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

In 2002, the 26th Pan American Sanitary Conference recognized chronic diseases as the greatest cause of premature death and morbidity in Latin America and the Caribbean (LAC) and adopted Resolution CSP26.R15, which called for increased and coordinated technical cooperation from PAHO.

In response to this resolution and recognizing the need for an updated inter-programmatic chronic disease strategy, PAHO has developed a Regional Strategy and Plan of Action. It notes that chronic diseases are devastating to individuals, families, and communities, particularly poor populations; and they are a growing threat to economic development. In the next two decades in LAC, it is estimated that there will be a near tripling of the incidence of ischemic heart disease and stroke. Moreover, vulnerable populations such as the poor are more likely to develop chronic diseases, and low income families are more likely to become impoverished from them. The societal costs associated with chronic diseases are staggering. For example, the total annual cost associated with diabetes was estimated at US\$ 65 billion for LAC in 2000.

This Regional Strategy has four lines of action that recognize that chronic diseases need to be prioritized in the political and public health agendas; identify surveillance as a key component; recognize that health systems must be reoriented to respond to the needs of people with chronic conditions; and note the essential role of health promotion and disease prevention. The four lines of action are vitally interdependent, inasmuch as one without the other leaves tremendous gaps in reaching all sectors of the population and in achieving the goal of the Regional Strategy—to prevent and reduce the burden of chronic diseases and related risk factors in the Americas.

Countries are now at a critical juncture. The evidence is clear, and the time has come for comprehensive and integrated action to reverse this deadly epidemic.

The Executive Committee is requested to consider the following actions: (1) reaffirm chronic diseases as a high priority; (2) ensure that Member States' commitment is translated into programmatic and financial support for chronic diseases; (3) review and provide feedback to PAHO's proposed Regional Strategy and Plan of Action; and (4) discuss strategies to mobilize technical and financial resources at the regional, subregional, and country levels.

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Introduction

1. Chronic diseases have not received the priority attention in public health policies and programs commensurate with their disease burden in this Region. There are clear evidence and cost- effective interventions available to prevent premature deaths from chronic diseases, and it is time to act to prevent the further loss of millions of lives and damage to economies (1).
2. Every country, regardless of the level of resources can make significant improvements in chronic disease prevention and control. This Regional Strategy aims to prevent and reduce the burden of chronic diseases and related risk factors in the Americas. It is intended to guide PAHO's technical cooperation on chronic diseases and to steer Member States in the development or strengthening of chronic disease national plans and programs.
3. The strategic approaches and lines of action identified in this Regional Strategy are consistent with those in Resolution CSP.R15, adopted by the Pan American Sanitary Conference in 2002. This proposal also incorporates themes from the Global Strategy on Diet, Physical Activity, and Health, which focuses on two of the main chronic disease risk factors. To address the epidemic of chronic diseases in the Region, a long-term, expounded strategy is needed that integrates current practice with new directions and approaches.

Process

4. In the past, the major challenges for PAHO's delivery of technical cooperation for chronic disease prevention and control have been the development of an interprogrammatic approach and the integration of activities across relevant PAHO technical offices, along with maximizing external partnerships to efficiently use the scarce resources available in the Region. For these reasons, the process to develop the Regional Strategy has been participatory and inclusive, involving all related PAHO technical units and country offices, and seeking input from a wide range of external stakeholders, including representatives from the health ministries, nongovernmental organizations (NGOs), universities, professional associations, and local governments. Country and subregional consultations were held and contributions were received from over 190 participants from 26 countries in the Region.

Rationale

5. A strategy is required to address the fact that the prevalence of all leading chronic diseases is increasing, with the majority occurring in developing countries, and are forecast to increase substantially over the next two decades (2). The Americas Region has one of the highest rates of chronic diseases of all WHO Regions. In addition, this Region

is the most inequitable, which is relevant given that poor people are more likely to develop and die from chronic diseases, further driving the socioeconomic inequities (2). This Region is characterized by well-established health systems and advances in primary health care which can be better oriented to address chronic conditions. For these reasons, a Regional Strategy is proposed which is appropriate to the cultural and socioeconomic circumstances of the Americas, and incorporates strategic approaches and actions suitable to this Region.

6. In addition, it is now recognized that intersectoral collaboration outside the health sector is required to achieve a meaningful impact on chronic diseases. Poverty, unhealthy environmental conditions, and low education are factors that contribute to chronic disease occurrence and are influenced by the geopolitical and economic situation. Moreover, chronic disease risk factors such as unhealthy diets and physical inactivity are affected by sectors such as agriculture, transport, and trade. Therefore, a Regional Strategy is required which addresses this need for comprehensive and integrated action with sectors outside of the traditional health sector.

Situation Analysis

7. The epidemic of chronic diseases threatens economic and social development, and the lives and health of millions of people. In 2005, an estimated 35 million people worldwide died from chronic diseases; this is double the number of deaths from all infectious diseases (including HIV/AIDS, malaria, and tuberculosis), maternal and perinatal conditions, and nutritional deficiencies combined (1). While deaths from infectious diseases, perinatal conditions, and nutritional deficiencies are expected to decline by 3% over the next 10 years, deaths due to chronic diseases are projected to increase by 17% by 2015 (1).

8. In LAC, chronic diseases are now the leading cause of premature mortality and disability in the vast majority of countries. In 2002, they accounted for 44% of deaths among men and women below the age of 70 years, and were responsible for two out of three deaths in the total population (3). Chronic diseases contributed to almost 50% of disability-adjusted life years lost in the Region (3). The chronic disease burden may be even greater than these statistics indicate, given the large proportion of underreporting in mortality data in the Region. The most commonly occurring chronic diseases and those of greatest public health importance in the Region are: cardiovascular disease including hypertension, cancer, chronic respiratory diseases, and diabetes.

9. In the first decade of the 21st century, cardiovascular diseases are expected to claim some 20.7 million lives in the Region (4). In 2005 in LAC, 31% of all deaths were attributable to cardiovascular diseases (4). Predictions for the next two decades include a near tripling of ischemic heart disease and stroke mortality in Latin America (2).

10. Hypertension is one of the most important risk factors for heart disease and affects between 8% and 30% of the population (5). Mexico, one of the few countries that has conducted more than one chronic-disease risk-factor survey, found that the prevalence of hypertension had increased from 26% in 1993 to 30% in 2000 (6).

11. Cancer accounts for 20% of chronic disease mortality, and in 2002 there were an estimated 459,000 deaths due to cancer (7). This represents a 33% increase since 1990 in the Region. The World Health Organization (WHO) estimates that by 2020, there will be 833,800 deaths due to cancer in LAC (7).

12. Thirty-five million people in the Region are currently affected by diabetes and WHO forecasts an increase to 64 million by 2025 (8). It is estimated that in 2003 diabetes was related to some 300,000 deaths in Latin America and the Caribbean, although official statistics link only some 70,000 annual deaths to the disease. Additionally, the societal costs of diabetes were estimated at \$65 billion in 2000 (8).

13. The “nutrition transition” in our Region is characterized by a decreased consumption of fruits, vegetables, whole grains, cereals, and legumes. Together with this goes an increased consumption of foods rich in saturated fat, sugars and salt, among them milk, meats, refined cereals, and processed foods. This is leading to a rise in conditions of overweight and obesity. Population- based surveys from LAC show that, in 2002, 50% to 60% of adults and 7% to 12% of children less than 5 years of age were overweight and obese (5). In Chile and Mexico, the 2004 national surveys showed that 15% of adolescents were obese (9). In Canada and the United States of America, 33% and 65% of adults are classified as overweight, respectively (10, 11).

14. Furthermore, 30% to 60% of the Region’s population does not achieve even the minimum recommended levels of physical activity (9). For adolescents, this lack of physical activity is particularly disturbing as the development of healthy habits is formed at this stage and tends to stay throughout life (12). As occupations shift from manual labor and agriculture to the service sector, physical activity levels have declined (13). This has been driven by increased urbanization and motorized transportation, urban zoning policies that promote car-dependent suburbs, lack of attention to needs of pedestrians and cyclists in urban planning, the ubiquitous presence of labor-saving devices in domestic life, and the growing use of computers at work and for entertainment (13).

