Recently constructed, state-of-the-art cardiovascular research facilities of the National Centre for Cardiovascular Diseases

National Center for Cardiovascular Diseases, affiliated with Fuwai Hospital, located just outside Beijing.

the-art research facilities of Fuwai Hospital and the NCCD, and with full support from their visionary director Professor Hu, this young group's scientific efforts are likely to shed more light into various unresolved issues related to this challenging heart disease. Moreover, the group members have research ambitions to cover all cardiomyopathies and ultimately provide better health care solutions for these patients and their relatives at risk. To this end, they intend to launch a nationwide screening program for cardiomyopathies and establish a comprehensive Chinese database, incorporating detailed clinical and pathological records, imaging data, genetic information, and a large-scale biobank in the near future.

'Learning is a treasure that will follow its owner everywhere', says a Chinese proverb. The young clinicians and researchers at Fuwai Hospital are putting tremendous effort to get more in-depth knowledge and experience in their fields of research. Without any doubt, their scientific work will follow them as a treasure and help them and others to understand mechanisms of cardiovascular diseases and improve management strategies.

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An African cardiology summit

The World Heart Federation African Summit on Best Practices in Policy and Access to Care in 2017 concluded with the Khartoum Action Plan, to improve cardiovascular on the African continent

The World Heart Federation (WHF) is the umbrella organization of continental and national cardiac societies and heart foundations globally, reporting to the World Health Organization (WHO). The WHF is dedicated to the global fight against CVD, including heart disease, stroke, and rheumatic heart disease (RHD). Building on the first Global Summit on Circulatory Health, held at the 2016 World Congress of Cardiology and Cardiovascular Health in Mexico City, the second Summit held in Singapore July 2017 focused on building a civil society movement for circulatory health.

The WHF African Summit took place in Khartoum, Sudan on the 10–11 October 2017. The Summit was held in conjunction with the Sudan Heart Society Annual Congress, The Pan African Society of Cardiology (PASCAR), and the African Heart Network (AHN). The Summit included more than 100 participants from Africa, Europe, Canada, and Asia among other areas, with active involvement from the members of the PASCAR, Sudanese and many other African Cardiac Societies, European Society of Cardiology, International Hypertension Society, AHN, and other non-governmental groups.

WHO Sudan representative

Representatives of WHO AFRO and WHO Sudan gave lectures and contributed to the discussions. Themes of policy implementation, access to essential medicine, and integrative care in Africa were extensively discussed.

The first workshop on *Policy Implementation* was opened by Prof Karen Sliwa, President-Elect of the WHF, and summarized the objectives of the Summit- speaking with one voice reducing 25% premature cardiovascular mortality by 2025- is that achievable for Africa? She provided data showing that in many regions of Africa the risk for cardiovascular disease has substantially increased and is predominately driven by markedly increased rates in

Sudanese Cardiac Society and PASCAR delegates

hypertension, smoking, and obesity, due to the adoption of a western lifestyle.

The number of people living with historically prevalent forms of diseases such as RHD is still high. The prevalence in populous African countries such as Nigeria, Ghana, and South Africa are 360, 415 and 220 per 100 000 people.[1] Most of them have no adequate access to health care which includes implementation of rheumatic fever prophylaxis.

Prof Bongani Mayosi, past-president of PASCAR presented data showing that through comprehensive strategies taken in different countries such as Tunisia, Morocco, Costa Rica, Cuba, and New Zealand the number of new cases of rheumatic fever have been substantially reduced.

An action plan for the control of RHD in Africa named the 'ASAP Programme' has been developed and contains four focus areas: Awareness raising, Surveillance, Advocacy, Prevention (ASAP).

On 1 June 2017, the WHO Executive Board recommended a Resolution on 'Rheumatic Fever and Rheumatic Heart Disease' for adoption at the World Health Assembly in May 2018. This resolution will become the first global policy on RHD endorsed by all governments to eliminate acute rheumatic fever and RHD. Civil societies need to work closely with governments to make RHD elimination a reality.

Dr Jean-Marie Dangou, WHO AFRO Regional Advisor summarized recent activities of the WHO and the challenges faced due to the heterogeneous access to care in Africa.

