NUTRITION SYMPOSIUM · SAINT LUCIA ·
12 NOVEMBER 2026

SESSION 2 · 3:00–4:30 PM · PANEL DISCUSSION

Nutrition for the Life Course and Implications for Policies

An economic policy emphasis in a Caribbean setting

How nutritional needs change from pregnancy and infancy through childhood, adolescence, adulthood and older age, and how policy can support appropriate nutrition at each stage.

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OUTLINE

What we will cover

Seven parts, following the life course. Each stage: what changes nutritionally, what the evidence says about the levers, what policy should contain and a question for the panel.

Panel format: ~60 minutes of evidence briefs, ~30 minutes of discussion.

1. **Why the life course?**
   Nutrition as an economic question in the Caribbean
2. **Pregnancy and infancy**
   Maternal and infant nutrition services
3. **Childhood**
   School feeding programmes
4. **Adolescence**
   The food environment before habits set
5. **Working age**
   Workplace initiatives
6. **Older age**
   Nutrition support for older adults
7. **Implications for policy**
   The integrated package, financing, data and governance

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PART 1

1

Why the life course?

Nutrition as an economic question in the Caribbean.



Why economists should care about nutrition

Not just what people should eat, but what they can afford, what is available, and what poor nutrition costs tomorrow.

GOOD NUTRITION →

Growth, learning, productivity, income and resilience

A capital investment: early shortfalls are largely irreversible and compound over the life course.

POOR NUTRITION →

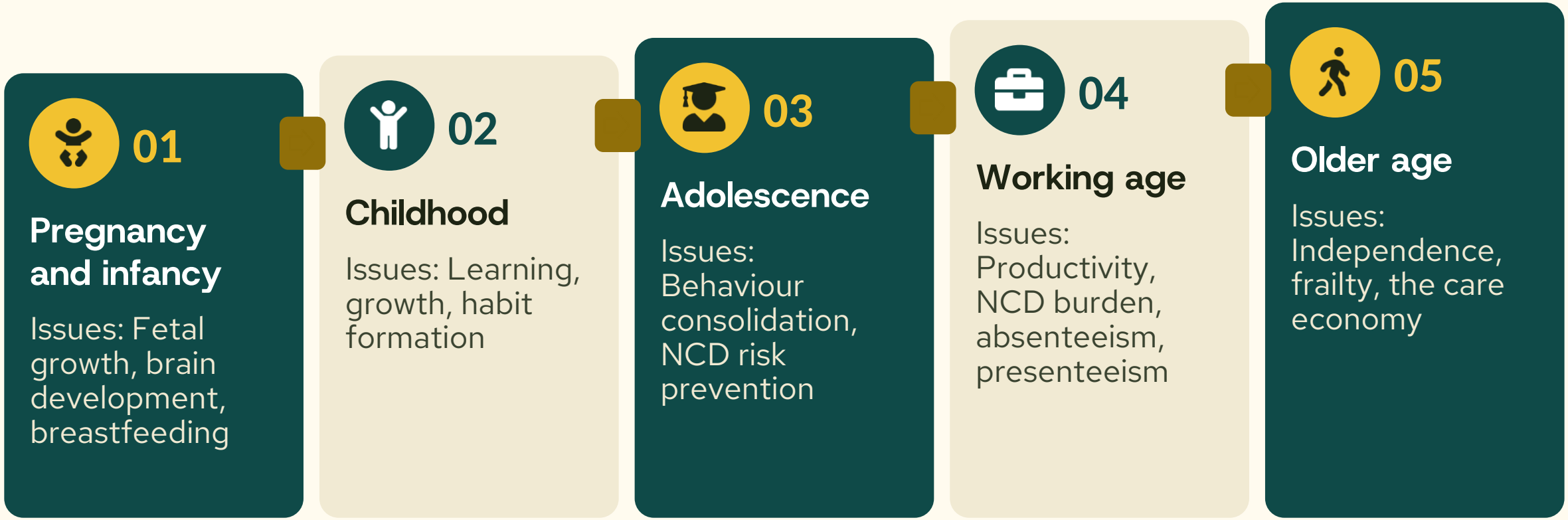
Healthcare spending, absenteeism, presenteeism, disability, premature death

Someone pays: a household, an employer, or the Treasury.

Saint Lucia's NCD burden: XCD 299.3M (2.34% of GDP), of which XCD 231M is productivity loss. Most of the damage is lost output, not hospital spending.

Source: UWI-HEU (2025), Investment Case for the Prevention and Control of NCDs in Saint Lucia (modelled estimates).

The life-course logic: decisions at one stage shape the next



Prevention versus remediation: protecting nutrition early is cheaper than financing downstream complications; chronic disease, disability and long-term care.

Framework: UWI-HEU (2025). At each stage ask: what is the binding constraint, and which policy lever addresses it?

Saint Lucia: diet-related risk is population-wide

83.2% insufficient fruit and vegetable intake

34.9%	obese: women 46.1%, men 20.6%
40%	hypertension, adults 30–79
35.4%	3 or more major NCD risk factors

