Controlling NCDs through Summitry: The CARICOM Case

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Executive Summary

The Challenge

In October 2006, Sir George Alleyne, chair of the Caribbean Commission on Health and Development (CCHD), asked the Caribbean Community (CARICOM) governments to take on the challenge of preventing and controlling non-communicable diseases (NCDs). He declared that more people in the region were dying from NCDs than from HIV/AIDS. The Caribbean governments agreed to mount a special leaders meeting on the topic, which Trinidad and Tobago agreed to host with the support of other key countries, including Barbados, and St. Kitts and Nevis. Thus the historic Special CARICOM Heads of Government Summit on NCDs was held in Port-of-Spain on September 15, 2007.

This unprecedented event successfully highlighted the importance and urgency of addressing NCDs by helping to debunk myths associated with the issue, instigating a first round of commitments, getting several countries to take steps to tackle them and, subsequently, moving the issue from a small group of countries and actors to a global audience. The leaders in attendance made several substantial, concrete commitments to help countries in the Caribbean region prevent and control the big four NCDs of cardiovascular disease, diabetes, cancer and respiratory disease as well as the four key drivers of those diseases, notably lack of physical activity, tobacco use, alcohol abuse and unhealthy diets. Since then, several leaders, ministers, council members, multilateral organizations and civil society organizations have implemented these commitments to some degree. However, substantial improvements are still needed, both in regard to the types of commitments crafted and their levels of implementation. CARICOM countries in general, and Barbados and Trinidad and Tobago in particular, have played a critical role in highlighting the challenges of NCDs and expanding the issues to an increasing number of forums. This process will reach another critical juncture when the UN holds its NCD High Level Meeting (HLM) in September 2011. To take full advantage of this upcoming

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opportunity, several lessons can and should be learned from the CARICOM NCD Summit.

The Critical CARICOM Case

The 2007 CARICOM NCD Summit constitutes a critical case study for those seeking to make the 2011 UN NCD HLM a success. The CARICOM NCD Summit is the only other case of an NCD-specific summit. It includes a diverse range of countries, representative of the global division, from developing Haiti to developed Barbados. It was responsible for getting a growing number of countries and forums, including the UN HLM itself, to focus on the issue. It is therefore important to examine it closely for key lessons to learn and apply to the upcoming meeting. These lessons include how to design and mount a special HLM on NCDs, engage key participants, establish the correct set of collective commitments, get countries to implement these commitments, institute an accountability architecture to assist with implementation and engage surrounding summits that will spread and solidify support for preventing and controlling NCDs.

The Analytical Approach

This study starts by identifying the commitments that were crafted at the CARICOM NCD Summit. It next assesses the available evidence of implementation of those commitments by each member. It then examines the potential causes of differences in implementation, considering as potential candidates a country's relative vulnerability to NCDs, its capability to cope with them, leaders' association with the centrally involved University of the West Indies (UWI), the country's level of international institutional inclusion and engagement, its participation in the accountability architecture that monitors implementation and the support from subsequent summits for controlling NCDs. In regard to the latter, this study also traces how the CARICOM NCD Summit came about, how NCDs evolved at regular CARICOM meetings following the special NCD summit and how the issue moved from the Caribbean to broader forums. This study presents an analysis and recommendations based on an overview of available aggregate data. This is a necessary prelude to the detailed process tracing that should accompany it in order to confirm, enrich and adjust the causal links and to inform the policy recommendations that result.

The Argument

This study concludes that the special, issue-specific CARICOM NCD Summit was successful in several ways: it highlighted the issues, helped to debunk misperceptions associated with NCDs, instigated the first round of commitments to address the challenges, got several countries to take strides in tackling them and moved the issue from a small sub-regional group of countries and actors to a global audience. The summit created an initial set of commitments and implementation mandates to control NCDs. It helped start a global health diplomacy process in support of NCD control that spread from CARICOM to subsequent leaders' meetings, including the Summit of the America (SOA), the Commonwealth, United Nations, Group of Twenty (G20) and the Asia-Pacific Economic Cooperation (APEC) summits. CARICOM countries have been more

likely to implement their NCD summit commitments if they are full members (not associates of CARICOM), if they sent a leader rather than a minister to the summit, if they are more vulnerable to NCDs, if they are more economically capable, if they are associated with UWI and if they are more institutionally involved in CARICOM. Overall compliance could be further improved by crafting commitments that contain the specific catalysts known to improve compliance in a G8 context and by avoiding the ones that hinder it. The support from surrounding summits flows largely from the same factors, above all the commitment of a region — the Caribbean — to take up the issue and extend it beyond its borders and a country — Trinidad and Tobago — willing and able to serve repeatedly as a successful summit host.

From this preliminary analysis, several lessons for crafting a successful UN NCD HLM stand out. It is important to get leaders themselves to attend; to build on commitments approved by previous summits; and to mobilize new money based on the overall summit, not in specific commitments, to assist countries that are willing but with low capacity for implementation. Summit leadership should be shared by several capable, committed countries and leaders. These countries and leaders should be encouraged to adopt a distinct responsibility and role in the initial meeting, in subsequent follow-up meetings and in an accompanying accountability architecture that will be key to the meeting's success (Grigorescu 2010). Commitments should be crafted in a way that gives priority placement to the most important ones, engages civil society before, during and after the meeting, and invokes international organizations, including the World Health Organization (WHO), International Monetary Fund (IMF), World Bank, Food and Agriculture Organization (FAO) and regional affiliates such as the Pan American Health Organization (PAHO).

The CARICOM NCD Summit's Commitments and Compliance

Commitments

On September 15, 2007, the CARICOM Summit on Chronic Non-Communicable Diseases was held in Port-of-Spain, Trinidad and Tobago. It was chaired by the prime minister of Barbados. The eleven leaders and five ministers present agreed that "immediate collective actions were necessary to manage and control NCDs" (CARICOM Secretariat 2007b). In their common declaration, issued at the end of their meeting, 27 concrete, discrete commitments were made (see Appendix A).[5]

In this concluding declaration, members agreed to act on "research and data collection; integrating lifestyle management into the formal education system; the empowerment of individuals to secure consumer behaviour change; pursuance of trade regulations such as appropriate labeling; and the banning of transfats," as well as tackling tobacco use, providing screening and quality treatment for NCDs, and the promotion of physical

[5] These commitments are identified according to the methodology developed by the G8 Research Group. They differ from the "15 actionable recommendations" identified by CARICOM members.

activity and healthy eating (CARICOM Secretariat 2007b). There was no specific commitment to address alcohol abuse.

Other summit participants agreed to assist CARICOM members achieve their goals. PAHO promised to "provide training and capacity-building for countries and Regional Health Institutions (RHIs) to monitor the epidemic and the risk factors and to plan appropriate responses using appropriate mechanisms; assist with the preparation of a revised Caribbean Regional Plan for NCDs Prevention; mobilise resources and partners to aid the fight, and jointly with the CARICOM Secretariat and within a year, convene an inter-disciplinary group to evaluate the impact of the Summit as part of the monitoring and evaluation and follow up to the Summit" (CARICOM Secretariat 2007b).

