

CONSULTANT'S FINAL REPORT

EXAMPLES OF BEST PRACTICES IN FOOD AND NUTRITION COMMUNICATION AND EDUCATION IN THE ENGLISH-SPEAKING CARIBBEAN

(The Bahamas, Barbados, Grenada and Jamaica)

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1. BACKGROUND

1.1 The Food and Nutrition Situation in the Caribbean

The Caribbean, like other regions in the world, has experienced an epidemiological transition in recent years. There is now a lower incidence of communicable diseases and nutrition deficiency associated diseases than some decades ago. However, there is an increase in nutrition related non-communicable diseases (NCDs) such as obesity, hypertension, diabetes, cardiovascular diseases and cancers.

Prevalence of obesity in adult Caribbean women is around 25%; this is almost twice as many as their male counterparts (1). In Barbados, the prevalence of overweight and obesity in adults is 56% in men, 64% in women and 60% overall (2). Younger Barbadians are especially at risk, as the prevalence of obesity in the 18-29 age group is high in both men (30%) and women (>50%). The report of the Jamaica Health and Lifestyle Survey 2007-2008 (JHLSII) states that 52% of Jamaicans 15 to 74 years old are overweight and obese (3). This includes 38% of men and 65% of females. Among younger Jamaicans, the 2006 Youth Risk and Resiliency Survey reports that a quarter of Jamaican adolescents between the ages of 15 and 19 years are overweight or obese (4). The situation is also urgent in Grenada, where recent data collected in schools in Grenada indicated that around one third of students in the schools surveyed were overweight or obese (5).

An analysis of data from the region of the Americas indicates that the Caribbean has the highest rate of NCDs in the region (6,7). From 2003 clinic data in Grenada, 12% of clinic attendees were diabetic. The prevalence of reported hypertension was 25% in Jamaica, similar for both men and women, but higher in rural dwellers (29%) than in urban dwellers (23%) (3). However, the prevalence of diabetes is lower, 8% overall, 6% in males and 9% in females, and similar in rural and urban areas. Mortality rates from NCDs are also high. According to Samuels and Fraser (6), diabetes mortality rates for Trinidad & Tobago and St. Vincent & the Grenadines are 600% than in Canada and the USA. Cardiovascular disease mortality rates are 84% higher in Trinidad & Tobago than in Canada and the USA.

Undernutrition in children is not a widespread or severe problem. Most countries in the region have rates less than 5%. Instead, there is a growing problem of obesity in children. Data collected from the Caribbean region show higher rates than the global

prevalence for overweight among preschool children, estimated at 3%. Overweight prevalence was found to be 9% in Dominica and 7% in St. Vincent and the Grenadines (8). However, introduction of the WHO growth charts in several countries and training in the use of the charts have improved the ability of health workers to recognize threats to nutrition among children. Many Caribbean countries, in implementing the Global Strategy on Infant and Young Child Feeding, have instituted various measures such as national committees on Infant and Young Child Feeding, the Baby Friendly Hospital Initiative and renewed efforts at growth monitoring. However, rates of exclusive breastfeeding remain low despite efforts to increase these rates.

Studies done on physical activity show that there has been an increase in sedentary lifestyles, attributed in part to increased urbanization, improved transportation and greater access to technology, as well as low levels of exercise (9,10). Results from a study conducted by the Caribbean Food and Nutrition Institute (CFNI) in Jamaica, Trinidad & Tobago, and Guyana revealed that 38%, 39% and 56% of adults respectively were sedentary, spending more time on sleep and light activity than other activities. According to the JHLSII report, 30% of Jamaicans 15 to 74 years old are inactive, 16% are active at a low level, 22% moderately so and 33% highly physically active (4). Men (72% moderately or highly active) are more active than women (38%).

There still remains a problem of anaemia in the countries, especially in groups recognized worldwide as vulnerable, i.e. young children and pregnant women. Surveys conducted in 1996 in Antigua and Barbuda, Dominica, Guyana, Jamaica, and St. Vincent and the Grenadines revealed a prevalence of anaemia ranging from 36% to 52% in pregnant women, 34% to 49% in young children and 24% to 57% in school children (11). More recent surveys indicate that anaemia is also a problem in adolescents. In Antigua and Barbuda, a 2006 survey revealed that prevalence of anaemia was 17% in male students, 29% in female students, and 25% overall (12).

There are inadequate data on food consumption practices in the English-speaking Caribbean. Only a few countries, Barbados, Guyana and Dominica have conducted food consumption surveys in the past couple of decades. However, the Caribbean Food and Nutrition Institute/Pan American Health Organization (CFNI/PAHO), having analysed data from food balance sheets prepared by the Food and Agriculture Organization (FAO), reports that the per caput availability of fat, sugar and energy in Caribbean countries have long surpassed the average requirement (population goals) for good health (1). For example, FAO data showed that the average available per capita intake per day in



the Bahamas in 2003 was 2709 kilocalories, 94g fat and 89g protein. The excess availability of fat above the recommended level was 87%. Of the fat supply, 69% was of animal origin, while 31% was from vegetable products. Most of the energy consumed was of animal origin and sugar, contrasting sharply with the contributions from pulses and nuts, roots and tubers, fruits and vegetables. The excess fat supply and the predominance of animal fat in the diet have important implications for the development of chronic non-communicable diseases (NCDs), especially coronary heart disease and some forms of cancer.

The Caribbean has several regional agreements relating to food, nutrition and health. These include the 2001 *Nassau Declaration on Health (13)*, the 2007 *Port of Spain Declaration: Uniting to Stop the Epidemic of Chronic Non-communicable Diseases (NCDs) (14)* and the 2007 *Declaration of St. Ann's Bay: Implementing Agriculture and Food Policies to Prevent Obesity and NCDs in the Caribbean Community (15)*.

1.2 Food and Nutrition Communication and Education (BP-FNCE) Programmes in the Caribbean

A variety of programmes have been/are conducted in the region, with the objective of improving the nutrition situation or health of various target groups. Food and Nutrition Communication and Education (FNCE) activities are often a feature of these programmes, and these are implemented by nutrition professionals and other professionals from the health, education, agriculture and other sectors. It was important to find out whether all these persons had received training in FNCE and possible training gaps that might call for specific training. It was therefore decided to compile an Inventory of Best Practices in Food and Nutrition Information, Communication and Education (IEC) (BP-FNCE) Programmes in the Caribbean. For this purpose, during the period March to June 2011, the Food and Agriculture Organization of the United Nations (FAO) collected information on Food and Nutrition Communication and Education programmes in the English-speaking Caribbean.