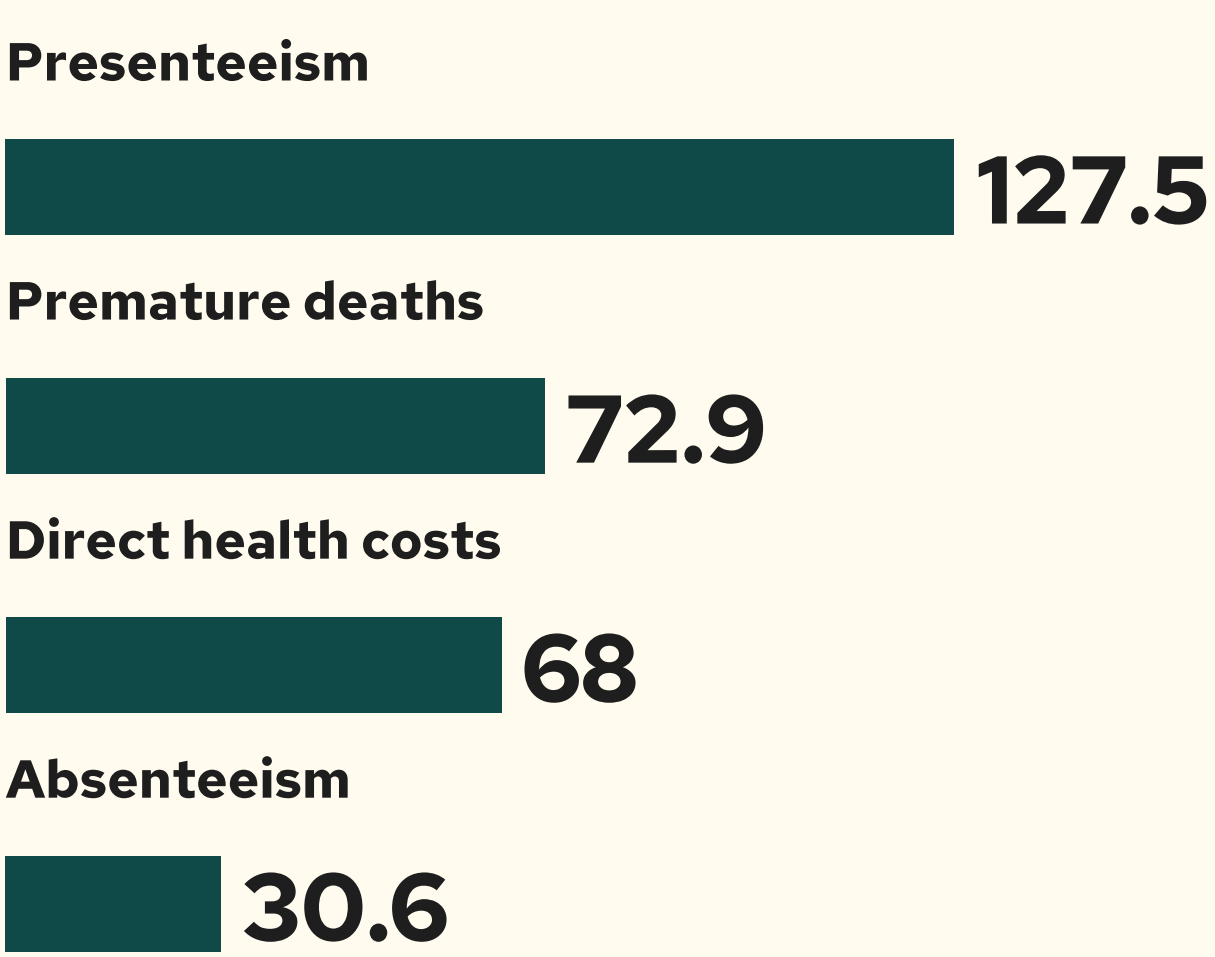
Source: UWI-HEU (2025), drawing on the Saint Lucia STEPS Survey 2019–2020 (Ministry of Health, Wellness and Elderly Affairs, WHO, PAHO).

WHAT THIS MEANS

Risks cluster, and they are built up over a lifetime

Someone with obesity is also more likely to have raised blood pressure, raised glucose, be physically inactive and eat poorly. Population-wide measures matter more than narrow targeting, a combination of measures is needed – and the stages before working age are where prevention is cheapest.

Saint Lucia: the economic burden of NCDs falls on workplaces and households



Components of Saint Lucia's annual NCD burden, XCD million (modelled)

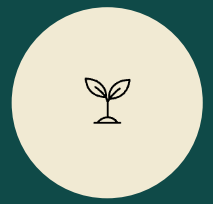
XCD 299.3M
total burden, 2.34% of GDP

XCD 231M
productivity losses — ~3.4× the direct health costs of XCD 68M

~XCD 78M
diabetes: highest indirect cost and highest presenteeism cost

Source: UWI-HEU (2025). Modelled estimates for NCDs in general, not diet alone; order-of-magnitude indicators of where costs fall.

Three economic concepts that make the case for investing early



HUMAN CAPITAL

Early nutrition builds cognition and schooling, which lift lifetime earnings, labour quality, growth and the tax base

Early shortfalls are largely irreversible. Maternal, infant and school nutrition is capital investment, not welfare spending.



OPPORTUNITY COST

Every dollar spent treating preventable disease is unavailable for education, infrastructure or social protection

XCD 231M in productivity losses and XCD 68M in direct costs are resources lost to other uses. Prevention creates fiscal space – over time.



RETURN ON INVESTMENT AND TIME

Prevention has a measurable return: 1.24 by 2030, 2.50 by 2037; 3.35 by year 15 for policy measures

Delay is a deferred cost. Time is a scarce input: it raises the effective price of healthy eating for time-poor workers.

Under-investment is not saved money. It is a cost paid later by households, employers and the Treasury.

Sources: UWI-HEU (2025), ROI figures are model projections; La Foucade et al. (2022). Externalities and relative prices were covered in Session 1.

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The life course is visible in the Caribbean survey data

ODDS OF UNHEALTHY DIET SELF-APPRAISAL (N=748)

Predictor (reference)	aOR	95% CI
Age 25–34 (vs 18–24)	0.73	0.44–1.18
Age 35–44 (vs 18–24)	0.68	0.40–1.16
Age 45+ (vs 18–24)	0.35	0.20–0.62
Male (vs female)	0.61	0.42–0.89
Married or common law (vs other)	0.66	0.45–0.96

JAMAICA · REASONS CITED BY UNHEALTHY EATERS, BY AGE

Age	Time constraints	Access to unhealthy foods
18–24	38.0%	39.4%
25–34	35.4%	38.5%
35–44	28.1%	30.5%
55+	16.0%	8.0%

Younger adults carry the most barriers; time, access, and the lunchtime soft drink. The stage, not only the person, shapes the diet. That is the case for stage-specific policy.

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PART 2

2

Pregnancy and infancy

Investment starts before birth: maternal and infant nutrition services.





Pregnancy and infancy: investment starts before birth

30%

exclusive breastfeeding in Trinidad and Tobago (UNICEF)

~US$35

returned for every US$1 invested in breastfeeding support (WHO/UNICEF, 2019)

WHAT CHANGES NUTRITIONALLY (GENERAL WHO GUIDANCE)

- Maternal nutrition before and during pregnancy shapes fetal growth and birth weight
- The brain grows fastest in the first 1,000 days; exclusive breastfeeding for six months, then safe complementary foods with continued breastfeeding

LEVERS TO TEST

- Maternal screening, targeted supplementation, food or cash support
- Baby-Friendly Hospitals, maternity protection, lactation spaces at work

Sources: UNICEF T&T profile; WHO/UNICEF Breastfeeding Scorecard (2019); WHO IYCF guidance.

