Ministry of Health

Pan American Health Organization

World Health Organization

REGIONAL OFFICE FOR THE Americas

NATIONAL OPERATIONAL ACTION PLAN

FOR THE

PREVENTION AND CONTROL OF OBESITY IN CHILDREN AND ADOLESCENTS

IN

JAMAICA

2016 – 2020

Ministry of Health

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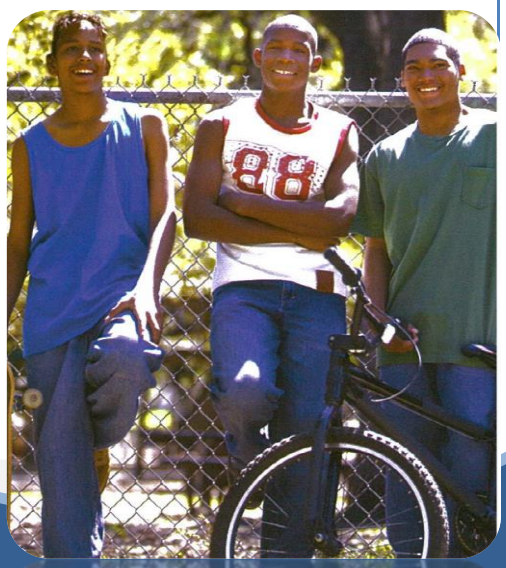


TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

BSJ	Bureau of Standards, Jamaica
CAC	Consumer Affairs Commission
CBO	Community Based Organization
CMO	Chief Medical Officer
DAJ	Diabetes Association of Jamaica
ECC	Early Childhood Commission
FAO	Food and Agriculture Organization
FBO	Faith Based Organization
HPE	Health Promotion and Education
HFLE	Health and Family Life Education
HPP	Health Promotion and Protection
IYCF	Infant and Young Child Feeding
JAPINAD	Jamaica Association of Professionals in Nutrition and Dietetics
LAC	Latin America and the Caribbean
M&E	Monitoring and Evaluation
MICAF	Ministry of Industry, Commerce and Agriculture
MIFP	Ministry of Finance and Planning
MOAF	Ministry of Agriculture and Fisheries
MOH	Ministry of Health
MLG	Ministry of Local Government
MLSS	Ministry of Labour and Social Security
MOEYI	Ministry of Education, Youth and Information
NCDs	Non-communicable Diseases
NERHA	North East Regional Health Authority
NGO	Nongovernmental Organization
NHF	National Health Fund
PAHO	Pan American Health Organization
PHC	Primary Health Care
PIOJ	Planning Institute of Jamaica
RADA	Rural Agricultural Development Authority
RHA	Regional Health Authority
SDC	Social Development Commission
SDF	Sports Development Foundation
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organization

EXECUTIVE SUMMARY

Overweight and obesity have become a major problem in developed and developing countries. Worldwide, obesity has nearly doubled since 1980 and approximately 3.4 million adults die each year as a result of being overweight or obese. The rise in obesity has been attributed to energy imbalances caused by: changes in lifestyle; increased availability and subsequent overindulgence in high calorie food; and sedentary lifestyles. Overweight and obesity are leading risk factor for NCDs and global deaths and are therefore a matter of concern because of the negative impact on the health and quality of life of those affected. The threat of obesity undermines social and economic development and threatens the achievement of internationally-agreed development goals in low-income and middle-income countries.

The issue of overweight and obesity among children is cause for anxiety since overweight and obese children are likely to become obese adults. This has implications for the health care system and the economic productivity of the countries affected as persons who are overweight and obese are at risk of developing health complications, which burden the health care system and put a strain on developing economies.

There is increasing global and regional recognition of the need for effective strategies to prevent and control childhood overweight and obesity. In 2012, the World Health Assembly (WHA) agreed to a target of no increase in childhood overweight by 2025. In May 2014, the Director-General of the World Health Organization (WHO) established a high-level Commission on Ending Childhood Obesity to accelerate the effort to address the issue. A Plan of Action for the Prevention of Obesity in Children and Adolescents was approved at the 53rd Directing Council of the Pan American Health Organization (PAHO/WHO). Its goal is to halt the rise of obesity in children and adolescents. This action recommends a multisectoral life-course approach that is based on the social-ecological model. It focuses on transforming the current obesogenic environment into opportunities for increased intake of nutritious foods and improved physical activity through the implementation of effective policies, laws, regulations, and interventions.

In keeping with these global and regional initiatives and in recognition of the urgent need to take steps to address the problem of overweight and obesity in Jamaica, a workshop to develop this Operational Plan of Action was convened. On July 28-29, 2015 representatives from the governmental health sector and non-health sector, non-governmental organizations, academia and private sector assembled at the Mona Visitor's Lodge, in Kingston. The attendees developed a draft Operational Plan of Action which outlines six lines of action with strategies to address childhood obesity, diet and physical activity-related risk factors and country capacity. This workshop was organized through the collaborative effort of Jamaica's Ministry of Health, and PAHO/WHO.

The National Operational Plan of Action for the Prevention and Control Obesity in Children and Adolescents has been prepared to operationalize the obesity prevention activities of the National Strategic and Action Plan for the Prevention and Control of Non-communicable Diseases (NCDs).

The six lines of action decided on include:

1. Obesity prevention and control in primary health care services
2. Protection, promotion and support of breastfeeding
3. School-based interventions
4. Fiscal policies and regulation of food marketing and labelling
5. Physical activity and health promotion
6. Surveillance, research and evaluation

These lines of action are to be implemented over the period 2016-2020.

I. BACKGROUND

The National Operational Plan of Action for the Prevention and Control Obesity in Children and Adolescents has been prepared to operationalize the obesity prevention activities of the National Strategic and Action Plan for the Prevention and Control of Non-communicable Diseases (NCDs).

A workshop to develop a multisectoral plan for the prevention of childhood and adolescent obesity in Jamaica was convened at the Mona Visitor's Lodge, in Kingston, 28-29 July, 2015 through the collaborative efforts of the Jamaica Ministry of Health and the Pan American Health organization (PAHO/WHO). The process brought together an array of partners from the governmental health sector and non-health sectors, non-governmental organizations, academia and private sector, to review the epidemiological data, evaluate the existing initiatives and to examine and discuss potential challenges and solutions.

The goal of the workshop was to prepare a draft National Action Plan on Childhood and Adolescent Obesity Prevention aligned with the Regional Plan of Action on the Prevention of Obesity in Children and Adolescents and the National NCD Strategic Plan.

The objectives of the workshop were to:

1. Present secondary data on country capacity and existing initiatives to prevent obesity in children and adolescents;
2. Define goals, objectives and activities for a draft action plan on childhood and adolescent obesity prevention;
3. Align the Plan of Action for the Prevention of Obesity in Children and Adolescents with the National Strategic and Action Plan for the Prevention and Control of NCDs and other applicable strategies and action plans related to NCDs and nutrition.
4. Review preparatory information for the High Level Regional Consultation of the WHO Commission on Childhood Obesity

To accomplish these goals and objectives the following steps were followed:

1. Strategic objectives for the Plan of Action were decided on;
2. Working groups aligned strategic objectives of the obesity operational plan with objectives and strategies of the National NCD Strategic Plan;
3. Working groups identified outcomes, activities and indicators.

The workshop outcome was a draft Operational Plan of Action outlining six lines of action with prioritized solutions to address childhood obesity, diet and physical activity-related risk factors

and country capacity. This plan of action will support implementation of the Regional Plan of Action for the Prevention of Obesity in Children and Adolescents, Jamaica's National Strategic and Action Plan for the Prevention and Control of NCDs (2013-2018), and other national strategies and plans relevant to nutrition and NCDs.

Following the workshop a writing group (Annex II) was convened to finalize the draft National Operational Plan of Action. Other steps in the development process include:

1. Circulation of Plan of Action for review;
2. Follow-up workshops with key stakeholders;
3. Submission of Plan of Action for approval.

