GLOBAL ALLIANCE AGAINST CHRONIC RESPIRATORY DISEASES (GARD)

9th General Meeting,
14-16 August 2014, Salvador, Brazil
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<th>Abbreviations</th>
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<tr>
<td>ACOCU</td>
<td>Asthma and COPD Outpatient Care Unit</td>
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<td>AHA</td>
<td>Active and Healthy Ageing</td>
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<td>AIRWAYS-ICPs</td>
<td>Integrated Care Pathways for Airway Diseases</td>
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<td>ARIA</td>
<td>Allergic Rhinitis and its Impact on Asthma</td>
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<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
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<td>CRD</td>
<td>chronic respiratory disease</td>
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<td>EAP</td>
<td>European Academy of Paediatrics</td>
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<td>EFP</td>
<td>Espace Francophone de Pneumologie</td>
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<td>EIP</td>
<td>European Innovation Partnership</td>
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<td>ELF</td>
<td>European Lung Foundation</td>
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<td>ERS</td>
<td>European Respiratory Society</td>
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<td>EU</td>
<td>European Union</td>
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<td>FCTC</td>
<td>Framework Convention on Tobacco Control</td>
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<td>FILHA</td>
<td>Finnish Lung Health Association</td>
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<td>GARD</td>
<td>Global Alliance against Chronic Respiratory Diseases</td>
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<td>GOLD</td>
<td>Global Initiative for Chronic Obstructive Lung Disease</td>
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<td>GRA</td>
<td>Georgian Respiratory Association</td>
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<td>LatAm</td>
<td>Latin America</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NCD</td>
<td>noncommunicable disease</td>
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<td>NGO</td>
<td>nongovernmental organization</td>
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<td>PACK</td>
<td>Practical Approach to Care Kit</td>
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<td>PAHO</td>
<td>Pan American Health Organization</td>
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<td>PAL</td>
<td>Practical Approach to Lung Health</td>
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<td>PALSA PLUS</td>
<td>Practical Approach to Lung Health in high-HIV prevalence countries</td>
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<td>PCP</td>
<td>primary care physician</td>
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The Global Alliance against Chronic Respiratory Diseases (GARD) is a voluntary alliance of national and international organizations, institutions and agencies committed to the common goal of improving global lung health. GARD is part of the global work to prevent and control chronic diseases.

Chronic respiratory disease (CRD) is one of the major categories of noncommunicable diseases (NCDs). Every year, millions of people in low- and middle-income countries are subject to unnecessary suffering because of inadequate primary care. Improving the quality of primary care is an urgent need in global heath. It may be the intervention that will help the most people at the lowest cost. Because most CRDs are underdiagnosed and undertreated and the access to essential medications in many countries is poor, a global effort to improve diagnosis, prevention and medical care is needed. GARD supports the work of the World Health Organization (WHO) to tackle prevention and control of NCDs.

Objectives

The purpose of the 2014 GARD General Meeting is to promote discussions on strengthening primary health care (PHC) for prevention and control of CRDs, to support the objectives of the WHO Action Plan for the Global Strategy for Prevention and Control of NCDs 2013–2020 (WHO Global NCD Action Plan) (1), by reviewing country reports, discussion and agreement on recommended actions and to consider the strengths, limitations and the future of GARD activities.
Expected outcomes

- Agreement that GARD will contribute to the global prevention and management of CRDs through an integrated approach to other NCDs and emphasis on PHC in a multisectoral approach, involving ministries of health (MoHs) and other governmental organizations.
- Strengthened collaboration with patient organizations and other partners.
- Knowledge translation and capacity-building for integrated prevention and management of CRDs in PHC.

1. Opening session

Dr Alvaro Cruz, Chair of the Organizing Committee of the GARD General Meeting 2014, stated that he was honoured to hold the 9th GARD general meeting in Salvador da Bahia, the first capital of Brazil, the location of the first school of medicine in the country and reminded the audience that GARD was now 8 years old. Previous meetings of representatives of the GARD network of organizations and country leaders have taken place every year; in order, meetings have been held in Beijing, Seoul, Istanbul, Rome, Toronto, Warsaw, Saint Petersburg and Astana, and in 2014 it had come to Brazil – the first time in Latin America. The meeting was made possible by the Brazilian Research Council (CNPq) and the ProAR Association, which together covered 95% of the expenditures, thanks to the efforts of the Co-Chairs, Dr Paulo Camargos and Dr Rafael Stelmach.

In his final statement, Dr Cruz touched on the issue of neglected NCDs in low- and middle-income countries, drawing attention to the fact that for CRDs the situation was even worse. Although it is listed as a priority by WHO, it has been last on the list of NCDs. Pointing to the example of asthma in Brazil, he reported that the MoH had conducted several surveys in collaboration with the Brazilian Institute for Statistics (IBGE). One of the most comprehensive was the National Survey of the Health of Students. Only in the most recent survey, conducted in 2012, had asthma been included. The survey sampled over 100,000 adolescents from all regions of Brazil. Symptoms of asthma were found in 23.2%, but only in 12.4% was a diagnosis of asthma made. This observation confirmed findings of the World Health Survey, conducted by WHO 10 years ago and published in 2012. From a sample of 5000 adults, and representative of the entire population of Brazil, 12.4% had a medical diagnosis of asthma, but 22.6% presented symptoms of asthma thus confirming underdiagnosis. For chronic obstructive pulmonary disease (COPD), the problem was much worse. Despite an impressive increase in provision of free essential medication from the Brazilian government and the availability of norms and guidelines developed by the MoH, there has been no formal action plan for prevention and control of CRD in Brazil.

He concluded by saying that the 2014 GARD General Meeting aimed to increase the recognition of CRDs and prioritize them in the public health scenario in low- and middle-income countries, and discuss successful examples of feasible and effective interventions. Dr Cruz once again welcomed the 114 registered participants, 50 of whom come from other countries and 64 from Brazil.

1.1. Update on GARD global activities, purpose and expectations for the 9th General Meeting

The Chair of GARD started by highlighting the global burden of NCDs: an estimated 36 million deaths occurred in 2008, including mainly cardiovascular diseases (48%), cancers (21%), CRDs (12%) and diabetes (3.5%). He pointed out that COPD is expected to become the fourth leading cause of death globally by 2030 with a predicted 3.8% of deaths, while lower respiratory infections were expected to decline. He reported that the WHO Global NCD Action Plan 2013–2020 had a vision of a world free of the avoidable burden of NCDs and the goal was to prevent the avoidable burden of morbidity, mortality and disability due to NCDs by means of
multisectoral collaboration and cooperation at national, regional and global levels. He presented the six objectives of the Action Plan and the nine global targets to be attained by 2025.

He mentioned that GARD is currently active in 44 countries and went on to highlight country activities that specifically matched the Action Plan objectives. These included Brazil, Turkey, Portugal, Georgia, Romania, and Syria. For example, in support of Objective 1 (To strengthen international cooperation and advocacy to raise the priority accorded to prevention and control of NCDs in the development agenda and in internationally agreed goals), Brazil formed a team to improve care for CRDs in PHC; a GARD Turkey project has been accepted by the European Innovation Partnership (EIP); Georgia is organizing several events such as World Spirometry Day, World COPD Day, World Pneumonia Day and World Asthma Day on a yearly basis; Romania organized a World COPD Day, an International Day of Sleep Disorders, a World Asthma Day and the 4th Seminar of the European French Space; and, in Syria, close collaboration with WHO and international partners led to the development of the National Centre for Research and Training for CRD and Co-morbidities.

To promote Objective 2 (To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for prevention and control of NCDs), researchers in Brazil published a research paper entitled “Knowledge of asthma and COPD: impact of education for PHC professionals”; GARD Turkey City councils in 81 cities have been conducting regional activities by the local representatives of 58 partners in the cities in conformity with the national plan; and Portugal issued a “Declaration for a better life: approach to chronic diseases through prevention”.

With regard to Objective 3 (To reduce exposure to modifiable risk factors for NCDs through creation of health-promoting environments), Turkey held a workshop for indoor and outdoor pollution and climate change; Portugal implemented measures outlined in the Framework Convention on Tobacco Control (FCTC); Georgia promoted a World No Tobacco Day; Romania supported the European Smoking Cessation Guidelines; and Syria organized a World No Tobacco Day and led a publication entitled “Impact of active and passive smoking as risk factors for asthma and COPD in women presenting to primary care in Syria: first report by the WHO-GARD survey group”.

To support Objective 4 (To strengthen and reorient health systems to address prevention and control of NCD through people-centred primary health care and universal coverage), Brazil adapted and used a guideline for common respiratory diseases based on PALSA PLUS to train 60 PHC physicians in one region of Minas Gerais State, resulting in an increase of diagnosis of tuberculosis (TB), use of spirometry and correct treatment of asthma and COPD; Turkey trained 400 pulmonologists, educated 17,000 out of 20,000 PHC physicians and prepared online educational modules; and Syria conducted a national multicentre GARD survey on a CRDs survey in PHC and prepared guidelines and training materials for CRD in primary care, emergency rooms and outpatient internal medicine clinics in hospitals, which are under implementation.

With regard to Objective 5 (To promote and support national capacity for high-quality research and development for prevention and control of NCDs), Brazil prepared the publication entitled “Matrix support in respiratory health as a tool of the multidisciplinary education to develop knowledge and practice in the diagnosis and treatment of asthma and COPD in primary care” and Turkey held the Pulmonary Rehabilitation and Home Care Symposia.

In relation to Objective 6 (To monitor trends and determinants of NCDs and evaluate progress on their prevention and control), Brazil was part of the PLATINO study, which provided prevalence estimates on COPD in five Latin American cities; in Turkey, a surveillance study has been completed by the MoH regarding all NCDs and common risk factors; Romania published its first national prevalence study combining spirometry and questionnaires.
He concluded by presenting success stories from Brazil (“Wheezing Child Program” in Belo Horizonte, a pilot project on control of severe asthma in Bahia, and the free medications programme, which brought benefits to 700,000 people in just one year), Tunisia (a pilot project on control of CRDs, which implemented Practical Approach to Lung Health [PAL], resulting in increased diagnosis, reduction of prescription of antibiotics and reduction of medication costs per patient), Georgia (screening programme that included standardized questionnaire and spirometry showed much higher rates of chronic bronchitis than official data), the Russian Federation (screening with spirometry), Uganda (a “Fresh Air” study) and Syria (data on smoking, especially narghile among children and adolescents).

