

CIVIL SOCIETY ACTION PLAN 2017-2021

PREVENTING CHILDHOOD OBESITY IN THE CARIBBEAN



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The increasing prevalence of childhood obesity in our places and in our time is an affront to us all. Yes it is a public health issue, but it is especially pernicious because it represents a flagrant negation of the rights of the powerless and the voiceless - rights to which the world has subscribed. It is past time for individuals and agencies to be outraged at the situation and I trust that this initiative by the HCC will help to stoke and stimulate some of that needed outrage as a primer for action. I strongly recommend the HCC Civil Society Action Plan for preventing childhood obesity in the Caribbean as a superb source of information and a clear guide to action for addressing the epidemic.

Sir George Alleyne,
HCC Patron, PAHO Director Emeritus



PREVENTING CHILDHOOD OBESITY IN THE CARIBBEAN








CIVIL SOCIETY ACTION PLAN
2017-2021



This work was supported by the NCD Alliance as part of the Expanding Access to Care, Supporting Global, Regional and Country Level NCD Action Programme in partnership with Medtronic Philanthropy.

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From our Partners

The Region has been grappling with the scourge of noncommunicable diseases (NCDs) as it creates a major developmental burden. Obesity in children is a harbinger to adult obesity and consequent related NCDs. Our policy makers are seeking guidance from all stakeholders to address this challenge. The States' Sectors, despite their enormous efforts, seem unable to effectively address the challenges. Civil Society, families and other non-state stakeholders must be incorporated in these efforts. It is therefore heartening to have HCC mobilizing this action which undoubtedly is most welcomed by all including the policy makers. On behalf of the CARICOM Secretariat and its relevant organs and Institutions that are needed to address nutrition and health related issues, I congratulate and welcome this HCC initiative. Working together certainly will enhance our chances of success in combating childhood obesity and ultimately NCDs.

Dr. Douglas Slater,

Assistant Secretary-General, Directorate for Human and Social Development, CARICOM.



The issue of childhood obesity is an alarming sign that the NCD epidemic is spreading. The drivers are the obesogenic food environments in which we live. The Caribbean, with mostly small open economies, is very vulnerable. CARPHA has led the development of a 6-point policy package to improve the healthiness of food environments, which has got support from regional Health and Economic sectors. The role of civil society and HCC will be indispensable. HCC is to be congratulated on this initiative.

Dr. James Hospedales,

Executive Director, Caribbean Public Health Agency; Senior Special Advisor, HCC.



Responding effectively to childhood obesity in the Caribbean will require a multifaceted and comprehensive suite of interventions drawing on the strengths of multiple stakeholders across all sectors. Evidence-based targeted education will be critical to build public awareness and create strong advocacy movements that drive policy change. The HCC and the UWI Open Campus signed an MOU aimed at leveraging the UWI OC platform to increase NCD awareness in the Caribbean. One central element in this partnership is supporting the capacity building elements of this HCC Civil Society Action Plan 2017-2021 for Preventing Childhood Obesity in the Caribbean. We congratulate the HCC for their leadership in developing this important resource and we welcome the opportunity to collaborate with civil society in this effort to halt the rise in childhood overweight and obesity in the Caribbean.

Professor Julie Meeks,

Deputy Principal, The University of the West Indies, Open Campus.

The Pan American Health Organization (PAHO) welcomes the Healthy Caribbean Coalition's Civil Society Action Plan 2017-2021: Preventing Childhood Obesity in the Caribbean, and acknowledges the continued efforts of the HCC in advocating for improved nutrition to enable Caribbean populations to enjoy better health. The successful implementation of the pillars of this Action Plan (Advocacy, Accountability, Capacity Development, Communication, and Sustainability), will go a long way to support PAHO's work in the prevention of obesity in children and adolescents. It is important to ensure sustained and multi-sectoral actions to make food environments more responsive to public health needs.

Dr Carissa F. Etienne,

Director, Pan American Health Organization.





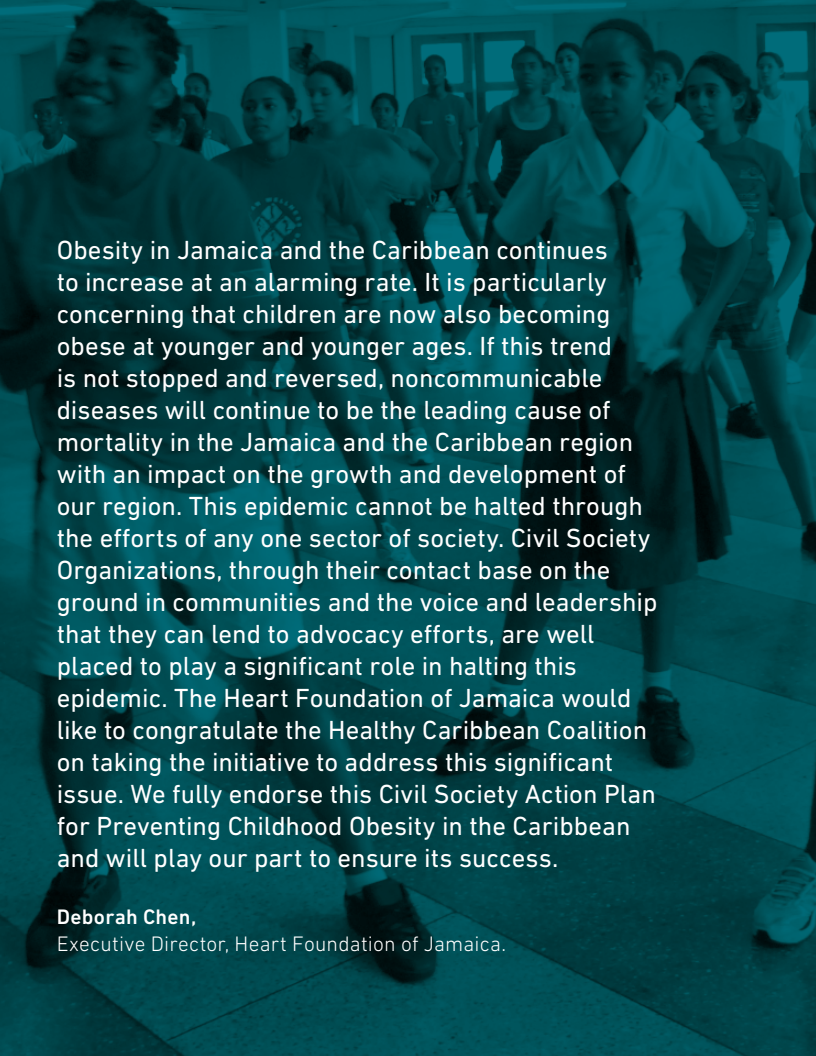
Childhood obesity is a relatively recent phenomenon, increasing at an alarming pace, and putting our youngest and most vulnerable on a trajectory of disease and disability. Bold government-led action across sectors to address its root causes is a moral and economic imperative. The NCD Alliance is proud to be supporting the work of the Healthy Caribbean Coalition to ensure that civil society has the evidence and tools to successfully advocate for and monitor government action.

Katie Dain,
Chief Executive Officer, NCD Alliance.



The mission of the World Obesity Federation is to lead and drive global efforts to reduce, prevent and treat obesity. Globally, obesity rates are rising steadily and require a coordinated and sustained multisectoral response with full engagement of civil society. The HCC Civil Society Action Plan for Preventing Childhood Obesity in the Caribbean represents a practical tool to guide and support civil society contributions to national efforts aimed at addressing the growing challenge of childhood obesity in the Caribbean. We applaud the leadership of the Healthy Caribbean Coalition in taking this important step which places civil society front and centre as an essential partner in creating healthier non-obesogenic environments for our children.

Johanna Ralston,
Chief Executive Officer, World Obesity Federation.

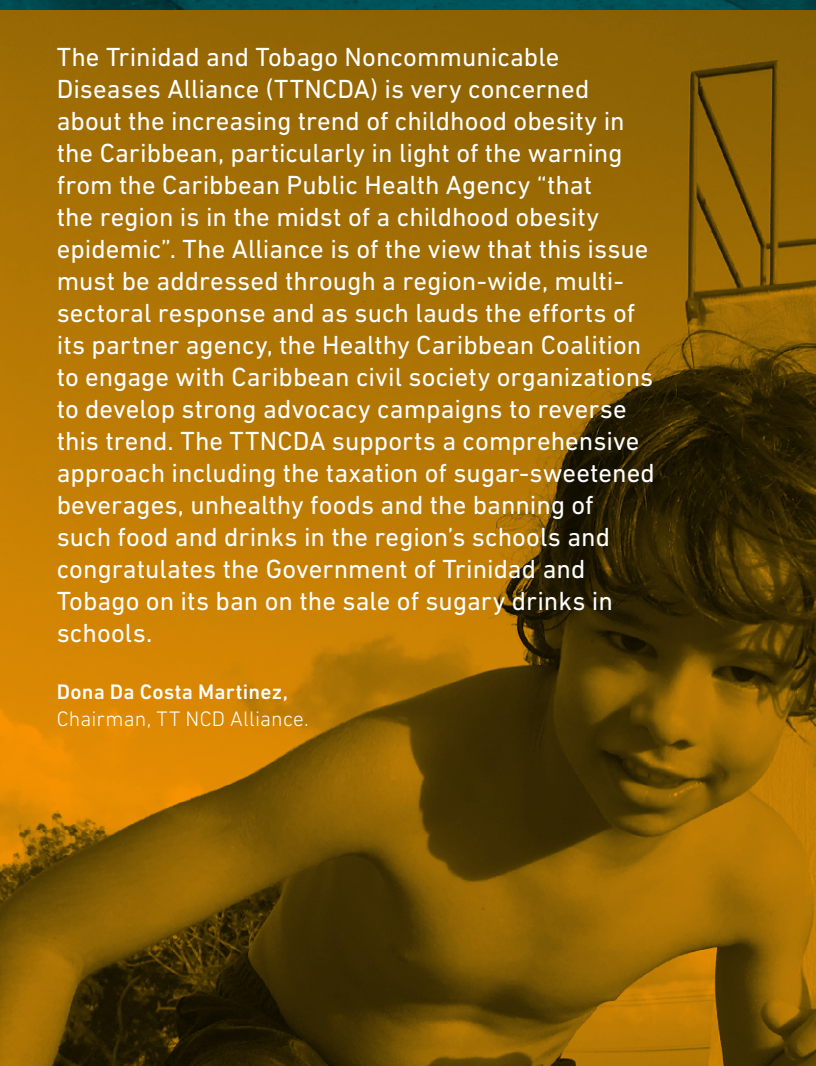


Obesity in Jamaica and the Caribbean continues to increase at an alarming rate. It is particularly concerning that children are now also becoming obese at younger and younger ages. If this trend is not stopped and reversed, noncommunicable diseases will continue to be the leading cause of mortality in the Jamaica and the Caribbean region with an impact on the growth and development of our region. This epidemic cannot be halted through the efforts of any one sector of society. Civil Society Organizations, through their contact base on the ground in communities and the voice and leadership that they can lend to advocacy efforts, are well placed to play a significant role in halting this epidemic. The Heart Foundation of Jamaica would like to congratulate the Healthy Caribbean Coalition on taking the initiative to address this significant issue. We fully endorse this Civil Society Action Plan for Preventing Childhood Obesity in the Caribbean and will play our part to ensure its success.

Deborah Chen,
Executive Director, Heart Foundation of Jamaica.

The Trinidad and Tobago Noncommunicable Diseases Alliance (TTNCDA) is very concerned about the increasing trend of childhood obesity in the Caribbean, particularly in light of the warning from the Caribbean Public Health Agency "that the region is in the midst of a childhood obesity epidemic". The Alliance is of the view that this issue must be addressed through a region-wide, multi-sectoral response and as such lauds the efforts of its partner agency, the Healthy Caribbean Coalition to engage with Caribbean civil society organizations to develop strong advocacy campaigns to reverse this trend. The TTNCDA supports a comprehensive approach including the taxation of sugar-sweetened beverages, unhealthy foods and the banning of such food and drinks in the region's schools and congratulates the Government of Trinidad and Tobago on its ban on the sale of sugary drinks in schools.

Dona Da Costa Martinez,
Chairman, TT NCD Alliance.



Acknowledgements

The Healthy Caribbean Coalition (HCC) expresses sincere appreciation to the NCD Alliance and Medtronic Philanthropy for the grant that supported the development of the HCC *Civil Society Action Plan 2017-2021: Preventing Childhood Obesity* in the Caribbean, which aligns with the HCC Strategic Plan 2017-2021.

We thank all HCC civil society organisations and members for their commitment, willingness, and active participation in addressing childhood obesity and other priority noncommunicable disease issues in the Caribbean, and express gratitude to Caribbean health and non-health ministries of government for their strong collaboration with HCC.

The support and contributions of our partners, including the Pan American Health Organisation/ World Health Organisation, the Caribbean Community Secretariat, the Caribbean Public Health Agency, and the University of the West Indies, particularly the George Alleyne Chronic Disease Research Centre, are much appreciated and valued.

Finally, we thank the primary author of the Action Plan, Dr. D. Beverley Barnett, and acknowledge the significant contributions of Mrs. Maisha Hutton and Sir Trevor Hassell. We also offer thanks to all those who provided input into the Action Plan, and to the editors and graphic designer for their contribution to the finished product.



Preface

The development of the Healthy Caribbean Coalition's (HCC's) *Civil Society Action Plan 2017-2021: Preventing Childhood Obesity in the Caribbean* is a further step in fulfilling HCC's mission "to harness the power of civil society, in collaboration with government, academia, international partners, and private sector, as appropriate, in the development and implementation of plans for the prevention and management of chronic noncommunicable diseases among Caribbean people". The NCD Alliance, a major partner of HCC, provided support for the development of the Action Plan, endorsed by HCC civil society organisations and partners at the 2017-2021 Strategic Plan development meeting in April 2016.

Increases in the prevalence of obesity among both adults and children have been documented globally, and the Caribbean region is no exception. The need to implement prevention and control measures to halt this public health threat, which contributes to increases in the prevalence of noncommunicable diseases (NCDs) and their complications, has been recognised by governments and other key stakeholders in the region and beyond.

Caribbean countries have grappled with undernutrition and have overcome it to a significant degree. They have begun in earnest to address the other end of the malnutrition spectrum – obesity – adapting relevant global and regional frameworks to national realities. Childhood obesity prevention, in particular, presents an opportunity to instil healthy habits at an early age and foster lifestyle changes that can prevent disease and maintain health throughout the life course.

HCC anticipates that this regional civil society Action Plan, developed to guide civil society's contribution to, and support for, national, regional, and global efforts to prevent childhood obesity, will assist in further strengthening collaboration among civil society and ministries of health, non-health ministries, the private sector, and international development partners in the region, to prevent and control childhood obesity and NCDs.

HCC looks forward to working with key stakeholders at national, regional, and global levels to implement multisectoral interventions for childhood obesity prevention, achieve the objectives of the Action Plan, and contribute to the health and happiness of the region's children.

At a glance

Civil Society Action Plan 2017-2021

Preventing Childhood Obesity in the Caribbean



The Healthy Caribbean Coalition's (HCC's) *Civil Society Action Plan 2017-2021: Preventing Childhood Obesity* in the Caribbean was developed to guide the response of Caribbean civil society to global, regional, and national recognition of the increasingly heavy burden of noncommunicable diseases (NCDs) and upward trends in the prevalence of overweight and obesity among children. Several regional and global frameworks have been developed to guide childhood obesity prevention at those levels and in countries, and some Caribbean countries have national strategic plans for NCD prevention and control that specifically target childhood obesity. National policies, legislation, and regulations that address two of the major NCD risk factors – unhealthy diet and physical inactivity – also contribute to childhood obesity prevention.



The major regional and global frameworks taken into account in developing the Civil Society Action Plan include the Caribbean Public Health Agency's (CARPHA's) 6-point policy package and its plan of action *Safeguarding Our Future Development, Plan of Action for Promoting Healthy Weights in the Caribbean: Prevention and Control of Childhood Obesity 2014-2019*; the Pan American Health Organisation's (PAHO's) *Plan of Action for the Prevention of Obesity in Children and Adolescents*; the World Health Organisation's (WHO's) *Population-based approaches to childhood obesity prevention* and the WHO's *Report of the Commission on Ending Childhood Obesity*. The HCC *Strategic Plan 2017-2021: Enabling Caribbean civil society's contribution to national, regional, and global action for NCD prevention and control*; the *Strategic Plan for the Caribbean Community (CARICOM) 2015-2019*; and the *Caribbean Cooperation in Health, Phase IV, 2016-2025 (CCH IV)*, which is the CARICOM regional health agenda, also provided reference points for the Action Plan 2017-2021.

Childhood obesity predisposes to the development of NCDs early in life and is a marker for adult obesity, which itself predisposes to NCD development. The rates of childhood overweight and obesity in the Caribbean are staggering and among the highest in the world. Left unchecked, they threaten to undermine the health of entire generations and reverse development gains across the region.

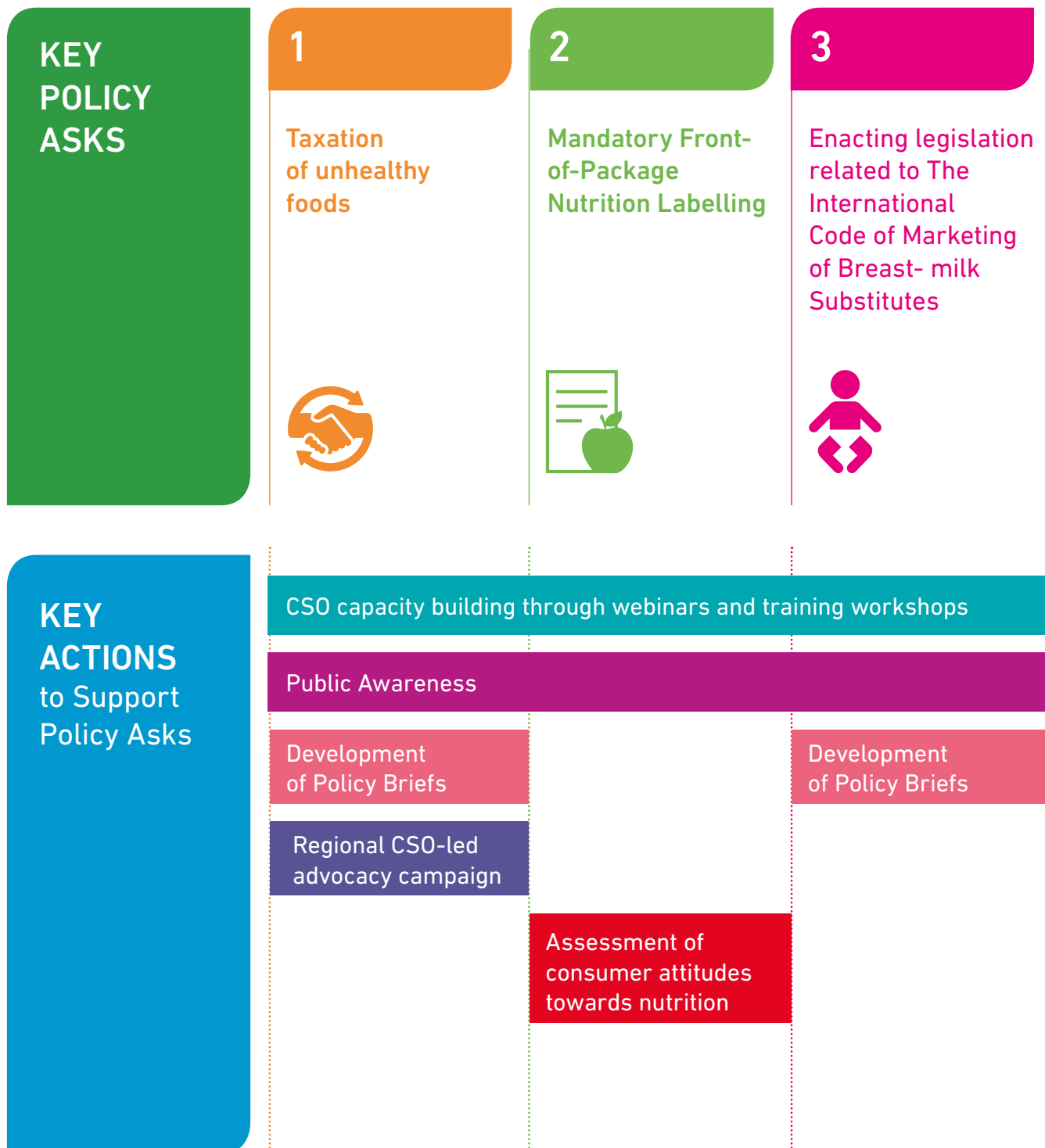
Civil society, collaborating with government and the private sector, has a critical role to play in taking action to address this condition, and the HCC, as the sole Caribbean regional civil society organisation (CSO) working in NCD prevention and control, recognised

the urgent need to develop a framework to support and coordinate civil society's actions in this arena. The Action Plan will guide the HCC secretariat and members in performing functions related to advocacy; health education and promotion; community engagement and mobilisation; holding governments, the private sector, and civil society itself accountable for their commitments; contributing to policy and programme development, implementation, monitoring, and evaluation (M&E); networking, promoting partnerships, and contributing to multisectoral action; and resource mobilisation, in order to contribute to childhood obesity prevention.

