Pan American Health Organization

Regional Office of the World Health Organization

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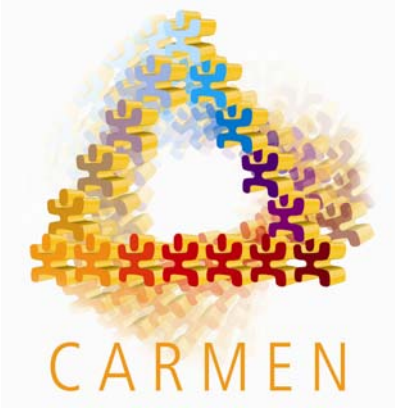
# CARMEN Management Committee




# Workshop Report

(Toronto, 15–16 March 2007)

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# I. Introduction

## Purpose and Objectives

The **purpose** of this meeting was to review progress to date and to discuss how a strengthened CARMEN initiative can support implementation of the Pan American Health Organization (PAHO) Regional Strategy.

**Specific objectives** included.

1. To report on progress to date.
2. To review the revised draft Terms of Reference.
3. To discuss future directions by:
    - Reviewing draft country profile tool.
    - Sharing information about supplementary tools.
    - Identifying possibilities for further development and piloting of tools and projects, as well as potential actions in support of the Regional Strategy and other actions to support an integrated approach to chronic disease.
4. To begin planning for the next CARMEN Biennial Meeting (November 2007).

## Participants

See Appendix A for a full list of participants.

## Opening Remarks

Dr. Sylvie Stachenko, Deputy Chief Public Health Officer at the Public Health Agency of Canada (PHAC), welcomed participants, noting that this meeting marks a critical time of transition for the CARMEN network. The new PAHO Regional Strategy and Plan of Action for an Integrated Approach to the Prevention and Control of Chronic Disease was launched in September 2006 to guide and accelerate action at the country level, and has created a new context in which CARMEN members can extend and unify this work toward their common goals.

CARMEN has now completed its first decade, Dr. Stachenko said. In that time, it has become a major vehicle for advancing chronic disease work within the region, and an important mechanism by which countries have shared a wealth of experience and knowledge. With the acceptance of the Regional Strategy by all CARMEN countries, the opportunity now exists for the network to serve an important role in facilitating uptake of the Strategy by member countries.

Canada is a member of both CARMEN and CINDI, the sister network of the World Health Organization (WHO) European region. Europe also has a new Regional Strategy, and CINDI is holding its own Management Committee meeting this month. The timing of these events encourages cross-fertilization, with Canada acting as a liaison. This intensive

international activity also coincides with a crucial development within Canada itself, where a new comprehensive, integrated Strategy for Healthy Living has recently been launched, with significant new investment relevant to chronic disease prevention and control at both national and provincial/territorial levels.

Dr. Maria Cristina Escobar, CARMEN Coordinator, noted that Chile, like Canada, was a founding member country of CARMEN. The organization began in emulation of CINDI, its sister network in Europe, raising awareness throughout the region and recruiting active support from PAHO. While CARMEN's profile declined somewhat after the first few years, aging populations and the issues associated with them have now led to an upsurge of interest in chronic disease prevention and control throughout the region. This new level of commitment, together with the launch of the Regional Strategy, offers a golden opportunity not only to revitalize CARMEN but to extend its role, making it a pillar of support for the Regional Strategy and an invaluable resource for member countries as they face the rising challenge of chronic disease.

Dr. James Hospedales, Chief of PAHO's Non-communicable Chronic Disease (NCD) Unit, compared CARMEN's position after its first ten years to that of someone who has just climbed a mountain, only to find that even higher mountains lie ahead. All member countries have approved the Regional Strategy; all have declared themselves ready to face the challenges that may come. The existence of CARMEN means that countries do not have to face the future alone. The network provides a vehicle by which shared problems can be tackled in an environment of mutual support. Along the way, many lives will be saved and all countries will be enriched.

# II. CARMEN: Past, Present and Future

## CARMEN Achievements and Challenges: Dr. James Hospedales

### CARMEN Chronology

CARMEN—*Conjunto de Acciónes para la Reducción Multifactorial de Enfermedades No transmisibles*—has just completed its first decade, and is now ready to assume leadership for implementing the Regional Strategy for the prevention and control of chronic diseases.

Essentially, CARMEN includes three components:

1. Member Countries,
2. PAHO/WHO as the secretariat, and
3. key organizations and networks as collaborating institutions.

Still unclear is how the network should function at the subregional level, and exactly how CARMEN should be aligned with national policies and programs.

CARMEN **accomplishments** to date include:

- A strong contribution to the visibility of chronic disease as a major public health problem in the Americas;
- Introduction of a preventive orientation, and capacity building for prevention and health promotion.
- An integrated approach to NCDs in regional and national public health policy;
- Innovative regional and country projects.
- Stimulation of applied and participatory research.
- Facilitation of international exchange of experiences.
- Provision of support to countries in collaboration with other institutions and networks.
- A shift in perception about chronic disease. Once considered a topic for researchers, it is now seen as properly part of government agendas as well.

Significant **milestones** over the past ten years include:

- 1997: CARMEN initiative established, modelled on the CINDI protocol, with Chile and Canada as founding member states.
- 1997–2000: Costa Rica, Cuba and Puerto Rico join CARMEN. Launch of CARMEN School.
- 2001: Argentina, Brazil, Colombia, Uruguay, and US Border-El Paso join CARMEN; CARMEN participates in 1st WHO Global Forum on Chronic Disease Prevention and Control.
- 2002: Pan-American Sanitary Conference recommends CARMEN as major vehicle for integrated NCD prevention.
- 2002–2005
  - All countries with projects related to NCDs invited to join CARMEN; El Salvador, Panama, Guatemala, Peru, Bolivia, Paraguay, Trinidad and Tobago, Nicaragua join.
  - Development of new tools by Chile (CARMEN School), Canada and PAHO (Policy Observatory), Brazil (indicators for evaluating community programs); Puerto Rico (communication tools); Peru (framework for country interventions).
  - CARLI (English and Dutch Caribbean) network for lifestyle intervention launched within CARMEN.
  - Chile, Brazil, Argentina, Colombia host projects to develop local systems for NCD surveillance.
  - NCD Policy Observatory pilot case studies conducted in Brazil, Costa Rica and Canada.
  - Collaboration between CARMEN and US National Institutes of Health (National Heart, Lung and Blood Institute); Pan-American Cardiovascular Initiative Joint International Conference held in Bethesda, Maryland (US).

- CARMEN biennial meeting held in Santiago, Chile; external partners attending include CDC and NIH-NHLBI (US), Pan American Network for Physical Activity (RAFA), Preventive Research Centres.

➔ 2006

- PAHO Regional Strategy launched;
- Bahamas, Ecuador join CARMEN;

1. Chile, Guatemala and Argentina conduct project on community mobilization for cardiovascular health promotion using lay health personnel.

