

THE 2000 VICTORIA DECLARATION ON WOMEN, HEART DISEASES AND STROKE

**Declaration of the Advisory
Board of the First International Conference
on Women, Heart Disease and Stroke
(Victoria, Canada) May 8–10, 2000**

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Declaration

Recognizing that heart diseases and stroke are the leading cause of death among women in the developed world and are fast approaching the same status in the developing world,

that gender inequity, poverty, illiteracy, unemployment, and lack of access to health services influence women's health,

that taking appropriate action to address these and other underlying determinants of health, and

that promoting a healthy lifestyle would help prevent heart diseases and stroke,

the Advisory Board of the First International Conference on Women, Heart Disease and Stroke calls upon

- women and men -
- health, media, education and social science professionals, and their associations -
 - the scientific research community -
- government agencies concerned with health, education, trade, finance, culture and recreation, commerce and agriculture -
 - the private sector -
- international organizations and agencies concerned with health and economic development -
 - community health coalitions -
 - voluntary health organizations -
 - employers and their organizations -

to marshal their efforts and invest resources in the prevention and management of heart diseases and stroke among women in both developed and developing countries,

and to adopt the following five values as the foundation for the development, implementation and evaluation of all policies, programs and services:

- health as a fundamental human right -
 - equity -
 - solidarity in action -
 - participation -
 - accountability -

**Advisory Board
First International Conference on Women, Heart Disease and Stroke
Victoria, Canada**

May 10, 2000

PREFACE

Hear diseases and stroke cause a great amount of suffering and disruption in the lives of individuals and their families. They are major contributors to health care costs. Together, they are the leading cause of death in all developed countries of the world and will likely remain so in the future. Heart diseases are fast approaching the same status in the developing countries.

In 1992, the first Heart Health Conference in Victoria produced the *Victoria Declaration on Heart Health*. It called upon the entire community to "join forces in eliminating this modern epidemic by adopting new policies, making regulatory changes and implementing disease prevention programs directed at whole populations." In the past eight years, progress has been made in response to this directive. A 1995 conference in Barcelona produced the *Catalonia Declaration: Investing in Heart Health*. It took up the theme of investing in heart health and its attendant humanitarian benefit. It also included specific examples of successful investments toward improving the heart health of the population. In 1998, the declaration from the third International Heart Health Conference held in Singapore (*The Singapore Declaration: Forging the Will for Heart Health in the Next Millennium*) focused on building capacity through the development of infrastructure and on forging the will for heart health.

In 2000, the International Heart Health Community returned to Victoria for another conference. Building on the three previous conferences, this conference broke new ground by focusing on heart diseases and stroke among women, bringing together two important international movements — Heart Health and Women's Health.

In 1995, the Fourth World Conference on Women, held in Beijing, had challenged the entire world through its *Beijing Declaration and Platform for Action* to respond to the inequities facing women in all countries. Its *Platform for Action* set an agenda for women's empowerment. Its mission was to remove "all the obstacles to women's active participation in all spheres of public and private life through a full and equal share in economic, social, cultural and political decision-making." This would lead to improved women's health and greater contribution of women to the social well-being and economic productivity of the country.

The objectives of the 2000 *Victoria Conference, Women, Heart Disease and Stroke* were:

- to increase awareness of the global problem of heart diseases and stroke in women;
- to highlight current scientific advances, gaps in knowledge and research opportunities for CVD (cardiovascular disease) in women from prevention through diagnosis and treatment in the context of interventions at the individual, community and policy level;
- to link scientific knowledge with heart health initiatives in an effort to facilitate the development of action agendas aimed at reducing the burden of heart diseases and stroke in women both globally and locally.

Lack of awareness of the women-specific aspects of heart health has impeded progress in this area. Higher rates of heart diseases among young and middle-aged men have created the false conception among women and health care practitioners that heart disease is primarily a "middle-aged male disease." The rate of coronary heart disease among women increases with age. As a result, when combined with the longer longevity of women, heart disease and stroke pose an equal threat to women and men.

The promotion of cardiovascular health and the prevention of heart diseases and stroke and its sequelae among women can only be accomplished with attention to the realities of women's various roles within the family, the workplace and the community, and their power base in the family and country. Equality between women and men varies from country to country. Ensuring that "health as a human right" is accessible to all requires that these fundamental socio-economic determinants of health be addressed.

More research focusing on the issues relevant to women would form a strong foundation for action on heart diseases and stroke. This includes research on risk factors, the effectiveness of prevention, pre-clinical and clinical interventions, and the quality and responsiveness of health services. Population surveillance and monitoring information would be more useful if it included whole- and sub-population gender-related indicators and analyses, and the collection and analysis of interventions and outcome data. The *International Conference on Women, Heart Disease and Stroke* held in Victoria provided an opportunity to discuss available research and identify gaps that needed to be addressed.

Following the example of the previous three reports from Victoria, Catalonia and Singapore, this report is designed to stimulate action. It is unique in that it focuses on a specific group of individuals rather than the entire population, and more emphasis has been placed on policy and social context.

While focusing on women, this report does not intend to diminish the continued importance of heart diseases and stroke among men. It is hoped, rather, that it will lead to major changes in this new century that will not only improve women's health, but also the health of children and men.

The 2000 Victoria Declaration on Women, Heart Diseases and Stroke is structured in the following way:

- Chapter 1 presents an overview of the importance of heart diseases and stroke to women's health.
- Chapter 2 focuses on the socio-economic determinants of women's health that support the four cornerstones to heart health and address the biological factors included in the *Victoria Declaration on Heart Health*.
- Chapter 3 describes the policies, community action, programs and services required to support heart diseases and stroke prevention and management, using the values of "health as a human right, equity, solidarity, participation and accountability."
- Based on the framework proposed in the Singapore Declaration, Chapter 4 identifies the means for building capacity in countries for the development and maintenance of a program that will address the specific needs of women's heart health.
- Chapter 5 summarizes the major conclusions of the report and outlines recommendations for action.

The development of this declaration has been shaped by the vision of the future that:

- Women will be valued, and their unique contributions, based on consensus, respect and reciprocal learning, will be realized. The "girl child" will be celebrated and will enjoy a higher quality of life throughout her lifetime. The socio-economic environment will support women in their many roles in both the family and community. Health inequities will be reduced within countries, not only between men and women but among women as well.
- Promotion of cardiovascular health throughout the lifespan and prevention and management of heart diseases and stroke will be on the political agenda. This will lead to an increased awareness of the specific needs of women and a balanced allocation of resources in response to their health needs. An integrated service system will exist for prevention, diagnosis, treatment and rehabilitation in all life stages. A variety of models appropriate to the specific needs of countries will be in place. To ensure sustainability, effective demonstration projects will be incorporated into the mainstream service sector.
- The differential impact of government policies on men and women will be reduced. Government policy development will include both an analysis of the impact of all policies on health in general and an analysis for their impact on women in particular. The feminization of poverty will be reduced.
- The quality of life will be improved for all women in the workplace and associated stress will be reduced. More women will be in positions of senior decision-making, and more women will have respect and control in their work situation. Barriers to women's involvement in all aspects of government, institutional and private sector jobs will be reduced. The education system will support access of women to all types of jobs.
- Research on heart diseases and stroke among women will provide a solid information base to guide policy, program and service decision-making. Innovative research methodologies will provide information on actual practices in the community. Formal processes will facilitate the sharing of "learnings" with others. Technical assistance will be provided to enhance the capacity of countries and communities to incorporate effective innovations into their systems.

This report will primarily discuss coronary or ischemic heart disease rather than other less common causes of heart disease, such as Chagas, rheumatic heart disease and cardiomyopathies. Some of the underlying determinants of these diseases are similar to those of coronary heart disease. Thus, the recommendations that focus on improving the socio-economic situation and access to health services for children and women will have a positive impact on these other diseases as well.

This declaration calls upon women and men to make a commitment to work together in families, communities and workplace, government and non-government settings to prevent and manage heart diseases and stroke among women. The globalization of the world's economy demands that international organizations and countries work together on this initiative. The meaningful participation by women will only be achieved if women decide to take up the challenge and receive the active support and collaboration of men. Now is the time to commit to making a difference!

CHAPTER 1

HEART DISEASES AND STROKE: A GLOBAL WOMEN'S ISSUE

Hear diseases, stroke and peripheral vascular disease are a major, important public health concern in all countries of the world. Together they are the leading cause of death and disability worldwide for men and women over the age of 65. In countries with established market economies, heart diseases and stroke still contribute to approximately half of all deaths in spite of declines in mortality rates in the past thirty years. In developing countries, a "second epidemic" of coronary heart disease and stroke will add to the current burden of infectious diseases and rheumatic heart disease, so that in the near future cardiovascular disease¹ will join infectious disease as the leading cause of death and disability.

Overall, ischemic or coronary heart disease mortality rates are about twice as high among men as women. Mortality rates from stroke are nearly the same for both sexes (Figures 1 and 2). However, in many countries the actual number of deaths among women from cardiovascular disease is similar to men due to their longer life expectancy (Table 1). The 1999 WHO *Health Report* indicates that worldwide there were approximately 16.7 million cardiovascular deaths for all ages (8 million men and 8.7 million women).

