



TRADE, TRADE AGREEMENTS AND NON-COMMUNICABLE DISEASES IN THE PACIFIC ISLANDS

Intersections, Lessons Learned, Challenges and Way Forward

“Addressing NCDs is critical for global public health, but it will also be good for the economy; for the environment; for the global public good in the broadest sense. If we come together to tackle NCDs, we can do more than heal individuals – we can safeguard our very future.”

Secretary-General Ban Ki-moon, United Nations General Assembly, 19 September 2011

Date: March 2013

The views expressed in this publication are those of the participants to the Workshop on “Trade, Trade Agreements and Non-Communicable Diseases” held in Nadi, Fiji Islands, 11-14 February 2013, and do not necessarily represent the views of C-POND, SPC, UNDP and WHO.

Trade, trade agreements and non-communicable diseases in the Pacific Islands

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Organizing Team

Pacific Research Centre for the Prevention of Obesity and Non-communicable Diseases (C-POND): Dr Wendy Snowdon

Secretariat of the Pacific Community (SPC): Jeanie McKenzie, Dr Viliami Puloka

United Nations Development Programme (UNDP): Adelle Khan, Ahmed Moustafa, Samita Singh, Ferdinand Strobel, Simone Troller

World Health Organization (WHO): Dr Colin Bell, Peter Hoejskov, Amele Maravou, Dr Temo Waqanivalu

Faculty Team

Dr Deborah Gleeson (La Trobe University)

Dr David Legge (La Trobe University)

Dr Benn McGrady (Georgetown University)

Dr Wendy Snowdon (C-POND, Deakin University and Fiji National University)

Dr Anne Marie Thow (University of Sydney)

Additional Resource Persons, Panellists and Observers

Mr Nicky Anaturin (PIFS)

Mr. David Clarke (Allen & Clarke –New Zealand)

Prof. Carlos Correa (University of Buenos Aires/ UNDP)

Ms Margaret Eastgate (Oceania National Olympic Committees)

Ms Mere Falemaka (Melanesian Spear Group Secretariat)

Ms Eva Jarawan (The World Bank)

Mr Brian Lutz (UNDP)

Ms Elenoa Puamau (Fiji National University)

Mr Ronseh Prasad (Fiji National University)

Ms Paulini Sesevu (AusAID)

Dr. Sripen Tantivess (Ministry of Health Thailand)

Mr. Kazuyuki Uji (UNDP APRC)

Dr. Godfrey Xuereb (WHO)

Ms. Joann Young (PIFS)

Country Delegations

Fiji

Mr Shaheen Ali (Permanent Secretary for Trade, Industry and Trade)

Mr. Samuela Bolalilai (Acting Senior Health Inspector, Food Safety Ministry of Health)

Ms Lice Cokanasiga (Campaign Assistant Pacific Network on Globalisation)

Ms Bindula Devi (Project Manager, Consumer Council of Fiji)

Ms Virisila N Tuimanu (Acting Principal Economist, Industry and Trade)

Dr Isimeli Tukana (National Advisor NCD/Wellness, Ministry of Health)

Mr Thompson Yuen (Acting Principal Economic Planning Officer, National Planning Office)

Samoa

Ms Rosemary Abigail Lee Hang (Principal Planning & Programming Officer, Ministry of Finance)
Ms Christine Quested (Principal Nutritionist, Ministry of Health)
Ms Liai Siitia (Samoa Umbrella of NGO)
Mr Henry Tunupopo (Principal Foreign Service Officer, Ministry of Foreign Affairs and Trade)

Tonga

Mr Malakai Heneli Ake (Chief Medical Officer Public Health, Ministry of Health)
Mr Onetoto Anisi (Economist, Ministry of Finance and National Planning)
Ms Mary Magdalena Fifita (Senior Tourism Officer, Ministry of Labour, Commerce & Industries)
Mr Vaipulu Tupou (Assistant Secretary, Ministry of Foreign Affairs and Trade)

Vanuatu

Mr Sumbue Antas (Director, Department of External Trade, Ministry of Trade, Commerce, Industries & Tourism)
Ms Leis Obed (Vanuatu Association of NGOs)
Mr John Tasserei (Primary Health Care Officer, Ministry of Health)

Kiribati

Ms Roreti Eritai (Senior Trade Promotion Officer, Ministry of Commerce, Industry & Cooperatives)
Ms Ntaene Tanua (Assistant Nutritionist, Ministry of Health & Medical Services)

Solomon Islands

Ms Tracey Robin Choko (Trade Officer and EIF Coordinator, Ministry of Foreign Affairs & External Trade)
Mr Joseph Major (Media Manager, Solomon Islands Development Trust)
Dr Lester Ross (Permanent Secretary for Health, Ministry of Health & Medical Services)

Nauru

Ms Isabella Amwano (Assistant Director for Nursing, Public Health Department of Health)
Mr Berrick Dowiyogo (Assistant Director for Trade, Department of Foreign Affairs & Trade)

Palau

Ms Yorah Demei (NCD Unit Administrator, Ministry of Health)
Ms Jerene Ngiraikelau (Economic Officer 1, Ministry of Public Infrastructure, Industries & Commerce)

Tuvalu

Ms Nese Ituaso-Conway (Chief Public Health, Department of Health)
Mr Pugameau Taufilo (Trade Officer and EIF Coordinator, Ministry of Foreign Affairs, Trade, Tourism, Environment & Labor)
Ms Pulafagu Toafa (Coordinator, National Council for Women)

Photograph credits:

Shobhna Decloitre, Thomas Jensen, Ferdinand Strobel (UNDP)
Dr Temo Waqanivalu and Peter Hoejskov (WHO)

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Abbreviations

C-POND	Pacific Research Centre for the Prevention of Obesity and Non-communicable Diseases
CSO	Civil Society Organisation
EPA	European Partnership Agreement
GATT	General Agreement on Tariffs and Trade
HIA	Health Impact Assessment
HIES	Household Income and Expenditure Surveys
HRIA	Human Rights Impact Assessment
IP	Intellectual Property
IPR	Intellectual Property Right
LDC	Least Developed Countries
MoH	Ministry of Health
MSG	Melanesia Spearhead Group
NCDs	Non-Communicable Diseases
PACER	Pacific Agreement on Closer Economic Relations
PICTA	Pacific Island Countries Trade Agreement
PIFS	Pacific Islands Forum Secretariat
RTA	Regional Trade Agreement
SIA	Social Impact Assessment
SPARTECA	South Pacific Regional Trade And Economic Co-operation Agreement
SPC	Secretariat of the Pacific Community
SPSS	Agreement on Sanitary and Phytosanitary Measures
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UNDP	United Nations Development Programme
WHO	World Health Organization
WTO	World Trade Organization

Introduction

Background

The Pacific islands have some of the highest rates of obesity and diabetes in the world, with obesity rates as high as 75% and diabetes rates as high as 47% in some countries¹. Increasing reliance on imported foods has contributed to an 'epidemic' of obesity and related non-communicable diseases (NCDs) in the region². In 2011 Pacific Island Forum Leaders as part of the 42nd Pacific Islands Forum communiqué declared the Pacific in a crisis due to the non-communicable disease epidemic.

Several trade agreements currently being negotiated by the Pacific island countries are likely to have a big impact on future ability to address NCDs, including PACER Plus (being negotiated between the Pacific Island Forum Countries including Australia and New Zealand) and the Economic Partnership Agreements (EPAs) with the European Union. For example, reductions in tariffs (import taxes) on unhealthy products such as fatty meats, tobacco and alcohol could lower the prices of these products, contributing to obesity, diabetes and heart disease. Trade agreements can also restrict governments from introducing policies and laws to address NCDs, such as bans on certain products, restrictions on food labelling, etc.

There is a need for closer engagement between the health and trade sectors in (i) developing health promotion strategies to address NCDs that are compliant with existing trade commitments; and (ii) contributing to the design of trade policies and trade agreements that are health promoting. The concept of policy coherence asks that health policies and trade agreements are formulated in ways which enable both trade objectives and public health objectives to be met at the same time. The need to work towards closer coherence between health policy and trade policy has been recognised in World Health Assembly Resolution 59.26³ and reiterated in many regional meeting and research reports.

Capacity development is needed to support such collaboration. In August 2011 during the NCD forum in Tonga, health officials with responsibility for NCD prevention and management from 14 Pacific island countries were interviewed regarding their capacity for health-trade collaboration in their countries. The findings from these interviews substantiate anecdotal evidence and concerns previously expressed in the literature that the health sectors of Pacific island countries are generally not well equipped to initiate cross-sectoral discussions about health and trade. Capacity building strategies that were prioritised most highly included training in technical disciplines such as epidemiology and health economics; support from regional organisations (particularly country-specific advice); and earning opportunities for health officials (focused on understanding trade agreements) and trade officials (focused on understanding the impact of trade agreements on NCDs). Also emphasised was a need for different sectors (health officials, trade officials, clinicians, civil society, media etc.) to coordinate interventions in the intersection between trade and health.

As a result of the above concerns and issues, C-POND (Pacific Research Centre for the Prevention of Obesity and Non-communicable Diseases), SPC (Secretariat of the Pacific Community), UNDP (United Nations development Program) and WHO (World Health Organization) jointly organised this workshop entitled 'Sub-regional workshop on Trade and NCDs in the Pacific'. A faculty team consisting of academics from La Trobe University, Georgetown University, Sydney University, Deakin University and Fiji National University contributed to the development of the workshop content and design.

¹ Cheng MH: Asia-Pacific faces diabetes challenge. *The Lancet* 2010, 375:2207-2210.

² Thow AM, Snowden W: The effect of trade and trade policy on diet and health in the Pacific islands. In *Trade, Food, Diet and Health: Perspectives and Policy Options*. Edited by Hawkes C, Blouin C, Spencer H, Drager N, Dube L. Chichester, England: Blackwell Publications; 2010:147-168 - Hughes RG, Lawrence MA: Globalisation, food and health in Pacific Island countries. *Asia Pac J Clin Nutr* 2005, 14(4):298-306

³ World Health Organization: WHA Resolution on International Trade and Health (WHA59.26). Geneva: World Health Organization; 2006.

Goal and Objectives of the Workshop

The overall goal of the workshop was to strengthen the capacity for effective collaboration between health and trade sectors in and across the Pacific Island countries, with a view to working towards trade relations which support health-promoting environments and accessible, affordable, available and adaptable health care and thus contribute to eliminating the excessive burden of NCDs in the Pacific Islands.