## The Challenge of Chronic Disease

Chronic diseases, namely cardiovascular disease, cancer, diabetes and chronic respiratory diseases, account for about 60% of deaths in almost all countries around the world, with most deaths occurring in less-developed countries or in poorer segments of the population. The chief risk factors for chronic disease are classified as follows, with each category causing or giving rise to the one below it:

- ***Social determinants of health:*** Knowledge, attitudes, beliefs, culture, poverty, private sector marketing leading to urbanization / globalization, and policies (e.g., taxation, pricing, agriculture, education, mass transit, access to health services);
- ***Behavioural risk factors:*** Unhealthy diet, physical inactivity, tobacco use, alcohol abuse;
- ***Physiological risk factors:*** Hypertension, hyperglycemia, hyperlipidemia, overweight/obesity.

These risk factors are widespread, and the threat is growing. Projections indicate that 388 million people will die worldwide from chronic diseases in the next ten years, and the associated economic losses will be staggering. Over a billion people in the world are overweight or obese, outnumbering those who suffer from a basic lack of caloric intake.

In the Americas, most of the top ten causes of death are chronic diseases. In the Caribbean, prevalence of overweight/obesity has been rising sharply since the 1970s.
The Central American Diabetes Initiative (CAMDI) has shown that diabetes prevalence ranges from 8% in Honduras to 10% in El Salvador, 11% in Guatemala and Costa Rica, 12% in Nicaragua, and close to 15% in Mexico. Similarly, hypertension prevalence ranges from 20% (Guatemala) to 33.9% (Mexico), and the prevalence of overweight (BMI > 25) from 57.6% (Honduras) to 69.2% (Nicaragua). Throughout the region, about 2/3 of the population is overweight.

These facts, coupled with the preventability of most chronic disease (80% of heart disease, stroke and type 2 diabetes, and 40% of cancers are preventable), and the availability of cost-effective and even inexpensive interventions, make the issue an obvious target for political action to strike a new balance between prevention and control. It is clearly not feasible to continue focusing on treatment. Nevertheless, response to date has been inadequate, but the

Regional Strategy does offer a comprehensive, evidence based approach to prevention and control.

Several models of successful action exist. Poland has achieved an annual 7% decline in cardiovascular deaths among those aged 45-64, and 10% in the 20-44 age group, thanks to a concerted effort to promote consumption of polyunsaturated dietary fats and fresh fruits, and to discourage tobacco use. This was done through practical measures such as removing existing subsidies on butter and ensuring the availability of inexpensive vegetable oils. Similarly, Finland has produced major declines in cardiovascular disease through a comprehensive nationwide effort, modelled on its successful North Karelia project.

These and similar projects have clearly demonstrated that huge benefits can be gained by stimulating small changes in several risk factors across whole populations. Nevertheless, population-wide approaches must always be combined with interventions on the individual level for those who already have, or are at high risk for, chronic conditions.

**Effective interventions** include:

- Laws and regulations;
- Tax and price interventions to encourage healthy choices;
- Improving the built environment for physical activity (as was done in Bogota);
- Advocacy, communication and information;
- Interventions based in communities, schools and workplaces.

All these are "healthy public policy" interventions that go well beyond the control of Ministries of Health. However, it is also essential to provide for individuals who already have chronic disease, or who are at high risk, in order to prevent disease onset, delay or prevent progression and minimize complications. **Specific responsibilities** within the health sector include:

- Screening (cardiovascular disease, diabetes, hypertension, some cancers);
- Clinical prevention, with focus on risk levels;
- Disease management;
- Rehabilitation;
- Palliative care.

Chronic disease has long been a priority for WHO/PAHO though the necessary resources have lagged behind. **Related resolutions** include:

- *The WHO Global Strategy for the Prevention and Control of Chronic Diseases* (WHA53.17, 2000);
- *Cardiovascular Disease, Especially Hypertension* (CD42.R9, 2000);
- *Public Health Response to Chronic Diseases* (CSP26/15, 2002);
- *Framework Convention for Tobacco Control* (WHA56.1, 2003);

- *Global Strategy on Diet, Physical Activity, and Health* (WHA57.17, 2004);
- *Cancer Prevention and Control* (WHA58.22, 2005);
- *Regional Strategy and Plan of Action on Nutrition in Health and Development, 2006–2015* (CD 47/18);
- *Regional Strategy on Health Promotion* (CD 47/16).

## The PAHO Regional Strategy and Plan of Action

The PAHO Regional Strategy has been accepted by all CARMEN Member Countries. Soundly based on current knowledge about chronic disease prevention and control, it includes both population and individual approaches. It is integrated, focusing on shared risk factors, prevention, care and surveillance. PAHO/WHO, member countries and external partners all have specific roles. The overall goal is to prevent and reduce the burden of chronic diseases and their related risk factors in the Americas, achieving a 2% annual reduction in the death rates from the major chronic diseases. This will prevent some three million deaths in the region.

The Strategy focuses on five major chronic diseases: heart disease, stroke, cancer, diabetes and chronic respiratory illness. **Specific objectives** include:

- To increase national capacity so that by 2010, 90% of countries will have a line item for NCD prevention and control and an NCD Unit. Currently, only 60% of countries meet this objective;
- To achieve a 10% reduction in tobacco use in half the countries by 2013;
- To stop the rise in obesity prevalence by 2013 in 10% of the countries which have a high obesity burden;
- To establish collection and use of population-based data on major risk factors in 75% of member states;
- To deliver an appropriate package of care and prevention, as defined by regional guidelines, to 75% of the population with chronic disease.

According to the results of the WHO/PAHO National Capacity Assessments ("country profiles") conducted in 2001 and 2005, the Central American and Caribbean areas have the least well developed programs in the Americas. Countries were surveyed on a range of NCD-related indicators, including presence of a national Focal Point; legislation; policies and programs; targets; implementation of the Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health; presence of national health reporting systems, including surveys; demonstration programs; guidelines and standards; quality of care and level of financial investment. Quality of care is one of the weakest areas in LAC: very little information is available.

Because CARMEN has a role as a major implementation vehicle for the Regional Strategy (2008-2013), its member countries now have an unprecedented opportunity to contribute to positive change. Working together, CARMEN can help countries commit to measuring their responses to the challenge of NCD, and use the results of the national capacity survey to

plan constructive action in support of the four Lines of Action in the Regional Strategy, described below:

- ***Policy and Advocacy***
  *Objective:* To strengthen NCD public policy development, implementation and evaluation. This entails ensuring and promoting the development and implementation of effective, integrated, sustainable and evidence-based public policies on chronic diseases, their risk factors and determinants.
- ***Surveillance***
  *Objective*: To develop and strengthen countries' capacity for better surveillance of NCDs, their consequences and risk factors, and the impact of public health interventions.
- ***Health Promotion / Disease Prevention***
  *Objective*: To foster, support and promote social and economic conditions that address the determinants of chronic disease, and empower people to increase control over their health and to adopt healthy behaviours. This objective involves action on the major risk factors – diet, physical activity, tobacco and alcohol. Key settings for implementation would include homes, schools, communities and workplaces.
- ***Integrated Management of NCDs***
  *Objective*: To provide technical assistance to countries in the development, strengthening, implementation and evaluation of their chronic disease management programs.

Horizontal actions are needed to complement the lines of action and NCDs must be integrated into both the PAHO Strategic Plan 2008–2013 and biennial program budgets. Necessary steps will include assessing national capacities; defining core actions for all countries; assigning "expanded" and "desirable" levels of action to selected countries or subregions based on needs and opportunities, and developing multi-country activities (e.g., Trans Fat Free Americas initiative).

