IDB – Jointly surveilling diseases in the Caribbean

Organization(s):
Ministries of Health of The Bahamas, Barbados, Belize, Guyana, Jamaica and Trinidad and Tobago. The strategic partners accompanying the initiative are the Inter-American Development Bank, the University of the West Indies (UWI)- St. Augustine Campus; the Pan-American Health Organization (PAHO)- mainly through the Caribbean Epidemiology Centre (CAREC); the Caribbean Community Secretariat (CARICOM).

Country (ies):
The Bahamas, Barbados, Belize, Guyana, Jamaica and Trinidad and Tobago

Overview:
The purpose of the project is to develop a Caribbean Regional Non-Communicable Disease (NCDs) Surveillance System which will contribute to better plan, deliver and monitor comprehensive and integrated responses to NCDs. The system aims to improve the collection, systematization and analysis of data associated with NCDs in the countries of the Caribbean. It will help define programs and health protocols targeting services for health promotion in the context of NCDs, their prevention and treatment. Ultimately, the project aims to achieve improvements in the capacity of countries to deliver cost-effective health services associated with NCDs, now recognized as the major cause of mortality and morbidity, both at the regional and the global levels.

Background:
Non-Communicable Diseases present a serious health challenge to the entire Caribbean region, one which is likely to overwhelm health systems and impact economic growth if no action is taken. The countries of the region have therefore accorded NCDs high priority status in regional and national agendas. At a regional Summit on the subject of NCDs held in September 2007, CARICOM Heads of Government recognized the need for comprehensive and integrated responses geared at prevention, control of risk factors and treatment. They agreed that immediate collective action was necessary to manage and control NCDs, and mandated their Ministries of Health to establish, by mid-2008, comprehensive plans for the screening and management of chronic diseases and their 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. During the Summit Heads of Government also agreed that effective action to achieve these objectives hinges on the availability of accurate, relevant and comparable data on the national and regional NCDs panorama. They therefore called for the use of regional and national NCDs surveillance systems to track disease, and to better plan, deliver and monitor responses.

Notwithstanding a high level of engagement and support for the fulfillment of these
commitments, the establishment of surveillance systems presents a significant institutional challenge for the region. Caribbean countries have limited surveillance capabilities and little available data to nourish systems of this kind. Progress in this regard has been slow in spite of the groundwork that the region has undertaken in the past several years. For instance, in 2002 Caribbean epidemiologists approved a Minimum Dataset on NCDs. In addition, CAREC/PAHO has been working with 21 Caribbean countries on surveillance mechanisms for a number of years. However, factors such as limited financial and human resources and competing health priorities have been a key challenge.

The Regional Non-Communicable Disease Surveillance Project responds to a health sector need present in the entire region and articulated through the CARICOM Heads of Government mandate, by providing a vehicle for six Caribbean IDB member countries to work together in order to improve the collection, systematization and analysis of data associated with NCDs. This joint effort emerged from a broad based recognition of the value of a regional approach to NCDs surveillance and responses. Acting as a block will allow the countries to increase the positive impact of health policies and programs and to better manage technical and financial resources, optimizing their use at the regional level. The countries have also been able to leverage more assistance working together than would have been forthcoming had they acted separately. These are key benefits given the resource constraints the countries face and the declining levels of Official Development Assistance (ODA) in the region.

Prior to the development of the project these countries had limited knowledge of each other’s progress or activities in NCDs surveillance. Even as the countries recognized the advantages of a collective approach, it became clear that asymmetries in their levels of development translated into varied country capacities. In order to address this challenge the countries agreed to set targets and undertake activities that all countries could feasibly reach. However, differences have also presented opportunities for learning, with countries sharing data collection methods and existing systems with each other.

The countries agreed that the University of the West Indies (UWI), a regional institution with in-house technical expertise on NCDs, would coordinate and facilitate the execution of the project. The project also leverages on the existing work of CAREC/PAHO, thus taking advantage of highly relevant existing resources and expertise. In this way, the project takes into consideration that many of the components needed for the monitoring of NCDs are already in place and that NCD surveillance can be improved upon by building on, harmonizing and complementing existing systems.