WHO promised to include the Caribbean in its global action plan for the prevention and control of chronic diseases, which was presented in January 2008. The Caribbean Unit of the World Bank promised to support the "inclusion of a target on NCDs as one of the United Nations Millennium Development plus Goals for the Caribbean" (CARICOM Secretariat 2007b). Within civil society, UWI committed to "continue to provide Governments with evidence-based research to enable them to formulate appropriate policies necessary to curtail NCDs." The summit thus included larger regional and multilateral organizations, accountability mechanisms and the independent, authoritative scientific-academic community in a significant way.

Healthy Caribbean Coalition Implementation Assessment

In 2010, Trevor Hassell (2010), chair of the Healthy Caribbean Coalition (HCC), assessed how well countries were implementing their NCD summit commitments, based on data compiled by UWI. He referred to the "15 actionable recommendations" in the leaders' declaration and highlighted 21 indicators of measurement. Hassell noted that, almost three years after the summit, countries' implementation was modest and very mixed (see appendices B and C). He found that Jamaica, Trinidad and Tobago, Guyana and Barbados were the highest complying countries. Haiti, Turks and Caicos and Montserrat complied the least.

Converted Implementation

This conclusion is consistent when the HCC findings are converted using the standard summit methodology developed by the G8 Research Group. The overall average was a modest +0.23, on a scale where +1.00 represents full implementation and –1.00 represents none. On the more common 0–100% scale, a score of +0.23 is equivalent to 61.5% (see Appendix D).[6] The average score for the 15 CARICOM members was slightly higher at +0.27. The score of the five associate CARICOM members was +0.08.

The highest implementation, in order, came from Jamaica at +0.86, Trinidad and Tobago at +0.82, Guyana at +0.65 and Barbados at +0.61. In the middle were Antigua and

[6] This average compliance score of 61.5% is substantially lower than the average of the G8 summits from 1975 to 2009, but about the same as the broader, more diverse G20 summits from 2008 to 2010.

Barbuda and Suriname at +0.43 and Grenada at +0.40. At or below average were St. Lucia at +0.26, the Bahamas at +0.24, Montserrat at +0.20, Belize at +0.19, Dominica at +0.12, and St. Vincent and the Grenadines at 0.00. St. Kitts and Nevis and Haiti fell on the negative side of the scale, at –0.21 and –0.80, respectively.

University of the West Indies Implementation Assessment

Scholars from UWI's Faculty of Medical Sciences have been monitoring implementation with CARICOM NCD commitments since the end of the summit. Working with government officials, every six months they have monitored and reported on countries' progress with the 15-point Port-of-Spain Declaration across 26 indicators (Hospedales et al. 2011). They too have found that implementation has been modest and mixed. In their most recent update in 2010, they found that Barbados and Trinidad and Tobago had done best. Haiti and Anguilla had the worst results.

Converted Implementation

When the G8 Research Group methodology is applied to the more up-to-date UWI results, with additional indicators, implementation remains mixed. The overall average was +0.06, or 53% (see Appendix E).[7] The average score for CARICOM members was slightly higher at +0.08. That of the five associate members was –0.01.[8]

The highest implementation came from, in order, Barbados +0.64, Trinidad and Tobago at +0.44, Bermuda at +0.43 and Dominica at +0.38. In the middle came Guyana at +0.36, Montserrat and Turks and Caicos at +0.33, Jamaica at +0.32, Grenada at +0.28, St. Lucia at +0.24, the British Virgin Islands (BVI) at +0.15 and the Bahamas at +0.11. Below average and on the negative side came Belize at –0.03, St. Kitts and Nevis and the Caymans at –0.10, Suriname at –0.17, Antigua and Barbuda at –0.18, St. Vincent and the Grenadines –0.45, Anguilla at –0.61 and Haiti at –0.83.

The FCTC Implementation Check

To confirm these findings, an independent assessment of each member's record in signing and ratifying the critical commitment on the Framework Convention on Tobacco Control (FCTC) was undertaken (see Appendix F) (Collin and Lee 2008). This evidence suggested that the CARICOM NCD Summit was successful in spurring an NCD-reducing shift from the status quo. Immediately before the summit, at a time when its "pull" on members' expectations and behaviour had arisen, Grenada ratified the FCTC. Suriname, the Bahamas, and St. Vincent and the Grenadines all did in the two and a half years after the summit afterward. Haiti and St. Kitts and Nevis are the only two members

[7] This average compliance score of 53% is also substantially lower than the average of the G8 summits from 1975 to 2009, but about the same as the broader, more diverse G20 summits from 2008 to 2010.

[8] The lower score was largely due to new indicators that measured food and nutrition commitments, which all scored poorly.

that have not yet ratified. These results suggest that the CARICOM NCD Summit was worth the investment for its results on this critical driver of tobacco reduction alone.[9]

The Caribbean Wellness Day Implementation Check

An additional independent assessment was made of members' compliance with the summit commitment to celebrate Caribbean Wellness Day on the second Saturday every September — a commitment announced at the 2007 CARICOM NCD Summit. It also revealed considerable implementation. In 2008, 14 countries participated in the event. Eighteen and nineteen countries — almost all of the 20 participants — took part in 2009 and 2010, respectively (see Appendix G; Samuels and Fraser 2010).

The National Policy Address Implementation Check

A preliminary selective assessment of the national policy addresses of CARICOM members from 2008 to the 2011 also suggests that the summit brought about a shift in defining domestic national policy emphasis on NCDs. A scan of speeches in Jamaica, Barbados, Antigua and Barbuda, Grenada, St. Lucia, St. Kitts and Nevis, and Belize all showed that countries continued to address NCDs at home in the years after the summit was held.

The Composite Conclusion about Implementation

The CARICOM NCD Summit thus appears to have some independent effect on inducing participating countries to place more emphasis on and undertake more action on the specific commitments it made. Without the summit, in a region where competing priorities abound, it is unlikely that many of these changes would have taken place. Yet much can still be done to improve implementation, particularly in Haiti, Anguilla, St. Vincent and the Grenadines and St. Kitts and Nevis. Regional organizations and those countries that have been more successful compliers should reach out to those that are struggling to help them keep their commitments.

Causes of Implementation

There are several candidates to explain why particular countries have been more successful than others in keeping their commitments. A country's relative vulnerability can affect implementation. Countries that suffer more as a result of NCDs are more likely to implement their commitments. However, non-NCD–related shocks and vulnerabilities can distract a country from reaching its goals. For example, a country hit by a natural disaster, such as Haiti in 2010, can be forced to divert its attention to an immediate crisis from chronic, less visible challenges such as NCDs. Thus even the best will to make progress can be overcome by other unforeseen deadly and destructive events.

[9] A renewal of this commitment could be important in maintaining forward-moving momentum and preventing backsliding, such as in Jamaica.

A country's relative capability can also affect implementation. The more governmental and societal resources a country has at its disposal, the more likely it is to keep its pledges.

Institutionalization and agency can also have an impact. The more invested a country is in a particular organization, the more likely it is to keep the commitments it makes there. If a country hosts or chairs a summit, it is more likely to implement its commitments (Kirton and Guebert 2009; Talberg 2010). Summit and institutional experience also correlate positively with accountability levels (Kirton 2011). The expertise and networks acquired from a common educational experience can help as well. Leaders can also embed particular catalysts or inhibitors within their commitments that help or harm implementation.

