Global Heart Hub

Women's Heart Health Action Agenda

Five Core Areas for Change

Foreword

Cardiovascular disease is the leading cause of death among women – yet for too long it has remained under-researched, under-diagnosed and overlooked in health systems around the world. Women continue to experience **late, missed and misdiagnosed heart disease**, often compounded by fragmented care. These gaps are not inevitable. They reflect systems that were not designed for women and they can be changed.

At Global Heart Hub, we hear these stories every day. They are experiences of fear and frustration, but also of resilience, leadership and determination. Women across the world are raising their voices and demanding better. The **Women's Heart Health Action Agenda** is born from that determination.

From 2–4 November 2025, Global Heart Hub convened our 5th Unite Annual Summit in Dublin, Ireland, bringing together a diverse global community to address what must change in women's cardiovascular health. The message was clear: the status quo is failing women and together we can change it. **Through dialogue and insights rooted in lived experience, a shared vision for change took shape.** This **Action Agenda** captures that shared ambition and is structured around five core areas for change:

- **POLICY, FUNDING & ACCOUNTABILITY**
- **HEALTH SYSTEMS TRANSFORMATION**
- **MEDICAL EDUCATION & WORKFORCE DEVELOPMENT**
- **RESEARCH & DATA EQUITY**
- **PUBLIC AWARENESS, ENGAGEMENT & EMPOWERMENT**

Together, these areas provide a coherent and actionable pathway to improve outcomes for women globally. Crucially, this Agenda is a co-created effort shaped by lived experience and clinical expertise. We are deeply grateful to the **global CVD patient community**, and to the clinicians, researchers, policymakers and public health leaders whose insight and collaboration shaped this work. We also thank our supporters, whose commitment made the Unite Summit possible.

Throughout the Summit, one call resonated above all:

Thinking heart first means recognising symptoms early, listening without bias, investing in research that includes women and designing care that reflects women's lives across the life course. It means moving from reaction to prevention, from fragmentation to coordination and from assumptions to evidence.

The opportunity before us is clear. By acting together – across policy, systems, education, research and communities – we can change the story of women's cardiovascular health and change the future.

Women's cardiovascular health cannot wait. When we act together, we can change the story and change the future. Let this Agenda be the moment we step forward together – thinking and acting heart first.

Neil Johnson
Executive Director,
Global Heart Hub

Acknowledgements

Partners

Global Heart Hub would like to acknowledge and extend our appreciation to our partners in women's cardiovascular health, especially the members of Global Heart Hub's Women & Heart Patient Network.

Women & Heart Patient Network

Contributors included representatives of the following organisations:

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ASSOCIATION OF HEART PATIENTS, NAVAL OFFICERS, COAST GUARD OFFICERS & FRIENDS
AVEC FRANCE (ASSOCIATION VIE ET CŒUR)
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BLACK HEART ASSOCIATION
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CANADIAN WOMEN WITH MEDICAL HEART ISSUES (HEARTLIFE WOMEN)
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ESTONIAN STROKE PATIENTS SOCIETY
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EUROPEAN COALITION OF PEOPLE LIVING WITH OBESITY
FH EUROPE FOUNDATION
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WOMENHEART

In addition, several individual patient advocates attended the 2025 Unite Summit and contributed to the Action Agenda.

Supporters

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Knowledge Partner

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GLOBAL HEART HUB 5TH UNITE ANNUAL SUMMIT – ADVANCING WOMEN'S CARDIOVASCULAR HEALTH

BUILDING THE WOMEN'S HEART HEALTH ACTION AGENDA

2–4 November 2025, Dublin, Ireland

Cardiovascular disease (CVD) remains the leading cause of death among women worldwide, yet progress in prevention, diagnosis and care continues to lag. Women continue to experience **late, missed and misdiagnosed heart disease**, driven by gaps in symptom recognition, male-centred diagnostic pathways, under-representation in research and fragmented care.

These gaps are not accidental. They reflect long-standing structural and systemic failures that must be urgently addressed.

The **Women's Heart Health Action** Agenda brings together the strongest insights and solutions generated through a global co-creation process at **Global Heart Hub's 5th Unite Annual Summit**. Patient community leaders, clinicians, researchers and policymakers came together in Dublin to define what must change, and how to improve women's cardiovascular health.

A unifying message shaped the Agenda:

WHY THIS MATTERS – THE CASE FOR ACTION

- CVD is the **No. 1 cause of death among women globally**.
- Women often experience **symptoms that differ** from those traditionally described in men, yet these are frequently not recognised as cardiac.
- Many **diagnostic pathways** rely on tools, biomarkers and thresholds developed primarily in male populations, limiting their ability to detect conditions that are more prevalent in, or differently expressed by, women.
- Women of colour, younger women, rural populations and underserved communities face **even greater inequities**.
- Pregnancy, postpartum health, perimenopause and menopause are **key cardiovascular windows**, but remain largely absent from routine care pathways.
- Research, registries and digital tools often lack **sex-disaggregated data**, limiting accuracy and quality of evidence for women.

These gaps result in **avoidable deaths, increased disability** and **economic** and **societal costs**.

Improving women's cardiovascular health is essential to achieving global health goals.

WHAT THIS AGENDA PROVIDES – FIVE CORE AREAS FOR CHANGE

The Women's Heart Health Action Agenda translates Summit insights into a **practical global blueprint** – structured around **five core areas for change:**

- **POLICY, FUNDING & ACCOUNTABILITY**
- **HEALTH SYSTEMS TRANSFORMATION**
- **MEDICAL EDUCATION & WORKFORCE DEVELOPMENT**
- **RESEARCH & DATA EQUITY**
- **PUBLIC AWARENESS, ENGAGEMENT & EMPOWERMENT**

Each area sets out **why change is needed, what must change and how progress can be measured**, providing actionable guidance for policymakers, health systems, clinicians, researchers and patient community leaders worldwide.

HOW WE BUILT THIS AGENDA – CO-CREATION & COLLABORATION

The Action Agenda was developed through a rigorous, inclusive and transparent co-creation process.

Unite
Annual Summit

2025 Unite Summit at a Glance

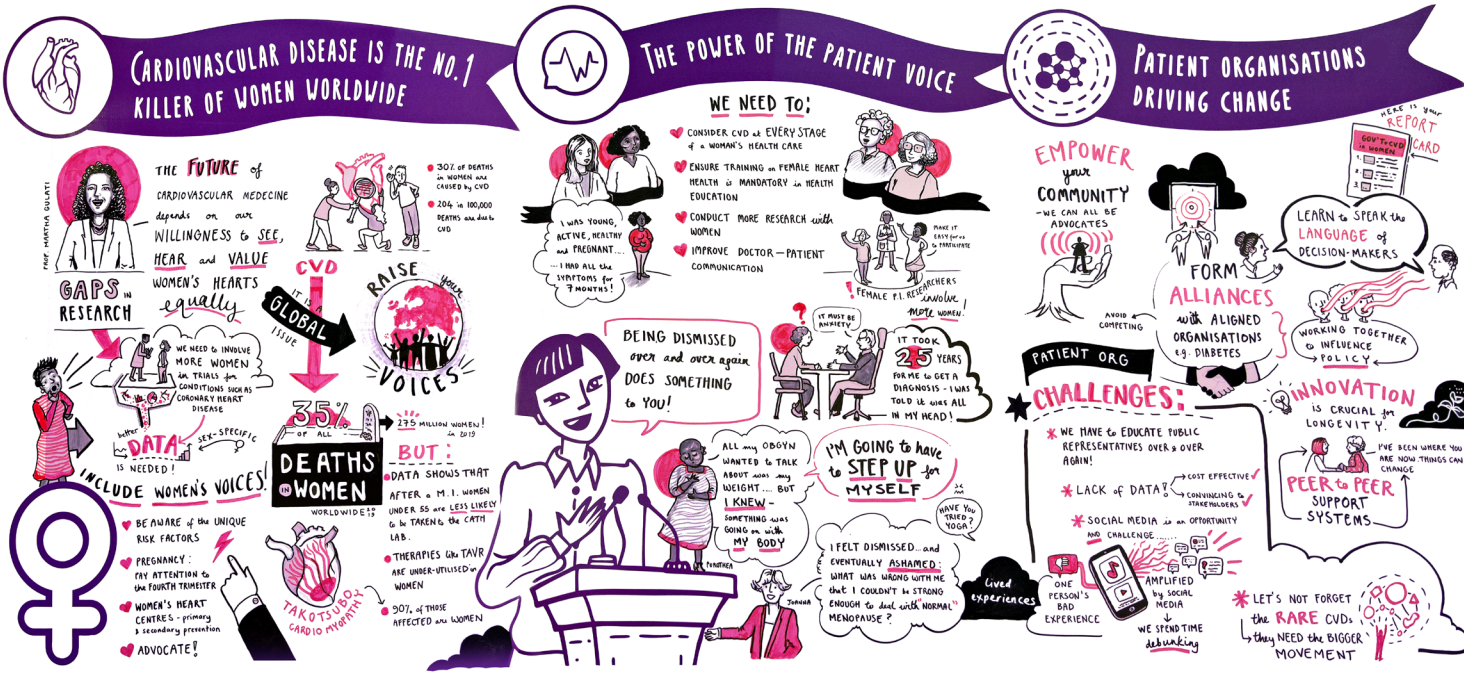
200
DELEGATES

37
COUNTRIES

35
SPEAKERS

64
PATIENT ORGANISATIONS
(represented from the global CVD patient community)

Multidisciplinary contributors across lived experience, cardiology, primary care, nursing, mental health, digital health, research and public policy