A communications plan, with the core message "Stop the chronic disease epidemic", will also be developed to support the Regional Strategy, and strategic internal and external partnerships will be developed. The latter is seen as particularly important to mobilize private sector and civil society. Disease-specific plans for cardiovascular disease, cancer and diabetes will need to be created or extended, with actions at local/municipal, national, subregional and regional levels.

The **overall framework for implementing the Regional Strategy** is as follows:

- Integration of Regional Strategy-related issues at biennial planning and evaluation meetings (2007, 2009, 2011, 2013);
- Formation of a Technical Advisory Group to assess the feasibility of Regional Strategy goal of 2% reduction in NCD mortality and provide scientific guidance to the chronic disease program.

- Establishment of a Partners' Forum to meet periodically to build and deepen alliances for chronic disease prevention and control;
- Development of a framework for monitoring and evaluation, with reports to the PAHO Directing Council.

To accomplish these objectives, CARMEN needs to build on the following **resources**:

- Strategic institutional and network-to-network alliances;
- Advances in policy and prevention (e.g., ratification of FCTC, CARMEN Policy Observatory);
- Instruments for surveillance: establishment of minimum dataset; Pan-American STEPs;
- Scientific evidence: Healthy Lifestyles, Healthy People (promotion and prevention); CAMDI Study, project on community and cardiovascular health (integrated disease management);
- Capacity building: The CARMEN School must grow to support each Line of Action in the Regional Strategy, expanding training programs and strengthening links to universities;
- Healthy eating programs (e.g., "Five a Day", "Trans Fat Free Americas");
- Physical activity programs, including urban planning and alternative transportation initiatives (e.g., bike paths).

In conclusion, CARMEN's work over the past ten years has laid a solid foundation. It is now essential that the network must expand and its member countries come together in support of the Regional Strategy and engage others to ensure that the challenge of NCDs is recognized and addressed.

## Discussion: CARMEN Achievements and Challenges

Participants raised the following points in discussion:

- Capacity must be built not only at the policy level, but also technically. The experience of countries such as Finland has shown the importance of strong technical support in such areas as establishment of an information base and economic modelling.
- Engagement of the media as an ally is a critical strategic step.
- Globalization is a key driver of change and will be increasingly important in the future. Trade patterns and their consequences are beyond the control of single nations. Hence, it is crucial to build and maintain international partnerships. It was noted that while individual nations may be dependent on food imports, there is scope under World Trade Organization regulations for setting and enforcing standards for the quality of imported food.
- In order to promote adoption of an integrated, comprehensive approach at the country level, both CARMEN and PAHO must expand their focus beyond primary

prevention and eliminate unnecessary stratification. As a first step, PAHO has established an interprogrammatic working group for NCD prevention and control, with a view to ensuring a more coordinated approach. It was also recommended that CARMEN member countries voice their call for integration to the highest levels of PAHO.

- It is important to act on secondary as well as primary prevention. Trinidad and Tobago has had considerable success in reducing the rate of serious complications of NCDs, including leg amputations and blindness.
- Reform, reorganization and consequent fragmentation are realities in the governments of many countries, and the resulting lack of continuity poses a major challenge to effective teamwork on NCDs. For this reason, formation of a Technical Advisory Group, together with provision of monitoring support, are among the most important steps CARMEN can take. Additional training for in-country health personnel is essential in order to establish uniform criteria relevant to NCDs and their risk factors.
- To date, demonstration projects have been a chief focus of CARMEN. While these have been very valuable, it may be more advantageous in future to focus on building capacity in countries with less developed strategies.
- Universities must be actively involved in order to increase the supply of trained personnel for these programs.
- Within countries, it is essential to ensure a place for healthy public policy in all sectors. Ministries of Health have a duty not just to deliver health services, but also to provide leadership, strengthening their connections with other sectors. In order to do this, Ministries need additional resources and support. In addition, PAHO plans to approach authorities in each country at the cabinet level to advocate for comprehensive, evidence based policies to stop the chronic disease epidemic.

## CARMEN Terms of Reference

**Document:** *The Organization and Management of the CARMEN Initiative and Network: Terms of Reference for Participating Members,* Draft for Discussion March 9, 2007

The following comments made during the Management Committee videoconference held in 2006, the CARMEN draft Terms of Reference have been revised and are now ready for review prior to presentation at the upcoming biennial meeting.

Participants made the following comments on the draft document:

### Vision

- It was noted that since not all chronic diseases are non-communicable (e.g., tuberculosis), use of both terms is mandatory. Consideration should be given to adding the term "lifestyle-related".
- It was recommended that the word "create" be replaced, since it implies a one-time act rather than an ongoing process.

- Use of the word "free" was questioned. It was noted that this vision statement is in accordance with the WHO concept of a world "free" of preventable chronic disease. However, several participants maintained that the goal should be set at "control" rather than eradication of chronic diseases, particularly in view of the wide diversity of CARMEN member countries.
- While the English version refers to "preventable, chronic, non-communicable diseases", the Spanish translation has "chronic, non-communicable and preventable diseases." The word "and" should be omitted from the Spanish version.

### Mission

- In drafting the mission statement, it is important to consider whether it adequately expresses CARMEN's unique strengths as a forum for sharing and innovation.
- It was recommended that the mission statement be redrafted in much broader terms. For example, "partner organizations" should include not just current partners involved in the health sector, but also other sectors. Additionally, the statement refers to "supporting the development, implementation and evaluation of…programs"; however, prevention and control cannot be achieved by programs alone. Changes are needed in industry, agriculture, trade, the consumer market and so on. It was suggested that the word "programs" might change to "actions" or "interventions".
- The reference to "member states of PAHO/WHO" was questioned. Not all PAHO members are members of CARMEN. While it is good to be inclusive, it is important not to lose sight of the fact that joining CARMEN implies a specific commitment, from which the network draws its strength.
- "Risk factors" should change to "risk factors and their underlying determinants".

### Objectives

As written, the draft seems to emphasize the objectives of the organization (PAHO) over those of CARMEN member countries. This emphasis should be reversed.

## Structure and Composition

This section should be more precise, emphasizing the inclusive nature of the network and the importance of external partners from all sectors, including the private sector and civil society. It should also note the diversity of relationships CARMEN may have with other networks or organizations, including short-term, long-term and strategic alliances. Overall, CARMEN should be presented as a vital, growing and inclusive network.

### Management Committee

The CARMEN Management Committee should include representation from partners, as well as from Member Countries and the secretariat.

### Subregional and Thematic Working Groups

- It may be advantageous to differentiate subregional groups from subregional networks such as CARLI.
- It was agreed that subgroups need not always be defined geographically. Thematic groups are also possible. Alternatively, groups could be defined by role (e.g., particular countries assigned to work on a particular issue).
- The formation of subregional networks was recommended as a way to enhance communication between biennial meetings. Subregional meetings could be held in alternate years. However, it was noted that a formal subregional group may not be appropriate in all circumstances. Instead, subregions should be permitted to choose from a list of options. For example, subregions with larger numbers of countries may benefit by establishing a technical working group rather than attempting to convene representatives for biennial subregional meetings.
- The perceived benefits to CARMEN of having an intermediate subregional level should be discussed and articulated in the Terms of Reference.

