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Return to [The Canadian Heart Health initiative](#) | [Main Page](#)

The Canadian Heart Health Initiative

A Policy in
Action

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THE CANADIAN HEART HEALTH INITIATIVE

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Table of Contents

The policy framework	3
Issues and goals	4
The strategies	6
 A blueprint for action	 10
Building databases	10
Provincial demonstration programs	13
 Making it work	 15
Collaboration is key	15
The international connection	17
The federal role	18
 Horizons	 19

The policy framework

The origins of Canada's approach to cardiovascular disease (CVD) prevention lie in the report entitled *Promoting Heart Health in Canada*. It was prepared by a special Working Group that was charged with reviewing the main issues in CVD

prevention and proposing goals and approaches to the development of prevention programs in this country.

In its introduction, the report noted that two of the health challenges identified in the federal government's 1986 discussion paper, *Achieving Health for All: A Framework for Health Promotion*, were of particular relevance to heart health: chronic disease prevention and the reduction of health inequities. *Achieving Health for All* had raised expectations for federal action through three strategies: coordinating healthy public policy, strengthening community health services and fostering public participation. "An effective national approach to cardiovascular disease prevention would be a major contribution in meeting these challenges and expectations," stated the report, concluding that the *Achieving Health for All* framework "would provide the necessary context for community programs of cardiovascular disease prevention to operate successfully and would bring Canada a step closer to the goal of 'Health for All by the Year 2000'."

Promoting Heart Health in Canada recommended "an integrated multifactorial approach" to the issue, one that would address the major risk factors that were preventable or controllable (namely, elevated blood cholesterol, smoking and high blood pressure). Noting the influence of the social, economic and cultural environments on people's behaviour, the report recommended that Canada's efforts in heart health should be directed primarily at the general population and should concentrate on achieving environmental changes supportive of "heart-healthy" habits and lifestyles.

It has been said that *Achieving Health for All* and the 1986 *Ottawa Charter for Health Promotion* paved the way for a renewal of public health in Canada. In its report, the Working Group recommended the adoption of a comprehensive heart health strategy based on a "public health approach." This approach was characterized as follows:

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- ◇ it targets *both* the population as a whole *and* those who are at high risk or already ill;
 - ◇ it seeks to bring about the kinds of environmental changes that will make it easier for people to make healthy choices;
 - ◇ it ensures that people have access to both appropriate health services and relevant community agencies and organizations, thus enabling those who are at risk or who already have heart disease to be identified early and helped to manage their condition; and
 - ◇ it requires the coordination of public, private and voluntary sector activities and policies.

Understood in their broadest sense, public health measures include public policies that address the root causes of poor health — for example, poverty, illiteracy and lack of social support. By acknowledging the need for action both within and outside of the health system, the Working Group was endorsing a fundamental principle of health promotion.

In 1988, about a year after the release of *Promoting Heart Health in Canada*, the public health approach was formally adopted as the cornerstone of the Canadian Heart Health Initiative and of the policies that would guide it. This move followed an extensive consultation process involving Canada's 10 provinces and two territories, as well as numerous voluntary, professional and community organizations across the country. The consultation demonstrated that there was broad national consensus on the cardiovascular disease prevention issues facing Canada, as well as on goals and strategies for the Heart Health Initiative. It also served to identify appropriate areas for joint federal-provincial action.

Issues and goals

The six main issues (and their related goals) spelled out in the 1987 report helped give direction to the country-wide consultation process, and provided a sound rationale for the development of Heart Health Initiative strategies and activities.

The issues were: quality of life and the social impact of cardiovascular disease; the widespread prevalence of risk factors; the early onset of these risk factors; the importance of diet; socio-economic and regional differences; and individuals at high risk.

The report's approach was to analyze each issue in terms of opportunities for prevention (as supported by the existing science base) and then to propose a broad goal addressing the issue. The following is a summary of the main cardiovascular disease prevention issues facing Canada and the goals associated with each, goals that now drive the Canadian Heart Health Initiative.

Quality of life and social impacts

Cardiovascular disease is the main cause of mortality in Canada, currently accounting for 43 per cent of all deaths. In the prime age group at risk — Canadians aged 35 to 64 years — the annual toll from heart disease and stroke is in excess of 10 000. Moreover, even though medical advances have improved the short-term survival chances of heart attack victims who reach hospital, mortality among this group remains high (about five per cent per year). Disability is a common result of cardiovascular disease, and the effect of this on both victims and their families can be profound. In economic terms, the costs are also high — cardiovascular disease is a major cause of hospital stays in Canada, and treatment approaches are increasingly calling for the use of expensive high technology.

