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Platform for International Action on Cardiovascular Disease

Based on International CVD Declarations

The Victoria Declaration on Heart Health
Victoria, Canada 1992

The Catalonia Declaration — Investing in Heart Health
Catalonia, Spain, 1995

Worldwide Efforts to Improve Heart Health: A Follow-up to the Catalonia Declaration
USA, 1997

The Singapore Declaration — Forging the Will for Heart Health in the Next Millennium
Singapore, 1998

The 2000 Victoria Declaration on Women, Heart Diseases and Stroke — Science and Policy in Action
Victoria, Canada 2000

The Osaka Declaration — Health, Economics and Political Action: Stemming the Global Tide of Cardiovascular Disease
Osaka, Japan 2001

All of the above declarations are available at the following Website: www.med.mum.ca/chhdbc/

Dedication

Dr. Andres Petrasovits
(1937—2001)

To you, Andres, we dedicate this Plan of Action based on the previous five Heart Health Declarations. Your spirit — your brilliance, perseverance and wholehearted commitment to improving the health of all individuals in all countries — will always shine as a beacon before us.

Acknowledgements

The Working Group gratefully acknowledges all the diligence, energy and vision of all those involved in the development of the five Heart Health Declarations that formed the basis for this report. (See Appendix.)

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Platform for International Action on Cardiovascular Disease

If steps to curb cardiovascular disease make such good sense for both our health and the economy, why are they not being taken in an efficient, widespread, and timely fashion? ...

The answer must reside ultimately in the thoughts, actions, and behaviour of individuals at all levels of society and of the organisations and systems to which they belong.

Catalonia, p. 45

Coronary heart disease and stroke, the principal components of cardiovascular disease (CVD), cause a great amount of suffering and disruption in the lives of individuals and their families. Together, coronary heart disease and stroke are the leading cause of death in all developed countries of the world and will likely remain so in the future. In the developing countries, cardiovascular disease is fast approaching the same status.

This is, therefore, a critical time for the heart health[1] movement worldwide!!

Over the last twenty years, our knowledge of the social and economic determinants of CVD has increased. In spite of this, however, activities aimed at the prevention and management of CVD have met serious challenges and barriers. These include:

- Lack of resources;
- Insufficient policies and strategies that target whole populations and communities;
- Failure in turning scientific knowledge into primary prevention policies and practice;
- Inadequate dissemination and implementation of proven disease prevention strategies;
- Lack of formal training programs that provide knowledge and skills for health service providers and others that enable the appropriate response to the social determinants of heart health;

[1] "Heart health" in this document is used interchangeably with "CVD".

Countries at all levels of economic development experience pressures that can militate against policies that promote health. For example, the need for jobs in a high-pollution industry may conflict with the need for clean air. Or it might be politically expedient to protect traditional agricultural practice, even if the crops are not beneficial to health or, as is the case with tobacco, they kill.

Meanwhile, cash-starved countries and those in the process of transition to a market economy seem destined to fall victim to the tobacco trade, which represents a prime example of commercialism and profit in exchange for death and diseases on a global scale.

Catalonia, p. 50

In the area of promotion and prevention there is no private sector or industrial base with a direct commercial interest in the primary prevention of cardiovascular disease. In contrast, there is a substantial industrial base behind the health care sector that is influential in creating demand, shaping policy and determining the resource allocations of health systems, all with a natural bias towards curative care.

Osaka, p. 19

- Lack of collaboration among health service providers and CVD groups and organizations;
- Lack of acceptance by health service providers and others that social marketing, advocacy, lobbying and political action are now, more than ever, essential components of a health agenda;
- Inertia on the part of senior decision-makers toward using existing evidence in the development of prevention policies and programs;
- Resistance to change among health service providers and others in the health care delivery system;
- Conflict between commercial and health interests; and
- Lack of a coordinated effort among countries.

Unfortunately, in spite of efforts to reduce or eliminate these barriers, they continue to impede progress. Investing in strategies to meet these challenges will be a necessary precursor to the effective implementation of policies, programs and services.

A great deal has been learned about both effective CVD interventions and methods for addressing the above barriers. Five international Heart Health conferences have facilitated the sharing of research data and experiences on these issues among experts from around the world. Each conference has produced its own declaration, all of which are available at the following Website: www.med.mun.ca/chhdbc/.

This document highlights the essential features and contributions of all of these declarations. It provides a framework for action that can provide direction in working towards a decrease in CVD across the world, whether at the local, national or international level. As such, this document can be a catalyst for synergistic activities among various groups who may be widely separated by geography, culture and access to resources.

Cardiovascular Disease Facts

The call for heart health has increased in urgency since the publication of The Victoria Declaration (1992) and The Catalonia Declaration (1996) because better estimates of the worldwide burden of cardiovascular disease (CVD) have become available.

