Heart Disease and Stroke in Canadian Women: Policy Development

*Ronald C. Plotnikoff, PhD,¹ Kylie Hugo, MEd,¹
Andy Wielgosz, MD, PhD,² Elinor Wilson, PhD,³ Doug MacQuarrie, MEd³*

Cardiovascular diseases* (CVD) continue to be the leading cause of mortality for both Canadian women and men.¹ The health problem for women is particularly pronounced when it is considered that 39% of all deaths in Canadian women are CVD-related, compared to 36% in men.² Heart disease and stroke, two major components of CVD, rank first and second respectively for all-cause mortality in Canadian women by specific disease.¹ The rate of death from heart disease and stroke increases significantly after menopause, placing senior women (particularly those aged 75 years and older) at greater risk.¹ This health burden is expected to magnify as the proportion of senior women in the population increases. Further, the notable increase in smoking by young women may also contribute to an increased health burden in the future. Finally, compared to men with heart disease and their contemporaries without the disease, women with heart disease report more pain, chronic conditions and activity restriction.³

In 1992, the Victoria Declaration⁴ recommended:

1. Health promotion programs dealing with the prevention of CVD address

the risk reduction needs of both women and men; and,

2. Public health and clinical guidelines to identify and manage women at high risk for CVD recognize the risk factors and clusters of risk factors that particularly affect women.

In response to this health problem and its commitment to the Victoria Declaration, the Heart and Stroke Foundation of Canada formed an expert working panel with the purpose of developing a discussion document⁵ with specific recommendations for Canadian stakeholders.

METHODS

First, a comprehensive literature review on heart disease and stroke in Canadian women was conducted addressing: mortality rates, burden of disability, risk factor profiles, social changes affecting women's heart health, behavioural issues, and medical issues (i.e., diagnosis and treatment, and prognosis).⁶ Data sources included monographs, technical reports and computer databases of published literature for the past 30 years (i.e., MEDLINE, HEALTH, CINAHL, PsychINFO, SOCIOFIL, ERIC). Second, a modified delphi technique (two iterations) was employed to solicit pertinent Canadian stakeholders (N=20) from government (i.e., Health Canada), research/academic institutions and the provincial Heart and Stroke Foundation groups for their: a) qualitative feedback on the thoroughness of the literature review; and b), suggested policy recommendations based upon the current literature. The expert working group finalized the document and recommendations.⁵

RESULTS

From the process described above, consensus was reached and recommendations were made towards policy on CVD in Canadian women. For prevention and treatment, multiple intervention strategies within and between the various intervention levels must be undertaken, using existing infrastructures and the specialized roles of different community organizations and government. These strategies must be integrated, and should be monitored to assess appropriate outcomes of individual change (i.e., cognitive and behavioural) and supportive environmental change (i.e., change of the social, organizational, community and political contexts).^{5,6}

In research, further studies on medical issues concerning Canadian women's heart health need to be conducted to have reliable data for clinical decision making and public health recommendations. Collaborative inter-disciplinary research and national databases should be designed to investigate and monitor the efficacy of medical management issues related to the diagnosis, treatment and prognosis of heart disease and stroke in Canadian women. As well as leading directly to health outcomes, the resulting information could provide – in conjunction with the Canadian Framework Policy on surveillance of mortality and risk factors for CVD – a continuous, structured knowledge base to guide efforts in heart disease and stroke prevention and treatment for Canadian women.^{5,6}

The following recommendations were proposed and disseminated to health professionals as future directions to reduce CVD in Canadian women:⁵

1. More attention must be paid to the significant burden borne by women,

1. University of Alberta

2. University of Ottawa

3. Heart and Stroke Foundation of Canada

Correspondence and reprint requests: Ron Plotnikoff, PhD, Assistant Professor, Centre for Health Promotion Studies, University of Alberta, 5-10A University Extension Centre, 8303 - 112 Street, Edmonton, AB T6G 2T4, Tel: 780-492-4372, Fax: 780-492-9579, E-mail: ron.plotnikoff@ualberta.ca

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* CVD represents all diseases of the circulatory system classified according to ICD-9 390-459, including acute myocardial infarction, ischemic heart disease, valvular heart disease, peripheral vascular disease, arrhythmias, high blood pressure and stroke.

- especially the elderly, due to morbidity and mortality from heart disease.
2. Special attention must be focussed on the prevention and treatment of heart disease and stroke in women as they enter their menopausal and post-menopausal years. Women should make more informed decisions about the use of HRT based on the best evidence available.
 3. Policies, practices, resources and support should be targeted to include marginalized groups of women, where the burden of heart disease is disproportionately high. Due consideration must be given to age, income, educational, professional and cultural diversity.
 4. Issues particular to women's CVD health should receive increased attention in medical and health professional curricula and continuing education programs.
 5. Resources and services to support women's CVD health must be easily accessible and reflect women's preferences related to delivery systems and health care providers.
 6. Initiatives should be developed and supported to enhance positive self-esteem, self-concept, and self-efficacy in women, especially young women, as a foundation for heart health behaviours throughout their lives.
 7. Resources must be directed towards programs, legislation and research designed to prevent and eliminate tobacco use among young women.
 8. Physical activity for young women must be encouraged both through quality daily physical education and equal access to resources and facilities for recreation and sport.
 9. Since women often make food choices for the family unit and can be advocates for healthy eating, approaches must be developed to assist with food selection and preparation.
 10. Strategies should be designed to promote accessibility to and use of cardiac rehabilitation programs for women.
 11. Research funding should be made available to address gaps in knowledge regarding women, heart disease and stroke commensurate with the significance of the issue.
 12. Women must be included appropriately in all heart and stroke research studies; any exclusion of women must be justified.
 13. A comprehensive school health approach should be promoted and adopted throughout the school system.

CONCLUSIONS

It is hoped that government agencies, researchers and practitioners follow these recommendations with the goal of improving heart health for women.

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