Coronary heart disease is a more common cause of death than stroke in most, but not all, countries. The mortality rate from stroke is very high in Portugal, China and sub-Saharan Africa, and may be a function of the increased prevalence of high blood pressure in these countries.

Rheumatic heart disease, Chagas disease resulting in heart disease, and cardiomyopathies have a significant impact on the health of children, women and men. Rheumatic and inflammatory heart diseases are the most common cause of heart diseases among children and young adults. They account for about 6% of cardiovascular disease mortality. Chagas disease is a major public health problem in rural Latin America, in part because of the poor socio-economic status of the women and men in these regions. Worldwide, cardiomyopathies

¹ Cardiovascular diseases include all heart diseases, vascular diseases and stroke.

caused by coronary heart disease, high blood pressure, alcohol abuse or nutritional deficiencies cause both prolonged disability and death.

It is recommended that:

Countries and international health, social and economic development agencies invest in the prevention and management of heart diseases and stroke among women, recognizing that women's health includes more than reproductive health.

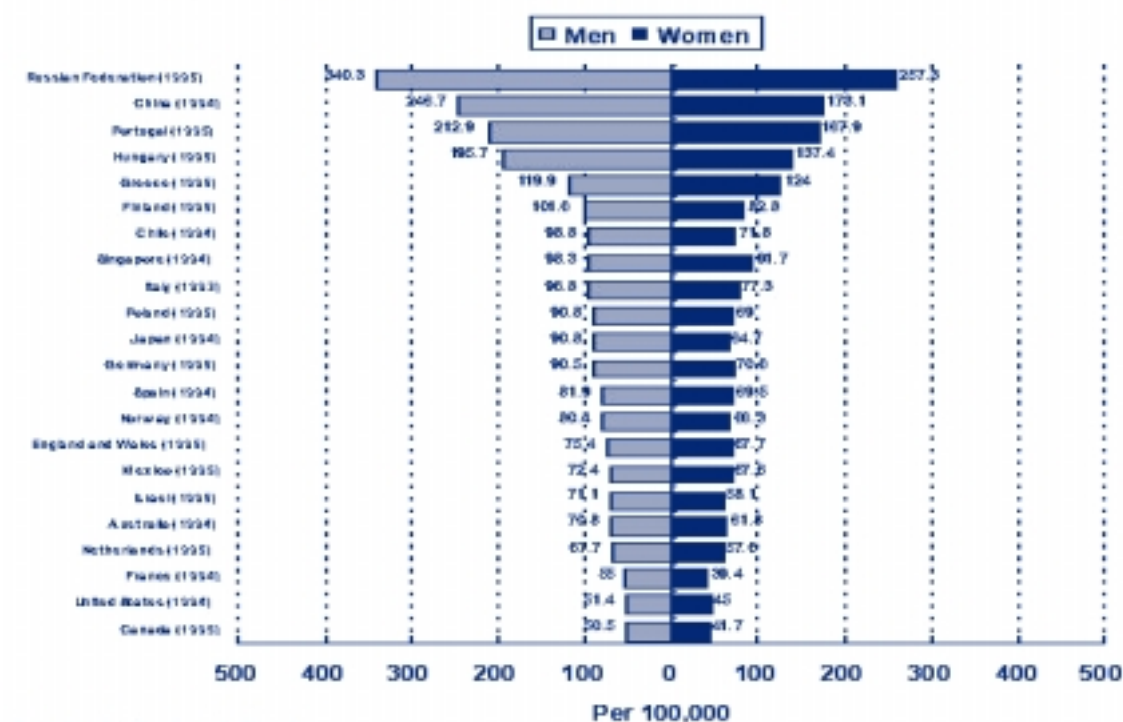
Deaths due to heart diseases and stroke provide only one indicator of their impact on women's lives. The inability to return to work, the onset of depression and anxiety, concern about a repeat heart attack or stroke, chronic pain, physical disability and the inability to fulfill previous family roles may all severely affect the quality of life of a woman who has experienced heart diseases or stroke. In addition, countries pay a high price for these health problems through health care costs, lost productivity and the need for social services.

The high prevalence of risk factors for these two conditions among young and middle-aged adults, combined with the aging of the world's population, indicates that the prevention and management of heart diseases and stroke will continue as a public health priority worldwide.

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.

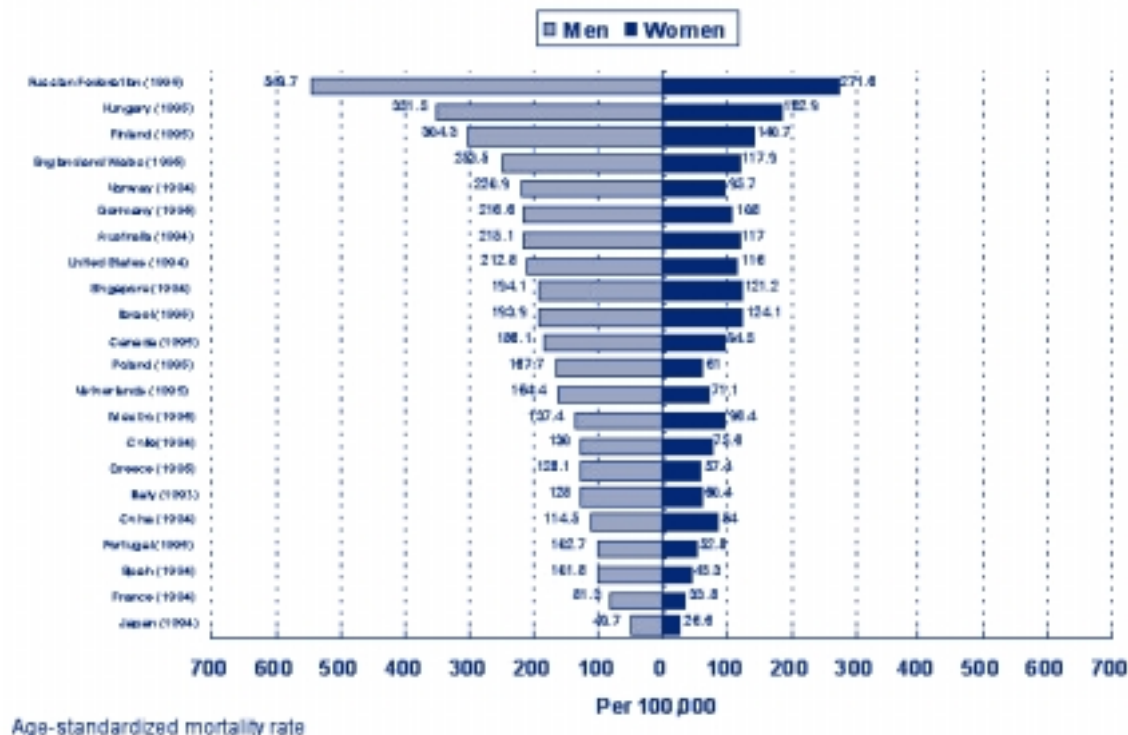
Region	Women	Women	Men
	IPD	CVD	CVD
Established Market Economies	12	227	483
Formerly Socialist Economies	6	163	263
India	240	481	611
China	89	439	576
Other Asia and Island	140	226	289
Sub-Saharan Africa	228	211	183
Latin America and Caribbean	48	147	186
Middle Eastern Crescent	85	215	285
World	798	2201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

Figure 1 Age-standardized mortality rates, cerebrovascular disease (stroke), World, mid-1990s



Source: 1996 World Health Statistics Annual, WHO

Figure 2 Age-standardized mortality rates, ischemic heart disease, World, mid-1990s



Source: 1996 World Health Statistics Annual, WHO

Heart Diseases and Stroke — Differences between Women and Men

Heart diseases and stroke differ among women and men in several ways. Coronary heart disease affects women approximately ten years later than men, possibly because of the protective effect of estrogen prior to the onset of menopause. Stroke accounts for a higher proportion of deaths among women than men, particularly women over age 85. Women are less likely than men to survive following a heart attack, and survivors have an increased rate of re-infarction, heart failure and death.

Some risk factors may affect women differently than men. For example, diabetes has a two times greater risk of coronary heart disease and stroke among women than among men. Elevated triglyceride levels are an independent risk factor in women and may be a better predictor of coronary heart disease than are low-density lipoproteins (LDL) cholesterol levels.

Women have additional risk factors for coronary heart disease and stroke than men, including oral contraceptive use in combination with smoking (a risk factor for stroke) and gestational diabetes (risk factor for diabetes, a risk factor for heart disease). Atrial fibrillation presents an important risk factor for stroke among older women. While in the past, rates of smoking were lower among women than men, in many developed countries they are similar and even higher among young women than among young men. The likelihood that young women in developing countries, with the further development of their economies, will follow this path in the future is a great source for concern.