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EXCLUSIVE BREASTFEEDING AT SIX MONTHS

~1.3

percentage-point rise in California and New Jersey after paid family leave, relative to other states

A labour-market policy can change an infant nutrition outcome.

Evidence (1): US paid family leave raised exclusive breastfeeding

COMPARISON

States with paid family leave versus states without

DESIGN

Difference-in-differences, 306,266 children; quasi-experimental, not a randomised trial

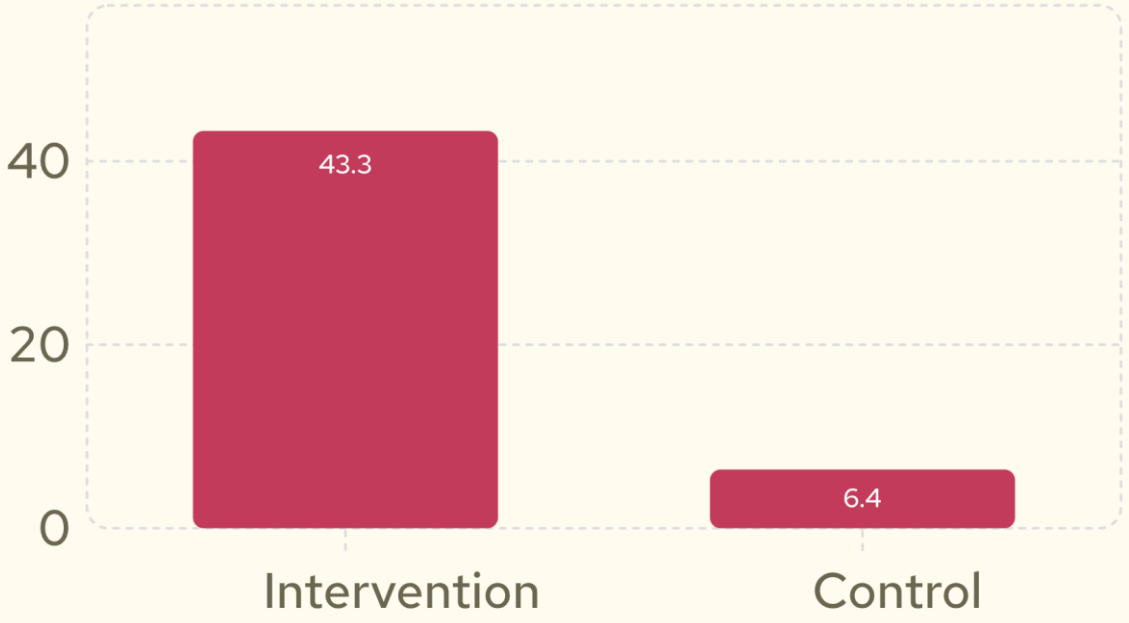
FOR THE CARIBBEAN

Most Caribbean countries already have paid maternity leave. The question is design: does leave last long enough, and do returning mothers have the time and a private place at work to express and store milk? A baby fed expressed breast milk still counts as exclusively breastfed.

Source: Hamad et al. (2019). Not a Caribbean effect estimate; illustrates the lever, not the size of the effect here.

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Evidence (2): Belarus PROBIT trial; Baby-Friendly practices, delivered consistently



Exclusive breastfeeding at 3 months (%). Cluster-randomised trial, 17,046 mother–infant pairs (Kramer et al., 2001).

CARIBBEAN CONTEXT: COVERAGE IS UNEVEN

- Jamaica: 12 of 23 public hospitals accredited (2026)
- Trinidad and Tobago: 5 of 6 public maternity hospitals (2026)
- Belize: all public hospitals certified;
- Guyana: 8 hospitals (May 2026)
- Saint Lucia: 0% of births in Baby-Friendly facilities in 2016 (WHO, 2017); implementation under way since 2024; no verified current figure

The policy question is implementation: consistent delivery, continuity from hospital to clinic, monitoring and retained certification.

Sources: Kramer et al. (2001); ministry and PAHO sources (2026); WHO (2017). Denominators differ across countries; not a comparable series.

Policy: maternal and infant nutrition services

HEALTH SERVICES

- Maternal nutrition screening and targeted supplementation in antenatal care
- Baby-Friendly practices delivered consistently; certification retained and monitored
- Continuity from maternity hospital to community follow-up

LABOUR AND SOCIAL PROTECTION

- Maternity protection long enough to sustain exclusive breastfeeding to six months
- Lactation breaks and a private place to express and store milk at work
- Food or cash support for pregnant women and infants through existing transfers (WIC: fresh fruit +28.6%)

Who: Health (services) · Labour (maternity protection, workplace rules) · Social Protection (transfers) · Employers (lactation space). Monitor: exclusive breastfeeding at 3 and 6 months; facility certification.

QUESTION FOR THE PANEL

Are Saint Lucia's maternity leave and workplace arrangements long and supportive enough to sustain exclusive breastfeeding to six months and how would we know?

Sources: Kramer et al. (2001); Hamad et al. (2019); Andreyeva and Luedicke (2015); UWI-HEU (2025) life-course package.

PART 3

3

Childhood

School feeding is more than a meal.



