

Raising the priority of chronic noncommunicable diseases in the Caribbean

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Suggested citation: Hospedales CJ, Samuels TA, Cummings R, Gollop G, Greene E. Raising the priority of chronic noncommunicable diseases in the Caribbean. *Rev Panam Salud Publica*. 2011;30(4):393–400.

SYNOPSIS

The Caribbean's long history of cooperation in health now focuses on noncommunicable diseases (NCDs), given that Caribbean Community (CARICOM) countries have the highest NCD burden in the Americas. The heads of government convened a first in the world one-day summit on NCDs, largely due to advocacy by George Alleyne and others, on the health, social, and economic impact of NCDs; the need for upstream multisectoral interventions to address the common, multifactorial risks; and the need for increased global attention to NCDs. Implementation of the NCD Summit Declaration mandates was most effective in larger countries with greater capacity, but countries of all sizes performed well, when they had regional or global support. Progress was limited in regional approaches to food security, labeling, and elimination of trans fats. Inadequate funding stymied several resource-dependent interventions. Monitoring mechanisms were established, but more concrete goals are needed, especially for actions of nonhealth government agencies.

Key words: chronic disease; political factors; United Nations; Caribbean region.

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This opinion piece reflects on the process of and lessons learned in achieving the political commitment of heads of government manifested by a one-day summit on the prevention and control of chronic noncommunicable diseases (NCDs) in the Caribbean Community (CARICOM) integration movement. Implementation of the Summit Declaration and applicability to the United Nations High Level Meeting (UN HLM) on NCDs in September 2011 are discussed.

BURDEN OF NONCOMMUNICABLE DISEASES

The World Health Organization estimates that in 2008, 63.0% of the 57 million deaths globally were due to chronic NCDs, with 44.0% occurring before 70 years of age. This is projected to increase from 36 million NCD deaths in 2008 to 44 million in 2020. In low- and middle-income countries, approximately 29.0% of NCD deaths occurred in the working population (< 60 years) compared with 13.0% in high-income countries. In the region of the Americas, 30.0% of all deaths are caused by preventable NCDs that occur prematurely (< 70 years) (1). English-speaking Caribbean countries with a population of 7.5 million—mostly African and Asian-Indian descent—are the worst affected by the NCD epidemic in the Americas. Diabetes-related lower extremity amputations in Barbados are among the highest recorded in the world (2). Compared with North America, diabetes mortality is 600% higher in Trinidad and Tobago (3), cardiovascular disease mortality is up to 84% higher (2), and cervical cancer rates are 3–12 times higher (4). While tobacco use is modest, obesity and overweight among females exceeds 50%–60% in most countries, and excessive alcohol use causes much morbidity and mortality (5–10). Over the past half century, hypertension, diabetes, and cardiovascular disease have grown exponentially (11–15); the economic impact of hypertension and diabetes has been estimated at 5%–8% of gross domestic product (16). While NCDs occur more frequently among the poor because of greater exposure to alcohol, tobacco, and unhealthy diets, they have less access to preventive and curative services; the cost of the illness or premature death of breadwinners then pushes their families further into poverty (17).

RESPONSE

NCDs are a major human and economic burden in low- and middle-income countries, neglected by their governments and international donors (e.g., their exclusion from the Millennium Development Goals) (1, 18). Of the US\$22.1 billion of health overseas development aid in 2007, there is no evidence of aid for NCDs

(1, 19). This absence of response may be due to the persistent myth that NCDs are mainly a problem of developed countries and that developing countries should focus on infectious diseases before addressing NCDs.

The response to NCDs should include upstream multisectoral policies and downstream health sector activities (20). Upstream, population-based policies address the social determinants of NCD risk factors and include taxation, trade, education, agriculture, diet and nutrition, physical activity, transport, and urban planning (21), which require action outside the health sector. Health sector actions include screening for NCDs and common risk factors, diagnosis and effective evidenced-based management of patients at high risk of or living with NCDs, evaluation, and planning (22–24).

