Youth and adult surveillance

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Rome, Italy October 2007

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Working for more than 50 years to *connect and support* everyone committed to advancing health promotion and to achieving equity in health.








Youth and adult surveillance at CDC

- YBRFS
- BRFS
- GYTS
-

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Youth Surveillance at CDC's National Center for Chronic Disease Prevention and Health Promotion

SAFER • HEALTHIER • PEOPLE™

Purposes of the YRBSS

- Focus the nation on behaviors among youth causing the most important health problems
- Assess how risk behaviors change over time
- Provide comparable data

Behaviors That Contribute to the Leading Causes of Morbidity and Mortality

- Behaviors that contribute to unintentional injuries and violence
- Tobacco use
- Alcohol and other drug use
- Sexual behaviors
- Unhealthy dietary behaviors
- Inadequate physical activity

Characteristics of the National, State, and Local School-Based YRBS

- 9th – 12th grade students
- Probability samples of schools and students
- Anonymous
- Self-administered, computer-scannable questionnaire or answer sheet
- Completed in one class period (45 minutes)
- Conducted every 2 years, usually during the spring *(next report to be issued in*

2005 National YRBS

- National probability sample of public and private schools
- Total sample size = 13,917
- School-level response rate = 78%
- Student-level response rate = 86%
- Overall response rate = 67%

YRBS: Policy and Program Applications

- Describe risk behaviors
- Create awareness
- Set program goals
- Develop programs and policies
- Support health-related legislation
- Seek funding

National Youth Tobacco Survey

- Items include correlates of tobacco use such as demographics, minors' access to tobacco, and exposure to secondhand smoke.
- Provides nationally representative data about middle and high school youth's
  - Tobacco-related beliefs
  - Attitudes
  - Behaviors
  - Exposure to pro- and anti-tobacco influences
- NYTS data are available for surveys conducted in 1999, 2000, 2002, and 2004.

International Youth Tobacco Surveys

- Global Youth Tobacco Survey – tracks tobacco use among youth across countries using a common methodology and core questionnaire.
- Global School Personnel Survey – **c**ollects information from school personnel concerning their use of tobacco and their tobacco-related school policies and programs.
- Both surveys developed by CDC and World

School Health Profiles: Monitoring Tool for State & District Education and Health Agencies

- Current status of school health education
- School health policies related to HIV/AIDS, tobacco use prevention, unintentional injuries and violence, physical activity, and food service
- Physical education
- Asthma management activities
- Family and community involvement in school health programs.

School Health Profiles

- Conducted by state and local education and health agencies
- Conduced every 2 years *(next report to be issued in December 2007)*
- Conducted at middle/junior high school and senior high school levels in states/districts

Example: School Policies for Competitive Foods and Beverages

- 89% of secondary scho
  sold high-fat, high-suga
  snack foods or beverag
- 44% of same schools
  sold fruits and vegetab

Source:
2004 School Health Profiles

School Health Policies and Programs Study

- Largest and most comprehensive study of health policies and programs in U.S. schools.
- National survey conducted in 1994, 2000, and 2006 (next survey planned for 2012)
- Assesses school health policies and practices at the all levels:
  - State
  - District

Questions Addressed by SHPPS 2006

- What are the characteristics of each school health program component across elementary, middle, and high schools?
- Are there persons responsible for coordinating and delivering each school health program component?
- What collaboration occurs among staff from each school component and with staff from outside agencies and organizations?

Sample Findings from SHPPS (2006 vs. 2000)

- States prohibiting schools from offering junk foods in vending machines increased from 8% to 32%
- States that required elementary schools to provide students with regularly scheduled recess increased from 4% to 12%
- Schools with comprehensive tobacco control policies increased from 46% to 64%
- Schools that sold cookies, cake, or other high-fat baked goods in vending machines or school stores decreased from 38% to 25%

Critical areas

- Surveillance and Response
- Public Health Infrastructure and Capacity
- Determination of Evidence
- Disease Prevention and Control
- Health Promotion

Health Promotion argues that “Context is everything” – world like/unlike us relationship to burden and health promotion

- Cultural differences
- Economic differences
- Our assumptions
- Historical development of International Health