The **seven priority areas for action in the Civil Society Action Plan** are trade and fiscal policies; nutrition literacy; early childhood nutrition; marketing of healthy and unhealthy foods and beverages to children; school- and community-based interventions; resource mobilisation; and strategic planning, monitoring, and evaluation.

- | | | |
|---|--|--|
| 1 |  | Trade and fiscal policies ⁴⁶ |
| 2 |  | Nutrition literacy ⁴⁷ |
| 3 |  | Early childhood nutrition |
| 4 |  | Marketing of healthy and unhealthy foods and beverages to children |
| 5 |  | School- and community-based interventions |
| 6 |  | Resource mobilisation |
| 7 |  | Strategic planning, monitoring, and evaluation |

Snapshot of the Plan



4

Banning the marketing of unhealthy foods and beverages to children



5

Banning the sale and marketing of unhealthy foods in schools



6

Mandatory physical activity in schools



7

Monitoring policy implementation



Ongoing policy monitoring through the use of the CSO Childhood Obesity Prevention Scorecard (COPS)

Regional CSO-led advocacy campaign

Assessment of consumer attitudes towards nutrition

Mapping marketing in schools

Activities will strengthen the contribution of Caribbean civil society to the development, implementation, monitoring, and evaluation of national and regional¹ policies, legislation, regulations, programmes, and other interventions related to childhood obesity prevention by CARICOM countries. These interventions, successfully implemented, will increase the likelihood of achieving the goal of halting, by 2025, increases in childhood obesity in the Caribbean.

The activities of the Civil Society Action Plan are guided by the five pillars of the HCC Strategic Plan 2017-2021: advocacy, accountability, capacity development, communication, and sustainability.

The outcomes of the activities include enhanced:

- national taxation on unhealthy foods and/or subsidies on healthy foods (including national taxes on sugar-sweetened beverages [SSB]);
- application of mandatory nutrition labelling, front-of-package warning labels, and information on foods ;
- interventions related to breastfeeding and complementary foods;
- restrictions for marketing of unhealthy foods and beverages to children, and promotion of healthy alternatives;
- regulation of the obesogenic environments in schools (including national school bans on SSB sales and marketing) and communities;
- resource mobilisation for interventions addressing childhood obesity prevention;
- development of CSO childhood obesity prevention strategies or plans;
- performance of the “watchdog” function by CSOs (including the use of the HCC Childhood Obesity Prevention Scorecard); and
- coordination, monitoring, and evaluation of the Action Plan.

¹ In this context, “regional” refers to the Caribbean.

The HCC secretariat will lead the coordination, implementation, and oversight of the Action Plan, emphasising collaboration and partnerships with key stakeholders, as well as engagement with older children and adolescents, multisectoral collaboration, and outreach to vulnerable or disadvantaged groups, such as children and adolescents outside of the formal education system. The organisational implementation structure will include a regional Steering Committee with specific terms of reference and representation from the HCC secretariat, CSO members working in childhood obesity prevention, government, private sector, and development partners. The secretariat will work to establish a CSO action network for childhood obesity prevention to advocate for related policies and interventions, including public outreach and education. The network could comprise subcommittees of National NCD Commissions/Wellness Commissions where they exist, and link with the regional Steering Committee described above.

Risks to implementation of the Action Plan have been considered and activities have been included in the Plan to mitigate them. The risks include resource limitations; inadequate commitment and buy-in from key stakeholders, due to competing priorities; and limited or deficient implementation by Caribbean countries of policies, legislation, and regulations related to childhood obesity prevention.



Overall, the HCC *Civil Society Action Plan 2017-2021: Preventing Childhood Obesity in the Caribbean* provides a sound basis for action by Caribbean civil society, in collaboration with governments, the private sector, and development partners, to address this priority issue and contribute to NCD prevention and control in the region.



The prevalence of childhood overweight and obesity has increased significantly in the Caribbean in the post-independence era putting a significant number of young people of the region at increased risk of developing adult obesity, associated NCDs, and their health and socio-economic consequences. There is ever increasing evidence that the epidemic of childhood obesity has resulted from, or been significantly contributed to, by an increased intake of sugar-sweetened beverages and unhealthy “junk” food marketed, promoted and sold to the youth, in environments that encourage and result in reduced physical activity. Childhood obesity and its contributing factors require positive and constructive action by all sectors of society. The HCC “Civil Society Action Plan: Preventing Childhood Obesity in the Caribbean” is a rich resource and a blueprint for regional and national action by Caribbean civil society and is anticipated over the next 5 years to be used by the HCC and its member organisations and collaborating partners as an instrument for assisting the Caribbean in reducing childhood obesity.

Sir Trevor Hassell,
President, HCC

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As a mother and an NCD advocate, I am deeply concerned about the escalating crisis of overweight and obesity in the Caribbean. Childhood obesity is one of the most urgent challenges of our time. At its core it is a social justice issue which reflects a deep violation of the rights of society's most innocent. We as parents, grandparents and caretakers of our communities need to be enraged - we need to feel indignation and anger when the healthy choice is the most costly choice; when our children are fed school meals loaded with sugars, fats and salts; when school curricula are doing away with physical education; and when the multimillion dollar food and beverage industry assaults our children with manipulative advertising driven solely by profit-making agendas. Through this plan, HCC hopes to stimulate the type of public awareness and frustration which triggers a social movement leading to the creation of an environment which results in healthier, happier children, young people and ultimately adults.

Maisha Hutton,
Executive Director, HCC



1. Introduction

In April 2016, the Healthy Caribbean Coalition,² a registered, not-for-profit regional civil society network and alliance that targets the prevention and control of noncommunicable diseases in the Caribbean region, held a strategic planning meeting in Barbados (1). The discussions and agreements arising from that meeting contributed significantly to the development of the HCC Strategic Plan 2017-2021 (2), which guides the work of the Coalition over a period that spans key regional and global NCD milestones. These milestones include the 10-year anniversary of the 2007 Port of Spain Declaration (POSD) on NCDs by the Heads of Government of the Caribbean Community (3); the 10-year anniversary of the establishment of the HCC in 2018; and the Third United Nations High Level Meeting (UNHLM) on NCDs, also in 2018.

At the strategic planning meeting, HCC CSO members and other stakeholders agreed that the prevention and control of childhood obesity should be a priority for civil society's contribution to the response to NCDs in the Caribbean over the period 2017-2021. This decision aligned well with the rising prevalence of childhood obesity in the Caribbean region and the development of the CARPHA *Plan of Action for Promoting Healthy Weights in the Caribbean: Prevention and Control of Childhood Obesity 2014-2019* (4); the formulation of the 2014 PAHO *Plan of Action for the Prevention of Obesity in Children and Adolescents* (5) to address the issue in the region of the Americas; and the 2016 *Report of the Commission on Ending Childhood Obesity* (6). The Commission was established by WHO to address the issue globally, and its recommendations complemented the guidance provided in the WHO 2012 publication, *Population-based approaches to childhood obesity prevention* (7).

The commitment to address the issue also aligned with activities being carried out through HCC's partnership with the NCD Alliance (NCDA)³ and Medtronic Philanthropy⁴ under the programme

"Strengthening Health Systems, Supporting NCD Action" and the specific goal "Improve the capacity for effective, targeted civil society-led NCD prevention and control in the Caribbean". A key activity contributing to the achievement of the goal is the development of an HCC regional civil society action plan on childhood obesity prevention, complementing and contributing to relevant national, regional, and global efforts. The outcome associated with this activity is "CSOs more aware of, and equipped to act and advocate for, childhood obesity prevention".

Civil society, distinct from government and the private sector, can operate in a relatively unencumbered and flexible manner, while maintaining strategic focus, responsibility, and accountability. The role of the HCC, as the sole civil society NCD alliance in the Caribbean and the only regional organisation with NCD prevention and control as its singular focus, will be critical in ensuring that civil society is a meaningful actor in the whole-of-society response to NCDs and childhood obesity.

The importance of this issue, and civil society's role, has been recognised globally. In its 2012 publication on prioritising population-based approaches to childhood obesity prevention (7), WHO highlights the role of civil society, noting that CSOs can help to protect public interests and can have an influential role when working with governments and the private sector by acting as a "voice for the people". In her speech at her final World Health Assembly in May 2017, Dr. Margaret Chan, former WHO Director-General, called on Member States to: "*Listen to civil society. Civil society organisations are society's conscience. They are best placed to hold governments and businesses, like the tobacco, food, and alcohol industries, accountable. They are the ones who can give the people who suffer the most a face and a voice.*"⁵

² See <http://www.healthycaribbean.org/>

³ See <https://ncdalliance.org/>

⁴ See <http://www.medtronic.com/ir-en/corporate-citizenship-4/philanthropy-programmes.html>

⁵ See <http://www.who.int/dg/speeches/2017/address-seventieth-assembly/en/>.

1. Introduction

Notwithstanding that the financial capacity of civil society entities is often limited, key roles of CSOs, including nongovernmental organisations (NGOs), in addressing this issue are identified as (7):

- **Advocacy** – “arguing the case”, especially for the creation and maintenance of healthy diet and physical activity environments, and for the provision of programmes and policies to address obesity;
- **Monitoring progress;**
- **Reporting and campaigning** on the performance of stakeholders;
- **Implementing social marketing and education** strategies and programmes to promote healthy eating, increased physical activity levels and healthy body weight; and
- **Contributing to research,** monitoring, and evaluation.

The 2016 Report of the WHO Commission on Ending Childhood Obesity (6) underscores these roles, noting the social, moral, and political pressure that civil society can place on governments to fulfil their commitments, and recommending that civil society’s agenda for advocacy and accountability should now include ending childhood obesity. The Commission notes that NGOs can:

- **Raise** the profile of childhood obesity prevention through advocacy efforts and the dissemination of information;
- **Motivate** consumers to demand that governments support healthy lifestyles and that the food and non-alcoholic beverage industries provide healthy products, and do not market unhealthy foods and SSBs to children; and
- **Contribute** to the development and implementation of a monitoring and accountability mechanism.

The United Nations Decade of Action on Nutrition, 2016–2025, was designated as a way of highlighting the Rome Declaration on Nutrition and other recommendations from the Second International Conference on Nutrition



(ICN2) held in Rome in 2014.⁶ The Declaration calls on countries to—among other things—ensure healthy diets throughout the life course, and create environments in which informed choices can be made for appropriate infant and young child feeding.

In 2017, the 70th World Health Assembly of the WHO welcomed the implementation plan for the recommendations of the Commission on Ending Childhood Obesity, and urged WHO Member States to “develop national responses, strategies and plans to end infant, child, and adolescent obesity, taking the implementation plan into account”.⁷ Given the evolution of scientific evidence and taking account of lessons learned, the 70th World Health Assembly also endorsed an expanded menu of policy options for achieving the objectives of the WHO Global Action Plan (GAP) for the Prevention and Control of Noncommunicable Diseases in Updated Appendix 3 of the GAP. The expanded policy options include legislation, regulations, and other interventions for the reduction of the consumption of unhealthy foods and beverages, and physical inactivity.⁸

The Caribbean region also took note of the issue and called on civil society to act. A 2014 civil society

⁶ Summary of the commitments of the Rome Declaration available at http://www.who.int/nutrition/decade-of-action/smart_commitments/en/; official Rome Declaration available at <http://www.fao.org/3/a-ml542e.pdf>.

⁷ WHO. Report of the Commission on Ending Childhood Obesity: implementation plan. Report by the Secretariat. Available at http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_31-en.pdf.

⁸ WHO. Preparation for the third High-level Meeting of the General Assembly on the prevention and control of NCDs, to be held in 2018 – Report by the Director-General. Document A70/21, Annex 1, 18 May 2017. Available at http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_27-en.pdf.



regional status report on NCD responses in the Caribbean, developed by HCC and supported by a grant from the NCDA, included a Call to Action that highlighted areas for CSO advocacy (8). CSOs were encouraged to advocate for policy on food, in particular banning the marketing of energy-dense, high-salt foods and SSBs to children; promoting reduction in salt and SSBs (including fruit juices); banning the use and sale of trans fats; and developing regional standards for clear, consistent food labelling. CSOs were also called on to advocate for policy on the promotion of physical activity, with the development, implementation, and monitoring of relevant national strategies (8).

A 2016 assessment of HCC CSO member organisations working in NCDs revealed that public information/education; advocacy; and screening were their major three activities, with lesser engagement in policy development and accountability (“watchdog”) functions (9), that is, holding governments, the private sector, and civil society itself accountable for their commitments.

The HCC Civil Society Action Plan 2017-2021 for childhood obesity complements, and makes operational, related targets in the HCC Strategic Plan 2017-2021, and is formulated in the context of the Strategic Plan’s vision, mission, and values/guiding principles, as well as its five pillars: advocacy, accountability, capacity development, communication, and sustainability (2). The Action Plan identifies the priority areas for action during the proscribed period and includes the overall goal



More people are dying from obesity than starvation, for the first time in the history of the world.

Michael R. Bloomberg
WHO Global Ambassador
for noncommunicable diseases.

and outcomes, as well as an Implementation Plan with the outputs, activities, inputs, resources for the first two years, an indicative budget, and an accountability framework. A summary of risks and related mitigation strategies is included, as well as an M&E framework, including sources of information/means of verification to facilitate assessment of the level of achievement of the indicators and objectives.

The Action Plan is informed by several frameworks developed at national, regional, and global levels in response to the epidemic of childhood obesity, including plans of action developed by CARPHA (4) and PAHO (5); WHO guidelines and recommendations (6, 7, 10); and the 2030 Sustainable Development Agenda and its Sustainable Development Goals (SDGs) (11).

The priority areas for action were selected based on the CARPHA 6-point policy package for addressing childhood obesity (12); the PAHO Plan of Action for the Prevention of Obesity in Children and Adolescents (5); the recommendations of the WHO Commission on Ending Childhood Obesity (6); and the WHO Population-based Approaches to Childhood Obesity Prevention (10). The major elements of the main frameworks are summarised in **Sections 2.6.1, 2.6.2, 2.6.3, 2.6.4, and 2.6.5**, and details are provided in a comparative matrix in **Annex 1. Section 2.6.6** summarises suggestions from the frameworks for civil society’s actions.

In making its contributions and carrying out its main functions in support of childhood obesity prevention in the Caribbean, civil society will collaborate with government, the private sector, and development partners, providing its unique perspective to add value to relevant policies, strategies, plans, and programmes.

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Childhood obesity is not just a problem in childhood, it tracks into adulthood and puts children at higher risk for a wide variety of physical and mental health issues. Unhealthy eating is the biggest challenge we face as a society, and the academics and partners need to do more in promoting delicious, healthy alternatives.

Dr. Alafia Samuels,
Director, George Alleyne Chronic Disease Research
Centre, UWI.



2. Background

2.1 General considerations

Threats to health gains

The obesity epidemic is threatening many of the gains made in health (13). In some settings overweight and obesity are becoming social norms, contributing to the perpetuation of the obesogenic environment (see Definitions) (6). Obesity has physical and psychological health consequences during childhood, adolescence, and into adulthood; physical consequences include accelerated onset of cardiovascular disease and type-2 diabetes, while psychological consequences include behavioural and emotional issues such as depression. Obesity can also lead to stigmatisation, poor socialization, and reduced educational attainment, and childhood obesity is a strong predictor of adult obesity (6).

Human rights obligations

All 14 independent CARICOM Member States⁹ and – through the United Kingdom (UK) – the UK Overseas Territories in the Caribbean, which include one CARICOM Member State¹⁰ and 5 Associate States¹¹, have ratified the Convention on the Rights of the Child (CRC)¹². Article 24 of the CRC affirms the right of the child to the enjoyment of the highest attainable standard of health, and specifically requests States Parties to “combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution”.

General comment No. 15 (2013) from the Committee on the Rights of the Child details the obligations in CRC Article 24, and specifically indicates that States should address obesity in children.¹³

Other global commitments

- The WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 includes Objective 3: “To reduce modifiable risk factors for noncommunicable diseases and underlying social determinants through creation of health-promoting environments”.¹⁴
- The 2014 Rome Declaration, made at ICN2, recognises malnutrition as encompassing not only undernutrition and micronutrient deficiency, but also overweight and obesity, and notes the negative social and economic consequences for individuals, families, communities, and States (14).
- The 2014 WHO Global Nutrition Targets 2025¹⁵ include Target 4: “No increase in childhood overweight”.
- SDG 2, “End hunger, achieve food security and improved nutrition and promote sustainable agriculture” provides a global framework that contributes to the prevention of childhood obesity, with Target 2.2 calling for an end to malnutrition in all its forms (11).
- SDG 3, “Ensure healthy lives and promote well-being for all at all ages” includes Target 3.4 “by 2030,

⁹ Antigua & Barbuda, The Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, St. Kitts & Nevis, St. Lucia, St. Vincent & the Grenadines, Suriname, Trinidad & Tobago.

¹⁰ Montserrat.

¹¹ Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Turks & Caicos Islands.

¹² Source: UN Human Rights – Office of the High Commissioner on Human Rights. Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>

¹³ Committee on the Rights of the Child. General comment No.15, paragraph 42. Available at <http://www.refworld.org/docid/51ef9e134.html>.

¹⁴ WHO. Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. Available at http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1.

¹⁵ Available at <http://www.who.int/nutrition/global-target-2025/en>.

2. Background

reduce by one-third premature mortality from noncommunicable diseases through prevention and treatment, and promote mental health and well-being" (11).

Caribbean regional commitments

NCDs have been recognised as a threat to the health of Caribbean people and an issue for joint cooperation at regional level since the initiation of the CCH, the CARICOM regional health agenda, in 1984.¹⁶ A selection of the CARICOM organs and bodies that have demonstrated the region's commitment to fighting NCDs follows:

- The CARICOM Council for Human and Social Development (COHSOD), which has consistently given priority to these conditions, with endorsement by the CARICOM Heads of Government in both the 2001 Nassau Declaration¹⁷ and the 2007 POSD (3).
- The CARICOM Council for Trade and Economic Development (COTED), which, in growing recognition of the need for a multisectoral approach to NCDs, at its 41st meeting in November 2015 recognised the cross-sectoral linkages and the need for action to confront NCDs. The COTED noted that NCDs "are having a deleterious effect on the health of the Region's workforce and have the potential to affect our competitiveness", and focused especially on childhood obesity. The Council agreed to have further consultations on matters falling within its purview, including: mandatory nutrition labelling on all packaged foods; recommendations on measures to encourage the consumption of healthier foods; nutrition standards and guidelines; food marketing and portion sizes; the level of harmful ingredients in food products; and trade and fiscal measures.¹⁸
- The CARICOM Heads of Government 37th Regular Meeting in July 2016, where the Heads of Government recognised the progress made in addressing NCDs, but acknowledged that progress was variable. They agreed to adopt a more holistic approach and address related issues, including trade-related measures; banning advertisement of potentially harmful foods which specifically target

children; and elevating taxes on foods high in sugar, salt and trans fats.¹⁹

- The COHSOD meeting in September 2016, where the Council endorsed the proposal for CCH IV (15). The proposal specifically addresses NCDs and childhood obesity under the Strategic Priority "Health and wellbeing of Caribbean people throughout the life course".

Governments therefore have international human rights obligations, policy agreements, and technical commitments to fulfil, in addition to addressing childhood obesity as a public health priority at national level, in collaboration with civil society, the private sector, and development partners. None of the policy and other "upstream" or structural factors influencing childhood obesity are in the control of the child, so that the condition should not be seen as a result of voluntary lifestyle choices, particularly by the younger child, but as one resulting from societal and environmental factors and circumstances. Governments and society have a moral responsibility to act on behalf of the child to reduce the risk of obesity (6).



¹⁶ See http://archive.caricom.org/jsp/communications/meetings_statements/health_cch.jsp?menu=communications

¹⁷ See http://archive.caricom.org/jsp/communications/meetings_statements/nassau_declaration_on_health.jsp?menu=communications

¹⁸ See COTED Statement available at <http://today.caricom.org/tag/forty-first-meeting-of-the-council-for-trade-and-economic-development/>

¹⁹ See communique from meeting, available at <http://caricom.org/cochog/view/communiqu-issued-at-the-conclusion-of-the-thirty-seventh-regular-meeting-of-the-conference-of-heads-of-government-of-the-caribbean-community-caricom-4-6-july-2016-georgetown-guyana>.

2.2 Selected factors that promote weight gain

Obesogenic environment

It is widely accepted that the most important factors that promote weight gain and obesity, as well as associated NCDs, are high intake of products poor in nutrients and high in sugar, fat, and salt – energy-dense nutrient-poor (EDNP) products – such as salty or sugary snacks and fast foods; routine intake of SSBs; and insufficient physical activity. These are all part of an obesogenic environment (5). Overindulgence in high-calorie food and indoor leisure activities, such as television viewing, internet, and computer games (screen-based activities), especially in combination with factors that dissuade walking and other outdoor activities, contribute to childhood obesity (6). Many schools have reduced the time allotted for physical education, while at the same time children's screen time, which is an opportunity for food consumption and exposure to food advertising, has increased to 3 hours per day or more (5). Urban planning and the built environment, with adequate sidewalks,

cycle paths, green spaces, and other facilities for safe recreation, are critical to encourage and enable regular physical activity.