Objectives

1. To encourage a shared understanding between health, trade, planning and civil society on the health implications of trade agreements in the Pacific
2. To identify tools and systems for assessing the potential impact of trade agreements on health, and health policy on trade
3. To draft country strategies for developing trade policies that support health, and health policies that are trade compliant

Opening Statements

The workshop began with an opening prayer from Dr Isimeli Tukana.

The opening address was given by the Attorney-General, and Minister for Justice, Anti-Corruption, Public Enterprises, Communications, Civil Aviation, Tourism, Industry and Trade Mr Aiyaz Sayed-Khaiyum. Mr Sayed-Khaiyum indicated that there was a need for a balancing act between trade and the efforts to control non-communicable diseases. He stressed the need to take the best of what trade agreements could offer, while ensuring they did not add to the NCD challenge. He highlighted some of the efforts the Government had made to support the fight against NCDs, including changing import duties on healthier and less healthy foods, alcohol and tobacco.

Opening remarks were also given by Dr Ezekiel Nukuro of the World Health Organization. He highlighted the scale of the NCD issue in the region, and the commitment given at global and regional level to tackling the problem. He emphasised how trade agreements and trade are affecting the supply of goods in and out of the region and stressed the importance of health being protected. There is also a need for greater understanding of how trade and health intersect.

Opening remarks were then delivered by Mrs Fekitamoeloa 'Utoikamanu, Deputy Director General of the Secretariat of the Pacific Community. Mrs 'Utoikamanu said the interests of public health should be considered in trade negotiations and that there was a need for 'compatibility' between government efforts to minimize the negative impacts associated with unhealthy products, and international commercial treaties that promote the freer flow of goods, services and investment.

Workshop participants were then asked to briefly introduce themselves and Dr Wendy Snowdon gave an overview of the aims and objectives of the workshop, and the programme content.

Session 1: The intersection of trade and NCDs: an overview

This session intended to provide an overview of health and trade intersection in the region, with a particular emphasis on NCDs.

Dr Wendy Snowdon introduced this session, using an interactive 'clicker' session where participants were asked to use remote clicker devices to answer questions. Questions focused on underlying causes of NCDs and food insecurity, and where trade and NCDs may be interlinked in their country.

Dr Temo Waqanivalu then provided an overview of NCD epidemiology and control in the region. He indicated that 75% of deaths in the region are due to NCDs and mostly premature. Recent surveys have found alarming rates; including diabetes prevalence in adults of almost 40% in one of the territories, and around 95% prevalence of obesity alongside high rates of tobacco use (60%) in another country. Dr Waqanivalu indicated that up to one in ten diabetics may have an amputation in some countries, and 75-80% of admissions, general surgeries and renal dialysis patients are due to NCDs. There are also immediate social costs due to relatives caring for NCD patients, and having to leave school or work. [Forum Leaders have declared NCDs to be a crisis, and globally the UN High Level political commitment has emphasised the need for urgent action.](#) Dr Waqanivalu also stressed the role of NCD Strategies in countries, and of using the "WHO Best Buys" interventions published by WHO and World Economic Forum. He challenged the meeting to consider whether we have healthy trade or whether we are trading health for something else.

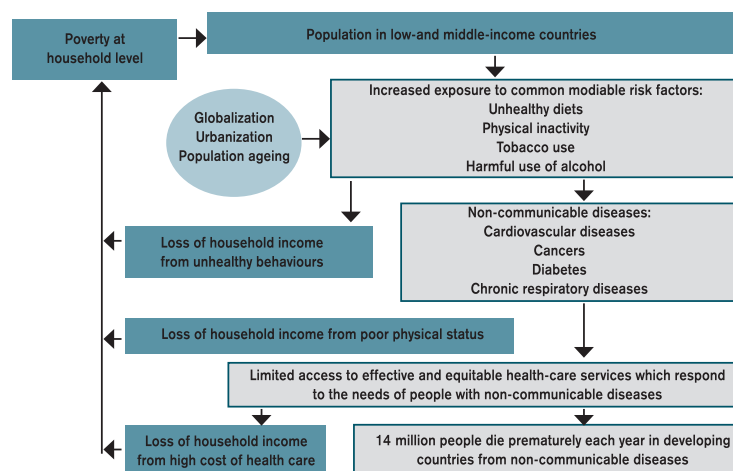
WHO "Best Buys" Interventions

Risk Factor / Disease	Interventions
Tobacco use	• Tax increases • Smoke-free indoor workplace and public places • Health information and warnings • Bans on tobacco advertising, promotion and sponsorship
Harmful alcohol use	• Tax increases • Restricted access to retailed alcohol • Bans on alcohol advertising
Unhealthy diet and physical inactivity	• Reduced salt intake in food • Replacement of trans fat with polyunsaturated fat • Public awareness through mass media on diet and physical activity
Cardiovascular diseases (CVD) and diabetes	• Counseling and multi-drug therapy for people with a high risk of developing heart attacks and strokes (including those with established CVD)
Cancer	• Hepatitis B immunisation to prevent liver cancer • Screening and treatment of pre-cancerous lesions to prevent cervical cancer

(Dr Waqanivalu - workshop PowerPoint presentation)

Dr Godfrey Xuereb began his presentation on the impact of trade on upstream determinants of NCDs, with an overview of the global situation with regard to NCDs. He emphasised that 60% of global deaths are due to NCDs and many of these premature deaths are now occurring among people who live in low and middle income countries. NCDs are clearly no longer synonymous with wealthy countries with ageing populations. Poverty increases the risk factors for NCDs through unhealthy diet, harmful use of alcohol, tobacco use and low physical activity rates. NCDs in turn increase the risk of poverty through health care costs, disability and premature death which cause decreased household income and further exacerbate the risks to poverty.

Poverty, socio-economic determinants and NCDs in low and middle income countries

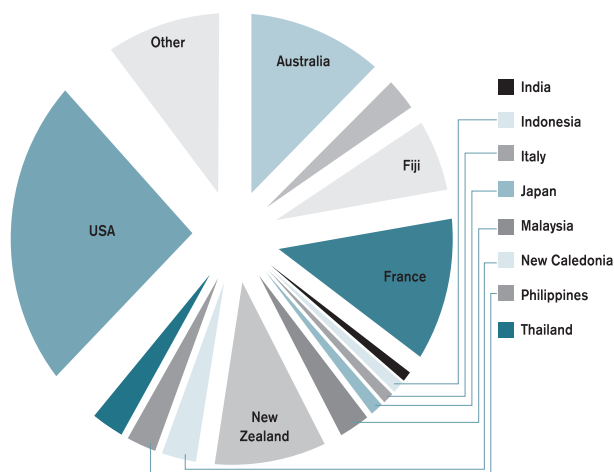


(Dr Xuereb - workshop PowerPoint presentation)

Dr Xuereb then discussed how the social determinants of health influence NCDs and require a multi-stakeholder and cross-sectoral approach and call for countries to intervene at specific levels to affect the social structure (including gender), education and employment, trade and fiscal policies and purchasing power. He highlighted that since trade agreements are often quite broad in scope, i.e: covering trade in goods and services, regulation of intellectual property rights (IPRs), labour mobility, protection of foreign investments, phytosanitary regulations and the supply of goods and services to government; they can affect the social determinants of health which in turn have a high influence on NCD risk factors and the management of NCDs. Dr. Xuereb concluded that there are both benefits and risks for health in these agreements which require careful consideration.

Dr Wendy Snowden provided examples of how upstream determinants were affecting NCD risk factors, with a focus on diets and food supply. She outlined how store surveys had identified 54 countries of origin for foods sold in five countries in the region. The impacts of foreign direct investment including by fast food chains and of urbanization on diets were also discussed. Even aid post-disaster has contributed to long-term changes in dietary patterns in selected countries.

Results of 5 country study on processed foods: 54 countries of origin of foods



(Dr Snowden - workshop PowerPoint presentation)

During the discussion, concern was expressed by one participant about a recent supermarket promotion in Fiji which gave away various high fat, sugar and salt items to customers. While consumers could refuse these items, there is also a need for work with all aspects of food industry including retailers so their activities support public health.

Session 2: Trade agreements and how they can intersect with NCDs

This session intended to introduce the intersection of trade and NCDs, from a trade perspective.

Dr Benn McGrady began this session with another round of thought-provoking questions using the 'clickers'. This included questions on how participants perceived the trade agreement development process and benefits in their country and the scope to implement trade regulation to address NCDs.

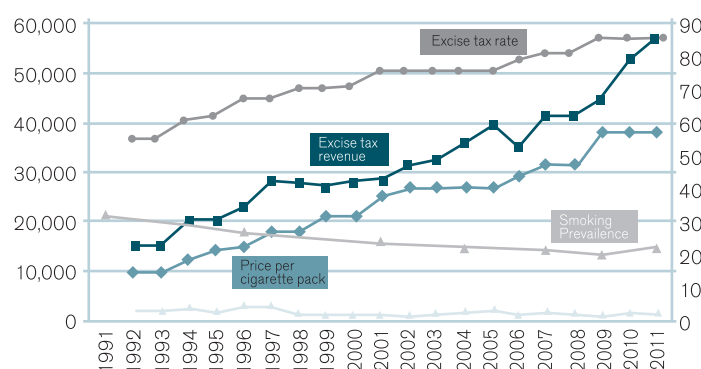
Dr McGrady then spoke on the trade architecture and mechanisms in the Pacific Islands. The underlying feature of trade agreements is a commitment to lower barriers to trade (both tariff and non-tariff). Non-tariff barriers include quotas which might limit import amounts or health regulations. Dr McGrady indicated that the World Trade Organization (WTO) was the central multilateral instrument of the international trade regime. The WTO agreements place upper limits on the imposition of tariffs (customs duties) on imported goods and restrict the use of non-tariff barriers to trade, including regulatory measures. The WTO Agreements are enforced through dispute settlement, with Member governments permitted to bring claims against one another alleging violation of the agreement. The WTO Agreements are also complemented by free trade agreements and customs unions, which are usually bilateral or regional in character. Trade agreements which exist or are under consideration in the Pacific include PICTA, SPARTECA, EPAs and PACER Plus.