## Requesting Participation in the CARMEN Network

- Both "countries" and "local governments" need further definition. For example, entry of a "country" implies a decision and commitment by the national government as a whole, not just the Ministry of Health. The term "local government" may mean many things—e.g., municipal, regional or provincial/territorial.
- If municipalities are to be accepted directly into CARMEN, the potential for conflict with PAHO (which also engages municipalities directly) should be considered.
- One option for consideration may be to accept "local governments" only as part of a Member Country.

### Management Responsibilities

- Country responsibilities need to be redrafted to emphasize the ultimate objective rather than the plan as proposed by PAHO. The text as it stands sounds prescriptive, rather than taking a truly collaborative approach.
- The first subtitle should read simply "For the secretariat".

### Observer Status

- It was recommended that the secretariat be empowered to issue invitations to countries, territories, organizations or networks, with admission subject to approval by the Management Committee.
- It was suggested that inclusiveness, knowledge transfer and participation could all be strengthened by allowing countries to join as "associate members" or "observers",

even if they do not currently meet all the requirements of full membership. There is a precedent for this: two of the three designated observers at the last CARMEN biennial meeting have now become full member countries. Members, but not observers, were eligible for financial support to attend that meeting. However, since financial support may not always be available, this criterion cannot be relied upon as the sole distinguishing characteristic.

- The participation of French, Dutch, and British territories should be facilitated within CARMEN, even though they are not strictly "countries". It was noted that this is already possible: the El Paso Border Office participates as a member, despite lack of country status. To allow for this situation, Section 3 of the Terms of Reference should refer to "countries and/or territories".

## Election of the Management Committee

- It was proposed that the Management Committee consist of representatives from six Member States, at least one from each subregion. Each member should serve for a term of four years, with rotation of half of the members every two years to preserve continuity.
- The description of the election process remains unclear in the draft document. In particular, the following points require clarification:
  - Whether the random lottery is a one-time or a continuing process;
  - How the first three members to be "rotated out" should be chosen, and what the procedure should be after the first rotation.

An *ad hoc* task group was formed to consider a revised election procedure for discussion later in the meeting. In its report, the group raised the following points:

- Item 3.2.2 (Management Committee): The first paragraph is generally satisfactory. However, consideration must be given to the fact that some countries have served on the Committee since its founding. For this reason, it may be advisable to replace all positions in the first election, rather than half of them. Further, consideration should be given to having countries "take turns" in Management Committee representation; that is, once a country representative completes his/her term, that country should not run a candidate again until all other countries have been represented.
- Item 3.3.4: This should include a statement to the effect that election of Management Committee members will appear on the agenda of each biennial meeting.
- One proposal was to use a scoring system, based on Management Committee accomplishments and projections for the next four years, to decide whether half or all the positions should be declared vacant at any one time. Alternatively, points could be assigned based on seniority (length of time in CARMEN).
- Pending further discussion, it may be advisable to remove election-related issues from Item 3.2.2 and treat them separately.
- Provision must also be made for resignation of representatives due to special circumstances. In that case, it is recommended that a new election may be called

immediately (e.g., using electronic voting) or the seat left vacant, depending on the time left before the next regular election.

➔ The provision that at least one member should be elected from each subregion still does not provide for adequate distribution, since some subregions have many more countries than others. This issue requires further discussion.

In plenary discussion, it was noted that a clear procedure remains to be developed. There was consensus that the secretariat should redraft this section and propose an election procedure for further discussion, bearing in mind the points and principles raised at this meeting.

### Resources to Support Representation

The Terms of Reference should include a section on resources. It was suggested that member countries bear the responsibility of supporting their representatives' attendance at meetings, including meetings of the Management Committee. However, it was noted that ability to support representatives varies among countries and can be a highly sensitive issue. Alternative and supplementary sources of support (e.g., PAHO, organizational or individual donors) should also be considered and provided for in the document. One suggestion was that the secretariat and the country bear joint responsibility for arranging support. It was also recommended that the Management Committee discuss innovative ways to reduce costs associated with meetings (e.g., holding videoconferences). In making a final decision, care should be taken to consider all relevant factors (economic, political and social), and to ensure that the outcome reflects the inclusive spirit of CARMEN.

## Annex I: Chronology of Key Events in the CARMEN Network

Two missing items were noted:

1. CARMEN Management Committee meeting in Cuba, May 2002;
2. Formation of CARLI, 2003.

# III. CARMEN in action

## NCD Country Profiles

**Document:** *National NCD Country Profile: Inputs to Key Concepts and Questions*

It is recommended that the Country Profile survey be done every two years in order to monitor progress over time. This process is distinct from, and much less formal than, the more intensive evaluation of the CARMEN network.

Small groups were assigned to discuss specific sections of the draft document. Because the draft document is still in an early stage, participants were asked to give special attention to the selection of topics covered in the survey, and to identify any gaps.

Participants made the following comments with respect to the document as a whole:

1. Care must be taken to ensure that the questionnaire is completed by the appropriate individual(s) in each country, and that constructive, timely feedback is provided.
2. It was recommended that a new section be created for the question of resources, and that financial as well as human resources be considered.
3. The document appears to include only governments and NGOs. It should also recognize participation of other entities (e.g., the private sector) in expanded partnerships.

## Group Reports

The oral reports covered general comments only. More specific comments are included in the discussion forms submitted by each group, which will be reviewed by the secretariat and incorporated into the next draft.

### Group 1

**Section A (Institutional Capacity)**
**Section B (Features of Policies, Strategies, Action Plans and Programmes)**

1. Additional questions should explore the extent to which other sectors are engaged (including involvement in implementation and enforcement), as well as identification of those sectors.
2. B8, dealing with legislation and policies, is the most important question in these two sections. It should cover subregional and local (e.g., municipal) legislation as well as national.
3. Other crucial points are the role of the Ministry of Health and a description of the Ministry's leadership techniques / mechanisms.
4. Questions should be added on the impact of legislation, policies and interventions: this is a major gap.
5. Sections A and B should not be separate.
6. The component on institutional capacity (currently Section A) should include questions on how policy is developed, operationalized, monitored and assessed.

### Group 2

**Section C (National Health Reporting/Information System, Surveys and Surveillance)**
**Section D (Community Awareness)**

1. Abbreviations should be used consistently throughout the document.
2. Consideration should be given to using terms specific to subregional cultures, rather than using "international" language.
3. Some items in this section are duplicates.

### Group 3

**Section E (National Protocols / Guidelines / Standards for Conditions and NCDs)**
**Section K (NCD Prevention and Control Services)**
**Section L (Human Resources)**
**Section N (Medicines)**
**Section O (Diagnosis and Screening of NCDs)**
**Section P (Procedures)**

1. Sections N (Medicines), O (Diagnosis and Screening) and P (Procedures) should be included under Section K.
2. These sections should be reviewed to ensure that all priority NCDs and risk factors are included.