From a diagnostic perspective, greater confusion exists between coronary and non-coronary chest pain syndromes among women than among men. For example, coronary artery spasm in the absence of fixed atherosclerotic coronary obstruction ("variant angina") predominates in women and the clinical course is typically benign. Access to diagnostic services may also vary by sex: women are less likely than men to be referred for invasive investigation. Women have smaller coronary arteries and more vaso-reactive diseases (such as Raynaud's phenomenon) than men — factors that might influence the impact of vasodilatation therapy.

Sex differences also exist in treatment of heart disease. For example, in the developed world, a lower proportion of women than men with coronary heart disease are treated with angioplasty and coronary artery bypass surgery.

Men have a higher mortality rate than women from stroke until the age of 85 when the trend reverses. In Western countries, women who survive strokes are more likely to live alone than men because of the longer life expectancy of women. This has major implications for the need for home support programs and institutionalization.

Rheumatic heart disease is still prevalent among the lower socio-economic groups in the developing world. It affects girls more than boys and results in significant mortality and morbidity as well as economic burden.

Social Context for Heart Diseases and Stroke among Women

It is useful to place the prevention and management of heart diseases and stroke within the social context of women's health in general. Traditionally, within the formal health care system, "women's health" focuses almost exclusively on childbearing and reproductive organ-related problems or diseases. This reflects, in part, the primary role given to women by society — the bearing and raising of children. Dramatic changes in women's roles in many countries challenge us to reconsider women's health beyond this narrow role definition.

The definition of women's health on which the Fourth World Conference on Women (Beijing, 1995) was based considers the whole woman and the overall context for her life, not just her reproductive function.

"Women's health involves women's emotional, social, cultural, spiritual and physical well-being and is determined by the social, political and economic context of women's lives as well as by biology. This broad definition recognizes the validity of women's life experiences and women's own beliefs and experiences of health. Every woman should be provided with the opportunity to achieve, sustain and maintain health as defined by that woman herself to her full potential." ²

² Phillips S. The Social Context of Woman's Health: Goals and Objectives for Medical Education. *Can Med Assoc J* 1995;154(4):507-11.

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... The status of women's health in old age is shaped throughout their lives by factors over which they have little if any control. If longer lives for women are to be years of quality, policies must be aimed at ensuring the best possible health for women as they age. These policies should be geared toward the problems that begin in infancy or childhood, and should cover the whole life span, through adolescence and adulthood into old age."³

Inequality presents a major barrier for women to the achievement of the highest attainable standard of health. These inequalities exist both between men and women and among women — women in different geographical regions, social classes, and indigenous and ethnic groups. Inequalities faced by women include:

- unequal access to and use of basic resources;
- unequal access to primary health care;
- health policies and programs that perpetuate gender stereotypes; and
- inadequate and inappropriate health services.

Health planners face an additional problem in that, because statistical data are not systematically collected, disaggregated and analyzed by age, sex and socio-economic status, the picture of women's health is unclear. In addition, in many countries medical research and epidemiological studies are often based solely on male subjects. Many drug therapy protocols and medical interventions administered to women are based on research solely on men without any investigation of and adjustment for gender differences.

³ WHO. *The 1998 World Health Report - Executive Summary*, p. 6.

Focusing prevention efforts for heart diseases and stroke among women has additional advantages beyond the women themselves. The babies who are born with a low birth weight have a higher risk of coronary heart disease as adults. Therefore, promoting healthy pregnancies is an important part of a comprehensive prevention program. Most lifestyle habits that are associated with heart diseases and stroke are established during childhood or adolescence.

While not the sole purview of the mother, women have a major role in influencing many of these habits in both sons and daughters. In many cultures, women are the nurturing providers of care to husbands, children and extended family members. They often play the initial role in identifying symptoms and seeking care for their relatives.

Conclusion

Heart diseases and stroke are major public health problems for women in all countries of the world. This situation will continue in the future because of the aging of the population and the high prevalence of risk factors among young and middle-aged women. Heart diseases and stroke will likely increase in prominence in developing countries in the near future and exceed the burden of communicable diseases. Differences exist between women and men in the impact of risk factors, presenting symptoms, therapeutic response and impact of social factors. Therefore, prevention and management of heart diseases and stroke among women must be tailored to their needs and reflect the reality of the social context of their lives.

CHAPTER 2

THE DETERMINANTS OF HEART HEALTH, HEART DISEASES AND STROKE

The prevention and management of heart diseases and stroke among women is a complex undertaking. As stated in the *Victoria Declaration*, "the hallmark of cardiovascular disease is in its multi-factorial nature... The presence of several risk factors places an individual at markedly increased risk." Among women who have experienced heart diseases and stroke, many factors will influence the quality of their lives and the possibility that they will have another stroke or heart attack.

The type of factors that interact to influence health, the onset of health problems and their outcome and impact on the individual's life include:

- lifestyle and biological factors (such as sex, biology and genetic endowment, personal health practices and coping skills, social support networks, healthy child development);
- the socio-economic environment (such as gender⁴, income and social status, employment, education, culture);
- the physical environment (such as air quality, sanitation), and
- access to and availability of appropriate health services.

This section of the report will focus on coronary heart disease and stroke because they are the most common causes of cardiovascular disease worldwide. The other heart diseases share some of the risk factors for these two diseases and the need for good access to health services. Therefore, focussing on these two will have a positive effect on the others.

⁴ Gender refers to the social factors specific to women and men that influence their lives.

Lifestyle and Biological Determinants

It is recommended that:

Governments address the key underlying socio-economic determinants of women's heart diseases and stroke — literacy and education, poverty, geography, women's roles and control over their lives, media and equality of access to services.

The *Victoria Declaration* cited "four cornerstones" that have the greatest influence on heart health and the risk of stroke for both men and women:

- health-promoting dietary habits;
- a tobacco-free lifestyle;
- regular physical activity; and
- a supportive psychosocial environment.

These factors are major determinants of other biological conditions that increase the risk of heart diseases and stroke — high blood pressure, abnormal blood lipids, obesity and diabetes. Together, these factors explain the majority of new cases of heart diseases and stroke.

It is recommended that:

Governments, non-government organizations, the private sector and health care system provide a supportive psychosocial environment and community support and education to encourage girls and women to adopt heart healthy behaviours — tobacco-free lifestyle, health-promoting dietary habits and regular physical activity.

Improving dietary habits for heart health should focus on a balance between the energy intake and energy expended to maintain a healthy weight, reducing the intake of fat and saturated fat and increasing consumption of fibre, fruits and vegetables. Access to healthy affordable food is a critical factor for women who live in poverty. Eliminating the use of tobacco requires interventions for both prevention and cessation, as well as protection from the exposure to environmental tobacco smoke. Encouraging regular physical activity can reverse the impact of the sedentary lifestyle prevalent in modern affluent societies. Addressing psychosocial factors in the family, workplace, school and community can reduce stress and help a woman cope with life's challenges.

In developing countries, rapid acculturation, urbanization and improvement in economic conditions have led to the gradual disappearance of the protective effects of a healthy diet and regular physical activity, and to increasing rates of smoking, obesity, alcohol use, stress, high blood pressure and diabetes. This phenomenon has influenced urban dwellers to a greater degree than those who have stayed in the rural setting. It also initially affects the more affluent members of a community, but as more and more people adopt the Western lifestyle, the country norms change and the poorer people also become affected.

Since it is such an important risk factor for heart diseases and stroke, the use of tobacco presents a particular concern. Compared to non-smokers, women who smoke have a two- to six-fold increase in risk of a heart attack, and a two- to three-time increased risk of stroke. The interaction of smoking and high blood pressure may

cause a higher combined risk of stroke among women. The lower age at which women now start smoking, the increase in smoking among young women and the greater intensity of smoking leads to the belief that smoking will become an even more important population risk factor for heart diseases and stroke among women in the future. Efforts must be intensified to reverse this trend.

Tobacco use is a major concern in developing countries and countries with emerging economies. Sixty-three percent of the world's tobacco production comes from developing countries creating conflict between economic development and health concerns. Tobacco companies have targeted developing countries to make up for lost ground in the developed countries where smoking rates among middle-aged and older adults have declined. In many countries, cigarettes can be bought one at a time, making them more accessible to children and adolescents. In countries with economies in transition, the proportion of women and men smoking is very high (up to 50% in urban areas). In Asian countries smoking is still much more common among men (up to 70%) than women. The emancipation of women with its concomitant increased stress, access to media and risk of adopting male-dominated behaviours puts women at great risk for increased tobacco use. The further spread of the tobacco epidemic must be stopped or developing and newly emerging economy countries will be faced with even greater rates of heart diseases and stroke in the future.

Children and youth form attitudes and develop skills associated with healthy eating, use of tobacco, physical activity and coping with stress, that have a profound impact on lifelong health behaviours. In fact, high blood pressure and coronary heart disease may begin during childhood or adolescence. Therefore, programs to reduce heart diseases and stroke among adults must begin in childhood.

It is recommended that:

Countries aggressively address the factors directly influencing tobacco use among girls and women so that the tobacco-use pandemic does not expand further into developing countries and is reversed in developed countries.

