



Growing Up: Expanding From Youth to Adult Risk Factor Surveillance Report on the January 26, 2011 Symposium

March 18, 2011

Contents

Introduction	1
Keynote Speakers	1
Dr. John Garcia: Using a systems approach to healthy living and the value added in Manitoba.....	1
Dr. Glennis Andall-Brereton: Adult risk factor surveillance – international success stories and lessons learned.....	2
Dr. Jane Griffith: Manitoba risk factor surveillance – building on success.....	4
Questions and Answers.....	5
Case Studies: Implementing Adult Risk Factor Surveillance in Manitoba	7
Tannis Erickson: Interlake RHA.....	7
Jody Allan: Assiniboine RHA	7
Nancy McPherson: Brandon RHA.....	7
Lessons Learned	8
Group Discussions	8
Next Steps for Partners in Planning for Healthy Living	11
Summary of Symposium Evaluations.....	12



Introduction

On January 26, 2011, Partners in Planning for Healthy Living (PPHL) held a symposium in Winnipeg that was attended by approximately eighty representatives from Manitoba's regional health authorities, federal and provincial government departments and agencies, and non-governmental organizations (NGOs). In addition, five people attended from various organizations in Saskatchewan to learn about the Manitoba experience so they can advance risk factor surveillance in their own province. The symposium, titled *Growing Up: Expanding from Youth to Adult Risk Factor Surveillance*, was designed to achieve three objectives:

- highlight the importance of community-level adult risk factor surveillance and address gaps in current data,
- review the pros and cons of different methodologies for adult risk factor surveillance, and
- identify existing resources and supports at the regional level to conduct adult risk factor surveillance in Manitoba.

Debbie Brown, Chair of PPHL, opened the symposium and introduced Jim Rondeau, Minister of Healthy Living, Youth and Seniors and Minister responsible for Healthy Child Manitoba, Mental Health, and Recreation. Minister Rondeau said he is impressed by PPHL and its Youth Health Survey (YHS) and by the fact that the survey was conducted at low cost by building on existing strengths within participating organizations. He noted that many groups within the provincial government are talking about the data from the YHS.

The minister wants Manitoba to be the healthiest province in Canada and a world leader in healthy living. He wants to set targets to achieve this goal and welcomes PPHL's advice on what those targets should be and how they can be achieved.

This report highlights the presentations by keynote speakers Dr. John Garcia (University of Waterloo) and Dr. Glennis Andall-Brereton (Pan American Health Organization), the presentation by Dr. Jane Griffith (CancerCare Manitoba) about Manitoba's success with the Youth Health Survey, and the question and answer session that followed the three presentations.

The report also includes key points from presentations on three regional health authorities' experiences doing adult risk factor surveillance in Manitoba and closes with a summary of the reports from group discussions on adult risk factor surveillance in the province.

Keynote Speakers

The presentations by Drs. Garcia, Andall-Brereton, and Griffith are available online at <http://www.healthincommon.ca/pphl/meetings/>.

Dr. John Garcia: Using a systems approach to healthy living and the value added in Manitoba

Dr. Garcia is an associate professor at the University of Waterloo's Department of Health Studies and Gerontology. He began his presentation by noting that Manitoba is a leader in using a systems approach for population health promotion and chronic disease prevention. A systems approach recognizes complexity and local variation, is holistic and multi-level, is self-directed and controlled, considers variety and social emergence, and includes feedback and adaptive and learning processes.

Dr. Garcia believes that surveillance and evaluation are necessary to achieve the vision to develop a sustainable, effective, comprehensive, and integrated health promotion and chronic disease prevention strategy in Manitoba.



Statistics Canada's Canadian Community Health Survey (CCHS) provides high-level surveillance data whereas Manitoba's Youth Health Survey and the proposed adult risk factor surveillance survey provide timely, local data on topics of particular interest.