Nicky Anaturin from the Pacific Island Forum Secretariat (PIFS) provided further information on the trade agreements in the region. He highlighted that 7 countries were currently trading under PICTA, with 4 yet to complete necessary domestic arrangements, and that other countries are yet to join. PICTA was regarded as a stepping stone for PACER Plus. EPAs are intended to be an instrument for development, and to assist Pacific Islands to be integrated into the world economy, as well

as to achieve sustainable development and eradicate poverty, enhance production, supply and trading capacity and improve capacity to handle all trade-related issues. Progress has been made in recent trade negotiations in October and December 2012 for EPAs and negotiations are expected to be concluded by mid-2013. PIFS is also assisting small island states to develop and implement Trade policy frameworks to mainstream trade plans into trade policy, with a focus on: trade policy analysis and negotiations, trade facilitation and export development.

Dr Sripen Tantivess shared an example of how health and trade agreements had overlapped in Thailand in the area of tobacco control. She highlighted the considerable burden of NCDs, and the importance of tobacco smoking as a risk factor. Since late 1980s government agencies, in collaboration with civil society organizations and private businesses, have introduced several measures to curb tobacco consumption. During the same period, smoking prevalence significantly declined.

Excise tax rate, revenue and smoking prevalence, Thailand 1991-2011



Source: Tobacco Control Research and Knowledge Management Center, Mahidol University
(Dr Tantivess - workshop PowerPoint presentation)

Evidence suggests that raising excise tax was effective in reducing smoking, especially in low-income groups. However, this intervention was challenged under regional and bilateral free trade agreements (FTA), which required the elimination of tariff on tobacco products. Dr Tantivess also described how trade agreements under discussion may cause problems for tobacco efforts if the Thai government does not balance health concerns with economic benefits of these agreements on the agriculture and industry sector. In this respect, intersectoral, evidence-informed policy development is essential for health protection.

During discussion of these three presentations a question was raised about whether any of the excise taxes in Thailand went to health promotion activities. Dr Tantivess clarified that 2% of the excise act were transferred to a Thai Health promotion Foundation. It was also highlighted that alcohol, food and tobacco cannot be tackled in exactly the same way, although some lessons may be drawn from successes in these areas. For example: that **efforts are needed to increase access to healthy foods e.g. through support for local agriculture as well as reducing access to less healthy products**. An additional question requested suggestions of what might be health-supporting interventions, which are trade compliant. Dr McGrady indicated that for tariffs, non-discriminatory excise taxes are preferred.

Dr McGrady next presented on trade rules and their implications through a series of case studies. Indonesia argued discrimination when they were unable to export clove cigarettes to the United States, although menthol cigarettes were imported. The WTO panel had to consider whether clove and menthol were 'like' products, and whether restriction was more restrictive than necessary to protect human health. Indonesia lost its case. In regard to the adoption of plain packaging for tobacco, Australia is being

challenged on the basis that the measure is restricting the use of a trademarks (tobacco company symbols and brands). A second case study was presented on the French ban on the import and sale of asbestos products. Canada complained under GATT (part of WTO) arguing discrimination as France uses asbestos substitutes (which pose no danger to health). The WTO panel found that the measure was discriminatory and favoured French substitutes but still ruled in favour of France because the measure was necessary for health. The final case study was on retread tyres, which Brazil banned the import of. They argued retread tyres have maximum lifespan of 5 years and then are discarded creating a breeding ground for mosquitoes. In fact less trade restrictive measures were available i.e. waste disposal, spraying, and ultimately the measure was found to be unlawful.

During the plenary discussion questions were raised about the level of evidence needed to prove that something was harmful to health. Dr McGrady indicated that it was largely about assessing the risk, however there are no strict evidentiary requirements. *It is important to ensure that product selection is consistent and 'like' products are regulated in similar ways, rather than targeting one particular product.*

Prof Carlos Correa then outlined how trade and public health could go hand in hand. Multilateral trade agreements contain rules allowing for the adoption of measures to protect public health, even when such measures may violate parties' obligations. Article XX(b) of GATT 1947, for instance, has been invoked in certain cases as a justification for trade restrictive measures. GATT/WTO jurisprudence has subjected the application of this provision to the so-called 'necessity test', in accordance to which only the least trade-restrictive available measure would be permissible. In the Thailand-Cigarettes case, a panel rejected arguments based on article xx(b) . In Canada-Asbestos, however, the Appellate Body clarified that '(1) the protection of health is a national objective of vital importance; (2) WTO members are free to select the level of health protection they believe appropriate for their populations; and (3) in cases analyzing measures to protect human health under the necessity test, the potential effectiveness of less trade -restrictive alternatives should receive strict scrutiny'. One of the objectives of the Agreement on Sanitary and Phytosanitary Measures (SPS) is to enhance human health. WTO members can adopt standards higher than those recommended by the relevant international organizations if scientifically justifiable. The burden of proof is then shifted to Member countries. *Governments should explore the ways for effectively using the public health-related provisions in the WTO system and in other trade agreements.*

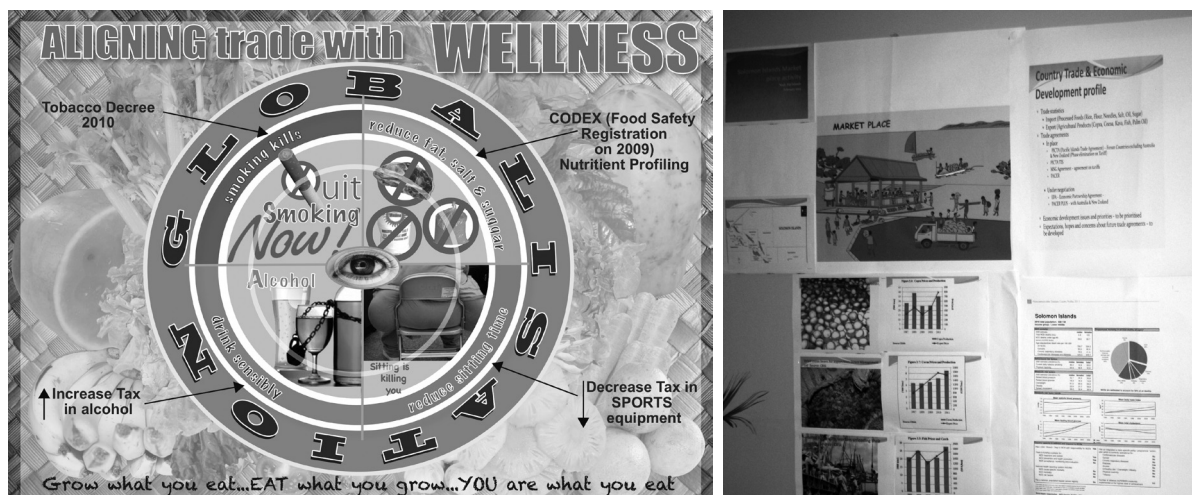
Clarification was requested during the plenary discussion on who sits on the dispute panels? Prof Correa clarified that this was determined by parties to the dispute and the panel may also request expert opinions. Concern was expressed by one participant about CODEX standards which are promoted to be only food standards, not being of relevance for NCDs. Dr McGrady agreed that this was historically the case, with emphasis on food safety, however new areas were being discussed, such as trans fats⁴ .

In the final session for day one, country teams were asked to share information about their country's situation in terms of both NCDs and trade and economic development, and to share any country-based examples of collaboration between health, trade and planning sectors. This was done through a pre-prepared poster, supported by a few minutes of explanation per team. This was a highly informative session for all participants, revealing considerable differences between countries and also some similarities. All countries highlighted their significant NCD burdens through mortality, morbidity and prevalence data. They also provided an overview of their NCD strategies and implementation approaches including multisectoral mechanisms (NCD committees) and regulatory interventions such as food regulations and sugar tax. Posters also included information on

⁴ This also includes food labelling and claims. A shift from trade-based standards to consumer-based standards and guidelines is underway in the Codex Alimentarius. This is a shift from a prevention of fraud approach (1960s) to providing more consumer information (1990s) and increasingly towards delivering health policy through labelling.

trade policies and economic country data, and their trade agreement environment. Civil society involvement in NCDs was also highlighted in some country presentations and some teams even identified actions they would pursue post-workshop to increase collaboration between trade and health. The presentations were lively and the posters provided a strong basis for the country group-work later in the workshop. Posters were left on display for closer examination during the remainder of the workshop.

Example of posters developed by country delegates at the workshop



Session 3: Regional cases where trade and NCDs have intersected

The intent of this session was to consider regional examples of how trade agreements and NCD issues have intersected and how they have developed.

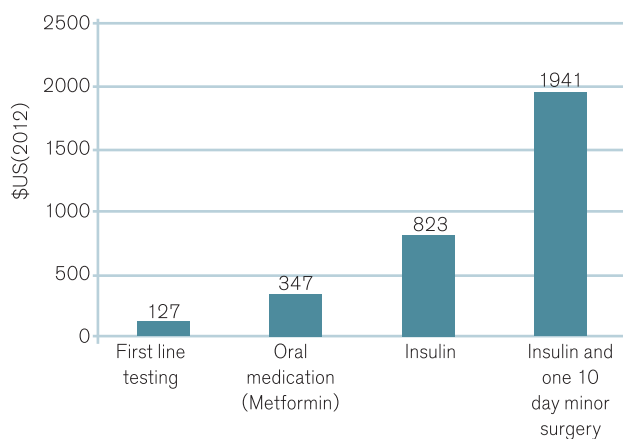
The session began with a panel discussion on trade and economic development chaired by Dr Anne Marie Thow. Ahmed Moustafa began the panel by outlining the mixed results on the Millennium Development Goals (MDGs), across the region, with some good progress but also some issues. He also stressed that trade agreements do not directly lead to economic development, especially for countries in the Pacific. The markets for exports are already out there and accessible, with or without trade agreements, but the region has had problems with providing the supply. Additionally the market for primary commodities is highly volatile and competitive, to increase its earnings and the stability of these earnings, the region needs to move up value-added chain in terms of its exports.

Mere Falemaka then spoke on the Melanesian Spearhead Group (MSG) and its role. She highlighted the growing exports and trade by MSG countries; exports from MSG countries have increased by 300% from 2005-2009. Intra MSG trade is however very small (3% of total). She stressed that trade agreements are not the cause of growing imports, for example there are no trade agreements with China in MSG countries, but their goods are very cheap, so highly competitive and therefore highly available. Ms Falemaka also indicated that there was a need to consider health during development of trade policies and trade agreements, such as PACER Plus. For example, Vanuatu has a national trade policy, which integrates food security concerns.

