systematic approach to dealing with NCDs has to be based on primary prevention, through the reduction of the risk factors responsible for the occurrence of these diseases. The *Declaration of Port-of-Spain* is clear that the favoured approach is population-based. As the WHO points out -

> *" 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 than approaches targeted to people with elevated levels of those risk factors or people who meet diagnostic criteria for hypercholesterolemia hypertension, obesity or diabetes."*

Both the population and the high-risk approaches are necessary. Population-wide approaches form the central strategy for preventing and controlling chronic disease epidemics, but should be combined with interventions for individuals. It will be necessary to treat NCDs when they occur and put in place effective secondary prevention for early detection and to avoid or postpone recurrence by adopting the appropriate intervention.

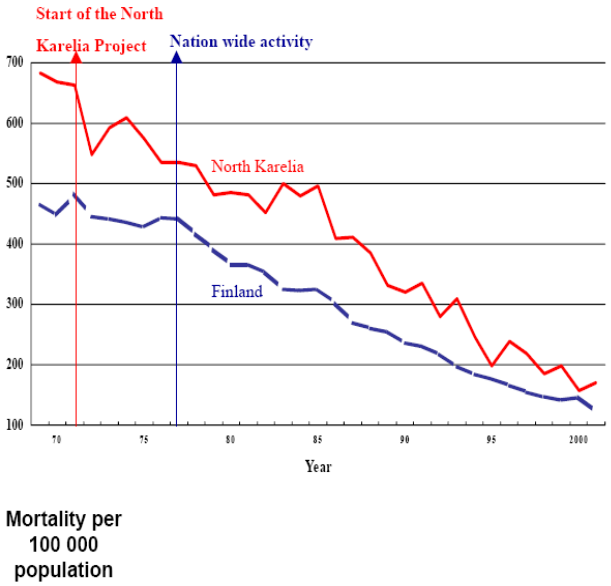
Successes in Other Countries

Countries that have made significant gains in NCD prevention and control did so mainly because of **comprehensive, integrated approaches that encompass interventions directed at the whole population and at individuals**, and that focus on common risk factors (e.g., tobacco, diet, physical activity, and alcohol), cutting across specific diseases.

In **Poland,** cigarette consumption dropped by 10 percent between 1990 and 1998, resulting in 10,000 fewer deaths each year. [45] In the **USA**, during the periods 1971 to 1982 and 1982 to 1992, cardiovascular mortality declined by 31%[46], equivalent to a 3% annual decline in cardiovascular mortality.[47] In **Canada**, mortality from myocardial infarction (MI) decreased by 3.9% annually between 1984 and 1993, with two-thirds of the decline occurring from reduced incidence of MI, and one-third, from a reduced case fatality rate.[48] In **Finland**, over the past 30 years, there have been dramatic declines in death rates from coronary heart disease, falling from 700/100,000 in 1969 to 150/100,000 in 2001 (see Figure 17). The majority (about 75%) of the decline in heart disease mortality was due to reductions in three risk factors: blood pressure, high cholesterol and smoking. [49]

Figure 17: Finland: Dramatic Declines in NCD Mortality

Age-adjusted mortality rates of coronary heart disease in North Karelia and the whole of Finland among males aged 35-64 years from 1969 to 2001



Global Strategy for Prevention and Control of Non-Communicable Disease (NCD)

In 2000, the World Health Assembly (WHA) called for a global strategy to prevent and control NCDs.

In 2005, the WHO released the Global Report, *Preventing Chronic Diseases: A Vital Investment,* which proposed a global goal of a 2% annual reduction in projected chronic disease death rates worldwide, per year, over the next 10 years. In addition to the Effective Interventions in Chronic Disease Prevention and Control (Table 7), there is also need for health improvements in health services organisation and delivery; human and financial resources and communication and information.

In 2007, the WHA approved Resolution WHA60.23 "*Prevention and Control of Non-Communicable Diseases: Implementation of the Global Strategy"*. The Resolution urges Member States to:

- strengthen **national and local political will** to prevent and control non-communicable diseases;
- develop and implement a **national multi-sectoral action plan** and strengthen the **capacity of health systems for prevention;** and to
- Make prevention and control of non-communicable diseases an **integral part of primary health-care** programmes.

Table 7:

Effective Interventions in Chronic Disease Prevention and Control

• Laws and Regulations • Tax and Price Interventions • Improving the built environment for physical activity	Intervention main focus
• Advocacy, communication and information • Community-based interventions • School-based interventions • Workplace interventions	Population-based
• Screening – CVD, diabetes, HBP, some cancers • Clinical prevention – focus on overall risk • Disease Management • Rehabilitation • Palliative care	Individual-based

Other relevant supporting initiatives for the prevention and control of NCDs include the -

- Global Strategy on Diet, Physical Activity and Health;
- Framework Convention on Tobacco Control; and
- WHA Resolution 58.22: Cancer Prevention and Control.

ALIGNMENT OF THE REGIONAL NCD PLAN WITH CCH-3

The Caribbean Cooperation in Health Initiative (CCH) represents a mechanism to unite Caribbean territories in a common goal to improve health and wellbeing, develop the productive potentials of the people and, by definition, the competitive advantage of the Region.

The aim is "Caribbean Countries helping themselves and one another to improve opportunities and systems for health in the Region."

The mandate of CCH-3[50] 2009-2015 addresses a new orientation towards:

- People-centred development;
- Genuine stakeholder and community participation and involvement;
- Effective regional coordination and public health leadership;
- Outcome-oriented planning and implementation and performance-based monitoring; and
- Resource mobilisation for health, health coverage and social protection for the people of the Region.

The Guiding Principles underlying CCH-3 are -

Primary Health Care

The Primary Health Care Approach will be the broad overarching health development framework that will guide health development in this Region. The guiding principles reflect the foundation upon which all interventions will be planned, implemented and evaluated.

The Right to the Highest Attainable Level of Health

Health is a fundamental human right. Every citizen of the Caribbean has a right to the highest attainable level of health. Services therefore need to be responsive to people's health needs. In addition, there is need for accountability in the health system, increased efficiency and effectiveness, while doing no harm.

Equity

Countries should be working towards eliminating unfair differences in health status, access to health care and health enhancing environments, and treatment within the health and social services system.

Solidarity

The people and institutions in the Caribbean working together to define and achieve the common good.

People-Centred

Common health needs will be addressed as public goods that all CARICOM Members and Associate Members identify with and support by virtue of their relevance to the national situation and the desire to promote the health of the community as a whole. The ultimate aim is to get people to be healthy and keep them healthy. This means that regional initiatives must have as their main aim, meeting the needs of the people, families and communities of the Region.

Leadership

Public health leadership is a major priority. The attainment of **Health for All** will be dependent on leadership that shares regional vision and creates an enabling environment for mobilising resources, improving performance, ensuring greater transparency and accountability of regional health systems.

Vision

In the new millennium, Caribbean people will be happier, healthier and more productive, each respected for his/her individuality and creativity and living more harmoniously within cleaner and greener environments.

Goal

To improve and sustain the health of the people of the Caribbean: "Adding Years to Life and Life to Years". Strategies and actions need to be:

- Cross-cutting;
- Inter-programmatic;
- Trans-sectoral; and
- Focused on the determinants of health.

The five project goals of **CCH-3** are:

1. Creation of a Healthy Caribbean environment conducive to promoting the health of its people and visitors;
2. Improved health and quality of life for Caribbean people throughout the life cycle, *"Adding Years to Life and Life to Years;"*
3. Health Services that respond effectively to the needs of the Caribbean people;
4. Adequate human resource capacity to support health development in the Region; and
5. Evidence-based decision-making as the mainstay of policy development in the Region.

CCH-3 complementarity

The following areas, contained in the substantive CCH-3 document, have not been extensively addressed in this *Plan*, but provide critical support to the effective implementation of the Regional *NCD Plan*:

Human Resources:

- Movement of health professionals
- Regional Health Human Resource Policy and Action Plans
- Strengthening the regional primary care workforce
- Strengthening the regional training institutions
- Building a public health workforce to promote health and development for CARICOM Members and Associate Members

Strengthening Health Systems:

- Reorientation of the health system for equitable, sustainable and high quality services
- Reorientation of health care to Primary Health Care-based systems

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NCD Guiding Principles

- **The Caribbean Charter for Health Promotion:** The *Caribbean Charter for Health Promotion*, as stipulated in the Caribbean Cooperation in Health Initiative, Phase III (CCH-3) document, is the strategic framework that will be applied to Chronic Disease Prevention and Control. In the Caribbean context, it is an approach that should strengthen the capacity of individuals and communities to control improve and maintain physical, mental, social and spiritual wellbeing.

- **Capacity-building in CMCs through** technical assistance to CARICOM Members and Associate Members (CMCs) wishing to undertake interventions. Emphasis will be placed on building the skills of country personnel, while maintaining and improving CARICOM/PAHO's capacity to provide the support required at the sub-regional level.

- **Focus on the gender dimensions of the epidemic:** Men and women seek, access and follow up with the health sector differently. While there is still a view that men have more chronic diseases than women (in fact, the genders are about equal), men, especially working class men, do not seek and maintain their chronic disease care as they should. Barber shops and workplaces could be considered as places providing opportunities to reach men.

- **Multi-sectoral approaches:** CMCs are encouraged to engage a broad range of functional or sectoral ministries and agencies in the response and to utilise broad-based strategies for preventing and controlling chronic diseases, including building alliances with public and private sector bodies, especially the media. The responses should be both intra- or inter-sectoral.

- **An integrated approach to prevention and control** of risk factors and chronic diseases, e.g., the application of a range of health promotion strategies, including public policy measures and interventions at the individual, community and national levels, form the major guiding principle of this Strategic Plan.

THE STRATEGIC PLAN OF ACTION FOR THE PREVENTION AND CONTROL OF CHRONIC NON-COMMUNICABLE DISEASES FOR COUNTRIES OF THE CARIBBEAN COMMUNITY (CARICOM) 2011 – 2015

IMPLEMENTING THE PORT OF SPAIN DECLARATION "UNITING TO STOP THE EPIDEMIC OF CHRONIC NON-COMMUNICABLE DISEASES"

This Plan, detailed in the log frame below, is based on the PAHO Strategic Plan for NCDs, informed by the WHO Resolutions in the context of CCH-3' and formulated in response to the *Declaration of Port-of-Spain* issued by CARICOM Heads of Government.

Goal: To reduce the burden (mortality and morbidity) from NCDs in the Caribbean, with Caribbean Governments taking the lead in articulating a collective response to the NCD epidemic.

Purpose:
To strengthen the capacity at the country and regional levels to mount and sustain a comprehensive inter-sectoral response for the prevention and control of chronic NCDs and their risk factors.

POS Summit Declaration / Expected Results	Objectively Verifiable Process / Output indicators	Assumptions	Sources of data for Verification
P.1) All-of-government, private sector, civil society triad mobilised in support of the implementation of the POS NCD Summit *Declaration* P.2) Advantage taken of the momentum from the NCD Summit *Declaration* and the actions that this has spurred, to date, in the private sector and civil society in the Caribbean in support of a multi-sectoral response to the *Declaration* P.3) POS#11 Gender dimensions mainstreamed into all policies, programmes and evaluation	P.1.1) NCD mortality declines by 2% / year P.1.2) Hospital admissions for diabetes, hypertension, asthma reduced by 5% in at least 2 countries by 2013 P.2.1) Multi-sectoral participation in prevention and control programmes in at least 10 countries by 2012 P.3.1) Gender analysis included in all programmes.	Stable political, economic, social and public health environment in Caribbean countries, with no major natural or other disasters Other priorities do not crowd out the NCD agenda Continued support of implementation of POS NCD *Declaration* by regional governments Effective means of working across all sectors established and maintained	Mortality data Risk factor surveys (STEPS or equivalent) Hospital admission data Minimum Data Set CFNI reports

LAYOUT OF LOG FRAME,

PRIORITY ACTION #1: RISK FACTOR REDUCTION AND HEALTH PROMOTION

1. NO TOBACCO, NO HARMFUL USE OF ALCOHOL
2. HEALTHY EATING (INCLUDING TRANSFAT, FAT, SUGAR)
3. SALT REDUCTION
4. PHYSICAL ACTIVITY
5. INTEGRATED PROGRAMMES, ESPECIALLY IN SCHOOLS, WORKPLACES AND FAITH-BASED SETTINGS

PRIORITY ACTION #2: INTEGRATED DISEASE MANAGEMENT AND PATIENT SELF-MANAGEMENT EDUCATION

6. SCALING UP EVIDENCE-BASED TREATMENT

PRIORITY ACTION #3: SURVEILLANCE, MONITORING AND EVALUATION

7. SURVEILLANCE, MONITORING AND EVALUATION

PRIORITY ACTION #4: PUBLIC POLICY, ADVOCACY AND COMMUNICATIONS

8. ADVOCACY AND HEALTHY PUBLIC POLICY
9. MEDIA AND SOCIAL COMMUNICATIONS

PRIORITY ACTION # 5: PROGRAMME MANAGEMENT

10. PROGRAMME MANAGEMENT, PARTNERSHIPS AND COORDINATION
11. RESOURCE MOBILISATION / HEALTH FINANCING
12. PHARMACEUTICALS

EACH SECTION INCLUDES -
Partners
Sources of data for Verification
POS Summit Declaration/Expected Results
Assumptions
Objectively Verifiable Process/Output indicators
Activities: Regional (R) and Country Support(C)
Recommendations for Country Plans

Table 8 displays the Annual Budget for Regional Actions and Regional Support to Countries in US $.

PRIORITY ACTION #1: RISK FACTOR REDUCTION AND HEALTH PROMOTION

Objective: To develop and implement public policies and programmes, supported by adequate resources and a comprehensive communication programme to facilitate the implementation of prevention and risk factor reduction strategies and interventions

Expected Result: Population-based strategies and interventions for risk factor reduction improved to facilitate a health-promoting environment in which people practice healthy behaviours, including promotion of healthy diets and physical activity, no tobacco and no harmful use of alcohol.