Surveillance systems can monitor the following:

- social determinants, risk factors, and health outcomes,
- interventions and systems'/organizations' capacity, and
- knowledge/evidence e.g. through a literature search.

While surveillance provides one type of information for action, evaluation provides another type of information based on systematic inquiry that is concerned about use and application (Patton, 1997, 2002, 2008). Evaluations interpret information and knowledge for social betterment. Dr. Garcia reviewed the three purposes of evaluation:

- summative – to ensure accountability for delivery and outcomes or to judge or justify,
- formative – for learning, orientation, or to improve interventions, and
- knowledge – to enlighten or contribute to science.

Surveillance and evaluation for practice-based learning have the following characteristics:

- are action oriented,
- involve a societal project for social betterment,
- take place in local or regional organizations or communities,
- have effect through learning and making sense,
- contribute to rigorous thought and methods,
- test reality using systematic methods,
- are an integral part of an intervention, and
- require data at an organizational, system, or community level.

Generally, surveillance and evaluation serve four purposes: they can inform decisions, behaviours, and actions; they enlighten, demystify, or change attitudes; they persuade or legitimize; and they can result in process changes even before results and reports are finalized.

In closing, Dr. Garcia referred to two examples of surveillance and evaluation – the Ontario Tobacco Strategy and the Ontario Risk Behaviour Surveillance. For details access Dr. Garcia's presentation at <http://www.healthincommon.ca/pphl/meetings/>.

Dr. Glennis Andall-Brereton: Adult risk factor surveillance – international success stories and lessons learned

Dr. Andall-Brereton is with CAREC, the Caribbean Epidemiology Centre. CAREC works in twenty-one countries that are members of the Pan American Health Organization (PAHO), the World Health Organization's Regional Office for the Americas. Dr Andall-Brereton presented information about three international approaches to surveillance of chronic disease risk factors in adults:

- The World Health Organization's STEPwise approach (www.who.int/chp/steps/en/), which is used throughout the CAREC countries,
- VIGITEL, which is used in Brazil, and
- PASSI, which is used in Italy (www.epicentro.iss.it/passi/surveillance_system.asp).

CAREC's regional strategy to control non-communicable chronic diseases began with a 2007 declaration signed by the governments of all English speaking Caribbean countries. The strategy has four components: health promotion, surveillance to quantify and track risk factors, integrated management of chronic disease and risk factors, and public policy and advocacy.



The strategy's surveillance component uses the WHO STEPwise system, which has three objectives:

- to empower countries to gather information on chronic disease risk factors for use in planning health programmes and interventions,
- to provide a standardized questionnaire that allows for comparisons but is flexible to meet country needs, and
- to build country capacity in all aspects of national survey implementation and in particular to develop skills in sample design, data collection, and data analysis.

STEPwise targets a nationally representative sample of adults aged 25-64. After a household is selected for inclusion in the survey, one member of the household who is within the target age group is randomly selected to participate in the three-step surveillance process.

In step 1, an interviewer visits the home and administers a survey that includes questions on behavioural risks such as tobacco use and physical activity. In step 2, the interviewer takes physical measurements such as height, weight and blood pressure. The interviewer returns for step 3, which involves a blood test for biochemical analysis.

Although interviewers can record survey answers and physical measurements on paper, most countries decide to equip their interviewers with personal digital assistants (PDAs) that CAREC provides. The PDA offers several advantages. The PDA software randomly selects one participant from each household, automatically directs the interviewer from question to question, performs automatic error checking, eliminates the need for data entry, and supports multiple languages.

In addition to providing PDAs, a manual, and the STEPS survey (which has a core, expanded, and optional module), CAREC also provides three days of training for a country's survey planning and coordinating committee; five days of training for interviewers, supervisors, and the coordinating committee; and another five days of training on analysis and reporting.