Socio-economic Determinants

For many women around the world the ability to achieve cardiovascular health remains severely limited by such socio-economic determinants as poverty, education, culture, equality of access to health services, the position and power of women in the culture, and the media that shape both women's self-perception and the perception of others in positions of power.

Education and Poverty

Among women in developed countries, those with less education are more likely to die from heart diseases. Socio-economic determinants act in part through an increase in prevalence of risk factors among people who are poor or who have a low level of education, but they also have an independent effect. The effect may be mediated through social isolation, coping styles, behaviour, job strain or stress, and anger and hostility. It also may be influenced by the characteristics of the neighbourhood in which poor people live.

Many developing countries have very low literacy levels among women. Countries with high rates of literacy among women are healthier not only in economic terms, but in the physical health of their citizens as well.

Poverty limits the ability of women and families to access basic medical assessment and treatment. It leads to higher levels of stress as women cope with the challenges of meeting the basic needs of food, shelter and clothing.

Eradicating poverty requires sustained economic growth and social development, environmental protection and social justice. Women must be involved in this social and economic development, with opportunities alongside men for full and equal participation as both the agents and the beneficiaries of change. Sustainable development and economic growth can be achieved by providing basic education, life-long education, literacy and training, and primary health care for girls and women. This will create "people-centred" sustainable development.

Roles of Women and Power of Women over Their Lives

"In many countries, the differences between women's and men's achievements and activities are still not recognized as the consequences of socially constructed gender roles rather than immutable biological differences." ⁵

While some progress has been made, in many countries women lack real influence in the policy- and decision-making of their communities. They are under-represented as elected representatives in all levels of government. Within the family, women often have very little control over their own lives. Within professions, women tend to be less valued and paid less than men. As well, predominately female professions tend to be less valued than those that are predominately male.

In the work setting, workers who are in high-demand positions within which they have low control, such as secretaries, salespersons or nurses, may have higher mortality and morbidity related to heart diseases. Studies comparing men and women in Sweden and in the United States found that many women are confined to jobs that are sex-segregated, women have fewer occupations from which to choose and, in general, women have less control than men over the process and content of their work. This work situation may reflect the position of women within the organization of society as a whole.

The roles of women vary from country to country and from culture to culture. They have the primary responsibility for maintaining the home and caring for family members, young and old. These duties often continue undiminished for women in economically developed countries after they join the paid work force outside of the home. This double workload can create high levels of stress.

Disparities in the power women have over their lives exist among women themselves in all countries. For example, well-educated women in urban centres may have much greater control over their lives than women in rural areas with low literacy.

⁵ Fourth World Conference on Women. Beijing Declaration and Platform for Action, Annex II, Chap. II, 27.

In many countries the "girl child" is less valued and develops lower self-esteem and personal acceptance than the "boy child." She has less access to education and life opportunities and does not develop a strong sense of her ability to choose a healthy lifestyle. In some settings the "girl child" might be more poorly nourished than the "boy child."

Equality of Access to Health Services

Health programs and services provide information and education on preventing heart diseases and stroke, and provide diagnostic and treatment services for those conditions. Differences in access to health care that exist between men and women, and even among women, influence women's health. The inaccessibility of services to women is often based on geography or the inability to pay. In addition, adequate knowledge about and confidence to use the service varies tremendously, depending on the education level of the woman. Health care providers may contribute to inequality of access through their lack of sensitivity to the realities of women's lives, or by not taking enough time to fully assess a woman's concerns. Women and the health professions, largely through unawareness, minimize the incidence of heart diseases and stroke in women. Chapter 3 discusses specific issues related to access to health care in more detail.

Media

The media exert a great influence on the socialization of men and women; their message reflects and reinforces the view of women in society. The messages also influence the adoption of healthy or unhealthy lifestyles. Tobacco advertising has had a damaging effect on women in all countries by encouraging the adoption of the most important risk behaviour for heart diseases and stroke. Changes required in the media industry will be discussed in more detail in Chapter 3.

Conclusion

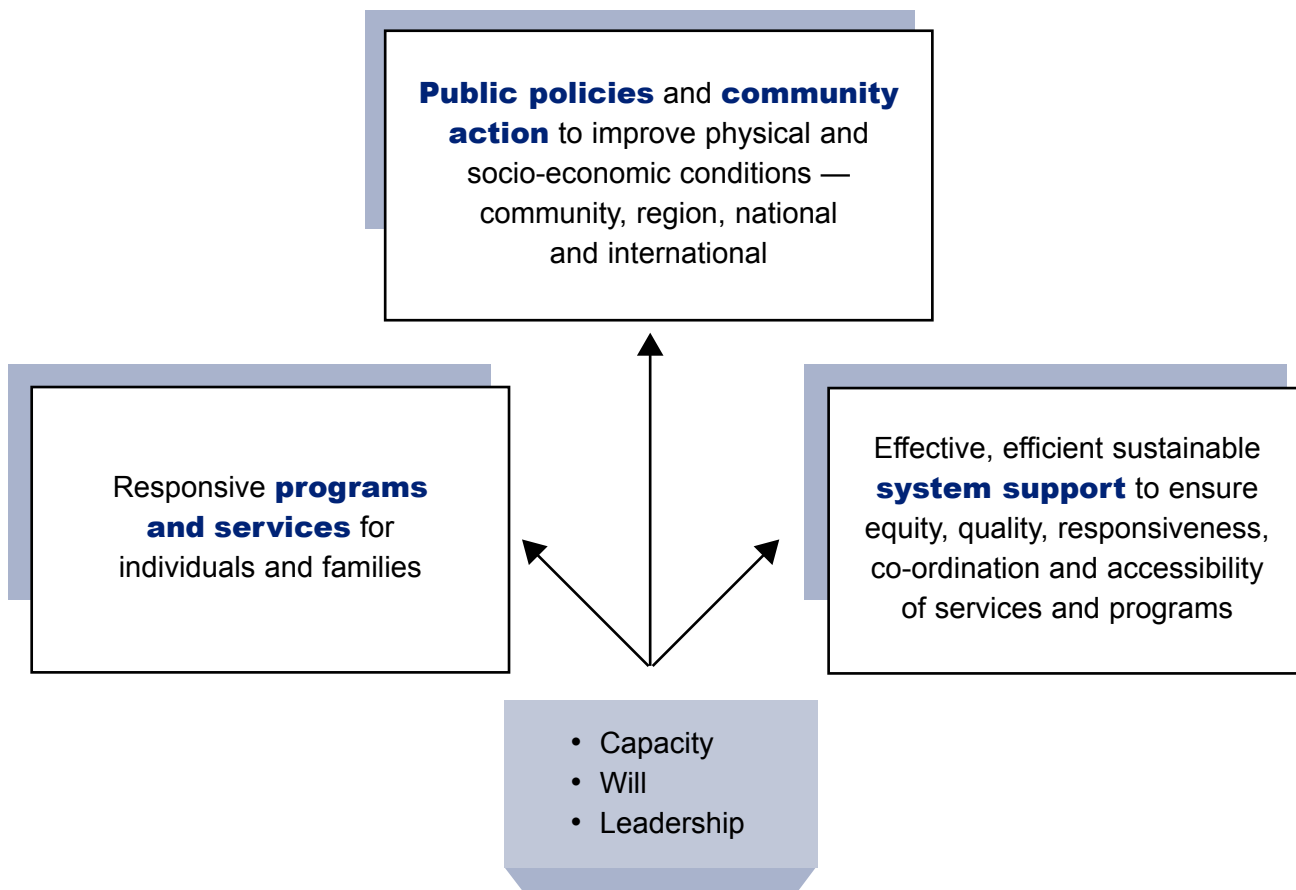
Many factors related to the individual (both biological and lifestyle), the socio-economic environment and the health care system influence heart health and the development of heart diseases and stroke among women. For the prevention and control of coronary heart disease and stroke, the four cornerstones of heart health are a tobacco-free lifestyle, healthy eating, regular physical activity and a supportive psychosocial environment. For women, the ability to positively influence these factors and others associated with heart diseases is strongly dependent on their level of income, education, role, control over their lives, culture, religion, access to health care and influence of the media. For the majority of women in the world, poverty, illiteracy and other social factors remain significant barriers to cardiovascular health. Many of these underlying determinants of health are interrelated and can be addressed together. Women need to be actively involved in identifying both key determinants of health and the processes for improving them at the international, national, regional and local levels, and within their own families.

CHAPTER 3

MAKING A DIFFERENCE — POLICIES, COMMUNITY ACTION, PROGRAMS AND SERVICES

The prevention and management of heart diseases and stroke requires the capacity, will and leadership for: a) public policies and community action to improve the physical and socio-economic conditions affecting health; b) responsive programs and services for individuals and families; and c) an effective and efficient sustainable system within which the policies are implemented and programs and services are provided.

Figure 3 Energy and resources necessary to address the prevention and management of heart diseases and stroke



It is recommended that:

Countries adopt and promote the following five values as the foundation for the development, implementation and evaluation of all policies, programs and services:

- health as a fundamental human right;
- gender equity;
- solidarity among women and men in working toward improved health for women;
- participation of women in leadership roles and in all aspects of decision-making; and
- accountability for outcomes of health policies, services and programs.