Prof Gerald Yonga, President of East African non-communicable disease (NCD) Alliance and Board member of Global NCD Alliance, showed data that tobacco use is growing in Africa due to aggressive marketing of the tobacco industry. Prevalence amongst adult males is 21% (94 M) while in women it is 3% (13 M), and in youths 18% (21% boys; 13% girls). Half of the adolescents (48%) are exposed to second-hand smoke. He emphasised that more evidence and data are needed for governments to create policies to take action. Factors such as media advertising and unit sales of cigarettes should not exist, while warning messages, higher taxation benefitting the health sector and more information on the negative effects of tobacco use should be promoted. He recommended that ministries and governments need to be aligned and cooperate regionally to create policies that will impact at a national level.

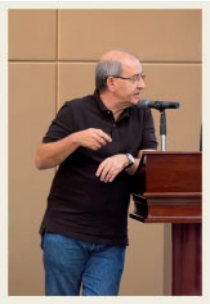
Dr Habib Gamra, President of The AHN highlighted that assessment of health care centres in Africa has proven that the level of primary health care in most of the countries of the region is inadequate, especially those with a low Gross Domestic Product. According to the research and programmes available, awareness and education of the population and governments, and government commitment to implement comprehensive programs is crucial if there is to be any form of effective policy implementation.

This session was followed by active discussions led by Prof David Wood, President of the WHF, Prof Amam Mbakwem, President of the Nigeria Cardiac Society and Prof Ana Mocumbi, Mozambique which continued over dinner with all the stakeholders present. It was concluded that the only way the WHO 25 × 25 target can be achieved is through a multi-sector approach urging leaders and regional stakeholders through advocacy to partner with organizations such as the WHF in conjunction with continental societies such as the European Society of Cardiology (represented at this meeting by Prof Fausto Pinto) and the PASCAR to commit to solutions, disseminate innovation, make substantial investment, and take actions.

On Wednesday 11 October, the workshop focused on *Access to Essential Cardiovascular Medicine and Integrative Care*- what can we learn from each other in Africa and globally?

This session was opened by presentations from Prof Salim Yusuf, Past-President of the WHF on what is essential care globally and

Prof Albertino Damasceno, Head of Cardiology Eduardo Modlane University, Maputo, Mozambique, providing an African perspective. Currently, African countries are 80% below the global average for



pharmaceutical spending and 20% below the global average on behavioural risk factors for hypertension. Managing hypertension is challenging in Africa due to the lack of drugs, high treatment costs, and inadequacy of health services for identification and management of CVD. Additionally, health systems in most low- to middle-income countries (LMICs) are already stretched by the high burden of infectious diseases (HIV, TB, and malaria).

Dr Ahmed Suliman, interventional cardiologist in Khartoum, Sudan, provided a local perspective. CVD has always been in the top 10 causes of in-hospital mortality in Sudan and primary health care is being given emphasis. Blood pressure, blood sugar, and urine tests are performed and benzathine penicillin for prevention of RHD is part of the primary care program. Tertiary care, mostly centred in the capital, is a co-payment system equally, between the patient and government for those with private insurance, although it is inefficient for urgent interventions due to logistical delays. Health care delivery is 70% private and 30% by the national health insurance.

Prof Ibrahim Toure, Niger, stressed the very poor health care facilities in his country. Many primary care clinics are not well prepared to implement the guidelines for accurate diagnosis and management of hypertension and other cardiovascular risk factors. Screening for blood pressure and diabetes is far below prevalence at the national level and basic equipment and quality essential medicines are inaccessible.

Prof Neil Poulter, President of the International Hypertension Society, showed early data of a global program on hypertension detection. Optimal CVD prevention consists of preventing its development, thus, awareness is key—without it, hypertension will not be treated and much less controlled, which is what is happening in LMICs. Simple measures beginning with screening and detection is the key to success. The CVD Roadmap of the WHF for hypertension has been adapted to the African region to achieve 25% control by 2025.