Co-Creation in Practice

The Women's Heart Health Action Agenda was co-created through multiple, structured insight touchpoints across the Summit. Participants contributed lived experience, clinical expertise and policy perspectives through plenary discussions, interactive Q&A, a live survey of all delegates, breakout sessions and post-event reflection.

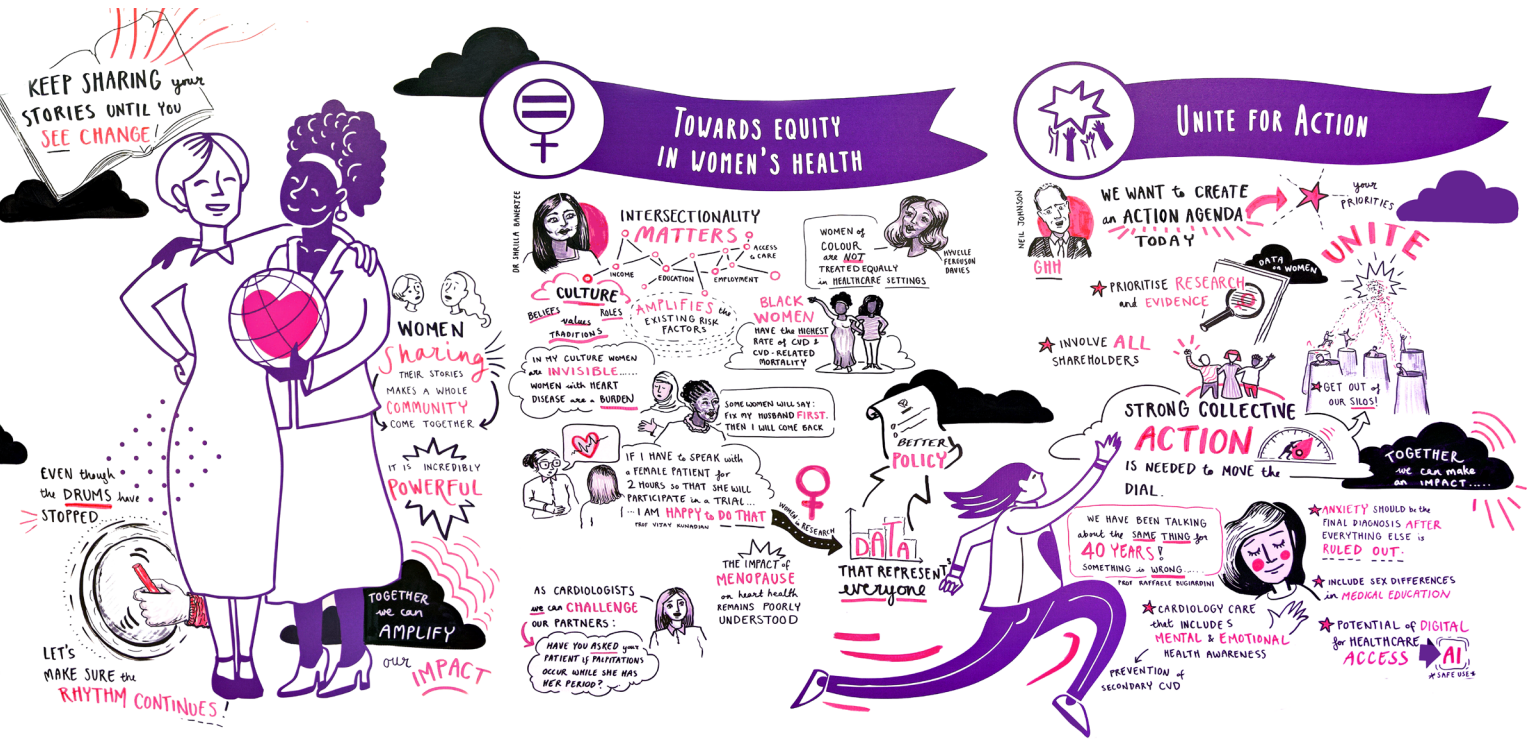
A central feature of the Summit was a structured breakout process. Across 20 tables and ten thematic areas, participants identified practical solutions and bold ideas spanning diagnosis, prevention, access, research, education, mental health, menopause, equity and health systems and cross-cutting issues. These discussions generated some of the most actionable insights of the Summit and form an essential evidence base for this Action Agenda.

These discussions generated some of the most actionable insights of the entire Summit. **Their outputs serve as a fundamental evidence base for this Action Agenda.**

The Power of Visuals in Collective Insight

A live visual illustration captured themes, challenges and solutions in real time, helping participants visualise the system as a whole and identify patterns across lived, clinical and policy experience. More than documentation, this process shaped collective understanding and ensured Summit insights directly informed the Action Agenda.

Seeing the whole picture made it possible to act on it – together.



THE PATH AHEAD – FROM AGENDA TO ACTION

This Action Agenda offers a shared narrative and a clear pathway for change that can be activated across diverse health systems and contexts. It is not a static document, but a living platform for collaboration, accountability and progress. While it does not capture every gap or solution, it reflects the strongest priorities and opportunities identified through the Summit and provides a foundation for continued learning, refinement and action.

Throughout the report, background context, challenges and strategic approaches are presented to support – and map back to – the Action Agenda's five core areas for change.

With aligned leadership and coordinated action, real transformation is within reach.

Introduction – Why Women's Heart Health, Why Now

Cardiovascular disease (CVD) is responsible for an estimated **9.6 million deaths in women globally each year.**[1]

CVD is the leading cause of death in women worldwide. Despite this risk, many women do not perceive it as their greatest health threat. In reality, CVD causes **more than twice as many deaths in women as all cancers combined.**[2]

Even at this scale, women's cardiovascular health has long been **under-recognised, under-prioritised, underfunded and poorly understood** across research, clinical practice and public awareness.

For decades, cardiovascular science, research, clinical training and diagnostic pathways have been built around **male physiology and male symptom patterns**. This legacy has created a deeply embedded bias, with women continuing to experience late, missed and misdiagnosed heart disease.

At our **5th Unite Annual Summit**, this reality was articulated with urgency by Professor Martha Gulati:

CONTEXT FOR CHANGE

The Women's Heart Health Action Agenda is shaped by the scale of the **disease burden, economic impact, societal pressures and health system gaps** facing women with CVD. Together, these pressures explain why coordinated action across the five core areas for change is urgently needed.

DISEASE BURDEN

CVD is the leading cause of death among women, responsible for approximately **35% of all female deaths worldwide**[3] and an estimated **9.6 million deaths globally each year.**[4] Furthermore, **women face a 20% higher risk of mortality following a heart attack compared to men.**[5]

> ***The future of cardiovascular medicine depends on our willingness to see, hear and value women's hearts equally. Women are not a 'special' population – we're special, but we're 51% of the population. We are the majority and we must be treated as such. We need to hold everyone accountable – in hospitals, communities, locally, nationally and internationally. When trials are funded, we must fight for women's inclusion and for sex-based analysis. Because when we study women, we often find differences. Let's raise our collective voices – and be silent no more.***

Prof Martha Gulati
Cardiologist and Director, Davis Women's Heart Center, DeBakey Heart & Vascular Institute, Houston Methodist Hospital, USA and Immediate Past President of the American Society for Preventive Cardiology, USA

WOMEN'S CARDIOVASCULAR HEALTH ACROSS THE LIFE COURSE

Women experience CVD differently across their lives – influenced by biological, hormonal and reproductive transitions often absent from male-centred models.