This chapter presents five values that provide the framework on which community action, policies, services and programs need to be built to meet women's needs. The practical implications of expressing each value while addressing the underlying socio-economic determinants of health are then discussed. These are followed by an outline of the programs and services required to prevent and manage heart diseases and stroke among women. The chapter concludes by summarizing the characteristics of an integrated responsive system of health services. Chapter 4 will review energy and resources — the leadership, capacity and will for action — that are required to implement such a system.

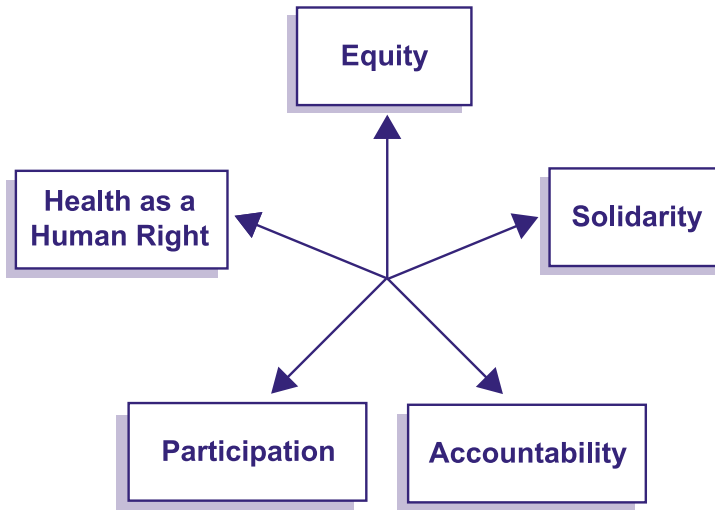
A Framework of Values

Policies need to be rooted in a clear set of values. For example, the policy framework for the WHO European Region suggests the following:

1. health as a fundamental *human right*;
2. *equity* in health and *solidarity* in action between countries, between groups of people within countries and between genders;
3. *participation* by and *accountability* of individuals, groups and communities, and of institutions, organizations and sectors in health development.

These values could also provide a strong framework for the promotion of women's heart health and the prevention and management of heart diseases and stroke.

Figure 4 Framework of values for the promotion of women's heart health and prevention and management of heart diseases and stroke



Health as a Human Right

Women have the right to the highest attainable standard of physical and mental health. This value directs an entire country to implement policies and invest as necessary to protect this right. This includes addressing the underlying socio-economic determinants of women's health and removing barriers to programs and services that can improve mental or physical health. Of particular importance is the protection of the rights of the girl child assured by the *Convention on the Rights of the Child*:

"For the girl child to develop to her fullest potential she needs to be nurtured in an enabling environment, where her spiritual, intellectual and material needs for survival, protection and development are met and her equal rights safeguarded."

Unfortunately, at this time, discrimination and violence against girls exists worldwide. Universal adoption of this value would be a major step toward changing this situation.⁶

In the delivery of health services, countries must take into account such factors as resources and culture when determining the mix of delivery options within the institutional sector. When profit margin is the primary goal of the private sector, it has less incentive to provide services to all. Government funding of basic programs and services may be necessary to ensure that the principle of equity applies. This approach supports the value that "health is a human right" and therefore requires a public investment of resources.

⁶ Fourth World Conference on Women. Beijing Declaration and Platform for Action, article 41.

Equity

Equity in health implies that ideally everyone should have a fair opportunity to attain his or her full health potential. It also implies, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. Gender equity policies are concerned with:

- improving living and working conditions for women;
- enabling women to adopt healthier lifestyles;
- decentralizing power and decision-making, encouraging women to participate in every stage of the policy-making process;
- assessing health impact and promoting inter-sectoral action to redress inequities identified in the assessment;
- ensuring, through mutual concern and control at the international level, that governments and international bankers do not inadvertently increase inequity with monetary policies implemented at times of crisis or at times of waves of migration;
- making high quality health care accessible to all; and
- conducting appropriate research, monitoring and evaluation.

All government departments need to assess the impact of policies on women's health as well as their impact on the socio-economic determinants of women's health, as outlined in Chapter 2.

Industry has a special role to play in improving equity in the workplace. Systemic barriers often exist that limit the involvement of women to their full potential in all aspects of industry. One such barrier is access to education with encouragement to consider the entire range of work options rather than only those traditionally associated with women. Reducing barriers in access to education in medicine and health sciences in particular will ensure that women are well represented in the health care sector.

It is recommended that:

Institutions conduct a health and a gender impact analysis during the development of all policies.

Equity also involves equal pay for work of equal value. There is a tendency for professions that are dominated by women to have lower income levels than those that are dominated by men.

Reducing inequity in the workplace also includes reducing inequities among women. It is as important to ensure that women providing administrative support are treated with respect and that their contribution is valued.

The media industry requires special attention as the past twenty years have seen an explosion in the field of communications. The *Beijing Declaration* states the implications of this phenomenon very succinctly:

"With advances in computer technology and satellite and cable television, global access to information continues to increase and expand, creating new opportunities for the participation of women in communications and the mass media, and for the dissemination of information about women. On the other hand, the global communication networks have been used to spread stereotyped and demeaning images of women for narrow commercial and consumerist purposes. Until women participate equally in both the technical and decision-making areas of communications and mass media, including the arts, they will continue to be misrepresented and awareness of the reality of women's lives will be lacking. The media have a great potential to promote the advancement of women and the equality of women and men by portraying women and men in a non-stereotypical, diverse and balanced manner, and by representing the dignity and worth of the human person."⁷

Solidarity

Solidarity means working together toward common goals and sharing resources and experience. Countries can learn from each other. The "West is best" concept is not necessarily best for health and limits creativity. Furthermore, it precludes the West from making significant changes based on lessons learned in other countries. Investment can be made that helps countries develop their own ways of collaboration, evaluating their results, and sharing these case studies with others.

Identifying regional, national and international goals and strategies to prevent and manage heart diseases and stroke among women provides a strong framework for collaboration among government, non-government organizations and the private sector. Gender equity

It is recommended that:

Employers provide a workplace that values and respects women, facilitates the progress of women in achieving their potential and implements policies to support women in their family responsibilities.

It is recommended that:

The media industry include women in both the technical and decision-making areas of mass media to change currently presented stereotypical roles and to increase awareness of the reality of women's lives.

⁷Fourth World Conference on Women. Beijing Declaration and Platform for Action, article #35.

does not necessarily require the development of a separate program for women. What it does require is consideration of the gender specific needs of both women and men (girls and boys) so that equal opportunities for health are provided to all. Ideally, men and women will work hand in hand to improve the health of all members of the population. By the same token, all international organizations and countries will work together toward common health goals. This includes organizations involved in economic development, such as the World Bank, who would make policy decisions based in part on improving the health of women in the country.

Participation

Participation by women in the development and implementation of policies, programs and services will ensure the inclusion of their values and their method of doing business. Women tend to work within a consensus model, share stories and learn from each other, respect diversity and embrace inclusiveness, and care for others — elements that facilitate the development of effective interventions.

It is recommended that:

Government, non-government organizations, the health care sector and private sector remove barriers to women's participation in leadership positions in all sectors. Communities facilitate the participation of both women and men in increasing equity for women as part of social responsibility.

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. This will require the removal of barriers to the involvement of women in politics and their advancement to senior positions. The creation and modification of policies that move toward the elimination of poverty and the elevation of education levels will, in turn, give women greater control over their lives and prepare them for positions of authority.

At a community level, women working together can challenge the status quo and raise awareness of women's issues that influence health. In providing mutual support and assistance with daily living, women help each other improve their personal situations. Telling their own stories to each other and gaining a greater understanding of the common underlying factors that influence their lives provides support and direction for personal growth and community action.

Men also have a critical role to play as both supplementary and complementary agents for change. This applies to not only senior policy makers in government and non-government organizations and in the private sector, but within the community and in the family as well. Attending to the issues identified in this report will create a world that is better for all — more humane, more equitable, more personally satisfying and with a higher quality of life. In fact, attention to some of the issues that cause inequity among men and impede

their ability to be all they can be, may indirectly affect women if men feel less like victims in their own lives and more empowered to create a better world for others.

Accountability

For those who invest resources to promote health and to prevent and manage health problems, accountability to the population in general and to women in particular is a necessity. This accountability requires the development of appropriate population indicators on the health of women and the impact of health services. This also needs to be supported by the ongoing collection, interpretation and dissemination of data.

Evaluation of the impact of policies, programs and services must address the various factors that women consider important, including progress toward equity. The performance and effectiveness of the health system, and not just its efficiency, must be assessed. Explicit performance goals for the health system need to be articulated and should focus on such criteria as health gain, equity, responsiveness and efficiency. Changes in the socio-economic factors that influence women's health need to be measured on an ongoing basis. Disseminating the results of these evaluations to women in the population and to women's organizations can provide the feedback necessary to ensure accountability of the institutional sector.

Effective Programs and Services for Women and their Families

It is recommended that:

Governments, non-government organizations, the health care system and the private sector provide primary prevention, screening, diagnosis and treatment, prevention of recurrence, rehabilitation and support programs and services that are tailored to women's needs.

