F. IMPLEMENTATION OF THE REGIONAL STRATEGY AND PLAN OF ACTION FOR AN INTEGRATED APPROACH TO THE PREVENTION AND CONTROL OF CHRONIC DISEASES, INCLUDING DIET, PHYSICAL ACTIVITY AND HEALTH

Background

79. In 2006, the Directing Council adopted Resolution CD47.R9, *Regional Strategy and Plan of Action for an Integrated Approach to the Prevention and Control of Chronic Diseases, Including Diet and Physical Activity*. The resolution urges Member States to implement integrated policies and plans, guided by the Regional Strategy, and requests the Director of the Pan American Sanitary Bureau (PASB) to strengthen Member States' capacity to implement comprehensive, multi-sectoral approaches and strengthen or establish new partnerships. The Regional Strategy follows four lines of action: policy and advocacy, surveillance, health promotion and disease prevention, and integrated management of chronic diseases and correlates well with the WHO Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, approved in 2008.

Update on Current Situation

80. Chronic diseases are now the leading cause of mortality with 3.0 million deaths[1] and disability in the vast majority of countries in the Americas. About 250 million people of a total of 890 million (in 2005) in the Region suffer from chronic diseases, mainly cardiovascular diseases, cancer, obesity and diabetes. These particularly affect low- and middle-income populations. An estimated 139 million (25%) of persons >15 years of age being obese (BMI>30) in 2005, of which 103 million were females, and rapidly increasing to reach an estimated 289 million (39%) by 2015 of which 164 million will be females.[2] There is also a growing concern over the rapid increase of obesity in children and adolescents. The toll in human suffering and economic cost from chronic diseases is enormous. Yet, these diseases are preventable and can be cost-effectively prevented and controlled through public policies, risk factor reduction, and the provision of health services for screening, early detection, and disease management. For example, the implementation of basic strategies to reduce tobacco use by 20%; salt intake by 15%; and to use simple multidrug regimens for patients with high-risk cardiovascular disease, could prevent more than 3.4 million deaths from chronic diseases in the Region over 10 years at reasonable cost.[3]

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[1] HSD/NC chronic non-communicable diseases mortality database

[2] Estimated from WHO Info Base. It can be consulted at https://apps.who.int/infobase/report.aspx.

[3] Gaziano T, et al. Scaling-up interventions for chronic disease prevention: the evidence. Lancet, 2007, 370: 1939-46; extrapolated to countries of Latin America and Caribbean countries.

81. Since the Directing Council adopted the resolution on chronic diseases in 2006, almost all Member States have made substantial progress in implementing national plans for their national chronic disease programs as noted in the End-of-biennium Report presented to the Executive Committee (see Table 1). In most cases, countries reported exceeding the Regional Expected Result indicators of the Strategic Plan related to chronic diseases.

82. During the 2008-2009 biennium, PAHO mobilized approximately US$ 21 million of the $28 million budgeted to support Strategic Objective 3[4] (non-communicable diseases (NCDs, mental health and injuries). At the international level, the resource picture for (NCDs) is at best mixed.[5] For example, in 2008 the Bill and Melinda Gates Foundation and Bloomberg Philanthropies committed $500 million to help 15 countries world-wide to improve tobacco control, of which two are in the Region of the Americas (Brazil and Mexico). World Bank lending between 1995 and 2005 was more than $300 million for NCDs and injuries. The level of Official Development Assistance (ODA) commitment to NCDs is unknown, but preliminary estimates are 1-2% of total. Most international development agencies find it challenging to support NCDs because they are not included in the Millennium Development Goals (MDGs). Nevertheless these challenges, some bilateral technical or donor agencies are investing, such as the Spanish International Cooperation Agency for Development (AECID), the US Centers for Disease Control and Prevention (CDC), and the Public Health Agency of Canada (PHAC). However, efforts to increase the level of attention and current resources are needed, given the huge burden.

Policy and Advocacy

83. In 2010 an assessment of the status of chronic disease national capacity to respond to this public health problem in the Region shows that 27 countries in Latin America and the Caribbean reported making program-related investments in chronic diseases, including having a national focal point in the ministry of health, training personnel, and creating multi-sectoral partnerships. Compared to 2005, when 63% of countries had a national focal point/unit and budget, all countries now report having such. However, more efforts are needed since only 16 countries are implementing a national plan for NCDs. In 2008, resolutions on diabetes and obesity, and on cervical cancer prevention and control, were also approved by the Directing Council. Many countries have also taken important steps to include NCDs, including medicines, in social protection packages.

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[4] Strategic Objective 3: To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.