Food system issues

Food system issues related to agriculture, food processing, food distribution, marketing, retail, and food service, and to food and nutrition security in general.

- **Food preferences,** purchasing decisions, and eating behaviours. An individual's food preferences, purchasing decisions, and eating behaviours are shaped by price, marketing, availability, and affordability, which are in turn influenced by upstream policies and regulations on trade and agriculture (16).
- **Food promotion and marketing.** In both developed and developing countries, there is significant food promotion to children (17). Television advertising is the most dominant promotional channel, but the full range of promotion and marketing techniques



One of the most alarming signs was the high incidence of childhood obesity, a major risk factor for NCDs. We simply cannot afford to continue the lifestyle and food consumption patterns which are literally killing us.

Dr. Rt. Hon Keith Mitchell,
Prime Minister of Grenada

Thirty-Eighth Meeting of the Conference of Heads of Government of CARICOM.

and strategies are used in food and advertising industries. Children recall, enjoy, and engage with the multiple promotions, including use of social media and messaging technologies, which offer direct-marketing opportunities. Evidence confirms that the food products promoted show an undesirable dietary profile, with heavy emphasis on energy-dense, high-fat, high-salt and high-sugar foods, and almost no promotion of foods that public health evidence encourages greater consumption of, such as fruit and vegetables (17).

- **Food and nutrition security.** In the Caribbean, at both regional and national levels, food and nutrition security include food availability, food access, nutritional adequacy, and the stability of these three components (18). Globalisation, trade liberalisation, reduction of trade barriers, emphasis on competitiveness, and removal of preferential quotas all have potential negative effects on Caribbean agriculture (18). These factors affect food prices, food availability, food sovereignty,²⁰ and food and nutrition security, often posing challenges to the prevention of obesity in children and adults when the healthy choice is the more expensive choice. Healthy nutrition depends on access to adequate and nutritious foods, the quality of diets, food preparation practices, educational levels, age, and gender, and the links among these factors mandate that there be multisectoral solutions to food insecurity (18).

Social, cultural, and economic issues

Undernutrition in early childhood places children at an especially high risk of developing obesity when food and physical activity patterns change (5).

- Breastfeeding has been shown to improve the health and nutrition of infants and young children, and in 1981 WHO and UNICEF spearheaded the development of the International Code of Marketing of Breast-Milk Substitutes²¹ to discourage the use of such substitutes. However, a WHO 2016

status report on national implementation of the International Code found several challenges and gaps, including limitations in legal measures and few monitoring and enforcement mechanisms.²²

- At the 69th World Health Assembly in 2016, WHO Member States approved Resolution WHA69.9 “Ending inappropriate promotion of foods for infants and young children”.²³ The Resolution welcomed related technical guidance, which aims to promote, protect, and support breastfeeding, prevent obesity and noncommunicable diseases, promote healthy diets, and ensure that caregivers receive clear and accurate information on feeding.²⁴
- Many countries face the burden of malnutrition in all its forms, with rising rates of childhood obesity as well as high rates of childhood undernutrition (including wasting, stunting, and micronutrient deficiency or insufficiency). In such settings, an overweight child may be considered to be healthy (5), and in some countries being subjectively “too slim” is considered to be a sign of ill-health in both children and adults. Within countries, poor and low-literate population groups with limited access to public health information and services, and to nutritious food, may be at high risk of becoming obese.

Preconception and pregnancy care

The Report of the Commission on Ending Childhood Obesity notes that maternal overweight or obesity and excess weight gain during pregnancy, among other maternal conditions, increase the likelihood of obesity during infancy and childhood (6). The Commission’s report also cites evidence of the positive impact of timely, quality care for women before, during, and after pregnancy on the health and development of their children throughout the life course, and points to emerging evidence that the health of fathers at the time of conception can influence the risk of obesity in their children.

²⁰ Food sovereignty is defined as “the right of peoples to healthy and culturally appropriate food produced through ecologically sound and sustainable methods, and their right to define their own food and agriculture systems”. World Forum for Food Sovereignty: Declaration of Nyéléni, Mali, 2007. Available at <https://nyeleni.org/IMG/pdf/DeclNyeleni-en.pdf>.

²¹ International Code of Marketing of Breast-Milk Substitutes (1981). Geneva: WHO, 1981. Available at http://www.who.int/nutrition/publications/code_english.pdf.

²² WHO, UNICEF, IBFAN. Marketing of breast-milk substitutes: national implementation of the International Code: status report 2016. Geneva: WHO, 2016. Available at http://apps.who.int/iris/bitstream/10665/206008/1/9789241565325_eng.pdf?ua=1&ua=1.

²³ Resolution WHA69.9, available at http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_R9-en.pdf.

²⁴ WHO. Maternal, infant, and young child nutrition: Guidance on ending inappropriate nutrition for infants and young children. Document A69/7 Add.1. Geneva: WHO, 13 May 2016. Available at http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_7Add1-en.pdf.

2.3 Approaches to childhood obesity prevention

As obtains for NCDs in general, obesity prevention and treatment require whole-of-government, health-in-all-policies, and whole-of-society approaches, where policies and interventions in non-health sectors take health and the social determinants of health²⁵ into account, aiming to avoid negative impacts on, and improve, health outcomes and health equity. Equitable coverage of interventions will be critical, particularly to reach excluded, marginalized, or otherwise vulnerable population groups that often have poor access to healthy foods, safe places for physical activity, and preventive health services and support (6); such groups often include children with physical and mental disabilities.

In 2017, WHO published a policy brief on “double-duty” actions that have the potential to simultaneously reduce the risk or burden of both undernutrition (wasting, stunting, and micronutrient deficiencies) and overweight, obesity, or diet-related NCDs.²⁶ Double-duty actions should be prioritized as a strategy to address the common underlying causes of these conditions and provide cost-effective solutions. The underlying causes include shared biological, environmental, and socioeconomic factors, and actions (policies, programmes, and interventions) to address them will result in healthier weights and positive short- and long-term health outcomes among children and young people. The WHO policy brief on double-duty actions emphasises that these interventions are often already used to address single forms of malnutrition, but have the potential to address multiple forms simultaneously and yield significant co-benefits.

Steady progress toward universal access to health and universal health coverage is a critical aspect of NCD and childhood obesity prevention. This involves the strengthening of health system components²⁷ to ensure that all people and communities have access, without any kind of discrimination, to comprehensive, appropriate, timely, quality health services according to needs, while ensuring that the use of the services does not expose users to financial difficulties.



We have responsibility on behalf of the world's children to stop them from being overly obese.

Sir Peter Gluckman,
Co-Chair of the WHO Commission on Ending
Childhood Obesity

²⁵ Social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. See http://www.who.int/social_determinants/en/.

²⁶ WHO. Double-duty actions for nutrition: policy brief. Geneva: WHO, 2017. Available at <http://www.who.int/nutrition/publications/double-duty-actions-nutrition-policybrief/en/>.

²⁷ WHO health system “building blocks” are leadership and governance; service delivery; health workforce; health financing; health information and research; and essential medicines and technologies. See http://www.who.int/healthsystems/strategy/everybodys_business.pdf.

Universal access to health and universal health coverage requires determination and implementation of multisectoral policies and actions to address the social determinants of health and promote a society-wide commitment to fostering health and well-being (19).

In summary, the prevention of childhood obesity requires life-course, comprehensive, integrated, strategies that target improvements in health outcomes, enable social inclusion, and reduce inequities. These efforts should be led by governments and involve all stakeholders, including health and non-health ministries, civil society, the private sector, and development partners. The Commission on Ending Childhood Obesity suggests that “the greatest obstacle to effective progress on reducing childhood obesity is a lack of political commitment and a failure of governments and other actors to take ownership, leadership, and necessary actions”, and notes that successful interventions will result in significant health, intergenerational, and economic benefits (6).

Countries, through their governmental, intergovernmental, and civil society entities and organisations, have sought to respond to both NCDs and childhood obesity at national, regional, and global levels. International agreements, strategies, plans of action, recommendations, guidelines, and tools are available to enable the planning, implementation, monitoring, and evaluation of relevant interventions, in addition to national policies, strategies, and plans. These frameworks address – among other topics – scientific evidence for obesity prevention, breastfeeding, the Baby-Friendly Hospital Initiative, inappropriate promotion of foods for infants and young children, diet, physical activity, food marketing and promotion, multisectorality, prioritising interventions, and monitoring and evaluation.

Selected responses by governments and civil society at global, regional, and national levels are listed in **Sections 3.1, 3.2, and 3.3**, respectively.

2.4 Global situation summary

Worldwide, the prevalence of obesity has nearly doubled since 1980; in 2014, 11% of men and 15% of women aged 18 years and older were obese, and more than 42 million children under the age of 5 years were overweight in 2013 (13). In absolute numbers, more overweight and obese children live in low- and middle-income countries than in high-income countries (6), but overweight and obesity among both children and adults have been increasing rapidly in all regions, with over 500 million adults affected by obesity in 2010.



... This is the first time in the history of humanity - 200,000 years - that our children will be fatter than their parents.

Dr. Anselm Hennis,
Director of the Department NCDs and Mental Health,
PAHO

Remarks at the 2017 Regional CARPHA *Meeting to Develop a Roadmap on Multi-Sectoral Action in Countries to Prevent Childhood Obesity* through Improved Food and Nutrition Security.

Dietary risk factors, together with inadequate physical activity, account for almost 10% of the global burden of disease and disability (13).

In 2013



More than

42 million CHILDREN

under the age of 5 years

WERE OVERWEIGHT

In 2014



11% of MEN

15% of WOMEN

aged 18 years and older

WERE OBESE

2.5 Regional²⁸ situation summary

The Americas

Compared with other WHO regions,²⁹ the prevalence of overweight and obesity in adults over 18 years of age is highest in the Americas, at 61% overweight or obese in both sexes, and 27% obese (13). In the American region, as in other WHO regions, women are more likely to be obese than men. In the European and Eastern Mediterranean Regions and the Region of the Americas, over 50% of women are overweight, and in all three regions roughly half of overweight women are obese: 25% in the European region, 24% in the Eastern Mediterranean Region, and 30% in the Region of the Americas (13).

An increase in the prevalence of overweight and obesity has also been observed in the Region's children aged 0-5 years, rising from 2.2% in 1991 to 5.6% in 2007 in the Dominican Republic; from 1.5% in 1993 to 3% in 2008 in El Salvador; and from 2.5% in 1992 to 3.2% in 2012 in Peru (5). Overall, 20%-25% of children under 19 years old in Latin America are affected by overweight and obesity (20).

The Caribbean

There is evidence of a significant and growing problem of unhealthy weights among young people in the Caribbean, with prevalence rates for overweight and obesity between 28% and 35% in Caribbean countries (4). A report from seven Eastern Caribbean countries indicated that between 2000 and 2010, the rates of overweight and obesity in children aged 0-4 years doubled, from 7.4% to 14.8% (21). A 2003 study in Jamaica tracked children at 7-8 years of age and again at 11-12 years of age, and demonstrated increases in obesity from 3.5% to 9.5% (22), while studies in Trinidad and Tobago in 2001 and 2010 showed, respectively, childhood obesity prevalence rates of 5% and 26%, with risk factors for hypertension, diabetes and cardiovascular diseases starting to emerge (23).

During the decade 2001-2010, the prevalence of overweight in Caribbean children less than 5 years old rose from 6% to 14%; for boys 11-13 years old, combined overweight and obesity prevalence was 27%, while for girls it was 33% (24). Results from the WHO Global



The HCC, in nine short years, has made and continues to make a tremendous regional impact on prevention and control of NCDs in the English Speaking Caribbean. The Government of Barbados fully recognizes that to fulfil our commitments to the Port of Spain Declaration in 2007 and to the United Nations High Level Meeting on NCDs 2011, we will need the collective efforts of Government, Civil Society, the Private Sector and our International Partners. We also recognize that responding to the epidemic of childhood obesity is a highly appropriate strategy if we really hope to secure the economic, health and social development of our future generations.

Honourable John D.E. Boyce,
MP, Minister of Health, Barbados.

School-based Student Health Survey (GSHS) indicate that among 13-15 year olds, overweight and obesity rates in Barbados were, respectively, 31.9% and 14.2% (2011); in Dominica, 24.8% and 9.1% (2009); and in Guyana, 15.3% and 4.1% (2010) (25), with no marked differences in the rates between boys and girls.

The Caribbean is facing a double burden of under- and over-nutrition, with factors that include falling rates of breastfeeding, unhealthy eating patterns, sedentary lifestyles, and advertising and promotion of unhealthy diets contributing to overweight and obesity in Caribbean children (4), even as stunting, wasting, and micronutrient deficiency continue to occur in

²⁸ In this context, "regional" refers to both the Region of the Americas and the Caribbean (CARICOM) Region.

²⁹ African, European, Mediterranean, South-East Asian, and Western Pacific.



The Revolution we seek with regard to healthier women and girls should be found in the kitchens and classrooms in the Caribbean.

Excellency Reema Carmona,
First Lady of Republic of Trinidad and Tobago

Opening Remarks at the 2017 *Regional Meeting Building Synergies for Implementation of the Global Strategy (GS) for Women's, Children's and Adolescents' Health in the Caribbean.*

certain settings and environments. The CARPHA Plan of Action references research in the region that shows significant variations in exclusive breastfeeding rates for the first 6 months of life, the average rate being about 39%, with some countries having rates as low as 5%; significant association of overweight and obesity with consumption of SSBs; limited fruit, vegetable, and water intake; low physical activity levels; and contribution of the school environment to unhealthy eating, where assessment of school meal options reveals children's consumption of foods high in fats and sugars (4).

The region has undergone a nutritional, as well as an epidemiological transition. The nutritional transition is characterised by a shift away from diets based on locally-grown indigenous staples (grains, starchy roots), locally-grown fruits, vegetables, legumes, and limited foods of animal origin, to diets that are more varied and energy-dense, consisting of foods that are more processed, (including processed beverages) and more of animal origin, with more added sugars and fats, and often more alcohol (18).

Data from food balance sheets can be used as a proxy for food consumption data to examine trends in food availability and consumption patterns (18). For CARICOM countries, aggregated food balance sheet data show that the availability of total food energy, macronutrients, sugars, and sweeteners has exceeded recommended population food goals from as early as the 1960s, and has been increasing. The contribution of fruits and vegetables has been also increasing since



that time, but their consumption remains well below the recommended population goals. In addition, the contribution of imports continues to exceed that of local production (18); the Caribbean region currently spends over USD³⁰ 4.5 billion annually on food imports to close the gap between food consumption and food production (26). Almost all CARICOM countries import more than 60% of the food they consume, with half of them importing more than 80% of the food they consume. Only three countries (Belize, Guyana, and Haiti) produce more than 50% percent of their consumption. Much of this food comprises EDNP products, high in fats, oils, sweeteners, and sodium, linked to the epidemic of overweight and obesity and increasing prevalence of NCDs in the region (26). As imports of highly processed foods continue to rise steadily, there have been notable declines in national per capita production of fruits and vegetables (26).

³⁰ USD = United States dollar

2.6 Selected childhood obesity prevention frameworks: summary of main elements and suggested civil society actions

2.6.1 WHO Population-based approaches to childhood obesity prevention

1	Structures within government to support policies and interventions.	2	Population-wide policies and initiatives.	3	Community-based interventions.
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2.6.2 WHO Commission on Ending Childhood Obesity – main recommendations

- Implement comprehensive programmes that promote the intake of healthy foods and reduce the intake of unhealthy foods and SSBs by children and adolescents.
 - Implement comprehensive programmes that promote physical activity and reduce sedentary behaviours in children and adolescents.
 - Integrate and strengthen guidance for NCD prevention with current guidance for preconception and antenatal care, to reduce the risk of childhood obesity.
 - Provide guidance on, and support for, healthy diet, sleep, and physical activity in early childhood to ensure children grow appropriately and develop healthy habits.
 - Implement comprehensive programmes that promote healthy school environments, health and nutrition literacy, and physical activity among school-age children and adolescents.
 - Provide family-based, multi-component lifestyle weight management services for children and young people who are obese.
- The recommended interventions and their intermediate and long-term outcomes are summarized in **Figure 1** below.

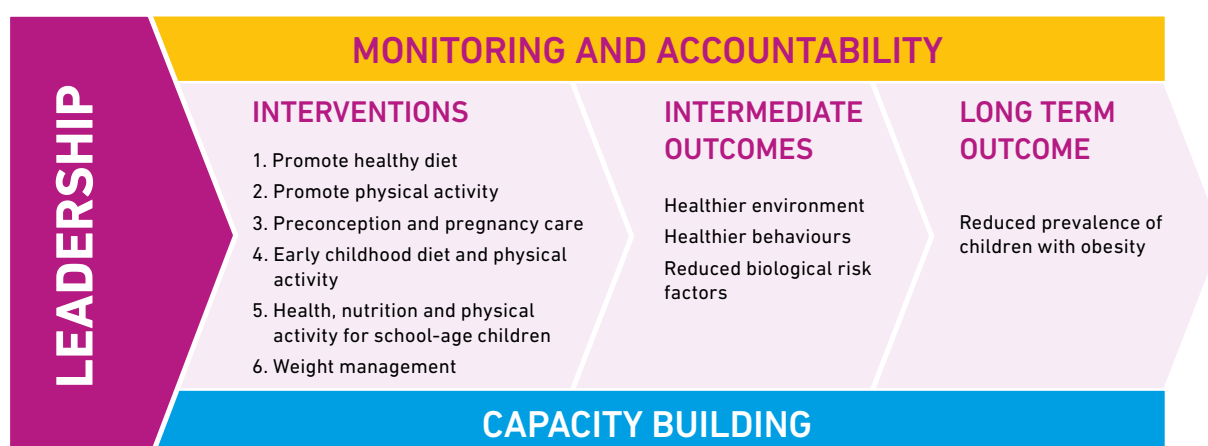


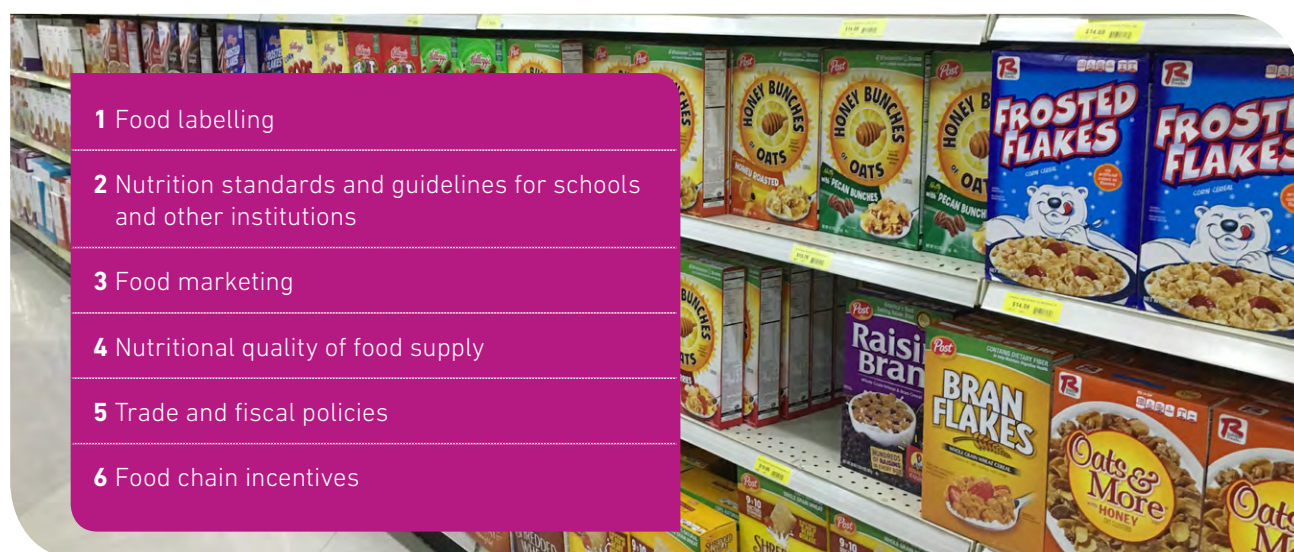
Figure 1. Action framework for ending childhood obesity

Source: WHO. Report of the Commission on Ending Childhood Obesity: implementation plan – Report of the Secretariat. Document A70/31, Annex: Draft implementation plan to guide further actions on the recommendations included in the report of the Commission on Ending Childhood Obesity. Geneva, WHO, 2017. Available at http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_31-en.pdf.

2.6.3 PAHO Plan of Action for the prevention of obesity in children and adolescents 2014-2019 – strategic lines of action

- Primary health care and promotion of breast-feeding and healthy eating.
- Improvement of school nutrition and physical activity environments.
- Fiscal policies and regulation of food marketing and labelling.
- Other multisectoral actions.
- Surveillance, research, and evaluation.