The promotion of heart health and the prevention and management of heart diseases and stroke require a comprehensive range of programs and services for girls and women and their families, including:

- *Primary prevention* (preventing the onset of disease by avoiding or reducing risk factors or adopting health-enhancing behaviours — tobacco-free lifestyle, healthy eating, regular physical activity, a supportive psychosocial environment, avoiding heavy alcohol use);
- *Screening* to detect biological conditions such as high blood pressure, hyperlipidemia and diabetes, followed by the provision of effective treatment;
- *Diagnosis, treatment and prevention of recurrences*; and
- *Rehabilitation and support* (improving the quality of life and functioning of those with heart diseases and those who have had a stroke).

Primary Prevention

Primary prevention activities need to be directed at the entire population as all girls and women are potentially at risk of developing heart diseases or stroke. The *Victoria Declaration on Heart Health* suggested that public education, community programs and primary care be the foundation for prevention. The *Singapore Declaration* proposed the use of a variety of settings including communities, schools, organizations, work sites and health care settings. Programs for men and women do not necessarily have to be separate but the unique perspectives and needs of each should be addressed. As discussed in Chapter 2, socio-economic factors influence women and men in different ways. Prevention activities, therefore, need to be responsive to the varied socio-economic circumstances of girls and women. In addition, the "non-health" sectors such as social services, education, recreation, religious institutions and industry can provide valuable support to girls and women by addressing these underlying socio-economic factors that influence health.

Screening

Screening is directed at the whole population in some situations (high blood pressure screening or obesity) and targeted only to higher risk groups in others (diabetes screening). Diabetes is more common among women in many countries and as such plays a more significant role in the risk of heart diseases for women than men. The inclusion criteria for high risk screening programs need to consider risk factors that are specific to women, such as gestational diabetes.

Diagnosis, Treatment and Prevention of Recurrence

Diagnosis and treatment services for women must consider the biological and gender differences between men and women if they are to be responsive to women's needs. This is made difficult by the fact that most research on diagnosis and treatment has used male subjects. As a result, in many cases appropriate diagnostic criteria, drug dosages and interventions effective for women are unknown. In particular, heart diseases may be missed in women because their presenting symptoms be different than men's. In addition, lower levels of education, income and status within the country can influence access to diagnostic and treatment services. Many women, for example, cannot afford to purchase medication or must purchase a sometimes inferior drug. Countries that have social assistance programs with drug benefit programs may inadvertently penalize women by offering a narrower selection of cheaper drugs covered under the plan and exclude more effective drugs. Women are penalized more than men because more of them, particularly older women, are poor compared to men.

The identification and reduction of risk factors among those who have heart diseases or stroke can reduce the risk of a recurrent event. Tailored education and support for smoking cessation, healthy eating and regular physical activity can assist women in making the necessary lifestyle changes. Access to health programs and services that are sensitive to women's life situations are essential to help women make the necessary lifestyle adjustments. High blood pressure control is essential to reduce the risk of recurrent stroke. Medication and surgical interventions also can play a role in reducing the risk of recurrences.

Rehabilitation and Support Services

Heart diseases and stroke, as chronic conditions, can severely compromise an individual's ability to function independently in the community. Rehabilitation and support services can have a profound impact on the individual's return to full functioning and his/her quality of life. The benefits of returning to paid employment and contributing to the community extend well beyond the individual alone. In most countries rehabilitation services are primarily provided in the hospital setting. While this is important, moving these services out into the community would have a significant impact on the reintegration of women into the family and community. Women often have less support than men, they are usually the primary caregivers in the family and, due to their longer life expectancy, older women are less likely than older men to have a partner to care for them. Home support services can be provided through formally funded programs or volunteer community groups. The informal friend and neighbour-based system is a powerful adjunct to the formal system and must be recognized as such. Investment in the organization and training of such volunteers has the potential to further improve women's lives, benefiting both the providers and recipients of care. The "non-health" sectors such as social services, housing, transportation and recreation can all make an important contribution to rehabilitation and support.

Balanced Response

At the present time, most formal health care resources are invested in diagnosis and treatment activities. Increasing investment in primary prevention, screening, and rehabilitation and support is essential to maintaining a balanced response to heart diseases and stroke for women. Investment by poorer countries in expensive high-technology solutions from the West that benefit only a few may not be the wisest use of resources. The disparity among countries will further increase and poor people in particular will suffer disproportionately unless we invest more in primary prevention.

An Effective, Sustainable Service System

Government, non-government organizations and the private sector have a critical role to play in the development of a comprehensive approach to heart diseases and stroke for women. They form an integral part of the health service system, either as funders or providers. In addition, each of the sectors has an essential role to play in addressing the socio-economic determinants of health described in Chapter 2.

Every country, based on geography, culture and resources organizes prevention and management services described above in a variety of ways. Most would include some form of the following components in their health system:

- *Public Health* — population health promotion and prevention activities using primarily information, education, community mobilization and policy advocacy;
- *Primary Care* — first point of contact for personal services to individuals and families for prevention, diagnosis and treatment, rehabilitation and support;
- *Investigation* — including laboratories, radiology, invasive techniques;
- *Specialty Care* — including specialist physicians, hospitals, surgery;
- *Home Support* — nursing, therapy, personal care, social services provided in the home; and
- *Volunteer Sector* — includes voluntary health organizations and community-based individuals and groups.

In many countries, each of these sectors tends to function autonomously with little integration. This succeeds in providing a group of services, but it does not provide an effective, efficient and sustainable *system* of services.

It is recommended that:

Governments provide a comprehensive coordinated system of programs and clinical services to ensure availability of services to all population groups, particularly women, with:

- both horizontal and vertical integration;
- equitable access to high quality programs and services responsive to women's needs;
- a strong primary health care system;
- establishment of ongoing benchmarking programs to encourage learning about effective practices from others;
- the involvement of women in the development, implementation and evaluation of programs and services;
- health care professionals who are gender sensitive in communications, practices, delivery, skills and attitudes; and
- appropriate investment of resources to create a better balance among health promotion, prevention, rehabilitation services and treatment 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, however. The system "connection functions" include:

- joint planning and evaluation, communication and coordination;
- ongoing needs assessment and participation of users in planning, development and evaluation of policies, services and programs;
- development of a strong information base (research) and a process to incorporate new findings from pilot projects into the mainstream services and programs;
- accountability to the community — monitoring of health services, program evaluation and an ongoing quality improvement process;
- surveillance to assess the health outcomes of the population;
- process to fund services adequately and reallocate resources as needed;
- human resource development; and
- policies that support equity, access and responsiveness to the needs of the population.

Access to programs and services is also a particular issue for girls and women in many countries. Where literacy rates and formal education among women are lower compared to men, fewer women are aware of and make use of services. In addition, the inferior status of women influences the response of the health care system to women. Lack of transportation to health care centres and restricted movement by women in the community affects their ability to access services. The need to arrange child care so that they can attend prevention programs or seek health care places an added burden on women. Gender-sensitive policies, programs and services consider all these issues and others to ensure equity of access not only between men and women, but among women themselves.

The adoption of the recommendations from the Beijing declaration would improve services, not only for girls and women but also for boys and men.

- Design and implement, in co-operation with women and community-based organizations, gender-sensitive health programs, including decentralized health services, “that address the needs of women throughout their lives and take into account their multiple roles and responsibilities, the demands on their time, the special needs of rural women and women with disabilities and the diversity of women's needs arising from age and socio-economic and cultural differences, among others; include women, especially local and indigenous women, in the identification and planning of health care priorities and programs; and remove all barriers to women's health services and provide a broad range of health care services.
- Provide more accessible, available and affordable high quality primary health care services.
- Redesign information, services and training for health care workers so that they are gender-sensitive and reflect the user's perspectives with regard to interpersonal and communication skills and the user's right to privacy and confidentiality. These services should take a holistic approach.
- Ensure that as girls mature they have continuing access to necessary health and nutrition information and services as they mature.
- Establish mechanisms to support and involve non-government organizations, particularly women's organizations, professional groups and bodies working to improve the health of girls and women, in government policy-making, program design, as appropriate, and implementation within the health sector and related sectors at all levels.
- Support non-governmental organizations working on women's health and help develop networks aimed at improving co-ordination and collaboration between all sectors that affect health.
- Ensure full and equal access to health care infrastructure and services for indigenous women.

Conclusion

A comprehensive co-ordinated system of policies, services and programs is needed to prevent and manage heart diseases and stroke among women. Investment in the system "connection functions" and in programs and services will ensure that women's needs are effectively met. By applying the values of "health as human right, equity, participation, solidarity and accountability," government, non-government organizations and the private sector can ensure the provision of quality health services and effectively address the socio-economic conditions that affect women's health. Facilitating community action is critical if women are to be active participants in this process.

CHAPTER 4

BUILDING CAPACITY FOR ACTION

Chapter 3 outlined the three main strategies to prevent and manage heart diseases and stroke among women: a) creating a healthy socio-economic environment in which women live and work; b) providing health services for girls and women; and c) ensuring the health system itself functions effectively and efficiently.