Vulnerability

On the first potential cause — a country's vulnerability to NCDs — as Alleyne pointed out in 2006, all CARICOM countries are at an economic and social disadvantage as a result of NCDs and their risk factors (see Appendix H). For example, the national average body mass index (BMI) of citizens of CARICOM countries in 2010 was 26.16, placing them in the overweight category (25–29.9). Countries that had a higher incidence of NCDs were more likely to implement their commitments. Barbados at 29.0 and Trinidad and Tobago at 28.6 have a national average BMI close to the obesity marker (30) and also have had high implementation rates. Jamaica and Trinidad and Tobago, which have the highest tobacco consumption rates, are high compliers. Dominica and Trinidad and Tobago, which have the highest incidence of diabetes, rank fourth and second in implementation, respectively. With the exception of Haiti, which has the highest incidence and mortality rates due to cancer and the lowest implementation, those countries with high incidence and mortality due to cancer, including Jamaica, Trinidad and Tobago and Guyana, also tend to have higher implementation. Citizens' vulnerability to NCDs thus seems to be a powerful cause of why countries implemented the summit commitments their leaders made. Outliers, such as Haiti, need to be assessed further.

Capability

The relative capability of CARICOM countries also appears to correlate with their degree of implementation (see Appendix I). On the whole, countries with higher levels of gross national income (GNI), income level, gross domestic product (GDP) and larger populations — the standard measures of overall national capability — were slightly more likely to implement their commitments. In the realm of specialized health capability, however, on the most relevant indicators countries with more capable health systems and countries with higher life expectancy, implementation tended to be lower. Further examination of this link is necessary.

Association with the University of the West Indies

UWI has long had a special role with CARICOM. It played an important role in getting NCDs onto the leaders' agenda and has remained heavily involved in accountability monitoring since the summit's completion. CARICOM leaders who have an association with UWI, such as attending the institution or teaching there, were more likely to keep their commitments.

Institutional Inclusion

Institutional inclusion also appears to correlate with higher implementation (see Appendix J). Countries with strong international institutional ties to CARICOM tend to keep their commitments to a higher degree. The 15 full members kept their NCD commitments to a greater degree than the five associate members did.[10] The oldest CARICOM members — Guyana, Jamaica, and Trinidad and Tobago — had better implementation. Haiti — the newest country to join as a full member, in 2002 — had the worst record.

Finally, members with a special relationship to the organization tended to have better implementation as well. The secretary general of CARICOM from 1992 to 2010 and during the NCD Summit came from Trinidad and Tobago, which had the second best implementation record. Trinidad and Tobago also hosted the NCD Summit. The CARICOM secretariat is located in Guyana, which ranked in the top five countries. Furthermore, when leaders themselves came to the summit, implementation was more likely for their countries than when a lower-level minister attended.

Catalysts

Commitments can be crafted in ways that enhance implementation (Kirton and Guebert 2009). Countries were more likely to keep CARICOM NCD commitments that had at least one embedded catalyst, such as the use of international law. With regard to health commitments made in other forums, such as the G8, references to the relevant international organizations, such as WHO, the United Nations and the World Bank, also correlate with better implementation. Other contributors include invoking civil society and identifying commitments as a priority in the preamble or summary of the communiqué. Implementation at the G8 summit is, on average, hindered when references are made to a specific country or region, references to past summits are made, the private sector is invoked, specific targets are identified or money is mobilized within specific commitment.

The 2007 CARICOM NCD commitments were fairly effective in avoiding the implementation-hindering catalysts, with only three commitments identifying targets and only one mobilizing money (see Appendix K). However, most of the commitments also

[10] This could be accounted for by the relative capability variable of size as measured by population. All five associate members have very small populations.

avoided invoking the implementation-enhancing ones, such as working with international organizations. Priority placement was adequately utilized in 11 commitments. However, there was only one reference to a core international organization and civil society and no references to any other multilateral organizations. More attention should be paid to incorporating appropriate catalysts in future commitments to have better implementation results.

Accountability Architecture

In their 2007 CARICOM NCD Declaration, summit participants noted that CARICOM and PAHO, as the joint secretariat for the Caribbean Cooperation in Health (CCH) Initiative, would be responsible the monitoring and evaluation (CARICOM Secretariat 2007b). Civil society also played a role in relaying and interpreting implementation results (Hassell 2010). Academic institutions have been asked to help compile accountability reports, which are given to CARICOM countries twice a year (Hospedales et al. 2011). The CARICOM Council for Human and Social Development (COHSOD) is also involved actively in this accountability monitoring. COHSOD is responsible for ensuring that the NCD commitments are implemented. It also provides recommendations to government officials on how pledges can and should be kept.

Surrounding Summit Support

The CARICOM NCD Summit Preparation

Careful summit preparation is also a key cause of crafting commitments that will be implemented and produce the intended results.

The world's first special subject-specific summit on NCDs was the product of several forces. Important officials from CARICOM countries were present at the initial, influential, scientific presentation on the topic, where the social and economic impacts of the diseases were highlighted. A direct request was made to put the topic on the leaders' agenda by George Alleyne, a highly respected individual from the region. Countries took immediate action by committing to hold a special summit on the topic. Financial resources to support the summit and its work were contributed by external actors, including Canada.[11]

Lower-level CARICOM officials had been discussing NCDs for more than a decade before the leaders agreed to host a special summit on the issue. In 1996, the agriculture ministers had noted 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" (CARICOM Secretariat 2007d). The CCH Initiative, which had been approved by health ministers in 1986, included NCDs as a priority area. In the 2001 Nassau Declaration, the CARICOM heads of government gave direction on NCDs (Hospedales et al. 2011). In

[11] However, little funding was provided for follow-up implementation.

2005, the CCHD named NCDs as a "super" priority. However, it was not until 2007 that the issue was highlighted in a major way at the leaders' level.

At the CARICOM Summit in July 2006, participants received a report on "the macro-economic implications of non-communicable diseases" (CARICOM Secretariat 2006b). It followed up on the initial report released by the CCHD and reported that the number of deaths from diabetes, hypertension and heart disease was ten times higher than the number resulting from HIV/AIDS. It also identified the high costs of treatment of diabetes and hypertension. In response to this report and the request made by Alleyne to take on the topic, Trinidad and Tobago agreed to host a special regional consultation to consider instruments that could be employed to help implement specific recommendations, including "a tax on tobacco products and a ban on smoking to combat tobacco use; making physical education compulsory in schools and ensuring healthy meals; and establishing regulations and standards by ensuring that marketed foods show calories and fat content and regulation of the importation of fats" (CARICOM Secretariat 2006b).

