

Data resource profile

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TITLE: Data Resource Profile: The Global H Health and P Population Project on A Access to C Care for C Cardiometabolic diseases (HPACC)

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Key Features

- Though more than 4 in 5 deaths due to cardiovascular disease (CVD) occur in low- and middle-income settings, there have been few data sources that allow for empirical estimation of key relationships relevant to the epidemiology, health behavior, and health services of CVD risk factors at the level of the individual. The Global **H** Health and **P**opulation Project on **A**ccess to **C**are for **C**ardiometabolic Diseases (HPACC) is a novel data resource that fills this gap.
- The HPACC dataset consists of 77 nationally representative, population-based surveys conducted after 2005 of adults 15 years and older.
- The dataset includes 1,269,542 participants from 76 countries; 46 of these have a repeat survey available.
- The main categories of data collection include demographic and socioeconomic data, anthropometry, biological measures of disease status, healthcare service utilization for hypertension, diabetes, and hyperlipidemia and self-reported information on health behaviors relevant to CVD. The dataset is currently being expanded to include mental health, cervical cancer, HIV and injuries where available.
- The collaboration includes a global team of physicians, economists, and health policymakers. Most surveys contained in the dataset are publicly available; the harmonized, deidentified data and an accompanying dictionary can be requested from the corresponding author.

KEYWORDS: cardiovascular disease, diabetes, hypertension, global health, epidemiology, access to care

Data Resource Basics

Cardiovascular disease (CVD) is the leading cause of morbidity and mortality globally.(1) In recent decades, a rising prevalence of major CVD risk factors including diabetes, hypertension, and hyperlipidemia has been observed in many low- and middle-income countries (LMICs) where CVD was not previously considered a major health priority. As economic development drives urbanization and changes in lifestyle habits in many LMICs, this trend is expected to continue.(2-4) While approximately 80% of CVD deaths now occur in LMICs,(5) there are fewer data sources from which *empirical* estimation of key indicators and relationships relevant to epidemiology, health behavior, and health services can be undertaken at the level of the individual. In this profile, we provide an overview of a novel data resource for the study of CVD risk factors in LMICs, entitled the Global **H**ealth and **P**opulation Project on **A**ccess to **C**are for **C**ardiometabolic Diseases (HPACC).

HPACC was initiated in 2016 by researchers at the University of Göttingen, Harvard and Heidelberg Universities, in collaboration with in-country partners, with the objective to gather and harmonize household survey data on CVD and its risk factors. The HPACC dataset is comprised of nationally representative, population-based, individual level surveys conducted in 2005 or later that are collated and then harmonized. The harmonization process is guided by the World Health Organization STEPwise approach to Surveillance (STEPS) survey instrument. This process is complex and includes aligning variable definitions across surveys such as income and asset data, checking data quality and ensuring consistency especially for biomarker measures, documenting variable skip patterns and confirming sample weights. This results in a dataset covering 76 LMICs (Figure 1) and including data from 1,269,542 participants from 77 surveys (the Republic of Tanzania, while one country, conducted two separate surveys for Tanzania and for Zanzibar). These 76 countries represent 4.4 billion adults, which is 79% of the LMIC and 65% of the global adult population share. The dataset is dynamic and new surveys are added as they become available. Furthermore, in many countries, eligible surveys are conducted

periodically, at least once every 5-10 years. For the most part, these repeat surveys consist of a subsequent cross-section of the population but do not follow the same participants longitudinally. The current version of the HPACC dataset includes the most recent data in a cross-sectional harmonization but there is an ongoing effort to expand the dataset to include repeated cross-sections where available. Availability of repeated survey waves by country is provided in detail in Table 2. The dataset is not publicly available, but access can be granted upon request.

The dataset was collated by an international group of collaborators to meet the need for rigorous, nationally representative evidence on key epidemiological relationships and health system performance relating to CVD risk factors in these understudied country contexts (Table 1). Its structure allows for the comparison of population groups across the socio-economic and demographic spectra within and across countries. Furthermore, it yields results that are representative of the entire population of the countries covered by the included surveys.

Data collected

Survey inclusion criteria and search methodology

A systematic search and inclusion procedure is used to identify eligible surveys for harmonization and inclusion in the HPACC dataset. The inclusion criteria are detailed in Table 1. In brief, the survey needs to have been conducted in a LMIC after 2005. Furthermore, individual-level data from surveys representative of a country's adult population need to be available and include either a blood pressure, blood glucose, or lipid measurement. The first systematic search was conducted in 2016. The search was updated in 2021, identifying additional surveys conducted in 2010 or later.

