

# GLOBAL ALLIANCE AGAINST CHRONIC RESPIRATORY DISEASES (GARD)

5<sup>th</sup> General Meeting,  
1 - 2 June 2010, Toronto, Canada



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## Abbreviations

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ACOCU	Asthma and COPD Outpatient Care Unit
AIDS	acquired immunodeficiency syndrome
BLF	Bangladesh Lung Foundation
COPD	chronic obstructive pulmonary disease
CRD	chronic respiratory disease
EPSCO	Employment, Social Policy, Health and Consumer Affairs Council
EU	European Union
GARD	Global Alliance against Chronic Respiratory Diseases
GARP	Global Alliance of Respiratory Patients
HAAMA	Hispanic-American Allergy, Asthma and Immunology Association
HIV	human immunodeficiency virus
ICC	International COPD Coalition
LAN	Lung Alliance Netherlands
MDG	Millennium Development Goal
NCD	noncommunicable disease
NCD Action Plan	WHO 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases
NCDnet	Global Noncommunicable Disease Network
NGO	nongovernmental organization
PAHO	Pan American Health Organization

PAL	Practical Approach to Lung Health
PHAC	Public Health Agency of Canada
TB	tuberculosis
UN	United Nations
USA	United States of America
WHO	World Health Organization
WHO PEN	WHO Package of Essential NCD Interventions
WR	WHO representative

## Opening session

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### Welcome and introduction to the 2010 GARD General Meeting; Update on GARD

The Public Health Agency of Canada (PHAC) and the organizing committee welcomed participants to the 5th General Meeting of the Global Alliance against Chronic Respiratory Diseases (GARD).

It was reported that in April 2009 the Canadian government announced a federal investment of US\$ 10 million for the establishment of the federal Lung Health Program to address gaps identified by the National Lung Health Framework steering committee, which completed its work in 2008. Funds will be allocated between 2009 and 2012 to PHAC and the First Nations and Inuit Health Branch of Health Canada. Thirteen pilot projects were recently approved, and information about them can be found at [www.lunghealthframework.ca](http://www.lunghealthframework.ca).

It was stressed that chronic respiratory diseases (CRDs) are firmly on the political and health-care agendas of the WHO 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases (NCD Action Plan), and that GARD should be in line with this plan. Collaborative health programmes in Brazil have not only proven cost effective, but also have improved their local economies, which is a key goal of the plan. Country initiatives in the Islamic Republic of Iran and other countries have proven to be powerful and important as well. Since CRDs are noncommunicable, all actions outlined in the plan should be undertaken.

Ten years ago, the Millennium Development Goals (MDGs) focused on maternal and perinatal conditions such as HIV/AIDS, tuberculosis (TB), malaria and other infectious diseases. However, there was a big gap: approximately half of disability-adjusted life years were incurred by chronic disease, making chronic disease the most important by far, Dr Bousquet stated.

In the next decade, the push will be to prioritize noncommunicable diseases (NCDs), to place primary health care at the cornerstone of management and to integrate patient management in a cost-effective manner.

On 14 May 2010, the United Nations (UN) General Assembly adopted a resolution on the prevention and control of NCDs, and it has called for a September 2011 meeting that will include heads of state and government. The MDGs will be discussed in relation to the rising incidence of NCDs and their socioeconomic impacts.

### Aligning the GARD Work Plan with the WHO 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases (NCD Action Plan)

#### Priorities of GARD work for 2010 to support the NCD Action Plan

In the past, NCDs were considered too big to take notice of, but with the May 2010 adoption of the UN General Assembly resolution to prevent and control NCDs, things are changing. The WHO Framework Convention on Tobacco Control, the Global Strategy on Diet, Physical Activity and Health and, more recently, the Global Strategy to Reduce the Harmful Use of Alcohol address all four main behavioural risk factors for NCDs.

The six objectives of the NCD Action Plan are:

#### 1. Raise the priority accorded to NCDs

A rapid sequence of events led to the 2010 resolution by the UN General Assembly to prevent and control NCDs. During the May 2009 meeting in Doha hosted by the Government of Qatar, ministers called for the integration of evidence-based indicators on NCDs and injuries with the core MDGs monitoring and evaluation system during the 2010 review of the MDGs. The ministers also called for raising the priority accorded to NCDs and injury prevention on the agendas of high-level forums. Finally, they called for a

review of international experience in the prevention and control of NCDs and injuries in low- and middle-income countries, including community-based programmes, and the identification and dissemination of successful approaches for intersectoral action.

The UN resolution was tabled on behalf of the Caribbean Community member states. It passed unanimously with support from 130 cosponsors, including Africa. The resolution calls for four measures:

- a General Assembly meeting involving heads of state to address prevention and control of NCDs, to take place in September 2011;
- continued consultations throughout 2010 to discuss what the General Assembly will do in 2011 concerning NCDs;
- consideration of NCDs to be included in the MDG review in September 2010;
- the Secretary-General to submit a report to the General Assembly on the global status of NCDs, with a focus on developmental challenges faced by developing countries.

## 2. Establish and strengthen national NCD policies and programmes

Many prominent global health initiatives have focused on packages for prevention and care that agencies can buy into, such as the WHO Package of Essential NCD Interventions (WHO PEN). This applies to development agencies and individual countries that are developing national programmes. An effort is under way to define the best buys and adapt the contents to the needs of countries. WHO PEN offers a core set of evidence-based interventions that can be implemented in primary care in low-resource settings.

## 3. Reduce and prevent NCD risk factors

Activities targeting tobacco control in GARD initiatives are in accordance with the NCD Action Plan. There is an evidence-based package that addresses six

interventions: Monitoring, Protection, Offer help, Warn against dangers, Enforce legislation, Raise taxes (MPOWER).

The Bill & Melinda Gates Foundation is investing in a hub to prevent the increase in tobacco use in Africa. The World Health Organization (WHO) has launched a pioneering initiative on gender, women and the tobacco epidemic that takes an epidemiological and human rights approach. Collaboration between TB control programmes and tobacco-free initiatives is growing. An analysis of the TB programme ascertained that among the 22 highest-burden countries for TB, the population-attributable fraction of TB from tobacco is 23%–25%. This is much higher than the 7% population-attributable fraction from the highly publicized HIV/AIDS epidemic.

#### 4. Promote NCD research

These activities are currently under consultation, and by the autumn of 2010 there will be a prioritized research agenda for NCD prevention and control.

#### 5. Promote partnerships

The Global Noncommunicable Disease Network (NCDnet) is a new network to combat NCDs in developing countries. Its goals are to raise awareness through advocacy, increase resource availability and catalyse country-level implementation.

#### 6. Surveillance, monitoring, and evaluation

The 193 Member States of WHO have been surveyed and analysed. The data collected will lead to the first Global Status Report on NCDs, for release in early 2011. The report will be presented at the UN General Assembly in September 2011.

The general partnership principles of WHO as they apply to GARD and other partners are described as follows:

- GARD is a WHO alliance. It is a voluntary alliance and not a legal entity. It cannot undertake any action in its own name. The legal identity of GARD emanates from WHO.