Essentials of a Sociobehavioral Monitoring System for Health to build evidence of the changing burden

- A theoretical base
- Time as a variable
- A systems approach
- Partnership

A theoretical base

BIG Theories

- Globalization
- Deprivation
- Migration
- Urbanization [a.k.a. sprawl]

Little Theories

- Risk Factors
- Social Determinants
- Lifestyle
- Personal Behavior

There is *dynamic change* in the population

Our concern is with

Change

Time

Two Major Areas of Concern for SMSH

Technical

- Questionnaire
- Sampling
- Data Collection Method
- Analysis
- Dissemination
- Translation

Structural

- Buy in
- Public Health Infrastructure
- Social Science Infrastructure
- Link to Health Promotion
- Sustainable Resources

Global success of Sociobehavioral Monitoring Systems for Health Dependent Chiefly on Two Key Factors

- Degree of structural development of countries
- Leadership and responsibilities of agencies engaged

The Great KAP Possibilities

- Risk assessment
- Fear and anxiety
- Civility
- Social capital
- Urbanization
- Road rage
- Commuting
- TV behaviors
- Internet behavior
- Religious practice
- Pill taking

Surveillance

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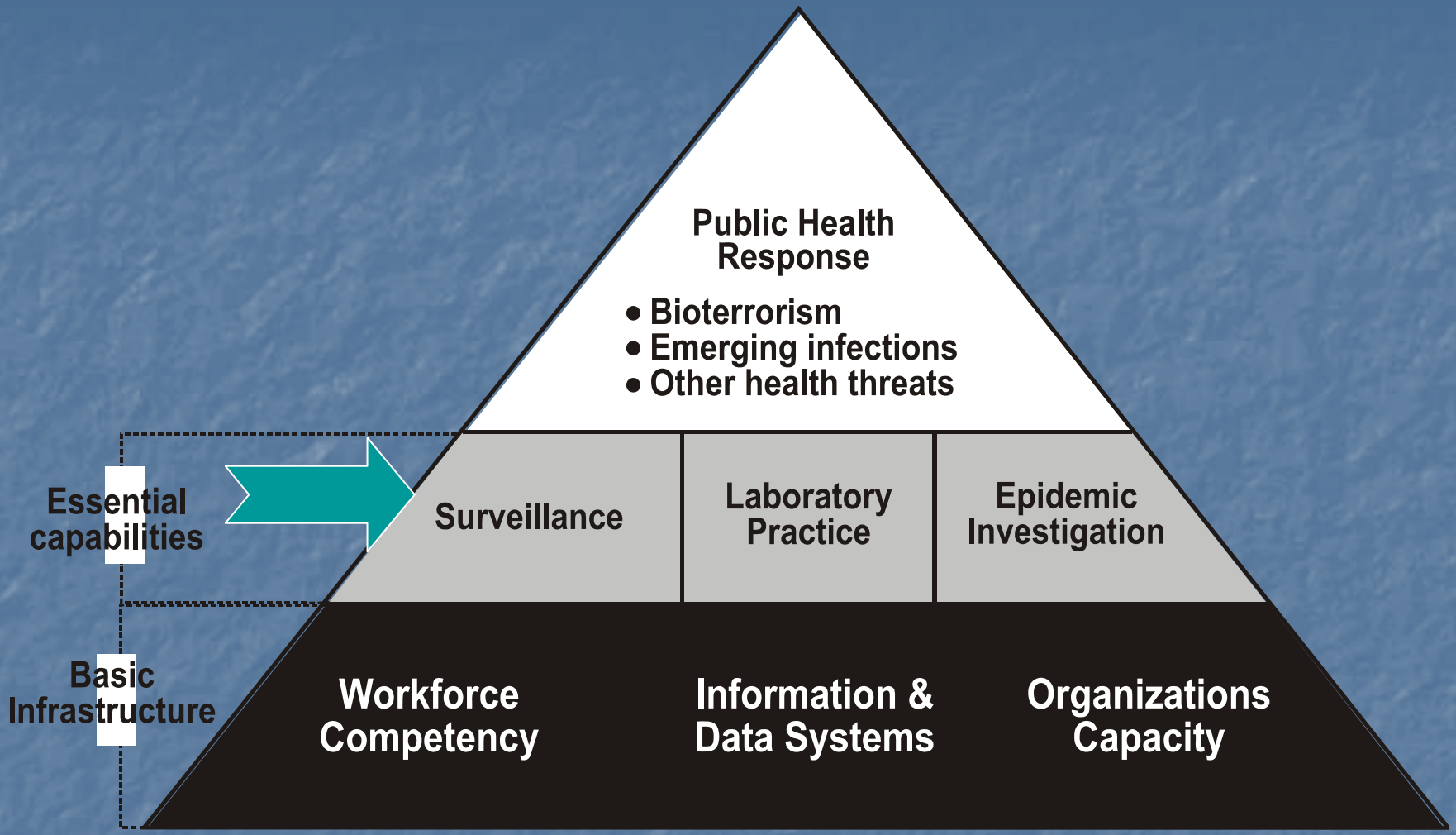
Research