Childhood: growth, learning and habits form — while one in three is overweight

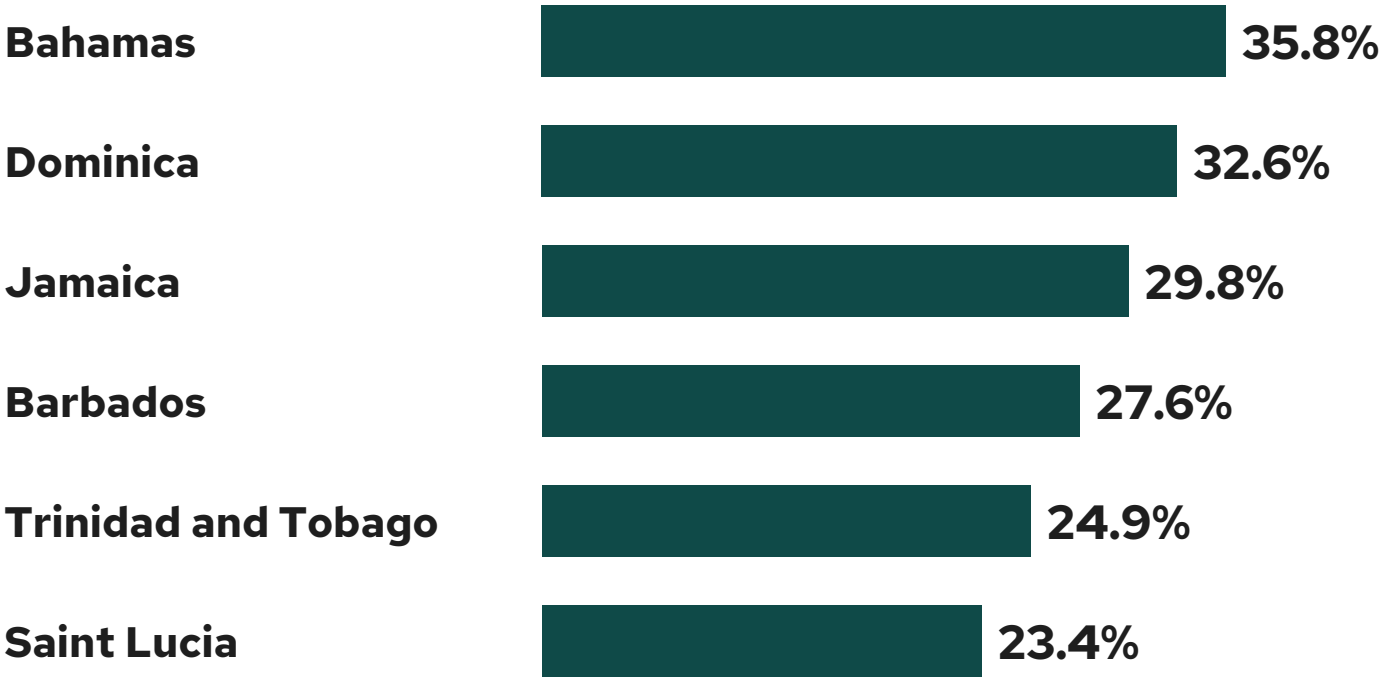
WHAT CHANGES NUTRITIONALLY

- Steady energy and nutrients for growth, concentration and learning – a hungry child does not learn
- Food preferences and habits form now: habit is cited by 49–69% of Caribbean adults as a reason for how they eat
- Under-nutrition risk for some and excess weight for others: schools face both

1 in 3

Caribbean children overweight or obese (CARPHA, UNICEF). LAC overweight, age 5–19: 30.6% (UNICEF, 2023).

Overweight prevalence among children, 2016 country estimates (%)



Sources: HCC, CARPHA, UNICEF, PAHO (2022); UNICEF LACRO (2023); UWI-HEU (2025); Gabriel et al. (2026).



School lunch · primary school

Childhood: school feeding is more than a meal

Nutrition → learning
Attendance, concentration and attainment: future productivity begins here. Schools face both under-nutrition risk and excess weight.

Equity
A reliable meal at school lowers the household food burden; an in-kind income transfer for low-income families.

Procurement → local economy
Predictable demand for local farmers and fishers. But "buy local" needs nutrition criteria: local does not automatically mean healthy.

Human capital investment, social protection and agricultural demand policy – in one instrument.

Sources: HCC, CARPHA, UNICEF, PAHO (2022); UWI-HEU (2025). Conceptual framing; the evidence follows.

School nutrition evidence: Jamaica and Trinidad and Tobago

JAMAICA · 9 A.M. SCHOOL MEAL

Improved attendance and arithmetic; no weight gain

One rural-school class received the government meal at about 9 a.m., with two classes as controls. Small evaluation; suggestive, not definitive.

TRINIDAD AND TOBAGO · SIX MODULES

Fewer fried foods, snacks and sodas; some effects at 18 months; no BMI effect

Six one-hour school-based modules on nutrition and physical activity. Intake self-reported.

UNITED STATES · MEAL STANDARDS

Meal quality improved; participation did not fall

After the Healthy, Hunger-Free Kids Act, the nutritional quality of meals students selected rose without a drop in school-lunch participation.

Benefits appear in attendance, learning and behaviour even when BMI does not move – and standards do not drive children away from the meal.

Sources: Powell et al. (1983); Grantham-McGregor et al. (1998); Francis et al. (2010); Nichols et al. (2014); Johnson et al. (2016).

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School kitchen · Trinidad

Policy: what a school feeding programme should contain

Standards for meals, canteens, vending and campus vendors

Adopt and enforce; the meal is only part of what children eat at school.

Water as the default; fewer high-sugar and high-sodium products

Change the default rather than the lecture.

Nutrition-sensitive procurement

Demand for healthy local produce and fish — with nutrition criteria attached to "buy local".

Monitor what is sold and eaten

Not what the policy document prescribes: compliance and consumption are the outcomes.

QUESTION FOR THE PANEL

What is actually sold and eaten on Saint Lucian school compounds, including by on-campus vendors and who monitors it?

Sources: UWI-HEU (2025) recommendation 3; Johnson et al. (2016); Taillie et al. (2020).

PART 4

4

Adolescence



Prevent risk before it becomes expensive disease.

Adolescence: autonomy arrives before habits are fixed



After school · Jamaica

WHAT CHANGES

- Rapid growth raises energy and nutrient needs (iron, calcium)
- Young people start buying their own food: marketing, peers, convenience and price drive habits

LEVERS TO TEST

Campus food standards · marketing limits · warning labels · healthy convenience · active transport

JAMAICA 18–24 yrs · REASONS

39.4% access	**38.0%** time
35.2% taste	**32.4%** cost

The youngest group had the highest odds of calling their diet unhealthy.

Change the environment early; the returns last decades.

Sources: La Foucade et al. (2022); Gabriel et al. (2026), Table 4. Non-representative samples.

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Adolescence evidence (1): Chile's combined package

THE PACKAGE

Warning labels, marketing limits and school-sales limits — together

- Black octagonal "high-in" warnings for sugar, sodium, saturated fat, calories
- Restrictions on marketing directed at children
- Restrictions on sales of high-in products in schools

Sources: Taillie et al. (2020); Dillman Carpentier et al. (2020).