- WHO retains the right of veto on all decisions made by any of the governance components of GARD.
- WHO provides technical leadership and Secretariat functions. WHO rules, regulations and administrative procedures apply to all GARD documents, reports and information products bearing the GARD name.
- All GARD communications and media products are subject to WHO review and approval to ensure compliance with WHO policies in relation to communications and branding.
- Given GARD's lack of legal identity, all GARD publications bear the WHO copyright and are therefore subject to the relevant internal WHO reviews, clearances and applicable timelines.
- It is important to stress that GARD does not engage in normative work, which is exclusively the role of WHO pursuant to its global public health mandate.
- In view of the legal status of GARD, all GARD projects and activities are de facto WHO projects and activities and are therefore subject to WHO review and approval in line with WHO priorities and work plans. In this regard, GARD is an important tool in advocating for the implementation of WHO-approved guidelines and work plans.
- All GARD activities should be in compliance with an integrated approach to NCDs and not focus on one disease only (e.g. allergic rhinitis). While WHO advocates for integrated national NCD policies and plans to ministries of health in low- and middle-income countries, GARD advocates for national plans on respiratory diseases, which is confusing to ministries of health in low- and middle-income countries.
- GARD activities and efforts should focus on (i) WHO priorities, such as primary care in low- and middle-income countries; (ii) prioritized NCDs, such as asthma and chronic obstructive pulmonary disease (COPD); and (iii) access to equitable care.

- GARD was set up to advocate for and facilitate the work of WHO in the area of respiratory health and in line with the NCD Action Plan. In this regard, the NCD Action Plan is central to the work of GARD and is the basis upon which all GARD activities are developed and undertaken.
- GARD is not an implementer of country projects. In this respect, all GARD activities at the country level should be coordinated through WHO, with the appropriate WHO representatives (WRs) and regional offices, to ensure appropriate visibility and alignment with regional and country-level work plans. Countries and stakeholders see GARD as part of WHO, and any messaging apart from this leads to confusion and reputational problems for GARD and for WHO.
- WHO determines the pace of its work with respect to its activities and is solely accountable to its Member States through its governing bodies.
- GARD was set up specifically to facilitate the work of WHO, and not for any other reason. This is the case with all partnerships, alliances and networks, whose added value is to facilitate and advocate for the implementation of WHO work plans as approved by Member States. The WHO partnerships policy clearly states the criteria that, first and foremost, alliances and other forms of collaborative arrangements must benefit global public health, be in synergy with WHO and not duplicate WHO efforts.

### *Discussion*

The discussion stressed the following points:

- the NCD programme in WHO should be adequately resourced to match the NCD burden;
- WHO should receive more funds both in assessed and voluntary contributions from Member States and other sources;

- adequate personnel staffing within WHO is needed to take on increased responsibility and control of GARD;
- keep the identity of respiratory diseases at the tertiary care level, while integrating with NCDs in primary care;
- develop strong public–private partnerships with an independent WHO that provides direction;
- present a united front at the UN General Assembly.

## GARD country initiatives

### *Turkey*

GARD Turkey has more than 50 collaborating partners. Short-, medium- and long-term activities have been established within its six working groups. The working groups report to the Executive Committee, which meets once per year. The activities of GARD Turkey include:

- The Ministry of Health has been restructured and its action plan for 2010–2014 has been prepared. Public institutions, universities and nongovernmental organizations (NGOs) participated in the action plan. Sharing official information has motivated the groups.
- A questionnaire for COPD and asthma public awareness has been developed. Awareness and advocacy materials have been prepared, and integration with other advocacy plans is under way.
- Efforts are being made to reduce the modifiable risk factors for NCDs, such as tobacco and obesity.
- An expert panel drawn from a variety of national groups and programmes has prepared a report on the evaluation of indoor and outdoor pollution with respect to climate change.
- A workshop for education in primary care settings is being planned.

Educators will focus on asthma, COPD, home care, pulmonary rehabilitation and tobacco control guidelines.

- Regarding the effective treatment of disease and the prevention of complications, a home-care workshop is being planned, along with integration with other NCD home-care and rehabilitation programmes. Reimbursement of the items for pulmonary rehabilitation and home care are being discussed.
- The monitoring group is trying to renovate the recording system and plan a new data collection system throughout the country.
- A manuscript detailing the accomplishments of GARD Turkey has been published and is available on MEDLINE.

### *Italy*

GARD Italy is an alliance between the Ministry of Health and several organizations. It is recognized at the international level among institutions, scientific societies and patient associations as an organization that shares opinions, recognizes problems and promotes solutions.

GARD Italy has five working groups. The groups report to the Executive Committee, which meets once per year.

The activities of GARD Italy include:

- A prevention programme to address the indoor risks for respiratory and allergic diseases targets schools that aims to: (i) revise context analyses; (ii) define guidelines; (iii) plan information and health education campaigns for students, families and school staff; and (iv) prevent and manage serious allergic reactions during school time.
- A project to address smoking and the indoor environment that aims to: (i) revise context analyses; (ii) define guidelines to improve indoor air quality according to the projects about allergies prevention in schools; and (iii) plan information and health education campaigns to support the action against

smoking behaviour.

- A project to predict the beginning of respiratory diseases according to appropriate criteria and characteristics.
- A project to implement early diagnosis of lung diseases.
- A project to address welfare continuity by improving the protection of respiratory disease patients through identification of integrated management models among services.

The working groups are expected to complete their projects within two years, with the Executive Committee evaluating them along the way.

GARD Italy could help the Ministry of Health to set the standards. Scientific societies, such as the Italian Scientific Interdisciplinary Association for Research in Respiratory Medicine, can help by creating a network of respiratory units and by putting ministry recommendations into practice. This is in fact being done, and results are expected in a few years.

#### *Islamic Republic of Iran*

The GARD Iran committee, which meets every two months, includes participants from the Ministry of Health and resource management groups.

The activities of GARD Iran include:

- A GARD package for presentations and introductory brochures for collaborators have been prepared.
- Negotiations are ongoing with the government to define a specific ratio of tobacco tax.
- Collaboration with the Ministry of Health, municipalities and research centres aims to establish research and service centres in the municipalities, especially in Tehran. People know about heart attack, stroke and cancer, but they know little about COPD, emphysema and bronchitis.
- GARD Iran succeeded in its effort to get the national tax increased from

10% to 20% on locally produced tobacco and from 20% to 40% on imported tobacco. It hopes to secure some of the tax funds to support GARD activities.

- Advocacy activities are focused on preparing an asthma registry, assessing the burden of CRDs and conducting clinical and epidemiological studies on asthma and other CRDs.
- National asthma guidelines are being integrated into the public health-care system. A pilot study on asthma integration is in progress in three provinces with different environments. National COPD guidelines are also being prepared.
- Provision and supply of essential anti-asthma drugs at the national level is a priority, along with supplying home oxygenators for patients with advanced COPD. Rehabilitation programmes are being set up at medical centres around the country. With ministry support, it is hoped that all rural and urban health centres will have peak flow meters.
- There are future plans to (i) establish a COPD and asthma surveillance system; (ii) continue providing epidemiological information about CRDs; (iii) introduce GARD to various congresses and societies; (iv) set up scientific working groups for each CRD; (v) prepare guidelines for other CRDs; and (vi) design a medical–social supportive system for patients.

