The Evaluation of the 2007 CARICOM Port-of-Spain NCD Summit Declaration

CHAPTER 4: National policy responses to NCDs and lessons learned

POS EVALUATION GROUP
AIM

• To identify existing policies towards NCD prevention and control, gaps in national policy responses, and factors promoting and hindering successful policy development and implementation in individual countries and territories.
Methods

• Two complementary methods:
  • Analysis of grid data on the 27 commitments
    – Collected annually from 20 CARICOM countries from 2007-2015 monitoring commitments
  • Detailed case studies of 7 countries
    – 76 interviews with 80 key informants
    – Data abstraction from policy documents
Grid: Key Findings

• Widely differing levels of policy development and report implementation.

• No country has met all of the indicators, but all have met at least one.

• 12 indicators fully complied with by at least 50% of members.

• Seven additional indicators partially complied with by at least 50% of members.

• At least 50% the members have completely or partially complied with 19 of 27 indicators.
Grid: Key Findings

• Seven indicators with poor compliance
  – less than 50% of members either complied or reported that they are in the process of complying.

• Six of the 7 indicators concern the macro-determinants of diet and physical activity.
  – the other indicator concerns banning tobacco advertising, promotion and sponsorship
Level of Compliance by Category

Surveillance (4)  +0.59
Physical Activity (3)  +0.43
General (4)  +0.28
Tobacco (4)  +0.24
Treatment (2)  +0.20
Education/promotion (5)  +0.06
Nutrition (5)  -0.41
Average (26)  +0.16

+1 for full implementation,
0 for partial compliance
-1 for no implementation at all
Grid: Key Findings

• Indicators with the highest levels of implementation:
  – those where it is clear what action is needed (i.e. protocols or ‘blue prints’)
  – there is support from regional organisations (e.g. risk factor surveys, Framework Convention on Tobacco Control)
Factors associated with indicator implementation

• Indicators containing specific reference to an activity mandated by a regional or international organisation were more likely to be met. (Framework Convention on Tobacco Control and Caribbean Wellness day)

• Countries with higher per capita Gross Domestic Product, larger populations and a higher burden per capita of NCDs have a better history of implementation.

• Two of the top four implementers (T & T and JA) had female leaders at the time this work was conducted, and all four have relatively high female participation in the workforce, and a relatively high proportion of female members of parliament.
CASE STUDIES FINDINGS
Mechanism for Success: Policy Creation

- Minister of Health willing to push the NCD agenda (e.g. through Cabinet)
- Political will: NCDS need to be on the overall political agenda
- Policy transfer: policy blueprint gives ease to replicate/craft policy
- Efficient consultation and resources to create policy
- Multisectorality: Working "commission" including collaboration with Ministries
- NCD focal point/champion to drive policy creation
Barriers to Success: Policy Creation

- **Policy transfer:** No existing blueprints for successful policies
- **Limited political recognition of NCDs as a priority leads to limited parliamentary/Cabinet support**
- **Lacking buy in at the Ministerial level to push policy through cabinet in a timely fashion**
- **Lack of local capacity /skills to create policies leading to reliance on consultants**
- **Lack of policy culture: more focus on action initiatives than on policy creation**
- **Timeliness: policy creation can take years to create, and then months for approval**
- **Lack of communication particularly across ministries (working in silos)**
Mechanisms for Success: Policy Implementation

- Enforcement of policies once passed by cabinet (related to M&E as well)
- NCD champion needed to drive implementation and keep momentum going
- Public & Private sector awareness and education on existence of policies in order for “buy in”
- Enforcement: Policies and actions must be aligned
- Ownership of policy: when multi-sectoral policies get pushed through then all sectors feel ownership
Barriers to Success: Policy Implementation

- Lack of policy culture: Initiatives/action on the ground easier than implementing policy
- Policy transfer: No existing blueprints for successful policies
- Limited political recognition of NCDs as a priority leads to limited parliamentary/Cabinet support
- No stability for funding and resources for implementation, therefore not always sustainable in the long-term
- Lacking buy in at the Ministerial level to push policy through cabinet in a timely fashion
- Lack of policy culture: Initiatives/action on the ground easier than implementing policy
## Level of Compliance by Category

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Mechanisms for Success: Risk Factors

- Designated health promotion staff and budget in MOH are required to enable planning and implementation.
- Policy transfer can successfully guide policy actions (e.g. FCTC).
- Community action and peer led health education led by NGOs.
- Addressing food security by collaborating with other ministries and private sector.
- Promoting PA with broader focus of active living requires whole of government approach.
Barriers to Success: Risk Factors

- Short project funding rather than sustained budgets hamper sustainability of actions
- Alcohol as core industry creates a barriers to political will for legislative action
- Undernutrition and food poverty as parallel concerns limit impact of obesity related health education
- Reliance on food imports limits reach of legislative action including quality, and affordability of healthy foods
- Overreliance on physical activity promotion in terms of sports and exercise limits broader reach
- Increase in foreign investment increased Westernized diets and fast food with low nutritional value
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Mechanisms for Success: Multisectoralism