[5] WHO. NCDnet Working Group on Innovative Resourcing Background Paper. Geneva 24 February 2010. www.who.int/ncdnet.

84. The CARMEN Policy Observatory is a joint initiative between PAHO and the PAHO/WHO Collaborating Center on Non-communicable Disease Policy of Public Health Agency of Canada (PHAC). The Observatory is a platform for the network of American countries and institutions engaged in the systematic analysis and monitoring of chronic disease policies

85. A compilation of the Latin American and English-Speaking Caribbean countries and territories legislation on prevention and control of obesity, diabetes and cardiovascular diseases was produced in 2009 and 2010 respectively followed by an electronic publication, as well as the drafting of guidelines to help in the up-grading of legislation when needed. A plan of work for the upgrading of legislation on the prevention and control of obesity in Latin America and Caribbean countries will begin in the second semester of 2010 with a regional meeting of legislators.

86. The economic, fiscal and welfare implications of chronic diseases and ageing were analyzed in a regional workshop held in 2009 with 10 countries and representatives from the Inter-American Development Bank and the World Development Bank. A regional study on economic burden will start in 2010. The output will be used to engage policy makers from ministries of health and finance in a meeting in 2011 to increase support to address NCDs.

87. At the subregional level, the Heads of State of the Caribbean Community (CARICOM) held a special summit on chronic diseases in 2007. The participants committed themselves to advance policies and monitor the implementation of the summit's declaration. On 13 May 2010, the UN General Assembly resolved to convene a high-level meeting about non-communicable diseases in September 2011, following a proposal from the CARICOM countries. RESSCAD/COMISCA[6] adopted resolutions on chronic diseases and cancer, and developed an annual operation plan that encompasses seven activities on chronic diseases. MERCOSUR[7] has made the surveillance of chronic diseases a priority to guide policy and decision makers. Courses were conducted on policy analysis and development, with special reference to chronic diseases, in the Caribbean and Central America.

[6] RESSCAD/COMISCA: *Reunión del Sector Salud de Centroamérica y República Dominicana/Consejo de Ministros de Salud de Centroamérica* (Meeting of the Health Sector of Central America and the Dominican Republic/Council of Ministers of Health of Central America).

[7] MERCOSUR: *Mercado Común del Sur* (Southern Common Market).

Surveillance

88. PAHO/WHO supports Member States in their efforts to strengthen their health information systems to monitor chronic diseases by providing guidance and tools for implementing the PanAm STEPS[8] methodology; for the surveillance of risk factors; as well as with a standardized list of minimum indicators, which includes mortality, morbidity, risk factors and quality of care. Twenty seven target countries in the Region have defined the set of NCD core indicators. Thirteen target countries have established a system to collect these data using PAHO methodology and analyzing these data from the social determinants and gender perspectives. Discussion forums on NCD surveillance have been established through technical groups of the Common Market of the Southern Cone (MERCOSUR), through the Caribbean epidemiologists' network coordinated by CAREC, and for Andean counties with the support of the Andean Health Agency (ORAS). Twenty seven target countries have produced at least one report on the situation of NCDs or included it in the report of the health situation of the country. PAHO/WHO supports the collection and analysis of data disaggregated by sex, age, and ethnic origin, including the participation of users and producers from governments and civil society.

Health Promotion and Disease Prevention

89. Healthy diet, the promotion of physical activity, and tobacco control continue to be the pillars of the regional strategy. Most of these programs lack the needed human and financial resources. Ten countries reported implementing multi-sector, population-wide approaches to promote risk factor reduction for chronic diseases.

90. A Trans-fat Free Americas Initiative was launched by PAHO in 2007 in collaboration with the private sector, which promotes regulations, guidelines and voluntary actions to eliminate trans-fats from processed foods. Such an initiative has the potential to reduce the population's risk for cardiovascular diseases.

91. The Dietary Salt Reduction Initiative with a consumption target to reach 5g/person/day by 2020 to prevent cardiovascular disease in the Americas was launched in 2009. An expert group on salt reduction was created, outlining actions for governments, industry and civil society, while preserving the benefits of salt fortification programs. Argentina, Barbados, Canada, Chile, and the United States are among the countries that have put dietary salt reduction high on the agenda.

[8] The PanAm STEPS approach to chronic disease adult risk factors surveillance was designed as part of a WHO-wide effort to help countries build and strengthen their capacity to conduct surveillance. It provides an entry point for low and middle-income countries of the Region to get started on chronic noncommunicable diseases surveillance. Similarly, Pan AM STEPS serves as a harmonizing tool to collect and display data throughout the Region in a unifying way.