### *North Africa*

French-speaking nations comprise 200 million people in 55 nations. They include the high-income countries of Europe and Canada, the middle-income countries of North Africa and the low-income countries of sub-Saharan Africa and South-East Asia.

GARD began in North Africa five years ago and is now in the action phase. The first action was the implementation of the Practical Approach to Lung Health (PAL). The second was the ASTHMA Insights and Reality in the Maghreb (AIRMAG) study published in *Respiratory Medicine* in December 2009. The study showed that the prevalence of asthma in the North African countries of

Algeria, Morocco and Tunisia is 3.8% and that fewer than 20% of the cases are controlled. The third action will be the COPD project, set to begin in September 2010, to assess the prevalence of COPD in North Africa.

In the low-income, sub-Saharan area of Africa, an epidemiological project and a training project are getting started. Potential obstacles include organizational failure, insufficient staff, insufficient and inadequately distributed medical equipment, and lack of epidemiological data.

The project aims to create a working plan for the management of respiratory diseases in sub-Saharan Africa. This will involve: (i) collecting epidemiological data; (ii) training physicians, nurses and technical staff; (iii) structuring patients' management and epidemiological networks; and (iv) strengthening national institutions. The following countries and actions are targeted:

- Benin: COPD and asthma;
- Burkina Faso: training and strengthening of primary health care;
- Côte d'Ivoire: HIV and TB;
- Guinea: epidemiological studies;
- Mali: smoking prevention and lung cancer.

If results are positive in these countries, feasibility projects will be extended to other countries. The thoracic forum of French-speaking countries was scheduled at a high-level meeting in Nice, France, in July 2010.

### *Pakistan*

Launching the GARD initiative in a low- or middle-income country can be challenging. Previous WHO-funded projects in Pakistan have been funded vertically and have garnered government and societal interest. However, because GARD is not funded, local WHO offices have not been supportive of it. Moreover, lack of secretarial support has led to administrative issues.

One of GARD Pakistan's accomplishments is the joint national task force for asthma and allergy, established by the Ministry of Environment and the

Ministry of Health. A focal point for GARD within the Ministry of Health has been nominated to the task force, as well as a GARD national coordinator. An affiliation with the National Anti-Tobacco Alliance in Pakistan has been created and has been very successful.

The International Study of Asthma and Allergies in Childhood (ISAAC) has provided baseline prevalence of asthma and rhinitis in Pakistan. While the prevalence of COPD is not known, tobacco use in Pakistan is known to be among the highest in the world.

GARD Pakistan members have learned that political and bureaucratic support is essential for conducting activities at the national level. Nongovernmental programmes are quicker and better administered and provide faster and more reliable results, but they are limited in magnitude and cost.

In Pakistan, it is extremely difficult to convince planners about a health issue unless there are sufficient data or a financial programme backing it up. Nearly 10% of the 170 million people living in Pakistan suffer from asthma, and there are no financial plans in place to deal with it.

Low-income countries have a greater burden of disease than richer countries, and this is magnified by illiteracy, denial, lack of awareness and non-affordability of therapies. In addition, multinational companies make it difficult for Pakistan to import low-cost inhalers. Awareness in the medical community and among health planners and administrators is paramount to implement successful interventions.

Strategies for monitoring and evaluation are being developed. It was noted that while Bangladesh is a phenomenal success story and there has been some success in launching GARD in Sri Lanka, there has been less accomplishment in the United Arab Emirates.

It was noted that in addition to classifying countries as low-, medium- or high-income, they should be classified according to how their systems are organized, as this might be an important consideration in influencing systems.

The suggestion was made to see whether it would be possible for the GARD community to draft a declaration or motion to promote an increase in cigarette cost in every country, with funds going to the Ministry of Health of each country and to WHO. It was pointed out that the WHO NCD Action Plan exists, and that WHO has contacted all the WRs. It was further noted that the problem also exists in the United States of America (USA), where people use their connections with politicians to push health agendas. In order to succeed at the national level, it is important to include GARD in the NCD Action Plan, which is happening in Syria. It might help to have a message from WHO stating that countries should include GARD in NCD strategies at regional or local levels.

GARD should undertake these issues to support Pakistan with adequate secretarial resources. It might be important to develop public–private partnerships not only within WHO, but also with other entities, as well as to develop a precise global plan with clear packages.

GARD is an alliance, not a programme. As such, it has no budget or strategic objectives. WRs are not required to coordinate with GARD, but there is nothing to stop it from entering into mutual advocacy, such as the Country Cooperation Strategy. Communication from WHO headquarters to directors of programme management and also communication with regional committees would be helpful, because that is where the key players are. A WHO presence at regional committee meetings could provide a push, which is something to explore.

### *Kyrgyzstan*

Kyrgyzstan's mountainous geography contributes to the country's high mortality rate for chronic lung diseases—the highest among Asian countries—especially for those living in high-altitude regions. One in 10 adults, or approximately 200 000 people, require a metered-dose inhaler for COPD and bronchial asthma. Risk factors include high rates of heavy smoking and widespread use of biomass for indoor heating and cooking.

The goal of the CRD Prevention and Control Program 2010–2015 is to reduce the socioeconomic burden of CRD by reducing its mortality and morbidity rates, while paying special attention to people living in high-altitude regions. Gathering information about spirometer use and creating a CRD registry will be the first steps in gaining a better idea about the size and nature of the epidemic. Next, patients and medical professionals will be educated about preventive measures, including smoking cessation programmes.

Changes will be made to the diagnostic strategy to improve early detection of CRD, and home-care service will be improved as a way to provide accessible and affordable health care to all patients, particularly those in remote areas. Continuous advanced training will be given to doctors on the diagnosis and treatment of CRD. With the support of the health-care ministry, a strategy that combines PAL with a disease-specific approach will address issues related to the prevention and control of CRD. Twelve organizations have been enlisted as partners to promote this effort, including the Kyrgyz Thoracic Society and the Kyrgyz-Finnish Lung Health Project 2007–2010.

Based on the predominantly high-altitude terrain and economic factors, some participants likened Kyrgyzstan's effort to that being carried out in Brazil. It was mentioned that despite similar problems in Brazil in the beginning, they succeeded in joining together to find resources. Solid mechanisms have been put into place to buy drugs at very low prices. Initially, only public resources were available to fund the first project. It was suggested that the Kyrgyzstan project could learn from Brazil's experience with integrating GARD and PAL in a low-income area. The Brazilian Ministry of Health CRD manual for primary care workers and family doctors was also mentioned as an effective tool.

Interest was expressed from the research project on respiratory diseases and indoor pollution in high-altitude locations conducted in Italy. The study is looking for partners and would be interested in getting involved in the projects described by Kyrgyzstan and Brazil.

### *Viet Nam*

Viet Nam is a small country with a large population, of which 61% are smokers. To reduce the morbidity rates of CRD, an Asthma and COPD Outpatient Care Unit (ACOCU) has been established at the University Medical Center in Ho Chi Minh City to increase community awareness about CRD, organize workshops on the management of asthma and COPD, and conduct research in the respiratory field.

The most important improvements have been in the diagnosis of CRD and storing patient data in hard copy and on a computer database. Events such as an Asthma and COPD Day have been organized to garner media attention, radio broadcasts have been used to educate the public and almost 1000 medical professionals have attended workshops on management of asthma and COPD. So far, 26 research studies have been conducted, the results of which help staff at ACOCU improve their understanding and treatment of CRD. Moving ahead, the plan is to expand the ACOCU programme into the 39 regions of the country that are currently without such a facility and eventually to upgrade these facilities to NCD care units.