LIFE COURSE STAGE	LIFE COURSE STAGE
Adolescence & Early Adulthood: Onset of Reproductive Years	Early and late menarche, polycystic ovary syndrome (PCOS), functional hypothalamic amenorrhea, migraine and mental health conditions increase long-term CVD risk. These risk factors typically appear before women are ever seen by cardiologists, yet they rarely inform cardiovascular prevention or screening.
Pregnancy & Postpartum	Adverse pregnancy outcomes (pre-eclampsia and hypertension during pregnancy, gestational diabetes, preterm delivery) strongly predict future CVD but are rarely captured, and patients are rarely informed of their future CVD risks or provided with a prevention plan. Women with a history of adverse pregnancy outcomes have up to a 4x higher risk of developing cardiovascular disease.[6]
Menopause & Midlife	Oestrogen decline drives changes in cholesterol including LDL (low-density lipoprotein) cholesterol, Lp(a) and triglycerides – yet screening and prevention remain inconsistent.
Older Age	Women face higher rates of heart failure with preserved ejection fraction (HFpEF), stroke, multimorbidity (living with multiple conditions), frailty and post-stroke disability.
Across the Lifespan	*Autoimmune diseases, hormonal therapies and accumulating lifestyle risks heighten cardiovascular vulnerability. Blood pressure rises from adolescence onward at a higher rate of change with age over time* than seen in males. Throughout their lifespan, women are under-treated for preventable cardiovascular risk factors.

Women are also disproportionately affected by some cardiovascular conditions. Around 60–70% of women with heart symptoms that are investigated for typical blockages during angiography (an imaging test used to look for blocked arteries) are found to have NOCAD (non-obstructive coronary artery disease).[7]

Women often experience ANOCA (angina with non-obstructive coronary arteries)[8] which is often the first clinical signal of underlying cardiovascular conditions. ANOCA may precede or coexist with conditions such as INOCA (ischaemia with non-obstructive coronary arteries), MINOCA (myocardial infarction with non-obstructive coronary arteries), SCAD (spontaneous coronary artery dissection), HFpEF (heart failure with preserved ejection fraction), coronary microvascular dysfunction and vasospastic angina.

Evidence shows that it can take an average of 2–5 years or longer for women initially presenting with ANOCA to receive a definitive diagnosis such as INOCA, contributing to prolonged symptoms, delayed treatment and avoidable harm.[9]

Emerging evidence also challenges the assumption that some female-predominant conditions are benign or transient. Takotsubo syndrome, historically viewed as a one-off stress-related event, is increasingly associated with recurrent episodes and longer-term cardiac consequences, including microvascular dysfunction. These findings underscore the need for sustained follow-up and more robust care pathways for women presenting with non-obstructive coronary syndromes.[10]

These conditions cause serious illness and death in women, but are often missed because they do not present like 'typical' blocked arteries – the pattern most diagnostic tests and clinical pathways were designed to detect.

Clinical presentations often differ from male-based teaching and training. Symptoms such as **shortness of breath, fatigue, nausea, dizziness, gastric discomfort and pain in the jaw, back or shoulders** can signal CVD in women, yet are frequently misattributed to stress, anxiety or menopause, leading to harmful delays in diagnosis and treatment.

> ***Even today, many doctors don't recognise the differences in how women experience heart disease. Women often present with atypical symptoms – nausea, fatigue, indigestion – which are easily dismissed as stress or tiredness. I've seen women having a heart attack who were told it was something else entirely. We need to change that mindset. When a woman presents with these symptoms, we must think heart first.***

Prof Vijay Kunadian
Professor of Interventional Cardiology,
Newcastle University & Hospitals, UK

This call to "**think heart first**" echoes throughout the Summit and underpins this entire Action Agenda.

ECONOMIC BURDEN

The overall economic impact of CVD is substantial, encompassing direct healthcare costs, productivity losses and long-term care needs worldwide. Women often bear a disproportionate share of this burden due to:

- later diagnosis and more severe complications
- higher likelihood of stopping or reducing paid work
- disproportionate caregiving responsibilities
- longer periods of disability
- greater financial vulnerability and lower lifetime earnings

Closing the women's health gap could unlock up to **USD $1 trillion** in global economic gains each year[11] – driven by reduced healthcare costs, increased workforce participation and improved productivity. In CVD alone, closing gender gaps in prevention, diagnosis and care would generate substantial gains in healthy life years and economic output. Recent national analyses show that these benefits are not theoretical: countries that invest in women's cardiovascular health stand to realise significant, measurable returns across health systems and economies.

THE ECONOMIC CASE FOR WOMEN'S HEART HEALTH

The economic case for investing in women's cardiovascular health becomes even clearer when examined at national level. Across settings, late diagnosis, avoidable complications and long-term disability drive substantial healthcare costs and productivity losses – costs that are not inevitable.

United States: CVD imposes a substantial economic burden, with an estimated **USD $418 billion in direct and indirect costs** between 2020 and 2021, including healthcare expenditure, productivity losses and premature mortality.[12] The McKinsey Health Institute further estimates that closing the CVD gap between women and men could help women regain **1.6 million years of higher-quality life** and add **USD $28 billion** annually to the US economy by 2040.[13]

Canada: A recent McKinsey Health Institute analysis estimates that closing the women's health gap could add **CAD $37 billion** annually to Canada's economy by 2040, largely through improved outcomes in CVD, mental health and other chronic conditions.[14]

European Union: At EU level, robust analyses exist on the overall economic burden of cardiovascular disease, estimated at €282 billion annually, driven by healthcare costs, productivity losses and long-term care needs.[15] However, women-specific economic analyses remain limited, constraining the ability to fully assess the economic impact of delayed diagnosis, under-treatment and long-term disability among women.

Taken together, national analyses demonstrate that investing in women's cardiovascular health delivers measurable economic returns. The absence of equivalent sex-disaggregated economic evidence at EU level reinforces the need for targeted research and policy attention, ensuring that future investment decisions fully reflect women's cardiovascular risk and impact.

SOCIETAL BURDEN

Women's cardiovascular health is shaped by broader determinants of health including **income, education, housing, access to nutritious food, air pollution, proximity to healthcare and commercial determinants, including the availability, marketing and affordability of unhealthy products.** Cultural norms and gendered expectations often delay care-seeking, while women in low-resource settings face additional barriers such as cost, distance from providers, access to care and language.

Racial and ethnic inequities compound these risks. Women of colour often experience higher rates of hypertension, diabetes, stroke and maternal mortality and frequently report feeling dismissed when presenting with symptoms. These disparities are further compounded by intersecting factors including structural racism, gender bias, social norms and barriers to accessing timely, culturally competent care.

Mental health conditions – **anxiety, depression and trauma** – more common in women, were also highlighted as under-recognised cardiovascular risk factors.

These societal pressures are intensified by health systems that are still not designed to recognise or respond to women's cardiovascular risk.

In **Low- and Middle-Income countries**, this system failure is particularly stark. Conditions such as rheumatic heart disease remain a leading cause of CVD in pregnancy, are often first diagnosed during pregnancy and are associated with severe valvular complications that significantly increase maternal risk.[16]

HEALTH SYSTEM BURDEN

Summit insights highlighted persistent system-level gaps:

- **male-centred diagnostics** leading to delayed electrocardiograms (ECGs), misinterpretation of findings based on male standards, less testing and lower referrals
- **limited integration of women's life course cardiovascular risk into screening and prevention**, including menstrual and hormonal factors, pregnancy and postpartum complications, and perimenopausal and menopausal risk transitions
- **poor recognition and follow-up of adverse pregnancy outcomes** (such as pre-eclampsia, gestational hypertension and diabetes), contributing to missed prevention opportunities and rising but largely preventable maternal morbidity and mortality
- **gaps in clinical education**, with limited sex- and gender-specific training
- **under-representation in research and weak sex-disaggregated data**
- **access barriers** across prevention, diagnosis and care in low- and middle-income settings

These cumulative system failures undermine early detection, hinder prevention and timely treatment, and obscure the true burden of CVD in women.

The Challenges – What We Heard and Why It Matters

Across the 5th Unite Annual Summit, participants described a consistent and troubling reality: despite decades of evidence, women's cardiovascular health remains poorly recognised, inconsistently diagnosed and unevenly supported across health systems. The experiences shared revealed not isolated failures, but **systemic gaps** that hinder early detection, delay treatment and undermine recovery.

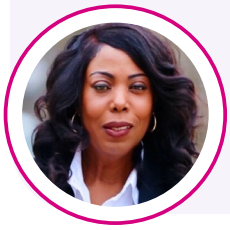
Several interconnected challenges emerged.