## Implementing the Lines of Action

### Line of Action 1: Policy/Advocacy

*James Hospedales*

**Specific objectives** for this section of the PAHO Plan of Action were presented. Participants were asked to give particular attention to the following points:

1. *(Objective 1):* Participants were asked to comment on the proposed division of responsibility between the secretariat and the countries, and in particular about the proposal for capacity-building workshops.
2. *(Objective 2):* A special initiative is proposed whereby PAHO would conduct an advocacy campaign aimed at cabinets in the countries.
3. *(Objective 3):* The secretariat is already engaged in the recommended core and expanded activities for some countries. Participants' views were requested on whether these activities should be expanded. It is also proposed that a policy dialogue "roadshow" be launched to discuss barriers to policy.
4. *(Objective 4):* The key proposal in this section is establishment of a regional policy observatory.
5. *(Objective 5):* Participants were asked to give concrete suggestions for creating a methodology for a national forum on policy.

#### ❖ *Discussion: Line of Action 1*

Participants raised the following points in discussion:

- ➔ Cuba's experience in this regard may provide a useful model for other countries. A health and quality of life program was created and led by the government as a whole; while the Ministry of Health was involved, it did not take the lead. Deputy ministers from transport, education and other sectors are all actively involved in developing and refining a variety of initiatives including healthy communities and tobacco control.

- Policy and advocacy should be more strongly integrated into the Country Profile survey. The questionnaire should cover policy characteristics, funding and mechanisms, as part of a region-wide monitoring process.
- Subregional networks would be useful to leverage existing political integration processes and implement an advocacy campaign aimed at cabinets / heads of states.
- The Spanish version currently uses a variety of terms (e.g., "oficina") in referring to the secretariat. The term "secretariat" should be used consistently.
- The term "NCD policy" implies matters of interest only to the health sphere, and is not especially meaningful to potential collaborators in other sectors. Instead, advocates should speak about developing public policy relevant to determinants (e.g., mass transport).
- Unfortunately, CARMEN community demonstration projects were too often approached as a "one-time" activity and were not sustained. To avoid this in future, it is essential to move to a higher level, securing buy-in from other sectors, and promoting formulation of policies that will have positive impact on determinants of health. This will require not only strong, evidence-based arguments and an emphasis on action, but also recognition that other sectors need specific incentives to get involved. Church-led NGOs, for example, are unlikely to respond to the same incentives that would attract private-sector businesses. In summary, the determinants of health give a basis for high-level integration, while economic factors (e.g., the cost of illness) provide a strong entry point for many other sectors. However, much more work is needed to identify the benefits to various sectors and present them as a coherent, persuasive package.

## Line of Action 2: Surveillance

*Branka Legetic*

**Essential elements** in this Line of Action include:

1. Positioning surveillance as part of national health reporting / information systems;
2. Going beyond individual conditions and risk factors to community determinants of health;
3. The need for reliable, comparable, high-quality data;
4. The need for timely, advanced analysis;
5. Dissemination of the results of analysis for use in national policy making, program planning and evaluation;
6. Ensuring the technical competency of the surveillance workforce;
7. Fostering creative thinking and innovation.

In the LAC area, there are significant challenges related to data availability and quality. WHO/PAHO reports that six of the countries have inadequacies related to mortality data;

four of them have no specific connection between mortality data and NCDs (as required for the PAHO Basic Data Initiative). Overall, underreporting of mortality ranges from 15% to 50%. Thirty-five LAC countries have data on at least one NCD risk factor, while ten have performed national risk factor surveys. Five of the countries have performed two or more of these surveys.

The vast majority of the countries (25) have some kind of health information system. Seventeen include data on NCDs in their systems, and the same number include risk factors. Mortality is included in the systems of 25 countries, and morbidity in 20. NCDs are part of routine surveillance in only eight countries.

The topics covered by existing surveys and surveillance in the LAC area are distributed as follows:

| | Studies / Surveys | Surveillance |
|---|---|---|
| Tobacco | 18 | 4 |
| Nutrition | 17 | 4 |
| Physical activity | 15 | 5 |
| Alcohol | 14 | 4 |
| Hypertension | 15 | 12 |
| Diabetes | 15 | 12 |
| Heart diseases | 10 | 9 |
| Cardiovascular disease | 9 | 7 |
| Cancer | 9 | 10 |
| Chronic respiratory disease | 4 | 7 |
| Dyslipidemia | 12 | 5 |
| Overweight / obesity | 16 | 7 |

Often, surveys are not repeated to give indications of trends, and follow-up is often neglected. While some countries do make good use of survey data in planning, most fall somewhere on the continuum between fully integrated information systems and fragmented, disconnected ones.

The overall objective of the Regional Plan of Action is to encourage and support the development and the strengthening of countries' capacity to better monitor chronic diseases, their impacts, their risk factors, and the impact of interventions as part of the integrated strategy on NCD prevention and control. To do this, a set of indicators will be used, linked to timelines and categorized into core and expanded levels.

**Specific objectives** include:

1. To encourage the development and strengthening of chronic disease surveillance systems which are ongoing, systematic, and linked to public health actions, in order to assess the burden (e.g., mortality, morbidity, disability, economic costs) of chronic diseases, their trends, related risk factors (e.g., tobacco use, unhealthy diet, physical inactivity, alcohol abuse), social determinants (e.g., social, economic and political conditions), and public health interventions (e.g., health services utilization);
2. To improve multi-partner collaboration to mobilize community, national, subregional, and regional partnerships to stimulate the effective development of surveillance systems and utilization of information;
3. To encourage development of national surveillance strategies, with a view to providing decision-makers with the surveillance information they need to develop and evaluate public health policies and programs.
4. To support improvement in quality (accuracy, completeness, and comprehensiveness), availability, and comparability of NCD surveillance information used for policy and program development;
5. To develop surveillance indicators for evaluation of the effectiveness, accessibility, and quality of population-based health services and interventions, as well as for the operations of the surveillance system itself;
6. To support the timely and effective communication of information about chronic diseases and risk factors to the appropriate target audiences;
7. To foster continuous education and training in order to ensure adequate capacity, human resources, expertise, and technical competency within the surveillance work force;
8. To encourage innovative ideas in chronic disease surveillance to meet new challenges and needs.

Currently, an implementation plan for surveillance is being developed based on the following **resources**:

1. The experience of countries which participated in CARMEN local surveillance demonstration projects;
2. The situational analysis for each country, based on the NCD Country Profile (the Profile assesses a range of factors including capacity, the availability of data and the degree to which the system as a whole is integrated);
3. The Caribbean proposal for a core set of indicators, supplemented with an expanded set as proposed by the PAHO CNCD Basic Data Initiative;
4. Existing tools for risk factor surveillance, such as Pan-American STEPs;
5. A data warehouse for information and analysis at regional, subregional and national levels (decentralized WHO infobase);
6. Guidelines for quality, underreporting and timelines from PAHO's program for Quality Improvement of Vital and Health Statistics.