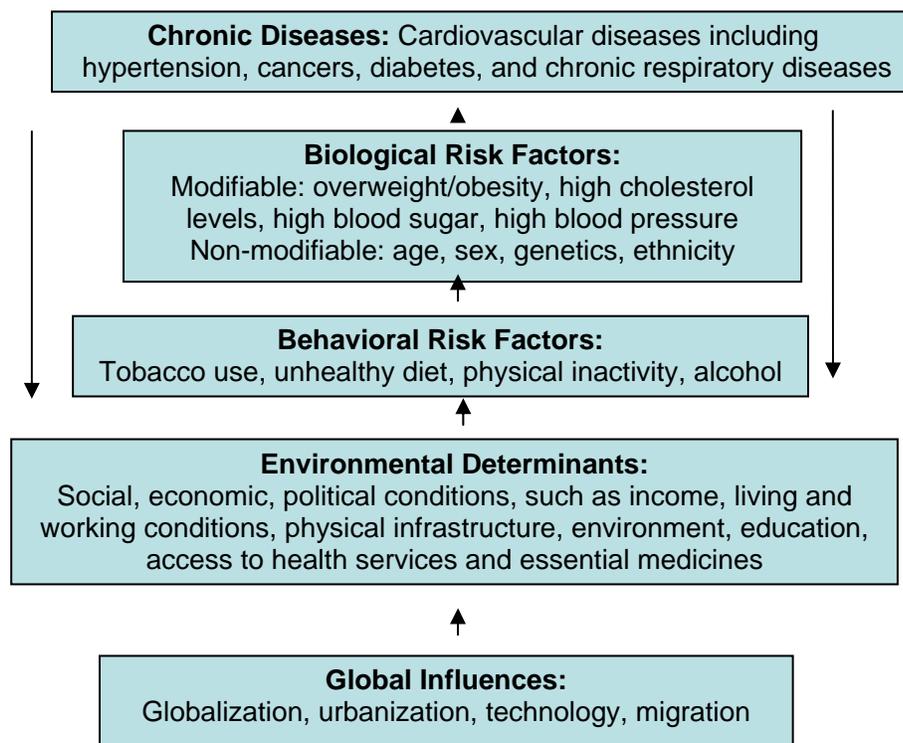
15. Tobacco consumption is the leading cause of avoidable death in the Americas. It is the cause of over one million deaths in the Region each year, and the Southern Cone has the highest mortality rate from smoking-related causes (5). Tobacco consumption is attributed to approximately one-third of all deaths from heart disease and cancer in the Americas. In the majority of the Region’s countries, more than 70% of smokers start smoking before the age of 18 (5). In a survey conducted in 2000, between 14% and 40%

of young people in Latin America and the Caribbean were using tobacco (5). In 2002, 25% of Canadian youth and 23% of youth in the United States reported using tobacco products (14, 15).

16. In addition to these modifiable risk factors, inadequate access to quality health services, including clinical prevention and diagnostic services, along with difficult access to essential medicines are significant factors which contribute to the burden of chronic diseases. The poor often face several health care barriers including the inability to afford user charges for health care, financial barriers for necessary prescription drugs, and lack of transportation to reach health services. In addition, vulnerable populations may face communication barriers, inhibiting the benefits of services.

17. For the purposes of this Strategy, the key determinants for chronic disease are illustrated below in Figure 1. The determinants are categorized within biological and behavioral risk factors, environmental conditions, and global influences.

Figure 1: Key Determinants of Chronic Diseases



Cost Effective Prevention and Management Practices

18. There is a strong evidence-base for the cost-effectiveness of disease prevention and early detection interventions. Cardiovascular diseases, some cancers and diabetes can be prevented or delayed by:

- changes in diet and lifestyle,
- screening for risk or for early manifestation of disease,
- treatment of precursor lesions or earlier treatment of disease, and
- pharmacological interventions (16).

19. Routine preventive health exams in primary care settings are a recommended approach for chronic disease prevention (17). The essential assessments include: blood pressure measures; calculation of body-mass index; lipid profile; blood glucose testing; for women, screening for cervical cancer (Pap test) and for breast cancer (clinical breast exam and mammography); and screening for colorectal cancer. In addition, the current evidence suggests that opportunistic screening should be conducted to detect prediabetes in overweight individuals aged 45 years or older (18).

20. For those already diagnosed with a chronic condition, cost-effective treatments are available. For example, medications such as beta blockers and aspirin are low-cost and effective measures to reduce the chance of recurrence of heart attacks. For people with diabetes, interventions include controlling blood sugar, ensuring access to insulin for people requiring it, blood pressure control (with or without medication), and foot care for the prevention of amputations. For cancer control, treatment is cost-effective for cervical, breast, oral, and colorectal cancers and includes surgical removal of tumors, chemotherapy, and radiation therapy (16).

21. WHO conducted a regional review of the cost-effectiveness of chronic disease interventions in the Americas. The most cost-effective strategies were those that were population-based, and included increasing tobacco taxes to the highest regional tax rate of 75% (1). The average cost effectiveness (ACE) for this intervention was \$19. Legislation to decrease salt content in processed foods, plus appropriate labeling and enforcement, and legislation and health education to reduce cholesterol were also cost effective with an ACE of \$127 and \$135 respectively. The least cost-effective were interventions directed to individuals, such as nicotine replacement therapy with an ACE of \$3,083, and the provision of statins and education on lifestyle modification delivered by physicians to patients whose cholesterol concentrations exceeded 220mg/dl with an ACE of \$1,326 (16).

22. Environmental and multisectoral interventions are effective. For example, it has been demonstrated that replacing the 2% of energy that comes from transfat with

polyunsaturated fat would reduce cardiovascular diseases (CVD) by 7% to 40% and would also reduce type 2 diabetes (16). Because transfat could be eliminated or significantly reduced by voluntary industry action, the cost amounts to no more than \$0.50 per person per year (16). Legislation that mandates reduced salt content in manufactured foods is also cost effective and when accompanied by an education campaign can reduce blood pressure at a cost of \$6.00 per year (16).

Guiding Principles

23. This Regional Strategy and Action Plan is based on PAHO's commitment to contextualize strategies and goals taking into consideration on the health priorities and the unique social, economic, and political conditions of Member States. It also considers the following:

- PAHO's Strategic Framework for health promotion, primary health care, social protection, and human rights.
- The Framework for the Technical Cooperation Strategy of addressing the unfinished agenda, protecting achievements, and facing new challenges.
- The Managerial Strategy for the Work of the Pan American Sanitary Bureau 2003-2007 by using a country-focused approach and targeting special population groups.

Framework for Action

24. The Strategy incorporates some of the concepts and themes from the following WHO and PAHO resolutions: the WHO Global Strategy for the Prevention and Control of Chronic Diseases (WHA53.17, 2000); Cardiovascular Disease, especially Hypertension (CD42.R9, 2000); Framework Convention for Tobacco Control (WHA56.1, 2003); Global Strategy on Diet, Physical Activity, and Health (WHA57.17, 2004); and Cancer Prevention and Control (WHA58.22, 2005). In addition, this Regional Strategy is consistent with the obesity prevention strategies laid out in the International Obesity Task Force (19). It will also consider the new regional and global initiatives that are being developed, such as the Regional Strategy on Nutrition and Development.

25. The life course perspective is considered in this Strategy and recognizes the environmental, economic and social factors, and the consequential behavioral, and biological processes that act across all stages of life to affect disease risk (20, 21). The main factors during different life stages include the following:

- fetal stage: slow fetal growth, poor maternal nutritional status, and low socioeconomic position at birth;
- infancy and childhood: lack of breast-feeding, inadequate growth rate, inadequate diet, lack of physical activity, low socioeconomic position, and poor education of the mother;
- adolescence: inadequate diet such as low intake of fruits and vegetables and high-energy intake, physical inactivity, and tobacco and alcohol use;
- adult: behavioral risk factors such as high saturated-fat intake, elevated salt consumption, reduced fruit and vegetable intake, tobacco and alcohol use, lack of physical activity, and related biological risk factors.

26. The recognition of risk factors acting at all stages of life and affected by socioeconomic circumstances warrants reorientation of policies and programs (21). It calls for the need to prioritize the poorest populations and vulnerable groups. It also indicates the need to direct preventive interventions to youth, inasmuch as lifestyle habits are established during childhood and adolescence.

27. Intersectoral collaboration needs to be developed with sectors outside the health sector in order to achieve an impact on chronic diseases. In this regard, collaboration is needed with the education, communication, agriculture, transportation, economic, and trade sectors.

