

Mega Country Health Promotion Network

Summary Report from the first Mega Country Behavioral Risk Factor Surveillance Meeting

Atlanta, Georgia USA
13-14 September, 2000



The most populous countries working together to build behavioral risk factor surveillance capacity

**Bangladesh * Brazil * China * India *
Indonesia * Japan * Mexico * Nigeria *
Pakistan * Russian Federation * USA**



Network Background

The **WHO Mega Country Health Promotion Network** was born out of recognition of the potential to impact world health by forming a partnership among the most populous countries. Eleven countries in the world have a population at or exceeding 100 million: Bangladesh, Brazil, China, India, Indonesia, Japan, Mexico, Nigeria, Pakistan, Russian Federation, and the United States. These Mega countries represent all levels of development and are experiencing different evolutions in the shifting disease and death patterns. Together, these diverse countries represent over 60% of the world's population.

The mission of the Mega Country Health Promotion Network is to strengthen capacity for global and national health promotion, enhance the health of the Mega country populations, and beyond the Mega countries, support the health of the world's population. One goal supporting this mission is to improve the evidence-base for health promotion by strengthening capacity to conduct behavioral risk factor surveillance.

The Mega countries, along with many countries of the world, are currently faced with a rapidly expanding and huge burden due to noncommunicable diseases (NCDs). Surveillance of risk factors is a key component for developing and implementing effective and targeted NCD prevention and health promotion policies and programs. In order for countries to collect global and national priority NCD risk factor data in a sustainable manner, capacity must be strengthened. The goal of the surveillance component of the Mega Country Health Promotion Network is for the Mega countries to work together to contribute to the development of a common core questionnaire and build country capacity to conduct behavioral risk factor surveillance.

This initiative builds on the momentum generated from a series of CDC-sponsored meetings to move the global behavioral risk factor surveillance agenda forward. The series of meetings began with a large conference held in Atlanta, Georgia USA on 22-24 September 1999, which addressed questions about the possibility of standardization and the building of infrastructure for global surveillance. The large conference was followed by two smaller meetings held this year in preparation for an upcoming conference to be held in Finland in October, 2001. The first meeting focused on analysis, interpretation, and data use among countries that have been involved in conducting behavioral risk factor surveillance for some time (14-16 June, 2000). The second meeting, held immediately before the first Mega country meeting on behavioral risk factor surveillance (11-13 September 2000) focused on capacity building, comparability, and use of data among countries that are interested in or just beginning to implement behavioral risk factor surveillance systems in their countries.

Mega Country Behavioral Risk Factor Surveillance Meeting

13-14 September, 2000

Summary

Mega country experts from the fields of surveillance and NCD prevention were invited to attend this meeting to begin working together to plan a concrete, systematic, and harmonized approach to behavioral risk factor surveillance that is scientifically-based and fosters sustainable data collection. Input was sought from the attendees to begin development of several key products: (1) core questionnaire consisting of key behavioral risk factors that impact NCD health outcomes, (2) protocol for conducting behavioral risk factor surveillance, and (3) materials binder to house the core questionnaire, protocol, and supporting surveillance technical information.

Core Questionnaire Development

General recommendations

1. Identify risk factor indicators rather than specific question wording.
2. Specify indicator rules to apply to question development. For example, specify time periods (e.g., past 30 days), number (e.g., smoked at least 100 cigarettes in lifetime), etc., to ensure comparability across countries wherever possible.
3. Include indicators in core that impact most on NCDs and where interventions are available/possible.
4. In addition to mortality indicators, also consider including indicators of disability and long-term chronic suffering.
5. Focus indicators on frequency, duration, and intensity of exposure.
6. Utilize biomarkers for critical risk factors that are hard to measure.
7. Whenever possible, use questions from well-established and existing questionnaires, utilizing the “best of the best” and validated questions.
8. Seek input from topic area content experts in the development of questions and to identify priority questions to include in the core questionnaire.

Indicator topic areas: considerations and recommendations

Points for consideration/recommendations made by participants during the meeting are summarized below by each indicator topic area considered for inclusion in the core questionnaire:

*** Tobacco use**

- An easy risk factor to measure.
- Determine which forms of tobacco use to include in core questionnaire (e.g., cigarette use only vs. also including chewing tobacco use).
- Seek input from the Tobacco Free Initiative and a shortened form of their questionnaires.

*** Alcohol use**

- Form of alcohol varies from country to country.
- Focus on clearly defining alcohol amount and drinking patterns.