1.2. Welcome address by WHO, nomination of chairperson and rapporteur

The WHO Assistant Director-General for NCDs and Mental Health was unable to attend the GARD General Meeting in Brazil, sent a welcome message to meeting participants which was presented by Dr Kocur.

He acknowledged the work after the previous 2013 GARD General Meeting in Astana and said he was pleased to see how GARD worked along the lines of objectives of the WHO Global NCD Action Plan 2013–2020.

In several countries, GARD helps to improve national capacity, governance, multisectoral action and partnerships to accelerate country response to address NCD/CRD. By supporting creation of health-promoting environments, GARD reduces exposure to modifiable risk factors for NCDs. While preparing the meeting, the Organizing Committee had taken into consideration the WHO suggestion, reflected in his letter to the Brazilian MoH, to have a pre-meeting workshop that provided a better way of discussing implementation of the key objectives of the NCD Global Action Plan 2013–2020 and, in particular, NCD integration, NCD management in PHC, building networks to fight CRDs and fund raising for global activities. He emphasized the supportive role of the MoHs in the activities of National GARD Alliances, for instance, in Brazil, Italy, Kyrgyzstan, Poland, Portugal, Syria and Turkey.

Furthermore, the MoH of Italy suggested holding a regional GARD meeting in Rome and the MoH of Portugal supports organization of the next GARD meeting in Lisbon in 2015.

He also acknowledged the fruitful work of the WHO collaborating centres. The WHO Collaborating Centre of Dokkyo University, Japan is active in monitoring CRD in the Western Pacific Region. The WHO Collaborating Centre of Tishreen University, Lattakia, Syria, is extending programmes of epidemiology, prevention and management of CRDs in consideration of NCDs and thus taking into account commonalities of risk factors and approaches for prevention and control. The former WHO Collaborating Centre of the University of Montpellier, France, which is now in the process of restructuring to support the work of GARD.

This year, GARD used a new approach to promote and advertise its activities through demonstration booths at big international events in the area of respiratory medicine. National GARD coordinators presented their programmes, achievements and shared their experiences with the visitors

He encouraged participants to critically revise their work, identify new areas of collaboration and intensify GARD contributions to the WHO Global NCD Action Plan 2013–2020 implementation with special emphasis on life-saving areas. He hopes GARD will be an active player in the recently developed Global Coordination Mechanism for NCDs and concluded by wishing the participants success in its deliberations for a “world where all people breathe freely”.

Dr Nikolai Khaltaev was nominated as chair, Dr Arzu Yorgancioglu as vice-chair, Dr Germania Pinheiro and Dr Moises Calderon as rapporteurs of the 2014 GARD General Meeting.
1.3. Introductory remarks
The representative of the WHO Liaison Office/PAHO in Brazil, speaking on behalf of Dr Joaquin Molina, thanked the organizers for the invitation and congratulated all meeting participants. He stated that according to the Global Burden of Diseases 2010 report, CRDs are the ninth leading cause of death in the world with important differences in the Region of the Americas. The diseases are complex and associated with many risk factors, such as smoking, poverty, urbanization and other social environmental factors.

The representative highlighted the high direct and indirect costs of CRDs for countries and also stated that WHO/PAHO and the MoH of Brazil fully support the Global NCD Action Plan 2013–2020 as well as the Brazilian Strategic Plan for Confronting NCDs 2011–2022.

In conclusion, he stated that policies that stimulate equity are essential and collaboration for prevention and control of CRDs are crucial. Every effort should be taken to promote early diagnosis, multisectoral approach, health education, surveillance and community mobilization. Only in this way can we prevent and control CRDs.

1.4. Address to the GARD General Meeting
The Coordinator of Care for People with Chronic Diseases of the Brazil MoH stated that CRDs are a priority for the MoH and the country is focusing on this area. Brazil wants to increase participation and collaboration.

She commented on the quality of presentations and congratulated GARD participants. He stressed the importance of a sustainable PHC system, especially for those suffering from CRDs, and concluded by saying that the MoH was willing to establish an intense collaboration and partnership with GARD/WHO for the future of CRD control in Brazil.

1.5. WHO Global NCD Action Plan 2013–2020
The representative of the WHO Assistant Director-General for NCDs and Mental Health explained the rationale for the WHO Global NCD Action Plan 2013–2020 and showed that NCDs are already among the most common diseases in low- and middle-income countries and that 85% of premature deaths from NCDs occur in developing countries, representing 11.8 million premature deaths. He pointed out that four types of NCDs (heart disease and stroke, diabetes, cancer and chronic lung disease) are largely preventable by means of effective interventions that tackle shared modifiable risk factors (tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol). He highlighted the cost of inaction versus action and the costs of scaling-up as well as the importance of the 2011 UN General Assembly, which issued a Political Declaration on the Prevention and Control of Noncommunicable Diseases. He emphasized the vision and goals of the Global NCD Action Plan 2013–2020, its six main objectives, the nine targets for 2025 and the 25 indicators of the Global Monitoring Framework in terms of morbidity and mortality, risk factors and national systems response.

Finally, he laid out the priority actions recommended for Member States to accelerate progress at the country level:
- governance
- reduce exposure to risk factors for NCDs
- enable health systems to respond
- measure results.

He concluded by saying that the Action Plan provides a road map and a set of actions that when carried out collectively by Member States, WHO and other UN organizations, nongovernmental organizations (NGOs) and the private sector entities will achieve the nine global targets for NCDs, including a 25% reduction in premature mortality from cardiovascular diseases cancer, diabetes and CRDs by 2025.
2. Session II: Accelerating country response for the prevention and control of NCD

2.1. Working with the MoH to combat CRDs
The Director of the Institute of Biomedicine and Molecular Immunology of Italy and member of the Executive Committee of GARD Italy presented the five projects carried out by GARD Italy in 2010–2012:

- prevention programme for schools of indoor risks for respiratory and allergic diseases;
- smoking and the environment in the household;
- development of predictive medicine for respiratory diseases;
- early diagnosis implementation through pathways for health staff;
- care continuity.

He then illustrated the activity of the five working groups (WGs) constituted by GARD Italy in 2012–2014:

- environment and respiratory diseases;
- surveillance of respiratory diseases;
- education: asthma and allergies in childhood;
- smoking and environment in the household;
- care continuity: respiratory impairment.

He announced that the Italian MoH, on behalf of GARD Italy, wished to organize a workshop of the GARD country organizations acting for the EU in Rome on 15 October 2014. Such a workshop is intended as a special session of the GARD Italy Annual Meeting. During the workshop, the following items would be discussed:

- relevant outcomes for CRDs of the Meeting of Chief Medical, Chief Nursing and Chief Dental Officers, Rome, 6–7 October 2014;
- CRD epidemiology, guidelines, pharmaco-epidemiology/economics;
- roles of DG-SANCO and DG-Research HORIZON 2020 against CRD;
- National Action Plan against CRD (round table).

In addition, he mentioned four scientific publications in which GARD Italy had been cited.

2.2. Collaboration between GARD Portugal and the MoH to tackle CRDs
The GARD Portugal coordinator and GARD Planning Group member started by describing the demographic characteristics of Portugal and stated that the country ranks forty-first on the 2014 United Nations Development (UNDP) Report. Portugal is one of the 10 safest countries for newborns and for life expectancy at birth for women. He presented a historical perspective of GARD activities in Portugal, starting with its 1st General Meeting in 2007, and the launch of GARD’s website in 2008, along with a Portuguese version of the “GARD Book”. He stressed that in 2009 GARD Portugal started a collaboration with Cape Verde, which culminated with an epidemiological study about the prevalence of CRD in PHC in Cape Verde and a publication entitled “Underreport and underdiagnosis of chronic respiratory diseases in an African country”.

In 2011, Portugal launched the Declaration for a Better Life, which was the support document for the Portuguese participation at the UN 2011 High-level Meeting on the Prevention and Control of Noncommunicable Diseases. One of its aims was a challenge to fight chronic diseases in Portugal beyond the public sector with a robust social movement with expression and visibility. The declaration contained six urgent measures:

- reducing health inequalities – decreasing disparities;
- improving citizen literacy;
- reducing the consumption of tobacco products;
- encouraging a balanced diet;
- encouraging practice of regular physical activity;
- decreasing the negative impact of excessive consumption of alcohol beverages.
In 2012, the Portuguese National Programme for Respiratory Diseases (PNDR 2012–2016) was unveiled. Its mission is aligned with GARD’s mission of “a world where all people breathe freely”. The programme has GARD as its strategic centre point, which is the most comprehensive and integrative for CRDs in strategic terms. Finally, he demonstrated that, according to 2003–2012 data, hospital admissions for asthma remained stable after a steep increase from 2004 to 2007, while asthma mortality remained relatively stable during the entire period; COPD admissions declined to baseline levels after a peak in 2005; by contrast, mortality remained at higher levels, after an increase in 2005. He concluded that GARD Portugal has come a long way since its inception in 2002 and public presentation in 2007, culminating with the integration with the National Programme for Respiratory Diseases in 2012, and that the interaction and collaboration with Portugal MoH is an opportunity to improve this strategy. In addition, the GARD Portugal coordinator accepted the commitment to organize the 10th GARD General Meeting.

In summary, the representative concluded that:

- good results were achieved concerning asthma and COPD mortality and hospital admissions at the European level despite present economic difficulties;
- there was an increasing number of pneumonia deaths in the last few years;
- there has been excellent collaboration between GARD Portugal and the MoH (Directorate General of Health) and the work presently being done by PNDR.