Dr Joann Young spoke of the work of the Pacific Island Forum Secretariat in regard to consideration of health in trade agreements, using the EPAs as examples. When Nauru, as part of its' EPA was asked to liberalise its market, it was allowed to exclude 20% of items from the agreement listing. It chose to exclude chapters 17-19, and it therefore can leave its tariffs for European goods unchanged – this includes sugary products thus meaning its sugar tax can remain in place. Dr Young also indicated that there was a provision in EPA for export tariffs – and this is allowed for 'special development needs'.

Paulini Sesevu from AusAid then spoke on the role of AusAID in the region, its strategic priorities and its emphasis on poverty reduction. The final presentation on the panel was from Dr Eva Jarawan from the World Bank who outlined the World Bank's commitments on health and development in the region. This includes improving health and nutrition, enhancing the performance of health care systems and sustainable health care financing. Dr Jarawan then provided a brief overview of a recent study by World Bank on costs of specific NCD treatments in three Pacific island countries. In particular she emphasised how costs increased as diseases worsened.

Costs of treatment in Vanuatu for diabetes



(Ms Jarawan - workshop PowerPoint presentation)

Ms. Jarawan also stressed that the fiscal space for health was shrinking and according to World Bank projections, raising the excise rate on tobacco and alcohol to reach WHO recommended level would generate extra excise revenue of 3.6 million Tala for Samoa (USD 1.57 million) and 2.5 million Pa'anga (USD 1.4 million) for Tonga each year, whilst discouraging uptake.

During the discussion component of the panel, it was highlighted by a participant that health officers need to ensure friendly and open dialogue with trade officers. There was a request from one country participant for more countries to have studies on costs of NCDs. Nauru asked if World Bank would include other countries going forward. Dr Jarawan responded that World Bank would need to assess the value of and interest in further studies in the region.

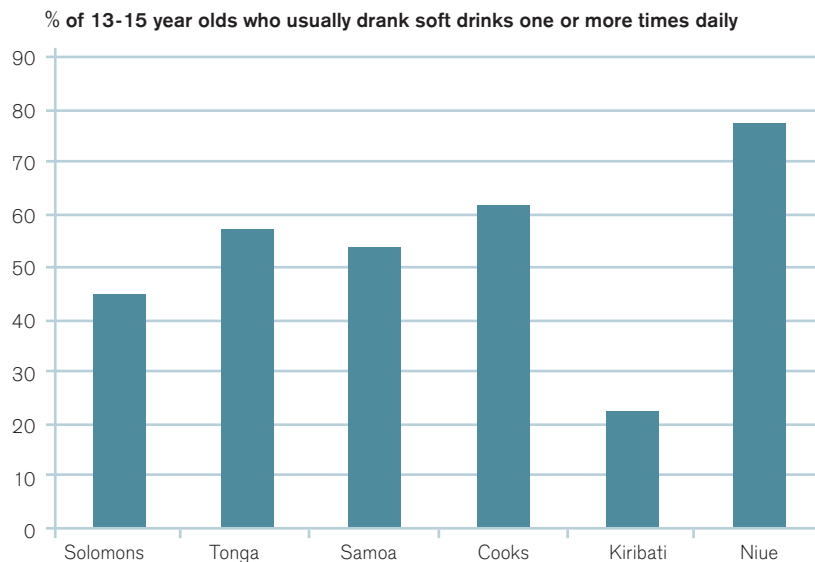
Dr Thow, Christine Quested and Samuela Bolalailai then spoke on mutton flaps and turkey tails. Mutton flaps and turkey tails were banned in Fiji and Samoa respectively. In Fiji, the ban was a health and commerce collaboration, proposed by health and implemented by commerce in the year 2000. Mutton flap imports declined significantly, but due to difficulties with enforcement mutton flaps have reappeared on the market despite the ban. In Samoa, the ban, first put in place in 2007 on turkey tails was proposed by the Prime Minister and implemented by Customs after a cabinet brief supporting the measure was prepared by the Ministry of Health. The ban resulted in removal of turkey tails from the food supply – consumers replaced consumption with a variety of foods, including seafood and chicken, and some consumers reported eating less meat as a result of the ban. Samoa's ban on imported turkey tails has since been lifted as part of Samoa's accession to WTO. [These case studies highlight bigger issues related to trade, food, agriculture and health. One is that unhealthy cheap imported food creates incentives for unhealthy diets, leading to NCDs. Another is that these cheap imports undercut local agricultural productions, leading to decreased production capacity and greater dependency on food imports.](#)

Dr Thow then spoke on the issues with agriculture, trade and NCDs. NCDs have implications for agriculture due to their negative effect on a productive labour force. The agricultural labour force is also affected by trade due to increasing labour mobility. Specific challenges for Small Island states in developing sustainable agricultural production for both high quality exports and traditional agricultural production include: Scaling up agriculture; Sale of fishing rights; Value adding; Climate change; Labour shortages; Competition from cheap imports; Export oriented agricultural investment; and Under-investment in traditional agriculture. Opportunities to overcome challenges include: Investment (local & international) in agriculture to enable farmers to engage with high quality export markets as well as traditional production (e.g. better land management for sustainable intensification), support for value adding and innovation in production and processing for traditional foods and collaboration between trade, agriculture and health sectors.

During the plenary discussions, a question was raised in regard to sustainability of bans, given problems experienced in Fiji and Samoa. Dr Thow suggested that fat-based standards which have been implemented in Ghana on fatty meats (effectively preventing sale of very fatty meat cuts) might be preferable to product specific bans. Dr McGrady also commented that these bans are not necessarily against WTO law, this depends on individual country accession agreements. What Ghana has done is consistent regulation across food product range, and this is much more in line with a WTO approach. A query was also raised about whether people had potentially shifted to other less healthy products when flaps or tails were unavailable. Ms Quested indicated that there had been no obvious shift to one alternative product, but overall to chicken and seafood, and also lowered consumption of meat overall. Dr McGrady also added that once a measure was in place, countries do not have to be able to demonstrate immediate impact (the long term impact is often more important).

Dr Snowden presented on sugary taxes in the region and began by outlining the evidence demonstrating links between high sugar intake, overweight, diabetes and cardiovascular disease. There is evidence of high consumption levels of sugar and other high-sugar items such as soft drinks in the region.

Daily intake of soft drinks by 13-15 year olds (global school health survey)



(Dr Snowden - PowerPoint workshop presentation)

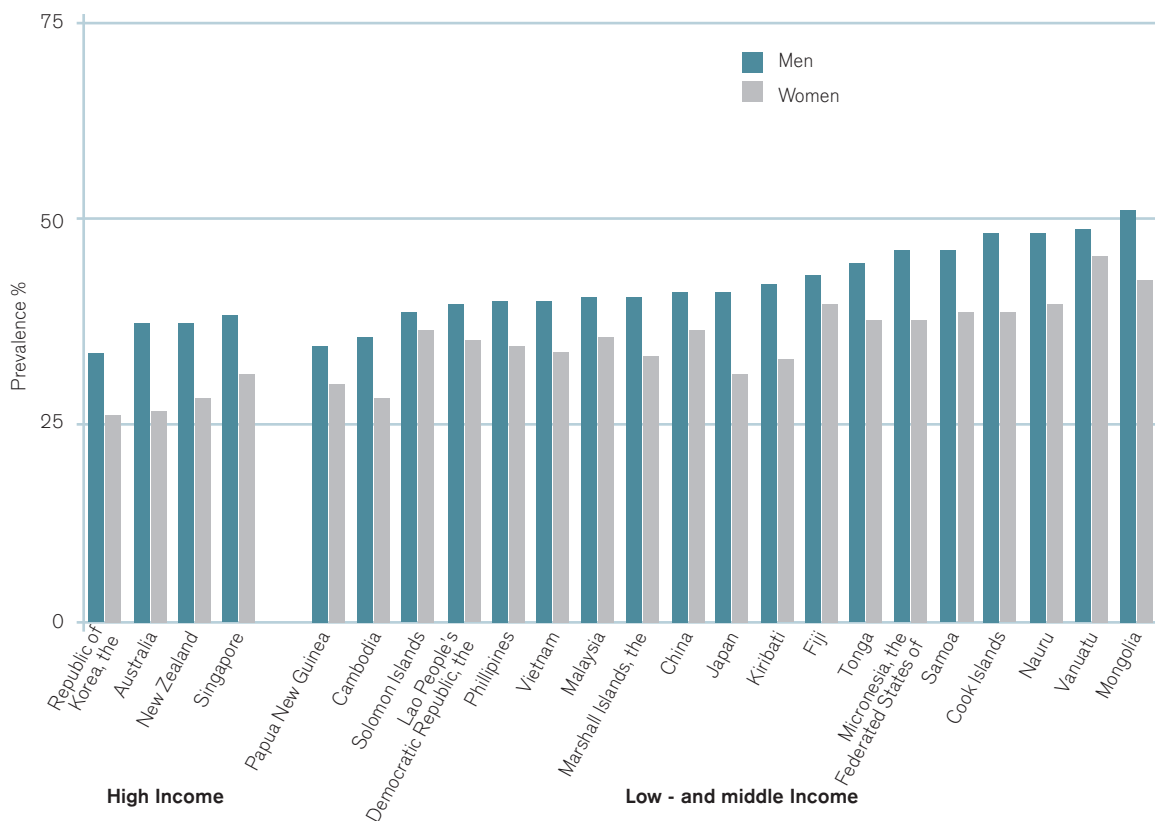
Dr Snowden also highlighted how sugar and high fructose corn syrup (an alternative to sugar, particularly used in the Americas) were heavily used across a wide array of processed foods, and were cheap commodities, in part because of production subsidies. This has led to significant global interest in taxing sugary products in an attempt to reduce consumption, and taxes are now in place in many countries. In this region Samoa, Nauru, French Polynesia and the Cook Islands are some of the countries which have tariffs on sugary products and/or soft drinks. Evidence globally is that they can lead to reduced purchasing by consumers if the tariffs are high enough to be noticeable to the consumer. [From a trade agreement perspective, these tariffs are unlikely to be problematic as long as they are applied equally to domestic and imported products, and if import duties are used then they must not exceed what has been agreed as the upper bound limit.](#)

Berrick Dowiyogo then spoke on the sugary tax that has been implemented in Nauru. This applies a 30% tax to a range of high-sugar products. Mr Dowiyogo commented that he has seen a greater supply of diet drinks since the tax. However, there has also been more sourcing of sugary products from Asia, which are cheaper, meaning that the price to the consumer for some products (e.g. can of soft drink) has not changed overall. During the plenary discussion it was emphasised any such measure needed to be undertaken as part of a comprehensive strategy (also addressing behaviours). Additionally, viable healthier alternatives need to be available and affordable. Concern was also expressed at possible side-effects of such tariffs, and it was emphasised that it was important to consider these prior to implementing a policy through health or social impact assessments.