2. AIMS AND OBJECTIVES

The project aimed to investigate the various contexts and scenarios in which Food and Nutrition Communication and Education (FNCE) Programmes are developed in the regions of Latin America and the Caribbean, targeting healthy people or people with malnutrition problems (undernutrition or obesity/overweight).

The objectives were:

- to identify the experiences and approaches used in FNCE programmes carried out in the Caribbean
- to identify good practices in FNCE programmes, and their success factor;
- to have a basis for systematizing and sharing experiences in Food and Nutrition Communication and Education

3. MATERIALS AND METHODS

3.1 Definition of BP-FNCE

Best Practices in Food and Nutrition Communication and Education were defined as practices that produce measurable behaviour changes, contribute to improving the nutritional status of the target population (impact evaluation), are culturally sensitive, economically feasible, and technically practical.

3.2 Survey Design and Sampling Strategy

Four Caribbean countries were selected in which to carry out the survey—The Bahamas, Barbados, Grenada and Jamaica.

In each country, entities either known or thought to be involved in food and nutrition communication and education programmes were selected and invited to participate. The entities were selected from the public sector (government ministries and departments), international organizations, non-governmental organizations (NGOs) and private individuals and companies.

Five criteria were used to decide whether programmes qualified to be included. These were that the programmes should:

1. be communication and/or education programmes
2. have a food and nutrition approach
3. be presently running, or have been implemented in the past five years
4. benefit at least 100 beneficiaries
5. have some sort of evaluation system



3.3 Survey Questionnaire

A questionnaire (Annex I), to be self administered, was designed to collect:

- general information about the institution/department
- general information about the programme (title, target group, area, persons responsible, partners etc.)
- information describing the programme:
 - ▶ background, problem and context
 - ▶ programme planning
 - ▶ objectives and expected outcomes
 - ▶ methodology
 - ▶ facilitators
 - ▶ sustainability
- information on the evaluation of the programme:
 - ▶ type of evaluation and results
 - ▶ lessons learned and recommendations
 - ▶ projections of the programme once completed
 - ▶ publications
 - ▶ systemization
- information on the budget and funding sources

3.4 Data Collection and Analysis

A national consultant was contracted to undertake the exercise in each participating country. Each consultant compiled an initial list of institutions and departments either known or thought to be involved in food and nutrition communication and education programmes. These entities were contacted by telephone or by e-mail, and initial information was collected on the existence of FNCE programmes and on the person responsible for nutrition and health-related programmes and programming. This list was updated several times with new information provided by informants.

If the initial response was positive, further information was requested using the project questionnaire, which was e-mailed to the identified key informants. Follow-up calls were made and/or e-mails sent as necessary in order to get compliance. On initial contact, if the person originally identified as an informant did not feel they were adequately qualified or authorized to respond, the questionnaire was sent to their superiors.

Once the questionnaires had been completed, they were reviewed, and when necessary, follow-up calls or checks were made to clarify some issues. Some face-to-

face interviews were also done to ensure completion. The information obtained was entered in an Excel database.

A rating system (Annex II) was then used on the completed questionnaires to determine whether programmes qualified as best practices. This enabled the identification of specific areas of programmes that need to be reinforced. The programmes were scored on 12 areas, with a total possible score of 60. A programme with a score ≥ 45 was labelled as a best practice (BP-FNCE).

The programmes were rated on the following criteria:

1. It takes into account the nutritional needs of the target group.
2. It explores the knowledge, attitudes, practices and perceptions of individuals, as well as their needs and priorities.
3. Among its objectives it includes the change of behaviours and practices.
4. It promotes not only knowledge transfer, but also specific behaviours.
5. It is based on methodologies that promote learning from practical experiences and from solving the problems that affect the population.
6. It is committed to long-term efforts to achieve a sustained behaviour change.
7. It empowers the beneficiaries so that they can make the intended changes, helping them to develop their abilities and skills.
8. It includes changes in people's environments to help them fulfil the proposed practices, e.g. sale of healthy foods at school.
9. It trained the nutrition educators¹ in consultation, communication and/or counselling skills.
10. The assessment shows that the desired behaviour changes/expected outcomes were achieved.
11. The Programme is part of plans and programmes that endeavour to improve the quality of life of the population in a comprehensive manner.
12. The Programme is related to a nationwide strategy/policy.

¹ Nutrition educators, meaning the agents of change that carry out the programme, such as community workers or teachers.



Table 1: General Information on the Institutions included in the Research on Best Practices (BP) in FNCE: The Caribbean, June 2011

Type of institution	Number of institutions/ programmes that were sent information	Number of institutions/ programmes that responded	Number of institutions/ programmes that meet the inclusion criteria	Number of institutions/ programmes that qualify as BP-FNCE programmes	Number of institutions/ programmes that DO NOT qualify as BP-FNCE programmes
Government Ministries and Departments	26	13	12	6	6
NGOs	16	6	5	4	1
International Organization	4	1	1	1	0
Private sector	9	4	4	0	4
Universities	5	0	0	0	0
TOTAL	60	24	22	11	11

4. RESULTS

4.1 Responses

The list of entities contacted across the four countries included 26 government ministries and departments within these ministries, 16 NGOs, 9 private individuals and companies, 5 universities and 4 international organizations, making a total of 60 entities (Table 1). Some of the private individuals were affiliated or contracted to NGOs or companies.

Many of the entities initially contacted reported that they did not apply a communication strategy or have a structured communication or education programme. In some cases, materials or information on food and nutrition were sometimes distributed, but not within the context of an FNCE programme. Other programmes were excluded because they covered less than 100 beneficiaries, or had not conducted a programme evaluation.

Even with extensive email and telephone contact, it was sometimes difficult to obtain responses to the questionnaire. Some entities reported that they had no programmes which fit the criteria, or had not properly documented the programmes. Some informants cited time constraints and others said that they had not previously given thought to some of the issues about which they were now being asked. Others welcomed the opportunity to participate in the survey, in the hope that their experiences could be shared and that their programmes could receive recognition or assistance.

Of the 60 entities contacted, information was collected from 24. Questionnaires were completed

by 13 public sector entities, 6 NGOs, 4 private sector individuals or entities and 1 international organization. From the entities from which data were collected, 22 programmes met the inclusion criteria and, of these, 11 qualified as BP-FNCE (Table 1).