2.6.4 CARPHA 6-point policy package



2.6.5 CARPHA Plan of Action for promoting healthy weights in the Caribbean: Prevention and control of childhood obesity 2014-2019 – objectives

- Make the environments where Caribbean children live and learn more supportive of physical activity and healthy eating.
- Create incentives to discourage unhealthy consumption patterns and to encourage healthier dietary choices
- Empower communities to embrace active living and healthful eating.
- Provide parents and children with accurate information about food, nutrition, and exercise to enable informed decisions.
- Provide children and families who are affected by overweight/obesity with the necessary care and support.
- Safeguard children who may be affected by overweight/obesity from bias and stigmatisation associated with their condition.
- Improve the capability of systems within government to mount effective responses.
- Foster multisectoral cooperation in responding to the epidemic.
- Provide core data for tracking the movements and determinants of the epidemic.
- Provide information for measuring and assessing results of the Plan of Action.

Details of these frameworks are in **Annex 1**.

2.6.6 Suggested civil society actions

All the major frameworks recognise the importance of a whole-of-society approach to childhood obesity prevention. They specifically recognise civil society as an important partner and call on governments to involve CSOs in their efforts to address the issue and coordinate relevant activities.

Both CARPHA and PAHO indicate that CSOs will contribute to the implementation of their respective Plans of Action (4, 5), with CARPHA naming CSOs as providers of in-kind resources. The CARPHA Plan of Action also indicates that the Agency's capacity development activities will focus on developing capacity to build and maintain strong partnerships among government, civil society, and private sector organisations.

The Report of the Commission on Ending Childhood Obesity (6) and its implementation plan ³¹ both note that ending childhood obesity should form part of civil society's agenda for advocacy and accountability, and that civil society can play a critical role in bringing social, moral, and political pressure on governments to fulfil their commitments. The Report and the implementation plan state that social movements can engage members of the community and provide a platform for advocacy and action, and that improving coordination of CSOs and strengthening their capacity to monitor effectively and ensure accountability for commitments made is vitally important. They highlight the importance of a robust mechanism and framework for monitoring policy development and implementation, thus facilitating the accountability of governments, civil society, and the private sector on the commitments made. Further, they urge governments to consider providing opportunities for formal participation by civil society in the policy-making, implementation, and evaluation process, with a view to ensuring mutual accountability and transparency.

The implementation plan for the Commission on Ending Childhood Obesity's recommendations specifically suggests that the tasks of developing nutrition information and education campaigns, implementing programmes, and monitoring and holding actors to account for commitments made may be shared between governments and civil society.

The implementation plan also suggests actions that CSOs can take, including:

Raise the profile of **prevention** of childhood obesity through advocacy and dissemination of information.

Motivate consumers to demand that governments support healthy lifestyles and that the food and non-alcoholic beverage industry provide healthy products and do not market unhealthy foods and beverages to children.

Call on governments to create the legal and regulatory frameworks needed to implement recommendations for ending childhood obesity.

Contribute to the development and implementation of a **mechanism for monitoring and accountability**.



Childhood obesity does not arise from lifestyle choices made by the child. It arises from environments created by society and supported by government policies. The argument that obesity is the result of personal lifestyle choices, often used to excuse governments from any responsibility to intervene, cannot apply to childhood obesity.

Dr. Margaret Chan,

Opening remarks at the Third meeting of the Commission on Ending Childhood Obesity,

³¹ WHO. Report of the Commission on Ending Childhood Obesity: implementation plan – Report of the Secretariat. Document A70/31, Annex: Draft implementation plan to guide further actions on the recommendations included in the report of the Commission on Ending Childhood Obesity. Geneva, WHO, 2017. Available at http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_31-en.pdf.



“

Obesity and overweight, rising in every region and nearly every country, are now a staggering global challenge. The number of children under 5 who are overweight is approaching the number who suffer from wasting.

2016 Global Nutrition Report

3 Selected global, regional, and national responses

3.1 Global responses

3.1.1 Intergovernmental

YEAR	RESPONSES
1981	WHO International code of marketing of breast-milk substitutes. http://www.who.int/nutrition/publications/code_english.pdf
2003	WHO and UNICEF Global strategy for infant and young child feeding. http://apps.who.int/iris/bitstream/10665/42590/1/9241562218.pdf?ua=1&ua=1
2004	WHO Global strategy on diet, physical activity and health (16).
2008	WHO School policy framework: implementation of the WHO global strategy on diet, physical activity and health. http://www.who.int/dietphysicalactivity/SPF-en-2008.pdf?ua=1
2008	WHO Global strategy on diet, physical activity and health: a framework to monitor and evaluate implementation. http://www.who.int/dietphysicalactivity/M&E-ENG-09.pdf?ua=1
2010	WHO Set of recommendations on the marketing of food and non-alcoholic beverages to children. http://apps.who.int/iris/bitstream/10665/44416/1/9789241500210_eng.pdf
2010	WHO Global recommendations on physical activity for health. http://apps.who.int/iris/bitstream/10665/44399/1/9789241599979_eng.pdf
2010	WHA resolution 63.23: Infant and young child nutrition. http://worldbreastfeedingweek.org/2010/pdf/wbw2010-ur-wha6323.pdf
2011	UN Political declaration of the High-Level Meeting of the General Assembly on the prevention and control of noncommunicable diseases. http://www.un.org/ga/search/view_doc.asp?symbol=A/66/L.1
2012	WHA resolution 65.6: Comprehensive implementation plan on maternal and young child nutrition. http://www.who.int/nutrition/topics/WHA65.6_resolution_en.pdf?ua=1
2012	WHO Framework for implementing the set of recommendations on the marketing of food and non-alcoholic beverages to children. http://www.who.int/dietphysicalactivity/framework_marketing_food_to_children/en/
2012	WHO Prioritising areas for action in the field of population-based prevention of childhood obesity (7).
2012	WHO Population-based approaches to childhood obesity prevention (10).
2013	WHO Global action plan for the prevention and control of noncommunicable diseases 2013-2020 (27).
2013	Nutrition for Growth Alliance. http://nutritionforgrowth.org/
2014	FAO and WHO Rome Declaration, Second International Conference on Nutrition (14).
2014	WHO Global nutrition targets 2025: Childhood overweight policy brief. http://apps.who.int/iris/bitstream/10665/149021/2/WHO_NMH_NHD_14.6_eng.pdf?ua=1
2015	UN 2030 Sustainable Development Agenda and the Sustainable Development Goals (11).

YEAR	RESPONSES
2016	WHO, UNICEF, IFBAN ³² Marketing of breast-milk substitutes: National implementation of the International Code – Status Report 2016. http://www.who.int/nutrition/publications/infantfeeding/code_report2016/en/
2016	WHO Report of the Commission on Ending Childhood Obesity (6).
2016	WHO Fiscal policies for diet and the prevention of noncommunicable diseases. http://www.who.int/dietphysicalactivity/publications/fiscal-policies-diet-prevention/en/
2016	UN Proclamation of the Decade of Action on Nutrition, 2016-2025 http://www.who.int/nutrition/GA_decade_action/en/
2016	WHO Guidance on ending the inappropriate promotion of foods for infants and young children. Document A69/7 Add.1 http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_7Add1-en.pdf?ua=1 .
2017	WHO. Report of the Commission on Ending Childhood Obesity: implementation plan. Report by the Secretariat. Document A70/31.

3.1.2 Civil society

YEAR	RESPONSES
1966 to 2014	Formation of the Obesity Association, with subsequent mergers and re-branding to become the World Obesity Federation. http://www.worldobesity.org/who-we-are/history/ , http://www.worldobesity.org/what-we-do/
2009	Establishment of the NCD Alliance.
2009 to present	Numerous NCDA publications and resources, available at https://ncdalliance.org/, including: <ul style="list-style-type: none"> NCDA Achieving 25x25 through civil society coalitions. https://ncdalliance.org/sites/default/files/resource_files/CSSA_fv1Dec2015.pdf NCDA Strategic Plan 2016-2020. https://ncdalliance.org/sites/default/files/resource_files/NCDA_StrategicPlan16-20_EN.pdf NCDA technical and financial support for CSOs in various regions, including for the HCC.
2011	The Lancet Obesity Series 1. http://www.thelancet.com/series/obesity
2015	The Lancet Obesity Series 2. http://www.thelancet.com/series/obesity-2015
2016	Establishment of the Lancet Commission on Obesity http://www.worldobesity.org/site_media/uploads/LCO_1-pager_04052016.pdf .

³² International Baby Food Action Network.

³³ Mr. Vincent Atkins, Trade Policy Advisor, CARICOM, based in Barbados, is a member of the Commission.

3.2 Regional responses

3.2.1 Intergovernmental

The Americas

YEAR	RESPONSES
2011	PAHO/WHO Recommendations from a Pan American Health Organization Expert Consultation on the Marketing of Food and Non-Alcoholic Beverages to Children in the Americas. http://iris.paho.org/xmlui/handle/123456789/3594
2012	PAHO Strategy for the prevention and control of noncommunicable diseases. http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=21345&Itemid=270&lang=en .
2013	PAHO Plan of action for the prevention and control on noncommunicable diseases in the Americas 2013-2019. http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&Itemid=270&gid=27517&lang=en .
2014	PAHO Menu of global and regional actions, targets, and tools to support the PAHO Strategic Lines of Action for 2013-2019 on the prevention and control of noncommunicable diseases. http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=21348&Itemid=270
2014	PAHO Plan of Action for the prevention of obesity in children and adolescents (5).
2015	Donaldson, E. Advocating for sugar-sweetened beverage taxation: a case study of Mexico. Johns Hopkins Bloomberg School of Public Health. http://www.jhsph.edu/departments/health-behavior-and-society/_pdf/Advocating_For_Sugar_Sweetened_Beverage_Taxation.pdf . PAHO/WHO Taxes on Sugar-sweetened Beverages as a Public Health Strategy: The Experience of Mexico. http://iris.paho.org/xmlui/handle/123456789/18391
2016	PAHO Nutrient Profile Model. http://iris.paho.org/xmlui/bitstream/handle/123456789/18621/9789275118733_eng.pdf?sequence=9

The Caribbean

YEAR	RESPONSES
2006	CARICOM and PAHO Report of the Caribbean Commission on Health and Development. http://www.who.int/macrohealth/action/PAHO_Report.pdf .
2007	CARICOM Port of Spain Declaration (3).
2007	FAO Manual from the English-speaking Caribbean: Developing food-based dietary guidelines. http://www.fao.org/3/a-ai800e.pdf .
2009	Inter-American Institute for Cooperation on Agriculture (IICA). The agriculture, food and health challenge: Critical issues, perspectives and options. http://orton.catie.ac.cr/REPD0C/A5356E/A5356E.PDF .

YEAR	RESPONSES
2010	CARICOM Regional food and nutrition security policy. http://www.fao.org/fileadmin/templates/righttofood/documents/project_m/caricom/CARICOMRegionalFoodandNutritionSecurityPolicy-5october2010.pdf .
2011	CARICOM and FAO Regional food and nutrition security action plan 2012-2016. http://www.fao.org/fileadmin/templates/righttofood/documents/project_m/caricom/CARICOMRegionalFoodandNutritionSecurityActionPlan-Oct2011.pdf .
2011	CARICOM and PAHO Strategic plan of action for the prevention and control of noncommunicable diseases for countries of the Caribbean Community 2011-2015. http://cms2.caricom.org/documents/12630-ncds_plan_of_action_2011_2015.pdf .
2011	Henry F. Obesity prevention: the key to noncommunicable disease control. West Indian Medical Journal (WIMJ) 2011; 60 (4): 446-451. http://caribbean.scielo.org/pdf/wimj/v60n4/a14v60n4.pdf .
2011	CFNI ³⁴ and PAHO The contribution of CFNI to Caribbean development 2001-2010. http://iris.paho.org/xmlui/handle/123456789/9991 .
2012	Henry F. Food and nutrition research in the Caribbean. WIMJ 2012; 61 (4): 335-350. http://caribbean.scielo.org/pdf/wimj/v61n4/09.pdf .
2015	FAO State of food insecurity in the CARICOM Caribbean – Meeting the 2015 hunger targets: Taking stock of uneven progress (26).
2015	Ballayram, Lawrence B, and Henry F. Food security and health in the Caribbean: imperatives for policy implementation (18).
2015	CARICOM. Strategic Plan for the Caribbean Community 2015-2019. http://cms2.caricom.org/documents/11265-executive_plan_vol_1_-_final.pdf .
2016	Port of Spain Evaluation Group Accelerating action on NCDs: Evaluation of the 2007 CARICOM Heads of Government Port of Spain NCD Summit Declaration – Report on behalf of PAHO/WHO and CARICOM (23).
2017	CARPHA meeting of high-level officials from Caribbean regional institutions to strengthen inter-institutional collaboration and develop a roadmap on multisectoral action in countries to prevent childhood obesity through improved food and nutrition security. http://carpha.org/articles/ID/134/The-Regional-Response-to-Childhood-Obesity-Intensifies .

3.2.2 Civil society

YEAR	RESPONSES
2008	Establishment of the Healthy Caribbean Coalition.
2008-present	Numerous HCC publications and resources, available at http://www.healthycaribbean.org/ , including:

³⁴ The Caribbean Food and Nutrition Institute (CFNI) was a CARICOM Regional Institution and a PAHO Specialised Centre which was established in 1967 to forge a regional approach to solving the nutrition problems of the Caribbean. It was decommissioned in December 2012 and its functions integrated into those of CARPHA, which was legally established as a CARICOM institution in 2011 and began operations in January 2013.

YEAR	RESPONSES
	HCC. Caribbean civil society action plan for tackling chronic noncommunicable diseases 2008-2011. HCC, 2008. http://www.archive.healthycaribbean.org/publications/documents/Caribbean_Civil_Society_Action_Plan.pdf .
	HCC. A civil society strategic plan of action for prevention and control of NCDs for countries of the Caribbean Community 2012-2016. HCC, 2011. http://www.archive.healthycaribbean.org/Strategic-Plan-2012-16/HCC_Strategic_Plan_2012-16.pdf .
	HCC. A civil society regional status report: Responses to NCDs in the Caribbean Community. HCC, 2014. http://www.healthycaribbean.org/hcc-launches-civil-society-regional-status-report/ .
	HCC. Capacity and information needs assessment of HCC civil society organisation members working in the prevention and control of NCDs. HCC, 2016. http://www.healthycaribbean.org/capacity-and-information-needs-assessment-report/ .
	HCC. Infographic on sugar consumption in the Caribbean. HCC, 2016. http://www.healthycaribbean.org/wp-content/uploads/2016/10/sugar-infographic-27-Oct-2016.pdf .
	HCC and NCDA. A closer look: The implementation of taxation on sugar-sweetened beverages by the Government of Barbados – a civil society perspective. HCC, 2016. http://www.healthycaribbean.org/wp-content/uploads/2016/07/HCC-SSB-Brief-2016.pdf .
	HCC: Numerous capacity development and strategic planning meetings and workshops; various communication products, including the HCC News Roundup, available at http://www.healthycaribbean.org .
2017	HCC. Strategic plan 2017-2021: Enabling Caribbean civil society's contribution to national, regional, and global action for NCD prevention and control (2).
2017	HCC spearheads regional campaign to ban SSB in schools. https://www.barbadosadvocate.com/news/campaign-ban-sweet-drinks-schools .
2017	HCC. Policy brief on NCDs and Trade.

3.3 National responses

Caribbean countries have taken steps to address undernutrition and micronutrient deficiency among their populations, developing food and nutrition policies and plans, and food-based dietary guidelines, aligned with regional frameworks. In response to the 2007 POSD (3), many Caribbean countries accelerated their development of national NCD policies, strategies or plans, and implemented interventions that focus on promoting healthy lifestyles. The 2011 UNHLM on NCDs and the 2013 WHO Global Action Plan for NCDs gave the countries added impetus to address the four main NCDs – cardiovascular disease, diabetes, cancer, and chronic respiratory diseases – and the four main NCD risk factors, namely tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol (28).

With a sharper focus on childhood obesity prevention, several countries are developing relevant policies, plans, and programmes, and are implementing or considering fiscal measures as mechanisms for enabling NCD prevention and control, as recommended in the POSD.

3.3.1 Governmental

YEAR	RESPONSES												
2002-present	Development of food-based dietary guidelines in: ³⁵ <table> <tr> <td>The Bahamas, 2002</td><td>Barbados, 2009</td></tr> <tr> <td>Guyana, 2004</td><td>St. Kitts & Nevis, 2010</td></tr> <tr> <td>Grenada, 2006</td><td>Belize, 2012</td></tr> <tr> <td>St. Vincent & the Grenadines, 2006</td><td>Antigua & Barbuda, 2013</td></tr> <tr> <td>Dominica, 2007</td><td>Jamaica, 2015</td></tr> <tr> <td>St. Lucia, 2007</td><td></td></tr> </table>	The Bahamas, 2002	Barbados, 2009	Guyana, 2004	St. Kitts & Nevis, 2010	Grenada, 2006	Belize, 2012	St. Vincent & the Grenadines, 2006	Antigua & Barbuda, 2013	Dominica, 2007	Jamaica, 2015	St. Lucia, 2007	
The Bahamas, 2002	Barbados, 2009												
Guyana, 2004	St. Kitts & Nevis, 2010												
Grenada, 2006	Belize, 2012												
St. Vincent & the Grenadines, 2006	Antigua & Barbuda, 2013												
Dominica, 2007	Jamaica, 2015												
St. Lucia, 2007													
2007-present	Establishment of multisectoral National NCD Commissions or their equivalents (28).												
2007	Jamaica: Camp-4: The Healthy Way. The programme comprised three 1-week camps for overweight and obese adolescents. In Consultant's final report: Examples of best practices in food and nutrition education and communication in the English-speaking Caribbean (The Bahamas, Barbados, Grenada and Jamaica). Prepared by Audrey Morris, Consultant Nutritionist. FAO, 2012. Available through www.fao.org .												
2008	Bermuda: Well Bermuda: A National Health Promotion Strategy. http://bhec.bm/wp-content/uploads/resources/docs/stats/well_bermuda___a_national_health_promotion_strategy_2008_0.pdf . Includes goal "Encourage maintenance of a healthy body weight for height", with specific objectives for children and adolescents.												
2009	Aruba: National Plan Aruba 2009-2018 for the fight against overweight, obesity, and related health issues. http://www.hls.aw/main/images/Plan%20National%20Aruba%202009-2018%20.pdf .												
2009	Trinidad and Tobago: Research on childhood obesity – Survey of BMI and Evaluation of School Meals Options in primary and secondary schools.												
2013	Implementation of a total of 19 obesity prevention projects in 10 countries, with most delivered in school-based settings and a large number lasting for less than 4 weeks (30).												
2013	Jamaica: National Strategic and Action Plan for the Prevention and Control of NCDs in Jamaica 2013 to 2018 http://moh.gov.jm/wp-content/uploads/2015/05/National-Strategic-and-Action-Plan-for-the-Prevention-and-Control-Non-Communicable-Diseases-NCDS-in-Jamaica-2013-2018.pdf .												
2015	Anguilla: National NonCommunicable Disease Action Plan (2015-2025). Addresses overweight and obesity, with specific reference to healthy options for school feeding programme.												
2015	Barbados: Nutritious and healthy foods in schools: Nutrition and Practical Guidelines for Barbados. http://nutritioncentre.health.gov.bb/public/uploaded_files/GNHFSAug2015.pdf .												
2015	Barbados: National Plan of Action for Childhood Obesity Prevention and Control and Barbados Childhood Obesity Prevention Programme (B-CHOPP). http://www.healthycaribbean.org/wp-content/uploads/2016/06/Barbados.pdf .												
2015	Barbados: Implementation of taxation on SSBs. ³⁶												

³⁵ See FAO. <http://www.fao.org/nutrition/education/food-dietary-guidelines/regions/countries/en/>.

³⁶ See <http://www.barbadosday.bb/2015/06/15/tax-on-sweet-drinks/> and <http://www.healthycaribbean.org/wp-content/uploads/2016/07/HCC-SSB-Brief-2016.pdf>.

2015 Dominica: Implementation of taxation on SSBs.³⁷

2015 Trinidad & Tobago: National Nutrition Standards for Foods Offered to Children in Schools. <http://www.looptt.com/content/health-ministry-combats-obesity-national-food-standards>.

National School Health Policy (2015).

2016 Bermuda: Premier's Youth Fitness Programme (PYFP) targeting schools, and Obesity and Diabetes Prevention Plan Framework (draft).

2016 Jamaica: National Operational Action Plan for the Prevention And Control Of Obesity In Children and Adolescents in Jamaica 2016 to 2020 (Advanced draft).

2016 St. Vincent & the Grenadines: National Strategic and Action Plan for the Prevention and Control of NonCommunicable Diseases (2016 -2020).