### ❖ *Discussion: Line of Action 2*

The following points were raised in discussion:

1. Attention to data quality is especially needed at local and national levels.
2. Care must be taken to collect information that is relevant to potential collaborators in other sectors. To this end, there is a need for capacity building in negotiating with representatives of other sectors.
3. Countries with the least developed systems must be seen as priorities. To this end, every effort must be made to engage those which are not already members of CARMEN.
4. Good models do exist in the region, and CARMEN must identify and build upon them.
5. In line with the emphasis on determinants, health surveillance must expand to include broad economic data such as changing wage levels. In addition, every effort must be made to take advantage of the private sector's knowledge of marketing and consumer behaviour. These broader approaches will require capacity building, especially in economic analysis. This kind of capacity building is also needed to assess the cost-benefit ratio for interventions.
6. Information flow must be defined and mapped at national and regional levels.
7. Information systems should take advantage of alternative data sources that exist in various sectors, such as trade information and school records.
8. PAHO must develop a process to facilitate exchange among programs.
9. Selection of the data to be collected should be done with specific local and national interests in mind.
10. Surveillance is a crucial foundation for every other part of the initiative, including policy and advocacy. Without information, it is impossible to justify investment in specific activities. Yet national budgets seldom provide adequate support for development of information systems.
11. Surveillance need not be confined to conventional topics (e.g., physical activity levels, number of smokers, etc.). Often, questions and topics can be chosen for their appeal to public interest, to other sectors or to the media. These might include, for example, a focus on air quality or time spent in transit to and from the workplace.
12. There is a basic need to clarify the purposes and processes of NCD surveillance, as distinct from surveillance of communicable diseases.

## Line of Action 3: Health Promotion and Disease Prevention

*Enrique Jacoby*

PAHO's Healthy Eating and Active Living Unit conducts activities and programs related to diet and healthy physical activity. Recent activities include phase 2 (building alliances and launch) of a new strategy for healthy living. Related issues, such as tobacco, alcohol and

violence, are within the mandates of other Units but part of the integrated strategy and plan of action.

Among the major NCD risk factors, tobacco use was associated with the highest number of deaths in the Americas in 2000. However, it was closely followed by hypertension, overweight, high total cholesterol, low consumption of fruits and vegetables, alcohol use and physical inactivity. All these NCD risk factors were far more likely to be associated with death than were other factors such as sexually transmitted diseases, contaminated water, low weight and anemia.

While the conventional advice to eat well and exercise more is obviously important, it has clearly not been very effective. Available information indicates that there has been a spectacular growth of obesity in the countries of the region since 1962. Nevertheless, there has been little change. Similarly, there has been virtually no change in physical activity rates in the US, which hovered at about 30% throughout the period 1990-2002.
This situation has led to an explosion in the number of official publications calling for action. Since nothing has changed, the time has come for a major shift in approach. Clearly, targeting individual behaviours has not worked. Instead, the focus needs to change to the environmental and policy sphere.

Studies show that people in less developed countries tend to be more physically active. One study (Pelotas, Brazil, 2005) showed that individuals in the lower socioeconomic strata walk primarily for utilitarian reasons, while those in higher SES groups are more likely to do so for recreational purposes. In Bogota (2003), 60% of the population used walking primarily as a means of transportation. The same is generally true for people in Costa Rica, Nicaragua, Honduras and El Salvador. Nevertheless, conventional health messages focus on recreation (e.g., promoting sports and health club memberships). The statistical picture in LAC indicates that a much more effective approach – and one that has been adopted in Bogota with great success – would be to preserve and promote existing behaviours through measures such as:

1. Improved and expanded rapid mass transit systems;
2. Provision for alternative transport (e.g., bicycles);
3. Improving road and street safety (e.g., crime control, traffic rerouting);
4. Building pedestrian-friendly environments (e.g., more compact communities).

In Bogota, this was done by  a undertaking a concerted program of change, including transformation of one of the most congested avenues in the downtown area into a pedestrian mall, with no involvement from the Ministry of Health. The results have included higher rates of walking and bicycling, and an increase in quality of life. Added benefits include lower air pollution, fewer traffic accidents, a one-third reduction in travel times, and a 110% reduction in the crime rate over five years.

Similarly, the "food pyramid", with breads and cereals at the bottom and fats, oils and refined sugars at the top, is a familiar tool in the health advocate's armamentarium. But it is overly complex and, like the advice to "join a health club", it simply has not been effective. High-fat, processed, "unhealthy" foods are often cheapest, and account for the greatest

market share. The following measures are much more likely to be effective than the traditional appeal to individuals:

1. Promote high quality rather than high yield in agriculture. High-yield crops contain fewer nutrients, and deplete the soil;
2. Adjust the relative prices of healthy food. Too often, "unhealthy" choices are cheapest;
3. Provide incentives for the fresh-produce and fish industries;
4. Ban marketing of food to children;
5. Collect and disseminate better and more nutritional information;
6. Encourage and facilitate consumer participation.

### ❖ *Discussion: Line of Action 3*

The following points were raised in discussion:

1. A serious challenge to the PAHO healthy living campaign is the question of resources. A comprehensive program is much easier to implement in a single country than in a region; and there is a danger that variable resource levels among countries will dilute effectiveness by forcing a lowest-common-denominator approach. This is a particular problem in LAC, where the health sector is widely perceived as being concerned only with beds and hospitals, and a major priority is to preserve existing levels of service. To address this situation, it was recommended that consideration be given to decentralized campaigns tailored to different countries and different cultures. In addition, health advocates must learn to promote and take advantage of actions by other sectors, without trying to take the lead: in essence, to "row" instead of "steer".
2. Costa Rica has adopted a similar approach to that described in the presentation, with emphasis on creating the environmental conditions that will facilitate healthy behaviour. It was stressed that it is in fact irresponsible to ask people to walk more if the streets are not safe.
3. Cuba's NCD program is fully incorporated into the national health system. There is also a national strategy for health and physical activity, based on the best practices identified in demonstration projects. The strategy incorporates community support and intersectoral participation, and national goals have been defined to 2015.
4. Development of formal charters for health promotion and prevention may be an effective way to take advantage of the political commitment already made by Caribbean states.
5. In Canada, reorganization has resulted in a functional split between health promotion and the "stewardship" aspect of public health. There is a need to explore ways of reintegrating or, at least, coordinating these functions.
6. Television promotion of the new healthy living strategy, especially that featuring popular personality Don Francisco, has been very effective in putting a "face" to NCDs.

7. With respect to stewardship, Costa Rica has developed conceptual and strategic models of social protection of health with stress on the determinants. Nine specific stewardship functions have been assigned to the Ministry of Health, which is no longer directly involved in health service provision. The processes, procedures and products related to this model are available for sharing. It was noted that this division of function is also present in Canada, where provinces and territories, not the federal government, are responsible for health service delivery.

## Line of Action 4: Integrated Management of NCDs and Risk factors

*Silvana Luciani*

In the most recent WHO capacity survey, 28 countries in the LAC subregion reported that they had no national guidelines or clinical practice protocols for six major NCDs (hypertension, diabetes, cardiovascular disease, stroke, cancer and chronic respiratory disease) or for the four most important associated health practices (smoking cessation, weight control, diet and physical activity). Clearly, there is an urgent need to strengthen capacity and competency within the health care system itself for the integrated management of NCDs and their risk factors.