The capacity of a country to implement these three strategies effectively — to plan, develop, implement, evaluate, and sustain policies, services and programs — will determine the country's impact on improving the health of girls and women. Capacity, or the ability to marshal energy and resources to achieve particular outcomes, depends on both an appropriate infrastructure and the will to mobilize it.

Capacity for action is also necessary at the international level. With the increasing globalization of the world's economy, residents of one country can be profoundly affected by the policy decisions of other countries or multinational organizations. As well, the ease with which the telecommunications industry crosses national boundaries facilitates the sharing of cultural norms and social behaviours between countries. A critical element, therefore, in the prevention and management of heart diseases and stroke among women is both the will and capacity for collaboration among governments, economic development organizations and multinational corporations.

Infrastructure

The infrastructure of a country, region or community includes both physical and human resources and their coordination as one entity. *The Singapore Declaration - Forging the Will for Heart Health in the Next Millennium* outlines the components of an infrastructure that are necessary to operationalize and sustain it in the long-term:

- policy generation and implementation
- scientific and technical knowledge
- physical and organizational capabilities
- economic or financial resources

Improvements can be made in the infrastructure in all countries that will improve the prevention and management of heart diseases and stroke among women.

Policy-making

Chapter 3 described some of the policy changes that are necessary to improve the socio-economic environment and health care system for women. Two of the most critical policy areas are the elimination of gender bias with the establishment of gender equity, and the reduction of poverty. Economic policies need to promote humane working environments and ensure equality between women and men.

The infrastructures at the national, regional and community levels must have policies and mechanisms in place that consult with women in a comprehensive manner and involve them directly in policy formulation. Through education and workplace policies, women can be encouraged and facilitated to enter senior positions in government, non-government and private sector organizations. This will require a commitment of support for women in their dual roles as child and family caregivers and workforce contributors.

All development projects have the potential to have some impact on the health of women by addressing either the underlying socio-economic determinants of health of specific behaviours associated with heart disease and stroke. Therefore, all funders and managers of development projects should consider how they can be modified or expanded to achieve the best possible outcomes.

It is recommended that:

The World Health Organization establish mechanisms to 8 organizations in setting policies to improve gender equity.

It is recommended that:

Development projects should, where appropriate, address the factors that will influence heart diseases and stroke, especially for women.

At the international level, the World Health Organization can take the lead in improving gender equity and reducing poverty. By establishing a mechanism involving other development organizations, such as the World Bank and World Trade Organization, international policies can be set that will improve gender equity and other factors that influence the socio-economic determinants of health. These "other factors" include investment in the economy to reduce poverty, or investment in the infrastructure of the health care system. These mechanisms can also assist countries in jointly addressing factors that influence each other, such as differential tobacco taxes that can contribute to smuggling from neighbouring countries.

Scientific and Technical Knowledge

Ideally, to ensure the selection of the optimal course, clinical and policy decisions are based on the best available information. The type and quality of information that is available for decision-making depends on a country's capacity for meaningful surveillance of health outcomes and for monitoring and evaluating health services. In turn the dissemination and effective use of this information will dictate whether an improvement occurs in women's health.

Understanding what is happening at the population level requires a variety of research methods. Use of qualitative data collection methods can add a richness and depth to quantitative data. They tell a story about a community — one that is essential for understanding the dynamics and interplay of factors that influence health. The funding of formal, organized research on communities that are actively preventing and managing heart diseases and stroke can create research "observatories" to conduct population case studies from which the community and others can learn. "Good practices" can be identified that others can adopt or adapt to their own context. Efforts are needed to reduce barriers associated with language and provide the financial resources needed to document what is happening in communities. Improving the ability to link databases will expand the knowledge base and enhance the ability to link programs and services to health outcomes.

It is recommended that:

Research funding bodies and universities expand research capacity to address the issues of heart diseases and stroke among women by:

- funding research on cardiovascular health and disease among women and the impact of preventive and therapeutic interventions on women;
- enhancing health system research through the development of "observatory" centres;
- providing resources to assist communities, regions and countries in documenting and evaluating services and activities;
- modifying the scientific infrastructure and capacity to support gender-sensitive research;
- providing appropriate education, training and supportive environments for women researchers; and
- involving women directly in the identification of women's research issues, methods, analyses and interpretation of results.

It is recommended that:

Governments conduct ongoing population surveillance of women's health outcomes and monitor and evaluate health services and community supports using gender-sensitive indicators to obtain information for program planning and demonstrate accountability to the population for the allocation of resources.

It is recommended that:

Governments, academic institutions and non-government organizations develop an "info-structure" that effectively disseminates research, surveillance, monitoring and evaluation findings to policy makers and service providers.

Involving women in the choice of indicators for surveillance, monitoring and evaluation will ensure the ongoing assessment of the values outlined in Chapter 3 (health as a human right, equity, solidarity, participation and accountability). Gender equity, for example, is frequently measured by the proportion of women in senior positions in political organizations or government. While this is an important statistic, measuring the proportion of women who are able to work in their preferred professions may be more valuable in evaluating progress for the vast majority of women.

The capacity among service providers and policy makers to interpret and use information is in part restricted by the lack of an effective "info-structure" to disseminate research, surveillance, monitoring and evaluation. This applies both within countries and among countries. The scientific community has a slow, labour-intensive system of disseminating research findings through scientific journals and conferences. While this may be effective for the scientific community, it is frustrating for service providers or policy makers. New approaches need to be developed that take advantage of the power of the communications industry to ensure that information is accessible in a format that facilitates its use in decision-making.

Greater participation of women in research, both as researchers and research subjects, will expand the knowledge base in critical ways. Most of the research on the prevention and management of heart diseases and stroke has been done by and on men. Biological and psychosocial differences between men and women may influence the impact of interventions in significant ways. Therefore, more research is needed not only with traditional interventions, but also with newer interventions that respect women's perspective and life context. Modifying the academic environment to encourage more women to pursue research careers and to facilitate collaborative interdisciplinary research will enhance women's contribution to the generation of knowledge. In addition, formal mechanisms to involve women in setting research priorities can be supported both within and among countries.

Physical and Organization Capabilities

The number, type and placement of physical and human resources combined with the ability to organize these resources effectively, influences how effectively a country can implement the three strategies outlined in Chapter 3.

The capability of a country to provide effective services and programs in all its regions may vary. Most countries have a disparity in

the availability of resources based on geography with a greater range and variety of services in urban areas. This influences women primarily in rural settings. The use of a variety of models that take advantage of the existing community infrastructures, such as schools, businesses or religious organizations, can expand the capability of the health services.

Central to an effective health system is the availability of appropriately trained people to provide the programs and services. The changes required to increase prevention activities and improve gender equity will challenge the capacity of the system to respond. Health professionals in the treatment sector do not always have the skills required to work in the community. They also may not want to relocate outside urban areas. Using community lay workers with special training and professional backup, providing financial incentives for relocation and gender sensitivity training may solve some of these problems.

One of the major challenges facing countries and communities is the incorporation of new ideas into the mainstream system. Often extra resources are placed in a community or region for a specific period of time to develop and evaluate a new approach to prevention or management. When the pilot funding is completed, the project dies unless it is picked up by existing funded organizations. Other communities who might be interested in adopting the new approach do not have the benefit of start-up funding, making it difficult to make the transition. Successful businesses in the private sector have special funds for research and development, and mechanisms to incorporate these findings into the ongoing work of the organization. This same capacity needs to be developed in the health care system. The development of an effective system as described in Chapter 3 can assist this process. In addition, a systematic approach that brings together the results of all the demonstration projects and learns from them will assist in identifying key "good practices" for dissemination.

Economic and Financial Resources

Every country faces challenges in finding sufficient resources to finance the health care system either publicly, privately or both. Thus, it is very important that financial resources be used wisely to achieve the greatest impact on the health of the population. Because of globalization, poorer countries have a tendency to want to be like the "West." Physicians who are trained in technologically more advanced countries want to practice in that way in their own country. Politicians who compare themselves to the "West" also want to invest resources in a high technology approach. This high technology,

It is recommended that:

Governments and other funders of health services develop mechanisms to incorporate the findings of successful pilot projects into the mainstream health system.

treatment-oriented approach is also difficult for higher-income countries with publicly funded health care systems to maintain. An analysis of the return on health care investment at the population level for women, men and children can assist in decisions about the best investment of resources.

The reduction of poverty and global inequity in the distribution of financial resources can have a profound impact on the health of girls and women. International and national infrastructure is required to make and implement these decisions. The World Bank can take the lead internationally in the setting of policies for economic development that consider the needs of women in the countries they serve. Within countries, a national financial infrastructure involving both the private and public sectors can provide direction and allocate resources in an equitable way. At the regional or community level, the implementation of locally responsive economic development and support that considers the unique contribution of women can address the feminization of poverty that occurs in many countries.

Building on existing programs may be the most efficient way to expand services for the prevention and management of heart diseases and stroke among women. For example, countries with a maternal/child health program can use it as a basis for a health education program for women. Adding to school health education programs is another example of this approach.