The immediate catalyst that spurred the decision to hold a summit on NCDs was a presentation made by Alleyne in October 2006 at which he asked CARICOM governments to tackle NCDs. He called on regional governments to give more attention to tackling NCDs without diminishing their efforts to fight HIV/AIDS. While "impressive gains" had been made in stemming malnutrition and infant mortality, he argued that "obesity was of growing concern, even among children" and diabetes was the "steady cause of death" among many in the Caribbean (CARICOM Secretariat 2006a). Alleyne suggested that changes needed to be made to address NCDs, including encouraging physical activity. He challenged CARICOM leaders to "introduce taxation, legislation and regulation as mechanisms to deter the desire for and sale of tobacco." He also asked schools to "market foods of nutritional value and reinforce physical education as an integral part of the school's curriculum." Alleyne's presentation had a major impact.

The leaders kept the topic on their agenda at subsequent meetings. At the 18th Inter-sessional CARICOM Summit in February 2007, Denzil Douglas, the prime minister of St. Kitts and Nevis and CARICOM minister of health in the quasi-Cabinet of the Heads of Government meeting, urged members to develop a "comprehensive regional strategic plan to respond to the chronic non-communicable diseases and the havoc they are wreaking on our Caribbean people" (CARICOM Secretariat 2007a). The participants took note again of the CCHD report and agreed to hold national consultations on the topic in the lead-up to their special summit. They set out a clear goal to "establish and agree on a regional approach to the prevention and control of non-communicable diseases" and to help evaluate the Caribbean situation in the global context. At the second CARICOM–Central American Integration System Summit in May 2007, participants promised to share their experiences in addressing NCDs. When CARICOM leaders met for their summit in July 2007, they agreed to participate fully in the CARICOM NCD Summit.

One thing missing from the lead-up to the summit was major involvement from civil society, particularly nongovernmental organizations (NGOs). They have played a critical role in mobilizing successful summit action in the past, but they did not seem to have been heavily involved in getting NCDs onto the CARICOM leaders' agenda (Guebert, Kirton and Kanth 2011). They have played an important role since 2008, however their inclusion in the lead-up and during the summit could have led to a more successful outcome.

Subsequent CARICOM Follow-up

Summit Level

Following the 2007 CARICOM NCD Summit, countries continued to emphasize the issue. Leaders followed up on their pledges. They noted that their "core activities" would focus on reducing tobacco, salt and fat, increasing exercise and lowering blood pressure. In addition to reiterating their commitment to the "15 actionable recommendations of the Port of Spain Declaration," governments also agreed to explore further issues (CARICOM Secretariat 2008b). The first Commonwealth Wellness Day was held on September 13, 2008.

At the 2009 CARICOM regular Heads of Government Summit, participants again reiterated their support for the 2007 NCD Declaration. They noted their support for their "six super priorities" and endorsed the theme of "Love That Body" for Commonwealth Wellness Day 2009 (CARICOM Secretariat 2009b).

In 2010, the leaders acknowledged the "role of CARICOM ambassadors to the United Nations in pioneering a resolution for a UN high level meeting on NCDs in September 2011" (CARICOM Secretariat 2010a). UN secretary general Ban Ki-moon, present at the summit, pledged his "full support [for the high-level meeting on NCDs] and commended the Community for raising this critical issue."

The Caribbean leaders worked on spreading the NCD theme to other countries. At the first CARICOM-Brazil Summit on April 26, 2010, participants discussed the possibility of cooperating on chronic NCDs. They noted that CARICOM and Brazil had both been pioneers in initiating non-traditional responses to the challenge of dealing with chronic NCDs. In September 2010, all CARICOM countries, except for Haiti, participated in the third Commonwealth Wellness Day.

Lower Levels

While leaders did follow up on their 2007 NCD pledges, much of the work was left to lower-level officials. On October 9, 2007, CARICOM agriculture ministers met to discuss the impact of food and agricultural policies on NCDs. They made 13 commitments to help combat NCDs (see Appendix L). One day later, COHSOD met. The assistant secretary general for human and social development noted COHSOD's achievements in coordinating "the activities leading up to the Summit on Chronic Non-Communicable Diseases … establishing 18 actionable programmes to address NCDs" (CARICOM Secretariat 2007c). COHSOD urged that the strategies put forth by the

CARICOM leaders be implemented in the culture and youth programs throughout the region. It also endorsed the priority areas of the CCH Initiative, which included NCDs.

At the meeting of the Council for Trade and Economic Development in April 2008, attention focused on the CCH Initiative to address chronic NCDs. At its November 2008 meeting, COHSOD centred on the connection between health and education, recognizing "the important role that education should play in creating awareness of preventive strategies and behaviour change necessary to improving wellness and maintaining healthy lifestyles" (CARICOM Secretariat 2008a). It also noted the importance of physical activity and healthy school meals.

At the June 2009 meeting of COHSOD, the chair called on the council "to help make the case for the Heads of Government of the Community to take a long view of development" (CARICOM Secretariat 2009a). He also pointed out that achieving the Millennium Development Goals (MDGs) by their 2015 deadline would reduce the rate of NCDs. COHSOD also agreed to emphasize five priorities related to tobacco, nutrition, physical facilities and activity, media engagement and the establishment of national coordinating committees.

Participants reaffirmed their commitment to tobacco regulation. They noted several programs being undertaken to support the NCD commitments, including the "Healthy Schools" Approach to address risk factors. This included a behaviour risk survey undertaken by countries with support from PAHO; models for school feeding by the Caribbean Food and Nutrition Institute (CFNI); promoting physical education in schools co-ordinated by the CARICOM Secretariat; and promoting networks of health-promoting schools led by PAHO" (CARICOM Secretariat 2009a).

At a workshop in November 2009 to review the draft CARICOM NCD Plan, attended by ministries of health from 10 CARICOM countries, UWI and PAHO, CARICOM health officials and experts stressed the importance of establishing a strategic plan of action for tackling NCDs. HCC chair Trevor Hassell told participants that "the issue of chronic NCDs was more a societal than a medical one and as such it was of critical importance to involve Civil Society in a major way, if the region were to make any kind of significant dent in controlling NCDs" (CARICOM Secretariat 2009c). Joy St. John, the chief medical officer of Barbados, called for a sound and complete document, noting that it was an opportunity "to produce a document that would be carefully scrutinised and considered globally as a model and a best practice in responding to chronic NCDs." The strategic plan focused on "risk factor reduction and health promotion, disease management, surveillance, public policy and advocacy, communications and patient education and programme management." The workshop was a response to the commitment to develop a strategic plan of action to be rolled out over four years from 2009 to 2013. By the start of 2011, this document had been completed and delivered to CARICOM and PAHO and distributed to the Caribbean member countries.

Expanding Beyond CARICOM

Efforts were also made to extend the NCD theme to countries beyond the home hemisphere. At the second meeting of CARICOM-Japan foreign ministers in September 2010, participants called for the "widest support of the United Nations High Level Meeting on Non-Communicable Diseases" (CARICOM Secretariat 2010b).

Summit of the Americas

Other leaders' forums also started to take up NCDs on their agendas following the 2007 CARICOM special summit. NCDs appeared on the agenda of the fifth Summit of the Americas in Trinidad and Tobago in April 2009 — which was attended by 14 CARICOM countries, representing 41% of the total 34 members. The leaders were "convinced" that they could "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" (Summit of the Americas 2009). They promised to support 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" (see PAHO 2007). They also committed to "measures to reduce tobacco consumption, including, where applicable, within the World Health Organisation (WHO) Framework Convention on Tobacco Control" (Summit of the Americas 2009). They instructed their health ministers "to incorporate the surveillance of NCDs and their risk factors into existing national health information reporting systems by 2015." They also encouraged "national planning and coordination of comprehensive prevention and control strategies for NCDs and the establishment of National Commissions where appropriate."

