In 2008, San Francisco’s mayor, Gavin Newsome, promoted a radical plan to shut down several miles of the city’s streets to car traffic on one weekend day so that walkers, joggers and bikers could take over the roads from morning until early afternoon. The so-called “Sunday Streets” scheme even involved “activity pods”—stopping points where people could participate in dance classes, do yoga, play hopscotch, jump rope and more. The idea was to help residents get up off the couch and become more physically active.

But even though San Francisco is known for its forward-thinking ethos, Newsome readily admitted that the Sunday Streets program was an imported idea. He brought it back from the yearly World Economic Forum meeting in Davos, Switzerland, where then-London Mayor Ken Livingstone sang the praises of the ciclovia concept that had been pioneered in Latin America. The ciclovia, or “bike path,” program was pioneered in Bogotá, Colombia, in the 1970s, and it has swelled dramatically since then. It has become so popular that some two million people now take to the city’s blocked-off streets on Sundays and holidays. Over the years the idea has been adopted and has taken off in places such as Lima, Mexico City and as far away as Winnipeg and Brussels.

The ciclovia shows that a good idea can really set the wheels in motion toward well-being. That is the guiding concept that lies at the heart of a key recom-
“The ciclovia, or “bike path” program, was pioneered in Bogotá, Colombia in the 1970s, and it has swelled dramatically since then.”
mendation by the U.S. Institute of Medicine’s 2010 consensus report on cardiovascular health: the need for countries to share information about interventions and innovations that most effectively lower the prevalence of hypertension, obesity, heart disease, diabetes and related ailments. It’s an approach that works especially well when knowledge is shared among places with similar resources and similar characteristics. For urban cities in a range of countries, the ciclovia concept was an inspiration. For more rural environments or cities with different cultural lifestyles, a different approach might emerge as the spark that works and can be shared.

THE NEED FOR SOLUTIONS

It’s clear that new solutions are needed. The global obesity epidemic continues to spread, placing an ever-increasing number of people in poor countries at risk of both diabetes and heart attack. From 1980 to 2008, the number of overweight or obese individuals in developing countries has nearly quadrupled, mushrooming from 250 million to 904 million.

With an estimated 44 million toddlers under the age of five overweight in 2012 and more than 10 percent of 13- to 15-year-olds in low-income countries using tobacco, the risk of developing cardiovascular disease (CVD) is beginning earlier for many people. It is becoming mandatory to intervene as early as during pregnancy and early childhood, and to continue prevention efforts throughout life.

Reversing the trend of rising global obesity—and the skyrocketing incidence of cardiovascular and other diseases—will require everything from local interventions to regional and global approaches.

GLOBAL MILESTONES

Last year, the world reached two significant milestones in the global response to the massive and growing problem of chronic disease. On May 27, 2013, ministers from 194 World Health Organization (WHO) member states adopted the Global Action Plan for the Prevention and Control of NCDs 2013–2020 at the 66th World Health Assembly. Two months later, the United Nations Economic and Social Council adopted a resolution requesting that the U.N. secretary general establish an Interagency Task Force on the Prevention and Control of NCDs.

The task force, convened and led by WHO, would help coordinate U.N. organization activities to implement the initiative. The action plan outlined nine voluntary global targets to lower the incidence of cardiovascular disease, cancer, diabetes and chronic respiratory diseases—and lower the rate of the premature deaths they cause by 25 percent within 12 years.

The plan also provided a concrete menu of policy options to reach these targets. To do so, cardiovascular and related diseases need greater prominence on national agendas and will require collaborations between WHO member states, U.N. organizations, government agencies, nonprofits and patient advocates, among others. For example, the plan recommends that member states legislate for 100 percent smoke-free environments in offices, restaurants, on public transportation and other indoor environments. Policy makers looking for a legal precedence for this type of measure, it notes, can find support in the WHO Framework Convention on Tobacco Control, specifically Article 8, which guarantees protection from exposure to tobacco smoke. It’s worth noting that smoking can double or triple the risk of death from coronary heart disease.

As requested by heads of state in the U.N., political declaration, WHO is also taking steps to establish a mechanism to facilitate implementation of the global NCD action plan. The purpose of this mechanism is to facilitate and enhance coordination of activities, multistakeholder engagement and action across sectors at the local, national, regional and international levels in order to contribute to the implementation of the initiative.

Meanwhile, WHO has also rallied industry cooperation to support national action, for example to promote healthy diets and to prevent obesity. The International Food and Beverage Alliance (IFBA), which includes members such as The Coca-Cola Co., General Mills and Unilever, along with certain other global private sector entities, were given an opportunity to discuss the action plan. The IFBA had previously committed to listing clear and fact-based nutritional information on its prod-
ucts, and members agreed to reformulate products to help improve diets. These promises have just begun to show some results, including Unilever’s global reduction of sodium content across its product platform.

**HEALTH IS LOCAL**

Former U.S. Speaker of the House Tip O’Neill famously said that “all politics is local,” but all health is local as well. Global cooperation alone won’t stem the rising tide of cardiovascular disease. It’s as important to expand regional mechanisms for reporting on CVD disease trends, to disseminate information on how to make successful intervention approaches work in different local environments and to capitalize on regional programs.

