

# **A rapid assessment of the burden of indicators and reporting requirements for health monitoring<sup>1</sup>**

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<sup>1</sup> Prepared for the multi-agency working group on Indicators and Reporting Requirements by the Department of Health Statistics and Information Systems, World Health Organization, February 2014.

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## Executive summary

Global health agency leaders agreed to critically review respective agency reporting requirements from countries with the aim of reducing country reporting burden. The purpose of this document is to give a brief overview of the global perspective on reporting requirements, assess the current indicator of reporting burden for selected countries, and identify areas where effort can be made to both strengthen and reduce reporting burden.

This rapid assessment of the burden of indicators and reporting for health illustrates how global investments in disease and program-specific M&E programmes have resulted in very large numbers of indicators, fragmented data collection, uncoordinated efforts to strengthen country institutional capacity, causing unnecessary reporting burden to countries and inefficiencies, and hampering overall analysis and decision-making.

### Too many indicators

- A review of indicators across only a selected number of partners, programs and resolutions revealed that countries are requested to report on as many as 600 indicators. This is a conservative estimate of the reporting requirements as many programs and partner reporting requirements are not included in the calculation.
- The indicators are associated with (i) the monitoring of international commitments and Member State resolutions (World Health Assembly, UN General Assembly), (ii) with global and regional disease program monitoring by UN agencies, and (iii) with the monitoring of grants and projects.
- The assessment showed that international reporting can easily increase the number of indicators in national M&E plans by an additional 40-50%. These additional indicators are either new indicators requiring other data, indicators that are similar but use different definitions, or required at different levels of disaggregation (e.g. for specific geographic areas or health facilities).

### Reporting requirements for countries are diverse and multiple

- The number of requests for data appears to be increasing, because there are more initiatives and efforts, such as those associated with accelerating MDG 4 and MDG 5 and with NCDs, and there are increasing demands for disaggregated data (e.g. by sex, age, wealth and geographic location).
- While most agencies agree on the benefits of harmonization and rationalization of indicators and reporting, and many are supporting harmonization efforts, the cumulative reporting burden for countries is still very heavy.
- The global reporting requirements have given rise to a significant number of challenges for countries. Countries must not only deal with a large volume of indicators, but also in many cases, with diverse indicator definitions, reporting periodicities and formats. This is often compounded by parallel, vertical data collection efforts, and limited capacity in-country.
- The impact of a fragmented approach and large numbers of indicators and reporting requirements is often felt hardest at the health facility level where frontline health workers have to complete large numbers of forms, registers and reports.

## Weak country monitoring and evaluation (M&E) with disease programme monitoring in silos

- In addition to the external demands for information, countries also collect many additional indicators to monitor their specific programs. National monitoring and planning processes in country are guided by both the M&E component of the national health sector strategic plans, as well as by specific health and disease programme M&E plans.
- The assessment showed that within many countries the alignment of indicators in national health sector strategic plans and programme-specific M&E plans (e.g. HIV, immunization, RMNCH) is poor, leading to unnecessary duplication and mushrooming of indicators. This may partly be due to the development of specific programme silos supported by external funding and its associated monitoring requirements.
- Country evidence reveals that partners only use a fraction of the information generated through the national M&E systems, partly because of quality concerns, and add significant reporting burden to country systems.

## Investments in country M&E systems are often fragmented and inefficient

- In principle, agencies agree that there is a need to use country systems rather than separate donor reporting systems, if the quality is adequate. Since country health information systems tend to be weak, and the need to demonstrate results of investments is urgent, partners tend to invest in separate and single-purpose data collection efforts, such as facility reporting systems (e.g. ART, immunization) or single-topic household and facility surveys.
- The multiplicity of data collection systems and the disjointed efforts in data analysis and use further compound the country situation and reporting burden.
- Quality control is essential, but investments to address it have often focused on fixing one problem but not improving the country system. While full integration is not always the best option, countries could benefit much more with better alignment and greater efficiency of these investments.

## Possible actions for global partners

Although there has been some progress in global efforts to harmonize data collection and minimize the reporting burden on countries, there is ample scope for further improvements:

1. **Core indicators:** Agreement upon a unified results measurement framework with a limited, core set of indicators, which would form the basis for streamlining country data requests, supported by global agency efforts to identify measures they can do without in the interest of better alignment;
2. **Alignment of reporting with the national M&E platform:** Collaboration on strengthening of country M&E platforms for information and accountability, so that this becomes the basis for global reporting with reliable, timely, high quality data for core indicators, with a clear consolidated strategy for data validation, including consolidation of country data collection efforts by agencies;
3. **Investment in M&E systems:** Well-aligned investments in country data systems, including births, deaths and cause of death reporting, harmonized regular surveys, facility and administrative data reporting systems and strengthening of institutional capacity for measurement of results; further efficiency gains and “on line” collection of data through scale up with IT and mhealth technologies.