1. NO TOBACCO, NO HARMFUL USE OF ALCOHOL

Partners: Ministries of Health, Finance, Trade, Offices of Attorneys- Gen, Legal Affairs, CROSQ, PAHO; Private: Bloomberg, Tourism, Health/Life insurance Cos. Private Sector employers; Civil society, Health NGOs, Trade Unions, Universities. Sources of data for Verification: STEPS, GSHS, GYTS, Tobacco legislation

POS Summit Declaration / Expected Results	Assumptions	Objectively Verifiable Process / Output indicators	Activities: Regional (R) and Country Support (C)	Recommendations for Country Plans
1.1) POS #3. FCTC ratified, compliant legislation passed and implemented	Political will for FCTC ratification and implementation Tobacco industry lobby does not succeed in derailing the implementation of the FCTC	1.1.1) FCTC ratified in all Caribbean countries by 2011. 1.1.2) 100% smoke-free public spaces (enclosed spaces) in at least 8 countries by 2013 1.1.3) 90% cigarettes sold in countries carrying FCTC compliant labels by 2012 1.1.4) Complete ban on tobacco ads, promotion and sponsorship in at least 7 countries by 2013 1.1.5) Smoking prevalence declines by 15% in at least 2 countries by 2013	C1.1.1.1) Disseminate Model legislation for tobacco control (e.g., TRT legislation) to countries. C.1.1.1.2) Conduct workshop for 4 countries to produce legislation for submission to the Cabinet. R.1.1.3.1) CROSQ completes standards for enforcing packaging and labelling of tobacco products with rotating pictorial warnings on 50% or more of the cigarette packages C.1.1.5.1) Develop and disseminate tobacco advocacy tool-kit and model public education programme to countries (See 9.1)	1.1.1.1) Haiti and St Kitts and Nevis ratify FCTC 1.1.1.2) FCTC legislation passed and enforced 1.1.1.3) Guyana, Jamaica and Trinidad and Tobago required to pass and enforce legislation on Advertising, Promotion and sponsorship bans (FCTC # 13), Smoke Free indoor public places (FCTC #8) by 2011. 1.1.5.1) Adapt and adopt model public education programmes 1.1.5.2) Implement Global Youth Tobacco Survey (GYTS) and use the information for national policy and programme development
1.2) Harmful use of alcohol reduced	Political will to address mortality and morbidity from harmful use of alcohol exhibited.	1.2.1) Reduction by 40% in the number of youths (< 18 years) in 6 countries) consuming alcohol by 2013 1.2.2) Reduction by 20% in motor vehicle and pedestrian fatalities associated with drunk driving	R.1.2.1.1) Conduct workshop to establish regional guidelines regarding the harmful use of alcohol C.1.2.1.2) Develop and disseminate Model legislation on alcohol advertising and promotion and on breathalyser programme to countries.	1.2.1.1) Enact and enforce legislation establishing the minimum age limit for the consumption and purchase of alcohol 1.2.1.2) Regulate or ban alcohol advertising and promotion, especially those ads aimed at children and young people. 1.2.2.1) Breathalyser legislation - Establish and enforce blood alcohol level limits for drivers; zero tolerance for new drivers, random breath testing; sobriety check points; license suspension

2. HEALTHY EATING (INCLUDING TRANSFAT, FAT, SUGAR)

Objective: To stimulate inter-sectoral action that promotes the availability, accessibility and consumption of safe, healthy, tasty foods by the Caribbean people.

Sources of data for Verification: Gazetted legislation, CFNI reports, CROSQ reports, Product labels, Food analysis reports, Published protocols, Campaign Materials, Published Guidelines

Partners: Ministries of Health, Finance, Trade, Offices of Attorneys- Gen/Legal Affairs, CROSQ, PAHO, Private: Food manufacturers, media; Civil society: Health NGOs, Trade Unions, Consumer Organisations, Universities

POS Summit Declaration / Expected Results	Assumptions	Objectively Verifiable Process / Output indicators	Activities: Regional (R) and Country Support (C)	Recommendations for Country Plans
Policies: 2.1) Legislation, regulations, multi-sectoral policies, incentives, plans, protocols and programmes developed and implemented to promote food security and healthy eating. For example: a) POS #7 CFNI, CARDI and the regional inter-governmental agencies to enhance food security b) POS #8 CRNM supports pricing and tariffs to ensure that healthy foods are available at affordable prices c)) Removal of transfats from the Caribbean food supply b) Regional nutritional and quality criteria for food manufacturers e) POS #9 User-friendly food labelling	Mechanism for monitoring food content established in one or two locations to serve the Caribbean Private sector self-regulates to meet self-imposed standards	2.1.1) At least 6 countries with legislation and regulations, multi-sectoral policies, incentives, plans, protocols and programmes that aim to improve dietary and lifestyle behaviours by 2015, supported by CFNI and CARDI 2.1.2) At least 7 countries with incentives or disincentives to increase healthy eating and physical activity by 2015 2.1.3) CROSQ develops regional standards for salt, fat and sugar content on imported and locally produced foods by 2013 2.1.4) All imported and locally produced foods with required nutritional labelling in at least 3 countries by 2013 2.1.5) At least 7 countries have developed and implemented transfat-free policies and strategies by 2013, for 100% elimination of transfat from the food supply in at least 3 countries by 2015	R.2.1.1.1) Review regional food policies and develop and disseminate model legislation to countries C.2.1.1.1) Provide support to countries for policy reviews, if requested R.2.1.1.2) Effect changes to (1) CET at the regional level and (2) dialogue with CRNM about WTO regulations (scope to adjust tariffs and subsidies on particular foods without violating any country's commitments) R.21.3.1) CROSQ institutes process to establish regional nutritional standards for food content, including salt, transfat, fat and sugar content, using CFNI dietary guidelines (R.3.1.1.1) specific to salt R.2.1.4.1) CROSQ develops user-friendly standards for labelling of nutritional content of foods R.2.1.5.1) Develop and disseminate Model Action Plan for the reduction of transfat in manufactured foods in the Caribbean	2.1.1.1) Food policy review at country level 2.1.1.2) Adapt, debate and enact recommended legislation and regulations to improve diet 2.1.2.1) Design and implement Incentives Programme (taxes and subsidies) for producers and buyers that subsidise low calorie nutritious foods, preferably local 2.1.4.1) Policy dialogue with local food manufacturers to ensure their use of national dietary guidelines in product development 2.1.5.1) Develop and implement transfat-free policies and programmes

2.2) Regional nutrition standards and food-based dietary guidelines for school meals and food sold at workplaces and institutions	Schools, workplaces and other institutions accept and adopt nutrition standards	2.2.1) Model nutritional standards for schools, workplaces and institutions developed by 2013 2.2.2) At least 6 countries adopt and implement food-based dietary guidelines in at least 2 sectors by 2015	C.2.2.1.1).Develop and disseminate model nutritional standards for school and workplace meals and cafeterias, in collaboration with CFNI C.2.2.2.1) Technical assistance to countries for implementation of institutional dietetic services, if requested	2.2.1.1) Implement food-based nutritional dietary guidelines in schools, workplaces and institutions
2.3) POS# 12 A comprehensive public education campaign to promote a balanced diet		2.3.1) Comprehensive public education campaign to promote healthy eating in all countries by 2013 (See 9.1 – Social Communications)		

3. SALT CONSUMPTION

POS Summit Declaration / Expected Results	Assumptions	Objectively Verifiable Process/ Output indicators	Activities: Regional (R) and Country Support (C)	Recommendations for Country Plans
3.1) Salt content of processed and prepared foods reduced	Effective means of population-based testing for salt consumption determined Capacity for full analysis of food content established in the Caribbean.	3.1.1) CROSQ issues standards for salt by 2012 3.1.2) At least 80% of large food manufacturers following the CAIC *Pledge* to reduce the salt and fat content of processed and prepared foods (including in schools, workplaces and fast-food outlets) by 2013	R 3.1.1.1) Initiate CROSQ process to establish standards for food content, including minimum levels for salt, in collaboration with CFNI R.3.1.2.1) Negotiate and/or legislate 10% reduction per year, over 3 years (total 30% reduction) in salt content of processed and prepared foods, manufactured or imported	3.1.2.1) Advocacy of local food manufacturers and importers to reduce the salt content of their products 3.1.2.2) Education programme for local caterers and fast food businesses about the risk of salt to health and reducing salt in their products
3.2) Salt consumption of the population reduced		3.2.1) Salt consumption declines by 20% in at least 2 countries by 2013 3.2.2) At least 10 countries using baseline and ongoing sampling for tracking salt consumption in the population by 2014	R.3.2.1.1) Design model public education campaign (See 9.1 – Social Communications) C.3.2.2.1) Provide support to countries for tracking sodium consumption in the population, if requested	3.2.1.1) Design and mount a public education campaign about the risk of salt to health, not to add salt at the table, and healthy, tasty alternatives 3.2.2.1) Implement population-based surveys to track salt consumption

4. POPULATION-BASED PHYSICAL ACTIVITY

Sources of data for Verification: Risk factor surveys, Posts for PE teachers, Town and country plans, Minutes of CWD planning committees, Media reports, CWD toolkit. Partners: Ministries of Education, Sports, Youth, Health, Urban Planning, Local Govt, Housing, Transport; CARICOM COHSOD, CDB; Private sector: Media, Sports-related companies – clothes, shoes, sports drinks, Workplace wellness; Civil society: Health NGOs, PA NGOs, Celebrities, Spokespersons, Community organisations, Universities

POS Summit Declaration / Expected Results	Assumptions	Objectively Verifiable Process / Output indicators	Activities: Regional (R) and Country Support (C)	Recommendations for Country Plans
4.1) Legislation, regulations, multi-sectoral policies, incentives, plans, protocols and programmes developed and implemented to promote physical activity	Supportive environments for physical exercise. Political will for supports for mass transportation systems	4.1.1) At least 4 countries with legislation, multi-sectoral policies, and programmes to promote physical activity by 2013 4.1.2) Physical activity levels increase by 10% in at least 2 countries by 2013 .	C.4.1.1.1) Develop and disseminate model legislation for supportive environments for physical activity C.4.1.2.1) Provide support for establishing collaboration with architects and town planners in countries to advocate urban planning to increase public spaces supportive of physical activity, mass transportation, pedestrian malls and walkable cities	4.1.1.1) Legislation to ensure that new housing developments include safe spaces for walking and biking 4.1.2.1) Advocacy of, and support for Town Planners in designing increased public spaces supportive of physical activity, mass transportation, pedestrian malls and walkable cities.
4.2) POS #10. Increase in adequate public facilities to encourage mass-based physical activity in the entire population		4.2.1) At least 5 countries with weekly car-free Sundays or some other ongoing mass-based low cost physical activity event by 2013 4.2.2.) At least 6 countries have new safe recreational spaces by 2012	C.4.2.1.1) Conduct training workshops for 2 community leaders from 6 countries with on-going physical activity initiatives by 2012 C.4.2.2.1) Identify and disseminate best practices for PA spaces (e.g., Barbados Seaside Boardwalk)	4.2.1.1) Private/public/civil society partnerships to sponsor and promote safe recreational spaces with trained staff and music, to stimulate population physical activity
4.3) POS #15. Second Saturday in September celebrated as "Caribbean Wellness Day," (CWD) in commemoration of NCD Summit	Support for regional branding of CWD continue Private sector and civil society support for CWD continue	4.3.1) At least 12 countries with CWD multi-sectoral planning and activities by 2011 4.3.2) CWD celebrations in at least 3 separate locations in each of 12 CARICOM countries by 2011 4.3.3) Caribbean branding of CWD established with common slogans and messages 4.3.4) Sustained multi-sectoral physical activity programmes spawned by CWD, in at least 4 countries by 2013 and 8 by 2015	R.4.3.2.1) Regional CWD FP and countries document and evaluate CWD, share best practices and make recommendations for improvements. R.4.3.3.1) Regional CWD FP support including a tool kit (slogans, jingles, media kits, posters, talking points) and support to assist countries in implementation R.4.3.3.2) Regional CWD FP facilitates web sites to support CWD.	4.3..1.1) Establish private and public sector, civil society, media committee for CWD, including communications plan 4.3..2.1) Country CWD committee implements CWD activities in multiple settings and multiple locations in the country 4.3.4.1) Use CWD as a catalyst for sustained, population-based activities

5. INTEGRATED PROGRAMMES ESPECIALLY IN SCHOOLS, WORKPLACES AND FAITH-BASED SETTINGS

Sources of data/Means of Verification: Ministry of Education records, Surveys, Amended school curricula to accommodate health promoting school initiatives, Workplace and school policies, Result of KAP studies,
Partners: Private Sector: Media Employers, Health Insurance Cos.; Civil Society: Trade unions, Faith-based organisations, PTSA, School Boards; Ministries of Health, Education, Youth, and Community Development

POS Summit Declaration / Expected Results	Assumptions	Objectively Verifiable Process / Output indicators	Activities: Regional (R) and Country Support (C)	Recommendations for Country Plans
5.1) POS #10 Healthy lifestyle and wellness policies and programmes in special settings, e.g. , schools, workplaces, faith-based settings enhanced/ implemented POS #6. Reintroduction of physical education in schools, where necessary, provide incentives and resources to effect this policy, promote programmes aimed at providing healthy school meals and promoting healthy eating	Schools with adequate resources – safe places for PA and trained instructors with staff positions. Employers and trade unions agree workplace wellness programmes. A Wellness Programme includes all components – HIV, injuries and NCDs.	5.1.1) At least 6 countries with established policies and programmes that include nutrition and physical activity for school/ worksite /faith organisations, etc. (Healthy Settings) by 2015 5.1.2) At least 20% increase in the number of schools with - a) healthy meal choices; b) physical ed programmes; by 2013 5.1.3) At least 50% increase in the number of workplaces with a) healthy food choices; b) Wellness Programmes, including screening and management of high risk by 2013 5.1.4) Strategies for engaging with faith-based organisations in 6 countries by 2012	C.5.1.1.1) Provide support to countries in developing and implementing school, workplace, faith-based consultations, policies and programmes, if requested R.5.1.2.1) Identify barriers to, and facilitators of implementation of physical activity programmes in schools C.5.1.2.2) Draft and disseminate model healthy schools/worksite policies, strategies and programmes R.5.1.2.3) Provide scholarships to G C Foster College of Physical Education and Sport and posts for PE instructors to facilitate mandatory physical education in schools C.5.1.3.1) Draft and disseminate model comprehensive Workplace Wellness Programme including NCDs, HIV and Injuries and Occupational Safety R.5.1.4.1) Convene regional workshop with FBOs to explore and develop model programme, including FBO health services	5.1.1.1) Designate Focal Point in Ministry of Health to liaise with schools, workplaces, FBOs (Settings) 5.1.1.2) Workshops to promote and train for healthy eating and active living in schools, workplaces and FBOs 5.1.1.3) Discontinue the excessive use of sugar and fat-containing foods offered by caterers, cafeterias and vendors at worksites and schools 5.1.3.1) Conduct workshop with key stakeholders to adapt and adopt and plan implementation of Workplace Wellness Programme 5.1.3.2) Implement risk factor screening, including, e.g., barbershops 5.1.3.3) Employers to adopt/ develop safe PA for their staff and the community, e.g., walking trails, physical activity trainers

