Moving From Political Declaration to Action on Reducing the Global Burden of Cardiovascular Diseases

A Statement From the Global Cardiovascular Disease Taskforce

WRITING COMMITTEE

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September 18, 2013, marks 2 years since the monumental meeting of Heads of State at the United Nations in New York to take action against noncommunicable diseases (NCDs), which includes cancer, cardiovascular disease (CVD), diabetes mellitus, and chronic respiratory disease. Recognizing that the rising human and financial costs of NCDs required a profound shift in the way countries viewed development, United Nations member states gathered for the second time in history to address a health concern (the first being the United Nations General Assembly Special Session on HIV/AIDS in 2001). Supporting the United Nations Political Declaration on the Prevention and Control of NCDs, countries acknowledged NCDs as a development issue and made a commitment to address this global crisis by taking action on the major modifiable risk factors—including tobacco use, raised blood pressure, poor nutrition, physical inactivity—triggering the new pandemic of NCDs, as well as the social, economic, and political determinants that shape these lifestyle choices. Although the declaration was a political commitment, it was an important first step, bringing together health and development leaders from across the globe to ensure that progress would be made to reduce the burden of NCDs. The past 2 years have witnessed concrete commitments, meaning that our work is only just beginning.

The World Heart Federation and its members spearheaded global advocacy, with other colleagues in the NCD community, calling on the World Health Organization and member states to commit to tangible and achievable goals. In 2012, a global target was adopted to reduce premature NCD mortality 25% by 2025—“25by25.” Now in 2013, this target, as well as 8 additional targets addressing modifiable risk factors and committing to the use of essential medicines, technologies, and drug therapies to prevent heart attacks and strokes, have been adopted as part of a global monitoring framework and included in the World Health Organization’s Global Action Plan for the Control of NCDs, countries acknowledged NCDs as a development issue and made a commitment to address this global crisis by taking action on the major modifiable risk factors—including tobacco use, raised blood pressure, poor nutrition, physical inactivity—triggering the new pandemic of NCDs, as well as the social, economic, and political determinants that shape these lifestyle choices. Although the declaration was a political commitment, it was an important first step, bringing together health and development leaders from across the globe to ensure that progress would be made to reduce the burden of NCDs. The past 2 years have witnessed concrete commitments, meaning that our work is only just beginning.

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Prevention and Control of NCDs (see online-only Appendix for a list of the globally agreed targets and indicators).4,5

These collective decisions taken by governments and ministers of health have ensured that a global architecture is in place that requires governments to be accountable for the actions they take to address NCDs in their countries. This is an extraordinary time of opportunity for the CVD community. As we move from political aspiration to practical application, what role can the CVD community play in developing and implementing a coordinated international strategy of action to attain these fundamental goals for the health of nations?

At the global level, the adoption of this architecture—a global monitoring framework with 9 ambitious targets and 25 indicators—means that governments, for the first time, are accountable for progress on NCDs. These commitments will be translated into action at the national level through strong and cost-effective national plans. Each of our professional organizations will advocate for and offer solutions that can be implemented nationally to address these targets. Systems change is not limited to systems that address health. As the world develops a framework to eradicate poverty and to reassesses the Millennium Development Goals, further progress will depend on recognizing that determinants outside health services affect the health of populations and patients. How people live, move, work, and eat is of paramount importance, and interventions to reduce exposure to modifiable risk factors, as well as address the underlying social determinants, must be planned and implemented now to protect future generations.

The changes we are seeing in models of care in high-income countries toward controlling upstream determinants of NCDs must be expanded. Even the most advanced healthcare systems need to improve how they address primordial and primary prevention through change in population behavior across the life span. Acknowledging that health systems in low- and middle-income countries have been built around infectious disease, these systems must now transform to address CVD morbidity and mortality. Tackling the growing burden of NCDs requires not only a whole of government approach but also a whole of society approach involving nongovernmental organizations, local communities, and industry, where appropriate. The CVD civil society community of heart and stroke foundations and societies across the globe must have a leading role in the implementation of national NCD plans and ensure a focus on CVD primordial, primary, and secondary prevention and rehabilitation. Sharing best practices, aligning measurements, fostering expertise, advancing implementation strategies, and providing leadership are critical and feasible measures to ensure that we achieve the “25by25” target, not only for NCDs, but for CVD as well (Figure6).