II. INTRODUCTION

Overweight and obesity have become a major problem in developed and developing countries, with the latter showing a higher prevalence in recent decades. Worldwide, obesity has nearly doubled since 1980 and approximately 3.4 million adults die each year as a result of being overweight or obese.

The fundamental cause of obesity and overweight is an energy imbalance between calories consumed and calories expended. The rise in obesity has been attributed to changes in lifestyle. The increased availability and subsequent overindulgence in high calorie food, improved mechanization and technology have facilitated sedentary lifestyles. Indoor leisure activities have gained popularity with the advent and proliferation of the television, computer, internet and video games, and have dissuaded walking and replaced other outdoor activities. These factors combined, contribute to the energy imbalances which drive the epidemic. (WHO, 2003)

In 2014, World Health Organization statistics reveal that 39% of adults aged 18 years and older were overweight (BMI 25-29.99) and between 1980 and 2014 the prevalence of obesity (BMI ≥30) nearly doubled when more than half a billion adults were classified as obese. The prevalence among this group is highest in the Region of the Americas (61% overweight or obese in both sexes, including 27% obese). In all WHO regions, women are more likely to be obese than men, and over 50% of women in the Americas, are overweight and approximately half of them are obese (WHO, 2014). (See Annex I).

The rise in overweight and obesity is a matter of concern because of its negative impact on the health and quality of life of those affected (Fraser, 2003). Left unchecked, the situation will propel into uncontrollable crisis proportions as obesity is a leading risk factor for NCDs and global deaths.

Forty-four percent (44%) of the diabetes burden, 23% of the ischaemic heart disease burden and between 7% and 41% of certain cancer burdens have been attributed to overweight and obesity (WHO, 2009). The global burden and threat of non-communicable diseases (NCDs) constitute a major challenge for development in the twenty-first century. These threats undermine social and economic development throughout the world and threaten the achievement of internationally-agreed development goals in low-income and middle-income countries. An estimated 36 million deaths, or 63% of deaths that occurred globally in 2008, were due to NCDs. Around 80% of all deaths from NCDs occurred in low- and middle-income countries (WHO, 2014).

Childhood obesity is associated with a higher chance of obesity, premature death and disability in adulthood. In addition to increased future risks, obese children experience breathing difficulties, increased risk of fractures, hypertension, early markers of cardiovascular disease, insulin resistance and psychological effects. The high prevalence of overweight and obesity

among children should therefore be a cause of concern to policy makers and health professionals as it has implications for the health care system and the economic productivity of the countries affected. Treating the co-morbidities of obesity will be a huge economic cost for the developing countries of the Caribbean and will become unsustainable as in some developed countries obesity accounts for 2-7% of health cost. (WHO, 2003; Fraser, 2003; Henry, 2004).

The causes of this epidemic are complex and not fully understood. However, the link between obesity, poor health outcomes and mortality is well established. Much is known about the consequences and actions that must be undertaken to halt it. Over the past decade, many countries in the Region of the Americas, have been putting some of those actions into place. (PAHO, 2015)

There has been an increasing global recognition of the need for effective strategies to prevent and control childhood overweight and obesity. In 2012, the World Health Assembly agreed to a target of no increase in childhood overweight by 2025. In May 2014 the Director-General of WHO established a high-level Commission on Ending Childhood Obesity to accelerate the effort to address the issue.

The Pan American Health Organization (PAHO) has assumed a leadership role in unifying the efforts of supporting Member States by launching a regional public health initiative. Ministers of Health of the Americas approved a Plan of Action for the Prevention of Obesity in Children and Adolescents at the 53rd Directing Council of the Pan American Health Organization. The overall goal of this Plan of Action is to halt the rise of the rapidly growing obesity epidemic in children and adolescents, so that there is no increase in current country prevalence rates. This goal requires a multisectoral life-course approach that is based on the social-ecological model and focuses on transforming the current obesogenic environment into opportunities for increased intake of nutritious foods and improved physical activity. This will be accomplished by implementing a set of effective policies, laws, regulations, and interventions, which will take into account the priorities and context of Member States, in the following strategic lines of action:

1. Primary health care and promotion of breastfeeding and healthy eating;
2. Improvement of school food and physical activity environments;
3. Fiscal policies and regulation of food marketing and labelling;
4. Other multisectoral actions; and
5. Surveillance, research and evaluation.

Changes in dietary and physical activity patterns are often the result of environmental and societal changes associated with development and supportive policies in sectors such as health, agriculture, transport, urban planning, environment, food processing, distribution, marketing and education. Cost-effective policies and interventions have been implemented in various countries to reduce the prevalence of obesity. These include:

- Legislation and national policies to promote breastfeeding, e.g. BFHI, implementation and monitoring of the Code, and protection of breastfeeding in the workplace.
- Taxation schemes on sugar-sweetened beverages and energy-dense nutrient-poor products with the aim of reducing their consumption. Large changes in price can change purchasing habit and are likely to improve health.
- Pricing strategies that offer incentives for purchasing healthier food options.
- Policies that improve the school food environment, in particular national school feeding programs and monitoring/regulating foods sold in schools.
- Agricultural subsidies which encourage fruit and vegetable production that translate into increased consumption of fruits and vegetables and improve dietary patterns.
- Regulations on food marketing to children (type and source).
- Trade and regulatory measures that reduce the availability of unhealthy foods thus changing population dietary patterns.
- Labeling that provides simple visual messages to indicate various food characteristics.

Of course, research is needed to evaluate the effectiveness of these interventions in each country or state. (WHO, 2014)

III. SITUATIONAL ANALYSIS

a) Epidemiology

According to the last Jamaica Health and Lifestyle Survey (JHLSII) 2007-8, 26.4% of adults 15-74 years are overweight (BMI 25-29.99) and 25.3% are obese (BMI ≥30), a 5.6% increase over 2000 (Wilks et al., 2008). Table 1 shows country data taken from the WHO's Global Status Report on NCDs 2014. It indicates increases in mean BMI and prevalence of overweight and obesity between 2010- 2014 among the adult population (WHO, 2014). Jamaican women also have a higher prevalence of NCD risk factors.

The prevalence of overweight and obesity is also increasing in children and adolescents. Between the years 2009 and 2013 it was estimated that 4% of Jamaican children 0-59 months were overweight. Although this is below the average reported for the World (6%) and countries of Latin America and the Caribbean (7%), it is still cause for concern (Table 2).

Table 1: Country estimates of NCD selected risk factors (18+ years), Jamaica

Risk Factor		2010	2014
Mean BMI	*Male*	25.1	25.5
	Female	28.6	29.2
	Both genders	26.9	27.4
Obesity	*Male*	15.4	18
	Female	32.4	35.3
	Both genders	24.1	26.8
Overweight	*Male*	47.9	51.2
	Female	63.0	65.5
	Both genders	55.6	58.4
Insufficient Physical activity	*Male*	23.7	
	Female	32.2	
	Both genders	28.1	

Table 2: Comparison of Indicators of Nutrition status in America & the Caribbean (LAC) & the World

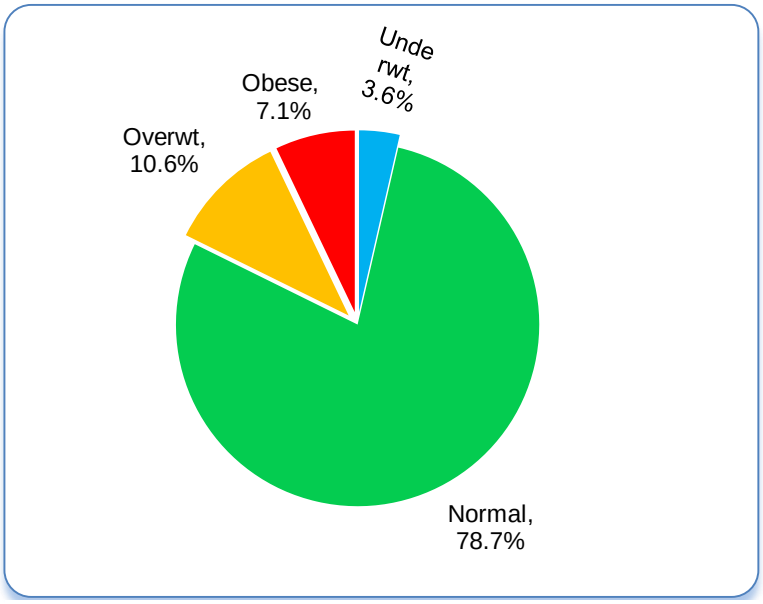
Indicator	Jamaica	World	LAC
	2009-2013	2009-2013	2009-2013
Low birth weight (% < 2500g at birth)	*11*	*16*	*9*
Underweight (% < -2SD Wt-for-age)	*3*	*15*	*3*
Stunting (% < -2SD Ht-for-age)	*5*	*25*	*11*
Wasting (% < -2SD Wt-for-Ht)	*4*	*8*	*1*
Overweight (% >+2SD Wt-for-Ht)	***4***	***6***	***7***

Source: State of the World's Children 2015: Executive Summary.

