



europaean
heart health
charter

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Introduction

In 2007, the European Heart Health Charter was conceived by the European Society of Cardiology and the European Heart Network with the support of the European Commission and WHO Regional Office for Europe. The aim of the Charter was to substantially reduce the burden of Cardiovascular Disease (CVD) in the European Union and the WHO European Region and to reduce disparities and inequalities in the disease burden within and between countries.

Since then, much has happened globally to raise CVD and other major noncommunicable diseases (NCDs) up the policy agenda. In 2013, the 66th World Health Assembly endorsed the Global action plan for the prevention and control of NCDs 2013-2020 (extended to 2030 in 2019)¹. In 2011, 2014 and 2018, there were UN high-level meetings on the Prevention and Control of NCDs² – each with Political Declarations^{3,4,5} – and in 2015 the UN General Assembly endorsed the Sustainable Development Goals⁶ including target 3.4 to reduce premature mortality from NCDs by a third by 2030.

In September 2021, the European Alliance for Cardiovascular Health (EACH) was launched⁷, gathering 17 partners representing patients, health insurance, scientific societies, and health industry, to urge policymakers to address CVD and develop a European strategy for cardiovascular health. The next year, in September 2022, EACH published its Vision for Europe⁸ with recommendations for an EU plan on cardiovascular health.

In June 2022, the European Commission published the Healthier Together⁹ – EU Non-Communicable Diseases Initiative (EU NCDs Initiative) guide to help Member States reduce the burden of NCDs and achieve SDG target 3.4. The initiative also envisions the launch of the largest health funding programme in its history.

In addition, the EU4Health Programme¹⁰ – the EU's key funding instrument for implementing EU health priorities and ensuring a healthier, more resilient, and better prepared EU for future pandemics – has a budget of €5.3 billion (2021-2027) to fund national authorities, health organisations, stakeholders and other entities through grants and public procurement for 10 specific objectives, including disease prevention and health promotion for NCDs (e.g., CVD).

The current revision of the European Heart Health Charter aims to build on the momentum of the UN Declarations, EU4Health Programme and the EU Healthier Together initiative and advocates for keeping cardiovascular health high on the policy agenda in all the Member States of the European Union and the WHO European Region. The current revision emphasises that **a coordinated European strategy for better cardiovascular health with defined plans for implementation and accountability is essential if we are to address the burden of this disease.**

The European Heart Health Charter is intended to serve as a framework for cooperation in all the countries of the European Union and the WHO European Region to promote successful cardiovascular health in all policies. The cardiovascular health in all policies approach, defined below, brings cardiovascular health considerations into policymaking across sectors such as education, employment, gender inequalities, environment, etc. to improve the health of all people. The approach ranges from promoting healthy behaviours to creating an environment that facilitates the promotion of cardiovascular health in all countries of the European Union and the WHO European Region.



The need for cardiovascular health in all policies

▲ The major burden of cardiovascular disease

Despite significant advancements in cardiovascular medicine, CVD remains the leading cause of death in Europe and worldwide. In the WHO European Region, 47% of deaths among women and 39% among men are caused by CVD¹¹. Premature mortality from NCDs is primarily due to CVD mortality, which varies significantly within and across countries and population groups. Hypertension is a key biological risk factor for CVD but often goes undetected, untreated or uncontrolled.

CVD is also a major cause of disability and reduced quality of life, impacting the lives of some 60 million people who live with CVD in the European Union.

COVID-19 has shown the danger of underdiagnosed and chronic CVD. People with CVD are among those most affected by COVID-19, not only in terms of their risk of developing severe forms of the disease and its complications but also in terms of their quality of life. CVD remains the number one long-term consequence of COVID-19. Unfortunately, policymakers have not taken action to address this issue adequately.

“Although COVID is the most visible pandemic of our lifetime, it is neither the deadliest nor the most preventable. Cardiovascular disease has killed five times as many people. We have the public health tools to tackle it. The question is, can we muster the social and political will to use them?” - WHO Europe 2022¹².

It is increasingly recognised that CVD can affect anyone at any age, and its impact extends beyond healthcare and reaches into our economies and entire societies. CVD acts as both a driver and mirror of major inequalities and inequities across geographies, genders, and generations. As we move towards a more holistic understanding of cardiovascular health as opposed to CVD, we must recognise that effectively tackling the burden of CVD requires going beyond health policy, as CVD is influenced by and affects all aspects of our lives such as education, employment, and environment among the others.