**Specific objectives**, and **planned or ongoing activities** associated with them, include:

1. To provide technical assistance to countries in developing, strengthening, implementing and evaluating their programs for NCDs and their risk factors, including coronary heart disease, stroke, hypertension, diabetes, major cancers, obesity, asthma, and hypercholesterolemia;
    a. *Related Activities:* Strengthening national capacity surveys; implementing needs assessments and evaluations; producing and disseminating program guides.
2. To facilitate the strengthening and/or reorientation of health systems for optimal management of NCDs and risk factors;
    b. *Related Activities:* Disseminating the chronic care model; promoting tools and lessons learned to improve care quality.
3. To foster the development, dissemination and implementation of evidence-based guidelines and protocols for prevention and control of NCDs and their risk factors.
    c. *Related Activities:* Providing advice and promoting guidelines for diabetes, hypertension and cancers, with expansion to other conditions planned.
4. To foster the development and improvement of competencies in the health workforce related to effective NCD management and control;
    d. *Related activities:* Providing support for training; creating internet-based training programs.
5. To facilitate the creation and utilization of health information systems for adequate patient and program management and evaluation as an integrated part of the surveillance system;

e. *Related activities:* Identifying indicators for monitoring; promoting a model information system.

6. To empower individuals and families affected by NCDs and risk factors for effective self-management;
   f. *Related activities:* Designing and disseminating effective self-management materials.
7. To ensure access to, and the rational use of, technologies and essential medicines for the management of NCDs and risk factors.
   g. *Related activities:* Improving access to medicines (e.g., through PAHO revolving fund).

While CARMEN provides the forum for delivery of technical cooperation, PAHO will work to implement the plan in the following **capacities**:

a. Providing direct technical advice;
b. Identifying partners with the necessary expertise to provide technical collaboration;
c. Facilitating collaboration with international partners such as PACT, IDF, CDC, PHAC and NHLBI;
d. Maximizing the effective work of PAHO/WHO Collaborating Centres;
e. Helping countries mobilize resources for plan-related activities.

Disease-specific implementation plans are also being developed for diabetes, cardiovascular disease and cancer to help countries and the region as a whole improve their management and control of these conditions. Each plan emphasizes proven cost-effective measures, such as blood pressure control (heart disease), glycemic control and foot care (diabetes) and screening (cervical and breast cancers).

### ❖ *Discussion: Line of Action 4*

The following points were raised in discussion:

1. Guideline preparation is a time-consuming and resource-intensive task, making it a difficult job for smaller nations to tackle alone. Further, compliance with guidelines is often less than optimal among people who are not involved in their preparation; this means that wholesale adoption of guidelines from other countries cannot be recommended. Chile has addressed this situation by developing a tool to analyze guidelines from other countries for quality and adaptability to national needs. This tool can be made available for sharing through CARMEN.
2. Guidelines must be linked to the capacity to deliver appropriate services at each level, and the primary responsibility of the health care sector is delivery of those services. Hence, the active participation of other sectors is essential if intervention is to move beyond the health sphere.

3. In addition to producing guidelines, it is crucial to establish standards of care that incorporate prevention and health promotion, together with mechanisms for auditing performance.
4. It is anticipated that integrated NCD management will take place chiefly at the level of primary care. It is at that level that such services as preventive counselling, routine screening and blood pressure monitoring would be provided. Other avenues (e.g., a system of "patient navigators") should be explored to increase integration at secondary and tertiary care levels.
5. Screening / early detection in primary care must be coupled with mechanisms for intervention. Maximal coverage and coordination are essential. In Cuba, all health institutions are cooperating in a concerted effort to follow up on those identified as high risk. However, intervention must go beyond the medical sphere if it is to be truly effective, reaching out to local governments and community resources to create the right environments for positive change. One successful initiative in Barbados, for example, held fiestas three times weekly for individuals with diabetes, to promote physical activity through dancing; the events were held at night in a variety of venues such as offices and health clinics.
6. The "centres-of-excellence" approach, where disease management is integrated under one roof, can produce good results but is expensive. Excellent results have also been achieved from much simpler interventions such as comprehensive foot care programs for people with diabetes, which have been proven effective in reducing amputation rates.
7. While nutritional efforts in LAC have traditionally focused on food delivery, times have changed. Undernourishment still exists, but food quality, safety and the need for healthy choices are the issues that affect the vast majority of the population today.

## Summary Presentation: Areas of Consensus

### ❖ *Line of Action 1: Policy and Advocacy*

1. Capacity building and a strong evidence base are required to enable effective negotiation and advocacy with other sectors.
2. Capacity building is also required in the area of policy development and the evidence needs to be linked to the interests of other sectors and actors.
3. There is a need to work together to achieve the active participation of other sectors (public, private, civil society) in the development and implementation of policies, health promotion and the establishment of healthful environments, based on sound evidence.

### ❖ *Line of Action 2: Surveillance and Information*

1. Capacity building is required to develop effective negotiation and presentation skills in areas such as health economics, which are of special interest to other sectors.

2. Special attention must be paid to the development of human resources for health surveillance, and to monitoring the use of human resources throughout the health system.
3. Surveillance information must include not only epidemiological data, but also indicators relevant to other sectors (e.g., cost, productivity, quality of life, profit), so that issues can be presented effectively.

### ❖ *Line of Action 3: Health Promotion / Disease Prevention*

1. Action on healthy diets, food quality and safety must include changes to agriculture and education policy, as well as engagement with the private sector to regulate / enforce labeling.
2. Action on physical activity, social cohesion and quality of life must include attention to mass transit, alternative transport, traffic safety and crime reduction.
3. Community endorsement and involvement are essential. Ways and means must be identified to promote and maintain this increased participation.
4. Conventional promotional efforts, such as nutritional campaigns, must be coordinated and integrated with the efforts of other sectors and groups working to reduce obesity and prevent chronic disease. There is only one type of "good nutrition"—that which is good for all people.
5. Emphasis should be placed on the determinants of health, creating the conditions necessary for healthy living. This involves a shift from an individual approach to a policy/environmental approach through engagement with other sectors. Examples include:
    a. The health sector role includes stewardship and participation in the health agendas of other sectors.

### ❖ *Line of Action 4: Integrated NCD management*

1. Evidence-based reorientation of health services is necessary to integrate primary and secondary prevention into routine health care. Examples include:
    a. *Non-pharmacological approaches* (e.g., smoking cessation, increased physical activity) as the first line of defence;
    b. *Comprehensive treatment and prophylactic treatment* (e.g., aspirin, antihypertensive drugs, cholesterol-lowering drugs);
    c. *Screening for risk factors and complications* (e.g., tests for retinopathy, albuminuria, routine foot examination).
2. Essential elements include integration of community resources to support prevention and control, and increased participation of civil society – i.e., patient NGOs, consumer NGOs, and the media. Ways and means must be identified to promote and maintain this increased participation.
3. Methodologies and tools should be shared with other network members.

### ❖ *Discussion on Summary Presentation*

Participants raised the following additional points:

1. BESIDES outreach to other sectors, there is a need to build institutional strength within countries in order to develop competency for both policy formulation and surveillance.
2. There needs to be a shift from epidemiological surveillance to health surveillance, with a focus on the determinants of health.
3. While it is important to build cross-sectoral skills within the health sphere, it should be borne in mind that not every health professional needs to be an economist. The best plan may be to build links with other sectors through existing networks and groups.