Strategic Approaches

Advocacy for policy changes and development of effective public policy

28. This Strategy will encourage and provide technical cooperation for the establishment of sound and explicit public policies that support better health status and a life free of chronic disease-related disability. The policies will be based on WHO resolutions and recommendations, particularly in relation to the Framework Convention on Tobacco Control; the Global Strategy on Diet, Physical Activity, and Health; and the Global Strategy for Infant and Young Child Feeding. Policies will address the broad social, economic, and political determinants of health and reflect the values of equity, excellence, social justice, respect, gender equality, and integrity. Advocacy will be utilized to advance policy and institutional changes that will support chronic disease programs. It will emphasize the key role of governmental functions and empower the health sector to engage other sectors in collaborative actions to ensure that chronic disease issues are collectively addressed.

Build capacity for community-based actions

29. Behavioral change is not based solely on individual decisions; rather it is influenced largely by environmental factors such as social norms, regulations, institutional policies, and the physical environment. Public health strategies therefore need to include community-based actions that influence changes within communities and within settings, promote healthy lifestyles and help prevent obesity.

30. This strategy will focus on community interventions that build supportive environments for risk-factor reduction, mobilize communities to change institutional policies, and to become active participants in the creation of enabling environments. It will also focus on healthy workplace and school settings. Interventions will be channeled through PAHO's CARMEN (strategies to reduce multifactor noncommunicable diseases) network, PAHO's initiatives on healthy settings and health-promoting schools; and they will adhere to WHO's Global Strategy for the Prevention and Control of Chronic Diseases and the Global Strategy on Diet, Physical Activity, and Health.

Strengthen health services for integrated prevention and management of chronic diseases

31. This Strategy recognizes that prevention and control of chronic diseases require long-term patient contact with accessible primary-health-care services, which are based on high standards of care and best practices. Integrated prevention involves interventions that simultaneously prevent and reduce a set of common modifiable risk factors. In addition, the management of chronic diseases requires integration of services through strengthened referrals and relationships among primary, secondary, and tertiary levels of care. Appropriate management should also cover prevention, screening and early detection, diagnosis, treatment, rehabilitation, and palliative care. This includes access to quality health services, including diagnostic services and access to essential medicines. Innovative models will be developed and tested for quality of care of chronic diseases.

32. The strategy will also include the development, testing, and dissemination of effective chronic disease management approaches, guidelines, and tools. Interventions will be based on the WHO recommendations in reports, such as Preventing Chronic Diseases: a Vital Investment, and Innovative Care for Chronic Conditions: Building Blocks for Action, as well as the resolution on cancer prevention and control.

Reinforce the competencies of the health-care workforce for chronic disease prevention and management

33. Health care providers are instrumental in improving health and preventing and managing chronic diseases in individuals. To provide effective care for chronic conditions, multidisciplinary health teams with an appropriate skill mix are required. The

skills of health professionals must be expanded so that they can tackle the complexities of chronic conditions with a team approach. Health professional curriculums should address the issues of prevention and management of chronic diseases and develop the appropriate abilities. This strategy considers the importance of continuing education for the health work force to reinforce competencies for patient-centered care, partnering with patients and with other providers, using continuous quality-improvement methods, effectively using information and communications technology, and adopting a public health perspective.

Create Multisectoral Partnerships and Networks for Chronic Disease

34. The successful implementation of chronic disease policies and programs requires the concerted efforts of multiple partners and stakeholders from the public and private health sectors, and health-related sectors such as the agricultural, economic, public works, trade, transportation, parks and recreation, and social services sectors. Furthermore, it requires action at the various levels of governmental and nongovernmental agencies, including international and multilateral organizations, and regional, subregional, national, and municipal organizations. Professional associations, academic institutions, civil society, patients' groups, and people affected by chronic diseases also have key roles to play in influencing chronic disease policies and programs. This strategy will facilitate dialogue and build partnerships among these key multisectoral stakeholders in order to advance the chronic disease agenda and to ensure stakeholder involvement in establishing policies and programs. The Strategy will also include working through existing regional networks such as CARMEN and the Physical Activity Network of the Americas (PANA).

Build Capacity for Chronic Disease Information Generation and Knowledge Management

35. Timely and accurate information on risk factors, chronic disease occurrence, distribution, and trends is essential for policy-making, program planning, and evaluation. Therefore, this strategy will build capacity in countries to incorporate chronic disease surveillance into the public health system and will utilize surveillance information for program development and policy formulation. The strategy will encourage integration among the multiple data sources in order to access the complete range of information to determine the status of chronic diseases. Information will be analyzed, synthesized, and disseminated at the country, subregional, and regional levels. Improvements are needed with the current mechanisms for systematic surveillance and for tracking the trends of chronic diseases and their risk factors at the national and subregional levels. In addition, information on new and emerging knowledge for effective interventions for noncommunicable disease prevention and control will be gathered and disseminated.

Plan of Action

Goal

36. To prevent and reduce the burden of chronic diseases and related risk factors in the Americas.

37. A detailed Plan of Action is included in the Annex.

Lines of Action

Public Policy and Advocacy

38. *Objective:* To ensure and promote the development and implementation of effective, integrated, sustainable, and evidence-based public policies on chronic disease, their risk factors, and determinants.

39. In various countries, several policies, laws, and regulations adopted have been successful in preventing disease and injury, such as tobacco taxation and the use of seat belts and helmets. Yet, as the 2005 national capacity assessment for chronic disease prevention and control revealed, a substantial proportion of countries in LAC have no policies or plans to combat chronic diseases. Developing a systematic process for policy formulation continues to be the primary challenge in combating chronic diseases and their risk factors.

40. The development of a unified, systematic framework for public policy is the first step in battling this epidemic. Defining policy priorities, establishing mechanisms for assessment and evaluation, engaging all sectors of society, and intercountry technical cooperation is also imperative to this action plan.

Surveillance

41. *Objective:* To encourage and support the development and strengthening of countries' capacity to better monitor chronic diseases, their consequences, their risk factors, and the impact of public health interventions.

42. Throughout the Region there are inadequacies and varying capacities for chronic disease surveillance. Most of the countries have limited resources to conduct chronic disease surveillance. In response to this paucity, PAHO has set an objective within this action plan to strengthen and/or expand established chronic disease surveillance systems in Member States.

43. To meet the differing needs of each country, this plan focuses on strengthening the following capacities in the countries: ongoing systematic collection of reliable, comparable, and quality data; timely and advanced analysis; dissemination and use of analysis results for national policy and program planning and evaluation; technical competency of the surveillance work force; and novel thinking and innovation. An established surveillance system will facilitate monitoring the progress of this Regional Strategy.

Health Promotion and Disease Prevention

44. *Objective:* To promote social and economic conditions that address the determinants of chronic diseases and empower people to increase control over their health and adopt healthy behaviors.

45. Health promotion is an essential part of an integrated approach for chronic disease prevention and control. To address the needs for health promotion, particularly to promote healthy diets, physical activity and tobacco control, this plan proposes the following:

- the promotion and adoption of healthy dietary habits, active lifestyles, and the control of obesity and nutrition-related chronic diseases;
- the development of public policies, guidelines, institutional changes, communication strategies, and research related to diet and physical activity;
- health promotion and disease prevention strategies;
- a life course perspective that considers health starting with fetal development and continuing into old age; and
- the concerted effort of multiple partners from the health and health-related sectors.

Integrated Management of Chronic Diseases and Risk Factors

46. *Objective:* To facilitate and support the strengthening of the capacity and competencies of the health system for the integrated management of chronic diseases and their risk factors.

47. The current acute health care model has not proven effective in dealing with prevention and management of chronic conditions. Successful chronic disease programs require an intersectoral approach and a reorientation of the health care system. It is necessary to improve the accessibility and availability of services and access to essential medicines and to have multidisciplinary health teams with the appropriate skill mix delivering services. Emphasis is needed on quality of care to reduce barriers related to social, economic, and cultural factors and to improve social protection for health, particularly among vulnerable populations.