The Summit participants concluded after the presentations that it is necessary for governments to interact with academic and other health care providers thinking long-term to improve public sector provision of care, increase health insurance coverage, and expand medical benefit policies in health insurance systems to increase access to essential CV quality medicines and care for everyone. It was concluded that care for infectious and NCDs need to be integrated into a joint system.

Dr Catriona Jennings, UK presented models of global nurse-led integrative care followed by examples of integrative care in Mozambique, by Prof Ana Mocumbi. Nurses and allied health professionals can contribute to prevention and control of CVD, especially in LMICs where care is not patient nor family centred and is delivered in siloes with a lack of access to essential CV medicines. Nurses are skilled in behavioural counselling and education, work closely together with physicians, are familiar with medicines and monitoring signs and symptoms, can be trained to follow care protocols, deliver multidisciplinary interventions and manage medications, and promote self-management and patient and family centred care. Task shifting among different health care professionals to reduce the burden of heart failure has been crucial in Mozambique.

Dr Sulafa Ali, Sudan presented the initiative Surveillance, Integration, Collaboration, Awareness, Advocacy, Training (SUR I CAAN) that has been implemented to treat RHD. This has been an interaction with WHO Sudan such as funding of medical assistants and mapping the disease with echo screenings.

Important remarks included that whatever the priorities for the Action Plan, it is necessary to effectively collaborate with government and decision-makers to create and drive the change we are looking for in the African region. It is crucial to engage all stake-holders, both state and non-state actors (and from both health and non-health sectors) in the CV health movement, from patients and communities to health care providers and policy makers.

Karen Sliwa, David Wood, Ahmed Suliman, Gerald Yonga, Jean-Luc Eisele, Pilar Millan, George Nel, Saad Subhai

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Reference

1. Watkins DA, Johnson CO, Colquhoun SM, Karthikeyan G, Beaton A, Bukhman G, Forouzanfar MH, Longenecker CT, Mayosi BM, Mensah GA, Nascimento BR, Ribeiro ALP, Sable CA, Steer AC, Naghavi M, Mokdad AH, Murray CJL, Vos T, Carapetis JR, Roth GA. Global, regional, and national Burden of rheumatic heart disease, 1990-2015. *N Engl J Med* 2017;**377**:713–722.

Conclusions for the Khartoum Action Plan

The following were clear conclusions for crucial actions that need to be taken to improve CV health and care in Africa:

(1) *Data collection* (via simple surveys and scorecards) on CVD burden for policy advocacy should be obligatory.
(2) Promote legislation that support *task sharing/shifting* and knowledge sharing for integrated care. There is a need to work together for improved training and collaboration, remove barriers for non-physicians and to break down silos in health care delivery.
(3) Improve *access to essential medicines* and technologies for NCDs and improve the *quality of generic medicines*.
    i. Set up standards for generics and create a Federal Drug Administration (FDA)- type organization for Africa where there would be strict supervision of registration process and quality control by a multi-disciplinary team.
    ii. Role of Polypill approach in Africa could be explored further
(4) Empower *patients* and work with/support patient groups, allow them to have a voice such as the treatment action campaigns for HIV.
(5) Advocate for enactment and effective implementation of policies that support bans on tobacco products and unhealthy foods, control alcohol consumption and support increased physical activity. Promote multi-disciplinary engagements to integrate policies with aim on policy coherence for NCDs, engage better with governments and their development partners.
    Work with national health programs, launch new ones, invite governments to open symposiums, connect with Ministry of Health (MoH) officials that understand the importance of health, support WHO with their strategies and by providing more evidence for NCD policies and actions.
(6) Provide adequate and continued *training* of health care providers at all levels. Medical education should study the problems and priorities of communities and focus education on these, and training should include data collection.
(7) Strengthen *primary health care*, integrate NCDs into national health care plans and provide Universal Healthcare Coverage (UHC) with sustainable healthcare financing plans.
(8) Focus on *RHD* to eliminate it—enforce surveillance, diagnosis, availability of penicillin, and improved access to reproductive health. Learn from the examples of successful countries.
(9) Focus on *population hypertension control programmes at community (prevention) and primary facility levels (treatment and control)*.
(10) Elaborate *tobacco* control programmes with education of the population on adverse effects on health and support smoking cessation programmes.

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