HISTORY OF RESPONSE TO NONCOMMUNICABLE DISEASES IN THE CARIBBEAN

There is a long history of CARICOM health collaboration (Table 1) (6). The Caribbean Cooperation in Health seeks greater collaboration among CARICOM, countries, and institutions to improve citizens' health and productivity (25). Caribbean successes include being the first region to eliminate indigenous polio, measles, and rubella transmission (26) and its response to HIV/AIDS (27, 28).

The 2001 Nassau Conference instructed that a regional plan be developed for preventing and controlling NCDs (29), but implementation languished because of inadequate resources and lack of ownership. It also established the Caribbean Commission on Health and Development to "propel health to the center of the development agenda," chaired by George Alleyne, chancellor of the University of the West Indies and former director of the Pan American Health Organization/World Health Organization (PAHO/WHO), and included authors C.J.H. and E.G.

During 2005–2006, Professor Alleyne and members of the commission used the Caribbean Commission on Health and Development Report to advocate for increased priority for NCDs and for a summit. Trinidad and Tobago with support from CARICOM,

TABLE 1. Landmark events in prevention and control of chronic noncommunicable diseases in the Caribbean Community, 1986–2011

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| 1. | Caribbean Cooperation in Health initiative approved by ministers of health in 1986: (1995–2003, 2005–2009, 2010–2015) includes NCDs as a priority area. |
| 2. | CARICOM Heads of Government, 2001 Nassau Declaration, "The Wealth of the Region is the Health of the Region" gave direction to a regional approach to NCDs. |
| 3. | Caribbean Commission on Health and Development, 2005, names NCDs a superpriority. |
| 4. | CARICOM Heads of Government Summit on NCDs, 2007, issues the NCD Summit Declaration "Uniting to Stop the Epidemic of Chronic NCDs." |

Note: NCD: noncommunicable disease, CARICOM: Caribbean Community.

PAHO/WHO, and the Public Health Agency of Canada (PHAC) hosted the Summit of CARICOM Heads of Government on Chronic NCDs in Port-of-Spain, Trinidad and Tobago, in September 2007, which issued the 15-point Port-of-Spain Declaration "Uniting to Stop the Epidemic of Chronic NCDs" (Table 2) (30). PAHO/WHO committed its support to help build surveillance capacity, develop a Caribbean NCD plan, mobilize partners and resources, and evaluate implementation of the NCD Summit Declaration.

LESSONS LEARNED FROM SUMMIT PROCESS

Heads of government convened the first summit dedicated to NCDs in 2007. The following year, a PAHO consultant facilitated by PHAC used semi-structured interviews with 28 key informants (ministers of health and senior officials in Caribbean governments, CARICOM Secretariat, PAHO/WHO, and the University of the West Indies) to document the process leading to this summit and declaration.

Lesson 1: political structure and history of Caribbean cooperation in health

CARICOM is a formal political structure supported by the Treaty of Chaguaramas. The supreme organ of the community is the Conference of Heads of

TABLE 2. Summary of Caribbean Community heads of government 15-point, multisectoral Port-of-Spain Summit Declaration "Uniting to Stop the Epidemic of Chronic Noncommunicable Diseases," 15 September 2007

Issue	Goal
Tobacco	Ratify and implement the WHO FCTC: taxes, banning smoking in public places, packaging, earmarking some revenue for health promotion and disease prevention.
Alcohol	Use tax revenue for health promotion and disease prevention.
Healthy diet	Trade policies on food imports, agriculture policies, healthy school and workplace meals, and food labeling; eliminate trans fats.
Physical activity	Physical education in schools, physical activity in workplaces, improve public facilities for physical activity, promote population-based physical activity.
Health services	Screening and managing NCDs to achieve 80% coverage by 2012; primary and secondary prevention, comprehensive health education.
Monitoring	Surveillance of risk factors; revision of regional NCD plan to include monitoring the actions agreed upon in declaration (CARICOM Secretariat, CAREC, UWI, and PAHO/WHO).
Mobilizing society	National intersectoral commissions on NCDs; collaborative programs, partnerships, and policies with public and private sector, civil society, media, and communications industry.
Caribbean Wellness Day	In commemoration of the summit on the second Saturday in September.