Singapore, p. 11

CVD is a major cause of death.

CVD has probably been the world's leading cause of death for at least the last two decades of the 20th century.

Osaka, p. 9

In 1999, the WHO *Health Report* indicated that, worldwide, CVD caused the deaths of approximately 16.7 million people of all ages (8 million men and 8.7 million women). CVD by far exceeds infectious and parasitic diseases as the leading cause of death on the planet (an estimated 14 million deaths versus 9 million in 1990).[2]

In developed countries, despite significant declines since 1970, CVD remains the leading cause of death (over 5 million deaths in 1990). Heart diseases and stroke still contribute to approximately half of all deaths, many occurring at a relatively young age.

In developing countries, a "second epidemic", that of coronary heart disease and stroke, is adding to the current burden of infectious diseases and rheumatic heart disease. CVD mortality rates in developing countries — where 80% of the world's population resides — are increasing. ''It is likely that CVD became the *developing* world's leading cause of death for the first time in the 1990s.''[3]

[2] Murray CJL, Lopez AD. Alternative projections of mortality and disability by cause 1990-2020: Global Burden of Disease Study. Lancet 1997;349:1498—1504.

[3] Murray CJL, Lopez AD. The Global burden of disease: A Comprehensive Assessment of Mortality and Disability from Disease, Injuries and Risk Factors in 1990 and Projected to 2020. Boston: Harvard Press, 1996.

CVD affects women and men of all ages and income levels.

Within the 30—69 year age group, CVD deaths for men and women still outpace those for infectious and parasitic diseases in all populations except those in sub-Saharan Africa, where the two numbers are almost equal (Table 1).[4] In developing countries, the affluent may be the first to adopt deleterious lifestyles and initially suffer higher rates of CVD. In later phases of the epidemic, rates are especially high in the poorest and least educated populations.[5,6]

Table 1 Deaths (in 000s) due to cardiovascular disease (CVD) and to infectious and parasitic diseases (IPD) in 30-69 year-olds by sex and region, 1990.

Region	Women		Men	
	IPD	CVD	IPD	CVD
Established Market Economies	12	227	42	483
Formerly Socialist Economies	6	163	20	263
India	240	481	429	611
China	89	439	158	576
Other Asia and Island	140	226	147	289
Sub-Saharan Africa	228	211	215	183
Latin America and Caribbean	48	147	62	186
Middle Eastern Crescent	85	215	83	285
World	798	2201	1128	3028

[4] Ibid.
[5] Rose G, Marmot MG. Social class and coronary heart disease. B.Heart, 1981;34:13—19.
[6] Kaplan LA, Keil JE. Socioeconomic factors and cardiovascular disease: a review of the literature. Circulation, 1993;88:1973-98.

Cardiovascular disease has a major economic impact.

> ***There is a growing recognition that health can make a decisive contribution to sustained social and economic development.***
>
> Victoria (1992), p. 39

"CVD is already a major cause of 'disability-adjusted life years' on a global scale..."[7] By the year 2020, it is estimated that "heart disease will be the third leading cause of disability and death; and stroke to be [sic] the fifth leading cause of disability and death. Between the two, they will easily be the leading cause of disability-adjusted life years by the year 2020."[8] This trend will require increases in both direct and indirect health care expenditures. Preventing coronary heart disease and stroke is, therefore, a proactive, financially responsible step toward protecting health care resources, improving workforce productivity, and enhancing the quality of life of the population.

> ***We are dedicated to the concept of investing in heart health; a financial preemptive strike can curb the cardiovascular epidemic and diminish unnecessary suffering worldwide.***
>
> Catalonia p. 5

Countries and regions are at different stages in the evolution of their cardiovascular disease epidemic.

CVD typifies the transition from an infectious disease-dominant to chronic disease-dominant pattern of diseases. This transition has four phases:[9,10,11]

- In the first stage, at age of pestilence and famine, CVD accounts for 5 to 10 percent of deaths. It now likely persists only in pockets of underdeveloped, often rural areas of Africa, Asia and Latin America.
- The second stage is characterized by 10 to 35 percent of deaths due to CVD from residual rheumatic fever plus an increase in hypertension-related disease (prominent in China and in urban Africa).

[7] The Singapore Declaration: Forging the Will for Heart Health in the Next Millennium, p. 13.
[8] Ibid.
[9] Omram AR. The epidemiological transition: a theory of the epidemiology of population change. Milbank Memorial Fund Quarterly, 1971;49:509—38.
[10] Olshansky SJ, Ault AB. The fourth stage of the epidemiology transition: the age of delayed degenerative diseases. Milbank Memorial Fund Quarterly, 1986;64:355—91.
[11] Pearson TA, Jamison DT, Trejo-Gutierrez J. Cardiovascular disease. In: Disease control priorities in developing countries. New York: Oxford University Press, 1993;577—94.