2.3. Leading a countrywide partnership for the prevention and control of CRDs
The GARD Turkey vice-coordinator and Turkish Thoracic Society GARD representative reported that in the past year activities of GARD Turkey are an example of “Leading a Countrywide Partnership for Prevention and Control of Chronic Diseases”. The GARD Turkey Project with its 58 partners has been conducting activities in 81 cities throughout the country in conformity with the action plans of the activities of the five WGs. WG 1 planned a surveillance study, which has been completed and published by the MoH regarding all NCDs and common risk factors. WG 2 has conducted and published the work of two studies regarding the awareness of asthma and COPD among public and health-care professionals and public awareness. WG 3 organized a workshop for indoor/outdoor pollution and climate change in June 2014 and WG 4 prepared the educational materials for trainers for primary care settings: 400 trainers (pulmonologists) have been trained and 17,000 out of 20,000 primary care physicians (PCPs) have been educated face-to-face by these trainers using the same structured materials. Online educational modules have been prepared and are required training materials for PCPs. WG 5A organized a pulmonary rehabilitation symposia in December 2013 and prepared a subsequent report. City councils have been organizing world COPD days, asthma days and pulmonary rehabilitation week activities in support of the national action plan. The National Control Plan was updated for 2013–2017 in December 2013 during the 3rd GARD General Meeting in Istanbul. A new project in collaboration with industry on the awareness of GARD, asthma, COPD, spirometry and inhalers has been planned.

2.4. Advocacy for recognition of CRD and major allergic diseases
The GARD Poland coordinator and GARD Planning Group member started his presentation by outlining the public health priorities of the country and the importance of closing the gaps in the health status of the EU’s population, referring to prevention, early detection and treatment of CRDs in children.

The prevalence of CRDs varies globally, but it is estimated that 600 million people suffer from allergic rhinitis worldwide, more than 130 million people in the EU suffer from allergies, 30 million Europeans have asthma, and one in two Europeans will suffer from some form of respiratory allergy by 2015.

As part of any public health programme, it is important to recognize the influence of respiratory diseases in childhood on healthy ageing. This concept is expressed in the phrase “healthy ageing depends on children’s health”.
Asthma and allergic rhinitis are the most common noncommunicable CRDs in children. Asthma is the most common reason for emergency room visits and hospital admissions among paediatric patients. The early prevention of allergic rhinitis prevents asthma development. Asthma is a risk factor for COPD. It is important to consider that COPD affects 44 million people in Europe, and is the fourth leading cause of death and will become the third leading cause of death by 2030. Asthmatics are 1.4 times more likely to have heart diseases and 1.3 times more likely to have high blood pressure than non-asthmatics. People with seasonal and chronic rhinitis have on average a 3.5 mmHg higher systolic blood pressure than those without allergic rhinitis.

The Gard Poland coordinator concluded with the following comments:
- when closing the gaps in health status in terms of public health, some “allergic respiratory diseases” also should be considered;
- childhood asthma and allergy should be included in research and community health programmes;
- it is important to recognize the influence of respiratory diseases in childhood on healthy ageing.

2.5. European Innovation Partnership (EIP) on Active and Healthy Ageing (AHA) – AIRWAYS-ICPs

The past-chair of WHO GARD stated that the objective of AIRWAYS-ICPs is to launch a collaboration to develop multisectoral care pathways for CRDs in European countries and regions, as part of the EIP on AHA (Area 5 of Action Plan B3 of EIP on AHA, DG Sanco, and DG CNECT) and to scale up globally with WHO GARD. AIRWAYS-ICPs has strategic relevance to the EU Health Strategy and the WHO Global NCD Action Plan 2013–2020, adding value to existing public health knowledge by: (i) proposing a common framework of care pathways for CRDs that will facilitate comparability and transnational initiatives; (ii) proposing plans targeted to all populations according to culture, health systems and income; (iii) developing a strategy based on the WHO Package of Essential NCD Interventions (PEN) and the essential list of drugs for low- and middle-income countries; (iv) informing cost-effective policy development, in particular, strengthening those on smoking and environment exposure; (v) aiding risk stratification for chronic disease patients with a common strategy; (vi) building a sentinel network for allergic diseases and asthma; (vii) having a significant impact on the health of citizens in the short term (reduction of morbidity, improvement of education in children and of work in adults) and the long term (healthy ageing); (viii) tackling chronic diseases across the life cycle; and (ix) ultimately reducing the health-care burden (emergency visits, avoidable hospitalizations, disability and costs), while improving quality of life and promoting AHA. In the longer term, the incidence of disease may be reduced by innovative prevention strategies.

In conclusion, AIRWAYS-ICPs:
- is aimed at strengthening the WHO NCD Action Plan 2013–2020;
- has been developed by the EIP on AHA;
- will be scaled up globally by WHO GARD.

3. Session III: Reducing modifiable risk factors for NCDs

3.1. Promoting air quality to protect the health of people

The GARD Paraguay coordinator, president-elect of Sociedad Latinoamericana de Alergia, Asma e Inmunología (SLAAI) and Fellow of the American College of Allergy, Asthma and Immunology (FACAAI), gave a presentation on environmental health and air pollutants.

According to WHO, environmental health covers “those aspects of human health determined by the interaction of man with biological, chemical, physical, social and psychosocial factors in the environment”. It includes the theory and practice of preventing, controlling, evaluating and correcting the factors in the environment that may affect the health of present and future generations. Asthma, asthma attacks, COPD, respiratory infections, rhinitis and sinusitis have been
associated with various types of air pollution, especially those relating to vehicle emissions and the resulting pollution.

There is a very close link between changes in the global climate and projected increases in the prevalence and severity of asthma and allergic diseases mediated through air pollution and regional changes in the production of pollen. The pattern of change varies by region, depending on latitude, altitude, rainfall and storms, land use, urbanization, transport and energy production. WHO estimates that 300 million people currently suffer from active asthma and approximately 250,000 people die from asthma annually.

Air pollution implies “the presence of contaminants that alter the composition of air and affecting any component of the ecosystem”. Contaminants associated with increased incidence of asthma and allergies are: nitrogen dioxide (NO₂); ozone (O₃); particulate matter (PM); and volatile organic compounds.

Air pollutants’ adverse effects on health may include: asthma and allergies exacerbations; chronic bronchitis; ocular, nasal and pharyngeal irritation; neurological symptoms such as headache, nausea, vomiting, dizziness and paresthesia; and carcinogenic effects in the lung, larynx, pancreas, bladder and kidney.

Epigenetics play a very important role in the evolution of CRDs.

There is no doubt that there is a close relationship between air pollution with atopic and respiratory conditions. Population-based studies have correlated the increase in asthma attacks and allergic nasal symptoms as well as the increase in the need for rescue medication when there are high levels of air pollutants.

An important link has also been identified between diesel particulate and lung injury, cardiovascular damage and metabolic damage. Diesel pollutants could be classified according to their diameter size as: ultra-thin (average size of 0.02 μ); and thin (average size of 0.2 μ). Diesel pollutants can be inorganic – e.g. CO₂ (carbon dioxide); CO (carbon monoxide); NOₓ (nitrogen oxides); and SO₂ (sulfur dioxide) – or organic (e.g. alkanes and alkenes, formaldehyde, aldehydes, and aromatic compounds). The International Agency for Research on Cancer, has classified diesel engine exhaust as carcinogenic to humans based on sufficient evidence that exposure is associated with an increase risk for lung cancer.

The effects of PM on health occur before the air quality levels are extra heavy. The population groups most affected are children under 5 years old and people over 65. There are conditions that cause increased susceptibility to the adverse effects of PM such as asthma, rhinitis, COPD, myocardial infarction cardiac arrest. Socioeconomic factors have a major influence on susceptibility to the effects of PM10, because the impact on mortality will be greater the lower the level of social and economic development of the exposed population.

Radiation has always been a natural part of our environment. Natural radioactive sources in the soil, water and air contribute to our exposure to ionizing radiation, as well as man-made sources resulting from mining and use of naturally radioactive materials in power generation, nuclear medicine, and military and industrial applications. These issues are currently assessed by the Inter-Agency Committee on Radiological and Nuclear Emergencies (IACRNE).

In conclusion:

- the degradation of the air that we breathe has severe effects on public health, signed today in terms of morbidity and mortality;
- it is very important to alert public health authorities about the urgent need to implement effective measures to reduce environmental pollution.

3.2. Prevalence, incidence and governmental policy with regard to CRD and smoking
The Georgian Respiratory Association (GRA) and GARD Georgia representative started her presentation with an overview of the demographic and socioeconomic situation of Georgia. She stated that according to the official epidemiological data, there was a trend of stable increase of new CRD cases throughout 2008–2012. Official data about CRD are scarce in Georgia. In 2012, COPD cases accounted for 59.1% of all registered cases of lower respiratory diseases, while asthma was responsible for 33.0% of the cases. A study, conducted by GRA with the support of GARD, covered more than 10 regions and demonstrated that COPD prevalence was five times higher than the official statistics. In 2013–2014, the number of national strategies and action plans has been increased in the field of NCDs. Among them is the Strategy and AP on CRD and on Tobacco.

She further stated that currently there are many guidelines and protocols in the field of CRDs endorsed by the MoH. A tool provided by WHO is being translated and adapted and guidelines for prevention and control of NCDs at the PHC level in low-resource settings are in the process of development.

According to the NCD risk-factor survey (STEPS 2010), the prevalence of current smoking is 30.3% (27.7% daily smokers); the proportion of smoking among men is nearly 11 times higher than among women (55.5% versus 4.8%).

A Multi-sectoral State Committee for Strengthening Tobacco Control Measures in Georgia has been established. The National Tobacco Control Strategy was approved in 2013 as well as the 5-year Action Plan. The Tobacco Control State Programme is soon to be launched and amendments to the laws regarding tobacco control have been sent to the Parliament for approval.

