Pan American Health Organization

Regional Office of the World Health Organization

TRANSFORMING NCD DECLARATIONS INTO ACTIONS

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INTRODUCTION

In its role of promoting the establishment of local and international networks focused on the management and prevention of chronic noncommunicable diseases (NCD) and their risk factors in the American continent, the CARMEN Network – Set of Actions for the Multifactorial Reduction of Noncommunicable Diseases – promoted on May 7-8, 2012, in Brasília, Brazil, the CARMEN Meeting 2012 - Transforming NCD declarations to actions.

Since its inception in 1997, the CARMEN Network enables the implementation of biennial meetings with the aim of not only stimulating discussion and development of programs and strategies aimed at the management and prevention of NCDs, but also strengthening and increasing the local, regional and national networks through the establishment of partnerships and collaboration mechanisms among the different social stakeholders participating in the meetings, such as government departments and agencies, nongovernmental organizations (NGOs) and academic research institutions, among others.

Organized by PAHO with the support of the Brazilian Ministry of Health and the World Diabetes Foundation, the CARMEN 2012 Meeting addressed as the central thematic core the design of mechanisms that can transform to action the Political Declaration on the Prevention and control of Noncommunicable Diseases agreed at the UN General Assembly in September 2011.

The meeting was attended by representatives from thirty-six countries of the Americas, PAHO, NGOs, academic institutions, health professionals associations, organizations such as the National Council of Health Secretaries (CONASS) and the National Council of Municipal Health Secretariats (CONASEMS), as well as contributing members of civil society.

The Pan-American Forum for Action Against Chronic Diseases was held on May 9, after the CARMEN 2012 Meeting, and was attended by representatives from government, private and civil society sectors discussing effective actions for the prevention of chronic diseases and health promotion.

OPENING CEREMONY

Dr. Joaquín Molina, PAHO/WHO Representative – Brazil
Dr. Marcos Espinal, Area of Health Surveillance, Disease Prevention and Control, PAHO – Washington DC
Dr. Anil Kapur, Director, World Diabetes Foundation
Dr. Jarbas Barbosa, Health Surveillance Secretary, Brazilian Ministry of Health

Joaquín Molina

Pan American Health Organization PAHO/WHO - Brazil

In the last century, in the early 1960s, a gradual process of change which established a new pattern of morbimortality called demographic and epidemiological transition emerged in the epidemiological profile of countries. Coupled directly to the NCD incidence rate growth, this pattern has been increasingly influenced by the environmental conditionants related to dietary patterns, sedentary lifestyle and other risk factors. This pattern has defined the way people are born and live and society unfolds.

The last meeting of the CARMEN Network in 2010 promoted a review of the progress made by countries in relation to the objectives of regional strategies for chronic diseases and provided an excellent opportunity for exchange and learning from successful experiences.

Convened again, we shall discuss the progress made since then, identifying new strategies for action and, at the same time, recognizing the achievements made in the control of communicable diseases and their risk factors. The process of reflection and information exchange to be experienced in the coming days will provide assistance to proceed with the review of targets, work plans and policies aimed at the management of NCDs. Certainly so, at the end of the event, the understanding of local and regional approaches for the control of NCDs will be further broadened.

By establishing the Strategic Action Plan to Combat Chronic Noncommunicable Diseases 2011-2022 and because of its actions of surveillance, prevention and control of noncommunicable diseases, Brazil should be considered an excellent host.

On behalf of PAHO/WHO, I thank you for your presence and wish you all a successful participation.

Welcome to all of you!

Anil Kapur

Director of the World Diabetes Foundation

NCDs should not be focused on through the prism of their numerical greatness, but rather as a public health problem of great magnitude which affects about one billion people around the world. We must address the issue broadly, covering not only the actions to be implemented or those related to prevention. We should also address the means to strengthen countries in the proper management of NCDs.

I point out diabetes as one example of the way and level of interference a non-communicable disease can cause to the health conditions of a population. People with diabetes are more likely to acquire a second disease, such as, for example, tuberculosis or HIV. All work towards the eradication of tuberculosis is threatened by the incidence of diabetes. On the other hand, there is the issue of gestational diabetes and its implications. Children born by mothers who acquired gestational diabetes are more likely to become diabetic in the future, are eight times more likely to be born with diabetes and are more likely to die during childbirth. Therefore, it is essential to ensure good maternal health, to screen cases of gestational diabetes and create mechanisms to monitor women after childbirth, providing them with preventive measures.

Moreover, it is essential to improve electronic information exchange systems, enabling case tracking and follow-up, the conduction of online training and a proper review of results. With regard to diabetes, thirty projects are currently being developed in Latin America, some of which with the financial backing of PAHO. The projects have been developed separately by each country in collaboration with the World Health Federation and the World Diabetes Foundation. It is essential that an initiative like this advances towards other diseases.

Finally, it is important to emphasize the importance of strengthening the training of health workers on the intelligent use of information technology.

Marcos Espinal

Director, Area of Health Surveillance, Disease Prevention and Control PAHO – Washington DC

Currently, the American continent has been recognized by WHO as a leading region in the management of NCDs. Advances achieved by the region in the inclusion of noncommunicable diseases in the global agenda, which culminated in the drafting of the Political Declaration on the Prevention and Control of Noncommunicable Diseases, raise this worldwide recognition, which is a source of pride for all those involved with the issue of NCDs.

Making concrete the proposals outlined in the declarations impute to all a strong commitment to transformation, with the possibility of transformation processes, be they related to policies, programs or actions aimed at both the prevention and control of noncommunicable diseases. The achievements of the

near future, advances to be obtained lie in the immediate actions, in what we do today.

I must recognize the important role played by national program managers present here in the conduction of research on national capacity for NCD prevention and control. It was possible to identify through it key information to design the profile of each country; information already compiled and, once reviewed and discussed, will be the basis for the definition of the Regional Strategy for Prevention and Control of NCDs, to be submitted in June to the PAHO Executive Committee and in September at the Pan-American Health Conference.

The CARMEN 2012 Meeting is the first event held after the adoption of the Political Declaration on Prevention and Control of Noncommunicable Diseases. Thus, it is timely to share successful experiences, advances and challenges to learn effective strategies for the prevention and control of noncommunicable diseases.

PAHO must not just promote technical cooperation at the regional, sub-regional and national levels, but also contribute to the design of standards through the viability of situations in which dialogue and multisectoral action can be established. The meeting of the CARMEN Network will enable the debate between Member States and civil society representatives. The Pan-American Forum for Action on Noncommunicable Diseases will extend the debate to a wider audience to consider the participation of representatives from the private sector, academic institutions and other civil society organizations. The responsibility for the management of NCDs does not only rest with governments, but with all citizens.

The meeting which is about to begin here will allow everyone to share the best experiences and draw guidelines for the future.

Jarbas Barbosa da Silva Júnior

Health Surveillance Secretary – Ministry of Health – Brazil

Brazil has today a Strategic Action Plan to Combat Chronic Noncommunicable Diseases for the period 2011-2022. Due to the fact that Brazil has a complex and decentralized health system, the design of this plan involved a broad set of actions permeated by countless negotiations processes which involved different social stakeholders. Experts, representatives from state and municipal health secretariats, civil society and also the people themselves through public consultations took part in the drafting process. The set of actions resulted in a plan consisting of global targets and axes of action.

Although the definition of global targets for various epidemiological situations is considered a process subject to limitations, we chose to establish a number of global targets, for these are essential to the monitoring, follow-up of results and assessment of progress achieved. Thus, the following global targets were outlined: reducing the rate of premature mortality (<70 years) caused by NCDs to 2% per year; reducing the prevalence of obesity in children and adolescents; delaying the growth of obesity in adults; reducing the

prevalence harmful alcohol consumption; increasing the prevalence of leisure physical activity; increasing the consumption of fruits and vegetables; reducing the average salt intake and reducing the prevalence of smoking.

Guided within the structuring limits imposed by the set of global targets, action programs were established and divided into three axes of action which complement one another: Axis I – Surveillance and Monitoring; Axis II – Prevention and Health Promotion; and Axis III – Comprehensive Care – aimed to control and improve the quality of life of patients with NCDs. Several actions have been showing effective results since the implementation of the plan.

With regard to surveillance and monitoring, three programs should be highlighted. The first one concerns the monitoring of risk and protection factors for noncommunicable chronic diseases, which has been implemented annually since 2006 by the Vigitel through telephone survey program. This program seeks not only to measure the prevalence of risk and protection factors for NCDs, but also to support with its information the establishment of health promotion and prevention actions. Risk factors are monitored by it. The recorded data give rise to a historical series, a source to assess trends and to define specific policies. For example, data collected by Vigitel show significant reduction in the percentage of adult smokers in Brazilian capitals; a current prevalence of 14.8%; higher incidence of smoking among people with less than eight years of schooling; reduction of physical inactivity – among men, from 16% (2009) to 14.1% (2011); significant growth in the number of overweight people, both among men and women, 52% and 45% respectively, in 2011; growth of the Body Mass Index (BMI) in people over 30 years of age, from 11% to 16%; growth in the number of women (50-69 years) who underwent mammography in the last two years, from 71.2% in 2007 to 73.3% in 2011; and an increase in the number of diagnoses of diabetes in adults (≥ 18 years of age), especially in males, from 4.4% to 5.2%.

Another important monitoring and surveillance program is the National Health Survey, conducted every five years, through which information of high qualitative value essential to the decision making processes is obtained. The survey conducted in partnership with the Brazilian Institute of Geography and Statistics (IBGE), the body responsible for population census, generates information related to the situation of people's health, risk and protection behavior, access to health care and use and financing of health services. Its instruments are data collection, household and individual questionnaires, anthropometric tests, collection of biological material (blood and urine) and blood pressure measurement, among others.

Associated with these two monitoring and surveillance programs is the National Students Health Survey (PeNSE). Aimed at determining the prevalence of behavioral risk factors in adolescents, monitoring trends over time and generating evidence to guide and assess the impact of interventions in reducing the prevalence of risk factors and the promotion of adolescent health, the survey is conducted every three years by the Ministries of Health and Education and by the IBGE, with adolescents from the 26 Brazilian state capitals and the DF (Federal District) enrolled in the 9th grade of elementary education at public and private schools. The latest survey results showed that

boys (60%) practice more physical activity than girls (31.3%); 63% of teens make regular use of tobacco; 31.5% eat beans at least five days a week and 62.6% fruits; 50.9% consume sweets and 37.2% take soft drinks.

Regarding prevention and health promotion actions, some programs are worth mentioning. The Health Gym Program provides to communities, especially those of lower income, a location with equipment for the practice of physical exercises to be performed under the guidance of professional experts funded by local government. Currently, 1,760 municipalities participate in the program. Four thousand new facilities will be deployed by 2015. All units are directly interconnected to the primary health care actions, known in Brazil as the Family Health Strategy. The Health in School Program, an activity conducted by the Ministries of Health and Education, promotes annually the Health in School Mobilization Week. In the latest event held in March 2012, with the topic of Prevention of obesity in childhood and adolescence, 11 million students aged 5 to 19 years from 2,271 Brazilian municipalities were assessed, including with regard to BMI. All students identified as overweight were referred to the monitoring of a Family Health Strategy team.

In addition to these two programs, actions specifically aimed at promoting healthy food have been implemented. The establishment of important voluntary agreements with different social stakeholders should be emphasized. With the production and industrial sector, to reduce the amount of sodium in manufactured or handmade foods - French bread, ready-made cakes, mayonnaise, sweet biscuits and crackers, reduction by 2014; French fries, straw potatoes, cake mixes and corn chips, by 2016 – or with the National Federation of Private Schools, for the implementation of Healthy School Canteens which will market only healthy foods to students.

As to smoking, new legal instruments have regulated smoking in enclosed public premises, the maximum limits of tar, nicotine and carbon monoxide of cigarettes and restricted the use of additives in tobacco-derived smoking products, prohibiting their use to disguise the smell of cigarette. A similar stance was adopted regarding alcohol. New legal instruments were established with the aim of curbing motor vehicle driving after consuming alcoholic beverages.

At the same time, active aging has been addressed by several initiatives: directly aimed at the elderly, fostering the practice of regular physical activity and the increase of self-care and rational use of drugs autonomy and independence; aimed at PHC professional teams, training for the treatment, reception and care of the elderly and people with chronic conditions; aimed at the community, training of caregivers for the elderly and people with chronic conditions.

Joining these actions are the promotion of mobilization and dissemination campaigns, such as Living Well is Healthy Living, anti-smoking campaign, a campaign to increase the consumption of fishery, campaigns conducted in partnership with the Brazilian Association of Supermarkets, advocating the adoption of a healthy lifestyle with less salt, or with the Brazilian Association of Advertising Agencies, conveying the proposal that immediate action is required for a healthy old age.

Regarding Axis III, actions for the strengthening of the network for the prevention, diagnosis and treatment of breast cancer and cervical cancer will result in investments equivalent to R$ 4.5 billion by 2014. The increase of mammography coverage in women aged 50 to 69 years, the increase of the percentage of high-resolution tests and the increase of the proportion of women diagnosed with cancer, whose treatment begins within 60 days are expected to occur this year. Currently, statistics show an increase in the number of mammograms performed in the country. However, in the face of regional inequalities, in the poorest states, it is observed that women's access to the test is still difficult, many tests were performed in low-resolution mammography and a long time interval occurs between the test and the delivery of results.

In addition to the prevention, diagnosis and treatment of breast cancer and cervical cancer, it is worth mentioning other important programs included In Axis III. The People's Pharmacy Program, composed of its own network of pharmacies and a number of private pharmacies associated with it, enables Brazilian free or at subsidized prices access to a series of drugs. The "Health is Priceless" Program provides free drugs for the treatment of hypertension and diabetes. The "Health at All Times" program, composed of the Emergency Care Network (RAU), increases and qualifies the humane and full access of users in emergency situations, by providing in swift and dynamic fashion a communication system between the central regulatory offices of SAMU 192, the Emergency Care Facilities (UPA 24h), the Basic Health Care Facilities (UBS) or hospitals; a system that makes emergency care faster and more efficient. And, the Home Care Service (SAD) – Health at Home enables patients to receive health care in their homes in a more humanized way.

As an Axis III program, it is worth mentioning the National Program for the Improvement of Access and Quality of Primary Health Care (PMAQ-AB), a program that includes a process of continuous improvement of health services endorsed by the three levels of government – federal, state and municipal. Through the PMAQ-AB, the quality of professional performance of health teams measured by teams outside the health system is linked to an additional transfer of financial resources. Health teams displaying a work performance consistent with established standards receive extra funding in addition to the amount originally planned. Some performance measurement markers include activities for the diagnosis and treatment of NCDs.

Finally, we must not forget that the CARMEN Network was established at a time when it was erroneously thought that chronic diseases are a problem inherent to the rich and developed countries. Currently, we know that NCDs not only affect the poorest people, but are also an agent of impoverishment.

SESSION I

NCD POLICIES: FROM DECLARATIONS TO ACTIONS
KEYNOTE ADDRESS
FROM DECLARATIONS TO ACTIONS

Dr. George Alleyne, PAHO

My participation in this meeting, which celebrates the fifteenth anniversary of the CARMEN Network, gave me the opportunity to reflect not only on the current context of NCDs, but also on the development, the role and operation of the network in achieving different hopes and aspirations towards the prevention and control of noncommunicable diseases.

It is known that statements have an important role in outlining policies and strategies. They rarely reach the scope of actions to be implemented. Turning policy into action has nowadays been one of the crucial factors of the work of public managers. Ways to make this "transformation" process more effective are being sought for years, without, however, achieving great success. The failure of this quest has been a source of frustration for professionals involved in the management of programs and, simultaneously, of impatience for the politicians. In political circles, it is not rare to pin the responsibility for not implementing a given policy on the wrong or nonexistent action of public managers. In governments where public service does not meet, on a priority basis, the needs of voters, especially in small societies, the difficulty in understanding the problems related to the process of transforming policies into action is very serious.