4.2 Characteristics of programmes that DO NOT qualify as BP-FNCE programmes

Table 2 shows the characteristics of the FNCE programmes for which information was collected but which did not qualify as best practices.

There were a number of reasons why these programmes did not qualify. In most of these programmes, the training provided to the nutrition educators (i.e. people carrying out the programmes) was weak, or the programmes lacked sufficient elements to ensure the sustainability of achievements. At times, the programme content and activities were not directly linked to objectives. Several programmes had not been assessed, or the assessment did not show the expected outcomes. While most of the programmes did have the objective of changing behaviours, often they did not promote specific behaviours, or focus on the knowledge, attitudes and practices of the targets.

However, many of these programmes had some commendable characteristics. In the Bahamas, for example, there were three programmes which did not fit the criteria for inclusion but were deemed to partially qualify as BP-FNCE. For the most part, the projects that did not qualify took into account the needs of the target groups, and included behaviour change in the objectives. Just over half of these programmes were related to national policies, programmes or strategies.



Table 2: Characteristics of programmes that DO NOT qualify as BP-FNCE programmes: The Caribbean*, June 2011

Number of programmes analyzed that DO NOT qualify as BP programmes = 11	n=22	Number of programmes that DO include BP-FNCE = 11		
		YES	PARTIALLY	NO
Elements to consider				
It takes into account the nutritional needs of the target group		7	1	3
It explores the knowledge, attitudes, practices and perceptions of individuals, as well as their needs and priorities		2	3	6
Among its objectives it includes the change of behaviours and practices		8	1	2
It promotes not only knowledge transfer, but also specific behaviours		3	3	5
It is based on methodologies that promote learning from practical experiences and from solving the problems that affect the population		2	4	5
It was committed to long-term efforts to achieve a sustained behaviour change		4	2	5
It empowers the beneficiaries so that they can make the intended changes, helping them to develop their abilities and skills		3	4	4
It includes changes in people's environments to help them fulfil the proposed practices, e.g. sale of healthy foods at school		3	0	8
It trained the nutrition educators in consultation, communication and/or counselling skills		2	1	8
The assessment shows that the desired behaviour changes/expected outcomes were achieved		0	4	7
The Programme is part of plans and programmes that endeavour to improve the quality of life of the population in a comprehensive manner		5	4	2
The Programme is related to a nationwide strategy/policy		6	2	3

*Excluding Bahamas

Table 3: General Characteristics of FNCE Programmes: The Caribbean, June 2011

Country	n	Geographical area			Target group					Duration (years)					Connection to national policies/strategies	
		Urb	Rural	SubR	Child	Wom	Adol	Adult	Other	≤1	2	3	4	≥5	Yes	No
Barbados	7	7	7	7	7	4	2	4	-	3	3	-	-	1	7	-
Jamaica	3	3	3	-	1	1	1	1	-	1	-	-	-	2	3	-
Regional	1	1	1	-	-	-	1	-	-	-	-	-	1	--	-	1
Total	11	11	11	7	8	5	4	5	-	4	3	-	1	3	10	1

n= number of BP-FNCE programmes that are included in the analysis; geographical area: urb=urban, rural=idem, SubR=Sub-rural/Urban-marginal; target group: Child=children, Wom=women, Adol=adolescents; Adult= adults.

4.3 Characteristics of programmes that qualify as BP-FNCE programmes

Eleven programmes were identified that satisfied the criteria, and were identified as best practices (BP-FNCE) (Table 3). Seven of these programmes were in Barbados, three in Jamaica, and one was a regional

project in the Caribbean. This was being implemented by the Caribbean Food and Nutrition Institute (CFNI), a specialized centre of the Pan American Health Organization/World Health Organization (PAHO/WHO) in four countries, one of which was Grenada. Although other FNCE programmes in the Caribbean had commendable elements, they did not qualify as



BP-FNCE, or did not satisfy the criteria to be included in the analysis.

The BP-FNCE programmes are briefly described below.

4.3.1 Barbados

The Nutrition Summer Camp

The nutrition summer camp for children aged 9-13 years is the oldest national programme addressing the promotion and preparation of local indigenous foods, healthy eating, nutrition and gardening. A variety of health professionals assist in the implementation, and attendance has been kept since its inception. There has been some modification to the programme using a knowledge, attitudes and practices (KAP) pre/post assessment at selected venues.

Building a Healthy Foundation

This programme, targeting 12-13 year olds, was a 10-week after school programme. It focused on nutrition education and physical fitness, giving students the opportunity to experience a variety of fitness activities and meal preparation. Ten schools participated in the programme. Based on pre/post assessments of students accepting the challenge, measurable changes in weight, dietary habits and levels of physical activity were achieved.

Healthy Snacking Project & Project Green

The *Healthy Snacking* school-based project was conducted during class time at three primary schools and one secondary school and targeted 5-12 year olds. Activities included snack preparation, nutrition and chronic disease lesson plans, outdoor fitness activities and gardening. Parents received activity plans and information on meal preparation. As evaluation of the *Healthy Snacking* programme indicated that the intervention should be carried out at a younger age, *Project Green* was developed, which targets nursery and pre-school children. The target was extended to include parents and staff at the participating nurseries and pre-schools. The project received additional funding from the government to do HbA1c blood testing for diabetes control of parents and staff after diabetes risk assessments revealed the high incidence of risk factors in this population.

The Ten Step Programme

This programme was developed as a community-based diabetes education programme targeting people who

were not available during working hours. It was a self-management programme for persons living with diabetes and included a peer-support programme and practical sessions of meal preparation, self-testing, lectures/interactive groups and discussion groups, exercise and a daily diary to monitor changes in behaviour. Long term HbA1c follow-up testing was funded by the Ministry of Health.

4-H Food and Nutrition Security Master Garden Programme

The 4-H Food and Nutrition Security Master Garden Programme is a school-based, after school programme run by teacher volunteers and focuses on the 4-H's: Head, Heart, Hands and Health. This programme was developed as a result of a regional consultation linking agriculture to nutrition and health through the promotion of garden-based learning and entrepreneurship. A training manual was validated by 4-H teacher/leaders to be used in the planning of lessons with science/health and garden activities. A summer leadership training programme was conducted. Individual clubs have adopted the programme but due to lack of resources a national implementation plan and additional follow-up training plan have not been developed.