Note: WHO: World Health Organization, FCTC: Framework Convention on Tobacco Control, NCD: noncommunicable disease, CARICOM: Caribbean Community, CAREC: Caribbean Epidemiology Center, UWI: University of the West Indies, PAHO/WHO: Pan American Health Organization/World Health Organization.

Government, including a quasi-cabinet with the prime minister of Saint Kitts and Nevis currently responsible for health. There are four ministerial councils, including the Council for Human and Social Development, which convenes the ministers of health annually.⁵ This political structure facilitated regional appreciation of the problem and could mandate regional action to complement national action. Heads and ministers of health could build on a history of regional successes with immunization and HIV/AIDS as examples.

Professor Alleyne's reputation and his relationships with the heads of government of the region propelled this problem to their attention.

Lesson 2: not a single event but a process

Barbados and the Bahamas began country initiatives before the summit, which helped the ministers of health recognize that NCD risk factor management was not a sectoral issue. This allowed for advocacy to the heads of government to enhance the "whole of government, whole of society" response.

Regionally and globally, increasing attention was paid to NCDs, which helped set the stage for the process—for example, the WHO report "Preventing chronic diseases: a vital investment" in 2005 (17) and the "Regional strategy on an integrated approach to the prevention and control of chronic diseases, including diet, physical activity, and health" by the PAHO Directing Council in 2006 (31).

Lesson 3: importance of political processes

Failure to assign priority is often due to a lack of political will (32–34), but that is not so in this case. In the Caribbean, health is valued and functional cooperation is important to the sense of community in the region. There are political incentives for leaders through the collective and individual benefits that would accrue to their addressing this critical area. However, it was necessary to show leaders that their declarations would have an impact and that implementation of their declarations should be reported regularly.

Lesson 4: importance of data packaged to "speak to head, heart, and pocket"

Well-presented evidence foments a higher priority for NCDs. The Caribbean Epidemiology Center and the Caribbean Food and Nutrition Institute performed serial data trend analysis on the NCDs and their risk factors and highlighted their leading and worsening burden, while, for example, the HIV/AIDS burden declined between 2000 and 2004. Countries were over target for consumption of calories, fats, oils, and sugar and were under target for roots, tubers, fruits, and vegetables.

Heads of government and delegations from each country were briefed. Posters prepared for the summit

by their ministries of health analyzed NCD and risk factor burden and trends, national response, and priorities. The major presentation by Prime Minister Denzil Douglas, "spoke to head, heart, and pocket" stressing the health, social, and economic impacts of the epidemic. This was supported by expert presentations on obesity, tobacco control, and fiscal aspects (the latter from the World Bank). A 7-minute video showing persons with diabetes and an amputation, hypertension, and a stroke plus a young woman with cervical cancer demonstrated the human face of NCDs, which some key informants thought was as important as the health and economic statistics.

Lesson 5: collaboration, coordination, and partnerships

PAHO/WHO and the CARICOM Secretariat as major health collaborators with the Caribbean countries have facilitated successes through technical cooperation programs and they provide the Joint Secretariat for the Caribbean Cooperation in Health. This secretariat, along with four chief medical officers, represented countries and ministries of health in planning and executing the summit. The PHAC and the Canadian International Development Agency were the major supporters of the summit. Collaboration with the media created a groundswell of opinion, and One Caribbean Media in 2007 distributed an NCD supplement with the Sunday papers to all households across the region.