48. In order to face these challenges, this action plan considers that prevention and management of chronic diseases requires integration through strengthened referrals and relationships among primary, secondary, and tertiary levels of care. The entire spectrum of disease management from prevention to screening and early detection, diagnosis, treatment, rehabilitation, and palliative care is necessary. The constructs of the Chronic Care Model are incorporated into the objective for the management of chronic diseases and risk factors, and are aimed at improving outcomes in five areas (22). These areas are as follows: a coherent approach to system improvement, development and adherence to guidelines, self-management support for people with chronic diseases, improved clinical information systems, and appropriate skill mix and improved technical competency of the health work force, including cultural competence and sensitivity. This plan also considers technical assistance for chronic disease programs, the reorientation of health services towards chronic diseases, and improved access to essential medicines and technologies.

49. This Strategy also recognizes the call for a renewed approach to primary health care and the highest attainable level of health for everyone as emphasized in the Regional Declaration on the New Orientations for Primary Health Care (promulgated at the 46th Directing Council). Also reflected in this plan is Resolution CD45.R7 which prioritizes access to medicine and other health supplies.

Budget for the Regional Strategy

50. The estimated budget for the implementation of this Regional Strategy and Plan of Action is approximately \$13 million per year. The Noncommunicable Diseases Unit needs to mobilize resources to move its current annual budget of \$1.1 million to an annual budget of \$4.1 million. In the related technical units of PAHO (i.e. Healthy Settings, Risk Assessment and Management, Health Services Organization, Health Policies and Systems, and Essential Medicines, Vaccines, and Health Technology), resource mobilization is needed to increase their budget from the current annual budget of \$7.8 million to \$9.8 million.

51. Following the completion of the Country Cooperation Strategy (CCS), several countries have identified the noncommunicable chronic diseases burden and have increased their national resources, as well as have assigned a priority level in the technical cooperation needs assessment. PAHO country advisors with specific skills for chronic disease management have been situated in Barbados, Chile, Costa Rica, Jamaica, as well as in the Caribbean Epidemiology Center (CAREC) and Caribbean Food and Nutrition Institute (CFNI).

Action by the Executive Committee

52. Based on the information in this Regional Strategy, the Executive Committee is requested to consider the following actions: (1) reaffirm chronic diseases as a high priority; (2) ensure that Member States' commitment is translated into programmatic and financial support for chronic diseases; (3) review and provide feedback to PAHO's proposed Regional Strategy and Plan of Action; and (4) discuss strategies to mobilize technical and financial resources at regional and country levels.

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**PLAN OF ACTION
FOR THE INTEGRATED PREVENTION AND CONTROL
OF CHRONIC DISEASES AND RISK FACTORS**

POLICY

Objective: To ensure and promote the development and implementation of effective, integrated, sustainable, and evidence-based public policies on chronic disease and their risk factors (RF) and determinants.		
Specific Objectives	Indicators	Activities
<p>1. To strengthen public policy development and implementation processes through the application of a systematic framework with the following core functions: (1) surveillance and advocacy for action, (2) formulation and adoption of policy, and (3) appropriate implementation of policy based on local consideration and needs.</p>	<p>By 2010 all countries will have policies to support noncommunicable disease (NCD) programs.</p> <ul style="list-style-type: none"> • By 2010 a prototype of a systematic framework for chronic disease public policy will be developed by PAHO/WHO and relevant stakeholders. • By 2010 PAHO/WHO and relevant stakeholders will have developed a process of technical collaboration to assist at least 6 Member States to implement components of a framework for public policy. • By 2010 at least 10 countries will be using the framework to create public policies. 	<p>CORE</p> <ul style="list-style-type: none"> • Establish public policies to support NCD programs. <p>EXPANDED</p> <ul style="list-style-type: none"> • Conduct workshops to create a framework for NCD Policy in Member States. • Hold working sessions for chronic disease planning with the ministry of health. <p>DESIRABLE</p> <ul style="list-style-type: none"> • Conduct studies to estimate the cost for chronic diseases.
<p>2. To identify and define policy priorities at the regional and country levels for chronic disease and their risk factors and determinants.</p>	<p>By 2010, 70% of Member States will establish a multisector policy advisory group to define priorities and to support public policy development processes.</p> <ul style="list-style-type: none"> • By 2010 PAHO/WHO and relevant stakeholders will convene subregional and regional consultations to define common policy priorities at subregional and national levels. 	<p>CORE</p> <ul style="list-style-type: none"> • Conduct meetings of stakeholders to define priority policies for chronic diseases. <p>DESIRABLE</p> <ul style="list-style-type: none"> • Establish working groups to develop NCD policies.
<p>3. To engage all sectors and civil society in influencing policy- and decision-making processes, including advocacy for the prevention and control of chronic disease in the Region.</p>	<ul style="list-style-type: none"> • By 2008, 70% of Member States will establish institutional mechanisms for the development of national alliances. • By 2008, 70% of Member States will cultivate an environment for the development of a national alliance among sectors of civil society interested in chronic disease prevention and control. • By 2010 members of the national alliance are visible as a strong partner in the processes of formulation, implementation, and evaluation of chronic disease public policy. 	<p>CORE</p> <ul style="list-style-type: none"> • Conduct multisectoral meetings to establish alliances with multiple sectors. <p>EXPANDED</p> <ul style="list-style-type: none"> • Conduct meetings to advocate for chronic disease prevention and control with potential members of the alliance.

<p>4. To establish a regional mechanism for the systematic assessment and analyses of country-specific public policies and the development of methodologies for their use in different countries.</p>	<ul style="list-style-type: none"> • By 2010 a formalized observatory for policy assessment and analysis is operational in the Americas with methodologies and tools for policy analysis. • By 2010, at least 3 new countries will establish a core technical capacity to engage in systematic policy analysis in chronic diseases. • By 2010, PAHO, in collaboration with participating countries, will produce policy reviews and progress reports from their policy observatory. 	<p>DESIRABLE</p> <ul style="list-style-type: none"> • Conduct 1 regional and 5 subregional workshops to establish a policy observatory in the Region and subregions.
<p>5. To encourage intersectoral cooperation within and between countries and the establishment of mechanisms for sharing best practices on the development and implementation of effective public policies.</p>	<ul style="list-style-type: none"> • By 2010, PAHO, in collaboration with policy observatory participating countries, will disseminate policy review reports from Member States. • By 2010 a mass communication strategy is established in 70% of Member States to disseminate information to interested parties and the public at large. • By 2010 Member States with relevant stakeholders will have established a national forum for public policy dialogue on chronic diseases and review of policy analysis reports and best practices. 	<p>Secretariat: CORE</p> <ul style="list-style-type: none"> • Develop and maintain a web-based clearing house for lessons and evidence from annual policy review reports and analyses. <p>EXPANDED</p> <ul style="list-style-type: none"> • Produce and publish an annual regional profile on best practices for effective public policy development and implementation in the Region. <p>Member States CORE</p> <ul style="list-style-type: none"> • Publish reports to disseminate and promote the use of evidence from the policy observatory at national, subnational, and local levels. <p>EXPANDED</p> <ul style="list-style-type: none"> • Develop a proposal for the government to adopt legislation in support of health promotion, such as tobacco control legislation consistent with the WHO Framework Convention on Tobacco Control (FCTC) .