Chemical-Free Garden Project

Linking health and the environment is the key strategy of this national programme which includes training of trainers in chemical-free garden practices, support of demonstration school garden, and a Saturday garden club which provides discussions on health/wellness topics. To ensure sustainability, seeds and seedlings grown by members of the 4-H community clubs are provided to members of the diabetes association. A long term objective is the development of a cooperative framework which will provide seeds and seedlings to the larger community, and a farmers' market where preparation of healthy food, composting education and chemical-free garden promotions will be included in monthly activities.

4.3.2 Jamaica

Camp 4 – the Healthy Way

Camp 4 was implemented in 2007, consisting of three 1-week camps for overweight and obese adolescents. The objective of MOH-Camp 4 was to promote behaviour modification towards a healthy lifestyle. Specific objectives were to promote healthy eating among overweight adolescents, to promote regular physical activity among these individuals, and to elicit



support for these individuals from their family, school and the wider community. The expected outcomes are changes in the diet and physical activity habits and reduction in obesity.

Infant and Young Child Feeding Programme

The *Infant and Young Child Feeding Programme* in Jamaica targets feeding practices of infants and young children, mainly through pregnant women and mothers of young children, as well as their families. The programme has been in operation for several years and is ongoing. The objectives of the IYCF programme which relate to FNCE are, to build capacity within all relevant agencies and at different levels of the health system and community for the promotion, protection and support of infant and young child feeding, and to develop and implement sustainable public education initiatives for the promotion and support of optimal infant and young child feeding practices. The expected outcomes of the programme are related to meeting the objectives of the WHO Global Strategy for Infant and Young Child Feeding.

Social Services/Home Economics Programme

This programme is implemented by the Rural Agricultural Development Authority (RADA), which is a department of the Ministry of Agriculture. The programme targets community groups and churches, women, members of the 4-H Club and senior citizens. This programme has been in operation since 1964. Originally the programme focused on the problem of malnutrition in children, but now focuses on obesity, diabetes and hypertension caused by poverty, lifestyle practices and poor eating habits. The objectives are to promote healthy eating habits, reduce incidence of malnutrition and nutrition-related communicable diseases, and facilitate income generation in rural communities.

4.3.3 Regional

Regional Lifestyle Intervention Project

Preventing Diabetes and Other Chronic Diseases through a School-Based Behavioural Intervention in Four Caribbean Countries, is being implemented in Grenada, Trinidad & Tobago, St. Kitts & Nevis and St. Vincent & the Grenadines by the Jamaica-based Caribbean Food and Nutrition Institute (CFNI/PAHO). The project is being implemented in two urban and two rural secondary/high schools in each participating country. The objective of the project is to improve diet and physical activity patterns among school children. The project is implemented through classroom teaching

to the participating grades/forms (specially prepared and delivered lessons), school-wide promotional activities, and by building support in the school and home environments.

4.3.4 General Characteristics of BP-FNCE Programmes

The programmes identified as BP-FNCE in the Caribbean are being implemented or had been implemented in both urban and rural areas, and target various population groups (Table 3). Children are most often the targets of these programmes: eight programmes targeted children, and four programmes targeted adolescents. Adults and women were each targeted by five programmes. The length of the programmes varies from less than one year to more than five years. They were implemented through health centres, schools, summer camps and communities.

Except for the regional Lifestyle Intervention Project, the programmes all supported national policies or strategies. For example, Jamaica's *IYCF programme* is linked to the country's draft National Infant and Young Child Feeding Policy, the Food and Nutrition Policy (1978), the National Health Policy (1991) and the National Nutrition Programme. *Camp 4* was implemented in the context of Jamaica's National Strategic Plan for the Promotion of Healthy Lifestyles.

The number of programmes beneficiaries varied (Table 4). There were just 50 participants in the *Building a Healthy Foundation* after-school programmes, and *Camp 4* accommodated 60 to 70 students in each of the three camps held. At the other end of the scale were national-level programmes, such as the chemical-free garden project in Barbados and the IYCF programme in Jamaica.

4.4 Collaboration and Partnerships

There is a high degree of collaboration in implementation of FNCE in the Caribbean. The BP-FNCE programmes are a combination of public sector

Table 4: Number of Total Beneficiaries served by the BP-FNCE programmes: The Caribbean, June 2011

Country	Number of programmes	Number of beneficiaries served by the programmes	
		Minimum	Maximum
Barbados	7	50	National
Jamaica	3	200	279 000* (national)
Regional	1	847	

*Population of children 0-4 years old



Table 5: Partnerships in the BP-FNCE programmes and contributions made by them: The Caribbean, June 2011

Country	It has partners?		Type of partners					Contributions		
	Yes	No	Univers.	Pub. S.	Priv. S.	NGOs	UN	\$	H.R.	Others
Barbados	7	-	-	6	3	5	4	5	3	3
Jamaica	3	-	1	3	-	-	2	3	3	3
Regional	1	-	-	1	-	-	-	1	1	-
Total	11	0	1	10	3	5	6	9	7	6

n= number of BP-FNCE programmes that are included in the analysis; Type of partners: Univers.= university; Pub. S.= public sector, Priv. S.=private sector, NGOs= Non Governmental Organizations, UN= United Nations agencies; Contributions: \$=economical, H.R.= human resources

and non-governmental initiatives, which also engage partners from institutions representing the target groups, and seek technical and financial support from international agencies (Table 5). In addition, funding and materials support are received from the public and private sector, and skilled professionals are recruited to share their expertise. However, these contributions are usually unquantified.

An example of effective use of partnerships is the *Lifestyle Intervention Project*, initiated by CFNI and funded by the World Diabetes Foundation (WDF). The Ministry of Education in each country and the school staff are partners in the implementation. School teachers have been trained to implement the behavioural change curriculum component of the project. Each of the participating countries formed a country team to support the project; the team consisted of representatives from such entities as the Ministry of Education’s home economics and physical education departments, Ministry of Health nutrition department, schools and parent teachers associations (PTAs).

In Barbados, the seven programmes that met the BP-FNCE criteria were initiated by three institutions—one public sector and two NGOs. The NGO programmes all received support from the government, international organizations and the private sector. The *Nutrition Summer Camp* receives support from both the private sector and the public sector. The *Building a Healthy Foundation* was supported by a cross-section of health and fitness professionals. The other four programmes have been beneficiaries of government and international funding, and also received time and expertise from volunteers in the private sector and individuals from within the community.

