

GLOBAL ALLIANCE AGAINST CHRONIC RESPIRATORY DISEASES (GARD)

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The report was prepared by the co-rapporteurs Alvaro A. Cruz, WHO, and Arzu Yorgancioglu, Turkey, assisted by Elisabetta Minelli, WHO.

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LIST OF ABBREVIATIONS

AAAF	Asian Allergy and Asthma Foundation
ADF	Asthma Drug Facility
AIMAR	Italian Scientific Interdisciplinary Association for Research in Respiratory Medicine
ARIA	Allergic Rhinitis and its Impact on Asthma
ATS	American Thoracic Society
BOLD	Burden of Lung Diseases Study
BTS	British Thoracic Society
COPD	Chronic obstructive lung disease
CRD	Chronic respiratory disease(s)
EAACI	European Academy of Allergology and Clinical Immunology
ECG	Electrocardiogram
EFA	European Federation of Allergy and Airways Diseases Patients' Association
ERS	European Respiratory Society
FEV1	Forced expiratory volume in one second
FIRS	Forum of the International Respiratory Societies
GAL ² EN	Global Allergy and Asthma European Network
GARD	Global Alliance against Chronic Respiratory Diseases
GINA	Global Initiative for Asthma
GOLD	Global Initiative for Chronic Obstructive Lung Disease
HIV	Human immunodeficiency virus
ICC	International Coalition for Chronic Obstructive Pulmonary Diseases
ISAAC	International Study of Asthma and Allergy in Childhood
KAF	Korean Asthma and Allergy Foundation
PAL	Practical Approach to Lung Health [WHO-led project]
PHAC	Public Health Agency of Canada
PSAAI	Paraguayan Society of Allergy, Asthma and Immunology
PSTP	Paraguayan Society of Tuberculosis and Pulmonology
SFAIC	Société Française d'Allergologie et d'Immunologie Clinique
SPLF	Société de Pulmonologie de Langue Française
TB	Tuberculosis
TNSACI	Turkish National Society of Allergy and Clinical Immunology
TTS	Turkish Thoracic Society
UN	United Nations
WAO	World Allergy Organization
WHO	World Health Organization
WONCA	World Organization of Family Doctors

INTRODUCTION

Everyone in the world is exposed to risk factors for chronic respiratory diseases (CRD). Three billion people live in urban areas and are exposed to outdoor air pollution. Two billion people are exposed to solid fuel combustion which represents one of the major risk factors worldwide. One billion people are exposed to tobacco smoke and everyone is exposed to allergens. These risk factors are of particular concern in developing countries and deprived areas.

One billion people suffer from CRD. Currently 300 million people have asthma, 210 million have chronic obstructive pulmonary diseases (COPD), 400 million have allergic rhinitis, over 100 million have sleep apnoea syndrome, and over 50 million have other CRD. Moreover, CRD are often unrecognized and undiagnosed (1).

The World Health Organization (WHO) estimates that, in 2005, some four million people died of CRD and that by 2030 COPD will be the fourth leading cause of death (1). Tobacco smoke will cause over 8 million deaths and biomass fuel combustion over 10 million.

The Global Alliance against Chronic Respiratory Diseases (GARD) was formed to help stop this global epidemic. GARD is a voluntary alliance of national and international organizations, institutions and agencies committed to the vision of a world where all people breathe freely. Its goal is to reduce the global burden of CRD. Its main objective is to initiate a comprehensive approach to fight CRD by: (1) developing a standard way of obtaining relevant data on the burden of CRD and their risk factors; (2) advocating for action on CRD; (3) encouraging countries to implement health promotion and CRD prevention policies; (4) developing simple and affordable strategies for management of CRD. WHO has a dual role in GARD, providing both technical leadership and secretariat support.

GARD provides a network through which collaborating parties can combine their strengths and knowledge, thereby achieving results that no single partner could attain alone. Collaborating parties are participants, observers and individual experts. Participants are organizations, institutions or agencies with an active involvement in the surveillance, prevention and control of CRD that declare their interest and commitment to the vision, goal and objective of the Alliance. Individual experts have international experience in the field of CRD. Commercial enterprises or private sector entities and their representatives can participate in GARD as observers.

The Alliance was formed in response to World Health Assembly Resolution WHA53.17 (2000) which requested the Director-General:

- To continue giving priority to prevention and control of noncommunicable diseases including chronic respiratory diseases, with special emphasis on developing countries and other deprived populations;
- To strengthen existing partnerships and develop new ones, notably with specialized national and international nongovernmental organizations, with a view to sharing responsibilities for implementation of the global strategy based on each partner's expertise;
- To coordinate, in collaboration with the international community, global partnerships and alliances for resource mobilization, advocacy, capacity building and collaborative research.

After several international expert consultations between 2001 and 2004 the terms of reference of GARD were approved by WHO and the first meeting of the Alliance was held at WHO Headquarters, Geneva, Switzerland on 18–19 January 2005. The Alliance was launched on 28 March 2006 in Beijing, China.

OPENING CEREMONY

Professor You-Young Kim, President, Korean Asthma and Allergy Foundation (KAF), on behalf of the Organizing Committee of the General Meeting, welcomed the participants, in particular Dr Nikolai Khaltsev, Responsible Officer, WHO, and Professor Jean Bousquet, GARD Chairperson. Professor Kim stressed the importance of having GARD collaborating parties gathered in Seoul to enable exchange of information and the generation of suggestions to reduce the burden of CRD and to work towards a world where all people breathe freely. Professor Kim also acknowledged the message from Dr José Antonio Ocampo, UN Under-Secretary-General (Annex 1) which conveyed the support of the UN Secretary-General for the efforts of GARD to combat the growing health crisis of CRD.

Dr Nikolai Khaltsev, Responsible Officer, Chronic Respiratory Diseases, WHO, thanked the hosts and organizers of the meeting. He also thanked GARD collaborating parties from all over the world for their participation in this General Meeting, the representative body of the Alliance. He explained that the purpose of the General Meeting was to review the reports and the activities of the secretariat, the Planning Group and the collaborating parties, and, where appropriate, endorse them. This meeting was the second General Meeting after the global launch of GARD in Beijing, China, on 28–29 March 2006. Dr Khaltsev underlined that one of the most important outcomes of the meeting would be a revision of the governance of the Alliance consisting of the following components: General Meeting, Planning Group and Executive Committee. The election of participants of the Planning Group and the Executive Committee would be carried out during this meeting.

Fifty-three representatives attended the meeting: 30 GARD participants, 9 GARD experts, 11 GARD observers and 3 WHO staff from GARD secretariat (see Annex 2). Representatives of the Ministry of Health and Welfare of the Republic of Korea were also present. In addition, many Korean colleagues attended from the Korean Asthma, Allergy and Clinical Immunology Society, the Korean Academy of Tuberculosis and Respiratory Diseases, the Korean Academy of Occupational Asthma, the Korean Academy of Pediatric Allergy and Respiratory Diseases and the Korean National Tuberculosis and Lung Association.

The participants nominated Professor Jean Bousquet, GARD Chairperson, to serve as Chair, and Dr Suzanne Hurd, United States of America, to serve as Co-Chair of the meeting. Dr Alvaro A. Cruz, WHO, and Professor Arzu Yorgancioglu, Turkey, were nominated as Co-Rapporteurs.

Professor Jean Bousquet welcomed the participants and thanked WHO staff for the hard work that they had undertaken for GARD over the past years. Since not all participants were familiar with the work of GARD, Professor Bousquet presented an overview of the Alliance and of its activities. After an explanation of the rationale, he illustrated the Alliance and its framework for action in the following steps: estimate population needs and advocate for action, formulate and adopt policy and implementation.

The present report summarizes the presentations and discussions that took place during the General Meeting. The material presented during the General Meeting is available on the GARD web site:

http://www.who.int/gard/news_events/GARD_General_Meeting_Seoul/en/index.html

A proposal for a statement on CRD (Annex 3) drawn up by KAF was presented to the General Meeting by Dr You-Young Kim, KAF President. The idea of the statement was accepted by the participants as a means to raise awareness of CRD among Ministries of Health, the media, the lay public, potential donors and partners of GARD. It was decided that the proposal would be revised, edited and published by the GARD secretariat.

REPORT OF THE SECRETARIAT

Advocacy and communications

Dr Nikolai Khaltsev proposed a series of tools aimed at engaging GARD collaborating parties in the achievement of GARD's goal of reducing the burden of chronic respiratory diseases. After defining the goal, purpose, expected results and activities of the Alliance, it would be necessary to clarify the role and responsibilities of each collaborating party. He hoped to work with GARD collaborating parties to develop a strategic framework for the Alliance.

Working proposals for the following tools were presented to GARD collaborating parties for their consideration: GARD cycle, problem tree, objective tree, and logical framework matrix (see GARD web site: www.who.int/respiratory/gard/launch).

The *GARD cycle* includes 12 proposed steps to develop and manage the Alliance. The cycle is continuous, each step having its own scope. For example, the scope of the first step is to understand the challenge, gather information, and consult stakeholders and potential resource providers. At present, GARD collaborating parties are facing the challenges of the building and planning phases, as well as the managing and resourcing phases.

Dr Nikolai Khaltsev started the report of the secretariat by emphasizing communications and advocacy. He stressed that communications and advocacy were crucial to increase awareness of CRD; diseases that were still underrecognized and underestimated. The first step was branding GARD with an appropriate logo that was accepted by all collaborating parties.



The second step was to develop a GARD co-brand web site (<http://www.who.int/gard>) that was regularly updated with activities from GARD and its collaborating parties. "Face to face with chronic respiratory diseases" was mentioned as one of the features on the web site. A flyer on GARD was developed and translated into WHO official languages (Arabic, Chinese, English, French, Russian and Spanish), and also into Portuguese. Two issues of the GARD Newsletter were published online and widely distributed.

Dr Khaltsev mentioned the following upcoming publications:

- *Global surveillance, prevention and control of chronic respiratory diseases: a comprehensive approach* (GARD Book), which will result in short "spin off" publications targeted towards lay public and media, health workers and policy-makers.
- GARD Basket CD-ROM which is a package of papers, tools and guidelines to be offered to countries for the development and implementation of country-specific action plans.
- "*Towards an alliance against chronic respiratory diseases at country level* (GARD Country)"; a document to help country initiators and stakeholders to explore, build and maintain alliances at country level in order to initiate or upgrade policies, plans and programmes on CRD.
- GARD Framework for Evaluation (encompassing baseline information on burden and risk factors of CRD, GARD process, GARD outputs, and health outcomes) to be used as a tool for the monitoring and evaluation of CRD and the impact of GARD at country level.

Discussion on advocacy and communications

- Logo: the possibility of adding the extended name of the Alliance to the logo was discussed. The final decision was to keep the current logo, and to mention the complete title of the Alliance in any context in which the logo is used.
- Web site: it was suggested that the GARD web site should be registered in different URLs. In this respect, it was recommended that all collaborating parties should cross-link the GARD web site on their respective web sites. This should increase the popularity of GARD web site on the research engines. Dr Alfred Loh, World Organization of Family Doctors (WONCA) proposed to add a cross-link to the GARD web site on the WONCA web site which got 90 000 visits/month. Additionally, the GARD web site could be featured one week on the WONCA home page. This would be a way to advocate among practitioners.
- Distribution: distribution of GARD advocacy and communications material should be global using the channels that collaborating parties offer, including the WHO distribution list.
- World Day: in considering Asthma World Day, World COPD Day, World Allergy Day, it was suggested that a World GARD Day should be considered to celebrate GARD as encompassing all CRD. However, an extra day might not have any added value, and it might compete with the World No Tobacco Day. It was decided that a proposal should be presented for discussion during the next General Meeting.
- GARD Book: it was proposed that the GARD Book should be launched during the European Respiratory Society (ERS) Congress to be held in Stockholm, Sweden, on 15–19 September 2007.

Collaborating parties

Ms Elisabetta Minelli, WHO, presented the current status of the collaborating parties and new applicants that are the strength of the Alliance. The Alliance comprised 47 participants (see Annex 4): professional associations from different specialties (respiratory, allergy, primary care, and specific disease), patient organizations, governmental institutions, WHO Collaborating Centres and foundations; and 11 observers from the private sector. In addition, 31 organizations demonstrated an interest in the Alliance and in becoming collaborating parties. The increasing interest in GARD was acknowledged, and it was questioned whether the Alliance should follow an inclusive or an exclusive approach. Some steps were suggested in order to provide criteria on which to decide whether to involve additional partners. These steps included agreeing on a strategic plan for the Alliance, analysing gaps towards the achievement of the goal of the Alliance and calling for new partners to fill the unmet needs.

Discussion on collaborating parties

The discussion focused around the question of whether GARD should be a restricted or an inclusive alliance. It was agreed that the Alliance should follow the principle of inclusiveness. However, all the steps needed for the efficient management of the Alliance should be put in place, i.e. developing an adequate strategic plan and appropriate governance. It was suggested that, in the future, the decision-making of the Alliance might be carried out by a smaller body than the General Meeting, such as the Planning Group, while the General Meeting should remain as a brainstorming forum. The role of alliances at country level was also underlined as a necessary first level of gathering for the interested parties. Furthermore, it was suggested that large national societies could be invited by GARD Country coordinators to apply to become GARD participants at the global level.

Launches in countries

Professor Jean Bousquet illustrated the launches of the Alliance at the global, regional and national level. The Alliance was launched globally in Beijing, China, on 28 March 2006 in the presence of the Ministry of Health of China. Regionally the Alliance was launched for Latin America (in Buenos Aires, Argentina, 17 August 2006), for South Africa (in Cape Town, South Africa, 5 March 2007), for Eastern Europe (in Zakopane, Poland, 23–24 March 2007), for francophone countries (in Paris, France, 11 April 2007), and for Euro-Asian countries (in Astana, Kazakhstan, 6–8 May 2007). At country level, the Alliance was launched in Brazil (dual launch in Recife, 7

October 2006 and in Fortaleza, 4 November 2006) and in the Republic of Korea (Seoul, 31 May 2007). In the coming months there will be launches in Algeria (Alger, 13 June 2007), Italy (Rome, 21 June 2007), Portugal (Lisbon, 20–21 October 2007), Norway (Oslo, 15 November 2007), and Turkey (Istanbul, 29 May 2008).

Discussion on launches in countries

The launches should be as inclusive as possible. It was underlined that at country level all stakeholders should be invited to participate in the launch of GARD as a crucial first step for building an alliance at country level.

REPORT OF THE PLANNING GROUP

Governance

Dr Nikolai Khaltsev presented the proposal for governance of the Alliance that was recommended by the current Planning Group. The components of governance discussed were: the General Meeting, the Executive Committee and the Planning Group.

The proposed function and composition of the components were the following:

- The General Meeting would maintain its decision-making function. The General Meeting comprises one representative from each collaborating party; WHO has a permanent seat.
- The Executive Committee would manage the Alliance and offer overall strategic direction and guidance. It comprises five participants: WHO, Chairperson, Vice-Chairperson, one participant elected by the General Meeting and one participant nominated by WHO, Chairperson and Vice-Chairperson and endorsed by the General Meeting.
- The Planning Group would coordinate the various activities of the Alliance and submit new proposals and ideas to the General Meeting for endorsement. The Planning Group should be composed of 15 participants: WHO, Chairperson, Vice-Chairperson, and a maximum of eight representing professional organizations in the fields of respiratory medicine (3), allergy (2), primary care (1), pharmacy, physiotherapy, nursing and other associations of professions allied to medicine (1), and other organizations devoted to specific diseases (1), a maximum of one representing patient organizations, a maximum of one representing governmental institutions, a maximum of one representing WHO Collaborating Centres, a maximum of one representing collaborating foundations, a maximum of two representing the Country-focus Group and the Scientific Group. The current participants belonging to the abovementioned categories were listed.

Decision-making should be by consensus. Only when the consensus of all participants was not reached should a two-thirds majority be accepted, and only in this case, would WHO retain the right of veto on all decisions made by the governance components of the Alliance. The procedures for acceptance of applications and for termination of participants were also presented.

Discussion on governance

The proposal on the composition of the governance components recommended by the Planning Group was endorsed by the General Meeting with the following amendments:

- The total number of participants of the Planning Group should be 17 in total: WHO responsible officer for GARD, Chairperson, Vice-Chairperson, eight representatives of professional organizations in the fields of respiratory medicine (3), allergy (2), primary care (1), pharmacy, physiotherapy, nursing and other associations of professions allied to medicine (1), and other organizations devoted to specific diseases (1), one representing patient organizations, one representing governmental institutions, one representing WHO Collaborating Centres, one representing collaborating foundations, two representing the Country-focus Group and the Scientific Group.