Findings from research conducted in the North East Regional Health Authority (NERHA) indicate that 18% of children 6-10 years are overweight or obese (See Figure 1). (Blake-Scarlett et al., 2013)

The prevalence of overweight and obesity is also high among Jamaican Adolescents. Statistics collated from Jamaican Youth Risk and Resiliency Surveys 2005 and 2006 show a prevalence of 11% among children 10-15 years and 25% among 15-19 year olds (Wilks, 2007). The Global School-Based Student Health Survey (2010) revealed that among students 13-15 years the prevalence of overweight and obesity is approximately 28% (WHO, 2010).

Figure 1: BMI Distribution of Children 6-10 years – North-East Health Region (NERHA) Jamaica



Source: Blake-Scarlett et. al., 2013

Table 3: Weight Status of Adolescents 10-19 Years – Jamaica

Indicators	Jamaican Youth Risk and Resiliency Behaviour Survey		Jamaica Global School Health Survey
	2005 10-15 years	2006 15-19 years	2010 13-15 years
Overweight & Obesity (%)	11	25	27.7
Underweight (%)	6.4	15.5	2.1

b) Dietary practices

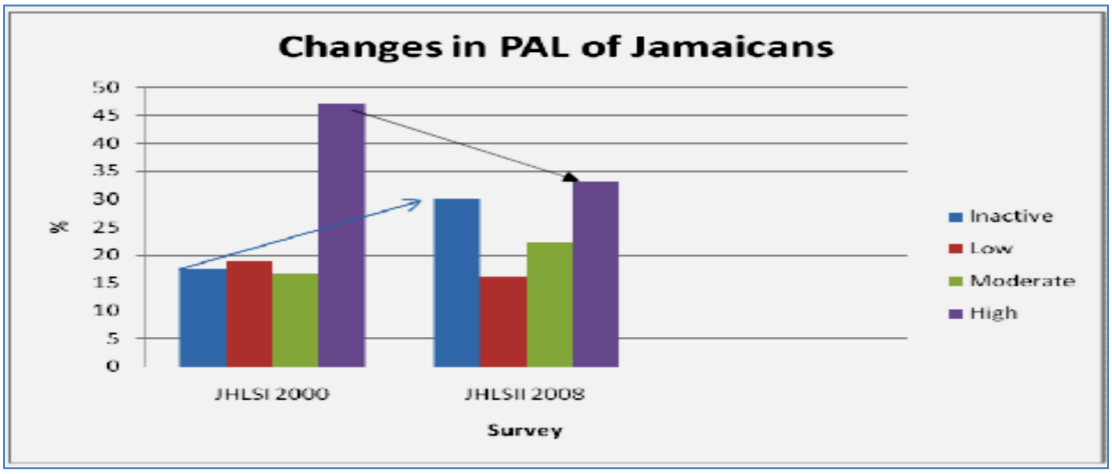
The rise in overweight and obesity is a consequence of a number of changes in children's behaviours with regards to diet and physical activity. The Global School-based Student Health Survey of 2010 showed that 71.8% ate fruit and vegetables less than five times per day, 72.5% of students drank carbonated soft drinks one or more times per day and 22.9% ate fast food 3 or

more days during the past 7 days (WHO, 2010). Consumption of carbonated soft drinks and fast foods was significantly higher in Jamaica than in other countries of the world.

c) Physical activity

As overweight and obesity increase, there has been a corresponding decrease in physical activity. Figure 2 shows changes in physical activity among Jamaicans 15-74 years. Over the 8-year period 2000-2008, inactivity increased by 13% while persons whose activity level was classified as high decreased by 14%. The Jamaican Youth Risk and Resiliency Behavior Survey (2006) reveal that among youths 15-19, 47.5% are involved in high levels of physical activity while 30.6% is low (Wilks et al., 2007). There are also concerns about the level of inactivity among young children, especially while attending school. Anecdotal evidence indicates that involvement in physical activity is sacrificed for the pursuit of academic excellence as children are restricted to classrooms during the period they are preparing for national assessments.

Figure 2: Changes in Physical Activity Levels of Jamaicans 15-74 years 2000-2008, JHLS II 2008

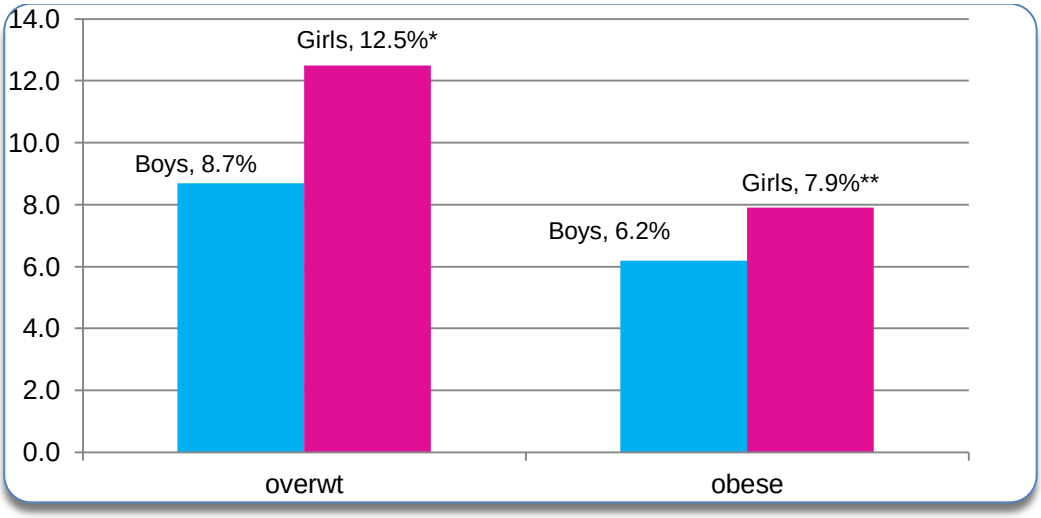


Source: Wilks et al., 2008

d) Social determinants of obesity

Research suggests an association between overweight and obesity in childhood and social determinants such as gender, household income, parental occupation and education. Higher prevalence of overweight and obesity was reported among 6-10 year old girls residing in NERHA (Girls, 20.4%; Boys, 14.9%) (See Figure 3). The situation was similar among 18-20 year olds where the prevalence was 20% among males and 30% for females. Findings also suggest that overweight and obesity is higher among adolescents males from lower income families with parents of a low educational levels and are semi or unskilled. (See Table 3). (Francis et. al.)