Commonwealth Heads of Government Meeting

NCDs were highlighted at the 2009 Commonwealth Heads of Government Meeting (CHOGM) in Trinidad and Tobago. The 53-member CHOGM included 12 CARICOM countries, or about 23% of the total. Participants called for "the consideration of a Summit on NCDs to be held in September 2011, under the auspices of the United Nations General Assembly, in order to develop strategic responses to these diseases and their repercussions. They also supported initiatives to include the monitoring of NCDs in existing national health information systems and emphasised the need for NCD indicators to be included in the monitoring of the MDGs" (CHOGM 2009). They also issued a separate, stand-alone statement devoted to the issue.

United Nations

In February 2010, CARICOM, WHO and Brazil made a joint presentation to UN permanent representatives in New York advocating for a UN HLM on NCDs. In May 2010, the United Nations General Assembly approved a resolution, presented on behalf of the Caribbean Community member states, to hold a special HLM on NCDs. The resolution indicated that participants would address the threats posed by NCDs to low-

and middle-income countries. Public health experts and government representatives were to seek solutions to deal with the growing dangers posed by NCDs (NCD Alliance 2010).

NCDs were also included in the discussions at the UN MDG Summit in September 2010. Participants committed to accelerate "progress in promoting global public health for all" through "strengthening the effectiveness of health systems and proven interventions to address evolving health challenges, including the increased incidence of non-communicable diseases" and to accelerate progress in order to achieve MDG 6 by "undertaking concerted action and a coordinated response at the nation, regional and global levels in order to adequately address the developmental and other challenges posed by non-communicable diseases, namely cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, working towards a successful high-level meeting of the General Assembly in 2011" (United Nations General Assembly 2010).

G20
After the UN MDG Summit, and efforts made at meetings between CARICOM and Brazil and CARICOM and Japan, NCDs had gained enough attention and momentum that a Caribbean champion was no longer necessary to get the issue onto summit agendas. At the G20's Seoul Summit on November 11-12, 2010, leaders directly noted, for the first time, the relevance of NCDs (Guebert and Lennox 2010). This reference was made at the initiative of Indonesia, as part of the G20's new development plan (G20 2010).

APEC
NCDs were also referred to for the first time at the APEC summit in Yokohama, Japan, on November 13-14, 2010. Leaders agreed that NCD control "should be enhanced" and improved (APEC 2010).

World Health Assembly
While NCDs have long been discussed at the ministerial-level World Health Assembly (WHA), in 2008 Guyanese health minister and WHA president Leslie Ramsammy pointed out that the issue of chronic NCDs was missing from the MDGs. He insisted that the issue be placed higher on the global public agenda. He called upon the WHO to identify chronic NCDs as an additional MDG and reported that Guyana had decided to proceed with doing so. Ramsammy (2008) acknowledged the CARICOM NCD Summit, referring to both its recognition of the problem and its willingness to collectively tackle the issue.

Conclusions

Several conclusions can be drawn from the available evidence. One, the CARICOM Summit on NCDs was well worth doing. It was the first-ever special summit on NCDs. It led to several important, collective, multilateral, multi-actor and multidimensional commitments to tackle the challenges in this area. Two, although there is much room for improvement, countries were motivated to implement the commitments they made at the summit. Certain countries had a better accountability record than others. These implementation levels correlated with a number of key factors, such as having leaders in

attendance and individual countries' NCD vulnerability and economic capability. Moreover, an accountability architecture that reports annually and publicly is critical for monitoring members' progress and highlighting where corrections and additional attention is necessary.

Recommendations: Lessons for the 2011 UN NCD HLM and Future CARICOM Summits

From these findings, there are several lessons to be learned from the CARICOM case, to be applied to the UN NCD HLM in September 2011 and future CARICOM summits. The major lessons and resulting recommendations are as follows:

1. Highlight the development, economic as well as broader health implications of NCDs in all countries, developed and developing ones.

2. Encourage as many participants as possible — countries, international organizations (including World Health Organization, International Monetary Fund, Food and Agriculture Organization, World Food Programme, International Fund for Agriculture and Development, International Labour Organization, Organisation for Economic Co-operation and Development, and World Trade Organization), civil society (including NGOs, professional organizations and academics), and the private sector (including transportation, exercise, food and beverage, agriculture and the pharmaceutical industries) — to engage fully and invest in all stages of the summit process (in the lead-up, during and following the summit). All actors should utilize the media and communications industry.

3. Encourage leaders — particularly from countries whose implementation of the commitments is critical to the prevention and control of NCDs — to attend the meeting.

4. Promote leadership roles for several key countries. Such leadership roles include chairing and hosting the meetings, chairing the accountability mechanisms, and chairing and hosting working groups.

5. Start drafting the final collective outcome document as soon as possible, beginning with those issues and commitments that were accepted at earlier meetings. It is important to codify, reconfirm and elaborate the considerable global consensus already achieved on NCDs.

6. Craft specific commitments to include the catalysts that correlate with higher implementation, and exclude those that lower it, based on transferable lessons from the CARICOM NCD and G8 summits.

7. Place NCDs on the agendas of surrounding summits and meetings, both in the lead-up and the follow-up to the focal meeting/summit.

8. Set up a multi-stakeholder NCD-specific fund with new money to help with implementation and to help willing countries, hampered by limited capacity.

9. Get countries actively engaged in creating and operating a multi-stakeholder accountability mechanism to monitor compliance and to report on implementation publicly and annually.

10. Have countries commit to hold follow-up meetings to take stock of progress, avoid backsliding, take note of what has been successful and make course corrections where necessary.

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Appendix A:
2007 CARICOM Commitments from the Declaration of Port-of-Spain: Uniting to Stop the Epidemic of Chronic NCDs

2007-1: [We declare] 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;

2007-2: [We declare] Our commitment to pursue immediately a legislative agenda for passage of the legal provisions related to the International Framework Convention on Tobacco Control;

2007-3: [we] support the immediate enactment of legislation to limit or eliminate smoking in public places,

2007-4: [we support the immediate enactment of legislation to] ban the sale [of tobacco products to children]

2007-5: [we support the immediate enactment of legislation to] ban the advertising [of tobacco products to children]

2007-6: [we support the immediate enactment of legislation to] ban the promotion [of tobacco products to children]

2007-7: [we] insist on effective warning labels [for tobacco]

2007-8: [we will] introduce such fiscal measures as will reduce accessibility of tobacco;

2007-9: [we declare] 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;

2007-10: [we declare] 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;

2007-11: [we declare] That we will mandate the re-introduction of physical education in our schools where necessary,

2007-12: [we declare that we will] provide incentives and resources to effect [the re-introduction of physical education in our schools]

2007-13: [we will] ensure that our education sectors promote programmes aimed at providing healthy school meals and promoting healthy eating;

2007-14 [we declare] 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

2007-15: [we declare] 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;

2007-16: [we declare] 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;

2007-17: [we declare] Our support for mandating the labelling of foods or such measures as are necessary to indicate their nutritional content through the establishment of the appropriate regional capability;

2007-18: [we declare] 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

2007-19: 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;

2007-20: [we declare] Our commitment to take account of the gender dimension in all our programmes aimed at the prevention and control of NCDs;

2007-21: [we declare] That we will provide incentives for comprehensive public education programmes in support of wellness,

2007-22: [we declare that we will provide incentives for comprehensive public education programmes in support of] healthy life-style changes,

2007-23: [we declare that we will provide incentives for comprehensive public education programmes in support of] improved self-management of NCDs

2007-24: [we will] embrace the role of the media as a responsible partner in all our efforts to prevent and control NCDs;

2007-25: [we declare] 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);

2007-26: [we declare] 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.