SURVEILLANCE

Objective: To encourage and support the development and the strengthening of countries' capacity for better surveillance of chronic diseases, their consequences, their risk factors, and the impact of public health interventions as part of the integrated strategy on NCD prevention and control.		
Specific Objectives	Indicators	Activities
<p>1. To encourage the development and strengthening of chronic disease surveillance systems which are ongoing, systematic, and linked to public health actions, in order to assess the burden (e.g. mortality, morbidity, disability, economic costs) of chronic diseases, their trends, related risk factors (e.g. obesity, food availability, and food consumption), including social determinants and public health interventions (e.g. health services utilization).</p>	<ul style="list-style-type: none"> • By 2010, 75% of Member States have defined indicators for national surveillance related to chronic diseases (NCD), associated risk factors, and public health interventions, within their national basic data; and that by 2015, 95% of Member States will have done so. • By 2010, 50% of Member States have established a surveillance system for NCD, RF, and public health interventions, as part of their national public health surveillance system; and that by 2015, 75% of Member States will have done so. • By 2010, 50% of Member States have collected population-based information on major chronic diseases, diet, physical activity, tobacco use, alcohol consumption, and preventive health services use; 75% of Member States by 2015. 	<p>Secretariat:</p> <p>CORE</p> <ul style="list-style-type: none"> • In collaboration with Member States, provide a situational analysis to assess country surveillance capacity and status in order to evaluate and refine target percentages for all indicators. • Establish guidelines/templates for development and evaluation of each level of surveillance system. • Provide recommendations and technical assistance on chronic disease surveillance (studies, training, workshops, technical cooperation among countries) to PAHO priority countries, on a targeted or on-request basis. • Assist countries with the development and implementation of national surveillance systems. • Provide support to countries with lesser capacity to develop surveillance systems. <p>EXPANDED</p> <ul style="list-style-type: none"> • Systematize best tools and practices in order to standardize and regionalize surveillance. • Produce ongoing situational analysis for surveillance, prevention, and control of chronic diseases (every 5 years). • In collaboration with Member States, develop a regional resource mobilization plan. • Coordinate and assist Member States with resource mobilization efforts in order to obtain funds to enable implementation of surveillance systems. <p>DESIRABLE</p> <ul style="list-style-type: none"> • Coordinate regional transfer of successful experience and lessons learned in surveillance among Member States. <p>Member States:</p> <p>CORE</p> <ul style="list-style-type: none"> • Utilize and modify as necessary the Secretariat-recommended surveillance guidelines/tools. • Define country indicators on NCD, RF, and public health interventions. • Include surveillance of NCD, RF, and public health interventions as an essential component of national chronic disease prevention and control programs. <p>EXPANDED</p> <ul style="list-style-type: none"> • Assist the Secretariat in the preparation of a regional situational analysis.

		<ul style="list-style-type: none"> • Assist the Secretariat in the preparation of surveillance guidelines/tools. • Assist the Secretariat in conducting studies and training workshops • Develop national resource mobilization plans. <p>DESIRABLE</p> <ul style="list-style-type: none"> • Assist the Secretariat in coordinating regional efforts in enhancing country surveillance capacities.
<p>2. To improve multipartner collaboration to mobilize community, national, subregional, and regional partnerships to stimulate the effective development of surveillance systems and utilization of information.</p>	<ul style="list-style-type: none"> • By 2010, a regional discussion forum for NCD surveillance has been established that involves 75% of Member States; and 95% of Member States by 2015. • By 2010, 75% of Member States have established a national coordinating committee with partners such as governments, NGOs, academia, professional networks, industries, experts, and the general public; 95% of Member States by 2015. 	<p>Secretariat: CORE</p> <ul style="list-style-type: none"> • In collaboration with Member States, identify regional and subregional priorities. • Conduct a regional stakeholder analysis to identify the stakeholders and partners for collaboration (governments, nongovernmental organizations (NGOs), academia, professional networks, industries, experts, and the general public). • Provide results of the stakeholder analysis to Member States to assist in their formation of national coordinating committees. • Monitor progress of formation of national coordinating committees to decide on the best time to establish a Regional Discussion Forum. <p>EXPANDED</p> <ul style="list-style-type: none"> • Provide terms of reference for a Regional Discussion Forum. • Convene consultations among all relevant actors, including Member States to set up a Forum. • In collaboration with Member States, identify key stakeholders and universities that can serve as WHO collaborating centers for chronic disease surveillance. <p>DESIRABLE</p> <ul style="list-style-type: none"> • Develop continuous quality improvement methods that will enhance the quality of surveillance systems. <p>Member States: CORE</p> <ul style="list-style-type: none"> • Identify country stakeholders and partners for collaboration. • Identify resources to establish national coordinating committees with stakeholders and partners. • Facilitate the development of national surveillance strategies. <p>•EXPANDED</p> <ul style="list-style-type: none"> • Assist the Secretariat in forming a Regional Discussion Forum. <p>•DESIRABLE</p> <ul style="list-style-type: none"> • Pretest and adopt quality improvement methods.
<p>3. To support improvement of quality (accuracy, completeness, and comprehensiveness), availability, and comparability of NCD surveillance information used for policy and program development purposes.</p>	<ul style="list-style-type: none"> • By 2010, 75% of Member States have defined their core set of surveillance indicators (NCD, RF, and public health interventions); 100% by 2015. 	<p>Secretariat: CORE</p> <ul style="list-style-type: none"> • In collaboration with Member States, key international partners, and collaborative centers and in accordance

	<ul style="list-style-type: none"> • By 2010, 50% of Member States have core NCD, RF, and public health intervention indicators available; 75% of Member States by 2015. • By 2010, 50% of Member States have demonstrated a reduced underreporting and misclassification related to NCD mortality; 75% by 2015. 	<p>with PAHO STEPwise criteria, establish working group(s) to propose a standard core and optimum set of indicators including selected NCDs, RF, and public health interventions, for the Region.</p> <ul style="list-style-type: none"> • Ensure comparability of data through standardization of instruments and units of measurements, and through training. • Establish consensus on the proposed set of core and optimum indicators through regional consultation meeting(s). • In collaboration with Member States and other agencies and networks (CARMEN, AMNET), conduct short training courses as part of continuing education to strengthen technical capacity for surveillance, improve data collection methods, and reduce the problem of misclassification. • Improve existing monitoring mechanisms to reduce the problem of underreporting. <p>EXPANDED</p> <ul style="list-style-type: none"> • Expand the role of expert groups on information management (CRAIS). <p>DESIRABLE</p> <ul style="list-style-type: none"> • In collaboration with Member States, stimulate horizontal cooperation between UN and other agencies and countries in planning joint research and training to improve surveillance. <p>Member States:</p> <p>CORE</p> <ul style="list-style-type: none"> • Develop a national core and optimum set of indicators. • Participate in the development of regional core and optimum indicators. <p>EXPANDED</p> <ul style="list-style-type: none"> • Suggest best mechanisms to reduce misclassification and underreporting.
<p>4. To develop indicators in the surveillance system for evaluation of the effectiveness, accessibility, and quality of population-based health services and interventions; as well as the operations of the surveillance system itself.</p>	<ul style="list-style-type: none"> • By 2010, 75% of Member States have produced at least one report on the situation of chronic diseases, risk factors, and/or evaluation of public health interventions; 95% of Member States by 2015. 	<p>Secretariat:</p> <p>CORE</p> <p>Encourage Member States to evaluate all chronic disease surveillance, and prevention and control activities, through surveillance.</p> <p>In collaboration with Member States, prepare and agree upon a standardized format for reporting, indicators, sources of data, and pilot in CARMEN countries.</p> <p>In collaboration with Member States, evaluate operations and performance of countries' surveillance systems and timeliness and effectiveness of translating surveillance information into policy.</p>

		<p>EXPANDED Provide guidelines on the evaluation of operations of surveillance, and effectiveness of transforming surveillance information into policies and programs.</p> <p>DESIRABLE Issue/prepare publications on effectiveness of public health interventions.</p> <p>Member States:</p> <p>CORE Evaluate operations and performance of country's surveillance systems Evaluate country's timeliness and effectiveness in translating surveillance information into policies and programs.</p> <p>EXPANDED Issue/prepare country publications on the effectiveness of public health interventions.</p> <p>DESIRABLE Contribute to the development of regional evaluation guidelines.</p>
<p>5. To support the timely and effective communication of information on chronic diseases and risk factors to the appropriate target audiences.</p>	<p>By 2010, 50% of Member States regularly contribute core data to regional and global databases; 75% of Member States contribute by 2015.</p> <p>By 2010, 25% of Member States, based on available data, have developed differential information packages for different target group audiences; 50% of Member States by 2015.</p>	<p>Secretariat:</p> <p>CORE In collaboration with Member States, train countries to establish their own as well as to contribute to a Regional InfoBase.</p> <p>EXPANDED Develop a Regional InfoBase that is linked to WHO InfoBase and other information databases. In collaboration with Member States, establish a working group with communication experts (expertise in mass communication, how to reach the audience) at regional and local levels. This group also is part of larger groups (national coordinating committee, regional discussion forum) Establish collaboration between this group, health promotion and risk factor management.</p> <p>DESIRABLE Establish a set of information packages/ materials at regional and national levels.</p> <p>Member States:</p> <p>CORE Establish country InfoBase. Contribute data to Regional InfoBase. Develop differential information packages.</p> <p>EXPANDED Contribute to regional working group with</p>