5.2) Health promoting schools developed in the Region and of the Caribbean Health Promoting School Network (CHPSN) strengthened		5.2.1) Health Promoting Schools defined, core indicators drafted, reviewed and adopted by at least 6 countries by 2012 5.2.2) Focal point appointed at sub-regional level for CHPSN by 2012 5.2.3) CHPSN supports countries in establishing country networks and collaboration and technical cooperation between countries by 2013	C.5.2.1.1) Document and disseminate Best Practices components and indicators of Health Promoting Schools R.5.2.2.1) Appoint Focal Point for CHPSN for the Caribbean R.5.2.3.1) Conduct CHPSN workshop to share Best Practices	5.2.1.1) Appoint and train Focal Point (FP) in Ministries of Health and Education, respectively, for Health Promoting Schools 5.2.1.2) FPs to convene workshops to train representatives from the Education sector in Best Practices, including health promoting schools components, implementation and evaluation
5.3) Curricula developed for primary, secondary and tertiary levels for NCD risk factors, prevention and control strategies.	Schools are receptive to including NCD prevention and control curricula	5.3.1) Model NCD prevention and control curriculum developed for at least one educational level (primary, secondary or tertiary) by 2012 and for all levels by 2015, in collaboration with HFLE (Health and Family Life Education)	R.5.3.1.1) Develop model NCD curricula for primary, secondary and tertiary institutions, including risk factor prevention and control modules and counselling techniques, as part of the education of teachers and health care workers. R.5.3.1.2) Engage with regional tertiary education institutions in adapting and adopting NCD prevention and control curriculum C.5.3.1.3) Support to countries to adapt and adopt NCD and risk factor curricula for schools, if requested	5.3.1.1) Convene Ministry of Health and Ministry of Education meeting to adapt and adopt NCD curricula 5.3.1.2) Introduce, monitor and evaluate NCD prevention and control curriculum in educational institutions

PRIORITY ACTION #2: INTEGRATED DISEASE MANAGEMENT AND PATIENT SELF-MANAGEMENT EDUCATION

Objective: To facilitate and support the strengthening of the capacity and competencies of the health system for the integrated management of chronic diseases and their risk factors

6. SCALING UP EVIDENCE-BASED TREATMENT

Sources of data for Verification: Chronic disease registries, Mortality records, Risk factor surveys Records from training programmes, CME training attendance register, Performance appraisals, Documentation of guidelines, Needs assessments, Clinical audits, Medication formulary, Minutes of meetings, Evaluation reports

Partners: Ministry of Health, CARICOM COHSOD, Regional Health Institutions; Civil Society: Health NGOs, Medical Associations, Trade Unions, CME certifiers; Private Sector: Pharmaceutical companies, Health insurance companies, Private medical practitioners

POS Summit Declaration / Expected Results	Assumptions	Objectively Verifiable Process / Output indicators	Activities: Regional (R) and Country Support (C)	Recommendations for Country Plans
6.1) POS #5. Countries' capacity strengthened for effectively and efficiently delivering quality assured chronic disease and risk factor screening and management, based on regional guidelines a) Effective management structure and reoriented Primary Health Care system based on the Chronic Care Model implemented. (Appendix V) b) Universal access to quality PHC improved. c) Access to technologies and safe, affordable and efficacious essential medicines for chronic disease prevention and control improved. d) Personal health skills and self-management among people with chronic conditions and risk factors and their families, improved.	Professionals accept and agree to implement evidence-based recommend-dations High quality generic drugs available User-fees eliminated for the poor	6.1.1) Integrated, evidence-based policies, guidelines and protocols for screening, prevention and control of NCDs, including cancers, especially cervical, breast, colon and prostate cancer reviewed and approved by Ministries of Health, in keeping with the best evidence from the CHRC or other national Guidelines, including risk chart approach, in at least 4 countries by 2013 6.1.2).80% of at risk populations screened and treated according to evidence-based guidelines in public, private and NGO health sectors, with ongoing auditing in at least 2 countries by 2013 and 8 countries by 2015 6.1.3) at least 80% of patients with high risk for CVD have improved access to Primary Care services by 2015 (e.g., at least one PHC visit each year). Access defined by Member Countries according to local context.	R.6.1.1.1) Conduct workshops to develop/ review/adapt produce model pocket QOC guidelines (protocols and standards) for priority diseases identified in the CCH-3: CVD, diabetes, (using the total risk approach) asthma and cancer prevention and control R.6.1.2.1) Provide estimates of target populations at risk C.6.1.2.2) Provide support to countries to finalise and implement national screening and treatment guidelines for NCDs, including cancers, especially cervical, breast, prostate and colon cancers, if requested R.6.1.3.1) Conduct study to assess the feasibility of establishing a Regional Health Insurance Scheme	6.1.1.1) Workshop to adapt and adopt proposed NCD Pocket Guidelines 6.1.1.2) Strategy for training, dissemination and implementation of NCD pocket guidelines utilised for NCDs, including cancers, especially cervical, breast, prostate and colon cancers 6.1.2.1) Needs audit to compare target population needs to country capacity for NCD screening and treatment 6.1.3.1) Define, evaluate and identify gaps in equity of access to quality care 6.1.3.2) Develop targetted interventions developed to address gaps and to provide coverage for vulnerable groups

		6.1.4) Chronic Care Model implemented in 50% of health facilities (public, private and NGO) in at least 4 Member States by 2013, and in 80% of health facilities in at least 8 countries by 2015 a. At least one CCM project in at least 4 Member States, by 2012. b. 40 % hypertensive patients at goal in 6 countries by 2013 c. 40 % high chol. patients at goal in 6 countries by 2013 d. 50% increase in number of women having Pap smears in 5 countries by 2013 e. Reduction of childhood obesity by 10% in at least 4 countries by 2015 f. Technologies and medicines – see Section 12 : Pharmaceuticals and Laboratory Support g. Patient self management education - See Section 9.2 – Media and Communications 6.1.5) Programmes for prevention and control of cancers are an integral part of the countries' NCD Strategic Plans, and are integrated into routine Primary Health Care services. 6.1.6) Countries and CARICOM develop and implement a proposal for shared tertiary treatment services that addresses technical, legal, economic and political realities	R.6.1.4.1) Adapt and disseminate Chronic Care Policy and Model of Care for the Region in concert with a revised Primary Health Care policy and model of care R.6.1.4.2) Provide regional support for countries to fund, develop, implement and evaluate pilot projects in CCM to improve QOC C.6.1.4.3) Provide support for countries to implement projects with partners in the private sector and civil society for community-based BP and weight screening, including at workplaces and in faith-based organisations R.6.1.5.1) Provide technical assistance for formulating policies that integrate cancer prevention and control into Primary Care Services, especially cervical, breast, prostate and colon cancers C.6.1.5.2)) Develop and disseminate model integrated programmes and related models of care - Men's Health, Women's Health and Care across the lifespan R.6.1.6.1) Work with countries and CARICOM to develop proposed policies, protocols and programmes for shared treatment services in tertiary care, including some disability and rehabilitation services that address technical, legal, economic and political realities	6.1.4.1) Adapt and adopt Chronic Care and PHC Policy and Model of Care 6.1.4.2) Implement at least one NCD quality of care improvement project 6.1.4.3) Conduct audit of patient records to assess adherence to guidelines, prevalence of hypertensive and high cholesterol patients, in compliance with treatment goals 6.1.4.4) Promote use of effective referral systems between levels of care 6.1.4.5) Implement projects with partners in private and civil society for community-based BP and weight screening, including at workplaces and in faith-based organisations 6.1.5.1) Build partnerships (NGOs, private sector, professional associations, academic, etc.) that coordinate inputs from key sectors, for commitment to national screening and management of cancers, especially cervical, breast, prostate and colon. 6.1.5.2) Adapt and adopt integrated programmes and related models of care 6.1.6.1) Promote shared tertiary services proposal(s) and coordinate implementation and management of systems

6.2) Countries' healthy work force competencies strengthened to appropriately and effectively deliver and manage quality NCD programmes, including cancer prevention and control programmes, especially cervical, breast, colon and prostate cancers		6.2.1) Training for Ministry of Health senior personnel, NCD programme managers and at least 50% of PHC professionals in NCD programme quality improvement, based on national guidelines Training for PHC professionals to also include management of cancer, HBP, DM, risk approach, tobacco and exercise screening implemented in at least 4 countries by 2013 and 8 countries by 2015 6.2.2) Current and future needs for specialised staff for cancer screening and control defined in 6 countries by 2014	C.6.2.1.1) Provide training and other resources for countries to strengthen NCD advocacy, programme design and evaluation in the public and private sectors, including CVD and diabetes management and cancer. Promote the use of the "*Caribbean Framework for Developing National Screening and Clinical Guidelines for Cancer Prevention and Control*" training by illuminate or other means. R.6.2.1.2) Support academic programmes in regional institutions in strengthening curricula in basic training programmes and continuing professional development courses in NCD prevention, screening and management, including cancer. R.6.2.1.3) Coordinate annual training workshop for national NCD and cancer coordinators/focal points in programme management R.6.2.2.1) Assist countries in determining current and future needs for training in cancer screening and treatment for pre-invasive lesions, especially for cervical, breast, prostate and colon cancers R.6.2.2.2) Develop regional certification and re-certification programmes for colposcopy and treatment of pre-invasive cervical lesions for all relevant categories of health care professionals, including by distance education	6.2.1.1) Conduct needs assessment with regard to competencies in NCD prevention and control 6.2.1.2) Develop training and continuing medical education programme with an evaluation component, based on the needs assessment 6.2.1.3) Re-evaluate competencies as a component of performance appraisal 6.2.2.1) Support development of regional certification and re-certification programmes for colposcopy or other technologies and treatment of pre-invasive cervical lesions.

PRIORITY ACTION #3: SURVEILLANCE, MONITORING AND EVALUATION

Objective: To encourage and support the development and strengthening of countries' capacity for surveillance and research of chronic diseases, their risk factors, determinants and consequences, as well as monitoring and evaluation of the impact of public health interventions.

7. SURVEILLANCE, MONITORING AND EVALUATION

Sources of data for Verification: NCD surveillance plan and budget, Mortality, Prevalence and incidence data, Behavioural Risk Factor data (e.g.., STEPS), Quality of Care/Health system performance data, Hospital admission data, Socioeconomic and contextual data, CFNI reports, Annual country reports on NCDs, including Regional Minimum Data Set, Sub-regional reports, Workshop reports, Minutes of research meetings, Resource mobilisation proposals

Partners: Ministries of Health, Community Development, Security; Private Sector: Media; Civil Society; Universities, Research institutes

POS Summit Declaration / Expected Results	Assumptions	Objectively Verifiable Process / Output indicators	Activities: Regional (R) and Country Support (C)	Recommendations for Country Plans
7.1) POS #13. Surveillance of risk factors for NCDs and burden of disease (BOD) conducted using chronic disease surveillance systems, aligned with WHO STEPS and a strengthened National Health Information System (HIS) in countries, including Minimum Data Set	Countries dedicate needed resources for data collection and reporting and agree to share results Efforts from pilot initiatives in select countries receive the support needed for national sustainability Private sector provides requested information	7.1.1) Health information policy and plan adopted in all countries by 2012 7.1.2) CARICOM countries collecting and reporting data at least annually on NCDs (risk factors, morbidity, mortality, determinants, health systems performance, including private sector data) using standardised methodologies in at least 10 countries by 2011 and in 14 countries by 2015 7.1.3) Reports of in-country assessment of NCD surveillance system and capacity every 3 to 5 years, starting 2011 in all countries	C 7.1.1.1) Draft NCD Health Information Policy Document completed and approved by the COHSOD, then circulated to Ministries of Health R.7.1.2.1) Build capacity at CAREC and in countries (human and financial resources) for supporting surveillance, including development, production and publication of sub-regional reports C.7.1.2.2) Develop and test metrics for assessing linkages to non-health sector, community resources, client satisfaction R.7.1.3.1) CAREC provides training to support implementation of standardised protocol for surveillance of selected NCDs, including CVD, DM and cancers, especially cervical, breast, prostate and colon cancer R.7.1.3.2) Study the Barbados *Chronic Disease Registries* and make recommendations for best practice in surveillance, for transmission to other countries	7.1.1.1) Adopt and implement NCD Health Information Policy Document to strengthen in-country Health Information Systems 7.1.2.1) Identify and establish partnerships (private and public sectors) for strengthening surveillance and research 7.1.2.2) Apply a standardised protocol for NCD surveillance to collect, analyse and report annually on risk factors, morbidity, mortality, determinants and health systems performance in the public and private sectors 7.1.2.3) Disseminate surveillance information, including publications 7.1.3.1) Conduct In-country assessment of NCD surveillance systems and capacity

7.2) Research initiatives implemented to assess disease burden, risk factors and determinants of chronic diseases	Regional institutions can establish a common agenda	7.2.1) Research agenda for NCDs developed in collaboration with universities, CAREC, CHRC, CDRC, PAHO and countries by 2011	R.7.2.1.1)) Establish partnerships for strengthening technical capacity for essential research and a regional operational research agenda, in collaboration with universities, CAREC, CHRC, CDRC, PAHO and countries C.7.2.1.2) Secure and circulate existing tools for audits in health care C.7.2.1.3) If requested, assist countries to undertake effective cancer research of prevalence of HPV high risk serotypes, alternative approaches to cytology, needs assessments of clinical services required, models of integrated service delivery, active recruitment and follow-up, and management of cervical cancer in women with HIV and AIDS	7.2.1.1) Define, initiate and participate in research projects. Disseminate research information, including publications 7.2.1.2) Implement health audit surveys for improving quality of care for specific NCDs including, CVD, DM and cancers, especially cervical, breast, prostate and colon cancer 7.2.1.3) Based on research and opportunity costs, make a determination about procurement of the HPV vaccine.
7.3) Strengthen capacity for collection and analysis of health information for monitoring and evaluation of NCD programme outcomes	Assessments, monitoring and evaluation necessary to chart progress and for accountability	7.3.1) Standardised monitoring and evaluation systems for all aspects of NCD prevention and control programmes in countries including cancer, especially cervical, breast, prostate and colon, developed and implemented by 2014 7.3.2) Regular regional analyses of available surveillance and programme evaluation data published by 2011 7.3.3) Risk factors & BOD data used to evaluate NCD Declaration in at least 8 countries by 2013	C.7.3.1.1) Develop a framework for M&E of NCD programmes, (including, cancer, especially cervical, breast, prostate and colon), and provide technical assistance to countries for its implementation, in collaboration with other stakeholders R.7.3.2.1) Seek support to develop and sustain the NCD InfoBase at CAREC for M&E of NCD programmes. R.7.3.3.1) CARICOM and PAHO convene interdisciplinary group to evaluate the implementation of the NCD Summit *Declaration*	7.3.1.1) Conduct and publish analyses of data on surveillance and programme evaluation of annual work plans for monitoring and evaluation of NCD programmes 7.3.2.1) Support the translation of operational research findings into strengthened programmes 7.3.3.1) Collect and share the data required for evaluation of the implementation of the NCD Summit *Declaration*

PRIORITY ACTION #4: PUBLIC POLICY, ADVOCACY and COMMUNICATIONS

Preamble: In various countries, several policies, laws, and regulations adopted have been successful in preventing or reducing the burden of disease and injury, such as tobacco taxation and the use of seat belts and helmets. However, a substantial proportion of Caribbean countries still have no policies, plans or programmes to combat NCDs to support a reduction in behavioural and environmental risk factors (nutrition and food security, physical activity, tobacco and alcohol use, workplace and school wellness, creation of appropriate physical environment, active transportation, etc.).