- The third stage of degenerative and man-made diseases is the ''epidemic form'' of CVD, in which coronary heart disease and stroke become the predominant cause of death (35 to 55 percent), especially in the socially and economically productive age groups (45 to 65 years). This stage has become established in urban areas of Asia, Africa and Latin America, and persists in the former socialist countries of Eastern Europe.
- The final stage of the epidemiological transition has been thought to be one in which coronary heart disease and stroke remain the dominant cause of death (< 50%), but only at older ages. These patterns characterize Western Europe, North America, Japan, and Australia/New Zealand. These regions have, in general, been characterized by declining CVD mortality rates since the 1970s and 1980s.

We have the scientific knowledge to create a world in which most heart disease and stroke could be eliminated.

Victoria (1992), p. 3

Cardiovascular disease is largely preventable.

Risk factors for CVD include tobacco use, high blood pressure, elevated blood cholesterol, unhealthy dietary habits, excessive alcohol consumption, obesity, a sedentary lifestyle, and psycho-social stress. Reducing these will lead to a reduction in not only CVD but also other non-communicable diseases that share similar risk factors, such as cancer, lung disease, diabetes, kidney disease and liver disease.

In 1992, it was estimated that 10% of the world's peoples — or some 450 million persons — will suffer and die prematurely as a result of the effects of cigarette smoking and tobacco use.[12] A major cause of increased CVD in the developing world will be the continued growth of tobacco use. Control of tobacco use is, therefore, a favourable place to begin preventing CVD within a multi-factorial approach.

Even small reductions in the major risk factors can have a substantial impact on mortality and morbidity. For example, a 1% population reduction in blood cholesterol level or a 1 mm Hg population reduction in diastolic blood pressure can each result in a 2 to 3 percent population decrease in the incidence of heart disease. People who quit smoking can reduce their risk of heart attack by as much as 50 percent.

[12] Peto R, Lopez AD, Boreham J, Thun M, Heath C. Mortality from tobacco in developed countries: indirect estimation from national vital statistics. Lancet, 1992;339:1268—78.

Multiple public health approaches, including policy and regulatory change such as tobacco control, have significantly reduced most risk factors and, in turn, have contributed to the dramatic decline of deaths from coronary heart disease during the past thirty years in the developed world. Together, *The Victoria Declaration* (1992), *The Catalonia Declaration* (1996), and *Worldwide Efforts to Improve Heart Health: A Follow-up to the Catalonia Declaration* [13] catalogue many of the successful CVD prevention programs implemented in diverse settings around the world.

While the prescription is simple, implementation is much more difficult. Cultural and socio-economic factors, access to resources, and policy changes exert a major influence on people's lifestyles. As a result, an individual's ability to adopt a healthy lifestyle faces challenges, such as limited healthy food choices, inadequate health information and skills, illiteracy, adverse living and working conditions, the marketing of unhealthy lifestyles (e.g., smoking and unhealthy fast foods), and health service providers who are inadequately trained to provide education and support.

CVD is a global problem that requires global solutions.

Historically, CVD prevention in all countries has involved action primarily at the local and state or provincial levels, with occasional intervention at the national level. The Osaka Declaration highlighted the global nature of the epidemic, however. For example, decisions made by international organizations have an impact on the economic prosperity of developing countries. As well, decisions about investment or exports by one country profoundly affect the availability of resources and harmful products, such as tobacco, in other countries. The global epidemic, then, is the consequence of deliberate, concerted and pervasive global forces, driven by economics, trade and profit. These global forces are so powerful that they have the capability of overwhelming the political will and policies of individual nations.

> ***To some extent, and for some people, certain aspects of globalization are positive, offering unprecedented opportunity for economic growth, cultural exchange and transfer of knowledge. Yet, for many others, the effects of globalization are damaging or even potentially devastating.***
>
> Osaka, p. 15

[13] Grabowsky TA, Farquhar JW, Sunnarborg KR, Bales VS (ed.). Worldwide efforts to improve heart health. A follow-up to the Catalonia Declaration: Selected program descriptions. Atlanta: Centers for Disease Control and Prevention, USDHHA, 1997.

The Framework for Action

The recommendations of the five international CVD declarations form the basis of this framework for action for CVD prevention and control. The framework for action includes the following four components:

- ➢ Adopt Core Values;
- ➢ Define Health Goals;
- ➢ Select Strategies; and
- ➢ Develop Capacity

An effective framework for action must include actions directed at the individual and family, community, and national and international levels of activity.