The South-South cooperation approach of the project is advantageous as it has allowed the countries the flexibility to identify the project objectives on the basis of national priorities. It has also provided a space for the countries to work together in developing and implementing innovative strategies to achieve project objectives, emphasizing the use of local systems and expertise. The project recognizes that by leveraging on existing experiences and initiatives and by bringing countries together to work collectively, a regional solution is being sought for a regional problem.
Implementation:
A Steering Committee, comprising the Chief Medical Officers (CMOs) from the participating countries, acts in an oversight capacity for the project and the regional system, making all high-level decisions for the project. Each CMO nominates a national Focal Point from within the Ministry of Health to act as the functional point of contact for project implementation and the link between the regional work environment and the national reality. A Project Coordination Unit (PCU) has been established at the St. Augustine Campus of UWI. The UWI Project Lead (Head of the Trinidad and Tobago National Commission on NCDs and Professor in the School of Medicine) provides overall technical guidance to the project. Further technical support is provided by the IDB, CAREC/PAHO, other UWI departments and campuses, the Caribbean Health Research Council and the CARICOM Secretariat.

The project comprises three main components:

i. The diagnosis and gap analysis of NCDs national registries and information systems, including on the minimum dataset.

ii. The design of the regional NCDs surveillance system and its components.

iii. The development of health protocols and mechanisms for regional harmonization of public policy on the promotion, prevention, treatment and rehabilitation of NCDs.

The Steering Committee meets once a year, while the Focal Points, through a network which is the central mechanism for knowledge exchange and learning in the project, have more regular contact. To date they have been able to meet each other at several face-to-face meetings and via teleconferences. This interaction has organically led to real sharing and learning. For example, Belize and Guyana have assisted The Bahamas in the development of its patient medical record systems. Similarly, countries are sharing experiences and information on the development of heart disease registries, diabetes registries and tobacco use checklists. Countries have also started to share experiences and ideas on data collection modalities. In one instance this exchange led to sharing on the available avenues for obtaining a representative population sample without current census data.

Several challenges have emerged in the early stages of implementation of the project. For example, there is a concern that momentum and leadership of the project may be lost because project participants, such as the Focal Points, either change or are unable to participate in project activities because of limited resources. Similarly, other pressing national priorities, such as the H1N1 influenza pandemic, distract attention and resources from the project. Another potential obstacle is the legal issues that may arise regarding the ownership and use of the data gathered by the surveillance system. Finally, the countries have expressed a concern about the future sustainability of the surveillance system once it has been developed.

Outcomes:
While the project is still in the early stages of implementation, a key achievement thus far is the finalization and agreement on the Caribbean Minimum Dataset on NCDs in March 2009, under the facilitation of CAREC/PAHO. The first activities targeting the development of technical capacities on the use of the Dataset in the six countries took place in October 2009. These countries now have the capacity to begin annual reporting on NCDs using the Minimum Dataset.
in 2010. In addition, the project has undertaken the diagnosis and gap analysis and has begun the development of the online surveillance system. One preliminary recommendation that has emerged from the project execution is that the online system be built as an interactive web-based database that is accessible to the public. A pilot of the system is expected at the end of 2010.

Another early, but very important outcome of the project is the increased engagement among national and regional health actors. For instance, national health authorities are in more frequent contact with each other. In addition, CAREC/PAHO is an active partner which brings key expertise and relevant country experience to specific project activities, while UWI acts as a communication hub and provides technical advice to the project. Each partner has a clearly defined role and there are no free-riders. This framework has engendered a significant level of trust among partners and particularly among the countries themselves. Rather than competing, countries are now actively working with each other and with regional development actors. This has begun to enrich strategic partnerships more generally. For example, countries are now more enthusiastic to submit national data to CAREC/PAHO, knowing that other countries will also supply information which can then be used to inform the region as a whole. At the heart of the development of these strategic partnerships lies the PCU at UWI. The enthusiasm and persistence of the PCU team and its ability to engage all parties are central to the project’s success.

**Aid Effectiveness:**
The NCDs Surveillance System project is guided by the principles of pragmatic innovation, institutional coordination and strategic partnership. In doing so, it adapts the framework of the global aid effectiveness agenda articulated in the 2005 Paris Declaration on Aid Effectiveness and the 2008 Accra Agenda for Action, using local level solutions and modifying international practices to local conditions in order to meet a collective development objective.