We use a four-part search methodology to screen surveys for inclusion in the dataset (Figure 2). First, all countries in which a World Health Organization (WHO) Stepwise Approach to Non-Communicable Disease (NCD) Risk-Factor Surveillance (STEPS) survey has been conducted are identified.⁽⁶⁾ All eligible STEPS survey data are requested from the WHO STEPS data repository.⁽⁷⁾ Prior to 2019, when these were not available from a repository, data requests were made directly to the country survey team. Second, a search of three well-regarded survey resources, the Demographic and Health Surveys (DHS),⁽⁸⁾ the WHO Study on Global Ageing and Adult Health (SAGE),⁽⁹⁾ and the Gateway to Global Aging studies,⁽¹⁰⁾ is conducted. Third, we search three other commonly used summary resources, the NCD Risk Factor Collaboration (NCD RisC),⁽¹¹⁾ Global Health Data Exchange (GHDx),⁽¹²⁾ and the International Diabetes Federation (IDF) Diabetes Atlas.⁽¹³⁾ If these yield a potentially eligible survey, we perform a Google search to confirm and request the most recent survey data from the designated point of contact. Fourth, a systematic Google search is conducted using prespecified search terms (Figure 2), and the first 30 returned results are reviewed. If two surveys are available for a particular country, we prioritize either the most recent survey and/or the one that contains a larger number of variables of interest. To access non-publicly available survey data that we identify at any step during the search process, we contact each survey's lead investigator(s) at least twice to invite them to share data and participate as an HPACC collaborator. Repeat surveys are included based on the same search methodology and eligibility criteria, as new data become available. The dataset is updated periodically when new surveys are released and harmonized. Table 2 indicates the countries for which repeat surveys are already available and the years in which the repeat survey was conducted.

Survey instruments

The HPACC dataset contains 57 STEPS surveys. The STEPS survey instrument is designed to help countries build and strengthen their surveillance capacity by obtaining core data on established chronic

disease risk factors. These surveys are the official approach developed by WHO for monitoring NCD risk factors in adults at the population level and include questionnaires, physical measurements, and biochemical measurements, with 'core,' 'expanded,' and 'optional' modules to allow for flexibility by country capacity and interest. The 'core' self-reported measures include data on demographic characteristics, tobacco and alcohol use, dietary behavior (fruit and vegetable intake), physical activity, and history of raised blood pressure, diabetes, raised total cholesterol, heart disease, and stroke. In addition, there are 20 non-STEPs surveys in the HPACC dataset. Among these, the DHS instrument is frequently used. The DHS, in partnership with country governments, are nationally representative household surveys that collect data on a wide range of health-related monitoring and impact evaluation indicators.⁽¹⁴⁾ The standard surveys have large sample sizes (usually greater than 5,000 participants) and are conducted, on average, once every five years. While they have historically focused on maternal and child health and more recently HIV, later surveys have increasingly incorporated questions about health behavior, nutrition, and tobacco use. These recent DHS have also begun to measure blood pressure and incorporate biomarkers for diabetes, consistent with the HPACC inclusion criteria.

Survey design, clustering, and weighting

Most surveys in the HPACC dataset use multi-stage cluster sampling of respondents and almost all provide documentation on the applied sampling strategy. In all analyses, sampling weights account for item non-response and are rescaled to ensure either population-size weighting or equal weighting for each country, depending on the primary question of interest.

Thematic content and measures

Demographic and socioeconomic characteristics

All surveys included in the HPACC dataset contain information on participants' age and sex, along with a measure of years of schooling or educational attainment. The majority of these surveys also include

information about location of residence (rural/urban, 46 surveys), marital status (68 surveys), working status (72 surveys), pregnancy status (70 surveys), and a measure of household wealth (62 surveys). The construction of the wealth quintile within each survey depends on the available household wealth indicator. Surveys using an asset index have surveyed household ownership of a range of assets, dwelling characteristics, and other country-specific wealth indicators. Based on the standard DHS approach, we use principal component analysis to derive an asset index, from which we create household wealth quintiles.⁽¹⁵⁾ Countries using a household income-based measurement mainly followed the WHO STEPS template questionnaire. In these cases, respondents were asked about the household earnings over the past year: weekly or monthly average, or year total. In cases where this question was left unanswered, respondents were asked to place their household in one of the given income brackets. These brackets usually were defined according to a country's national household income quintile thresholds. Both, continuous income and income brackets, are used in the creation of the wealth quintiles.