92. The creation, in July 2008, of the Pan American Alliance for Nutrition and Development makes it possible to implement comprehensive, intersectoral programs that are both sustainable and coordinated, within the framework of the MDGs. The Alliance addresses social determinants such as malnutrition and poverty as a way to prevent obesity and NCDs, as often the child that is malnourished or stunted is at greater risk of obesity in adulthood. The participation of civil society in issues such as food marketing to children and child obesity has increased significantly over the past five years, notably in Brazil, Canada, Chile, Mexico, and the United States.[9]

93. Seventy-six cities of 14 countries[10] across the Americas have established *Ciclovias Recreativas* (recreational bike paths). Nine countries[11] have developed programs on Bus Rapid Transit, which contribute to reduce traffic congestion, reduce road-accidents and facilitate utilitarian and recreational physical activities. The Caribbean countries have all implemented Caribbean Wellness Day, emphasizing mass physical activity.

94. Twenty-seven countries have ratified the Framework Convention on Tobacco Control.[12] Although several countries have increased taxes on tobacco, only three Chile, Cuba, and Venezuela have achieved the goal to have at least 75% of the retail price of tobacco products be related to taxes. Eight countries have national or subnational legislation banning smoking in public places and indoor workplaces.

95. PAHO is also promoting the concept of urban health as a means to address the needs in situations of vulnerability, through urban planning that promotes safe spaces for physical activity and healthy eating habits, two important protective factors for the prevention of chronic diseases. World Health Day 2010 stimulated all the countries of the Region of the Americas to promote activities related to physical activity and healthy lifestyles. PAHO's programs on healthy schools and on healthy workplaces include attention to healthy diet, physical activity and other measures which support chronic disease prevention. A major objective of the WHO workers' health plan is healthy workplaces.

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[9] Data was obtained during the AMRO consultation (Marketing of Food and Beverages to Children) and is based on country responses. No document has been released to the public on this consultation as yet.

[10] Argentina, Brazil, Chile, Colombia, Costa Rica, El Salvador, Canada, Ecuador, Guatemala, Honduras, Mexico, Nicaragua, Peru, United States.

[11] Brazil, Chile, Colombia, Canada, Ecuador, Guatemala, Mexico, Peru, United States.

[12] PAHO. WHO Framework Convention on Tobacco Control: Opportunities and Challenges for its Implementation in the Region of the Americas (Document CE146/INF/6-E) 2 May 2010).

Integrated Management of Chronic Diseases and Risk Factors

96. PAHO, working closely with Member States, professional associations, and other partners has supported the development and implementation of evidence-based guidelines and protocols on the integrated management of chronic diseases, targeting cervical cancer, breast cancer, diabetes, and cardiovascular diseases. Currently, 18 countries report implementing integrated primary health care strategies to improve quality of care for persons living with chronic diseases. The Chronic Care Model to improve the quality of care delivered through primary health services for persons with chronic conditions has been promoted by PAHO and is being applied in 15 countries. A rapid assessment in 24 countries on disease management capacity showed the availability of guidelines or protocols for hypertension and diabetes in 23 countries (97%). Twenty (86%) have protocols for cancer, but a very low proportion have guidelines and protocols for weight control and physical activity. There are no policies for the access to some medications and services, particularly for low-income groups. All countries in the Region have a list of essential medicines for chronic diseases.

97. The Central American subregion, through the support of AECID, has developed a list of essential medicines, mainly on cancer, for consolidated subregional procurement. Chronic diseases are associated with catastrophic family expenditure, which sharpens and deepens poverty. Access to treatment for low-income persons is hindered by 39-63% of the population having to pay full cost of basic medications for diabetes and hypertension.[13] Between 25-75% of basic procedures/tests, including blood glucose monitor, x-rays, mammography, cervical cancer smears, colonoscopy, lipid profile, and dialysis, are not mentioned in guidelines to address NCDs. They are available however in about 85% of the countries of the Region. Dialysis services are accessible in 83% of countries. It is estimated that around 40% of the population have to pay from their pocket an average of $99 per dialysis session, or $15,500 a year.

Strengthening Networks and Partnerships

98. The CARMEN network of national chronic disease program managers, WHO Collaborating Centers, and nongovernmental organizations, has been strengthened and expanded to 32 countries. Regional courses have been conducted under the CARMEN school, in collaboration with academic and technical institutions in evidence-based public health practice, social marketing, physical activity, and chronic disease care.