Lesson 6: importance of champions

Vocal and effective champions at technical and political levels are critical. The Prime Minister of Saint Kitts and Nevis, the Honorable Dr. Denzil Douglas, CARICOM's Minister of Health, articulated cogently about the importance of NCDs. The previous Prime Minister of Trinidad and Tobago, the Honorable Patrick Manning, invited his colleague heads to the summit in Port-of-Spain in 2007 and hosted the Commonwealth Heads of Government Meeting and the Summit of the Americas in 2009, both of which issued NCD declarations.

Professor Alleyne was the preeminent Caribbean champion for NCD prevention and control identified by most of the key informant interviews, which was evidenced by his commitment and persistence in drawing attention to the problem and his stature among political leaders in the Caribbean and internationally. This demonstrates the impact that one influential person from civil society can have.

IMPACT OF PORT-OF-SPAIN DECLARATION

Implementation of the Port-of-Spain Declaration has been tracked, with regional monitoring and reporting to the Council for Human and Social Development every 6 months, coordinated by T.A.S. using a reporting grid that countries update at least annually.

⁵ For more details, refer to www.caricom.org.

CARICOM country income ranges from Barbados, a high-income developed country, to Haiti, the only low-income country, with 4 other high-income and 14 middle-income countries (Table 3), yet it is population size that is associated with compliance (Figure 1, Table 4). The smallest countries have less capacity, both before and after the 2007 Port-of-Spain Declaration. In many small countries, one officer may be assigned to NCDs and to several other portfolios, while large countries often have an NCD department with several dedicated staff.

This capacity gap has been overcome for declaration mandates receiving regional or global supports directly to countries (Tables 5 and 6). For example, Caribbean Wellness Day (CWD), Framework Convention on Tobacco Control (FCTC) ratification, and surveillance (Global School Health, Global Youth Tobacco and STEPS NCD risk factor surveys) have been implemented successfully in countries of all sizes.

CWD was celebrated in 19 of 20 Caribbean countries during 2008–2010 (Port-of-Spain Declaration 15). Countries have institutionalized the celebrations, many with activities in each administrative area, and, as planned, are using CWD as a catalyst for ongoing physical activities (35).

TABLE 3. Population size indicators and income classification of 20 CARICOM countries

Country	Population (thousands), 2003–2005 ^a	Population size indicator	World Bank classification, 2009 ^b
Anguilla	14	1	N/A
Antigua and Barbuda	86	2	Upper middle
Bahamas	342	4	High
Barbados	256	4	High, developed
Belize	307	4	Lower middle
Bermuda	68	2	High
British Virgin Islands	24	1	N/A
Cayman Islands	49	1	High
Dominica	73	2	Upper middle
Grenada	104	3	Upper middle
Guyana	762	5	Lower middle
Haiti	10 033	6	Low
Jamaica	2 719	6	Upper middle
Montserrat	5	0.5	N/A
St. Kitts and Nevis	40	1	Upper middle
St. Lucia	172	3	Upper middle
St. Vincent and the Grenadines	109	3	Upper middle
Suriname	520	5	Upper middle
Trinidad and Tobago	1 339	6	High
Turks and Caicos Islands	23	1	High

Note: CARICOM: Caribbean Community, N/A: not applicable.

^a Source: Health Situation in the Americas, Basic Indicators (3).

^b World Bank classification using 2009 gross national income per capita per year, World Bank Atlas method: low income, \$995 or less; lower middle income, \$996–\$3 945; upper middle income, \$3 946–\$12 195; high income, \$12 196 or more.

The FCTC has been ratified in all CARICOM member states except Haiti. Trinidad and Tobago passed robust tobacco legislation, which was shared with the other countries to be used as a model for their own legislation, if they choose. However, the region has yet to implement pictorial warning labels on tobacco products, an FCTC mandate (Port-of-Spain Declaration 3). At this time, consensus agreement is being blocked by one country whose internal tobacco lobby is well connected and influential. CARICOM Ministers of Health have since decided to implement the standards in individual countries.