Participants praised the research project for its attention to issues of surveillance and asked how the problem of expensive medication is being managed. It was noted that the medication is always a problem. Many of the poor in Ho Chi Min City cannot afford prescriptions. Every effort is made to provide insurance to cover everyone. It is possible to obtain financial support at the provincial and district levels, but not at the community level. It is hoped that an asthma foundation will help find cheaper asthma medication for the poor.

### *Syria*

A CRD survey was presented, the first of its type in Syria that used a questionnaire and spirometry with a reversibility test. It is a multi-centre survey aimed at tracking both the prevalence of CRD in patients treated in primary care centres and emergency rooms and the patients' risk factors. The

project has the strong support of the Minister of Health, Tishreen University and the GARD country office. So far, 1450 patients have been surveyed and, of those, spirometry has been used on 1085.

The findings from this study were presented, including a separate analysis of the results for women. Monitoring the results of the spirometry tests has made it clear that proper training of staff on the use of the spirometer is crucial to obtaining valid data. As a capacity-building exercise, the research team plans to present a draft of a national strategy on the protocols and execution of such surveys.

On the NCD front, a proposal for a national research project is being developed. GARD working group members were invited to participate in meetings about how to structure this project.

The suggestion was made to compare the results of the work with a spirometry study conducted in Cape Verde with what was described in Syria. Considering the difficulty in teaching medical personnel how to achieve consistent results and how commonly mistakes are made, concerns were raised about how these matters would be addressed in the research. To ensure reliable spirometry results, the need for effective trainers and the importance of having repeated training sessions to make sure that the procedures are being done correctly were emphasized. It was pointed out that Syria is a tobacco producer, thus the limiting economic factor of the cost of smoking is less relevant.

### *Bangladesh*

The National Institute of Chest Diseases & Hospital in Dhaka is the only tertiary care facility for lung health in the country. The Bangladesh Lung Foundation (BLF), the primary association for pulmonologists, is a pioneer in implementing GARD programmes nationally and has been joined by other organizations, such as Club Excel—a group for asthma and COPD patients—and the Bangladesh Society of Allergy and Immunology (BANSAL).

Together, these organizations have initiated a number of programmes, including: (i) a hospital on wheels—a mobile unit that travels throughout the country to offer spirometry and other services to underserved populations; (ii) the publication of a lung health manual, featuring a volume on asthma that has been distributed to doctors throughout the country; (iii) workshops on evidence-based medicine for health professionals in collaboration with Columbia University in New York; and (iv) sponsoring a telehealth project along with the leading mobile telephone operator in the country, where BLF members respond to queries from the community through a help line.

BLF will coordinate the second International Conference on Lung Health on 13–14 October 2010, and on 14 October 2010 it will observe World Spirometry Day by arranging several mass spirometry camps. By 2011, due to the support of knowledgeable personnel within the Ministry of Health, there is hope that Bangladesh will be a fully functioning GARD country. A monitoring cell, comprising both government and private sector agencies, will supervise and evaluate these activities.

### *Discussion*

In the discussion that followed, participants requested the following:

- to increase WHO support to GARD country-level activities in accordance with WHO rules;
- to allow for better access to public–private partnerships as a way to generate resources for GARD that would not be part of a collaboration with WHO.

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## GARD collaboration and interactions with patients

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### Design of the National COPD Framework in the Netherlands: Focus on lifestyle and patient self-management

While the Netherlands has not established a GARD office, its Lung Alliance Netherlands (LAN) is “very GARD-like”. LAN is an NGO in which 25 organizations of patients, medical professionals, health branch associations and pharmaceutical companies work together to improve the prevention of lung diseases, improve the integral care of patients with lung diseases and achieve better quality of life for lung patients.

Even though it is a relatively small country, the Netherlands has over one million lung patients and approximately 23 000 die every year, making lung disease the fourth most common cause of death. Stark regional differences in health outcomes of these patients, with no underlying ethnic or cultural explanation, show that there is room for improvement in the medical care these patients receive.

The idea behind LAN is to amalgamate various lung organizations to deepen their political and social influence. LAN has just delivered an integrated care standard for COPD, made possible by the cooperation of all parties in LAN, including patients. There are also plans to develop care standards for asthma and cystic fibrosis. Due to the country’s economic crisis, the government’s announced spending cuts of €30 billion means that “health care has to bleed too”.

LAN has developed a national action plan to address CRD in the Netherlands. One of its platforms is the development of a smoking prevention campaign. Considering that 3.7 million people smoke in the Netherlands, or 28% of the Dutch adult population, this is a crucial step.

The marked differences in regional admission rates for respiratory problems indicate that attention should be paid to changing local health-care culture. For

COPD patients, physicians must emphasize management of exacerbations and focus on self-management. These programmes can be made attractive as well. COPD patients often suffer from loneliness, so putting them in touch with each other can improve their quality of life. There is also great potential in the e-health field.

In the Netherlands, the estimate is that CRD might rise by 20%–30%, while health-care spending is being reduced by 10%. This is seen as a human resources problem, and the only way to cope is to include patients in the care programme. In the coming months, LAN will approach powerful groups, such as insurance companies and government agencies, to help support the implementation of the national action plan.

The alliance's costs are covered by membership fees that are quite expensive, and some organizations band together and choose one spokesperson to represent them all, thereby saving on fees. LAN has managed to gain good representation of all stakeholders in the respiratory field.

Referring to the list of member organizations provided, it was pointed out that 10 pharmaceutical companies are members of LAN, and the question was raised about how conflicts of interest are handled. It was clarified that the Netherlands is such a small country and representatives from every sector have to be at the table. However, the pharmaceutical companies do not have representation on the board, which is completely independent, although they do have a vote at the annual general meeting on the constituency of the board. The board makes all of the decisions. In response to statistics, information was shared about the high smoking rate and 2000 deaths from asthma among workers. It was asked whether the alliance has parameters and programmes in place to drive these numbers down. It was mentioned that health-care companies are asking for very detailed information, and there has been some talk of establishing two types of benchmarks: an internal one, between doctors; and an external one, to be made public.

An example of an internal benchmark would be the number of smoking cessation attempts made by a doctor's patients. Currently, the goal is to reduce smoking by 2% within four years in the hopes of sparking a paradigm shift among smokers in general.

Patient education:

The need to involve patients in the management of their respiratory diseases

The importance of patient education in ensuring the effective treatment of CRD was emphasized. Studies show that patients are often mistaken about how to take their medications, and that they do want to be educated. Most medical professionals assume a higher level of understanding than actually exists. Patient education was defined as "a planned learning experience using a combination of methods, such as teaching, counselling and behaviour modification techniques, which influence patients' knowledge and health behaviour; it involves an interactive process which assists patients to participate actively in their health care". Furthermore, arriving at a shared decision between physician and patient can sometimes be a demanding exercise. However, patients will be more motivated to follow a treatment programme if they have the tools and means to apply self-management skills and have the support of their physicians.