Literature richly shows theoretical and methodological conceptions about the process of transforming policies into action. Among the many publications, it is worth mentioning USAID's "The art of moving from policy to action" – a process which in fact should be considered an art –, in which ten topics are presented to make a policy become action. Among them, I shall highlight the ones most relevant to policies stemming from statements on NCDs.

The first element to be highlighted is regarding data. The analysis and use of data cannot be underestimated, but rather evidenced, provided that we always assume that data itself is virtually useless. Therefore, data must be analyzed and transformed into information, a process that depends not only on relations of power or computing resources, but on several variables. Aspects relating to the use of information, such as, for example, to whom it is addressed or when and how it is presented should be considered.

Most experienced politicians do not like their sins of omission to be reminded by the presentation of information that criticizes them frontally and publicly. We are currently facing the challenge of promoting the fusion of evidence and data with the enthusiasm in vogue of formulating “evidence-based” public policies, a term whose origin, as has been stated, seems to stem from evidence-based medicine. In particular, I question the indiscriminate use

of the term "evidence-based", as well as its application to anything whatsoever, including policy development. Some important aspects must be considered in this regard. It should be considered to be impossible to say that past policy decisions have not been conducted based on evidence or made from empirical findings or other ideological bias common to the resolution of any public policy. One must consider that evidence is necessary, but not sufficient for structuring a good policy. Finally, we must consider that not all evidence-supported policies are good policies. We seek a good policy supported by solid evidence. The ultimate test of any policy is achieving the objectives for which it was framed.

Leadership and governance are on the list of the ten topics listed in the publication. The abandonment of a particular statement by political leaders is a true elicitor to the possible failure of a given policy. Effective leadership signals guaranteed resources, as well as the implementation of activities aimed at assessment, monitoring and accountability. Monitoring and assessment that are dissociated from a process of accountability are not the ideal way to the successful implementation of a given policy.

In this context, leadership involves not only the summit of managers, but also the whole range of individuals and organizations that have interests linked to policy outcomes and may exert some influence capable of making the implementation of the policy a quite successful action. The recent Lancet series, which includes articles on noncommunicable diseases, emphasized the critical role that national and international leaders have in transforming policy into action. Governance, understood here as structures and processes, is also required for the optimal execution of a policy.

The third element relates to the planning, now effectively made possible by the use of several management approaches and tools to promote the proper distribution of responsibility and the allocation of resources and responsibilities to achieve the objectives.

We must understand that the process of defining a public policy set forth by a statement or not is not linear, but rather permeated by challenges to the logic, not always subject to the application of quantitative data structured by analysts. Therefore, the movement of transforming policy into action should include an interactive process in which analysis and review in an atmosphere of learning are allowed. The steps to be followed in this transformation process cannot be strictly separated, since they often overlap conceptually and operationally.

An analysis of the processes by which statements dealing specifically with NCDs – regional and global levels of the United Nations and resolutions of PAHO Governing Bodies for political statements – shows interesting aspects in the actions.

In 2000, PAHO Directing Council adopted Resolution CD42.R9 on cardiovascular diseases, especially hypertension, in which it recognized the need to adopt measures aimed at the prevention and control of cardiovascular diseases. In 2002, the Sanitary Conference adopted another resolution, particularly significant for the CARMEN Network.

"In accordance with Resolution CD42.R9 on cardiovascular diseases, with emphasis on hypertension, which endorses an integrated approach to the prevention of cardiovascular diseases through the Set of Actions for the Multifactorial Reduction of Noncommunicable Diseases (CARMEN); and noting that CARMEN is a path for the integration of risk factors and diseases; ...

Approve the CARMEN initiative as a major strategy for the integrated prevention of chronic diseases.... "

In the document, it asks the Director to:

"Provide technical cooperation to Member States in the development of an integrated approach to noncommunicable diseases, based on the CARMEN initiative..."

The way which the Directing Council granted the leadership and support to the issue of NCDs is now an important historical fact, as is the progress made by the CARMEN Network. In 1997, the Network was established two years after the creation of PAHO's program for noncommunicable diseases. In one of its first meetings, Armando Peruga suggested its name, referring to the opera Carmen by Bizet. In proposing it, he wished that the initiative, being as beautiful as the seductive gypsy, would not see a fate similar to that of the character, killed by the jealous lover. I remembered the beautiful Carmens of Albaicin, in Granada, Spain, homes built in the Moorish tradition on the slopes of the region. At the time, the term "multifactorial" was dropped. However, its conception is still important.

I would like to refer to two important declarations, the Regional Strategy and Action Plan on the Integrated Approach to the Prevention and Control of Chronic Diseases, established by PAHO Directing Council in 2006, and the Political Declaration of the UN High-Level Summit on the Prevention and Control of Noncommunicable Diseases, agreed in September 2011.

It is gratifying to note the careful review and detailed monitoring being carried out by PAHO, as well as the extent of available data on each Member State. It is clear that many parts of the declarations were or are being translated into action. The final report is nearing completion and will clearly show the results achieved and will emphasize aspects that currently require a more targeted approach. I shall make some considerations about them.

The first one seems critical to me, because it goes to the heart of problems related to the transformation of declarations into actions.

"Despite the great gains achieved by Member States in their national programs for chronic diseases, the attention and resources devoted to this public health issue are not proportional to the extreme severity of diseases and economic costs. PAHO and Member States must continue working together to promote intersectoral policy changes before, during and after the meeting of the UN High-Level Summit on NCDs".

Intersectoral action is the key to getting successful responses to the issue of noncommunicable diseases. The UN Political Declaration mentions the term "intersectoral" for at least fifteen times throughout its text, associating it with other terms, such as national policies, interventions, action, approaches

and commitment. The main problem with intersectoral actions is the real incentive and promotion of genuine intersectoral action. The first issue to be addressed, which is related to the premise that intersectoral action stems from the multifactorial and multisectoral nature of risk factors, encompasses the division of multisectoral categories that are vital to NCDs. Thus, one has to observe the different dimensions of intersectoral action. There is one called "government's approach", which involves the distribution of administrative responsibilities among the sectors of public service, finance, agriculture, education, transportation, among others.

There is another one regarding the pluralist State, a reality of our days, and its three main stakeholders, the public sector or government, the private sector and civil society, the latter characterized not by a monolithic block, but rather a wide range of stakeholders, for example, different non-governmental organizations, called "society's approach".

The cry for a multisectoral public health approach is old. The widespread yearning for sectoral collaboration is far less attractive than the firm intention to perform a joint work towards specific issues. NCDs are an issue clearly benefited by multisectoral action. All risk factors can only be handled competently through multisectoral action.

We are aware of its decisive role in the positive outcomes achieved by different primary health care actions. Therefore, one has to question why there is still anxiety about the productive capacity of joint action. Although intrinsically different, since there may be a multisectoral approach without intersectoral action, I do not make a distinction at this point between the two approaches. There are several reasons for the lack of progress of multisectoral approach. I believe that the main one refers to the begging posture adopted by the industry while addressing other sectors, asking them for help. The health sector seldom displays its important role in the promotion of human development, the platform of any government. It fails to demonstrate in justified and documented fashion the argument that health is a fundamental aspect in the process of human development. One of the major shortcomings of technical cooperation to countries nowadays is not providing the health sector with tools to advocate this argument on the tables of power.

On the other hand, intersectoral action does not arise spontaneously. Motivating the process of emergence and maintenance of intersectoral action is a challenge to be faced, which is worsened when the areas for multisectoral action are not clearly identified. The creative movement should stem from both the base and highest levels of government. Intersectoral action in democratic governments is often stimulated by the decision of government leadership and certainly becomes more attractive when there are voices at the base urging it.

State-level multisectoral action faces different challenges because it deals with the public sector, private sector and civil society. Theoretically, government sectors strictly follow a coherent pre-established policy; they are mainly concerned with the distribution of public goods and the maintenance of public order. Civil society represents community values, but, because it is composed of different groups, has difficulties in finding a common expression of its interests. The private sector is mainly concerned with the efficient

production of products and services. In this case, multisectoral action does not necessarily deal with the three stakeholders simultaneously but, in practice, always involves sections forming part of the three sectors, imputing to it a high level of challenges. Today, we can see a major movement by which the three stakeholders support the effective involvement of all in the programs related to health promotion, adopting contribution and collaboration demeanors. A movement which is a new concept of shared values. For example, regarding NCDs, we noted that there was a slowdown in the negative role of the private sector in combating smoking.

Civil society has shown it can play an important role without contributing directly to the management of programs that are policy objectives. The NCD Alliance, a partnership of four major NGOs related to the four main NCDs, provides us with an excellent example of the role that civil society plays in the lobby for the adoption of structured policies and proposals. The Caribbean Health Coalition presents us with a similar example at sub-regional level.

There are always discussions about the role of each of the three stakeholders in a public policy. The dominant view states that the government is responsible for the definition of policies relating to issues such as NCDs. The private sector's roles are to implement policies and translate them into action, as well as to provide data, to inform policies and to never participate in the formatting of the policy itself. In turn, civil society must advocate for the formulation of good policies and support their implementation locally. The guardian role of civil society can be clearly seen in relation to actions to promote healthy eating habits.

More than PAHO Resolutions, the UN Policy Declaration emphasizes that NCDs are a challenge to development, a concept imputing an even larger role to the process of transformation of policy into action. It is not appropriate to address here the various factors that contribute to national development, or even the national human development. Actions to achieve and keep this development in sustainable fashion depend on broad measures that involve the interaction of three large areas: social, economic and environmental. When they suffer the impacts caused by each of these areas, NCDs affect the level of human development. Therefore, actions that ensure development must include the prevention and control of NCDs.

Some of the policies defined in the Political Declaration of the United Nations require international or intergovernmental actions, some of them with cross-border vectors. There is a belief that the standard capacity of action resides primarily within the borders of a particular nation. However, the recent global financial crisis has shown us that some problems require a genuinely global approach that can cross the sovereignty of each State. It is hoped that this appetite for global governance is experienced in health-related matters. The field of NCDs can be submitted to this approach.

Finally, we should not forget to address the role that the CARMEN Network has been developing in the process of turning statements into actions. History shows us that the network has been an essential part of the process. By revealing what really works in practice, demonstration sites provide tools to

establish the full advocacy of the approaches to be adopted. The work of civil society involvement is exquisite. The wide range of sensitized stakeholders strengthens the ability to mobilize public opinion and also evidences concretely the existence of a multisectoral approach. The development of the observatory as a source of information and education is essential to the existence of any network, which only becomes viable if a source of energy is there to keep it. The credit of this energy's supply lies with PAHO, which also enables the emergence of a stronger voice both nationally and regionally.

The survival and growth achieved over these fifteen years is an indication of the strength of the CARMEN Network. Given the numerous challenges to be faced, especially now, with the increasing attention to NCDs at regional and global levels, we need to further integrate diverse talents in large quantities around the major goal to ensure that grandiose and ambitious declarations are translated into actions that can prevent and control NCDs, both at individual and population levels.

Let me wish you success. I believe that the CARMEN Network will remain as beautiful as fifteen years ago, or become even more beautiful.

Comments and recommendations:

- Health policy should not be done "in isolation", but based on evidence. There are fantastic ongoing experiences aimed at the prevention of risk factors in different countries;

- To be successful, initiatives focused on healthy eating habits must always be adapted to the family context;

- It is important that projects are strongly institutionalized, transformed into law before the end of each government. The politicization ensures sustainability and the continuity of projects;

- The social movement aimed at the prevention of NCDs at the local level must be strengthened;

- It is strategic to raise the awareness of public opinion makers, sensitizing them about the NCDs. It is essential that agencies or local bodies constantly produce and disseminate reliable information on risk factors and NCDs. Universities are great settings to sow the seed of public opinion, since students will be the great advocates of the future;

- PAHO cannot punish countries; it is not the role of the organization. Its mission is to offer technical cooperation to them;

- One of the problems is the ongoing stagnation regarding "binary thinking" in terms of right and wrong. We must give attention to positive and negative aspects in all the projects. We must change the way we think;

- How to allocate the amount of available funding? This is a key question, because financial resources should be allocated where they will be more effective. Much of the available resources are often intended for

healthcare and not prevention. We need to think about the two aspects in order to establish priorities.

DISCUSSION PANEL
COUNTRY PERSPECTIVES ON MOVING NCD DECLARATIONS TO ACTIONS

Dr. Sylvie Desjardins, Canada
Dr. Margarita Claramunt Garro, Costa Rica
Dr. Blanca Estel Fernandez, Mexico
Dr. Yvonne Lewis, Trinidad & Tobago

Topic – Impact of the UN High-Level Meeting on NCD management policies

Mexico – Dr. Blanca Estel Fernandes

As is the case with other countries, Mexico notes the serious effects caused by chronic diseases in the health of its people. Diabetes, followed by cardiovascular diseases, is the leading cause of death of Mexicans. Thus, in addition to establishing internally intersectoral programs aimed at the structuring of policies and the development of prevention and control of NCDs, Mexico has sought to actively participate in various meetings held to discuss the issue of NCDs.

The country has observed that international agreements and international support are very important for the management of NCDs because, among other things, they provide reference for the conduction of actions and measurement of outcomes. Thus, it has sought to define its work proposals in line with both internationally agreed strategies and recommendations.

Discontinuities caused by periodic changes at the Government's command are one of the main constraints to NCD control and prevention programs today in the country. To address this issue, Mexico has relied on the systematic collection of results achieved by actions developed in the management of NCDs and the review of these results in light of international references. This initiative has enabled the structuring of a reliable source of information which is used as a subsidy to perform along with new managers and politicians a sensitization process to support the continuity of NCD management programs. This line of conduct has caused continued effective actions, regardless of changes of government, even becoming emblems of the new government programs.

Trinidad & Tobago – Dr. Yvonne Lewis

The High Level Meeting resulted in important advances, especially in relation to the control and prevention of NCDs. Since 2006, Trinidad & Tobago has emphasized the issue of NCDs as one of the essential elements of its government programs. Three movements supported this prioritization process, namely, a national consultation, the Meeting of Caribbean countries and the UN High Level Meeting. Entrusting NCD management to Heads of Governments has led to extremely positive effects in the country. Until then, although effective, the activities implemented by the Ministry of Health proved insufficiently strong when analyzed from the perspective of the national context. Due to the new focus given by the High Level Meeting, NCDs were no

longer seen exclusively through the prism of health and started to be considered a factor falling under the responsibility of the government to be analyzed from different perspectives, including the economic one. Since most answers to questions related to NCDs are not linked to the medical perspective, but rather include other sectors, Trinidad & Tobago, with the backing of the governmental summit, has been discussing the issue and developing mechanisms related to the management of NCDs with various sectors. Thus, it seeks to meet the recommendations proposed at the Meeting and, consequently, promote the improvement of health markers in the country.

Costa Rica – Dr. Margarita Claramunt Garro

The series of declarations, including agreements between Latin American countries in relation to chronic diseases, has led to an important platform to promote the implementation of action aimed at NCD prevention and control. It became a tool capable of bringing about the integration of Central America Heads of State, authorities and managers around the design of new activities and the strengthening of the ongoing ones. As a consequence, different activities were optimized, such as: consolidation of a food safety plan; implementation of the smoke-free law; establishment of a public and physical health plan; and implementation of systems for the monitoring of risk factors and of prevention activities aimed at the school's population to foster physical activity and healthy eating habits.

Canada – Dr. Sylvie Desjardins

The High Level Meeting ratified by the United Nations Assembly in September 2011 played an important role for Canada in that it advocated action proposals related to NCD promotion and prevention compatible with those that had been adopted by the country for some time. Based on the meeting, all Canadian provinces committed to working closely, involving the various NCD-related sectors and not just the health sector in order to ensure to the population the social, economic and physical conditions capable of promoting the well-being of Canadians. One of the avenues chosen addressed the population. The implemented activities made the population aware about the different aspects related to NCDs and, consequently, become a natural partner, a collaboration core and a driving force for the process of design and implementation of actions related to the management of NCDs. The future will show the results of these actions. Without any doubt, declarations like the UN's provide the inputs needed to perform this work and make the Canadian population nationwide continue to realize the seriousness of NCDs, increasingly committing themselves to actions aimed at reducing the markers related to these diseases.