## Supporting the Regional Strategy: CARMEN Strengths and Gaps

Participants identified the following **strengths** which the CARMEN network can contribute in support of the Regional Strategy:

1. Built-in credibility and commitment, as a network of governments working on a common agenda;
2. Ability to facilitate both national and international action;
3. Ability to facilitate inter-country sharing of experiences, methodologies, best practices and lessons learned for use in planning and program implementation;
4. Ability to provide continuity for the NCD message, giving it "staying power" through national reorganization and regime changes;
5. Ability to provide "clout" through an essential link to PAHO, and through PAHO to WHO and other important international organizations;
6. Ability to act as a "laboratory" to test innovations at a practical level and deliver practice-based evidence;
7. Ability to provide a forum to promote creative thinking and innovation;
8. Ability to provide a framework and models for engaging other sectors (e.g., intersectoral meeting held in Puerto Rico);
9. Specific resources including the CARMEN School, the Policy Observatory and the *Chronic Disease in the Americas* newsletter.

In discussing **gaps**, participants identified the following needs:

1. A sharper focus on the objectives and outcome of interventions, as opposed to process;
2. Autonomous action – Individual countries should move forward, establishing their own objectives and programs;
3. Communications – CARMEN activities, achievements and resources are not as widely known outside the network as they should be;
4. Expanded access and increased coordination of care;
5. Network expansion – Additional countries and partners should be included in CARMEN;

6. Resources – It was noted that TCC funding may be an underutilized mechanism for supporting specific countries and projects. It was proposed that TCC funding be sought to prepare an inventory of resources and specific expertise in member countries;
7. Tools and mechanisms to assess guidelines and to audit quality of care.

It was proposed that CARMEN host a meeting with actual and prospective partners to discuss the potential for collaboration.

# IV. CARMEN Biennial Meeting

**Document:** *The Biennial CARMEN Meeting: Fall 2007*

## Vision

Asked to envision successful outcomes for the 2007 Biennial Meeting, participants contributed the following:

1. A clear plan of action was established for CARMEN based on the four Lines of Action.
2. After the meeting, all who attended had a clear idea about next steps and their particular role.
3. All member states had access to the resources they needed to send representatives to the meeting.
4. As a result of the meeting, existing partnerships with organizations such as RAFA and AMNET were strengthened and enriched. Partners left the meeting with a better understanding of how their networks and organizations fit together, which objectives are shared, and how the plan of action will be coordinated.
5. Countries have identified common issues.
6. Countries have worked jointly to submit proposals for funding.
7. Definite, visible progress has been made in individual countries thanks to CARMEN.
8. Funds have been mobilized for activities, both network and in-country.
9. Intervention strategies and associated resources were well defined.
10. Representatives of non-member countries and non-health sectors attended and participated actively in the meeting. This is a priority, second only to attaining full attendance of CARMEN members.
11. The meeting began and ended on time and stayed on track.
12. The meeting featured a learning session on the theory and practice of networking, including best practices.
13. The meeting had clear objectives, which were met.
14. The meeting reviewed past commitments of members and assessed the progress that has been made in those areas.

## Review of Draft Objectives

The following points were raised in discussion:

1. Additional objectives should include:
   - Reaching final consensus on a process for electing the Management Committee, together with a clear mandate for that Committee.
   - Identifying ways to "market" healthy choices effectively
   - Adjusting the Action Plan in the light of the impact of globalization on the region (NAFTA etc.)
2. It may be advisable to select high-priority objectives among those listed, to avoid overcrowding the agenda.
3. Objective #2 should refer to a review and celebration of progress and achievements, rather than simply a celebration of the first ten years.
4. Objective #3 should include rehabilitation.
5. The central purpose of the meeting needs clarification (e.g., technical exchange, strategic planning, resource mobilization). It was recommended that representatives of member countries be polled for their viewpoints.
6. The language of the document should be revised to convey the idea that CARMEN is at a turning point, that this is a crucial meeting, and that strategic discussions will be a priority. It was suggested that at least some of this could be expressed in a preamble.
7. The meeting should work toward a concrete action plan for CARMEN as a whole, rather than relying on individual countries' plans.

## Timelines

The meeting is tentatively scheduled for 6-9 November 2007. The Management Committee will meet on the afternoon of 5 November 2007 to finalize plans. Following elections, the new Management Committee will meet directly after the main meeting.

## Review of Draft Agenda

8. Section D (Biennial Planning): It was recommended that the last item read "CARMEN role as a think tank", with the rest of the sentence deleted to leave the meaning as broad as possible.
   - *Additional items* should include:
     - A Partners' Forum to encourage collaboration;
     - A major section on policy.
9. Key considerations throughout the agenda should include:
   - Specific plans should be developed to engage external partners, including the private sector.

- The Biennial Meeting is a CARMEN event, as distinct from PAHO. The CARMEN name and perspective should be predominant throughout.
- The event should be planned with a view to positioning health on the agendas of other sectors and potential partners. To this end, it may be helpful to develop a "tagline" for the event with facts-viewpoints that appeal to various sectors, each backed up with statistics. One suggested tagline *was "Contributing to saving lives, increasing productivity, decreasing poverty and reducing health care costs";* however, some participants noted that this statement may be too negative and disease-focused. It was recommended that the chosen tagline be short, with no more than 2–3 claims.

## Conference Package

Documents distributed at the conference should include the Regional Strategy, the CARMEN chronology, special papers or statements on policy/advocacy and other central issues.

## Knowledge Exchange

The conference should provide an opportunity for countries to present their accomplishments, activities and innovations.

## Input from Member Countries prior to the Meeting

Member countries should be given time to consider the draft objectives and agenda from their own viewpoints and to make recommendations for additions or changes.

## Venue

To be announced.

## Next Steps

➔ The secretariat will revise the objectives and agenda in the light of this discussion. Management Committee members will have the opportunity to review the revised draft prior to distribution to all CARMEN members, who will also be invited to comment.

➔ A Management Committee teleconference will be held within the next few months to plan the agenda in more detail.

# Appendix A: List of Participants

**Chile**
Dr. Maria Cristina Escobar
Dr. Tomo Kanda

**Canada**
Ms. Barbara Legowski
Ms. Lise Mathieu
Dr. Sylvie Stachenko

**Costa Rica**
Dr. Roberto del Aguila
Dr. Rossana Garcia Gonzalez
Dr. Luis Tacsan Chen

**Cuba**
Dr. Ana Ibis Gámez Bernal
Dr. Rolando Miyar
Dr. Taimi Porto Hernández

**Eastern Caribbean Countries**
Dr. Gina Watson

**Panama**
Ms. Sara Maritza Díaz de Casis
Dr. Washington Lum

**Puerto Rico**
Dr. Raúl Castellano Bran
Dr. Olga Cruz

**Trinidad & Tobago**
Dr. Carol Boyd-Scopie
Dr. Mohammed Rahaman

**PAHO NCD Unit**
Ms. Elizabeth Cafiero
Dr. James Hospedales
Dr. Enrique Jacoby
Dr. Branka Legetic
Ms. Silvana Luciani
Dr. Enrique Perez Flores

**Facilitator**
Ms. Dorothy Strachan

**Proceedings**
Dr. Sheila Penney

**Administrative support**
Ms. Natalia Chalaeva
Ms. Nataliya Mitrofanova