As at March 2017 Policies addressing childhood obesity in (30):³⁸

- Anguilla: National School Health Policy (2015); National Sports Policy (2017-2027).
- Aruba: Health Policy Health Promotion.
- Bermuda: Healthy Schools Nutrition Policy, Healthy Schools Programme (2004).
- Dominica: School Health Nutrition Policy <http://www.dominicavibes.dm/news-203148/>.
- Jamaica: Food and Nutrition Security Policy; Infant and Young Child Feeding Policy
- Montserrat: Healthy Schools and Physical Activity Policy.
- St. Vincent & the Grenadines: National Child Nutrition Policy and Plan of Action (birth to 17 years), 2016-2025; Adolescent Health Policy.
- Trinidad & Tobago: Childhood Obesity Prevention Policy.

2017 Anguilla: FIT TEEN programme targeting 12-17 year olds; School Feeding and Physical Activity Programme

2017 Jamaica: Considering tax on SSB.³⁹

2017 Trinidad & Tobago: Ban on sales of SSB at all government and government-assisted schools.⁴⁰

3.3.2 Civil society

YEAR	RESPONSES
Over the years	Through CSOs that target specific diseases such as diabetes, cancer, and heart disease, civil society has made interventions at the national level to promote healthy lifestyles, mainly targeting adults, but sometimes addressing children and adolescents, especially in the school setting.
Over the years	CSOs have collaborated with government and the private sector to support activities related to nutrition and physical activity in schools, exemplified by some of the programmes in Section 5.

³⁷ See <http://dominicanewsonline.com/news/homepage/news/taxes-to-be-increased-on-alcohol-cigarettes-and-high-sugar-foods/> and <http://caribbeanmedicalnews.com/2015/08/hcc-lauds-dominica-for-hike-in-tax-on-cigarettes-alcoholic-and-sweetened-beverages/>.

³⁸ With additional information obtained from countries through HCC, February-March 2017.

³⁹ See http://www.jamaicaobserver.com/health/Tax-on-sugary-drinks-_66622.

⁴⁰ See <http://www.guardian.co.tt/news/2017-01-28/ban-soft-drinks-government-schools>.

4. The Action Agenda

4.1 High-level objectives, indicators, and targets

Goal

Halt the increase in childhood obesity in the Caribbean, by 2025.

Indicator

Number of CARICOM countries⁴¹ showing no increase in age-standardised prevalence of overweight and obesity in adolescents (defined according to the WHO growth reference for school-aged children and adolescents)⁴².

Baseline: 0

Target: 4



Purpose

Improved development and implementation by CARICOM countries of policies, and/or legislation, and/or regulations to prevent childhood obesity, by 2021.

Indicator

Number of CARICOM countries developing and implementing one or more policies, and/or legislation, and/or regulations aimed at preventing childhood obesity, including taxation on SSB and other unhealthy foods and beverages; restrictions on marketing of unhealthy foods to children; restrictions in the provision, vending, and marketing of unhealthy foods in the school environment; mandatory front-of-package labelling in line with Caribbean regional standards; and facilities/mechanisms for physical activity in schools.

Baseline: 7

(BRB – SSB taxation; BMU – Healthy Schools Policy; DMA – SSB taxation, School Health Nutrition Policy; JAM – Food and Nutrition Security Policy, Infant and Young Child Feeding Policy; MSR – Healthy Schools and Physical Activity Policy; VCT – National Child Nutrition Policy; and TTO – Ban on sale or serving of SSB in government and government-assisted schools);

Target: 14

⁴¹ CARICOM includes 15 Member States and 5 Associate Members; the denominator for this indicator is 20.

⁴² See Definitions, page 8

Overall outcome

Strengthened contribution of Caribbean civil society to the development, implementation, monitoring, and evaluation of national and regional⁴³ policies, legislation, regulations, programmes, and interventions related to childhood obesity prevention, by 2021.

Indicator

Number of HCC entities (secretariat and member organisations)⁴⁴ reporting involvement⁴⁵ in childhood obesity prevention initiatives and/or interventions at regional or national level.

Baseline: 4

Target: 10

Specific outcomes

The specific outcomes for civil society related to the priority areas for action, focusing on selected pillars of the HCC Strategic Plan 2017-2021, are listed in **Table 1** below, with their indicators and targets. The specific outcomes will contribute to the overall outcome, which in turn will contribute to the purpose of the Action Plan, and the achievement of its goal.

Table 1 also includes the expected national outcomes and demonstrates alignment of the Action Plan with the main elements of four of the major frameworks for childhood obesity prevention.

Priority areas for action

There are seven priority areas for civil society's action over the period 2017-2021:

1



Trade and fiscal policies⁴⁶

2



Nutrition literacy⁴⁷

3



Early childhood nutrition

4



Marketing of healthy and unhealthy foods and beverages to children

5



School- and community-based interventions

6



Resource mobilisation

7



Strategic planning, monitoring, and evaluation

⁴³ In this context, "regional" refers to the Caribbean.

⁴⁴ The denominator for the number of HCC entities comprises CSOs that expressed interest in addressing childhood obesity prevention at HCC strategic planning meetings in April 2016 and February 2017, plus the HCC secretariat, a total of 15.

⁴⁵ "Involvement" means leadership of an initiative or intervention; and/or official recognition as primary partner in an initiative or intervention; and/or active participation in an initiative or intervention; and/or implementation of current plan for childhood obesity prevention developed by the entity.









⁴⁶ Fiscal policy is the use of government spending and taxation to influence the economy or achieve macro-economic objectives.

⁴⁷ Nutrition literacy refers to the set of abilities needed to understand the importance of good nutrition in maintaining health <https://www.diet.com/g/nutrition-literacy?get=nutrition-literacy#D>.

Table 1

HCC CIVIL SOCIETY ACTION PLAN 2017-2021: PRIORITY AREAS FOR ACTION,

expected national and specific civil society outcomes, indicators, and targets,⁴⁸ linked to HCC Strategic Plan pillars and the main elements of four major frameworks for childhood obesity prevention












HCC priority areas for action	HCC Strategic Plan pillars	Expected national outcomes	Specific civil society outcomes	Indicators and Targets ⁴⁹
1  Trade and fiscal policies	 Advocacy  Communication  Capacity development	Expanded national taxation on SSBs ⁵⁰ and/or EDNP products, and/or subsidies on healthy foods.	1.1 Strengthened advocacy by CSOs for national taxation on SSBs and/or EDNP products, and/or subsidies on healthy foods.	Number of CSOs promoting or advocating for national taxation on SSBs or EDNP products, or for subsidies on healthy foods. 50% of CSOs
2  Nutrition literacy	 Capacity development  Advocacy  Communication	Mandatory front-of-package nutrition labelling that satisfies regional standards and strengthened provision of information on foods.	2.1 Strengthened CSO capacity for, and contribution to, improving nutrition literacy among key stakeholders, including policymakers, parents, caregivers, and children.	Number of CSOs with built capacity in nutrition literacy and other areas related to childhood obesity prevention. 60% of CSOs Number of CSOs promoting or advocating for the development and implementation of standards for national or regional user-friendly, mandatory front-of-pack nutrition labelling. 30% of CSOs Number of CSOs providing information on healthy nutrition at community level that specifically targets vulnerable populations, such as out-of-school youth. 30% of CSOs Number of CSOs contributing evidence and/or information on nutrition interventions to prevent childhood obesity. 30% of CSOs

⁴⁸ Baselines to be determined; targets to be achieved by 2021 unless otherwise specified.








CARPHA 6-point policy package (12)	PAHO Plan of Action – Strategic Lines of Action (5)	WHO Commission on Ending Childhood Obesity – major recommendations (6)	WHO Population-based approaches to childhood obesity prevention (10)
Trade and fiscal policies Food chain incentives	<ul style="list-style-type: none"> Fiscal policies and regulation of food marketing and labelling Other multisectoral actions 	Implement comprehensive programmes that promote the intake of healthy foods and reduce the intake of unhealthy foods and SSBs by children and adolescents	Structures within government to support policies and interventions
Food labelling	<ul style="list-style-type: none"> Primary health care and promotion of breast feeding and healthy eating Fiscal policies and regulation of food marketing and labelling Other multisectoral actions Surveillance, research, and evaluation 	Implement comprehensive programmes that promote the intake of healthy foods and reduce the intake of unhealthy foods and SSBs by children and adolescents	<ul style="list-style-type: none"> Structures within government to support policies and interventions Population-wide policies and initiatives

⁴⁹ Total number of CSOs (denominator) = 15.

⁵⁰ WHO recommends at least 20% taxation rate on SSBs.

HCC priority areas for action	HCC Strategic Plan pillars	Expected national outcomes	Specific civil society outcomes	Indicators and Targets ⁴⁹
3  Early childhood nutrition	 Communication  Advocacy	Increased promotion of breastfeeding and appropriate complementary food for infants and young children.	3.1 Enhanced CSO promotion of internationally agreed guidance to enhance breastfeeding, including Baby-Friendly Hospitals, the International Code of Marketing of Breast-milk Substitutes, and Guidance on Ending Inappropriate Nutrition for Infants and Young Children.	Number of CSOs providing information to communities on breastfeeding, Baby-Friendly Hospitals, the International Code of Marketing of Breast-milk substitutes, and Guidance on Ending Inappropriate Nutrition for Infants and Young Children. 30% of CSOs
4  Marketing of healthy and unhealthy foods and beverages to children	 Capacity development  Advocacy  Communication	Restrictions on the marketing of unhealthy foods and beverages to children, and increased promotion of healthy alternatives.	4.1 Strengthened CSO contribution to reduction in the marketing of unhealthy foods and beverages to children, and increased promotion of healthy alternatives.	Number of CSOs with enhanced capacity to contribute to identification of unhealthy foods, based on regional or international nutrient profiles. 20% of CSOs <hr/> Number of CSOs promoting and advocating for restrictions on the marketing of unhealthy foods, and for greater promotion of healthy foods to children. 50% of CSOs
5  School- and community-based interventions	 Capacity development  Advocacy  Communication	Regulation of the obesogenic environments in schools and communities.	5.1 Strengthened CSO contribution to reduction in obesogenic environments in schools and communities.	Number of CSOs promoting and advocating for a ban on the sale, marketing and promotion of SSBs and EDNP products in and around schools. 50% of CSOs <hr/> Number of CSOs promoting and advocating for the establishment of standards for school meals, based on national food-based dietary guidelines. 50% of CSOs

CARPHA 6-point policy package (12)	PAHO Plan of Action – Strategic Lines of Action (5)	WHO Commission on Ending Childhood Obesity – major recommendations (6)	WHO Population-based approaches to childhood obesity prevention (10)
Nutrition standards and guidelines for schools and other institutions	Primary health care and promotion of breast feeding and healthy eating	<ul style="list-style-type: none"> Implement comprehensive programmes that promote the intake of healthy foods and reduce the intake of unhealthy foods and SSBs by children and adolescents Integrate and strengthen guidance for NCD prevention with current guidance for preconception and antenatal care, to reduce the risk of childhood obesity Provide guidance on, and support for, healthy diet, sleep, and physical activity in early childhood to ensure children grow appropriately and develop healthy habits 	<ul style="list-style-type: none"> Structures within government to support policies and interventions Population-wide policies and initiatives Community-based interventions
Food marketing Nutritional quality of food supply	<ul style="list-style-type: none"> Improvement of school nutrition and physical activity environments Other multisectoral actions 	Implement comprehensive programmes that promote the intake of healthy foods and reduce the intake of unhealthy foods and SSBs by children and adolescents	<ul style="list-style-type: none"> Structures within government to support policies and interventions Population-wide policies and initiatives Community-based interventions
Nutrition standards and guidelines for schools and other institutions	<ul style="list-style-type: none"> Improvement of school nutrition and physical activity environments Other multisectoral actions 	<ul style="list-style-type: none"> Implement comprehensive programmes that promote healthy school environments, health and nutrition literacy, and physical activity among school-age children and adolescents Implement comprehensive programmes that promote physical activity and reduce sedentary behaviours in children and adolescents 	<ul style="list-style-type: none"> Population-wide policies and initiatives Community-based interventions


HCC priority areas for action	HCC Strategic Plan pillars	Expected national outcomes	Specific civil society outcomes	Indicators and Targets ⁴⁹
5  School- and community-based interventions				<p>Number of CSOs advocating for inclusion of mandatory physical activity in the daily routine and/or curriculum of schools.</p> <p>50% of CSOs</p> <hr/> <p>Number of CSOs advocating for, promoting, organising, or contributing to interventions at community level aimed at enhancing physical activity, including appropriate urban planning.</p> <p>50% of CSOs</p>
6  Resource mobilisation	 Capacity development  Sustainability	Enhanced resource mobilisation for interventions addressing childhood obesity prevention.	6.1 Strengthened CSO resource mobilisation for the planning, implementation, and assessment of programmes and interventions addressing childhood obesity prevention.	<p>Number of CSOs developing and submitting at least one project proposal annually to prospective funding agencies to address priority interventions for childhood obesity prevention.</p> <p>20% of CSOs</p>
7  Strategic planning, monitoring, and evaluation	 Capacity development  Sustainability	Improved accountability of national authorities, civil society, and other key stakeholders in childhood obesity prevention.	7.1 Enhanced CSO development of their own childhood obesity prevention strategies/plans <hr/> 7.2 Enhanced CSO monitoring of governments' and other stakeholders' fulfilment of key aspects of national and internationally agreed commitments, policies, and plans associated with childhood obesity prevention. <hr/> 7.3 Strengthened coordination, monitoring, and evaluation of the HCC "Civil Society Action Plan 2017-2021: Preventing Childhood Obesity".	<p>Number of CSOs with their own childhood obesity prevention strategies/plans.</p> <p>20% of CSOs</p> <hr/> <p>Number of CSOs completing HCC-developed national Childhood Obesity Prevention Scorecard to monitor key childhood obesity prevention interventions annually.</p> <p>50% of CSOs</p> <hr/> <p>Number of CSOs and key stakeholders participating in fora to coordinate, monitor, and evaluate the HCC "Civil Society Action Plan 2017-2021: Preventing Childhood Obesity".</p> <p>50% of CSOs at and least 3 non-HCC stakeholders participating in at least 1 forum annually.</p>

CARPHA 6-point policy package (12)	PAHO Plan of Action – Strategic Lines of Action (5)	WHO Commission on Ending Childhood Obesity – major recommendations (6)	WHO Population-based approaches to childhood obesity prevention (10)
	Other multisectoral actions		Structures within government to support policies and interventions
	Surveillance, research, and evaluation Other multisectoral actions		Structures within government to support policies and interventions

4.2 Implementation plan 2017-2019

Table 2 below outlines the implementation plan for the first two years of the Action Plan, with a summary of outputs, their indicators, deliverables, and activities for each specific outcome. The entities responsible, potential partners, and indicative inputs and resources for executing the activities are included, and an indicative budget for each outcome and the total estimated budget are calculated, based on the inputs and resources for each activity.


Table 2: Outputs, deliverables, activities, and indicative inputs and resources 2017-2019

SPECIFIC OUTCOMES	Outputs (OPT) and Indicators (IND)
1. Trade and fiscal policies  1.1 Strengthened advocacy by CSOs for national taxation on SSBs and/or EDNP products, and/or subsidies on healthy foods.	OPT 1.1.1 Advocacy targeting policymakers regarding taxation on SSBs and/or EDNP products, and/or subsidies on healthy foods. IND Number of CSOs implementing advocacy strategies targeting policymakers for taxes on SSBs and/or EDNP products and/ or subsidies on healthy foods.




DELIVERABLES (Products and services)	ACTIVITIES (ACT)/Inputs/Resources (I/R)		
Advocacy strategies targeting policymakers. Policy briefs on NCDs and Trade; Dominica (DMU) SSB taxation; and Trinidad & Tobago (TTO) SSB ban.	ACT 1.1.1.1		
	Provide guidance for CSOs in advocacy to policymakers regarding taxation on SSBs and EDNP, and subsidies on healthy foods, highlighting the importance of fiscal measures in NCD prevention and control.	Responsible	HCC secretariat
		Partners	PAHO/WHO, CARPHA, FAO, IAHF Caribbean, academia
		I/R	Development of communication materials/guidelines - USD 5,000
	ACT 1.1.1.2		
	Develop and implement advocacy strategies targeting policymakers regarding implementation of effective taxes on SSBs (at least 20%) and/or EDNP products and/or subsidies on healthy foods.	Responsible	CSOs
		Partners	PAHO/WHO, CARPHA, HCC secretariat, media, UNICEF, FAO, IAHF Caribbean, academia
		I/R	Communications consultant - USD 10,000
	ACT 1.1.1.3		
	Finalize and disseminate policy briefs on NCDs and Trade, the DMU SSB tax and the TTO SSB ban.	Responsible	HCC secretariat
		Partners	National authorities, DMU, TTO
		I/R	Consultant(s) - USD 7,500
Total budget: USD 22,500			



SPECIFIC OUTCOMES	Outputs (OPT) and Indicators (IND)
<h2 data-bbox="164 317 496 359">2. Nutrition literacy</h2> <div data-bbox="164 380 237 464">  </div> <h3 data-bbox="261 380 315 422">2.1</h3> <p data-bbox="261 443 634 684">Strengthened CSO capacity for, and contribution to, improving nutritional literacy among key stakeholders, including policymakers, parents, caregivers, and children.</p>	
<p>OPT 2.1.1</p> <p>CSOs' participation in capacity building exercises to improve their own nutrition literacy and readiness to contribute to childhood obesity prevention.</p> <p>IND</p> <p>Number of CSOs participating in capacity building intervention(s) related to nutrition literacy and other issues specific to childhood obesity prevention.</p>	<p>OPT 2.1.2</p> <p>Collaboration between CSOs and key partners in advocacy for, and the development and implementation of standards for national or regional user-friendly, mandatory front-of-pack nutrition labelling.</p> <p>IND</p> <p>Number of CSOs in collaborative partnerships with key stakeholders for development of national or regional mandatory front-of-pack nutrition labelling.</p>
<p>OPT 2.1.3</p> <p>Collaboration between CSOs and key national and international partners for dissemination of up-to-date information on healthy nutrition.</p> <p>IND</p> <p>Number of CSOs in collaborative partnerships with key stakeholders for the development and dissemination of nutrition literacy products for at least two target groups, including vulnerable or disadvantaged populations.</p>	<p>OPT 2.1.4</p> <p>Widely shared nutrition evidence and information relevant to the Caribbean using both digital and non-digital media.</p> <p>IND</p> <p>Number of CSOs contributing to and/or publishing articles and features with evidence on nutrition in the Caribbean, and related to priority nutrition issues in the region.</p>


DELIVERABLES (Products and services)	ACTIVITIES (ACT)/Inputs/Resources (I/R)
Training interventions for CSOs.	ACT 2.1.1.1
	Conduct basic CSO training/capacity building focusing on nutrition literacy – including nutrition labelling – and other issues related to childhood obesity in the Caribbean such as advocacy, highlighting successes, challenges, and lessons learned.
	Responsible HCC secretariat
	Partners UWI OC, CARPHA, PAHO/WHO, IAHF Caribbean
Contribution to development and implementation of standards for national or regional user-friendly, mandatory front-of-pack nutrition labelling.	I/R Consultant/trainer – USD 3,000 Training workshop – USD 6,000
	ACT 2.1.2.1
	Conduct community supermarket surveys of consumer attitudes towards nutritional labels to inform sensitization and advocacy on the importance of mandatory nutrition labelling.
	Responsible HCC secretariat, CSOs
	Partners UWI OC, CARPHA, PAHO/WHO
	I/R Consultant for training, survey analysis and reporting – USD 1,500 Materials for survey – USD 500
	ACT 2.1.2.2
	Engage partners, and identify and take advantage of opportunities to participate in the development and implementation of standards for national or regional user-friendly, mandatory front-of-pack nutrition labelling.
	Responsible HCC secretariat, CSOs
	Partners Ministries of Health, Trade; CARPHA, CROSC, FAO, PAHO/WHO
	I/R Participation in meetings/provision of feedback – USD 5,000
Information, education and communication (IEC) products on healthy nutrition.	ACT 2.1.3.1
	Engage partners, and identify specific target groups, including vulnerable or disadvantaged groups, for sharing up-to-date information on healthy nutrition, unhealthy foods and beverages, and prevention of childhood obesity.
	Responsible CSOs, HCC secretariat
	Partners Ministries of Health, Education, Agriculture; PAHO/WHO, CARPHA, FAO; media
	I/R Communications consultant – USD 5,000 Preparation and dissemination of information and materials – USD 10,000
	ACT 2.1.4.1
	Develop and disseminate communication materials based on evidence provided by partners and through HCC projects to improve knowledge on issues related to childhood obesity prevention in the Caribbean.
	Responsible HCC secretariat, CSOs
CSOs' involvement in production of evidence-based articles and infographics providing information on priority nutrition issues and the nutrition situation in Caribbean countries.	Partners Ministries of Health, Education, Agriculture; PAHO/WHO, CARPHA, FAO; media
	I/R Communications consultant – included in ACT 2.1.3.1. Preparation and dissemination of information and materials – USD 10,000
Total budget: USD 41,000	