Figure 3: Prevalence of Overweight and Obesity among Children 6-10 years by gender- NERHA



Source: Blake-Scarlett et.al., 2013

Table 4: The Association between adiposity and youth, parents and family characteristics

		Overweight/Obesity (%)		
Characteristic	**Category**	**Male**	**Female**	**All**
Sex	Male			19.58
	Female			30.2
Household income	Low	18.37	39.26	32.17
	Medium	15.69	31.85	24.89
	High	43.59	21.74	31.76
Parental Occupation	Semi/unskilled	12.77	41.96	28.64
	Skilled	19.30	27.15	23.72
	Highly Skilled	25.61	23.30	24.32
Parental Education	Primary/lower	21.05	45.31	36.27
	Secondary	16.92	28.13	22.91
	Tertiary	25.93	34.55	24.92

Source: Francis et.al. (2009).

e) Opportunities and Challenges

Primary Health Care

Many primary care facilities are not properly equipped to conduct proper nutritional and other types of assessments; however international partners and NGOs offer assistance and private health care providers fill some of the gaps. This poses a problem for the development of an effective surveillance system as there is little reporting of health data from these sources. It is hoped that screening and assessment services offered in primary health care will improve from the implementation of The Programme for the Reduction of Maternal and Child Mortality (PROMAC) an EU funded project aimed at improving maternal and child care services through the upgrade of health centers. (PIOJ, 2014)

Physical activity

Physical education is a core subject of the school curriculum for students up to the grade 9 level however it is not considered a priority as the time allotted is short and sometimes it is sacrificed to allow more time for academic pursuits. Students especially girls are also reluctant to participate.

The sport system is poorly structured. Previously urban planning and development made little allowances for green spaces and infrastructure that support physical activity at the community level. Across the island there are upwards of 800 sport fields and 500 community centers however many are in a state of disrepair or they are not being properly managed. Several sports are played in Jamaica and there are some 40 sporting associations and federations but coordination is lacking at the national level and participation in a desired sport can also be a challenge due to prohibitive costs and poor access to the required infrastructure. (Samuda, 2014)

Nutrition and dietary practices

Nutrition is included in the school's science, HFLE and food and nutrition curricula from pre-school to the secondary level. It covers a wide range of topics such as: food nutrients, importance and sources, food groups, nutrition fact labels, food preparation etc. Some educators however have limited knowledge of nutrition and are not equipped to convey the important concepts. There is also a plethora of unqualified persons offering nutrition advice which is the result of poor or inadequate monitoring by the registration body for nutrition personnel.

At present standards exist for nutrition labeling however it is not a not a requirement for locally produced foods. Compliance with such a regulation will require constant monitoring and stringent enforcement.

Research

The country has an impressive cadre of qualified researchers however research is not always considered a priority and therefore little funding is made available for these activities.

IV. JAMAICA'S RESPONSE TO OBESITY: POLICIES AND PROGRAMMES IN PLACE

Jamaica has instituted many programmes and policies and initiated several strategies and activities to prevent and respond to childhood obesity. These programmes, activities and policies are listed below:

Policy and Advocacy

- Healthy Lifestyle Policy and Strategic Plan implemented from 2004-2008
- Schools Health Enhancement Committee established in 2009
- Abolition of User Fees at government health facilities in 2007 (partial) and 2008 (full)
- Early Childhood Commission (ECC) and National Strategic Plan for the early childhood sector with a Child Health and Development Passport implemented in 2010.
- National Health Policy 2006 – 2015
- Food Security and Nutrition Policy (2006) - a joint effort between the Ministries of Agriculture and Health
- National Infant Feeding Policy (1995)
- Programme for Advancement Through Health and Education (PATH) – Launched 2002
- School feeding policy has been drafted.

Healthy Diet

- Schools Nutrition Pilots (2003, 2006): Developed Procedures & Operations Manuals on: Nutrient & Meal Standards, Cycle Menus, and Recipes & Ingredients Lists
- Modernization of the School Feeding Program project which is concerned with developing implementing standardized recipes and menus based on age appropriate recommended dietary allowances (RDAs).
- Review and adaptation of best practices through bilateral technical cooperation activities such as south-south cooperation with Brazil for the purpose of improving the school feeding program.
- Strengthening of inter-ministerial collaborations (Ministries of Education, Health and Agriculture) to advance the school feeding agenda.
- Guidelines for promotion of healthy eating options in the operation of tuck shops and canteens
- The School Health Enhancement Committee, co-chaired by the Ministries of Education and Health has developed criteria for healthy schools, which include nutrition as a vital component.

- Nutritional Standards for the Operation, Management and Administration of Early Childhood Institutions
- Food Based Dietary Guidelines for the Population were launched in early 2015.
- Implemented Exclusive Breastfeeding Pilot Project in St. Catherine and Clarendon and implementation of the Baby Friendly Hospital Initiative at government hospitals
- Nutritional management in some health centres and hospital clinics by staff nutritionists
- The Caribbean Food and Nutrition Institute Jamaica Protocol for the Nutritional Management of Obesity, Diabetes and Hypertension in the Caribbean (launched in 2004)
- The MOAF lobbies on behalf of farmers for ready markets such as School Feeding Program.
- Access to healthy foods enhanced with the Implementation of Farmers' Markets.
- Ongoing Eat What You Grow campaign.
- Discussions regarding regulation of food marketing have been initiated. A concept paper on nutrition labelling has been drafted for submission to Cabinet. Discussions have been initiated with the standard setting body (Bureau of Standards Jamaica), academia and the food industry.

Physical Activity

- National campaign promoting physical activity under the Healthy Lifestyle project 2004-2008
- Caribbean Wellness Day – programmes focused on increasing physical activity
- Mandatory physical education in school curriculum up to grade 9.
- National Cheerleading Initiative in High Schools - Promoted physical activity in High Schools targeting girls however boys were involved.
- Healthy Lifestyle Camp - The main focus of the camp was physical activity although other areas were taught.
- National Dance Competition - Promoted physical activity amongst out of school youth
- The formation of Healthy Lifestyle Clubs in High Schools - This included physical activity as the main component but involved students being engaged in a healthy lifestyle project and presentation.
- The establishment of Healthy Zones - A jogging trail, stretch area, landscaping and fencing were done to open spaces that were accessible to surrounding communities for physical activity
- Celebrating Health Festivals - This was done prior to the genesis of Caribbean Wellness Day – There was a targeted focus on physical activity through a 5k Fun walk/run as well as several demonstrations regarding different types of physical activity
- Move for Health Day activities - These were initiatives that were done across the island to promote physical activity to the general public, patients and staff.
- Other multisectoral actions include frequent 5K and/or 10K walk/run races across the island.

Other programmes

- Camp-4 - the Healthy Way: targeted obese adolescents with intervention including: promotion of physical activity, mental health, and nutrition counselling.
- Life style in Schools 2004 -2008 Implementation of the Health and Family Life Education Curriculum 2008 for grades 1-9

Chronic Disease Surveillance and Management

Special surveys conducted include:

- Youth Risk and Resiliency Behaviour Survey 2005 and 2006
- Global School-based Student Health Survey
- Health Promoting Schools Survey (2011) – sub-national survey of select secondary/high schools
- Global School Health Survey 2010 - routine surveillance system.

V. STRATEGIC PLAN

a) Scope

Obesity has adverse health consequences from the early stages of life and overweight or obese children have a greater risk of remaining overweight or obese in older years. This Operational Plan of Action focuses on the prevention of obesity in children and adolescents. The plan will be implemented through multisectoral population-based policies and interventions that promote lifestyle changes such as regular physical activity and healthy diet.

b) Purpose

This Operational Plan of Action complements and supports the implementation of the National Strategic and Action Plan for the Prevention and Control of NCDs in the area of obesity prevention in children and adolescents. It is a roadmap with concrete results and activities, responsible institutions and a timeline.

c) Vision

Healthy Jamaican children and adolescents, living in healthy communities with optimal quality of life.

d) Mission

To facilitate opportunities for all Jamaican children and adolescents to live a healthy life by implementing integrated, "whole of society" actions to promote social and environmental policies and systems improvement that support health in all places; thus improving national productivity and development.

e) Overarching principles and approaches

The following core principles will guide this Operational Action Plan:

- Leadership and Governance
- Integration into national development and economic agenda and plan
- Health in All Policies
- Promotion of " Whole of Society", multisectoral partnerships and actions
- Universal access, equity and gender equality.

