Reporting burden on Member States: options for reduction and proposal for a joint monitoring framework

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The purpose of this document is twofold:

1. to propose options for the reduction of reporting burden on Member States; and
2. to describe the process and content of a joint monitoring framework (JMF).

Section 1. Options for reducing the reporting burden on Member States

Although the mapping exercise and the related proposed minimum joint set of core indicators are critical for ensuring a reduction of the reporting burden on Member States, other reporting and data collection processes will still continue to impact them. It is estimated that more than 30 data collection requests per year are sent to Member States by WHO (both the Regional Office for Europe and headquarters). These requests require data from a wide range of sources, including routine administrative sources, surveys, civil registration and censuses. Furthermore, given their commitments to reporting on progress towards the Sustainable Development Goals (SDG), Member States will have to report on other health-related SDG indicators using different mechanisms. The options below outline potential ways to reduce the reporting burden.

Table 1: Options for reducing the burden of reporting on Member States

Options	Current situation	Proposed option	Pros and cons
Option 1: Streamlining Indicators	Currently Member States have to report on many indicators from different frameworks and data collection mechanisms, including Health 2020, the Global Monitoring Framework on Noncommunicable Diseases (NCD) and the European Health for All database (HFA). Many more indicators will be required for reporting on the Sustainable Development Goals (SDGs), further increasing the reporting burden on Member States.	Agree on a reporting framework with one minimum joint core set of indicators for the three main frameworks (H2020, NCD and a priority list from SDG). This set could form the basis for streamlining the reporting on the three frameworks.	Pros: Shorter list of indicators; reporting done once, not 3 times on similar indicators; focus would be on the agreed list of indicators; could prioritize indicators generated from routine data sources Cons: Would require prioritization and dropping of some indicators in the longer term; significant amount of country consultation needed for any change on the indicator list already adopted
Option 2: Timing of reporting	Currently, the timing of reporting is spread throughout the year with peaks at the beginning and end of the year. There is no formal coordination of data collection requests and each division sends its requests based on its own timelines.	Group reporting requests and send them out twice a year, for example, in March and September. Timing should be well planned to avoid the peak period of countries' internal work (for example, end of the year or beginning of the year). An online survey would help the Regional Office assess the best timing for sending the data requests.	Pros: Better planning within the Regional Office; better coordination with Member States; more time for quality assurance on data collection tools; Member States are better prepared to answer requests; better time management and increased response rate. Cons: Need to review and better coordinate Regional Office timelines for data collection; stricter time and quality management of requests may not be welcomed by all sections/divisions; new timelines may not be suitable for some divisions.
Option 3: Pooling/merging data collection	Each division sends its data collection request and questionnaires/templates without consulting other divisions or programmes within the same division. This leads to missed opportunities for synergies and for reduction of requests sent to Member	Increased consultation and collaboration within and between divisions through the Statistical Policy Group Gatekeeper function so that opportunities for pooling/merging questionnaires are further explored and implemented. This would entail 2 or 3 divisions/programmes with similar goals (or similar countries	Pros: Less data collection requests are sent to Member States; shorter list of indicators/variables; better quality of tools and questionnaires. Cons: Programmes/divisions may not be willing to reduce the number of questions or to merge with another questionnaire.

	States.	covered) merging their questionnaires into 1, resulting in a significant reduction of the number of questions/variables/indicators in the final questionnaire.	
Option 4: Combination of the 2 first options above Considered the best option		Development of a minimum joint core set of indicators on the main frameworks (Health 2020, SDG and NCD) and sending of data collection requests only 2 or 3 times a year	Pros: Shorter list of indicators; reporting done once, not 3 times; focus would only be on agreed priority list of indicators; better planning within the Regional Office; better coordination with Member States; more time for quality assurance on data collection tools Cons: Needs to be built into a several-step process, building also on the global indicator proposals; need to review and better coordinate Regional Office timelines for data collection; would require prioritization and dropping of some indicators (significant country consultation would be needed for any change on the indicator list already adopted); stricter time and quality management of requests may not be welcomed by all sections/divisions; new timelines may not be suitable for some divisions.
Option 5: Combination of the 3 first options above			Pros: Less indicators; better timing and coordination; improved quality of submissions. Cons: Extensive amount of internal coordination

The Division of Information, Evidence, Research and Innovation (DIR) prefers Option 4, which combines a streamlining of indicators and a further rationalization of the number and the timing of data collection requests. The process outlined below could help with the implementation of this option.

1. Streamlining Indicators: See Section II for a description of how a minimum joint core set of indicators could help streamline indicators from three frameworks: Health 2020, NCD and SDG. The agreed indicators would be considered the minimum joint core set for reporting. In consultation with the Regional Office, Member States would

agree on mechanisms by which they would report on other NCD and SDG indicators not included in the minimum joint core set.