However, the NCD Summit in September 2007 delivered high-level support for multi-sectoral policies to combat NCDs. This action should be used by Member Countries to develop a unified, systematic framework for the formulation of public policy and action plans, defining policy priorities, establishing mechanisms for assessment and evaluation, engaging all sectors of society and fostering inter-country technical cooperation.

8. ADVOCACY AND HEALTHY PUBLIC POLICY

Sources of data for Verification: CARICOM reports, Health promotion policies gazetted, Reports of annual meetings of NCD focal points, CARMEN, CMOs' annual meetings, COHSOD, and the Conference of Ministers of Health, Copy of TOR and tool kits for national NCD focal points.

Partners: Private Sector: Media, employers; Civil Society: Trade Unions, consumer org; Ministries of Health, Education, Offices of Attorneys- General/ Legal Affairs

POS Summit Declaration / Expected Results	Assumptions	Objectively Verifiable Process / Output indicators	Activities: Regional (R) and Country Support (C)	Recommendations for Country Plans
8.1) Effective and sustainable evidence-based healthy public policies and action plans for NCDs, their risk factors and determinants developed and implemented a) Advocacy and sensitisation of policy-makers to the need for evidence-based, effective and sustainable health promoting public policy enhanced b) Countries' capacity for advocacy of NCD policies improved c) Legislation enacted or appropriately amended to support health promotion activities	Stable political, economic, social and public health environment, with no major natural or other disasters Policy-makers accept the importance of NCD prevention and control, and facilitate their incorporation into national plans and programmes NCD and cancer prevention and control is a priority for policy- makers and practitioners	8.1.1) Progress reports of NCDs and the need for healthy public policies, (details in each section of the NCD Plan) presented to Heads of Government and of Ministers (Ministries of Agriculture, Health, Education, Human and Social Development, and COHSOD) from 2010 8.1.2) Development of model regional guidelines for advocacy of NCD policy framework and legislation, identifying networking resources by end of 2012 8.1.3) Capacity built for health professionals, NGOs and Civil Society in networking, information sharing and advocacy strategies to lobby for healthy public policies in 5 countries by 2013 8.1.4) Priority government ministries and agencies review their policies which are relevant to NCD by 2013	R.8.1.1.1) Provide reports on NCD progress and the need for healthy public policies based on consolidated country reports to CARICOM and the COHSOD, annual meetings of Ministers of Health, NCD focal points, CARMEN and CMOs C.8.1.2.1) Develop and disseminate model healthy public policies and advocacy guidelines R.8.1.2.2) NCD Secretariat assists countries in establishing sustainable NCD funding C.8.1.3.1) Train health and other related professionals, private sector and Civil Society using guidelines in advocacy and preparation of national policies for NCD in countries, as requested	8.1.1.1) Use standardised format to report on NCD policies, capacity and programmes 8.1.2.1) Adapt and adopt model healthy public policies and advocacy guidelines, if needed 8.1.3.1) Train civil society, private and public sector partners on healthy public policies that affect NCD prevention and control, using strategies outlined in the *Caribbean Charter for Health Promotion* 8.1.3.2) Implement effective NCD policies, including cancer prevention and control 8.1.4.1) Priority government entities identify and address gaps in current NCD-related legislation and policies

9. MEDIA AND SOCIAL COMMUNICATIONS

Sources of data for Verification: Documentation of region-wide media coverage – print, major publications, photographs, video, public education programmes.

Partners: Private Sector: Media, Employers; Civil Society: Trade Unions, Consumer Orgs; Ministries of Health, Education, Communications, Agriculture, Trade

POS Summit Declaration / Expected Results	Assumptions	Objectively Verifiable Process/ Output indicators	Activities: Regional (R) and Country Support (C)	Recommendations for Country Plans
9.1) POS #12. Comprehensive public education programmes, based on social change and participatory communication strategies, in support of wellness, healthy lifestyle changes and improved self-management of NCDs by empowering patients and their families across the life cycle, developed and implemented a) Communication strategy and plan documented, implemented and evaluated. b) Special alliance established with media for comprehensive public education c) Increased awareness among clients and other stakeholders that many NCDs including cancers are preventable through screening, early diagnosis and treatment of pre-cancerous lesions.	Strategic communication and behaviour change communication strategies to educate the public; reach target audiences, are accepted and acted on. Support from relevant media and platforms in public education as part of their role Civil society effectively participates in this component Resources can be mobilised to finance this intervention	9.1.1) Media and communication plan for NCD advocacy, including audience research and stakeholder analysis to inform suitable communication strategies; message development; selection of appropriate media developed and implemented by 2011 9.1.2) Production of media packages on healthy eating, (salt and fat, balanced diets, portion sizes and reading of labels), active living, tobacco, alcohol abuse, school health, workplace wellness, treatment and self-management, available by 2012 9.1.3) Capacity-building for media (health journalists and reporters) to empower them to be more effective behaviour change and communication agents in 4 countries by 2012 and 10 countries by 2015 9.1.4) Social Change Communication strategies, public education and information for preventive education and self-management, implemented in at least 5 of countries by 2013	C.9.1.1.1) Conduct audience research and stakeholder analysis to inform suitable communication strategies; message development; selection of appropriate media for NCD advocacy in countries, including preventive education and self-management, healthy eating, active living, tobacco control, no abuse of alcohol and treatment C 9.1.1.2) Complete regional and model country media and communications plan for NCD advocacy and media packages R.9.1.3.1) Strengthen links with regional communications networks for their participation in health promotion/social marketing, e.g., CANA, CARIB VISION, music entities R.9.1.4.1) Improve use of internet (websites, blogs, You Tube) R.9.1.4.2) Develop and disseminate a popular brochure-style version of the *Declaration of Port-of-Spain* and the regional *Plan* for NCDs	9.1.1.1) Review, adapt, adopt and implement NCD media, communications and advocacy plan and public education campaign on healthy eating, active living, no tobacco, alcohol abuse and treatment, e.g., radio serial 9.1.2.1) Implement mass media programming to educate on wellness and self-management of NCDs 9.1.3.1) Nurture and build relations with local media, including Annual Media Awards for best reporting on NCD risk factors and interventions 9.1.4.1) Utilise regional media and the Internet for communications and education 9.1.4.2) Circulate popular brochure-style version of the *Declaration of Port- Spain* and the NCD Regional Plan to stakeholders in the public sector, private sector and civil society

9.2) Advertisement of unhealthy foods to children restricted 9.3) Social communications for NCD and cancer control		9.2.1) Restrict advertising of unhealthy products to children in 6 countries by 2014 9.3.1) Social change communication and participatory interventions and information dissemination to educate and mobilise target audience about the necessity for NCD screenings, (blood lipids, blood sugar, blood pressure, BMI, tobacco use, exercise), including cancers, especially cervical, breast and colon cancer, in 4 countries by 2013 9.3.2) Advocacy programmes to lobby policy-makers to facilitate the enabling environment and appropriate resources for cancer screenings in 4 countries by 2013	R.9.2.1.1) Establish regional model standards to restrict the promotion of foods high in sugar, refined starch, saturated fats and transfats to children on TV and elsewhere C 9.3.1.1) Develop model NCD and cancer screening guidelines based on review and adapting existing model programmes for the empowerment of patients and their families for their self-management R.9.3.1.2) Develop a communications strategy for dissemination of surveillance and research information R.9.3.1.3) Review and adapt a model Caribbean NCD and Cancer Communication advocacy plan for NCD and cancer screening and control, especially cervical, breast, prostate and colon cancers	9.2.1.1) Promote advocacy and/or implement legislation to restrict the promotion of foods high in sugar, refined starch, saturated fats and transfats to children via TV and other forms of media 9.3.1.1) Build capacity to develop effective, sustainable Information, Education and Communication (IEC) campaigns on advocacy, implementation and monitoring of NCD programmes 9.3.1.2) Disseminate surveillance and research information to the public 9.3.1.2) Develop healthy public policies to strengthen the supportive environment for the implementation of the *Caribbean Cancer Communication Plan*
9.4) Media and social communications evaluation		9.4.1) Evaluation of social communications programmes achieved/ impact analysis by 2015	R.9.4.1.1) Develop a model system for monitoring and evaluating the implementation of the communication process C.9.4.1.2) Support data-gathering, including research to inform strategic decisions for communication strategies	9.4.1.1) Adapt, adopt and implement an appropriate system for monitoring and evaluating the communication process

PRIORITY ACTION # 5: PROGRAMME MANAGEMENT

Objective: Human, financial and organisational resources within the health sector developed to respond to the health needs of the people. Countries' capacity for inter-sectoral work strengthened.

10. PROGRAMME MANAGEMENT, PARTNERSHIPS AND COORDINATION

Sources of data for Verification: Country reports, CARICOM Secretariat reports, PAHO reports, Reports from training workshops and seminars. Membership and minutes of NCD Commission meetings, Training programme records, Reports of NCD Secretariat meetings, Progress reports on Strategic Plan, Evaluation Instrument used at national level, Report of evaluation of Plan.

Partners: Private Sector; Civil Society; Ministries and Agencies of Government

POS Summit Declaration / Expected Results	Assumptions	Objectively Verifiable Process / Output indicators	Activities: Regional (R) and Country Support (C)	Recommendations for Country Plans
10.1) POS#2. Intersectoral National Chronic Diseases Commissions or analogous bodies established to guide NCD policies and programmes 10.2) NCD Commissions and national NCD programmes coordinated and/or facilitated by NCD Focal Point in the Ministry of Health (Figure 18 – Management Organogram for NCD programme) .	Other priorities do not crowd out the NCD agenda Effective means of working across all sectors established and maintained Persons trained in management are retained or replaced NCD prevention and control mechanisms integrated into sector policies, plans and programmes and adequate resources allocated	10.1.1) Intersectoral NCD Commissions or analogous bodies appointed and functioning in at least 10 countries by 2012 and in all countries by 2014 10.1.2) Model TORs define multi-sectoral composition, mandates to make policy recommendations and to evaluate NCD programmes, including public policies at the national level by 2012 10.1.3) Required support for NCD Commissions (administrative, technical and budgetary) provided in at least 8 countries by 2013 10.1.4) Relationship between National Commissions and the public sector determined and established by 2013 10.1.5)Training in NCD prevention and control, partnerships, programme management and evaluation for Ministry of Health personnel, and members of the national NCD Commissions in at least 8 countries by 2013 10.2.1) At least 10 countries have NCD units or focal points by 2011, and all countries by 2013	C.10.1.2.1) Draft model TORs, appropriate legislation and quality framework for NCD Commissions C.10.1.5.1) Develop and disseminate model training programme; train members of the national NCD Commissions, public, private and civil society in NCD prevention and control, partnerships, programme management and evaluation, as requested R.10.1.5.2) Support technical cooperation with countries to develop capacity in programme design and service delivery C.10.2.1.1) Develop and disseminate model for national NCD focal points C.10.2.1.2) Develop and disseminate a tool kit for the orientation of national focal points R.10.2.1.3) Identify TCC opportunities for national focal points	10.1.1.1) PM &/or Health Minister convenes national inter-sectoral NCD Summit to sensitise stakeholders in the public and private sectors and civil society 10.1.2.1) Adapt or develop TOR for NCD Commission 10.1.3.1) PM appoints inter-sectoral NCD Commission or analogous body with TORs and necessary support 10.1.4.1) Determine and establish relationship between National Commissions and the public sector 10.1.5.1) Adapt, adopt and implement orientation package and training for the guidance of Commission members 10.1.5.2) NCD Commission recommends comprehensive, integrated plan of action and evaluation mechanism; Assigns major aspects to relevant agencies and sectors 10.2.1.1) Adapt or adopt model TORs, designate and train NCD Focal Point in Ministry of Health

10.3) POS #1 and #14: NCD Summit Secretariat established, supported by CARICOM and PAHO as a component of CCH to plan, monitor and evaluate NCD programme and implementation of POS *Declaration*.		10.3.1) Regional (Caribbean) NCD *Plan* developed and finalised by April 2011 10.3.2) National NCD programmes and priorities based on Regional NCD *Plan* developed in 8 countries by 2013 and 15 countries by 2015 10.3.3) At least two (2) priority interventions from national NCD *Plan* implemented in at least 6 countries by 2011; in 12 by 2014; and in all countries by 2015 10.3.4) NCD Summit Secretariat develops, pilot tests and executes framework for coordination, monitoring and evaluation of NCD *Plan* and NCD Summit *Declaration* by 2012 10.3.5) Meetings of NCD Summit Secretariat conducted quarterly (virtually) and in person, annually, from 2009; and annual reports produced and submitted to the COHSOD, National NCD Commissions and other stakeholders 10.3.6) External evaluation of implementation of the Regional NCD *Plan* and *Declaration* conducted by end 2013	R.10.3.1.1) Develop NCD *Plan* for the Region C.10.3.1.2) Develop and disseminate model NCD *Plan* to countries C.10.3.2.1) Develop model policies and guidelines which countries could use to address the key risk factors identified within the model NCD *Plan of Action* C.10.3.3.1) Provide technical support to countries in adapting and implementing the NCD plan, as requested by countries R.10.3.4.1) Secretariat develops, pilot tests and implements evaluation of NCD *Plan* R.10.3.5.1) NCD Summit Secretariat meetings convened virtually, quarterly and in person, annually from 2009, and produce and submit annual reports to COHSOD and other stakeholders R.10.3.6.1) NCD Secretariat appoints an independent external evaluator for the implementation of the NCD *Plan* and NCD Summit *Declaration*	10.3.2.1) Adapt or develop national inter-sectoral NCD policies and *Plans of Action* based on model plan 10.2.2.1) NCD FP/Unit identifies and implements priority NCD interventions 1.3.4.1) Evaluate programmes and use reports for reviewing the Plan by multi-sectoral partners