"HIGH-IN" BEVERAGE PURCHASES

−23.7%

below the modelled counterfactual after the package took effect

MARKETING

−44% / −58%

TV advertising exposure to high-in foods: preschoolers / adolescents

DESIGN

National observational before-and-after study. The effect belongs to the package, not to labels alone.

Policy works through information, commercial exposure and what firms choose to supply — all at once.

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Adolescence evidence (2): firms reformulate, shoppers understand labels

CHILE · PRODUCTS WITH ANY "HIGH-IN" LABEL

51% → 44%

after implementation, with larger reductions for sugar and sodium

WHAT IT SHOWS

Firms respond to thresholds. Reformulating to avoid a warning reaches consumers who never read a label. Nonexperimental prospective study.

JAMAICA · RANDOMISED EXPERIMENT, 1,206 ADULTS

OR 2.07

odds of picking the least harmful option with black octagonal warnings vs control (95% CI)

WHAT IT SHOWS

Caribbean shoppers understand the octagon better than traffic lights or the magnifying glass. Outcomes were comprehension and intention, not real purchases.

A policy package acts on information, commercial exposure and product supply simultaneously.

Sources: Reyes et al. (2020); White-Barrow et al. (2023).

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Policy: a package for adolescents, where autonomy is exercised



Campus food standards

In and around secondary schools, colleges and the university campus,



Marketing limits

High-in products: television, digital and social media, sponsorship, the school gate



Warning labels

Front-of-package octagons, the format Jamaican shoppers understood best



Healthy convenience

The quick, cheap option near school and work has to be a good one (time 38%, access 39%)



Active transport

Safe walking and cycling to school: activity and diet cluster

Together, not one at a time. Chile's effect belonged to the package; a single measure is easy to route around. Who: Education and campuses · Health · Trade and Commerce · Local Government.

QUESTION FOR THE PANEL

Which of these could Saint Lucia implement together, as a package – and who would enforce them on and around school campuses?

Sources: UWI-HEU (2025) life-course package; Taillie et al. (2020); White-Barrow et al. (2023); La Foucade et al. (2022).

PART 5

5

Working age

Nutrition as productivity policy: workplace initiatives.





Staff canteen · Saint Lucia

Working-age adults: nutrition as productivity policy

WHAT CHANGES

- Energy needs plateau; diet quality; sodium, sugar, fruit and vegetables, drives NCD risk (general guidance)
- Time and the workplace food environment shape meals; STEPS: 83.2% low fruit and vegetables, 34.9% obese, 40% hypertension, 15.9% raised glucose

PRESENTEEISM

XCD 127.5M

at work but less productive: the largest, least visible loss

ABSENTEEISM

XCD 30.6M

the loss that does appear in the accounts

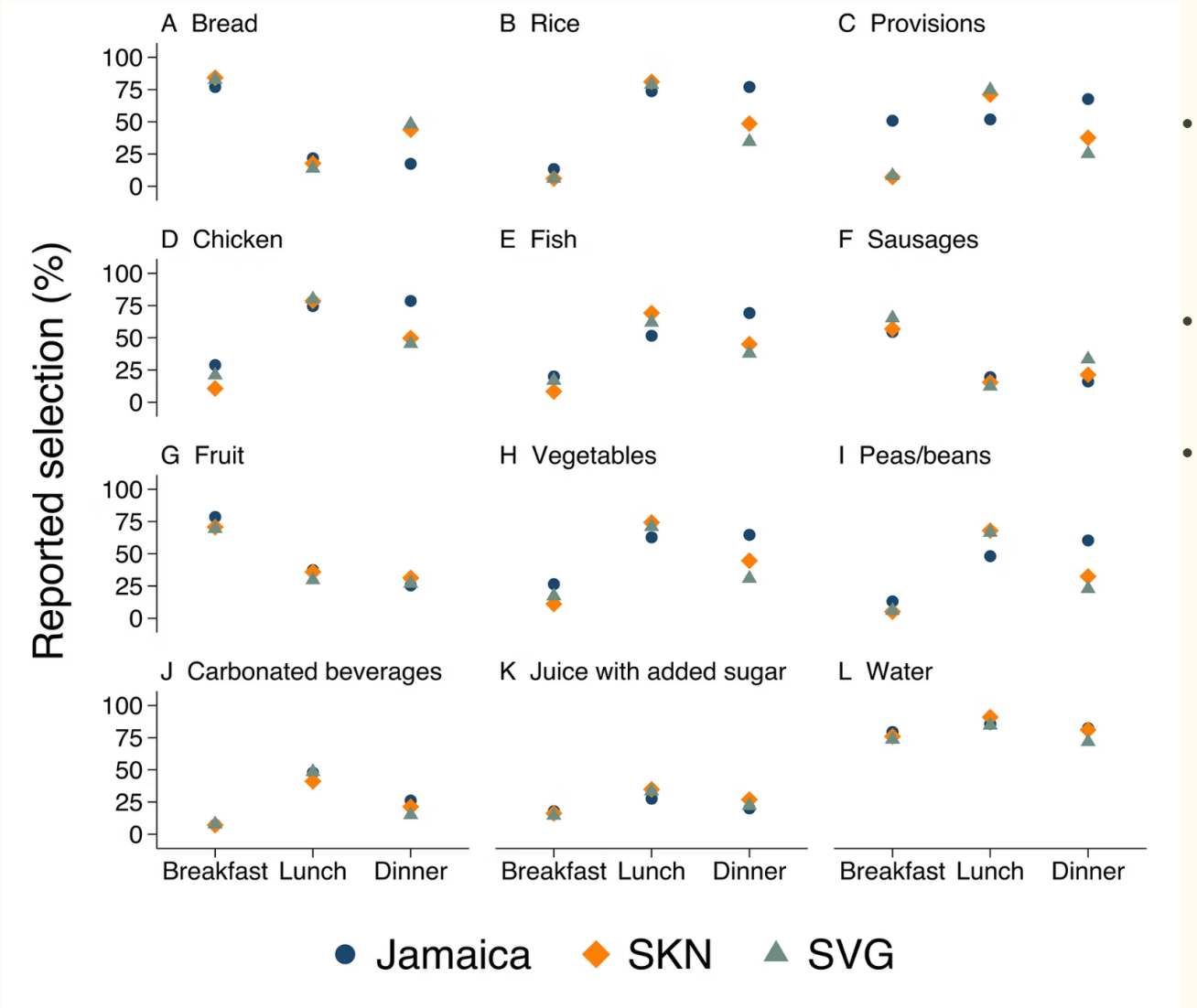
Time is part of a meal's price: 61.3% of unhealthy eaters in Jamaica cite preparation time.