Diagnosis	Momentum	Impediments	Possible actions
1. Too many indicators for countries	Willingness to reduce indicators, more emphasis on quality	Demand for more results, more disaggregation and accountability	Agree upon global core set of indicators
2. Definitions of indicators highly variable	Good standards available for many indicators	Demand for data tailored for the needs of one organisation	Improve access and use of standard definitions
3. Reporting requirements are diverse and multiple	Willingness of partners to align	Demand for results and emphasis on “tit-for-tat” accountability (specific results for specified external resources)	Agreement by partners to support one national platform for information & accountability that meets IHP+ criteria
4. Poor country systems alignment between M&E of health sector and disease plans	More focus on a smaller set of indicators and targets	Verticalization of programs, fuelled by separate funding streams	Ensure better alignment between plans (IHP+ behaviours)
5. Investments in M&E systems are fragmented and inefficient	Awareness of the need to support systems and address data availability and quality gaps; innovative approaches possible	Program-specific approaches lead to fragmentation; donor constituency demands for tit-for-tat results	Strengthen alignment of M&E investments, including data quality, in support of national M&E platform, including innovative approaches

## 1. Introduction

At the informal meeting of global health leaders in New York September 24, 2013, it was decided to establish a group of senior focal points from the participating global health agencies, to critically review respective agency reporting requirements from countries. A working group of 19 agency representatives was established and chaired by the Director-General of WHO with the aim of taking stock of respective global practices and reporting requirements with the goal to reduce the burden on countries. A key informant survey was completed by 16 agencies. The responses provided insights into the current situation from the global perspective, including the indicator requirements from each, ongoing efforts to rationalize the set of indicators on which data are collected, and the awareness of the need to strengthen and rely more on country systems.

In addition to the global landscaping exercise, a “reality check” assessment of the reporting burden from the country perspective was conducted. Because of the short time frame this was carried out by engaging WHO Country Offices in selected countries<sup>2</sup>. The country offices provided country monitoring and evaluation plans and reports as the basis for a desk review of indicators and reporting practices. In addition, telephone interviews were held with country offices to glean a qualitative assessment of the extent of the reporting burden for the government and the efforts of partners to work together and align.

The purpose of this document is to give a brief overview of the global perspective on reporting requirements, assess the current indicator of reporting burden for selected countries, and identify areas where effort can be made to both strengthen and reduce reporting burden.

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<sup>2</sup> The contributing country offices included Afghanistan, Cambodia, Egypt, Haiti, Nigeria, Nepal, Rwanda, Tanzania, Togo, Uzbekistan, Viet Nam, and Zimbabwe. Information was gathered through desk review of global reporting instruments and reports and interviews with country offices.

## 2. What are the global reporting requirements?

- ▶ *Monitoring of international commitments and Member State resolutions in global governing bodies: 144 indicators and 100 targets during 2000-2013*
- ▶ *WHO and other UN agencies reporting on specific health and disease programmes: over 150 indicators annually to inform global reports and tracking databases*
- ▶ *Monitoring associated with grants and specific projects: there is overlap in the indicators collected with UN agencies, but countries also have to report separately on many additional indicators, mostly to Global Fund, GAVI, and US government.*

### Monitoring of international commitments & resolutions

The first requirement relates to progress monitoring with regard to international declarations of commitment in which government leaders have committed their countries to the achievement of specific goals. During the past decade, the Member States have adopted 248 resolutions in the World Health Assembly. Not all commitments have targets and indicators, but there appears to be an increasing trend. Between 2000 and 2013, for example, the World Health Assembly (WHA) adopted resolutions requiring monitoring of a total of 144 indicators and 100 targets.

The 144 indicators associated with WHA resolutions include the 22 health MDG indicators and 6 targets, 25 indicators and nine targets proposed to monitor the action plan to control NCDs (WHA 66.10), six targets and indicators for maternal and child nutrition (WHA 65.6), and 12 targets and indicators for neglected tropical diseases (multiple resolutions). Reporting frequencies for indicators in WHA resolutions vary greatly.

**Table 1: Number of indicators recommended in selected resolutions and in guidelines of selected development partners.**

	Total Number of indicators		Frequency of reporting
<b>WHA Declarations/resolutions</b>			
World Health Assembly (WHA) Resolutions (2000-2013)	144 (100 targets)	MDGs, eye health, financing, HIV, IHR, immunization, influenza, malaria, RMNCH, mental health, NCD, NTD, nutrition, ODA, research, STI, TB, water and sanitation	Variable
<b>Selected disease programme specific focus</b>			
Tuberculosis	10 indicators	WHO	Annual
HIV (Global Aids Response)	31 indicators	UNAIDS	Annual from 2013
HIV (Universal Access)	47 indicators	WHO/UNICEF	Annual from 2013
Malaria	15 core indicators 19 additional indicators	WHO	Annual
Immunization	50 indicators	WHO/UNICEF	Annual
Noncommunicable Diseases (NCDs)	25 core indicators + 35 additional	WHO	Every 5 years Some every 2 years
<b>Donor /project</b>			
GAVI	7 core indicators	Immunization	Annual
Global Fund	114: 42 for HIV, 27 for TB, 28 for Malaria and 17 for HSS	HIV, TB, malaria, health system strengthening	Annual or half-yearly
World Bank	10 core indicators	Health sector	Annual
USAID	73 core indicators	Health sector	Annual
PEPFAR	35 core indicators	HIV/AIDS	Annual
President's Malaria Initiative	46 core indicators	Malaria (excluding sentinel site data)	Annual

Some reporting of data and statistics is mandatory or specified in the constitution of WHO. The International Health Regulations (IHR) that came into effect in 2007 for example requires countries to report to WHO a set of notifiable events involving epidemic prone diseases that are considered of public health concern, based on a situational public health criteria. In addition, four notifiable infectious diseases (smallpox, poliomyelitis due to wild type poliovirus, human influenza caused by a new subtype and severe acute respiratory syndrome) must always be notified to WHO. In addition, implementation of IHR core capacity in country is monitored by 20 mandatory indicators.

Annual reporting of data on mortality by age, sex and cause, is another example of required reporting that is referred to in the WHO constitution. Mortality statistics along with about 120 core health indicators are compiled and published in the World Health Statistics on an annual basis by WHO to inform the World Health Assembly deliberations. As part of this process WHO HQ, in collaboration with other UN agencies, produces comparable estimates for key indicators and conducts a country consultation about the estimates and their methods in line with a WHO resolution in 2001.