2. Grouping requests: The Regional Office will gather and send data collection requests twice a year after consultation with Member States on the best timing for sending the requests.
3. Consulting: the Regional Office will consult with Member States for full-scale implementation of the option.
4. Updating databases: The Regional Office will update its databases, metadata and information platforms to accommodate changes due to the minimum joint core set of indicators, and reflect in particular the different levels of disaggregation (such as sex, gender, socio-economic status, urban, rural, etc.).

Section 2. JMF process and content

Table 2 below presents a proposal for a JMF. It describes the process and content of the JMF as well as the timelines, roles and responsibilities. The process can be divided into the following three phases.

1. DIR proposes a list of a minimum joint core set of indicators. This list is built on the outcomes of the mapping exercise that identified indicators aligned across the three frameworks (Health 2020, NCD and SDG). The 37 Health 2020 indicators (see Table A in Annex 1) should form the basis of the list, completed by 13 indicators from the two other frameworks (see proposal in Table B and C in Annex 1). These 37 Health 2020 indicators already include or measure at least 28 SDG indicators or topics (from at least eight goals) and more than one-third of NCD indicators and topics. In total, the minimum joint core set would be comprised of some 50 indicators.
2. DIR's proposed list will then be reviewed and validated by a recognized body, which could be an expert group assembled for this purpose or the internal, interdivisional working group on SDGs. DIR will submit the validated list for consultation, review and adoption by Member States.
3. This will be followed by a circular note to inform Member States that the JMF, based on the minimum joint core set of indicators, will replace reporting on health-related indicators on the three frameworks. The circular will also describe a clear mechanism for reporting on health-related indicators not included in the joint core set, given Member States' commitment to report on the SDG and NCD frameworks.

Table 2: Proposal for the JMF

Stage	Process	Content: activities/indicator/ deliverable	Division responsible	Timeline
Conceptualization /preparation	DIR proposes a list of 50 minimum joint core indicators based on: 1. all 37 H2020 indicators; 2. the 3 most relevant and unique indicators from the NCD framework; and 3. the 10 most relevant indicators from the SDG framework that are not captured by the Health 2020 framework.	Table A below (which includes all Health 2020 indicators) will form the basis for the minimum joint core set of indicators. It comprises 28 indicators that overlap across Health 2020 and SDG frameworks. Other indicators to be considered include: - 3 important indicators from the NCD framework not captured in Table A from Table C (see Annex 1); and - 10 more of the most relevant SDG indicators for the WHO European Region not captured in the Health 2020 framework.	DIR	Q2/2016
	Proposed minimum joint core set of indicators is discussed and validated by an expert group meeting (or the interdivisional meeting within the Regional Office).	The proposed minimum joint core set of indicators is submitted to Member States.	DIR/Interdivisional working group on SDGs	Q3/ 2016
	A consultation of Member States is carried out to validate and adopt the minimum joint core set of indicators.	The minimum joint core set of indicators is adopted for reporting on the 3 frameworks.	DIR/Member States	Q4/2016
Implementation	DIR prepares a reporting template which include the indicators and meta-data	Reporting template	DIR	Q42016
	The Regional Office prepares and disseminates an information circular to officially inform Member States on the minimum joint core set of indicators and the JMF.	Information circular	DIR/Regional Director	Q1/2017

ANNEX 1

Table A. Basis of the minimum joint core set of indicators: H2020 indicators

Domain	H2020 Core / Additional	Health 2020 Indicator
Premature mortality from NCDs	Core	C. 1.1.a. Standardized overall premature mortality rate (age 30 to 69) for 4 NCDs (cardiovascular, cancer, diabetes, chronic respiratory disease) (*variation in ICD codes for chronic respiratory disease)
Unemployment	Core	C. 3.1.d. Unemployment rate, disaggregated by age
Sanitation	Core	C. 4.1.c. Percentage of population with improved sanitation facilities
Mortality of children	Core	C. 3.1.a. Infant mortality per 1000 live births, disaggregated by sex
Overweight and obesity	Core	C. 1.1.d. Age-standardized prevalence of overweight and obesity in persons aged 18+ years
Health 2020-specific Indicators	Core	C. 2.1. Life expectancy at birth
Health 2020-specific Indicators	Core	C. 4.1.a. Life satisfaction
Health 2020-specific Indicators	Core	C. 6.1.a. Establishment of process for target-setting documented (mode of documenting to be decided by individual Member States)
Health 2020-specific Indicators	Core	C. 6.1.b. Evidence documenting: (a) establishment of national policies aligned with Health 2020; (b) implementation plan; (c) accountability mechanism (mode of 'documentation' to be decided by individual Member States)
Smoking	Core	C. 1.1.b. Age-standardized prevalence of current tobacco use among people aged 18 years and over
Alcohol	Core	C. 1.1.c.Total per capita alcohol consumption among people aged 15+ years within a calendar year