The Global Cardiovascular Disease Taskforce—comprising the World Heart Federation, American Heart Association, American College of Cardiology Foundation, European Heart Network, and European Society of Cardiology, and expanded representation from Asia, Africa, and Latin America along with global CVD experts—is helping to sharpen our collective efforts to address CVDs. Working with the World Health Organization, we are assessing and defining those specific metrics for addressing CVD that will be key to achieving the global target of “25by25.” These metrics will extend beyond health systems and will be essential to preventing premature mortality. As CVD organizations operating with and through the World Heart Federation, which itself represents >200 organizations across the globe, and as partners to the World Health Organization, we are committed to the following:

1. Developing and publishing metrics around the “25by25” target that are specific to CVD and tailored by geography by 2014.
2. Shaping and supporting inclusion of CVD language in national plans.
3. Coordinating and aligning efforts around implementation of the CVD-related targets under the “25by25” global target, with a particular focus on reducing tobacco use and hypertension and improving secondary prevention and rehabilitation of CVD.

As we move forward together as professional societies and heart foundations, let us be the global advocates, speaking with one voice, calling for CVD prevention, treatment, and care. We celebrate the Political Declaration of “25by25” and its aspiration to reduce the burden of NCDs, and we now face the challenges of ensuring its reality and ensuring that government plans turn to action to improve the health of all of our populations.
References


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Correction

In the article by Smith et al, “Moving From Political Declaration to Action on Reducing the Global Burden of Cardiovascular Diseases: A Statement From the Global Cardiovascular Disease Taskforce,” which published online September 17, 2013, and appeared in the December 3/10, 2013, issue of the journal (Circulation. 2013;128:2546-2548), several corrections were needed.

On page 2548 in the Writing Group Disclosures table, several of the disclosures for David A. Wood, MSc, FRCP, FRCPE, FFPHM, FESC, were incorrect:

- Under Employment, the listing read, “National Heart and Lung Institute, United Kingdom.” It has been changed to read, “Imperial College London.”
- Under Research Grant, the disclosure read, “PI for EUROACTION+Study and EUROASPIRE IV survey (central coordination).†” It has been changed to read, “None.”
- Under Other Research Support, the disclosure read, “EUROASPIRE IV split between: Roche, MSD, Bristol-Myers Squibb Emea Sarl, AstraZeneca, GlaxoSmithKline (central coordination).†” It has been changed to read, “None.”
- Under Ownership Interest, the disclosure read, “Non-executive director of MyAction Ltd (Imperial College/Innovations healthcare company). 5% equity stake.†” It has been changed to read, “None.”
- Under Consultant/Advisory Board, the disclosure read, “Merck*; Sharp & Dohme.*” It has been changed to read “MSD.”

The revised section of the Writing Group Disclosures table is reproduced here.

<table>
<thead>
<tr>
<th>Writing Group Member</th>
<th>Employment</th>
<th>Research Grant</th>
<th>Other Research Support</th>
<th>Speakers’ Bureau/ Honoraria</th>
<th>Expert Witness</th>
<th>Ownership Interest</th>
<th>Consultant/ Advisory Board</th>
<th>Other</th>
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<tbody>
<tr>
<td>David A. Wood</td>
<td>Imperial College London</td>
<td>None</td>
<td>None</td>
<td>AstraZeneca*; Kowa*; MSD*</td>
<td>None</td>
<td>None</td>
<td>MSD*</td>
<td>None</td>
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</table>

These corrections have been made to the print version and to the current online version of the article, which is available at http://circ.ahajournals.org/content/128/23/2546.