Topic – challenges faced in the process of transforming the proposals contained in the declarations into actions

Trinidad & Tobago – Dr. Yvonne Lewis

Although familiar, the concept of multisectoral action is still uncommon among health professionals, since in the past, chronic diseases were only seen through the prism of treatment and care and little from the standpoint of prevention. The current concept imposes the challenge of forming partnerships with agents not traditionally linked to the health sector. Thus, Trinidad & Tobago began working together with PAHO in the establishment of partnerships, leading different sectors to discuss NCD-related issues.

As an example, it brought up for discussion with the private sector, specifically with the food industry, the impact of fatty foods and with high-sugar levels in NCD epidemics. In dealing with NGOs and civil society different agendas, it found different ideas than those advocated by the Government. The establishment of partnerships has been a challenge, but on the other hand, has been an opportunity.

It is a process that involves not the imposition of laws, but rather the gradual building of an avenue permeated by negotiation activities, in which information is a valuable tool. For example, the elimination of hydrogenated fats in processed foods has brought about discussions with the food industry in which interests and limits were discussed, including the issue of generating unemployment due to the elimination of trans fat from food. However, during the process, the different interests and limits gained new focus when they started to be analyzed from the perspective of promoting the health of the population as a whole. Therefore, one of the biggest challenges to be faced is the establishment of partnerships with different social stakeholders, the private sector, civil society, chambers of commerce, manufacturing sectors, associations and cooperatives, among others.

Mexico – Dr. Blanca Estel Fernandes

The integration of actions for health promotion and NCD prevention for a population of more than 110 million inhabitants scattered and with great cultural diversity is one of the main challenges facing the country today. Associated to it is also the challenge to integrate these actions with other health care services. Mexico has more than nineteen thousand health facilities, distributed in different service-providing institutions and also with the popular insurance, a new type of service that is still under construction.

The country has been developing work sites involving different sectors, which have shown positive results. For example, the National Strategy to Combat Overweight and Obesity implements actions aimed at 70% of the Mexican population that is overweight, a factor directly related to the increase of chronic diseases. One of the initiatives essential to the effectiveness of this Strategy was the creation of a council to deal with the issue of overweight and obesity, composed of 15 secretariats, such as, for example, economy, food and public education. Great advances have been achieved by the Strategy, especially the involvement of civil society with the issue of NCDs. Healthy

eating habits in schools, fostering physical activity are examples of achievements. Finally, it is important to note that, in order to become effective, the integration of actions requires an information system capable of providing support not only to the alignment of national policies among themselves and with international covenants, but also to the monitoring and analysis of results obtained regarding the performance of other countries.

Costa Rica – Dr. Margarita Claramunt Garro

The mobilization of resources to support the achievement of the proposed targets for the next ten years, as well as the establishment of strategic intersectoral alliances, involving various bodies, including civil society and the private sector, are the main challenges faced by Costa Rica. In the coming weeks, the country will host for the first time a national congress with the industry to discuss the issue of chronic diseases. The issue has been addressed mainly with the food industry, to promote the elimination of trans fats and reduce the levels of fat, sugar and sodium in processed foods. Recently, the country enacted legislation aimed at promoting healthy eating habits in schools, whose implementation faced movements of resistance on the part of the food industry. In this process, it can be noted that the political backing stemming from the high-level summit is fundamental to enact the proposed actions and to ensure timely access of the population to the health system. Today, the country's health services promote coverage of ninety percent of the population. However, ensuring access to quality services is a major challenge.

Canada – Dr. Sylvie Desjardins

The operationalization of the declaration, the definition and establishment of sustainable multisectoral actions, a process that requires a shift in the paradigm of work employed by the country up to that moment, by advocating that action takes place in interface with various sectors whose vocabulary and culture differ from those adopted by the health industry, turns out to be a major challenge for Canada. Promoting the understanding and discussion of health issues with various sectors, sensitizing them to prioritize health promotion at the expense of other priorities and goals, revealing to them the benefits to be achieved as a result of improved health conditions of the population requires a careful design of initiatives, as these should be capable of promoting the creation of successful partnerships, the adoption of a common language and the establishment of policies favorable to all social stakeholders. The country does not yet have concrete evidence to support this process of raising awareness and discussing with other sectors, there is still no objective information indicating the impact of improved health conditions of the population under the performance of each sector and the economic markers of each sector and of the country as a whole. Multisectoral action requires the development of participatory and transparent discussion processes, in which the rules of engagement and conflicts of interest among social stakeholders are brought to light. The management of this process of negotiation and the establishment of partnerships brought new elements to the competence profile of health professionals, who now have to master the ability of reasoning, qualitative listening and knowledge of the technical information

necessary for the effective management of the negotiation process. The declaration mentions multisectorality fifteen times, however, the country is faced with scarce resources for the qualitative construction of multisectoral action, not knowing how to make it possible before the many challenges to be faced.

Topic – suggestions aimed at countries experiencing similar challenges

Mexico – Dr. Blanca Estel Fernandes

The effectiveness of multisectoral work in the country was ensured through the presidential support to the developed actions, which resulted in the commitment of the entire summit of managers and the involvement of the highest spheres with the issue of NCD management. Another essential aspect to be adopted is the formation of a bank of information that enables countries to compare markers, assess the results achieved and analyze the progress made by all the nations.

Canada – Dr. Sylvie Desjardins

Canada has taken measures to prevent NCDs, providing Canadians with information and conditions for the feasibility of a healthy life. In addition, the local Agency for Health Research has adopted NCDs as one of its main lines of research, a fact which will provide critical scientific data for the development of actions aimed at NCD prevention. In parallel, different policies and legal instruments encompassing preventive measures for chronic diseases have been enacted, leading to significant results. Regarding tobacco, for example, the country has obtained significant effects. Markers continue to subside throughout the country, thanks to the adoption of a set of policies and programs aimed at tobacco control. School is one of the most important places for children to learn healthy lifestyle habits; programs to promote healthy living in schools were established throughout the country. Moreover, the government has undertaken actions aimed at reducing childhood obesity and promoting physical activity, acting as a catalyst, an agent of mobilization and integration of different sectors that are somehow related to the promotion of people's quality of life. With the premise of achieving effective results and making viable accountability actions, the government established specific lines of conduct. Strategies developed for the management of cancer is a good example. The government created a fund for cancer control, an independent organization that has established partnerships with experts, agencies, health organizations, social organizations and local governments and has significantly optimized the service provided to the population in cancer control. Similarly, such stance is being expanded to other sectors, achieving effective results.

Costa Rica – Dr. Margarita Claramunt Garro

Besides the suggestions already made, it is important to stress the need to improve the collection of epidemiological data, since these are an essential tool for monitoring, comparison of results between countries, survey of trends and needs regarding NCDs and intersectoral coordination of work from care to rehabilitation. Reliable and timely information is an effective weapon for the design and implementation of activities related to communicable diseases. One

has to consider that any NCD-management action should scale both the government and the non-governmental sides, since both sides have interests, needs and contributions to be respected. The private sector, previously seen as an enemy, should be involved and sensitized, since it has an important role to play in the prevention of chronic diseases. One has to build increasingly coordinated coalitions for NCD management, holistically and not piecemeal, as is occurring today.

Trinidad & Tobago – Dr. Yvonne Lewis

The advances of public health in the control and prevention of NCDs are enabled through a paradigm shift, which requires the exclusive biomedical approach of the NCD issue to include other social determinants. There is a custom to conceive chronic illness only through the prism of the disease. However, the paradigm shift is a valuable opportunity to begin analyzing NCDs through the prism of health promotion. For it, the focus of action is broadened, allowing other agents to be involved with the process of managing chronic diseases. All are part of the causes of chronic diseases and all may provide keys to improve all the efforts for NCD control and prevention. In order for this paradigm shift to occur, it is necessary to develop a common language that is understandable to all social stakeholders. In parallel, it is necessary to improve the documentation of actions. Working from this perspective opens up opportunities, enables the establishment of commitments towards improving the quality of life of people and provides a way to revolutionize the health system of a country.

Comments and recommendations:

- Social mobilization is a "key element". It is important to include non-healthcare collaborators in the initiatives aimed at the prevention of risk factors and NCDs;

- Implementing change is not easy. There is a certainty that changes must occur in the easiest way possible. However, it is essential to include civil society, not just resorting to restrictive measures through the establishment of standards or regulations. Laws have an impact, but the best strategy is one that occurs “bottom-up”;

- The dissemination of good practice and evidence is key task for all who are involved in the fight against NCDs. There is a need to systematize information and strive for the excellence of epidemiological surveillance systems;

- NCD prevention work is an educational activity that does not show immediate results. Therefore, it is difficult to "sell" projects related to this issue. One should address the financial and social costs of the non-operationalization of programs aimed at the prevention of NCDs. These are key elements for planning public health policies;

- There is a great concern about the epidemiological transition in Latin America, with the combination of chronic and communicable diseases, such as multi-drug resistant tuberculosis and HIV, diabetes and tuberculosis, Chagas disease and diabetes, etc.;
- It is essential to have the support of international organizations to sensitize authorities with decision making power in relation to NCDs;
- It is necessary to emphasize aspects related to both the process of advocacy and raising the awareness of society in general in the construction of a project aimed at the prevention of risk factors;
- Training, as well as finding the best evidence for disease prevention and health promotion are central tasks for all who work with NCDs;
- The fight against smoking is a health problem in general, since smoking affects all diseases.

PRESENTATION

REGIONAL PERSPECTIVES ON NCD POLICIES AND PLANS

Dr. James Hospedales, PAHO – Washington DC

The Political Declaration on the Prevention and Control of Noncommunicable Diseases agreed upon at High-Level Conference on NCDs of the United Nations (UN) certainly signals and elicits advances in policies and initiatives aimed at the fight, prevention and control of NCDs. However, the new regional strategy prepared under the scenario imposed by the 2006 Strategy, the design of the UN HLM (2011) and by the WHO Action Plan for NCDs (2008-13), still imposes the challenge of identifying what is really new in relation to goals, objectives and future prospects.

The Political Declaration of the UN Summit shows consensus and clear positions. It consolidates the concept that NCDs should be addressed as a priority in development agendas, as well as WHO's role in the global coordination of NCDs. It also establishes specific responsibilities to be met by countries in the coming months and years, for which it is important to warn that the implementation of PAHO recommendations on surveillance, prevention and health care must be performed by actions in which government and society jointly participate.

In his speech, Barbados Prime Minister said: *"WHO specific duties are: to develop a global monitoring framework for the prevention and control of NCDs, including the establishment of a set of markers; to prepare recommendations capable of supporting processes for the definition of global and voluntary goals aimed at NCD prevention and control; and to guide Member States in their processes of designing national targets and markers compatible with each national context".*

The approach and analysis of experiments conducted by the countries must be based on some key documents such as the CARICOM POS Declaration on NCDs; the Regional Declaration on NCDs & Obesity established in 2011 in Mexico City; the Aruba Call to Action on NCDs; and the 2011 Declaration of the High Level Meeting of the United Nations on NCDs.

We must work with clear evidence that measure both the "burden" NCDs impose on the population and the economic impact caused by them, since, in addition to being large and rapidly growing, it includes both direct and indirect costs. Estimates indicate a cost of 30 trillion dollars to global economy over the next 20 years (*World Economic Forum & Harvard University, 2011*).

The 2011 Basic Markers for the Americas show demographic and socioeconomic data, of specific mortality per years of potential life lost (YPLL), life expectancy, access to health services (prevention tests), as well as information on technical specifications and on the policies adopted by different countries. Among the collection of information, it is relevant to point out those related to mortality. The trend of premature mortality caused by NCDs in the Americas, from 2000 to 2007 (adjustable age rates/100,000 - 43 countries sample set), decreased by 12% in both females and males. Considering the percentage of deaths in the three most populous countries / total deaths in the

Americas, the United States ranked first (39%), followed by Brazil (26%) and Mexico (9%). The main causes of death are related to cardiovascular disease (43%), neoplasia (41%), diabetes *mellitus* (9%) and chronic respiratory disease (7%). Mortality rates generally began to be significantly impacted by Guatemala and Guyana, evidence of an epidemiological transition framework.

Since 2006, numerous advances have been achieved by countries in implementing policies and programs aimed at addressing the NCD-related risk factors, among them tobacco, obesity, excessive use of salt and blood pressure control. Actions which were brilliantly conducted, mainly because they evoked the participation of different sectors, which resulted in the integration of various social stakeholders in the issue of NCDs. NCDs have been addressed based on multisectoral strategies, involving government, civil society and the private sector through the construction and dissemination of "health agendas". Several work fronts are being conducted by countries. With regard to civil society, it is worth highlighting the ongoing initiatives, such as the Healthy Latin American Coalition (HLAC); the Caribbean Health Coalition, the 40-member NGOs Alliance; the NCD Alliance (Global Advocacy), focused on heart disease, diabetes, cancer and lung/TB; and the Preventive Health Partnership (USA).

The United States is doing some interesting work based on respect for diversity. Regarding the private sector, with which the building of agreements is extremely important, also due to the fact that some companies are larger than some countries, it is worth highlighting alliances such as the International Food and Beverage Alliance, the Alliance for Healthy Life of Mexico or those signed with the International Pharmaceutical Federation or the Brazilian Association of Food Industries (ABIA).

Regarding risk factors, multisectoral interventions and strategies across all sectors are also ongoing. Regarding tobacco: tax increase, restriction of use in workplaces and public places, campaigns to disseminate information on health and publicity and advertising ban. As for alcohol: tax increase, retail restrictions and advertising ban. With respect to unhealthy diets and sedentary lifestyle: reducing salt intake, replacing hydrogenated fats and public awareness campaigns. In relation to cardiovascular disease and diabetes: counseling and drug therapy (including blood glucose control for diabetics) for people with >30% risk of CVD (including those with CVD) and treatment of heart attacks with aspirin. With regard to cancer prevention: immunization against hepatitis B to prevent liver cancer, screening and treatment of precancerous lesions for cancer prevention. (Source: Global Status Report on NCDs, WHO, 2011). The Strategy and Planning *"4 x 4" more obesity* should be highlighted, because it is an activity that not only encompasses four risk factors, namely, alcohol use, inactivity, inadequate diets and smoking, but also addresses the issue of obesity, a major public health problem.

In addition, we note the important process of including NCDs in the economic agendas of national and international development (PAHO/ECLAC, Economy & NCDs), as well as of building strategies from the standpoint of multisectoral approach in which society as a whole is contextualized.

It is worth mentioning that the implementation of any program requires the performance of analyses such as that of cost-benefit or the characteristics of the communication system to be used with the population, as well as the adoption of actions that can reinforce, adapt and strengthen health services to address NCDs. It also requires to align regional objectives and goals with those agreed by WHO, as well as to increase the monitoring mechanisms of actions, policies and "rules of engagement" in other sectors.

The Strategy and Action Planning for the Prevention and Control of NCDs is based on the idea that it is not simply required to intervene on diseases, but also to act on the three pillars, namely, prevention, control and treatment. Consisting of ten guiding principles, four main goals and thirty-two monitoring and assessment markers, it aims to reduce avoidable mortality, morbidity, risk factors and economic costs, as well as promoting well-being and boost productivity and development in the Americas.

Objective 1 – Multisectoral Partnerships and Policies for the prevention and control of NCDs

I) Specific objective: to establish multisectoral partnerships and integration of NCD prevention policies in sectors outside health

Indicators: a) number of countries with widely intersectoral governance mechanisms, including public-private partnership, to coordinate, promote and implement multisectoral policies and planning in NCDs; b) number of countries with multisectoral initiatives for well-being at the workplace and occupational health, to protect and promote health and prevent NCDs at the workplace; c) number of countries with evidence based on interventions on NCDs, drugs and diagnostics in their national social protection schemes.