Surveys of NCD risk factors have been conducted in seven countries, most using WHO STEPS NCD risk factor surveillance tools, supported by the Caribbean Epidemiology Center and PAHO; other surveys are planned. An NCD surveillance minimum data set was established by PAHO/WHO and a project sponsored by the Inter-American Development Bank established a model web-based reporting system (Port-of-Spain Declaration 13).

Also providing regional support, the Healthy Caribbean Coalition, a 30-member civil society alliance to combat chronic diseases was established in 2008 in direct response to the CARICOM NCD Summit Declaration. At the regional level, the Healthy Caribbean Coalition has been very successful with its website www.healthycaribbean.org and program of regular advocacy letters to heads of government. However, enhanced civil society networks are still needed at the country level to carry out these mandates.

Mandates with the lowest implementation rates are those that need a system response to issues of trade and food security requiring regional or global policies—for example, elimination of trans fats.

Inadequate funding has precluded “comprehensive public education programmes in support of wellness, healthy life-style changes, and improved self-management of NCDs” (Port-of-Spain Declaration 12) and stymied implementation in several other areas (Table 5). Alcohol abuse has not been adequately addressed, and the health sector has not made sufficient progress in implementing evidence-based preventive treatment for people living with NCDs.

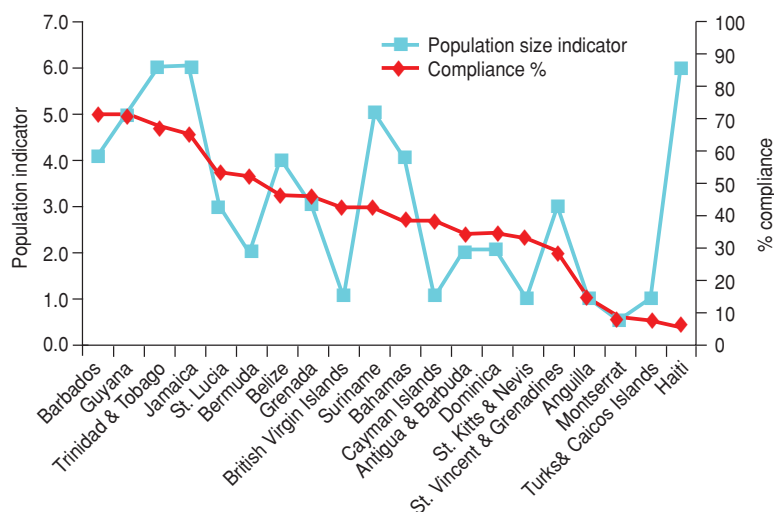
All four PAHO/WHO commitments—building surveillance capacity, Caribbean NCD plan, mobilizing partners and resources, and evaluating implementation of the NCD Summit Declaration—have now been accomplished, with the exception of mobilizing resources.

DISCUSSION

CARICOM summit in the Caribbean and lessons learned

While we celebrate our successes (Healthy Caribbean Coalition, CWD, FCTC, surveillance), showing the value of the political commitment of the CARICOM heads and support from regional institu-

FIGURE 1. CARICOM countries' percent compliance with noncommunicable diseases Summit Declaration versus population indicator, 2010.



tions, progress has been moderate partly due to lack of resources and an inadequate mechanism for establishing milestones for “all of government” actions. Except for the target of 80% coverage of people with NCDs by the end of 2012 and CWD in September, the CARICOM Summit Declaration did not establish an implementation matrix with clear short- and longer-term targets and milestones for health and, importantly, nonhealth government agencies. The mechanism established in the Port-of-Spain Declaration for mobilizing resources, Declaration 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” in the main has not been implemented and there is no agreement to set up a regional fund to support efforts in prevention and control. The anticipated donors meeting for NCDs has not occurred partly due to the focus on establishing the Caribbean Public Health Agency, which will integrate the five main Caribbean regional health institutions.

Finally, although the Port-of-Spain Declaration provides valuable collective political commitment, ongoing in-country work is still needed to make the case for and support policy changes in other sectors—agriculture, food production, education, and tourism. The Port-of-Spain Declaration perhaps now needs some course corrections to improve implementation.