We assume that household incomes within a country follow a log-normal distribution and we are therefore able to combine income quintiles and categories.⁽¹⁶⁾ In 11 surveys, we dismissed pre-coded income brackets as they displayed very large discrepancies with respect to the continuous income range or could otherwise not be correctly identified. However, as the pre-coded estimates were typically only asked of respondents that had not indicated a continuous income, this has resulted in only minor information losses.

Anthropometric and biological measures of disease status

The dataset includes height and weight measurements in all surveys and 69 surveys include waist and/or hip circumference. In terms of the three CVD risk factors of interest, 54 surveys measured blood pressure and diabetes and lipid biomarkers, and 9 surveys measured blood pressure and diabetes biomarkers only (Table 2). Blood pressure measurement was standardized, though the number of measurements that were taken and subsequently averaged per survey ranged from one to three. The most meaningful

differences exist in the assessment of diabetes biomarkers as a variety of different measures were used. 56 surveys measured fasting blood glucose only, four measured hemoglobin A1c only, and five measured both. We have collected extensive documentation of measurement details relating to each survey's approach to measurement of the biomarkers. For blood pressure measurements, we note the number of measurements, details of the procedure, and devices and cuff-sizes used. Documentation on the diabetes biomarker includes information on type of glucometer or measurement device, whether samples were capillary or venous, if plasma conversions are required, and the fasting status of respondents. The lipid measurements were also subject to modest variation in the approach to measurement, with countries choosing either a point-of-care approach or a lab-based measurement. In case of the former, the CardioCheck PA device was most frequently utilized. Of the surveys with lipid measurements, all measures total cholesterol and many additionally collect HDL, triglycerides, and LDL cholesterol. Details of these measurement approaches are available in Supplementary Tables S1, S2, and S3.

Measures of healthcare service utilization

A unique feature of the HPACC dataset is that underlying surveys collected information on measures of healthcare service utilization for hypertension, diabetes, and/or hyperlipidemia. For the vast majority of surveys this includes a question about (1) whether a person had ever received a screening test for the respective condition, (2) whether they have been diagnosed with this condition, and (3) whether they are treated (have received advice or currently take medication) for the condition. 60 surveys include information on ever having visited a traditional healer and 65 on whether they currently use traditional medicine for the respective condition. 44 of the included surveys asked respondents about prior history of CVD including heart attack or stroke. In addition, in the case of diabetes, of the 70 surveys with information on diabetes medication, 66 contained questions about use of oral medications and insulin separately. 68 surveys also included a suite of questions about whether a participant had received lifestyle counseling from a healthcare provider with respect to losing weight, physical activity, reducing salt intake, increasing fruit and vegetable intake, and/or smoking cessation.

Behavioral measures

The majority of surveys include self-reported information on health behaviors relevant to CVD. This includes information about dietary patterns of fruit and vegetable consumption and salt intake (61 surveys). In addition, 63 include a physical activity inventory mainly using the Global Physical Activity Questionnaire (GPAQ). The GPAQ measures moderate and vigorous activity at work and during leisure time and travel to and from places. This enables the calculation of a standardized estimate of activity in Metabolic Equivalents of Tasks (METs), which is in turn a ratio of the person's working metabolic rate relative to their resting rate. Furthermore, 60 surveys capture sedentary behavior. The GPAQ has been validated for use in several LMICs previously and is a recognized tool for assessing physical activity level in resource-limited settings.(17-19) Surveys included in the HPACC dataset also ask questions about alcohol (67 surveys) and tobacco use (76 surveys), including the history of use, frequency, and intensity.

Novel research frontiers

The STEPS surveys and several of the other surveys included in the HPACC dataset also have available modules on other chronic conditions that are of particular interest globally. These include sections about mental health, cervical cancer, and oral health within the context of the STEPS surveys. Furthermore, recent STEPS surveys include information on injury and violence. The DHS includes additional modules about nuanced health behaviors (sugar-sweetened beverage intake or fast/fried food consumption, for example), HIV, and expanded nutritional biomarkers (for example micronutrient status). A codebook summarizing all harmonized variables is provided in the appendix (Appendix Table IV).

Harmonization process

To harmonize these surveys, we performed a detailed review of the survey documentation with respect to the design and questionnaires from which the data were obtained. The harmonization process is based on and guided by the STEPS survey instrument. We defined the core group of variables that were

preserved across instruments and established common definitions for variables where response items were heterogeneous. We perform detailed data quality assessments prior to harmonization and collation.

