In the last 20 years there has been considerable interest in studies which have suggested that there has been a widespread increase in the prevalence of asthma [1]. However, interpretation of these studies has been limited by the problems inherent with the methods used to measure asthma prevalence, and the lack of international agreement in defining asthma. Case ascertainment criteria have often differed between studies, which has made comparisons over time or between different geographic locations difficult.

Despite the introduction of field methods for measuring airway hyperresponsiveness, the vast majority of studies have relied upon questionnaire data to ascertain information. A variety of questions have been developed for this purpose, usually focused on reported asthma symptoms such as wheezing or coughing over a defined period, usually 12 months. However, it has become apparent that such questionnaire-based studies, comparing communities with different languages and cultures, may give rise to problems. For example, some languages do not contain clear translations of the onomatopoeic term ‘wheezing’ [2-4].

These problems led us to develop a unique video questionnaire to collect asthma prevalence data. The hypothesis behind the use of the video questionnaire was that by showing, rather than describing, signs and symptoms of asthma, a more accurate recognition of clinical asthma would be achieved. The video questionnaire comprises videotaped sequences of individuals with clinical asthma in different circumstances, with the respondents being asked to complete a questionnaire documenting whether their breathing had been like that of the individuals presented on the videotape. The term ‘asthma’ is not mentioned during the video questionnaire. We have developed a number of such video questionnaires and have validated two of them [5, 6].

In the recently developed International Study of Asthma and Allergies in Childhood (ISAAC) [Asher et al., submitted], this video questionnaire technique was thought to be particularly
applicable, as this study is attempting to examine asthma prevalence in many countries worldwide. To provide the necessary racial variation for use in the ISAAC programme, we have developed a specific international version of the video questionnaire, with five video sequences of children from New Zealand, Polynesia, Hong Kong and India. This international version of the video questionnaire is currently being used to determine the self-reported prevalence of asthma in 13- to 14-year-old children in the ISAAC survey. It is hoped that it will provide asthma prevalence data from different populations that will be relatively free from the bias due to literacy, language, culture or interviewing techniques that may occur with the administration of standard written questionnaires.

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References