2007-27: We hereby declare the second Saturday in September "Caribbean Wellness Day"

Appendix B:
Combined Compliance Chart

Country	Healthy Caribbean Coalition	Global Health Diplomacy Program Conversion	University of the West Indies with Conversion	Framework Convention on Tobacco Control	Caribbean Wellness Day
Members					
01 Jamaica	18	+.86	+.32	2005	3
02 Trinidad and Tobago	15	+.82	+.44	2004	3
03 Guyana	15	+.65	+.36	2005	3
04 Barbados	12	+.61	+.64	2005	3
05 Antigua	05	+.43	-.18	2006	2
06 Suriname	05	+.43	-.17	2008	3
07 Grenada	11	+.40	+.28	2007	2
08 St. Lucia	10	+.26	+.24	2005	3
09 Bahamas	12	+.24	+.11	2009	2
10 Montserrat	03	+.20	+.33	—	3
11 Belize	08	+.19	-.03	2005	3
12 Dominica	07	+.12	+.38	2006	3
13 St. Vincent and Grenadines	06	.00	-.45	2010	3
14 St. Kitts and Nevis	06	-.21	-.10	—	3
15 Haiti	01	-.80	-.83	—	0
Associates					
01 British Virgin Islands	09	+.54	+.15		3
02 Bermuda	12	+.53	+.43		3
03 Turks and Caicos	03	+.07	+.33		2
04 Cayman Islands	08	+.05	-.10		3
05 Anguilla	04	-.57	-0.61		3
Hassell = In place only					

Appendix C:
Healthy Caribbean Coalition Reported Compliance Results[12]

Country	In Place	In Process/Part Implemented	Not in Place/Not Applicable	Missing/No Information
Anguilla	4	1	16	0
Antigua and Barbuda	5	0	2	14
Bahamas	12	2	7	0
Barbados	12	5	1	3
Belize	8	9	4	0
Bermuda	12	2	3	4
British Virgin Islands	9	2	2	8
Cayman Islands	8	6	7	0
Dominica	7	5	5	4
Grenada	11	6	3	1
Guyana	15	3	2	1
Haiti	1	2	17	1
Jamaica	18	3	0	0
Montserrat	3	0	2	16
St. Kitts and Nevis	6	3	10	2
St. Lucia	10	4	5	2
St. Vincent and Grenadines	6	2	6	7
Suriname	5	0	2	14
Trinidad and Tobago	15	1	1	4
Turks and Caicos	3	0	2	16

Source: Hassell 2010.

[12] Trevor Hassell's presentation on implementation of NCD summit commitments made by CARICOM countries used data from February 2010 that had been compiled by the University of the West Indies.

Appendix D: Converted Healthy Caribbean Coalition Compliance with NCD Summit Commitments

Country	G8RG -1 to +1 Scale	As a Percentage	Rank
Members			
Antigua and Barbuda	+0.43 (L)	71.5%	7
Bahamas	+0.24 (L)	62.0%	10
Barbados	+0.61 (C/L)	80.5%	4
Belize	+0.19 (M)	59.5%	12
Dominica	+0.12 (L)	56.0%	13
Grenada	+0.40 (M)	70.0%	8
Guyana	+0.65 (M)	82.5%	3
Haiti	-0.80 (M)	10.0%	19
Jamaica	+0.86 (L)	93.0%	1
Montserrat	+0.20 (L)	60.0%	11
St. Lucia	+0.26 (L)	63.0%	9
St. Kitts and Nevis	-0.21 (L)	39.5%	17
St. Vincent and Grenadines	0.00 (L)	50.0%	16
Suriname	+0.43 (L)	71.5%	7
Trinidad and Tobago	+0.82 (H/L)	91.0%	2
Members Average	+0.27	63.5%	9.27
Associates			
Anguilla	-0.57 (M)	21.5%	18
Bermuda	+0.53 (N)	76.5%	6
British Virgin Islands	+0.54 (N)	77.0%	5
Cayman Islands	+0.05 (N)	52.5%	15
Turks and Caicos	+0.07 (N)	53.5%	14
Associates Average	+0.08	54.0%	11.6
Overall Average	+0.23	61.5%	

Source: Hassell 2010.
Notes: Hassell scores have been converted using the G8 Research Group's compliance methodology (see <www.g8.utoronto.ca/evaluations/compliancemanual-090909.pdf>). Averages are calculated using the compliance information available for each commitment assessed (which varies across country) and not the overall country averages.
H = host of the CARICOM NCD Summit.
C = chair of the CARICOM NCD Summit.
L = leader attended the CARICOM NCD Summit.
M = minister attended the CARICOM NCD Summit.
N = no one attended the CARICOM NCD Summit.

Appendix E:
Converted University of the West Indies Compliance to NCD Summit Commitments