The studies that suggest that patient education does not contribute to positive health outcomes were addressed, stating that the methods used in these studies are often deficient. At least in the respiratory field, there is evidence that patient education works and is a cost-effective process. Education programmes must adapt to patients' needs. Too often, medical professionals try to educate those who do not need it; efforts must be made to identify those most in need.

Canada is fortunate to have a sub-specialization for asthma as part of the certification programme for health educators. Proper training of these

professionals makes “all the difference”. The Living Well with COPD programme is a good example of the benefits of health education. This self-management programme resulted in a dramatic drop in hospitalization rates and significant cost savings for the health-care system. In addition, the Lung Association runs a number of programmes, AllerGen is devoted to research and knowledge transfer regarding patient education, and many provincial programmes have built in a focus on this area—for example, Ontario’s Asthma Plan of Action. More research is needed to improve understanding about how best to provide education to patients.

Some participants asked where the patient education programmes take place and how much they cost. It was explained that this is a free programme that is considered part of their treatment. Most of the programmes are delivered in a centre located in the hospital, but they can also be found in community centres and outpatient clinics. Often groups of general practitioners will hire part-time educators. The length of the intervention varies, and every educator is required to perform an educational diagnosis to determine what the patients need to know. Obviously, the time it takes to achieve that goal depends in large part on the patient. Some need to be followed for a very long time, but usually the programme is completed in a few half-hour or full-hour sessions. Sometimes a patient’s partner might participate, and there are occasionally some group sessions, but most sessions are individualized due to the importance of delivering content that is appropriate for each patient.

It was also suggested that this system seems similar to what the Netherlands plans to implement. Moving to a working relationship that is more like an individual partnership is a significant paradigm shift for doctors and patients. Thinking in terms of partnership means that the next step will be to engage the awareness of the patient who experiences a condition for 365 days a year, as opposed to the doctor who sees it for just a few hours a year. The doctor should serve as an adviser, not as the person giving orders.

It was mentioned that the patient–doctor relationship should be a partnership. Such an approach would be an effective antidote to the misinformation patients end up receiving through other channels, which can do a considerable amount of damage. Those who suffer from a disease should become experts of their own disease. An association of patients could be very effective in lobbying government to put more energy and resources into education. These programmes need support to continue.

Global Alliance of Respiratory Patients (GARP):  
Helping to develop the influence of patients

The organization’s mission is to fight together against chronic lung diseases and to be of relevance to those afflicted. Among its goals is to raise the level at which patients function on the “ladder of participation”, which ranges from being manipulated at the bottom level and extends to designing service at the top.

To achieve this promotion of patient involvement, GARP could, among other possibilities, co-produce and support a political lobby for patients, produce standards of care, evaluate perceived quality of care and promote a “treatment contract”. To build this movement, GARP should undertake the following:

- develop and disseminate a vision on the role of patient organizations in the fight against CRDs;
- develop a baseline action model for emerging patient organizations in low- and middle-income countries globally;
- adopt one (start-up) patient organization in each continent to develop a pilot scheme on how patient organizations can work effectively in low- and middle-income countries.

GARP sought support and positive response from GARD members, and invited them to help by joining a small task force to develop the GARP vision, model and adoption scheme.

It was mentioned that GARP is not a new idea, since such an organization already exists in the USA, where these groups go to insurance companies and governments to raise awareness about patient rights and new treatments.

### Contributions to GARD and experience from other initiatives

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Primary prevention of CRDs by addressing environmental factors such as indoor and outdoor air pollution

Smoking is not the only risk factor for CRD, especially among youth, women and those from developing countries. Other risks include occupational exposure, Alpha-1 antitrypsin deficiency, traffic and other outdoor pollution, second-hand smoke, biomass smoke, dietary factors and TB. Unfortunately, except in the case of smoking, the evidence base for these risks is not well established, thus further studies are needed for the purposes of international comparisons.

An example of the kind of robust study needed in this field is the Prospective Urban Rural Epidemiology (PURE) study, a global effort conducted in 17 countries that examined societal influences on health behaviours and the influence of risk factors on cardiovascular disease, lung disease, cancer and injuries. On a broad level, this study looked at the interaction between the environment, behaviour and individual health. Remarkable for the thoroughness of its investigation, the study went far beyond looking at a single exposure. It was also a very large study, covering over 100 000 households, with a total of 424 371 individuals.

Because epidemiologists tend to prefer looking at causation, environmental risk factor studies typically report on associations and rarely track the effectiveness of medical interventions. “The key issue here is analogous to the situation of harm caused by medications. The assumption is that removal of a drug, or no exposure, leads to no adverse effects, yet what degree of confidence is there that removal of the association is effective in preventing disease?” An editorial was cited speaking in favour of adopting research standards based on the more diverse evidence domains put forward by Bradford-Hill, as opposed to the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system currently used by WHO.

In response to a comment that too often public health cost estimates do not take into account the cost of doing nothing, it was pointed out that these models must imagine the cost of the alternative and the opportunity cost. Often, in the public health field, the imprecision of these cost projections stems directly from a lack of research into these matters.

It was also mentioned that the Bradford-Hill criteria should not be taken as a “tell it from the mountain” type of prophecy. Though in the intervening years the science concerning a biological basis of risk factors has left Bradford-Hill behind in that area, it does not affect the validity of the other criteria.

It was commented by some participants that there is nothing new about the idea put forward in the Bradford-Hill criteria about establishing causality. However, a lot of work is secondary prevention, so one may not need to establish causality “to make recommendations”. For example, there may not be solid evidence that air pollution is a cause of lung disease, but the association is strong enough to move into prevention activity, such as advising people not to go jogging on smog days.

It was agreed that the presentation implicitly raised the question about a connection between exposure and causation.

## HAAMA/PAHO: Coordination of CRD activities and progress in Central and South America

The Hispanic-American Allergy, Asthma and Immunology Association (HAAMA) is a non-profit organization that has existed for 20 years and whose members are physicians in North, Central and South America. Its activities include a focus on care of asthma and CRD in underserved populations, educational and research programmes, and conducting outreach to patients, physicians and politicians. Its goal is to follow a comprehensive approach to battle CRDs by following the four objectives of GARD: advocacy, partnership, national prevention and control plans, and surveillance. HAAMA has had meetings at the White House to coordinate efforts on NCD issues, collaborates with the Pan American Health Organization (PAHO) through its Washington, DC, regional office, and has organized meetings to develop a respiratory disease action plan in the Americas.

Reviewing data from prevalence studies of asthma in the USA among people of different ethnic and geographical origins, it was noted that the far lower numbers for Mexicans as compared to Puerto Ricans might indicate that genetics play a part in this difference. Efforts that HAAMA has engaged in include the USA statement on the prevention and control of NCD, the Let's Move campaign to fight childhood obesity, and various sports programmes aimed at increasing both awareness and the activity level of asthmatic children.

HAAMA forms partnerships with health organizations in the region to improve prevention, diagnosis and care of respiratory disease and to work with WHO GARD representatives. Pointing out that the regions where these organizations work cover a wide range of income levels, the efforts that have been undertaken in various countries were reviewed, along with the funding, training and personnel shortfalls that exist in the poorer countries. HAAMA looks forward to continuing its efforts to expand knowledge of proper

respiratory disease diagnosis, management and prevention and to working with GARD in Central America.