It was recommended that the Planning Group would review the governance proposal according to the following suggestions of the General Meeting and would present the revised proposal to the 2008 General Meeting:

- It was recommended that the participants of the Planning Group should be organizations and not individuals. It was also decided that only the organizations that were active GARD participants and

- that had predefined their representatives would be eligible for election to the Planning Group and the Executive Committee.
- It was proposed and approved that the term of Chairperson and Vice-Chairperson should be two years, but that they were eligible for re-election for two further two-year terms. This is to provide the Alliance with continuity. Also in this respect, it was suggested that the Planning Group should propose a mechanism to guarantee continuity in the leadership of the Alliance. The idea of having a "Chairperson-Elect" before the end of the term of the current Chairperson was put forward as an option.
 - It was recommended to add that the term of the Planning Group participants as well as that of the Executive Committee participants was two years, but that they were eligible for re-election for one further two-year term.
 - It was suggested that participants of the Planning Group should not sit at the same time on the Executive Committee.
 - It was suggested that the representative of the commercial sector who served as observer in the Planning Group should be elected by GARD observers.

It was acknowledged that paediatrics is a major field of GARD activities, and consequently should have an important role in the Alliance. It was mentioned that paediatrics was widely represented among GARD participant organizations although no general paediatric organization was currently a GARD active participant. Unless a paediatric organization is actively participating in the Alliance, no post could be added on the Planning Group. However, it was recommended that for the time being the post "pharmacy, physiotherapy, nursing and other associations of professions allied to medicine" could be occupied by a paediatrician. It was accepted that the list should be flexible and an extra position could eventually be opened for paediatric organizations if needed. With this purpose, it was suggested that paediatric organizations such as the American Pediatric Society and the Brazilian Pediatric Society, both having over 20 000 members, be contacted and invited to become GARD participants.

It was decided that the governance as described in the amended proposal should take effect from the date of this General Meeting.

It was reiterated that GARD should work on the commitment of governments, in particular from developing countries, and it was underlined that there should be a higher representation of low and middle-income countries in the Planning Group.

Elections

A committee composed of Dr Suzanne Hurd, Ms Elisabetta Minelli and Professor Teresa To was elected to count the votes. Only participants that had an up-to-date donor agreement with WHO were admitted to vote.

Concerning the Planning Group, it was asked whether the current participants of the Planning Group (Eric Bateman, Michael Boland, Claude Lenfant, Ruby Pawankar, Archie Turnbull, Erkkka Valovirta) should remain or whether the participants should be elected anew. The General Meeting decided to maintain the current participants of the Planning Group, with the exception of Eric Bateman who was later elected to the Executive Committee.

The elections of the additional participants were by secret ballot. The results of the elections of the Planning Group are listed below.

- Professional associations – Respiratory (3): Philip Hopewell (ATS), Arzu Yorgancioglu (TTS), Archie Turnbull (ERS-FIRS);
- Professional associations – Allergy (2): You-Young Kim (KAF), Roy Gerth Van Wijk (EAACI);
- Professional associations – Primary Care (1): Michael Boland (WONCA);
- Professional associations – Pharmacy, physiotherapy, nursing and other associations of professions allied to medicine (1): Erkkka Valovirta as representative of paediatrics;

- Professional associations – Disease specific (1): Claude Lenfant (GINA/GOLD);
- Patient organizations: Svein-Eric Myrseth (EFA);
- Governmental institutions: Lianne Vardy (PHAC);
- WHO Collaborating Centres: Sohei Makino (Dokkyo University, Tochigi, Japan);
- Foundations: Ruby Pawankar (AAAF);
- Scientific Group: Giovanni Viegi (Chairman, Working Group 1 on Burden, risk factors and surveillance);
- Country-focus Group: Abai K Baigenzhin (Kazakhstan).

Antje Fink-Wagner of Altana Pharma was nominated by GARD observers to serve as their representative on the Planning Group.

For the Executive Committee, Professor Carlos Baena-Cagnani was nominated by WHO, Chairperson and Vice-Chairperson, and endorsed by the General Meeting. Dr Eric Bateman was elected by the General Meeting.

Discussion on elections

- It was recommended that only the participant organizations present during the General Meeting or officially represented by another organization could stand for election in the future.
- It was proposed that the representative of the patients' organizations should be a patient.
- It was recommended that if a participant of the Planning Group or of the Executive Committee stepped down, that participant's organization should nominate candidates for the replacement and the General Meeting should vote among the proposed candidates.

A working proposal for the development of the strategic plan of the Alliance

Professor Jean Bousquet presented a working proposal for the development of the strategic plan of the Alliance. He stressed that the purpose of the strategic plan was to help to plan the activities of the Alliance, to monitor its achievements on a regular basis, to evaluate its impact at specific times during its development and to be used as an advocacy tool to raise funds to support the Alliance. Professor Bousquet described a proposed outline of the plan. The following parts should be developed and agreed in a participative way by the collaborating parties:

- WHY the Alliance is needed: core problem
- WHAT principles are guiding the Alliance: guiding principles
- WHAT the Alliance is expected to achieve: goal, objective, expected outputs
- HOW the Alliance is going to achieve the outputs: activities
- HOW to assess its success: indicators
- WHERE to find the data required to assess its success: means of verification
- WHICH internal and external factors are crucial for its success: assumptions
- WHEN it is expected to achieve the results: chronogram
- WHO in the Alliance is going to work towards identified expected outputs: activity schedule
- HOW MUCH is available and how much is needed: resource schedule

Discussion on the working proposal for the development of the strategic plan of the Alliance

- The outline and the content of the proposal were approved by the General Meeting. It was recommended that the Planning Group would move it forward and present a strategic plan for either 3 or 5 years (2008–2011 or 2008–2013) during the next General Meeting.
- It was underlined that it was important to analyse the resource needs at the global level, not only for building the Alliance, but also for implementing the activities.
- It was suggested that a list of potential donors and funding agencies should be developed.
- It was stressed that the achievements of the Alliance should be measured in terms of process, output and impact indicators. This would eventually facilitate effective fund-raising.

Resources to implement the strategic plan

Discussion on resources to implement the strategic plan

Dr Nikolai Khaltsev summarized the financial report for the period 1 January 2006 – 17 May 2007. He showed that the Alliance received three different types of contributions: contributions from participants (25%); contributions from observers (33%); and contributions in kind from WHO (42%) giving a total of US\$ 1 426 000. He also illustrated the various types of expenditures totalling US\$ 965 277. Expenses included staff (29%), operational expenses (15%) including GARD meetings and travel, and other expenses (3%) including publications, procurement of medical devices, contractual services and temporary advisers. The remaining part related to the expenditures of WHO (47%) and to the programme support cost (6%). The expenditures were specified for each category.

- It was mentioned that the Working Groups had not received any funding. Nevertheless, the secretariat had prepared several proposals either in collaboration with the Working Groups or for their comments. A mechanism for raising funds specifically for the Working Groups should be developed.
- It was underlined the key role that WHO has in the Alliance. The importance of WHO in working with low- and middle-countries was mentioned as crucial for scaling-up GARD actions.
- It was argued that only the in-kind contribution from WHO was mentioned. The contributions in kind from GARD collaborating parties should also be included in the next financial report. A comprehensive budget should be developed including all the resources that the collaborating parties provide. The Planning Group should be charged with this task.
- It was reiterated that “annual fee” should be added to the term “voluntary contribution or donation”, implying a strong and long-term commitment. It was decided that this issue should be discussed with WHO.

ACTION AT COUNTRY LEVEL

Towards an Alliance against Chronic Respiratory Diseases at country level (GARD Country)

Dr Khaltaev mentioned that GARD was a global alliance that focused on the needs of countries, and fostered country-specific initiatives tailored to local conditions. In order for the activities of the Alliance to meet the specific needs of countries, alliances at country level (GARD Country) might be established to provide a coordination role and create the necessary momentum to strengthen the national capacity to face the increasing burden of CRD.

GARD Country could act as a platform for all parties that are interested in CRD in the country and that want to play a role in an alliance for health. The desired outcome at country level was to initiate or upgrade a sustainable programme on the surveillance, prevention and control of CRD.

Dr Khaltaev presented a template that was intended to serve as a guide to potential GARD Country initiators who were considering the development of an alliance at country level. GARD Country initiators could adapt the described basic steps to the local situation, taking into consideration the specific characteristics of the country.

Dr Khaltaev described the role of the GARD Country initiator and the core group of interested parties. He illustrated the basic prerequisites for the development of an alliance at country level:

- The situation with regard to the surveillance, prevention and control of CRD in the country is analysed.
- The Ministry of Health of the country is informed about GARD and agrees to be involved in discussions on the development of an alliance for GARD at country level.
- The WHO Regional Office and WHO Representative in the country are informed about GARD and agree to be involved in discussions on the development of an alliance for GARD at country level.

After describing the prerequisites, Dr Khaltaev outlined the steps to develop an alliance at country level:

1. Agreeing on a definition of alliance
2. Identifying other partners
3. Running an exploratory workshop
4. Nominating the GARD Country coordinator
5. Defining the terms of reference
6. Defining the structure
7. Reviewing the work of the alliance

Professor Bousquet summarized in a map the current activities of GARD at country level stressing that GARD was present in all continents and WHO Regions. He outlined the countries where a GARD Country had been presented and initiated: Algeria (Professor Habib Douagui), Argentina (Professor Carlos Baena Cagnani), Brazil (Professor Paulo Camargos), Bulgaria (Professor Ted Popov), Canada (Ms Lianne Vardy), Cape Verde (Dr Maria do Céu Texeira and Dr José Rosado Pinto), China (Professor Nanshan Zhong), Czech Republic (Professor Vaclav Spicak and Professor Vitezslav Kolek), France (Professor Etienne Lemarié), Georgia (Professor Tamaz Maglakelidze), Italy (Dr Donato Greco and Dr Giovanna Laurendi), Kazakhstan (Dr Abai K Baigenzhin), Lithuania (Professor Arunas Valiulis), Norway (Professor Karin C Lødrup Carlsen), Paraguay (Professor Carlos Baena-Cagnani), Philippines (Professor Sohei Makino), Poland (Dr Kazimierz Roszkowski-Sliz), Portugal (Dr José Rosado Pinto and Dr Mario Morais de Almeida), Republic of Korea (Professor You-Young Kim), Russian Federation (Professor Alexander Chuchalin), South Africa (Professor Eric Bateman), Tunisia (Professor Ali Ben Kheder), Turkey (Professor Arzu Yorgancioglu), Viet Nam (Dr Claude Lenfant).

He also mentioned that Ministries of Health were involved in Algeria, Brazil, Bulgaria, Italy, Kazakhstan, Paraguay, Poland, Republic of Korea, Tunisia, and Turkey.

Discussion on the proposal on GARD Country

- The outline and the content of the proposal for the development of an alliance at country level were approved by the General Meeting. It was recommended that the secretariat would bring it forward for WHO clearance and publication.
- Participants congratulated WHO on what had been achieved in one year.
- It was suggested that a presentation of GARD Country and of the current activities of the Alliance could be distributed to collaborating parties who could use it to advocate for GARD and commit the ministries of health.

Surveys of chronic respiratory diseases at the primary health-care level

Surveys of chronic respiratory diseases at the primary health care were carried out. The progress in Cape Verde, Georgia, Russian Federation and Philippines was described. Other surveys in Northern Brazil, Netherlands, Northern India and Nepal were presented. The major points are summarized below.

Cape Verde

No representative from Cape Verde was able to be present at this meeting. Dr Nikolai Khaltsev reported that the first and second stages of the survey on chronic respiratory diseases at the primary health-care level were completed by Dr Maria do Ceu Teixeira and colleagues, Hospital Agostinho Neto, Praia, Cape Verde, in collaboration with Dr José Rosado Pinto, Head, Serviço de Imunoalergologia, Hospital de Dona Estefânia, Lisbon, Portugal, and colleagues. The data entry was completed and soon the analysis would be undertaken for publication.

Georgia

Dr Nino Maglakelidze reported on GARD activities in Georgia, on behalf of Professor Tamaz Maglakelidze, Vice-President of the Georgian Respiratory Association. Prof Maglakelidze was designated GARD Georgia coordinator in agreement with the Ministry of Health of Georgia, but was not able to attend the General Meeting. The Georgian Respiratory Association became a GARD collaborating party in 2006.

Dr Khaltsev, responsible officer for GARD in WHO, visited Georgia on 13–16 February 2007 to initiate GARD Georgia at the request of the Ministry of Health and of the Respiratory Association. As a first step GARD Georgia agreed to start pilot projects on surveillance of CRD at the primary health-care level.

A first project started in the Family Medicine Centre of Sagarejo in March 2007, followed by another in Mtskheta in April 2007. During a two-month period, 3816 questionnaires were completed, of which 3640, which had been correctly filled, were included in the analysis (176 were excluded). The sample for analysis was of 2647 patients (≥ 5 years of age) from Sagarejo and 993 from Mtskheta. The average frequency of cough was 19.9%, of wheezing was 13.6%, of bronchial asthma 4.8% and of chronic bronchitis 10.1%. These figures appear to show that the prevalence of asthma and COPD is far higher than the official figures (below 1%). Dr Maglakelidze pointed out that the results raised major concerns that CRD were underestimated to an unacceptable extent in Georgia, and she concluded it was urgently necessary to perform epidemiological studies in the general population. The investigators from Georgia also called attention to the necessity for capacity building among health services in the country for timely diagnosis and management of COPD, asthma and other CRD.

Northern Brazil, Netherlands, Northern India and Nepal

Dr Niels Chavannes, representative of the International Primary Care Respiratory Group, presented the results of projects that he conducted or proposed in various settings.

The first project, in a resource-limited area of northern Brazil, aimed to assess the current competence for diagnosing COPD in primary care, and to develop a local patient profile for case-finding. Thirty-four general practitioners (GP) in five areas of northern Brazil recruited adult patients with principal complaints of cough and/or shortness of breath and performed spirometry (n = 142). For the dichotomous variable 'COPD' the degree of agreement between GP diagnosis (n = 64, 18.3%) and spirometric outcome (n = 36, 25.4%) was poor. False-positive and false-negative diagnosis proportions were 19.8% and 75%, respectively. The conclusion was that COPD was a common yet underdiagnosed disease in Brazilian primary care. Spirometry improved diagnostic competence and case-finding substantially. If applied in a pre-selected high-risk population, spirometry could be a cost-effective diagnostic tool for case-finding in the resource-limited setting.

The second study was a trial conducted in the Netherlands assessing the impact of a primary care COPD management programme on quality of life. The study compared 75 patients submitted to optimal care (integrated disease management; optimal medication, rehabilitation, establishment of personal goals and action plans) and 75 undergoing usual care for two years. The outcomes were statistically significantly in favour of the optimal care interventions group in quality of life and dyspnoea scores.

Thirdly, Dr Chavannes presented an intervention study entitled FRESH AIR, to be carried out in Northern India and Nepal by the International Primary Care Respiratory Group, with the support of Practical Action Nepal and the Asian Allergy & Asthma Foundation. The proposal consisted of a cross-sectional diagnostic component and a longitudinal secondary prevention and therapeutical intervention.

At the end of Dr Chavannes' presentation, a proposal for future GARD activities was put forward. He suggested the development of a link between GARD demonstration project teams and national coordinators for the exchange of experiences and approaches. This could be obtained through a forum on the GARD web site using a GARD interactive world map as a platform.

Discussion

It was strongly recommended by many panel participants that when new protocols are introduced, they should be identical to previous ones, with additional questions (if necessary). A lack of standardization will make it impossible to compare data.

Philippines

Professor Sohei Makino, Head of WHO Collaborating Centre for Prevention and Control of Chronic Respiratory Diseases, Dokkyo Medical University, presented a preliminary report of a survey of CRD frequency in Guimaras Province.

The island province of Guimaras is situated in the middle part of the Philippines, with a total population estimated to be 159 462 in 2005. A total of 52 536 persons were less than 15 years of age and 6462 were more than 65 years of age. Those belonging to the working age group (15–64 years of age) comprised more than one half (56.10%) of the total population. Economic activities on the island are based primarily on agriculture. The province has three hospitals with a total bed capacity of 90. The Guimaras Provincial Hospital is equipped with X-ray.