All in all, a prevention approach appears to offer the best hope of improving the quality of life of the millions of Canadians affected by cardiovascular disease. In estimating the potential value of such an approach, it is instructive to consider Canada's mortality rates relative to those of other countries. If Canada's rates of ischemic heart disease equalled those in Japan, Canadian deaths from this cause would plunge by 80 per cent!

Based on existing knowledge concerning heart disease in Canada, the Working Group proposed the following overall objective :

To reduce Canada's rate of morbidity, disability and premature mortality due to cardiovascular disease.

Widespread prevalence of risk factors

Heart health surveys carried out in Canada's 10 provinces show that over two out of three adult Canadians have one or more of the primary risk factors for cardiovascular disease (that is, they either smoke or have high blood pressure, elevated blood cholesterol or some combination of these). What is encouraging, however, is that unlike other risk factors — such as age, family history and male sex — these major risk factors are all either preventable or controllable.

The goal?

To enable Canadians to improve their cardiovascular health by controlling/reducing their risk levels, and to improve the environments in which they live and work — namely, their communities.

Early onset of risk factors

Elevated blood pressure, elevated blood lipids and obesity in childhood and adolescence are conditions that tend to persist into adult life. Thus, today's young people with risk factors may be tomorrow's candidates for cardiovascular disease. When coupled with the finding that smoking frequently begins in childhood, this suggests that prevention efforts should commence early in life.

The goal?

For Canadian children and their families to adopt healthy patterns of eating and physical activity and to avoid smoking.

The importance of eating habits

Diet is the most modifiable of all the factors that influence a person's blood cholesterol level. In simple terms, a lower blood cholesterol level means a lower risk of heart attack. On average, Canadians eat 25 per cent more fat daily than is advised in the Nutrition Recommendations. Although it is true that public interest in nutrition is growing, there is still considerable consumer confusion as to what constitutes a healthy diet, since the media and other sources often seem to deliver mixed messages. The main challenge is to empower consumers by providing them with practical information on choosing a healthy diet. Barriers to healthy eating include the fact that the food choices available are not always conducive to a healthy diet, and that "healthier foods" — namely, low-fat and low-sodium products — are sometimes more expensive.

The goal?

For Canadians to have access to, and to be able to afford, a healthy diet.

Socio-economic and regional differences

Cardiovascular disease mortality rates are significantly higher among lower-income groups. This fits with the findings that, first, certain risk factors (for example, smoking and overweight) are more prevalent among people with lower education, and second, that knowledge and awareness levels of "heart-healthy" behaviours are lower in groups with lower socio-economic status.

The disparities do not end there. Marked differences have been found in cardiovascular mortality in various parts of Canada — for example, the rates in the Maritimes are significantly higher than those in the Western provinces. As well, variations have been found between communities within a given province and even between sub-groups within a given population.

The goal?

To reduce differences in cardiovascular health that result from socio-economic or regional disparities.

Individuals at high risk

A person's risk of developing cardiovascular disease has been shown to rise sharply when more than one risk factor is present — for example, the risk associated with having high blood cholesterol doubles if the individual concerned is also a smoker. If high blood pressure is present as well, the risk quadruples. Moreover, when there are minor elevations of several risk factors, the overall risk of cardiovascular disease rises significantly.

This is cause for concern, considering that about 15 per cent of Canadians (or one in approximately seven) have highly elevated levels of blood cholesterol, 18 per cent have elevated blood pressure, more than 25 per cent (or one in four) are smokers, and that diabetes — another important risk factor — affects well over five per cent (or one in 20) of Canada's adults. A staggering two out of three Canadians have one or more of these risk factors.

Prevention opportunities exist in various areas. For example, physicians working with individuals who exhibit one risk condition can use the opportunity to counsel them about other risk factors. A hypertensive smoker may thus be urged to

give up smoking. Again, the kinds of diet and exercise regimes that physicians prescribe for those with elevated blood cholesterol levels, diabetes, obesity and high blood pressure also benefit the general public. This means that heart health messages given to high-risk individuals can be reinforced by education and awareness programs targeted to the population as a whole.

The goal?

For individuals who are at high risk or have clinical symptoms of cardiovascular disease to be identified early for management and/or rehabilitation.

These, then, are the six broad goals to be addressed by the long-term Canadian Heart Health Initiative.