## Disease & programme specific reporting

The second type of international reporting requirements relates to reporting to UN agencies by specific health and disease programme, including maternal, newborn, HIV, tuberculosis, malaria, and immunization. The monitoring of global and regional health situation and trends is one of WHO's core functions. Health data are gathered by Member States and reported to WHO or collected from other sources such as international survey programmes and then compiled, analysed, and published. Disease and health programmes often require annual data collection on indicators, including policies, service delivery, coverage, risk factors etc., for annual status and progress reports. Some of the indicators used by these programmes are those specified in the World Health Assembly (WHA) Resolutions, many others are additional. Globally, WHO compiles data from all programmes (approximately 800 indicators in total), and makes them publically available through the WHO Global Health Observatory. This does not include WHO Regional Office indicators and data collection, which are reasonably well-aligned with headquarters, albeit not completely.

### Tuberculosis (TB)

WHO has supported a standardized country system to monitor TB epidemiology and interventions since the nineties, based on standard clinical records and registers. WHO collects TB data from countries on an annual basis through a web-based survey on the main indicators including financing and programme implementation. The volume of data collected is quite extensive because of the need for disaggregation of several indicators e.g. age, sex, HIV status, previous treatment history and type of disease), the increasing complexity of the epidemiology (HIV, MDR TB, new diagnostic methods) and the demand for more data (financing, service access).

There is generally good alignment of indicators and definitions among global partners, with the WHO indicators. Global Fund coverage and impact indicators for example are globally aligned with the WHO indicators, but may pose an extra burden on countries of its requirements for specific input/process and output data. USAID has only two TB output indicators in its core list.

### HIV/AIDS

The HIV/AIDS programme has very many indicators, partly due to the multisectoral nature of the response, partly due to inefficiencies. UNAIDS, WHO and UNICEF are reporting on the progress of the global AIDS response based on a recommended set of core indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS. The Global AIDS Response Progress Reporting (GARPR) (previously known as UNGASS indicators) for example, now includes 31 indicators and 10 targets on HIV/AIDS, representing a substantial reduction as compared with previous numbers of indicators. In addition, countries also have

to respond to a set of policy-relevant questions. Reporting to UNAIDS is usually done by the national AIDS coordinating body, supported by UNAIDS staff in-country.

WHO and UNICEF collect annual data on the health sector response towards the goal of Universal Access for regular progress monitoring. A total of 64 indicators and a set of HIV policy related questions are requested from all countries. Of the 64 indicators, 17 are the same as the GARPR indicators. This results in 47 unique HIV indicators for monitoring Universal Access. In an effort to harmonize data collection and minimize the reporting burden on countries WHO, UNAIDS and UNICEF have developed a Joint Online Reporting Tool. WHO and UNAIDS have also begun work on a consolidated guide on strategic information for the health sector response, with the aim to further reduce the indicator reporting burden.

## **Malaria**

The Global Malaria Programme at WHO recommends that countries track 15 key and supportive indicators for malaria. In addition, the WHO malaria program also requests countries to answer questions on topics including population at risk, vectors, total cases, admissions, deaths, reporting completeness, community diagnosis, active case detection, national policies related to malaria, interventions, information from household surveys, and malaria financing. This is done annually in order to compile the global malaria report and can involve collecting responses from countries on approximately 150 questions.

## **Immunization**

Since 1998 WHO and UNICEF have been jointly collecting information on immunization indicators (including, immunization coverage, incidence from vaccine preventable diseases, immunization schedule). This annual data collection is conducted through a web-based questionnaire in an attempt to reduce burden on national authorities. The joint reporting form includes approximately 50 indicators derived from about 200 questions on topics including surveillance systems, disease cases, routine immunization schedules and reporting, coverage estimates, planning and management, supply chain, safety, and financing. The data is consolidated and available for other partners by internet. According to a WHO country office source this list of indicators gets longer every year.

## **Reproductive, maternal and child health**

There are five MDG coverage indicators and two mortality (child and maternal) indicators, as well as one child anthropometric indicator relating to reproductive, maternal and child health. The Commission on Information and Accountability proposed 11 indicators, including the eight health MDG indicators (adding pneumonia treatment, breastfeeding and postnatal care). The Countdown 2015 for maternal, newborn and child survival produces regular progress reports for about 25 intervention coverage indicators drawn from household surveys (DHS and MICS), and a dozen health system indicators collected through key informant surveys.

WHO, UNICEF and UNFPA collect further data from countries on specific child health indicators in conjunction with global reports. At present, there does not appear to be a heavy reporting burden. However, new initiatives in the context of the Global Strategy are developing monitoring mechanisms that need to be aligned, and build upon the country monitoring and evaluation system. The follow up of the recommendations of the UN Commission on Life-Saving Commodities for Women and Children for example includes a questionnaire for countries, which could be translated into over 40 indicators. The FP 2020 initiative is developing ways to monitor progress. More attention for newborn care and quality of care is also leading to more indicators (e.g. in relation to the Newborn Action Plan).

## Non-communicable diseases and risk factors

A UN declaration and WHA resolution have led to a global monitoring plan that includes nine targets and 25 indicators which will be monitored once every five years. In addition, the NCD country capacity assessment is carried out every two years collects information on a further 35 non mandatory indicators. The integration of NCD surveillance into national health information systems and improved coordination of NCD risk factor surveys, is needed to significantly reduce the burden of data collection and reporting for countries.