LEVERS TO TEST

Cafeteria and vending standards · meal breaks · ready-to-eat healthy options · screening via the health system.

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Lunch is the workplace meal — and it is where the soft drink appears



WHAT STANDS OUT

- Carbonated beverages peak at lunch: 47.9% / 41.1% / 48.5%, against 7–8% at breakfast; juice with added sugar peaks at lunch too (28–35%)
- So do the good things: vegetables 63–74%, peas and beans 48–68%, fish 52–69% at lunch
- Limited time to prepare healthy meals: 61.3% / 43.8% / 46.2% of unhealthy eaters

The lunchtime choice is made in or near the workplace: canteen, vendor, shop. That makes the employer part of the food environment, and the public sector the largest one.

Source: Gabriel et al., 2026 (FaN three-country survey; n=893), Figure 5, Tables S5 and 3B. Meals are separate percentages; amounts were not measured.

Workplace and product standards evidence

US HOSPITAL CAFETERIA · 5,695 EMPLOYEES, 2 YEARS

−6.2%

calories purchased per transaction with traffic-light labels and repositioning; “red” item calories −23%

DESIGN

Longitudinal observational cohort, not randomised; sustained change in purchasing. No bans, no price changes.

ENGLAND SALT PROGRAMME, 2003–2011

9.5 → 8.1

g salt per day; blood pressure down ~3.0/1.4 mmHg. Voluntary targets and reformulation with public awareness

DESIGN

Population observational analysis; other risk factors and treatment changed too. Caribbean sodium ~2× WHO level: large headroom.

Change the defaults and the product, and exposure falls without a new decision at every meal.

Sources: Thorndike et al. (2019); He et al. (2014); PAHO (2025); UWI-HEU (2025).

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THE STAKE

XCD 231M

productivity losses, XCD 127.5M of it presenteeism (modelled)

EVIDENCE STATUS

Cafeteria study measured purchases, not productivity. No direct evidence yet of productivity gains from workplace nutrition programmes, so evaluate.

Sources: UWI-HEU (2025) recommendation 4; Thorndike et al. (2019); He et al. (2014).

Policy: workplace initiatives as productivity policy

Standards first in the public sector

Healthy food and procurement standards for canteens, vending and water, the default lunch is a good one.

Pair wellness with structural change

Healthier on-site food plus paid time for health checks. Screening and referral stay with the health system; the workplace is an access point. Confidentiality protected.

Evaluate absenteeism and presenteeism, not participation

Attendance at a wellness event does not tell you whether productivity improved.

QUESTION FOR THE PANEL

Should public-sector canteens and vending go first, and would employers accept absenteeism and presenteeism as the outcomes to be evaluated?

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Price policy reaches every table: taxes and incentives in brief

BARBADOS 10% SSB TAX, 2015

−4.3%

SSB sales vs counterfactual; water +7.5%; trading down

+26%

BERMUDA 75% DUTY

SSB prices; share ~8 points lower; tiny produce duty cut moved nothing

−7.6%

MEXICO 1 PESO/L, 2014

purchases over 2 years; largest in poorer homes

+0.32

SNAP INCENTIVE PILOT (RANDOMISED)

cups of fruit and veg per day with a 30% rebate

FOR THE LIFE COURSE: vouchers can target pregnant women, children and older adults; the tax falls most on young adults, where price response is largest. Design decides equity.

Price policy complements school and workplace policy at every table.

Sources: Alvarado et al. (2019); Segal et al. (2022); Colchero et al. (2017); Olsho et al. (2016). All but SNAP are observational.

PART 6

6

Older age

Nutrition, function and the care economy: support for older adults.





Family care · Saint Lucia

Older adults: nutrition, function and the care economy

12%

of Saint Lucia's population was aged 65+ in 2022

14.4%

of people 65+ in Latin America and the Caribbean need long-term care: ~8 million

WHAT CHANGES NUTRITIONALLY (GENERAL GUIDANCE)

- Energy needs fall but protein and micronutrient needs do not: a denser diet in a smaller quantity
- Appetite, dentition, medication, mobility and living alone affect intake; muscle and strength protect function

HEALTH SYSTEM

Poor nutrition → frailty → falls → hospital costs

HOUSEHOLDS

Loss of independence → unpaid caregiving → lost earnings, mostly women

Preventing diabetes at 40 changes care needs at 70.

Sources: CSO Saint Lucia 2022 Census (2025); PAHO long-term care policy guidance (2026); UWI-HEU (2025).

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Older adults: evidence for nutrition support

EVIDENCE STATUS

Positive nutritional effects are common in the literature, but randomised evidence is limited and the settings differ: in Saint Lucia, family care and community networks carry much of what formal services carry elsewhere. Evaluate locally.

Sources: Zhu and An (2013); Berkowitz et al. (2019).

HOME-DELIVERED MEALS · SYSTEMATIC REVIEW

6 of 8

studies improved diet quality, nutrient intake, food security or nutritional risk among older adults living at home

MEDICALLY TAILORED MEALS · US, COMPLEX ADULTS

IRR ~0.51

inpatient admissions, about half the rate of the comparison group; modelled monthly costs US$3,838 vs US$4,591, including the meals

Even after paying for the meals, modelled costs were lower.

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Policy: nutrition support for older adults

PRIMARY CARE

- Routine nutrition and frailty screening to protect strength and prevent falls
- Nutrition support within NCD care, more systematic and consistent, with follow-up — building on HEARTS and PBF, not a new service

COMMUNITY

- Food support for vulnerable older adults through existing transfers
- Community meals; home-delivered meals where feasible
- Local evaluation built in

CAREGIVERS

- Respite and information for family caregivers, mostly women
- Recognition of unpaid care in social protection

Who: Health and primary care · Social Protection · Local Government · civil society and churches. Monitor: frailty and falls, hospitalisation, care dependence, caregiver burden.