The VIGITEL surveillance system used in Brazil is based on the Centre for Disease Control's Behavioural Risk Factor Surveillance System (www.cdc.gov/brfss/). The VIGITEL system monitors populations in all Brazilian state capitals and the Federal District using random samples of adults age eighteen and older living in households with landlines. Participating adults are interviewed by landline telephone every month.

Like VIGITEL, Italy's PASSIS surveillance system is based on the CDC's Behavioural Risk Factor Surveillance System and uses monthly telephone interviews to gather data from randomly selected adults aged 18-69.

Dr. Andall-Brereton reviewed several lessons learned for successful adult risk factor surveillance systems:

- secure high-level political commitment,
- establish partnerships with local organizations and institutions,
- involve all parties at the planning phase,
- use a standardized methodology to facilitate comparisons,
- offer some flexibility for to include additional, customized questions,
- provide support and training for survey planning, implementation, data entry, analysis, and report writing,
- offer assured funding to ensure the system is sustainable, and
- enhance accountability through annual reporting, a minimum data set, and political support.

Dr. Andall-Brereton highlighted the benefits provided by adult risk factor surveillance. Data can be used to identify populations at risk, forecast the need for specific health services, and to develop policy. Other uses include developing and implementing programs, evaluating interventions, monitoring trends, making comparisons to other countries or regions, and conducting research.



Dr. Jane Griffith: Manitoba risk factor surveillance – building on success

Dr. Griffith, an epidemiologist and team leader at CancerCare Manitoba, provided background information about Partners in Planning for Healthy Living, reviewed Manitoba's experience and success with youth risk factor surveillance, and looked at what Manitoba has in place and what it will need to develop to conduct adult risk factor surveillance.

PPHL is a formalized partnership of non-governmental health organizations, regional health authorities, Manitoba Education, Manitoba Healthy Living, Youth and Seniors, Manitoba Health, Healthy Child Manitoba, Health in Common, the Public Health Agency of Canada, and others. PPHL's vision is to build prevention capacity in Manitoba, a province-wide chronic disease risk factor surveillance system that is integrated with community planning and best practices, and a sustainable system that fits into planning cycles at all levels.

To achieve this vision, PPHL is guided by its values (inclusive and flexible, non-judgmental, community friendly) and its principles:

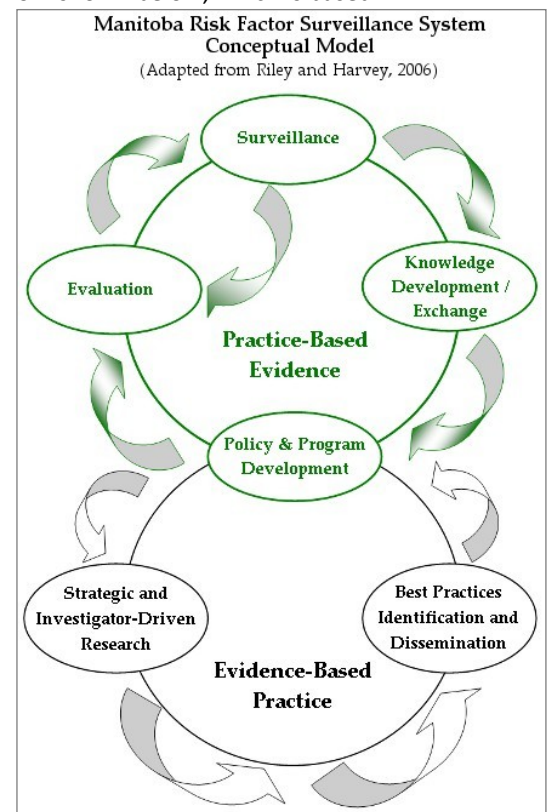
- focus on evidence,
- support the development of knowledge and capacity within communities, and
- support integrated, community planning for healthy living.

Partners in Planning for Healthy Living uses the conceptual framework shown below, which is based on a blueprint for knowledge integration that Barb Riley and Dexter Harvey developed in 2006. The framework shows the connections among surveillance, knowledge development/exchange and evaluation and between practice-based evidence and evidence-based practice.