The strategies

Promoting Heart Health in Canada sets out a series of "strategic options" — avenues of action considered appropriate by the Working Group, given its recommendation that Canada should implement a comprehensive, integrated program to address the issue of heart health. The strategic options were intended to provide a basis for action by the numerous jurisdictions, voluntary agencies, professional organizations, researchers and private-sector interests taking part in the nation-wide policy consultation process. The report outlined specific roles these partners might play, and discussed levels of participation and the need for some commitment of resources. It also served as a stimulus for ideas and suggestions from the general public on appropriate prevention activities. What were, in 1987, "strategic options" have now been formally adopted as strategies by the Canadian Heart Health Initiative; as such, they have become guideposts for cardiovascular disease prevention activities across the country.

The strategies fall into six broad categories: public health system leadership; community programs; intersectoral coordination; appropriate health services; public education and information; and monitoring, evaluation and research.

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Public health system leadership

The Canadian Heart Health Initiative has been at pains to avoid creating any new or parallel structures or institutions. Instead it has recognized the value

and potential benefits of building on those already in existence. In a comprehensive undertaking of this kind, no institution is better placed than Canada's public health system to act as a catalyst, to provide the needed continuity, and to play a central role in coordinating the multiplicity of resources that must be mobilized at the community level. Acknowledging this, provincial/territorial departments of health across Canada have given their respective public health systems a clear mandate, backed by the necessary allocation of resources, to promote comprehensive prevention programs. The principal strategy used by public health departments to draw in concerned groups and organizations from government, private enterprise and the voluntary sector has been that of coalition-building. This strategy is discussed more fully in the section entitled "Making it work."

Community programs

In the final analysis, the community is where heart health strategies must have their impact. This means that community involvement and the mobilization of community resources are fundamental to the success of any local-level program, something that has been well documented in various countries. Here in Canada, a growing number of communities have launched heart health programs since the mid-1980s.

A partnership between Health and Welfare Canada, the provinces and the Heart and Stroke Foundation of Canada has helped to build an infrastructure for effective community programming across the country. It consists of two elements — heart health surveys and community-level heart health demonstration programs in all 10 provinces.

Many of the findings of the provincial heart health surveys have already been reported. They provide vital baseline data for effective planning and evaluation. For their part, the demonstration projects (still under way) are proving to be a valuable training ground for coalition-building, community action and the complex task of setting up integrated multifactorial programming in the community setting.

Clear goals for these demonstration projects have been articulated and a standard protocol will be used to evaluate each. The hope is that they will yield information and lessons that can be transferred to interested communities across the country.

Intersectoral coordination

Addressing the many determinants of cardiovascular disease risk factors/conditions means involving a wide range of interests and sectors. Take the example of nutrition. Helping consumers make healthy choices is not something that health educators, health professionals or, indeed, any one group, can do alone. There are other issues involved, including the supply of food, marketing, pricing and consumer demand.

The same thing applies where regulatory or legislative measures are needed to implement healthy public policies (those that create healthy environments and support healthy choices). Input from a wide range of players is necessary in such cases. Two examples come to mind. First, the development and implementation of nutrition labelling regulations (providing Canadian consumers with helpful quantitative information on nutrients) was an exercise that required collaboration between the health sector, the food industry, scientists and federal government departments. Second, the implementation of Canadian legislation to create smoke-free areas provided a model for coordinated action among federal and provincial government departments, voluntary agencies and professional associations.

Models of successful public-private sector include "Active Living," a Fitness Canada initiative, and ParticipACTION. Both are helping to promote the attainment of cardiovascular disease prevention goals.

Access to health services

This strategy is aimed at ensuring that high-risk individuals can have their condition detected as early as possible and be referred for appropriate counselling and treatment. It provides opportunities for collaboration between governments, professional associations and universities, both in the development of cardiovascular disease prevention and management guidelines and in the training of health professionals in the promotion of cardiovascular health.

It is not widely known that Canada has the highest percentage of family doctors among the industrialized countries. This, coupled with the fact that medical services are accessible to all Canadians and that most Canadians see their doctor at least once a year, provides an unprecedented prevention opportunity. The clinical setting of the family doctor is ideal for identifying individuals who are at risk and ensuring that they are appropriately counselled and followed up.

Considerable work has been done both here and abroad on making health services as sensitive as possible to the needs of communities, and there are many good models to show how health professionals and non-governmental organizations, researchers, volunteers and self-help groups can work collaboratively in this area.

Public education and information

This strategy is aimed at providing the Canadian public with a clear understanding of the multifactorial nature of cardiovascular disease and the consequent need for a comprehensive approach to heart health. The social marketing challenge is to do this in a positive and motivating manner — that is, by appealing to Canadians' tastes, their pocket books and their desire to enjoy the benefits of good health, rather than dwelling on the dangers of disease.