Exhibit 2

Pyramid of Public Health System Preparedness



What is needed to build INFRASTRUCTURE?

- Long-term public health monitoring
  - not tied to universities
  - ongoing support
- Level of operation
  - regional, transnational
  - national
  - state, local
- Focal Point
  - organizations (WHO)
  - players, partners

What is needed to build INFRASTRUCTURE?

- "Resource Groups"
  - technical assistance
  - policy analysis
  - dissemination
- Global community
  - added value
- Fit in in-depth surveys

Data analysis: a main feature for Surveillance Systems and analysis as evidence

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SURVEILLANCE

SURVEYS SYSTEM-leading to evidence

...

data collection

data analysis

interpretation

data use ...

...time

...

The spiral of surveillance (as a learning system leading to evidence)

data collection

data analysis

interpretation

data use

New knowledge as evidence

need for new

data collection

Seeking evidence on the changing burden of disease leads to an interaction with the very foundations of health promotion: an example from Ottawa

A foundation of “health promotion”

- One of the five strategies identified in the Ottawa Charter in 1986 was on supportive environments of health promotion – this is key to understanding present day health promotion in the West

Create Supportive Environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable. Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

The meaning of the statement

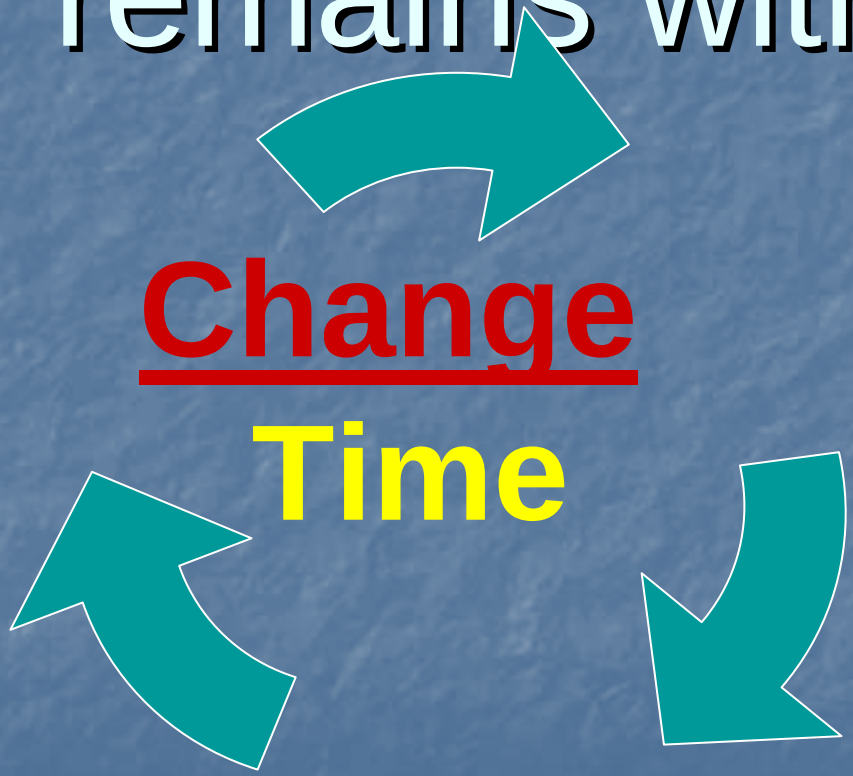
- Our societies are **complex** and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a **socioecological** approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our **communities and our natural environment.** The conservation of natural resources throughout the world should be emphasized as a global responsibility.

- Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society.

But how do we track the changes over time in these conditions?

- **Systematic assessment of the health impact of a rapidly changing environment** - particularly in areas of technology, work, energy production and **urbanization** - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and **built environments** and the conservation of natural resources must be addressed in any health promotion strategy.

Our concern remains with



A widely held assertion

There are those who believe that the environment, supportive or unsupportive, for health promotion **has changed** markedly since the development of the Ottawa Charter: Bangkok Charter* reflects this notion

- Increasing inequalities - inequities
- Newly emerging patterns of consumption, communication, (globalization)
- Global environmental change
- Urbanization

*The WHO Bangkok Charter for Health Promotion in a Globalized World (2005) identifies actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion. The Charter affirms that policies and partnerships to empower communities, and to improve health and health equality, should be at the centre of global and national development.

Bangkok Charter: Scope and Purpose

The Bangkok Charter identifies actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion.

The Charter affirms that policies and partnerships to empower communities, and to improve health and health equality, should be at the centre of global and national development.

We are concerned with

- The environment and we focus on the CONTEXT as our word for “environment”
- Social context
- Cultural context
- Reference is made to social determinants seen as context

The Components of Social Determinants from a HP Perspective

- ***LIFESTYLE***: Collective pattern of life conduct
- ***LIFE CONDUCT***: Pattern of behavior of an individual in their day-to-day lives
- ***LIFE CONDITIONS***: Patterns of resources of an individual or group (including health status)
- ***LIFE SITUATION***: Collective pattern of life conditions
- ***LIFE CHANCES***: Structural-based probability of correspondence of lifestyle and life situation

- Adapted from Rutten, A. (1995). The implementation of health promotion: a new structural perspective. Social Science & Medicine, 41(2), 1627-1637.

The context and determinants are seen as changeable through intervention

- We track that change through surveillance

And build the evidence

The challenge of ‘evidence’

- What is new, what is old
- What work needs to be done
- What is “inside” the evidence debate
- What is “outside” the debate
- Recognize what we “know” versus what we “wish for”.

How to build “good” evidence

- Distinguish evidence of success from evidence of harm
- Methodology of deleting vs building evidence – reduction vs complexity
- Operationalize judgment
- Distinguish evidence from effectiveness from evaluation

How to build “better” evidence

- Distinguish levels of complexity
- Methods follow complexity
- Build data retrieval that is complex
- Move away from reduction
- Collect more data
- More interventions