10.4) Capacity-building by strengthening of human resources, and strengthening of the health system	These components will be substantively addressed under CCH-3	CCH-3: Enhance skills and competencies of human resources and training institutions. Human resource capacity developed to support health in the Region Mobilise institutional actors at the national, regional and global levels of the health sector and other relevant civil society actors, to collectively strengthen the human resources in health through policies, interventions and networks CCH-3: Strengthening Health Systems: 1.To improve universal access to health care services 2.To strengthen health information systems 3.To reorient health care to Primary Health Care-based Systems 4.Strengthen public health leadership 5.Develop human resources within the health sector to respond to the health needs of the people	CCH-3: Regional Strategic Plan for healthy human resources; Regional Health Profession Registration Database; trans-sectoral policies and protocols for health workforce planning; coordination of schools of public health in the Caribbean for the strengthening of research and training in public health; coordination of schools of medicine, nursing and allied health professions in the Caribbean to strengthen training; regionally accepted competencies in the health workforce for primary and secondary prevention, quality health and health care; development of the infrastructure to enable the free movement of skilled health personnel in the CARICOM Region Develop model policies, institutional and regulatory frameworks for advocacy, development, monitoring and evaluation of programmes and structures for strengthening and sustaining Primary Health Care within a structured, integrated overall health system. Develop a Caribbean health information system, Health sector observatory, Drug Management (pooled procurement and quality control harmonisation), Regional quality management system - Patients Charter and accreditation framework. Build capacity in public health leadership, strategic planning, monitoring and evaluation of health sector performance. Design a regional machinery for resource mobilisation for the health sector and response to health coverage and social protection	

11. RESOURCE MOBILISATION / HEALTH FINANCING

Sources of data for Verification: Reports from donors meeting, Financial accounting records, Reports of training workshops, Copies of project proposals, Country reports.
Partners: Private Sector: Foundations, Media; Civil Society: Banks; Ministries of Health, Education, Finance,

POS Summit Declaration / Expected Results	Assumptions	Objectively Verifiable Process / Output indicators	Activities: Regional (R) and Country Support (C)	Recommendations for Country Plans
11.1) Resource allocation and mobilisation strategies planned and implemented a) Increased capacity at sub-regional and national levels for securing additional revenue streams 11.2) Financial resources mobilised and/or redistributed so that national health budget is sufficient to address priority health needs 11.3) Evaluation of financial streams in the health sector and their alignment to health priorities	Models of financing care acceptable to stakeholders Strategies to mobilise resources successful Resources effectively used by relevant stakeholders	11.1.1) Fundable projects identified from the Regional Plan presented to donors and funding secured for national NCD programmes, with regional support, by Dec 2011 11.1.2) Joint training for stakeholders (public, private, civil society) in resource mobilisation and grant applications held in at least 2 countries by 2012 11.1.3) At least one project proposal to facilitate implementation of national NCD plans developed and submitted for funding each year, 2011 – 2015 11.2.1) National health expenditure budget is a suggested minimum of at least 6% of GDP and distributed to address priority health needs in at least 6 countries by 2014 11.2.2) Additional (new) financial resources identified for health financing in at least 6 of countries by 2013 11.2.3) Financing of priority areas meets or exceeds planned levels in at least 6 countries by 2013 11.3.1) Evaluation of financial expenditure vs. health priorities conducted in 5 countries by 2015	R.11.1.1.1) Mobilise resources mobilisation in collaboration with CARICOM, PAHO/WHO, private sector and other stakeholders through donors meeting in 2011 to present projects based on the NCD Plan and mobilise resources for chronic disease prevention and control programmes R.11.1.1.2) Develop regional machinery for resource mobilisation for the health sector and response to health coverage and social protection C.11.1.3.1) Conduct training workshops for stakeholders (public, private, civil society) in resource mobilisation and grant applications in 2 countries C.11.2.1.1) Develop model In-country resource mobilisation methods in association with the private sector and other stakeholders, reviewing Jamaica's National Health Fund as a possible model C.11.3.1.2) Develop and disseminate model methods for evaluation of expenditure vs. priorities	11.1.2.1) Provide local support for training of stakeholders (pubic, private civil society) in resource mobilisation and grant applications 11.1.3.1) Implement projects, conduct evaluation of intervention from the NCD *Plans* 11.2.1.1) Cabinet approves national health expenditure budgets of at least 6% of GDP, and distributes to address priority health needs 11.2.2.1) Policy dialogues to identify, document and share best practices in sustainable NCD financing, e.g., Jamaica's National Health Fund 11.2.3.1) Provide training and capacity-building to conduct National Health Account analyses 11.3.1.1) Conduct evaluation of financing of priority areas to assess whether expenditure meet or exceed planned levels, with expenditure aligned to priorities

POS Summit Declaration / Expected Results	Assumptions	Objectively Verifiable Process / Output indicators	Activities: Regional (R) and Country Support (C)	Recommendations for Country Plans
11.4) POS #4 Tobacco taxes directed to support health promotion, NCD prevention and control	Ministries of Finance do not resist earmarking tobacco taxes for NCD prevention and control.	11.4.1) Tobacco taxes funding NCD prevention and control activities in at least 8 countries by 2013	C.11.4.1.1) Provide technical support to share, adapt and adopt best practices (e.g., Jamaica's National Health Fund), if requested	11.4.1.1) Raise tobacco taxes to 66% of sale price. 11.4.1.2) Earmark tobacco and other taxes for NCD prevention and control programmes

12. PHARMACEUTICALS AND LABORATORY SUPPORT

Sources of data for Verification: Country essential medication formulary exists, Regional plan for procurement exists, Records of mass procurement
Partners: Private Sector: Pharmaceutical companies, laboratory companies and services, health and life insurance companies; Civil Society: Health NGOs, Trade Unions, Consumer Orgs, Ministries of Health, Finance, Agriculture, Trade

POS Summit Declaration / Expected Results	Assumptions	Objectively Verifiable Process / Output indicators	Activities: Regional (R) and Country Support (C)	Recommendations for Country Plans
12.1) Access to safe, affordable and efficacious NCD medicines improved by strengthening regulation of medicines, including legislation and drug registration 12.2) Generic drugs for NCD prevention and control included on the Vital List of country formularies 12.3) Harmonised procurement and supply management of quality drugs for NCD management 12.4) Vital laboratory services for screening and management of NCDs available	Practitioners accept the recommended evidence-based treatment regimes Successful sourcing of required drugs	12.1.1) Common drug registration system agreed and implemented in at least 8 countries by 2014 12.1.2) At least 10 countries have formularies for vital, essential and necessary drugs established by 2013 12.2.1) Essential (accessible, affordable and high quality) generic drugs for NCD prevention and control available in 8 countries by 2012 – aspirin, beta blocker, statin, thiazide diuretic, ACE inhibitor 12.3.1) A harmonised list of standard criteria for procurement and indicators of performance implemented by 2012 in 8 countries of Caribbean Regional Network of Procurement and Supply Management Agencies (CARIPROSUM) 12.4.1) Model laboratory services protocols developed and disseminated to countries by 2013 12.4.2) Improved maintenance of relevant equipment in countries by 2015 12.4.3) Pharmaceutical and laboratory information integrated into the health information systems in support of NCD prevention and control, in at least 5 countries by 2013	R.12.1.1.1) Develop model regional drug management system, including generic policy R.12.1.1.2) Implement recommendations from PANDRH (Pan American Network of Drug Regulatory Harmonisation) R.12.3.1.1) Develop and implement regional plan for bulk procurement and distribution of essential medications and technologies. Link with global or regional pooled procurement initiatives R.12.3.1.2) Implement project to strengthen CRDTL (Caribbean Regional Drug Testing Laboratory) C.12.4.1.1) Develop and disseminate model standard criteria for procurement and indicators of performance R.12.4.2.1) Develop regional mechanism to support maintenance of equipment R.12.4.3.1) Ensure that pharmaceutical regulations support pooled procurement, quality control harmonisation and data capture	12.1.2.1) Establish vital, essential and necessary medicine formularies 12.2.1.2) Establish generic drug policy 12.3.1.1) Essential generic drugs for NCD prevention and control available in the public and private sectors: aspirin, beta blocker, statin, thiazide diuretic, ACE inhibitor 12.4.1.1) Adapt and implement standard criteria for procurement and indicators of performance 12.4.3.1) Develop and integrate pharmacy and lab data capture systems into Health Information System

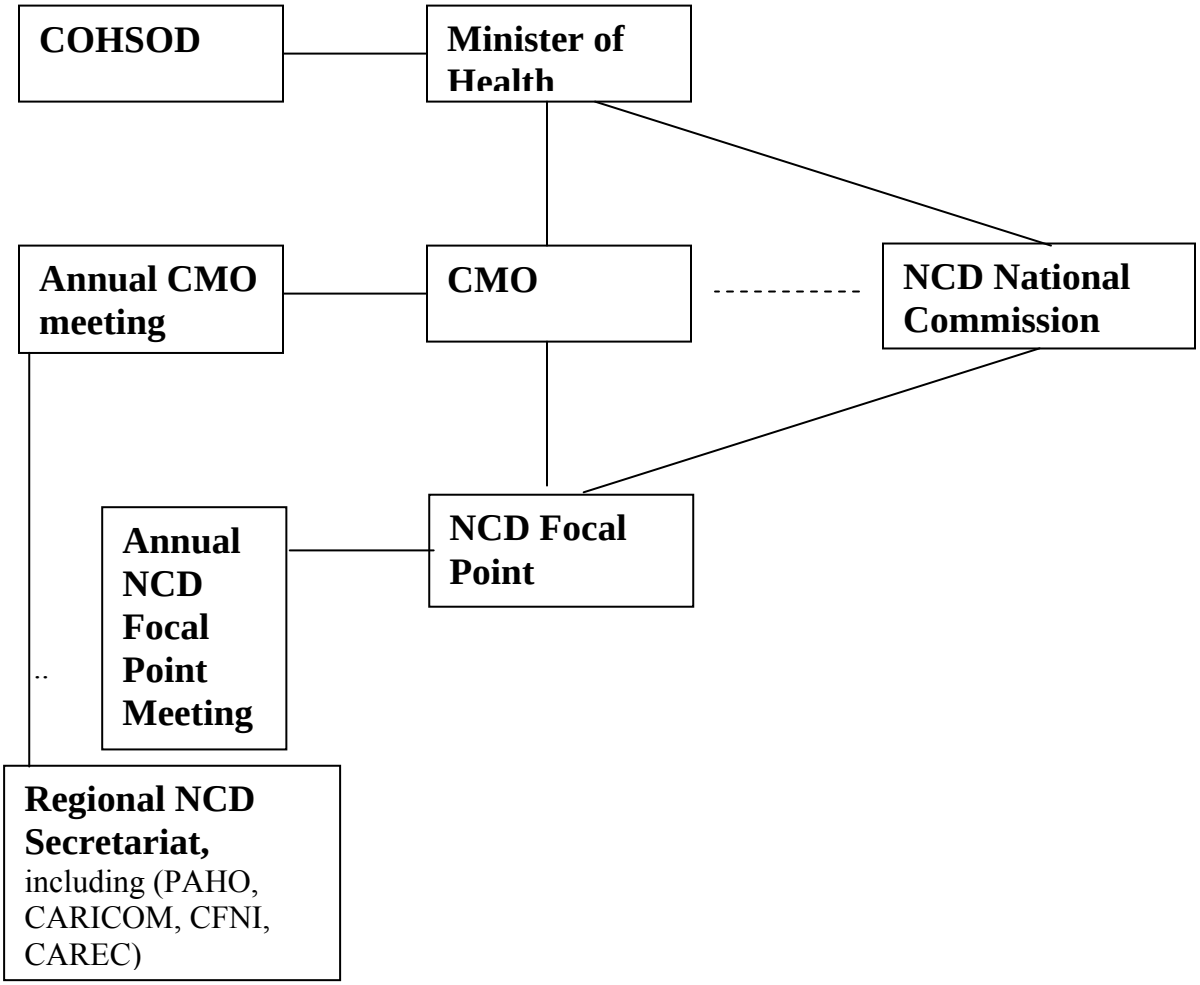
BUDGET SUMMARY

Table 8: Annual Budget for Regional Actions and Regional Support to Countries in US $

PRIORITY ACTION #1: RISK FACTOR REDUCTION AND HEALTH PROMOTION	
1. NO TOBACCO, NO HARMFUL USE OF ALCOHOL	**$100,000**
2. HEALTHY EATING (INCLUDING TRANSFAT, FAT, SUGAR)	**$75,000**
3. SALT REDUCTION	**$31,000**
4. PHYSICAL ACTIVITY	**$103,000**
5. INTEGRATED PROGRAMMES ESPECIALLY IN SCHOOLS, WORKPLACES AND FAITH-BASED SETTINGS	**$195,000**
PRIORITY ACTION #2: INTEGRATED DISEASE MANAGEMENTAND PATIENT SELF-MANAGEMENT EDUCATION	
6. SCALING UP EVIDENCE-BASED TREATMENT	**$400,000**
PRIORITY ACTION #3: SURVEILLANCE, MONITORING AND EVALUATION	
7. SURVEILLANCE, MONITORING AND EVALUATION	**$492,000**
PRIORITY ACTION #4: PUBLIC POLICY, ADVOCACY AND COMMUNICATIONS	
8. ADVOCACY AND HEALTHY PUBLIC POLICY	**$85,000**
9. MEDIA AND SOCIAL COMMUNICATIONS	**$220,000**
PRIORITY ACTION # 5: PROGRAMME MANAGEMENT	
10. PROGRAMME MANAGEMENT, PARTNERSHIPS AND COORDINATION	**$135,000**
11. RESOURCE MOBILISATION/HEALTH FINANCING	**$235,000**
12. PHARMACEUTICALS	**$70,000**
Sub-total	**$2,141,000**
STAFF (1 AT CARICOM, 1 LONG TERM CONSULTANT, 2 SHORT TERM CONSULTANTS, TRAVEL AND PER DIEM)	**$250,000**
Total	**$2,391,000**
10% contingency	**$239,100**
Grand Total	**$2,630,100**

Figure 18: MANAGEMENT ORGANOGRAM FOR NCD PROGRAMME

REGIONAL LEVEL **NATIONAL LEVEL**



EVALUATION FRAMEWORK

The Heads of Government have accepted the Evaluation Framework at **Appendix VI** for assessing the implementation of the Port -of- Spain NCD Summit *Declaration*. Those data are captured in the grid at Table 5: Summary of NCD Status/Capacity by Country 2010.

The data will come from national PANAM STEPS NCD Risk Factor Surveys in Member Countries and from the Minimum Data Set and other sources.

A critical aspect of the evaluation will be the funding provided for implementation of this *Plan*.