LATE, MISSED AND MISDIAGNOSIS OF HEART DISEASE IN WOMEN

Women across regions described not being believed when they sought care for cardiovascular symptoms. Symptoms were frequently attributed to stress, hormones, anxiety or indigestion, while opportunities for early diagnosis were missed.

Bias in symptom interpretation and reliance on male-centred diagnostic models remain deeply embedded across care settings.

> ***Women of colour are not treated equally in healthcare settings. I was dismissed, denied... and I almost died because of it. It shouldn't be this way.***



Hyvelle Ferguson-Davis
Patient Advocate,
Heart Sistas Inc., USA

> ***I was in my early thirties when I started having severe chest pain, shortness of breath and fatigue. I went to my doctors, worried it might be my heart. But because I looked healthy and fit, I was told it was anxiety, stress, hormones – anything but my heart. I went through countless unnecessary tests, but never the one I needed. They kept looking for blockages in my large arteries – because male heart health is still the standard in cardiology. And because my arteries weren't blocked, I was told I was fine. I wasn't. It took 25 years to finally get the right diagnosis. Twenty-five years.***

Renate Kaal-Poppelaars
Patient Advocate, Stichting VrouwenHart
and FH Europe Foundation, Netherlands

EDUCATION, CLINICAL TRAINING AND AWARENESS GAPS

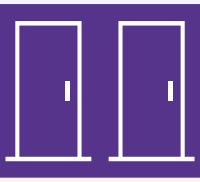
Another pervasive challenge is the absence of comprehensive sex- and gender-specific cardiovascular education across medical training and professional development. Many clinicians continue to rely on male-based models of symptoms and risk.

Evidence from professional societies and Summit discussions consistently shows that medical education remains heavily male-centred, with limited mandatory training on sex- and gender-specific cardiovascular risk, symptoms and diagnosis.

As a result, common presentations in women – such as breathlessness, fatigue, nausea, dizziness or jaw and back pain – are often not recognised as cardiac red flags.

Awareness gaps also extend beyond clinical settings: many women are unaware that pregnancy complications and menopause substantially increase long-term cardiovascular risk.

Evidence highlights the scale of these gaps: around **41% of women delay seeking care for chest pain by more than 12 hours**, women can **wait up to six times longer than men for a diagnosis of heart failure**, and **hospital admissions for acute coronary syndromes among younger women have risen sharply over the past two decades** – all reflecting persistent gaps in awareness, training and diagnostic bias.[17]



BARRIERS TO ACCESS, AFFORDABILITY AND CONTINUITY OF CARE

Across diverse health systems, women face structural barriers to timely cardiovascular care, including delayed assessment and diagnosis, fragmented referral pathways, limited specialist access, financial barriers and long waiting times. These challenges are often compounded in low- and middle-income settings by income inequality and gendered constraints on care-seeking. Caregiving responsibilities, misattribution of symptoms, stigma and previous negative healthcare experiences further delay help-seeking.

Women frequently described fragmented pathways, with poor coordination between cardiology, primary care, obstetrics and mental health services. Even when symptoms were recognised, responsibility for navigating care often fell to women themselves – leading to missed prevention opportunities and avoidable deterioration.

Inequities also extend to recovery. Exercise-based cardiac rehabilitation significantly lowers mortality risk after a heart attack, with even greater benefit in women than in men.[18] However, women continue to be referred at much lower rates than men.[19]

LIFE COURSE, HORMONAL AND MENTAL HEALTH FACTORS

Participants highlighted a persistent and systemic failure to integrate women's hormonal, reproductive and psychosocial life course into cardiovascular prevention and care. Key transitions – **adolescence, pregnancy, postpartum, perimenopause and menopause** – remain largely absent from routine screening, risk assessment and follow-up pathways, despite strong evidence that they shape long-term cardiovascular risk.

Mental health emerged as both a **driver and a consequence** of cardiovascular inequity. Conditions such as anxiety, depression and trauma – more prevalent among women – are frequently treated as explanations instead of warning signals, leading to misattribution of symptoms and delayed cardiovascular investigation. For many women, repeated dismissal, missed or late diagnosis and fragmented care contribute to significant psychological distress, loss of trust in health systems and reluctance to seek further care.

Failing to embed a life course and mental health lens leaves critical prevention opportunities unrealised and fractures continuity of care. This is most evident during perimenopause and menopause – predictable, high-risk transitions that remain among the most consistently missed opportunities for early cardiovascular risk identification and intervention.

> ***I felt dismissed and, to be honest, ashamed. Ashamed that I wasn't being strong enough. So I stopped talking about it. My symptoms were getting worse, but I gave up trying to have the conversation. I felt unheard and retreated into myself – until I finally realised I had to step out of the shadows and speak up.***

Joanna Markle
WomenHeart Champion, USA

RESEARCH, DATA AND DIGITAL BIAS

Women remain under-represented in cardiovascular research, with sex-specific analyses often underpowered, inconsistently reported and insufficiently analysed within health data systems. Women are also under-prioritised in digital innovation, limiting the equity and accuracy of emerging tools. Many clinical trials still enrol disproportionately fewer women, and pregnant and postpartum women are routinely excluded from research entirely.

A review of 1,079 all registered cardiovascular trials from 2017 to 2023 found that only 41% of participants were women.[20]

Women's under-representation in research reflects structural design choices – including trial protocols, recruitment models and risk frameworks that fail to accommodate women's life stages, caregiving realities and biological diversity.

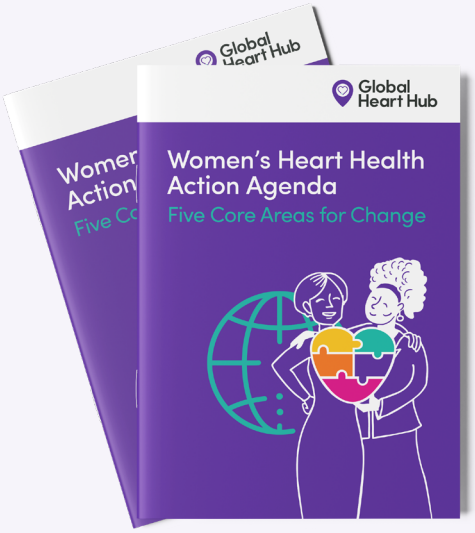
Additionally, trials do not always account for sex differences in presentation, pathophysiology, biomarkers and anatomic measures, with the reference standard being men.

Digital tools can reinforce these gaps. Artificial intelligence (AI) systems trained on historically male-dominant and biased datasets may miss women's cardiovascular presentations and amplify inequities. Women from minority racial and ethnic groups face additional invisibility, with their symptoms, outcomes and lived experiences often absent from datasets – making inequities harder to identify and address.

A SYSTEM REQUIRING FUNDAMENTAL REDESIGN

Across all challenges, the Summit's message was unequivocal: women are not receiving cardiovascular care that reflects their biology, symptoms or lived realities. Participants emphasised that trust, culture and community context shape whether women seek care, are believed and remain engaged in prevention and recovery.

These challenges are interconnected and demand a coordinated, system-wide response.



Addressing them requires moving beyond isolated fixes toward structural reform, setting the foundation for the **Women's Heart Health Action Agenda – Five Core Areas for Change.**

Strategic Approaches – Transforming Women's Heart Health

EMERGING SOLUTIONS FROM THE GLOBAL HEART HUB UNITE SUMMIT

Across the 5th Unite Annual Summit, participants from diverse regions and disciplines agreed on a central point: **women's cardiovascular health can be transformed, but only through coordinated, system-level action**. Incremental or isolated interventions will not close the gaps identified throughout the Summit.

This section summarises the strategic solutions that emerged consistently across plenary discussions, breakout sessions and live surveys. Together, they inform how the five core areas for change can be implemented in practice.

Each strategic area responds directly to one or more of the challenges identified above, translating systemic gaps into coordinated solutions aligned with the Action Agenda's five core areas.

EARLIER DETECTION AND DIAGNOSTIC EQUITY

Participants emphasised that meaningful change must begin earlier. Women's cardiovascular risk develops over decades, yet assessment often occurs only once symptoms are advanced.

Priority approaches included:

- life course–based screening, including pregnancy, postpartum and perimenopause touchpoints
- routine inclusion of family history and inherited risk assessment
- improved access to diagnostics beyond obstructive coronary disease when symptoms suggest ischemia
- outreach models to reach underserved and remote populations

Early and accurate diagnosis was consistently identified as one of the **highest-impact and most cost-effective** levers for change.