QUESTION FOR THE PANEL

Who in Saint Lucia's primary-care system would own nutrition and frailty screening for older adults — and how would meals reach those living alone?

Sources: UWI-HEU (2025) recommendation 8; Zhu and An (2013); Berkowitz et al. (2019); PAHO (2026).

PART 7

7

Implications for policy

The integrated package, financing, data and governance.



Prevention as investment: the Saint Lucia case

COST

XCD 182.4M

over 15 years (~1.43% of 2023 GDP)

BENEFITS BY 2037

XCD 470.2M

~3.68% of GDP; 4,597 healthy life years

OVERALL ROI

1.24 → 2.50

by 2030 → by 2037

POLICY ROI

3.35

by year 15, at only ~XCD 5.3M (2.92% of the package)

WHAT IT TELLS US

Benefits are back-loaded: returns rise from 2030 to 2037. The cheapest measures, population-wide policies, produced the highest return in the model. When budgets are tight, prevention is the first thing cut and the last thing that should be.

Source: UWI-HEU (2025). Model projections, to be paired with monitoring.

Financing: protect prevention, target support

PROTECT PREVENTION SPENDING

- Use investment cases and cost-effectiveness analysis in budget setting
- Do not let urgent treatment needs fully crowd out prevention
- Medium-term financing plans that shield prevention from annual discretionary cuts (policy ROI 3.35, modelled)

TARGET SUPPORT WHERE THE BUDGET BINDS

- Healthy-food vouchers and subsidies for pregnant women, children, older adults and low-income households
- Through existing transfer systems, not new programmes (SNAP trial, WIC reform)
- Review VAT and duty treatment of healthy and unhealthy foods

Opportunity cost and time inconsistency: the benefits of prevention arrive after the budget cycle, so protecting it needs institutional design, and the targeted money belongs where the life-course return is highest, at the beginning.

Sources: UWI-HEU (2025) recommendations 1 and 7; Olsho et al. (2016); Andreyeva and Luedicke (2015); La Foucade et al. (2022).

Data and governance: the enabling recommendations

09 · DATA

- Regular STEPS and MICS; dietary intake and food-price monitoring; track healthy-diet affordability, not only inflation
- Evaluate with interrupted time series or phased implementation; equity by income, sex, age and geography
- Life-course indicators: exclusive breastfeeding at 3 and 6 months; what is sold and eaten in schools; child BMI; absenteeism and presenteeism; frailty and care dependence

10 · GOVERNANCE

- Clear ministry ownership of each lever, with timelines and measurable indicators
- A standing multisectoral mechanism
- Civil society, academia and the private sector included, with conflicts of interest managed transparently

Every stage needs at least three ministries: Health with Labour and Social Protection (infancy) · Education and Agriculture (childhood) · Trade and Local Government (adolescence) · the public service and employers (working age) · Social Protection and community organisations (older age).

Source: UWI-HEU (2025) recommendations 9 and 10. Saint Lucia has no survey of eating practices and perceptions comparable to the FaN study — a gap to fill.

The integrated life-course policy package

Life stage	Economic objective	Priority instruments
Pregnancy and infancy	Invest early	Maternal screening, supplementation, breastfeeding support, maternity protection, food or cash support
Childhood	Build human capital	School meals, food standards, water as default, healthy local procurement
Adolescence	Prevent risk consolidation	Marketing controls, campus standards, healthy convenience, active transport, labels
Working age	Protect productivity	Workplace food standards, paid time for health checks, evaluation of absenteeism and presenteeism, ready-to-eat supply, screening via the health system, fiscal policies
Older age	Protect function	Nutrition screening in primary care to prevent frailty and falls, NCD-care nutrition support, food support, community meals, caregiver support
All stages	**Fix the food system**	Affordability, nutrition-sensitive agriculture and trade, sodium standards, data (Session 1)

Source: UWI-HEU (2025). The last row is a foundation shared by every age; the stage rows target each group's binding constraint. The package is stronger than any component.

Data to policy (1): Saint Lucia NCDs, productivity and prevention

Evidence signal	Recommendation	Rationale	Monitor
34.9% obese, 40% hypertension, 15.9% raised glucose, 35.4% with 3+ risks	Prevention + screening + disease management	Risks cluster and compound	BMI, BP, glucose, treatment costs
Sodium ~2× WHO level	Targets, reformulation, labels, procurement	Sodium is embedded in the food supply	Sodium intake, product sodium, BP
XCD 231M productivity loss; XCD 127.5M presenteeism	Workplace nutrition as productivity policy	External costs fall on employers	Absenteeism, presenteeism, screening uptake via primary care