Societies, governments and health systems recognize the need and desirability for their citizens to access treatment and other health services - to the extent that societal resources permit. Indeed, some countries have codified health as a basic human right that is directly tied to issues of equity, solidarity, patients' rights and quality of care.

Osaka, p. 21

Adopt Core Values

A set of core values provides a strong ethical framework for developing policies, programs and services. The essence of the values represented in the CVD reports and declarations are consistent with the five core values of the World Health Organization (WHO) European Region[14].

- ➢ Health as a fundamental ***human right***;
- ➢ ***Equity*** in health and ***solidarity*** in action between countries, between groups of people within countries and between genders;
- ➢ ***Participation*** by and ***accountability*** of individuals, groups and communities, and of institutions, organizations and sectors in health development.

[14] The 2000 Victoria Declaration on Women, Heart Diseases and Stroke — Science and Policy in Action, p. 24.

Health as a Human Right

All people have the right to the highest attainable standard of physical and mental health. This value directs an entire country to protect this right by implementing policies and investing as necessary. Countries have an ethical obligation to invest in CVD prevention to improve the health of the population. This includes addressing the underlying socio-economic determinants of health. It also includes removing barriers to programs and services that can improve health. With limited resources, a careful balance must be achieved between investment in primary health care, which has an impact on the health of the whole population, and investment in expensive high tech care, which benefits only a subset of the population.

Resource allocations to public health, primary health care, and specific NCD [Non-Communicable Disease] prevention programs are woefully inadequate when compared to those available for curative services.

The responsibility for the fact that prevention loses in the competition with clinical care lies more with reasons of political economy than effectiveness.

Osaka, p. 27 & 22

Equity in Health

Equity in health implies that everyone should have a fair opportunity to attain his or her full health potential. This also implies that, if it can be avoided, no one should be at a disadvantage in achieving his or her potential. Inequities presently exist between developed and developing countries, between the rich and poor within countries, and between men and women. The needs of children, because they lack a voice in policy development, can also be overlooked. These inequities influence access to information, health services, education, employment, housing, and income. These factors, in turn, influence the adoption of behaviours that contribute to CVD, such as tobacco use.

The 1998 World Health Report states that:

"Women's health is inextricably linked to their status in society. It benefits from equality and suffers from discrimination. Today the status and well-being of countless women worldwide remain tragically low. As a result, human well-being in general suffers, and the prospects for future generations are dimmer..."

Victoria (2000), p. 12

With the help of partnerships, no community is lacking the means to develop effective programmes in heart health.

Catalonia, p.16.

Solidarity in Action

Solidarity involves working together toward common goals and sharing resources and experience. Because of the multi-factorial etiology of CVD, policies, programs and services for addressing CVD will be complex. As a result, partnerships within and among communities, professional groups, governments, non-governmental organizations (NGOs), and the private sector are essential for optimizing technical and financial capacities and achieving the best results. Given the reality of globalization, the control of CVD also depends on international partnerships.

Women have a key role to play as influential agents for change within the family and community and at the national and international levels. To do so, they must be encouraged - in some cases, allowed - to become more involved at the planning and policy-making levels.

Victoria (2000), p. 28

Participation

Participation of the community in developing and implementing policies, programs and services will ensure not only responsiveness to community needs but also commitment within the community. This applies to both women and men. In addition, community members themselves can be powerful agents of change through, for example, citizen participation in limiting sales of tobacco to minors. Effective community participation requires education and support. Volunteer organizations that deal with heart disease, stroke and related conditions can provide a vehicle for community involvement.

Accountability

Those in leadership positions in government, non-government organizations, and academic centres are accountable to the population. Investing public resources in the most cost-effective manner is an important aspect of this accountability. It is essential, therefore, that policy makers invest sufficient resources in prevention to reduce the risk of heart disease in the population as a whole.

Leaders can demonstrate accountability by reporting to the population on the impact of policies, programs and services. A variety of approaches can be used to achieve this, taking full advantage of latest technology and communication methods. Investment in a comprehensive surveillance and monitoring system is a necessary step for providing the information base for evaluating CVD programs. Facilitating comparison among countries requires international co-ordination of surveillance. The development of a standard set of indicators that could be used by all countries could form the basis of a report card on progress in CVD prevention and control. Many countries have developed their own indicators, and the WHO has led collaborative projects, such as the Global Cardiovascular Disease InfoBase[15], that provide the basis for an international surveillance system. Surveillance and monitoring can identify the problem, an important first step. A key and often-neglected step, however, is the dissemination of proven methods for surveillance throughout all communities and organizations to encourage the use of these methods in other countries.