*** Physical activity**

- Related to other risk factors and disease outcomes (e.g., obesity, blood pressure, and hypertension).
- For some countries, applicable only in urban areas.
- Must capture total physical activity (e.g., covering work, transportation, home, and leisure activity).
- The International Physical Activity Questionnaire (IPAQ) provides a good model for other topic areas with regard to global question development/validation. IPAQ focuses on vigorous and moderate activity, walking, and inactivity (time spent sitting) and has been tested and validated in a number of developing countries.

*** Dietary behaviors**

- Very difficult to measure.
- Determine how many Mega countries have dietary guidelines in order to explore the possibility of developing indicators around guidelines.

*** Mental health**

- Self-report of combination of mental and physical health in terms of days/months, and in a small number of questions (CDC example).
- There is currently no public health intervention for stress.

Indicator topic areas: considerations and recommendations

* **Injury**

- Injury is an outcome.
- Consider both types of injuries—intentional (e.g., violence, suicide attempts) and nonintentional (e.g., car, motorbike, or bicycle crashes) injuries.
- Focus on concept of injury associated with transport, leaving form/choice up to country (e.g., seat belt or helmet use).
- Although injury indicators may currently have little meaning for some countries, this may change over time (e.g., as more people drive). Therefore, think in the long term with regard to adding questions to the core.

* **Sexual behaviors**

- This category of behaviors has both a health promotion tie and provides a link to communicable diseases.
- Main emphasis is on STDs, including HIV infection, and unintended pregnancies.
- See how to integrate with existing HIV surveys.

* **BMI**

- Consensus of group to include as a proxy for changes in dietary patterns.
- Self-reported knowledge of height and weight may vary country to country.

* **Blood pressure**

- Blood pressure question includes a health seeking element, plus a form of assessment of health system ability to provide services.
- Consider asking question about whether respondent has had blood pressure measured during a particular time frame (look at Preventive Services report to determine time frame).

* **Preventive health/health seeking behaviors**

- Include cervical cancer screening.

* **Demographics**

- Include age and gender; may need to use estimated date of birth for some countries.
- Differentiate between urban and rural.
- Obtain some measure of educational and employment status.

Methodology and Data Collection Considerations

1. To ensure a scientific basis, the sample should be a random probability sample.
2. Start small and build—begin with one or more sentinel sites and work towards a national sample.
3. With regard to frequency for conducting surveillance, balance what is feasible against the need to work towards a surveillance model that moves beyond conducting a series of surveys and includes time as an element.
4. Take seasonal variations for data collection into account (e.g., crop planting season, etc.)
5. Consider impact of methodology on type of data that can be collected. For example, when conducting face-to-face interviews, physical assessment may not require much more effort/expense. If using a telephone-based interview method, physical assessment is prohibitive.
6. If doing physical assessment, offer information/education to the participants (e.g., provide blood pressure results).

Protocol Development Considerations

Rather than offering a prescriptive, standardized surveillance procedure, the protocol to be developed will focus on harmonizing principals that the Mega countries will agree to so that we can move forward together to build sound and culturally relevant behavioral risk factor surveillance systems. Specific suggestions and considerations to be included in the protocol include:

1. Clearly indicate that data belong to each country. Countries will donate global core data to WHO, to be used with agreed upon rules, including the rule that data are not to be used to rank countries.
2. Address poverty and equity issues in connection with why we are interested in strengthening behavioral risk factor surveillance systems, how a population focus offers a sense of equity and service to the population, and how surveillance contributes to a larger public good.
3. List the pros and cons of surveys and surveillance and develop a long-term plan to work towards continuous surveillance.
4. Address issues, such as how to introduce a global core questionnaire into national questionnaires that are already in existence, and have been in existence for a long time.
5. Identify analytic approaches to use.

6. Help ensure that future data collection is more comparable across countries by using the same core instrument, age groups, and by collecting data during the same time period (e.g., collecting data during the same year).

Recommendations for WHO Role

- Assume leadership for this effort: (1) classify this activity as a priority area with an attached budget, (2) establish a secretariat to coordinate this effort, (3) create a technical core group, (4) inform and convince governments/authorities of this initiative's importance, and (5) utilize alliances to advocate on the initiative's behalf.
- Identify technical role for, and partnerships with, other agencies such as CDC and Finland institutes, to support surveillance in the Mega countries (e.g., providing data analysis support). Ensure country access to technical support.
- Before offering country support, determine a country's commitment to move forward to conduct surveillance and sign an agreement. Delineate key commitment steps to be followed.
- Develop materials and provide a clearinghouse of tools (e.g., protocol, guidelines, questionnaire, analysis strategies, etc.). Provide supporting materials to countries to start a pilot test in one sentinel site (at a minimum). Provide training to help countries strengthen capacity and implement their surveillance plan.
- Provide recommended surveillance standards for global core questionnaire.
- Mobilize resources from foundations (e.g., Gates Foundation) and pool resources wherever possible.
- Develop a plan to expand surveillance efforts within the Mega countries and to other countries beyond the Mega countries.