**Appendix**

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**Final Comprehensive Global Monitoring Framework For NCDs**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Target</th>
<th>Target-specific indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality and Morbidity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Premature mortality from</td>
<td>1. 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases</td>
<td>1. Unconditional probability of dying between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases</td>
</tr>
<tr>
<td>NCDs</td>
<td></td>
<td>2. Cancer incidence, by type of cancer per 100 000 population</td>
</tr>
<tr>
<td><strong>Risk Factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavioural Risk Factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td>2. 30% reduction in prevalence of current tobacco smoking</td>
<td>3. Age standardized prevalence of current tobacco use among person aged 15+ years</td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>3. 10% relative reduction in prevalence of insufficient physical activity</td>
<td>4. Prevalence of current tobacco use among adolescents</td>
</tr>
<tr>
<td>Alcohol</td>
<td>4. At least 10% relative reduction in overall of alcohol (including hazardous and harmful drinking)</td>
<td>5. Age-standardized prevalence of insufficiently active persons aged 18+ years (defines as less than 150 minutes of moderate-intensity activity per week, or equivalent)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Prevalence of insufficiently physically active adolescents defined as less than 60 minutes of moderate to vigorous intensity activity daily</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in litres of pure alcohol as appropriate within the national context</td>
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<tr>
<td></td>
<td></td>
<td>8. Age standardized prevalence of heavy episodic drinking among (adolescents and adults) as appropriate, within the national context</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. Alcohol related morbidity and mortality among adolescents and adults, as appropriate within the national context</td>
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</tbody>
</table>
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<table>
<thead>
<tr>
<th>Salt/sodium</th>
<th>5. 30% relative reduction in mean population intake of salt with aim of achieving recommended level of less 5 grams per day</th>
<th>10. Age-standardized mean population intake of salt (sodium chloride) per day in grams persons aged 18+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological Risk Factors</td>
<td>6. 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure according to national circumstances</td>
<td>11. Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure &gt; 140 mmHg and/or diastolic blood pressure &gt; 90 mmHg)</td>
</tr>
<tr>
<td>Raised blood pressure</td>
<td>12. Age-standardized prevalence of raised blood glucose/diabetes among adults aged 18+ years (defined as fasting plasma glucose value ≥ 7.0 mmol/L (126 mg/dl) or on medication for raised blood glucose)</td>
<td></td>
</tr>
<tr>
<td>Diabetes and obesity</td>
<td>7. Halt the rise in diabetes and obesity</td>
<td>13. Age-standardized prevalence of overweight and obesity in adults aged 18+ years (defined as body mass index greater than 25 kg/m² for overweight or 30 kg/m² for obesity)</td>
</tr>
<tr>
<td></td>
<td>14. Prevalence of overweight and obesity in adolescents (defined according to the WHO Growth Reference, overweight - one standard deviation BMI for age and sex and obese - two standard deviations body mass index for age and sex)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15. Age-standardized prevalence of adult (aged 18+ years) population consuming less than five total servings (400 grams) of fruit and vegetables per day</td>
<td></td>
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<tr>
<td></td>
<td>16. Age-standardized prevalence of raised total cholesterol among persons aged 18+ years (defined as total cholesterol ≥ 5.0 mmol/L or 190 mg/dl) and mean total cholesterol</td>
<td></td>
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<tr>
<td></td>
<td>17. Age-standardized mean proportion of total energy intake from saturated fatty acids in persons aged 18+ years.</td>
<td></td>
</tr>
<tr>
<td>National Systems Response:</td>
<td></td>
<td>18. Availability and affordability of quality, safe and efficacious essential NCD medicines, including generics, and basic technologies in both public and private facilities</td>
</tr>
<tr>
<td>Essential non-communicable medicines and technologies to treat major non-communicable diseases</td>
<td>8. 80% availability of affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities</td>
<td>19. Proportion of eligible persons (defined as aged 40 years and over with a 10-year</td>
</tr>
</tbody>
</table>
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stroke counseling (including glycemic control) to prevent heart attacks and strokes cardiovascular risk greater than or equal to 30% including those with existing cardiovascular disease) receiving drug therapy and counseling (including glycemic control) to prevent heart attacks and strokes

Additional indicators under National Systems Response:

20. Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer

21. Proportion of women between the ages of 30-49 screened for cervical cancer at least once, or more often, and for lower or higher age groups according to national programmes or policies

22. Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply as appropriate within the national context and national programmes

23. Policies to reduce the impact on children of marketing on foods and non-alcoholic beverages high in saturated fats, trans fatty acids, free sugars, or salt

24. Vaccination coverage against hepatitis B virus monitored by number of third doses of Hep-B vaccine (HepB3) administered to infants

25. Availability, as appropriate, of cost-effective, affordable, of HPV vaccines, according to national programmes and policies