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Experts call for urgent action to reduce global burden of cardiovascular disease in women by 2030 – The Lancet

In the first-ever global report on cardiovascular disease (CVD) in women, researchers call for urgent action to improve care and prevention, fill knowledge gaps, and increase awareness to tackle the worldwide leading cause of death among women.

The Lancet Women and Cardiovascular Disease Commission: reducing the global burden by 2030 is authored by an all-female team of 17 leading experts from 11 countries including the University of Cape Town (UCT)'s Professor Liesl Zühlke of the Red Cross Children's and Groote Schuur hospitals, the only African among the commissioners.

The commission aims to help reduce the global burden of cardiovascular conditions – including heart disease and stroke – that account for 35% of deaths in women worldwide by 2030.

The authors have outlined 10 ambitious recommendations to tackle inequities in diagnosis, treatment, and prevention to reduce CVD in women, including educating health care providers and patients on early detection to prevent heart disease in women; scaling up heart health programs in highly populated and underdeveloped regions; and prioritising sex-specific research on heart disease in women and intervention strategies.

In 2019, there were approximately 275 million women around the world with CVD, with the leading cause of death from CVD worldwide that year being ischemic heart disease (47% of CVD deaths), followed by stroke (36% of CVD deaths). While the prevalence of CVD in women globally has been declining, some of the world's most populous nations have seen an increase, including China (10% increase), Indonesia (7%), and India (3%).

High blood pressure is the greatest risk factor contributing to years of lost life from CVD in women, followed by high body mass index and high low-density lipoprotein (LDL), sometimes called "bad" cholesterol. While these well-established risk factors might affect women differently than men, there are sex-specific risk factors such as premature menopause and pregnancy related-disorders that must be more widely recognised and prioritised as part of treatment and prevention efforts worldwide.

The commissioners highlight a number of under-recognised CVD risk factors that also require attention. These include social factors – such as unemployment – linked to anxiety and depression, and disparities based on socioeconomic and cultural status, race, and poverty.

Among their recommendations are a greater focus on mental health in clinical practice, and targeted policy work to support low socioeconomic status populations in developed and emerging countries.

Professor Bairey Merz, of the Cedars-Sinai Medical Center, USA, says: "While some risk factors for CVD are similar for women and men, women are more likely to suffer from health disparities due to cultural, political or socioeconomic factors. For instance, some social or religious norms – such as restrictions on participation in sport and physical activities – can contribute to CVD in women, highlighting an urgent need for culturally appropriate initiatives that are tailored to different regions and populations."

Interventions to reduce CVD should be tailored for the most vulnerable populations globally, including women from minority or indigenous populations and those whose roles in society are strongly defined by traditional or religious norms. However, it is also important to reach groups not typically viewed as being at high risk, such as young women – a group in which heart attacks and smoking rates are increasing.

Despite a vital need for knowledge about sex-related differences in optimal treatment and improved outcomes in patients of both sexes, women have long been under-represented in CVD clinical trials. The commissioners recommend a number of strategies to include more women, including addressing barriers to participation – such as family care issues – adopting more inclusive enrolment criteria, and educating recruitment staff on the importance of involving women in trials.

Professor Zühlke says: "The momentum to strive for equity and equality more broadly for women socially and culturally translates to an extraordinary time to channel that same energy into improving women's health. Being the leading killer of women globally, CVD must take precedence for our attention and action. This commission's work is both a starting point and a call to action to mobilise and energise health care professionals, policymakers – and women themselves – to work toward a healthier future."

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Note to editors

The commissioners acknowledge some limitations to their report. As this was a report aiming to capture sex-related differences in cardiovascular disease, and not a systematic review, a bias towards highlighting evidence for sex-related disparities over neutral findings cannot be excluded. There was only limited assessment of the important distinction between sex and gender in the report, in part because the terms are often used interchangeably in the literature. The limited availability of quality data on transgender women also meant the commission was unable to investigate cardiovascular health for this group. Overall evidence presented in the report may be dominated by data from white women and developed countries, reflecting the current availability of more robust data from these populations and regions. More research to explore all these factors is needed.

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