Future actions include the development and improvement of a CRD a surveillance system to build supportive environments for behavioural changes in order to increase community awareness related to CRD, strengthen the PHC system, integrate CRDs into the Continuous Medical Education system, monitor utilization of modern clinical guidelines and put more focus and priority on conducting research in the field of CRD.

Resources are needed for pushing forward regional collaboration (GARD Transcaucasia). Local partners are ready for collaboration and the support of WHO GARD in advocacy with government representatives of neighbouring countries.

In conclusion:
- CRD Strategy and AP is being developed and the tobacco control policy has been strengthened in Georgia;
- there still are challenges mainly related to the lack of resources to be addressed in future;
- Georgia is ready to push forward GARD Transcaucasia and assistance is needed from GARD and WHO in advocacy on the policy level with the neighbouring countries.

3.3. Initiatives of the Romanian Society of Pulmonology in 2013
The president of the Romanian Society of Pulmonology and National GARD representative stated that the society congregates 700 members within its seven sections, four workshop groups and one nurses section. In a very fruitful year, Romania organized traditional actions in 2013 such as COPD Day, Asthma Day and Somnology Day. Activities included: workshops and conferences on non-invasive ventilation, somnology and home assistance of respiratory patients; an EU project on e-learning; the inquiry on the “Wake Up Bus Campaign”; the ENSP Guideline for counselling smokers (with a structure derived from the Romanian guideline “GREFA”); educational activities (“Journal of the COPD” and “Asthma Patients”); the first national prevalence study on COPD and common action together with other professional associations at the NCDs congress, the lung cancer conference and the management of CRDs conference. Every two years, the conference of the sections and the national congress are organized. Important lessons were learnt: it is not enough to be a dynamic society and to be awarded for this in national competitions. The power of the associations also comes from partnerships with other representatives from professional associations, such as the Cardiology Society, which started with the prevention programme in The
Forum of Prevention. The Pulmonology Society is collaborating with in national conferences on common topics and is signing, together with Romania and 20 other associations, the first national reactions in favour of the new EU directive for tobacco control, against the strategies of ex-ministers of health and economy who tried to protect the tobacco industry. In the future, Romania must strengthen relations with authorities and the most powerful leaders and NGOs for controlling noncommunicable CRDs.

4. Session IV: Strengthening and orienting health systems to address the prevention and control of NCD

4.1. Building capacity of the PHC work force for CRDs in low-resource settings

The representative of GARD South Africa introduced their expanded portfolio of integrated care guidelines and tools: Practical Approach to Care Kit (PACK) Global. He stated that in many low- and middle-income countries, a shortage of frontline clinicians presents a serious obstacle to providing access to health care, and in many countries that nurses serve in this role. However, regardless of the clinical context, access to care does not guarantee the provision of quality care, and methods for better equipping and empowering frontline clinicians in the management of CRDs is an essential component of strategies to address these diseases. For doctors, the following approaches should be considered: revision of curricula to include more instruction on PHC, preferably on rural campuses; obligatory community service; providing supervision to practitioners in rural settings through networking; telemedicine and matrix support methods; the use of integrated clinical practice guidelines for common and chronic conditions; and more focus on a team approach that includes task sharing with nurses and other health-care workers.

For nurses, options are instruction in primary care and use of integrated care guidelines in nursing colleges, involvement in care pathways (task sharing), expanded provision of prescribing or re-prescribing and dispensing drugs for chronic diseases. Other approaches for building capacity in primary care include the development of context-specific integrated clinical practice guidelines containing clear definition of authorized division of tasks among doctors, nurses, pharmacists and other health personnel, and clear instructions for referral of problem conditions. Teaching strategies shown to be effective are in-service, onsite instruction that is continuous and supported by a trusted instructor. Examples from South Africa include the PALSA Plus and PC101 guidelines and approach as well as a global version of PACK.

4.2. Contribution of GARD Brazil to primary care in the public health system

The GARD Brazil coordinator highlighted that it was launched in October 2006, during the Brazilian Congress of Pediatrics by Dr Khaltaev and several Brazilian players, supporters and stakeholders.

The first GARD Brazil initiative was the planning and implementation of a GARD–PAL demonstration project in 2009, using guidelines based on PALSA-PLUS guidelines developed by the Knowledge Translation Unit, University of Cape Town Lung Institute and Stop-TB/PAL/WHO.

Some interesting goals were achieved in this project, including:
- an increase in the rate of TB diagnosis;
- improvements in the proportion of patients undergoing spirometry;
- appropriate prescribing of inhaled steroids for asthma;
- an increase in the referral rate of patients from the pulmonologist to the general practitioner.

The second main achievement occurred in 2010, with the publication of the first Brazilian guidelines for CRDs. These guidelines (35 000 booklets) were addressed mainly to health professionals (doctors, nurses, pharmacists, etc.) working at PHC facilities.
Along with these GARD Brazil initiatives, the MoH launched two programmes that reinforced the fight against CRDs in the country.

First, with the slogan “Health is Priceless Policy”, the MoH launched the Farmácia Popular Program, which ensured free inhaled beclomethasone and salbutamol and intranasal budesonide countrywide through a wide network of private sector pharmacies.

Second, the MoH launched a plan for fighting chronic NCDs for the period 2011–2022 that highlighted tobacco control, without a necessary emphasis on COPD and asthma.

The main achievement, however, was the implementation in 2014 of the first statewide program addressing CRDs for all age groups, the so-called “Respira Minas” (Breathe Minas Gerais State) Program.

The Minas Gerais State has a surface area similar to France with 20 million inhabitants. Approximately US$ 4 million was allocated in early September 2014 for the first phase of the Respira Minas Program. The GARD Brazil coordinator was a voting member of the Steering Committee.

Goals for the next few years are to:
- strengthen the “Global Alliance”;
- gain political support from WHO;
- achieve close collaboration with the MoH;
- collaborate with CRD initiatives in other Brazilian provinces;
- expand Breathe Minas Gerais to other Brazilian provinces;
- find new stakeholders;
- continue education for health professionals;
- merge GARD Brazil with PACK.

4.3. Providing reference centres to strengthen primary care in fighting CRD

The representative of GARD Viet Nam focused on the primary care system, the chronic disease management model and reference centres as options for improving chronic respiratory care in primary care in Viet Nam. She stated that the country has an extensive primary care system with 10,917 health posts at the community level, but problems remain such as: quality of health services is lower than expected; lack of training resulting in ineffectiveness of PHC providers; self-medication; low utilization of community health centres; and overutilization of tertiary health-care facilities, especially in rural areas. These are important issues that should be addressed, since Viet Nam ranked 160 among 190 WHO Member States.

She affirmed that there is a need to strengthen the competence of CRD management in primary care with the Asthma and COPD Outpatient Care Unit (ACOCU) programme. She gave an overview of the programme saying that the first reference centre was established in Ho Chi Minh City in 2000 and since then has greatly expanded throughout the country at provincial and district levels. There was an ACOCU day in 2014.

She stated that the management of CRDs at the PHC level should be simple and listed the importance of:
- simple guidelines, such as WHO guidelines, e.g. WHO PEN;
- simple screening tools: COPD – peak flow meter;
- essential drugs included on the insurance list;
- family doctors and other health-care professionals involved in the management of CRDs;
- good mechanisms for referral and contra-referral of patients if needed.
The representative mentioned that the ACOCU model in Ho Chi Minh City is strengthening CRD management in Viet Nam in different ways, such as cooperating with family doctor centres and providing training to medical schools, providing continuous medical education for family doctors by telemonitoring, and advocating for equipment and medication that should be included on the insurance list of PHC units. In addition, it is important to conduct simple studies in the area of CRD in the country. Currently, there are 90 family doctors in 90 PHC units and a professional society of family doctors in Ho Chi Minh City was launched. She highlighted that WHO NCD protocols were implemented at a polyclinic in Ho Chi Minh City. Also, the ACOCU at different levels are serving as reference centres to strengthen competence of CRD management in primary care in Viet Nam and the collaboration of many partners was essential. She concluded that the CRD programme is being disseminated to family doctors at all levels in Viet Nam and that the ACOCU could also develop a polyclinic to address other NCDs.

4.4. Supporting the public health system for the management of CRD

The GARD Bangladesh coordinator stated that like many other resource-limited countries, delivering public health is a great challenge in the country. CRDs are an agonizing burden for Bangladesh and to address these ailments in a proper way is a substantial problem. The most common CRDs are asthma, COPD, bronchiectasis, the consequences of pulmonary TB and interstitial lung diseases.

PHC at the grass-roots level in Bangladesh is provided through community clinics. This is an ambitious public–private partnership concept in which one health care establishment is planned for every 6000 people in rural areas, and within 10 minutes walking distance from every household. The primary referral centre is placed at the subdistrict level, where CRDs are addressed by qualified physicians.

The Bangladesh Lung Foundation (BLF), the prime professional body of pulmonologists in Bangladesh, is implementing various programmes in accordance with GARD priorities and directives. These activities are supporting the Public Health System for the management of CRDs, directly or indirectly. In Bangladesh, the government gives very low priority to noncommunicable respiratory diseases. There is a scarcity of qualified pulmonologists and an absence of validated, effective long-term respiratory training for PCPs. The tobacco promotion programme is very strong and ruthless. Moreover, financial hardship makes it difficult for people to access good quality care and drugs thus increasing the misery.

Gradual changes in patient’s attitude as well as the practice behaviour of the health professionals may bring about some positive changes. Training and education for PHC professionals and campaigning against tobacco use and other risk factors in schools and other institutes are needed. A strong link between primary care and secondary and tertiary care should be developed so that the “gap” between them is reduced. An active and strong patient’s forum for the support, advocacy and sharing experiences is also in demand at this time.