Brief overview of the study population

The current HPACC dataset contains data from 1,269,542 individuals aged 15 years and older who were eligible for at least one of the three measurements: blood pressure, blood glucose/glycated haemoglobin (HbA1c), or lipids. Their unweighted mean age is 35.1 (SD: 13.9) and 73.9% are female. The educational attainment of the population is 21.9% with no formal schooling, 20.2% with at least some primary school education or primary school completed and 56.6% with at least some secondary education or greater. The overall weighted prevalence (derived from the respective body measurement and self-reported use of medication) of hypertension is 29.4% (95% CI 28.8-30.0) of diabetes 8.6% (95% CI: 7.9-9.4), and of hyperlipidemia 6.7% (95% CI 6.2-7.2).

Data Resource Use

The HPACC dataset has already provided several important and novel insights about the epidemiological relationships and health system performance for CVD risk factors in LMICs. To date, over 15 research articles using the HPACC dataset have been published in peer-reviewed journals. These analyses cover a range of topics such as an evaluation of health system performance for the management of hypertension (in 44 LMICs),(20) the variation in eligibility for hypertension treatment depending on clinical guideline (in 50 LMICs),(21) targeting of hypertension screening through easily identifiable individual characteristics,(22) and the relationship between estimated CVD risk and hypertension undertreatment/overtreatment (in 45 LMICs).(23) Health system performance for the management of diabetes has been analyzed in three separate studies using the HPACC data, which included 12, 28, and 55 LMICs, respectively.(24-26) Furthermore, analyses of the association between diabetes and socio-

economic status,(27) as well as anthropometric measures, including body mass index (BMI)(28), and adult height(29) have been conducted. In addition to analyses focused on diabetes and hypertension, the HPACC data have been used to describe the cascade of care for hypercholesterolemia and estimate statin coverage in LMICs.(30, 31) Health systems investigation in this dataset has also included a comprehensive consideration of country preparedness indicators for management of CVD risk factors.(32)

Furthermore, the HPACC data have been used to explore important behavioral risk factors for CVD and diabetes, including the patterns of fruit and vegetable consumption,(33) as well as sex differences in dietary behaviors..(34) Another study estimated the lifetime prevalence of cervical cancer screening.(35) Furthermore, the HPACC dataset is used in modeling studies such as the impact of increased diagnosis, treatment and control of diabetes.(36)

Participating countries institutions and researchers

The harmonization of survey data for the HPACC dataset is only possible thanks to the large number of collaborators from these countries. These researchers play an active and crucial role in all studies that have been published so far and those which are planned. We have ongoing efforts to identify, contact, and foster collaboration with the survey teams of publicly available datasets. Furthermore, the involvement of young researchers from LMICs is one of HPACC's priorities and efforts to do so are being intensified.

Strengths and Weaknesses

Strengths

The HPACC dataset has several important strengths. First, uniquely, the data are at the individual-level and population-based and are harmonized to allow granular examination of key epidemiological and

health systems relationships, including variation across demographic and socioeconomic groups within countries. Moreover, the dataset includes nationally representative survey data from 76 countries whose combined population is approximately 79% (4.4 billion people) of the adult population living in LMICs. The extensive geographic coverage has enabled analyses at the global and regional levels, along with cross-country comparisons. Second, these surveys all contain biomarkers and biological measurements, including blood pressure, fasting blood glucose/hemoglobin A1c, and/or lipids, as well as anthropometry. Given that CVD risk factors of interest are defined based on these measurements, the HPACC dataset represents a substantial advance as few population-based surveys collected blood-based measurements prior to 2005. Third, most of these surveys include at least one measure of household income or asset ownership, which have been harmonized into wealth quintiles. The availability of this measure has allowed for a unique exploration of important relationships between prevalence and care for CVD risk factors and an individual's socioeconomic status.

Weaknesses

The limitations of the HPACC dataset center primarily on the challenge of harmonizing heterogeneous measures across many surveys from diverse geographic and cultural contexts. This includes the wealth measure which varies across surveys. In addition, there is substantial heterogeneity in the measurement of biomarkers of diabetes and hyperlipidemia. To ensure transparency, we have documented these variations, including the survey-specific approach to eliciting fasting status, biomarker measurement (point-of-care versus laboratory-based), and nuances about the specific measurement instruments that can impact the interpretation of results, such as plasma-equivalent blood glucose measures. We would like to note that surveys recording self-reported information are standardized within survey types (STEPS, DHS) and largely comparable. A second limitation is that the measures of access to care for all CVD risk factors are self-reported by survey participants and thus subject to recall bias. Moreover, self-report of access may be affected by education, or health literacy, which may lead to underestimates in the prevalence of health behaviors and barriers to health care. Other potential biases are those of the

interviewer and social desirability. Third, the included survey were conducted during the past 15 years. In particular older surveys do not necessarily describe the current situation in the respective country. However, the dataset is updated on a regular basis and, thus, includes the newest available data. Fourth, due to the cross-sectional nature of the data, it is currently not possible to describe time trends. It is planned to harmonize and include older and future waves conducted in LMICs, which will allow us to look at changes over time.