Commitment	Antigua	Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Haiti	Jamaica	Montserrat	St. Kitts and Nevis	St. Lucia	St. Vincent and Grenadines	Suriname	Trinidad and Tobago	Members Average	Anguilla	Bermuda	British Virgin Islands	Cayman Islands	Turks and Caicos	Associates Average	Total Average
	-1	0	1	0	1	1	1	-1	1		1	1	0	0	1	.43	-1	1	0	-1		0	.28
	1	1	1	1	1	1	1	-1	1	*	0	1	1	1	1	.79	*	*	*	1	*	1.0	.80
	1	-1	1	0		1	1	-1	0		-1	1	-1	0	1	.15	-1	1	1	1		0.6	.24
	-1	-1	0	-1		-1	0	-1	1		-1	-1	-1	0	1	-.46	-1	1	1	1		0.6	-.2
	-1	-1	0	-1		-1	0	-1	1		-1	-1	-1	0	1	-.46	-1	1	1	1		0.6	-.2
	-1	-1	0	-1		-1	0	-1	1		-1	-1	-1	0	1	-.46	-1	1	1	1		0.6	-.2
	-1	-1	1	-1	-1		1	-1	1		0	-1	-1	1	-1	-.31	-1			0		-.67	-.3
	-1	-1	1	0	0	-1	0	-1	-1		-1	1	-1	-1	1	-.36	-1	-1	-1	-1		-.60	-.5
)	1	1	0	0	-1	0	0	-1	1		-1	1	-1	-1	1	.22	-1	0	-1	0		.10	.14
)		1	1	0	-1	1	1	0	1		0	1	-1	1	1		0	0	0	1			
1			1	1			0		-1				-1	-1	1	0		0		1		.67	.11
2			1	1			0		-1				-1	-1	1	0		0		1		.67	.11
3	1		1	0			0		1		0		-1	-1	0	.11		1	-1	0		0	.08
4	1	1	0	0	1	1	1	-1	1	1	0	-1	1	-1	0	.33	1	-1	1	-1	1	0	.30
5				-1					0				-1	-1	-1	-.80				-1		-1.0	-.8
6				0			0		-1				-1	-1	1	-.33				-1		0	-.4
7	-1			-1			0		-1				-1	0	-1	-.71		0		0		-.33	-.5
8			1	1			-1		-1				-1	-1		-.54				-1		-1.0	-.6
8	-1			-1			0					0	-1	-1	-1				-1	-1			
9			1	1			-1		-1				-1	-1		.44				-1		-.17	.26
9	-1	1	1	1		1	1		1		1	1	1	1	1		-1	1	-1	0			
4	1		1	-1			1		1		1	0	-1	-1	-1	-.13		1	-1	0		-.22	-.1
4	-1	0	0	-1	0	0	1	-1	0		-1	0	-1	-1	1		-1	1	-1	-1			
5b	-1	1	1	1	1	0	0	-1	1		1	0	-1	0	0	.27	-1	0	1	-1		.05	.19
5b	-1	-1	-1	-1	1	-1	-1	-1	-1	-1	-1	-1	1	1	-1		-1	1	1	-1	-1		
5b	1	1	1	1	1	1	1	1	1		0	1	1	1	1		-1	-1	1	0			
5b	1	1	0	0		1	1	-1	1		0	1	1	1	1		1		1	0			
6	-1	0	1	0	1	1	1	-1	1		1	1	0	0	1	.43	-1	1	0	-1		0	
7	1	1	1	1	1	1	1	-1	1	1	1	1	1	1	1	.87	1	1	1	1	1	1	.28
VE	-.18	.11	.64	-.03	.38	.28	.36	-.83	.32	.33	-.10	.24	-.45	-.17	.44	.08	-.61	.43	.15	-.10	.33	-.01	.06
)	41	55.5	82	48.5	69	64	68	8.5	66	66.5	45	62	27.5	41.5	72	54	19.5	71.5	57.5	45	66.5	49.5	53
ank	16	11	1	12	4	8	5	19	7	6	13	9	17	15	2	9.7	18	3	10	14	6	10.2	9.8

Notes: 1 = In place; 0 = In process/partially implemented; -1 = Not in place; * = Not applicable. Numbers may not add up due to rounding, but rankings are based on or fourth decimal places.

Appendix F: Confirmed Compliance with the Framework Convention on Tobacco Control

Country	Signed	Ratified
St. Kitts and Nevis	29 June 2004	
Jamaica	24 September 2003	7 July 2005
Trinidad and Tobago	27 August 2003	19 August 2004
Barbados	28 June 2004	3 November 2005
Antigua and Barbuda	28 June 2004	5 June 2006
Bahamas	29 June 2004	3 November 2009
Belize	26 September 2003	15 December 2005
Dominica	29 June 2004	24 July 2006
Grenada	29 June 2004	14 August 2007
Guyana		15 September 2005
Haiti	23 July 2003	
Montserrat	(NA)	
Saint Lucia	29 June 2004	7 November 2005
Saint Vincent and the Grenadines	14 June 2004	29 October 2010
Suriname	24 June 2004	16 December 2008

Source: World Health Organization 2011. Parties to the WHO Framework Convention on Tobacco Control, 20 January. <www.who.int/fctc/signatories_parties/en> (March 2011).

Appendix G:
Caribbean Wellness Day Participation

Country	2008	2009	2010	Total
Anguilla	1	1	1	3
Antigua		1	1	2
Bahamas		1	1	2
Barbados	1	1	1	3
Belize	1	1	1	3
Bermuda		1	1	2
British Virgin Islands	1	1	1	3
Cayman Islands	1		1	2
Dominica	1	1	1	3
Grenada		1	1	2
Guyana	1	1	1	3
Haiti				0
Jamaica	1	1	1	3
Montserrat	1	1	1	3
St. Kitts and Nevis	1	1	1	3
St. Lucia	1	1	1	3
St. Vincent and Grenadines	1	1	1	3
Suriname	1	1	1	3
Trinidad and Tobago	1	1	1	3
Turks and Caicos		1	1	2
Total	14	18	19	51

Appendix H: CARICOM NCD Vulnerabilities

		Blood Pressure[b]		Cholesterol[c]		Tobacco[d]			Cancer			
						Male	Female		Incidence [t]	Mortality [t]		
	Body Mass Index[a]	Male	Female	Male	Female	Combined		Diabetes Incidence % [s]			Hassel Compliance Rank	UWI Compliance Rank
Antigua and Barbuda	26.1	124.6	123.0	5.5	5.5	14.4%[e]		7.1			8	16
Bahamas	26.6	139.2	142.4	5.7	5.7	18.6%[f]		10.2	511	296	11	11
Barbados	29.0	123.6	119.0	5.5	5.5	17.4%	3.5%	9.2	758	456	4	1
Belize	25.4	124.6	123.0	5.3	5.3	10.2%[g]		7.9	226	147	13	13
Dominica	28.5[h]	124.6	123.0	5.3	5.3	20.5%[i]		11.5			14	4
Grenada	25.8	124.6	123.0	5.4	5.4	16.4%		8.5			9	8
Guyana	24.8[j]	124.6	123.0	5.2	5.2	10.1%[k]		10.2	1079	653	3	5
Haiti	22.4[l]	122.4[m]	120.7[m]	5.0	5.0	18.5%[n]		5.9	8414	5360	20	19
Jamaica	26.3[o]	NA	NA	5.2	5.2	28.0%	16.3%	10.2	5063	3151	1	7
St. Lucia	25.9[p]	126.8	122.2	5.3	5.3	28.9%[q]	12.3%[q]	9.3			10	9
St. Kitts and Nevis	26.1	124.6	123.0	5.5	5.5	20.4%[r]	15.7%[r]	9.0			18	12
St. Vincent and the Grenadines	25.5	124.6	123.0	5.3	5.3	19.3%[q]	6.1%[q]				17	17
Suriname	25.2	124.6	123.0	5.2	5.2	NA		10.3	676	376	7	15
Trinidad and Tobago	28.6	128.4	123.3	6.1	6.0	35.9%[q]	7.8%[q]	11.4	2080	1358	2	2
Average	26.16	125.94	123.97	5.39	5.39	16.86%		9.28	2350.9	1474.6		

Sources: World Health Organization, WHO Global Infobase <apps.who.int/infobase>; International Diabetes Federation <www.diabetesatlas.org/map>; World Health Organization International Agency for Research on Cancer <globocan.iarc.fr>.

Notes: Data unavailable for the members and associates not listed. Cancer incidence includes all cancers except non-melanoma skin cancer.

[a] Unit of measure = mean body mass index kg/m², sample age = 15–100. Figures given are from 2010 and include both sexes unless otherwise noted.