PPHL is working toward an ongoing, integrated risk factor surveillance system in Manitoba that operates at the community level, is consistent and sustainable across the province, builds capacity at all levels (community, school, region, province), is based on evidence, produces practice-based learning, and allows participating organizations to learn as they go.

As a first step toward this goal, PPHL initiated a Youth Health Survey that was conducted as a census of almost 50,000 students in grades 9 to 12 across the province. Over 400 schools and all of the province's 11 regional health authorities participated. PPHL's member organizations provided resources and funding with additional funding provided by non-members such as the Canadian Partnership Against Cancer and Canadian Institutes of Health Research.

Survey findings were summarized into user-friendly reports for each school and each school division. Regional data was compiled into reports for regional health authorities and provincial data was consolidated into the *Youth Health Survey Report 2009*.¹ Dr. Griffith described the youth risk factor surveillance survey as a significant collaboration of many partners that was conducted at low cost and produced reliable baseline data that is useful for strategic and program planning.



¹ The Youth Health Survey Report is available online at <http://www.healthincommon.ca/wp-content/uploads/Youth-Health-Survey-Report-2009.pdf>



As Manitoba moves toward adult risk factor surveillance, organizations should consider doing the following:

- sharing lessons learned and best practices from the YHS,
- involving regional health authorities in leadership roles that include collecting, disseminating, and using the data, and
- applying expertise and insights gained from the YHS (evidence-based practice, communicating and mobilizing, collaboration, and partnerships) to adult risk factor surveillance.

To be successful, adult risk factor surveillance will need champions, funding, and a commitment to PPHL's values and principles. It will also require acknowledgement that regional health authorities own their data, that governments benefit from regional leadership and should concentrate on providing infrastructure to support that leadership, and that a lack of resources is not always a barrier.

Dr Griffith ended her presentation by noting that on-going risk factor surveillance will:

- lead to development of new tools, a coordinated approach, and a shared experience for all involved,
- support research about the effectiveness of policies and programs such as Manitoba's physical education/health education curriculum, and
- challenge organizations and sectors to
 - develop shared meaning, link surveillance to planning, interventions, and further evaluation, and
 - think and act as a system.

Questions and Answers

Following their presentations Drs. Garcia, Andall-Brereton, and Griffith answered questions from symposium participants.

Q. How much do the PDAs cost for the STEPwise survey and are there problems with loss and data security?

A. Andall-Brereton The PDAs cost about \$250 US; there have been no problems with interviewers losing them. Although the survey is available in several languages, interviewers administer the survey in one language – interviewers must speak the survey language, ask the questions, and enter the data. Interviewees never handle the PDAs.

Q. Where is the flexibility in the STEPwise survey?

A. Andall-Brereton Questions in the core module are set and the expanded module explores the core questions in more detail. The flexibility comes when a country adds questions to the survey or when an interviewer rephrases a question so that the interviewee understands what is being asked.

Q. What are the participation rates for STEPwise in the CAREC countries?

A. Andall-Brereton Participation rates range from 60 to 65% although one country achieved rates around 40% because it required interviewees to have been resident in the country for at least five years and many people in that country move away and come back depending on employment



opportunities. CAREC now advises countries not to set a residency requirement that is greater than one year.

A. Garcia In Canada there are concerns about surveying people by telephone – many people don't answer the phone, others answer but won't participate in a survey, and many people do not have landlines so are excluded from a telephone survey.

Q. How can you survey hard-to-reach populations?

A. Andall-Brereton A good communication strategy is critical to ensure that people know about the survey before it is conducted and know what to expect. Communication must begin before the survey starts and continue until the last survey is done. Communication can include TV, radio, and community meetings and must answer the question, What is in it for me?