Public education programs have traditionally adopted a single-factor approach — for example, concentrating on smoking or high blood pressure. The Heart Health Initiative seeks to encourage the developers and organizers of such programs to deal — wherever feasible — with other risk factors as well. This might mean talking about smoking and weight control at the same time, or providing a greater number of general lifeskills programs.

With regard to the role of cholesterol as a risk factor, there is an ongoing need for authoritative information. While Health and Welfare Canada's *Guidelines for Healthy Eating* and the Canadian Dietetic Association's *Eat Well — Live Well* campaign go a long way towards reinforcing the importance of a healthy diet, these will need to be supported by appropriate public education programs if consumer confusion is to be cleared up.

Monitoring, evaluation and research

Without an adequate database, the design and evaluation of prevention programs can become a "hit-and-miss" affair. With vital baseline data it becomes possible to track mortality and morbidity, the prevalence of risk factors and the socio-economic and environmental conditions that give rise to them. Obtaining data at the national and provincial levels is one of the main strategies driving the Heart Health Initiative. The provincial risk factor survey findings provide a scientific basis for planning, while the effective "marketing" of the survey results has secured the required public and political support for heart health across Canada.

The "magic of data" has stimulated public action; in much the same way, the "magic of evaluation" will be the force that consolidates and diffuses the results of the Initiative in the future.

A blueprint for action

***P*ublic health system leadership ... coalition-and partnershipbuilding ... the development of a national database on cardiovascular disease risk factors ... the implementation, evaluation and diffusion of community-level demonstration programs in every Canadian province ... this is the blueprint for the Canadian**

approach to heart health. The corporation of the Canadian Heart Health Initiative are:

- ◇ to encourage the adoption of "heart-healthy" policies and programs by all levels of government, voluntary and professional organizations, and the private sector;
- ◇ to promote the development of programs and policies that take an integrated approach to preventing and controlling cardiovascular disease risk factors;
- ◇ to secure consensus on the nature of public health action to be taken, given that the scientific information base may be incomplete; and
- ◇ to set up coalitions among the many partners who can contribute to the effective implementation of an "integrated multifactorial approach" to heart health, and to develop mechanisms that facilitate further collaboration.

There are no short-term solutions to cardiovascular disease. International studies have shown that embarking on a prevention program requires a long-term perspective; ideally, such an initiative should be thought of in a 15-year time frame.

In the first phase of the Canadian Heart Health Initiative (1985-89), a master plan (or policy) was developed and several provinces carried out cardiovascular disease risk factor surveys. The second phase (1989-93) is currently under way. It will see the completion of the national database and the implementation by all provinces of their own heart health programming initiatives. The twin focus of the third phase (1993-2000) will be on evaluating heart health programs and ensuring that key findings are disseminated to communities across the country.

Building databases

From the outset, those involved in the Canadian Heart Health Initiative recognized the importance of having comprehensive epidemiological data to provide both a basis for rational goal-setting and a baseline for future program evaluation. They knew, too, that the activities surrounding the planning and implementation of a survey — not to mention the interest generated by its results — would help to get concerned community groups and members of the academic community involved in follow-up programs.

Risk factor surveys

In 1986, at the same time when *Promoting Heart Health in Canada* was being written, the province of Nova Scotia was embarking on a cardiovascular disease risk factor survey. The widespread prevalence of risk factors revealed in the survey when it was released in 1988 provided additional impetus for the Canadian Heart Health Initiative.

The Nova Scotia survey protocol — which was later to serve as a model for the other provincial surveys — was developed using a rigorous peer review process. Experts from fields relevant to cardiovascular disease prevention reviewed the draft protocol at an open "critique session" which was also attended by representatives from the various organizations and professional associations who were to be involved in implementing the Nova Scotia survey.

In addition to providing information on the prevalence of risk factors, the surveys carried out by Nova Scotia and the other provinces yielded data on people's awareness, knowledge, attitudes and behaviours concerning those risk factors. Each survey respondent was interviewed at home as well as making a clinic visit. Between 2000 and 2400 individuals (18 to 74 years of age) in every province participated and all samples were representative of the adult population in the province concerned.

***Canada's heart health database is a
key resource for research in
epidemiology, as well as in policy
development and program evaluation***

Public health nurses from the provincial departments of health administered the questionnaires, taking respondents' blood pressure and height and weight measurements, as well as a blood sample for lipid analysis. All were trained according to a common protocol. To ensure standardization according to the Lipid Clinics Research protocol (and thus permit interprovincial and international comparability) all the blood lipid analyses were carried out at J. Alick Little Lipid Research Laboratory, St. Michael's Hospital, University of Toronto.