<p>6. To encourage development of national surveillance strategies to define the best framework to exchange with decision-makers surveillance information necessary for the development and evaluation of public health policies and programs.</p>	<ul style="list-style-type: none"> • By 2010, all Member States have established a national coordinating committee to work on a national surveillance strategy within the national NCD strategy. • By 2010, 50% of Member States have developed within their national strategy for NCD, a national surveillance strategy based on WHO's surveillance framework; 75% have done so by 2015. • By 2010, 25% of Member States have documented the use of surveillance information for policy formulation; 40% have done so by 2015. 	<p>communication experts.</p> <p>Secretariat</p> <p>CORE</p> <ul style="list-style-type: none"> • Provide terms of reference for national coordinating committees. • Assist Member States in the development of national coordinating committees. • Provide guidelines for national surveillance strategies. • Assist Member States in the development of national surveillance strategies. <p>EXPANDED</p> <ul style="list-style-type: none"> • In collaboration with Member States, use the CARMEN policy observatory as a channel for assessment and measurement of the transfer of surveillance data into policy formulation. • Include in the CARMEN policy observatory the collection of information regarding the use of surveillance data for policy formulation, implementation, and evaluation. <p>DESIRABLE</p> <ul style="list-style-type: none"> • Produce regional maps of the Americas on country surveillance capacity, including the stages of development of the national surveillance strategy. <p>Member States:</p> <p>CORE</p> <ul style="list-style-type: none"> • Establish a national coordinating committee. • Develop a national surveillance strategy within the national NCD strategy. <p>EXPANDED</p> <ul style="list-style-type: none"> • Collect and document information on the use of surveillance for policies and programs. <p>DESIRABLE</p> <ul style="list-style-type: none"> • Assist the Secretariat in the development of regional surveillance strategy.
<p>7. To foster continuous education and training in order to improve capacity, human resources, expertise, and technical competency of the surveillance work force.</p>	<ul style="list-style-type: none"> • By 2010, 50% of Member States have incorporated chronic disease surveillance training in health professional training programs (e.g. university medical and nursing courses); 75% by 2015. • By 2010, 50% of Member States have implemented continuing education for the surveillance work force to reinforce the skills and competencies for conducting NCD surveillance; 75% by 2015. • By 2010, 25% of Member States have developed a course related to chronic disease surveillance; 75% have done so 	<p>Secretariat:</p> <p>CORE</p> <ul style="list-style-type: none"> • Collaborate with Member States, universities, and professional networks/societies (e.g. AMNET) to develop curriculum for chronic disease surveillance training. • Offer training to countries on surveillance system protocol and tools application and placement of data on InfoBase. <p>EXPANDED</p> <ul style="list-style-type: none"> • Prepare supporting materials for chronic disease surveillance training (such as a textbook on basic surveillance). <p>DESIRABLE</p> <ul style="list-style-type: none"> • Conduct studies to identify expertise gaps and training needs.

	<p>by 2015.</p>	<ul style="list-style-type: none"> Identify countries which are in need of surveillance training. <p>Member States:</p> <p>CORE</p> <ul style="list-style-type: none"> Develop surveillance training curriculum. Offer training in surveillance. <p>EXPANDED</p> <ul style="list-style-type: none"> Develop a course in surveillance. <p>DESIRABLE</p> <ul style="list-style-type: none"> Assist the Secretariat in regionwide surveillance training and workshops.
<p>8. Encourage novel thinking and innovative ideas in chronic disease surveillance to meet new challenges and needs.</p>	<p>Novelty, by definition, cannot have predetermined performance measures.</p>	<p>Secretariat:</p> <p>CORE Encourage the development and utilization of novel methods in surveillance.</p> <p>EXPANDED Collect and identify new ideas and practice in surveillance in the Region and worldwide, for promotion with regard to regional surveillance activities.</p> <p>DESIRABLE In collaboration with experts and researchers, develop new methods to tackle new challenges in surveillance data collection (e.g. a privacy-in-information act that prevents useful record linkage projects).</p> <p>Explore marketing tactics including a name change from “chronic disease” or “NCD” to something more compelling.</p> <p>Research information to improve use of evidence for policy.</p> <p>Research techniques for motivating people to use information for action.</p> <p>Disseminate information to high-risk groups rather than the general population.</p> <p>Integrate knowledge into culture through “health songs,” soap operas, etc.</p> <p>Organize regional popular performance events (e.g. regional rotational concerts) to create a social environment for change and public opinion shift towards actions on obesity and chronic disease pandemics.</p> <p>Carry out a health proverb contest.</p> <p>Member States:</p> <p>CORE Encourage the development and utilization of novel methods in surveillance.</p> <p>EXPANDED Provide country novel ideas and practice in surveillance for promotion to the Region.</p>

HEALTH PROMOTION AND DISEASE PREVENTION

Objective: To promote the social and economic conditions that address the determinants of chronic diseases and empower people to increase control over their health, especially the adoption of sustained healthy behavior.		
Specific Objectives	Indicators	Activities
<p>1. To advocate for the development, implementation and evaluation of public policies (prioritizing most cost-effective policies) to address the major NCD risk factors, in collaboration with policy-makers and civil society leaders (e.g. NGOs, the private sector, and academic institutions).</p>	<ul style="list-style-type: none"> • By 2015, all Member States will have implemented the most cost-effective supply and demand (as appropriate) policies in a stepwise manner to: <ul style="list-style-type: none"> • Promote a healthy diet (Diet and Physical Activity Strategy (DPAS) implementation). • Increase physical activity (DPAS implementation) • Reduce tobacco use (FCTC implementation). • Other risk factors such as violence/alcohol/housing/ environment, etc. • By 2015, a determined number of Member States will implement DPAS and FCTC. 	<p>Secretariat:</p> <p>CORE</p> <ul style="list-style-type: none"> • Support countries in building the commitment of institutional leaders in health and non-health settings to understand the need to change (to become healthy settings). • Strengthen the regional infrastructure to build capacity for those responsible for institutional change to empower application of health promotion strategies in key settings, building on existing networks and the university consortium. • Implement activities addressing the full range of determinants of NCDs (step by step as necessary). <p>EXPANDED</p> <ul style="list-style-type: none"> • Develop and disseminate model public policies, legislation, and regulations (best practice) for the prevention of major NCDs and risk and protective factors and facilitate the sharing of experiences of successes and failures between countries based on country requests/needs. Examples: <u>Countries:</u> participate in regional network meetings to share experiences on NCD prevention in school settings on a biennial basis (participation when appropriate). <u>Secretariat:</u> Convene a meeting among technical units working on NCD-related issues to share information on activities and to identify appropriate coordinated activities. <p>DESIRABLE</p> <ul style="list-style-type: none"> • Convene a meeting among technical units working on NCD-related issues to share information on activities and to identify appropriate coordinated activities. • Prepare and disseminate a regional situation analysis based on country reports. • Support workable international guidelines on diet, physical activity and tobacco control, and allocate resources (e.g. ministries of health). <p>Member States:</p> <p>CORE</p> <ul style="list-style-type: none"> • Implement consultation processes with stakeholders to build constituencies and gain support for implementation of priority public policies. <p>DESIRABLE</p>

		<ul style="list-style-type: none"> • Prepare a situation analysis of current plans, policies, resources, initiatives, programs and activities in each country to address each of the major risk factors for NCDs in that country. • Participate in regional network meetings to share experiences on NCD prevention in school settings on a biennial basis.
<p>2. To implement strategies and actions for health promotion in key settings and, in particular, the workplace and schools (with emphasis on healthy diet, physical activity, and tobacco)</p>	<ul style="list-style-type: none"> • By 2015, a determined number of Member States will have implemented strategies and actions in schools, the workplace, and other settings. 	<p>Secretariat: CORE</p> <ul style="list-style-type: none"> • Support countries in building the commitment of institutional leaders in health and nonhealth settings to understand the need to change (to become healthy settings). • Strengthen the regional infrastructure to build capacity for those responsible for institutional change to empower application of health promotion strategies in key settings, building on existing networks, and the university consortium. • Implement activities addressing the full range of determinants of NCDs (step by step as necessary). <p>Member States: CORE</p> <ul style="list-style-type: none"> • Build the commitment of institutional leaders in health and nonhealth settings to understand the need to change (to become healthy settings). • Identify committed leaders in institutions and make resources (training, funding, etc.) available to support them. • Strengthen national infrastructure to build capacity for those responsible for institutional change to empower the application of health promotion strategies in key settings.
<p>3. To support communication strategies and information dissemination that support healthy eating, active living, and tobacco control.</p>	<ul style="list-style-type: none"> • By 2010, all Member States should plan and implement a comprehensive communications strategy for each of the major risk factors for chronic disease. • By 2010, all Member States should measure public perceptions and knowledge of chronic disease determinants and behavioral changes to prevent NCDs, pre- and post-intervention. 	<p>Secretariat: CORE</p> <ul style="list-style-type: none"> • Create mechanisms to share country experiences and disseminate related information. • Develop guidelines and provide technical cooperation for effective communication strategies as appropriate. <p>EXPANDED</p> <ul style="list-style-type: none"> • Develop capacity and methods to measure public knowledge and perceptions and use data to monitor progress.
<p>4. To increase community participation and local collective action to adopt public policies, support healthy eating, active living, and the absence of tobacco use.</p>	<ul style="list-style-type: none"> • By 2015, all Member States will have a plan to involve community organizations and local governments in activities and decision-making and to empower them to lead efforts for NCD health promotion and disease 	<p>Secretariat: CORE</p> <ul style="list-style-type: none"> • Facilitate the sharing of experiences. • Develop guidelines and training, and identify knowledge resources for capacity building. <p>Member States:</p>