Data Resource Access

Many surveys contained in the HPACC dataset are publicly available. The two most common data sources are the WHO data repository and the DHS website.(7, 8, 37) Several additional surveys have been obtained through formal requests of survey teams whose data is not already made public. The pooled, harmonized, deidentified participant-level HPACC dataset and accompanying data dictionary have been created through a partnership between Harvard University, University of Göttingen and Heidelberg University, in collaboration with all country-level survey teams. Access can be requested through the corresponding author. More information about HPACC including additional contact information for the collaboration can be found on www.hpaccproject.org or by emailing Jennifer Manne-Goehler at jmanne@post.harvard.edu.

Ethics approval

The included population-based surveys sought ethical approval from the respective country's ethics review committee prior to data collection. All surveys followed standardized ethics procedures, such as asking for participants' informed consent to participate in the respective survey. The final collated HPACC dataset is de-identified and no investigator can contact nor re-identify subjects. The Federal Policy for the Protection of Human Subjects (45 CFR Part 46) states that studies are excluded from an IRB review if "information, which may include information about biospecimens, is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained directly or through

identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify subjects.” The HPACC dataset was designated as Non-Human Subjects Research by the Harvard T. H. Chan School of Public Health in 2018 under protocol #IRB16-1915.

Data availability

See Data Resource Access, above.

Supplementary data

Supplementary data are available at IJE online.

Author contributions

JMG and MT wrote the original draft. DF and MEM validated the results. JMG, MT, DF, MEM, LMJ, RA, JID, PG, SV, and TWB co-conceived the HPACC project. All authors participated in the data curation and critically reviewed the article draft. JMG and MT are the guarantors of the work.

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Conflict of interest

None declared

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Figures and Tables

Figure 1. Map of geographic coverage and number of conditions measured by country across 76 low-income and middle-income countries

Note: Fiji had information on blood glucose but not blood pressure. Countries marked as high-income countries were consistently classified as high-income countries from 2005-2018 by the World Bank. The following countries are represented by dots: Cabo Verde, Comoros, Fiji, Kiribati, Marshall Islands, Samoa, São Tomé and Príncipe, Seychelles, Solomon Islands, St. Vincent and the Grenadines, Tonga, Vanuatu. Abbreviations: BP = blood pressure, BG = blood glucose, HbA1c = haemoglobin A1c, HIC = high-income country, LMIC = low- and middle-income country, CVD = cardiovascular disease

The map was generated using the ggplot2 package in R.

Table 1. Key details about the Global Health and Population Project on Access to Care for Cardiometabolic Diseases (HPACC) Data Resource

Figure 2. Global Health and Population Project on Access to Care for Cardiometabolic Diseases (HPACC) search strategy

Abbreviations: DHS = Demographic and Health Survey; GHDx = Global Health Data Exchange; IDF = International Diabetes Federation; NCD RisC = NCD Risk Factor Collaboration; SAGE = Study of Global Ageing and Adult Health; STEPS = Stepwise Approach to Non-Communicable Disease Risk-Factor Surveillance, See S4 for a list of countries that were classified as low- or middle-income for at least one year from 2005-2021.

Table 2. Survey type and year, sample size, response rate, and available measures and indicators by country

1. Abbreviations: STEPS = Stepwise Approach to Non-Communicable Disease Risk-Factor Surveillance, HH=household wealth

2. *Median response rate

3. Albania, Egypt, Fiji, Indonesia, Mexico, Peru, Romania, Uganda, and Ukraine only collect data on tobacco use.

4. Repeat data are already pooled for the following countries and years: Bangladesh 2011 and 2018, Benin 2015 and 2018, Bhutan 2014 and 2019, Brazil 2013 and 2019, Ecuador 2012 and 2018, Chile 2009-10 and 2016-17, China 2009 and 2015, Fiji 2009 and 2011, Mexico 2009-12 and 2018-19, Kyrgyz Republic 2012 and 2013, Lebanon 2008-09 and 2017, Lesotho 2012 and 2014, Mongolia 2009 and 2013, Mozambique 2005 and 2015, Nepal 2013 and 2019, Sao Tome and Principe 2009 and 2019, South Africa 2012 and 2016, India 2015-16 and 2017-19.