- Reorientation of health systems and reinforcing competence of Health workforce.
- Emphasis on health promotion, education, primary prevention, early detection, treatment, rehabilitation and quality of care for children and adolescents who are overweight, obese or at risk.
- Integrated disease prevention and control
- Building capacity for community based action and empowerment of people.
- Consideration of a life course approach in obesity prevention and control policies and programmes,
- Evidence-based or evidence-informed

f) Goal

The goal of the operational plan of action is to reduce the prevalence of obesity in children and adolescents by 5% by 2020.

g) Timeframe

The operational plan of action will be implemented over the period 2016 – 2020 and the Ministry of Health together with other relevant sectors will support its implementation.

h) Lines of Action

The plan includes these lines of action:

1. Obesity prevention and control in primary healthcare settings
2. Protection, promotion and support of breastfeeding
3. School-based interventions
4. Fiscal policies and regulation of food marketing and labelling
5. Physical activity and health promotion
6. Surveillance, research and evaluation

i) Implementation

The plan will be implemented on a phased basis over the five-year period.

- Phase I - Short-term, these are actions to be implemented over one to two years
- Phase II – Medium-term actions to be implemented over three years
- Phase III - Long-term actions to be implemented over five years

Adjustments may be made periodically to this phasing depending on existing resources and evidence.

j) Monitoring and evaluation

Monitoring and Evaluation is a critical component of any plan that allows for assessment of progress in achieving targets and identification of gaps and strengths in the response.

A comprehensive monitoring and evaluation plan will be developed to guide the Childhood Obesity Prevention Taskforce/Committee which will be established to monitor the implementation of the operational plan.

The table below outlines the lead indicators and targets for the plan.

Table 5: National Operational Action Plan for the Prevention and Control of Obesity in Children and Adolescents in Jamaica: Lead Indicators and Targets

Lead Indicator	Target (2020)
Percentage of facilities that screen, educate, treat and refer at risk, overweight and obese infants, children and adolescents.	70%
Percentage PHC facilities offering family-oriented obesity prevention activities throughout the life course.	90%
Percentage of vulnerable districts with programmes for family and community support groups	20%
HFLE curriculum implemented in all schools and physical education taught in all schools at all levels.	100%
School Feeding Policy approved and implemented in all schools.	100%
Percentage of schools with active community involvement in school wellness programme	50%
Legislation for implementing tax measures on SSBs and energy dense, nutrient poor foods.	Legislation promulgated
Legislation for restricting the marketing of foods and non-alcoholic beverages to children enacted	Legislation promulgated
Percentage of relevant processed foods with front package nutrition labelling	100%
Percentage of food establishments displaying nutrition information.	80%
Percentage of children and adolescents reporting moderate to high PA levels	60%
Percentage of public schools reporting data on overweight, obesity and under-nutrition.	50%

Overall the accomplishment of these targets should result in a:

- 5% relative reduction in the prevalence of insufficient physical activity in adolescents;
- 5% relative reduction in the prevalence of obesity in adolescents;
- 5% relative reduction in the prevalence of childhood overweight.

VI. OPERATIONAL PLAN OF ACTION

LINE OF ACTION 1: Obesity Prevention and Control in Primary Healthcare Services

Outcomes:

1. Improved quality of services for obesity prevention and control;
2. Increased utilization of services for obesity prevention and control;
3. Increased levels of physical activity and healthy eating for internal and external clients throughout the life course;
4. Increased availability of healthy food options in and around health facilities;
5. Increased collaboration in community-based interventions for healthy lifestyle;

Results and Indicative Activities		**Target**	**Responsible**	**2016**	**2017**	**2018**	**2019**	**2020**
Result 1.1	**Indicator**							
Increased capacity for screening, education, treatment and referral of at risk, overweight and obese: ∗ infants and young children (<5 years) using child welfare services; ∗ children 5 – 9 years using paediatric and curative services; and, ∗ adolescents using curative services.	I. Percentage of facilities that screen, educate, treat and refer at risk, overweight and obese: ∗ infants and young children (<5 years) from child welfare services ∗ children 5 – 9 years from paediatric and curative services; and, ∗ adolescents from curative services	 100% 80% 70%	MOH					

Results and Indicative Activities		Target	Responsible	2016	2017	2018	2019	2020
	II. Percentage accessing services * infants and young children <5 years * children 5 – 9 years * adolescents 10-19 years	 ? ? 30%	MOH					
Activities								
1.1.1 Adapt treatment guidelines for the management of overweight and obesity in infants, children and adolescents.			MOH	*	*			
1.1.2 Review and update referral protocols for at risk, overweight and obese infants, children and adolescents.			MOH	*	*			
1.1.3 Train HCWs in the use of treatment guidelines and referral protocols for infants, children and adolescents.			MOH		*	*	*	*
1.1.4 Train HCWs in the use of age and gender specific WHO Growth References			MOH	*	*	*	*	*
1.1.5 Conduct equipment audit			RHA , MOH	*	*			
1.1.6 Provide food models, age and gender specific growth charts, length boards, scales and stadiometers where needed.			RHA, MOH	*	*	*	*	*
1.1.7 Develop communication plan regarding child and adolescent obesity (e.g. key messages, display boards, and IEC materials)			MOH, MOEYI, NGOs	*	*			
1.1.8 Establish family and community support for at risk, overweight and obese infants, children and adolescents. (Nutritionists, Social workers)			MOH, MLSS, MOEYI, MONS, MLG , SDC	*	*	*		
1.1.9 Reintroduce the Camp-4-the-Healthy-Way concept (a specialized behaviour modification			MOH, NHF, NGOs, IDPs	*	*	*	*	*

Results and Indicative Activities		Target	Responsible	2016	2017	2018	2019	2020
programme) for at risk, overweight and obese children and adolescents.								
Result 1.2	**Indicator**							
Increased capacity of Primary Health Care (PHC) services to incorporate family-oriented obesity prevention activities, including promotion of healthy eating and physical activity throughout the life course.	Percentage PHC facilities offering family-oriented obesity prevention activities throughout the life course	90%	MOH					
Activities								
1.2.1 Adapt physical activity guidelines and implement exercise prescription into primary health care services			MOH	*	*			
1.2.2 Train HCW in the use of Food Based Dietary Guidelines			MOH	*	*			
1.2.3 Regulate and monitor access to healthy foods in and around health facilities (incl. vending machines)			MOH	*	*	*	*	*
1.2.4 Conduct food demonstrations for preparation of low cost nutritionally adequate meals			MOH, RADA, MLSS, MOEYI (PSC)	*	*	*	*	*

LINE OF ACTION 2: Protection, Promotion and Support Of Breastfeeding

Outcomes:

1. Increased rate of early initiation of breastfeeding
2. Increased rate of exclusive breastfeeding for 6 completed months

Results and indicative activities		**Target**	**Responsible**	**2016**	**2017**	**2018**	**2019**	**2020**
Result 2.1	**Indicator**							
Social marketing campaign on breastfeeding implemented and evaluated	Percentage of target groups who have heard the messages about the benefits of breastfeeding	80%	MOH					
Activities								
2.1.1 Conduct qualitative market research to determine perceptions about the benefits and challenges of breastfeeding.			MOH	*				
2.1.2 Revise the HFLE Curriculum in schools to include benefits of breastfeeding.			MOEYI, MOH	*				
2.1.3 Develop and integrate module for training teachers about breastfeeding to strengthen content and delivery at the school level.			MOEYI, MOH		*	*		
2.1.4 Develop and integrate modules on breastfeeding in the curriculum of health education, public health and agricultural professionals.			MOH	*	*			
2.1.5 Develop and integrate modules on breastfeeding in curriculum for medical doctors and nurses and provided MOH endorsed certification.			MOH	*	*			