Q. We know that social-economic variables affect health. Can you insert an equity lens into the survey?

A. Andall-Brereton The STEPwise survey has a section to gather information on demographics and during analysis the data is weighted to be representative of the total population. In addition, households are randomly pre-selected for inclusion in the survey. If a selected household does not participate, the reason for the non-participation is recorded and considered when the data is weighted.

A. Garcia Researchers need to be aware of potential biases. If you think a survey is not getting a representative sample, say it is missing unemployed people, then go where you will find people who are unemployed and interview them there.

Q. Who developed and funded the Ontario Tobacco Strategy?

A. Garcia In the 1990s, the Ontario government invested \$1 million to build capacity in tobacco control and research. The CDC believes that tobacco control requires investments of \$7 to \$15 per capita.

Q. How do you get around the subjectivity of survey responses?

A. Griffith The literature says that self-reporting on healthy living – physical activity, diet, and tobacco use – is accurate. However, self-reporting is less reliable for weight and BMI particularly for youth who are growing.

At the time that the YHS was conducted, some students were asked to wear a device that measures physical activity. Information from these devices was compared to the self-reported survey data on physical activity.

A. Garcia There is always some social desirability in self-reporting. Researchers must assess the magnitude of the bias and look for a way to validate responses. For example, if self-reporting reveals that smokers consume a certain number of cigarettes, researchers can compare that number to information on cigarette sales volumes.



Case Studies: Implementing Adult Risk Factor Surveillance in Manitoba

Representatives from three of Manitoba's regional health authorities spoke about their RHAs' experiences implementing adult risk factor surveillance. The Interlake RHA conducted a paper survey by mail, the Assiniboine RHA conducted a telephone survey, and the Brandon RHA conducted a paper survey that was hand delivered to workplaces.

The presentation is available online at <http://www.healthincommon.ca/pphl/>.

Tannis Erickson: Interlake RHA

The Interlake RHA identified the need for local data on adult risk factors to inform planning especially for the Chronic Disease Prevention Initiative (CDPI).

In 2006, a working group developed a survey for adults using questions that had already been used in other surveys (e.g. SHAPES, CCHS) then telephone listings were used to select a random sample of households in six CDPI and control communities. Households were called to secure agreement to participate then a survey was mailed to participants along with a postage paid return envelope.

Of the 3,000 surveys that were distributed, 2,300 were returned providing a response rate of almost 80%. The completed surveys were scanned, the data compiled, and reports prepared and distributed within the RHA and to CDPI committees and community partners who used the information to identify target populations and develop targeted health promotion strategies.

The Interlake RHA is now receiving requests to repeat the survey in the original six communities and to do it for the first time in several others.

Jody Allan: Assiniboine RHA

The Assiniboine RHA secured a grant from the Public Health Agency of Canada to conduct an adult risk factor surveillance survey by telephone that would provide valid, reliable local risk factor data using the survey that that was developed by the Interlake RHA.

In 2008-2009, the RHA hired a professional market research company to conduct a random telephone survey of 2,600 adults in nine CDPI and five control communities. Findings have been disseminated to regional programs and managers and to CDPI committees. A regional summary report has been posted online.

Nancy McPherson: Brandon RHA

The Brandon RHA wanted to focus on influencing workplace culture rather than individual behaviour trends so decided to survey adults in the 30-59 age group at their workplaces. The intent was to initially gather baseline data and identify trends among workplaces over time. Surveys were developed on four different life style/risk factor topics and 402 surveys were randomly distributed to workplaces that agreed to participate.

Pilot testing of the comprehensive survey tool identified gender differences among respondents; women tended to complete the survey whereas men reported the questionnaire was too long and did not hold their attention. As a result, four tools were developed to address specific modifiable risk factors.



Of the 402 surveys that were distributed, 228 were returned providing a 57% response rate. Data analysis proved challenging because it was difficult to draw conclusions from very small workplaces and it was not possible to identify meaningful trends by size of workplace or by type of industry.