### Year of the Lung

A brief overview of the activities surrounding the 2010 Year of the Lung was presented. The campaign has four objectives: (i) to increase awareness of lung health and advocate for policy action to combat lung disease; (ii) to increase resources for basic and clinical research; (iii) to convey the message that prevention is highly cost effective; and (iv) to spread the message that clean indoor and outdoor air is a fundamental human right and should be recognized as such.

Visitors to the campaign's web site ([www.2010yearofthelung.org](http://www.2010yearofthelung.org)) can register their organization as a partner, sign a declaration or volunteer to contribute to official events.

The cornerstone projects of Year of the Lung are the first-ever World Spirometry Day, scheduled for 14 October 2010, and a European Union (EU) Presidency conference on CRD on 19 October 2010. Those interested in becoming involved can order a World Spirometry Day kit, which includes a spirometry starter pack, signage and promotional materials, correspondence examples and patient information, all of which can be customized to fit specific country needs.

### The International COPD Coalition Campaign for COPD Patients' Rights

A brief update was presented on the attempts of the International COPD Coalition (ICC) to disseminate and implement the COPD Patients' Global Bill of Rights, which was endorsed by all 83 member organizations at the First World

Conference for COPD Patients held in Rome in June 2009. Feedback on the adoption of the rights was sought via a questionnaire sent to member organizations. Based on the responses, it appears that promotion efforts are just beginning. In general, spirometry is more available in specialist settings and less available in primary care and occupational settings.

The survey responses indicate that some common obstacles to early diagnosis of COPD include lack of awareness of COPD among the general public and primary care physicians as well as a lack of spirometry, limited access to educational materials and patient education programmes in some areas, poor coordination of care between different health-care professionals and limited availability of specialist care.

ICC is launching a web site ([www.global-health-policy.org](http://www.global-health-policy.org)) featuring a library and resource centre that will have evidence-based information supporting the COPD Patients' Global Bill of Rights. In 2011, ICC will hold the 2nd World Conference for COPD Patients in Shanghai, China, in conjunction with the Asian Pacific Society of Respiriology meeting. At the conference, 800 committed COPD patient advocates and educators, along with other stakeholders, will aggressively pursue advocacy and educational mandates on behalf of COPD patients.

## General discussion

The following points were highlighted during the general discussion:

- the reports of the country initiatives shared on the first day of this meeting provided evidence of GARD activities at the country level;
- the need to follow WHO rules and regulations when conducting GARD country activities;
- WHO is open to receive all comments and recommendations regarding the WHO PEN publication;

- the suggestions to possibly set up new entities along the lines of a public–private partnership would have to be examined very carefully;
- the GARD name must not be used by any group or entity that exists outside the scope and terms of reference of GARD;
- transparency in the working relations between WHO and GARD is necessary for the success of GARD;
- the idea of establishing a new entity would be examined.

Report of the GARD Executive Committee, Planning Group and  
GARD Secretariat for endorsement by the GARD General Meeting

GARD proposed activities for 2010–2011

The following key points were highlighted:

- GARD has succeeded in establishing several country initiatives that have brought together allied health professionals to work on integrated CRD projects. It has increased cooperation among health authorities, patients' organizations and professional societies and thereby has reduced duplication of work and wasted resources.
- Action must be taken to prevent GARD from becoming secondary to other NCDs—it should be on the same footing as diabetes and chronic heart failure. GARD would welcome being an equal partner in a strategy to implement programmes such as PAL and WHO PEN. In 2011, GARD will work to have NCD as a priority with the consecutive chairs of the EU.
- The GARD basket was a resource that served its purpose, but it will be necessary to revise it to support the NCD Action Plan. The structure and

function of GARD also must evolve in order to better support GARD country activities.

- Every WHO country office that has achieved something significant could publish a report in a journal listed in MEDLINE, and which subsequently could be considered in a summary of the next GARD publication.

Endorsement of communications and advocacy actions;  
status of collaborating parties and new applicants;  
financial status

The following issues were identified:

- GARD's income in 2010 was not as impressive as in past years, mainly due to a decrease in the amount that some member organizations pay. GARD's membership is growing, while the number of paying members is decreasing. This decline is most likely due to GARD's voluntary pay-what-you-can policy.
- NCDnet is a new activity run by WHO Member States that are NGOs, and GARD is also represented in the network. This group reports to decision-making politicians. In 2011, GARD should be involved in the UN-sponsored conference on NCD for heads of state, at which CRD will certainly be discussed.
- The new applicants to GARD from Kuwait (Kuwait Society of Allergy and Clinical Immunology, President Dr Mona Al-Ahmad) and Brazil (Latin American Society of Allergy, Asthma and Immunology, President Dr Dirceu Solé) were recommended to be approved, and the application for the Valencian Association for Prevention, Control and Treatment of Tobacco Smoking (President Dr Ahmad Khalaf Ayash, Castellon de la Plana, Spain) was recommended to be sent to the Executive Committee for further review.

## Update and review of the status of GARD working groups

The working groups are not functioning and, because of the difficult financial situation, it is not easy to make them work without secretarial and logistical support.

## General discussion

Several participants were concerned about the level of detail shared in the WHO financial report. It was explained that the position of WHO is that it does not report its internal financial information.

## Planning the next steps for GARD

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### Proposals for the next General Meeting (2011)

Some final thoughts on the proceedings were offered:

- The number of GARD activities is impressive.
- It was suggested by some members that in addition to GARD secretariat continuing to be hosted by WHO, a new structure be developed with links to GARD. A small working group could be formed to examine, in consultation with WHO, the advantages, disadvantages and implications of doing this.
- It was suggested that the next meeting should be held in Warsaw on 20 October 2011. Poland will hold the EU presidency at that time and, according to sources there, NCD will be an EU priority.

- It was decided to hold the next GARD Executive Committee and Planning Group meeting on 22–23 September 2010 on the occasion of the annual European Respiratory Society (ERS) Congress in Barcelona.
- Dr Holger Schünemann, Canada, was approved on his appointment as GARD adviser.
- Poland will hold the presidency of the EU from 1 July to 31 December 2011. Asthma is worsening in Poland, along with an increased prevalence of rhinitis, wheezing and eczema. In total, 13 million Poles suffer from allergies. The goal is to convince the Polish presidency to: (i) make it a policy priority to implement early detection, prevention and treatment of noncommunicable respiratory diseases with particular emphasis on developmental age; (ii) include NCDs (GARD Work Plan) in the health policy of EU member countries; and (iii) improve cooperation between EU bodies and WHO. In advance of the presidency, the public health working party is the body that can put forward the case to make CRD a priority. Results are initially presented in the Employment, Social Policy, Health and Consumer Affairs Council (EPSCO), then in informal ministers' meetings, all the way up to the parliament itself.
- The experts' conference is scheduled for 24–25 October 2010, prior to the last EPSCO meeting before ministerial agreement is reached on a final proposal to include the GARD Work Plan in each EU member state's health policy.