Results and indicative activities		Target	Responsible	2016	2017	2018	2019	2020
2.1.6 Develop social marketing plan to promote breastfeeding initiatives.			MOH HRM	*				
2.1.7 Convene technical working group to coordinate implementation of social marketing plan.			MOH Communication Officer	*				
2.1.8 Increase cadre of skilled personnel to support infant and young child feeding.			MOH –HRM, RHAs	*	*			
2.1.9 Develop policy guideline to support mother friendly workplaces and parenting places in school.			MOH, MLSS, MOEYI, PSC	*	*			
Result 2.2	**Indicator**							
Baby Friendly Hospital Initiative implemented	Percentage of hospitals certified	50%						
Activities								
2.2.1 Establish hospital infant and young child feeding committees to drive the BFHI certification.			MOH	*	*	*		
2.2.2 Develop implementation plan for BFHI at hospital level			Hospital IYCF Committee	*	*	*	*	*
2.2.3 Establish algorithm to strengthen linkages among stakeholders.			MOH	*	*			
2.2.4 Train all members of staff on BFHI and hospital policy.			Hospital IYCF Committee	*	*	*	*	*
2.2.5 Document hospital policy and orientation process			Hospital IYCF committee, RHAs, MOH	*	*			
2.2.6 Conduct hospital self-appraisal and monitoring			Hospital IYCF Committee	*	*			
2.2.7 Monitor the use of breastfeeding substitutes in hospitals			Hospital IYCF Committee	*	*	*	*	*

Results and indicative activities		Target	Responsible	2016	2017	2018	2019	2020
2.2.8 Publish a list of certified Baby Friendly Hospitals			MOH	*	*	*	*	*
2.2.9 Design and implement checklist for antenatal education at all institutions providing maternal health care			National IYCF Committee, Hospital IYCF Committee	*				
Result 2.3	**Indicator**							
International Code of marketing of breast milk substitutes implemented and monitored	Legislation adopted. Timely monitoring of reports	Promulgation of legislation						
Activities								
2.3.1 Develop legislation for the marketing of breastmilk substitutes.			MOH - HPPB, Policy	*	*			
2.3.2 Develop public education campaign about the International Code of marketing of breast milk substitutes			MOH (HEP)	*	*			
2.3.3 Develop strategy for monitoring commercial marketing of breast milk substitutes.			Hospital IYCF Committee	*	*			
2.3.4 Develop sanctions for accepting breast milk substitute that is in breach of the International Code of marketing breast milk substitute			MOH Legal Unit	*	*			
2.3.5 Develop a training programme for early childhood institutions/employees in infant and young child feeding			ECC Nutrition Committee	*	*			
Result 2.4	**Indicator**							
Family and community support groups organized and	Percentage of districts with programmes for family and community support groups	20%						

Results and indicative activities	Target	Responsible	2016	2017	2018	2019	2020
functioning at community level							
Activities							
2.4.1 Develop TOR for parish infant and young child feeding committees		National IYCF Committee	*				
2.4.2 Develop TOR for community breastfeeding support groups		National IYCF Committee	*				
2.4.3 Establish parish infant and young child feeding committees		MO(H)	*				
2.4.4 Establish community breastfeeding support group from already existing groups (church groups/ youth clubs etc.)		Parish IYCF Committee	*	*			
2.4.5 Conduct training of community breastfeeding support group		Parish IYCF Committee	*	*	*	*	*
2.4.6 Establish linkages between community breastfeeding support group and breastfeeding promoters		Parish IYCF Committee	*	*	*	*	*

LINE OF ACTION 3: School/Community-based interventions

Outcomes:

1. Increased knowledge about healthy diets and benefits of physical activity
2. Improved dietary habits and physical activity levels of school-aged children

Results and indicative activities		**Target**	**Responsible**	**2016**	**2017**	**2018**	**2019**	**2020**
Result 3.1	**Indicator**							
Amend Education and Public Health Acts to include provisions for school health/wellness. (Components: healthy diet, school vending, physical education)	Public Health and Education Acts amended. School Wellness legislation approved and promulgated. School Wellness policy developed.							
Activities								
0.0.1. Revitalize the School Health Enhancement Committee for Health Promoting Schools (HPS).			MOH, MOEYI	*				
0.0.2. Draft policy brief for school health/wellness legislation.			MOH, MOEYI	*				
0.0.3. Prepare Cabinet Submission for amendment to Education Act.			MOEYI, MOH		*			
0.0.4. Sensitize stakeholders, generate support for amendments to Acts			MOH, MOEYI, PIOJ, NGOs	*	*			

Results and indicative activities		Target	Responsible	2016	2017	2018	2019	2020
0.0.5. Compile and submit recommendations for school health/wellness legislation.			MOH, MOEYI		*			
0.0.6. Amend Public Health Act to include school health/wellness regulation.			MOH			*	*	*
0.0.7. Amend Education Act to include school health/wellness regulation.			MOEYI			*	*	*
0.0.8. Develop School health/wellness policy			MOH, MOEYI, PIOJ		*	*		
0.0.9. Identify and allocate resources (physical, human, financial) for implementation of policy at all schools.			MOH, MOEYI, PIOJ	*	*	*	*	*
Result 3.2	**Indicator**							
Nutrition and physical activity incorporated in the school curriculum	HFLE curriculum implemented in all schools. Physical education taught in all schools from Pre-primary to secondary.	100% 100%	MOEYI					
Activities								
3.2.1 Build capacity of teachers to implement diet and fitness components of the HFLE curriculum.					*	*	*	*
3.2.2 Implement the diet and fitness components of the revised HFLE in all types and levels of school from Pre-primary to secondary.			MOE, ECC and institutions they supervise, MOH, Other stakeholders	*	*	*	*	*

Results and indicative activities		Target	Responsible	2016	2017	2018	2019	2020
3.2.3 Advocate for implementation of diet and fitness component of HFLE curriculum in private schools.			MOEYI, Private schools, Stakeholders	*	*	*		
3.2.4 Strengthen and expand PE curriculum to include wider variety of sports/physical activities			MOEYI		*	*		
3.2.5 Build capacity of teachers to implement expanded PE curriculum.			MOEYI		*			
3.2.6 Implement expanded PE curriculum in all types and levels of school from Pre-primary to secondary.			MOEYI		*	*		
3.2.7 Conduct sensitization workshops/seminars to inform parents about the importance and benefits of physical activity for children.			MOEYI		*	*	*	*
3.2.8 Build capacity of student leaders through training in peer education			MOEYI		*	*	*	*
Result 3.3	**Indicator**							
Standards for school feeding programmes in place according to FBDGs and PAHO's nutrient profiling	School Feeding Policy approved and implemented in all schools Periodic monitoring and timely reports	100%						
Activities								
3.3.1 Approve and implement the School Feeding Policy.			MOEYI		*			
3.3.2 Develop and implement system for reporting on school feeding programme			MOEYI		*	*	*	*
3.3.3 Recruit and train nutrition personnel in the use of school feeding policy guidelines			MOEYI		*	*	*	*

Results and indicative activities		Target	Responsible	2016	2017	2018	2019	2020
3.3.4 Train School Feeding Focal Points in schools in the use of school feeding policy guidelines			MOEYI		*	*	*	*
3.3.5 Periodic inspection of and reporting on school feeding programmes offered in schools by nutrition personnel.			MOEYI		*	*	*	*
Result 3.4	**Indicator**							
Families and communities actively involved in the school wellness programme	Percentage of schools with active community involvement in school wellness programme.	50%	MOEYI, MOH, Schools, MOAF, other stakeholders					
Activities								
3.4.1 Educate and train school vendors on healthy food choices for children.			MOEYI, Parish Council, MOH, SDC, 4-H, MOS	*	*	*	*	*
3.4.2 Investigate community structures (SDC, SDF, 4-H, RADA, NPTA, National Parenting Commission, community and service, social clubs etc.), to determine existing health/wellness related activities and programmes.			MOH, Parish Council, SDC, MOEYI	*	*	*	*	*
3.4.3 Initiate national school campaign on healthy eating and active living highlighting the National FBDGs and physical activity guidelines.			SDC, SDF, 4-H, RADA, NPTA, National Parenting Commission Media, private sector	*				
3.4.4. Establish school gardens and encourage linkages between schools and community farmers for supply locally grown produce for school feeding programmes.			4H Clubs, RADA, MOA, PTA, Community Assoc.	*	*	*	*	*