▲ Geographic inequalities in cardiovascular health

Lack of progress demonstrated by countries, in follow up to the UN NCD Declarations, has suggested that many health systems are not keeping pace with the rising NCD burden¹³. **Significant differences exist within and across countries in access to essential health services, medication, technologies, and procedures for detecting and treating patients with CVD.** These differences correlate to some degree with a country's per capita healthcare spending. The COVID-19 pandemic has worsened this challenge by significantly impacting the care delivery for patients with CVD. Many recovered COVID-19 patients have developed new cardiovascular health conditions^{14,15}. According to Article 35 of the Charter of Fundamental Rights, everyone has the right of access to preventive health care and the right to benefit from medical treatment in



accordance with national laws and practises¹⁶. Achievement of universal health coverage is one goal of SDG3, highlighted also as a main pillar of WHO's General and European Programmes of Work^{17,18}.

Yet, **inequalities in cardiovascular health** remain both within and across countries in the WHO European Region and globally.

▲ Gender inequalities in cardiovascular health

Although often misunderstood as a “men’s disease,” CVD is the top cause of death among women in the WHO European Region. Stroke affects not just elderly women, but also accounts for 8.2% of maternal deaths annually¹⁹. Both pregnancy and postpartum periods increase the risk of all stroke subtypes, including young women at risk due to factors such as pregnancy-related complications like preeclampsia²⁰.

Heart attacks in women account for one third of all women deaths and have worse outcomes and higher mortality rates than men²¹. Women are less likely to receive evidence-based treatments for cardiovascular conditions, and when they do, they are more likely to experience delays. It is therefore unsurprising that the risk of mortality following a heart attack is 20% greater in women compared to men²². These **gender inequalities** are also present in the development of new treatments for CVD, where less than 27% of participants in clinical trial for new treatments for CVD in the EU are women²³. Effectively tackling CVD must be recognised as synonymous with tackling gender equalities.

▲ The cost of cardiovascular disease

The burden of CVD has an enormous impact, not only on health care systems and patients’ quality of life, but also on their productivity and the productivity of their informal caregivers.

CVD costs €210 billion annually in the EU (€111 billion in health care costs, €54 billion in lost productivity, and €45 billion in informal care costs)²⁴. **Productivity losses** represent a major negative impact on CVD patients, their families, caregivers, and society. Cardiovascular events in working-age adults impact the labour market through²⁵:

- ▲ Early exit from the labour force due to mortality or severe disability;
- ▲ Long-term absence from work during hospitalization and in the post discharge period;
- ▲ Temporary or permanent reduction in work hours after return to work, and
- ▲ Impaired work performance, also known as presenteeism (employees who continue to work while sick despite reduced productivity or negative consequences).

▲ Cardiovascular health research

The translation of new knowledge in cardiovascular health into useful technologies and their ultimate implementation in clinical care is insufficient and inadequate²⁶. A fundamental element in effectively combating CVD is more financial investment in **basic and translational cardiovascular research**. In addition to increased financial investment, there is a need for collaboration and communication between researchers, healthcare providers, and policymakers



to ensure that new technologies and treatments are effectively implemented in clinical care. This includes identifying barriers to implementation and finding solutions through partnerships.

▲ Planetary health and CVD

As the Earth's temperature increases, heat waves will become more frequent and intense. Apart from the negative impact on the planet itself (food insecurity, water pollution, floods, etc.) they have a direct impact on human beings, as they can cause dehydration, exhaustion, stroke, and heart issues. Climate change may worsen cardiovascular problems by increasing air pollution events' frequency and severity. Air and noise pollution are responsible for 75% of the CVD burden attributable to environmental risk factors in Europe. Air pollution is a major health hazard linked to 6.5 million premature deaths annually in Europe²⁷. Fine particulate matter and ozone increase the risk of heart disease, heart attack, and stroke. Noise pollution may also increase the risk of CVD.

From gender equality to research and innovation, from employment to social equality, from the environment to regional development, **cardiovascular health should matter to all policymakers.**

Intersectoral Cooperation and Action

The goal of protecting health and improving the quality of life of the European population by reducing the impact of CVD is fully enshrined in the EU Treaty, where Article 168 TFEU states "a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities"²⁸.