## Group presentations

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### Group 1:

Capacity strengthening for integrated prevention and control of NCDs in primary care

### Suggestions and recommendations:

- Awareness of CRDs is a problem, especially in low- and middle-income countries, and this gap requires action.
- Scientific advisory groups should be established to develop algorithms and integrate CRD into the training of health-care staff. The Ministry of Health is requested to work with higher education and schools to integrate these algorithms in undergraduate curricula.
- The role of WHO country officers should be strengthened so that ministries of health will recognize GARD. GARD officers should have scientific and clinical backgrounds, be well connected and collaborate with NCD focal points at the local ministries of health. The ministries can then supply GARD officers with scientific updates and other assistance.
- NCD integration into basic training should start with nurses and physician assistants in primary care and move on to physicians (e.g. in Viet Nam). A train-the-trainer approach works well with this kind of training.
- CRD management protocols should be flexible and tailored to available resources within countries.
- Information from WHO headquarters should be well communicated to WHO officers and regional officers. The information should be made available to the ministries of health.
- Scientific committees, which can play a role in training, research, advocacy and awareness, should be established within the ministries of health. In these committees, medical schools should take the role of leaders in research and training.

### *Group 1 Discussion notes*

- Regarding the components that should be added at the level of basic training, precautions should be included for cases where a patient has many diseases at the same time.
- There is a need for basic information about CRD treatment and management in primary care. Many useful materials have been produced, and it would be helpful if a GARD initiative provided these basic materials.
- It would be helpful to link the materials through the GARD web site, if technically possible. The materials targeting patients and non-physicians could become an extension of the baskets.
- There is a great opportunity for primary care physicians to collect information. In Toronto, Ontario, the Respiratory Global Research and Training (GREAT) Network has had a programme for two years to train participants in study design, critical appraisals and analysis. Training is conducted via the Internet for two hours per week for three months, at no cost. There were five graduates in the first year and eight graduates in the second year.
- The PAL model for NCDs has been implemented in Finland and is working well. It was suggested that the PAL model is needed for NCDs and the group would like to see it and provide feedback.
- WHO could integrate CRDs with other NCDs, such as diabetes and cardiovascular disease, to bring WHO PEN or PAL or anything respiration-related to the countries. Additionally, it would be ideal to have a syndromic approach for all levels of health-care workers to tap into.

## Group 2: Self-management and home care

### Suggestions and recommendations:

- A doctor-activated approach can lead to the development of regular asthma self-management courses or one-week summer courses for children with asthma.
- A patient-activated approach would require that patients receive information about their disease and that they have some peer support. School- and community-based resources, such as churches and Big Brother associations, can be very effective. The greatest success is seen when patients are willing to improve their status, such as those who join smoking cessation programmes.
- Written agreements or contracts could be drawn up between patients and physicians as a tool to facilitate implementation of self-management.
- Written treatment and prevention plans would be helpful tools for the self-management of CRDs as well as for hypertension and diabetes. National information centres and phone centres are also helpful.
- The GARD basket provides good peer support for self-management. GARD could support patient–doctor cooperation and promote written treatment and prevention plans. GARD could promote the roles of nurses and other health-care allies in self-management and could write a script for patient–doctor relationships. GARD could initiate the establishment of an NCD health assistant position within the ministries of health to assist with self-management of NCDs, similar to the one that exists for infectious diseases. In particular, this idea deserves consideration for low- and middle-income countries. GARD could promote a high-quality lifestyle, both during and after treatment. GARD could promote the provision of CRD treatment at no charge or with government subsidies. Good examples of this can be seen in Brazil, the Republic of Korea and Spain.

### *Group 2 Discussion notes*

There has been great success in teaching children to manage their diabetes, and the same could be done for children with asthma. It would be interesting to see whether videos could be produced to address the self-management of all four main NCDs in various languages, so that people could learn at home. Perhaps ministries of health could produce short television broadcasts about the four main NCDs.

The existing materials should be effectively linked, and they should also reach elderly, chronic patients.

### Group 3: Equitable access to asthma medicines

#### Suggestions and recommendations:

- To ensure equitable access to asthma medications, the medicines must be on the national essential medicine list, and they also must be available at an affordable price in countries. In addition, countries must have information about how to use these essential medications and should decide whether to prescribe them at the primary care level, in clinics or in hospitals.
- Lack of equal access can be due to high costs, essential medicines that are not on the essential medications list or countries that need to review their essential medicine lists to integrate new recommendations from the latest version of the WHO essential medicine list. In many countries, ministries of health are using the expert committees to review their lists. To improve equitable access, two actions for GARD and WHO were suggested. First, GARD and WHO should make sure the WHO essential medicine list

includes the necessary essential medicines necessary to treat CRDs in low- and middle-income countries. Second, GARD country leaders should ensure that the essential medicines proposed on the WHO essential medicine list are on their own country lists. They should encourage the development and implementation of a national policy/strategy whereby these essential medicines should be used and should develop ways to ensure access to essential medicines at a reasonable price.

- One way to improve equitable access to asthma medications is to make the medicines tax exempt, and GARD could play a role in making this happen. Furthermore, doctors, nurses and patients can be trained to use the medications effectively.
- The Asthma Drug Facility has created a way to provide access to affordable essential asthma medicines. In addition to its procurement activities, this facility is promoting a model in which donors will pay for a first order of medicines, then patients are charged a small fee, and the recovered funds will be used to place new orders. This revolving fund mechanism has been successful in countries where it has been implemented for essential medicines. The action item for GARD is for the Asthma Drug Facility to provide a donor model strategy to show how it works, help countries raise funds from donors for asthma medications and show how costs can be recovered.
- Each country needs a strategy that would be a how-to template for implementing asthma education programmes. GARD should develop a clearly defined package for adoption and adaptation in each country.
- A global approach to statistics/economic analysis is needed to show the cost of medications, the cost of care and the impact of actions taken. GARD should develop a format for data collection, statistics/economic analysis on hospitalizations, costs, implementation of goals and developing benchmarks.
- GARD should request and provide a template for GARD national leaders. In each annual report the group would like to hear more information from

each GARD leader on which asthma medicines they are using, how they are getting them on their essential medicine list, how expensive they are and what barriers exist to make them available for the population through health services.

### *Group 3 Discussion notes*

- One of GARD Turkey's working groups has been accepted as an advisory board within the country, and it is hoped that it will maintain a leading role.
- Asthma medications are on the essential drug list in Brazil and are available, but they are not being used properly to support the public health system to build capacity for proper use within primary care.
- The WHO respiratory unit has recently proposed the addition of long-acting beta-2 agonists to the essential drug list to the WHO essential drug list group. A follow up is needed for implementation of the proposal.
- If GARD members unanimously believe a long-acting beta-2 agonist is needed, they should approach WHO with this proposal.
- Drugs need to be affordable and of good quality. In some countries, quality has been questionable, and GARD should support any initiative that would help guarantee quality.

### Group 4:

Primary prevention of CRDs (tobacco and environmental pollution)

Four challenges were identified for implementing prevention strategies:

- While effective strategies exist—e.g. legislation, taxation, pricing—enforcing them and translating them into practice is challenging.

- Implementation may not be equally effective for all populations.
- Not everyone can be educated by television, so radio should be kept in mind. Teachers, primary care doctors and community leaders can be powerful educators.
- There are different kinds of tobacco smoke other than cigarettes, such as biri, water pipes and biomass produced during cooking.