TABLE 4. Compliance with NCD Summit Declaration performance indicators among 19 middle- and high-income CARICOM countries, 2010

Population size	Count	Compliance (%) ^a	Range (%)
≤ 100 000	9	29.3	8–52
100 000–500 000	6	47.5	29–71
> 500 000	4	61.6	42–71

Note: NCD: noncommunicable disease, CARICOM: Caribbean Community. *P* = 0.001.

^a Compliance measure was calculated from country NCD Summit Declaration implementation grid (8, p. 29).

Legacy of CARICOM Summit internationally

The stimulant effect of the CARICOM Summit on international events leading to the UN HLM on NCDs can be traced as follows:

- April 2009: Summit of the Americas in Port-of-Spain, including 14 CARICOM members, reaffirmed the WHO/PAHO and CARICOM policies and plans for NCD prevention and control.
- July 2009: 30th Conference of CARICOM Heads of Government in Guyana agreed to advocate for a UN General Assembly Special Session on NCDs.
- November 2009: Commonwealth Heads of Government Meeting in Trinidad and Tobago included 12 CARICOM members. The declaration emphasized their importance, committed the Commonwealth countries to elevate the priority of NCDs, and supported the call for a UN meeting on NCDs.
- February 2010: UN briefing on NCDs followed by Caribbean diplomats systematically lobbying their colleagues.
- May 2010: UN General Assembly agreed to an HLM on NCDs in September 2011.
- September 2010: NCDs were included in the UN Millennium Development Goal Summit.
- December 2010: the scope and modalities of the HLM were approved—a 2-day meeting 19–20 Sep-

TABLE 5. Compliance with NCD summit performance indicators and regional/global supports, 2010

Level of implementation	Regional/global support	NCD summit performance indicator	Compliance (%)
Country	CARICOM and PAHO	Caribbean Wellness Day	95
Country	FCTC	FCTC ratified	86
Country	WHO/CDC	Global youth tobacco survey	75
Country	CFNI/PAHO	Implement food and nutrition plan	65
Country	WHO/CDC	Global school health survey	65
Country	...	Ongoing, mass physical activity	63
Country	PAHO	Diabetes quality project	60
Country	...	NCD plan	58
Country	CAREC/PAHO	NCD minimum data set reporting	55
Country	FCTC	Smoke-free indoor public places	53
Country	CAREC/PAHO	Surveillance: STEPS or equivalent	50
Country	...	NCD summit convened	43
Country	...	Multisectoral NCD commission	43
Country	...	NCD prescription protocols in $\geq 50\%$ of facilities	40
Country	...	≥ 30 days of media broadcasts on NCD	35
Regional	FCTC	Tobacco ad and sponsorship bans	33
Country	...	Healthy eating in schools implemented	33
Country	...	NCD communications plan	30
Country	...	Tobacco taxes $> 50\%$ of sale price	25
Country	...	Mandatory physical activity in all grades in schools	25
Country	...	NCD budget	23
Regional	CARICOM	Trade agreements: food security and health	10
Regional	CARICOM	Mandatory labeling of packaged foods	10
Country	...	Mandate PA space in new housing	10
Country	...	$\geq 50\%$ workplace PA and healthy eating	5
Regional	CARICOM	Trans-fat-free food supply	3

Note: CARICOM: Caribbean Community, PAHO: Pan American Health Organization, FCTC: Framework Convention on Tobacco Control, WHO: World Health Organization, CDC: US Centers for Disease Control and Prevention, CFNI: Caribbean Food and Nutrition Institute, CAREC: Caribbean Epidemiology Center, ... : none, PA: physical activity.

TABLE 6. Country compliance versus regional/global support, 2010 summary of Table 5

	Average compliance (%) ^a	Range (%)
Direct to country supports ($n = 10$)	64	33–95
Regional actions ($n = 3$)	8	3–10
No supports ($n = 13$)	33	5–63

^a $P = 0.001$.

tember 2011, which will include plenary and round-table sessions.