MEDICAL EDUCATION, WORKFORCE TRAINING AND CULTURE CHANGE

Education and workforce development emerged as a central enabler of transformation. At a time of global healthcare workforce shortages[21] and rising system pressures, participants highlighted the need to move beyond male-centred teaching and embed sex- and gender-specific cardiovascular knowledge across all levels of training.

Key priorities included:

- mandatory sex-specific cardiovascular education across the healthcare workforce – from undergraduate medical training through continuing professional development – aligned with sex-specific considerations in cardiovascular guidelines and spanning primary care, nursing, emergency medicine and allied health professionals
- integration of pregnancy-related risk and perimenopausal cardiovascular risk changes into clinical curricula
- addressing implicit bias and dismissal in clinical encounters

Without workforce readiness, system reform cannot succeed.

INTEGRATED LIFE COURSE CARE AND COORDINATED PATHWAYS

Participants consistently called for a shift away from fragmented, episodic care toward **integrated, life course models** that reflect women's lived realities.

This approach directly addresses the failure to integrate women's hormonal, reproductive and mental health transitions into cardiovascular prevention and care, as highlighted in the life course challenge above.

Strategic opportunities included:

- embedding cardio-obstetrics team care and structured postpartum follow-up for those at future risk of CVD
- integrating cardiovascular risk assessment into perimenopause and menopause care
- multidisciplinary team-based approaches across cardiology, obstetrics and gynaecology, primary care, mental health, and women's health services
- strengthening navigation and coordination systems so continuity of care is an essential responsibility of the health system and providers, not women living with CVD

Mental health was recognised as integral to cardiovascular outcomes and trust in care.

COMMUNITY, CULTURE, AWARENESS AND ENGAGEMENT

Effective solutions must be rooted in communities and cultural contexts. Participants stressed that awareness strategies designed without community input risk reinforcing inequities.

Priority approaches included:

- community-based prevention and education in trusted settings
- use of peer educators and community messengers
- culturally relevant communication and health literacy tools
- early education to build cardiovascular awareness across the life course

Community engagement was seen as essential to early help-seeking and sustained prevention.

RESEARCH, DATA AND DIGITAL INNOVATION DESIGNED FOR WOMEN

Participants were unequivocal that research, data systems and digital tools must be redesigned to reflect women's realities.

Key priorities included:

- sex-disaggregated analysis and reporting as standard practice
- inclusive recruitment across age, ethnicity and socioeconomic context
- integration of reproductive, primary and cardiovascular data to enable life course risk tracking and continuity of care
- scrutiny of AI and digital tools for gender, sex and racial bias
- ensuring women can access and understand their own health data

Closing the gender and sex data gap was identified as foundational to better diagnosis, treatment and innovation.

These approaches highlight what is possible; the Action Agenda that follows translates these insights into a structured framework for implementation and accountability.

Women's Heart Health Action Agenda – Overview

WHY AN ACTION AGENDA IS NEEDED NOW

Across the Summit, participants shared a wide range of solutions – from improving diagnosis and redesigning care pathways, to investing in education, strengthening research equity, expanding community engagement and driving policy reform. Yet one theme was universal: without coordination, these efforts risk remaining fragmented and insufficiently scalable.

Women's cardiovascular health is shaped by interconnected systems. Progress requires a unifying structure that links policy, clinical practice, research, education and public understanding.

The Women's Heart Health Action Agenda provides that structure.

A UNIFYING FRAMEWORK FOR SYSTEM-WIDE CHANGE

Co-created through the insights, lived experience and expertise of participants from 37 countries, the Action Agenda distils the strongest **Summit** priorities into **five core areas for change**:

- POLICY, FUNDING & ACCOUNTABILITY
- HEALTH SYSTEMS TRANSFORMATION
- MEDICAL EDUCATION & WORKFORCE DEVELOPMENT
- RESEARCH & DATA EQUITY
- PUBLIC AWARENESS, ENGAGEMENT & EMPOWERMENT

Together, these five areas form a single, coherent and action-oriented framework for improving outcomes for women. They connect the enablers of change (policy, investment, accountability), the places where change must occur (systems, workforce, evidence) and the public-facing drivers that shape behaviour and early action.

FROM INSIGHT TO ACTION

The Action Agenda translates insights from the Summit, the Global Heart Hub patient community and the wider evidence base into practical guidance that can be activated across global, regional and national contexts.

The Action Agenda is designed to operate across levels. Global and regional actors play a critical role in driving evidence generation, guideline development and alignment, while national and local actors are central to adoption, access, financing and delivery. The actions that follow reflect these complementary roles and the need for coordination across systems.

Each of the five areas outlines:

- why it matters
- what must change
- a strategic commitment
- priority actions
- key actors
- indicators to track progress
- suggested bold ideas

This is where insights become actionable reform and where change can begin.

Women's Heart Health Action Agenda – Five Core Areas for Change

The Action Agenda is structured around **five core areas for change** that together provide a practical blueprint for improving outcomes for women globally.

The following tables synthesise the evidence, challenges and strategic approaches outlined earlier in the report, translating them into a practical action framework. While aligned with preceding sections, they introduce additional operational elements to support implementation, accountability and measurement.

POLICY, FUNDING & ACCOUNTABILITY

WHY THIS MATTERS

Policy sets the standards, mandates, incentives and resources that determine whether women receive timely, equitable cardiovascular care. Without explicit policy prioritisation, women's cardiovascular needs remain invisible – leading to delayed diagnosis, unequal treatment and avoidable harm. Without clear commitments and accountability, including targets and monitoring, system-wide change cannot scale.

WHAT NEEDS TO CHANGE (SYSTEM CONDITIONS)

- Name women's CVD explicitly in global, regional and national strategies.
- Set sex-specific diagnostic and follow-up standards across the life course.
- Align global, regional and national plans to accelerate adoption.
- Establish public accountability for delays, treatment equity and outcomes.
- Protect long-term financing for women's CVD pathways, training, data and research.
- Include women's cardiovascular health in national performance frameworks, reimbursement mechanisms and quality indicators.

STRATEGIC COMMITMENT

Make women's cardiovascular health a clear priority across global, regional and national strategies – backed by sustained investment and public accountability.

PRIORITY ACTIONS (FIVE PER CORE AREA)

1. **Embed women's CVD in all national and regional cardiovascular, women's health and noncommunicable disease (NCD) strategies.**
2. **Require sex-disaggregated data reporting and public dashboards** on delays and outcomes.
3. **Introduce national targets for diagnostic timelines and treatment equity.**
4. **Create sustained financing lines** for pathways, training and research equity.
5. **Include alignment clauses in national plans** to reflect global and regional frameworks.

WHO NEEDS TO ACT (AND WHAT THEY NEED TO DO)

- **National Ministries of Health & Finance** – adopt standards, allocate funding, drive implementation.
- **Global and regional institutions (WHO, UN, regional bodies)** – set global guidance, benchmarks, monitoring requirements and alignment mechanisms.
- **Payers and purchasers (public and private)** – align reimbursement, incentives and quality metrics with sex-specific standards and equity goals.

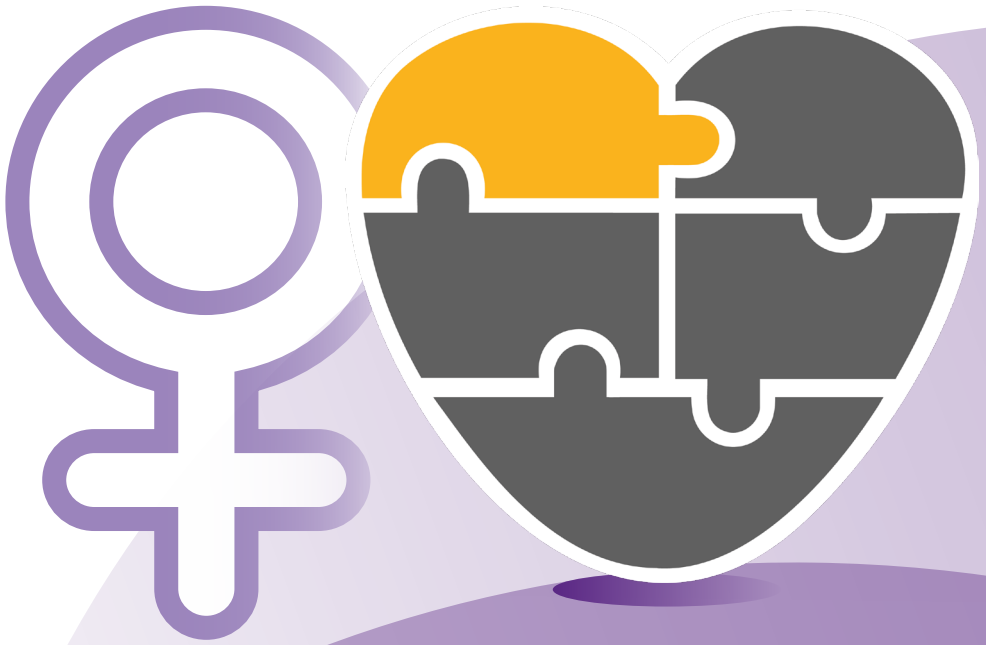
- **Professional societies** – integrate sex-specific standards into guidelines, audits and accreditation.
- **Patient organisations – in partnership with policymakers and funders** – monitor delivery, advocate for accountability and mobilise communities.