APPENDICES

Appendix I

DECLARATION OF PORT-OF -SPAIN: UNITING TO STOP THE EPIDEMIC OF CHRONIC NCDs

We, the Heads of Government of the Caribbean Community (CARICOM), meeting at the Crowne Plaza Hotel, Port-of-Spain, Trinidad and Tobago on 15 September 2007 on the occasion of a special Regional Summit on Chronic Non-Communicable Diseases (NCDs);

Conscious of the collective actions which have in the past fuelled regional integration, the goal of which is to enhance the well-being of the citizens of our countries;

Recalling the Nassau Declaration (2001), that "the health of the Region is the wealth of Region", which underscored the importance of health to development;

Inspired by the successes of our joint and several efforts that resulted in the Caribbean being the first Region in the world to eradicate poliomyelitis and measles;

Affirming the main recommendations of the Caribbean Commission on Health and Development which included strategies to prevent and control heart disease, stroke, diabetes, hypertension, obesity and cancer in the Region by addressing their causal risk factors of unhealthy diets, physical inactivity, tobacco use and alcohol abuse and strengthening our health services;

Impelled by a determination to reduce the suffering and burdens caused by NCDs on the citizens of our Region that is the one worst affected in the Americas;

Fully convinced that the burdens of NCDs 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 governments, private sectors, NGOs and our other social, regional and international partners;

Declare -

1. • Our full support for the initiatives and mechanisms aimed at strengthening regional health institutions, to provide critical leadership required for implementing our agreed strategies for the reduction of the burden of Chronic, Non-Communicable Diseases as a central priority of the Caribbean Cooperation in Health Initiative Phase III (CCH III), being coordinated by the CARICOM Secretariat, with able support from the Pan American Health Organisation/World Health Organisation (PAHO/WHO) and other relevant partners;
2. • That we strongly encourage the establishment of National Commissions on NCDs or analogous bodies to plan and coordinate the comprehensive prevention and control of chronic NCDs;
3. • Our commitment to pursue immediately 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 limit or eliminate smoking in public places, ban the sale, advertising and promotion of tobacco products to children, insist on effective warning labels and introduce such fiscal measures as will reduce accessibility of tobacco;
4. • That public revenue derived from tobacco, alcohol or other such products should be employed, inter alia for preventing chronic NCDs, promoting health and supporting the work of the Commissions;
5. • That our Ministries of Health, in collaboration with other sectors, will establish by mid-2008 comprehensive plans for the screening and management of chronic diseases and risk factors so that by 2012, 80% of people with NCDs would receive quality care and have access to preventive education based on regional guidelines;

6. • That we will mandate the re-introduction of physical education in our schools where necessary, provide incentives and resources to effect this policy and ensure that our education sectors promote programmes aimed at providing healthy school meals and promoting healthy eating;
7. • Our endorsement of the efforts of the Caribbean Food and Nutrition Institute (CFNI), Caribbean Agricultural Research and Development Institute (CARDI) and the regional inter-governmental agencies to enhance food security and our strong support for the elimination of trans-fats from the diet of our citizens, using the CFNI as a focal point for providing guidance and public education designed toward this end;
8. • Our support for the efforts of the Caribbean Regional Negotiating Machinery (CRNM) to pursue fair trade policies in all international trade negotiations thereby promoting greater use of indigenous agricultural products and foods by our populations and reducing the negative effects of globalisation on our food supply;
9. • Our support for mandating the labeling of foods or such measures as are necessary to indicate their nutritional content through the establishment of the appropriate regional capability;
10. • That we will promote policies and actions aimed at increasing physical activity in the entire population, e.g. at work sites, through sport, especially mass activities, as vehicles for improving the health of the population and conflict resolution and in this context we commit to increasing adequate public facilities such as parks and other recreational spaces to encourage physical activity by the widest cross-section of our citizens;
11. • Our commitment to take account of the gender dimension in all our programmes aimed at the prevention and control of NCDs;
12. • That we will provide incentives for comprehensive public education programmes in support of wellness, healthy life-style changes, improved self-management of NCDs and embrace the role of the media as a responsible partner in all our efforts to prevent and control NCDs;
13. • That we will establish, as a matter of urgency, the programmes necessary for research and surveillance of the risk factors for NCDs with the support of our Universities and the Caribbean Epidemiology Centre/Pan American Health Organisation (CAREC/PAHO);
14. • Our continuing support for CARICOM and PAHO as the joint Secretariat for the Caribbean Cooperation in Health (CCH) Initiative to be the entity responsible for revision of the regional plan for the prevention and control of NCDs, and the monitoring and evaluation of this Declaration.
15. We hereby declare the second Saturday in September "Caribbean Wellness Day," in commemoration of this landmark Summit.

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Appendix II

CARIBBEAN PRIVATE SECTOR PLEDGE IN SUPPORT OF "DECLARATION OF PORT-OF-SPAIN: "UNITING TO STOP THE EPIDEMIC OF CHRONIC NON-COMMUNICABLE DISEASES"

We the participants of the conference on "Caribbean Private Sector Response to Chronic Diseases" held by the Pan American Health Organization and the Caribbean Association of Industry and Commerce on May 8th & 9th, 2008 in Port-of-Spain, Trinidad & Tobago fully support the historic CARICOM Heads of Government Declaration of Port-of-Spain: 'Uniting to Stop the Epidemic of Chronic Non-Communicable Diseases' made on September 15th, 2007 in Port-of-Spain, Trinidad & Tobago.

Recognizing that the non-communicable diseases such as heart disease, stroke, diabetes and cancer, hypertension, and high cholesterol are increasingly burdening our populations as causes of premature death and suffering;
That the burden includes high and increasing levels of avoidable health costs, as well as lost productivity;
That the four shared, modifiable risk factors for all the NCDs are unhealthy diets, physical inactivity, tobacco use and harmful use of alcohol;
That these factors are socially-determined including government policies, regional and global market forces, population knowledge and demand for health, poverty and education

Considering that comprehensive action to reduce NCDs and their risk factors is in the fundamental interests of the private sector:

- improve shareholder value
- develop new market opportunities
- decreased costs, e.g., for health insurance
- reduce absenteeism
- improve wellbeing among employees
- avoid future litigation
- demonstrate leadership in corporate social responsibility

Proposing

1. to greatly increase awareness at all levels of the issues, policies and interventions for chronic disease prevention and control, risk factor reduction and social determinants of health..
2. to provide a stage for synergy of evidenced–based joint action for the prevention, management and control of chronic diseases, risk factor reduction and social determinants of health.
3. to mobilize resources and other partners to support the effort

Declare: The private sector has a crucial role to play in the prevention and control of Non-Communicable Diseases (NCDs) in relation to employees and the public

The private sector commits to:

Participating in, and supporting, National and Regional inter-sectoral planning and action, including National NCD Commissions

Participating in the "Caribbean Wellness Day" on the second Saturday in September 2008 and onwards.

A – Raising Awareness and Providing Information and Education

1. Commit to support comprehensive public education programs on wellness, healthy lifestyle changes, especially physical activity, healthy diets, and tobacco free environments; improved self management of NCDs, focusing on reduction of sodium (salt), fats (especially trans fats) and sugars in the diet; and screening, diagnosis and management of obesity, high blood pressure and high cholesterol

2. Support and promote the role of the media as responsible partners in comprehensive public education programs in support of wellness, healthy lifestyle changes and improved self management of NCDs, e.g. eat 5 servings of fruits and vegetables per day; participate in physical activity at least 30 minutes each day; no tobacco use, and avoid harmful use consumption of alcohol
3. Support a strategy for the definition, dissemination and evaluation of appropriate health information to the public

B – <u>Healthy Diets</u>

4. Food manufacturers commit to
    a. Eliminating industrially-produced trans fatty acids in processed foods, bakery products and domestic cooking oils
    b. Reducing levels of sugar and salt in processed foods

5. Ensure enhanced food security through promotion of greater use of indigenous foods by our populations.

6. Ensure healthy foods are imported.

7. Commit to the labeling of foods to indicate their nutritional content.

C – <u>Physical Activity</u>

8. Promote policies and actions aimed at increasing physical activity at the workplace and among the entire population

D – <u>Workplace Wellness</u>

9. Ensure that Senior Management lead by example in taking responsibility for promoting and advocating workplace wellness policies and programs.

10. Ensure workplace policies and practices are introduced within the organization with regard to
    a. Increase availability and consumption of fresh fruits and vegetables in cafeterias
    b. Low salt, low cholesterol, trans-fat free, foods in the workplace
    c. 100% smoke free workplace
    d. Screening for blood pressure, weight and other risk factors among our workers.
    e. Promotion and facilitation of physical activity in the workplace.
    f. Stress reduction.

11. Examine and change policies and practices that favor health and wellness and prevention of NCDs.

12. Document and disseminate best practices

E – <u>Partnerships</u>

13. Strengthen or develop partnership between the private sector, Government and the wider civil society to ensure the support for laws, regulations and other measures in support of NCD prevention and control.

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CARIBBEAN CIVIL SOCIETY BRIDGETOWN DECLARATION FOR TACKLING THE EPIDEMIC OF CHRONIC DISEASES

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 screening and prevention of these conditions or treatment of persons already affected;

Recognizing that prevention of disease and promotion of good health is affordable and effective and would avoid 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, such as regular physical activity, healthy eating and weight control, avoidance of alcohol abuse, tobacco consumption and exposure to tobacco smoke;

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

Acknowledging that many circumstances of daily living provide opportunities to practice and 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 programs, 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 behavior change; and

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.

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, slow 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 31st 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 Diseases in all countries of the Caribbean;

3. Advocate for and participate actively in partnerships between civil society, government and the private sector in developing and implementing strategies for preventing and managing CNCDs nationally and regionally;

4. Advocate for policies and programs 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 programs, among others;

6. Promote a healthier diet by ensuring the availability of affordable and nutritious foods, preferably locally grown, banning of trans fats, reducing salt, harmful fats and sugar in the diet, establishing regional standards for food labeling and services, encouraging breast feeding, and protecting children and society's other vulnerable groups, through legislative and other measures;

7. Seek the full implementation of the Framework Convention on Tobacco Control (FCTC), following the recommendations from 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 policy change;

9. Foster and lead sustained and well-targeted Caribbean wide public education and media campaign to promote prevention, screening and treatment of CNCDs, including annual Caribbean Wellness Days;

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 prevention and control of CNCDs as well as promoting collaboration on risk factor surveillance and other research approaches; and

12. Commit to strengthening civil society signatory organizations to this declaration to enable them to be active and effective participants in this effort, to fluid and open communications among coalition members, and a biennial meeting to monitor and carry forward commitments made in this declaration.

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Appendix IV

DECLARATION OF ST. ANN

Implementing Agriculture and Food Policies to prevent Obesity and Non-Communicable Diseases (NCDs) in the Caribbean Community

We, the Ministers of Agriculture of CARICOM, meeting at the Gran Bahia Principe Hotel, Runaway Bay, St. Ann, Jamaica on 9 October 2007 on the occasion of a special Symposium on Food and Agriculture Policies and Obesity: Prevention of NCDs in the Caribbean;

Recalling the 1996 declaration in The Bahamas of the region's Ministers of Agriculture that "*Food and nutritional security in the Caribbean is also related to chronic nutritional life style diseases* [NCDs] *such as obesity, stroke and heart attack",* and the 2007 Heads of Government Declaration of Port of Spain in which a commitment was made, ***"****to provide critical leadership required for implementing…agreed strategies for the reduction of the burden of Chronic Non-Communicable Diseases as a central priority of the Caribbean Cooperation in Health Initiative …*";

Affirming the main recommendations of the Caribbean Commission on Health and Development which included strategies to prevent and control heart disease, stroke, diabetes, hypertension, obesity and cancer in the Region by addressing their causal risk factors of unhealthy diets, physical inactivity, tobacco use and alcohol abuse and strengthening our health and agricultural policies;

Impelled by a determination to reduce the suffering and burdens caused by NCDs through the promotion and implementation of effective food and agricultural policies as part of our overall development plans;

Fully convinced that the burdens of NCDs 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 governments, private sectors, NGOs and our other social, regional and international partners;

Declare –

- Our full support for the initiatives and mechanisms aimed at strengthening regional health and agricultural institutions, to provide critical leadership required for implementing our agreed strategies for the reduction of the burden of Chronic Non-Communicable Diseases as a central priority of the Caribbean Cooperation in Health Initiative Phase III (CCH III), being coordinated by the CARICOM Secretariat, with able support from the Pan American Health Organisation/World Health Organisation (PAHO/WHO) and other relevant partners;

- Our determination to exhaust all options within Regional and WTO agreements to ensure the availability and affordability of healthy foods;

- Our support for the efforts of the Caribbean Regional Negotiating Machinery (CRNM) to pursue fair trade policies in all international trade negotiations thereby promoting greater use of indigenous agricultural products and foods by our populations and reducing the negative effects of globalisation on our food supply;

- Our commitment to develop food and agriculture policies that explicitly incorporate nutritional goals including the use of dietary guidelines in designing food production strategies;

- That we will explore the development of appropriate incentives and disincentives that encourage the production and consumption of regionally produced foods, particularly fruits and vegetables;

- That we will establish, as a matter of urgency, the programmes necessary for research and surveillance on the aspects of agricultural policy and programmes that impact on the availability and accessibility of foods that affect obesity and NCDs;

- Our support for the establishment of formal planning linkages between the agriculture sector and other sectors (especially, health, tourism, trade and planning) in order to ensure a more integrated and coordinated approach to policy and programme development aimed at reducing obesity;

- Our strong support for the elimination of transfats from our food supply using CFNI as a focal point for providing guidance and public education designed toward this end;

- Our support for mandating the labelling of foods or such measures necessary to indicate their nutritional content;

- That we will advocate for incentives for comprehensive public education programmes in support of wellness and increased consumption of fruits and vegetables and embrace the role of the media as a partner in all our efforts to prevent and control NCDs;

Our continuing support for CARICOM, CFNI/PAHO, FAO, IICA and CARDI as the entities responsible for leading the development of the regional Food Security Plan for the prevention and control of NCDs, and the monitoring and evaluation of this Declaration.