A cross-sectional survey on CRD was carried out in September–November 2006 by the staff of the WHO Western Pacific Region Office, by the Ministry of Health Philippines, and by health-care officials of the provincial government, with participation of the WHO Collaborating Centre for Prevention and Control of CRD. Surveys of the adult population (≥ 20 years) and children were conducted to determine the prevalence of CRD,

especially asthma and COPD in adults and mainly asthma in children and young adults. The surveys were conducted in the community through a two-cluster sample of households. All the adults ≥ 20 years and children (6–7 years of age) were included in the household surveys. The questionnaire for adults was developed on the basis of the WHO Protocol for Rapid Assessment of Frequency of Respiratory Diseases in Primary Care (WHO Chronic Respiratory Diseases and Arthritis, 2004) and modified for local risk factor assessment according to other international survey approaches. The questionnaire for children was developed on the basis of that of the International Study of Asthma and Allergy in Childhood (ISAAC) and modified for local risk factors. Spirometry was performed in adults. Reversibility testing was not performed, as it was decided to be unacceptable to regional survey groups. The prevalence of "wheezing in the last 12 months" among 1794 adults varied from 7.4%, among those aged 20–29 years, to 26.8% in those aged 50–59 years, and 31.5% in those aged > 70 years. The prevalence of asthma was 5.8, 12.5, and 20.3% respectively for these same age groups. A subsample of adults (951) aged > 40 years was investigated regarding symptoms suggestive of COPD, and the prevalence was 36.7%. Prevalence of symptoms of rhinitis among adults varied from 11.1 to 24%, being correlated with asthma. Among children aged 6–7 years (590), 19.3% had "wheezing in the last 12 months" and 27.5% had symptoms of rhino-conjunctivitis in the last year. It should be noted that the analysis of the survey data has not yet been finalized, and the values shown here could be subject to change.

Russian Federation

Professor Alexander G Chuchalin, GARD Russian Federation initiator, presented a summary of a survey on CRD in the Russian Federation. He stated that valid data on the prevalence of CRD in the country were scarce. The survey was proposed by Dr Nikolai Khaltsev and conducted under the supervision of Professors Alexander Chuchalin, Vladimir Abrosimov and Andrey Shutov. The aim was to determine the frequency of the most common CRD and their risk factors in primary health-care setting, as a basis for action plans to prevent and control these common ailments in the national health system.

The survey was carried out at the rural-based primary health-care facilities of the Ryazan region, a typical region for central Russia, from October 2004 – March 2005. The first phase was a survey of the frequency of respiratory diseases in individuals ≥ 5 years of age (total of 2467 patients) attending pre-selected facilities for any reason. It consisted of a brief questionnaire administered by a doctor/nurse to obtain information about demographics, exposure to risk factors (smoking, occupational exposure and domestic exposure) and respiratory symptoms, diagnosis and co-morbidities. The next phase was aimed at estimating the frequency of CRD in the general population. A population-based survey of 4146 randomly selected individuals (about 20% of the population) was conducted to obtain the same information as collected in the first phase. Sixteen facilities were equipped with portable spirometers and lung function was measured in approximately 1500 individuals. Results of this study showed a very high prevalence of smoking in the rural districts. Up to 70% of adult males were smokers. Chronic respiratory symptoms were observed in 31% of individuals, and spirometric abnormalities were present in 14%. However, only a small fraction of these subjects (11%) had a previously diagnosed CRD and only 2% of them received appropriate treatment. Patients visited health care services at late stages of their diseases with multiple complications.

These findings stressed the need for training to build capacity of primary health-care professionals. Moreover, this presentation called attention to the strong necessity to improve screening methods at the primary health-care level for early diagnosis, as well as to improve the availability of pharmaceutical assistance.

Plans and action on chronic respiratory diseases at country level

Plans and actions on chronic respiratory diseases in different countries were described. The major points made by the speakers are summarized below.

Algeria

The presentation was made by Professor Habib Douagui, GARD Algeria coordinator and former Vice-President of the Senate of Algeria.

Professor Douagui started by stressing the dimensions and population of his country: 2.5 million km² and 33 million inhabitants. The population is 59% urban and 28.1% < 15 years of age. Life expectancy is 74 years. Algeria is divided into five health regions and each region into various "Wilaya". Health expenditure is 8% of the gross national product, comprising US\$ 220 per year per inhabitant. There are 13 university hospitals and 185 health facilities providing a total of 52 000 beds in the country. There is 1 physician per 1000 inhabitants, and 1 registered nurse for 900 inhabitants. Surveys show a prevalence of 3% of asthma and 10% of rhinitis. There is no information on prevalence of COPD or occupational diseases.

According to Professor Douagui's evaluation, GARD action in Algeria could provide a response to claims by leaders and health professionals for a strategy to fight CRD. He pointed out that the proposed objectives for GARD Algeria were: (i) to coordinate health plans for prevention and management of CRD; (ii) to obtain valid information on burden and risk factors of CRD; (iii) to propose feasible interventions for prevention and control. After various meetings with the Minister of Health (July, November and December 2006), GARD activities were started and from January to March 2007, four regional GARD seminars were conducted aiming to inform potential partners (health professionals, opinion leaders, media) of GARD proposals. From March to May 2007, a collection of standardized information on the frequency and severity of CRD and allergies was conducted in health services. In June 2007, a committee would be elected for a national campaign for smoking cessation. In July 2007, a draft GARD action plan would be elaborated, including cost estimates. September 2007 would be dedicated to raising funds and obtaining commitment by policy-makers. From November 2007, GARD action would be implemented, beginning with CRD surveys. The first products of GARD Algeria are the establishment of a tobacco ban, the acceptance of an asthma plan by the government and the availability of free medications for asthma.

Canada

Ms Lianne Vardy, Director of the Centre for Chronic Diseases Prevention and Control, Public Health Agency of Canada, presented the National Lung Health Framework.

Ms Vardy opened her presentation by summarizing that the population of Canada is 33 million, one in five Canadians has a lung disease, which account for the majority of emergency room visits, and respiratory diseases cost 15 billion Canadian dollars/year.

The National Lung Health Framework was initiated in April 2006 as an intersectoral process having multiple stakeholders involved; government, nongovernmental organizations, private sector, academia, researchers, patient groups, as well as "First Nations" representatives. Four working groups were constituted (tobacco control, chronic diseases, infectious diseases and environment) and an evaluation of assets and gaps was undertaken. The most valuable assets acknowledged were: successful tobacco control and excellent partnerships and inter-institutional collaborations.

The weaknesses identified were: lack of public awareness, poor respiratory health education in schools, insufficient use of spirometry, limited access to sleep laboratories, lack of educators for disease management, disconnection between environmental pollution and health policies, lack of overall strategic plan.

The most important goals of the Framework were to:

- establish a vision, principles and objectives for national action
- chose strategic priorities
- provide support to strategies at various levels (provincial, territorial and federal)
- develop a mechanism for coordination and leveraging of resources.

The anticipated impacts of the Framework were: better respiratory health of Canadians, better quality information to guide policy and interventions, strategies to support vulnerable populations, and availability of measurable outcomes such as reduction in mortality, hospitalizations and emergency room visits.

A stakeholder consultation meeting with 225 participants was organized in April 2007 and the next steps would be to: undertake additional consultations to expand engagement, refine activities and priorities; clarify stakeholders' roles and accountabilities; expand asset list and introduce an online database; develop a communications strategy; complete the risk management/cost-benefit analysis, financial and evaluation plans; develop an action plan and lay the foundation for future investment.

Italy

Dr Stefano Nardini, Secretary General of the Italian Scientific Interdisciplinary Association for Research in Respiratory Medicine (AIMAR), presented proposals for GARD in Italy.

Dr Nardini started with general information on Italy: a population of 58 million; a life expectancy of 78 years for males and 84 years for females; health expenditure per capita of US\$ 2414 per year; and total expenditure on health of 8.7% of the gross national product. He presented the number of deaths due to respiratory diseases in 2006: 37 782 (43% of which were due to COPD and asthma). He mentioned that respiratory diseases would be the second cause of death if lung cancer was included. The prevalence of COPD is 5.5 % among males and 3.7% among females. COPD results in 7 million consultations/year and 130 000 hospitalizations, ranking fifth in costs for hospital care. In 2005, 25.6% of Italians still smoked. Dr Nardini presented a critical analysis of the current situation of prevention of CRD in Italy. In primary prevention there is good protection by laws on environment tobacco smoke and other pollutants; in secondary prevention, however, there is much to improve, such as awareness of CRD in the population which is still low; spirometry is underused and CRD under-diagnosed and under-treated. Concerning tertiary prevention, COPD is usually diagnosed at a late stage in patients with severe airflow obstruction. Rehabilitation is not delivered consistently. In 2006, the National Health Plan included CRD among its four top priorities. A publication was recently launched on prevention of CRD. In particular, a revision of diseases managed in primary care by health districts might include smoking cessation support.

Dr Nardini considered that GARD could contribute to: (i) stimulate the Ministry of Health to take the lead and launch a national plan; (ii) recommend to the Ministry of Health the strengthening of smoking cessation activities; (iii) coordinate multilateral efforts for continued education and training.

Many organizations have joined GARD in Italy including AIMAR, the Centre for Disease Prevention and Control of the Ministry of Health and the Italian Society of Respiratory Medicine. A first GARD meeting among the Ministry of Health and respiratory societies will take place in Rome on 21 June 2007.

Paraguay

Professor Carlos Baefia-Cagnani, Past-President of the World Allergy Organization, started by depicting the prevalence of the most common CRD in childhood in Paraguay: asthma 20.9% and rhinitis 45.1%. He then reported on a meeting with the Minister of Health, Dr Oscar Martinez Doldán, in Asunción, on 9 March 2007. The meeting was attended by Anahy Yáñez (Argentina), Jaime Guggiari Dutreleau and Juan Sisul Alvariza (Paraguayan Society of Allergy, Asthma and Immunology - PSAAI), Guilherme Arbo (Paraguayan Society of Tuberculosis and Pulmonology -

PSTP). After an introduction of GARD to the Minister, and following discussions on possibilities of action in Paraguay to reduce the morbidity and mortality of CRD, the following points were agreed:

- The creation of a GARD working group in Paraguay with members of PSAAI and PSTP.
- Inclusion of beclomethasone (or other inhaled corticosteroid) and a short-acting beta-agonist bronchodilator (inhaled salbutamol or terbutaline) in the list of essential medicines recognized by Paraguay.
- Free provision of these medicines to low-income patients without medical insurance.
- Development and implementation of an educational programme on prevention, diagnosis and treatment of CRD for general practitioners, family doctors, paediatricians, nurses, and pharmacists, sponsored by the Ministry, with COPD and asthma being addressed in the first step.
- Production and distribution of free printed educational material for parents and patients.

A second visit to the Ministry of Health of Paraguay took place on 2 May 2007, when Juan Sisul, Jaime Dutreleau, Manuel Ratti, Hector Ratti and Maria Troche (PSAAI), as well as Domingo Perez and Guilherme Arbo (PSTP), met Dr Oscar Lugo, representing the Minister of Health, and established the next steps for GARD.

- The official establishment of a GARD working group in Paraguay.
- The proposal for a GARD Paraguay launch.
- The development of an action plan that would include the dissemination of information to other Paraguayan professional societies, patient organizations and nongovernmental organizations that should also be invited to join the working group.

Poland

Dr Pawel Sliwinski, from the Institute of Tuberculosis and Lung Diseases of Warsaw, reported on GARD activities in his country.

The population of Poland is 38.18 million inhabitants, with a life expectancy of 71 years for males and 79 years for females. Health expenditure is US\$ 744 per year, and the gross national product is US\$ 12 847 per capita. Prevalence of smoking in Poland among adults has decreased in males, but is increasing in females.

An important National Programme of Early Detection and Prevention of COPD has started in Poland targeting smokers > 40 years of age in outpatient chest clinics. They had spirometry and were advised to quit smoking. The Programme was funded by the National Health Fund and costs were €7 per person screened. So far 105 190 subjects have been screened (62% current smokers, 28% ex-smokers and 10% non-smokers). The average tobacco exposure is 27 pack/years. Airflow limitation was found in 21% of the individuals (7.8% mild, 6.9% moderate and 6.3% severe).

Subsequently, a programme for prevention of COPD was launched by the National Health Fund, in which primary care physicians were encouraged to perform spirometry in their patients 40–65 years old if they are smokers (>10 pack/years), or if they had chronic cough or dyspnoea related to physical activities. All patients with an abnormal spirometry were referred to chest clinics for further evaluation. Patients with a $FEV_1 > 50\%$ remained in primary care, whereas those with a $FEV_1 < 50\%$ were transferred to a specialized clinic. From 2004 to 2006, 200 000 subjects on average were investigated each year and COPD was diagnosed in 20% approximately. The cost of the detection of one case of COPD is €50.

The Polish Society of Phtisiopneumology established an accreditation committee in 2003, with the following main goals: (i) to elaborate recommendations for spirometry; (ii) to prepare accreditation criteria for laboratories and clinics performing spirometry; (iii) to ensure uniform methods of performance and interpretation, increasing the quality of services. The accreditation committee has published standards, presented

them on 18 occasions (for a total of 1500 physicians), trained 200 physicians fully, and warranted accreditation to five laboratories. The Polish Association of COPD Patients has had an important role in the country in raising awareness, disseminating knowledge and providing advice to patients.

Republic of Korea

Information on GARD activities in Korea was conveyed by Dr Eun Kyeong Jeong, Director of the Division of Diseases Control, Ministry of Health and Welfare.

Dr Eun Kyeong Jeong introduced the subject by stating that CRD are the eighth cause of death in Korea with a crude death rate of 15.5 per 100 000 per year; the death rate is much higher in individuals > 70 years of age, being the fifth cause of death in this subpopulation. Asthma is very frequent and its total costs were estimated to be over US\$ 2 billion in 2005. The total costs of CRD are estimated to be similar to those of cancer or cardiovascular diseases. Prevention and management of CRD are considered unsatisfactory in Korea, where there is a high prevalence of smoking (47.5%), a high proportion of uncontrolled asthma, and of under-treated asthma and COPD.

Following these comments, Dr Jeong described multiple activities of the Ministry of Health and Welfare for tobacco control, starting with the 1995 Health Promotion Act, followed by non-smoking campaigns and community-based tobacco control programmes, National Tobacco Control Policy, expanded smoke-free areas, raised taxation on tobacco products and smoking cessation clinics.

Regarding asthma, the vision is to improve quality of life and reduce socioeconomic burden by implementing best practice guidelines and trigger control supported by evidence. This would include five key areas of action:

- Awareness campaigns using dissemination of patient guidelines for trigger avoidance, smoking cessation, media campaigns, and World Asthma Day activities.
- Proper management of symptoms through the use of best practice guidelines and a computerized decision support system, self-management and asthma action plan, and an asthma call centre.
- Development of asthma-friendly environments (asthma-friendly school certification): a school programme on building community networks and asthma management guidelines for schools, improving living conditions with indoor air quality control and avoidance of asthma triggers.
- Surveillance and support for disadvantaged groups: development of indicators of asthma, strengthening asthma surveillance and monitoring, and increased investment in research and development.

Professor You-Young Kim was nominated GARD Korea coordinator.

Tunisia

Professor Ali Ben Kheder, GARD Tunisia coordinator made the presentation on Tunisia.

Professor Ben Kheder began with information on Tunisia which has a population of 9.87 million inhabitants, gross domestic product per capita of US\$ 2100, and where health expenditure is 5.6% of gross domestic product. He mentioned that there are 220 chest physicians and 12 000 general practitioners, 2029 of whom work in primary care. Whereas the morbidity associated with communicable diseases is declining in the country, noncommunicable chronic diseases are on the rise. The prevalence of asthma is 5% and of COPD 6.8%.

A pilot study of a syndromic approach to diagnosis of respiratory diseases, promoted by WHO's Practical Approach to Lung Health (PAL), had been conducted in Tunisia since 2002.

The role of the Minister of Health of Tunisia in GARD is to:

- agree on the proposed approach for the development of a

- respiratory health policy
- promote improved surveillance
- develop, in collaboration with other members of GARD Tunisia (nongovernmental organizations and health professional representatives), an action plan against chronic respiratory diseases
- support resource mobilization.

The strategy should be:

- determine priorities
- set national action plans integrated into existing health system and policies
- increase the accessibility of health care for patients and to support applied research for some target conditions.

Priority should be given to prevention and patient education. A chronogram of activities was presented for dissemination of PAL from 2007–2011; GARD could be promoted with PAL.

Turkey

Professor Arzu Yorgancıoğlu, GARD Turkey coordinator, presented the situation in Turkey. TTS was one of the first GARD partners.

Professor Yorgancıoğlu reported that Turkey, with its 774,815km² surface area and 67.8 million inhabitants (2000 census), is the most populous country of the Middle East. The annual population growth rate is above the average growth rate of developed and developing countries. Life expectancy is 71 years for females and 67 years for males. With the high fertility and growth rates, Turkey has a young population structure (30 % < 15 years, 11 % < 5 years of age).