## Nutrition

In 2012 a WHO resolution has specified six indicators and targets for nutrition. A framework for monitoring progress towards the achievement of these six global targets under development will suggest approximately 39 indicators for use at global and national levels. This includes indicators like child and adult anthropometry (under- and overweight), child feeding practices, micronutrient deficiencies, nutritional intervention coverage.

## Grants and project monitoring

A third group of reporting requirements is associated with grants and projects that involve reporting on a specific set of indicators to development and bilateral partners. While there is some overlap in the indicators collected for monitoring grants and projects with information collected through UN agencies, reporting burden is not mitigated at the country level as countries still have to report to the different entities.

*The Global Fund* has a core set of indicators for grant monitoring. These include impact, outcome and coverage indicators. Currently, there are about 114 indicators, including 42 for HIV, and 27 each for TB, 28 for malaria and 17 for health systems strengthening. The requirements for these indicators are based on type of epidemic or the disease burden. The recommended number of indicators to be included in grants is 10-15 coverage/output indicators. The actual number used for reporting depends on the program areas supported by the grants. A comprehensive 250-page Global Fund M&E toolkit was developed with partners and published in 2011. The Global fund is currently revising its measurement guidance under the New Funding Model with a focus on impact, outcome and coverage. Input and process indicators are not included in the core list of indicators. The indicators are reported to the Global Fund every 6 or 12 months.

GAVI requires countries to submit Annual Progress Reports (APR) through which countries report once a year against specific indicators agreed to as part of their grants. There are 7 core indicators required from all countries and these include number and proportion of the target population reached and wastage for vaccine support and 4 additional health systems strengthening (HSS) indicators. Reports to GAVI for vaccine grants are written as stand-alone reports from Ministries of Health, drawing upon national reports. For HSS grants, countries report on indicators that they have defined for inclusion in their performance frameworks. These include coverage (with equity) and service delivery indicators which are available through routine information systems and surveys. Depending on country situation, there can be additional reported indicators but the total number usually does not exceed 20.

USAID tracks performance through annual reports that must be completed by USAID missions, guided by a core list of 73 indicators and focusing on USG directly-supported results, e.g. number of specific services provided in US government clinics. In addition, USAID relies on heavily on higher level outcome indicators from DHS surveys, in close collaboration with host country governments.

In 2013, *PEPFAR* amended its core indicator guide, with the aim of better alignment of indicators and reporting requirements with globally harmonized indicators and within the context of the national HIV/AIDS M&E plan of each country. There are a core set of 35 indicators that are required from countries to be submitted to headquarters. In addition, there are indicators that are essential for *PEPFAR* programs and are tracked within country but are not reported to headquarters. For example, *PEPFAR* requires detailed information on programs and clinics that it supports, which often require parallel data investments in data collection and monitoring in countries.

*The President's Malaria Initiative* has a set of 46 core indicators required from those countries where they are working in, though there is tailoring of reporting requirements based on country context. Additionally, PMI also collects a set of 19 indicators from sentinel sites. The 46 PMI indicators include 9 of the WHO recommended 15 core indicators and 6 of the 19 additional indicators.

The *World Bank* support with a health component requires annual reporting of up to 10 core sector indicators, which need to be measured to the extent that they are relevant to the scope of the project. Reporting on additional project-specific indicators are required when relevant. Countries generally routinely monitor these indicators, and they therefore rarely put a large reporting burden on countries.

*The European Union's* bilateral support to health as a focal sector covers 42 countries under the current financial framework 2007-2013. In line with the Commission's commitment to the Paris Declaration and to the IHP+, the EU follows its partner countries' monitoring frameworks to account for progress in the health sector, and refers to internationally recognized indicators, originating from the WHO Compendium of Health Indicators 2012 and the IHP+/WHO 2011, "Monitoring, evaluation and review of national health strategies: a country-led platform for information and accountability".

Most bilateral partners such as Canada, France, Germany, Japan, Norway, and Sweden indicated that they mainly use statistics from WHO/UNICEF/UNAIDS joint-reporting systems and country information systems for their own reporting and do not request additional information from countries. Bilateral partners also indicated that only exceptionally additional data collection is supported to fill gaps. Germany is working on a new set of key performance indicators informed by the work of IHP+, aiming to be compatible with existing national monitoring frameworks and country reporting capabilities. In countries with sector wide approaches (SWAp) and common funding mechanisms, bilateral donors generally require no additional reporting.

The Rockefeller and Bill and Melinda Gates Foundations do not require countries to report any data though their grantees do report information based on the programs/interventions supported. While individual grants may have heavy reporting requirements, they cause little direct burden on countries. Research grantees align with country systems to variable degrees, often depending on the project nature.

### Country example: data burden in Viet Nam

Viet Nam receives external support from the Global Fund (GF), GAVI and PEPFAR. On the one hand, these resources have allowed the country to make progress in controlling diseases particularly, TB, HIV/AIDS and Malaria, and HSS. On the other hand, however, while donors seek agreement on harmonizing their support, the implementation of the resources has also generated a data collection burden to the implementers from the national to the commune health stations. The total number of indicators collected for the monitoring for GF, GAVI and PEPFAR programmes alone, based on the reporting templates of each partner, is 158 plus 195 sub- indicators.

**Number of indicators used in the three programmes**

Donor	Number of monitoring indicators	
	Key indicators	Sub-indicators
Global Fund	92	
GAVI	22	
PEPFAR	44	195
Total	158	

The collection of these data is undertaken at different levels, such as the commune health stations, treatment centers (for HIV) and service providers, such as district hospitals and district health centres. These data are collated at the provincial level and eventually at the national level. The data collection is basically paper-based especially at the level of the commune stations- where the number of forms to complete can range from 30-60. The resources spent on data collection, including the cost for the retrieval of forms and monitoring supervision, is a significant part of donor and government resources.