Over the past half century, extensive and successful research has been conducted on the prevention of cardiovascular disease. In return for this investment, society expects that the knowledge gained will be used and disseminated in a timely fashion. Yet in the field of cardiovascular disease, new knowledge on risk factors has taken 20-30 years to filter into public health policy.

Catalonia, p. 48

[15] http://www.cvdinfobase.ic.gc.ca.

The value of community-based heart health programs in reducing cardiovascular disease and its risk factors has been demonstrated.

Victoria (1992), p. 36

Define Health Goals

The identification of health goals is a critical component of any strategic plan. Goals clearly outline the changes that are needed in the population in order to improve health. The Heart Health Declarations have identified the following health goals of a comprehensive CVD program:

- To **promote heart health** among all members of the population;
- To **prevent** the onset of CVD by promoting a tobacco-free lifestyle, regular physical activity, health promoting dietary habits, and a supportive psychosocial environment;
- To **detect and treat underlying conditions** leading to CVD — high blood pressure, abnormal blood lipids, abdominal obesity, diabetes;
- To effectively **diagnose and treat CVD and prevent recurrences**; and
- To **enhance the quality of life** of those with CVD.

Reducing or, ideally, eradicating [CVD risk factors] will lead to a reduction not only in cardiovascular disease but also in other noncommunicable diseases that share similar risk factors...

Victoria (1992), p. 4

Develop an Integrated Chronic Disease Program

Ideally, a CVD program is placed within a program that addresses the prevention and management of all chronic disease. Many chronic conditions share common risk factors and conditions. They also use the same data sources and similar indicators for surveillance and monitoring. The development of healthy public policies, mobilization of the community, and delivery of similar education programs are essential components of all chronic disease programs. In addition, promoting healthy behaviours in childhood can not only reduce the likelihood that children develop CVD later in life, but also set the pattern of healthy behaviour they carry into adulthood. Organizing all initiatives in a collaborative way, including the delivery of health care, can lead to greater effectiveness and resource-efficiency.

Select Strategies

A comprehensive CVD program is based on seven pillars or groups of strategies. The balance among them may vary from country to country and from community to community, depending on need and availability of resources and expertise. All pillars are essential to provide the foundation for a comprehensive, integrated approach to the prevention and control of CVD. These seven pillars are:

- **Programs and services** (such as health promotion, treatment services, rehabilitation) for individuals and families to increase knowledge, skills and healthy behaviours, and to respond to health problems;
- **Public policies** to address the cultural and socio-economic factors that affect an individual's ability to adopt a healthy lifestyle, such as:
  - ⇒ Eradicating tobacco use and the advertising of, promotion of, and trafficking in tobacco products;
  - ⇒ Increasing the availability of, access to, and ease of making healthy food choices;
  - ⇒ Providing opportunities for regular physical activity; and
  - ⇒ Creating positive living environments.
- **Community action** to develop and promote voluntary activities around education, advocacy, lobbying and political action;
- **Research** to add new knowledge on the causes of CVD and the effectiveness of interventions, policies and services;
- **Training** to increase knowledge and skills and promote the use of novel health promotion strategies by health service providers, including social marketing, advocacy, lobbying and political action;
- **Surveillance** to collect data on the prevalence of risk factors, incidence of disease, use of health services and health outcomes; and
- **International collective action** to address the global factors affecting CVD prevention and control.

Establishing these pillars requires the development of a response on many fronts in order to take advantage of, and effectively channel, existing energy and resources. Internationally, the capacity to plan, develop, implement, evaluate and sustain policies, programs and services varies widely. An analysis of each country's needs and resources is the first step toward developing the most effective investment strategy.

Since individual behavior change is difficult and expensive to bring about without broad social and environmental supports, the cornerstone of contemporary heart health programs is the effort to achieve policy and environmental changes…

Singapore, p. 20

If scientists, health professionals and members of civil society are to play a role in political action and advocacy, they need skills not traditionally associated with training in the health professions.

Osaka, p. 32

TOP-DOWN OR BOTTOM-UP?

The generalization can be made that higher levels of government, because of their top-down relationship … to health and other social areas, are effective in providing financial resources, policy recommendations, and regulatory actions that affect areas such as taxation, transportation, environmental conditions, education, recreation, and fiscal accountability. They can also provide the critical mass of pooled national or regional talents for research and the linkage with international resources.

By contrast, as one ascends from the community level up the ladder - in a bottom-up relationship… to social areas like health - the principal medium for achieving change in public health stems from education that informs, provides skills, and activates the public. Top-down and bottom-up relationships exist throughout the examples described in [the Catalonia Declaration].

Catalonia, p. 56

In-Country Implementation Processes

The following implementation processes comprise a comprehensive approach for capitalizing on the many resources within a country.