The EU has an important role to play in improving public health, preventing, and treating disease, reducing cross-border health threats and inequalities, and harmonising health strategies among countries. However, the responsibility for health protection, and for the financing and organisation of health systems, remains with the Member States.

Countries across the European Union and the WHO European Region should be supported to develop an **integrated approach to cardiovascular health** that will help achieve the nine voluntary NCD targets set by the UN and the WHO to combat NCDs by 2025 and achieve Sustainable Development Goal 3.4 to reduce premature deaths from NCDs by one-third by 2030. Two of the targets specifically mention raised blood pressure and prevention of heart attacks and strokes.²⁹

The Health in All Policies approach codified in the TFEU, and the Charter of Fundamental Rights of the European Union (Charter) recognise the cross-sectoral nature of public health issues and aims to integrate health aspects into all relevant policies³⁰.

Those policies should identify and reduce CVD risk factors in a comprehensive and collaborative manner.



However, **control of risk factors remains patchy and poorly coordinated** across Europe.

Cross-sectoral and cross-cutting actions addressing common risk factors and scaling up CVD interventions through the work of the Steering Group on Health Promotion, Disease Prevention and Noncommunicable Disease Management are key to promoting cardiovascular health, leading to better health and economic outcomes in the EU and beyond.

The goal of the European Heart Health Charter is to address the major causes of CVD and barriers to good cardiovascular health. This will be done by collaborating across various policy sectors, such as health, environment, urban planning and transportation, agriculture, and economic development. This should result in better prevention measures at population and individual level. It also means closer consultation with all interested parties.

The Charter supports the implementation of the WHO Global Action Plan for the prevention and control of NCDs 2013–2020 (extended to 2030 in 2019).

The European Heart Network and the European Society of Cardiology invite concerned European and International Organisations to sign up to the 2023 European Heart Health Charter.



Article 1 Aim of the Charter

The aim of the European Heart Health Charter is to promote cardiovascular health in all policies of the European Union and the WHO European Region and to reduce disparities and inequalities in the burden of CVD within and between countries.

The Charter recommends that all signatories promote and support creation of a strong collaborative framework to reduce the number of premature and preventable fatal and non-fatal CVD events in the European Union and the WHO European Region countries by one-third, in line with UN & WHO Sustainable Development Goal Target 3.4³¹.

Article 2 Signatories recognize

CVD is a group of conditions related to the heart and circulatory system. Some cardiovascular conditions are inherited and may not manifest until adulthood. There are also several lifestyle factors that can increase the risk of developing CVD.

1.1 The importance of cardiovascular disease prevention

Contrary to common belief CVD are not just caused by behavioural factors. People live in environments where many factors do not contribute to their health. Examples are excessive marketing of unhealthy foods, air pollution, lack of opportunities for physical activity in urban areas, etc. This leads to many people already being disabled by ill health before they reach retirement age.

Globally, unhealthy diet (including high salt, high trans-fat, low fibre, low vegetable and fruit consumption, high red meat consumption) is attributed to 41% of CVD, indoor air pollution 21%, tobacco use 19%, physical inactivity 4%, and harmful use of alcohol 1%³².



Many risk factors for CVD also contribute to other conditions like cancer, diabetes, renal failure, chronic obstructive pulmonary disease (COPD), pregnancy complications, infertility, and impotence. CVD prevention should not be seen in isolation because non-communicable diseases often share common risk factors. Effective preventive measures against CVD can benefit these other conditions as well.

It is important to note the relationship between CVD and diabetes. Most deaths in people with diabetes are caused by CVD because high blood sugar levels can damage blood vessels over time, leading to atherosclerosis (hardening and narrowing of arteries). This increases the risk of heart attack and stroke. People with diabetes often have other risk factors for CVD such as high blood pressure, abnormal cholesterol levels, obesity, and physical inactivity.

Greater reduction of exposure to the main behavioural risk factors would increase the number of years lived in good health.

Effective population-wide interventions to prevent CVD have the potential to provide both human and economic benefits with considerable returns on investment. Even small reductions in CVD risk factors across the population will produce large societal gain.

Risk factor reduction is possible at the population and individual level.

Policymakers can put measures in place to assure people live in healthy environments. The list of measures that can be taken is endless (some priority actions have been identified in the Appendix).