In Jamaica, one programme, *Camp 4*, initiated by the Ministry of Health, has support from the University of the West Indies through the Tropical Medicine Research Institute (TMRI). CFNI, in addition to implementing the *Lifestyle Intervention Project* in four countries, partners

with the *IYCF programme* offering technical support, while the PAHO-Jamaica office offers funding for the same programme. The FAO offers both technical support and funding for RADA’s *Social Services/Home Economics Programme*.

4.5 Nutritional Problems Addressed by the BP-FNCE Programmes

The nutritional problems addressed by the programmes range from undernutrition and anaemia to obesity and NCDs, and target various population groups (Table 6). However, in Barbados, even though there is a high prevalence of overweight and obesity, there are no FNCE programmes which address obesity and NCDs in adults, although the *Ten Step* self management programme aims to improve the ability of persons living with diabetes to manage their condition. Most of the programmes in Jamaica and Barbados target obesity in children and adolescents. Obesity in adolescents was the focus of the *Camp 4* programme. The CFNI *Lifestyle Intervention Project (Preventing Diabetes and Other Chronic Diseases through a School-Based Behavioural Intervention in Four Caribbean Countries)*, addresses diet and physical activity behaviours in adolescents. However, as the title of the project suggests, the long-term objective is to prevent diabetes (and other NCDs) in the target group. RADA’s *Social Services/Home Economics Programme* in Jamaica targets both undernutrition and obesity in children and elderly people, as well as access to nutritious food.

Poor dietary practices or poor feeding practices were targeted by seven of the 11 programmes, including the *IYCF programme*, *Camp 4* and *Social Services/Home Economics Programme* in Jamaica, and the regional *Lifestyle Intervention Project*.



Table 6: Nutritional problems addressed by the BP-FNCE programmes: The Caribbean, June 2011

Country	n	Childhood/ Adolescents		Adults					Other food-related issues perceived in the country			
		Malnut.	Obesity	Obesity	CVD	Diabetes	HTN	Anaemia	Food Access	Poor feeding/ dietary practices	Food cost	Lupus
Barbados	7	-	5	-	-	1	-	-	-	3	1	1
Jamaica	3	2	3	1	-	-	-	1	1	3	-	-
Regional	1	-	1	-	1	1	1	-	-	1	-	-
Total	11	2	9	1	1	2	1	1	1	7	1	1

Malnut.=malnutrition; CVD= cardiovascular diseases; HTN=hypertension

4.6 Methodologies, Objectives and Expected Results of the BP-FNCE Programmes

4.6.1 Methodologies

Most interventions were developed based on the results of research data and successful best practices from projects in other countries. Although there is some use of a didactic approach, interactive learning and skill building are often used. Many programmes also try to build a supportive environment for changing behaviours.

4.6.2 Objectives

The objectives of the FNCE programmes are varied but centre around:

- improved nutrition knowledge
- adoption of healthy lifestyle habits
 - ▶ promotion of healthy eating habits, such as increased consumption of fresh fruits and vegetables, decreased consumption of packaged snacks, and portion control
 - ▶ improved physical activity habits
 - ▶ fostering a supportive environment for healthy; diet and physical activity practices
- prevention and control of NCDs
 - ▶ reduced incidence of NCDs such as diabetes
 - ▶ improved self-management of diabetes

- promotion and support of optimal infant and young child feeding practices
- reduced prevalence of undernutrition in children
- improved income generation or self sufficiency
- improved access to fresh vegetables

4.6.3 Expected Results

The expected results of the various programmes being implemented in the region are usually related to the objectives. The expected results of the programmes that were assessed were generally to do with:

- improved diet and physical activity
 - ▶ increased awareness
 - ▶ improved behaviours
- reduction in obesity
- raised awareness and creation of a supportive environment for infant and young child feeding
- decreased prevalence of malnutrition (under-nutrition and obesity)
- improved knowledge of:
 - ▶ nutrition
 - ▶ new recipes/food preparation methods
- decreased consumption of imported foods/ increased consumption of locally-grown foods.



Many programmes are short-term and make no provision for long term follow-up to determine the impact on behaviour change and the prevalence of obesity or other chronic diseases.

4.6.4 Activities

The main activities include:

- pre-assessment to identify the extent of the problem
- classes and workshops
- interactive talks
- group discussions
- counselling sessions
- demonstrations and practical sessions
- observation of promotional days/weeks, e.g. Caribbean Nutrition Day, World Diabetes Day, National Breastfeeding Week
- media promotion

4.7 Educational Materials used in the BP-FNCE Programmes

All the programmes used materials specifically created for the programmes, and many also used or adapted materials from other programmes (Table 7). However, the materials were often not validated. The materials were documented, and either hard copies or electronic copies can be accessed.

The range of materials included:

- handouts, brochures, pamphlets, leaflets
- charts/posters

- manuals
- books
- lesson plans
- worksheets and activity sheets
- newsletters
- journals, diaries, food diaries
- games
- picture cards
- promotional items (t-shirts, mugs, pencils, pedometers)
- recipes
- videos

4.8 Characteristics of the personnel implementing the BP-FNCE programmes.

4.8.1 Operational Personnel

Nutrition professionals play key roles in the development and implementation of the FNCE programmes, though technical support is provided by other professionals (Table 8). These include nurses, agriculturists, teachers, fitness instructors, health and wellness consultants, health educators, nurses, nurse midwives and doctors. In Barbados, for example, the programmes classified as BP-FNCE programmes were conducted by the staff of the National Nutrition Centre (NNC), and the programmes were supported by a range of health professionals and experts from within the public sector. The programmes initiated by NGOs such as the Diabetes Association of

Table 7: Educational Materials used in BP-FNCE Programmes: The Caribbean, June 2011

Country	Created for the programme	Adapted from other programmes	Validated		Can the materials be found as a CD or hardcopy?	
			Yes	No	Yes	No
Barbados	7	6	3	5	7	-
Jamaica	3	2	3	1	3	-
Regional	1	1	1	1	1	-
Total	11	9	7	7	11	-



Table 8: Operational Personnel/Staff that run the BP-FNCE programmes: The Caribbean, June 2011

Country	Nutritionists	Health professionals	Agriculture professionals	Teachers	Non-professionals
Barbados	7	7	6	6	7
Jamaica	3	3	1	0	1
Regional	1	1	-	1	-
Total	11	11	7	7	8

Barbados and the Barbados 4-H Foundation are staffed by volunteers.

4.8.2 Training, Technical Topics and Methodologies

Training of the nutrition educators (i.e. the people carrying out the programme, such as community workers or teachers) using FNCE methodologies, was common in most programmes (Table 9). Training usually relied on the expertise of nutrition and dietetics professionals.