Burden and risk factors for CRD have been tested using the Burden of Lung Diseases study (BOLD). COPD is responsible for 5.8 % of all deaths in Turkey. COPD ranks eighth among the diseases in terms of years of life lost, fifth in causing years of life lost due to disability and eighth in disability adjusted life years. The deaths due to respiratory diseases are projected to increase 2.8 fold from year 2000 to year 2030 if no action is taken. Cigarette smoking is very common in Turkey and the total number of cigarettes consumed in Turkey has increased from 37 506 million pieces (mp) (in 1970) to 115 500 mp (in 2000), an increase of 207%, with a 34% increment in per capita consumption. Overall, Turkey accounted for 2.25% of total world cigarette consumption in 1999 (World Bank) and is a major producer of tobacco. In 2002, production in Turkey was reduced by 119 000 tons, an important achievement considering the hard opposition of tobacco companies to initiatives to reduce consumption. Prevention of smoking might avoid 54 699 deaths each year in Turkey.

GARD Turkey has been initiated. A GARD Committee was established in TTS with the collaboration of other stakeholders including the Turkish National Society of Allergy and Clinical Immunology (TNSACI), one of the GARD collaborating parties. It was decided to elaborate a proposal for "A National Policy in Chronic Airway Disease (asthma and COPD)" based on the national data showing that CRD are a significant cause of death and of disease burden. The Committee prepared a project proposal for surveillance, prevention and control of these diseases in the country. The aim of the project was to prevent chronic airway diseases, thereby reducing mortality and morbidity as well as the social and economic burden of disease. Strategies and action plans for prevention of the development of chronic airway diseases, early diagnosis and management were defined in the project proposal.

GARD Turkey includes the following members: GARD country coordinator, members of TTS, the Turkish Board of Pulmonology, TNSACI and collaborating parties including the Society of General Practitioners, Society of Family Physicians, Public Health Society, Society of Medical Oncology, Ministry of Health (Human Resources Development Department, Health Statistics Department, Health Finance Department, Drug Control Department, Health Education Department, Environmental Health Unit), other related ministries (education, social welfare, sport and leisure, labour, industry, environment), National Institute of Planning, National Institute of

Statistics, the Alliance of Turkish Pharmacists, as well as representatives of patient groups, pharmaceutical companies, religious leaders, other enterprises in the private sector and the media.

As recommended by the GARD secretariat, a meeting with the Turkish Ministry of Health was undertaken and the project was approved. An officer was appointed as a focal point. GARD Turkey launch will take place in 2008.

Viet Nam

GARD was introduced in Viet Nam in March 2007 by Dr Claude Lenfant and Dr Suzanne Hurd both representatives of GINA and GOLD. Early in this visit, a meeting with representatives of various public and private organizations had been organized in Ho Chi Minh City by the Chancellor of the University of Medicine and Pharmacy, Professor Dan Van Phuoc and his colleague from the Department of Physiology, Associate Professor Le Thi Tuyet Lan. Included in the meeting were the Directors of the Department of Science and Training and the Department of Treatment from the National Health Ministry. Officers from various organizations and hospitals from Ho Chi Minh City, Hanoi, and other cities were also present. The purpose of this meeting was to stimulate the formation of a group of national coordinators for GARD in Viet Nam. This meeting was followed by visits of Dr Lenfant and Dr Hurd to several institutions in Ho Chi Minh City and Hanoi including to government officials of the City of Hanoi who were presented with the goals of GARD.

To the credit of Professor Le Thi Tuyet Lan, Viet Nam has long been concerned about the problems of CRD, especially asthma and COPD. Efforts have been ongoing for years to implement GINA and GOLD guidelines, but these efforts have been mostly limited to Ho Chi Minh City and Hanoi. Following the discussions held at the meeting mentioned above, a national commitment to extend the effort throughout the entire country appears to have been made.

It was mentioned that further progress and developments would undoubtedly take place in Viet Nam in the near future.

GARD demonstration projects

GARD demonstration projects were described. The major points made by the speakers are summarized below.

Brazil

Asthma is the fourth cause of admissions in the public health system in Brazil. The prevalence of wheezing in adolescents of Salvador, capital of Bahia, is 25%. Facing increasing demands from medical societies and nongovernmental organizations (pulmonary, allergy, paediatrics, ARIA Initiative), the Brazilian Ministry of Health issued decrees that warranted universal reimbursement for medication prescribed for severe asthma (in 2002), and free access to inhaled corticosteroids and bronchodilators in primary care for mild to moderate cases (in 2005). Treatment for allergic rhinitis was also provided. However, the distribution of medication in primary care was not regular, the primary health-care professionals were not familiar with the use of inhalers for asthma or with treatment of allergic rhinitis, and the process for individual reimbursement of costs of medication for a severe case was extremely complex.

Professor Paulo Camargos, GARD Country coordinator in Brazil, presented the results of two demonstration intervention projects, one in Minas Gerais and the other in Bahia, on the management of asthma among underprivileged populations.

Minas Gerais

Project: "Reduction in hospitalizations and emergency room visits in asthmatic children and adolescents from low-income families after enrolment in a Public Asthma Programme, Belo Horizonte City", coordinated by Professor Camargos.

Prevalence surveys demonstrated that 40% of infants < 15 months old and

20% of adolescents aged 13–14 years old had suffered from at least one episode of wheezing in the past 12 months in Belo Horizonte (2). Belo Horizonte has 2.4 million inhabitants, one third of them < 18 years of age. After a first hospitalization for acute asthma, 50% of the patients were readmitted within the next three months (3). High prevalence rates combined with lack of affordability of inhaled steroids led to higher asthma morbidity. Acute episodes were one of the leading causes of hospital admissions and readmissions in children and adolescents.

To face this major public health problem, a partnership between the Belo Horizonte Municipal Health Authority and the Federal University of Minas Gerais was officially established in December 1996. This inter-institutional collaboration was aimed at implementing an Asthma Programme (Wheezy Child Programme) targeted to children and adolescents from low-income families assisted by the public health system.

The key points of the programme were:

- drawing and defining a specific budget supported exclusively from local/municipal resources;
- building a comprehensive health network involving the primary, secondary and tertiary health-care facilities;
- training pediatricians, nurses, pharmacists and allied health personnel to deal with asthma;
- unrestricted availability of inhaled beta 2-agonists (salbutamol) and inhaled corticosteroids (beclomethasone dipropionate), and of small and large volume, pear-shaped, plastic-valved spacers for persistent cases. Inhaled or oral beta 2-agonists and oral corticosteroids were provided for exacerbations.

A preliminary assessment aimed at:

- assessing the total number of assisted individuals since the implementation of the programme;
- estimating the programme coverage among the target population and assessing the impact on hospital admissions and emergency department visits. The database provided the number of assisted patients up to December 2006.

Surveys were carried out to verify the rate of use of inhaled steroids in the target population. To assess the impact on hospitalizations, medical charts of 821 children < 15 years of age presenting with wheezing and other asthma-related symptoms were assessed retrospectively; the frequency of hospital admissions and emergency department visits due to acute asthma or acute wheezing episodes were evaluated before and after enrolment in the programme. The 'before treatment' period comprised the 12 preceding months and 'after treatment' ranged from 12 to 56 months.

Overall 20 000 children and adolescents have been assisted by the programme in the past 10 years. Three thousand patients are currently on follow-up. The overall coverage with inhaled steroids increased from less than 3% in 1996, to 17% by the end of 2000 (4), and to 30% by the end of 2006 (Camargos P, Valente B. Unpublished data from an interim analysis). There were 1086 hospitalizations and 6213 emergency department visits in the 'before treatment' period whereas in the 'after treatment' period, there were 263 (24.2%) and 935 (15.0%), respectively. In conclusion, there has been a continuous and progressive recruitment of asthmatic children from the target population with an unequivocal increase in the proportion of users of inhaled steroids in the past 10 years. The different programme components, i.e. training, implementation of a specific network, and the accessibility to beclomethasone dipropionate, led to a significant decrease in the frequency of hospital admissions and emergency department visits.

Bahia

Project: "Impact of a public health intervention for management of severe asthma in underserved population", coordinated by Dr Alvaro A Cruz.

Aimed at reducing morbidity and mortality due to asthma in the State of Bahia, the Programme for Control of Asthma and Allergic Rhinitis in Bahia (ProAR), an operational intervention research project, was proposed by the Federal University of Bahia School of Medicine in collaboration with the State and City departments of public health, and gained support from the Ministry of Health. As a second objective, training of primary health-care professionals in the State to deal with asthma and rhinitis was pursued and would be evaluated in the future.

Dr Cruz provided a preliminary report of the impact of ProAR on its first direct target, the control of the most severe asthmatics. Four reference centres for severe asthma were established in 2004 in Salvador (2.5 million inhabitants) (5), providing health care by pulmonary physicians, nurses and pharmacists, regular combination therapy (long-acting beta agonists and inhaled corticosteroids) and education sessions for patients and their families. Subjects with persistent rhinitis were treated with intranasal corticosteroids. All medications were given free of charge and all subjects underwent spirometry. By April 2007, 2385 severe asthmatics had entered the programme.

Three studies were given priority:

- Impact of ProAR on health resources utilization – a sub-sample of 269 consecutive patients > 12 years of age with severe asthma and reaching one year of follow-up were included in this analysis, in which the frequency of hospital admissions, emergency department visits, systemic corticosteroid use and school and work days lost was compared to the year before admission to ProAR.
- Impact on costs – the costs to the public health system and ProAR, as well as direct health-related costs to each patient and his/her family, before and after their inclusion in the programme, were estimated in a subsample of 81 subjects followed for 1 year, using validated questionnaires.
- Impact on trends of public health statistics of Salvador City – information from 1998 to 2005 was collected from the public health system database.

Results are already available:

- Health resources utilization (6) in the sample of severe asthmatic patients – ProAR resulted in a significant reduction in the frequency of hospital admissions (-90%), emergency department visits (-85%), systemic corticosteroid use (-67%) and school and work days lost (-86%).
- Costs (7) in 64 patients of this subsample concluding one year of follow-up – In the year after admission to the programme patients had five fewer days of hospitalization and 68 fewer visits to emergency/non-scheduled visits, on average. Asthma control scores improved by 50% and quality of life by 74%. The annual saving in public resources was US\$ 387 per patient. Family annual income increased US\$ 512, and family costs were reduced by US\$ 733. If the reduction in family costs was combined with the increase in family income, both related to asthma control, an annual surplus of US\$ 1245 became available to these low-income families.
- Public health statistics (8) – Hospital admissions due to asthma were reduced by 56% and inpatient mortality was reduced by 53%. An inverse correlation between hospitalization rate and use of combination of inhaled corticosteroids and long-acting beta agonists was also found (-0.675; $P < 0.000$). In conclusion, a public health programme targeted to patients with severe asthma, providing specialized care and free medication for asthma and rhinitis, reduced health resources utilization, reduced costs for the health system and for the patient and their families, increased their family income, and was associated with a remarkable early reduction in asthma admissions and hospital mortality.

China

Professor Huahao Shen reported on behalf of Professor Nanshan Zhong, GARD China coordinator and President of the Chinese Medical Association. The network of GARD China consists of the Department of Chronic Disease Management, Ministry of Public Health, Chinese Society of Respiriology, China Asthma Alliance and China COPD Alliance.

After the GARD Launch Meeting in 2006, a significant amount of work has been achieved, including organization of the first China COPD Alliance meeting and second China Asthma Alliance meeting, further investigation on COPD prevalence in China, a pilot study of early intervention on COPD management at the community level, a community-based physician training programme, and education on prevention and management of asthma in public sessions and in the media.

Respiratory diseases are the fourth leading cause of mortality in cities and third leading cause in rural areas in China. Prevalence of COPD is 8.2% (males, 12.4%; females, 5.1%) in the population > 40 years of age. One study showed that the cost per hospitalization for patients with COPD was 1820 RMB in 1998–1999, and increased significantly to 4640 RMB in 2002–2004. The study showed that pollution arising from bread baking, carpet weaving, biomass combustion, poultry rearing, and household heating was an important risk factor leading to pulmonary diseases, including COPD. Univariate analysis showed significant association between COPD and exposure to biomass fuel combustion for cooking (9).

In a five-year study, it was found that annual mean decline in FEV₁ (ml/yr) was greater in COPD smokers than in non-smokers among 1410 patients followed up in a community intervention. The intervention comprised health education, consultation (including advice on indoor ventilation), active management and routine therapy. The proportions of attendance to health education, COPD awareness, awareness of tobacco hazards, improvement of outdoor environment, improvement of occupational environment and tobacco cessation were significantly higher in the intervention group than in controls. It was demonstrated that community intervention might lead to effective reduction of COPD risk factors and a significant attenuation of the decline in lung function ($P < 0.01$).

A one-year, double-blind, placebo-controlled study showed that low-dose, slow release oral theophylline was effective and well-tolerated in long-term treatment of stable COPD although it did not improve post-bronchodilator lung function.

South Africa

Professor Eric D Bateman, GARD South Africa coordinator, reported on intervention projects in his country.

The burden of CRD in South Africa includes a mix of infectious (with very high rates of tuberculosis (TB) and HIV infection) and non-infectious diseases typical of a society in economic transition (10). While the prevalence of asthma (using ISAAC methodology) is similar to the global average, a recent population study suggested a very high prevalence of COPD (11).

A network of 4500 primary care clinics provided by national, provincial and municipal departments of health delivers the majority of health care for 80% of the population. A major obstacle to the delivery of quality care is the shortage of both physicians and nurses, and a policy of nurse-led primary care applies in most rural and even urban clinics. Free essential drugs for CRD including TB and antiretrovirals are available at these clinics, but access to care is limited by clinic capacity.

The WHO PAL was adapted for use in primary care in South Africa (PALSA Plus), and was introduced in two of the nine provinces (covering more than 500 primary care facilities).

PALSA Plus is an integrated plan used primarily by primary care nurses for the management of priority respiratory diseases including TB and HIV infection. Key features are a diagnostic algorithm (largely syndromic), a simplified approach to confirming diagnoses and/or referring to the next level of care, rational and evidence-based use of essential drugs, and a training model involving in-situ patient- and problem-based learning techniques. The development and rollout of PALSA Plus was accompanied by a series of qualitative and randomized controlled trial evaluations (12, 13, 14). A National PALSA Plus Core Team is in the process of being established.

The potential role of GARD in South Africa and sub-Saharan Africa was explored at a 2-day symposium held in Cape Town, South Africa, in March 2007. Organized jointly by the South African Thoracic Society and the Pan-African Thoracic Society, the meeting was attended by physicians from more than 10 countries. Although no firm proposals for country initiatives were received at that time, delegates recognized the potential value of introducing GARD to their ministries of health. They also acknowledged the benefits that might be obtained by introducing GARD-endorsed models for improving quality of care of respiratory diseases in their countries.

OTHER INFORMATION ON CHRONIC RESPIRATORY DISEASES

Pulmonary hypertension

The report of pulmonary hypertension was prepared by Professor Marc Humbert, who could not attend the meeting, and presented by Dr Nikolai Khaltaev.

Dr Khaltaev opened by mentioning that the true burden of pulmonary hypertension is unknown but it is widely believed to be a rare disease. This might be true for idiopathic pulmonary hypertension (formerly known as primary pulmonary hypertension), but not at all for secondary pulmonary arterial hypertension. Pulmonary hypertension and cor pulmonale may complicate many advanced pulmonary conditions including COPD, bronchiectasis, cystic fibrosis, lung fibrosis, sarcoidosis and TB. Pulmonary hypertension is a major cause of disability and mortality in patients with sickle cell disease and thalassemia, and also occurs in patients with schistosomiasis. It affects a significant proportion of highlanders in many countries, such as Bolivia, China and Peru. Up to 3% of patients may develop chronic thromboembolic pulmonary disease after acute severe thromboembolism, which may lead to chronic pulmonary hypertension. Pulmonary hypertension might be also related to other conditions, such as HIV infection, liver cirrhosis, autoimmune diseases, or congenital heart diseases.

In countries where there was increased risk for pulmonary hypertension, it would be advisable to plan on: better case detection/early diagnosis and better management, including basic therapy (exercise limitation, diuretics, oxygen, anticoagulants) and evaluation of cost-effectiveness of novel therapeutic strategies with a focus on oral drugs.

The objectives for the next five years are to:

- undertake epidemiological studies to identify the burden
- raise awareness about the burden, risk factors and clinical manifestations
- provide information on management of dyspnoea of unknown origin
- provide information on abnormal findings in ECG and chest X-ray that were suggestive of pulmonary hypertension
- develop reference centres in each country with access to echodoppler for screening of suspected cases of pulmonary hypertension, and possibly right heart catheterization for confirmation
- improve access to conventional therapy (oxygen, diuretics and anticoagulants)
- evaluate efficacy of novel therapies in different forms of pulmonary hypertension.