Among the three donors, GF and GAVI use some country indicators that are routinely collected for HSS and for TB, but indicators used for malaria and HIV are GF-specific, based on the performance framework approved by GF. PEPFAR uses a totally different set of indicators that those used in national plans. At the national level, the number of staff working in support of M&E for PEPFAR, Global Fund and GAVI may exceed the number of staff working in the health information system. The M&E staff positions are part of the external grants. For instance, in Viet Nam, about 15 staff is funded as part of the GAVI HSS grant focusing on the M&E of the HSS grant, while the national health statistics unit has only 5 staff. This also occurs at the subnational level, especially in PEPFAR supported programmes, with designated M&E staff linked to the grant.

### 3. What are the indicators and reporting requirements in countries?

- ▶ *Countries themselves use large numbers of health indicators for monitoring progress.*
- ▶ *Progress of the national health sector strategic plan is usually monitored annually with 25-50 core indicators with targets, and RMNCH and health systems indicators are the two most common;*
- ▶ *In addition, M&E plans of national disease and programme plans (HIV, TB, RMNCH, malaria, immunization) include over 200 indicators, often poorly aligned with the overall M&E plan of the health sector strategy, and focusing more on inputs, service delivery and coverage.*
- ▶ *The burden of many indicators and reporting requirements is often felt hardest at facility level where multiple forms, registers and reports have to be filled by frontline health workers.*

#### Indicators in national health plans

National health sector plans usually span a five-year period and often comprise an M&E component that addresses how the goals and objectives of the national health plan will be monitored, evaluated and reviewed. This includes a selection of indicators that are used to monitor progress and performance. Core indicators for health plan should reflect the broad health priorities, but be parsimonious in number and well-balanced across the monitoring and evaluation results chain, covering inputs such as resources invested and activities undertaken; outputs such as services provided, and quality of services; intervention coverage and risk factors; and outcome or impact indicators such as the health status of a population.

National health sector plans often use internationally recommended indicators, although definitions may vary slightly. Uzbekistan and Zimbabwe did not have a national M&E plan, as part of the health sector strategic plan. Across the 10 plans reviewed, the median number of core indicators in health sector plans is 34, ranging from a total of 17 in Haiti (2011-2021 plan) to 92 in Rwanda (2009-2012 plan). In most plans, indicators have targets, but many do not have good baselines.

**Table 2: Indicators in National Health Strategies, with breakdown by group**

Country	Sector Plan Years	Total Indicators	RMNCH	Nutrition	EPI	HIV	TB	Malaria	NCD	Health System	Environmental	NTD	Notifiable Diseases
Nigeria	2010 - 2015	54	15	1	2	4	3	5	0	23	0	0	1
Uganda	2010 - 2014	26	9	2	2	2	1	2	0	7	1	0	0
Rwanda	2012 - 2018	92	28	5	2	5	2	6	2	38	3	1	0
Sierra Leone	2010 - 2015	18	6	1	1	1	0	1	0	6	2	0	0
Burkina Faso	2001 - 2010	43	10	1	3	4	1	2	0	22	0	0	0
Tanzania	2003 - 2008	39	12	2	4	4	2	2	0	9	0	2	2
Cambodia	2008 - 2015	83	30	3	3	5	3	3	14	21	0	0	1
Viet Nam	2011 - 2015	19	8	1	1	1	0	0	0	8	0	0	0
Haiti	2011 - 2021	17	5	2	1	2	2	2	0	1	2	0	0
Benin	2009 - 2018	28	5	1	1	3	1	3	0	11	2	1	0
<b>Average</b>		<b>42</b>	<b>13</b>	<b>2</b>	<b>2</b>	<b>3</b>	<b>2</b>	<b>3</b>	<b>2</b>	<b>15</b>	<b>1</b>	<b>0</b>	<b>0</b>
<b>Median</b>		<b>34</b>	<b>10</b>	<b>2</b>	<b>2</b>	<b>4</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>10</b>	<b>1</b>	<b>0</b>	<b>0</b>

The two most prominent groups of indicators in health sector strategic plans are those measuring progress towards RMNCH targets and those measuring various dimensions of the health system (such as health workforce, financing, service delivery, governance) (Table 2). The health MDG indicators are included in the majority of countries. Of the countries reviewed only Cambodia and Rwanda included NCD indicators in their national strategy.

There is a focus on coverage and impact indicators but input and services delivery indicators are not ignored. Most countries have a balanced set of indicators across the results chain to monitor how inputs to the system and processes are reflected in outputs and eventual outcomes and impact (Table 3).

**Table 3: Number of core indicators in national health plans, by results framework**

Country	National health Sector Plan (years)	Total Indicators	Indicator by Type			
			Input	Output	Coverage	Impact
Nigeria	2010 - 2015	54	18	5	20	11
Uganda	2010 - 2014	26	4	5	12	5
Rwanda	2012 - 2018	92	33	14	37	8
Sierra Leone	2010 - 2015	18	4	1	8	5
Burkina Faso	2001 - 2010	43	21	3	10	9
Tanzania	2003 - 2008	39	6	4	12	17
Cambodia	2008 - 2015	83	15	23	29	16
Viet Nam	2011 - 2015	19	7	1	3	8
Haiti	2011 - 2021	17	0	2	7	8
Benin	2009 - 2018	28	3	12	11	2
Median		34	7	5	12	8

## Indicators in programme/disease specific plans

In addition to the national health sector plan, countries have specific health or disease plans. Program specific M&E plans have larger numbers of indicators, especially relating to input and process and service delivery indicators used to monitor programme implementation. Often, within-country alignment of the indicators between the national health sector plan and the program-specific plans is poor. Programme indicators in the national health sector plan should be included in the programme plan. However, this is not always the case. Furthermore, different definitions are used for the same indicators between the two plans.