	<p>promotion.</p> <ul style="list-style-type: none"> By 2015, all Member States will have the appropriate resources available to support community organizations and local governments in activities that contribute to NCD prevention. 	<p>CORE</p> <ul style="list-style-type: none"> Build the capacity of relevant community groups to incorporate determinants of NCDs into their activities and mandates, including facilitation of coordinated strategies. Commit resources to groups to enable them to do activities listed. <p>DESIRABLE</p> <ul style="list-style-type: none"> Conduct an “environmental scan” to identify community groups and interests.
<p>5. To facilitate the continuous development and strengthening of health promotion research that encourages active living, healthy eating, and tobacco control.</p>	<ul style="list-style-type: none"> All countries will have resource mobilization plans to support research into health promotion strategies to reduce and prevent NCDs and risk factors. PAHO should actively engage the IDB, World Bank, and other major funders to support health promotion and NCD prevention research. 	<p>Secretariat:</p> <p>CORE</p> <ul style="list-style-type: none"> Investigate the impact of urban planning and public transportation and health. Investigate the determinants of fruit and vegetable consumption in different populations. Investigate how to improve production, trade, price, and other marketing strategies to encourage consumption of fruits and vegetables with current resources. Investigate the relationship between tobacco industry promotional spending and per capita consumption. Conduct research to show not only that we can impact NCDs but also that investments in NCD risk factors and in reductions in NCDs are related to individual poverty, national development, and economic growth. <p>DESIRABLE</p> <ul style="list-style-type: none"> Revisit the MDGs and adapt them to address/explicitly include determinants of NCDs. <p>Member States:</p> <p>CORE</p> <ul style="list-style-type: none"> Identify research needs and an agenda at national level. <p>DESIRABLE</p> <ul style="list-style-type: none"> Establish national and regional funds for research.
<p>6. To facilitate the continuous development and strengthening of the evaluation of health promotion strategies that encourage active living, healthy eating, and tobacco control.</p>	<ul style="list-style-type: none"> All countries will include an evaluation plan as an essential component of all NCD health promotion and disease prevention activities to measure the impact of those activities on NCD-related determinants (process, structure, and outcome). All countries will have a mechanism to ensure that their evaluations are disseminated widely to the national population and to other countries. 	<p>Secretariat:</p> <p>CORE</p> <ul style="list-style-type: none"> Develop and disseminate regional guidelines for evaluation processes. Disseminate evidence and best practices, and successes and failures. <p>Member States:</p> <ul style="list-style-type: none"> Adapt and implement the regional guidelines into evaluation activities. Document and share experiences with other countries, facilitated by the Secretariat.

INTEGRATED MANAGEMENT OF CHRONIC DISEASES AND RISK FACTORS

Objective: To facilitate and support the strengthening of the capacity and competencies of the health system for prevention and control in the integrated management of chronic diseases and their risk factors.		
Specific Objectives	Indicators	Activities
<p>1. To provide technical assistance to countries in the development, strengthening, implementation, and evaluation of their chronic disease programs. (Country programs include the following chronic diseases and risk factors: heart disease, stroke, hypertension, diabetes, major cancers, palliative care, obesity, asthma, and hypercholesterolemia.)</p>	<ul style="list-style-type: none"> • By 2008, all Member States have developed a program (with budget, manager, plan, etc.) for the integrated prevention and control of NCDs and their risk factors. • By 2010, all Member States have initiated the implementation of the programs. • By 2015, all Member States have fully implemented the programs. 	<p>Secretariat: CORE</p> <ul style="list-style-type: none"> • Develop and provide a standard template/matrix for countries to assess their country chronic disease programs. • In collaboration with Member States, conduct assessments every 5 years to assess gaps, advances, etc. • Provide recommendations and technical assistance to Member States on introducing new cost-effective technologies into chronic disease programs (e.g. adapting cervical cancer prevention programs to accommodate the human papillomavirus (HPV) vaccine). • Assist countries with the implementation of signed/agreed upon international resolutions/agreements (e.g. FCTC, DPAS, Cancer Control, etc.) Develop and disseminate guides/manuals on chronic disease program development, implementation, and management. • Develop program evaluation tools, assist countries in evaluating their chronic disease programs, and provide suggestions for improving the organization, delivery, and management of programs. <p>EXPANDED</p> <ul style="list-style-type: none"> • In collaboration with Member States, develop a resource mobilization plan. • Coordinate and assist Member States with resource mobilization efforts in order to obtain funds to enable implementation of chronic disease programs. • Organize donor meetings, pursue partnerships with potential donors, advocate with donors for chronic diseases. • Facilitate the in-country cooperation of interdisciplinary, intersectoral, and interministerial actions. • Create and foster partnerships with organizations that share our goals, in order to undertake joint activities and mobilize resources, including writing joint project proposals.

		<p>DESIRABLE</p> <ul style="list-style-type: none"> • Share information, lessons learned, and experiences from countries in the Region that may provide useful direction to address chronic diseases. <p>Member States:</p> <p>CORE</p> <ul style="list-style-type: none"> • Utilize and modify as necessary Secretariat recommended evaluation tools. • Incorporate Secretariat-recommended cost-effective technologies and adapt them to the country-specific environment. <p>EXPANDED</p> <ul style="list-style-type: none"> • Develop a resource mobilization plan. • Organize donor meetings, pursue partnerships with potential donors, and advocate with donors for chronic diseases.
<p>2. To facilitate the strengthening and/or reorientation of health systems to optimally manage chronic diseases and their risk factors.</p>	<ul style="list-style-type: none"> • By 2010, all Member States increase coverage of preventive health care services by 10% to the population. • By 2015, all Member States increase coverage of preventive health care services by 20% to the population. • By 2008, all Member States have established multidisciplinary health teams as the main deliverers of primary care services. • All Member States have reoriented their health system, based on a strong primary health care model that enables the implementation of chronic disease management programs and policies by 2015. • All Member States have established and monitor indicators for quality of care (access, opportunity, affordability, quality, and coverage) according to accepted standards for chronic disease prevention and control. 	<p>Secretariat:</p> <p>CORE</p> <ul style="list-style-type: none"> • Assist countries to incorporate health promotion, education, and primary prevention into routine primary care services. • Measure quality of care of chronic disease services (e.g. compliance with guidelines/protocols, appointment schedules, referrals, outreach of primary care teams, home care, community interventions, rehabilitation, palliative care, etc.) • Develop continuous quality improvement methods, including exit interviews and provider feedback mechanisms, to test methods that will enhance quality of care for chronic conditions. <p>EXPANDED</p> <ul style="list-style-type: none"> • Assist Member States to reorient their health systems based on primary health care, according to the Regional Declaration. • Measure access, opportunity, affordability, quality, and coverage of health care services for chronic disease prevention and control. <p>DESIRABLE</p> <ul style="list-style-type: none"> ▪ Undertake studies on the barriers to quality care and user satisfaction with chronic disease services in order to better understand the issues and the corrective actions required to improve care. <p>Member States:</p> <p>CORE</p> <ul style="list-style-type: none"> • Measure utilization of preventive health services (screening, health exams, education