Objective 2 - Reduction and protection from NCDs risk factors and strengthening of protection factors

I) Specific objective – to reduce smoking and the exposure of passive smokers

Indicators: number of countries with the four “most viable options” of the Table of the WHO Convention on Tobacco Control implemented, art. 6 (taxes); art. 8 (tobacco-free environments); art. 11 (packaging and labeling); art. 13 (publicity, advertising and sponsorship complete ban).

II) Specific objective: to reduce the harmful effect of alcohol

Indicators: number of countries with 10% reduction in the per capita consumption of alcohol in people above the age of 15.

III) Specific objective: to promote healthy eating habits

Indicators: a) number of countries with national nutrition policies aimed at supporting healthy eating habits in schools; b) number of countries with at least 15% increase in the proportion of children, adolescents and adults who perform physical activities as per

WHO guide; c) number of countries that have reduced the amount of daily salt intake per capita to less than five grams; d) number of countries that have established restrictions on the advertising of food and soft drinks for children, according to WHO rules; e) number of countries that have national policies prohibiting the industrialized production of foods with hydrogenated fat.

Objective 3 – Health system's response to NCDs

Indicators: a) number of countries that have strengthened the capacity of primary health care providers in NCD prevention, screening, early diagnosis, treatment, rehabilitation and palliative care; b) number of countries that are implementing an NCD integrated management model (e.g. evidence-based guidelines, clinical information system, self-care, community support); c) number of countries using PAHO/WHO Strategic Fund's Resolutions for the supply of drugs to combat NCDs; d) number of countries covering 80% of multi-drug therapy (including blood glucose control) for the high-risk level in people above the age of 30.

Following the appeal made by UNHLM to build a healthier future, the Pan-American Forum for Action on Noncommunicable Diseases (PAFNCD) will seek to provide a platform for governments and societies to tackle the NCD epidemic in the Americas. To do so, it will gather governments, scientific and academic communities, private sector and civil society representatives, seeking to raise the awareness and support to new and innovative NCD prevention and control initiatives.

Finally, attention must be drawn to the fact that the process of building broad regional strategies (NCD & Health) requires a specific timing inherent to it. Moreover, it is necessary to establish the critical processes for monitoring targets and markers.

The new regional strategy advances while being outlined on recent and past evidence and setting explicit goals aligned with WHO. One of the key points to its implementation is to maintain NCDs in political and development agendas. As stated by Dr. Mirta Roses Periago, Director of the Pan American Health Organization (PAHO): "*It took decades for all of us, governments, individuals and industries to get in the mess (NCD epidemic). It will take years for all of us working together to leave it*".

Comments and recommendations

- The existing social network must be used to prevent NCDs. Civil society's participation is important;
- It is important that health professionals understand the value of practicing healthy eating habits and healthy habits. Thus, they must be sensitized and trained;
- There is already evidence of decrease in the amount of salt in foods, as well as the most appropriate disclosure about the components of each food on packaging labels;

- Innovative and interesting initiatives on ways to address NCDs must be implemented. There are insufficient alternative strategies to deal with the issue. Aspects such as rehabilitation and suffering of patients with NCD should be addressed. There is a need to work with other aspects, such as mental health;

- It is important to work with the new information and communication technologies.

SESSION II
HEALTH PROMOTION AND NCD PREVENTION

PRESENTATION
ARUBA CALL TO ACTION FOR THE PREVENTION OF OBESITY

Dr. Richard Visser, Aruba Health Minister

The issue of obesity, especially childhood obesity, has been strongly addressed in Aruba. Advocacy of the healthy life concept led the country to redirect behavior, establishing a broad process of change, including how to address the issue among its inhabitants. The result of this process, namely, the creation of a new brand, as displayed in the image below, composed of several symbols linked to both the characteristics of the island and the concept of food, physical activity and healthy life. Characterized by its dynamic, playful and easy-to-understand way, this image has been used as a useful tool for the dissemination of information and the sensitization of local inhabitants and visitors to adopt a healthy lifestyle.

The First Pan American Conference on Obesity, held in Aruba in June 2011 and attended by representatives from 22 countries throughout the Americas, focused on the problem of childhood obesity, highlighting the alarming level of growth and its impacts, including in the economic development of the Americas, by reducing the productivity of the adult population, increasing health services costs and dramatically reducing the learning capacity of children.

The issues presented at the Conference were the basis for Aruba to structure a new work model aimed not only at combating childhood obesity,

but also promoting healthy weight. At the time, despite the growing number of physical activity adepts, and characterized by an alarming score, the amount of obesity in the country showed an upward trend – 36% of children, 42% of adolescents and 81% of obese adults. A similar situation occurred in other Caribbean countries, a fact that posed an even greater risk of obesity and NCDs to the region. This context led Aruba to return to the design of a work platform aimed solely at the issue of obesity and the promotion of healthy weight that would embrace the working field in all its amplitude.

The strategy was designed with the participation of different social stakeholders linked to various sectors – government ministers, politicians, scientists, entrepreneurs and health professionals, among others – in the midst of great challenges. One of the challenges was the implementation of a communication process actually capable of raising the awareness of the population to engage in actions to promote healthy weight and fight obesity at the expense of various stimuli against the proposal conveyed by different forms of dissemination, for example, publicity campaigns such as those of fast food chains. During the activity, one could note the favorable role that people linked to the community, service providers and community leaders exercised as communication and sensitization agents. At the same time, to achieve the involvement of various stakeholders in the strategy laid the challenge of introducing an economic vision to the issue capable of accommodating the interests of different groups and, at the same time, preserving the unity of all involved towards the achievement of the desired goals of the work strategy.

In addition to these challenges, it was necessary to find ways to deal with the political deadlocks, mainly those related to discontinuities imposed by changes of government, a big threat to the preservation of the strategy. Therefore, the design of the action should encompass a philosophical proposal consistent with structural bases and composed of clear proposals that could promote effective results. Such conduct would ensure the continuity of the strategy, regardless of command changes in the State, hindering any rupture activity by new political leaders who would face serious difficulties to unconfigure the established strategy.

With the overcoming of challenges, the implementation of the proposed work involved the design of policies and programs of action, which resulted in different fronts aimed at, inter alia, the promotion of breastfeeding, the restriction of advertising and marketing of unhealthy food and soft drinks to children, including in children's or sports programs and the population's access to the practice of physical activity and the consumption of healthy food.

Thus, physical activity conducive environments were made available to the community and health promotion actions designed. The construction of bike paths, city streets ban on Sundays, namely for the practice of physical activity, when promoting matches of popular games, musical and artistic performances and educational campaigns are examples of activities that led to the involvement of families with the new concept of lifestyle.

However, one should consider that effectively promoting a change in the lifestyle of thousands of people is a daunting task. It requires an active attitude, which goes beyond the straightforward implementation of activities or

offering the necessary conditions to adopt the new lifestyle. There must be multisectoral cooperation and the construction of policies involving different subjects related to the issue. People must work together.

On the other hand, we must not forget to measure stakeholders and their level of understanding about the consequences that a particular lifestyle can cause to health conditions. People in general do not have enough information to enable them to draw such connections and fully understand the problem. We must develop a communication system by which messages addressed to the population are sufficiently strong and specific to not only inform, but also raise awareness among different population groups as to the need for change. Messages must bear the power of transformation. There is plenty to be done to that effect, both by the media and all involved.

Moreover, it is not enough to make available to the public infrastructure for the practice of physical activity. It is necessary to pay attention to details. In general, people do not return alone to physical activity. It is necessary to provide incentives, for example, promoting the practice of the most popular sports nearing the cultural identity of the community. For children and youth, specific actions must be outlined, in which one can work the full concept of body image, covering the impacts that overweight gives to self-image. In conducting the work strategy, one must identify the lines of action that will actually be capable of sensitizing stakeholders to adopt a new lifestyle. These lines should be established on the basis of gender, age, cultural characteristics and several other factors. For example, physical activity many times requires young people to change their uniform usually in a collective space in which their bodies, especially the obese, are presented to the living group and, consequently, exposed to negative social criticism, severe self-criticism and bullying; factors that end up keeping young people away from physical activities and, at the same time, giving rise to social subgroups. Situations like these, which are very common, must be addressed and sized in the design of actions to be conducted with that particular group. Typically, teenagers do not understand that sport practice now will provide future benefits. They crave immediate benefits, seek pleasurable activities which provide them with social interaction. Providing them with collective physical activities involving music, working all the senses, such as street dance or capoeira can be an effective action strategy that is also capable of fostering the development of social skills. Young people do not need to think about the benefits that physical activity can bring to their lives. They need to feel involved and motivated. Thus, they engage in any activity promoting healthy living. If we do not take into consideration these aspects, the change of lifestyle will not occur and strategy does not become effective. We need to analyze the details to identify what really works.

A quick assessment on the management of NCDs in 24 countries showed that 97% of the sample – 23 countries – had policies and protocols aimed at the issue of hypertension and diabetes and 86% - 20 countries - cancer. However, a small portion had guidelines and protocols aimed at weight control and incentive to the practice of physical activity. When Michele Obama created the “motion wave”, Aruba decided to partner with her, believing that all countries needed to work together and create a unique platform to address the

problem. The fight against obesity and even against NCDs requires the work of all. It requires all leaders to position themselves in its favor, implementing actions that are popular or not, sending strong, clear and creative messages capable of promoting thinking about it and moving toward combating obesity and promoting a healthy life.

Holding PAHO's Second Meeting in June this year brings out favorable expectations in addressing obesity. It will bring novelties and creations. The "doing" and what is being done, rather than the "talking", will be addressed. Aruba will present its information system. All the primary health care system of the island is coupled with an electronic information record which enables to access online data of all those served by the health system, a characteristic that increases the boundaries of medical clinics, enabling an immediate and global view of the different aspects related to the health conditions of the population. A system that results in enormous benefits, such as immediate monitoring, stratification of information of interest or the provision of longitudinal data related to certain time intervals. Aruba will also present the third part of electronic medicine, through which patients have access to their electronic medical records and can communicate with the health teams, doctors, hospitals, with the government, establishing a procedure for the exchange of information. We shall also show a new project, the Health Bus, an itinerant medical clinic that travels across the country, disseminating information and guidance on NCDs and basic knowledge about health-related issues, raising the awareness of islanders to adopt a healthy lifestyle and undertake actions that promote public health, for example, to combat dengue. Furthermore, we shall also present actions of the Institute for Healthy and Active Life - IBISA, an institute exclusively devoted to the design of proposals based on multisectoral work related to health promotion and disease prevention through the adoption of a new lifestyle.

We believe that the prevention of obesity is a major challenge but at the same time an opportunity for change. It is also one of the most pressing obligations of humanity. Many deficiencies and contradictions are associated with this task; however, never have so many political leaders, scientists and health experts been so involved with the issue. We must address the problem now, using the strength of our professional knowledge, our ability of research, diplomatic cooperation and public awareness. We can prevent obesity with contributions from all stakeholders. We must carry on working the best we can.

Comments and recommendations

- To reduce childhood obesity, it is necessary to carry out preventive work, which begins from the prenatal period, with actions such as monitoring the weight of the mother during pregnancy or guidance as to the duration of breastfeeding. These are extremely simple actions that do not require financial resources. Health professionals, especially nurses must be trained to carry out this work;

- Childhood obesity is a serious public health problem. Children born underweight are equally likely to be overweight, depending on where they live;

- The issue of nutrition, malnutrition of mothers and children is very important for the CARMEN Network, as is the issue of childhood obesity;

- It is very important to conduct local surveys, checking the impact of the consumption of unhealthy foods in the last two generations. The population must abandon bad eating habits: this is a great challenge;

- It is necessary to adapt the standards of measuring Body Mass Index (BMI) to the black population. There are differences in the constitution of the body, especially in terms of the amount of muscle mass;

- The Double Energy X-ray Absorptiometry (DEXA) is considered as the technique that enables to obtain more accurate results, but its cost is higher. BMI is faster and easier to use. It is necessary to verify the purpose of measurement, to assess the need of using a more sophisticated index. BMI remains a useful tool for measurement;

- It is extremely important to consider the mental health component at the workplace, especially while addressing the issue of obesity;

- A key question is the work to be done: what makes the community happy? The *happiness* factor should be considered in the NCD prevention work. We need to involve social networks, so that programs and projects are sustainable;

- The search for evidence and information in general to support different types of intervention is crucial. Countries should give priority to conducting research including: eating habits, sexual practices, smoking, etc.;

- Processed food is cheaper and easily accessible; a fact which makes the inclusion of healthy eating habits in the population a major challenge. It is necessary to share experiences among countries;

- The financial cost of projects focused on health promotion and prevention of NCDs is an important aspect to be considered in planning actions, especially in developing countries;

- There are interesting initiatives regarding the promotion of healthy eating habits, such as: sticker on the packaging indicating the healthy version of food; certification of companies adopting healthy initiatives; banning advertisements that are inappropriate for children; *healthy school* initiative. It is necessary to foster dialogue with the private sector, with producers and food vendors. It is also necessary to seek social mobilization, aiming at the integration of various social groups and movements so that they become allies in the fight for NCD prevention. Brazil is an example to be followed, since the country took very courageous decisions for the prevention of risk factors;

- Projects aimed at the prevention of NCDs must have clear and objective messages. Moreover, it is mandatory to work with the principle of inclusion and social mobilization, basic assumptions without which there cannot be society participation. We also need to consider the lessons learned, using them as mobilization tools to raise the awareness of institutions and social organizations.

DISCUSSION PANEL

COUNTRY EXPERIENCES IN HEALTH PROMOTION

Dr. Sebastian Laspiur, Argentina
Dr. Fernando Ramírez, Colombia
Dr. Clara Niz, Uruguay

Topic – Positive outcomes achieved by countries with activities aimed at NCD prevention

Argentina – Dr. Fernando Ramírez

Achievements and progress related to promoting healthy eating habits in Argentina are reported. Intersectoral activities conducted through strong coordination among ministries, involving food producers, were carried out seeking a joint solution to the issue. One of the first conducts addressed the gradual elimination of food transgenic fats – implemented in two to four years according to the type of food. Another initiative focused on reducing salt intake by the population, which required actions aimed both at raising public awareness and the establishment of agreements with the food industry. One of the first agreements, signed with the Federation of Bakers, involved artisan bakeries in reducing the percentage of sodium used in the manufacture of bread – food widely consumed by the population and which resulted in the average daily intake of 330 milligrams of sodium. Recently, agreements have been established with producers from four food groups – soups, sausages, meats and mass consumption products – to reduce by 25% the amount of sodium in foods. These and other agreements, all with feasible goals, signal the achievement of positive outcomes in relation to the prevention of NCDs, because it will be possible to cover much of the population through some of them, such as the agreement with common crackers industries that will affect about 90 % of the market. From now on, the effects of these activities are being monitored so that concrete results may be noted. Also in relation to sodium intake, public awareness actions were promoted and the issue was placed on the political agenda, a fact that resulted in legislative projects. In addition to these activities are other ones, mainly educational, aimed at promoting healthy eating habits.

Colombia – Dr. Fernando Ramírez

The last survey conducted in the country showed an increase in the number of physically active individuals. However, it showed a decrease in the use of bicycles as a means of transport or as a tool for physical activity. This result fostered the idealization of work aimed at valuing the habit of walking and the incentive of active transport. The first promoted conduct consisted in activities aimed at raising public awareness about the importance of physical activity, the adoption of healthy eating habits and the reduction of smoking. The Ministry of Health and Social Welfare established a multipurpose working platform focused on NCD prevention, geared specifically to the topic of physical activity, conducted by the healthy lifestyle group of the Ministry. Different work fronts were implemented.

The fact that other government sectors often believe that initiatives aimed at health promotion are the responsibility of the health technical department led to the establishment of specific initiatives capable of causing the rupture of such a paradigm. Thus, opportunities have been created to enable the involvement, support and follow-up of different partners on the agendas aimed at addressing NCDs. In Colombia, several examples of activities performed with this purpose may be quoted: partnership with the National Sports System, civil society, scientific and sports societies to promote events aimed at promoting physical activity practice of the population – last year, seven million Colombians participated in the promoted events –; projects providing advisory services to departmental and municipal managers on the development of methodologies to help people to perform physical activities more easily, without the use of a lot of equipment; partnership with the Ministry of Education to promote a healthy lifestyle – implemented nearly two years ago and focused on the inclusion of the issue as an educational system tool –; the establishment of healthy universities – incentive to research and application of knowledge in nearby communities located in the suburbs.