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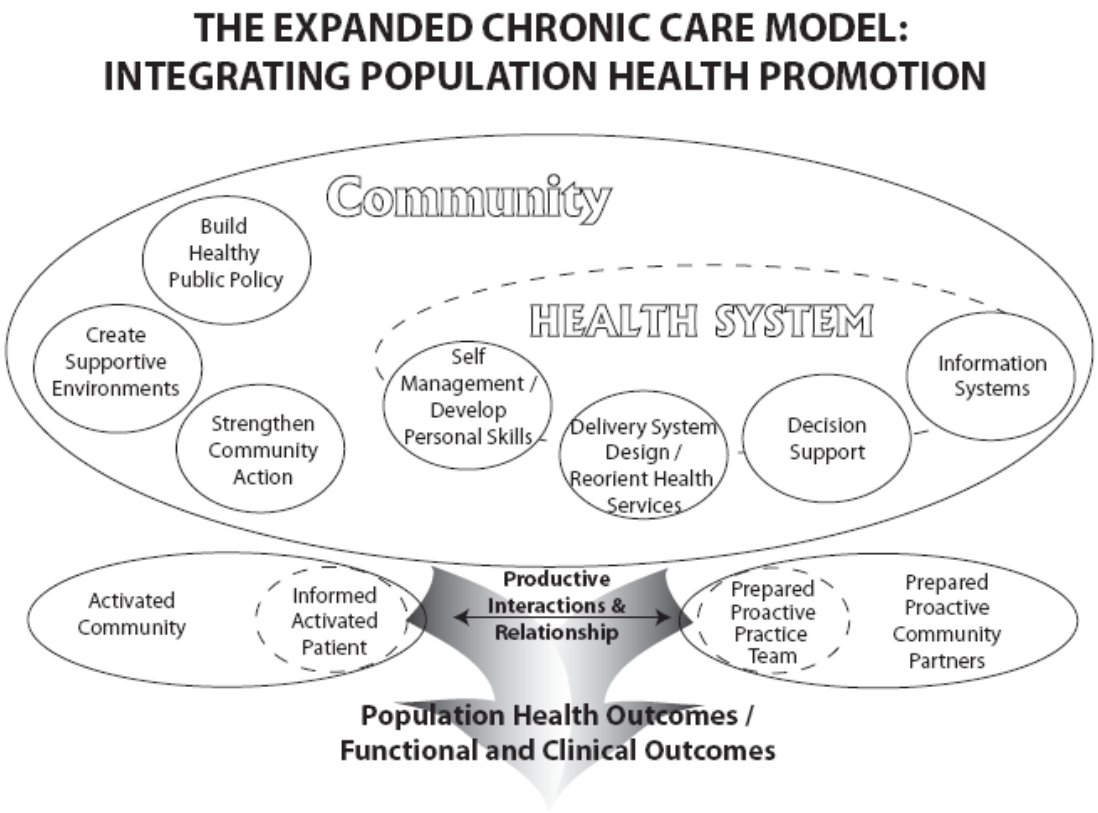
Appendix V



POLICIES

1. **Health Financing (POS #3)**

- That public revenue derived from tobacco, alcohol or other such products should be employed, *inter alia,* for preventing chronic NCDs, promoting health and supporting the work of the Commissions

2. **Health care organization**

- Visibly support improvement in chronic illness care at all levels of the organisation
- Provide incentives to encourage better chronic illness care
- Facilitate care coordination throughout the organisation

3. **Community**
    a. Build healthy public policies
    b. Create supportive environments
    c. Strengthen community actions

- Form partnerships with community organisations to support and develop interventions that fill gaps in needed services
- Encourage patients to participate in effective community programmes
- Advocate policies to promote health, prevent disease and improve patient care

4. Self-Management Support

- Emphasise the patient's central role in managing his/her health
- Use effective self-management support strategies that include goal setting, action planning and problem-solving
- Organise internal and community resources to provide ongoing self-management support to patients

5. Delivery system design / reorient health services

- Define roles and distribute tasks among team members
- Use planned interactions to support evidence-based care
- Ensure active and regular follow-up by the care team
- Seek to give care that patients understand and that fits their cultural background

6. Decision support

- Embed evidence-based guidelines into daily clinical practice
- Share evidence-based guidelines and information with patients to encourage their participation
- Integrate specialist expertise and primary care

7. Information systems

- Provide timely reminders for providers and patients
- Identify sub-populations for proactive care
- Facilitate individual care planning
- Share information with patients and providers to coordinate care
- Monitor performance of practice team and care system

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Appendix VI

NCD SUMMIT DECLARATION EVALUATION FRAMEWORK

Country:_____ Date:_____ Name of Respondent: _____

	POS #	Process Measure	Output Measure	Indicator	Source of Data
Infrastructure: Secretariat / CCH-3 / Regional Plans, Monitoring and Evaluation	1 14	Regional NCD plan reviewed and approved Monitoring framework approved Quarterly reports of NCD national situation using framework	National NCD Plan and programme Monitoring and evaluation NCD Declaration	Document Reports received	NCD National Capacity Survey (NCS)
Infrastructure: National Commission	2	National Commission established and meetings convened Sub-committees have plan of action	MOH NCD Unit /Focal Point Plan of action implemented	MOH staff in place # and date of meetings Composition of NCD Commission	NCS/MOH staff list; Minutes of meetings
Advocacy, Communications, Social marketing	12	Communication plan for NCD advocacy	Media coverage of NCDs	Documentation of region-wide media coverage.	Print and electronic media
Sustainable Financing	4	Feasibility studies Consultation and TCC from countries with successful programmes Legislation	Tobacco and/or other taxes for NCD health promotion, disease prevention and control entrenched in legislation	% increase in health budget % increase for HP /NCD	NCS/ MOH budget
Surveillance: Gender	13 11	Strengthen HIS/national surveillance system, including for NCDs. Training for PAN AM STEPS Research: budget, priorities defined, multi-centre programmes, demonstration projects, publications) Review curricula	Conduct, analyse, and utilise surveys: PAN AM STEPS, GSHS, etc. University curriculum for health professionals includes NCD and risk factors	n countries with population-based data on mortality, risk factors and behaviours. n risk factors included in surveillance system. n universities with updated NCD curriculum. n professionals trained in chronic care model.	Reports of surveys. NCS. University curricula content.
Tobacco	3	FCTC ratified FCTC implemented: 1. 100% smoke-free public places 2. Taxes earmarked for NCDs 3. No ads, promotion, sponsorship 4. Labelling 5. Treatment 6. Monitoring and evaluation surveys Increased capacity – staff, legal support	National health programme includes comprehensive cessation programme	% smoke-free public spaces % cigarettes sold with FCTC compliant labels % adult smokers % youth smokers (13-15 yrs) n attempting to quit n ads, promotion, sponsorship	STEPS GSHS GYTS Media adverts

	POS #	Process Measure	Output Measure	Indicator	Source of Data
Food Security: -Transfat -Trade -Labelling	 7 8 9	Cabinet passes nutrition policy, including no transfats and labelling CRNM impact analysis on food security and trade. Advocacy for policies for less fats, salt, more fruits and vegetables Active engagement of private sector as employers and food suppliers Technical support from CARDI and CFNI	Tax structure to support healthy eating and tax calorie dense foods Law/pledge to reduce fats, salt, ads to kids, to eliminate transfats and ensure labelling of food products	Consumption of - fruits and vegetables - fats - salt % Companies following pledge % Companies following pledge	CFNI / CARDI surveys
Active Living -Population-wide activities -Facilities -2nd Saturday in Sept: "Caribbean Wellness Day"	10 15	Mayors engaged in discussion re population activities. Sustained community physical activity Urban planning process modified	Physical activity - Number participating - Duration of physical activity. Multi-sectoral participation in Caribbean Wellness Day. Increase in supportive environment: parks, sidewalks, alternate healthy transportation.	# safe recreational spaces: parks, sidewalks. Caribbean Wellness Day actions. Sustained CWD actions.	Media reports Surveys
Schools:	6	Policy development to mandate the reintroduction of physical education programmes for healthy school meals and promoting healthy eating	Schools implement physical ed programmes Healthy eating programmes	n schools with physical ed programmes n schools with healthy meals	GSHS
Workplace	10	Policy development for healthy workplace meals, physical activity, Wellness Programmes Define components of Workplace Wellness Programmes	Workplace programmes for healthy foods, physical activity and Workplace Wellness	n companies with healthy foods n companies with Wellness Programmes	Surveys
Screening and integrated management	5	Reorientation of PHC to CCM Package of essential interventions and services in PHC (Screening clinical management of high risk population; User friendly evidence-based guidelines and interventions; essential medicines; chronic care model, including NCD registries; obesity, smoking and alcohol abuse interventions). QOC monitoring in public and /or private care. Self-management skills training for patients and their families.	Quality of diabetes, asthma care % hypertensives at goal % high chol. at goal n HPV vaccine n quality of care improvement projects / CMI (Continuous Measurable Improvement) in applying CCM	n PHC professionals trained in management of HBP, DM, risk approach n patients trained in self-management	CME records

Appendix VII

GAP ANALYSIS SUMMARY AND FUNDABLE PROJECTS

NCD Policies, Achievements, Plans, Programmes and Proposed Projects for CARICOM

Background:

The CARICOM Summit on Chronic Non-Communicable Diseases (NCDs), which was convened in September 2007, was a first-in-the world event in which Heads of Government took policy decisions to prevent and control the NCD epidemic. This epidemic has the common root causes of unhealthy diets, physical inactivity, tobacco use and harmful use of alcohol, in turn, driven by social determinants and global influences.

The Summit issued the Port of Spain Declaration "Uniting to Stop the Epidemic of Chronic Non-Communicable Diseases" – a 15 point road map for prevention and control of NCDs in CARICOM (**Appendix I**). Since then, the Summit of the Americas and the Commonwealth Heads of Government Meeting have endorsed this approach and CARICOM is leading an initiative for a United Nations High Level Meeting (UNHLM) on NCDs. CARICOM has put itself on the world stage in the fight against NCDs, and the implementation of this Summit Declaration should become a model for best practices in NCD prevention and control.

The Governments of CARICOM and the Ministries of Health have been making progress in implementation of the NCD Summit Declaration, but the international community has not yet recognised the need for support of NCD prevention and control. CARICOM is hampered by the fact that Overseas Development Aid (ODA) for NCDs is almost zero (www.kff.org/globalhealth), and the Millennium Development Goals does not cover NCDs, despite the fact that NCDs cause 60% of global deaths, half of which are premature (before the age of 70 years) and 80% of NCD deaths occur in low and middle income developing countries.

Thus, there is need for supplemental funding to enhance the implementation of the NCD Summit Declaration.

This Gap Analysis identifies the components of the Heads of Government NCD Summit Declaration, (see **Appendix** I for full document), identifies NCD policies and strategies, indicates what countries are already doing to implement actions within resource constraints, what structures already exist, then identifies the resource gaps and project proposals. These "Fundable Projects" have been further detailed in a companion document for donors. The estimated costs are NCD Programme US$2.5 million / year; fundable projects, approximately $14.5 million over three (3) years.

This Gap Analysis includes an assessment of the capacity to manage regional programmes, including regional institutions to support NCD programmes, their current capacity and the capacity gap / need for institutional strengthening, e.g., CARICOM, CARPHA, UWI, CROSQ.

Policies and Strategies	Current Status	2010 Regional Implementation	PROJECTS PROPOSED
POS #1, 14: Programme Support: Strengthening regional health institutions to provide critical leadership required for implementing agreed strategies for the reduction of the burden of NCDs, as a central priority of the Caribbean Cooperation in Health Initiative Phase III (CCH- 3) CARICOM and PAHO as the joint Secretariat for CCH-3 Initiative to be the entity responsible for revision of the regional plan for the prevention and control of NCDs, and the monitoring and evaluation of this *Declaration*	The Regional NCD Secretariat last met November 2009. The discussion focused on Jamaica and Barbados' experience in mobilising civil society, especially faith-based organisations (FBOs), and emphasised the need to support the enhancing of civil society networking and collaboration in countries. The Draft NCD Plan of Action has been completed.	Support countries in developing national NCD Plans, based on the regional NCD plan. Develop a model NCD plan for countries based on the Regional Plan Facilitate an annual meeting of NCD focal points from Ministries of Health and PAHO for capacity-building and harmonising implementation of NCD plans and programmes	BUILDING CAPACITY FOR LEGISLATION IN SUPPORT OF HEALTH AND WELLNESS, PRODUCTION OF MODEL PLANS, POLICIES AND PROGRAMMES
POS #2: National NCD Commission Establishment of National Commissions on NCDs or analogous bodies to plan and coordinate the comprehensive prevention and control of chronic NCDs	Eight countries report the establishment of NCD Commissions. Other countries are still seeking guidance on its composition, recommended terms of reference and function Civil Society Partners: The Healthy Caribbean Coalition has been established to support implementation of the POS NCD Summit *Declaration*. (Appendix II) www.healthycaribbean.org Private Sector Partners: The CAIC (Caribbean Association of Industry and Commerce) the regional umbrella private sector organisation has issued a pledge in support of the NCD Summit Declaration (Appendix III).	Support countries in the establishment of National Commissions on NCDs or analogous NCDs Develop model TORs and provide technical supports for establishing NCD National Commissions Those countries that have not yet done so, should hold inter-sectoral NCD summits and appoint inter-sectoral NCD Commissions with representation from government agencies, civil society and the private sector Partners Forum with Healthy Caribbean Coalition, Caribbean Assoc of Industry and Commerce should be convened	CAPACITY-BUILDING FOR INTER-SECTORAL WORK IN SUPPORT OF NATIONAL PROGRAMME ORGANISATION AND DEVELOPMENT - SUPPORT FOR NCD NATIONAL COMMISSIONS - STRENGTHENING OF CIVIL SOCIETY NETWORKS IN COUNTRIES - NATIONAL PARTNERS FORUM - CARIBBEAN / REGIONAL PARTNERS FORUM

Policies and Strategies	Current Status	2010 Regional Implementation	PROJECTS PROPOSED
POS # 12: Advocacy / Communications Comprehensive public education programmes in support of wellness, healthy life-style changes, improved self-management of NCDs and embrace the role of the media as a responsible partner in all the Region's efforts to prevent and control NCDs	The Regional NCD Plan proposes the development of Social Change Communication strategies, public education and information for preventive education and self-management including audience research and stakeholder analysis to inform suitable communication strategies; message development and selection of appropriate media	A RFP (Request for Proposal) has been prepared for the development of NCD messaging.	In addition to sporadic national efforts, there is need for funding for a comprehensive programme.
POS # 11, 13: Surveillance, M & E, Gender Inclusion of the gender dimension in all the Region's programmes aimed at the prevention and control of NCDs Programmes necessary for research and surveillance of the risk factors for NCDs with the support of our Universities and the Caribbean Epidemiology Centre/Pan American Health Organisation (CAREC/PAHO)	6 countries have completed risk factor surveys. Reporting on the Minimum Data Set was to begin in early 2010. An NCD grid has been developed as a summary. The IDB-funded Regional NCD Surveillance Systems Project was executed by the UWI for the 6 IDB countries - with continuing CAREC support Caribbean Public Health Agency (CARPHA) being established.	Purchase of palm pilots for direct entry of risk factor survey data. Ministers of Health approved the following evaluation matrices: 1. STEPS surveys in those countries that have not yet done so. 2. NCD Minimum Data Set reporting 3. Updating NCD grid annually	IMPLEMENTATION OF THE SURVEILLANCE SYSTEM DESIGNED BY THE IDB PROJECT & EXTEND TO NON-IDB STATES - EVALUATE THE IMPLEMENTATION OF THE POS NCD DECLARATION - SUPPORT FOR CARPHA - SUPPORT FOR UNIVERSITY OF THE WEST INDIES, (UWI) FOR NCD RESEARCH & EVALUATION