In conclusion, the changes that can really make a difference in the country are:

- gradual changes of patient attitudes as well as the practice behaviour of health professionals;
- training and education for PCPs, nurses, pharmacists and other PHC professionals for respiratory diseases;
- campaigning against tobacco in schools and other institutions where young people attend regularly and fighting other risk factors such as indoor air pollution caused by and other risk factors, in particular, by biomass fumes;
- developing a strong link between primary care and secondary and tertiary care so that the “gap” between them is reduced;
- forming a patients’ group for support, advocacy and sharing experiences.

The meeting participants were invited to PULMOCON 2015, the 4th International Conference on Lung Health in Bangladesh.
5. Session V: Strengthening and orienting health systems to address the prevention and control of NCD

5.1. GARD activities supported by the Société de Pneumologie de Langue Française (SPLF) and Espace Francophone de Pneumologie (EFP)

The representative of SPLF and EFP stated that communication in its broadest sense is the key word for development. Respiratory sleep disorders (RSD) is the new frontier of CRDs among NCDs.

EFP brings together 28 francophone countries and over 10 000 pulmonologists and has also welcomed groups of French-speaking pulmonologists from non-francophone countries. Belgium and Switzerland are new members and French-speaking communities are Bulgaria, Poland, Hungary and Moldavia. EFP is in charge of the development of the international reach of SPLF: since 2009, presidents of all the francophone pulmonology societies are representative members on the Executive Committee at the SPLF General Assembly.

Targeted actions include:

- spirometrics standards: studies conducted in Lebanon, Madagascar and Tunisia, with international training (Tunisia September 2014);
- set up of a human resources bank: opened on the website of EFP to collect member data through a standardized form;
- Certificated Etude Complémentaire Francophone du Sommeil (CECFRAS): started in Côte d’Ivoire (July 2014) with the sponsorship of the SFAX School of Medicine (Tunisia); 20 students from 10 countries of francophone sub-Saharan Africa; large part in eLearning;
- La TRIENNALE DE L’EFP: EFP congress which will be organized every three years; the main goals focused on daily practice; the first event will be in Beirut, Lebanon on 4–6 June 2015 (www.efpneumo.org).

5.2. How GARD Syria has initiated national guidelines for NCD and co-morbidities

The GARD Syria coordinator and Director of the WHO Collaborating Centre, stated that Tishreen University has been a non-paying member of GARD since 2008. In 2010, the first national meeting for CRD/NCD was organized for GARD in collaboration with the WHO Regional Office for the Eastern Mediterranean, the Syria MoH and the WHO Country Office. The aim was to launch the GARD survey on prevalence and risk factors for CRDs in primary care. They surveyed 22 primary care centres, including 19 emergency rooms. Of 1599 patients, 51% were women. Lung function showed FEV1<80% predicted in 36.23% of patients, while asthma was reported by general practitioners in 13% and COPD in 4%. They concluded that there is underdiagnosis, underprescription of inhaled corticosteroids for asthma and overprescription of oral corticosteroids for COPD and asthma.

Consequently, they recommended:

- develop for use in primary care of:
  - guidelines: forms to be filled at first presentation of the patient for CRD, and a follow-up form; then teachers or trainers review and correct each form for continuing medical education;
  - training materials for health professionals and patients;
- adapt curricula in universities to new concepts of CRD.

Primary care in Syria includes several health-care facilities, emergency rooms, dispensaries, general and internal medicine outpatient clinics in hospitals and private general and internal medicine facilities. The country hopes that WHO will consider including these health faculties in programmes. Officially, the National Center for Research and Training for CRD and Co-morbidities has been created: it published results of a survey and views as a contribution to the International COPD Coalition (ICC) column of the Chinese Journal of Thoracic Diseases. Since World Asthma Day 2014, the country is launching a nursing programme. In addition, Syria included CRD in a TB-WHO proposal for global funding.
5.3. Coaching primary care practitioners for best practice in asthma

The Chief Executive Officer of the National Asthma Council of Australia started her presentation by giving an overview of asthma facts in the country: asthma prevalence is estimated at 10% and childhood prevalence declined over the past 10 years. With 25 years of asthma education, awareness and research, deaths decreased 70% since the 1980s to 1.5 per 100 000. Emergency department visits also declined. However, patients still rely on bronchodilators and do not adhere to controllers. In addition, general practitioners still do not prescribe appropriately, despite an 89% awareness of guidelines. Primary care in Australia involves general practitioners, nurses, pharmacists, a few asthma educators and Aboriginal health workers. General practitioners are generally overwhelmed by a plethora of treatment guidelines. By contrast, Aboriginal medical services and health workers have different requirements for education.

She highlighted the Australian Asthma Handbook, which is in its seventh edition. It was written with a primary care, multidisciplinary approach. The guideline also has a companion, the Quick Reference Guide, which was extensively promoted: more than 50 000 copies were distributed to primary care professionals. The Australian Asthma Council also has an ongoing national workshop programme, with several resources for training. They are essential to implement treatment guidelines throughout the country, especially given the geographical challenges. In fact, over 50% of the workshops are conducted in rural and remote Australia. These workshops are funded by the Australian Department of Health. She stated that an evaluation of the workshops’ programme is automatic, in consultation with key stakeholders. Impact measurements are the expectations prior, immediately and six months after the workshop. It is expected that the majority of participants will meet their learning needs.

Finally, she mentioned the implementation of Practitioners Asthma Communication and Education (PACE) Australia, a programme that provides clinicians with evidence-based asthma management guidelines and counselling skills aimed at improving patient outcomes and career satisfaction.

She concluded that:
- national treatment guidelines are the basis for best practice in asthma;
- asthma guidelines must be written for those who treat asthma most;
- primary care must be involved in guideline development;
- workshops must be designed for primary care needs and promoted to primary care;
- evaluation is essential because it leads to workshop improvements and demonstrates programme effectiveness to the government, host organizations and potential participants;
- the National Asthma Council also conducts these courses in other countries based on lessons learnt.

5.4. GARD Lithuanian collaboration with the European Academy of Paediatrics (EAP) with special focus on prevention and control of CRD in primary care

The GARD Lithuania coordinator stated that the Strategic Pediatric Alliance for Child Health includes: (i) the European Academy of Paediatrics–European Union of Medical Specialists (EAP–UEMS); (ii) the European Paediatric Association (EPA/UNEPSA); (iii) the European Confederation of Primary Care Pediatricians (ECPCP); and (iv) the International Pediatric Association (IPA).

The EAP–UEMS is a non-profit organization that represents the Paediatric Section of UEMS. It is represented by 82 078 paediatricians, including 40.4% working in primary care in Europe. The main aim is to recognize the specialty among current and future EU members.

In 2013, with the election of a new Executive Committee, the EAP set up a 3-step programme that shares similar goals with GARD. Step 1 includes balanced priorities between primary care and secondary/tertiary care. Step 2 accepts new UEMS rules of non-profit organizations with specific allocation of finances for research and networking. Step 3 establishes a new structure for horizontal contacts (e.g. Committee of Inequalities and Harmonization of Child Health Care) supporting guidelines for a focused approach and networking.
Both GARD and the EAP are umbrella organizations that work for better quality of health care in overcoming inequalities. This could be achieved through the EAP Committee of Inequalities and Harmonization of Child Health Care using regular questionnaires to measure quality of medical care.

A comprehensive EAP programme has been structured, including education, research and service enlargement issues. The AIRWAYS-ICPs programme is included.

Research of the phenotypes of infant wheezing (e.g. transient wheeze; non-atopic wheeze – viral induced; and atopic wheeze) have been recently conducted as part of the EAP initiative aiming to provide guidelines for screening for A1AD. This information will provide the basis for the future classification of two major phenotypes of paediatric asthma, leading to defining the genetic and structural predisposition to COPD or asthma.

5.5. GARD Islamic Republic of Iran report
The GARD Islamic Republic of Iran coordinator and GARD Planning Group member stated that after the approval of the GARD programme by the country’s MoH the first step was to establish and organize a national team that includes all related medical societies, institutes, governmental organizations, research centres, NGOs, charities and mass media. Thereafter, several meetings and workshops were carried out on the subjects of NCDs and CRDs.

To summarize, the comprehensive actions of GARD Islamic Republic of IRAN can be divided into four major parts:

- Collaboration with the MoH: as a partner and active member of the Respiratory Unit of the Department of Noncommunicable Diseases, it tries to take advantage of all possible opportunities, particularly in view of the new national health promotion plan of the country, in the context of a national NCDs action plan to include and prioritize CRDs activities, mainly:
  - preparation of national asthma prevention and management guidelines;
  - preparation of national COPD prevention and management guideline;
  - incorporation of the guidelines into the National Health Electronic File and the PHC framework;
  - piloting practical implementation of the guidelines into two selected provinces and 51 cities.
- Active participation and collaboration with the Parliament and the government in order to approve and enact the Comprehensive National Tobacco Control law. Meanwhile, the country was successful in getting approval of an annual tax increase on tobacco products and the implementation of MPOWER-FCTC rules and regulations.
- Public and decision-makers awareness – increasing awareness of top people at the level of the MoH and the national organizations concerning NCDs and the inclusion of CRDs, and their importance among the other NCDs, as essential information.

Therefore, the country tried to use all the capacities of the mass media, news agencies and public newspapers in this regard, particularly during national and international occasions and special events such as National Non-tobacco Week, World Asthma Day, World COPD Day and World Spirometry Day. During these events, several campaigns in Tehran (the capital) and major cities were conducted with the help of the Iran Pulmonology Society by providing medical consultation, pulmonary function tests and tobacco cessation advice and brochures on NCDs and CRDs.

- Research activities: in parallel with all the above mentioned activities and in order for better planning and programming, a comprehensive research project was initiated with the help of the American Thoracic Society, using a bold method for studying COPD and asthma prevalence at the national level. After completing the study in Tehran, a preliminary report was sent for publication and the study will be carried out further in other provinces.
6. Session VI: To monitor the trends and determinants of NCD

6.1. Surveillance of CRD in Mongolia, Cambodia and the Lao People’s Democratic Republic

The director of the WHO Collaborating Centre in Japan and GARD Planning Group member reported the results on the prevalence of CRDs based on surveys conducted by the WHO Collaborating Centre for Prevention and Control of Chronic Respiratory Diseases in Mongolia, Cambodia and the Lao People’s Democratic Republic.