[b] Unit of measure = mmHg, systolic blood pressure. Sample age = 15–100. Figures given are from 2010 unless otherwise noted.

[c] Unit of measure = mmol/l total cholesterol, sample age = 15–100. Figures given are from 2010 unless otherwise noted.

[d] Unit of measure = current user, all tobacco products, sample age = 13–15. Figures given are from 2010 unless otherwise noted.

[e] Data from 2004.

[f] Data from 2000.

[g] Sample age is 20–100. Data from 2006.

[h] Sample is females aged 20–55. Data from 1997.

[i] Data from 2000.

[j] Sample age is 20–100. Data from 1997.

[k] Data from 2004.

[l] Sample is females aged 15–49. Data from 2006.

[m] Sample age is 18-100. Data from 2000.

[n] Data from 2001.

[o] Sample age is 25–74. Data from 1996.

[p] Sample age is 25–100. Data from 1994.

[q] Sample age is 15–100.

[r] Data from 2002.

[s] Data from 2010.

[t] Data from 2008.

Appendix I:
CARICOM Relative Capability

	Gross National Income per capita (current US$)[e]	Income Level	Gross Domestic Product (in millions)	Population	Hospital Beds (per 1000)	Life Expectancy from birth (years) [e]	Hassell Compliance Rank	UWI Complian Rank
Members								
Bahamas	21,390 (07)	High	$8,878.0	310,426	3.2[b]	73.98	11	11
Trinidad and Tobago	16,700	High	$27,100.0	1,228,691	2.7[b]	73.20	2	2
Antigua and Barbuda	12,130	Upper middle	$1,433.0	86,754	1.7[a]	74.80	8	16
St. Kitts and Nevis	10,150	Upper middle	$719.5	49,898	5.5[a]	74.00	18	12
Barbados	9,140 (02)	High	$6,196.0	285,653	7.6[a]	73.90	4	1
Grenada	5,580	Upper middle	$1,127.0	107,818	2.6[a]	72.70	9	8
St. Vincent and Grenadines	5,130	Upper middle	$1,107.0	104,217	3.0[b]	73.70	17	17
St. Lucia	5,190	Upper middle	$1,789.0	160,922	2.8[b]	76.50	10	9
Dominica	4,900	Upper middle	$765.4	72,813	3.8[a]	75.60	14	4
Suriname	4,760 (08)	Upper middle	$4,794.0	486,618	3.1[b]	69.16	7	15
Jamaica	4,590	Upper middle	$23,930.0	2,847,232	1.7[b]	72.12	1	7
Belize	3,740 (08)	Lower middle	$2,652.0	314,522	1.2[a]	76.60	13	13
Guyana	1,450 (08)	Lower middle	$5,069.0	748,486	1.9[b]	67.43	3	5
Haiti	NA	Low	$11,180.0	9,719,932	1.3[b]	61.48	20	19
Montserrat	NA	NA	$29.0[c]	5,118	NA	72.00	12	6
Members Average	8,065		$6,451.26	1,101,940	3.01	72.48		
Associates								
Bermuda	32,760 (97)	High	$4,500.0	68,265	NA	80.40	6	3
Cayman Islands	NA	High	$2,250.0	50,209	NA	80.40	16	14
Turks and Caicos	NA	High	$216.0[c]	23,528	NA	75.40	15	6
British Virgin Islands	NA	NA	$853.4[d]	24,939	NA	NA	5	10
Anguilla	NA	NA	$175.4	14,766	NA	80.70	19	18
Associates Average	32,760		$1,598.9	36,341	NA	79.23		
Total Average	9,829		$5,238.19	835,540	3.01[a]	73.90		

Source (gross domestic product and population data): United States Central Intelligence Agency (2011). CIA World Factbook <www.cia.gov/library/publications/the-world-factbook> (March 2011).
Notes: All figures for gross domestic product and population are from 2010 and are reported in 2010 U.S. dollars.
[a] Data from 2008.
[b] Data from 2007.
[c] Data from 2002.
[d] Data from 2004.
[e] Data from 2009.
Gross National Income: data from http://data.worldbank.org/indicator/NY.GNP.PCAP.CD
Life Expectancy data: from PAHO Basic Indicator Browser http://ais.paho.org/phip/viz/basicindicatorbrowaser.asp

Appendix J:
Institutional Inclusion — CARICOM NCD Summit Participants

Country	Date Joined	Participant	Other
Members			
Antigua and Barbuda	July 4, 1974	Leader	
Bahamas	July 4, 1983	Leader	
Barbados	August 1, 1973	Leader	Chair
Belize	May 1, 1974	Minister	
Dominica	May 1, 1974	Leader	
Grenada	May 1, 1974	Minister	
Guyana	August 1, 1973	Minister	Secretariat
Haiti	July 4, 2002 (suspended from 2004 to 2006)	Minister	
Jamaica	August 1, 1973	Leader	
Montserrat	May 1, 1974	Leader	
St. Lucia	May 1, 1974	Leader	
St. Kitts and Nevis	July 26, 1974	Leader	
St. Vincent and the Grenadines	May 1, 1974	Leader	
Suriname	July 4, 1995	Leader	
Trinidad and Tobago	August 1, 1973	Leader	Host
Associates			
Anguilla	July 4, 1999	Minister	
Bermuda	July 2, 2003	None	
British Virgin Islands	July 2, 1991	None	
Cayman Islands	May 15, 2002	None	
Turks and Caicos	July 2, 1991	None	

Appendix K:
Compliance Catalysts in Commitments

Catalysts	Total
Priority placement	11
International law	5
CARICOM body	4
Target	3
Specified agent	3
Regional organization	3
One-year timetable	1
Multi-year timetable	1
Money mobilized	1
Core international organization	1
Ministers	1
Accountability ask	1
Civil Society	1
Past reference – summit	0
Past reference – ministerial	0
Remit	0
Self-monitoring	0
Other international organization	0
Private sector	0
Country or region	0
Total	36

Appendix L: 2007 CARICOM Commitments from the Declaration of St. Ann: Implementing Agriculture and Food Policies to Prevent Obesity and NCDs in the Caribbean Community

2007-1: 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 Organization/World Health Organization (PAHO/WHO) and other relevant partners

2007-2: Our determination to exhaust all options within Regional and WTO agreements to ensure the availability and affordability of healthy foods

2007-3: 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 globalization on our food supply;

2007-4: Our commitment to develop food and agriculture policies that explicitly incorporate nutritional goals including the use of dietary guidelines in designing food production strategies;

2007-5: 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;

2007-6: 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;

2007-7: 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;

2007-8: Our strong support for the elimination of trans-fats from our food supply using CFNI as a focal point for providing guidance and public education designed toward this end;

2007-9: Our support for mandating the labeling of foods or such measures necessary to indicate their nutritional content;

2007-10: That we will advocate for incentives for comprehensive public education programmes in support of wellness

2007-11: [That we will advocate for incentives for comprehensive public education programmes in support of] increased consumption of fruits and vegetables and

2007-12: [That we will] embrace the role of the media as a partner in all our efforts to prevent and control NCDs;

2007-13: 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.