Policies and Strategies	Current Status	2010 Regional Implementation	PROJECTS PROPOSED
POS # 4: Sustainable Financing Public revenue derived from tobacco, alcohol or other such products should be employed, *inter alia*, for preventing chronic NCDs, promoting health and supporting the work of the Commissions	Many countries have increased taxes on tobacco products, and a few have allocated some of these funds to NCD programmes	Capacity development for resource mobilisation, with the emphasis on Grants Countries should seek to establish sustainable financing for NCD programmes, perhaps from tobacco taxes.	REQUEST CARICOM SUPPORT TO SEEK FUNDS TO IMPLEMENT THE NCD SUMMIT DECLARATION.
POS #3: Tobacco Immediate pursuit of a legislative agenda for passage of the legal provisions related to the International Framework Convention on Tobacco Control; its immediate ratification in all States which have not already done so; and support for the immediate enactment of the FCTC compliant legislation	13 CARICOM countries have ratified the FCTC; 2 need to ratify - Haiti and St. Kitts and Nevis Trinidad and Tobago passed robust Tobacco Control legislation in November 2009 that could be used as a model for other countries. Bloomberg Global Initiative Tobacco Control Project ends April 2010. It supported FCTC-compliant packaging and labelling with rotating pictorial warnings. Member States voted in several rounds on edited standards. Now requires endorsement by CROSQ Council then approval by the COTED	Active follow up with CROSQ on tobacco packaging and labelling. Implementation of packaging and labelling standards Assistance to countries in drafting tobacco legislation, using TRT legislation as a model Haiti and St. Kitts and Nevis still need to ratify Countries need to pass tobacco legislation	BUILDING CAPACITY FOR FCTC-COMPLIANT LEGISLATION INCLUDING INCREASING TAXES ON TOBACCO SUPPORT FOR COUNTRIES IN PASSING LEGISLATION AND IMPLEMENTING PROVISIONS CAPACITY-BUILDING FOR CROSQ. THIS REGIONAL INSTITUTION NEEDS ADDITIONAL CAPACITY TO RESPOND IN A TIMELY MANNER TO SET REGIONAL STANDARDS FOR PRODUCTS TO ENHANCE THE PUBLIC'S HEALTH
POS #7, 8, 9: Food Security / Transfat / Trade / Labelling Regional institutions to enhance food security Elimination of transfats from the Region Caribbean Regional Negotiating Machinery (CRNM) negotiates fair international trade policies to reduce the negative effects of globalisation on our food supply; Labelling of foods to indicate their nutritional content	CFNI has received limited funding for transfat assessment for Jamaica. CROSQ has begun the process of reviewing labelling standards for foods in the Region	Active follow up with CROSQ on- a. Setting standards for salt in manufactured foods in the Region b. food labelling Ministers of Agriculture issued the *St. Ann Declaration* (Appendix IV) in support of the POS NCD Summit *Declaration* CFNI as a focal point for providing guidance and public education designed toward elimination of transfat	SUPPORT FOR REGIONAL INSTITUTIONS - Caribbean Food and Nutrition Institute (CFNI), Caribbean Agricultural Research and Development Institute (CARDI) IMPROVE CAPACITY OF CROSQ TO DEVELOP, IMPLEMENT AND MONITOR REGIONAL STANDARDS – SALT, LABELLLING.

Policies and Strategies	Current Status	2010 Regional Implementation	PROJECTS PROPOSED
POS #10, 15: Active Living, population-wide activities: increasing physical activity in the entire population, e.g. at work sites, through sport, especially mass activities, increasing adequate public facilities such as parks and other recreational spaces to encourage physical activity by the widest cross-section of our citizens; In commemoration of the NCD Summit the second Saturday in September celebrated as "Caribbean Wellness Day	Caribbean Wellness Day is now well established with regional branding and products, and activities in multiple locations in 19 / 20 CARICOM countries in 2010, the third celebrations, to promote ongoing physical activities. Private and public sectors with civil society partnerships in several communities are sustaining these. Details can be accessed at www.paho.org/cwd09 and www.paho.org/cwd10	Support for Caribbean branding of physical activity initiatives. Countries are proposing a Caribbean Billion Mile Challenge, modeled on Guyana's Million Mile Challenge. Countries celebrated World Health Day "1,000 cities, 1,000 lives," focussed on urbanisation and health, incorporating health into urban policy. This was the launch pad for Caribbean Wellness celebrations 2010.	SUPPORTS FOR THE DEVELOPMENT OF URBAN PLANNING CAPACITY TO PROVIDE PUBLIC FACILITIES FOR PHYSICAL ACTIVITY AND IN SUPPORT OF EXPANDING MASS TRANSPORTATION
POS #6: Schools Re-introduction of physical education in the Region's schools Providing healthy school meals and promoting healthy eating	Insufficient systematic programmes	Proposal written for funding for model NCD curricula. Need to provide incentives and resources to effect this policy and ensure that the Region's education sectors promote programmes aimed at healthy eating and physical activity in schools	CURRICULUM DEVELOPMENT AND TRAINING PREVENTING OBESITY & NCDS IN CARIBBEAN ADOLESCENTS THROUGH BEHAVIOURAL INTERVENTION
POS # 10; Workplace / Faith-based wellness initiatives Promote policies and actions aimed at increasing physical activity in the entire population, e.g., at work sites	Jamaica and Trinidad & Tobago have developed Workplace Wellness Policies The CAIC (Caribbean Association of Industry and Commerce) the regional private sector organisation, has issued a pledge in support of the NCD Summit Declaration and workplace wellness programmes Jamaica and Barbados have engaged faith-based organisations in the campaign to mitigate risk factors.	Proposal written for funding for model, Workplace Wellness Programme which includes the components of NCDs, HIV/AIDS, and occupational safety Support for Barbados and Jamaica FBO initiatives. TCC on sharing interventions should be pursued Target workplaces and faith-organisations to participate in Caribbean Wellness Day campaign.	PUBLIC POLICY, ADVOCACY AND COMMUNICATIONS HEALTHY SCHOOLS, WORKPLACE WELLNESS PROGRAMMES, FAITH- BASED WELLNESS PROGRAMMES

Policies and Strategies	Current Status	2010 Regional Implementation	PROJECTS PROPOSED
POS #5: Screening and integrated management Screening and management of chronic diseases and risk factors so that by 2012, 80% of people with NCDs would receive quality care and have access to preventive education based on regional guidelines	Caribbean Experts on control of Cardiovascular Disease and Diabetes have recommended the adoption of the Total Risk Approach and the Chronic Care Model for management of high-risk patients with cardiovascular disease. This initiative would be the most costly, but would yield the most lives saved. Capacity-Building / Training by the Caribbean Chronic Care Collaborative for Improving the Quality of Diabetes Care. Teams from 9 countries were trained in diabetes quality improvement initiatives.	Strengthen health systems and re-orient primary health care through development of the Integrated Care for Chronic Conditions. Strengthen human resource capacity for evidence-based prevention, control and treatment of NCDs to align with evidence-based guidelines 1. Develop draft pocket guidelines. 2. Seek consensus from Caribbean CVD Experts on pocket guidelines 3. Capacity-building workshops / training in a. NCD Commission b. CVD management in two of the countries which have completed baseline NCD risk factor surveys *Drug procurement for 5 essential generics (thiazide diuretic, aspirin, beta blocker, statin, ace inhibitor)* Prescribe exercise; Report risk factors in a similar way to reports of vital signs	TRAINING FOR SCREENING AND MANAGEMENT OF NCDS: CARIBBEAN COUNTRIES INTEGRATED CARE FOR CHRONIC CONDITIONS DEMONSTRATION SITE; AND INTEGRATION OF CHRONIC DISEASES – COMMUNICABLE AND NON-COMMUNICABLE STRATEGIC PLAN FOR CANCER PREVENTION AND CONTROL IN THE CARIBBEAN ESTABLISHMENT OF TWO REGIONAL CENTRES OF EXCELLENCE FOR KIDNEY TRANSPLANTATION; ESTABLISHMENT OF MECHANISMS FOR QUALITY CONTROL IN DIALYSIS

Project Proposals Requiring Funding:

NCD PREVENTION AND CONTROL IN THE CARIBBEAN 2011 – 2015:
STRATEGIC PLAN OF ACTION FOR COUNTRIES OF THE CARIBBEAN COMMUNITY

BUDGET SUMMARY (in US $)	**Sub-total**	**15% contingency**	**Total**
CAPACITY-BUILDING			
1. CAPACITY-BUILDING FOR INTER-SECTORAL WORK IN SUPPORT OF NCD PREVENTION AND CONTROL a. SUPPORT FOR NCD NATIONAL COMMISSIONS C. b. CARIBBEAN AND NATIONAL PARTNERS FORUMSTRENGTHENING CIVIL SOCIETY NETWORKS IN COUNTRIES	$565,000	$84,750	**$649,750**
2. BUILDING CAPACITY FOR LEGISLATION	$400,000	$60,000	**$460,000**
3. CURRICULUM DEVELOPMENT AND TRAINING	$2,410,000	$361,500	**$2,771,500**
RISK FACTOR REDUCTION			
4. BUILDING CAPACITY FOR IMPLEMENTING THE FCTC			-TBD-
5. CFNI TRANSFAT PROPOSAL			**$1,500,000**
6. REDUCE SALT CONSUMPTION	$1,675,000	$251,250	**$1,926,250**
7. CARIBBEAN WELLNESS DAY CELEBRATIONS AND ONGOING MASS PHYSICAL ACTIVITY	$455,000	$68,250	**$523,250**
8. PUBLIC POLICY, ADVOCACY AND COMMUNICATIONS	$1,040,000	$156,000	**$1,196,000**
9. HEALTHY SCHOOLS,WORKPLACES, FBOs	$450,000	$67,500	**$517,500**
10. PREVENTING OBESITY AND NCDs IN CARIBBEAN ADOLESCENTS THROUGH BEHAVIOURAL INTERVENTION	**$160,855**		**$785,744**
DISEASE MANAGEMENT			
11. IMPLEMENTATION OF ENHANCED SURVEILLANCE SYSTEM DESIGNED BY IDB PROJECT			-TBD-
12. INTEGRATED MANAGEMENT OF NCDs:	$2,730,000	$409,500	**$3,139,500**
13. STRATEGIC PLAN FOR CANCER PREVENTION AND CONTROL IN THE CARIBBEAN: 2011-2015	$945,000	$141,750	**$1,086,750**
14. ESTABLISHMENT OF TWO REGIONAL CENTRES OF EXCELLENCE FOR KIDNEY TRANSPLANTATIONAND CONTROL IN DIALYSIS			-TBD-
GRAND TOTAL			**$14,556,244**

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ACRONYMS

AECI	Spanish Agency for International Cooperation
AIDS	Acquired Immune Deficiency Syndrome
ASR	Age Specific Rate
BMI	Body Mass Index
BOD	Burden of Disease
BP	Blood Pressure
CAIC	Caribbean Association of Industry and Commerce
CARDI	Caribbean Agricultural Research and Development Institute
CAREC	Caribbean Epidemiological Research Centre
CARICOM	Caribbean Community
CARIFTA	Caribbean Free Trade Association
CARIPROSUM	Caribbean Procurement Supply Management
CARMEN	Collaborative Action for Risk Factor Reduction and Effective Management of NCDs
CARPHA	Caribbean Public Health Agency
CBU	Caribbean Broadcasting Union
CCH	Caribbean Cooperation in Health Initiative
CCHD	Caribbean Commission on Health and Development
CCM	Chronic Care Model
CDB	Caribbean Development Bank
CDC	U.S. Centers for Disease Control and Prevention
CDRC	Chronic Disease Research Centre
CEHI	Caribbean Environmental Health Institution
CET	Common External Tariff
CIDA	Canadian International Development Agency
CFNI	Caribbean Food and Nutrition Institute
CHPSN	Caribbean Health Promoting Schools Network
CHRC	Caribbean Health Research Centre
CMC	CARICOM Member Countries and Associate Members
CME	Continuing Medical Education
CMH	Conference of Ministers responsible for Health
CMI	Continuous Measurable Improvement
CMO	Chief Medical Officer
CNCD	Chronic Non-Communicable Disease
CNHPS	Caribbean Network of Health Promoting Schools
COHSOD	Council for Human and Social Development
COTED	Council for Trade and Economic Development
CRDTL	Caribbean Regional Drug Testing Laboratory
CRNM	Caribbean Regional Negotiating Machinery
CROSQ	Caribbean Regional Organisation for Standards and Quality
CSME	CARICOM Single Market and Economy
CVD	Cardiovascular disease
CWD	Caribbean Wellness Day
DALY	Disability Adjusted Life Years
DM	Diabetes Mellitus
DPAS	Diet and Physical Activity Strategy
EPI	Expanded Programme of Immunisation
FAO	United Nations Food and Agricultural Organisation
FBO	Faith-based Organisation
FCTC	World Health Organisation Framework Convention on Tobacco Control
FP	Focal Point
GDP	Gross Domestic Product

GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GSHS	Global School Health Survey
GYTS	Global Youth Tobacco Survey
HBP	High Blood Pressure
HCC	Healthy Caribbean Coalition
HFLE	Health and Family Life Education
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IDB	Inter-American Development Bank
IAHF	Inter- American Heart Foundation
IMAI	Integrated Management of Adolescent and Adult Illness
IMAN	Integrated Management of Adolescents and their Needs
IMCI	Integrated Management of Childhood Illnesses
ISO	International Organisation for Standardisation
JHLS	Jamaica Healthy Lifestyles Survey
LAC	Latin America and the Caribbean
MDG	United Nations Millennium Development Goal
M&E	Monitoring and Evaluation
NGO	Non –Governmental Organisation
OAS	Organisation of American States
OECS	Organisation of Eastern Caribbean States
PA	Physical Activity
PAHO	Pan American Health Organisation
PANAM	Pan American
PANCAP	Pan Caribbean Partnership against HIV and AIDS
PANDRH	Pan American Network for Drug Regulatory Harmonisation
PE	Physical Education
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
POS	Port-of-Spain
PTSA	Parent, Teachers, Students Associations
PYLL	Potential Years of Life Lost
QI	Quality Improvement
QOC	Quality of Care
RHI	Regional Health Institutions
STEPS	WHO STEPwise approach to NCD risk factor surveillance
TCC	Technical Cooperation among Countries
TOR	Terms of Reference
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USA	United States of America
USAID	United States Agency for International Development
WB	World Bank
WDF	World Development Federation
WHA	World Health Assembly
WHO	World Health Organisation
WTO	World Trade Organisation

ACKNOWLEDGEMENTS

This plan was reviewed at two meetings of stakeholders:

July 2008 in Barbados:
Barbados, Bahamas, Belize, British Virgin Islands, Dominica, Guyana, Jamaica, Montserrat, St. Kitts and Nevis, St. Vincent & Grenadines, Turks and Caicos Islands, Suriname, PAHO, CARICOM

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Special acknowledgements to
Dr. Katherine Israel and Dr. James Hospedales of PAHO
Ms. Petronella Edwards, NCD focal point, St. Kitts and Nevis
Prof Trevor Hassell, Healthy Caribbean Coalition
Dr. Rudoph Cummings, Director of the Health Desk, CARICOM Secretariat
Ms. Sandra Grainger for final editing

T. Alafia Samuels – Principal consultant in preparing the document

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