Health professionals can identify individuals at increased CVD risk and assist them in receiving appropriate treatment while adhering to a healthy lifestyle. Additionally, they can pinpoint research gaps that address the needs of individuals with CVD.

Heart foundations and patient organisations can create awareness and advocate for healthy living environments to become the default option. They can also support people with their cardiovascular care and patients regarding self-management of chronic conditions.

1.2 Cardiovascular diseases are not always preventable

CVD is not always preventable; however, its impact can be mitigated. Many conditions can be inherited such as familial hypercholesterolemia, cardiomyopathies, or genetic tendency to rhythm disturbances or sudden death. Inherited conditions may not manifest until adulthood. Treatment and socio-environmental changes can be made available to improve people's lives.

CVD is closely interlinked with other major chronic diseases. Many CVDs may be caused or worsened by other chronic conditions or their treatments, and other CVDs may be incurred or exacerbated due to ageing.

1.3 Cardiovascular health goes beyond healthcare and affects our economies and entire societies (Cardiovascular Health in all policies)

Cardiovascular health affects not only personal well-being but also the economy and society. Illness or premature death from poor cardiovascular health can reduce productivity, negatively impacting economic growth. Additionally, healthcare costs for CVD are high and can strain national budgets significantly.

To address these issues, we recognize the need for a “Cardiovascular Health in all policies” approach. Policymakers should consider how their decisions impact on cardiovascular health and how they can contribute to creating healthy living environments and promoting healthy behaviours.

For instance, urban planning choices can impact access to physical activity options like building parks and walkways for biking or walking. Food regulations can promote healthier eating habits by endorsing fruits, vegetables, whole grains, and lean proteins or by restricting marketing of processed foods that are high in sugar, salt or saturated fats.

Article 3 Signatories agree to

- 1.** Build and strengthen cardiovascular health alliances to support policies that promote healthy environments, reducing the burden of CVD.
- 2.** Advocate for a “cardiovascular health in all policies” approach and support comprehensive health strategies and policies at the European, national, regional, and local levels.
- 3.** Create effective quality health systems to support identification and treatment of high-risk patients, prevent CVD, and care for those with established CVD.
- 4.** Educate policymakers and citizens about health issues, raise awareness of available resources, and promote healthy behaviours by engaging media and social marketing.
- 5.** Share information about the WHO CVD signature initiative³³ to raise awareness of preventing and treating CVD.



Appendix

Priority health policy actions

When deciding on interventions to prevent and control NCDs, it is important to consider both economic and non-economic factors. Both will impact how successful the intervention is. Non-economic considerations include health impact, acceptability, sustainability, scalability, equity, ethics, multisectoral actions, training needs, suitability of existing facilities and monitoring. These are all crucial in preparing for achieving global action plan targets and should be considered before implementing any items shown below.

The list of priority interventions below is divided into the evidence-based “Best Buys”³⁴ interventions for noncommunicable diseases and other recommended interventions to promote cardiovascular health.

▲ Cardiovascular Health “Best Buy” policy actions

1. Reduce unhealthy diet

- ▲ Reformulation policies for healthier food and beverage products (for example, elimination of trans-fatty acids and/or reduction of saturated fats, free sugars and/or salt).
- ▲ Front-of-pack labelling as part of comprehensive nutrition labelling policies for facilitating consumers’ understanding and choice of food for healthy diets.
- ▲ Public food procurement and service policies for healthy diets (for example, to reduce the intake of free sugars, salt, and unhealthy fats, and to increase the consumption of legumes, wholegrains, fruits, and vegetables).
- ▲ Behavioural change communication and mass media campaigns for healthy diets (for example, to reduce the intake of energy, free sugars, salt, and unhealthy fats, and to increase the consumption of legumes, wholegrains, fruits, and vegetables).
- ▲ Policies to protect children from the harmful impact of food marketing on their diet.
- ▲ Protection, promotion, and support of optimal breastfeeding practices.

2. Reduce tobacco use

- ▲ Increase excise taxes and prices on all tobacco products, including heated tobacco products and novel smoking devices such as e-cigarettes.
- ▲ Implement plain/standardized packaging and/or large graphic health warnings on all tobacco packages.
- ▲ Enact and enforce comprehensive bans on tobacco advertising, promotion, and sponsorship.
- ▲ Eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places, and public transport.
- ▲ Implement effective mass media campaigns that educate the public about the harms of smoking/tobacco use and second-hand smoke and encourage behavioural change.
- ▲ Provision of cost-covered effective population-wide support (including brief advice, national toll-free quit line services and mCessation) for tobacco cessation to all tobacco users.