SPECIFIC OUTCOMES	Outputs (OPT) and Indicators (IND)
3. Early childhood nutrition	
 3.1 Enhanced CSO promotion of internationally agreed guidance to enhance breast feeding, including Baby-Friendly Hospitals, the International Code of Marketing of Breast-milk Substitutes, and WHO's Guidance on Ending Inappropriate Nutrition for Infants and Young Children.	<p>OPT 3.1.1</p> <p>Collaboration between CSOs and key national and international partners for promotion of breast-feeding, Baby-Friendly Hospitals, the International Code of Marketing of Breast-milk Substitutes, and WHO's Guidance on Ending Inappropriate Nutrition for Infants and Young Children.</p> <p>IND</p> <p>Number of CSOs in collaborative partnerships with key national and international stakeholders to promote strategies to enhance breast feeding, including Baby-Friendly Hospitals, the International Code of Marketing of Breast-milk Substitutes, and WHO's Guidance on Ending Inappropriate Nutrition for Infants and Young Children.</p>
4. Marketing of healthy and unhealthy foods and beverages to children	
 4.1 Strengthened CSO contribution to restrictions on the marketing of unhealthy foods and beverages to children, and increased promotion of healthy alternatives.	<p>OPT 4.1.1</p> <p>Increased CSO awareness and understanding of the marketing of unhealthy foods and beverages to children, and of regional or international nutrient profiles that permit the identification of unhealthy and healthy products.</p> <p>IND</p> <p>Number of CSOs that demonstrate increased awareness and understanding of the marketing of unhealthy foods and beverages to children, and of regional or international nutrient profiles that permit the identification of unhealthy and healthy products.</p> <hr/> <p>OPT 4.1.2</p> <p>Collaboration between CSOs and key national and international partners to promote and disseminate regional or international nutrient profiles that permit the identification of unhealthy and healthy foods and beverages, to advocate for, respectively, restrictions on their marketing, and their promotion, to children.</p> <p>IND</p> <p>Number of CSOs in collaborative partnerships with key national and international stakeholders to promote and disseminate regional or international nutrient profiles that permit the identification of unhealthy and healthy foods and beverages, and to advocate for, respectively, restrictions on their marketing, and their promotion, to children.</p>

DELIVERABLES (Products and services)	ACTIVITIES (ACT)/Inputs/Resources (I/R)		
Policy brief on breastfeeding in the Caribbean. IEC products on breast feeding, Baby-Friendly Hospitals, the International Code of Marketing of Breast-milk Substitutes, and WHO's Guidance on Ending Inappropriate Nutrition for Infants and Young Children.	ACT 3.1.1.1		
	Develop and disseminate policy brief on breastfeeding in the Caribbean to inform CSO advocacy.	Responsible	HCC secretariat, CSOs
		Partners	PAHO/WHO, UNICEF, FAO
		I/R	Consultant – USD 2,000
	ACT 3.1.1.2		
	Engage partners, and identify specific target groups and institutions for sharing information related to breast-feeding, Baby-Friendly Hospitals, the International Code of Marketing of Breast-milk Substitutes, and WHO's Guidance on Ending Inappropriate Nutrition for Infants and Young Children.	Responsible	CSOs, HCC secretariat
Partners		Ministry of Health; PAHO/WHO, UNICEF, FAO; media	
I/R		Preparation and dissemination of information and materials – USD 5,000	
Total budget: USD 7,000			
Results of mapping of marketing unhealthy foods and beverages to children in selected countries. Capacity building workshop.	ACT 4.1.1.1		
	Conduct mapping of marketing of unhealthy foods and beverages to children in selected countries, starting with BRB.	Responsible	HCC secretariat
		Partners	PAHO/WHO
		I/R	Consultant, survey materials – USD 20,000
	ACT 4.1.1.2		
	Train selected CSO representatives in regional or international nutrient profiles and their use in the identification of unhealthy foods and beverages.	Responsible	HCC secretariat
Partners		Ministries of Health, Education; CARPHA, PAHO/WHO, FAO; UWI OC; media	
I/R		Preparation and dissemination of information and materials; training workshop – USD 10,000	
Advocacy and IEC products on unhealthy foods and beverages and restrictions on their marketing to children, and for the promotion of healthy foods.	ACT 4.1.2.1		
	Engage partners, and develop and implement advocacy strategies for restricting the marketing of unhealthy foods and beverages to children, including dissemination of the simplified version of the nutrient profile.	Responsible	CSOs, HCC secretariat
		Partners	Ministries of Health, Education; CARPHA, PAHO/WHO, FAO; media
		I/R	Preparation and dissemination of materials – USD 10,000
	ACT 4.1.2.2		
	Engage partners and develop, or contribute to the development of, communication products that promote healthy foods to children.	Responsible	CSOs, HCC secretariat
Partners		Ministries of Health, Education; CARPHA, PAHO/WHO, FAO; media	
I/R		Preparation and dissemination of materials – USD 10,000	
Total budget: USD 50,000			


SPECIFIC OUTCOMES	Outputs (OPT) and Indicators (IND)
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5. School- and community-based interventions

 5.1 Strengthened CSO contribution to regulation of obesogenic environments in schools and communities⁵¹.	<p>OPT 5.1.1</p> <p>Collaboration between CSOs and key national and international partners to promote and advocate for a ban on promotion of SSBs and EDNP products in and around schools.</p> <p>IND</p> <p>Number of CSOs in collaborative partnerships with key national and international stakeholders to promote and advocate for a ban on promotion of SSBs and EDNP products in and around schools.</p>
	<p>OPT 5.1.2</p> <p>Collaboration between CSOs and key national and international partners to promote and advocate for the establishment of standards for school meals, based on national food-based dietary guidelines.</p> <p>IND</p> <p>Number of CSOs in collaborative partnerships with key national and international stakeholders to promote and advocate for the establishment of standards for school meals, based on national food-based dietary guidelines.</p>
	<p>OPT 5.1.3</p> <p>Collaboration between CSOs and key national and international partners to promote and advocate for the inclusion of mandatory physical activity in the daily routine and/or curriculum of schools.</p> <p>IND</p> <p>Number of CSOs in collaborative partnerships with key national and international stakeholders to promote and advocate for the inclusion of mandatory physical activity in the daily routine and/or curriculum of schools.</p>

⁵¹ In the next implementation cycle, CSOs' participation in review and updating of the Health and Family Life Education (HFLE) programme in selected countries, with advocacy for the participation of older children and adolescents, could be an output for this outcome, to foster a holistic approach to prevention of childhood obesity in the school setting. Information on the HFLE programme in the Caribbean is available in a 2009 UNICEF report, https://www.unicef.org/easterncaribbean/Final_HFLE.pdf.

DELIVERABLES (Products and services)	ACTIVITIES (ACT)/Inputs/Resources (I/R)		
<p>Advocacy and IEC products regarding:</p> <ul style="list-style-type: none">Ban on promotion of SSBs and EDNP products in school setting;Establishment of standards for school meals aligned with national food-based dietary guidelines;Inclusion of mandatory physical activity in daily routine and/or curriculum of schools; andInterventions at community-level to enhance physical activity, including relevant urban planning.	ACT 5.1.1.1		
	Undertake an assessment of student attitudes towards the sale and marketing of SSBs in schools to inform regional campaign aimed at banning SSBs in schools.	Responsible	HCC secretariat, CSOs
		Partners	Ministries of Health, Education; CARPHA, PAHO/WHO, UNICEF
		I/R	Survey implementation and related materials – USD 2,000
	ACT 5.1.1.2		
	Engage partners, including older children and adolescents (with caregivers' approval), to participate in training regarding advocacy campaigns, and in the subsequent development and implementation of a regional campaign to promote, and advocate for, a ban on promotion of SSBs and EDNP products in and around schools (including provision of healthy beverage alternatives in schools such as water i.e. water campaign for children).	Responsible	HCC secretariat, CSOs
		Partners	PAHO/WHO; Ministries of Health, Education, Trade; CARPHA, UNICEF, FAO
		I/R	Preparation and dissemination of materials – USD 25,000
	ACT 5.1.2.1		
	Engage partners, develop and implement strategies to promote and advocate for the establishment of standards for school meals, based on national food-based dietary guidelines.	Responsible	CSOs, HCC secretariat
		Partners	Ministries of Health, Education; CARPHA, PAHO/WHO, UNICEF, FAO; media
		I/R	Review of national food-based dietary guidelines, and preparation and dissemination of materials – USD 5,000
	ACT 5.1.3.1		
	Engage partners, including older children and adolescents, and develop and implement strategies to promote and advocate for inclusion of mandatory physical activity in the daily routine and/or curriculum of schools.	Responsible	CSOs, HCC secretariat
		Partners	Ministries of Health, Education, Sports; Private sector; PAHO/WHO, UNESCO, UNICEF, PSI Caribbean, media
		I/R	Preparation and dissemination of materials, preparation of facilities – USD 5,000

SPECIFIC OUTCOMES	Outputs (OPT) and Indicators (IND)
 5.1	<p>OPT 5.1.4</p> <p>Collaboration between CSOs and key national and international partners to advocate for, promote, organise, and contribute to interventions at community level aimed at enabling safe physical activity.</p> <p>IND</p> <p>Number of CSOs in collaborative partnerships with key national and international stakeholders to advocate for, promote, organise, and contribute to interventions at community level aimed at enabling safe physical activity.</p>

6. Resource mobilisation



6.1

Strengthened CSO resource mobilisation for the planning, implementation, and assessment of programmes and interventions addressing childhood obesity prevention.

OPT 6.1.1

Development of grant and/or project proposals by CSOs and submission to prospective development partners/funders.

IND



Number of CSOs completing and submitting proposals to prospective funders.




DELIVERABLES (Products and services)	ACTIVITIES (ACT)/Inputs/Resources (I/R)		
	ACT 5.1.4.1		
	Engage partners, including community leaders and members, and develop and implement strategies to advocate for, promote, organise, and contribute to interventions at community level aimed at enabling safe physical activity and recreation, including appropriate urban planning.	Responsible	CSOs, HCC secretariat
		Partners	Ministries of Health, Local Government, Sports; Town Planning Department, Police Department; Private sector; PAHO/WHO, UNESCO, CARPHA, PSI Caribbean
		I/R	Preparation and dissemination of advocacy and other materials; holding events – USD 8,000
Total budget: USD 45,000			

Capacity building in grant writing. Grant/project proposals addressing priorities for childhood obesity prevention.	ACT 6.1.1.1		
	Collaborate with development agencies and/or international CSOs to conduct training for selected Caribbean CSO representatives in project development and grant writing.	Responsible	HCC secretariat
		Partners	PAHO/WHO, UNICEF; UWI OC; NCDA
		I/R	Training sessions, one each year – USD 8,000
	ACT 6.1.1.2		
	Develop and submit project or grant proposals to prospective development partners/funders to mobilise resources for improvements in nutrition, healthy diets, and physical activity among children, especially targeting more at-risk children and their caregivers.	Responsible	CSOs, HCC Secretariat
		Partners	Government, Community leaders, PAHO/WHO, UNICEF
		I/R	Technical cooperation with CSOs to develop and submit proposals – USD 3,000
Total budget: USD 11,000			



SPECIFIC OUTCOMES	Outputs (OPT) and Indicators (IND)
7. Strategic planning, monitoring, and evaluation	
 7.1 Enhanced CSO development of their own childhood obesity prevention strategies/ plans.	OPT 7.1.1 Collaboration between CSOs and national and international partners to develop childhood obesity prevention strategies or plans. IND Number of CSOs with childhood obesity prevention strategies or plans developed collaboratively.
 7.2 Enhanced CSO monitoring of governments' and other stakeholders' fulfilment of key aspects of national and internationally agreed commitments, policies, and plans associated with childhood obesity prevention.	OPT.7.2.1 Completion and timely submission of Childhood Obesity Prevention Scorecard for CSO monitoring of priority policy interventions, including fiscal measures, legislation, and regulations. IND Number of CSOs submitting fully completed Scorecards.

DELIVERABLES (Products and services)	ACTIVITIES (ACT)/Inputs/Resources (I/R)		
CSO strategies or plans for childhood obesity prevention.	ACT 7.1.1.1		
	Conduct training for CSOs in formulation of their childhood obesity prevention strategies or plans, based on the HCC Civil Society Action Plan 2017-2021, and support the collaborative development of the strategies or plans, as well as their publication and dissemination.	Responsible	HCC Secretariat
		Partners	PAHO/WHO, CARPHA
		I/R	Training materials, facilitation, and publication of plans – USD 8,000
	Total budget: USD 8,000		
Final Scorecards sent to CSOs. Completed Scorecards received from CSOs.	ACT 7.2.1.1		
	Finalise and disseminate Scorecard and guidelines; support Scorecard completion.	Responsible	HCC secretariat
		Partners	ARPHA, PAHO/WHO, NCDA
		I/R	Consultant – USD 1,000
	ACT 7.2.1.2		
	Obtain information at national level; complete and return Scorecards.	Responsible	CSOs
		Partners	Government
		I/R	In-kind
	ACT 7.2.1.3		
	Analyse Scorecard information, and prepare and disseminate summary report with recommendations for improvement.	Responsible	HCC secretariat
		Partners	CARPHA, PAHOWHO, NCDA
		I/R	Consultant – USD 3,500
	ACT 7.2.1.4		
	Develop a virtual live platform for the Childhood Obesity Prevention Scorecard to share current country implementation status across the key indicators of the scorecard including resources (e.g. policy documents, briefs, media coverage).	Responsible	HCC secretariat, CSOs
		Partners	CARPHA, PAHO/WHO, NCDA, CSOs
		I/R	Consultant – USD 2,000
	Total budget: USD 6,500		

SPECIFIC OUTCOMES	Outputs (OPT) and Indicators (IND)
<p> 7.3 Strengthened coordination, monitoring and evaluation of the HCC “Civil Society Action Plan 2017-2021: Preventing Childhood Obesity”.</p>	<p>OPT 7.3.1 Participatory coordination, monitoring, and evaluation of HCC Civil Society Action Plan.</p> <p>IND Number of CSOs and other key stakeholders participating in fora to coordinate, monitor, and evaluate the HCC Civil Society Action Plan.</p>



DELIVERABLES (Products and services)	ACTIVITIES (ACT)/Inputs/Resources (I/R)		
Establishment of Steering Committee for the Action Plan. Annual virtual and face-to-face interactions among HCC secretariat, CSOs, and other key stakeholders to monitor and evaluate the Civil Society Action Plan.	ACT 7.3.1.1		
	Establish a Steering Committee with terms of reference to coordinate and oversee the implementation of the Action Plan.	Responsible	HCC secretariat
		Partners	PAHO/WHO, CARPHA, UWI
		I/R	In kind
	ACT 7.3.1.2		
	Establish a CSO action network comprising national entities to advocate for and promote childhood obesity prevention and liaise with the Steering Committee.	Responsible	HCC secretariat, CSOs
		Partners	PAHO/WHO, CARPHA
		I/R	In kind
	ACT 7.3.1.3		
	Convene virtual quarterly Steering Committee coordination meetings, and annual face-to-face meetings involving CSOs and other key stakeholders to discuss achievements, challenges, gaps, and lessons learned during implementation of the Action Plan and agree on adjustments as needed to achieve the outputs and outcomes.	Responsible	CC secretariat
		Partners	PAHO/WHO, CARPHA, UWI
		I/R	Facilitator - USD 8,000 (4,000 each year); face-to-face meeting costs - USD 30,000 (15,000 each year)
Total budget: USD 38,000			

Total budget: USD 52,500

Total indicative budget for Implementation Plan 2017-2019: USD 229,000



4.3 Implementation strategies

The HCC secretariat will lead the coordination, implementation, and oversight of the Action Plan, in close collaboration with HCC members and other key stakeholders. There will be a regional Steering Committee, with specific terms of reference and representation from the HCC secretariat; CSO members working in childhood obesity prevention; government; private sector; and development partners, to coordinate and oversee the Action Plan. The secretariat will seek to collaborate with national CSOs for the establishment of a CSO action network of national entities for childhood obesity prevention to advocate for related policies and interventions, including public outreach and education. The network could comprise subcommittees of National NCD Commissions/Wellness Commissions where they exist, and link with the regional Steering Committee described above.

HCC will, specifically:

- Engage with older children and adolescents to ensure that they have a voice in shaping relevant interventions and to enable their full participation and benefit (6).
- Advocate for (and facilitate, where feasible):
 - Integration of interventions, outputs, and outcomes into existing programmes and initiatives in health and non-health sectors where possible, in order to foster efficiency and sustainability (6). Such programmes include those targeting NCD prevention and control, maternal and child health, and food and nutrition security.
 - Alignment of national childhood obesity prevention policies, plans, and programmes with the respective national food and nutrition security policies, plans, and programmes, including national food-based dietary guidelines.
 - Consideration of the environmental context and a life-course approach to childhood obesity prevention, to address three critical time periods in the life course: preconception and pregnancy, infancy and early childhood, and older childhood and adolescence (6). Thus, the main focus is on primary school-age



Childhood obesity rates in the Caribbean are higher than the global average, and are increasing rapidly. The trends reflect economically and culturally driven shifts in dietary practices towards over-consumption of energy coupled with shifts towards lower levels of physical activity.

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children and adolescents, but several interventions also benefit younger children, including infants.

- Close collaboration among the health, education, and agriculture sectors to enable healthy school environments, given that the compulsory school years provide an easy entry point to engage this age group and embed healthy eating and physical activity habits (6).
- Development and implementation of programmes to reach vulnerable or disadvantaged groups, such as children and adolescents outside of the formal education system (6).
- Strengthened collaboration with traditional partners such as the CARICOM secretariat and regional institutions; regional and national academic institutions; health and non-health government ministries; national, regional, and global CSOs, the last-mentioned including NCD, Inter American Heart Foundation (IAHF) Caribbean;⁵² and Population Services International (PSI) Caribbean;⁵³ the private sector; and development partners such as PAHO/WHO, FAO, and IICA, as well as collaboration with non-traditional partners.

⁵² See Jamaica Coalition for Tobacco Control/IAHF Caribbean Network <https://www.facebook.com/JCTCJamaica/>.

⁵³ See <http://psicaribbean.com/>.



- Technical cooperation and the mobilisation of technical, financial, human, and other resources as needed for the implementation, monitoring, and evaluation of the Action Plan, bearing in mind and managing potential conflicts of interest.
- Advocate for and promote the use of existing Caribbean regional frameworks that directly address childhood obesity and NCD prevention and control, as well as frameworks that can contribute to achievement of the outputs and outcome, including the *Caribbean Charter for Health Promotion*⁵⁴ developed by CARICOM and PAHO/WHO, and *Communicating for Health in the Caribbean: A manual for action*⁵⁵ developed by PAHO/WHO.
- Include relevant activities under the Memoranda of Understanding between HCC and CARPHA, and HCC and PAHO/WHO, and seek to establish similar agreements with other development partners to enable implementation of specific activities in the Plan.

4.4 Selected risks to Action Plan implementation, and mitigation strategies

There are several risks to successful implementation of the HCC Civil Society Action Plan 2017–2021, and strategies to avoid or manage them are needed. **Table 3** lists selected risks and related mitigation strategies – the latter have been incorporated into the Action Plan.

⁵⁴ See <http://www.archive.healthycaribbean.org/publications/documents/cchp.pdf>.

⁵⁵ See http://www.paho.org/ecc/index.php?option=com_docman&view=download&category_slug=publications&alias=3-communicating-health-in-the-caribbean-2000&Itemid=154.

Table 3. Selected risks associated with Action Plan implementation, and mitigation strategies

Risks	Mitigation strategies
1. Failure to mobilise adequate resources – technical, financial, and human – to implement the Plan.	<ul style="list-style-type: none"> • Strengthening of resource mobilisation strategies to obtain relevant funding from traditional and non-traditional partners. • Strengthening of partnerships with, and technical cooperation from, development partners. • Capacity building in project proposal development and grant writing.
2. Limited capacity in the HCC secretariat to effectively lead implementation of all components of the Action Plan due to limited resources and competing priorities.	<ul style="list-style-type: none"> • Resource mobilisation and collaboration with partners to expand technical and human resources available to the secretariat.
3. Inadequate “buy-in” and commitment from HCC CSO members to the Civil Society Action Plan and its successful implementation, due to competing priorities and limited capacity.	<ul style="list-style-type: none"> • Sensitisation of CSOs working in NCD prevention and control to the importance of childhood obesity prevention as a “priority among priorities”, in addressing NCDs. • Dissemination of evidence and information on the situation regarding childhood obesity in the Caribbean, and on interventions that can be adopted by, or adapted to, the region. • CSO capacity development in childhood obesity prevention strategies. • Mobilisation of resources to contribute to HCC members’ action and training for CSOs in resource mobilisation strategies.
4. Significant variations in CSO capacity to undertake activities.	<ul style="list-style-type: none"> • Capacity development of CSOs in selected areas.
5. Limited awareness of the importance of childhood obesity prevention in addressing NCDs, and the need for the whole-of-government, multisectoral approach to the issue, by several non-health sectors.	<ul style="list-style-type: none"> • Continued promotion to key stakeholders in government, civil society, and the private sector of the social determinants of health, the health-in-all-policies approach, and regional and international frameworks, guidelines, and tools for childhood obesity prevention.
6. Inadequate M&E of national interventions for childhood obesity prevention and of the Civil Society Action Plan, to allow for adjustments and strengthened actions.	<ul style="list-style-type: none"> • Inclusion in the Action Plan of an outcome and related outputs on M&E, with an indicative budget.
7. Limitations or deficiencies in countries’ development and implementation of policies, legislation, and regulations related to childhood obesity prevention, due to competing political priorities, limited national capacity, and insufficient resources.	<ul style="list-style-type: none"> • Strengthened advocacy, including policy briefs, for multisectoral action – involving civil society – and technical cooperation to prevent childhood obesity. • Information-sharing on good practices and cost-effective interventions for childhood obesity prevention; contribution to strengthening national capacity for development and implementation of policies, legislation, and regulations; and involvement in the mobilisation of resources, all in collaboration with national authorities and development partners such as PAHO/WHO and CARPHA.