Peter Hoejskov spoke on the issue of salt and salt standards for sale or import. He highlighted how high sodium intake increases blood pressure and contributes to increased risk of cardiovascular disease. Other damaging effects of high sodium intake include cancer, kidney disease, renal stones and osteoporosis. Raised blood pressure is one of the key intermediate NCD risk factors and cardiovascular diseases including stroke are among the leading causes of death in Pacific Island Countries. [Population salt reduction has been found to be one of the most cost effective interventions for NCD prevention and control.](#) Salt intake originates from three main sources: food prepared at home; food and meals prepared by the foodservice sector; and processed food. In the Pacific, eleven countries have developed salt reduction strategies and are in the process of implementing a mix of regulatory

and non-regulatory interventions. He discussed some of the activities underway in Fiji, including voluntary salt reduction targets and discussions with the private sector on reducing salt in processed food. The regulation on nutrition content labeling has also been amended to include sodium. In Cook Islands, the Ministry of Health has developed draft standards for maximum content of salt in selected processed foods and integrated nutrition messages into the training curriculum for food handlers. Elsewhere, South Africa has developed standards for maximum content of salt in a range of processed foods. He encouraged the Pacific Island Countries to consider the possible effects of regulatory versus non-regulatory measures on population salt intake and to gather the necessary evidence to support these.

Comparable prevalence of raised blood pressure in adults +25 yrs in 2008 Western Pacific Region



(Mr Hoejskov - PowerPoint workshop presentation)

Jeanie McKenzie then spoke about the experiences with the issue of exclusion of tobacco and alcohol from the Pacific Islands Countries Trade Agreement (PICTA). She began with an overview of PICTA's development and then outlined the process that had resulted in alcohol and tobacco being excluded. This was primarily more about concerns over declines in duties and taxes than health issues. [The need for early and thorough assessment of legal, socio-economic and health impacts before entering into trade agreements was highlighted, particularly to ensure policy coherence between trade and health.](#) The interests of various stakeholders including national governments e.g. revenue/taxation, manufacturers and health interests, showed that finally the agreement on the exclusion of tobacco and Alcohol from PICTA suited all parties but for very different reasons; protectionism, lack of readiness to adopt tax changes and the growing concerns about NCDs. She also indicated that the long term future for the exclusion of tobacco and alcohol from PICTA is yet to be determined but the Forum Communiqué on Regional Health Initiatives

'acknowledged urgent need for health systems strengthening and cross-sectoral, whole of country initiatives to achieve better health outcomes at national level', which would indicate that alcohol and tobacco will continue to be excluded from PICTA for the foreseeable future.

A comment was raised after this presentation that the exclusion of alcohol/tobacco from PACER Plus or EPAs may be more difficult, as the process is likely to be more stringent regarding exclusions as the discussions include non-Pacific island countries.

Dr Benn McGrady then spoke about the relationship between the WHO's Framework Convention on Tobacco Control (FCTC) and trade agreements. FCTC is an international treaty that binds Parties to implement a wide range of tobacco control measures. These measures include tax or price measures, mandatory warnings on tobacco product packaging and a comprehensive prohibition on tobacco advertising, sponsorship and promotion. The Convention is supplemented by guidelines designed to assist the Parties in implementing their obligations. All Pacific island countries (but not the Territories of the Pacific) are Parties to the WHO FCTC. Dr Lester Ross shared the experience of the Solomon Islands with tobacco control. The country has developed a comprehensive Tobacco Control Action Plan, tobacco-free school policy and a tobacco control Bill. More work is underway, to develop and enforce regulations for example, and there is a need to gain more support from important stakeholders such as Chamber of Commerce and Ministries of Commerce and Trade.

Dr David Legge spoke about trade in services as part of trade agreements and how this might impact on health systems in the Pacific. He mentioned that the main agreement on trade in services is WTO's GATS (General Agreement on Trade in Services) but that most bilateral or regional trade agreements now have a Services Chapter which covers much of the same ground. The four modes of trade in services (i) cross border supply, (ii) consumption abroad, (iii) corporate presence, (iv) presence of natural persons. In health care these could be exemplified by: (i) telemedicine or internet transcription services; (ii) medical tourism; (iii) foreign investment in hospitals; (iv) importing doctors. **Dr Legge argued that trade in services provisions are virtually irreversible and all of the benefits can also be achieved through development cooperation; because of the irreversibility, there is good reason to be very careful about committing to such agreements.** Since GATS at least is negotiated on an 'opt in' basis he recommended that Pacific countries should be cautious about including health services or health related services in their 'offers'. He expressed some doubt as to the significance of trade in services agreements for the Pacific. Dr. Legge also stressed that the interests of Pacific countries in relation to the four kinds of trade in services could be well advanced through international or commercial negotiation. He spoke about brain drain and the development of tertiary care in particular as important issues for the Pacific which could best be dealt with through direct international or commercial negotiation.

Prof Correa presented on the issue of access to medicines. The adoption of the TRIPS (Trade-related aspects of intellectual property rights) Agreement (part of WTO) brought about a drastic change in the policy space that countries had in regard to intellectual property (IP). Notably, TRIPS obligates all Member countries (with a transitional exemption for least developed countries only) to grant patents in all fields of technology, including pharmaceuticals. Patents create a tension with public health as they can permit the charging of high monopolistic prices on patented medicines. TRIPS contains, however, a number of 'flexibilities' that allow Members to mitigate the impact of exclusive rights including through: certain exceptions, compulsory licenses and parallel imports. The legal challenge by a number of multinational companies to block the use by South Africa of some of the TRIPS flexibilities eventually led to the adoption of the Doha Declaration on the TRIPS Agreement and Public

Health, in 2001 which confirmed those flexibilities. Despite this, developing countries still face the problem of proliferation of pharmaceutical patents on derivatives, formulations, new uses, etc. of known substances, which may unduly prevent or delay the commercialization of cheaper generic drugs. **Non-WTO Members should use the policy space that they have to frame their IP regimes in accordance with their national interests. WTO members should use to the fullest extent possible the TRIPS flexibilities.**

Christine Quested then shared her experiences of involvement in TRIPS discussions during Samoa's WTO accession process. They were now rewriting their intellectual property legislation to be WTO compliant and made sure it encompassed TRIPS flexibilities (e.g. removing data exclusivity from its draft IP law). She highlighted the importance of the health sector being knowledgeable and engaged in trade issues and of cross-sectoral collaboration and coordination during development of trade agreements. She also added that health needs to get involved with trade even if feeling uncomfortable.

During the plenary discussion, Dr Gleeson added that countries need to be aware of newer trade agreements (bilateral and multi-lateral) which include much more IP protection (known as TRIPS plus). A participant suggested that a system be created within Ministries of Health to train such professionals. It was also commented that it was important to verify the patent status of medicines, as absence of patents on certain medicines allow for importation of their generic, more affordable versions.

Session 4: Assessing potential impacts of trade agreements on health and feasibility of policy options

This session intended to briefly familiarise participants with some of the tools and methods available to assess trade agreements and policies for their relevance and health impacts.

Dr Gleeson began with an overview of the methods and tools available for impact assessment. The focus of the session was on assessing the impact of trade agreements, but the methods and tools were also discussed in relation to assessing the impact of health policies. The three main methods discussed were Health Impact Assessment (HIA), Social Impact Assessment (SIA) and Human Rights Impact Assessment (HRIA). Dr Gleeson explained that Impact Assessments can be conducted either *ex ante* (before or during trade negotiations, to highlight likely impacts and inform the negotiations) or *ex poste* (after a trade agreement has been implemented, to measure actual impacts and assist in identifying mitigating measures). Each of the methods discussed (HIA, SIA and HRIA) follow a similar series of steps, which includes screening, scoping, collecting information, assessing the information, making decisions and recommendations, and evaluation, monitoring and follow up. They all use a combination of data collection methods, which may include quantitative data (such as economic data) and qualitative data such as community consultations, focus group or key informant interviews. There are various practical guides available for all of these methods.

While the methods are similar, there are important differences in the normative frameworks of these three methods. HIA focuses on the social determinants of health and the differential effects that policies can have on the health of different population groups. SIA includes a focus on the social, environmental and economic impacts of trade agreements. HRIA is explicitly referenced to the human rights obligations of states and includes a focus of the impact on the most vulnerable and disadvantaged groups.

Issues that need to be considered in an impact assessment (whichever model is chosen):

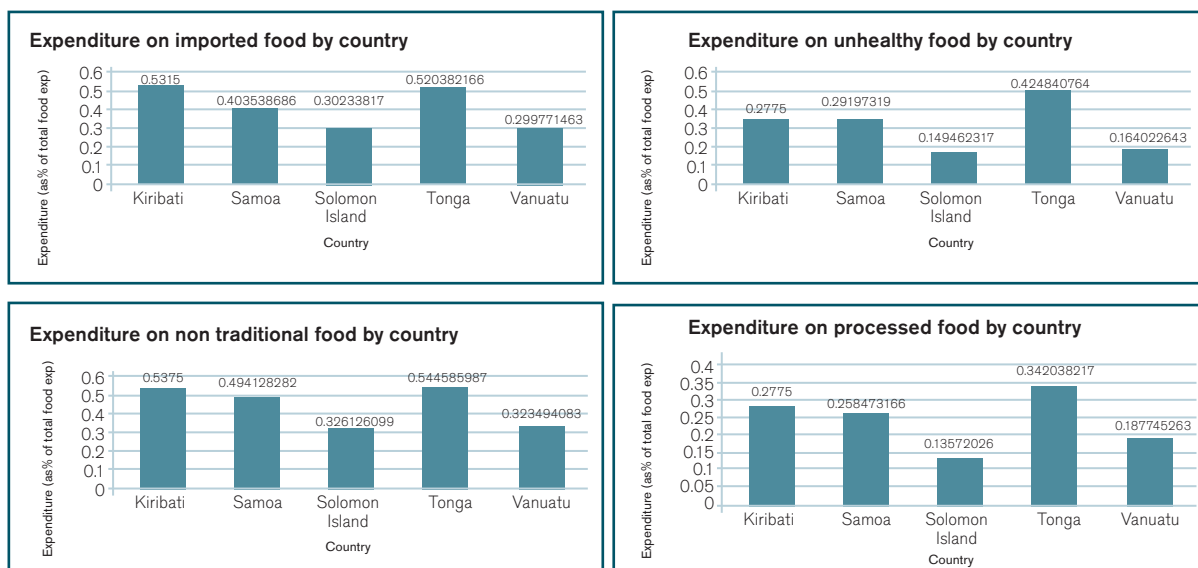
- When to conduct the impact assessment (before, during or after the negotiations, or as a cyclical process);
- The appropriate scope and level of detail given the time and resources available;
- Who is best placed to undertake the impact assessment (keeping in mind factors such as independence from the negotiations, expertise, and the implicit assumptions that different actors might bring to the task);
- The best mix of methods for the particular situation;
- Transparency (of objectives and decision making criteria, of consultation processes, and findings and recommendations) and inclusiveness; and
- Opportunities for the findings to feed into policy decision making.