The objectives of the survey were to investigate the prevalence of asthma and COPD and to determine the risk factors of these CRDs. They collaborated with the Health Sciences University of Mongolia, the Centre for Tuberculosis and Leprosy Control of the MoH of Cambodia and the National Tuberculosis Control Programme Centre of the MoH of the Lao People’s Democratic Republic. The director of the WHO Collaborating Centre stated that approximately 1200 adults 20 years old and over were randomly recruited from 200,000 people based in each area, of which 50% were above and below 40 years old and split close to 50% between genders. The definition of current asthma was assessed using a questionnaire: presence of wheezes and dyspnea in the past 12 months and at least one asthma-related symptom identified using the European Community Respiratory Health Survey (ECRHS)-based questionnaire. COPD definition, following GOLD guidelines, was defined as patients presenting FEV₁/FVC below 70% after inhalation of salbutamol measured by spirometry. The results of the study showed that the prevalence of asthma was the highest in Mongolia, followed by Cambodia, and then the Lao People’s Democratic Republic. Compared to these countries, the province of Guimaras in the Philippines also recorded a high prevalence. In Japan, the prevalence was slightly higher than in Cambodia and in the Lao People’s Democratic Republic.

The presenter mentioned that the correct use of spirometry in the diagnosis of COPD is very important. He showed a graph comparing the diagnosis of COPD using spirometry in comparison with doctor-diagnosed COPD and concluded that the disease is:

- underdiagnosed in Japan;
- overdiagnosed in Ulaanbaatar;
- misdiagnosed in Phnom Penh and Vientiane;

He added that only 3 of 15 doctor-diagnosed COPD cases and 2 of 8 doctor-diagnosed COPD cases matched spirometry-based diagnosis.

The representative also spoke about COPD prevalence between smokers and non-smokers in adults over 40 years old, stating that smoking and COPD prevalence are deeply related in Mongolia, Cambodia and the Lao People’s Democratic Republic. The prevalence, in general, is higher among men. In Mongolia, males and females presented almost the same prevalence. Regarding the prevalence of asthma among children in Cambodia, female children recorded higher, and in the Lao People’s Democratic Republic, male children are prone to a higher prevalence. These results are proportional to the accuracy of diagnosis, and can mean that further investigation may be needed. The main conclusions of the presenter were that asthma has been underdiagnosed, spirometry was very important for the correct diagnosis of COPD and that smoking was a very important risk factor for COPD in these countries.

Another survey on the prevalence of asthma and COPD and their overlap in adults in Cambodia was conducted by the WHO Collaborating Centre for Prevention and Control of Chronic Respiratory Disease. The study was part of the Survey of Prevalence of Chronic Respiratory Diseases in Developing Countries in Asia Pacific and Future Approach for Prevention and Control of Chronic Respiratory Diseases, which was supported by the WHO Regional Office for the Western Pacific. The objectives of this study were to determine the prevalence of asthma and COPD in Cambodia (Phnom Penh) and their overlap in adults over 40 years old. In this study the prevalence of both asthma and COPD were low compared to other developed countries. The prevalence of COPD was
about 10 times higher in middle-aged individuals with wheezing compared to those with non-wheezing. And finally, asthma is thought to be a risk factor for COPD.

6.2. Innovative ways to monitor CRDs
The ERS past-president and GARD Greece representative started his presentation by asking the question why chronic non-infectious respiratory diseases should be targeted and went on to answer that they are chronic (and have an impact on life), are very common, have significant morbidity and mortality, and carry an enormous economic burden.

He stated that the aim of his proposal, called HORIZON 2020, is to evaluate, monitor, prevent exacerbations and reduce the economic burden of non-infectious CRDs in Europe by using simple application(s) on a smart-phone. He showed that there are already many applications (apps) and that the Federal Drug Administration has regulated 103 mobile medical applications: examples include an alcohol tester, a non-invasive oximeter and a mobile phone spirometer. He mentioned that the terms of the consortium include an academic computer engineering team, an academic medical team and industry. The application will contain several respiratory health questions and track many biomarkers, including O₂ (oxygen) saturation, heart rate, temperature, peak flow, walking distance and cough frequency. He provided details on how the device will work, with specifics on inputs and system algorithms. He concluded by saying that the smart phone application M-Breathing would improve management of patients with CRDs, reduce health sources utilization and admissions to hospitals and intensive care units, and thus improve morbidity and mortality of CRDs, resulting in significant reduction in the economic burden of CRDs.

6.3. GARD in Latin America: Argentina, Paraguay, Venezuela
The incidence and prevalence of CRDs are increasing around the world. In Latin America (LatAm), the prevalence of asthma, according to the International Study of Asthma and Allergies in Childhood (ISAAC) survey is high and an upward trend has been recorded.

The PLATINO study was conducted in Brazil, Chile, Mexico, Uruguay and Venezuela and provided insight about the prevalence of COPD in LatAm. The highest prevalence was found in Chile and Uruguay (~12%); the lowest was in Mexico (>5%). Patients at stage 3–4 (GOLD) are few (2.5%). A systematic review conducted in 11 centres in LatAm established that the pooled COPD prevalence defined by GOLD criteria was 13.4%; the prevalence increased by age and was 1.75 times higher in men than in women. Of 1000 hospitalizations, 35 were due to COPD and the in-hospital mortality ranged from 6.7 to 29.5. The allergic rhinitis prevalence is high and is the second highest prevalence of this disorder in the world.

Emerging risk factors could be of the cause of CRDs in the region. Allergen exposure, tobacco, obesity, biomass fuel and poverty are attracting the attention of researchers. Poverty is associated with higher exposure to risk factors. The LatAm population is becoming older and it is expected that about 200 million people will be over 60 years old by 2050 and prone to suffer a constellation of NCDs, including CRDs. ICP has to be established with particular emphasis on AIRWAYS-ICPs. Public health authorities in LatAm have to face this problem to assure AHA.

In summary,
- the incidence and prevalence of asthma, COPD and rhinitis is high in LatAm;
- the LatAm population is getting older (~200 million over 60 years old by 2050);
- the ICP approach should be established in the region.

6.4. Initiatives of the Finnish Lung Health Association (FILHA) in Kyrgyzstan and Tajikistan
The representative of FILHA and GARD Finland reported their activities in Central Asia. Background information was given concerning the implemented Finnish National Programmes on Respiratory Disease in Finland (asthma, COPD, sleep apnea, allergy, TB) and a project on healthy ageing for elderly people with respiratory disease. The role of PHC in implementing these programmes was
emphasized and the challenge of sustainability after the implementation of any project or programme was discussed.

The successful programmes led to an extensive PAL (Practical Approach to Lung Health/WHO) intervention in Kyrgyzstan in 2002–2010. According to official statistics, mortality from respiratory disease might have decreased by one third during the implementation period 2004–2010. The effect on TB detection rate was modest, perhaps partly due to local problems of collaboration.

FILHA is implementing a limited PAL project (training of trainers) in Tajikistan. GARD strategies are included in this project. The need to include TB prevention, diagnostics and care at the PHC level is obvious, but challenging. A revision of the PAL strategy for the WHO European Region is planned. An emphasis on TB and TB risk factors and prevention of smoking will be emphasized.

FILHA is implementing a community-based tobacco control project in Kyrgyzstan. Preliminary results are promising. This strategy is also to be used with the Tajikistan PAL project, phase 2.

In summary:
- many strategies for respiratory disease control are emerging – communication and collaboration is important, as is country adaption; operational research is needed and more collaboration with the Tobacco Free Initiative and the FCTC is recommended.
- The role of PHC, nurses, self-management and evidence-based electronic decision support should be increased, especially concerning the issue of healthy ageing;
- affordable equipment and drugs are to be developed and supported in low-income countries and although support from the pharmaceutical industry is needed, it may be controversial.

6.5. GARD surveillance proposal

The representative of the Hospital for Sick Children, Toronto, Canada, and GARD Planning Group member gave a presentation on the Primary Care Asthma Performance Indicator (PC-API). Despite well-established management guidelines, variations in performance of asthma care are common in primary care settings. Quality asthma care leads to better asthma control, improved quality of life and less health-care use. It is, therefore, paramount to measure the quality of asthma care delivered. The Ontario Asthma Surveillance Information System (OASIS) with a panel of 17 experts reviewed published literature (from 1998 to 2008) and used a modified RAND Appropriateness Method to derive 15 evidence-based PC-APIs that covered nine domains: use of spirometry (diagnosis and monitoring); asthma medication use; asthma control; exacerbations; health-care use; asthma action plan; asthma education; smoking cessation; and quality of life. The feasibility of implementing the PC-APIs was tested in five primary care pilot sites in Ontario. Results showed that variations in asthma care existed across participating sites. Combined results can potentially be used as a “benchmark” for the respective indicators. The overall pilot experience suggested that the PC-APIs were easy to use. These validated PC-APIs provide comparable and standardized information about the quality of asthma care across primary care settings and countries. Implementation of these indicators in primary care is feasible and data collected could help establish benchmarks for optimal health service delivery and identify areas for improvement in asthma care. GARD countries and programmes are encouraged to consider using the web-based PC-API to quantify, monitor and evaluate the impact of asthma programmes and quality of care.

7. Session VII: Reports of the GARD Secretariat and planning for the future

7.1 GARD Action Plan 2014–2020, a proposal for discussion

Dr Cruz, GARD Executive Committee member and Chair of the Organizing Committee, presented a draft outline of the GARD Action Plan 2014–2020 for discussion with participants. The outline was

**Essential information on chronic respiratory diseases**

Hundreds of millions of people suffer from these chronic respiratory diseases worldwide: 235 million have asthma; 210 million have COPD; and millions have other chronic respiratory diseases. In 2005, 250 000 people died of asthma and 3 million of COPD. By 2030, COPD is predicted to become the third leading cause of death worldwide. Despite the priority proposed by WHO, approved by the World Health Organization General Assembly and the resolution of the United Nations General Assembly in 2011, the recognition of the problem, the resources mobilized and the current action for prevention and control of chronic respiratory diseases in most low- and middle-income countries are too far from what is needed.