In addition, specific actions have been promoted. Last year, during the U-20 Football World Cup, a massive communication campaign was carried out with the participation of soccer stars in favor of healthy eating habits, tobacco control and physical activity. The pilot project "11 for Health" was implemented jointly with the Fédération Internationale de Football Association (FIFA), by which children learn to stay healthy by playing football. There are 11 health-protection practices, conveyed through simple messages directed at children aged 11, for a period of 11 weeks. In the "first half", called "Play football," soccer skills are taught. In the "second half", information about the specific issue of health is disseminated and healthy behaviors are taught. As a result, behavioral changes among children could be noted. Furthermore, with the proposal to foster the topic of physical activity not only as a government line of action, but also as a line of research, mechanisms for promoting research were defined with the National Science and Technology System.

Uruguay – Dr. Clara Niz

In 2003, Uruguay signed the Framework Convention on Tobacco Control (FCTC). In 2005, it created the National Tobacco Control Program and, in 2006, it became the first country in the Americas to be 100% smoke-free by introducing smoke-free environments. Currently, the country meets the five FCTC points.

One of the first measures taken for tobacco control was to significantly raise the price of the product – today, a box of 20 cigarettes costs four dollars, more than three times the value prevailing before the implementation of the measure. In addition, the number of smoke-free environments was significantly increased – a research conducted in restaurants and other places where smoking was previously allowed revealed that the measure did not cause an economic impact –, the marketing of only one brand of cigarette was established, without different qualifications, such as light or suave, as well as printing striking images on 80% of the packaging surface.

Regarding advertising, major advances have been achieved, although there are still weaknesses. Advertising is permitted only in the internal areas of retail sale outlets and is prohibited in other media such as television or radio. A study conducted on this topic revealed that 40% of adults and 60% of adolescents watch the advertisement at sale outlets. In addition, it showed the existence of subliminal advertising, such as, for example, the association of trade colors with the cigarette’s colors. Tobacco industries invest a large amount of financial resources so that owners of commercial outlets paint their shops with colors evoking the cigarette. About 16% of adults and 34% of adolescents associate the outlet’s colors with those of the cigarette.

Addiction treatment measures are universal and free in the country. Everyone has the right and quick access to comprehensive care and is offered help for the abandonment of tobacco consumption. It is mandatory to register smoking in the patient's clinical records. Also, research on smoking is also conducted and brief counseling provided.

Markers show significant gains in terms of sensitization of the population. The approval of measures adopted is high even among smokers. There has been a significant increase in risk perception, mainly among young people, which is an important result. In 2003, 34% of young people saw smoking as dangerous. Currently, 62% make this judgment. About 90% of people who do not smoke believe that cigarette smoke from another smoker is harmful to health. Despite these markers, it appears that not everyone clearly understands the harm caused to health by various types of cigarettes.

As a result of this package of measures, we note that the smoking rate in the country has declined from 32% to 25%. Among adolescents aged below 18, from 33% to 18% and among physicians, from 27% to about 9%. About 70% of smokers had a smoking-cessation behavior, which does not mean that they succeeded in their intention.

Topic – involving the other sectors

Argentina – Dr. Sebastian Laspiur

The strategy adopted by Argentina for the elimination of transgenic fats can only be made possible through the involvement of sectors such as agriculture and the private food manufacturing industry. Modifying aspects of the food code of a country is not an easy task, it does not only depend on the Ministry of Health, but rather the involvement of various stakeholders and other ministries and scientific committees, for example. The Argentine National Food Commission is quite broad. Reaching a consensus on a food-related modification resulted in various negotiations so that industry could establish the necessary changes and adjustments. When the first evidence that the genetically modified fats were bad for health emerged, an important sector of the industry began to make the necessary changes. Other sectors were gradually involved. When the regulation occurred, more than 60% of the food industry had already made the necessary adjustments.

A similar process is underway in relation to the reduction of sodium. The proposal and implementation of measures requires assessment on the actual

feasibility. There must be technical feasibility in order to implement changes without causing food flavor modification. Companies themselves should be the agents in the negotiation process. The Ministry of Health cannot monitor each individual facility and does not have the technical capacity to check the salt concentration and enforce labeling standards. It should therefore support the negotiation process. For this purpose, it established a partnership with the National Food Institute, which has great expertise in the subject and employs food technologists.

The Argentine Federation of Bakers has incorporated into its agenda the proposal to reduce the use of sodium in bread. It would not have probably implemented such a measure without the incentive elicited by the negotiation process, because it perceived effects of sodium intake in the population’s health. The topic was included in the specific agenda of the industry, equaling others in importance, such as taxes and marketing. As all corporations, by employing a language of its own, the Federation can more effectively raise the awareness of all those associated with it.

Initiatives cannot be performed only by health authorities. They are about working together. Stakeholders do not need to incorporate into their own agendas the proposed initiatives, but it is important that they follow a minimum agenda.

Colombia – Dr. Fernando Ramirez

Part of the success stems from the involvement of local, municipal and national governments in the issue. The key point is to motivate local governments in carrying out activities, encouraging them to formulate plans. Furthermore, it is important to have the involvement of other sectors, for example, to obtain a physical space to perform any intervention. The health sector should provide knowledge and tools and monitor the implementation of field work, so that other sectors do not feel that they are alone or performing an additional task. We need to involve sectors such as education, sport and culture, making them co-managers and leading them to participate actively in the planning and execution. Cooperation through the creation of international networks and alliances is very important to enable these initiatives achieve effective results and be monitored by governments.

Almost all municipalities in the country have initiatives for the development of physical education practice. The monitoring of such projects is often poor. Success markers should not be sectoral, but rather reflect local development.

Uruguay – Dr. Clara Niz

One of the greatest success of measures against smoking in the country was decentralization and the ensuing empowerment. Municipalities were present in each initiative. Moreover, it is important to integrate users and civil society by establishing alliances with sectors related to trade, tourism and chamber of restaurants, among others. Alliances promote several benefits, especially when industries feel threatened by the implementation of measures.

Topic – Advice for the application of these experiences in other countries

Argentina – Dr. Sebastian Laspiur

Sustainability is one of the main challenges to intersectoral action. The good news is that, fortunately, established partnerships typically inflate in favor of the continuation of works aimed at NCD prevention. Alliances are one avenue to ensure the sustainability of projects. The fact that stakeholders feel protagonists can influence the generation of technology for the production of healthier foods. The proposal is that, regardless of changes existing in the government, new technologies are created to continue the project.

The great challenge with regard to the food policy is related to the need for stronger regulations. Voluntary arrangements, such as the reduction of sodium, should become mandatory after a certain period. It is necessary to chart a preliminary course in order to work with the stakeholders who will be regulated later, otherwise results will become unviable. After regulation, effective monitoring should be ensured, since it will no longer be possible to market products that do not meet standards. Actions become sustainable only if there is a regulation involving all the participating stakeholders. It should be remembered that agreements are signed with both large companies and small local businesses that require the support from other government spheres to adapt the proposed measures.

Other challenges are associated with the issue of regulation. One of them is helping people to better choose their diet to make it more suitable and healthy. This challenge involves, for example, the regulation of information appearing on food labels, including issues such as the calculation of the caloric intake of fractionated food portions. In parallel, one should proceed with the regulation of advertising and the standardization of food labels in all spheres of government, including MERCOSUR, the creation of an efficient monitoring system regarding food sodium concentration and the incorporation of initiatives of other governmental and private market sectors that are not yet participating in the fight against NCDs, such as, for example, the transport sector, through alliances and ventures that can be capitalized and conducted.

It is important to note that initiatives only become effective through a strategic area, superintendence or departments aiming at monitoring the process. The health agenda of the Ministry and the States are overloaded. There must be specific and coordination areas aimed at fostering discussion and accelerating alliances leading the work process for effective change to occur. The fight against NCDs is extremely complex. For example, an intersectoral commission for the fight against NCDs at local and national levels should be created. The process of building alliances should be broad and established through the involvement of authorities and each of the remaining sectors. Responsibility lies with various sectors, since activities are intersectoral, but the conduction of works must be performed by the technical area of the health sector.

Colombia – Dr. Fernando Ramírez

The topic of physical activity should be socially attractive. Young people should engage in physical activities they enjoy. In the various territories, we must recognize the existence of knowledge that is not necessarily officially documented and social and cultural practices. It is necessary to perform work to harmonize health practice based on evidence and surveillance trends with existing practices in the communities. The agenda must also be changed, we need to address welfare, quality of life and happiness and not NCDs. Social and motivating concepts must be our working tools.

With regard to sustainability elements in intersectoral work, there is a challenge of harmonizing sectoral and intersectoral goals in order to meet the guidelines set out in national plans, such as education, culture or sport. These strategies and presuppositions generally require international support, because, although there are financial resources, these may be exhausted when changes of government – and consequently managers – occur.

Moreover, it is necessary to adopt the view that physical activity is not the same as sport. There can be no athletes if physical activities are not carried out since childhood. However, physical activity does not necessarily require the existence of sophisticated sports scenarios for its practice. We need to think about healthy eating habits, social activity and physical activity itself.

Uruguay – Dr. Clara Niz

A major challenge is to achieve equity. Although tobacco use has decreased in Uruguay, we note that people with the poorest and least amount of schooling are the ones consuming tobacco the most in the country. This result demonstrates that measures taken so far did not impact equally across the population.

There must be progress on the advertising ban, restraining especially the subliminal one specifically aimed at adolescents. The smoking habit should be seen as a problem, the adolescent should say “it is a shame that you are smoking”.

Furthermore, it should be ensured that enforcement is always present. The recommendation is to raise awareness and involve local people in monitoring, making them an ally. We need to involve all stakeholders, making the smoking habit to be conceived as a negative social value. Finally, it is noteworthy that specific and isolated so-called “pilot” initiatives do not have the desired impact.

Comments and recommendations

- Epidemiological surveillance systems must have the ability to analyze, process and disseminate information quickly and safely;
- Another important front for the NCD prevention work is the implementation of a healthy working environment as part of labor rights. It is necessary to outline recommendations regarding the establishment of markers, rates of intelligent breaks at the workplace, offering fruits and vegetables in meals. Attesting whether companies adopt these initiatives is a good strategy;

- Tobacco is banned in many workplaces. Considerations must be made because work often occupies a very important space in the life of each individual. People usually stay in their workplace for eight or more hours. Smokers have free smoking periods in spaces that are unrelated to the workplace. Non-smokers say that this strategy is strange and negatively assess this measure. A better proposal would be to provide treatment and encourage the smoker to abandon the smoking habit.

SESSION III

NCD INTEGRATED ACTIONS

PRESENTATION
APPLYING NCD INTEGRATED ACTIONS TO HEALTH SERVICES

Dr. Maria Cristina Escobar, Chile

What does it mean to live with a chronic disease? You can answer that question with an analogy: living with a chronic disease is like flying a small plane. The patient must be a skilled pilot. He can count on a co-pilot, the health team, but for a few hours per year. It is necessary to reach destination safely. The health team should provide the qualified pilot with an aircraft with flying conditions, develop a flight plan that allows him to successfully reach his destination and monitor air traffic to avoid accidents and keep the plane on course. However, qualified pilots and their families bring with them symptoms, disabilities, emotional impact, complex treatment regimens, difficulties in making changes in the lifestyle and the need to get proper medical care. Health teams develop their role under these conditions.

According to Dr. Joanne Epping-Jordan, we are currently experiencing the *radar syndrome*. The patient appears, treatment begins and the patient is discharged and disappears from the radar screen because there is no continuous segment. The radar's logic does not work with patients suffering from noncommunicable chronic disease.

The health system is designed to serve those patients with diseases in which the patient is not that relevant, since he requires sporadic monitoring and does not need support for self-care. There is a discrepancy between the needs of patients and the development of health care models. NCDs require the identification of new components, the new design of health systems for an effective care. The central elements of effective care are: to be patient-centered, based on primary care; focused on the needs of the population; proactivity, thus anticipatory, providing a planned care and focused on prevention.

Effective health systems for the care of people with NCD must be developed. The chronic patient care model identifies the components to achieve the best results. There must be a productive interaction between prepared and proactive teams and informed and active patients.

The first and extremely important component of the health system is to support management and organizational leaders. Incentives, whether financial or not, must be provided; sometimes the only ones that really work are monetary. It is necessary to promote effective strategies to improve quality, to establish agreements between organizations to facilitate coordination of care in the health system.

Changes are required outside the clinical setting. For example, regarding the financing of health systems, not to deem possible the reimbursement of distance intervention performed by telephone and/or through the internet is a

hindrance to the care of patient with a noncommunicable disease and to the coordination of the health system.

Enabling the sharing of experiences through group consultation is another example. Consultations and distance individual and group controls should be held.

Support to self-care is a central element. Self-care is understood as the capacity that people have to manage the symptoms, treatment and physical and social consequences of changes in lifestyle caused by the chronic condition. The patient must have the ability to cope with his symptoms and the physical consequences of NCDs. He should take care of himself, of his daily treatment; he should know how to ask for help and must have effective communication with health professionals. Individual and group interventions aim at empowering the patient to acquire skills for his self-care by setting goals and establishing plans of action. They are crucial for the patient to assume his role in relation to the responsibility of maintaining his health and functionality. It is important to ensure the regular monitoring of the patient, which can even be done remotely. Patients should receive care in tune with their socio-cultural context. Not all patients who are in a care system are the same; case management must be provided for complex patients.

An efficient and effective health care system aimed at supporting self-care should promote effective care. To do so, roles should be defined and tasks distributed among members of the healthcare team, including specialists and non-professionals. Doing a better job will not necessarily improve the outcome. Often a change of health care system is what is needed. It is necessary to foster care and treatment consistent with scientific evidence. Thus, it is essential to incorporate clinical practice manuals, which, for various reasons, are often not applied. It is also necessary to value the experience of primary health care professionals and improve communication with experts (the use of telemedicine can be a good alternative). The idea is that the expert is an interconsultant to the primary health care team.

To coordinate treatment and care, it is important to monitor health systems by tracking the performance of health team and the quality of care. It is essential to share information with patients and providers to coordinate care. In general, in Latin America, professionals tend to be paternalistic. However, it is necessary to share clinical information systems and information with patients.

Identifying how the health system will relate to the resources that exist in the community is another key element, since it is essential to mobilize community resources to meet the patients' needs. There is a need to encourage patients' participation in Community programs, build alliances and partnerships with community organizations and sports clubs so that patients may exercise. It is also important to promote policies that contribute to better patient care.

Evidence shows that successful interventions are multifaceted and include one or more of the following components, whether associated or not:

health teams; continuing education; information systems; educational interventions to support the patient and management of visits and follow-up.

The combinations of different interventions have a greater chance of success. Eventually, in a process of change, it is impossible to incorporate all the elements of this chronic care model. However, the inclusion of at least two or three of these aspects should be sought.

This proposal is just one of the chronic care models. There are other models. Perhaps the best known is the Kaiser Model, in which patients with NCD are identified and separated into different levels of the pyramid. Those requiring individual care are placed on top.

Experts say that one of the "recipes" to improve results is to establish a conceptual framework capable of changing the system. Changes must be based on scientific evidence. It is essential to have strategies to improve the quality of care and also critical mass to support change.

Comments and recommendations

- Maybe this is the first CARMEN Meeting with the presence of Medical Societies, which can already be considered an indication of change. It is important to have integration between the different paradigms or models: disease prevention / health promotion, health care and rehabilitation. New ways of thinking about public health, with integration proposals that include the different approaches are essential;

- The chronic care model is a relatively new proposal for Latin America. It is necessary to train professionals, involve universities and foster dialogue for changes to occur in health systems;

- By empowering the health team to work with chronic patients, a work to "match" health care models must be performed. There are not many “how-to-do-it” publications, there are no recipes. It is also necessary to implement a policy of non-financial incentives to motivate servants towards change in their professional practice;

- There is an important gender issue: how to encourage the 40 year-old man to undergo prevention tests and medical visits? Male adherence to prevention programs is still a challenge;

- It is necessary to forcefully establish the theoretical framework in order to establish dialogue later. No progress will be achieved if the theoretical models are not shared. There must be leaders, people with decision-making power supporting and strengthening a unified and integrated strategy for the prevention of NCDs.