INDICATORS OF PROGRESS

- **Women's CVD explicitly included in global, regional and national strategies.**
- **Public dashboards** on diagnostic timelines, treatment equity and outcomes.
- **Dedicated national budget lines** for women's CVD.
- **Sex-specific diagnostic and follow-up standards adopted.**
- **National plans aligned** with global and regional frameworks.
- **Action taken** when women's cardiovascular equity targets are not met.

BOLD IDEAS

- **Global Policy Platform on Women's Cardiovascular Diagnosis Equity** – A multistakeholder platform uniting countries around shared diagnostic principles and cross-country pilot solutions.
- **Global Cardiovascular Women's Health Index** – A benchmarking tool comparing national performance on diagnosis, follow-up, equity and data. *(Advocacy tool)*
- **Global Accountability Metrics** – A structured monitoring framework aligned with global, regional and national plans to track progress over time. *(Technical monitoring framework)*



HEALTH SYSTEMS TRANSFORMATION

WHY THIS MATTERS

Current health systems are not built around women's cardiovascular needs. Delays, misdiagnosis and fragmented care persist across the life course. System transformation is essential to ensure timely, equitable, sex-specific care for every woman.

WHAT NEEDS TO CHANGE (SYSTEM CONDITIONS)

- Embed sex-specific diagnostic pathways across the female life course (including INOCA, MINOCA, SCAD).
- Integrate cardio-obstetrics teams for both high risk deliveries with CVD risk and those requiring follow-up after adverse pregnancy outcomes that place them at future risk of CVD.
- Incorporate perimenopause-focused cardiovascular risk assessment into primary care.
- Strengthen access to diagnostics and multidisciplinary, culturally competent care, including mental health support.
- Address emergency response and access inequities affecting women across diverse and underserved populations.

STRATEGIC COMMITMENT

Guarantee timely, sex-specific diagnosis and integrated life course cardiovascular care for every woman, in every health system.

PRIORITY ACTIONS (FIVE PER CORE AREA)

1. **Establish national sex-specific diagnostic pathways** with clear frontline guidance.
2. **Integrate life course pathways**, including follow-up 6–12 months postpartum and menopause cardiovascular assessment.
3. **Strengthen frontline capacity** with decision-support tools, interoperable records and wider access to specialist diagnostics.
4. **Implement patient navigation roles** (nurses, midwives, health navigators) to support coordination and shared decision-making.
5. **Ensure gender-sensitive cardiac rehabilitation** and recovery programmes across community and virtual settings.

WHO NEEDS TO ACT (AND WHAT THEY NEED TO DO)

- **National Ministries of Health / Finance / Social Affairs** – adopt and fund national diagnostic pathways; mandate postpartum and menopause cardiovascular follow-up.
- **Regional health authorities** – set standards and financing requirements for integrated cardiovascular pathways.
- **Primary care networks** – implement structured assessment and referral protocols.

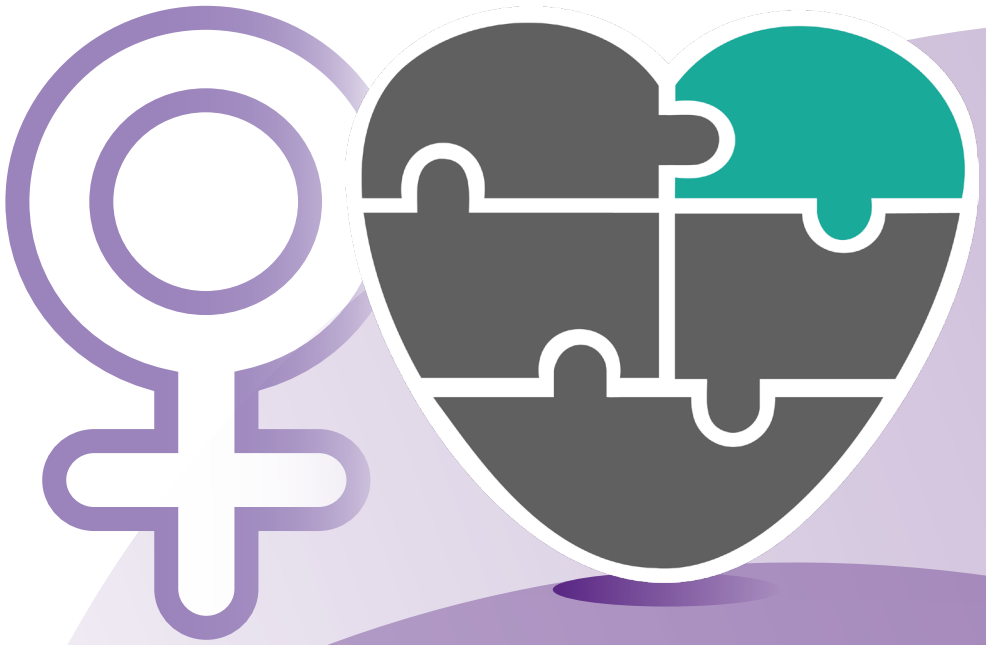
- **Cardiology, primary care, emergency medicine, obstetrics & gynaecology and menopause societies** – co-develop and disseminate sex-specific cardiovascular prevention and diagnostic guidance.
- **Hospitals and diagnostic centres** – implement diagnostic pathways, navigation, cardiac rehab and advanced testing.
- **Patient organisations and community health bodies** – support navigation, symptom literacy and early help-seeking.

INDICATORS OF PROGRESS

- **Reduced diagnostic delays** for women with chest pain or suspected CVD.
- **Postpartum cardiovascular follow-up completed** within 6–12 months after adverse pregnancy outcomes.
- **Systematic inclusion of reproductive, pregnancy, menopause and perimenopause history in cardiovascular risk assessment across primary and specialist care.**
- **National adoption of sex-specific diagnostic pathways, where appropriate.**
- **Improved access indicators for minority, rural and underserved women.**
- **Uptake of structured family history tools** across primary, cardiology and obstetrics & gynaecology care.
- **Increased enrolment and completion of women in cardiac rehabilitation in women.**
- **Improved emergency response outcomes**, including equitable cardiopulmonary resuscitation (CPR), automated external defibrillator (AED) use and emergency department (ED/A&E) triage.

BOLD IDEAS

- **Women's Cardiovascular Community Hubs** – integrated neighbourhood centres combining diagnostics, cardio-obstetrics, menopause care, navigation and mental health support.
- **Integrated data-driven life course pathways** connecting obstetrics, gynaecology, primary care and cardiology through interoperable technology.
- **Cardiovascular Family Passport** – a digital tool enabling structured risk tracking across generations.



MEDICAL EDUCATION & WORKFORCE DEVELOPMENT

WHY THIS MATTERS

Training gaps mean many clinicians are not prepared to recognise women's cardiovascular symptoms or risk patterns, leading to missed diagnoses and unequal care – particularly for younger women and women of colour. Strengthening education is essential to ensure women are recognised, believed, evaluated and treated in time.

WHAT NEEDS TO CHANGE (SYSTEM CONDITIONS)

- Integrate sex- and gender-specific cardiovascular science into undergraduate medical education.
- Embed women's symptoms, diagnostics and risk factors into postgraduate and specialty training.
- Integrate perimenopause-related cardiovascular risk and menopause-associated cardiovascular risk, into GP, nursing, obstetrics and gynaecology training.
- Strengthen cardio-obstetrics education across disciplines.
- Require medical education and continuing professional development (CME/CPD) on women's cardiovascular health across the workforce.
- Strengthen partnerships by incorporating patient and lived-experience voices across curriculum design, delivery and assessment.

STRATEGIC COMMITMENT

Mandate sex-specific cardiovascular competence across the entire healthcare workforce – from early training to frontline practice.