Lessons Learned

The Interlake RHA discovered that conducting a mail survey requires a significant amount of staff time for training, recruiting participants, and capturing data. However, the process helped the RHA develop internal capacity and may have helped it form connections with community members.

The RHA concluded that a mail survey may exclude community members with lower literacy skills, the cost per survey increases or decreases depending on the response rate, and a mail survey is appropriate only for smaller-scale surveillance.

The Assiniboine RHA discovered that a telephone survey excludes people who do not have a landline. Using a market research firm to conduct the survey is efficient, minimizes the impact on staff, and guarantees a specified sample size for a predetermined cost.

The Brandon RHA learned that a workplace survey is an efficient way to collect data and provides an opportunity to form connections in the community especially if staff drop off and pick up the surveys. However, survey participants were not representative of the region and there are challenges interpreting and reporting data due to variation in size and type of workplace. In addition, small workplaces present challenges with confidentiality.

Based on their experiences, the three presenters concluded that regions are at different stages of readiness and it is important to build on others' success and to participate in knowledge exchange. Regions may be able to achieve economies of scale if they work together on large survey projects. RHAs should conduct surveillance at a time that is appropriate for a community and use surveillance programs to build internal capacity and connections with communities.

Group Discussions

Participants from government departments, agencies, and NGOs joined the RHA tables to discuss the following questions:

1. What benefits/value have youth or other risk factor surveillance provided to your organization and communities?
2. What is the value of expanding to adult risk factor surveillance (ARFS) in your region?
3. What supports and internal resources are available in your RHA for adult risk factor surveillance?
4. Who could/should be involved in ARFS in your region and what would their role be?
5. Who else could/should be involved in ARFS and what would their roles be?
6. What are the next steps for conducting ARFS in your region?

Following their discussions, groups shared their answers and submitted notes that provided the information for this report.



Q1. What benefits/value have youth or other risk factor surveillance provided to your organization and communities?

Risk factor surveillance provided the following benefits:

- provided information at the local level that serves as a baseline for identifying and monitoring trends,
- raised community awareness about health issues,
- contributed to new relationships (e.g. between the RHA and schools/school divisions and among schools),
- built trust,
- provided information to identify gaps, inform planning at the community, school, and program level (e.g. CDPI and health promotion) and inform policy development; focus on target groups and issues; select community health assessment (CHA) priorities; and create a healthy living framework,
- helped schools and other groups secure grants,
- influenced funding decisions, and
- provided information that was included in reports, used during interviews with the media, and shared with communities.

One group reported that in its region, findings from the Youth Health Survey have not been used optimally to address risk factors.

Q2. What is the value of expanding to adult risk factor surveillance (ARFS) in your region?

Adult risk factor surveillance will provide a more complete picture about the population and could link adult and youth behaviours and risks. Other benefits may include the following:

- provide an opportunity to build on the knowledge and expertise gained from conducting the Youth Health Survey and using the findings,
- increase engagement with other partners and sectors including First Nations,
- provide information about local communities and neighbourhoods that is not available from national surveys and the Census,
- identify trends over time and inform planning and policy,
- provide an opportunity to take an equity lens (perhaps by conducting a door-to-door survey) and to focus attention on the social determinants of health,
- justify the allocation of resources for prevention and health promotion,
- provide information that can be shared and used to form partnership with community members, committees, groups such as chronic disease networks, and other sectors,
- get people thinking about their own behaviours and demystify some norms and beliefs,
- lead to stronger relationships between adults and health care providers that could result in adults taking action to reduce their health risks, and over time
- contribute to reduced rates of chronic disease.

One RHA believes that there is value in moving to ARFS but questions whether surveillance should be done at a regional level or by enhancing CCHS (Canadian Community Health Survey) data collection.



Q3. What supports and internal resources are available in your RHA for adult risk factor surveillance?