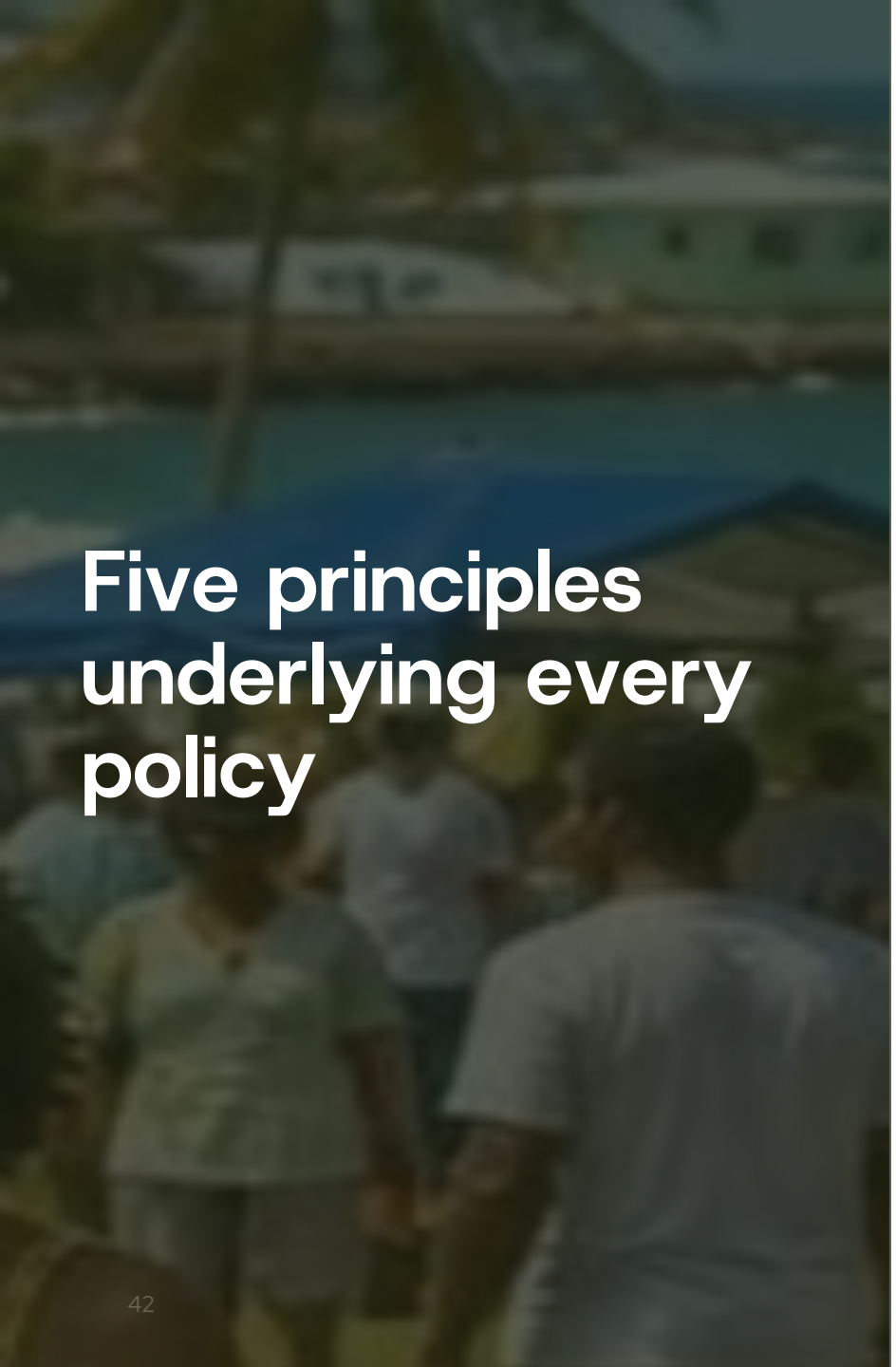
Sources: UWI-HEU (2025), STEPS 2019–2020; PAHO (2025); He et al. (2014). Economic figures modelled; prevalence survey-based.

The monitoring column is as important as the recommendation: it is what makes the policy accountable.

Data to policy (2): the life stages and evaluation

Evidence signal	Recommendation	Rationale	Monitor
30% exclusive breastfeeding (T&T); PROBIT 43.3% vs 6.4%	Consistent Baby-Friendly delivery; maternity protection designed for six months	Service design and labour policy both change infant feeding	Exclusive breastfeeding at 3 and 6 months; facility certification
1 in 3 children overweight; school evidence (Jamaica, T&T)	School standards, procurement with nutrition criteria, a campus package	Habits form early; the school environment can be controlled	What is sold and eaten in schools; child BMI; marketing exposure
12% of Saint Lucians aged 65+; 14.4% of older people in LAC need long-term care	Nutrition and frailty screening in primary care; food and caregiver support	Decline costs households and the state	Frailty, hospitalisation, care dependence, caregiver burden
Dominica: taxed in 2015 and 2024, no rigorous evaluation	Build evaluation in from the start	No baseline, no answer	Baseline and post-policy prices, sales, intake, equity

Sources: UNICEF; Kramer et al. (2001); HCC, CARPHA, UNICEF, PAHO (2022); CSO Saint Lucia (2025); PAHO (2026); Government of Dominica (2015).



Five principles underlying every policy

FIVE PRINCIPLES UNDERLYING EVERY POLICY

Affordability	Healthy choices within financial reach, especially for lower-income households
Access	Nutritious food physically available in communities, schools and workplaces
Convenience	Lower the time cost: ready-to-eat options and meal support
Equity	By income, sex, age and geography: the feasible response differs
Evidence	Every recommendation from observed data, with evaluation built in

Delivered by: Health · Finance · Agriculture · Trade · Education · Labour · Social Protection · Local Government · Private Sector · Civil Society

Test for any proposal: does it improve affordability, access or convenience – for whom – and how will we know?

Source: UWI-HEU (2025); Gabriel et al. (2026); La Foucade et al. (2022).

For the panel (1): fiscal space, employers and finance ministries

QUESTION

Where to invest first?

Prioritise by burden, cost-effectiveness, equity, reach, feasibility and time to benefit. Protect prevention (policy ROI 3.35, modelled). The earlier the stage, the longer the return.

QUESTION

What should employers do?

XCD 127.5M in presenteeism makes prevention a productivity investment: healthy workplace food, meal breaks, screening access. Evidence on productivity gains is still to be built.

QUESTION

Why should Finance care?

Productivity losses exceed three times direct health costs. Treating preventable disease crowds out other priorities; the investment case shows prevention returns.

ROI and burden figures are model estimates; pair every commitment with monitoring.

Sources: UWI-HEU (2025); Thorndike et al. (2019).

For the panel (2): responsibility, poverty and the biggest obstacle

QUESTION **Isn't it individual responsibility?**	Choice is constrained by price, time and access, and the constraints differ by stage: an infant has no choice, a worker is constrained by time, an older person by function. Policy improves the choice set; it does not make the choice.
QUESTION **Isn't the real issue poverty?**	Partly. Households with the same income face different prices, transport, food environments and time. The aim is purchasing power for a healthy diet specifically.
QUESTION **The biggest obstacle?**	Coordination and political economy, not knowledge: fiscal constraints, lobbying, data gaps, inter-ministerial collaboration. Data and governance make the rest possible.

The survey evidence is from non-representative samples: consistent evidence, not conclusive proof.

Sources: Gabriel et al. (2026); La Foucade et al. (2022); UWI-HEU (2025).



Invest early, or pay later

- Needs change at every stage; the economic principle does not: invest early, or pay later.
- People respond to prices, incomes, availability, convenience and time, at every age.
- Make the healthy choice the affordable, accessible, convenient one, from the first 1,000 days to the last.

Nutrition as health expenditure or as investment in Caribbean human capital, productivity and resilience?

Thank you. We open the discussion.

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