3. Reduce the harmful use of alcohol

- ▲ Increase excise taxes on alcoholic beverages.
- ▲ Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising for example, across multiple types of media.
- ▲ Enact and enforce restrictions on the physical availability of retailed alcohol for example, via reduced hours of sale.

4. Reduce physical inactivity

- ▲ Implement sustained, population-wide communication campaign about best practices to promote physical activity, with links to community-based programmes and environmental improvements to enable and support behavioural change.

▲ Other recommended interventions to address Cardiovascular Health

1. Promote gender equity in cardiovascular health

- ▲ Recognise, as part of the European Gender Strategy, the need for action on CVD to have a gender perspective and gender responsive services.

2. Leverage big data analytics

- ▲ Promote and support the development of harmonised and comprehensive continuous patient registries in CVD, as well as the digital capability to enable the evidence generated within health systems to improve the speed and efficiency of randomised clinical trials.
- ▲ Leverage experience from existing medical registries.
- ▲ Use EU funds (EU4Health, Horizon Europe) to support data collection tools for the healthcare provision and research purposes.

3. Improve CVD research

- ▲ Recognise key areas of CVD research as priorities in the Horizon Europe Programmes
- ▲ Create and support public-private partnerships using EU funds focused on advancing CVD research initiatives.
- ▲ Support research and deployment of digital health technologies in CVD prevention and management.

4. Improve patient care

- ▲ Establish a network of Member States and experts to identify effective policies for managing individuals at high risk of developing CVD.
- ▲ Ensure that the European Commission services responsible for implementing the Medical Devices regulation have sufficient human and financial resources.

List of Signatories



The European Society of Cardiology



The European Heart Network



Footnotes

- 1 WHO Global action plan for the prevention and control of NCDs 2013–2020. Geneva: World Health Organization; 2013, [link](#), Last Accessed 5 April 2023
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- 12 Dr Hans Kluge (2022) Speech given at the seventy-second session of the WHO Regional Committee for Europe, September 2022. [LINK](#)
- 13 Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases Report by the Director-General. EB148/7 https://apps.who.int/gb/ebwha/pdf_files/EB148/B148_7-en.pdf
- 14 The abstract ‘Persistent dyspnea 1 year after COVID-19 infection in apparently healthy subjects: a potential indicator of subclinical cardiac dysfunction’ will be presented during the session ‘More insights from imaging into outcome after COVID-19 infection’ which takes place on 9 December at 16:00 CET in Live discussion room1.
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- 16 Charter of Fundamental Rights of the European Union, Article 35, [LINK](#), Consulted 10/01/2023.
- 17 Thirteenth General Programme of Work, 2019–2023. Geneva: World Health Organization; 2019. <https://www.who.int/publications/i/item/thirteenth-general-programme-of-work-2019-2023>
- 18 The European Programme of Work, 2020–2025: United Action for Better Health. Copenhagen: WHO Regional Office for Europe; 2021. <https://www.who.int/europe/publications/i/item/WHO-EURO-2021-1919-41670-56993>

- 19 The European Stroke Organization (ESO) also offers valuable information and references on stroke and women. Their website features articles, research studies, and guidelines related to stroke prevention, treatment, and rehabilitation in women. <https://eso-stroke.org/projects/wise/> , last accessed on 8 April 2023
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- 29 Target 6: Reduce global prevalence of raised blood pressure by 25% between 2010 and 2025. Target 8: At least 50% of eligible people should receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes by 2025. WHO Cardiovascular Disease Fact Sheet: [LINK](#) Consulted 10/01/2023.
- 30 Treaty on Functioning of the European Union, Articles 9 and 168(1) TFEU; Charter of Fundamental Rights of the European Union, Article 35, [LINK](#) , Consulted 10/01/2023.
- 31 Target 3.4. Noncommunicable diseases: By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment, and promote mental health and well-being. WHO, [LINK](#) Consulted 28/02/2023
- 32 Institute for Health Metrics and Evaluation (IHME), Global Burden of Disease Collaborative Network. Global Burden of Disease (GBD) Cardiovascular Burden Estimates 1990 and 2021. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), 2022.
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