Results and indicative activities	Target	Responsible	2016	2017	2018	2019	2020
3.4.5 Conduct school health fairs and wellness seminars, e.g. at PTA meetings to inform community/parents of the importance of healthy eating and active living.		MOEYI, SDC, MOH, RHA, NHF	*	*	*	*	*
3.4.6 Establish school-community, regional and national wellness competitions (sport days, exhibitions, cheerleading etc.)		MOEYI, SDC, PTA, Corporate sponsors, MOH-HPE, NHF	*	*	*	*	*
3.4.7 Establish after-school physical activity programmes for school and community members.		SDF, SDC, PTA, School clubs and Societies		*	*	*	*

LINE OF ACTION 4: Fiscal policies and regulation of food marketing and labelling

Outcomes:

1. Reduced consumption of energy dense, nutrient poor foods and beverages and increased consumption of fresh fruits and vegetables
2. Reduced exposure to marketing of energy dense, nutrient poor foods and beverages
3. Improved consumer information in order to make informed healthy choices

Results and indicative activities		**Target**	**Responsible**	**2016**	**2017**	**2018**	**2019**	**2020**
Result 4.1	**Indicator**							
Legislation promulgated for implementing tax measures on SSBs and energy dense, nutrient poor foods and beverages.	Legislation for implementing tax measures on SSBs and energy dense, nutrient poor foods. Enforcement strategy developed. Percentage increase in retail prices of SSBs through taxation.	Legislation approved and promulgated.						
Activities								
4.1.1 Review international best practices with respect to taxation on sugar/SSBs to reduce sugar to determine fiscal policies that are feasible for local situation[1].			MOFP, MOH, MICAF	*	*			

[1] Suggested options: (a) Taxation on sugar at point of import or production (≥20%); (b)Taxation on retail price of SSBs by content or volume (≥20%); (c) Increase taxation on energy dense, nutrient poor and foods; (d) Tax exemption or incentives for healthy, nutrient dense foods and beverages; (e) Agricultural subsidies that encourage increased production and consumption of fruits and vegetables and (f) Special tax breaks to organizations that support obesity prevention programmes or implement wellness initiatives for employees and their children.

Results and indicative activities		Target	Responsible	2016	2017	2018	2019	2020
4.1.2 Adapt and implement PAHO/WHO system of nutrient profiling for Jamaica			MOH; MICAF, (SRC) MOA, (MOF customs importations)	*	*	*	*	*
4.1.3 Conduct tax-economic evaluation of proposed fiscal policy on SSBs and energy dense, nutrient poor foods.			MOH, MOF		*			
4.1.4 Draft policy brief with assistance from PAHO/WHO and technical experts			MOH		*			
4.1.5 Conduct high-level advocacy for support for new tax measures.			MOH, NGOs		*			
4.1.6 Compile and submit recommendations to MOF.			MOH		*			
4.1.7 Amend legislation to include new tax measures on SSBs and energy dense, nutrient poor foods.			MOF		*	*		
Result 4.2	**Indicator(s)**							
Legislation adopted for restricting the marketing of foods and non-alcoholic beverages to children	Legislation for restricting the marketing of foods and non-alcoholic beverages to children enacted Enforcement strategy developed	Legislation adopted. Marketing of foods and non-alcoholic beverages to children restricted.						

Results and indicative activities		Target	Responsible	2016	2017	2018	2019	2020
Activities								
4.2.1 Identify unhealthy foods and beverages using nutrient profiling for Jamaica.			MOH, PAHO, CARPHA	*				
4.2.2 Conduct a situational analysis of marketing practices targeting children.			MOH, CAC,	*		*		*
4.2.3 Make recommendations for standard development for marketing of foods and non-alcoholic beverages to children.			MOH, BSJ, Broadcasting Comm., CAC	*				
4.2.4 Draft policy brief with assistance from PAHO/WHO and technical experts.			MOH, PAHO	*				
4.2.5 Conduct high-level advocacy and consultations to generate position papers and support for new marketing legislation.			MOE, MOH, MOEYI, NGOs, Food Industry Task Force	*				
4.2.6 Compile and submit recommendations to MoF.			MOH	*				
4.2.7 Establish a monitoring system to ensure compliance.				*				
4.2.8 Establish clear definition of sanctions and system for reporting complaints			MOJ, Consumer Affairs Comm., Broadcasting Comm., Bureau of Standards, MOH	*				
Result 4.3	**Indicator**							
Front of package nutrition labelling implemented	Percentage of relevant processed foods with front package nutrition labelling – Imported – Local	 100% 100%	BSJ, Customs, MOH					
Activities								

Results and indicative activities		Target	Responsible	2016	2017	2018	2019	2020
4.3.1 Committee formed to review nutrition labelling standards to make amendments				*				
4.3.2 Make recommendations to labelling committee for adoption			MOH, BSJ	*	*			
4.3.3 Draft policy brief with assistance from PAHO/WHO and technical experts			MOH	*	*			
4.3.4 Submit revised labelling standard for approval and gazetting			MOH		*			
4.3.5 Implement mandatory front of package labelling for all pre-packaged foods and beverages.			MOH, Bureau of Standards, JBDC MOA, Ministry of Trade & Industry		*			
4.3.6 Establish a monitoring system to ensure compliance with labeling standard.					*	*	*	*
4.3.7 Establish a system of healthy food branding.				*	*			
4.3.8 Implement a social marketing campaign regarding food labelling					*	*	*	*
Result 4.4	**Indicator**							
Nutrition information on foods served by institutions and quick service restaurants.	Percentage of food establishments displaying nutrition information.	80%						
Activities								
4.4.1 Conduct survey on food establishment displays			CAC, MOH	*				
4.4.2 Determine specifications for displays			MOH, BSJ		*			
4.4.3 Develop policy requiring adequate nutrition information on foods served by restaurants and fast food outlets				*	*			
4.4.4 Review for inclusion in relevant law					*	*		

Results and indicative activities	Target	Responsible	2016	2017	2018	2019	2020
4.4.5 Implement monitoring system to ensure compliance					*	*	*
4.4.6 Training of enforcement team.				*	*		
4.4.7 Sensitize key stakeholders including food handlers permit training.				*	*		

LINE OF ACTION 5: Physical Activity and Health Promotion

Outcomes:

1. Increased number of children and adolescents meeting the physical activity recommendation of minimum 60 minutes daily of moderate-intensity physical activity.
2. Increase the promotion of nutrition information while ensuring consumption of available and accessible nutritious foods.

Results and indicative activities		**Target**	**Responsible**	**2016**	**2017**	**2018**	**2019**	**2020**
Result 5.1	**Indicator**							
Behaviour change communication campaign conducted to promote physical activity (PA)	Percentage of children and adolescents reporting moderate to high PA levels.	60%						
Activities								
5.1.1 Conduct baseline research to determine existing areas where PA is promoted or conducted.			MOH, MOEYI, MLG	*	*			
5.1.2 Review all legislation and policies that relate to promoting PA			MOH, MOEYI, MLG	*	*			
5.1.3 Partner with Ministry of National Security (MNS), Ministry of Local Govt. (MLG), the community and civil society to create safer environments.			MOH, MOEYI, MLG, MNS, CBOs	*	*	*	*	*
5.1.4 Develop campaign strategy for promoting PA.			MOH, Media		*	*		
5.1.5 Establish support systems to encourage involvement in PA (clubs, buddy system, hotline, etc.)			MOH, MOEYI, MLG, CBOs		*	*	*	
5.1.6 Mobilize and educate community members about the importance to participate in physical activity.			MOH, MOEYI, MLG, CBOs	*	*	*	*	*