The following recommendations for tackling these challenges were presented:

- Encourage smoke-free pregnancies, smoke-free homes, smoke-free schools and strategies to reduce smoking prevalence. Avoidance of environmental tobacco smoking for all members of the population would be key, and smoking cessation programmes with pharmaceutical options should be made available. Increased taxation is an option, with funds reinvested into prevention programmes.
- Identify and monitor early exposure to smoke to lower incidence of childhood asthma. Breastfeeding also plays a major role in preventing asthma, and is another primary prevention that should be implemented early. It may be more applicable in developed countries, but the other benefits of breastfeeding in developing countries cannot be denied.
- Prevent and control obesity in adults and children. Encourage physical activity and support approaches to create safe and clean environments for healthy lifestyles.
- Focus on indoor exposure. Reduce the smoke emitted in cooking stoves, install chimneys and relocate people to safe places. Automobile manufacturers and other industries should be required to minimize air pollution. Communication with local and regional authorities to implement and enforce air pollution policies should be encouraged. Monitoring air pollutants, including pollen counts, is important.
- Better statistics should be gathered soon. This would allow for the determination of population-attributable risks due to various types of

exposure and would help with evidence-based prevention and programme planning. Educating the public about potential risks to their lungs could be improved upon.

*Group 4 Discussion notes*

There was no Group 4 Discussion

Participants praised the progress of all four groups and stated the work should be followed up.

**ANNEX 1.**

WORLD HEALTH ORGANIZATION

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**5<sup>th</sup> General Meeting of the Global Alliance  
against Chronic Respiratory Diseases (GARD)****Toronto, Canada, 1–2 June 2010****PROGRAMME****Tuesday, 1 June 2010**

07:30–08:30      Breakfast

08:30–09:00      Registration of participants

**Opening**09:00–09:20      Welcome speech - Address to the General Meeting (Public  
Health Agency of Canada/PHAC)09:20–09:40      Introduction to the General Meeting; nomination of  
chairperson and rapporteur; discussion and agreement on the  
agenda and programme of the meeting (L. Vardy)

- 09:40–10:00 Update on GARD; purpose and expectations for the 2010 General Meeting (J. Bousquet)
- 10:00–10:30 *Coffee break and group photo*
- Session 1: Aligning the GARD 2008–2013 Work Plan with the WHO 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases (NCD Action Plan)**
- 10:30–10:45 Priorities of GARD work for 2010 to support the NCD Action Plan (G. Galea)
- 10:45–12:30 GARD country initiatives; **Moderator:** A. Yorgancioglu
- GARD Turkey update and integration with other NCDs (A. Yorgancioglu, Turkey)
  - GARD Italy (G. Viegi, Italy)
  - National Program for Integrated Prevention and Control of Chronic Respiratory Diseases in Kyrgyzstan: Interaction and Support of NCD Activities (T. Sooronbaev, Kyrgyzstan)
  - GARD IRAN: Report of national activities (M. Masjedi, Islamic Republic of Iran)
  - GARD in a French-speaking country: African Action Plan (A. Ben Kheder, Tunisia)
- 12:30–13:30 *Buffet lunch*
- 13:30–15:00 GARD country initiatives; **Moderator:** A. Yorgancioglu

- GARD in Pakistan – The way forward (O. Yussuf, Pakistan)
- The GARD demonstration site in Viet Nam and the network of CRD management units (Lan Le Thi Tuyet, Viet Nam)
- Integration of the GARD survey in the NCD programme in Syria and EMRO (Y. Mohammad, Syria)
- Promoting lung health in Bangladesh: Tale of an emerging society (K.S. Bennoor, Bangladesh)

15:00–15:30 *Coffee break*

**Session 2: GARD collaboration and interactions with patients;**  
**Moderator: R. Dahl**

15:30–15:45 Design of the National COPD Framework in the Netherlands: Focus on lifestyle and patient self-management (N. Chavannes)

15:45–16:00 Patient education: The need to involve patients in the management of their respiratory diseases (L.P. Boulet)

16:00–16:15 Global Alliance of Respiratory Patients (GARP): Helping to develop the influence of patients (M. Rutgers)

16:15–16:30 Discussion

**Session 3: Contributions to GARD and experience from other initiatives; Moderator: C. Lenfant**

16:30–16:45 The International COPD Coalition's (ICC) campaign for COPD patients' rights (Y. Mohammad)

- 16:45–17:00 Primary prevention of CRDs by addressing environmental factors such as indoor and outdoor air pollution (H. Schünemann)
- 17:00–17:15 HAAMA/PAHO: Coordination of CRD/NET activities and progress in Central and South America (J. Quel)
- 17:15–17:30 General discussion
- 18:00–18:15 *Walk to pier for reception and gala dinner cruise aboard the Captain Matthew Flinders Vessel*
- 18:15–21:45 *Reception & gala dinner cruise*

### **Wednesday, 2 June 2010**

- 07:30–08:30 Breakfast
- 08:45–09:00 Report of the previous day (Rapporteur)
- Session 4: GARD collaboration and interactions with primary care;**  
**Moderator: N. Chavannes**
- 09:00–09:15 Scaling up prevention and control of CRDs through an integrated approach (E. Zheleznyakov)
- 09:15–09:30 Introduction to four parallel workshops on GARD proposed activities for 2010–2011 (four groups)

09:30–11:00      Group work

11:00–11:30      *Coffee break*

Presentations of results by the groups

11:30–11:45      Group 1: Capacity strengthening for integrated prevention  
and control of NCD in primary care

11:45–12:00      Discussion

12:00–12:15      Group 2: Self-management and home care

12:15–12:30      Discussion

12:30–12:45      Group 3: Equitable access to asthma medicines

12:45–13:00      Discussion

13:00–13:15      Group 4: Primary prevention of CRDs (tobacco and  
environmental pollution)

13:15–13:30      Discussion

13:30–15:00      *Buffet lunch*

**Session 5:**      **Report of GARD Executive Committee, Planning Group and  
GARD Secretariat for endorsement by the GARD General  
Meeting; Moderator: C. Baena-Cagnani**

15:00–15:15      GARD proposed activities for 2010–2011 (R. Dahl)

- 15:15–15:30 Endorsement of communications and advocacy actions; status of collaborating parties and new applicants; financial status (January–December 2009) (N. Khaltaev)
- 15:30–15:45 Update and review of the status of GARD working group and panel of advisers; possible revision of ToRs (N. Khaltaev)
- 15:45–16:00 Discussion of proposals on a strategy for resource mobilization, EU priority for 2011
- 16:00–16:30 General discussion
- 16:30–17:00 *Coffee break*
- Session 6: Planning the next steps for GARD;**  
**Moderator:** C. Baena-Cagnani
- 17:00–17:15 Recommendations for the future: The role of GARD in supporting the WHO 2008–2013 Action Plan for the Global Strategy for Prevention and Control of Noncommunicable Diseases (NCD Action Plan)
- 17:15–17:30 Proposals for the next General Meeting (2011), including location and date
- 17:30–17:45 Summary of decisions and plans for the next steps
- 17:45–18:00 Meeting conclusion

*Joint IPCRG–GARD reception at the Westin Hotel*

**ANNEX 2.**



WORLD HEALTH ORGANIZATION

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**Global Alliance against Chronic Respiratory  
Diseases (GARD) General Meeting**

**Toronto, Canada, 1–2 June 2010**

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