		<p>programs, etc.).</p> <ul style="list-style-type: none"> • Develop and implement demonstration projects on the integrated management of chronic diseases that help strengthen health services for chronic disease prevention and control. <p>EXPANDED</p> <ul style="list-style-type: none"> • Develop a patient charter of rights (regarding quality of care). • Identify availability and strengths of community services linked to health care services. <p>DESIRABLE</p> <ul style="list-style-type: none"> • Measure access, opportunity, affordability, quality, and coverage of health care services for chronic disease prevention and control. • Undertake studies on the barriers to quality care and user satisfaction with chronic disease services in order to better understand the issues and the corrective actions required to improve care.
<p>3. To foster the development, dissemination, and implementation of integrated, evidence-based guidelines and protocols for the prevention and control of chronic diseases and their risk factors.</p>	<ul style="list-style-type: none"> • By 2008, all countries have developed guidelines/protocols, made them widely available, and have initiated training in their use. • By 2010, all Member States have institutionalized clinical guidelines for the detection and integrated management of the main chronic diseases and risk factors such as stroke, heart disease, hypertension, major cancers and palliative care, diabetes, and asthma. • By 2015, all Member States have evaluated the application of guidelines. 	<p>Secretariat:</p> <p>CORE</p> <ul style="list-style-type: none"> • Facilitate and assist countries in the creation and/or updating of clinical practice guidelines and programmatic protocols that are appropriate for the country, using a participatory process. • Assist countries in training providers in the application and use of guidelines (train the trainer program, e-learning courses, etc.) <p>EXPANDED</p> <ul style="list-style-type: none"> • Disseminate guidelines on the main chronic diseases and risk factors such as stroke, heart disease, hypertension, major cancers and palliative care, diabetes, asthma, obesity, and hypercholesterolemia. • Assist countries with the creation of incentive systems to encourage good clinical practice according to established guidelines. <p>DESIRABLE</p> <ul style="list-style-type: none"> • Review, consolidate, and disseminate new knowledge on cost-effective strategies for chronic disease prevention and control that will assist countries in establishing guidelines and protocols. • Assist countries in establishing minimum standards and monitoring-supervision systems to oversee the application of guidelines. <p>Member States:</p> <p>CORE</p> <ul style="list-style-type: none"> • Disseminate guidelines on the main chronic

		<p>diseases and risk factors such as stroke, heart disease, hypertension, major cancers and palliative care, diabetes, asthma, obesity, and hypercholesterolemia.</p> <ul style="list-style-type: none"> • Monitor and evaluate the application of the guidelines. <p>EXPANDED</p> <ul style="list-style-type: none"> • Establish a task force or monitoring committee to ensure proper use of protocols and periodic training on all aspects of guidelines and protocols, from development to implementation. <p>DESIRABLE</p> <ul style="list-style-type: none"> • Collaborate and advocate with professional associations for the continuous application of standard guidelines.
<p>4. To foster the development and improvement of competencies in the health work force to appropriately and effectively manage chronic disease prevention and control.</p>	<ul style="list-style-type: none"> • By 2010, all Member States incorporate chronic disease management training curricula in their health professions education programs (medical schools, nursing schools, and allied medical training, etc.). • By 2008, all Member States implement continuing education for the health work force to reinforce the skills and competencies for chronic disease management, including quality of care. 	<p>Secretariat: CORE</p> <ul style="list-style-type: none"> • Develop profiles for minimum competencies/practical tasks for health professionals and program managers. • Influence the creation and implementation of training curricula on chronic disease prevention and control into health professional education. <p>EXPANDED</p> <ul style="list-style-type: none"> • Foster the creation of regional training networks/centers to support countries with their continuing education initiatives on chronic disease prevention and control. <p>DESIRABLE</p> <ul style="list-style-type: none"> • Assist and encourage Member States in staffing health services with multidisciplinary teams. • Develop profiles for the minimum composition of multidisciplinary health teams for the provision of chronic disease prevention and control in health services. • Encourage countries to utilize the profiles in their programs. • Facilitate, broker, and promote learning opportunities and exchanges among countries to support health professional development in the area of chronic disease management.
<p>5. To facilitate the creation and utilization of health information systems for adequate patient and program management and evaluation as an integrated part of the surveillance system.</p>	<ul style="list-style-type: none"> • By 2015, countries will have developed information (technology) systems for clinical health records that are integrated within the surveillance system. • That all Member States have implemented clinical information systems, based on the clinical practice 	<p>Secretariat: CORE</p> <ul style="list-style-type: none"> • Develop templates for model information systems for chronic diseases. <p>EXPANDED</p>

	<p>guidelines for patient management in their health care system by 2015.</p>	<ul style="list-style-type: none"> Gather and share information on the tools, methods, and experiences on health information systems for chronic disease programs in countries of the Region. <p>Member States: CORE</p> <ul style="list-style-type: none"> Promote the automation of clinical health information collection processes. Facilitate the utilization and monitor the use of the clinical health information system for appropriate patient management. <p>EXPANDED</p> <ul style="list-style-type: none"> Promote the use of the International Classification of Primary Care. <p>DESIRABLE</p> <ul style="list-style-type: none"> Collaborate with the private health sector to obtain necessary data (on chronic disease management).
<p>6. To empower self-management among people with chronic conditions and risk factors and their families.</p>	<ul style="list-style-type: none"> By 2015, all Member States have incorporated patient education, including self-management as part of their chronic- disease management programs. 	<p>Secretariat: CORE</p> <ul style="list-style-type: none"> Assist countries in establishing programs to build self-management skills among patients and families, build compliance, empower individuals, and foster self- responsibility for health. Assist countries in improving health professionals’ competencies in counseling and patient education. <p>EXPANDED</p> <ul style="list-style-type: none"> Identify and promote successful strategies used by other health groups (e.g. AIDS) on self-management skills. Develop and disseminate tools on self-management skills. <p>Member States: CORE</p> <ul style="list-style-type: none"> Develop health professional guidelines on behavioral education and change. Improve health professionals’ competencies in counseling and patient education. <p>EXPANDED</p> <ul style="list-style-type: none"> Develop and disseminate tools on self-management skills for persons with chronic conditions and at risk for chronic disease. Stimulate and empower patient groups for supportive care. Identify and promote successful strategies used by other health groups (e.g. AIDS) on self-management skills.

<p>7. To ensure improved access to technologies and essential medicines for chronic disease and risk-factor management and ensure their rational use.</p>	<ul style="list-style-type: none"> • By 2008, all Member States have evaluated the access to essential medicines for chronic diseases. • By 2010, all Member States ensure the availability and accessibility of technologies for diagnosis, treatment, and self-management. • By 2010, all Member States have a strategy for rational use of medicines including DESIRABLE list of essential medicines, prescribing guidelines, dispensing, cross-effects with other meds, and pricing. • By 2015, all Member States have increased accessibility by the population to essential medicines for chronic diseases by 70%. 	<p>Secretariat: CORE</p> <ul style="list-style-type: none"> • Assist countries in improving access to essential medicines for chronic diseases. • Evaluate the situation of access to essential medicines for chronic diseases and identify specific needs. • Support countries to ensure the quality of medicines from production and distribution to dispensing. • Support countries in their promotion of rational drug use. • Prepare or update lists of essential drugs, including those necessary for the treatment and management of NCDs. <p>EXPANDED</p> <ul style="list-style-type: none"> • Strengthen strategies to improve capacity for negotiation: utilize PAHO's strategic fund, negotiate with pharmaceutical producers and wholesalers, promote policies that encourage prescribing and utilizing generic drugs as a strategy to reduce prices, and exchange information among countries regarding the cost of medicines. • Advocate and encourage countries to favorably view the use of necessary medicines for palliative care. • Implement and disseminate best practices for pharmacy operation and pharmaceutical treatment <p>DESIRABLE</p> <ul style="list-style-type: none"> • Support countries in the evaluation, incorporation, and management of health technologies. • Evaluate countries health technology needs for diagnosis, treatment, rehabilitation, and self-management. • Evaluate technologies and the impact of technology interventions through specific studies. • Support countries to improve capacity for regulating medical devices. • Assist countries in improving access to sources of information needed for cost-effective health technologies. • Improve Member States' capacities to negotiate for the procurement of health equipment and facilitate their understanding of the different state-of-the-art options available in the field.
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