As seen in Table 4, for both Nigeria and Zimbabwe, the indicators in just five programme plans sum up to 200-300 indicators. For both countries, across these programs, approximately two-thirds of the indicators are input, process, or output indicators. This is expected as most national programmes tend to use these indicators to monitor annual programme planning and management purposes. However, the huge volume of indicators is also fuelled by separate funding channels related to global initiatives and grant proposals.

In some cases, there are multiple plans for the same programme or disease area that have different indicators. For instance, in Nigeria there appears to be multiple national plans for immunization and inadequate alignment of indicators with the WHO/UNICEF joint reporting. The National Routine Immunization Strategic Plan (2013-2015) has 21 key performance indicators and 37 accountability framework indicators. In addition there are 11 indicators included in the Country Multi Year /cMYP) Plan 2011-15. There is not a lot of overlap between the different sets of indicators and plans.

**Table 4: Additional indicators in programme specific national monitoring and evaluation plans**

		Inputs/ Process	Outputs	Coverage	Impact	Total indicators in programme-plans
Nigeria	HIV	0	46	18	5	<b>69</b>
	TB	10	9	10	3	<b>32</b>
	Malaria	12	41	17	6	<b>76</b>
	Immunization	23	20	17	2	<b>62</b>
	RMNCH	11	14	15	7	<b>47</b>
	<b>TOTAL</b>	<b>56</b>	<b>130</b>	<b>77</b>	<b>23</b>	<b>286</b>
Zimbabwe	HIV	11	5	16	2	<b>34</b>
	TB	0	2	2	1	<b>5</b>
	Malaria	10	20	12	5	<b>47</b>
	Immunization	27	12	14	0	<b>53</b>
	RMNCH	6	31	38	6	<b>81</b>
	<b>TOTAL</b>	<b>54</b>	<b>70</b>	<b>82</b>	<b>14</b>	<b>220</b>

The burden of many indicators and reporting requirements is often greatest at the health facility level where frontline health workers spend considerable time on completing numerous forms, registers and reports. In Viet Nam, the number of forms for commune health stations ranged from 30 to 60. In Nigeria, a single primary health care facility has 13 registers. Several countries reported vertical data collection through facility visits by designated staff paid for by donors to gather data only for donor reporting purposes with poor links to strengthening the country's system. The large volume of paper work for frontline health workers is not entirely due to donor reporting. Country systems also tend to create far more indicators, registers and reporting forms than is actually useful for decision-making.

### Crisis countries

The assessment did not look into issues specifically related to countries affected by conflict or disaster. There are examples of countries where the M&E system has strengthened following the acute phase of a crisis (e.g. Afghanistan). There are also examples where M&E has deteriorated and remains poor and fragmented.

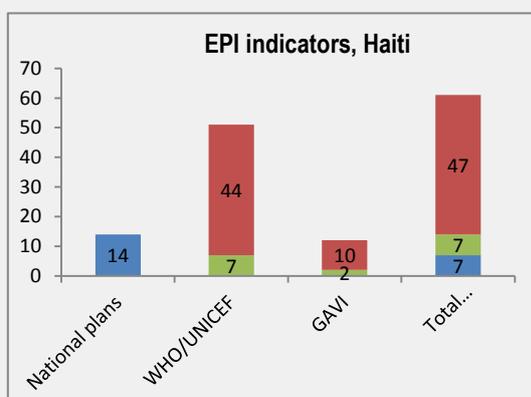
During the acute phase, there are often many rapid population-based surveys conducted by civil society organizations and others (e.g. Darfur has had dozens of surveys) with a focus on mortality and health service coverage. These are generally not conducted in an organized manner, with lots of duplication, variability in quality and sometimes widely divergent results.

Previous efforts to improve collaboration in monitoring health and nutrition in crisis situations through a partnership have not been successful. There is however guidance for indicators and data collection methods that may have improved data collection and analysis. The strengthening of M&E systems in crisis countries would benefit from a more coordinated approach of global partners.

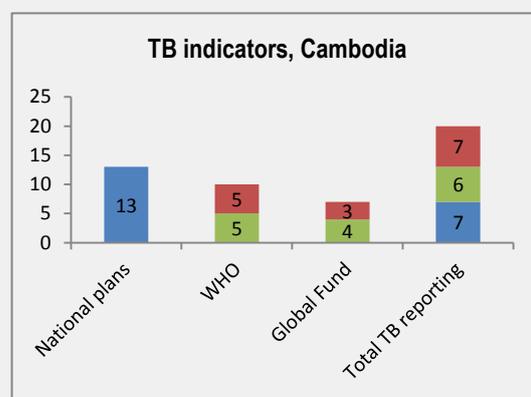
## 4. How well are partners aligned with country indicators and monitoring?

