Adapting the World Heart Federation Roadmaps at the National Level

Next Steps and Conclusions

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There is proven value to the implementation of effective strategies for cardiovascular secondary prevention and for tackling hypertension and tobacco control. However, their uptake is currently disappointingly very low, particularly in low- and middle-income countries where mortality rates for cardiovascular diseases (CVD) is much greater than in high-income countries [1]. The widespread deployment of these strategies can reduce both the risk of recurrent CVD events (secondary prevention) and the risk of developing CVD in the first place (primary prevention). Collectively widespread implementation of these three strategies is absolutely essential if we are to reduce CVD premature mortality by 25% by 2025.

The World Heart Federation (WHF) Roadmaps published in this issue of *Global Heart* examine key barriers at the policy and health-systems levels and propose potential solutions for overcoming them [2–4].

In 2014, the UN High Level Review of the Non Communicable Disease (NCD) Political Declaration stated that implementation of the global targets at national level is the critical next step to achieving the "25 by 25" goal for NCDs and that a multi-sectoral approach is essential. All of the 193 member countries of the WHO will be required to implement these targets and to report back to the World Health Assembly on what has been achieved.

A coordinated response is needed. The WHF Roadmaps are essential tools to reduce CVD premature mortality. However, to be effective, they will need to be adapted to overcome local barriers and develop solutions that are relevant to specific regional and national settings.

National roadmaps should be developed within multisectoral partnerships, including inter-governmental organizations, heart health advocacy foundations, cardiovascular scientific organizations, healthcare leaders, providers from primary and specialized care, private-sector stakeholders and people affected by CVD (including patients and caregivers). To be successful, they will also require effective advocacy towards policy makers and politicians in national governments.

The necessary steps for adapting the WHF Roadmaps at national level include (Figure 1):

1. Develop and convene a multi-sectoral coalition to adapt the global Roadmaps to local circumstances.
2. Conduct a situation analysis, including epidemiologic profiling, within the healthcare system for patients with CVD and those with hypertension. Relevant policies and assets should also be mapped.
3. Conduct policy dialogues with multiple local stakeholders. Local problems, specific barriers and potential solutions should be discussed and appropriate strategies selected according to context.
4. Develop a plan to evaluate the implementation of the selected strategies.

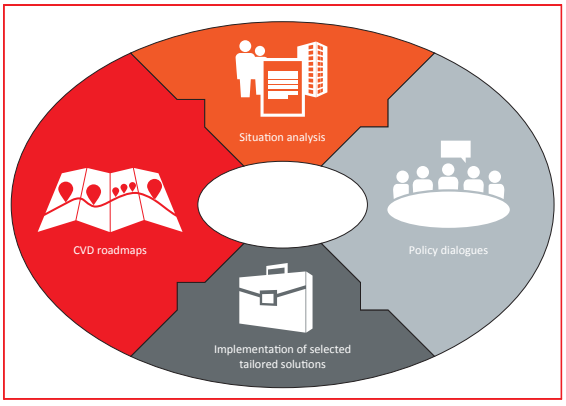

FIGURE 1. Adapting the WHF Roadmaps at the national level.

REGIONAL AND NATIONAL ROADMAP PROCESSES

Different strategies and tools can be used to successfully navigate the regional and national roadmap processes. For example:

Health system appraisals

These are multi-method assessments that have been used to understand the barriers and facilitating factors for optimal care of different chronic conditions [5]. They start by exploring patient-level outcomes, in terms of health, acceptability and fit with values and preferences. They then identify why health system functions may be suboptimal and trace barriers to effective management at service

Dr. Perel lead several studies on preventive cardiology for which his institution has received grants. He has no conflicts related to this particular article. Dr. Wood lead several studies on preventive cardiology for which his institution has received grants from both peer review organizations as well as from a number of pharmaceutical companies. He has also received honoraria for lectures and travel expenses for talks. He has no conflicts related to this particular article. Dr. Yusuf lead several trials with a range of drugs as well as lifestyle interventions involving CVD prevention for which his institution has received grants from both peer review organizations as well as from a number of pharmaceutical companies. He has also received honoraria for lectures and travel expenses for talks. He has no conflicts related to this particular article. The remaining authors report no relationships that could be construed as a conflict of interest.

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delivery level. Specific pathways are identified with regard to how inputs translate to outcomes, by asking not just 'what works?' but 'how?' and 'why?'

This approach typically involves mixed methods, depending on the availability of data for each domain. The first step involves review and synthesis of official statistics, published and grey literature, survey data and government reports to understand the formal health system and how it is expected to work. In the second step, primary data are collected (using locally appropriate methods) to identify problems, as perceived by users. The formal and actual situations are compared analytically and reasons identified.

Policy dialogues

These are platforms for sharing knowledge and experiences and for bringing evidence to practice [6]. A policy dialogue is facilitated by an impartial mediator and promotes knowledge transfer. Other knowledge brokers taking part should include international experts, academics and policy makers from other countries who have experience in implementing the policy under discussion.

Policy dialogues commonly involve multiple stakeholders and focus on discussing the problem, the specific barriers and potential solutions. A bundle of appropriate strategies can then be selected according to context.

They provide an opportunity for policy makers within a specific country to discuss policy questions and areas of concern regarding the selected policy, in this case tobacco control, hypertension control and cardiovascular secondary prevention.

Participants should be encouraged to contribute their views and experiences. Relevant experts can provide brief presentations to highlight the main evidence and policy concerns. Finally, a report must be produced and distributed among participants, documenting the key issues, recommendations and next steps.

WHF MICROSITE AND MEETINGS

The WHF has developed a microsite to support countries in their local adaptation and implementation of the WHF Roadmaps. It includes links to the relevant Roadmaps, as well as practical toolkits for conducting situation analyses and policy dialogues.

In partnership with its members, the WHF will also be organizing regional and national meetings to roll out the roadmaps.

CONCLUSIONS

The WHF Roadmaps have been conceived as a collective, 'living' initiative. The national Roadmaps will be used to further inform, provide feedback on and refine the evidence presented in the existing WHF Roadmaps.

Future WHF Roadmaps are planned for other common cardiovascular conditions, such as rheumatic heart disease, heart failure, cholesterol and atrial fibrillation. Tackling these conditions, which are also included in the WHO Global Action Plan will be vital to achieving the expected reduction in premature CVD mortality by 2025.

This is an extraordinary moment in history for the global CVD community whereby we can all work towards reducing CVD globally by building upon a common vision and aligned goals to reduce premature mortality for CVD globally by 25% by 2025.

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