- **Marshalling institutional support** for the implementation of heart health policies, specifically those related to the creation of living and working environments and the social supports that enhance a healthy lifestyle.
- **Educating the public** to develop the personal knowledge of and skills to enable them to adopt a healthy lifestyle. Education can also enable the public to advocate for and develop environments that support the adoption of health-promoting dietary patterns, create environmental and advertising restrictions to decrease smoking by adolescents, and encourage the adoption of physical activity as a part of the daily life of the population.
- **Promoting and supporting organized health promotion and heart health activities in all communities** by ensuring their genuine involvement in assessing their needs. Building the community capacity through education and support for organized activity will lead to the planning and implementation of effective preventive interventions, including advocacy for regulations and laws that promote health.
- Influencing society at large, institutions and employers to create **heart-healthy child care, school and working environments** and reduce work-related stress, which will increase productivity.
- Strengthening the capacity of the **primary care sector** to educate, train and motivate individuals and communities to adopt healthy lifestyles, and to provide optimal treatment for the management of CVD and its attendant risk conditions.
- Setting up appropriate, affordable **information and surveillance systems** to monitor CVD, its attendant risk factors and the social and economic conditions that contribute to these, and to evaluate preventive interventions.
- **Involve academic centres** in the education and training of health service providers and other professionals for advocacy, policy development, community and organizational development, systematic leadership development and education of their population.

International Implementation Processes

Success at stemming the tide of the CVD epidemic will require the ability to influence the social, economic and political factors that, to date, have been manipulated to fuel, rather than quench, the worldwide spread of the disease. The Osaka Declaration, therefore, exhorts all to work not only individually or even collectively at a local, state or country wide level, but also to strategize and act at a level that encompasses a global reach. This demands, in effect, that CVD issues be viewed with more than clinical and epidemiological analysis, and include analysis of the motivation, strategies, tactics and policies of the major multinational players.

Based on this evidence, strategies can then be designed to mitigate their reach and counter their success. Implementing these strategies will require global leadership by countries with "champions" skillful at building international partnerships and coalitions. New structures and organizations, such as the Framework Convention Alliance[16] may be required to provide the leadership for challenging commercial interests on a multinational scale with strategies of global advocacy, influence, political action and policy development.

Achieving success requires action on the following fronts:

- **Assume leadership** in developing and convening global coalitions and partnerships for CVD prevention.
- **Engage** in global/international public awareness/ communications strategies to inform and educate the public, governments and others as to the effects of globalization.
- **Advocate globally** for actions and healthy policies to mitigate the harmful effects of globalization on people's lives.
- **Develop international health policy** to address the economic, social and political factors that influence CVD prevention and control.
- **Regulate international trade** of products that influence CVD health, such as tobacco.
- **Support collaboration** of governments and NGOs with their counterparts in other countries.
- **Share databases** to create a global report card on progress in CVD prevention and control.
- **Conduct research** on the global factors affecting CVD and effective interventions.

> ***International health agencies and those concerned with economic and social development have a major role to play in ensuring that governments and non-governmental organizations adopt and implement broad policies for cardiovascular disease prevention.***
>
> Victoria (1992), p. 49

[16] Framework Convention Alliance — An international alliance of non-government organizations committed to securing a strong and effective framework convention on tobacco control.

- **Provide economic support** to international health agencies that provide the leadership and the will to effect change at the international level.
- **Disseminate proven CVD interventions** to support and facilitate shared learning across countries.
- **Support international work** by CVD professional societies, volunteer organizations, and governments.
- **Support the development of trained personnel** in developing countries to facilitate the development and implementation of CVD prevention programs.
- **Support the development of countries** toward increasing the standard of living, education level and overall self-sufficiency.

In a globalizing world, unhealthy lifestyles and environments that are the root of the CVD global epidemic can be as communicable as infectious agents. That the successful experience in tobacco control in certain countries has not been applied on a global scale is a political economy question. Tobacco continues to be a prosperous growth industry world wide, with increasing smoking rates in most low and middle income countries, and increasing smoking rates among youth.

Osaka, p. 18

The greatest opportunity for the most immediate effect may rest on the recognition of the following three key concepts:

1. An **economic perspective** is needed for global CVD prevention;
2. Commercial forces are important barriers to achieving CVD health goals;
3. Health professionals, voluntary organizations and governments need to address the commercial forces that are influencing the CVD epidemic.

Through their large advertising campaigns, both the international tobacco industry and the agri-business have clearly had great success in achieving product adoption. However, they widely use their economic power to influence legislation in matters such as taxation and advertising policies that promotes product use.