**Countries interested in GARD proposals**

GARD welcomes all countries interested in the approach proposed for prevention and control of chronic respiratory diseases. Since the global launch in 2006, leaders of many countries have expressed an interest in being involved in its development. For the purpose of this planning exercise, a list of 44 participating countries, which was determined on the dual basis of high burden of diseases and willingness to adopt the GARD approach, was prepared.

There are 26 low- and middle-income countries in which GARD has been discussed: Algeria, Argentina, Bangladesh, Brazil, Bulgaria, Cape Verde, China, Costa Rica, Egypt, Georgia, India, Islamic Republic of Iran, Kazakhstan, Kyrgyzstan, Mexico, Morocco, Pakistan, Paraguay, the Philippines, Romania, South Africa, Syria, Tunisia, Turkey, Viet Nam and Zambia.

GARD will also seek to engage a number of high-income countries that have expressed interest in developing the GARD approach; 19 of them have been active in the process: Canada, Czech Republic, Denmark, Finland, France, Greece, Italy, Japan, Lithuania, Netherlands, Norway, Poland, Portugal, the Republic of Korea, the Russian Federation, Spain, the United Arab Emirates, the United Kingdom and the United States of America. These countries may also provide technical and financial support to low- and middle-income countries.

Current projects vary in countries according to country-specific needs and the level of engagement of government health departments, as summarized in a report on GARD country activities published in 2014. These activities demonstrate that the GARD proposed approach is feasible and adaptable to different settings. Furthermore, it does not require major international funding. However, it is clear that the recognition of CRD as a major public health problem and the engagement of the ministries of health are fundamental. WHO leadership and coordination are important to unite national stakeholders towards a common plan. The expected outcome for national plans is the strengthening of existing initiatives for CRDs and the adoption of multisectoral national policies which conform to the WHO Action Plan for the Global Strategy for Prevention and Control of Noncommunicable Diseases 2013–2020.

The purpose of GARD is to promote a comprehensive approach to fight chronic respiratory diseases. Such an approach is described in the publication "Global surveillance, prevention and control of chronic respiratory diseases: a comprehensive approach". In synthesis, the GARD approach consists of building alliances at the country level to assist participating countries, under the leadership of their ministries of health, in obtaining relevant data on the burden of chronic respiratory diseases and their risk factors; advocating for action on chronic respiratory diseases; implementing policies for health promotion and prevention of chronic respiratory diseases; and implementing simple and affordable strategies for management of chronic respiratory diseases.

**Strategic objectives**
In order to achieve its purpose, GARD has set out four strategic objectives. The first two strategic objectives relate to the functions of the GARD, in terms of advocating and raising awareness, providing a network for discussion, enhancing partnerships at global, regional and country levels and resource mobilization for chronic respiratory diseases. The other two are related to the support that GARD provides to WHO technical work.

**GARD core strategic objectives:**

**ADVOCACY**
To raise the priority accorded to the prevention and control of chronic respiratory diseases in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy.

**PARTNERSHIP**
To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of chronic respiratory diseases.

**GARD strategic objectives to support WHO:**

**NATIONAL PLANS**
To strengthen and orient health systems to address the prevention and control of chronic respiratory diseases through people-centred integrated primary health care (PHC) and universal health coverage.

**SURVEILLANCE AND RESEARCH**
To monitor the trends and determinants of chronic respiratory diseases and evaluate progress in their prevention and control.

In addition, GARD shall also:
- promote interventions to reduce the main shared modifiable risk factors for noncommunicable diseases, in particular, tobacco, outdoor and indoor air pollution, unhealthy diet and physical inactivity;
- contribute to the identification of gaps in knowledge and gaps in knowledge implementation, as well as priorities for research on chronic respiratory diseases relevant to its goal, and advocate for funding for research on these topics;
- harmonize plans and activities against chronic respiratory diseases with WHO workplans for cardiovascular diseases, cancer and diabetes, with a focus on primary care and the prevention of the common risk factors;
- collaborate with WHO initiatives in the fields of: Health Action in Crisis; Health Security and Environment; HIV/AIDS, Tuberculosis and Malaria; Neglected Tropical Diseases; Information, Evidence and Research; Family and Community Health; Health Systems and Services;
- collaborate with the United Nations system in areas related to its work – e.g. United Nations Environment Programme (UNEP) and the United Nations Children’s Fund (UNICEF).

**Strategy to action**

For each strategic objective, the expected outputs, indicators, milestones and core activities are set out.

**ADVOCACY (Strategic Objective 1)**
Activities:
- foster country networks with the aim of pursuing GARD objectives at the country level;
- identify potential partners, including the MoH and WHO country offices; organize exploratory workshops; propose a GARD country coordinator, subject to endorsement of the MoH;
mobilize organizations, patients, families and communities; support events; identify champions; and advocate for CRD on the health and development agenda;
• develop communication messages and advocacy materials (newsletters, flyers, posters) and a website;
• develop or edit WHO–GARD normative documents on asthma and COPD;
• define terms of reference and structure.

PARTNERSHIPS (Strategic Objective 2)
Activities:
• strengthen GARD global network to support objectives at the country level;
• mobilize major national and international organizations interested in CRD to apply for GARD membership to contribute with financial and human resources and to attend GARD annual general meetings;
• keep current GARD participants (member organizations) active.

NATIONAL PLANS (Strategic Objective 3)
Activities:
• support the development, revision or adaptation of current best evidence-based government approved guidelines for integrated management of NCD, including CRDs in primary health care (PHC);
• coordinate efforts of GARD Country leaders, GARD participants and GARD advisers to support WHO assistance to the MoH.

SURVEILLANCE AND RESEARCH (Strategic Objective 4)
Activities:
• support countries in the development and implementation of NCD surveillance and monitoring, including CRD for the global NCD targets and promote public health priority research in CRD;
• to create an inventory of studies on prevalence and severity of CRD and to implement the GARD framework for evaluation using an electronic information system developed to generate standard reports on essential indicators.

In finalizing the presentation, it was proposed that further development of the Action Plan outlined herein requires approval of GARD governance bodies and support of WHO and shall include estimates of cost and likely sources of financial aid.

7.2. Scaling up GARD country activities
The GARD Vice-Chair stated that scaling up is often considered as a continuous process of change and adaptation that can take different forms. The 5-step framework of EIP on the AHA scaling-up strategy is shown in Table 2.

<table>
<thead>
<tr>
<th>Step</th>
<th>Scaling-up strategy</th>
<th>Individual scaling-up strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>What to scale up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Database of good practices</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Assessment of viability of good scaling-up practices</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Classification of good practices for replication locally</td>
<td></td>
</tr>
<tr>
<td>How to scale up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Facilitating partnership for scaling up</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Planning and initiating the service</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Scaling-up strategy: 5-step framework
The Vice-Chair stressed that GARD’s greatest achievement is its ability to forge collaborative partnerships and develop a shared vision with a large number of parties. Lessons that had been learnt from the country activities were listed in the GARD country report with suggestions for scaling up GARD country activities that include the following components:

- identify a leader to become GARD initiator;
- persuade health authorities at all levels (country, provincial and municipal) to plan and implement a CRD programme in collaboration with local stakeholders;
- include all stakeholders;
- willingness of the MoH to join a national partnership and the nomination of a focal point and GARD country coordinator is important;
- support of WHO, including the WHO country offices;
- development of a working group to plan on the terms of reference of the initiative, while conducting a situation analysis to identify the needs;
- development and implementation of an action plan to support the GARD Action Plan.

7.3. Raising funds for the implementation of the GARD Action Plan and status of collaborating parties, new applicants and report on financial status

The GARD Chair presented a summary of GARD income and expenses in the period January 2009–July 2014. The total income for this period was US$ 1 435,794. WHO assessed and voluntary contributions have been the major part of the income, followed by GARD participants and GARD observers. Expenses totalled US$ 1 608,820 for the above mentioned period, with staff being the majority of expenses.

With regard to the status of GARD collaborating parties, there are currently 90 entities, which comprise more than 1.5 million health professionals. A few organizations are no longer GARD members: American College of Allergy, Asthma and Immunology (ACAAI); World Allergy Organization (WAO); and World Organization of Family Doctors (WONCA). By contrast, GARD received the following new applications:

- Argentinean Association of Allergy and Clinical Immunology (AAAelC); Jorge Quel, HAAMA.
- Chest Research Foundation for research on COPD in non-smokers; Dr Sundeep Salvi, Puna, India.
- Department of Internal Medicine, University Teaching Hospital, Lusaka, Zambia; Dr Shabir Lakhi.
- Use-inhalers, London, United Kingdom; Dr Fiona Shetty.

The GARD Chair mentioned that there are currently 30 active GARD countries and explained that there are nine categories of members, according to the current bylaws, including world NGOs, regional NGOs, national NGOs, foundations, international groups of experts, patient associations, international research networks, WHO collaborating centres and government organizations. A total of 13 major pharmaceutical companies in the area of chronic diseases and allergy are authorized by the WHO Legal Office to donate funds to WHO GARD activities. The presenter highlighted that GSK, Chiesi, and Novartis remain active GARD partners.

The GARD Chair made the following recommendations to make GARD attractive to partners:

- strengthen GARD coordination from WHO (recruitment of WHO staff for CRD/GARD);
- extend GARD country-focused activities using existing experience;
- promote GARD-initiated collaborative projects;
- consider the development of WHO GARD normative documents;
- development of GARD monitoring and assessment mechanism.
Finally, he presented the WHO GARD co-brand website and concluded by saying: “In many ways, we are the heirs of the choices that were made by previous generations: politicians, business leaders, financiers and ordinary people. Future generations will in turn be affected by the decisions that we make today. Each of us has a choice: whether to continue with the status quo, or to take up the challenge and invest now in chronic disease prevention. Without action, an estimated 388 million people will die from chronic diseases in the next 10 years. Likewise, countries will forego billions in national income. With increased investment in chronic disease prevention, it will be possible to prevent 36 million premature deaths in the next 10 years. Averted deaths would in turn translate into substantial economic gains. The knowledge of how to prevent these diseases is available now. The way forward is clear. It’s our turn to take action!”