- **MOH/specialist consultation** needed to guide other ministries’ projects.
- **Political will** (Cabinet approval) strengthens co-operations and shared budgets (e.g., for school nutrition).
- **Well-connected individuals** (often through change of roles) can forge alliances and buy-in across government or sectors.
- **True NGO/private representation and consultation** enables buy-in and shared responsibilities.
- **Formalized collaborations** with other ministries ensure clear partners for actions (e.g., backyard gardening with Agriculture).
- **Establishment of commissions** can initiate whole of society partnerships leading to “buy in” to address NCDs.
Barriers to Success: Multisectorality

- **Lack of support structure (e.g. gov’t funding, resources for secretariat etc.)** curtails effectiveness of commissions.
- **Limited political recognition of NCDs as a priority** leads to limited parliamentary/Cabinet support.
- **Lacking leadership** leads to limited cross-sector and cross-Ministry buy-in and initiatives.
- **Only nominal collaboration with third sector** threatens buy-in and community solutions.
- **Silo working and designated budgets** hamper ‘health in all remit’ initiatives.
Mechanisms for Success: Health Promotion

- Health promotion as a holistic approach that also addresses upstream determinants
- Gov't and private sector funding for health promotion initiatives
- Established culture of health fares – incl. Caribbean Wellness Day – with third and private sector cooperation
- NCD Champion to drive health promotion activities and initiatives
- Designated posts and budget for health promotion unit at Ministry of Health to ensure sustainable programme
- Capability of health promotion consultancy for other Ministries to inform about evidence based and effective actions
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Barriers to Success: Health Promotion

- Lacking qualified human resources for evidence based programmes
- Short term and limited funding for NCD health promotion (as opposed to HIV/AIDS) limits initiation and sustainability of programmes.
- Reliance on third and private sector to fund and initiate health promotion limits government response and commitment.
- Lack of designated/active NCD Focal Point leads to lack of leadership for health promotion initiatives
- Limited recognition of burden of NCDs in the population leads to limited political recognition for the need to fund health promotion
- Population culture of indifference towards NCDs

Population culture of indifference towards NCDs leads to lack of leadership for health promotion initiatives.
Mechanisms for Success: Chronic Care/Control

- National Health Insurance encourages compliance to guidelines
- NHI facilitates affordable access to medication
- E-Health / Telemedicine can fill specialist care gap
- Cooperation of health NGOs and international organisations (PAHO) facilitates integrated care
- National strategic plan modelled on WHO Plan of Action (Policy Transfer)
Barriers to Success: Chronic Care/Control

- Limited access to specialized care: small settings need to provide the same range of treatment services.
- Small settings have limited human resources with specialized training (e.g., podiatry, oncology).
- Limited use of regional guidelines and limited drive to put chronic care model in place.
- Budgetary emphasis on tertiary care and medical technologies limit effective delivery of primary care and prevention.
- Funding of state-of-the-art technology/equipment, buildings, but no long term technical support for these.
- Large geographical spread/diversity (urban-remote rural) leads to unequal care access and provision.
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Mechanisms for Success: Surveillance

- Electronic health information system enables low resource surveillance and can support research.
- Recognition of importance of M&E enables sustainability (e.g., funding and staffing commitment).
- Skilled/trained staff enables sustained M&E program and local input in regional surveillance or research.
- Collaboration with academic institutions and international organisations.
- National Health Insurance enables automatic audit supported by inbuilt reward system.

Collaboration with academic institutions and international organisations
Barriers to Success: Surveillance

No electronic system or registries for surveillance

Initiatives are planned without measurable targets, monitoring or evaluation components

Limited local capacity: lack of human resources skills, and use of consultancies instead of building local capacity

Unlinked public system, private health system and civic organization data limits ability for surveillance

Lack of resources other than manpower (computer/office space) limit surveillance ability

Lack of collaboration with local or offshore universities limits research ability and knowledge translation
Mechanisms for Success: SUMMARY

Whole of society and whole of government approach initiated and formalised (e.g. in commission or partnership)

Sustained human and financial resources for public health dedicated at the Ministry of Health

Health initiatives across Ministries, but does not require health label (e.g. food security, labour productivity)

Shift from medical model to holistic and prevention approach to NCDs

International (FCTC), regional (CARPHA guidelines) and local (e.g. from HIV to NCD programmes) policy transfer to inform policy

NCD agenda driven by designated (focal points), dedicated (community champions), or well-connected (policy entrepreneurs) individuals

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Barriers to Success: SUMMARY

- Lengthy bureaucratic process of policy formulation to implementation discourages action and motivation.
- Geographical barriers: remoteness curtailing healthcare access/roll out; water scarcity for agriculture; small population with limited human resources.
- Political will a reflection of public awareness and acceptability, e.g. emphasis on personal responsibility.
- Limited reliable surveillance and evaluation of local initiatives to provide local evidence base.
- International political and economic barriers to effective legislation and initiatives (e.g. food labelling and availability of healthy options).
Conclusions

• Grids tend to overestimate compliance
• Compliance lowest related to macro-determinants of risk factors
• NCDs still lack political priority (in gov’ts and CARICOM)
• Policy transfer and support from regional agencies works
• Factors outside the control of individual countries
• Surveillance data is inadequate to identify NCD trends
Potential Actions

• Firm up definitions and reporting on grid
• Macro-determinants of diet need to be addressed
• NCDs must be given high political priority (both Gov’t and CARICOM) and needs to be a regular and substantive agenda item
• NCD commissions need to be supported by gov’t but independent
• Cross ministry committees—with resources
• Detailed policy guidance
• Better surveillance and evaluation