Overall, the level of training received by the people implementing BP-FNCE programmes can be considered adequate, especially when coupled with tertiary training already received by many of these people. Therefore, much of the training fulfilled the purpose of augmenting their existing knowledge and skills. In addition to areas such as the objectives, expected outcomes and data collection procedures, training content included basic nutrition such as the Caribbean Six Food Groups, increasing consumption of fruit and vegetables, hands-on preparation of healthy snacks and beverages and setting up gardens.

One example of intensive training is the IYCF Programme in Jamaica. Regular training is done for health workers who come into contact with mothers and young children. This training is based on the WHO/UNICEF Integrated Infant and Young Child Feeding Counselling Course or the previous breastfeeding and complementary feeding counselling courses. Depending on the particular audience and the training conditions, the course length and contents are modified. Training is done by members of the National IYCF Committee, who have generally received training themselves in using the training of trainers format. The members of the IYCF committee are also trained in Baby Friendly Hospital Initiative (BFHI) assessment. The various training topics, which include practical sessions, include:

- principles of infant and young child feeding practices

- breastfeeding promotion and support
- breastfeeding practices
- complementary feeding practices
- counselling skills
- HIV and infant feeding
- International Code of Marketing of Breastmilk Substitutes
- replacement feeding
- feeding during illness and low-birth-weight babies
- growth promotion

The main implementers in each country of the regional *Lifestyle Intervention Programme* are trained by CFNI technical officers, in particular the Institute's nutritionists. Thus, the teachers who are expected to teach lessons in the behavioural curriculum component (Component 1) of the programme are trained before commencement of each school term. The standardized content of teacher training over three days is:

1. overview of the project
2. the behavioural curriculum (Component 1)
 - ▶ motivating students
 - ▶ teaching and delivery
 - ▶ the infusion process
3. review of project ('straight') lessons, which are prepared beforehand and distributed
4. development of infused lessons by participating teachers
5. presentation of lessons by teachers



Table 9: Training of the Operational Staff that runs the BP-FNCE programmes: The Caribbean, June 2011

Country	n	Training was delivered		By FNCE experts		Included technical contents		Methodologies		Adequate length	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Barbados	7	7	-	7	-	7	-	7	-	5	2
Jamaica	3	3	-	3	-	3	-	3	-	3	-
Regional	1	1	-	1	-	1	-	1	-	1	-

6. review and discussion of other aspects of the curriculum, including personal reflection, take home assignments and portfolios

7. discussion of other components of the project:

- ▶ Component 2 – Building Supportive Environments at School
- ▶ Component 3 – Nutrition and Physical Activity Programmes (school-wide)
- ▶ Component 4 – Building Supportive Environments at Home and Community

A teacher training manual developed for this project is used. A two-day refresher training session is held once each school year. The country coordinator is also trained in some of these areas in addition to undergoing orientation to the project.

4.9 Evaluation of the BP-FNCE programmes

Many of the FNCE programmes are insufficiently evaluated. In fact, the lack of evaluation prevented many of the programmes from qualifying to BP-FNCE status.

The BP-FNCE programmes identified had all been evaluated, as this was one of the criteria for their inclusion in the analysis. However, most of them had only had an impact evaluation (Table 10). The

objectives had been achieved in all these programmes. Only three programmes have had evaluations of the process of implementation. Thus, in most cases, the implementers may not have had enough evidence to assess if the project implementation went as planned. Additionally, the outcomes used to measure the impact of the programme were sometimes not comprehensive enough to give a complete picture of the level of success of the programme.

The various evaluation methods used included:

- qualitative methods
 - ▶ focus groups
 - ▶ key informant interviews
 - ▶ group meetings/discussions
 - ▶ review of workbooks/journals
 - ▶ observation checklists
- quantitative measurements
 - ▶ anthropometry
 - ▶ questionnaires (knowledge, attitudes, practices, awareness etc.)
 - ▶ blood pressure, blood glucose, fitness
 - ▶ rates (e.g. exclusive breastfeeding)
 - ▶ attendance

Some of the programmes have attempted to institute measures to make the programmes sustainable. Some

Table 10: Evaluation of the BP-FNCE Programmes: The Caribbean, June 2011

Country	n	Evaluated		Type of evaluation		Objectives were achieved		Sustainability strategies are considered	
		Yes	No	Process	Impact	Yes	No	Yes	No
Barbados	7	7	-	1	7	7*	-	3	4
Jamaica	3	3	-	1	3	3	-	3	-
Regional	1	1	-	1	1	**	-	1	-
Total	11	11	-	3	11	10	-	7	4

* 1 partial

**Results not yet available for CFNI-LIP project evaluation



of the strategies used were capacity building, including the use of training of trainers methodology, and efforts to integrate training into in-service education programmes. There has been varying degrees of success in making the various programmes sustainable, however, and resources (human and financial) may play an important role in this.

Some BP-FNCE programmes are being integrated into the programme plans of the relevant implementing institutions. This is also a recommendation from the regional *Lifestyle Intervention Project*, which, although implemented in collaboration with the Ministry of Education, utilized some country coordinators from outside the school system and was not fully integrated into the school curriculum.

4.10 Lessons Learnt and Projected expansion of the BP-FNCE Programmes

Certain BP-FNCE programmes, with support, can provide a template for expanded local, regional and international translation. This is because they present a creative approach to engagement at the population level, with strategies that can address the current concerns about the role of food and nutrition in influencing healthy behaviour. Some of these programmes target youth, whose habits can be influenced through access and environment. For example, the summer training for leaders done in the 4H Nutrition/Food Security Programme in Barbados has the potential to be repeated annually for new leaders. Furthermore, the possibility exists for this programme to be linked to the Chemical Free Garden Project, which will support the sustainability component by allowing two organizations to work together in a seed-store/seedling co-operative project.

Another example is the *Healthy Snacking Project* in primary and secondary schools in Barbados. The evaluation showed that the intervention would be

more effective if started at nursery schools and day care centres, and thus *Project Green* was developed. Primary school children would be more prepared to continue healthy behaviour already introduced at a younger age.

Even with the multisectoral involvement in most programmes, there is recognition of the need for additional skills and competences which would enhance the development and implementation of the programmes. For example, the implementers of the *IYCF Programme* in Jamaica felt that the programme could be strengthened by the inclusion of personnel with relevant knowledge and skills to develop, implement and evaluate integrated communication strategies. In the case of the *Social Services/Home Economics Programme* there was a perceived need for a rural sociologist or other behaviour expert to identify behaviour, attitude and cultural norms and influence these within the boundaries of the project.