99. In 2009, PAHO established a multi-stakeholder Partners' Forum for Action on Chronic Diseases to serve as an instrument to engage the private sector and the civil society together with Member States, given that no one sector can solve the problem

[13] PAHO, National Capacity for the Management of Chronic Diseases in Latin America and the Caribbean. 2009.

alone. This novel mechanism aims to leverage unique roles and capacities of each sector to take joint action to accomplish policy and environmental change to promote health and prevent chronic disease. Future meetings and activation are planned for 2010.

Next Steps

100. Despite the major gains made by Member States on their national chronic disease programs, the attention and resources devoted to this public health issue are not commensurate with the extent of the disease burden and economic costs. PAHO and Member States must continue working together to promote intersectoral policy changes before, during, and after the high-level meeting of the United Nations on NCDs in September 2011.

101. Member States and PAHO should make a concerted effort to build competencies and capacity for comprehensive, integrated prevention and control of chronic diseases at all levels, including surveillance, policy, tobacco control, salt reduction, healthy diets and physical activity, improved disease management, and multi-stakeholder engagement mechanisms with a strengthened stewardship role of Ministries of Health.

102. In addition, with PAHO support, Member States should continue to scale up access to medicines and quality health services for screening, early detection, and control of chronic diseases. The latter includes patient self care, especially for treating cardiovascular disease, cancer, and diabetes in populations in situations of vulnerability.

103. PAHO and Member States will continue to improve the quality and timeliness of health information designed to guide policy, planning, and evaluation, especially risk factor information, pursue gender-based analysis and novel approaches and technologies (e.g., use of telephone/cell phone surveys) to increase participation.

104. Technical cooperation between countries on successful practices and sharing of experiences on NCDs will continue to be actively pursued. PAHO will facilitate and support mechanisms and opportunities for sharing of experiences between Member States, including the CARMEN Network and electronic platforms.

105. PAHO and Member States will continue strengthening national and subregional intersectoral efforts, partnerships, and alliances as a key cross-cutting strategy. PAHO will continue to support the CARMEN Network and the Partners Forum as innovative mechanisms to support the countries' efforts to engage the private sector and civil society.

106. PAHO will strengthen efforts to support Member States to review their legislation and norms for addressing chronic diseases and tobacco control, including implementation

of WHO guidelines on marketing foods and non-alcoholic beverages to, children as approved at the 63rd World Health Assembly.

Table 1: Region-wide Expected Results (RER) Indicators Target and List of Countries and Territories Reporting Progress [14]

RER Indicator No.	RER Indicator Text	Target 2009	Countries and Territories Reporting Progress
3.1.3	Number of countries whose health ministries have a unit or department for chronic noncommunicable conditions with its own budget	26	Argentina, Bahamas, Barbados, Bolivia, Brazil, Colombia, Costa Rica, Cuba, Chile, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, Suriname, Trinidad and Tobago, Uruguay, Venezuela
3.1.4	Number of countries where an integrated chronic disease and health promotion advocacy campaign has been undertaken	10	Anguilla, Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, British Virgin Islands, Dominica, Dominican Republic, Grenada, Guyana, Montserrat, Panama, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago
3.2.4	Number of countries that are implementing a national policy and plan for the prevention and control of chronic non-communicable conditions	32 (not achieved)	Anguilla, Argentina, Barbados, Belize, Bermuda, Bolivia, British Virgin Islands, Canada, Cayman Islands, Chile, Colombia, Cuba, Dominica, Ecuador, Grenada, Guyana, Haiti, Jamaica, Mexico, Montserrat, Nicaragua, Panama, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States, Uruguay, Venezuela
3.2.5	Number of countries in the CARMEN network (an Initiative for integrated Prevention and Control of Noncommunicable Diseases in the Americas)	27	Anguilla, Antigua and Barbuda, Argentina, Bahamas, Barbados, Brazil, British Virgin Islands, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Jamaica, Mexico, Montserrat, Netherlands Antilles, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay

[14] PAHO Strategic Plan 2008-2012 (October 2007 version).