PRIORITY ACTIONS (FIVE PER CORE AREA)

1. **Mandate sex-specific cardiovascular training within undergraduate medical programmes,** with clear learning outcomes and assessment standards.
2. **Introduce accredited CME/CPD modules** for primary care, emergency medicine, cardiology and obstetrics/gynaecology.
3. **Expand postgraduate cardio-obstetrics rotations** across specialties.
4. **Integrate menopause-focused cardiovascular education** into clinical training programmes.
5. **Formalise patient and lived-experience contributors** within training pathways.

WHO NEEDS TO ACT (AND WHAT THEY NEED TO DO)

- **Universities & medical schools** – integrate sex-specific curriculum standards.
- **Accreditation bodies & professional societies** – embed competencies within accreditation and exams.
- **Cardiology, emergency medicine, obstetrics & gynaecology, menopause specialists** – co-develop and disseminate clinical guidance.

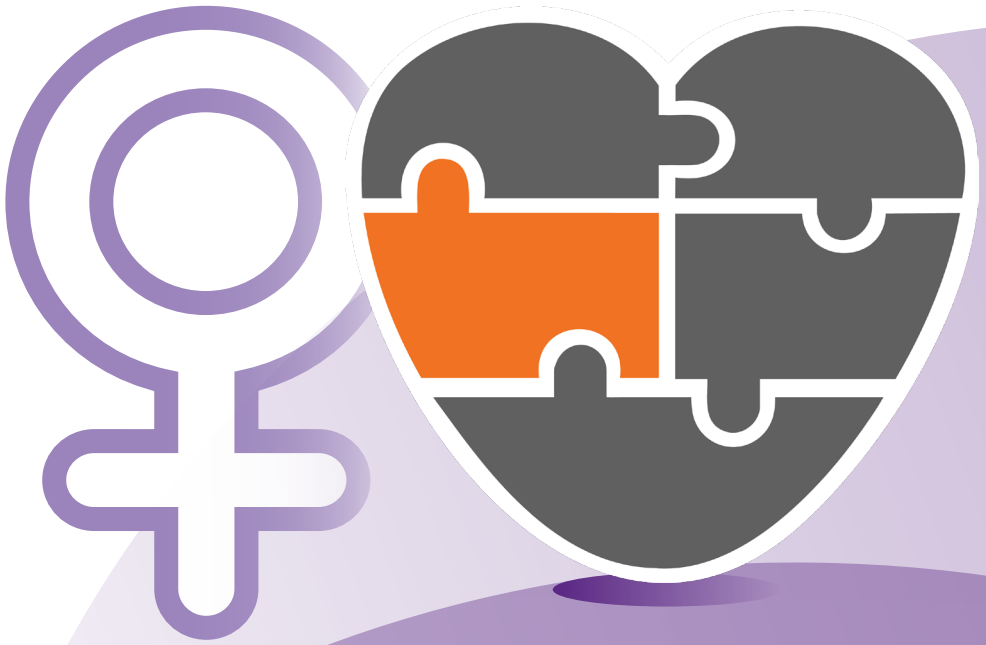
- **Training authorities and Ministries of Health and Education** – mandate CME/CPD and standardise workforce skills.
- **Hospitals and teaching centres** – implement structured rotations and competency-based programmes.
- **Patient organisations** – provide lived-experience contributors and support curriculum development.

INDICATORS OF PROGRESS

- **Uptake of sex-specific curriculum standards** in undergraduate education.
- **Mandatory CME/CPD on women's CVD** implemented nationally.
- **Menopause and postpartum cardiovascular risk integrated** into training.
- **Women's CVD competencies included** in accreditation standards.
- **Representation of lived-experience contributors** in programmes.
- **Improved diagnostic accuracy** for women in emergency and primary care.
- **Participation in cardio-obstetrics and women's CVD modules** across specialties.

BOLD IDEAS

- **International Curriculum on Women's Cardiovascular Health** – A global competency framework co-developed by leading academic centres, clinical societies and patient organisations.
- **Pan-Regional Training Network** – Shared modules, case libraries, mentorship and faculty exchange across countries.
- **Competency-Based Certification in Women's CVD** – An accreditation pathway for clinicians demonstrating advanced expertise in women's cardiovascular diagnosis, care and life course risk management.



RESEARCH & DATA EQUITY

WHY THIS MATTERS

Women remain understudied and under-represented in cardiovascular research, producing male-centred evidence that leads to delayed diagnosis, poorer outcomes and inequitable innovation. Closing this gap is essential for better care.

WHAT NEEDS TO CHANGE (SYSTEM CONDITIONS)

- Require sex- and gender-specific evidence across studies, trials and registries.
- Ensure equitable inclusion of women across ages, ethnicities and socioeconomic backgrounds.
- Capture pregnancy and menopause as cardiovascular risk phases in all datasets and registries; safely include pregnant / postpartum women in research.
- Redesign study methods and endpoints to reflect women's symptoms, diagnostic pathways and lived experience.
- Modernise digital infrastructure linking reproductive, primary and cardiology data.
- Embed patient partners and audit AI tools for sex and gender bias.

STRATEGIC COMMITMENT

Close the sex and gender data gap by requiring sex-disaggregated evidence and representative participation across all cardiovascular research, registries and AI tools.

PRIORITY ACTIONS (FIVE PER CORE AREA)

1. **Mandate sex-disaggregated reporting and analysis across** all cardiovascular research, including national and EU-funded studies and real-world registries.
2. **Set minimum representation targets for women** – including older women and women of colour – in trials and observational studies.
3. **Develop integrated digital cardiovascular registries** linking obstetrics and gynaecology, primary care and cardiology to support life course tracking.
4. **Fund dedicated CVD research** on female-specific and female-predominant conditions, adverse pregnancy outcomes and menopause-related risk.
5. **Implement AI fairness and bias auditing** for cardiovascular algorithms.

WHO NEEDS TO ACT (AND WHAT THEY NEED TO DO)

- **National and regional research funders** – mandate sex-disaggregated data and representation standards.
- **Regulators, Health Technology Assessment (HTA) bodies and ethics committees** – require sex-disaggregated reporting, representative recruitment, inclusion of pregnancy/menopause variables and safeguard equitable participation (including safe inclusion of pregnant/postpartum women).

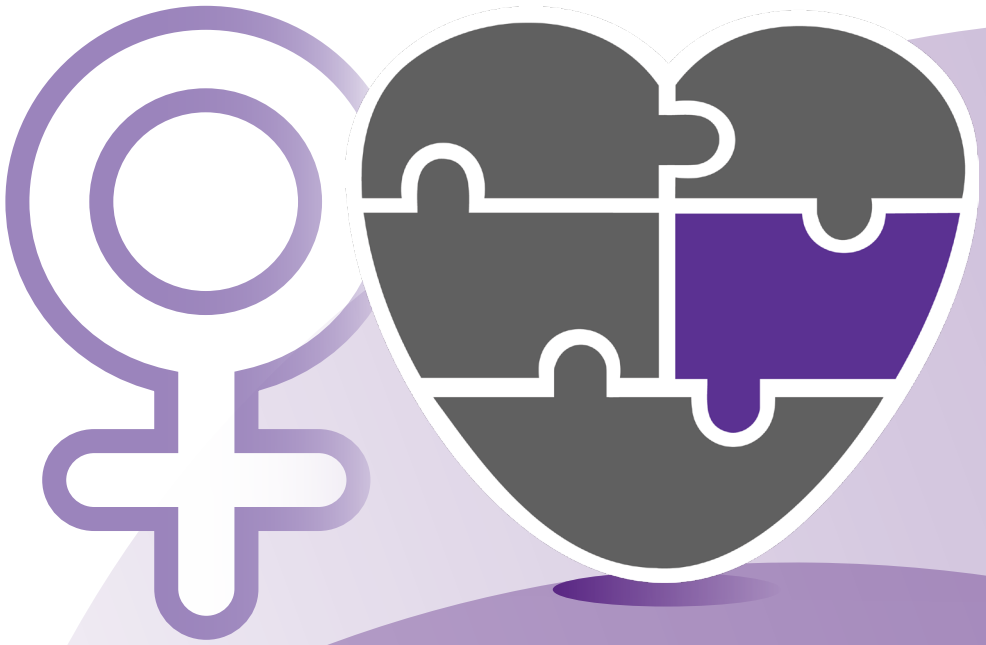
- **Universities & academic centres** – embed sex-specific methods in research training and governance.
- **Cardiology, obstetrics & gynaecology, emergency and menopause specialists** – co-develop standards and disseminate research guidance.
- **Digital health and AI developers** – implement fairness auditing and bias correction.
- **National public health agencies and patient organisations** – support data collection and accountability.