- It is often difficult to access the health system, especially working men and women do not have much time and do not prioritize the search for health services that offer programs focused on health promotion. Prevention programs should be offered at the workplace. Health Centers usually have a working logic adequate to serve the elderly, since they only work during the week at times that coincide with the working hours of the majority population;

- It is necessary to invest in professional education in order to change the health system. There is a need to work with universities, which have the challenging

task of changing their education program. Continuing education is the key element for change and should be emphasized. Professionals must be trained with a model in which "practice" has a large dimension in the training process. Professionals must have skills to perform NCD prevention and treatment work in an aging population;

- It is necessary to bring the academy and foster discussion forums with the ministries (health and education) in order to discuss changes in the health care model;
- Pilot projects results should be carefully assessed. Patients should not participate in studies or research right after the diagnosis of disease. They need to first understand diabetes and learn to perform self-care;
- The training of health professionals must view the different stakeholders involved in a health system, providing the necessary updates and modifications;
- Part of health financial resources should be applied in intersectoral action, such as, for example, actions that aim to foster physical activity.

DISCUSSION PANEL

COUNTRY EXPERIENCES IN NCD INTEGRATED ACTIONS AND PRIMARY HEALTH CARE

COUNTRY EXPERIENCES

Dr. Heider Pinto, Brazil
Dr. Orlando Landrove, Cuba
Dr. Tamu Davidson, Jamaica
Dr. Felicia Canete, Paraguay

Topic – integration of NCD management and primary health care actions

Cuba – Dr. Orlando Landrove

The long experience of Cuba in the provision of integrated family-care services, of more than thirty years, supported the development of a primary health care program in the country. Two years ago, with the reorientation of this program, 90% of the population started to be assisted by a primary health care team composed of a doctor and a nurse, both experienced professionals.

However, despite this context, major challenges permeate the country's health system in relation to NCD management. The unpreparedness to develop actions aimed at NCDs that was initially noted led Cuba to adopt, as a first line of conduct, different work fronts in order to remedy this deficiency. Among them, the preparation of manuals to support the continued training process of health teams and the sensitization and training of primary health care teams managers to conduct NCD-related activities.

Despite the progress achieved so far, challenges remain. Today, each primary health care team monitors between 25 and 30 thousand inhabitants, a distribution that is detrimental to the effective delivery of service. In turn, for historical reasons, the local pharmaceutical industry has a technology park capable of ensuring the adequate supply of reactive drugs, but unable to provide effective coverage of basic drugs required for the monitoring of NCD patients.

Cuba currently walks towards the strengthening of referral and counter-referral services, by specializing them, including in the physical and emotional rehabilitation of patients, as well as it turns to the supply of equipment required for the management of NCDs.

Paraguay – Dr. Felicia Canete

Four years ago, the country structured policies that paved the way to the process of reorganization of health services. It implemented primary health care as a gateway to the system and reorganized the previously independent polyclinics, subdividing them by disease under a single and fully integrated system.

Based on the experience of the “Step by Step” program for diabetes control, the country promoted, in parallel with the remodeling of the family

health strategy, the restructuring of the NCD service system, leading the “Step by Step” to the other components. Linking the restructuring of the family health strategy to the “Step by Step” logic enabled a more harmonious integration between the management of NCDs and the primary health care model.

Currently, besides the support of a dental care team, each primary health care team is composed of a doctor, a nurse, a nursing assistant and a health technician. Each facility that is responsible for a territorial map has to develop, among other activities, actions aimed at the prevention and care of chronic patients with a noncommunicable disease.

The restructuring of the NCD service system involved a set of specific actions, such as: the establishment of protocols for each pathology and NCD manuals, made available to family health teams, for their training and to support their work; the implementation of clinical records and a chronic care passport for each patient, a passport containing all the information about the patient’s care and which must be presented at each visit; the free distribution of prepaid drugs; the training of community leaders and health workers on NCDs; the creation of clubs for people with hypertension and diabetes, which, among other activities, mediate between health services, government and local authorities.

This set of actions enabled the transition from a disease-centered provision of health services to a patient-oriented provision of services, with the patient seen in his entirety and not as a specific disease carrier.

Topic – reasons that led the MOH to introduce a health chronic care model

Jamaica – Dr. Tamu Davidson

Currently, the life expectancy of the population in Jamaica is 72 years. Diabetes is the leading cause of death in men and women, as well as the main reason for admission to health services in the country – 20 percent. Over the past eight years, findings of increased prevalence of the disease have caused the country to conduct an assessment of the quality of medical care services offered to the population. Internal audits and studies were developed to analyze the compatibility between services provided and the proposed guidelines for the provision of health services. As a result, it was noted that there was a need to both promote acute care education programs among health professionals and change the design of health services, shifting them from a curative treatment approach to the design of planned care, scaled under the long-term perspective. Although the concept of chronic treatment is not something new for the country, it was observed that the practice failed to accomplish important guidelines inherent to chronic treatment. Thus, activities were introduced in order to promote the provision of health services in the perspective of long-term care. As an example, the creation of the Diabetes Day and the structuring of diabetes education programs aimed at diabetes patients.

Brazil – Dr. Heider Pinto

The public primary health care system covers currently 70 percent of the Brazilian population, approximately one hundred and twenty million people. Activities are developed from the perspective of comprehensive care and chronic diseases have been totally measured for some years now. Since 2010, activities focused on the establishment of integrated health care networks have been prioritized, as well as different actions related to NCD management.

The People's Pharmacy Program has increased its range of coverage to include private pharmacies as an agent of free distribution or supply of drugs at subsidized prices.

The National Program for the Improvement of Access and Quality of Primary Health Care-PMAQ caused primary health care teams, on joining the program voluntarily, to agree goals and direct their performance toward achieving the proposed objectives, a condition that made possible the realization of a monitoring system for chronic diseases and other diseases through markers. Furthermore, it enabled the work teams to have their performance certified through self-assessments and external assessments conducted by twenty-two universities in the country. According to the results achieved in external assessments, federal funds to be invested in health services and transferred to each municipality may suffer up to a 100% increase in their amount.

The development and implementation of the national electronic medical record resized the collection of information about patients serviced by the health system, enabling the stratification of information by risk and by clinical practice, as well as the visualization of data per individual and not just per municipality. Currently, all health teams in the country are using electronic medical records.

Working in interface with primary health care teams, in addition to targeting health promotion, the Health Academy Program extended its scope of action to the rehabilitation of patients suffering from some chronic disease. The Health at School Program, in turn, included the issue of obesity in children and adolescents in their list of assignments. And the Telesaúde (TeleHealth) Project enabled the integration between specialty centers and primary health care teams, optimizing the issuing of diagnostics by enabling the swift production of medical reports, as well as it enabled municipalities to expand and humanize their health centers.

Finally, a series of publications were developed and made available to health teams, in parallel to performing distance training activities and creating a website for diabetic patients.

Topic – challenge to integrate CND services

Cuba – Dr. Orlando Landrove

There remain some challenges: 18% of the Cuban population is aged more than 60, 60% of family physicians are women, over 90% of diseases affect women. Such markers threaten the stability of primary health care teams.

Moreover, it is necessary to ensure the continued training of health teams and not just the initial training. We must establish a means of disseminating scientific collection, research, health studies, as well as epidemiological surveys. In Cuba, 25% of the population participated in the last survey. The information should be published and made available to the public so that people know the health situation of their community. In addition, primary health care must count on the participation of doctors and its sustainability should be ensured. Economic investments to this end will enable the reduction of future expenditures.

Paraguay – Dr. Felicia Canete

As this is a recent strategy, the country still cannot measure the impact of the family health strategy in relation to the established markers. However, it may be noted that, since the implementation of the strategy, there has been a 38% increase in the number of patients treated by primary health care teams and an increase in the number of early diagnoses of chronic diseases and risk factors. Moreover, it was noted that the approximation of health workers to the population caused the community to become more active. Currently, although present in all states of the country, 40% coverage is considered low.

Jamaica – Dr. Tamu Davidson

The diabetes program was initially implemented in seven health centers and a clinic for diabetics, facilities selected due to the availability of resources, the existence of multidisciplinary teams and access to support services. Most patients treated daily attended services. Several models have been assessed before implementing the program. Gaps were identified, such as, for example, in information systems that led patients to receive treatment regardless of their health condition, due to the lack of proper recording of information. The data collected resulted in a redirection of the system as a whole. Initially, much focus was given to training and the dissemination of knowledge and program guidelines for both health teams and for patients, since access to information turns out to be a strong source of incentive to self-care.

In addition, medical records for the registration of the measures adopted have been implemented. The chronic diseases passport, which enabled the interconnection between primary and secondary health care, shows essential information about the patient and about the action taken. Not only did this tool made it possible to the patient to identify the treatment received, but also to improve the self-management of treatment.

The implementation of the program was marked by resistance on the part of health teams which, used to a standard routine, had difficulties in adapting to the new work process. Such resistance was significantly minimized in those facilities in which senior teams supported the project. In them, the entire team of professionals was involved with the project, acting in interconnected fashion on all components related to chronic diseases. However, in some facilities, such resistance made it impossible to implement the program. Data collection to assess the results of the program is being carried out, specifically covering self-control and self-management.

Topic – ways of strengthening health systems which can improve NCD management

Cuba – Dr. Orlando Landrove

Multidisciplinary participation in both primary health care programs and those related to specialized care is very important. Furthermore, strong emphasis should be given to the dissemination of knowledge, either through manuals or protocols or through courses and/or other activities. Thus, it is vital to involve universities and information centers. Another important factor relates to the deployment of service assessment systems. Data collection enables the identification and elimination of loopholes that may lead to the inefficiency of the system as a whole. Finally, we highlight the need to ensure national coverage through an integrated system in which access to medicines is ensured.

Paraguay – Dr. Felicia Canete

It is necessary to promote the sharing of experiences, to support the medical facilities of family health and to promote communication between health teams, including the coverage of referrals and counter-referrals of the chronic patient in the health system.

Jamaica – Dr. Tamu Davidson

The chronic disease model brings a good structure. To introduce it, it is necessary to consider, on the one hand, what each health professional brings in, his activities and, on the other, what should be brought to this professional based on existing knowledge. Furthermore, work must be performed within the community, since each one has an important role as the source and agent disseminating information. The different ways of doing things must be considered, all the integration opportunities addressed and all health professionals from all levels reoriented.

Brazil – Dr. Heider Pinto

It is essential to empower primary health care to develop mechanisms of integration between services, recognize the quality of primary health care, work since graduation with topics related to chronic diseases, improve the quality of services provided, some ways that evoke the integration of services and integrate visually while looking at the future.

SESSION IV

NCD SURVEILLANCE AND RISK FACTORS

PRESENTATION
NCD MONITORING FRAMEWORK AND GLOBAL AND REGIONAL TARGETS

Dr. Leanne Riley, WHO

In September 2011, the Political Declaration on the Prevention and Control of Noncommunicable Diseases approved by Member States of the United Nations - UN established, inter alia, in Articles 61 to 63, the foundation for the design and implementation of activities aimed at both the establishment of global and regional targets for the prevention and control of NCDs and the monitoring of actions actually implemented.

Article 61 – The World Health Organization, in cooperation with the Member States, UN agencies, funds, programs and other regional and international organizations is committed to develop, before the end of 2012, a systematic of a comprehensive and multisectoral global monitoring of NCDs, which should include the definition of a set of markers that can be applied in different regional and national contexts and are aimed at monitoring trends and assessing progress in implementing national strategies and plans on NCDs.

Article 62 – The World Health Organization, in cooperation with the Member States, UN agencies and other regional and international organizations, based on the work already underway, undertakes to prepare recommendations to be adopted by Member States for the voluntary establishment of global targets for prevention and control of NCDs before the end of 2012.

Article 63 – Member States undertake to establish targets and markers compatible with the national context of their countries and WHO guidelines, concentrating efforts in addressing the impacts, risk factors and determinants of noncommunicable diseases.

Based on this milestone, the World Health Organization, in partnership with Member States, has developed a set of actions aiming to make concrete the commitments described above. To ensure the effectiveness of these actions, it set out the following specific outcomes to be achieved:

- ✓ *To complete the design of the NCD global monitoring system by the end of 2012, including defining the set of markers and targets to be achieved by Member States;*
- ✓ *To present at the 65th World Health Assembly the set of markers and targets set by Member States, as well as an analysis of the progress of NCD prevention and control activities;*

- ✓ *To present at the 132nd Session of the World Health Assembly a report on the recommendations related to paragraphs 61 and 62 of the Political Declaration on the Prevention and Control of Noncommunicable Diseases.*

Started in January 2011, the working methodology employed by the activities is essentially the promotion of wheels of formal and informal consultations, held mostly through electronic means. Participants are Member States, UN agencies, NGOs and/or private sector representatives.

Of the developed activities so far, the following are worth highlighting:

- ✓ *January 2011:* establishment of the WHO Technical Working Group responsible for the epidemiological survey of NCDs and the selection of target markers.
- ✓ *July 2011*: conduction of an electronic consultation aimed at analyzing the recommendations proposed by the WHO Technical Working Group – participation of 19 Member States.
- ✓ *December 15, 2011*: promoting an informal consultation wheel with NGOs.
- ✓ *December 20, 2011 to February 29, 2012*: holding an electronic consultation to discuss the First Consultation Report – participation of 22 Member States.
- ✓ *January 09, 2012*: performing the first informal consultation with Member States and UN agencies.
- ✓ *March 22 to April 24, 2012*: holding an electronic consultation to discuss the Second Consultation Report.
- ✓ *April 07, 2012*: implementing the second informal consultation with Member States and UN agencies – participation of 59 Member States and 11 UN agencies.
- ✓ *April 30, 2012:* promoting an informal consultation wheel with NGOs – participation of 27 NGOs.
- ✓ *May 2, 2012:* performing an informal consultation with the private sector – participation of 11 institutions.

As a result of the actions implemented so far, important contributions stand out regarding the aspects and criteria to be considered in the definition process of global and regional targets for the prevention and control of NCDs. Regional targets must be compatible with overall targets; they must be adapted to the reality of each nation; they must be feasible and established according to the performance and the ability of each country to implement them; and may be greater or lesser than global targets. The criteria, in turn, should cover markers such as: level of relevance to epidemiological and public health in the country; consistency with the main health strategies of the country; compatibility with the priorities portrayed in the Global Strategy for Prevention and Control of Noncommunicable Diseases and the Political Declaration on the

Prevention and Control of Noncommunicable Diseases; compatibility with the priorities set by the exposure monitoring system, outcomes and response of health systems; evidence-oriented; efficacy and viability potential; feasibility potential; possibility of longitudinal monitoring through existing data collection instruments.

The first set of consultations wheels, whose agreements gave rise to the First Consultation Report, resulted in the development of a framework of targets which was then analyzed by Member States as to the consistency of the criteria proposed for the process of defining targets and markers for the NCDs. Sixty-five Member States participated in the analysis of the report, of which 22 in print and 43 electronically.

As a result of the review process, Member States had concerns about the feasibility and measurability of targets related to salt intake, diabetes, alcohol consumption, multiple drug therapy, cervical cancer, obesity and the elimination of trans fats from food; they noted the lack of targets and markers addressed to physical inactivity, other food-related risk factors and access to drugs and diagnostics and expressed support to the targets related to hypertension, mortality and smoking.