Links between rhinitis and asthma in the workplace

Professor Jean Bousquet, Chairman of GARD, made a brief presentation on the interrelationship between rhinitis and asthma. He emphasized the possibility of rhinitis being an early marker of airway disease in occupational exposures, and therefore to be taken as a sign for early action towards prevention of lower airway illnesses. There are some guidelines and position papers available on this subject. However, up-to-date comprehensive statements were needed, including on occupational upper and lower airway diseases, as well as the impact of upper airway viral infections on lower airways. A WHO Workshop (InterAirways) with support from GAL²EN (European Union Network of Excellence), Allergen (Canada) and ARIA Initiative, was organized in San Diego, USA, in 2007 and a

publication is being prepared as a result of this meeting.

A major subject of discussion was the natural history of work-related asthma caused by high and low molecular weight agents, as it appeared that rhinitis preceded asthma, and could be taken as an early alert. What needs to be studied is whether the early recognition of rhinitis might contribute to the prevention of severe asthma. A specific workshop was planned on this subject in the first quarter of 2008 in France, with the support of various French medical societies and of MEDEF (Mouvement des Entreprises de France, the union of French employers).

The objectives of this workshop are to:

- better define and implement the diagnosis of work-related rhinitis;
- propose a strategy to prevent work-related asthma from the diagnosis of rhinitis, and how to implement it in a pilot study;
- listen to the perspectives of unions, employers and community.

It was mentioned that these proposals would be posted on the GARD web site.

ACTION AT THE REGIONAL LEVEL

Different proposals for developing GARD at the regional level were put forward. The grouping of countries was made according to different criteria, such as geographic location, language and culture.

Eastern European proposal

Professor Bousquet reported that the GARD Symposium for Eastern European countries was held in Zakopane, Poland, on 23–24 March 2007. It was organized by the National Institute of Tuberculosis and Lung Diseases under the auspices of Professor Zbigniew Religa, Minister of Health for Poland. Representatives of the following countries were present: Bulgaria, Croatia, Czech Republic, Lithuania, Poland, Romania, Russian Federation, and Slovakia. Representatives from Belarus, Serbia, Slovenia and Ukraine also expressed their interest in participating, but were unable to attend the meeting.

The purpose of the Symposium was to explore the possible contribution of GARD to the surveillance, prevention and control of CRD in eastern European countries. In particular, the approach of building alliances against CRD at country level was proposed to the participants for their consideration.

Professor Bousquet underlined that the main recommendation from the Symposium was that an annual meeting be organized on a rotating basis by one of the countries involved in order to exchange information and report on progress of the work of the alliances at country level. It was agreed that Professor Roszkowski-Śliż, GARD Poland coordinator, would organize the next meeting in Warsaw, Poland, in March 2008.

Euro-Asian proposal

Professor Abai K Baigenzhin, Republic of Kazakhstan, reported on the GARD Symposium for Euro-Asian countries that was held in Astana, Kazakhstan, on 6–8 May 2007. It was organized by the Euro-Asian Respiratory Society that gathered scientists from the following countries: Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, and Uzbekistan.

Professor Baigenzhin underlined the role of the Euro-Asian Respiratory Society in coordinating the work of Euro-Asian scientists against CRD. The Society was founded in 2005 and is based in the National Research Medical Centre of the Ministry of Health, Astana. Its mission is to develop respiratory medicine in the Euro-Asian region in collaboration with the national societies within the Region. He also mentioned that GARD was adopted as a possible way to upgrade the surveillance, prevention and control programmes in these countries.

Francophone proposal

Professor Ali Ben Kheder, Tunisia, reported on the launch of GARD for Francophone countries that was held in Paris, France, on 11 April 2007 during the Second Francophone Congress of Allergology. Professor Ben Kheder explained that this new coordination mechanism aimed at grouping organizations, institutions and agencies to fight against the burden of CRD in France and francophone Africa. At a later stage, francophone countries from other continents might join.

The linguistic and cultural vector was used to group 55 countries with a total of 200 million people in different continents: Europe, America and Asia. Professor Ben Kheder pointed out that French-speaking countries include

high-, middle- and low-income countries that faced different situations. It was proposed that a relationship between high- and middle- and low-income countries was established through the support of organizations such as the Organisation Internationale de la Francophonie (International Organization of French-speaking countries) which would offer political support, the Société de Pulmonologie de Langue Française (SPLF) and the Société Française d'Allergologie et d'Immunologie Clinique (SFAIC) which would offer scientific support. High-income countries had the goals to promote and continue the existing action, while middle- and low-income countries had the goal to start organizing a programme because nothing existed.

It was suggested that GARD be used as a reference to initiate and update programmes on surveillance, prevention and control of CRD in high- and middle- and low-income countries. SPLF, with the help of SFAIC, was recommended as a leader in this process, while national authorities and societies should always be asked for contributions in order to ensure the implementation of the programme. It was considered crucial to adapt health policy according to the needs and the economic status of countries.

PROPOSALS FOR DISCUSSION WITH WORKING GROUPS

Framework to evaluate the burden of chronic respiratory diseases and the impact of GARD at country level

Dr Alvaro A. Cruz, from the GARD secretariat in WHO, presented a draft proposal for a framework to evaluate the burden of CRD and the impact of GARD at country level. This proposal was recently submitted to the GARD Working Group on burden and risk factors, but the suggestions were not yet incorporated.

Dr Cruz mentioned that the availability of accurate and timely health information was essential to optimize decision-making and more effective resource allocation for better health. This was the basis of public health action plans at all levels. However, measuring health was a complex task. Specific knowledge of each disease and intervention under consideration was required. The usefulness of measurements depends on disease-specific tests or diagnosis, the feasibility of applying these tests to population for screening, and the support of health services. Therefore, health statistics vary greatly in reliability and validity of indicators. Hence, the accuracy and applicability of measurement instruments was a matter of continuous scrutiny.

The control of major diseases should be evaluated in a comprehensive approach, and be based in a health information system that combined individual and community health interventions. Health outcomes, modifiable risks and general determinants of health should be regularly measured, as well as interventions aiming to improve health conditions, in order to allow for an evaluation of possible impacts. Users of health information were not only health professionals, but also policy-makers at various levels. Entities representing civil society, the media and the community in general should be informed of the dimension and costs of major health problems, and the availability of cost-effective interventions for prevention and control, in order to properly play their role of influencing decisions.

Dr Cruz proposed a comprehensive model for the evaluation and monitoring of the burden of CRD at country level, and the concomitant assessment of the development of GARD alliances at country level, as well as the elaboration and implementation of national action plans for prevention and control of CRD. He mentioned that the framework would allow each country to investigate whether there was an impact, measure the size of the effect of GARD, and observe the trends in the burden of CRD at country level.

The evaluation of the GARD process would be divided as follows:

- estimating needs
- advocating for action
- formulating policies.

These topics express the stepwise framework for action suggested by WHO and adopted by GARD.

For the evaluation of GARD output, the following items will be taken into consideration, as proposed by WHO, for initiatives for prevention and control of chronic diseases in GARD Book (1):

- core interventions
- expanded interventions
- desirable interventions.

Dr Cruz proposed **essential indicators** that should be available in all countries, and provided an **extended list of indicators** that could be used in countries in which they exist. The CRD indicators should be assessed at baseline (if possible before or at the beginning of the GARD action plan) and at regular intervals to assess the benefits of the plan.

Asthma and COPD are the CRD associated with highest morbidity, mortality and costs. Therefore Dr Cruz proposed to include them as a priority for the development of the essential list of indicators. The fundamental questions to be asked are:

- Are asthma and COPD health problems in the country?
- If so, how big is the problem?
- How are we doing in managing the problem?

Six **essential indicators** fall into three general categories:

- health status and health outcomes (mortality and prevalence)
- health services utilization (hospitalizations, emergency department visits and medication use)
- risk factors (prevalence of smoking).

Extended indicators include:

- incidence
- quality of life
- outpatient care visits
- other risk factors such as solid fuel combustion, prevalence of obesity and frequency of occupational exposures.

Benchmarking and measuring impact

Professor Teresa To, University of Toronto, on sabbatical with WHO Chronic Respiratory Diseases Group, provided a summary on the selection and adaptation of relevant chronic respiratory health indicators to measure outcomes and impact of GARD. These indicators should be integrated in the GARD evaluation framework.

Along with the evaluation framework and indicators, Professor To proposed to use the newly-developed electronic data and statistics collection tool for baseline and follow-up information collection in participating countries. Along with the data collection, this electronic tool provides documentation on:

- definitions of indicators
- methods of statistical analysis
- confidentiality of data
- copyright and ownership.

In the country-specific summary profile, age- and sex-specific rates would be calculated. Costs calculated will be based on cost estimates provided by the country.

In the global comparisons, all rates would be age-standardized according to the world population as recommended and used by the UN and WHO.

A test for trend would be conducted in trend analysis. This test would allow the statistical determination of the likelihood that the increase or decrease in an outcome of interest (such as mortality, hospitalization rate, emergency department visits rate) was be greater than expected due to random chance. Disease grouping for prevalence and mortality would follow the International Classification of Diseases coding system, 9th or 10th revision. While data and statistics were for public use, care should be taken in interpreting any results.

National-level data are important in measuring health, health status and health outcomes of a population. While statistics based on national data were representative of the population of interest, they often lack clinical details, uniform standards or definitions. Therefore, data collected tended to underestimate disease prevalence and the associated morbidity and mortality. On the other hand, regional or community disease-specific surveys using standardized tools, while having smaller sample sizes, often collected more detailed data that complement those of the national data nicely and efficiently. Data from both sources, when put together, help to give the picture of the epidemiology of a disease of interest.

In collaboration with the GARD secretariat in WHO, Professor To has initiated and developed templates and evaluation methods. These tools need to be finalized and pilot tested. The development of such a pilot project would be carried out through ongoing consultation and collaboration with WHO. It was proposed to publicize the information generated using the InfoBase platform developed by WHO for assembling, organizing and

presenting global data and statistics.

Professor To proposed to establish a centre at the Ontario Asthma Surveillance Information System located at the Research Institute of the Hospital for Sick Children. In this centre all CRD surveillance, outcome monitoring and evaluation activities would be coordinated and supervised so that data reliability (consistency) and validity (accuracy) would be ensured. The goals of such a centre should be to gather population-level data for common CRD indicators and regional or survey-based data for specific CRD indicators. The centre could provide the physical home and some basic infrastructure support to this collaboration with WHO and GARD. The proposed activities are to:

- standardize methods and activities of surveillance, outcomes, monitoring and evaluation;
- provide uniform training to participating countries;
- provide support to analysis and data processing of country information, in order elaborate regional and global reports on CRD;
- provide reports to WHO and GARD;
- establish a training centre where representatives from participating GARD countries would be encouraged to spend 1–3 months to discuss, further analyse and enter information from their countries. Shared office space with a computer and access to free internet and Medline searches will be provided.

Raising awareness and advocating for action

Dr Claude Lenfant, Chair of the Working Group on awareness and advocacy, gave an overview of the recent working group activities. The project "*Face to face with chronic respiratory diseases*", which started in January 2007, was enthusiastically received by GARD participants. The aim of the project was to enrich GARD advocacy and communications material (publications, web site, leaflets, newsletter, several World Days on CRD) by a series of case studies of persons suffering from CRD. The ultimate goal was to increase awareness on CRD, strengthen commitment for action across a wide range of interested parties, and to make CRD a public health priority in all countries. So far, stories and pictures were collected in Georgia, Italy, Spain, Switzerland and USA. Three stories, one on asthma and two on COPD, were scheduled to be on the GARD and WHO web site from August 2007. Dr Lenfant thanked especially GOLD, ICC and AIMAR for their contributions to this project.

To support World Asthma Day 2007, the working group produced a fact file on asthma which profiled the symptoms and risk factors of asthma and included a selection of the winning entries from the 16th annual "Living with Asthma" poster contest in 2006. The contest was open to children (aged 6–14 years) from the USA who suffered from asthma. The American Academy of Allergy, Asthma & Immunology and the American Academy of Pediatrics jointly sponsored the contest. Similar activities might be developed for the upcoming World Allergy Day 2007. The awareness and advocacy working group, GARD secretariat and WAO (organizer of World Allergy Day 2007) will work closely on advocacy activities for this event.

Allergy diagnosis

Professor Carlos Baena-Cagnani, in collaboration with Professor Walter Canonica, presented the recommendation of WAO for diagnosis of allergy in low- to middle-income countries. The recommendation proposed a three-step process:

- survey of allergy diagnosis procedures
- survey of prevalence of allergens
- development of cheap and simple diagnostic test.

For the first and second steps, questionnaires were sent out to all member societies to collect data about the diagnostic procedures used in the country or region, and simultaneously to collect information on the most relevant allergens in the country or region. The questionnaires were collected and the results of this survey should be presented in the forthcoming meeting of the European Academy of Allergy and Clinical Immunology, 12 June 2007. For the third step, a simple and cheap tool, such as a skin multitest, might be developed on the basis of regional needs. Based on previous

experiences, it was estimated that for large-scale use, the test would cost less than US\$ 2.

It was mentioned that all GARD collaborating parties interested in this initiative are welcome to take part and should contact Professor Canonica.

FIRS Task Force on Simple Pulmonary Function Tests

Professor Giovanni Viegi, Past-President of the European Respiratory Society, reported on this topic with a presentation entitled "Implementing FIRS pulmonary function testing programme in emerging countries".

The FIRS Task Force was coordinated by Professor Marc Zelter (France) and had representatives of various countries: China, China (Hong Kong Special Administrative Region), Colombia, India, Italy, Mexico, South Africa, Spain, and the USA. The Task Force was established taking into consideration the rise in smoking, and indoor and outdoor air pollution in emerging countries and the consequent need for early detection of obstructive pulmonary diseases (and COPD in particular) in low-resource environments. Numerous available guidelines are not feasible in many locations due to their requirements for well-trained personnel and unaffordable equipment. Current international guidelines (ATS, ERS, BTS, and GOLD) recommend the use of post-bronchodilator spirometry to detect obstruction, as defined by a low FEV₁/VC ratio and a low FEV₁. The performance standards for spirometers and spirometry tests are well established for hospital and university laboratories; however, high-quality standards are not available for more than 90% of the population of many countries.

The major points raised by the Task Force were:

- COPD screening and case finding should be directed towards people with a high risk of COPD, such as heavy smokers over 45 years of age and people exposed to smoke presenting with dyspnoea;
- make a checklist comprising – age group, years of smoking, presence of dyspnoea and chronic cough, and history of wheezing;
- make an elementary pulmonary function test using wristwatch and stethoscope – measure the forced exhalation time (a cut-off screening value should be determined, above which a referral to must be requested);
- alternative choices of pulmonary function tests are: peak flow meters, pocket spirometers and field spirometers.

Therefore, the recommendations were: when the checklist identifies a patient at high risk, according to the availability of resources, ideally the subject should be referred to regular office spirometry with bronchodilator reversibility test performed by certified technicians, but if this is not available, the next choice would be a primary-care facility with a field spirometer. If the spirometer is not available, a pocket spirometer could be used by a local health-care provider. If this is not available either, a peak expiratory flow measurement would be the option. The sole measurement of the forced expiratory time, the least precise of all, should only be taken into consideration for the diagnosis when no other objective measurement is available.

It was mentioned that spirometry training was fundamental. The vast majority of physicians in developing countries have the possibility to be connected to the Internet (if only for an hour a week), making distance-based, self-paced learning possible. Of several media used by various spirometry projects to educate primary-care providers, a dozen patient vignettes were the most popular. These cases could be translated and adapted to many languages and cultures.

The person who works with patients to perform the spirometry test does not need to be a physician, a nurse, or a technologist. It was underlined that any available health-care worker could be trained. The skills needed to coach patients to perform good quality spirometry tests differed considerably from those needed to interpret the results. A basic education programme would need only to address simple issues: how to perform a good blow; simple quality control; simple vignette patient cases; when to

refer; and hygiene.

To finalize, Professor Viegi underlined that preliminary observations indicate that knowledge of abnormal spirometry improved significantly the success rate of standard smoking cessation interventions.

Asthma Drug Facility

Dr Nils E Billo, Executive Director of the International Union against Tuberculosis and Lung Diseases (The Union), presented the Asthma Drug Facility (ADF).

Dr Billo opened with a few remarks on burden, health policy and health services. He mentioned that the majority of patients with asthma and COPD lived in developing countries. In these countries priority is given to communicable diseases, health services are not organized for long-term care of any chronic disease, health workers are not trained, and costs will increase if patients are not treated appropriately.