Recommendations for Mega Country Role

- Identify a national focal point.
- Determine if agenda is acceptable to government and seek commitment to support sustainability of behavioral risk factor surveillance efforts.
- Link/integrate with NCD intervention projects and policy development.
- Identify sentinel site(s) to pilot test.
- Translate surveillance materials to facilitate dissemination of information.



Next Steps

1. Develop draft protocol for partner review and input by 31 December 2000.
2. Identify/develop draft core and optional questionnaire indicators:
 - WHO collect, compile, and distribute existing questions from the key topic areas currently used by the Mega countries
 - Create working groups around indicator topic areas:
 - Appoint working group coordinators from participating countries or agencies
 - Working groups complete first draft work by 31 December 2000
3. Develop Mega country surveillance commitment criteria for partner review and input by 31 December 2000.
4. Begin technical surveillance material development and prepare drafts for review at next meeting.
5. Schedule second surveillance meeting (April, 2001) to finalize core questionnaire and develop country plans for surveillance implementation.
6. Seek support to establish an Internet List Serv to maintain ongoing surveillance-related communication with partners (see annex D for a brief description of a List Serv).
7. Seek WHO support to establish secretariat to coordinate initiative.

Moving Forward

We have a very big agenda before us to strengthen capacity within the Mega countries to conduct behavioral risk factor surveillance. Fortunately, we have the partnership of the Mega countries to help us focus our efforts, share experiences, and encourage each other to move forward quickly to contribute to the much needed global NCD data base. At the national level, this data also will contribute significantly to the development and implementation of effective and targeted NCD prevention and health promotion policies and programs.

Together, through our consensus building process, we can strengthen our capacity to establish and maintain behavioral risk factor surveillance systems in each of our countries. As we begin, let us keep the following sentiments in mind, expressed by Mega country representatives during our first meeting:

Think big, start small, act now!

(Indonesia)

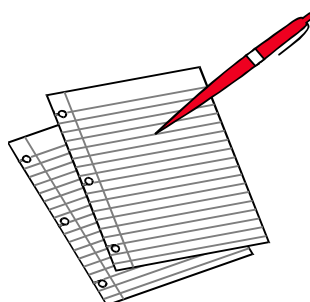
Right now!

(Mexico)

Annex A

Materials Development Outline

- Core questionnaire
- Optional questionnaire
- Protocol
- Supporting technical and management tools and information, for example:
 - Calculating sample sizes
 - Sampling strategies
 - Training curriculum
 - Interviewing techniques
 - Reliability/validity of questions
 - Increasing response rates: refusal conversion techniques
 - Respondent confidentiality and burden
 - Data processing procedures
 - Communicating data effectively
 - Quality control considerations
- Cases demonstrating good examples of surveillance application designed to target:
 - Special populations
 - Specific health issues or risk factors
 - Settings approaches
- Reference materials
- Secretariat and country contact information



Annex B



LIST SERV for Behavioral Risk Factor Surveillance

Many of us have questions that arise on a daily basis to which we may not know the answer, but we are also fully aware that someone, somewhere in our professional field does possess the knowledge we need. With the Internet, we can not only search websites for information, but also communicate with people we rarely have the opportunity to meet—especially given the physical distance between countries in the Mega Country Health Promotion Network. List Servs provide a mechanism whereby e-mail messages are systematically made available to defined groups of people. This allows for communication to occur between the members regarding a topic of interest to them all.

- LISTSERV is a program that maintains a mailing list and forwards all mail to members on the list.
- For several years, List Servs have been a staple for rapid and broad distribution of information on the Internet.
- Unlike newsgroups, they are not interactive—subscribers simply read and respond to written postings. One can read what others have written and then post one's own comments. One can also just read what others have posted without responding.
- A List Serv would be highly beneficial for us all to communicate and exchange ideas or information in regards to our professional agenda. It would serve the needs of the surveillance component of the Mega Country Health Promotion Network.
- We can use a List Serv to discuss any topic of relevance to behavioral risk factor surveillance, ranging from core questionnaire planning, to sampling strategies, to data management, to quality control, to communicating data, or to any topic that may arise.

A List Serv is simple for anyone with Internet access to use. There is no extra fee for this service and all you need is an e-mail account. Once a List Serve is set up by an administrator, all that needs to be done is simply reply to an e-mail message from the administrator, indicating that you want to subscribe. We can all use this as a tool to broaden our knowledge and foster greater communication and research among our Mega country surveillance colleagues.