Some countries have achieved large reductions in tobacco use, however, through major advocacy campaigns leading to legislative changes, such as taxation and tobacco advertising restriction. International agri-business policies have an impact similar to those of the tobacco industry on a nation's health. Building on the lessons from the successes in tobacco control, political economy strategies can be directed at other CVD factors, such as nutrition and unhealthy diets and sedentary lifestyles.

Too often, health professionals fail to regard advocacy and social marketing as part of their obligation to society. Counteracting commercial pressures that detract from heart health, however, is a vital role for health professionals. To effect this requires increased training of and the facilitation of practical experience among scientists and health professionals in social marketing and advocacy.

Develop Capacity

> ***"Never doubt the capacity of a few dedicated individuals to change the world: in fact, it is the only way it ever has."***
> ***- Margaret Mead***
>
> Catalonia, p. 55

A country's capacity to plan, develop, implement, evaluate, and sustain CVD policies, services and programs will determine its impact on the health of its population. Capacity depends on both an appropriate infrastructure and the will to mobilize it.[17,18]

> ***[Infrastructures] without the will to use them, are like stranded whales; perhaps magnificent in appearance but unable to function.***
>
> Singapore, p.35

Implementing an effective CVD prevention and control program requires strong leadership. Ideally, this leadership will come from the three pillars of civil society — government, non-government organizations (NGOs) and the private sector. As well, a strong and important fourth pillar emerges with the growth of strong and representative leadership within communities.

> ***Creating the political will to ensure that the health of the public is not compromised constitutes a central task in building a heart-healthy environment.***
>
> Victoria (1992), p. 15

The infrastructure of a country, region or community includes both physical and human resources and their potential co-ordination as one system. The health system requires strong public health and primary care components for delivering heart health and CVD prevention programs and services:

- *Public Health* - population health promotion and prevention activities using primarily information, education, community mobilization and advocacy for policy change;
- *Primary Care* - first point of contact for personal services to individuals and families for prevention, diagnosis and treatment, rehabilitation and support;

The health system also needs the capacity to: *investigate health problems* (including laboratories, radiology, invasive techniques, etc.); provide s*pecialty care* (including specialist physicians, nurses and other health professionals); provide *home support* (nursing, therapy, personal care, social services provided in the home); and ensure *volunteer participation* (voluntary organizations, individuals and groups).

[17] The 2000 Victoria Declaration on Women, Heart Diseases and Stroke — Science and Policy in Action, p. 37.
[18] The Singapore Declaration — Forging the Will for Heart Health in the Next Millennium, p. 25.

At the higher, central levels, however, evidence of collaboration is often lacking. Especially within the health system itself, territoriality may make it difficult to collaborate fruitfully with other institutions or bureaucracies.

Catalonia, p. 52

Most research funding goes to the support of new understandings of disease processes, new treatment modalities and the development of new technology. Very little funding supports implementation research for heart health programs thorough health promotion and disease prevention approaches.

Osaka, p. 23

In many countries, each of these sectors tends to function autonomously with little integration. This succeeds in providing a group of services, but not an effective, efficient and sustainable *system* of services. A well-functioning system includes effective connections, both vertically (among different levels) and horizontally (within a level). Such a system can only be developed with firm political, financial and policy support. Unfortunately, in some developing countries the specialty care sector achieves a disproportionate level of support that limits the amount of resources for critically important Public Health and Primary Care sectors.

Heart health programs that are not integrated into the formal health system are not likely to be sustainable.

Osaka, p. 31

Operationalizing and sustaining an infrastructure requires the following components:[19]

- Policy generation and implementation to provide a supportive environment for both individuals and health service providers;
- Research to continually expand the scientific and technical knowledge base, and the dissemination of this knowledge and the training needed for its practical application by managers and service providers;
- Physical capabilities (including both the physical plant and human resources) and organizational capabilities (such as partnerships and community coalitions); and
- Economic or financial resources invested in policies, programs and services.

Health care providers, in addition to providing individual care, also need to become more involved in activities, such as advocacy, partnerships and social marketing. In order to fulfill this function, they also need training in order to move beyond their traditional roles. One key role may be to provide leadership at the local, regional or national level.

[19] The Singapore Declaration — Forging the Will for Heart Health in the Next Millennium, p. 26.

All countries have existing programs, such as family planning or immunization programs, that can contribute to the infrastructure of a CVD prevention program. Schools, voluntary health organizations, religious congregations, professional associations, and work sites all form part of a community's infrastructure and hold potential as resources, whether they mobilize themselves or serve as catalysts for mobilizing others.

Building on existing programs may be the most efficient way to expand services for the prevention and management of heart diseases and stroke...