Targets	Markers	Monitoring
Noncommunicable disease mortality – 25% reduction in mortality caused by cardiovascular disease, cancer, diabetes or chronic respiratory disease.	Number of deaths of people within the 30-70 years age range caused by cardiovascular disease, cancer, diabetes or chronic respiratory disease.	Civil registration system, with medical certificate of the cause of death or research with verbal autopsy.
Diabetes – 10% reduction in the prevalence of diabetes.	Percentage of people above the age of 25 with diabetes.	National survey.
Smoking – 40% reduction in the prevalence of smoking.	Percentage of smoking among the elderly and people above the age of 15.	National survey.
Alcohol – 10% reduction in the per capita number of people consuming alcohol above the age of 15.	Per capita liters of pure alcohol consumption of people above the age of 15.	Official statistics and production, import, export and sales communication systems; fiscal data and national survey.
Salt intake – average daily intake per person below 5 grams.	Daily salt intake per capita consumption.	National survey.
Hypertension – 25% reduction of hypertension cases.	Percentage of people above the age of 25 with arterial hypertension.	National survey.
Obesity – non increase of obesity rates.	Percentage of obese people above the age of 25.	National survey.
Prevention of heart attack and stroke – 80% coverage of polychemiotherapy (including glycemic control) of people above the age of 30 with heart attack and stroke risk ≥ 30% in 10 years, or with existing cardiovascular disease.	Percentage of people above the age of 30 with a heart attack or stroke risk ≥ 30% in 10 years, or with existing cardiovascular disease under multiple drug therapy (including glycemic control).	National survey.
Cervical cancer – tracking, at least once, in 80% of women aged between 30 and 49.	Cervical cancer tracking percentage, at least once, in women aged between 30 and 49.	National survey, data from health facilities.
Elimination of trans fats foods	Adoption of national policies that ban the use of partially hydrogenated vegetable oil in food manufacturing.	Public policies review.

The second set of consultations wheels, whose agreed commitments led to the Second Consultation Report, resulted in the inclusion of new markers, as well as the condensation, review and subsequent reorganization of targets and markers previously proposed into a single global target linked to epidemiological and health services monitoring markers; action which enabled the contextualization of NCDs in their entirety and not by a dichotomized view of a number of unrelated pathologies.

<table>
<tr><th colspan="4">Global Target</th></tr>
<tr><td colspan="4">Reduction of 25% in the mortality rate of people aged between 30 and 70, per CVD, cancer, diabetes or chronic respiratory disease.</td></tr>
<tr><td>Hypertension – 25% reduction</td><td>Smoking – 30% reduction</td><td>Salt consumption – 30% reduction – up to 5mg/day</td><td>Physical inactivity – 10% reduction</td></tr>
<tr><td colspan="2">Epidemiological markers</td><td colspan="2">Health services</td></tr>
<tr><td colspan="2">⇒ Per capita adult alcohol consumption;
⇒ Sporadic alcoholic consumption;
⇒ Physical inactivity;
⇒ Fruit and vegetable consumption;
⇒ Overweight / obesity;
⇒ Blood glucose / incidence of diabetes;
⇒ Hypertension;
⇒ Total cholesterol;
⇒ Salt / sodium intake;
⇒ Smoking.</td><td colspan="2">⇒ Access to palliative care;
⇒ Availability of basic diagnostics and access to drugs;
⇒ Tracking cervical cancer;
⇒ Polychemiotherapy to reduce risk of CVD;
⇒ Policies banning the manufacture of trans fats foods;
⇒ Policies reducing the sale of unhealthy foods to children;
⇒ Vaccination: Hepatitis B and HPV</td></tr>
</table>

Currently, new work fronts have been conducted in order to support the prevention and control of NCDs by Member States:

- ✓ Development of guidelines aimed at reducing morbidity and rates of mortality caused by noncommunicable diseases, to be published in a public document;
- ✓ Establishment of multisectoral policies and partnerships to address risk factors and optimization of protection factors;
- ✓ Review of targets for the Americas in light of global targets and epidemiological data of each nation.
- ✓ Dismemberment of mortality rates per NCD, gender and/or schooling.
- ✓ Setting targets to reduce mortality for each of the four NCDs.
- ✓ Inclusion of markers for motor and disabling diseases.

NONCOMMUNICABLE DISEASES PREVENTION AND CONTROL POLITICAL DECLARATION, PAHO COMMITMENTS, REGIONAL GOALS AND MARKERS FOR THE AMERICAS

Dr. Branka Legetic, PAHO

Two important documents were published in 2010, aiming to provide Member States with support to the processes of decision making to be effected during the UN Assembly, which resulted in the Political Declaration on the Prevention and Control of Noncommunicable Diseases. The first one, "Noncommunicable Diseases in the Americas", presents information on policies and epidemiological picture of NCDs in the Americas, and the other one, "Building a healthier future", addresses multisectoral work and its progress.

As a result of the agreements achieved in the Political Declaration, specific work fronts were directed to PAHO:

- ✓ Reviewing regional strategies in relation to NCD and action plans, including regional targets and markers.
- ✓ Promoting technical cooperation among Member States.
- ✓ Continuing advocacy in world forums: Social Determinants, G8/G20 and Summit of the Americas, among others.
- ✓ Promoting multisectoral partnerships, including enabling the Pan American Forum for Action against NCDs.
- ✓ Fostering exchange on noncommunicable diseases between the Americas and other UN agencies.

Since then, a wide-ranging discussion on NCDs, involving all countries in the Americas has been mediated by PAHO. Their results will be part of a public document, whose final version is undergoing consolidation and will probably be available to the community in June this year.

A large-scale target was drawn as regional strategies and as action plans for NCD prevention and control. Linked to them are a set of markers. This target includes targets proposed by WHO in the First Consultation Report released in December 2011. It addresses early mortality caused by NCDs.

Target Baseline – 2010 Target Year – 2020
Reduce avoidable mortality and morbidity caused by NCDs, leading nations and sub-regions to respond sustainably to the threats posed by NCDs to health conditions and the development of each country.
Markers Proposed by WHO in the Global Monitoring Framework – targets for 2025 - subject to additional modifications after the WHA 2012.
✓ 25% reduction in the mortality rates caused by cardiovascular diseases, cancer, diabetes or chronic respiratory disease. ✓ 25% reduction in the incidence of arterial hypertension in people aged above 25. ✓ 10% reduction in the incidence of diabetes in people aged above 25. ✓ Maintaining the percentage of frequency of obese adults and reducing by 2% the incidence of obese children and adolescents.

Four major objectives guide the set of actions aimed at achieving this target and its markers.

OBJECTIVE *1* – Establishing multisectoral partnerships and integrating NCD prevention policies in the different health sectors.

OBJECTIVE *2* – Reducing tobacco consumption and indirect exposure to smoking; reducing the harmful consumption of alcohol; promoting healthy eating habits and physical activity.

OBJECTIVE *3* – Strengthening the capacity to provide primary health care services; implementing an integrated management model for noncommunicable diseases; ensuring access to drugs; ensuring polychemiotherapy coverage.

OBJECTIVE 4 – Developing systems of registration of patients affected by NCDs or exposed to risk factors, including cancer incidence records; employing surveillance systems for NCDs and their risk factors in the planning and monitoring of NCD control and prevention programs.

Currently, a group of experts from different academic areas, social scientists, economists and sociologists, among other specialties, and representatives from different countries have been working virtually or physically towards reviewing the targets and markers set for the Americas in light of the global targets. They work in pursuit of strengthening the scientific argument to be used as a support to the establishment of NCD-related objectives and markers, using to that end epidemiological and social science dimensions.

Specifically, the working group intends to propose one or two targets linked to economic and development markers, thus allowing the

contextualization of the social costs of noncommunicable diseases and the impact on economic growth. It also proposes to revise NCD targets and markers for the Americas, based on global targets, measuring one or more of the following criteria:

- ✓ Focus on NCD prevention.
- ✓ Involvement of senior policy makers, for example Heads of State and Ministers, with the implementation and execution of the proposed set of actions for NCD control and prevention.
- ✓ Presentation of short-term outcomes, preferably in cycles that are shorter than electoral cycles.
- ✓ Possibility of cumulative incremental improvements in performance.
- ✓ Multisectoral response to epidemics, involving other sectors.
- ✓ Targeting quality and effectiveness of interventions, including cost and effectiveness markers.
- ✓ Focus on the quality of life and not just on mortality.
- ✓ Measuring the context of each country, since each one presents specific limitations to achieving the targets, especially the poorest countries.
- ✓ As development-related economic markers, using the percentage of net GDP invested by the public sector in the prevention of NCDs and the percentage of population below the national poverty line, capable of purchasing staples.

The analysis of regional targets and epidemiological markers of different countries performed by the working group showed that the target of reducing mortality rates proposed by WHO is feasible and appropriate to the American continent as a whole, but only consistent with the reality of some countries. In order to establish concrete and feasible targets, the group of experts suggests: to consider premature mortality as the 30-69 years age range; to set out, where possible, markers by gender, schooling and economic condition; and to fix targets to reduce mortality for each of the four major noncommunicable diseases (cardiovascular diseases, cancer, diabetes and chronic respiratory diseases).

In relation to hypertension and diabetes, the working group suggests that: the establishment of targets uses as a parameter the ten best performances achieved by countries in reducing the incidence rates of these two diseases; both prevention-related and effectiveness-related markers are considered; and the gradual and sustained decrease in the consumption of salt by the population by 2020 is used as a marker related to the prevention of hypertension, whereas the internationally recommended daily target is less than 5 grams per person.

The working group also proposes the inclusion of specific markers aimed at children and adolescents, such as: lowering the minimum age limit to be considered as onset of smoking; reducing to zero the incidence of tobacco use and reducing the prevalence of alcohol use, considering as consumption the use in the last month.

It also suggests other aspects to be considered in the process of setting NCD targets and markers: introducing markers related to protection and risk factors; measuring barriers, such as the occurrence of civil strife or natural disasters and their impacts on the achievement of goals; identifying the influence of risk factors in the performance of mortality targets, idealizing longitudinal measurement mechanisms. Finally, experts emphasize the importance of markers extrapolating the monitoring of shortcomings and outcomes of health services, also covering risk and protection factors.

Comments and recommendations:

- Diabetes mellitus is a major public health problem, with a high social and economic burden, that is why it is difficult to deal with the disease and its possible consequences. The proposed 10% reduction of the disease, presented in the first stage of the *Strategy and Action Plan for NCD prevention and control*, was very ambitious. Perhaps this was why the target was not approved;

- The proposition of the objectives of the *Strategy and Action Plan for NCD prevention and control* was designed based on the reality of countries that had better performance, such as Canada. For countries that have more resources, targets are achievable. This can further deepen existing inequalities;

- It is very difficult to establish regional goals, since the objectives of the *Action Plan for NCD prevention and control* must be ambitious. The proposed reduction in mortality at the suggested level is an important strategy, because governments will feel pressured. Ambitious targets can "work" and have the potential to motivate leaders of different countries to achieve them;

- Salt intake reduction interventions should be strengthened. This is an important action that will benefit everyone, including children;

- The expression "use of evidence" should not be used. All policies, either good or bad, are evidence-based;

- There is great expectation from countries in relation to the upcoming World Health Assembly with reference to morbidity markers, there are questions regarding factors, such as epidemiological and demographic transition, increasing obesity, markers to measure access to treatment. Countries should be able to work with other markers, as well as being monitored by various instruments;

- In relation to salt intake, the daily five-gram consumption is an excellent target, although representing a major challenge for some countries. The possibility of spreading the targets according to the country’s possibilities should be discussed;

- It is necessary to view globally the performance of each country in order to offer programs/projects that enable the achievement of targets. The establishment of global targets to be applied in different contexts is a major challenge;

- There are countries in the Region with better epidemiological surveillance systems. Other countries have very fragile information and some agencies have no reliable cause of death records. In this scenario, the monitoring of markers is an arduous task.

DISCUSSION PANEL

COUNTRY EXPERIENCES ON IMPROVING THE SURVEILLANCE OF NCD-BORNE MORBIDITY

Sebastian Laspiur - Argentina
Dr. Kenneth George – Barbados
Dr. Deborah Malta - Brazil
Dr. Paul Ricketts – Dominica

Dr. Paul Ricketts – Dominica

NCDs are the leading cause of death and morbidity in the country. Thus, they are regarded as high priority by the Government. In 2006, the Minister of Health implemented a pilot project aimed at collecting data on noncommunicable diseases. The Dominican Republic was the first nation in the Caribbean region to conduct a national survey on NCDs, a study that boosted the implementation of a NCD-borne mortality monitoring system in the country. In 2007, for the first time, a census sampling was conducted covering the population aged between 15 and 64 aimed at obtaining information about some noncommunicable diseases. Since then, the country has conducted global health censuses and censuses specifically aimed at teenagers.

NCD surveillance requires a minimum set of information. In the country, information is obtained from different sources, both from routine data provided by the Ministry of Health and other means. For example, mortality data are obtained from death certificates filled by doctors from the public or private sector.

The first sampling census faced several challenges, both related to the process of data collection and financing. Additional resources had to be made available to ensure the continuity of the project. Data collection was influenced by missing individuals caused both by the loss of contacts or the death of respondents and the period of the research – from November 2007 and May 2008 (between Christmas and Carnival). The response rate achieved was 50%.

Data obtained from the national survey on NCDs are being used to support the development of policies and programs in the country, such as the Guidelines for Hypertension and Diabetes, the NCD National Policy and the National Health Strategic Plan 2010/2019.

My advice to colleagues who want to improve risk factors surveillance and implement policies to address NCDs is to identify sources of financing, invest in qualification and training and integrate information systems.

Dr. Kenneth George – Barbados

NCD surveillance work began with the monitoring of the myocardial infarction incidence in the country. In 2006, the Ministry of Health created the *National Chronic NCD Commission*, establishing a program of technical cooperation with the London Center. Initially, it even relied on funding from the European Union (EU).

In order to collect accurately and timely data about stroke, Cerebral Vascular Accident (CVA) and cancer, to contribute to the prevention, control and treatment of these diseases and to promote the development of programs and policies related to the diseases mentioned, data collection is being held across the island, both in public and private sectors. It covers three types of data collection: directly, for hospitalized patients; information survey, for patients dying inside or outside hospitals and patients treated in the community, following hospital discharge; and regressive survey, for patients with cancer. The data collection methods it employs are already established protocols, different from those used to carry out prospective studies on the health conditions, which involve passive and active aspects.

Financed by the Ministry of Health, its technical expertise is provided by health professionals and academic centers in the country. Each team involved in the work consists of a manager, epidemiologists working with the recording of information, technical advisors and nurses responsible for monitoring the data.

It is necessary to ensure that surveillance information is capable of identifying gaps pointing out health needs and, therefore, resulting in impacts on the strategic planning. In Barbados, trainings were conducted to strengthen the surveillance system and certification processes were established. We noted that not only did the system increase the ability to monitor NCDs, but it also improved direct patient care, favoring the confirmation of diagnoses, the supply of feedback to doctors and the assessment of rehabilitation levels.

Health policies should have three components: prevention, promotion and rehabilitation. There must be a total commitment with the NCD issue, not only from Ministry of Health, but also other sectors. It is necessary to develop specific, sub-national work. High government levels and health system users must be committed to the issue. The Ministry of Health is often unable to implement and manage alone the surveillance system. There must be a collaboration of academia, through the support of epidemiologists and statisticians, among others. People must be involved so that citizens feel they are part of the process.

At the UN High Level Meeting held in September 2001, Prime Minister of Barbados Freundel Stuart, by emphasizing that the Caribbean is the region most impacted by NCDs in the Americas, an “unsustainable burden to our fragile economies”, urged everyone to “an immediate and effective action”.

Dr. Deborah Malta - Brazil

The Chronic Disease Surveillance System was established in Brazil 10 years ago to monitor information on mortality, morbidity and risk and protection factors. Regarding mortality, NCDs contribute to about 70% of deaths in the country. Cardiovascular and respiratory diseases show a decline trend, diabetes, an increase trend, and cancer, a stabilization trend.