Will for Action

The best infrastructures "without the will to use them, are liked stranded whales; perhaps magnificent in appearance, but unable to function."⁸ The will to act, individually or collectively, involves first a *desire* to act, and then the *investment of energy* to actually act. The desire to act comes from beliefs, convictions, confidence and values that exist at the core of will. Following the desire to act, the investment of energy provides leadership, mobilizes partnerships, engages the infrastructure and obtains constituency support.

⁸ Singapore Declaration, p. 35.

Values

Many people share the five values described in the third chapter — health as a human right, equity, participation, solidarity and accountability — that are essential to the prevention and management of heart diseases and stroke among women. However, these values are either not shared by, or are not the driving force of, key people in positions of authority in all countries. Therefore, one of the first steps toward making this Victoria 2000 Declaration a reality is to present the case for the adoption of these values widely in the public, private and non-government sectors.

Available, Capable Leadership

Joint leadership by women and men is vital to making the prevention and management of heart diseases and stroke a priority and to effecting the necessary changes in programs, services, the health care system and the socio-economic environment. Identifying women with the potential for leadership and providing them with the necessary skills can facilitate their active involvement in this process.

Partnerships and Engaging the Infrastructure

The investment of resources in coalitions that identify common goals (solidarity) can mobilize collective will that can do more than individual organizations working alone. Completing a capacity and needs assessment will enable the partnership to identify how to effectively engage the existing infrastructure in the change process. Ideally, the components of the infrastructure that are needed have been directly involved in the partnership. This will facilitate the allocation of resources as needed. Ongoing evaluation can provide direction and fuel the will to keep working together.

Working with existing coalitions, such as those focussed on poverty reduction, can create partnerships that have more impact than either one in isolation. This approach can take advantage of existing infrastructure and community visibility and mobilization.

It is recommended that:

Developed countries share their technical ability and experience with policy, program and service development and evaluation with developing countries, and that all countries share their research and experience to facilitate mutual learning.

It is recommended that:

Non-governmental organizations strengthen their networks and organizational capacity at the national, regional and local levels to support health promotion and cardiovascular disease prevention initiatives for all women.

It is recommended that:

Women in all countries work in partnership with men to implement the recommendations in this Declaration.

It is recommended that:

The International Planning Committee of the First International Conference on Women, Heart Disease and Stroke widely disseminate this Declaration.

Countries can share with other countries their learnings and successes. While this could apply to all countries, it is particularly important for developed countries that have the resources to develop policies, programs and services to share this expertise and experience with developing countries. By working in partnership the developing country can expand their capacity and tailor their response to their own needs.

Constituency Support

Initiatives that engage the constituency itself in the action are more successful than those that rely on a few organizations to effect change. Obtaining constituency support mobilizes the will and leadership of many, many people. Politicians in democracies are influenced by this phenomenon. The involvement of the media is also essential to creating a broad-based community awareness of the issues.

Conclusion

The capacity of a country to effectively prevent and manage heart diseases and stroke among women is dependent on an effective infrastructure, and the will to take action to mobilize that infrastructure. Required improvements in the infrastructure include: a) changing the policy-making process so that more women participate and inequities are reduced; b) using a broader range of methods for knowledge generation and dissemination including setting up "observatories" in communities; c) enhancing organizational capabilities to provide equitable services in all regions and to incorporate new findings into the mainstream health care system; and d) further investment in the health infrastructure of a country based on the return of investment rather than taking a "more technology is better" approach. In addition, supporting leadership by women alongside men, developing partnerships and engaging the existing government, non-government and private institutions in the change process, and encouraging constituency support can create the collective will needed to effect true, long-lasting change. Partnerships among developed and developing countries can share the technical expertise and experience of those countries with more resources and enhance the capacity of the developing countries.

CHAPTER 5

RECOMMENDATIONS FOR ACTION ON WOMEN, HEART DISEASES AND STROKE

Hearth disease and stroke are important health problems for women in all countries. In many, inequities between the perceived value of women and men dictate the amount of control that women have over their own lives. Access to education, income, services and decision-making in the family, workplace, community and government all have a profound impact on the health status of girls and women and on the disparities in health status among women.

Now is the time for action! Previous declarations from Victoria, Catalonia and Singapore have identified the steps necessary for promoting heart health and preventing and managing heart diseases and stroke. This 2000 Victoria Declaration has identified new, specific directions that will ensure equity in health status both between women and men, and among women themselves, in all countries.

The following recommendations provide guidance for action. Together they address the determinants of health, the development of a comprehensive, coordinated system of more responsive high-quality programs and services. These recommendations also identify the will and infrastructure needed to support the capacity to improve women's heart health. The recommendations will have to be tailored to have the greatest impact, given the varying status of women and the girl child, resources, political organizations, health system infrastructure and resources in all the countries in the world. The innovation created by this diversity can be used to strengthen policies, programs and services in all countries by sharing both successes and failures.

Recommendations

General

It is recommended that:

1. Countries and international health, social and economic development agencies invest in the prevention and management of heart diseases and stroke among women, recognizing that women's health includes more than reproductive health.

Determinants

It is recommended that:

2. Governments address the key underlying socio-economic determinants of women's heart diseases and stroke — literacy and education, poverty, geography, women's roles and control over their lives, media and equality of access to services.
3. Governments, non-government organizations, the private sector and health care system provide a supportive psycho-social environment, community supports and education to encourage girls and women to adopt heart healthy behaviours — tobacco-free lifestyle, health-promoting dietary habits and regular physical activity.
4. Countries aggressively address the factors directly influencing tobacco use among girls and women so that the tobacco-use pandemic does not expand further into developing countries and is reversed in developed countries.

Policies, Community Action, Programs and Services

It is recommended that:

5. Countries adopt and promote the following five values as the foundation for the development, implementation and evaluation of all policies, programs and services:
 - health as a fundamental human right;
 - gender equity;
 - solidarity among women and men in working toward improved health for women;

- participation of women in leadership roles and in all aspects of decision-making; and
 - accountability for outcomes of health policies, services and programs.
6. Institutions conduct a health and a gender impact analysis during the development of all policies.
 7. Employers provide a workplace that values and respects women, facilitates the progress of women in achieving their potential and implements policies to support women in their family responsibilities.
 8. The media industry include women in both the technical and decision-making areas of mass media to change currently presented stereotypical roles and to increase awareness of the reality of women's lives.
 9. Government, non-government organizations, the health care sector and private sector remove barriers to women's participation in leadership positions in all sectors.
 10. Communities facilitate the participation of both women and men in increasing equity for women as part of social responsibility.
 11. Governments, non-government organizations, the health care system and the private sector provide primary prevention, screening, diagnosis and treatment, prevention of recurrence, rehabilitation and support programs and services that are tailored to women's needs.
 12. Governments provide a comprehensive co-ordinated system of programs and clinical services to ensure availability of services to all population groups, particularly women, with:
 - both horizontal and vertical integration;
 - equitable access to high quality programs and services responsive to women's needs;
 - a strong primary health care system;
 - establishment of ongoing benchmarking programs to encourage learning about effective practices from others;

- the involvement of women in the development, implementation and evaluation of programs and services;
- care professionals who are gender sensitive in communications, practices, delivery, skills and attitudes; and
- appropriate investment of resources to create a better balance among health promotion, prevention, rehabilitation services and treatment services.

Capacity for Action

It is recommended that:

13. The World Health Organization establish mechanisms to involve international development organizations in setting policies to improve gender equity.
14. Development projects should, where appropriate, address the factors that will influence heart diseases and stroke, especially for women.
15. Research funding bodies and universities expand research capacity to address the issue of heart disease and stroke among women by:
 - funding research on cardiovascular health and disease among women and the impact of preventive and therapeutic interventions on women;
 - enhancing health system research through the development of "observatory" centres;
 - providing resources to assist communities, regions and countries in documenting and evaluating services and activities;
 - modifying the scientific infrastructure and capacity to support gender-sensitive research;
 - providing appropriate education, training and supportive environments for women researchers; and
 - involving women directly in the identification of women's research issues, methods, analyses and interpretation of results.

16. Governments conduct ongoing population surveillance of women's health outcomes, and monitor and evaluate health services and community supports using gender-sensitive indicators to obtain information for program planning and demonstrate accountability to the population for the allocation of resources.
17. Governments, academic institutions and non-government organizations develop an "info-structure" that effectively disseminates research, surveillance, monitoring and evaluation findings to policy makers, service providers and the public.
18. Governments and other funders of health services develop mechanisms to incorporate the findings of successful pilot projects into the mainstream health system.
19. Developed countries share their technical ability and experience with policy, program and service development and evaluation with developing countries, and that all countries share their research and experience to facilitate mutual learning.
20. Non-governmental organizations strengthen their networks and organizational capacity at the national, regional and local levels to support health promotion and cardiovascular disease prevention initiatives for all women.
21. Women in all countries work in partnership with men to implement the recommendations in this Declaration.
22. The International Planning Committee of the First International Conference on Women, Heart Disease and Stroke widely disseminate this Declaration.

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