**MAKING IT EASIER TO SHARE SOLUTIONS**

Prior to creation of the Global Action Plan 2013–2020, WHO identified a core set of cost-effective preventive and curative interventions that are feasible for implementation even in “resource constrained” settings. In 2010 WHO also developed the Package of Essential Noncommunicable Disease Interventions (WHO PEN), a resource that is chock-full of details on how doctors working in developing countries might treat cardiovascular disease and other chronic illnesses in primary care facilities. The WHO PEN report notes that, “Selecting the appropriate mix of the most cost-effective technological applications is particularly challenging when investment in health is small and inadequate as is the case in many low-resource settings.”

WHO PEN offers basic information on affordable drug treatment to prevent heart attacks and strokes (including antihypertensive drugs for patients with blood pressure readings higher than 160/100 and statins to lower cholesterol in people at high risk). It also lists the equipment that primary care facilities need to have on hand: blood glucose test strips for diabetes monitoring, blood pressure cuffs and other basics that are often lacking, such as scales and stethoscopes. When resources permit, it advises stocking items such as nebulizers, blood cholesterol assays and defibrillators.

One of WHO’s core functions is providing resources that provide health care guidance that meets global, regional and country-level needs—in a range of formats and languages. Many developing countries lack key information on NCDs, despite the need to exchange data, experiences and hard-won solutions across borders. Relevant knowledge may exist unused, may not be stored in acceptable formats—or additional research may be required to generate and harness that knowledge.

To address this problem, WHO offers electronic library services, provides document repositories, statistical databases, global status reports and more—all to help promote shared information on the fight against global killers such as heart disease.

CARICOM leaders signed a declaration in 2007 that outlined measures to improve heart health. That included promoting a healthier diet with lower fat content and less added sugar—because fast food has become the world’s diet.
attacking and stroke. For example, its cardiovascular disease Web site portal contains a wide array of publications that include a 2013 global brief on hypertension, a 2010 global status report on noncommunicable diseases, a global atlas on cardiovascular disease and implementation tools for WHO PEN including cardiovascular disease risk prediction charts. A Web portal devoted to noncommunicable diseases and risk factors points to fact sheets on tobacco, diet, alcohol and recommended physical activity for different age groups. WHO Web sites provide multilingual access for millions of users worldwide. In addition, WHO’s global status report 2014 will be published later this year to provide new data on communicable diseases as well as practical guidance on how to implement and scale up affordable interventions.

These tools provide a treasure trove for all those who play a role in prevention and control of noncommunicable diseases: national policy makers, professional organizations, health professionals, the academic and research communities, nonprofit organizations and the general public, among others. The goal is to provide equitable access to knowledge and innovations.

THE BIRTH OF CARMEN

For more than a decade, countries in the Americas have shared strategies for fighting diseases such as obesity and hypertension through the CARMEN Initiative (a Spanish acronym meaning an Initiative for Integrated Noncommunicable Disease Prevention in the Americas). It’s grown from three founding members in 1996 into a network of the entire region’s ministries of health as well as vital players from universities, nonprofit organizations and others.

The CARMEN initiative was launched by the world’s oldest international public health agency, the Pan American Health Organization (PAHO), which was founded in 1902. Part of its current mission is to collect, analyze and distribute information as well as share knowledge about the chronic disease problem and successful strategies for creating, executing and evaluating policies and programs that address it. PAHO serves as the network’s secretariat, and operates a Listserv to disseminate updates to members. The CARMEN “Policy Observatory”—a platform for countries and institutions to share information—emerged as a useful forum for the spread of proven health policies.

The CARMEN network forms the core of the Pan American Forum for Action on NCDs. The forum’s first meeting took place in Brasilia, Brazil, in May 2012 with 260 participants, including government officials from all 36 PAHO member countries and representatives from 24 companies. Last year, the forum helped convene a “Salt Smart Consortium” meeting, a group that raises awareness about the health impacts of high salt intake and tries to align targets and timelines for salt reduction across the region.

LOCAL GOVERNMENTS CAN TAKE COLLECTIVE ACTION

Another way to share what works among places with similar needs and resources is to come together for collective action. For example, Caribbean countries were the first to eliminate measles, thanks in part to local governments coordinating unprecedented mass vaccinations in 1988 when members of the Caribbean Community and Common Market (CARICOM) pledged to eliminate the virus from the region. May 1991 became “Measles Immunization Month,” with the goal of immunizing every child—from nine-month-old infants to 15-year-olds—in 18 countries, nearly 1.8 million children. This joint action was made possible, in part, by existing ties between health ministries in nations such as Antigua, Jamaica and Barbados.

Although measles may not have much in common with heart disease, the underlying idea is that nations within the same region can jointly tackle tough health challenges. English-speaking Caribbean countries are hardest hit by the epidemic of cardiovascular and other noncommunicable diseases of any of the countries in the Americas. The figures are striking: In Trinidad and Tobago, the rate of death from diabetes is 600 percent higher and from cardiovascular disease 84 percent higher than it is in North America.

Faced with these realities, CARICOM leaders came together to take collective action against these diseases. They signed a declaration at a 2007 summit in Port of Spain that outlined measures to improve heart health—from promoting an improved diet and reducing tobacco use to heightened physical education requirements in schools
More than 10 percent of 13- to 15-year-olds in developing countries are using tobacco in some form.

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