Victoria (2000), p. 42

The international level also requires capacity for collaborative action. With increasing globalization of the world's economy, policy decisions made by one country or multinational organization can have a profound effect on the residents of several other countries. The ease with which the telecommunications industry crosses national boundaries facilitates the sharing of cultural norms and social behaviours. While this can be beneficial and lead to international collaboration, it also has a downside, as in the example of tobacco advertising that crosses national borders.

An important consideration... is that, in a globalizing world, unhealthy lifestyles and environments that are at the root of the CVD global epidemic can be as communicable as infectious agents.

Osaka, p. 18

Currently, few if any global policies address CVD issues. The concerned heart health constituency can improve the situation by placing heart health on the agendas of existing international organizations such as the various United Nations agencies, the World Bank, the World Trade Organization, the Food and Agriculture Organization, and the International Labor Office. CVD could also be promoted on the agendas of political unions of nation states such as the European Union, the Organization of American States, the Organization of African Unity, and the Association of Southeast Asian Nations.

International organizations exist to take the lead in promoting this international collaboration. This will require financial support to enhance the international capacity for CVD prevention.

It would measurably enhance the international capacity for CVD prevention if the resource base of agencies such as WHO and federations of health professionals concerned with international heart health could be strengthened.

Singapore, p. 28

Conclusion

Those concerned with CVD prevention are in a position of advantage to make a major contribution to the global health agenda since we have the science and evidence base, the tools, platforms and networks that can be scaled up to attain major improvements in health.

Osaka, p. 6

Cardiovascular disease (CVD) is a challenge of global proportions. It is largely preventable. Unfortunately, overall investment in CVD prevention has been insufficient to achieve optimal results. Applying the existing scientific knowledge with the wisdom that has accumulated over the past twenty years could stem the epidemic of CVD around the world. A strong international effort could encourage, promote and facilitate country-led initiatives. International organizations have a critical role to play in harnessing globalization in the service of health.

Now is the time for action!

Recommendations

It is recommended that:

1. International organizations and countries[20] adopt and promote the WHO European Region five core values (health as a human right, equity, solidarity, participation and accountability) as the foundation for CVD prevention and control programs.
2. The WHO, World Heart Federation and the International Heart Health Society and the Centers for Disease Control and Prevention (Atlanta) undertake a leadership role in facilitating effective international collaboration and communication among all countries and international organizations.
3. Governments invest in international CVD coalitions to support their leadership in CVD prevention and control.
4. International organizations and governments implement public policies in both health and non-health government ministries to address the socio-economic and lifestyle determinants of CVD.
5. International organizations and governments develop strategies with the private sector to ensure that globalization has no adverse effect on the health of the population.
6. International organizations and governments recognize and create policy based on the known economic benefits of primary prevention of CVD.
7. International organizations and countries collaborate to address inequities between developed and developing countries, the rich and poor within countries, and genders at all ages.
8. Countries facilitate effective collaboration between government, non-government organizations, the private sector, community groups, and partners outside of the health sector to establish a systematic, strategic approach to program planning, development, implementation and evaluation.
9. Governments invest in ongoing surveillance and monitoring of CVD and the WHO establish a mechanism for international collaboration on surveillance.

[20] In this report, "countries" means governments, non-government organizations, academia, the health care sector, and the private sector.

10. Government and other research bodies fund interdisciplinary CVD research with a focus on CVD prevention policies.
11. Governments create a balanced, coordinated and comprehensive prevention and treatment health system that is founded on:
    - ➢ The five health goals of the CVD declarations;
    - ➢ Includes CVD prevention and control in a program that addresses all chronic disease;
    - ➢ Adds CVD elements to existing programs to capitalize on the available infrastructure;
    - ➢ Provides a comprehensive set of strategies that include programs and services, public policies, community action, research and surveillance, and training of health service providers and other professionals;
    - ➢ Disseminates and implements effective prevention strategies; and
    - ➢ Invests adequate resources in public health and primary health care while balancing attention to specialty care.
12. Governments, academia and non-government organizations provide education and training on CVD prevention and control to health service providers and other professionals.

Appendix - CVD Declarations: International Advisory Boards

The Victoria Declaration on Heart Health
Victoria, Canada 1992

Chair	**Dr. John W. Farquhar,** USA
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	Dr. Yukio Yarnon, Japan

The Catalonia Declaration — Investing in Heart Health
Catalonia, Spain, 1995

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Dr. J. R. Viskoper, Israel
Dr. Y. Yarnon, Japan

The Singapore Declaration — Forging the Will for Heart Health in the Next Millennium *Singapore, 1998*

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The 2000 Victoria Declaration on Women, Heart Diseases and Stroke — Science and Policy in Action
Victoria, Canada 2000

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The Osaka Declaration — Health Economics and Political Action: Stemming the Global Tide of Cardiovascular Disease
Osaka, Japan 2001

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