Dr Wendy Snowdon, reflecting on her experience with HIA to predict the possible impact of introducing policies for health and nutrition on other health and social issues, emphasised the value of these tools to ‘flag’ policies which might have potentially negative side-effects and warranted further investigation before being considered for action. She also highlighted that the screening process was relatively simple to undertake in a participatory way with a strong working group and tool.

Simone Troller then presented on Human Rights Impact Assessments. She stressed that Trade agreements and human rights conventions both impose legal obligations on countries, and therefore **countries should make sure that one set of binding rules does not undermine another set of legal obligations**. Trade agreements and policies can positively or negatively impact on people’s enjoyment of their right, including their right to the highest attainable standard of health; and they can positively or negatively impact countries’ abilities to realize human rights, including the availability, accessibility, affordability, and quality of health-related facilities, goods, and services. Increasing attention therefore is being paid to human rights impact assessments as a tool that provides countries with evidence on how to mitigate negative impacts of trade on human rights, including the right to health, and how to maximize positive outcomes. The UN has adopted guiding principles for assessing the impact of trade agreements and policies on human rights in 2011, and the same year the EU Parliament has called for human rights impact assessments to be carried out for all trade agreements with the EU.

Brian Lutz discussed how statistics could be used to support analysis of impacts, with a focus on Household Income and Expenditure Surveys (HIES). While evidence-informed policy-making requires reliable, regular data, especially on NCDs and their risk factors, obtaining primary data, can be costly. Analyzing secondary data (i.e., existing data collected through other means) could provide a workable – if sometimes imperfect – solution. Regularly administered in Pacific countries, the HIES captures relevant, disaggregated food expenditure at household level. This is collected through food frequency assessments and is used as an indicator of calorie/energy consumption. These data can be classified by users into four binary, non-mutually exclusive categories (e.g., imported/local, unhealthy/healthy, processed/unprocessed, non-traditional/traditional) to develop descriptive food profiles. Analyses can also be conducted that examine relationships among food classifications (e.g., imported and unhealthy food) and among food classifications and NCD risk factors (e.g., imported food and obesity). The approach can provide an indication of problematic foods at the nexus of health-trade policy. It can also be used potentially to estimate policy impacts and build policy impact scenarios. Mr Lutz shared some cross-country results from five Pacific countries and requested consideration of scope for improvements in the methodology.

Example of HIES data analysis as a tool for policy decision



The participants were then asked to work in groups and to think through the issues related to impact assessment of trade agreements. Country participants were asked to choose a trade agreement their country was currently negotiating and consider whether they might think about doing an impact assessment, what issues they might need to consider and how they would ensure the findings of such an assessment would inform trade policy making. Non-country participants were asked to discuss whether impact assessment should be used more systematically in the region, how countries might be better supported in assessing the impact of trade agreements on health and whether there is a case for regional level impact assessment. The outcomes of these discussions were picked up again in the country work on Day Four.

Session 5: Towards health and trade policy coherence

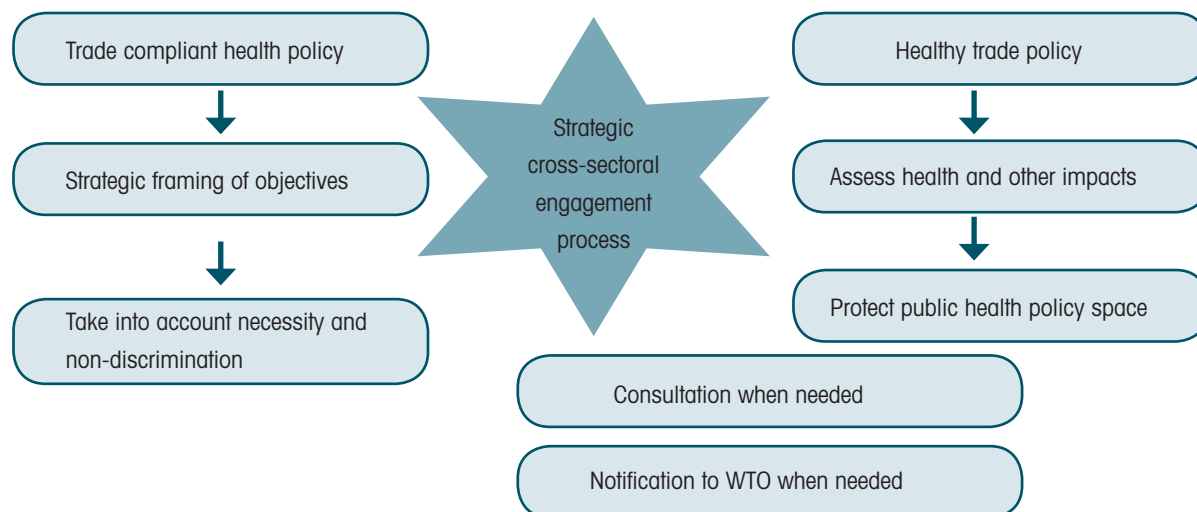
This session intended to consider how to build an environment where health promotion policies are trade compliant and trade policies support health.

This session commenced with a presentation from Dr Tantivess on Health in all Policies, the Thailand experience. Health in All Policies (HiAP) is an innovative, horizontal policy strategy to improve population health and health equity. The focus of this is development of healthy public policy, across non-health sectors, which may have impacts on health such as agriculture, education, trade, industry and transport. In response to the need for health system reforms since 1980s, Thailand includes HiAP concept in its 2007 National Health Act. Under this law the National Health Assembly is annually convened, with the aim of providing public space where health problems and solutions are openly discussed among stakeholders from all sectors including government agencies, civil society organizations, private companies and provincial networks of lay people. Throughout the processes, deliberative exchange of knowledge, information and experience between different interests is encouraged as a means to pursue consensus on each resolution. During 2008-2012, evaluation studies indicated that the Assembly, as an alternative policy venue, provides opportunity for social mobilization and policy engagement of general public, although there is still substantial room for improvement.

During plenary discussion a question was posed on how Thailand had been able to secure representation of the range of government officials and business people in the national health assembly and how does Thailand bring in people who are reluctant? Dr Tantivess responded that the process was now 5 years old and is currently being evaluated. The Commission has tried to solve the problem to make sure different sectors understand each other better, but the process is still fairly new and will take some time. She also emphasised that while alcohol and tobacco companies were excluded from the assembly; other companies are present including asbestos manufacturers.

Dr Anne Marie Thow then presented on health promotion strategies which are trade compliant and trade policies which promote development and create healthy environments. This includes health promotion interventions consistent with commitments within trade agreements and policy interventions or improvements in coherence within trade, commerce, finance, agriculture. These policy directions must consider strategic framing of policy objectives that ensures that they are able to defend necessity and non-discrimination as key principles for trade compliance. Healthy trade policy includes: Trade policy and negotiations that are sensitive to protecting policy space for NCD prevention; and Implementation of specific interventions for health.

Principles of healthy trade



(Adapted from Dr Thow - PowerPoint workshop presentation)

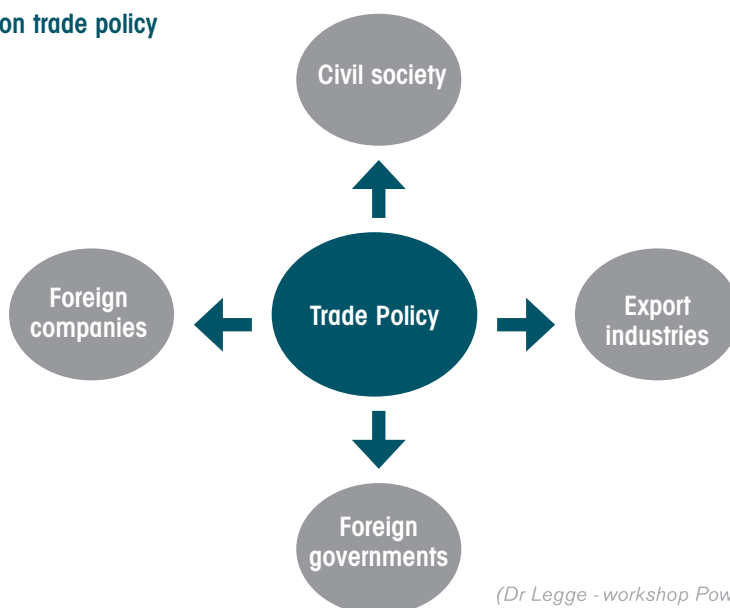
In developing these policy directions, assessment of health and other impacts is essential, as is ensuring flexibilities and policy space to protect public health. The opportunities created by collaboration between trade and health in the prevention and management of NCDs include: Potential for new strategic policy directions and innovation in NCD prevention; Development of more feasible multisectoral health interventions to prevent NCDs; and Pro-active engagement with trade negotiations to ensure public health is protected.

A question was raised as to whether a country should pursue policy measures if they are associated with risk to other areas of health, or if countries should just pursue a health education approach. Dr McGrady emphasised that this is not either/or, policy and education may both be needed, but it's important to find the best approach. Prof Correa also added that in reality there is scope to try a policy measure, and then see if there is a WTO objection to it, and if there is then the measure can be revised, while if there is no objection, then the measure can be maintained. Prof Correa stressed that the WTO functioning is based on diplomacy and negotiation.