Dr Billo indicated why ADF was created. Because of the high cost of essential asthma drugs, particularly inhaled corticosteroids, the majority of patients living in low- and middle-income countries cannot afford medication. In most countries the cost of a single beclomethasone 250 mg inhaler is US\$ 10–29.

ADF will be launched during the World Asthma Meeting in 2007. The structure consisted of The Union technical team, two expert committees and external advisers. A procurement system was supported by selected agents, followed by selection of manufacturer, consultancy with expert pharmacists for quality assurance, and elaboration of documents, procedures and a catalogue for UN Web Buy.

The Union Asthma Guide was revised with the new information on metered dose inhalers using hydrofluoroalkane as the propellant gas, as well as new recommendations for management. The Union also provided training materials and instruments for development of databases and follow-up of individual cases. In order to assure quality of care, Dr Billo stressed the role of the clients in organizing training and implementation, registering cases of persistent asthma, sending quarterly reports, and finding funds for regular training and technical support. The chances of success of ADF were related to competitive prices with quality assurance, support by a technical package for guidance of management, expanded country demand and awareness fostered by initiatives such as GARD, PAL and The Union.

Several challenges are anticipated in countries: obtaining political commitment for resources to buy medication; convincing governments to buy essential drugs for the majority of their population; promoting public/private complementary partnerships; adoption of The Union management proposal which is standardized and cost-effective.

InterAirways

The presentation on the WHO InterAirways Project was made by Professor Omer Kalayci, Secretary General of the Turkish National Society of Allergy and Clinical Immunology and Co-rapporteur of the InterAirways Workshop held in San Diego, USA, on 28 February–1 March 2007.

Professor Kalayci called attention to the high frequency of rhinitis among asthmatics and conversely, the high frequency of asthma in individuals with rhinitis; to the fact occupational rhinitis, which might be an early surrogate of entire airway diseases is often neglected; to the association between chronic rhinosinusitis and nasal polyposis with lower airway diseases; and to interactions between upper airway infections and exacerbation of lower airway illnesses.

The objectives of the InterAirways project are: (i) to analyse current recommendations, (ii) to develop an evidence-based document (epidemiology, diagnosis, integrated prevention and integrated management); (iii) to define existing knowledge gaps and research priorities; (iv) to develop educational material, particularly on prevention.

The InterAirways matched GARD objectives of increasing awareness, improving prevention and management, and searches for new knowledge to fight CRD.

During the workshop in San Diego, there was agreement on a draft proposal. Two major source documents would be taken into consideration: the ARIA Update (Allergic Rhinitis and its Impact on Asthma), and the European Position Paper on Rhinosinusitis and Nasal Polyps (EP3OS). The topics to be covered would be: allergic rhinitis; aspirin hypersensitivity; occupational airway diseases; rhinosinusitis and nasal polyposis; other nasal diseases with an impact on lower airways; infections of the upper airways impacting lower airways; co-morbidities between inhalant and skin allergies; physical activity, nutrition and airways; rhinitis in children; and, interactions between upper and lower airways in deprived populations and in people in developing countries.

PLANNING THE NEXT STEPS

Professor Jean Bousquet reflected upon how the presentations and discussions at the General Meeting would affect the future of the Alliance. During 2007–2008, GARD should expand the current activities and, in particular, should focus on building a five-year strategic plan to be presented to the General Meeting in 2008. This plan should include: developing a standardized approach for surveillance, developing spin-off documents from GARD Book, improving political commitment through the Seoul Statement (see Annex 3), possibly through a resolution of the World Health Assembly, as well as through a meeting on macroeconomics. Professor Bousquet underlined that investment on the prevention and control of CRD at the country level would improve the economy of the country, improve air quality on a global scale and reduce deforestation. An economic model should be developed.

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ANNEXES

ANNEX 1

Message of support from Dr José Antonio Ocampo, UN Under-Secretary-General

UNITED NATIONS



NATIONS UNIES

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Reference: DESA-07/45

6 March 2007

Dear Messrs. Kim and Chang,

On behalf of the Secretary-General, I thank you for your letter of 15 February and for the kind words of congratulations you offered him.

The Secretary-General would like to express his support for your efforts to combat the growing health crisis of chronic respiratory diseases through the Global Alliance Against Chronic Respiratory Diseases (GARD). The Alliance represents a forward-looking strategy and an opportunity to address head-on the dire problems of diseases caused by environmental pollution. Your commitment to ensuring broad participation in this initiative is also most welcome.

While the Secretary-General is unable to send a formal message to the Alliance, he would like to take this occasion to extend his appreciation for your contribution to the promotion of good health, peace and cooperation.

Yours sincerely,

A handwritten signature in dark ink, appearing to read "José Antonio Ocampo".

José Antonio Ocampo
Under-Secretary-General

Mr. Yu-Young Kim
Chairman, Organizing Committee of
The Second WHO/GARD General Meeting

Mr. Suk-II Chang
Chairman, Organizing Committee of
The Second WHO/GARD General Meeting

ANNEX 2

List of attendees

Representatives of GARD participants ¹	
Professor C. Baena-Cagnani	Past President, World Allergy Organization (WAO), Faculty of Medicine, Catholic University of Cordoba, Cordoba, Argentina
Professor A.K. Baigenzhin	Executive Director, Euro-Asian Respiratory Society (EARS), Astana City, Republic of Kazakhstan
Dr F. Baigenzhina	Euro-Asian Respiratory Society (EARS), Astana City, Republic of Kazakhstan
Dr E. Bateman	Professor of Respiratory Medicine, American Thoracic Society (ATS), Director UCT Lung Institute, Cape Town, South Africa
Dr N. Billo	Executive Director, International Union Against Tuberculosis and Lung Diseases (The Union), Paris, France
Professor J. Bousquet	Chair, Allergy Rhinitis & its Impact on Asthma (ARIA), Service des Maladies Respiratoires, Hôpital Arnaud de Villeneuve, Montpellier, France
Dr S. Chang	Secretary General, Korea Asthma Allergy Foundation (KAF), General Director, Sung Ae General Hospital, Seoul, Republic of Korea
Dr N. Chavannes	International Primary Care Respirator Group (IPCRG), Health Center Zuiderkroon/ Maastricht University, Rotterdam, Netherlands
Dr S. Cho	Vice-Secretary General, Korea Asthma Allergy Foundation (KAF), Department of Internal Medicine, Seoul National University, College of Medicine, Seoul, Republic of Korea
Professor A.G. Chuchalin	President, Russian Association of Pulmonologists (RSP), Pulmonology Research Institute, Moscow, Russian Federation
Dr W. Dolen	Past President, American College of Allergy, Asthma and Immunology (ACAAI), Medical College of Georgia, Augusta, GA, United States of America
Professor R. Gerth van Wijk	First Vice-President, European Academy of Allergy & Clinical Immunology (EAACI), Head, Department of Allergology, Erasmus Medical Center, Rotterdam, Netherlands
Dr S. Hurd	Scientific Director GINA/GOLD, Global Initiative for Asthma (GINA), Gaithersburg, MD, United States of America
Dr O. Kalayci	Secretary General, Turkish National Society of Allergy and Clinical Immunology (TNSACI), Hacettepe University School of Medicine, Pediatric Allergy and Asthma Unit, Ankara, Turkey
Dr R. Kauppinen	Chairman of Board, Finnish Lung Health Association (FILHA), Helsinki, Finland
Professor Y. Kim	President, Korea Asthma Allergy Foundation (KAF), Department of Internal Medicine, Seoul National University, College of Medicine, Seoul, Republic of Korea
Dr C. Lenfant	Executive Director GINA/GOLD, Global Initiative for Asthma (GINA), Gaithersburg, MD, United States of America
Dr A.W. T. Loh	Chief Executive Officer, World Organization of Family Doctors (WONCA), Singapore, Singapore
Dr M. Maglakelidze	Assistant to UN Theme Group, Georgian Respiratory Association (GRA), UNICEF Georgia, Tbilisi, Georgia
Professor S. Makino	Head, WHO Collaborating Centre for Prevention and Control of Chronic Respiratory Diseases (DU-WCC), Dokkyo University - School of Medicine, Department Respiratory Medicine and Clinical Immunology, Tochigi, Japan
Dr H. Moon	Chair, Steering Committee, Korea Asthma Allergy Foundation (KAF), Department of Allergy and Rheumatology, Asian Medical Center, University of Ulsan College of Medicine, Seoul, Republic of Korea
Dr M. Morais de Almeida	President, Portuguese Society of Allergology and Clinical Immunology (SPAIC), Lisbon, Portugal

Dr S. Nardini	Secretary General/Treasurer, Italian Scientific Interdisciplinary Association for Research in Respiratory Medicine (AIMAR), Hospital V. Veneto, Vittorio Veneto, Italy
Professor R. Pawankar	Director, Asian Allergy & Asthma Foundation (AAAF), Nippon Medical School, ENT and Allergology, Department of Otolaryngology, Tokyo, Japan
Professor E. Sabri	President, Turkish Thoracic Society (TTS), Ankara, Turkey
Dr Y. Soo Shim	International Coalition for Chronic Obstructive Pulmonary Disease (ICC), Seoul National University, College of Medicine, Seoul, Republic of Korea
Professor E.R. Simons	Head, Section of Allergy and Clinical Immunology American Academy of Allergy, Asthma and Immunology (AAAAI), University of Manitoba, Childrens Hospital/Health Sciences Centre, Winnipeg, Manitoba, Canada
Dr A. Tsoy	General Secretary, Euro-Asian Respiratory Society (EARS), Astana City, Republic of Kazakhstan
Ms L. Vardy	Director, Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada (PHAC), Ottawa, Ontario, Canada
Professor G. Viegi	Past-President, European Respiratory Society (ERS), CNR Istituto di Fisiologia Clinica, Pisa, Italy
Professor P. Yang	Secretary General, The Asian Pacific Society of Respirology (APSR), National Taiwan University Hospital, Taipei, Taiwan
Professor A. Yorgancioglu	Secretary of Foreign Affairs, Turkish Thoracic Society (TTS), Ankara, Turkey
Professor T. Zuberbier	Head, European Centre for Allergy Research Foundation (ECARF), Department of Dermatology and Allergy, Charité - Universitätsmedizin Berlin, Berlin, Germany

GARD experts¹

Professor C. Bai	Director, Department of Pulmonary Medicine, Center of Combined Modality Treatment, Zhongshan Hospital, Fudan University, Shanghai, People's Republic of China
Professor A. Ben Kheder	Hôpital A. Mami Ariana, Ariana, Tunisia
Professor J. Chen	Director, Key Lab of Health Technology Assessment, Ministry of Health, Department of Hospital Management, School of Public Health, Fudan University, Shanghai, People's Republic of China
Professor H. Douagui	Centre Hospitalo-Universitaire de Béni-Messous, Service de Pneumo-Allergologie, Algiers, Algeria
Dr N. Maglakelidze,	Training and Retraining of PHC Staff in Georgia, State Programme Coordinator, Georgia Health and Social Projects Implementation Center, Tbilisi, Georgia
Professor P. Camargos	Professor of Medicine, Medical School, Department of Pediatrics, Federal University of Minas Gerais, Belo Horizonte, Brazil
Professor H. Shen	Second Hospital of Zhejiang University, Hangzhou, People's Republic of China
Dr P. Sliwinski	National Institute of Tuberculosis and Lung Diseases, Warsaw, Poland

GARD observers¹

Mr P. De Angeli	General Manager, International Division, Chiesi Farmaceutici S.p.A., Parma, Italy
Dr A. Fink-Wagner	Manager Professional Relations Respiratory, Global Franchise Management, Medical Communications, Altana Pharma AG, Konstanz, Germany
Dr P. Gregory	Regional Director, Asia Pacific, Pharmaxis, Shanghai, People's Republic of China
Ms K. Hong	Representative Manager, Altana Pharma AG, Branch Office Korea, Seoul, Republic of Korea

Mr D. Lee	Marketing Manager, Marketing Respiratory, GlaxoSmithKline (GSK), Seoul, Republic of Korea
Dr H. O	General Director, O & S International, Moscow, Russian Federation

GARD secretariat

Dr N. Khaltaev	Responsible Officer, Chronic Diseases Prevention and Management, Chronic Diseases and Health Promotion
Ms E. Minelli	Technical Officer, Chronic Diseases Prevention and Management, Chronic Diseases and Health Promotion
Dr A. Cruz	Medical Officer, Chronic Diseases Prevention and Management, Chronic Diseases and Health Promotion
Professor T. To	Epidemiologist and Biostatistician, Visiting Scientist, Chronic Diseases Prevention and Management, Chronic Diseases and Health Promotion
Ms S. Jong	Intern, Chronic Diseases Prevention and Management, Chronic Diseases and Health Promotion

1 Unable to attend:

Dr K. Allan	Head of Global Product Advocacy, Novartis Pharma AG, Basel, Switzerland
Professor S. Bonini	Italian National Research Council, Institute of Neurobiology and Molecular Medicine (CNR-INMM), Rome, Italy
Dr A. S. Buist	Chair, Gold Initiative for Chronic Obstructive Pulmonary Disease (GOLD), Pulmonary & Critical Care Medicine, Oregon Health & Science University, Portland, OR, United States of America
Professor R. Dahl	University Hospital of Aarhus, Department of Respiratory Diseases, Aarhus, Denmark
Dr C. F. Donner	President, Italian Scientific Interdisciplinary Association for Research in Respiratory Medicine (AIMAR), Borgomanero, Italy
Ms A. Josley	Global Brand Leader/Respiratory, Merck & Co., Inc., Whitehouse Station, N.J., United States of America
Professor P.J. Jousilahti	Research Professor, Finnish National Public Health, Department of Epidemiology & Health Promotion, Helsinki, Finland
Dr C. Justus	International Market Development Manager, Boehringer-Ingelheim Int. GmbH, Ingelheim, Germany
Dr T. S. Karibekov	Director, Akimat of Astana City, Public Health Department, Astana City, Republic of Kazakhstan
Dr M. R. Kechrid	Ministre de la Santé Publique, Ministère de la Santé Publique, Tunis, Tunisia
Prof M. Kowalski	President, Polish Society of Allergology (PSA), Head, Department of Immunology, Rheumatology and Allergy, Medical University of Lodz, Lodz, Poland
Dr A. U. Mamin	Akimat of Astana City, Public Health Department, Astana City, Republic of Kazakhstan
Professor C. Nunes	Portuguese Society of Allergology and Clinical Immunology (SPAIC), Lisbon, Portugal
Dr A. Razumov	World Federation of Hydrotherapy and Climatotherapy (FEMTEC), All-Russian Scientific Research Center for Restorative and Resort Medicine, Moscow, Russian Federation
Dr A. Saporta	Chairman and CEO, Stallergenes SA, Antony, France
Dr S. Shrimpton	Director, Commercial Strategy, Respiratory, GlaxoSmithKline (GSK), Greenford, Middlesex, United Kingdom
Professor U. Solimene	Secretary-General, World Federation of Hydrotherapy and Climatotherapy (FEMTEC), Faculty of Medicine, University of Milan, Milan, Italy
Professor N. Storozhenko	President, World Federation of Hydrotherapy and Climatotherapy (FEMTEC), National SPA Association of Russia, Moscow, Russian Federation

Dr C. Torres	Past-President, Latin American Thoracic Society (ALAT), Fundacion Neumologica Colombiana, Bogota, Colombia
Mr A. Turnbull	Executive Secretary, Forum of the International Respiratory Societies (FIRS), Lausanne, Switzerland

ANNEX 3

Statement of the General Meeting of the Global Alliance against Chronic Respiratory Diseases, Seoul, Republic of Korea, 1–2 June 2007

The General Meeting of the Global Alliance against Chronic Respiratory Diseases (GARD), gathered together in Seoul, Republic of Korea, on 1–2 June 2007, expressed the urgent need to tackle chronic respiratory diseases and to improve global lung health.

GARD was launched in 2006 as a voluntary alliance of national and international organizations, institutions and agencies committed to the vision of a world where all people breathe freely. Its goal is to reduce the global burden of chronic respiratory diseases. Its main objective is to initiate a comprehensive approach to fight chronic respiratory diseases by: (1) developing a standard way of obtaining relevant data on the burden of chronic respiratory diseases and their risk factors; (2) advocating for action on chronic respiratory diseases; (3) encouraging countries to implement policies for health promotion and prevention of chronic respiratory diseases; (4) developing simple and affordable strategies for management of chronic respiratory diseases. The World Health Organization provides technical leadership and secretariat support.

GARD provides a network through which collaborating parties from different sectors of society can achieve results that no single partner could attain alone. GARD also improves the coordination between existing governmental and nongovernmental programmes, thereby minimizing duplication of effort and wastage of resources.