Applicability of CARICOM Summit to UN HLM on NCDs

The first NCD Summit and its legacy have increased awareness of several country groupings of NCDs and the UN HLM in 2011.

While recognizing that the political interests of the main stakeholders may be different in the Caribbean than in other regions, the following can be considered in preparation for the meeting.

- Leverage regional and global consultations in support of the UN HLM.

- Link the commitments to other agendas—for example, economic development, poverty reduction, and environmental issues such as climate change.
- Show strong evidence of the health, social, and economic impact of NCDs and risk factors of development to stimulate a global, multisectoral response.
- Heads of state, especially from the middle- and low-income countries, should attend the HLM.
- Build strong relationship with ministries of foreign affairs, which are primarily responsible for the UN HLM. WHO regional directors should engage their UN counterparts.
- Civil society and the media should raise a groundswell of public awareness.
- The commitments and monitoring system in the outcome document of the UN HLM should embed a set of short-term (1 year), medium-term (to 2015), and long-term (to 2020) targets, including a parallel set of goals and indicators to the Millennium Development Goals. They will provide leaders with the possibility of demonstrable short-term, tangible success.
- Provide funding, especially for smaller, highly indebted countries.
- Relate the global price tag for NCD prevention and control to the costs of inaction and the return on investment for different packages of interventions. NCD-related costs are significant impediments to

the medium-term fiscal consolidation of the Group of Twenty.

- Political champions will be needed from developed and developing countries. Professor Alleyne and Caribbean heads need to continue to play a strong leadership role.

CONCLUSION

The Summit of CARICOM Heads of Government on NCDs was a first in the world, as their declaration focused on prevention and control of NCDs and gave clear policy directions for an intersectoral approach that addresses many key risk factors. It is possible to make the case and persuade policy makers to take high-level action by creating or enhancing certain conditions. Data presentation buttresses the arguments and a political structure can facilitate collective action supported by international agencies, the private sector, nongovernmental organizations, and supporting governments—in this case, Canada. A key ingredient is the strong support of capable technical and political champions.

Implementation needs regional support, especially in small countries with limited capacity. Monitoring of implementation after the summit is essential. Clear short- and longer-term targets as well as a mechanism for funding priority interventions are needed.

SINOPSIS

Aumentar la prioridad de las enfermedades crónicas no transmisibles en el Caribe

La larga trayectoria de cooperación de los países del Caribe en materia de salud se centra ahora en las enfermedades no transmisibles (ENT), puesto que los países integrantes de la Comunidad del Caribe (CARICOM) soportan la mayor carga de estas enfermedades en la Región de las Américas. Los jefes de gobierno convocaron una cumbre de un día, la primera del mundo, sobre las ENT, en gran parte gracias a la tarea de concientización llevada a cabo por George Alleyne y otros, con objeto de tratar las repercusiones sanitarias, sociales y económicas de las ENT; la necesidad de intervenciones multisectoriales tempranas para abordar los riesgos comunes y multifactoriales; y la necesidad de que se conceda mayor atención a las ENT a escala mundial.

La ejecución de los mandatos de la Declaración de la Cumbre sobre las ENT fue más eficaz en los países más grandes y con mayor capacidad, pero países de distintos tamaños actuaron satisfactoriamente cuando contaron con la ayuda regional o mundial. En los enfoques regionales, el progreso se limitó a la seguridad alimentaria, la rotulación y la eliminación de las grasas trans. El financiamiento insuficiente obstaculizó diversas intervenciones que dependían del aporte de recursos. Se establecieron mecanismos de vigilancia, pero es preciso establecer metas más concretas, especialmente en lo referente a las actividades de los organismos gubernamentales de ámbitos ajenos a la salud.

Palabras clave: enfermedad crónica; factores políticos; Naciones Unidas; región del Caribe.

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