- ▶ Global partners use indicators that are the same as those in national plans and request information, or invest in data collection, on indicators not in national plans, referred to as additional indicators.
- ▶ The extent to which there is requirement for additional indicators varies between countries and between programmes, but can easily double the national number, as is shown for several countries

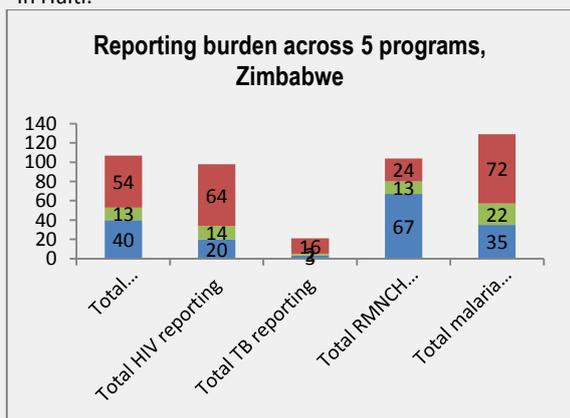
Some of the discrepancies between national and partner requirements are detailed in the Figures below, showing the number of indicators in the national health sector M&E plan and program-specific M&E plans, and those associated with reporting for WHO/UNICEF/UNAIDS, Global Fund, GAVI and others. Green indicates that the indicators already existed in the national plans; red refers to additional indicators that came on top of national sets of indicators. Indicators are additional if they require other data than existing indicators, if they are similar but use different definitions and if they require different levels of disaggregation (e.g. geographically or specific health facilities).



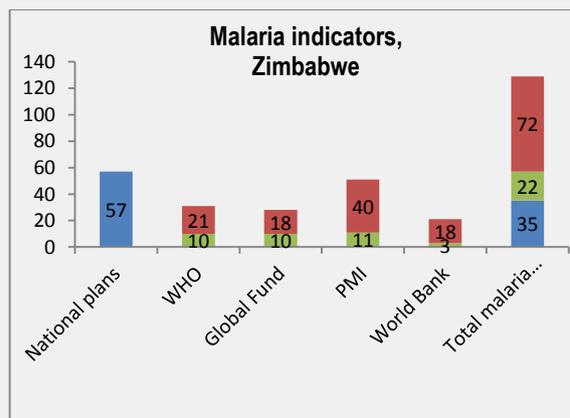
The 2011-2015 cMYP for Haiti specifies 14 core indicators. Seven of them are similar or equal to the indicators derived from the WHO/UNICEF Joint Reporting Form. Partner requirements add 47 indicators on immunization in Haiti.



In Cambodia, one third of the indicators on TB are requested only by the Government and one third only by partners. The last third is used both by the Government and partners.



Zimbabwe has a total of 229 indicators in 5 national programme plans - malaria, tuberculosis, HIV/AIDS, immunization and RMNCH. Sixty four of these indicators also feature in partner plans. In addition, partners request 230 additional indicators across these 5 programme areas.

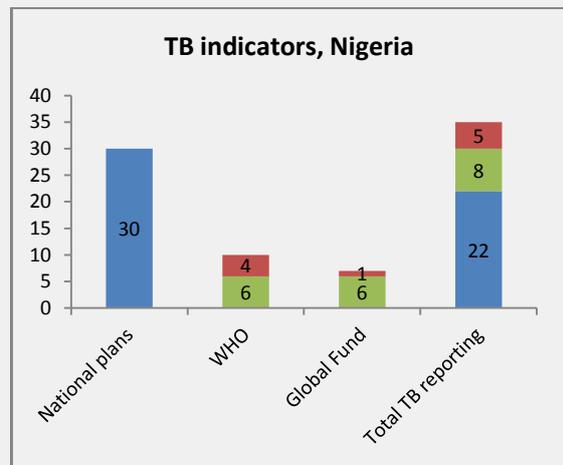
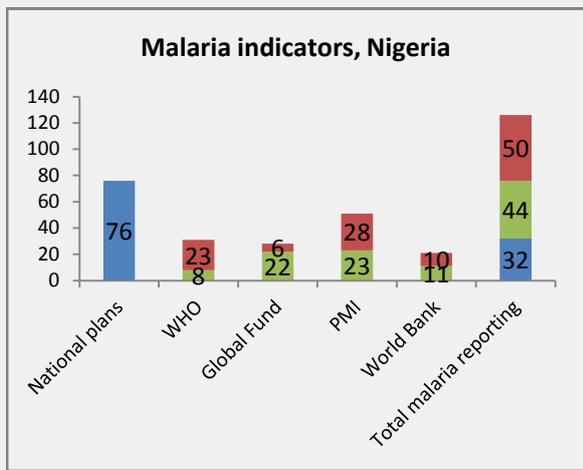
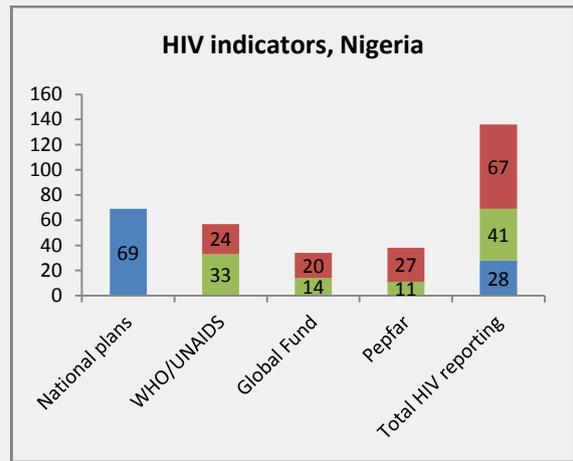
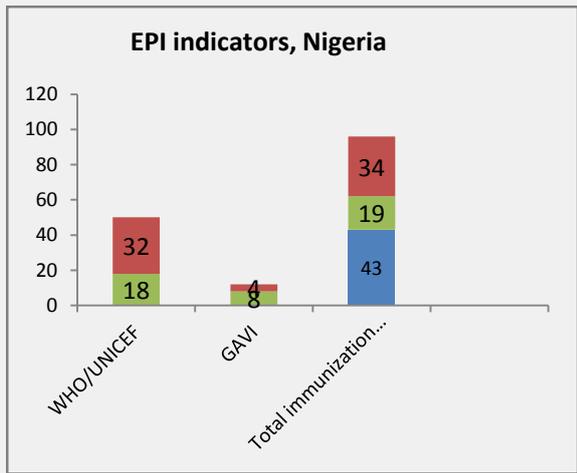


In malaria alone there are a total of 129 indicators being requested /monitored across national and partner plans. Fifty seven of these indicators are included in the national plan. However, partners use only 22 of the national malaria indicators and request an additional 72 indicators.