Each province appointed a Data Interpretation Committee (DIC) to scrutinize its survey results. The process was as follows. The Principal Investigator (the leader of the provincial Heart Health Initiative) presented, in open session, the methodology, findings and public health implications of the survey. The Committee — consisting of a Chairperson and a panel of scientists (mostly from out of province) — were then invited to review the methodology as well as the validity of the interpretation.

This impartial review of the data provided the core "heart health group" in each province with an opportunity to begin marketing the issue and to commence the process of building partnerships with other concerned groups — in this case, with the representatives of various professional associations, voluntary organizations and the scientific disciplines who came to the data review sessions.

The development of their own risk factor databases signalled that the provinces were prepared to take a lead role in cardiovascular disease prevention and heart health promotion. The provincial departments of health assumed responsibility not only for the funding and conduct of the surveys, but also for making the required public health nursing staff available to do the work. In each province, the Principal Investigator acted as "broker" in the collaborative process and organized the implementation of the surveys.

Canadian Heart Health Database

All data gathered in the provincial heart health surveys are currently being compiled into a national database. This database is being assembled by Health and Welfare Canada and the provincial health departments. When complete in 1992, the Canadian Heart Health Database will contain cardiovascular disease risk profiles and other information on upwards of 22 000 individuals. For about 18 000 of these, there will be a complete profile of cardiovascular disease risk, including measurements of fasting blood lipids, blood pressure (four measurements), anthropometric information, information on smoking and physical activity habits, and finally, information on knowledge and awareness levels concerning the causes and consequences of cardiovascular disease. The database is a key resource for research in epidemiology, as well as in policy development and program evaluation.

Nutrition surveys

The high prevalence of obesity and elevated blood cholesterol recorded in all of Canada's provinces has strengthened the need to make diet the cornerstone of cardiovascular disease prevention policy in this country. This is a timely effort, in view of the recent publication of *Canada's Guidelines for Healthy Eating*.

Knowing what people eat is the first step in developing appropriate nutrition policies — for example, policies that promote the use of indigenous food supplies, and that are sensitive to Canada's cultural diversity. With this in mind, provincial nutrition surveys (designed along the same lines as those conducted on risk factors) are currently under way. The Food Directorate of Health and Welfare Canada's Health Protection Branch is working with provincial heart health programs, providing technical and research support for these surveys. Nova Scotia and Quebec have already completed their surveys and other provinces are likely to do the same in the near future.

All the data will eventually be assembled into a national nutrition database, as a companion to the national heart health (risk factor) database. Together, these databases will constitute a precious resource and policy tool. They will enable researchers to evaluate progress made in implementing *Canada's Guidelines for Healthy Eating*, as well as to measure the long-term impacts of the Canadian Heart Health Initiative.

Tracking the bottom line

Two provinces — Nova Scotia and Saskatchewan — have piloted a research project aimed at utilizing data-linkage techniques to track the number of first heart attacks (incidence of acute myocardial infarction). These data will enable researchers to tell whether reductions in mortality from cardiovascular disease are attributable to positive lifestyle change or to improvements in the treatment — and thus the survival rates — of individuals who have cardiovascular disease. The Laboratory Centre for Disease Control in the Health Protection Branch and the Health Division of Statistics Canada are partners in the project.

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These surveillance systems, which are to be extended to other Canadian provinces, complement and build on the experience of international monitoring programs such as the World Health Organization's MONICA (Multinational Monitoring of Trends and Determinants in Cardiovascular Disease), which has a Canadian pilot site in Halifax.

Provincial demonstration programs

The public health system's leadership role in heart health received a further boost when all 10 provincial health departments committed themselves to develop and implement five-year heart health demonstration programs. The kind of leadership required is not that of directing some hierarchical operation; rather, the public health system acts as a catalyst by bringing together a broadly based coalition of community organizations, agencies and individuals who can assist with the implementation of a comprehensive heart health program. The broader the coalition, the larger the resource base. This squares with the overall approach of the Canadian Heart Health Initiative, which is to integrate heart health into the existing system of health, and to avoid positioning itself as something new or separate from other public health programs.

Funding for the research-based provincial heart health demonstration programs comes from both levels of government, with Health and Welfare Canada's contribution — channelled through the National Health Research and Development Program (NHRDP) — being matched by contributions from the provinces.