RER Indicator No.	RER Indicator Text	Target 2009	Countries and Territories Reporting Progress
3.3.4	Number of countries with a national health reporting system and annual reports that include indicators of chronic, noncommunicable conditions and their risk factors	28	Anguilla, Antigua and Barbuda, Argentina, Bahamas, Barbados, Barbuda, Belize, Bolivia, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, Grenada, Guyana, Haiti, Jamaica, Mexico, Montserrat, Nicaragua, Panama, Paraguay, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Uruguay, Venezuela
3.5.4	Number of countries implementing the Regional Strategy on an Integrated approach to prevention and control of Chronic Diseases, including Diet and Physical Activity	10 (not achieved)	Ecuador, Guatemala, Honduras, Jamaica, Trinidad and Tobago
3.6.4	Number of countries implementing integrated primary health-care strategies recommended by WHO in the management of chronic noncommunicable conditions	17	Anguilla, Antigua and Barbuda, Bahamas, Barbados, Belize, Bolivia, British Islands, Chile, Costa Rica, Cuba, Dominica, El Salvador, Guatemala, Jamaica, Montserrat, Nicaragua, Peru, Saint Kitts and Nevis, Suriname, Trinidad and Tobago, Venezuela,
3.6.5	Number of countries with strengthened health-system services for the treatment of tobacco dependence as a result of using WHO's policy recommendations.	12	Argentina, Bolivia, Brazil, Chile, Cuba, Guatemala, Guyana, Jamaica, Mexico, Panama, Trinidad and Tobago, Uruguay, Venezuela
6.2.1	Number of countries that have developed a functioning national surveillance system using Pan Am STEPS (Pan American Stepwise approach to chronic disease risk factor surveillance) methodology for regular reports on major health risk factors in adults	10	Anguilla, Argentina, Bahamas, Barbados, Belize, Brazil, British Virgin Islands, Chile, Costa Rica, Dominica, Grenada, Guyana, Montserrat, Netherlands Antilles, Panama, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Uruguay

RER Indicator No.	RER Indicator Text	Target 2009	Countries and Territories Reporting Progress
6.2.3	Number of countries generating information on risk factors (through registers and population studies); to be included in the Regional Non-communicable Disease and Risk Factor information database (NCD INFO base)	15	Argentina, Barbados, Belize, Bolivia, Brazil, Canada Chile, Colombia, Costa Rica, Guyana, Mexico, Peru, Trinidad and Tobago, United States of America, Uruguay
6.3.1	Number of countries that have adopted smoking bans in health care and educational facilities consistent with the Framework Convention on Tobacco Control	10	Anguilla, Antigua and Barbuda, Argentina, Barbados, Belize, Bolivia, Brazil, British Islands, Chile, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Mexico, Montserrat, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Suriname, Trinidad and Tobago, Uruguay, Venezuela
6.4.1	Number of countries that have implemented policies, plans, or programs for preventing public health problems caused by alcohol, drugs and other psychoactive substance use	13	Argentina, Barbados, Belize, Bolivia, Brazil, Chile, Costa Rica, Cuba, Dominica, Dominican Republic, Honduras, Mexico, Nicaragua, Panama, Peru, Uruguay
6.5.1	Number of countries that have developed national guidelines to promote healthy diet and physical activity including DPAS (Diet and Physical Activity Strategy)	10	Argentina, Barbados, Belize, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, Dominican Republic, El Salvador, Guatemala, Jamaica, Mexico, Panama, United States of America, Uruguay
6.5.2	Number of countries that have initiated or established rapid mass transportation systems in at least one of their major cities	10	Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Guatemala, Mexico, Panama, Uruguay, Venezuela
6.5.4	Number of countries that have created pedestrian and bike-friendly environments, physical activity promotion programs and crime control initiatives, in at least one of their major cities	7 (not achieved)	Brazil, Canada, Chile, Mexico, United States of America

RER Indicator No.	RER Indicator Text	Target 2009	Countries and Territories Reporting Progress
7.2.3	Number of countries which have implemented the Faces, Voices and Places initiative	12	Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, Venezuela
7.5.1	Number of PAHO publications that contribute to building evidence on the impact of gender inequalities in health	12 (not achieved)	Chile, Cuba, Dominican Republic, Nicaragua, Panama
9.4.3	Number of countries that have developed national programs that implement strategies for promotion of healthy dietary practices in order to prevent diet-related chronic diseases	16	Anguilla, Antigua and Barbuda, Argentina, Bahamas, Belize, Brazil, British Virgin Islands, Chile, Colombia, Costa Rica, Dominica, El Salvador, Grenada, Guatemala, Honduras, Jamaica, Montserrat, Nicaragua, Panama, Peru, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Uruguay
12.3.2	Number of countries with a national list of essential medical products and technologies updated within the last five years and used for public procurement and/or re-imbursement	31	Anguilla, Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, British Virgin Islands, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Montserrat, Nicaragua, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Venezuela
	Member States that have ratified the WHO Framework Convention on Tobacco Control[15]		Antigua and Barbuda, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, Ecuador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, Suriname, Trinidad and Tobago, Uruguay, Venezuela

[15] For further information please see Information Document CE146/INF/6-E.