INDICATORS OF PROGRESS

- **100% of cardiovascular studies reporting sex-disaggregated data.**
- **Increased clinical representation of women** – across age, ethnicity and socioeconomic background.
- **Inclusion of pregnancy and menopause variables** in all national registries.
- **Availability of integrated digital health records** linking reproductive and cardiovascular data.
- **Routine AI bias audits** in cardiovascular diagnostics and risk modelling.
- **Growth in women-specific research funding** and publications.
- **Updated clinical guidelines informed by new sex-specific evidence.**

BOLD IDEAS

- **International Women's Cardiovascular Research Consortium** – a global network harmonising trial design and accelerating evidence generation.
- **Global Registry for Women with INOCA/MINOCA (including coronary microvascular dysfunction) and SCAD** – a multinational real-world dataset addressing long-neglected conditions.
- **Global AI Compass for Women's Cardiovascular Health** – a framework guiding ethical, transparent and equitable AI in diagnosis and decision support.



PUBLIC AWARENESS, ENGAGEMENT & EMPOWERMENT

WHY THIS MATTERS

When women do not recognise symptoms, face stigma or distrust systems, delays escalate and outcomes worsen. Awareness that is culturally relevant, emotionally safe and life course aligned is essential for early action.

WHAT NEEDS TO CHANGE (SYSTEM CONDITIONS)

- Normalise women's cardiovascular symptoms and life course risk.
- Embed cardiovascular education across adolescence, reproductive years, pregnancy, postpartum and menopause.
- Co-design culturally relevant messaging with community voices and trusted messengers.
- Integrate mental health awareness into public communication.
- Improve digital inclusion with accessible, plain-language tools.
- Amplify lived-experience storytelling to shift norms and reduce stigma.

STRATEGIC COMMITMENT

Make women's cardiovascular health visible and culturally resonant –empowering every woman, in every community, to recognise symptoms early and seek timely care.

PRIORITY ACTIONS (FIVE PER CORE AREA)

1. **Launch coordinated national/regional awareness initiatives**, including public service announcements (PSAs) on women's symptoms, risk factors and life course triggers.
2. **Co-design community programmes in trusted settings** (workplaces, faith groups, women's organisations, community centres, sports clubs).
3. **Scale peer-support and ambassador models** using lived experience to reduce stigma and normalise symptoms.
4. **Integrate digital tools** (symptom checkers, pregnancy/menopause–CVD interfaces, blood pressure reminders) using culturally sensitive, accessible design.
5. **Strengthen youth education** with school-based cardiovascular modules.

WHO NEEDS TO ACT (AND WHAT THEY NEED TO DO)

- **Ministries of Health, Public Health Agencies & Ministries of Education** – commission national awareness campaigns; embed school-based cardiovascular education.
- **Patient organisations** – lead storytelling, peer support and outreach.
- **Community organisations, cultural leaders & local influencers** – tailor messaging and build trust.
- **Schools & educational institutions** – deliver life course cardiovascular education.

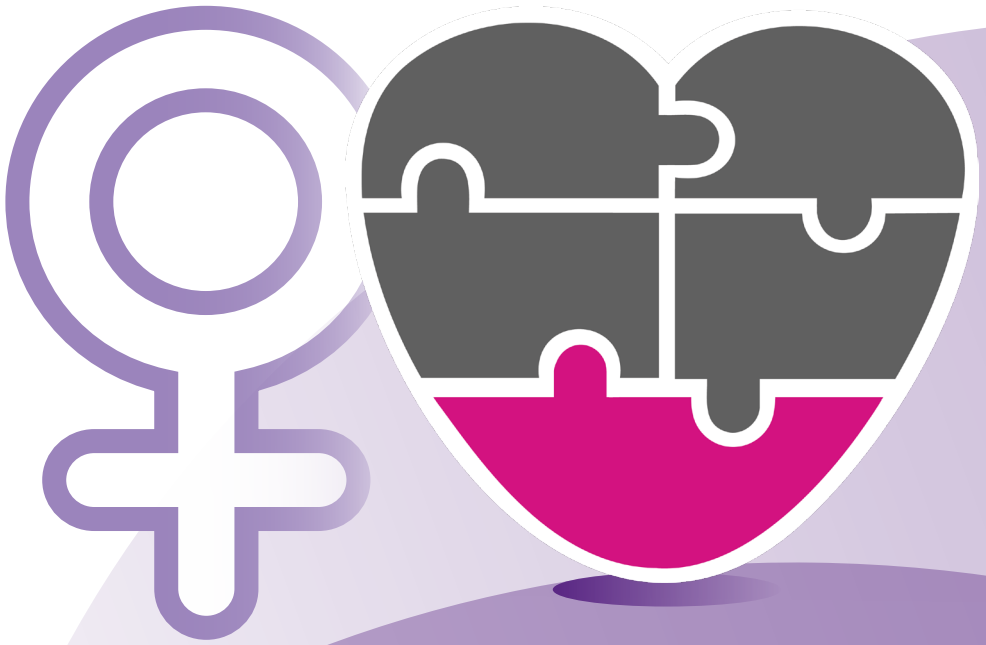
- **Employers & workplace programmes** – promote midlife and menopause awareness.
- **Professional societies** – ensure accurate, bias-free symptom guidance.
- **Digital health partners, media & broadcasters** – expand reach through accessible design and inclusive representation.

INDICATORS OF PROGRESS

- **Increased public awareness** of women's cardiovascular symptoms.
- **Earlier help-seeking behaviour** across age and demographic groups.
- **Higher reach and engagement** of PSAs and campaigns.
- **Greater uptake** of culturally tailored programmes and digital tools.
- **Integration of mental health supports** across women's cardiovascular pathways.
- **Improved symptom recognition** among diverse groups.
- **Reduced diagnostic delays linked to awareness gaps.**

BOLD IDEAS

- **A Global Women's Cardiovascular Awareness Campaign** – a coordinated, multi-country movement elevating women's heart health as a global public health priority.
- **Cultural "Pathways of Trust" Models** – mapping cultural trust points (not just clinical touchpoints) to design outreach that authentically resonates with diverse communities.



Signs of Progress: Emerging Models and Policy Momentum

With the **Women's Heart Health Action Agenda** and its **five core areas for change** established, attention turns to where momentum is already building.

At a global level, the **2025 UN Political declaration on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being** explicitly calls for action to address diagnostic gaps in cardiovascular conditions in women.

Across regions, Summit participants highlighted encouraging signs of progress – where targeted action, collaboration and leadership are already translating principles into practice.

Click on the map buttons above or visit globalhearthub.org/womens-action-agenda to see country and policy spotlights. These spotlights illustrate how priorities discussed at the Summit are being applied across health systems, communities and policy settings, offering early signals of what is possible when women's cardiovascular health is deliberately prioritised.

Conclusion: Bringing the Action Agenda Together

KEY MESSAGE:

The Women's Heart Health Action Agenda brings policy, systems, education, research and public awareness into a single, coherent structure for change. It translates insights from patient community leaders, clinicians, researchers and policymakers across 37 countries into a practical, co-created blueprint aligned with emerging global, regional and national opportunities.

Its purpose is clear: **to make women's cardiovascular health visible, prioritised and structurally supported**.

ENABLING IMPLEMENTATION

Sustained progress relies on key enablers that turn ambition into measurable reform:

- **Coordinated governance** across ministries, agencies and disciplines – with meaningful patient partnership.
- **Long-term investment** in integrated pathways, diagnostic equity, workforce training and research.
- **Shared accountability** through clear indicators, performance reporting and public transparency.
- **Continued communication** to maintain visibility, strengthen awareness and keep inequities on the agenda.

These enablers ensure the **Action Agenda** can be adopted, scaled and sustained across countries and regions.

LOOKING AHEAD

Next steps include embedding the Action Agenda's **five core areas for change** into global and national health strategies, strengthening implementation through collaborative partnerships, advancing sex-specific education and accelerating research and data equity worldwide.

The Action Agenda reflects the strongest priorities identified through the Summit and is intended to be strengthened through implementation, learning and continued collaboration.

Progress will be revisited at future Global Heart Hub convenings to maintain momentum and alignment.

FINAL NOTE

Across the Summit, one message echoed more powerfully than any other:

THINK HEART FIRST – FOR EVERY WOMAN, EVERYWHERE.

This Action Agenda provides the foundation to make that principle real – through policy, systems, evidence and community.

Appendices

Summit Programme and Event Page
https://globalhearthub.org/unite-2025/

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