Not many programmes are projected for expansion, as many are already implemented at national level (Table 11). The *Social Services/Home Economics Programme* originally developed for rural areas, is projected to be used in urban areas. One objective of the *Lifestyle Intervention Project* was the testing of the methodology in a few schools in each country; after completion of the project the various components are projected to be implemented nationally and also by other countries. The current plans are to distribute project materials to schools used as controls in the project; country organizers and Ministry of Education personnel have indicated that the materials are very useful and would be used in other secondary/high schools too.

4.11 Budget of BP-FNCE programmes

Precise information on the budgets of all the programmes was not available. Furthermore, several

Table 11: Projected expansion of the BP-FNCE Programmes: The Caribbean, June 2011

Country	n	Projection of the programmes				Systematized		Evidence of systematization	
		Other regions	National level	Other countries	The materials are still in use	Yes	No	Yes	No
Barbados	7	1	1	1	2	1	3	1	-
Jamaica	3	-	1	-	2	-	3	-	-
Regional	1	1	1	1	1	1	0	1	-
Total	11	2	3	2	5	2	6	2	-



programmes had no precise figures on the scope of the target groups so that it became difficult to accurately quantify the cost of implementation per person. The programmes being implemented in Barbados for which information was available ranged in funding from US\$9 500 to US\$12 350, but the number of beneficiaries varied widely.

Another obstacle to the calculation of the cost of implementation was the fact that, in addition to monetary funding from donors etc., there were often other, unquantified inputs from contributing entities. For example, the base funding from the World Diabetes Foundation and CFNI for the regional Lifestyle Intervention Programme was approximately US\$386 per intervention student. However, this is an underestimation, since there were separate unaccounted costs for staff time and for some of the extracurricular activities, and also contributions from schools and Ministries of Education, Sports and Health in the form of staff, equipment, facilities etc.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 BP-FNCE programmes in the Caribbean

Despite the growing problem of obesity and NCDs in the Caribbean and other problems such as rising food and fuel prices that also put the population at risk, the current research found only 11 FNCE programmes throughout the four Caribbean countries that could be regarded as using best practices. FNCE is one way of tackling the nutrition problems which are affecting the region. FNCE programmes, if well organized and adequately funded, have the possibility of reaching a wide audience. At the same time, they can be tailored to suit the needs of different target groups.

The various programmes targeted a wide cross-section of the population—infants and children, adolescents/teenagers and adults. In addition to nutrition education sessions, demonstrations and practical sessions were commonly used. This shows that the programmes recognise the importance of using these methods to assist their targeted population to transform information into action.

Several programmes for which information was collected did not qualify as BP-FNCE, and there were also other programmes for which no information was available. Some of these programmes could be strengthened, especially in the area of evaluation and feedback, which was lacking in a number of them. Information on why these programmes were not evaluated was not available, but the implementers of

these programmes need to be more cognizant of the importance of programme evaluation in generating information for strengthening the programmes and optimizing the available resources. In addition, even some of the programmes that qualified as BP-FNCE had not used evidence collected in pre-assessments to develop the programme, although other sources of information may have been used.

Although the pool of nutritionists and dietitians in the Caribbean is small, collaboration with other sectors through shared expertise, efforts and resources strengthens the implementation of FNCE programmes. Additionally, there is considerable use of resources from international agencies such as WHO (including PAHO and CFNI/PAHO), UNICEF and FAO. However, the programmes sometimes suffer from a lack of resources, which include both human and financial resources. There is a danger that if organizations do not have the organizational capacity or enough technical expertise and/or staffing to manage FNCE programmes, then food and nutrition programmes may be initiated with skeleton staffing and with an insufficient budget to cover administration, a project team or training materials. With more resources these programmes could reach a larger audience, develop more nutrition-focused teaching/learning tools, and have a better chance of being sustainable. Training in materials development and educational tools and/or training in communication would also enhance these programmes and facilitate the expansion of their reach. The materials could also be used to create a library of indigenous food and nutrition materials for education to accommodate all age groups, schools and home education.

Based on the stated programme objectives and the programme design and content, it is possible to say that programme implementers generally recognize the need to promote healthy dietary and lifestyle habits among the population. Children and adolescents were most often targeted by the programmes. However, considering the growing problems of obesity and NCDs in the region, an insufficient number of programmes are directly addressing this issue in adults. Although it is hoped that by tackling the problem of obesity in children one can develop good dietary and physical activity practices that will stay with them throughout life, there is already a cohort of adults who are affected by obesity and NCDs who should also be targeted.

The following recommendations are made on ways to improve the implementation of FNCE programmes in the Caribbean.

1. A cohesive IEC strategy for food and nutrition should be developed and implemented for each country.



2. Food and nutrition communication and education programmes should be planned based on an assessment of the prevailing food and nutrition situation and health problems.
3. The collaborative environment that already exists should be strengthened through establishing or revitalizing multisectoral committees and by sharing information and responsibility for programme implementation.
4. The various entities already involved in food and nutrition communication and education should be supported in implementing the programmes. Support can be through increased availability of resources, and the provision of training. Such training should include programme evaluation.
5. Entities planning FNCE programmes should include monitoring and evaluation components with a feedback mechanism to strengthen and improve programme implementation.
6. A planning tool, which contains the relevant information that FNCE programme planners should take into consideration when conceptualizing new programmes, should be developed and widely disseminated.

5.2 Comments on the collection of information on BP-FNCE Programmes

To the best of our knowledge, this is the first assessment that has been carried out on FNCE programmes in the Caribbean. There are limitations to the current research, as it was conducted only in four Caribbean countries, and for various reasons, not all relevant institutions/programmes participated. Though caution must be exercised in generalizing these findings, the exercise yielded valuable information on the status of FNCE in the Caribbean.

While some informants responded readily to telephone calls, e-mails or other efforts to contact them, others were not as forthcoming. Face-to-face interviews were done in a few instances. The collection of information was facilitated by the relatively small size of the participating countries, and by the fact that a country's complement of nutrition professionals was relatively small and well connected, making it easier to network. Name recognition of FAO assisted in the process of data collection.

Some key informants said that the questions were daunting and some questions required information that was not usually considered when developing and/or presenting food and nutrition programmes or health communication programmes in general. However, the questions concerned information that was relevant to programme development, that programme planners and implementers should be aware of (see Recommendation 5 above).