GARD collaborating parties noted that:

- a. Hundreds of millions of people suffer worldwide from a chronic respiratory disease. Currently 300 million people have asthma, 210 million people have chronic obstructive pulmonary disease, while millions of others have allergic rhinitis, occupational lung diseases, pulmonary hypertension, bronchiectasis, and other often undiagnosed chronic respiratory diseases.
- b. The growing number of smokers, especially among young people and women, brings the perspective of an increasing burden of chronic respiratory diseases in the future.
- c. Air pollution continues to pose a significant threat to health worldwide. According to a WHO assessment of the burden of disease due to air pollution, more than 2 million premature deaths each year can be attributed to the effects of urban outdoor air pollution and indoor air pollution (caused by the burning of solid fuels). More than half of this disease burden is borne by the populations of developing countries.
- d. Women and children are the most vulnerable. Most of their time is spent indoors and they are exposed on a daily basis to indoor air pollution from solid fuels for cooking and heating, which is still very common in many low- and middle-income countries.
- e. Many risk factors, such as tobacco smoking and exposure to outdoor and indoor air pollution, have been identified and can be controlled and prevented.
- f. Medications for effective treatment of chronic respiratory diseases are not always affordable especially for low-income

families.

GARD collaborating parties recognized that:

- a. Taking up the challenge of chronic respiratory disease prevention requires a comprehensive approach, integrated with prevention of other chronic diseases.
- b. The burden of chronic respiratory diseases is a socioeconomic problem that cannot be addressed by the public health sector alone.
- c. Tackling chronic respiratory diseases requires the collaboration of partners from all sectors of society (multilateral and bilateral agencies, governments, civil society and the private sector).
- d. Affordability of and accessibility to treatment requires urgent attention.

GARD collaborating parties decided to continue to work together to accelerate action against chronic respiratory diseases by:

- a. Developing a standard way of obtaining relevant data on the burden of chronic respiratory diseases and their risk factors.
- b. Advocating for action on chronic respiratory diseases to increase awareness and strengthen commitment across a wide range of interested parties.
- c. Encouraging countries to establish, implement, monitor and evaluate a national health promotion and chronic respiratory disease prevention policy.
- d. Developing simple and affordable strategies for management of chronic respiratory diseases.
- e. Mobilizing human and financial resources on a sustainable basis to meet the challenges of fighting chronic respiratory diseases.
- f. Ensuring that the implementation capacity is developed to utilize these resources efficiently and effectively.
- g. Preparing and developing educational tools which are focused on prevention and tailored to local cultural and economic conditions.

While recognizing that it is the responsibility of affected countries to take the necessary actions, GARD collaborating parties called attention to the fact that the problem is often the greatest in countries which can least afford it. It is in the interest of the global community to support the fight against chronic respiratory diseases worldwide.

Realizing the magnitude of the task ahead, GARD collaborating parties agreed to tackle the burden of chronic respiratory diseases by:

- a. Sharing information on chronic respiratory diseases.
- b. Mobilizing and involving patients, families, the community and the media to raise awareness of chronic respiratory diseases.
- c. Enhancing the recognition of chronic respiratory diseases on the global health agenda through seeking support of the ministries of health as well as other related ministries such as finance.
- d. Promoting the development of national and international networks with all possible interested parties in society, including governments, the private health sector, industry,

nongovernmental organizations and the community to help reduce the burden of chronic respiratory diseases.

- e. Supporting country-focused activities in the field of chronic respiratory diseases, which are crucial to scale up the interventions to reduce the chronic respiratory disease burden.

ANNEX 4

Directory of GARD participants

Name of Organization	Year established	Journal and Website address	Mission	Category (Int.Org./NGO/etc.)	Interest sections or assemblies	Number of members/partners and representation by WHO Region
Allergic Rhinitis and its Impact on Asthma (ARIA)	1999	www.whiar.org	To educate and implement evidence-based management of allergic rhinitis in conjunction with asthma worldwide, through planning, managing, and financing pilot projects to improve the health of broad sectors of the population throughout the world, setting up rural healthcare activities, providing support for preventive diagnostic and therapeutic measures as part of basic healthcare.	Nongovernmental organization		200: AFRO, AMRO, EMRO, EURO, SEARO, WPRO
ALLERG.O.S	2003		To improve, at a regional level (French Languedoc-Roussillon region), the diagnosis of patients with a suspected severe allergic reactions	Nongovernmental organization, nonprofit organization for clinicians	Missions split into work packages (hymenoptera venom and food anaphylaxis, drug allergy, difficult to control asthma)	70 members (physicians, pharmacists, nurses involved in the network), EURO Region
American Academy of Allergy, Asthma and Immunology (AAAAI)	1943	<i>Journal of Allergy & Clinical Immunology</i> www.aaaai.org	The advancement of the knowledge and practice of allergy, asthma and immunology for optimal patient care.	Nongovernmental organization	7 interest sections: Asthma Diagnosis and Treatment; Basic and Clinical Immunology; Environmental and Occupational Respiratory Diseases; Food Allergy, Dermatologic Diseases and Anaphylaxis; Health Care Education, Delivery and Quality; Mechanisms of Asthma and Allergic Inflammation; Rhinitis, Sinusitis and Ocular Diseases	6000 in Canada, United States of America and 60 other countries: AFRO, AMRO, EMRO, EURO, SEARO, WPRO
American College of Allergy, Asthma and Immunology (ACAAI)	1942	<i>Annals of Allergy, Asthma & Immunology</i> www.acaai.org	To improve the quality of patient care in allergy and immunology through research, advocacy and professional and public education; maintain and advance diagnostic and therapeutic skills of members; sponsor and conduct educational and scientific programmes and publications; develop and disseminate educational information for members, patients, health-plan purchasers and administrators, and other physicians and health professionals.	Nongovernmental professional association for allergists and immunologists		4900 allergists and immunologists: AMRO and possibly other regions through international affiliate membership

GLOBAL ALLIANCE AGAINST CHRONIC RESPIRATORY DISEASES

Name of Organization	Year established	Journal and Website address	Mission	Category (Int.Org./NGO/etc.)	Interest sections or assemblies	Number of members/partners and representation by WHO Region
American Thoracic Society (ATS)	1905	<i>American Journal of Respiratory and Critical Care Medicine;</i> <i>American Journal of Respiratory Cell and Molecular Biology;</i> <i>Proceedings of the American Thoracic Society</i> www.thoracic.org	To prevent and treat respiratory disease through research, education, patient care and advocacy; to decrease morbidity and mortality from respiratory disorders and life-threatening acute illnesses in people of all ages, interacting with national and international organizations that have similar goals.	Nongovernmental, nonprofit, international, professional and scientific society for respiratory and critical-care medicine.	12 specialized assemblies	13 000 globally: AFRO, AMRO, EMRO, EURO, SEARO, WPRO
Asian Allergy and Asthma Foundation (AAAF)	2004	website in preparation	To advance excellent clinical practice of allergic diseases and to reduce their burden through education, training, research, cost effective treatment and public awareness through continuous dialogue with the health ministry and world organizations with the same goals.	Regional nongovernmental organization		50 members representing all Asian countries: SEARO, WPRO
Asian Pacific Association of Allergology and Clinical Immunology (APAACI)	1989	www.apaaci.org	To support the development of the discipline of allergy, asthma and clinical immunology in the region; to encourage and assist in forming national societies where none exist; to promote the exchange and progress of knowledge in the region; to study the prevention and treatment of allergy, asthma and immune-mediated diseases specific to the region; to promote exchanges in training programmes between member countries; to help cooperation between clinical and basic research; to develop programmes for public education; to cooperate with other international organizations with similar goals; to disseminate knowledge through international congresses and by other means.	Association of national societies of allergy and clinical immunology in the Asia-Pacific region		15 national societies in SEARO, WPRO
Asian Pacific Society of Respirology (APSR)	1985	<i>Respirology</i> www.apspresp.org	To advance and promote knowledge of the respiratory system in health and disease; to strive to encourage research and improve clinical practice through teaching; to increase awareness of health problems in the area and to promote exchange of knowledge among respirologists in the Asia-Pacific region.	Regional nongovernmental organization		10,150: SEARO, WPRO
Asthma and Allergy Association (AAA)	1991	<i>Journal Asthme & Allergies Infos</i> www.asmanet.com	To promote information, medical training and patients' education. Disseminate scientific information; function as a reference body for health organizations and media; encourage and provide training and continuing education. Answer patients' questions through a free hotline.	Nongovernmental, nonprofit organization for patients, doctors and health professionnals	sections for asthma, dermatology, paediatrics and allergies to improve information to patients and to promote patients' education. Can propose task forces and joint sessions with other specialist societies.	Over 2 500 members France

Name of Organization	Year established	Journal and Website address	Mission	Category (Int.Org./NGO/etc.)	Interest sections or assemblies	Number of members/partners and representation by WHO Region
Danish Lung Health Association (DLHA)	1901	www.lungeforening.dk	To improve prevention and treatment of lung diseases in Denmark and to help patients with these diseases (especially chronic obstructive pulmonary disease) in the country.	National nongovernmental organization		3493 members from the Faroe Islands and Greenland: EURO
Dokkyo University School of Medicine, WHO Collaborating Centre for Prevention and Control of Chronic Respiratory Diseases. (DU-WCC)			Terms of reference as WHO Collaborating Centre; Asia-Pacific Initiative for Chronic Respiratory Diseases.	WHO Collaborating Centre		SEARO, WPRO
European Academy of Allergy and Clinical Immunology (EAACI)	1956	<i>Allergy (European Journal of Allergy and Clinical Immunology)</i> www.eaaci.net	To promote basic and clinical research; assess and disseminate scientific information; function as a reference body for other scientific, health and political organizations; encourage and provide training and continuing education; promote good patient care for allergic and immunological diseases.	Nongovernmental, nonprofit organization for academicians, research investigators and clinicians	Sections for asthma, dermatology, otorhinolaryngology, immunology and paediatrics to improve information exchange and collaboration between scientists within and outside EAACI. Sections can propose task forces and joint sessions with other specialist societies.	39 European national societies, over 3 500 members: EURO
European Centre for Allergy Research Foundation (ECARF)	2003	www.ecarf.org	To improve knowledge, research and awareness of allergies; decrease the burden of disease in patients and in society through structural research in allergy, spreading of excellence and knowledge among physicians and the public, initiatives for improving patient care, activities for a better quality of life for allergic patients.	Nongovernmental foundation		Collaboration with Allergy Centre Charité, specialized in clinical work, research and dissemination of knowledge in allergy: EURO
European Federation of Allergy and Airways Diseases Patients' Associations (EFA)	1992	www.efanet.org	To improve the quality of life of people with asthma, chronic obstructive pulmonary disease and allergy and of their carers throughout Europe, contributing to a European community that shares the responsibility for substantially reducing the frequency and severity of these conditions and recognizes the social, environmental, economic and health implications.	Foundation		Alliance of 41 organizations in 23 countries in Europe representing 250 000 persons: EURO

GLOBAL ALLIANCE AGAINST CHRONIC RESPIRATORY DISEASES

Name of Organization	Year established	Journal and Website address	Mission	Category (Int.Org./NGO/etc.)	Interest sections or assemblies	Number of members/partners and representation by WHO Region
European Respiratory Society (ERS)	1990	<i>European Respiratory Journal</i> , <i>European Respiratory Monograph</i> , <i>European Respiratory Review</i> , <i>European Respiratory Topic</i> , <i>ERS Newsletter</i> , <i>Breathe</i> www.ersnet.org	Promoting research; fostering education; exchanging knowledge; improving patient care.	Nongovernmental, nonprofit international medical organization	10 scientific assemblies serve as forum to present and discuss scientific work at yearly congress	Over 7000 members in 100 countries: AFRO, AMRO, EMRO, EURO, SEARO, WPRO
Finnish Lung Health Association (FILHA)	1907	www.filha.fi	Training and education of management of chronic respiratory diseases; design, implementation of national programmes for diseases (asthma, chronic obstructive pulmonary disease, sleep apnoea), for smoking cessation (since 1994) and implementation of international project (tuberculosis); research, expert networking and human resource development.	National nongovernmental organization	WHO collaborating centre	EURO (Finland, Russian Federation, Baltic nations), SEARO (Kyrgyzstan, Mongolia), WPRO (China)
Forum of International Respiratory Societies (FIRS)	2002		Advocacy for global respiratory health and identification of new areas for global initiatives. Aims to be attained by the consideration of needs and the proposal of related projects, implemented jointly or individually by the member organizations.	Cooperative union of international professional and scientific societies		Participating organizations include ACCP, ALAT, APSR, ATS, ERS, UNION and ULASTER.
Georgian Respiratory Association (GRA)	2004	<i>sakartvelos respiraciuli jurnali</i> (Georgian) www.georanel.org.ge	To promote basic, epidemiological and clinical research in respiratory medicine; to organize regular congresses, conferences, symposia, seminars, scientific meetings, exhibitions and all other clinical and scientific events; to develop and maintain high standards of continuing medical education for medical specialists; to produce scientific publications by the editing, printing, and publishing of reviews, journals, and bulletins to promote, encourage or disseminate research or educational work in the field of respiratory medicine; to produce guidelines on the diagnostic and management of respiratory diseases; to collaborate with other national and international organizations having a similar objectives or similar functions.	National nongovernmental, nonprofit organization	10 scientific working groups	420 members, 6 branches throughout Georgia; EURO
Ghent University, WHO Collaborating Centre (GU-WCC) Dept. Respiratory Diseases.	1817	www.uhent.be	To offer high-quality, research-based education; to play an important role in fundamental and applied research; to be an open, pluralistic, international institute with a social responsibility (full mission statement: www.uhent.be/en/ghentuniv/management/mission).	WHO Collaborating Centre		EURO

Name of Organization	Year established	Journal and Website address	Mission	Category (Int.Org./NGO/etc.)	Interest sections or assemblies	Number of members/partners and representation by WHO Region
Global Allergy and Asthma European Network (GA2LEN)	2004	www.ga2len.net	To establish an internationally competitive network; to enhance quality and relevance of research and address all aspects of the disease; to decrease the burden of allergy and asthma throughout Europe. Activities consist of integration, coordination of scientific activities and spreading excellence.	Research network in allergy and asthma	Work packages include: nutrition, infection, environment and pollution, occupation, gender sensitization and allergic disease, airway remodelling, clinical care, genetics and genomics	26 leading European teams, EAACI and EFA, one or more centres in each European country: EURO
Global Initiative for Asthma (GINA)	1991	www.ginasthma.com	Works with health care professionals and public health officials around the world to reduce asthma prevalence, morbidity and mortality. Through evidence-based guidelines for asthma management, and events such as the annual celebration of World Asthma Day, the Global Initiative for Asthma works to improve the lives of people with asthma in every corner of the globe.	Programme launched in collaboration with WHO and National Institutes of Health/National Heart, Lung and Blood Institute	Executive, Science and Dissemination Committees; national launch leaders	AFRO, AMRO, EMRO, EURO, SEARO, WPRO (GARD target countries: Argentina, Brazil, Costa Rica, Portugal, Georgia, Russian Federation, Syrian Arab Republic, Vietnam)
Global Initiative for Chronic Obstructive Lung Disease (GOLD)	1998	www.goldcopd.com	Increase awareness of medical community, public health officials and general public that chronic obstructive pulmonary disease is a public health problem; decrease its morbidity and mortality through implementing effective programmes for its diagnosis, management and prevention strategies for use in all countries and promoting studies into the etiology of its increasing prevalence.	Programme launched in collaboration with WHO and National Institutes of Health/National Heart, Lung and Blood Institute	Executive, Science and Dissemination Committees. National Launch Leaders	AMRO, EURO