4.5 Monitoring and evaluation framework

Indicators

The indicators outlined in **Sections 4.1** and **4.2** above provide the framework for monitoring and evaluation of the Action and Implementation Plans over the respective time frames.

Means of verification of the indicators include, but are not limited to:

1. Reports from CSOs, with both quantitative and qualitative information.
2. National statistical and epidemiological reports, results of national surveys, and other research gleaned from national health information systems, as well as data collected and analysed by CARPHA, the UWI, and other academic institutions in the Caribbean.
 - a. Information to be gathered regarding impact should include BMI-for-age, to establish prevalence and trends in childhood obesity at national and subnational levels, disaggregated by age, sex, geographic location, and other equity stratifiers.⁵⁶ Data should also be collected on nutrition, eating behaviours, and physical activity across socioeconomic groups and settings (6).
 - b. Surveys include the Global School-based Student Health Survey (GSHS) and the WHO STEPwise approach to risk factor surveillance.⁵⁷
3. Reports from key national stakeholders, including government ministries, the private sector, and civil society entities such as the media and health professional associations.
4. Results of surveys conducted by the HCC secretariat.
5. Reports from international development and technical cooperation partners such as PAHO/WHO and other UN agencies, as well as international CSOs, including reports on the fulfilment of human rights obligations, reduction of health inequities, and progress towards universal access to health and universal health coverage.

Reporting periodicity and report dissemination

Annual progress reports will summarise achievements, challenges, gaps, lessons learned, mitigation of risks identified, and adjustments proposed for more efficient and effective implementation. The reports will also summarise resources allocated and mobilised, and financial execution.

As the Action Plan approaches its termination date, both internal and external evaluations (the latter contingent on the mobilisation of relevant resources) will be conducted, with a view to documenting the extent to which the specific civil society outcomes, the expected national outcomes, and the overall outcome were achieved. The evaluation will include recommendations for the next cycle of planning for civil society's continued work to address this important health issue in the Caribbean. The progress and evaluation reports will be posted on the HCC website, and presented to key stakeholders at national, regional, and international levels.

⁵⁶ While health monitoring only needs to consider data related to health indicators, health inequality monitoring requires an additional intersecting stream of data related to a dimension of inequality (for example, wealth, education, region or sex). This is sometimes referred to as an equity stratifier. From WHO Handbook on Health Inequality Monitoring, http://apps.who.int/iris/bitstream/10665/85345/1/9789241548632_eng.pdf?ua=1.

⁵⁷ See <http://www.who.int/chp/steps/en/>.



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Childhood obesity must be accepted as an urgent and global challenge of major significance to global health and to all countries that requires leadership by governments and coordinated action with other actors.

Interim Report of the Commission on Ending Childhood Obesity, WHO

5. Spotlight on civil society interventions for childhood obesity prevention



5.1 Trade and fiscal policies

MEXICO

SSB tax for obesity and diabetes prevention

In response to obesity and diabetes epidemics in Mexico, in October 2013 the Mexican legislature passed a specific excise tax of 1 peso (0.08 U.S. dollars)* per litre of SSBs. The legislation went into effect on 1 January 2014 and increased the average price of a litre of soda by about 10%. The tax is levied on concentrates, powders, syrups, essences, or flavour extracts added to beverages and therefore applies to any beverages with added sugar, syrups, powders, or other caloric sweeteners, including soft drinks, energy drinks, bottled teas and coffees, as well as fruit juices and fruit-flavoured drinks with added sugar.

Representatives from national NGOs involved in promoting the SSB tax, developing the advocacy strategies, and carrying out key features of the **campaign in Mexico included:**

- **Advocacy** and rights-based organisations, e.g., El Poder del Consumidor (consumer association), Fundación Mídete (dedicated to preventing and treating overweight and diabetes), Centro de Orientación Alimentaria (COA) Nutrición (company dedicated to guiding and promoting health and

wellbeing through nutrition), and REDIM (Network for Children's Rights in Mexico).

- **Media.**
- **Public interest lobbyists**, e.g., Polithink (consultancy specializing in advocacy).
- **Academic and medical institutions**, e.g., National Institute of Public Health and National Institute of Medical Science and Nutrition.
- **Lawyers.**

Also involved were international and multilateral institutions, e.g., PAHO and WHO.

While a comprehensive evaluation of the tax's effect on purchase patterns is ongoing, preliminary data from a study being conducted by the Mexican National Institute of Public Health (INSP) and the University of North Carolina (UNC) suggest SSB purchases are declining in Mexico.

See

http://www.jhsph.edu/departments/health-behavior-and-society/_pdf/Advocating_For_Sugar_Sweetened_Beverage_Taxation.pdf.

* Peso-dollar exchange rate at the date of passage of the taxation.



BARBADOS

Monitoring the effect of taxes on SSBs

The UWI, Cave Hill, has been working with the Government of Barbados – the Ministries of Health and Finance – and other partners to assess the impact of the 10% excise tax that was imposed on SSBs in 2015 as a response to the country's high rates of obesity.

Other partners include:

- International Development Research Centre (Canada)

- Private sector: local grocery stores
- Civil society: HCC, University of Cambridge

A PhD candidate at the University is coordinating the research, and presented interim findings at a seminar held at the UWI in January 2017.

Given that marketers have absorbed most of the tax to keep prices at point-of-purchase from increasing, consideration is being given to increasing the tax to 20%, or higher.

See

The presentation with interim findings, available at <http://onecaribbeanhealth.org/wp-content/uploads/2017/01/Evaluation-of-the-Barbados-Sugar-Sweetened-Beverage-Tax-Miriam-Alvarado.pdf> and HCC policy brief on the implementation of the Barbados SSB tax, available at <https://www.healthycaribbean.org/hcc-brief-taxation-sugar-sweetened-beverages-barbados/>.



5.2 Nutrition literacy

UNITED KINGDOM Labelling for health

ASDA, a food retail chain in the United Kingdom (www.asda.com), launched the “Good for you!”(Gfy!) food project targeting its customers and the general public.

The Gfy! brand – a low fat, healthy eating brand – replaced the Healthy Choice range, was launched in 1994, with all products meeting strict criteria for fat, saturated fat, salt, and sugar, and having a defined calorie target.

All ASDA Gfy! foods have a consistent design with clear front of pack ‘fat content’ declaration.

In addition, ASDA provides full nutrition information per 100g on all relevant food and drink products. Where space is limited, the priority values for declaration are

Big 8 per 100g, thus enabling a salt value to be declared also. Additionally, more prominent fat, calorie, and salt information is included through the introduction of ‘per serving’ boxes.



MEXICO Obesity prevention interventions

Strong civil society organizations in Mexico embraced the prevention of obesity as their goal and used evidence from academia to position obesity prevention in the public debate and in the government agenda.

Public hearings and the negotiations stimulated the interest of NGOs engaged in preventing obesity and promoting children’s rights.

The Mexican Alliance for Healthy Nutrition, a consortium representing more than 20 NGOs, launched a very effective media campaign against sugary beverages using non-traditional media such as social networks, billboards, and posters in subway lines, as well as traditional media coverage.

See

Barquera S, Campos I, and Rivera JA. Mexico attempts to tackle obesity: the process, results, push backs and future challenges. *Obesity Reviews* 2013; 14 (Suppl. 2): 69-78. Available at <http://onlinelibrary.wiley.com/doi/10.1111/obr.12096/pdf>.



5.3 Early childhood nutrition

PAKISTAN

Civil society takes action for World Breastfeeding Week 2014

In 2014, the Network for Consumer Protection of Pakistan and Child Rights Movement, in collaboration with Save the Children, organised a consultation to discuss the reasons for low breastfeeding rates and the role of civil society organisations in the protection and promotion of breastfeeding in the country.

Participants included representatives of CSOs, the Child Rights Movement, media, and development partners working in nutrition.

See

<http://crm.com.pk/consultation-on-role-of-civil-society-in-protection-and-promotion-of-breastfeeding-in-pakistan/>



It's time to realise that this vicious cycle of supply and demand for unhealthy foods can be broken with 'smart food policies' by governments alongside joint efforts from industry and civil society to create healthier food systems.

Dr Christina Roberto
Harvard T.H. Chan School of Public Health



5.4 Marketing of healthy and unhealthy foods and beverages to children

BARBADOS

Call to action from the Chronic Disease Research Centre, UWI: Restrict fast foods, promote healthy choices

In a 2016 presentation on Childhood Obesity in Barbados, Dr. T. Alafia Samuels, Director of the Chronic Disease Research Centre, UWI, Cave Hill, Barbados, presented epidemiological data and other information on the global and regional obesity epidemic.

The presentation summarised the causes and complications of childhood obesity, and included telling photographs and drawings illustrating sedentary lifestyles and marketing of unhealthy foods to children.

Marketing of fast foods to children was a particular focus, and the presentation provided an example of a specific national fast food chain that provides branded blackboards, calendars, and school supplies to primary schools in the country.

Legislation was cited as a powerful instrument of public health; one of the objectives of the Barbados draft National Plan of Action for Childhood Obesity Prevention and Control is: "To develop and implement policies and regulations to reduce the impact on children of marketing of non-alcoholic beverages and foods high in saturated fats, trans fatty acids, free sugars or salt". This aligns with recommendations from WHO and the CARICOM Heads of Government Port of Spain Declaration.

See

<http://onecaribbeanhealth.org/wp-content/uploads/2016/11/Childhood-Obesity-Dr-T-Alafia-Samuels.pdf>.



Childhood obesity is the most visible, and arguably the most tragic, expression of the forces that are driving the rise of NCDs. It is the warning signal that bad trouble, in the form of more heart disease, cancer, and diabetes, is on its way.

Dr Margaret Chan,

Director-General of the World Health Organization

Address to the Seventieth World Health Assembly,

CHILE

Laws to fight childhood obesity

In Latin America, Chile is one of two countries with the highest rates of overweight and obesity. Chile has the highest rate of child obesity, specifically in children under five, and for the past eight years, the country has recorded 10% of its child population as overweight.

In July 2012 the Government of Chile approved the Law of Food Labelling and Advertising, commonly known as the “Super 8 Law”, which was implemented 26 June 2016. Civil society made a significant contribution, as the law resulted from the joint efforts of a group of health professionals, researchers, and legislators who proposed a regulatory framework in support of healthy diets and active living.

With this legislation, Chile became a world leader in anti-obesity regulation, as the law addresses three key areas – front of pack labelling, advertising to children, and sale of unhealthy foods in children’s settings. Article 5 of the new Chilean law requires

that all foods high in saturated fat, salt, sugar and/or calories feature a stop-sign warning label (one for each applicable nutrient). This definition of ‘unhealthy foods’ is then applied to the regulation of advertising, with Articles 6, 7, and 8 of the law prohibiting advertising and promotion of stop-sign labelled foods to children.

Chile’s laws are robust, innovative, and comprehensive. The ban applies to any form of marketing, communication, recommendation, propaganda, information, or action intended to promote the consumption of a product. The law also addresses the use of gifts, contests, toys, games, stickers, animated characters, children’s voices, cartoons, toys, children’s music, animals, child figures, and depictions of situations common to a child’s daily life, such as school.

See

http://www.desarrollando-ideas.com/wp-content/uploads/sites/5/2016/05/160504_DI_report_food_chile_ENG.pdf; <http://onlinelibrary.wiley.com/doi/10.1111/obr.12099/full>; and <http://junkbusters.com.au/chile-stops-the-junk/>.

CANCER COUNCIL NSW

“Junkbusting” for health!

Cancer Council NSW is an independent, 96% community-funded charity in New South Wales, Australia, dedicated to reducing the impact of cancer on individuals and the community, and to lessening the burden for people affected by cancer.

Cancer Council NSW recognises that junk food marketing is one of the factors that helps to create an unhealthy environment and contributes to overweight and obesity; that overweight children are likely to become overweight adults, and that being overweight or obese increases the risk of some types of cancer.

Therefore, as part of its holistic approach, Cancer Council NSW wants tougher regulation of junk food marketing to children, and has a “Junkbusters” programme that provides a “one stop shop” for information, alternatives, and solutions to junk food and junk food marketing. “Junkbusters” provides a voice for parents and other community members to share their concerns on this issue.

See

<http://junkbusters.com.au/>.



5.5 School- and community-based interventions

ANGUILLA FIT TEEN programme

The 3-month FIT TEEN programme aims to encourage young people to participate in physical activities, while fostering positive behaviours and wellbeing, and reducing the propensity to health issues, specifically chronic diseases.

This public-private partnership involves:

Ministry of Health and Social Development;
Department of Youth & Culture; Department of
Sports; Department of Education; School Health
Unit; Chronic Disease Unit

Health Authority of Anguilla: Food & Nutrition Unit;
Paediatric Unit

Private sector: Results Driven Fitness Centre

Supporting partner: Department of Social
Development

The programme was initiated by the Results Driven Fitness Centre in 2016 and targets adolescent youth, ages 12 to 17, who fit into the categories of overweight, obese, and morbidly obese; the closing ceremony of the 2016 programme and the launch of the 2017 programme took place at the end of February 2017.

See

<http://theanguillian.com/2017/03/2016-fit-teen-program-closes-on-high-note-2017-program-now-underway/>.



BARBADOS

Teenage Kicks YUTE Programme

The Heart and Stroke Foundation of Barbados (HSFB) launched the Teenage Kicks YUTE Gym in 2015 to improve the health and well-being of youth aged 8-19 years old.

The programme:

- Is for children who suffer from overweight or obesity, or any child who would benefit from interventions to prevent or reduce the risk of NCDs. The children can be referred by their paediatrician, general practitioner, schoolteacher or any concerned health care professional.
- Aims to offer the children a safe, age-appropriate environment for physical activity, with monthly monitoring of weight, BMI, and blood pressure.
- Was developed to contribute to improving the health of the children and reduce the risk of NCDs in this age group.
- Also guides the children on how to recognise healthy behaviours, and addresses issues such as health and nutrition, and food preparation and purchase.

From 9:00 a.m. to 10:30 a.m. on Saturday mornings, the children participate in physical activity guided by a fitness instructor, with the support of a nursing assistant and volunteers from the HSFB's Volunteer Programme.

HSFB partners with dietetic students from McGill University, who provide the nutritional education for the children, and there are plans to incorporate a registered nutritionist into the programme and explore with the University of the West Indies to establish if the students currently registered in the Sport Science programmes can rotate through the Teenage Kicks YUTE programme as part of their placements.

See

www.hsfbarbados.org



BERMUDA

Premier's Youth Fitness Program (PYFP)

Launched in September 2016, PYFP is a school-based initiative that aims to track the fitness levels of students in primary (P), middle (M), and high/senior (S) school, specifically grade levels P5, P6, M1-M3, and S1-S3).

The goal is to help improve students' fitness levels (Healthy Fitness Zone) and to encourage students to increase their daily physical activity and healthy eating outside of school with their families.

Partners include:

- Government: Ministries of Health, Education; Premier's Council on Fitness, Sports, and Nutrition; public schools
- Civil society: Bermuda Diabetes Association
- Private sector: Insurance companies BF&M and the Argus Group; private schools

See

Remarks by the Premier of Bermuda, September 2016, <https://www.gov.bm/articles/premiers-council-fitness-sports-and-nutrition> and Ministerial Statement by the Minister of Health and Seniors to the House of Assembly, Bermuda, February 2017, <https://www.gov.bm/articles/premier%E2%80%99s-youth-fitness-programme>.



TRINIDAD AND TOBAGO

PSI CORE Youth Movement Program

In 2016 PSI Caribbean, the regional arm of the global network of Population Services International (PSI), launched a physical activity programme targeting youth aged 13–16 years as part of its CORE programme for the prevention and control of NCDs.

The 8-week programme, to be repeated at intervals, targets not only improvement in physical fitness, but also in confidence and self-worth, and includes information on healthy nutrition.

A key partner with PSI Caribbean in this programme is Movement Mechanics, a private sector entity which states that it is “A Centre for Sport Performance Enhancement, Corrective Exercise, Therapeutic Massage Therapy, Nutrition and Weight Loss Solutions”.

See

<http://psicaribbean.com/youth-movement-program/> for information on the PSI Caribbean Youth Movement Programme, <http://psicaribbean.com/core/> for information on its CORE programme, and [https://www.facebook.com/pg/movementmechanics/about/?ref=page_](https://www.facebook.com/pg/movementmechanics/about/?ref=page_internal) internal for information on Movement Mechanics.

BRAZIL

Healthy Habits, Healthy Girls

“Healthy Habits, Healthy Girls” was a randomised, controlled trial of an innovative, school-based 6-month intervention programme that combined a range of evidence-based behaviour-change strategies to promote healthy eating and physical activity and prevent unhealthy weight in adolescent girls from low-income communities in São Paulo, Brazil. The School of Public Health, University of São Paulo, Brazil conducted the study.

The programme began in 2014 and included enhanced physical education classes, physical activities during recess, weekly nutritional and physical activity messages, nutrition and physical activity handbooks, interactive seminars, nutrition workshops, parents’ newsletters, text messages, and dietary and physical activities diaries for the girls. The activities were implemented over three school terms (6 months) at no cost to the schools or students.

The weekly messages included: “Eat fruit and vegetables every day”; “Do physical exercise, respect your limits”; “Eat a healthy breakfast every day”; “Do physical exercise with family and friends”; “Control the size of meal portions and sit while eating”; “Reduce your chair time during recess, after school, and weekends”; “Eat less ‘junk food’ and munch less”; “Identify your excuses for not doing physical exercise”; “Drink water and replace sodas and artificial juices with water, homemade natural fruit juices, and coconut water”; and “Make family meals”.

At the end of the study period, although changes in BMI were not statistically significant, differences favoured the intervention group. Statistically significant intervention effects were found for waist circumference, computer screen time on the weekends, total sedentary activities on the weekends, and vegetable intake.

See

http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2015000701381&lng=en&tling=en and <https://www.ncbi.nlm.nih.gov/pubmed/26851152>.



5.6 Resource mobilisation

HCC AND NCDA collaborating to prevent childhood obesity and NCDs in the Caribbean

As part of its programme “Expanding Access to Care, Supporting Global, Regional, and Country Level NCD Action” the NCD Alliance, in partnership with Medtronic Philanthropy, has provided both financial and technical resources to the HCC to support civil society’s contribution to NCD prevention and control in the Caribbean, including childhood obesity prevention.

The Civil Society Action Plan, 2017-2021: Preventing Childhood Obesity in the Caribbean, was developed in

response to the findings of the 2014 Caribbean NCD Status Report that was formulated as part of the NCDA programme.

NCDA’s commitment and provision of resources is not only benefitting the HCC secretariat and CSO members, but is also contributing to strengthening national health systems for NCD prevention and control in the Caribbean.

See

<https://ncdalliance.org/what-we-do/capacity-development/capacity-development-programmes/supporting-national-and-regional-action/caribbean>.





5.7 Strategic planning, monitoring, and evaluation

CARIBBEAN

Multisectoral initiatives for NCD and risk factor prevention and control

In their 2007 Declaration of Port of Spain “Uniting to Stop the Epidemic of Chronic, Noncommunicable Diseases”, the CARICOM Heads of Government stated that “we strongly encourage the establishment of National Commissions on NCDs or analogous bodies to plan and coordinate the comprehensive prevention and control of chronic NCDs”. Since then, several Caribbean countries have established, or are in the process of establishing, multisectoral National NCD Commissions (NNCDCs), Wellness Commissions, or analogous bodies.

On 28 March 2017, Jamaica launched its National Food Industry Task Force (NFITF), which aims to engage the food industry with Health and other sectors of government, and with civil society, as it expedites programmes to tackle obesity and NCDs in Jamaica.

The NFITF initiative engages all stakeholders in the food and beverage industry, government ministries and policymakers, and key quality-control agencies, such as the Scientific Research Council, the Bureau of Standards Jamaica, and the United Vendors Association.

The NFITF will address food product reformulation; food labelling; nutrition/health education and promotion; inappropriate food marketing; healthy government institutions; fiscal policies on promoting health; and young child nutrition. The Task Force is in dialogue with restaurants and itinerant vendors operating cook shops for them to provide information on choices and to display the nutritional value of food served in the establishments.