Typically, the launching of a provincial heart health program is organized to coincide with the release of provincial heart health survey results. The "kick-off" event — often attended by the provincial health minister and senior federal officials — provides an opportunity for the government concerned to make a formal commitment to heart health. Media coverage is encouraged, and because the program launch catches the attention of many potential partners, it provides the beginnings of a strong provincial coalition, and helps to establish the program identity in the public's mind.

The provincial heart health demonstration programs all follow different models, with the priorities and activities of each reflecting regional and community circumstances and needs. For example, some projects (in Nova Scotia, Quebec, Ontario, Alberta

and British Columbia) are attempting to use a community mobilization approach to bring heart health to disadvantaged populations. They are developing intervention models that recognize the links between the socio-economic determinants of risk and cardiovascular disease.

The characteristics

The provincial heart health demonstration programs all share certain characteristics: first, the provincial heart health coalition has been under the leadership of the province's public health system; second, the heart health program has adopted a public health, multifactorial approach to cardiovascular disease prevention; third, the program includes interventions of different types (for example, public and professional education, worksite programs, school health, heart health inequalities) which are targeted to specific geographic areas or regions of the province. In addition, all the provincial heart health demonstration protocols are subjected to independent review by on-site scientific panels convened by the NHRDP.


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The evaluation component

A requirement for NHRDP funding for the provincial heart health demonstration programs is that they should have a scientifically valid evaluation component. Typically, this consists of two parts — the establishment of tracking systems to monitor cardiovascular disease mortality, morbidity and risk factors over the long term at the provincial level, and, at the demonstration site level, the carrying out of a process evaluation to identify the precise steps involved in implementing the project as well as the performance of each aspect of the intervention.

Evaluation guidelines for the provincial heart health programs were developed by Health and Welfare Canada, drawing on the knowledge and support of Canadian and international experts. By encouraging evaluation research for carefully selected program development questions, the guidelines emphasize the importance of a practical approach to evaluation which continually feeds back into the program without encumbering it unnecessarily.

Making it work

The Canadian Heart Health Initiative is much more than a policy and a series of research projects. It is a new way of working.

The following is a brief look at some of the processes and approaches that have breathed life into the Initiative.

Collaboration is key

Traditional formulae for coordination have been based on pyramidal organizational concepts. By contrast, the main tool used by the Initiative to nurture collaboration is the building and management of coalitions. Today, over 200 organizations at the national, provincial and local levels are actively involved in heart health coalitions across the country, effectively boosting the resources contributed by both levels of government.

These coalitions work like a set of interconnected cogwheels, each representing a different organization or program, or targeting some health-related issue — for example, nutrition, smoking, physical fitness, high blood pressure, diabetes or cholesterol. A variety of structures and processes — most of them fairly informal — have been devised to facilitate the process of collaboration. The following is a brief description of the main coalitions involved in the Canadian Heart Health Initiative.

The national coalition

Key partners in the Canadian Heart Health Initiative are the federal government, the provincial/territorial health departments, and the Heart and Stroke Foundation of Canada and its provincial affiliates. The main coalition began to coalesce around the time when *Promoting Heart Health in Canada* was released in 1987. Since then, an increasing number of non heart health organizations have joined the partnership. For example, the Canadian Cancer Society and the National Cancer Institute are collaborating with coalition partners in the development of smoking programs and policies. Further into the future there is the potential for collaborative research activities in nutritional epidemiology and other areas. For their part, the Canadian Atherosclerosis Society, the Canadian Coalition on High Blood Pressure and the Canadian Dietetic Association — to name a few — have collaborated in such areas as the building of scientific consensus, the development of educational approaches for health professionals and the validation of public education messages. The Initiative and the departments of health are indebted to these associations for their continuing support.

Provincial and community coalitions

The national coalition is mirrored in the provinces, where each provincial demonstration program has built up its own group. These provincial coalitions play a front-line role in mobilizing community resources and attracting public and political support for the demonstration programs. Typically, they consist of representatives from about 20 organizations, the impetus for creating them having come from the Principal Investigators and the provincial departments of health.

Some provinces have built their coalitions by identifying specific persons/groups they felt should participate, and issuing invitations to them to do so through the Minister of Health. In others, the coalitions have been assembled as a result of an informal negotiation process involving the many players in heart health — the provincial department of health, the provincial Heart and Stroke Foundation, universities, professional associations, industry and various groups working on related issues (for example, anti-smoking groups and diabetes associations).