GLOBAL ALLIANCE AGAINST CHRONIC RESPIRATORY DISEASES

Name of Organization	Year established	Journal and Website address	Mission	Category (Int.Org./NGO/etc.)	Interest sections or assemblies	Number of members/partners and representation by WHO Region
Institute of Neurobiology and Molecular Medicine - Italian National Research Council (INMM-CNR)	1923	www.cnr.it	CNR promotes and carries on research activities, in pursuit of excellence and strategic relevance within the national and international ambit, in the frame of European cooperation and integration. In cooperation with the academic research and with other private and public organizations, CNR ensures the dissemination of results inside the Country, defines, manages and coordinates national and international research programs, in addition to support scientific and research activities of major relevance for the national system. It promotes the valorization, the pre-competitive development and the technological transfer of research results carried on by its own scientific network and by third parties with whom cooperation relationships have been established. It promotes the collaboration in the scientific and technological field, and in the technical regulations field, with organizations and institutions of other Countries, and with supranational organizations in the frame of extra-governmental agreements. It provides, upon request of government authorities, specific skills for the participation of Italy to organizations or international scientific programs of inter-governmental nature. It carries on, through its own program of scholarships and research fellowships, educational and training activities in Ph.D. courses, in advanced after-university specialization courses, and in programs of continuous or recurrent education;	Public organization with autonomous rules and regulations, in accordance with the existing laws and the Italian Civil Code	The Institute of Neurobiology and Molecular Medicine (INMM) resulted from the merging of two historical major Institutes of the CNR: The Institute of Neurobiology and The Institute of Molecular Medicine. The Institute is divided in three sections : Neurobiology; Molecular Medicine and Genetics and Molecular Pathophysiology. The research activity of the INMM is mainly focussed on genetic, cellular and molecular mechanisms in health and disease with special reference to allergic and immunologic diseases, diseases of the nervous system, cancerogenesis. The following ongoing/planned studies might be relevant: Allergy and Infections; Innate immunity; IgE sensitisation and inflammation; Tissue remodelling; Biomarkers; Novel drugs; Public Awareness/Education	CNR is made of 108 Institutes with 6962 research workers (2260 Female and 4702 Male).
Interdisciplinary Association for Research in Lung Disease (AIMAR)	2001	<i>Multidisciplinary Respiratory Medicine</i> www.aimarnetwork.org	To prevent lung disease and promote lung health; to improve the quality of patient care by educating physicians and allied professionals and providing them with programmes and strategies for fighting lung disease such as asthma, chronic obstructive pulmonary disease, infections, tobacco and environmental pollution; to promote research on lung disease; to increase the awareness of public about lung diseases and their risks; to involve all decision-makers in campaigns to reduce environmental and tobacco pollution. To promote and maintain links with all societies and agencies interested in lung health, including patients' organizations, especially in the Mediterranean area.	Nonprofit interdisciplinary association for research in lung disease	Medical areas involved : environmental, general, internal and occupational medicine, intensive care, cardiology, thoracic surgery, radiology, endocrinology, epidemiology, pharmacology, gastroenterology, geriatrics, immunology, infectious diseases, microbiology, neurology, oncology, otolaryngology, paediatrics, pneumology	EURO

Name of Organization	Year established	Journal and Website address	Mission	Category (Int.Org./NGO/etc.)	Interest sections or assemblies	Number of members/partners and representation by WHO Region
International Association of Asthmology (INTERASMA)	1954	<i>Journal of Investigational Allergology & Clinical Immunology</i> , <i>Interasma News newsletter</i> www.interasma.org	A forum for interdisciplinary discussions among pneumologists, allergists, paediatricians and general practitioners to exchange information on asthma research, practice and management: to focus on all aspects of asthma, bridging the gap between research and clinical practice; to encourage asthma education programmes for all health care professionals, educators and administrators; to improve the quality of life of asthmatics; to decrease the prevalence, morbidity and mortality of asthma.	International nongovernmental organization	Executive Committee, regional chapters	AMRO, AFRO, EMRO, EURO, WPRO
International Chronic Obstructive Pulmonary Disease Coalition (ICC)	1999	www.internationalcopd.org	To improve care of chronic obstructive pulmonary disease patients through increasing awareness of the disease and an understanding of its diagnosis and management for both carers and patients. To create alliances with professional groups to accomplish these ends. To encourage and support national and regional groups in advocacy efforts toward policy-makers to prioritize chronic obstructive pulmonary disease in research and care.	Nonprofit corporation; outreach of Global Initiative for Chronic Obstructive Lung Disease and the United States Chronic Obstructive Pulmonary Disease Coalition		220 000 members: AMRO, EMRO, EURO, WPRO
International Pediatric Respiratory and Allergies Immunological Societies (IPRAIS)	1992		To promote a high standard and clinical service and research for children with respiratory, allergy and immunological disorders. This has been achieved by organising meetings every 2-4 years (Prague 2000, Hong Kong 2003,) and by developing clinical guidelines.	Officially established as a forum, since 1998 IPRAIS became a society		Members from all WHO regions but with particularly strong representation of Asia/Pacific region

GLOBAL ALLIANCE AGAINST CHRONIC RESPIRATORY DISEASES

Name of Organization	Year established	Journal and Website address	Mission	Category (Int.Org./NGO/etc.)	Interest sections or assemblies	Number of members/partners and representation by WHO Region
International Primary Care Respiratory Group (IPCRG)	2000	<i>Primary Care Respiratory Journal</i> www.theipcr.org	The primary objects of the charity are to improve public health by raising funds to organise research and reviews into the care, treatment and prevention of respiratory illnesses, diseases and problems in a community setting, and to make available the results of such research for the benefit of the public and healthcare professionals.	Scottish Charity, Company Limited by Guarantee	Sub Committees: Research, Education, Membership, Guidelines and Governance	15 Ordinary Members with voting rights, 19 Associate Members, 2 International Organisations and 6 Invited specialists
International Union Against Tuberculosis and Lung Disease (the UNION)	1956	<i>International Journal of Tuberculosis & Lung Disease</i> www.iumtld.org	To prevent and control tuberculosis and lung disease, particularly in low-income countries. To promote national autonomy, within the framework of priorities of each country, by developing, implementing and assessing antituberculosis and respiratory health programmes. To disseminate knowledge on tuberculosis, lung disease, HIV and resulting community health problems in order to alert doctors, decision-makers, opinion-leaders and the general public to the diseases' related dangers. To coordinate, assist and promote the work of its constituent members throughout the world. To establish and maintain close links with WHO, other United Nations organizations, governmental and nongovernmental institutions in health and development sectors.	Membership organization with partners in all regions of the world	Scientific groups in asthma, tuberculosis, tobacco prevention, nursing, child lung health	Partners include WHO tuberculosis programme; Stop TB Initiative; Global Fund to Fight AIDS, Tuberculosis and Malaria; Centers for Disease Control and Prevention: AFRO
Italian Society of Respiratory Medicine (SIMER)	1993	<i>Medicina Toracica</i> www.simernet.eu	To promote education respiratory medicine and respiratory research, to bridge academic and hospital based respiratory medicine and research by fostering innovation in graduate and post-graduate training, to raise the standards of respiratory care by the production and dissemination of evidence based guidelines and the interaction with the public health political and administrative bodies at the national and regional levels.	Scientific, nonprofit organization	Clinical Problems, Respiratory Biology, Intensive and home care, Respiratory Patophysiology, Interventional pneumology, Allergology and Immunology; Infections and Tuberculosis, Epidemiology, Interstitial Lung Disease, Quality in Medicine, Pulmonary Oncology, Sleep Medicine	2100 members EURO Region

Name of Organization	Year established	Journal and Website address	Mission	Category (Int.Org./NGO/etc.)	Interest sections or assemblies	Number of members/partners and representation by WHO Region
Korea Asthma Allergy Foundation (KAF)	2003	www.kaaf.org	To increase the awareness of asthma and allergy to the government and the public and to increase the priority of asthma and allergy in the national health system and to improve the prevention and management of asthma and allergy.	National nongovernmental organization	Sections for special task forces such as Burden of Asthma and Computer Assisted Easy Asthma Management and sections for Public Awareness and Education of Physicians and Patients to improve the management of asthma and allergy and to increase priority of asthma and allergy in national health system.	286 members focusing on respiratory medicine and allergy, Republic of Korea
Latin American Thoracic Society (ALAT)	1996	www.alatorax.com	To record and disseminate scientific information about lung diseases; to teach and to promote research on thoracic diseases in Latin America; to stimulate scientific contact between the society's members and other national and international respiratory societies; to develop guidelines for the management of thoracic diseases; to develop scientific departments inside the association; to edit scientific publications.	Nongovernmental organization	Asthma, chronic obstructive pulmonary disease, critical pulmonology, endoscopy, interstitial lung diseases, lung infections, thoracic surgery, paediatric pulmonology, pulmonary circulation, respiratory pathophysiology, tuberculosis	5700: AMRO, EURO
Libra Project (LIBRA)	2006	<i>News Letter Progetto Libra</i> www.progettolibra.it	To raise awareness in public institutions, amongst healthcare workers and the general public on the importance of chronic obstructive diseases which should be considered and dealt with as one of the major problems regarding public health; to make the guidelines known and to change diagnostic and therapeutic standpoints by promoting educational and formative initiatives for healthcare workers; to reduce the number of unrecognized cases and to improve their treatment and optimize costs for the National Health Service whilst improving the quality of diagnostic and therapeutic treatment.	Nongovernmental, nonprofit organization for academicians, research investigators and clinicians	LIBRA (Linee Guida Italiane per BPCO, Rinite e Asma – COPD, Rhinitis and Asthma Guidelines) is the joint Italian project for the dissemination of COPD, Rhinitis and Asthma Guidelines which incorporates in one unique structure the Italian GINA, ARIA and GOLD-ERS/ATS projects.	The Executive Committee is made up of the national reporting members of the International Projects: S. Bonini (Rome), G.W. Canonica (Genoa), L.M. Fabbri (Modena), L. Corbetta (Florence), G. Passalacqua (Genoa), P.L. Paggiaro (Pisa). EURO Region
National Centre for Disease Prevention and Control, Ministry of Health, Italy (CCM)	2004	www.ccm.ministerosalute.it	To analyze health risks; coordinate surveillance and active prevention plans of the national alert and response systems; promote and train on the implementation of annual programmes; implement and evaluate annual programmes; network with other national and international health institutions; and information.	Governmental organization	The Centre is responsible for active prevention of chronic diseases and life styles.	EURO

GLOBAL ALLIANCE AGAINST CHRONIC RESPIRATORY DISEASES

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National Heart, Lung and Blood Institute (NHBLI), Division of Lung Diseases		www.nhlbi.nih.gov	Programme on asthma and chronic obstructive pulmonary diseases includes goals on epidemiology, research, genetics and pharmacogenetics, clinical trials, demonstration and education initiatives.	Governmental organization		Active partner with Global Initiative for Chronic Obstructive Lung Disease and with WHO: AFRO, AMRO, EMRO, EURO, SEARO, WPRO
National Public Health Institute, Finland (KTL)	1911	www.ktl.fi/portal/enGLISH	To promote people's possibility of living healthy lives. International collaboration (e.g. multilateral monitoring of trends and determinants in cardiovascular diseases (MONICA) project).	Governmental institute (under the Ministry of Social Affairs and Health), WHO Collaborating Centre		Finland: EURO
Polish Society of Allergology (PSA)	1982	<i>International Review of Allergology & Clinical Immunology; Pulmonologia i Alergologia Polska; Alergia Astma Immunologia</i> www.pta.med.pl	The objective of the society is to organize and support research and scientific works in the field of experimental and clinical allergology, to associate persons working in these fields and to popularize achievements in pertinent branches of science, as well as to care for a proper level of treatment in allergology.	Nonprofit organization	Sections for dermatology, otorhinolaryngology, clinical immunology, eye diseases, young allergologists and paediatrics to improve information exchange and collaboration between scientists within and outside PSA. Sections can propose task forces and joint sessions with other specialist societies	13 Regional Branches, about 1000 members EURO
Portuguese Society of Allergology and Clinical Immunology (SPAIC)	1950	<i>Revista Portuguesa de Imunoalergologia</i> www.spaic.pt	To prevent and treat allergic diseases through research, education, patient care and advocacy. To decrease morbidity and mortality from allergic and respiratory disorders, including asthma, in people of all ages, interacting with national and international organizations that have similar goals.	Nonprofit, nongovernmental, national, professional and scientific society for allergic and respiratory care medicine	12 specialized interest sections: aerobiology, allergy and asthma in sports, asthma, drug allergy, epidemiology, food allergy, immunotherapy, insect venom allergy, latex allergy, primary immunodeficiency, skin allergy, rhinitis	355 active members: EURO
Public Health Agency of Canada (PHAC)	2004	www.phac-aspc.gc.ca	To promote and protect the health of Canadians through leadership, partnership, innovation and action in public health.	Federal Government	The Centre for Chronic Disease Prevention and Control has several sections including cancer, diabetes, cardiovascular and respiratory disease, and works in the areas of prevention, control, surveillance, risk assessment and policy.	PAHO region

Name of Organization	Year established	Journal and Website address	Mission	Category (Int.Org./NGO/etc.)	Interest sections or assemblies	Number of members/partners and representation by WHO Region
Respiratory Society of French Speaking countries (SPLF)	1916	<i>Revue des maladies respiratoires, Info-Respiration</i> www.splf.org	To promote all aspects of research in the field of lung diseases; to educate health professionals and patients in order to increase quality of care and awareness; to elaborate programmes for screening, prevention and treatment of lung diseases such as asthma, chronic obstructive pulmonary disease and occupational diseases; to interact with respiratory health officials in order to produce evidence-based guidelines.	Society	22 working groups involved in the preparation and conduct of a yearly congress	Over 1500 members from various French-speaking countries (central and eastern Europe, African and Asian countries): AFRO, EURO, WPRO
Russian Society of Pulmonologists (RSP)		No information available.				
Société Française d'Allergologie et d'Immunologie Clinique (SFAIC)	1950	<i>Revue Française d'Allergologie et d'Immunologie Clinique</i> www.sfaic.com	To promote basic and clinical research; assess and disseminate scientific information; function as a reference body for other scientific, health and political organizations particularly in French speaking countries; encourage and provide training and continuing education; promote good patient care especially for allergic diseases and also for immunological diseases.	Nongovernmental, nonprofit organization for academicians, research investigators and clinicians	sections for asthma, pulmonology, gastroenterology, ophthalmology, dermatology, otorhinolaryngology, immunology and paediatrics, occupational diseases to improve information exchange and collaboration between scientists within and outside SFAIC Sections can propose task forces and joint sessions with other specialist societies.	Over 1500 members all over the world but especially EURO Region.
Turkish National Society of Allergy and Clinical Immunology (TNSACI)	1989	<i>Turkish Journal of Allergy Asthma and Immunology</i> www.aid.org.tr	Tackle with and try to solve medical, social and economic problems of allergic patients. Conduct investigations into the medical and social aspects of the allergic diseases, and providing support to studies carried out by the government, other associations and organizations in this field. Make propogandas through various publication and broadcasting means and organize conferences in order to elucidate the society in the struggle against allergic diseases and harms caused by them.	Nongovernmental nonprofit organization	Asthma, dermatology, immunotherapy, education, rhinitis, immunology and paediatrics	145 members, EURO Region.
Turkish Thoracic Society (TTS)	1992	<i>Turkish Respiratory Journal</i> www.toraks.org.tr/english	To provide the most effective scientific methods for prevention, control and treatment of respiratory diseases, and to increase national respiratory health through patient care, research, education and promotion of national policies.	National, nonprofit educational and scientific society	14 scientific working groups	1500 members, 15 branches throughout Turkey: EURO

GLOBAL ALLIANCE AGAINST CHRONIC RESPIRATORY DISEASES

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World Allergy Organization (WAO)	1950	<i>Journal of World Allergy Organization, International Archives of Allergy & Immunology</i> www.worldallergy.org	To build a global alliance of allergy societies to advance excellence in clinical care, research, education and training.	Worldwide nongovernmental organization; member of Council for International Organizations of Medical Sciences; working relationship with WHO	Federation of 70 national, regional and affiliate organizations	Total individual membership of member societies over 38 000, representing 92 countries: AFRO, AMRO, EMRO, EURO, SEARO, WPRO
World Federation of Hydrotherapy and Climatotherapy (FEMTEC)	1937	www.femteconline.com	To explain the medical spa world; to promote it in an international context among States and governing bodies; to encourage international cooperation between spas; to exchange studies, research and practices in the field of hydrotherapy; to promote development of medical spas and climatic resorts among members and worldwide.	Nongovernmental organization in official relations with WHO since 1985	2 500 medical centers involved in activities; once a year, general meeting of Executive Board; meeting of the four permanent committees - medical, economic, technical and social	35 members: thermal and medical spa associations, federations and organizations dealing with spa problems from various countries: AFRO, AMRO, EMRO, EURO, SEARO, WPRO
World Organization of Family Doctors (WONCA)	1972	www.globalfamilydoctor.com	To improve the quality of life of peoples of the world through defining and promoting its values; by maintaining high standards of care in general practice/family medicine; by promoting personal, comprehensive and continuing care for the individual in the context of the family; by supporting development of academic organizations of general practitioners/family physicians; by providing education to members; by presenting educational, research and service activities of members in other world medical and health organizations.	Nongovernmental organization in official relations with WHO	Governing council meets every three years; regional councils in each region; executive committee meets annually	97 member organizations in 79 countries, total membership over 200 000 general practitioners and family physicians: AFRO, AMRO, EMRO, EURO, SEARO, WPRO

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