If we have unhealthy adolescents we risk reversing the development we have achieved and we risk economic and social collapse.

Dr. Godfrey Xuereb,
PAHO/WHO Representative for Barbados and the Eastern Caribbean.

Opening Remarks at the 2017 Regional PAHO Meeting *Building Synergies for Implementation of the Global Strategy (GS) for Women's, Children's and Adolescents' Health in the Caribbean*.

See

Links at HCC www.healthycaribbean.org/ (<http://bit.ly/2sdzatB> and <http://bit.ly/2sdtklT>) for information on NNCDs, and <http://jamaica-gleaner.com/article/lead-stories/20170330/stakeholders-govt-team-fight-lifestyle-diseases>; <http://thedeskat13west.pr.co/147579-7-things-you-need-to-know-about-the-national-food-industry-task-force>; and <http://jis.gov.jm/health-ministry-mission-reduce-obesity/> for information on the Jamaica NFITF.

REPUBLIC OF PALAU

Developing a National NCD Strategic Plan

Civil society played a major role in developing the Republic of Palau's NCD Prevention and Control Strategic Action Plan: Healthy Palau, Healthy Communities 2015-2020.

The Foreword by the President calls for a whole-of-society approach, and in his message, the Minister of Health notes that "community partners have also risen to address NCDs, with social marketing campaigns on healthy living targeting parents, families, and the working age population".

The Strategic Plan includes a message from the community partners – civil society organisations – themselves. They note that "Community partners

have been fully engaged with the Ministry of Health in the development of this plan from the initial decision to move forward with a new plan, to the organisation of the NCD Strategic Planning Workshop, and to the many hours of follow-up required to hone the recommendations into their final form. As community partners, we are committed to doing our part in seeing that the plan is fully implemented."

The Strategic Plan includes areas of action "reducing physical inactivity" and "improving nutritional intake", as well as a specific objective for childhood obesity: "By 2020, decrease prevalence of overweight/obesity among school-aged children by 10%".

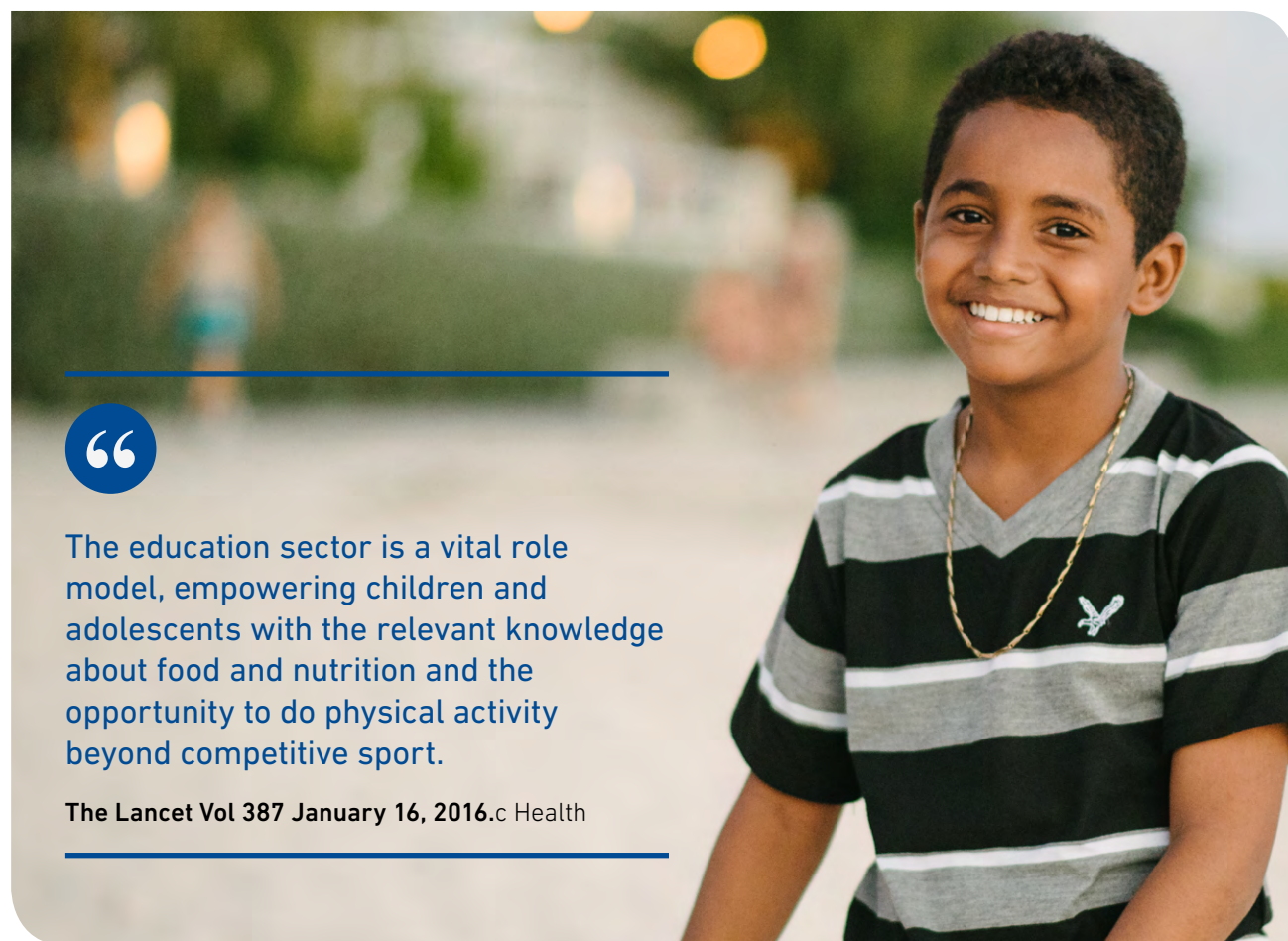
See

[http://www.palauhealth.org/files/FinalDraft-PalauNCDPlan_complete%20pages-dc%20\(Low%20Res\).pdf](http://www.palauhealth.org/files/FinalDraft-PalauNCDPlan_complete%20pages-dc%20(Low%20Res).pdf)



The education sector is a vital role model, empowering children and adolescents with the relevant knowledge about food and nutrition and the opportunity to do physical activity beyond competitive sport.

The Lancet Vol 387 January 16, 2016.^c Health



Annex

Matrix of strategies, recommendations, high-level objectives, and outcomes for childhood obesity prevention from CARPHA, PAHO, and WHO

Acronyms and abbreviations

Definitions

References

Annex

Matrix of strategies, recommendations, high-level objectives, and outcomes for childhood obesity prevention from CARPHA, PAHO, and WHO

WHO population-based approaches (10)	CARPHA 6- point policy package (12)
<p>1 Structures within governments to support childhood obesity prevention policies and interventions.</p> <p>Include:</p> <ul style="list-style-type: none"> • High-level strategic leadership • Health-in-all-policies • Dedicated funding for health promotion • Workforce capacity • Networks and partnerships • Standards and guidelines • NCD monitoring systems 	<p>Nutrition standards and guidelines for schools and other institutions:</p> <ul style="list-style-type: none"> • Mandatory national nutrition standards for all foods provided and sold in schools and early childhood services, based on regional guidelines. • Regional guidelines for food in other institutions, including workplaces. <p>Trade and fiscal policies:</p> <ul style="list-style-type: none"> • Selective adjustment of internal taxes to align with the nutritional value of foods and beverages • Alignment of tariff schedules with the healthfulness of foods by selectively adjusting import duties on foods and beverages which are non-originating in the Caribbean Single Market and Economy • Tailoring of public assistance, such as subsidies (including price discounts and vouchers) and welfare payments, to provide incentives for healthy food consumption. <p>Food chain incentives:</p> <ul style="list-style-type: none"> • Preferential targeting of agricultural supports and incentives towards nutrient-rich commodities, especially fruits and vegetables. • Promotion of demand-side incentives for healthy domestic food chains. • Identification of, and implementation of strategies to overcome, bottlenecks in domestic healthy food chains • Collaboration with food processors/suppliers to promote use of healthier ingredients • Promotion of, and support for, community food production.

	CARPHA Plan of Action outcomes (4)	PAHO Plan of Action objectives (5)	WHO Commission on Ending Childhood Obesity recommendations (6)
	<ul style="list-style-type: none"> • Education officials better equipped to strengthen the school curriculum to promote emphasis on nutrition and physical activity. • Systems in education, health and trade sector better equipped to conduct activities in the Plan of Action. • National multisectoral country teams have the technical capacity to develop and implement multisectoral Action Plans for population-based childhood obesity prevention. • Quality comparable data on nutrition status and the food environment available for policy and programming. • Childhood obesity programmes informed by comparable data on the cost and consequences of the epidemic and the impact of prevention measures. 	<ul style="list-style-type: none"> • Reinforce efforts to implement the Global Strategy for Infant and Young Child Feeding. • Engage other government institutions and, as appropriate, other sectors. • Strengthen country information systems so that trends and determinants of obesity, disaggregated by at least two equity stratifiers*, are routinely available for policy decision-making. 	<ul style="list-style-type: none"> • Ensure that appropriate and context-specific nutrition information and guidelines for both adults and children are developed and disseminated in a simple, understandable and accessible manner to all groups in society. • Implement the Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children to reduce the exposure of children and adolescent to, and the power of, the marketing of unhealthy foods. • Establish cooperation between Member States to reduce the impact of cross-border marketing of unhealthy foods and beverages. • Implement a standardised global nutrient labelling system. • Enforce regulatory measures such as the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions. • Support mothers to breastfeed, through regulatory measures such as maternity leave, facilities, and time for breastfeeding in the workplace. • Develop regulations on the marketing of complementary foods and beverages, in line with WHO recommendations, to limit the consumption of foods and beverages high in fat, sugar, and salt by infants and young children.

* While health monitoring only needs to consider data related to health indicators, health inequality monitoring requires an additional intersecting stream of data related to a dimension of inequality (for example, wealth, education, region or sex). This is sometimes referred to as an equity stratifier. From WHO Handbook on Health Inequality Monitoring, http://apps.who.int/iris/bitstream/10665/85345/1/9789241548632_eng.pdf?ua=1.

WHO population-based approaches (10)	CARPHA 6- point policy package (12)
<p>2 Population-wide policies and initiatives</p> <p>Include interventions designed to alter the food and physical activity environments and make the healthier choices the easier choices for individuals:</p> <ul style="list-style-type: none"> • Restrictions on marketing unhealthy foods and non-alcoholic beverages to children • Nutrition labelling • Food taxes and subsidies • Fruit and vegetable initiatives • Other food policies, e.g. restricting trans fats • Physical activity policies • Social marketing campaigns 	<p>Food marketing:</p> <ul style="list-style-type: none"> • Regional guidelines to reduce children's overall exposure to unhealthy foods. <p>Food labelling:</p> <ul style="list-style-type: none"> • Mandatory, uniform Nutrition Facts Panels (NFP) on all packaged retail grocery foods and beverages sold within the region. • Regulation of nutrient content, nutrient function, health claims, and on-pack marketing, including promotions and characters, for use in conjunction with NFP • Guidelines for mandatory nutrition labelling on menus and menu boards in restaurants, vending machines, movie theatres, and other entertainment venues. <p>Nutritional quality of food supply:</p> <ul style="list-style-type: none"> • Mandatory removal of artificial trans fats in all food products. • Regional standards and time-bound salt, fat, and sugar reduction targets for specific food product categories • Guidelines for, and collaboration with, food service outlets and street vendors to improve nutritional quality of ingredients and food sold.

CARPHA Plan of Action outcomes (4)	PAHO Plan of Action objectives (5)	WHO Commission on Ending Childhood Obesity recommendations (6)
<ul style="list-style-type: none"> • Member States enact strong regulatory frameworks for reducing obesogenic environments. • Evidence-based policies to support production, access, and consumption of safe, affordable, nutritious, high-quality food commodities implemented in Member States. • Infant and child-feeding policies, programmes, and interventions strengthened. • National obesity prevention initiatives scaled up in accordance with the Caribbean Charter for Health Promotion. • Social marketing campaigns for obesity prevention strengthened to integrate traditional and new forms of media. • National policies and programmes more responsive to the ethical issues concerning childhood obesity and childhood weight management. 	<ul style="list-style-type: none"> • Promote and strengthen school and early learning policies and programmes that increase physical activity. • Implement policies to reduce children's and adolescents' consumption of SSBs and EDNP products. • Enact regulations to protect children and adolescents from the impact of marketing of SSBs, EDNP products, and fast foods. • Develop and implement norms for front-of-package labelling that promote healthy choices by allowing for quick and easy identification of EDNP products. • Take measures at national or subnational level to increase the availability of and accessibility to nutritious foods. 	<ul style="list-style-type: none"> • Implement an effective tax on SSBs. • Develop nutrient profiles to identify unhealthy foods and beverages. • Implement interpretive front-of-pack labelling, supported by public education of both adults and children for nutrition literacy. • Develop clear guidance and support for the promotion of good nutrition, healthy diets, and physical activity, and for avoiding the use of and exposure to tobacco, alcohol, drugs, and other toxins.

WHO population-based approaches (10)	CARPHA Plan of Action outcomes (4)	PAHO Plan of Action objectives (5)
<p>3 Community-based interventions</p> <p>Include multi-component interventions and programmes, typically applied across multiple settings – including early childcare settings, primary and secondary schools, and other community settings – tailored to the local environment, and implemented locally</p>	<ul style="list-style-type: none"> • Strengthened community capacity to provide opportunities for healthful eating and physical activity in their environments (home, schools, places of worship, etc.). • Evidence-based weight management services more available, accessible, and acceptable to children. 	<ul style="list-style-type: none"> • Include in health care services the promotion of healthy eating based on national food-based dietary guidelines as well as other activities related to the prevention of obesity. • Ensure that national school feeding programmes as well as the sale of foods and beverages in schools (“competitive foods”) comply with norms and/or regulations that promote the consumption of healthy foods and water, and prevent the availability of EDNP products and SSBs. • Improve access to urban recreational spaces such as the “open streets” programme.

WHO Commission on Ending Childhood Obesity recommendations (6)

- Require settings such as schools, child-care settings, children's sports facilities and events to create healthy food environments.
- Increase access to healthy food in disadvantaged communities.
- Provide guidance to children and adolescents, their parents, caregivers, teachers, and health professionals, on healthy body size, physical activity, sleep behaviours, and appropriate use of screen-based entertainment.
- Ensure that adequate facilities are available on school premises and in public spaces for physical activity during recreational time for all children (including those with disabilities), with the provision of gender-friendly spaces where appropriate.
- Diagnose and manage hyperglycaemia and gestational hypertension.
- Monitor and manage appropriate gestational weight gain.
- Include an additional focus on appropriate nutrition in guidance and advice for both prospective mothers and fathers before conception and during pregnancy.
- Ensure all maternity facilities fully practice the Ten Steps to Successful Breastfeeding.
- Promote the benefits of breastfeeding for both mother and child through broad-based education to parents and the community at large.
- Provide clear guidance and support to caregivers to avoid specific categories of foods (e.g. sugar-sweetened milks and fruit juices or EDNP foods) for the prevention of excess weight gain.
- Provide clear guidance and support to caregivers to encourage the consumption of a wide variety of healthy foods.
- Provide guidance to caregivers on appropriate nutrition, diet, and portion size for this age group.
- Ensure only healthy foods, beverages, and snacks are served in formal child-care settings or institutions.
- Ensure food education and understanding are incorporated into the curriculum in formal child-care settings or institutions.
- Ensure physical activity is incorporated into the curriculum in formal child-care settings or institutions.
- Provide guidance on appropriate sleep time, sedentary or screen-time, and physical activity or active play for the 2-5 years of age group.
- Engage whole-of-community support for caregivers and child-care settings to promote healthy lifestyles for young children.
- Establish standards for meals provided in schools or foods and beverages sold in schools, that meeting health nutrition guidelines.
- Eliminate the provision or sale of unhealthy foods such as SSBs and EDNP foods, in the school environment.
- Ensure access to potable water in schools and sports facilities.
- Require inclusion of nutrition and health education within the core curriculum of schools.
- Improve the nutrition literacy and skills of parents and caregivers.
- Make food preparation classes available to children, their parents, and caregivers.
- Include Quality Physical Education⁶¹ in the school curriculum and provide adequate and appropriate staffing and facilities to support this.
- Develop and support appropriate weight management services for children and adolescents who are overweight or obesity that are family-based, multicomponent (including nutrition, physical activity, and psychosocial support) and delivered by multi-professional teams with appropriate training and resources, as part of Universal Health Coverage.

⁶¹ UN Educational, Scientific, and Cultural Organisation (UNESCO). Quality physical education (QPE) – Guidelines for policymakers. Paris: UNESCO, 2015. <http://unesdoc.unesco.org/images/0023/002311/231101E.pdf>.

Acronyms and abbreviations

CARICOM	Caribbean Community
CARPHA	Caribbean Public Health Agency
CCH	Caribbean Cooperation in Health
CFNI	Caribbean Food and Nutrition Institute
COHSOD	Council for Health and Social Development (CARICOM)
COTED	Council for Trade and Economic Development (CARICOM)
CRC	Convention on the Rights of the Child
CSO(s)	Civil society organisation(s)
EDNP	Energy-dense, nutrient-poor
FAO	Food and Agriculture Organisation (UN)
HCC	Healthy Caribbean Coalition
IAHF	Inter-American Heart Foundation
ICN2	Second International Conference on Nutrition
IICA	Inter-American Institute for Cooperation on Agriculture
M&E	Monitoring and evaluation
NCD(s)	Noncommunicable disease(s)
NCDA	NCD Alliance
NGO(s)	Non-governmental organisation(s)
PAHO	Pan American Health Organisation
POSD	Port of Spain Declaration
PSI	Population Services International
SSBs	Sugar-sweetened beverages
UN	United Nations
UNESCO	UN Educational, Scientific, and Cultural Organisation
UNHLM	UN High-Level Meeting
UNICEF	UN Children's Fund
UWI	University of the West Indies
UWI OC	UWI Open Campus
WHO	World Health Organisation

Acronyms for CARICOM countries (http://www.nationsonline.org/oneworld/country_code_list.htm)

*These countries are CARICOM Associate Members

AIA*	Anguilla
ATG	Antigua and Barbuda,
BHS	The Bahamas
BRB	Barbados
BMU*	Bermuda
BLZ	Belize
VGB*	British Virgin Islands
CYM*	Cayman Islands
DMA	Dominica
GRD*	Grenada
GUY	Guyana,
HTI	Haiti
JAM	Jamaica
MSR	Montserrat
KNA	St. Kitts and Nevis
LCA	St. Lucia
VCT	St. Vincent & the Grenadines
SUR	Suriname
TTO	Trinidad & Tobago
TCA*	Turks & Caicos Islands

Definitions

BMI

Body mass index = weight (kg)/height (m²).

BMI-for-age

BMI adjusted for age, standardised for children.

Children

Those less than 18 years of age.

Infants

Those less than 12 months of age.

Young children

Those less than 5 years of age.

Adolescents

Those between 10 and 19 years of age.

Healthy foods

Foods that contribute to healthy diets if consumed in appropriate amounts.

Unhealthy foods

Foods high in saturated fats, trans-fatty acids, free sugars, or salt (i.e. energy-dense, nutrient-poor foods).

Overweight

From birth to less than 5 years of age: weight-for-height more than 2 SD above the WHO Child Growth Standards median.

From age 5 to less than 19 years: BMI-for-age and sex more than 1 SD above the WHO growth reference median.

Obesity

From birth to less than 5 years of age: weight-for-height more than 3 Standard Deviations (SD) above the WHO Child Growth Standards median.

From age 5 to less than 19 years: BMI-for-age and sex more than 2 SD above the WHO growth reference median.

Obesogenic environment (WHO)

An environment that promotes high energy intake and sedentary behaviour. This includes the foods that are available, affordable, accessible, and promoted; physical activity opportunities; and the social norms in relation to food and physical activity.

Obesogenic environment (PAHO)

An environment that promotes and supports obesity in individuals or populations through physical, economic, legislative, and sociocultural factors.

Nutrient profiling

The science of classifying or ranking foods according to their nutritional composition for reasons related to preventing disease and promoting health.

Sugar-sweetened beverages (CDC)

Sugar-sweetened beverages are any liquids that are sweetened with various forms of added sugars like brown sugar, corn sweetener, corn syrup, dextrose, fructose, glucose, high-fructose corn syrup, honey, lactose, malt syrup, maltose, molasses, raw sugar, and sucrose. Examples include, but are not limited to, regular soda (not sugar-free), fruit drinks, sports drinks, energy drinks, sweetened waters, and coffee and tea beverages with added sugars.

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Design and layout: Mar Nieto

ISBN: 978-976-96088-0-1



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This work was supported by the NCD Alliance as part of the Expanding Access to Care, Supporting Global, Regional and Country Level NCD Action Programme in partnership with Medtronic Philanthropy.



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The work of the HCC would not be possible without the kind support of
Sagicor Life Inc.