The project has organically fostered country ownership by virtue of being demand driven and aligned with national and regional priorities. In this sense, the project is aligned with the mandates arising from the CARICOM NCDs Summit in 2007 and with national development plans. For example, Jamaica’s development plan, Vision 2030 Jamaica, includes the goal of a healthy population with an explicit strategy to strengthen disease surveillance, mitigation, risk reduction and the responsiveness of the health system. Similarly, Guyana’s National Health Sector Strategy 2008-2012 includes nationally led efforts to inform individuals about how they can reduce their risk of developing chronic diseases, and to promote environmental change through actions in other sectors: taxation of harmful products, promotion of physical activity in schools and communities, policies and regulations about smoking and alcohol. In Trinidad and Tobago, the Government has developed the Chronic Disease Assistance Programme and has just initiated the implementation of the Tobacco Control Act 2009. The project is also aligned with -- and is fast tracking- a number of components of PAHO’s Regional Strategy on an Integrated Approach to the Prevention and Control of Chronic Diseases.

The project’s design, including the use of technical Focal Points in each country alongside high level guidance from the Chief Medical Officers, emphasizes country leadership and a bottom-up approach rooted in the experiences of medical practitioners, epidemiologists, statisticians and
hospital registrars working on the ground. As the stakeholders work together, one of the cornerstones of the project is the mutual accountability that has emerged as the countries, as well as the institutions, have signed letters of agreement outlining their respective responsibilities.

The governance system of the project is based on country public policy officials making decisions based on input provided by technicians and the countries coordinating among themselves to reach project goals. All decision-making is consensus based and it is agreed to base all decisions on the “lowest common denominator hypothesis” to ensure that all countries are able to implement the strategies devised to achieve the project objectives. In addition, the IDB and the Project Coordinating Unit at UWI are working together to harmonize monitoring and evaluation systems, including financial reporting and procurement processes, and to focus on measuring results.

The Regional NCDs Surveillance System project is an example of both South-South Cooperation and Triangular or South-South-North cooperation, being led and implemented by Southern countries with financial and technical support from the IDB. Using this collective approach to development, the project strives to take advantage of the strengths of South-South Cooperation, such as well-adapted expertise and innovative solutions. At the same time, it aims to use the comparative advantages of each Southern partner while leveraging the resources and knowledge of the multilateral donor.

In spite of clear advantages, this approach presents challenges related to issues such as ownership, alignment, coordination and sustainability. The project is overcoming these challenges by adapting South-South and Triangular cooperation modalities to the aid effectiveness parameters outlined in the Paris Declaration. In this regard, the project seeks to be aligned with local priorities. In addition, the roles and responsibilities of the partners are well defined, most procedures are harmonised and there is a focus on mutual accountability and managing for results. Similarly, the project is actively trying to address the key elements outlined in the Accra Agenda for Action by focusing on country ownership, effective and inclusive partnerships, achieving development results and openly accounting for them. By applying this framework the project remains deeply grounded in the real needs of the countries and in local contexts, thereby increasing the effectiveness of the resources invested.

**Capacity Development:**
The development of national capacities lies at the core of the project. Technical capacity is being built in the participating countries in a mix of innovative and traditional ways. For example, consensus building capabilities inside Health Ministries and strengthening of coordination between the health and statistics institutions present an innovative approach to developing capacity, while the training on the Minimum Dataset and the workshops on surveillance mechanisms consist of more traditional capacity development.

The project also offers a horizontal mechanism for mutual learning among the involved partners. The project has created a two-sided system of exchange, through the Steering Committee and through the Focal Point network, to leverage on the experiences of one country to build capacity in other countries, thus developing capacities and value added at the regional level that cannot be
attained by North-South cooperation or even bilateral SSC. Countries are already sharing ideas and experiences on patient medical record systems, disease registries and modalities for data collection. This system can be extended to take advantage of learning in other areas, as well as to share information on pandemics such as the H1N1 influenza. As a result of the regional South-South approach, countries better understand each other’s situation and challenges and therefore trust that lessons learned can be applied more effectively than lessons learned in other contexts. These deepened relationships can provide benefits beyond the specific scope of the project, advancing the process of regional integration and motivating officials to approach each other and share experiences more readily.

Capacity is also being enhanced at UWI. While the University has been training health professionals for the past sixty years, through this project both practitioners and systems are now emanating from a coordinated institutional framework. In addition, the Faculty of Medical Sciences will be able to leverage on the outcomes of the project to enrich its work. For example, as a result of the project, the medical school is introducing its students to new protocols for death certificates that capture NCDs.

These developments can be potentially strong tools for effective policy interventions and outcomes in the region. Since the implementation of the project is grounded in local contexts and is being addressed by local experts, it is likely that future policy interventions will better respond to the challenges that NCDs pose to the region.

**Duration:** Execution Period: 36 months Disbursement Period: 42 months

**Budget (Optional):** IDB – FRPG US$ 650,000 Local Counterpart US$ 580,000 Total US$ 1,230,000

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