At the community level, a heart health coalition (or coordinating committee) typically consists of physicians, nutritionists, nurses, community developers, business people, health educators and epidemiologists, as well as volunteers from various sectors of the community.

***A local heart health coalition typically
consists of physicians, nutritionists,
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business people, health educators,
epidemiologists and volunteers***

The Heart Health Network

The Canadian Heart Health Network is a dynamic, informally organized coalition whose membership includes organizations and individuals from provincial and community programs, health professionals concerned with various aspects of health promotion and disease prevention, representatives from the voluntary and private sectors, and from all three levels of government. The Heart and Stroke Foundation of Canada provides the

Secretariat for the Network, and a Steering Committee looks after administrative and funding issues related to meetings — held once or twice a year — as well as taking on follow-up responsibilities. The meetings provide opportunities for information-sharing and skill development, as well as for general networking activities.

Since it was first started in 1988, the Network has met seven times and in all regions of Canada. The value of these rotating meetings is that, over the years, they have enabled more than 2000 individuals in communities across the country to get involved with the Network. Each meeting has had a major theme — examples include health inequalities, program evaluation, policy directions and agenda-setting strategies. In some provinces (Ontario and Saskatchewan, for instance) the meetings have led to the development of provincial heart health networks.

COPI

The Conference of Principal Investigators (COPI) of Provincial Heart Health Programs is a different kind of group. It consists of "Principal Investigators" (PIs) and "Co-Investigators" from each province, as well as representatives from Health and Welfare Canada. The PIs are individuals whose involvement in some form of cardiovascular disease prevention activity in their own jurisdictions — whether at the government, academic or community level — coupled with their "people" skills and dedication, made them leaders of the heart

health initiatives in their provinces. Most PIs are senior public health officials, medical officers of health or provincial health professionals (some with university research appointments).

Creating the COPI coalition was one of the early challenges faced by the Canadian Heart Health Initiative. The exercise required extensive reflection on aims and shared agendas, the development of a common vision for the Initiative itself and — very importantly — a mission for the COPI group. This process was guided by a professional facilitator who helped participants to articulate a mission statement and long-term corporate plan that would harmonize the activities of the various provincial heart health programs, determine major program priorities, and identify work that could be tackled in a collaborative manner.

COPI's corporate goals include achieving visibility and political priority for heart health, nationally as well as provincially, and ensuring quality programming. A useful result of COPI — one that helps avoid duplication of activities (and thus, unnecessary expenditures), has been the establishment of working groups to address areas of special interest. Currently, there are groups working to develop program modules on subjects such as promoting heart health at the workplace, professional education, public education, and research and evaluation.

Together, the Heart Health Network and COPI help to ensure that the multiplicity of organizations and groups they each represent have opportunities to meet and interact regularly with one another, keep abreast of developments in the field and move towards general agreement in areas of common interest and concern.

The international connection

Heart health transcends national borders. Exposure to other countries' ideas and approaches and the continual exchange of information with colleagues from abroad are essential elements in maintaining a dynamic and state-of-the-art framework for policy development.

CINDI

CINDI-Canada is part of an exciting international endeavour called the WHO/EURO Countrywide Intervention Noncommunicable Disease Program (CINDI). Besides Canada, 14 other countries are members of CINDI, including European nations, Israel and some members of the Commonwealth of Independent States. Through the program, members have a unique opportunity to share their experiences in developing and implementing broad policies and programs aimed at addressing noncommunicable disease.

The purpose of CINDI is to promote integrated action on risk factors that are common to some of the major noncommunicable diseases — for example, smoking, alcohol consumption and inappropriate diets are risk factors for some common types of cancer as well as for cardiovascular disease. Intersectoral collaboration at all levels, from the lay public to governments, is crucial to ensuring its success.

Here in Canada, Nova Scotia has become a CINDI demonstration site, and there is a possibility that other provinces may be enrolled in the future. In June of 1990, Canada sponsored a major international event relating to CINDI — a technical workshop in Toronto entitled "Challenges for Health Promotion and Prevention of Noncommunicable Diseases." Participants discussed a range of issues, including the improvement of preventive practices among health professionals and the development of innovative approaches to address socio-economic risk factor determinants in disadvantaged groups.

Other links

Another recently formed international group of six francophone countries in which Canada participates is the Francophone Heart Health Network (La santé du cœur en Francophonie). The purpose of this network is to facilitate information exchanges on approaches to heart health in a context which is

culturally appropriate to francophone societies. Its inaugural meeting was held in Montreal in the fall of 1991.