Education attainment	Core	C. 3.1.c. Proportion of children of official primary school age not enrolled
Health 2020-specific Indicators	Core	C. 3.1.e. National and/or subnational policy addressing the reduction of health inequities established and documented
Reducing income inequality	Core	C. 3.1.f. GINI coefficient
Social support	Core	C. 4.1.b. Availability of social support
Health expenditure	Core	C. 5.1.a. Private household out-of-pocket expenditure as a proportion of total health expenditure
Health expenditure	Core	C. 5.1.c. Total expenditure on health (as a % of GDP)
Vaccination	Core	C. 1.2.a. Percentage of children vaccinated against measles, polio and rubella
Mortality (general)	Core	C. 1.3.a. Standardized mortality rates from all external causes and injuries
Smoking	Additional	A. 1.1.b. Prevalence of weekly tobacco smoking among adolescents
Alcohol	Additional	A. 1.1.c. Heavy episodic drinking among adolescents *(feasible through age-group disaggregation of adolescents)
Mortality from traffic accidents	Additional	A. 1.3.a. Standardized mortality rates from motor vehicle traffic accidents
Accidental poisonings	Additional	A. 1.3.b. Standardized mortality rates from accidental poisonings
Suicide rate	Additional	A. 1.3.d. Standardized mortality rates from suicides
Deaths from homicides	Additional	A. 1.3.f. Standardized mortality rates from homicides and assaults
Maternal mortality	Additional	A. 5.1.a. Maternal deaths per 100 000 live births
Overweight and obesity	Additional	A. 1.1.d. Prevalence of overweight and obesity among adolescents (defined as BMI-for-age value above +1 Z-score and +2 Z-score relative to the 2007 WHO growth reference median, respectively)
Health 2020-specific Indicators	Additional	A. 2.1.a. Life expectancy at birth and at ages 1, 15, 45 and 65
Health 2020-specific Indicators	Additional	A. 2.1.b. Healthy life years at age 65
Health 2020-specific Indicators	Additional	A. 4.1.b. Percentage of people aged 65+ living alone
Alcohol	Additional	A. 1.3.c. Standardized mortality rates from alcohol poisoning
Household consumption	Additional	A. 4.1.c. Household final consumption expenditure per capita

Education attainment	Additional	A. 4.1.d. Educational attainment of people age 25+ who have completed at least secondary education
Vaccination	Additional	A. 5.1.b. Percentage of people treated successfully among laboratory confirmed pulmonary tuberculosis who completed treatment
Health expenditure	Additional	A. 5.1c. Government expenditure on health as a percentage of GDP
Mortality (general)	Additional	A. 1.1.a. Standardized mortality rate from all causes, disaggregated by cause of death
Mortality (general)	Additional	A. 1.3.e. Standardized mortality rates from accidental falls

Table B: Proposed unique indicators from NCD Framework to be included in the Minimum Joint Core Set of indicators: Must select maximum 3 indicators max (proposed list highlighted in yellow)

NCD Domain	Indicator
Salt/sodium intake	8. Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years
Physical inactivity	6. Prevalence of insufficiently physically active adolescents, defined as less than 60 minutes of moderate to vigorous intensity activity daily
Diabetes and obesity	14. Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as body mass index $\geqslant$ 25 kg/m² for overweight and body mass index $\geqslant$ 30 kg/m² for obesity)
Diet	16. Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day
Cholesterol	17. Age-standardized prevalence of raised total cholesterol among persons aged 18+ years (defined as total cholesterol $\geqslant$ 5.0 mmol/l or $\geqslant$ 190 mg/dl); and mean total cholesterol concentration
Policies	21. Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply, as appropriate, within the national context and national programmes
Cancer	25. Proportion of women between the ages of 30–49 screened for cervical cancer at least once, or more often, and for lower or higher age groups according to national programmes or policies

Table C: Proposed additional list of SDG indicators (relevant to the European Region) to be included in the JMF: Select 10 max

Domain/Goal	Indicators
● Goal 3: Universal Health Coverage, Unfinished MDG business and other health: (6 indicators)	– Target 3d - IHR – Total Health Expenditure as % of GDP – Target 3c Health worker density – Target 3.1 (maternal mortality) – Target 3.2. (neonatal mortality) – Target 3.2. (Under-five mortality rate) – Target 3.3. TB/HIV/Hepatitis/ – Target 3.9 (Mortality rate attributed to household and ambient air pollution)