8. Session VIII: Closing Session

8.1. Meeting conclusions and proposals for the next general meeting (2015), including location and date

The GARD Chair thanked all attendees for their participation. He mentioned that there were plenty of plans for the future and that he would do his best to persuade high-ranking leadership at WHO to support GARD.

There were several proposals for locations to host future GARD meetings. The first was for Lisbon – this venue was proposed three years ago. The GARD Chair reported that the MoH of Portugal was ready to support the meeting.

The GARD Portugal representative explained that after meetings in Asia and Latin America, it would be good to return to Europe. In addition, GARD Portugal has a very good relationship with the MoH as it was recognized as an institution that works effectively with WHO. In addition, because of its location, Portugal is a platform for Africa, Europe and Latin America, and could make it easier for countries in those regions to attend. He also intended to use the meeting to produce documents that would be important for the future of GARD. He mentioned that in the beginning, GARD had a strong support structure. Currently, there are difficulties with infrastructure. He concluded that Portugal needed financial support from donors to sponsor a successful meeting. A final decision will be made at the end of October 2014.
Annex 1.
PROVISIONAL PROGRAMME

Friday, 15 August 2014 - GARD General Meeting 2014 (GARD Assembly)

Session I: Opening

14h00-14h10 Welcome speech
Alvaro Cruz, Chair of the National Organising Committee

14h10-14h30 Update on GARD global activities, purpose and expectations for the 9th General Meeting
Niels Brøndsted, Chair of GARD

14h30-14h40 Welcome address of the World Health Organization (WHO), nomination of chairperson and rapporteur
Olga Chasnov, WHO Assistant Director General for Noncommunicable Diseases and Mental Health

14h40-14h50 Introductory remarks
Joaquim Molina, WHO Liaison Office, Brazil

14h50-15h00 Address to the GARD General Meeting
Patricia Change, Coordinator of Care for People with Chronic Diseases, Brazilian Ministry of Health

15h00-15h20 WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020
Olga Chasnov, WHO Assistant Director General for Noncommunicable Diseases and Mental Health

Coffee break

Session II: Accelerating country response for the prevention and control of NCD

Moderators: Nicolas Similä, European Respiratory Society Past President, GARD Co-Founder and Mónica Caldeira, European Academy of Allergy and Clinical Immunology

15h40-15h50 Working with the Ministry of Health to combat chronic respiratory diseases
Giovanna Viani, Director, Institute of Biomedicine and Molecular Immunology of Italy, GARD Italy
Friday, 15 August 2014 – GARD General Meeting 2014 (continued)

Session II: Accelerating country response for the prevention and control of NCD (continued)

15h50-16h00  Collaboration between GARD Portugal and the Ministry of Health to tackle chronic respiratory diseases
José Rosado, GARD Portugal Coordinator, GARD Planning Group Member

16h00-16h10  Leading a countrywide partnership for the prevention and control of chronic diseases
Edum Gamractoglu, Turkish Thoracic Society and GARD Turkey

16h10-16h20  Advocacy for recognition of CRD and major allergic disease
Peter Knox, GARD Poland Coordinator, GARD Planning Group Member

16h20-16h40  European Innovation Partnership on Active and Healthy Ageing - Integrated Care Pathways for Airway Diseases (AIRWAYS-ICPs)
Jean Bouquet, GARD Past-Chair

16h40-17h00  Discussion

Session III: Reducing modifiable risk factors for NCD

Moderators: James Kiley, Director of the Division of Lung Diseases, National Heart, Lung, and Blood Institute of the National Institutes of Health, USA and Alberto Caliari, Associate Professor of University of São Paulo, Brazil

17h10-17h20  Promoting air quality to protect the health of people
Jean Carlos Salas, GARD Paraguay Coordinator

17h20-17h30  Prevalence, incidence, and governmental policy with regard to CRD and smoking
Marian Maglalaitia, Georgian Respiratory Association and GARD Georgia

17h30-17h40  GARD and NCD control in Kyrgyzstan: achievements and prospects
Talant Sooronbaev, GARD Kyrgyzstan Coordinator, GARD Planning Group Member

17h40-17h50  Initiatives of the Romanian Society of Pulmonology in 2013
Florin Mihalas, GARD Romania

17h50-18h10  Discussion

19h30 – Departure for special dinner outside Hotel Desilla Salvador
Saturday, 16 August 2014 – GARD General Meeting 2014 (GARD Assembly)

**Session IV:** Strengthening and orienting health systems to address the prevention and control of NCD
Moderator: Jorge Que, Chair of Hispanic Asthma and Allergy Medical Association and Anna Yorganski, GARD Vice-Chair

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<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Details</th>
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<tbody>
<tr>
<td>08h30-08h40</td>
<td>Building Capacity of PHC work force for CRD in low resource settings</td>
<td>Eric Bembono, GARD South Africa</td>
</tr>
<tr>
<td>08h40-08h50</td>
<td>Contribution of GARD Brazil to primary care in the public health system</td>
<td>Paulo Camargos, GARD Brasil Coordinator</td>
</tr>
<tr>
<td>08h50-09h00</td>
<td>Providing reference centres to strengthen primary care in fighting CRD</td>
<td>Lan Le Thi Tuyet, GARD Vietnam Coordinator</td>
</tr>
<tr>
<td>09h00-09h10</td>
<td>Supporting the public health system for the management of CRD</td>
<td>Reza Bannoo, GARD Bangladesh Coordinator</td>
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<tr>
<td>09h10-09h30</td>
<td>Discussion</td>
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**Session V:** Strengthening and orienting health systems to address the prevention and control of NCD
Moderators: José Rosado Pinto, GARD Portugal Coordinator and Sandra Gonzales Dias, Latin American Asthma and Allergy Society

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<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>09h30-09h40</td>
<td>GARD activities supported by the Société de Pneumologie de Langue Française and Espace Francophone de Pneumologie</td>
<td>Bernard Pigeonais, Société de Pneumologie de Langue Française</td>
</tr>
<tr>
<td>09h40-09h50</td>
<td>How GARD Syria has initiated national guidelines for NCD and comorbidities</td>
<td>Youssef Mohammed, GARD Syria Coordinator, Director WHO Collaborating Centre</td>
</tr>
<tr>
<td>09h50-10h00</td>
<td>Coaching primary care practitioners for best practice in asthma</td>
<td>Kristine Whorton, CEO of National Asthma Council, Australia</td>
</tr>
<tr>
<td>10h00-10h10</td>
<td>OARD Lithuanian collaboration with the European Academy of Pediatrics with special focus on prevention and control of CRD in primary care</td>
<td>Aivaras Vailvils, GARD Lithuanian Coordinator</td>
</tr>
<tr>
<td>10h10-10h20</td>
<td>GARD Iran Report</td>
<td>M. Reza Moghad, GARD Iran Coordinator, GARD Planning Group</td>
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<tr>
<td>10h20-10h30</td>
<td>Discussion</td>
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Coffee break
Saturday, 16 August 2014 – GARD General Meeting 2014 (continued)

Session VI: To monitor the trends and determinants of NCD
Moderator: Nikolai Khatutsev, GARD Chair and Paulo Camargo, GARD Brazil Coordinator

10h30-11h00 Surveillance of CRD in the Russian Federation with GARD assistance
Alexander Chuchalin, GARD Russia Coordinator, GARD Executive Committee Member

11h00-11h30 Surveillance of CRD in Mongolia, Cambodia and Laos
Hrmoni Sagara, Director WHO Collaborating Center, Japan, GARD Planning Group Member

11h30-11h50 Innovative ways to monitor chronic respiratory diseases
Nikolaos Sifakis, European Respiratory Society Past President, GARD Greece

11h30-11h35 GARD in Latin America: Argentina, Paraguay, Venezuela
Carlos Basena-Capurro, INTERASMA President, GARD Argentina, GARD Planning Group

11h30-11h40 Initiatives of the Finnish Lung Health Association (FilHs) in Kyrgyzstan and Tajikistan
Arold Ilberg, FILHA, GARD Finland

11h40-11h50 GARD surveillance proposal
Teresa To, Hospital for Sick Kids, Toronto, Canada, GARD Planning Group

11h50-12h10 Discussion

Lunch break

Session VII: Report of the GARD secretariat and planning for the future
Moderator: Nikolai Khatutsev, GARD Chair and Peter Kune, GARD Planning Group

14h00-14h20 GARD Action Plan 2014-2020, a proposal for discussion
Alberto Cruz, GARD Executive Committee

14h20-14h40 Scaling up GARD country activities
Arzu Topargioglu, GARD Pros-Chair

14h40-15h00 Raising funds for the implementation of the GARD action plan
Nikolai Khatutsev, GARD Chair

15h00-15h20 Status of collaborating parties, new applications and report on financial status
Nikolai Khatutsev, GARD Chair

15h20-15h40 Discussion

Coffee break
Saturday, 16 August 2014 – GARD General Meeting 2014 (continued)

Session VIII: Closing Session
Moderators: Oleg Chestnov, Assistant-Director General for NCD, WHO and Alvaro Cruz, GARD Executive Committee

16h30-16h40 Recommendations for the Future of GARD
Oleg Chestnov, Assistant-Director General for NCD, WHO

16h40-16h45 Meeting conclusions and proposals for the next general meeting (2015), including location and date
Miodal Khaltiev, GARD Chair

16h45-17h00 Discussion

17h00 Meeting closing remarks
Oleg Chestnov, Assistant-Director General for NCD, WHO

Meeting Closes
Annex 2.
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