The Initiative also maintains working links with such hemispheric organizations such as PAHO (the Pan American Health Organization) and the Union de Sociedades de Cardiología de America del Sur (USCAS) — the Union of Cardiology Societies of South America — and with many other international organizations, including the World Organization of Family Doctors, the World Hypertension League and the International Heart Network. Other valuable contacts include colleagues in a number of international heart health demonstration programs — for example, Dr. J. Farquhar (Stanford, USA), Dr. T. Lasater (Pawtucket, USA), Dr. R. Luepker (Minnesota, USA), Dr. P. Puska (North Karelia, Finland) and Dr. J. Catford (Heart Beat Wales, UK).

The federal role

Health and Welfare Canada has been involved from the outset. The department's Health Services and Promotion Branch provided technical and expert support to the provinces as they undertook their surveys and began their demonstration programs. It did this by sponsoring and organizing a myriad of developmental and scientific meetings and workshops. In addition, the department ensured that all the surveys retained a standardized core. In an almost continuous process, departmental staff engage their provincial colleagues in informal discussions concerning the future shape and direction of the demonstration programs.

Departmental officials also work continually with partners across the country in an effort to develop consensus on future policy directions. In areas requiring scientific consensus, Health and Welfare Canada has worked collaboratively with professional associations, scientific groups, the provincial/territorial health departments and the Heart and Stroke Foundation of Canada. The issue of cholesterol provides a good example. The Canadian Cholesterol

Consensus Conference, convened jointly in March, 1988 by the Canadian Atherosclerosis Society and the Department, proposed a set of goals and a series of recommendations aimed at the general population as well as at high-risk groups. A number of provincial health departments have subsequently reviewed these guidelines and modified them in keeping with their own priorities. Another similar event — the Consensus Conference on the Nonpharmacological Management of High Blood Pressure — was convened jointly in March, 1989 by the Canadian Coalition on High Blood Pressure, the Canadian Hypertension Society and the Department.

In each of these areas, a certain amount of good scientific information was available. For conference participants, the challenge was to determine whether the level of knowledge justified taking action on the issue, and, where the knowledge base was agreed to be deficient, to ensure that this

would be remedied. The recommendations that came out of these two landmark conferences have been publicized extensively in scientific journals, and have been the subject of a series of presentations to professional associations and various interested community groups.

Health and Welfare Canada has also organized technical workshops on the improvement of preventive practices in the health professions, the establishment of guidelines for the evaluation of heart health programs, the development of cardiovascular disease surveillance systems, and the need for community mobilization approaches to heart health.

Horizons

The Canadian Heart Health Initiative has spent its first five years laying a firm foundation for the future. It has done so by building a well defined policy, developing and consolidating an extensive knowledge base, and planning

the implementation of community demonstration programs across the country — all within a collaborative framework. To put it another way, the Initiative's most important accomplishments to date have been to promote recognition in Canada that cardiovascular disease is an area where major health gains can be made, and to establish an infrastructure that enables the issue to be addressed at the national, provincial and community levels.

Many people believe that the strength of Canada's Heart Health Initiative lies in its ability to draw continually on an ever-growing number of individuals and organizations from coast to coast — and even from beyond Canada's borders — who continue to give freely of their time and energy, often at great sacrifice. They do so because they support the goals of the Initiative and they think it will work. And, as heart health gains increasing visibility and credibility, still other partners are coming on board. The success of the programs will ultimately depend on whether they are absorbed into the organizational fabric of the future "health system." To maintain momentum, the Initiative will need to continually enlist new talents and resources from industry, from networks concerned with a variety of other health issues, and even from non health-related constituencies.

As the Initiative progresses, there will be increasing emphasis on integrating heart health programs into the broader overall goals of noncommunicable disease prevention and health promotion. At each stage of development, the Initiative will need to draw on those resources that are best suited to meet its future requirements.

Other countries have adopted different approaches to heart health — in many cases, national interest in cardiovascular disease prevention was sparked by highly visible research projects, but these were not necessarily integrated into the health promotion/disease prevention system. By contrast, the Canadian initiative has taken advantage of the intervention knowledge already available, building its policy and demonstration projects into the existing health system from the first day.

There is no secret recipe. Canada's circumstances and conditions, including its political arrangements, have clearly shaped our country's response to heart health. A great deal of valuable experience has already been accumulated, and the knowledge base is growing daily. "With the continued evolution towards increased collaboration, and as we gain experience and taste success, we will have much to offer other nations considering similar projects." Although taken from a *Cancer 2000* discussion paper (Canadian Cancer Society, 1991), these words might just as well have been written about the Canadian Heart Health Initiative.