Prof Carlos Correa then spoke about how to achieve trade agreements which progress healthy policy. He spoke of the importance of a clear identification of national interests in relation to NCDs and, more broadly, public health, being crucial when engaging in trade negotiations. It is also essential to assess the extent to which trade agreements may permit the achievement of such interests. Thus, access to markets will not automatically lead to an increase in exports; even if such an increase takes place, it will not automatically lead to poverty alleviation. Prof Correa also emphasised that the new generation of 'trade agreements' include a number of disciplines that limit governments' policy space, such as those on investment, labour and environmental standards. Investment disciplines, for instance, may be used (as illustrated by the cases of Uruguay and Australia relating to cigarettes packaging) to challenge public health measures. Improving the technical capacity to deal with the complex issues involved in trade negotiations is certainly crucial. But this is not sufficient to attain the desired objectives in the context of an asymmetric economic relationship, or when pursuit of a trade agreement is primarily driven by political reasons. **Trade negotiations, should also be transparent; various government departments and civil society should be given an opportunity to continuously assess the process and express their concerns and aspirations.**

Dr David Legge considered the role of advocacy in the pursuit of healthy trade in his presentation. He commenced this joint presentation by comparing trade policy to a 'tug of war' with various interest groups, industry lobbies, foreign corporations and foreign governments all pulling in different directions to better achieve their own objectives.

Multiple pressures on trade policy



(Dr Legge - workshop PowerPoint presentation)

For example, the multinational food industry had been very effective at the UN High level meeting on NCDs in ensuring that there were few references to regulation and where they appear they are very general. Dr Legge argued that while governments have a responsibility to manage these pressures and align the outcomes to the national interest, civil society participation in the conversation can be a very effective support for governments. Dr Legge described 'civil society' as including professional organisations, academics, NGOs, trade unions and churches. He instanced three NGOs which have been particularly influential in trade negotiations: Third World Network, Medecins Sans Frontieres and the Institute for Agriculture and Trade Policy. Dr Legge returned to the South African Treatment Action Campaign which Prof Carlos Correa had mentioned earlier and described how civil society mobilisation had been critical to the success of this campaign including AIDS solidarity activists campaigning in both the US and in South Africa.

Dr Deborah Gleeson then provided an additional example from Australia, and reflected on advocacy work undertaken by the Public Health Association of Australia around the proposed Trans Pacific Partnership Agreement (TPP). She mentioned the concerns of civil society organisations including the impact of tighter intellectual property provisions and restrictions on pharmaceutical programs on the cost of medicines, and restrictions on the scope for governments to regulate for public health as a consequence of the proposed investor state dispute settlement provisions. Dr Gleeson described the many facets of this episode of civil society advocacy including writing submissions, literature reviews, consulting with experts, raising awareness, advocacy at public health conferences, and involvement in stakeholder events during negotiating rounds. This example highlights the important role civil society can play in providing a counter-balance to the industry interest groups and corporations, which lobby governments and trade negotiators to promote their interests through trade agreements.

In the last presentation in session five, Henry Tunupopo shared the experience in Samoa of working intersectorally on trade issues. When Samoa decided to join the WTO a public-private stakeholder committee was set up, chaired by the deputy Prime Minister with participation of various government Ministries including foreign affairs, finance, health, agriculture, environment, Attorney General's office and SUNGO (a local civil society umbrella organization). Academia and other groups were also invited to join. The terms of reference of the committee is to provide advice to Cabinet on trade arrangements, so that cabinet may make informed decisions to ensure that Samoa's gains from trade arrangements are in line with international agreements and the country's interests. The committee signs off on all matters relating to trade agreements. Issues have ranged from tariffs and turkey tails, to quarantine regulations. Consultations have been considered to be effective and included the general public. Negotiations are not kept secret from other stakeholders. All members of committee were invited to negotiations; they were allowed to sit in the room during negotiations. Having one committee with all stakeholders included, saves time overall, and as senior staff from Ministries attend, this makes overall decision-making much faster.

Briefly at the end of session five, sector teams met to consider what the strategies and structures operating in their countries to facilitate trade and policy coherence might be and how could they be improved. They were also asked to consider what might be best practices in ensuring trade and policy coherence. The feedback by the different sectors was undertaken in the country team groups during session six.

Sessions 6 & 7: **Way forward and commitments**

Country teams considered specific actions they would pursue and what further support they would need for this. To facilitate this exercise, Brian Lutz provided an overview of what the country team discussions could cover:

1. Feedback from sector teams from session five and consideration of how intersectoral collaboration in their country on trade and health could be achieved;
2. Review their national strategies and other relevant existing commitments on NCD policy interventions, and along with the public health interventions discussed in this workshop, draw up a 'possible' list of public health interventions;
3. Review each option for NCD impact, trade relevance and importance (using provided excel sheet templates) to develop a short list;
4. Develop this short list into a detailed action plan, including specification of support needed.

The country teams then worked on these tasks for the remainder of day three of the workshop, and also for an hour on the morning of day four. Each country team was asked to prepare a ten minutes presentation on their action plans, using a provided PowerPoint template.

Samoa Country Presentation

The team from Samoa identified three top priority actions:

- Completion and implementation of the WTO study on practical and realistic options to combat Samoa's health problems
- Reduction in import tax on fruit and vegetables (to increase affordability)
- Introduction of a tax on sugary products and sugar (to complement their existing tax on soft drinks)

They identified partners who would need to be involved in each of these, including their National Working Committee on Trade Agreements, government Ministries, SUNGO and SPARKEL (advocacy group in Samoa). They also identified their external assistance needs including technical assistance in the areas of taxation, WTO, law, HIA and nutrition, and agencies that can provide this support.

On the issue of building multisectoral collaboration, particularly between health and trade they identified challenges as being of sustainability and data availability. Their proposed solutions were to have back-up members for committees, capacity building for other sectors and to strengthen their information and data systems.

Fiji Country Presentation

The team from Fiji then shared their action plan. Their top three action areas were identified as:

- Graphic labeling on tobacco
- Controls on alcohol advertising, promotion and sponsorship
- Increased fiscal duty on alcohol

They identified a need for technical support in the areas of policy formulation, monitoring and evaluation and enforcement. They also indicated that they needed a study on the economic impacts of NCDs in Fiji.

In regard to the issue of intersectoral collaboration, they indicated a need to strengthen the existing National Trade Policy Committee and strengthen the development of evidence-based policy submissions. They also identified a need for impact assessments of trade agreements during accession discussion, and for capacity building on HIA. Additionally they suggested that there be a regional network on NCD awareness and knowledge sharing.

Dr Neil Sharma, Minister of Health for Fiji commented that he was happy that the meeting had been held in Fiji and that Trade officials were being involved. He added that Fiji is trying to implement 'best buys' and have implemented tobacco registration fees to provide funding assistance for health promotion work. He also shared experiences of working with the food industry in Fiji, and that legislation may be needed when progress is slow.

Tonga Country Presentation

The team from Tonga spoke initially on their Technical Committee for Tax which was established by the Prime Minister in October 2012. The membership includes Revenue and Customs, Finance/National Planning, Health, Commerce and Trade (soon to be Foreign Affairs and Trade). The aim of the committee is to make the healthier choices the easier choices, through the development of cabinet submissions.

The issues they identified for action were:

- Removal of import taxes for tinned fish
- Increased tax rate on dripping and lowered rate on vegetable oil to encourage a shift in fat consumption
- Increased tax on sugary drinks

The intended process was for the collection on data on quantity of imports and tariff rates from Trade, consultation with stakeholders and then work via their Technical Committee for Tax.

They requested support for a review of their existing legislation, awareness campaigns before policy implementation and implementation of their MAF acceleration framework.

In regard to multisectoral collaboration they emphasised need for health promotion to support policy change and acceptance, and clear responsibilities for policy enforcement to be defined. They also stressed the importance of ensuring that senior health officers were involved in trade negotiations, and that they would need to make an application to the respective Ministry to ensure this.

Nauru Country Presentation

The team from Nauru identified several areas for action:

- Establishment of a committee on trade and health
- Maintenance and improvement of sugar tax procedure and implementation
- National workshop on trade and health connections to emphasise the importance of health in the Trade Policy Framework
- Development of a mechanism for a health promotion fund, to support preventive measures

They identified the key stakeholders who would need to be involved in each of these, including government ministries and external technical experts.

In regard to multisectoral collaboration, they highlighted the importance of the above committee or of expanding on existing committees with health and trade.

There was some discussion after this presentation on how to ensure actions progressed when multiple organisations were listed to lead actions.

Vanuatu Country Presentation

The presentation from Vanuatu identified the three key areas of action:

- Maintaining high taxes on alcohol and enhancing alcohol policy
- Establishing food standards to allow for stronger labeling and packaging regulations and taxing fatty foods higher
- Increasing tobacco tax and a ban on the sale of locally grown tobacco.

They identified that these actions would require multisectoral involvement from across the government, and that they would need financial and technical assistance, including some local capacity building in regard to food standards. A local food laboratory may also be required.

They emphasised the importance of integrating health and trade policies, greater collaboration between health and trade committees and for developing an information exchange programme between health and trade.

After the country presentation the possibility of regional food standards supported by regional or shared food testing was raised and discussed. Mr Hoejskov clarified that testing of the nutrient content of processed food can be done by existing laboratories in the region and is relative simple and inexpensive.

Tuvalu Country Presentation

To support healthy trade policy the team identified a need for a Memorandum of Understanding (MOU) between health and trade, which would support greater information sharing, networking and incorporation of health issues into annual trade work plan. They also indicated a need for proper co-ordination of policy development, including consultations.

Their priority action areas were also to:

- Implement a tax on sugary, fatty and salty foods, alcohol and tobacco. This would need to be compatible with existing trade policies
- To undertake a feasibility study on sourcing alternative domestic healthier foods
- To undertake an impact assessment (health, gender and climate change issues) on PACERPlus and establish a monitoring system.

They identified the need to involve a number of government departments in these actions, and also a need for some technical assistance and capacity building.

During plenary discussion, the possibility of a regional impact assessment of PACERPlus was raised. It was agreed that this might be useful, however it would not replace the need for country specific impact assessments due to considerable inter-country differences.

Palau Country Presentation

The team shared the content of the Executive Order number 295, in which the President of Palau ordered the Minister of Health to coordinate activities to manage the NCD crisis, including calling upon all Ministers and head of National government agencies to assist in his effort at tackling this national crisis. Additionally, the Minister of Health is requested to record all assistance from other Ministers and heads of national government agencies and report to the President every 6 months.

A national NCD committee is already in place and includes representatives from across the government, civil society and private sector. Following an NCD summit early in 2012, a sub-committee on policy/legislation was formed. This committee includes Ministries of Justice, Health, Public Infrastructure, Industries & Commerce, Finance and Education. This committee would review existing legislation and priorities policies for action.