The exercise was an important one and the findings, if applied, will be useful in strengthening existing programmes and designing new ones.

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ANNEX I - Questionnaire

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AMÉRICA LATINA Y CARIBE
SIN HAMBRE



Form 1

Food and Nutrition Communication and Education (FNCE) Programmes

Place and Date: _____

I. GENERAL INFORMATION:

- 1. Institution(s):**
Name of the institution
- 2. Mission and vision of the institution (purpose):**
Write down the mission and vision of the institution
- 3. Address/Country:**
Mailing address of the institution, including telephone number
- 4. Name of the FNCE Programme:**
Official name of the Programme
- 5. Geographical area where the project was carried out (or is being carried out):**
Name of the departments, estates, municipalities or towns where the programme was implemented or is being implemented.
- 6. Target group(s) to whom the Programme is aimed at**
Describe who is targeted by the FNCE Programme, and give an approximate indication of the direct and indirect beneficiaries of the Programme.
- 7. Start and end dates:**
Month and year when the Programme started and finished (or will be finished).
- 8. Allied actors involved and contributions given by them:**
List the institutions that participated in the programme and specify the contributions that were made by each one of them, e.g. financial, human resources, technical assistance, materials, transportation, etc.
- 9. Person(s) responsible for the FNCE Programme (maximum 3):** Enter name(s), profession, position(s) held and organization(s) that they work for, address(es), email, telephone number(s). Specific responsibility(ies) in the Programme.
- 10. Contact person:** Enter full name, position and organization(s) that (s)he works for, address, email, telephone number.



II. DESCRIPTION OF THE FNCE PROGRAMME

11. Background, problem and context

- What is the food and nutrition situation of the population where the FNCE Programme is being carried out? What are the main problems affecting the population and their causes?
- Which social groups are mostly affected by the problem(s) (women, men, youth, boys, girls, ethnic minority groups)?
- What was the food-nutrition problem targeted by the FNCE Programme?
- Is the FNCE Programme related to any policy or strategy at national level? If yes, what policy or strategy?
- Is the FNCE Programme part of a more comprehensive programme?

12. Programme planning

- Was any research carried out to define the FNCE Programme? If yes, describe the research and its main findings.

13. Objectives of the FNCE Programme

- What are the objectives of the FNCE Programme?

14. Expected outcomes of the FNCE Programme

- What were the expected outcomes of the Programme?

15. Methodological process developed in the Programme

- What methodologies were used in the FNCE Programme? Briefly describe each one of them.
- What were the main activities performed to achieve the objectives?
- What information, education or communication materials were used?
- Were they specifically created for the Programme?
- Were they adapted from other studies or institutions? If yes, from which ones?
- Was the Programme validated prior to its introduction to the target group?

Please include a list of the materials used, and if possible a copy of each one of them on a CD.

16. Facilitators (Staff which implemented the FNCE Programme)

- Who implemented the Programme at the field level?



- What is the academic background of the people that implemented the Programme?
- Were they given any type of training? If yes, who trained them?
- What were the contents of the training?
- What was the training methodology?
- How long was the training?
- Do they have a curriculum or training programme? Please include a copy if possible.
- Were manuals developed for the staff which implemented the programme? Please include a copy if possible.

17. Sustainability

Were any strategies considered to achieve the sustainability of the intervention? If yes, please describe them.

III. EVALUATION

18. What results were obtained at the end of the intervention?

List the main findings of the evaluation

19. Was the Programme evaluated? If yes, what type of evaluation was performed?

Please describe briefly if the evaluation performed was a process or an impact evaluation, whether it was qualitative or quantitative, and who carried it out.

20. Lessons learned and recommendations to improve the effectiveness of future interventions

If you had to implement the FNCE Programme again, what would you repeat and what wouldn't you?

21. Projections of the Programme once completed

Use in other programmes; at national, international level, etc.

22. Publications

Please list publications, and include the electronic files or links to download the documents.

23. Was the experience systematized? If yes, please provide a copy of it preferably in digital format.

24. Budget and funding sources. Please indicate the total amount for the execution of the intervention and the funding sources.



ANNEX II - Scoring/Grading System for FNCE Programmes

No.	Elements of the programme	It was considered in the FNCE Programme		
		YES 5 points	PARTIALLY 2 points	NO 0 points
1	It takes into account the nutritional needs of the target group			
2	It explores the knowledge, attitudes, practices and perceptions of individuals, as well as their needs and priorities			
3	Among its objectives it includes the change of behaviours and practices			
4	It promotes not only knowledge transfer, but also specific behaviours			
5	It is based on methodologies that promote learning from practical experiences and from solving the problems that affect the population			
6	It was committed to long-term efforts to achieve a sustained behaviour change			
7	It empowers the beneficiaries so that they can make the intended changes, helping them to develop their abilities and skills			
8	It includes changes in people's environments to help them fulfil the proposed practices, e.g. sale of healthy foods at school			
9	It trained the nutrition educators ¹ in consultation, communication and/or counselling skills			
10	The assessment shows that the desired behaviour changes/ expected outcomes were achieved			
11	The Programme is part of plans and programmes that endeavour to improve the quality of life of the population in a comprehensive manner			
12	The Programme is related to a nationwide strategy/policy			
Sub-total		N x 5	N x 2	N x 0
TOTAL SCORE				

Maximum score 60; minimum score 0. A programme is considered as a "Best Practices Programme" when it gets a score ≥ 45 points.

¹ Nutrition educators, meaning the agents of change that carry out the programme, such as community workers or teachers.



There has been an increase in nutrition related non-communicable diseases such as obesity, hypertension, diabetes, cardiovascular diseases and cancers in the English-speaking Caribbean in recent years. Undernutrition in children is no longer a widespread problem. Instead, there is a growing problem of obesity in children. Micronutrient deficiencies are also common, for example, iron deficiency anaemia among young children and pregnant women. A variety of programmes have been conducted in the region with the objective of improving the nutrition situation or health of various target groups. Food and Nutrition Communication and Education (FNCE) activities are often a feature of these programmes. The FAO set out to identify the experiences and approaches used in FNCE programmes carried out in the Caribbean, in order to identify best practices in such programmes and their success factors. By compiling this inventory of best practices, we hope to provide a basis for systematizing and sharing experiences in Food and Nutrition Communication and Education. This report summarizes results obtained for the Bahamas, Barbados, Grenada and Jamaica.