The Mortality Information System (SIM), which has advanced with regard to the improvement of the quality of information, reducing the number of data related to ill-defined causes, covers 93% of deaths. The Hospital Information

System (SIH) covers 80% of hospitalization events that occur in public hospitals or accredited by the SUS. It monitors the percentage of hospitalization and costs generated by chronic diseases. Cancer is the seventh leading cause of hospitalization and is ranked third in financial costs. Respiratory diseases are the second leading cause of hospitalization and are ranked first in financial costs.

In addition to these data collection systems is the one aimed at the monitoring of cancer, the Population-based Cancer Records (RCBP), conducted by the Health Surveillance Secretariat (SVS) and the National Cancer Institute (INCA). There are currently 20 RCBPs and 218 Hospital Cancer Records (RHC). Since 2005, the SVS has been financing the program and monitoring the achievement of targets jointly with INCA. Regular submission of data and the improvement of the quality of information are assessed. INCA has technically supported the processes of data collection, entry and analysis. Data collected in the country project that, in 2012, the three types of cancers with the higher incidence among men will be: prostate; trachea, bronchus and lung; and colon and rectum. Among women: breast; cervical; and colon and rectum. Incidence data are important information, since they support decision making and consequently the development of public policies.

It is important to highlight that there are four types of surveys in the country: household, held every five years; school, the National Students Health Survey (PeNSE), organized every three years in public and private schools; and on violence, the Accidents and Violence Surveillance (VIVA). The Surveillance of Risk and Protection Factors for Chronic Diseases through Telephone Survey (Vigitel), held annually for six years now, generates quick responses at low cost. Vigitel enables the monitoring of risk factors, as well as the performance of income-related analyses. For example, regarding the prevalence of risk and protection factors for NCDs in the Brazilian capitals according to schooling, the data obtained through the program show that, in relation to smoking, the percentage of smokers is 18.8% in the population with less schooling years (0-8 schooling years) and 10.3% in that with higher education (12 or more schooling years).

On the other hand, in relation to physical activity, the result is reversed – 24% of the population with less schooling years and 42.2% with higher education perform physical activity.

We note that the information obtained by the different surveillance systems can be used to support policy making, set targets and monitor markers and contribute to the construction of health promotion and priority setting actions. In addition, they support educational activities when disseminated to professionals, the media and the public. Data generated enables the analysis of trends and the assessment of programs.

Sebastian Laspiur- Argentina

South America has the same global trend in relation to epidemiological changes. The regional surveillance of NCDs began in 2007 in Argentina, with the work of an *ad hoc* committee of consultants. In 2008, an *ad hoc* group for the surveillance of NCDs and injuries in the MERCOSUR was created.

Composed of representatives from Brazil, Argentina, Paraguay, Uruguay and Chile, the latter as an associate country, the group's main objective is seeking alternatives to "reduce the burden of NCDs as a result of changes in health policies, programs and services based on the timely surveillance of NCDs and injuries in Member and Associated States of MERCOSUR".

With respect to surveillance systems in the MERCOSUR, the existence of inequalities was a reality. Brazil had and still has a highly developed surveillance system, Argentina did not. At the time, Paraguay and Uruguay had similar processes. This fact enriched the process of building a regional surveillance of NCDs which was established through the exchange of information.

Initially, the group prioritized the issues. Then, the surveillance methodology to be pursued was defined and markers to be used as comparability and availability criteria were selected. The findings of this work are recorded in documents that address surveillance in the Region, prepared by member countries and also by Chile. Recently, in 2011, a regional document was prepared, entitled *Primer Reporte de Vigilancia de Enfermedades no Trasmisibles (ENT) – Situación Epidemiológica de las ENT y Lesiones en Argentina, Brasil, Chile, Paraguay e Uruguay (Free translation: "First Report on the Surveillance of Noncommunicable Diseases (NCDs) – Epidemiological Situation of NCDs and Injuries in Argentina, Brazil, Chile, Paraguay and Uruguay")* . All countries cooperated in the delivery of data and the final revision of the document which provides information regarding mortality, morbidity and risk factors.

Its development required the establishment of priorities in the selection of markers and a "harmonization" between the different surveillance systems in each country. The document enables the graphical comparison of information from all the countries participating in the initiative and should be used to support decision making. Information must be updated to start working "according to the regional report".

It is necessary to advance in monitoring the quality of health services, as well as to promote/foster experiences of successful surveillance in the Region. It is essential that production of publications, such as reports and periodic reports continues, as well as analyses showing the progress of surveillance systems in the Region.

The challenge is to continue this integration process of national surveillance systems, progressing through the inclusion and/or building of other markers, especially those focused on health care that have not yet been addressed, promoting better mechanisms to assess the impact of public policies.

WORKING GROUPS

CENTRAL AMERICA

MEXICO AND HISPANIC CARIBBEAN

The current context of NCDs in Mexico and the Hispanic Caribbean countries set up the need for efforts towards the fulfillment of the agreements reached at the Summit, since this has not produced, at the political level, sufficient effects in the implementation and the development of various programs required for the management of NCDs. We must promote actions that will reduce the morbidity and premature mortality and improve the quality of life and the disabling condition of those affected by chronic disease. Support from PAHO is therefore crucial, following-up and monitoring country performance to ensure the performance of the motto of the World Summit – “The beginning of the end for NCDs."

Currently, the following data describe the context of Mexico and Hispanic Caribbean countries:

- ✓ 33% of countries develop action plans aimed at NCDs.
- ✓ 42 % have NCD policies.
- ✓ 43 % have political backing.
- ✓ The UN Summit caused changes in 29% of countries.
- ✓ 43% of countries see a favorable context for the strengthening programs aimed at NCDs.
- ✓ 100% of countries receive PAHO’s support.
- ✓ NCD programs from all countries have budgetary limitations. Health-related budgets are aimed at healthcare programs.
- ✓ Only country has a budgetary allocation directly targeting NCD activities.
- ✓ 100% of countries do not have a budgetary allocation directly targeted at surveillance. Resources are global and are aimed at surveillance programs as a whole.

In this context, as a base line of conduct, the prioritization of the following strategic objectives outlined in the Plan of Action is suggested:

Objective 1 – Multisectoral Policies

Specific objective 1.1

Promote the participation of different sectors, and not just the health sector in the design of policies and action programs aimed at NCD prevention.

Objective 2 – Reducing NCD risk factors and strengthening protection factors

Specific objective – 2.3

Promote active living and healthy eating habits to prevent obesity and promote health and well-being conditions.

Objective 3 – Health systems' response to NCDs.

Specific objective – 3.1

Promote the development or improvement of skills of health services and health surveillance providers in relation to the prevention and control of NCDs under a multidisciplinary approach.

Objective 4 – Surveillance and investigation of NCDs

Specific objective – 4.1

Improve the quality of surveillance systems of NCDs and their risk factors, including cancer control.

ANDEAN COUNTRIES

BOLIVIA, CHILE, COLOMBIA, ECUADOR AND VENEZUELA

Priority activities

- ✓ Implementation of the NCD Sub-regional Plan.
- ✓ Improvement of information systems on mortality and risk factors, especially the registration process with regard to breadth, data quality and systematization of data collection.
- ✓ Introduction of markers aimed at monitoring the quality of NCD care services, for example, AMI survival and disability components.
- ✓ Strengthening demographic surveillance systems – dependency rate and aging rate.
- ✓ Implementation and improvement of primary health care systems aimed at NCD.
- ✓ Strengthening multisectoral and community interfaces.
- ✓ Preparation of the first report on the monitoring of the Andean region.
- ✓ Feasibility of studies to examine contents linked to the relationship between pathogenic complex of communicable diseases residues and noncommunicable diseases.

- ✓ Implementation of the first sub-regional course on the NCD care model.

Suggested support behavior to be adopted by PAHO

- ✓ Promote the implementation of the Cooperation Agreement between the Andean countries on NCD surveillance, prevention and control strategies, respecting similar ones between the nations and the progress made by each country.
- ✓ Support social protection action and the financing of NCD-related programs.
- ✓ Provide technical support to the analysis of NCD-related health situation.
- ✓ Organize the first sub-regional course on the NCD care model.

SOUTHERN CONE COUNTRIES

ARGENTINA, BRAZIL, CHILE, URUGUAY AND PARAGUAY

Remarks and suggestions regarding targets

Target – 25% reduction in the rate of premature death among people aged 30 to 69 due to cardiovascular disease, cancer, diabetes or chronic respiratory disease.

Comments – Only Brazil has a decreasing trend. Countries suggest strengthening the commitment to achieve the target and that specific markers per disease group and per country are set.

Target – Reducing the case of people aged above 18 diagnosed with hypertension.

Comments – Countries support the effective coverage and the performance of efforts toward achieving the target, which will result in the adoption of strategies for the population as a whole, such as reducing salt intake. They propose to set markers that include treatment; making adjustments to the marker's value, since the 25% reduction appears unrealistic to the context of countries; the clear definition of the set of flags that would characterize the diagnosis of high arterial pressure and the establishment of an interval range to be addressed by the target through the definition of an upper age limit - 64 years is being proposed.

Target – reduction of physical inactivity

Comments – Countries support the inclusion of the target. However, they note the difficulty of the trustworthy record of results to be achieved. They suggest that alternative instruments are introduced in addition to GPack.

Target – daily salt intake of up to 5 grams

Comments – The target is valid, but at the same time ambitious. However, it can lead to the implementation of public policies.

Target – 25% reduction in the number of tobacco consumers aged above 15

Comments – Countries suggest to consider as smoker the daily or occasional users of all kinds of snuff, whether smoke-producing or not, as well as propose to include process markers at regional level, regardless of target; the implementation of the Framework Convention and the introduction of specific markers for young people.

Target – diabetes

Comments – Countries consider the target complete. They propose that markers related to the effective coverage of patients are included in regional goals, such as, for example, the proportion of diabetic of adequately controlled patients -HbA1c-7%.

Target – obesity

Comments – As a regional target, countries suggest to maintain markers related to the incidence of obese adults and to establish the 2%-reduction marker in the number of young obese. In parallel, they propose that an agreement to reduce the population's excess weight is established between countries.

Target – alcoholism

Comments – Countries suggest to include a specific marker for the region and to establish actions aimed at the prevention of harmful alcohol consumption, especially for young people and, among other strategies, composed of educational campaigns showing the relationship between alcohol consumption and the occurrence of accidents and other serious problems. Also, they note that reducing OH consumption should be understood as a public health strategy.

Remarks and suggestions regarding objectives

Objective 1 – Multisectoral policies

Comments – Countries suggest withdrawing from sub-section 1.1.1. the terms "whole government" and "public-private partnerships" and add a reference to NCD prevention, as well as to eliminate sub-section 1.3.2., since its contents are also included in objective 3.

Objective 2 – Reducing NCD risk factors and strengthening of protection factors

Comments – Countries suggest that two separate sub-groups – children/adolescents and adults – are established in sub-section 2.3.2; that markers related to trans fats are maintained in sub-section 2.3.5, however, the amount of countries that have legislation or other regulatory instruments on the subject should be changed; and that a marker that includes the consumption of five daily servings of fruits and vegetables is introduced.

Objective 3 – Health systems response to NCDs.

Comments – Countries deem the expression "strengthening the whole" ambiguous and broad. They consider that the use of such a statement may raise constraints for the proper breakdown of the results to be achieved. Therefore, they propose to break down markers so that these start to consider separately screening, early diagnosis, treatment and palliative care. Countries also suggest: to restrict the marker related to the access to basic technologies for diagnosis and treatment of NCDs, through the definition of three or four types of technologies; to specify a list of essential drugs for the management of NCDs; to reset the marker of sub-section 3.4.1, also proposing an age limit – 35 or 40 years –, since this is the only marker addressing cardiovascular patients; to clarify marker 3.4.2, introducing the term "controlled hypertensive patients"; to assign to marker 3.4.3 the 25-64 years age range and a three-year to perform coverage; to increase the 3.4.4 marker to 70%, to change the age range to read 50-69 years and establish new coverage period – two years.

Objective 4 – Surveillance and investigation of NCDs

Comments – Countries suggest that markers addressing the reduction of disparities and inequalities in relation to health and the effective application of costs are introduced.

ENGLISH CARIBBEAN COUNTRIES

DOMINICA, JAMAICA, ST. LUCIA, ANTIGUA, ST. KITTS AND TRINIDAD & TOBAGO

Proposed priorities

Technical cooperation actions

✓ Development of a NCD management strategy and action plan under a multisectoral approach.

✓ Promotion of activities related to the following thematic cores: health education, health promotion, social marketing and changes in social behavior.

✓ Development and implementation of a universal coverage plan, measuring services, drugs, diagnostics and technologies.

- ✓ Development and implementation of the diabetes self-management program.

Actions supporting the strengthening health systems

- ✓ Design of SIH SIM – NCD data management and use of CEDEMS.
- ✓ Development of policies aimed at NCD and tobacco.
- ✓ Implementation of actions aimed at training and professional development covering issues related to the reorientation of health services, the application of the new care model for chronic diseases and the treatment of people who are abandoning the use of tobacco - St. Lucia, Antigua, St. Kitts and Dominica.
- ✓ Review and update of guidelines related to diabetes and hypertension, proceeding to include non-pharmacological methods – Jamaica and Dominica to share guidance for the management of NCDs.
- ✓ Adaptation of the WHO cardiovascular risk assessment protocol to the context of the Caribbean islands.

Technical cooperation actions for the strengthening of health systems

Related to community organizations

- ✓ Promote the creation and offer the support to community organizations that provide services aimed at NCD management.
- ✓ Collaborate with the mobilization of financial resources.
- ✓ Grant authorizations.

Related to the monitoring and the assessment of outcomes

- ✓ Support actions conducive to the trustworthy record of NCD-related information – CTP projects, considering BAR, TRT and SUR.
- ✓ Support the implantation of information systems in the applicant countries.
- ✓ Improve the quality of statistical data, bettering national information systems.

Related to scientific research

- ✓ Support research projects on ANI and SUR as from the initial stages.
- ✓ Collaborate with PHAC in the development of comparative and cross-cutting research on risk factors.

- ✓ Develop jointly with PHAC a proposal for the access to specific funds of each country from donor agencies.
- ✓ Assess the progress achieved by countries with regard to the objectives of the POS Declaration, to be presented to the Heads of State of the Caribbean community.

Related to the procurement of financial resources

- ✓ Support countries in the process of identifying funding sources, providing them with declarations, when necessary.
- ✓ Support the development of economic arguments that can justify to the ministers of finance and other sectors the increase of funds to NCD programs.
- ✓ Support the process of raising the awareness of politicians and government managers regarding the UN Declaration, promoting reflections on the role, duties and responsibilities of every social stakeholder.

Acronyms

ABIA	Brazilian Association of Food Industries
APS	Primary Health Care
BMI	Body Mass Index
CARICOM	Caribbean Community
CARMEN	Multifactorial Reduction of Noncommunicable Diseases
NCD	Chronic Non-Communicable Disease
CONASEMS	National Council of Municipal Health Secretariats
CONASS	National Council of Health Secretaries
CVA	Cerebral Vascular Accident
DEXA	Double Energy X-ray Absorptiometry
DF	Federal District (Brazil)
ENT	Noncommunicable diseases
HIV	Human Immunodeficiency Virus
HLAC	Healthy Latin American Coalition
IBGE	Brazilian Institute of Geography and Statistics
INCA	National Cancer Institute
MERCOSUR	Common Market of the South
NGOs	Non-Governmental Organizations
PAFNCD	Pan-American Forum for Action on Noncommunicable Diseases
PeNSE	National Students Health Survey
PMAQ-AB	National Program for the Improvement of Access and Quality of Primary Health Care
RAU	Emergency Care Network
RCBP	Population-Based Cancer Records
RHC	Hospital Cancer Records
SAD	Home Care Service
SAMU	Mobile Emergency Care Service
SIH	Hospital Information System
SIM	Mortality Information System
SVS	Health Surveillance Secretariat
UBS	Basic Health Care Facility
UPA	Emergency Care Facility
Vigitel	Surveillance of Risk and Protection Factors for Chronic Diseases through Telephone Survey
VIVA	Accidents and Violence Surveillance
YPLL	Years of potential life lost