The team emphasized a need for data on the burden of disease, health insurance and possibly other trade issues. They requested technical assistance and support for a cost of NCD study, health impact assessment and also further training –in-country on issues of trade negotiations and also taxation.

A query was raised as to whether Palau was able to sign up for trade agreements, as under a Compact with the United States. It is able to so, as long as compliant/consistent with the Compact.

Kiribati Country Presentation

The team identified a number of action areas related to alcohol and tobacco prices

- To remove tobacco from price control (via submission of concept paper, meeting and consultations with Parliament/Cabinet)
- Increasing tax on tobacco and alcohol: along with survey of effects on health, and consideration of implications of the intervention

These would need to involve actions by Trade, Finance, Health and the Attorney Generals' office and may require some financial and technical assistance. They recognised issues of multisectoral collaboration and suggested they needed a balancing act towards common national goals.

It was suggested that health be allowed to join the Trade Policy Advisory Committee (TPAC) and Trade and Finance become members of the NCD committee (NCDCC), which would need to be mandated by Cabinet.

Delegates developing and presenting action plans



Overview Of Post-Workshop Support And Assistance

Following the presentations from the country teams, Dr Wendy Snowdon shared the proposed way forward on behalf of C-POND, SPC, UNDP and WHO.

It was suggested that country teams should before the end of March

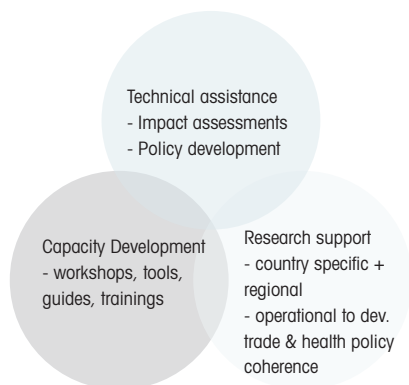
- Review their action plan and update if needed, based on further consideration
- Discuss drafts with their respective CEOs /managers and incorporate their input
- Forward revised PowerPoint presentations to the Secretariat contact point

On receipt of these, C-POND, SPC, UNDP and WHO committed to review the action plans and discuss and agree on a joint approach to supporting each country.

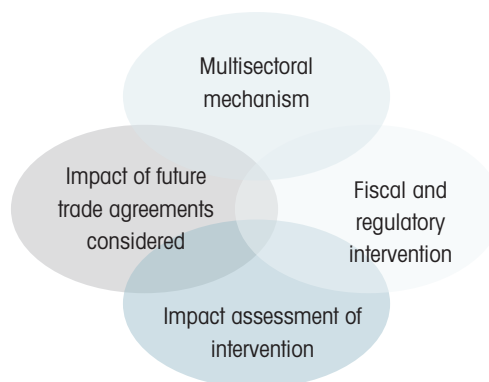
By 10th April, each country team would be contacted by the secretariat to advise them of how support would be provided, and by which organisation primarily. In-country support for actions and associated research and data gathering actions would then occur, in line with country needs. Additional capacity building would be considered at regional, sub-regional and national level.

The scope of support was then further clarified, as shown below in figures three and four. Resources would be sourced from existing projects, existing programmes and through new sources.

Scope of support



Key areas of support



Meeting Statement

Discussions took place to draft and finalise a meeting statement entitled “the Nadi Outcomes Document” in line with the proceedings (See pages 26 – 27).

Closing Session

Following the awarding of certificates to participants and an evaluation session, the Fiji Minister of Health Dr Neil Sharma delivered the closing remarks. He highlighted that this was a landmark meeting and that he was impressed with the interactions and contributions from countries. He thanked the organisers who have made this event possible. He was pleased to see collaboration occurring between sectors, through discussions and sharing of experiences. The Yanuca declaration introduced the concept of healthy islands and this workshop was really supporting those commitments and ideals. He also stressed that the involvement of the health sector in trade issues is important.

He highlighted some of the actions in Fiji, including data collection such as STEPS, salt intake assessment and the oral health survey. He added that Fiji has just upgraded its food labelling requirements and was now considering a new approach to support this. He emphasised his interest in regulating the marketing of food and non-alcoholic beverages to children in line with controls on the promotion of breast milk substitutes and tobacco advertising. He recommended countries to have national strategies which were aligned, time bound – and relevant for NCDs and trade.

Berrick Dowyiyogo then gave a vote of thanks on behalf of the participants. He thanked regional and international organisations for coming together and making this workshop happen. He mentioned that the workshop had been valuable for the participants and provided information and advice that they can take back and use in their countries to strengthen the intersection between NCDs and trade.

Dr Tukana then provided a closing prayer.

The Nadi Outcomes Document

Pacific Sub Regional Workshop on Trade and Non Communicable Diseases (NCDs) Nadi, Fiji, 11-14 February 2013

Preamble

Recognizing that Non Communicable Diseases (NCDs) are a threat to human development and national economies of many countries in the Pacific region and may lead to increasing inequalities between countries and populations, the political declaration of the UN High Level Meeting on Non Communicable Diseases (NCDs) identified trade as one of the main areas which influences the social determinants of health and plays an essential role in the prevention of NCDs.

Recognizing that at the Forty-Second Pacific Islands Forum in Auckland, New Zealand, the leaders of the Pacific were deeply concerned that an estimated 75 percent of all adult deaths in the Pacific were due to NCDs, with the majority of the deaths occurring in adults in the economically-active age bracket and that there are huge economic losses due to NCDs and the resultant impact on national health budgets and possibly the region's ultimate achievement of the MDGs.

Recognizing that the WHA Resolution 59.26 also identified the need for ministries of health, trade, commerce, finance and foreign affairs to work together constructively in order to ensure that the interests of trade and health are appropriately balanced and coordinated.

Recognizing that addressing social determinants of health, social inequality and poverty, as well as the legal, policy, and regulatory frameworks, is essential for development and enjoyment of the right to the highest attainable standard of health.

Recognizing that a number of factors, including the protection of intellectual property rights, individual behavior and lifestyle choices, and national capacity to provide adequate health-related goods, facilities, and services, affect the prevention and treatment of NCDs.

Recognizing that trade agreements provide both threats and opportunities for improving public health.

Recognizing that health gains from trade are important for economic growth and sustainable development which in turn lead to exponential gains in the health of the country, including through the prevention of NCDs.

Recognizing the essential role of civil society in advocating for healthy trade and in holding governments accountable with regards to policy commitments and legal obligations.

Emphasizing that the Pacific region should not be treated as a dumping ground for unhealthy products that are unwanted in other countries

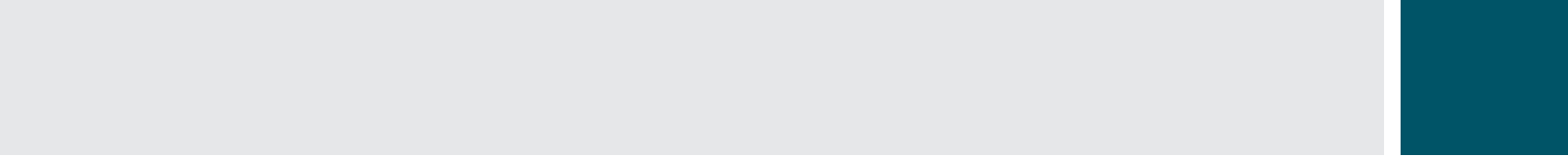
The workshop participants agreed on the need;

- to apply or establish where necessary, coordination mechanisms involving ministries of finance, health and trade, and other relevant ministries, institutions and civil society to address the NCD crisis
- to strengthen national capacities and regulatory mechanisms (where established) to include among others, undertaking impact assessments, introducing policies, including incentives (e.g. subsidies) and disincentives (e.g. taxation), which affect the risk factors for NCDs and participating in international trade negotiations
- for international, regional agencies and development partners to continue to support countries including through provision of technical assistance to support policy coherence between trade and health sectors at a national and regional level and specifically enhance informed decision making and trade negotiations,
- to accelerate the regional and national efforts to develop and implement food standards for relevant nutrients (e.g. fat, sugar and salt content in processed foods).

The participants of the workshop agreed to communicate these outcomes to the upcoming Forum Trade Ministers Meeting (FTMM) to be held in Apia in 2013 and the Pacific Health Ministers meeting 2-4 July 2013 (Apia, Samoa).

Appendix: Workshop programme

Day 1	Day 2	Day 3	Day 4
• Opening statements • Self-introductions • Overview of programme Session 1: Intersection of Trade and NCDs • Overview of NCDs in region and costs • Impact of trade on upstream determinants of NCDs	Session 3: Regional cases where trade and NCDs have intersected • Panel discussion on trade and economic development • Mutton flaps and turkey tails case studies • Food and agriculture case studies	Session 5: Towards health and trade policy coherence • Governance and mechanisms to promote health in all policies • Health promotion strategies which are trade compliant • Achieving trade agreements which promote health • Mobilizing and advocacy for health trade • Example of intersectoral collaboration • Sector discussion groups	Session 7: Way forward • Country presentations and discussion
Morning tea			
Session 2: Trade agreements and how intersect with NCDs • Regional trade architecture and possible future trade agreements Pacific Islands Forum • Secretariat and Trade agreements • Intersection of trade and NCDs: a case study	Session 3 continued • Sugar content tax • Salt standards • Trans fat bans • Tobacco and FCTC • Alcohol, tobacco & PICTA Discussions	Session 6: Way forward and commitment Country group work and action planning	Session 7: continued Country presentations and discussion
Lunch			
Session 2 continued • Trade rules and how they can intersect with NCDs and health: case studies • Trade agreements and public health Discussions	Session 3 continued • Health services • Access to medicine Discussions	Session 6 continued	Session 7: continued Country presentations and discussion
Afternoon tea			
Country presentations on trade and NCDs (via a marketplace style poster). Evaluation	Session 4: Assessing potential impacts of trade agreements on health and feasibility of policy options • Mapping, modeling, consultation • HIA, HRIA • Group discussion of tools Evaluation	Session 6 continued Evaluation	Session 7: continued • Support available from partners and other organisations • Recommendations for future support • Discussion Evaluation Close





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United Nations Development Programme Pacic Centre
Level 7, Kadavu House,
Victoria Parade
Private Mail Bag
Suva, Fiji Islands.

Telephone: (+679) 330 0399,

Fax: (+679) 330 1976,

Email: registry.paciccentre@undp.org,
www.undppc.org.fj