Answers to this question varied considerably with some groups stating that they have staff with the necessary skills and knowledge but they are not available for ARFS and/or they have limited financial resources. Other groups provided long lists of internal supports and resources such as the following:

- a steering committee,
- staff who understand that surveillance is important,
- staff who developed expertise working on the Youth Health Survey,
- staff who are bilingual (English and French) and have the ability to translate surveys into other languages,
- Medical Officers of Health,
- the continuous quality improvement team, community health assessment (CHA) staff, the planning/research and evaluation department, communications staff, the mobile team, and staff who can analyze data,
- commitment from senior leadership and the board of directors,
- IT staff and technology such as a voice over IP telephone system,
- financial, in-kind, and volunteer resources,
- physicians, primary health care nurses, wellness facilitators, and mental health programs/workers
- mechanisms for tracking data using PHINs (personal health information numbers),
- community interest and desire for data that influences the RHA's decisions and planning, and
- existing data provided by the CCHS, Manitoba Centre for Health Policy (MCHP), and In-Motion.

One RHA questioned the validity of surveys that rely on self-reporting.

Q4. Who could/should be involved in ARFS in your region and what would their role be?

Q5. Who else could/should be involved in ARFS and what would their roles be?

Questions 4 and 5 generated lots of ideas about groups and organizations that could or should be involved in ARFS. Because the answers to these questions overlapped, they have been combined into one list:

- community groups and networks, CDPI committees, and other partners,
- district health advisory councils,
- mayors, municipal councils, chambers of commerce,
- academics, colleges, and universities,
- First Nations chiefs, tribal/band councils, chiefs' organizations like MKO, and the Manitoba Métis Federation,
- local media to create awareness and interest,
- pharmacies and local businesses/employers,
- schools, family resource centres, and libraries,
- specific organizations
 - Canadian Mental Health Association and others involved in mental health,
 - CancerCare Manitoba,
 - Community Futures organizations in rural and northern Manitoba,
 - Health in Common,
 - Manitoba Centre for Health Policy,



- Manitoba in motion,
- other RHAs,
- Partners in Planning for Healthy Living,
- Peg (a partnership between the United Way Winnipeg and the Institute for Sustainable Development that measures and publishes key indicators about community well being),
- the Canadian Cancer Society's Knowledge Exchange Network (KEN),
- municipal, provincial, and federal government departments and agencies such as Manitoba Health and Healthy Living and PHAC,
- arts, environmental, immigration, neighbourhood revitalization, and recreation groups,
- health charities and foundations including the Addictions Foundation of Manitoba, and
- topic-specific partners such as the police service and Manitoba Public Insurance.

Q6. What are the next steps for conducting ARFS in your region?

The groups identified next steps that span the continuum from discussing opportunities with other RHAs to conducting a pilot survey:

- talk with other RHAs to discuss opportunities to work together,
- secure approval from senior management to proceed with ARFS and secure buy-in from others within the RHA,
- identify a leader for ARFS,
- form a working group for ARFS and consider involving community leaders/champions,
- decide whether to partner with other RHAs or to encourage the province to develop a standardized questionnaire that allows for some customization,
- encourage a coordinated provincial approach with resources to engage regions,
- decide whether to invest more in CCHS, do a community survey, or do a combination of CCHS and a survey,
- determine the appropriate questions for ARFS (consider questions about poverty, mental health, and trauma in early life),
- determine whether to use a combination of self-reporting and physical measures,
- identify the target population for ARFS,
- compare the benefits of doing a mail or telephone survey and decide whether to use one or both techniques,
- determine the budget and process,
- develop plans to communicate about ARFS, disseminate findings, build local capacity to use the data, and engage in knowledge exchange,
- secure funding to hire and train people, possibly students, to conduct the survey,
- select high density areas to initiate surveillance,
- conduct a pilot survey, and
- continue discussions about linking risk factor surveillance with community health assessment and integrating it into existing planning and decision-making processes.