Results and indicative activities		Target	Responsible	2016	2017	2018	2019	2020
Result 5.2	**Indicator**							
Access to physical activity included in urban planning and transportation policies	Existing policies and guidelines reviewed and updated to include provisions for physical activity.	Updated policies and guidelines						
5.2.1 Review NEPA Manual/Guidelines regarding PA to determine feasibility of recommendations.			MOH	*	*			
5.2.2 Review all legislation and policy documents relating to facilitating PA			MOH	*	*			
5.2.3 Conduct base-line research to identify communities that have green spaces for physical activity.			MOH, SDC	*	*			
5.2.4 Enforce existing guidelines and legislation			MLG	*	*	*	*	*
Result 5.3	**Indicator**							
Criteria developed for school and community-based programmes that promote healthy living (PA and healthy eating)	Documented criteria							
Activities								
5.3.1 Conduct baseline research to identify facilities available for physical activity programmes in schools/communities and their utilization status.			MOH, SDC, MOEYI	*	*			
5.3.2 Develop framework for collaborative working relationships to improve variety and			MOH, MOEYI, SDC		*	*		

Results and indicative activities	Target	Responsible	2016	2017	2018	2019	2020
adequacy of PA available for children and adolescents.							
5.3.3 Engage NGOs, CBOs and FBOs in developing community-based healthy lifestyle (PA and nutrition) programmes.		MOH, SDC, NGOs, FBOs, CBOs	*	*	*	*	*

LINE OF ACTION 6: Surveillance, research and evaluation

Outcomes:

1. Timely reporting of accurate surveillance data on prevalence and risk factors of childhood obesity
2. Data available to inform policy and planning

Results and indicative activities		**Target**	**Responsible**	**2016**	**2017**	**2018**	**2019**	**2020**
Result 6.1	**Indicator**							
Surveillance system established for childhood and adolescent obesity Monitoring and evaluation system established for action plan for prevention of childhood and adolescence obesity.	M&E system implemented for all Lines of Action indicated in action plan.	Functional M&E system for all Lines of Action in place.	MOH	*	*			
Activities								
6.1.1 Establish M&E plan to include all components of the childhood obesity control and prevention action plan			MOH	*	*			
6.1.2 Create tool (reporting format) to report on action plan.			MOH	*	*			
6.1.3 Establish and train M&E team.			MOH	*	*			
6.1.4 Conduct mid-term evaluation of implementation of childhood obesity action plan			MOH	*	*			
6.1.5 Harmonize and standardize current routine surveys with international standards.			MOH, PIOJ		*			

Results and indicative activities		Target	Responsible	2016	2017	2018	2019	2020
6.1.6 Generate and disseminate annual reports on implementation of action plan			MOH	*	*	*	*	*
Result 6.2	**Indicator**							
Health system producing accurate data for nutritional status of children < 5yrs old	Growth monitoring data reported in keeping with WHO growth standards for all children attending public health centres							
Activities								
6.2.1 Modify Monthly Clinic Summary Report (MCSR) system to include WHO growth standards indicators			MOH	*	*			
6.2.2 Database for capturing child development passport data developed			MOEYI, MOH	*	*			
6.2.3 Equip health centres with anthropometric tools			MOH	*	*	*	*	*
6.2.4 Train health staff in data management procedures			MOH	*	*	*	*	*
6.2.6 Implement annual training programme for HCWs			MOH	*	*	*	*	*
6.2.7 Conduct periodic auditing of data quality and conformance to practice standards			MOH	*	*	*	*	*
Result 6.3	**Indicator**							
Develop surveillance system which produces accurate and adequate data for nutritional status of children aged 6-17 years.	Percentage of public schools reporting data on overweight, obesity and undernutrition. Percentage of private schools reporting data on	50% 25%						

Results and indicative activities		Target	Responsible	2016	2017	2018	2019	2020
	overweight, obesity and undernutrition.							
Activities								
6.3.1 Design surveillance system to capture school data			MOH, MOEYI	*	*			
6.3.2 Create and implement a standardized data capture tool for children aged 6-17 years to be used in schools to include growth references based on standardized school medical reporting forms			MOEYI, MOH	*	*			
6.3.3 Identify and train staff in data collection and management			MOH		*	*		
Result 6.4	**Indicator**							
Research on risk factors and prevalence of childhood obesity	Research agenda established Routine surveys conducted							
Activities								
6.4.1 Establish a multidisciplinary research team			MOH	*	*			
6.4.2 Establish research agenda for Childhood Obesity plan of action (See Annex II)			MOH	*	*			
6.4.3 Identify current routine data sources on prevalence and risk factors of childhood obesity			MOH	*	*	*	*	*
6.4.4 Generate fact sheet and reports on childhood and adolescent obesity			MOH	*	*	*	*	*

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ANNEXES

Annex I: Measures of Obesity

Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m^2).

The WHO definition is:

- a BMI greater than or equal to 25 is overweight
- a BMI greater than or equal to 30 is obesity. (WHO, 2003)

WHO Definitions of Overweight and Obesity		
Age	**OverWt**	**Obese**
> 19 years	*BMI ≥ 25*	*BMI ≥ 30*
5-19 years	*BMI-for-age > +1SD*	*BMI-for-age > +2 SD*
< 5 years	*Wt-for-Ht > +2 SD*	*Wt-for-Ht > +3 SD*

BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of adults. However, it should be considered a rough guide because it may not correspond to the same degree of fatness in different individuals.

It is difficult to develop one simple index for the measurement of overweight and obesity in children and adolescents because their bodies undergo a number of physiological changes as they grow. Depending on the age, different methods to measure a body's healthy weight are available:

The WHO Child Growth Standards, launched in April 2006, include measures for overweight and obesity for infants and young children up to age 5. Overweight is defined as weight-for-height above +2 standard deviations of the WHO Child Growth Standards median. (World Health Organization, 2006)

WHO developed the Growth Reference Data for children aged 5-19 years (World Health Organization, 2007). It is a reconstruction of the 1977 National Centre for Health Statistics (NCHS)/WHO reference and uses the original NCHS data set supplemented with data from the WHO child growth standards sample for young children up to age 5. Overweight is defined as BMI-for-age above +1 standard deviation and obesity as BMI-for-age above +2 standard deviation. (World Health Organization, 2007)

Annex II: Writing Group

Development of Multisectoral Action Plan for Prevention of Childhood and Adolescent Obesity

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Annex III: Research Agenda Items included in Childhood Obesity Plan of Action

(a) Conduct qualitative market research to determine the challenges /thoughts of persons about the benefits of breastfeeding (Action 2: Activity 2.1.1)
(b) Conduct baseline study to determine existing community structures and health related programmes. (Action 3: Activity 3.4.2)
(c) Desk review to determine feasibility of specific fiscal measures. (Action 4: Activity 4.1.1)
(d) Conduct tax-economic evaluation of proposed fiscal policy on SSBs and energy dense, nutrient poor foods. (Action 4: Activity 4.1.3)
(e) Conduct research to identify unhealthy foods and beverages using nutrient profiling (Action 4: Activity 4.2.1)
(f) Conduct a situation analysis on marketing practices targeting children. (Action 4: Activity 4.2.2)
(g) Conduct study on food establishment displays. (Action 4:Activity 4.4.1)
(h) Conduct research to determine existing areas where physical activity is promoted or conducted. (Action 5: activity 5.1.1)
(i) Conduct research to identify communities with green spaces and facilities available for physical activity and their utilization status. (Action 5: Activity 5.2.3)
(j) Conduct research to identify facilities available for physical activity programmes in schools/communities and their utilization (Action 5: Activity 5.3.1.)
(k) Conduct desk review and consultations to determine the feasibility of NEPA Manual/Guidelines regarding physical activity. (Action 5: Activity 5.2.1)
(l) Conduct feasibility study to inform surveillance system to capture school data[2]. (Action 6: Activity 6.3.1 & 6.3.2.)
(m) Implement Global School Health Survey

[2] Suggested options: (a) Use of trained HCW versus trained school personnel; (b) Use of school entry medical; (c) Use of retained consultant