Evidence is

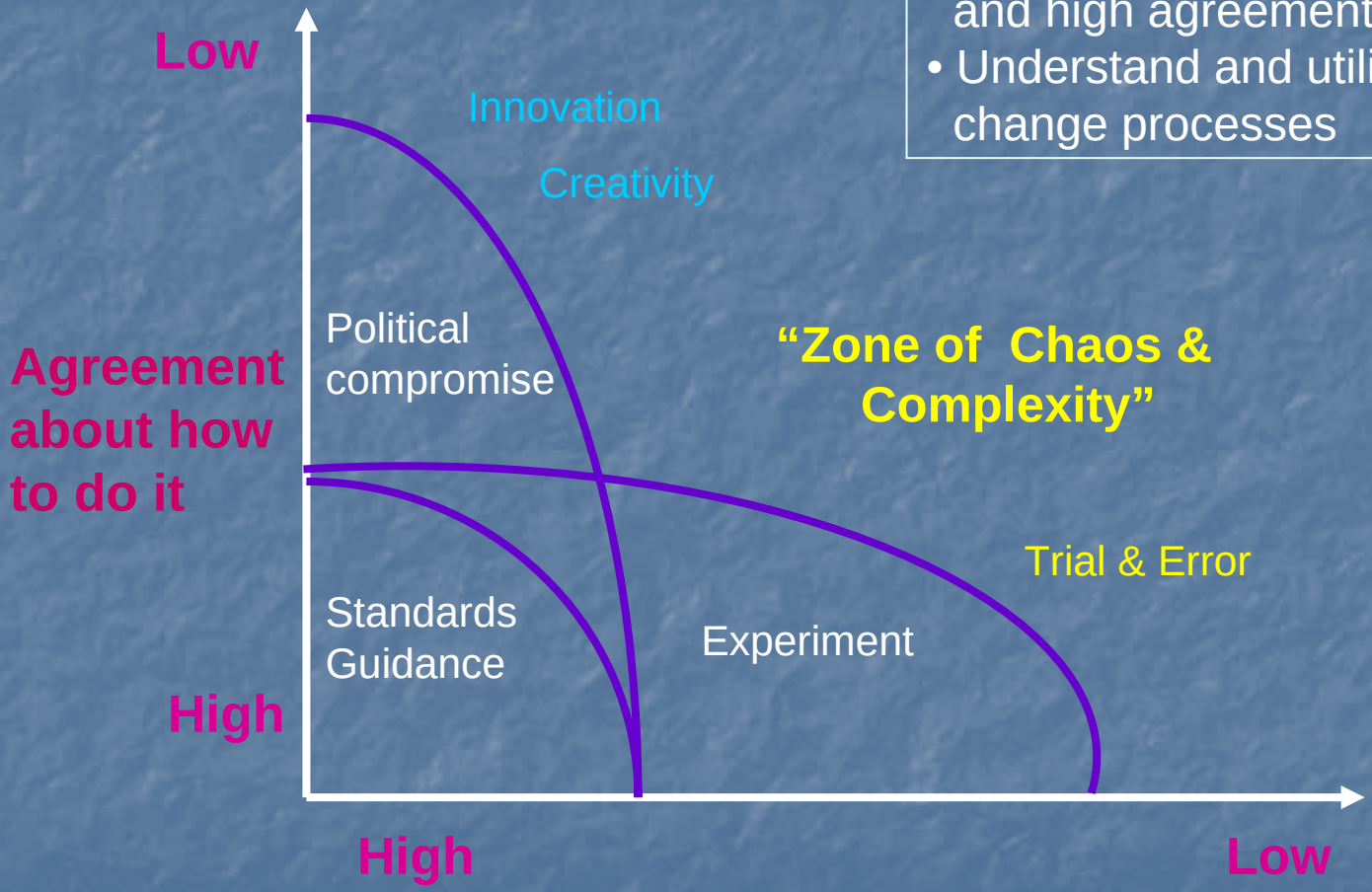
- Strength of knowledge base for what works

Effectiveness is

- Agreement about translating the evidence to application

Understanding change processes*: where effectiveness meets evidence

- Focus on areas with high certainty and high agreement
- Understand and utilize effective change processes



*HDA V Speller

DM1

Zone of Chaos and Complexity: Characteristics

Multiple determinants
Multiple intervention settings
Multiple outcomes
Multiple actors
Multiple paradigms
Cultural diversity
Everything/interactions=probabalistic
Politics

Diapositiva 52

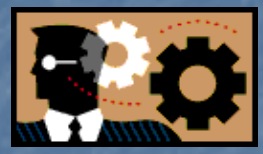
DM1 David McQueen; 12/07/2006

So what can we conclude?

- We have initial evidence that health promotion interventions on the social determinants of health work
- However, comprehensive and/or systematic reviews have only been conducted on a few interventions and almost entirely on western literature
- More importantly, we have no systematic tracking of supposed changes over time attributable to interventions

Three things that we need

- **Many more** health promotion **interventions** based on the best theory of practice
- **Many Comprehensive** and/or systematic **evaluations** of interventions
- A **comprehensive monitoring system that builds the evidence for change over time**



- More information:dvmcqueen@cdc.gov

Q and A

The 51st World Health Assembly

Urged all Member States to:

"adopt an **evidence-based approach** to health promotion policy and practice, using the full range of quantitative and qualitative methodologies"

WHO, 51st World Health Assembly, Agenda Item 20, Geneva, (1998)