Next Steps for Partners in Planning for Healthy Living

In her closing comments, Doreen Fey (Interlake RHA) promised that a report on the symposium would be prepared and distributed to all who participated and that PPHL's board of directors would discuss the role that Partners in Planning for Healthy Living can play in advancing adult risk factor surveillance in Manitoba.



Summary of Symposium Evaluations

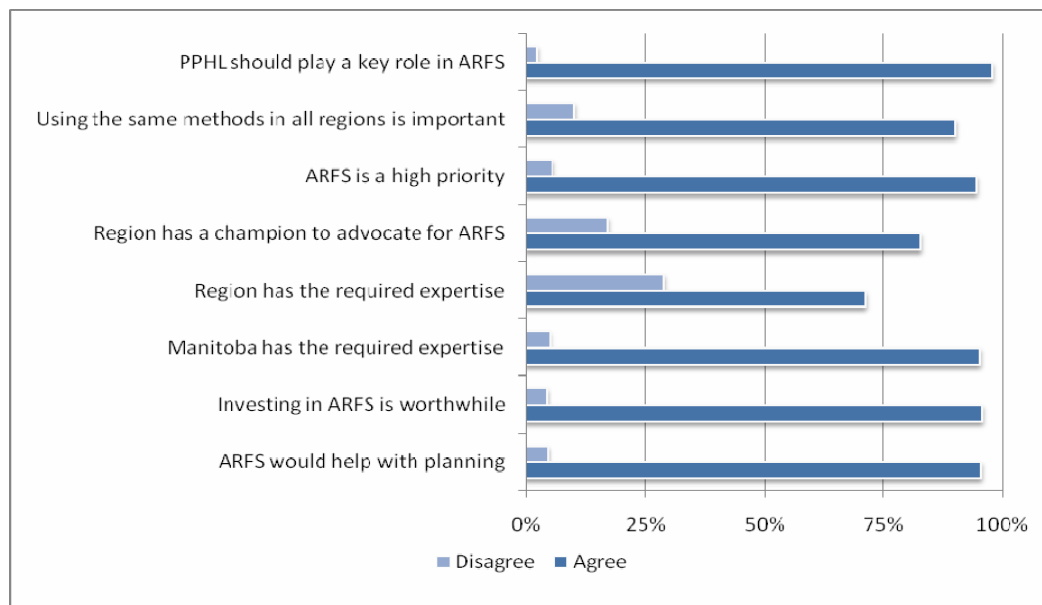
At the close of the January 2011 symposium on adult risk factor surveillance, participants were asked to complete an evaluation of the event. Forty-seven participants submitted an evaluation form, which included questions about the future of ARFS in Manitoba.

The evaluation form asked participants to describe how the information presented would impact their involvement in ARFS going forward. Responses indicate the following:

- 91% will stay informed of ARFS activities
- 88% will share the information with others
- 62% will identify partners to involve in ARFS
- 41% will become involved in the ARFS working group
- 29% will work to implement ARFS in their region

Participants were asked to indicate their level of agreement on various aspects of ARFS implementation in Manitoba. The evaluations reveal almost full agreement that ARFS is useful, worthwhile, and should be a priority. Increasing regional capacity to implement ARFS would be an important aspect of rolling out the surveillance system.

Level of agreement with aspects related to moving ARFS forward in Manitoba



All regions reported some progress on ARFS. Over one third of those who submitted the evaluation form (38%) have discussed ARFS within their region, 35% have initiated planning, and 25% have gathered and are using ARFS data.

Overall feedback on the day was positive. All participants who completed an evaluation felt that the objectives had been met. The symposium was most successful at highlighting the importance of community level ARFS. The positive reaction to hearing about experiences implementing ARFS in the Caribbean and Manitoba speaks to the high level of interest in learning about the practical application of risk factor surveillance.

The full symposium evaluation is available at www.healthincommon.ca/pphl/