- Additional partner indicators
- Partner reporting overlap with national plans
- National reporting

### Nigeria Case Study

Comparison across programs in Nigeria shows that out of a total of 484 total indicators across 5 programs – HIV, immunization, RMNCH, TB and malaria - 191 are **additional** indicators requested from partners. These additional indicators comprise 40% of the overall total. The reporting burden is the most prominent for HIV with almost 50% additional indicators required by donors and partners (and this computation did not include all the required dis-aggregations). The TB program is best-aligned with the lowest additional reporting burden. EPI had multiple national plans and multiple lists of indicators thus indicating the need to better harmonize within the program area.



- Additional partner indicators
- Partner reporting overlap with national plans
- National reporting

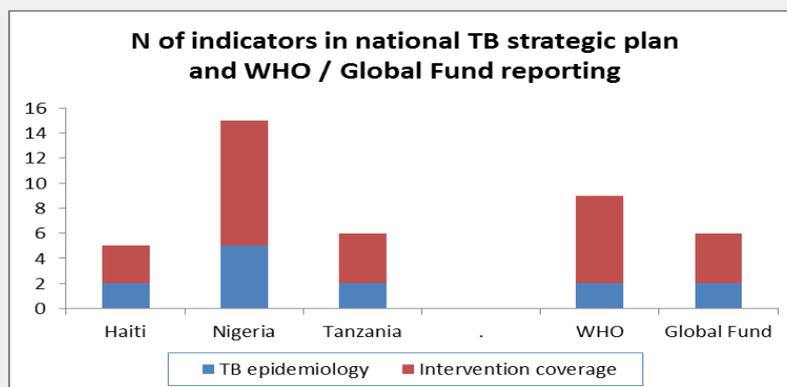
### Example: TB global and country reporting

TB is an example of fairly good alignment of indicators and reporting, with a uniform reporting system, partners drawing upon WHO for progress reporting, and good focused country M&E plans.

#### Global

- Incidence, prevalence and death rates associated with TB and the proportion of TB cases detected and cured under DOTS are the four indicators included in the MDGs. The Global Plan to Stop TB 2011-2015 has 16 main indicators with baselines and targets for the implementation component.<sup>1</sup>
- WHO has supported a standardized country system to monitor TB epidemiology and interventions since the nineties, based on standard clinical records and registers. WHO collects TB data from countries on an annual basis through a web-based survey of the main indicators. The volume of data collected about reported cases is quite extensive because the standard recording and reporting system recommended by WHO and partners includes disaggregation by age, sex, HIV status, previous treatment history and type of disease as well as separate reporting of cases with drug-susceptible and drug-resistant TB. In addition, there is considerable demand for data about intervention coverage and financing.
- The Global Fund indicators are globally aligned with the WHO indicators. In 2013, a core set of indicators for periodic assessment of impact and outcomes and regular (every 6-12 months) monitoring of process and output indicators was agreed upon, in addition to a more detailed list of indicators that are harmonized with those recommended by WHO. Country performance reports however may deviate. Although USAID has only two TB output indicators in its core list, but regularly requests data on many other indicators from WHO (and is the primary source of funding for global TB monitoring in WHO).

#### Country



- The overall national plan in countries usually includes the same two TB indicators as the MDGs. The TB programme strategic plans contain additional coverage indicators and the alignment with WHO indicators is fairly good. The national TB plans also contain many input and process indicators: 20 in Nigeria, 50 in Haiti and 150 in Tanzania. The Global Fund TB indicators are aligned with WHO and do not appear to pose an extra reporting burden if the same reporting channels are used.

## 5. Country data collection systems

- ▶ *Since country health information systems tend to be weak, there is a tendency to support separate data collection efforts, such as single-purpose surveys and data validation, parallel reporting systems, or project M&E staff that has limited benefits for country systems*
- ▶ *There have been successful efforts towards harmonization, such as the DHS MICS alignment, and there are increasingly efforts to invest in more efficient sustainable country M&E systems.*

Health data are derived from multiple data sources, including household surveys, routine facility reporting systems, facility assessments, administrative data such as health workforce and financing data, civil registration and vital statistic systems. The availability and quality of data across the different sources varies, but is often an issue. Facility reporting systems are an important source of data for output and coverage data, but quality tends to be problematic. Facility assessments are a critical source of information on service delivery, but are not conducted regularly. Birth and death registration with cause of death, is usually the weakest source of data. Household survey data, mainly through the implementation of DHS and MICS surveys are often the strongest, but cannot meet the demand for annual monitoring and subnational data.

Since country health information systems tend to be weak, and the need to demonstrate results of investments is urgent, partners have a tendency to set up separate data collection efforts, conduct single-purpose surveys or data validation exercises, and recruit project M&E staff. Examples are investments by specific programmes and partners in parallel facility reporting systems (e.g. ART, immunization), implementation of single-disease household surveys (e.g. TB, HIV), facility surveys with limited scope such as emergency obstetric care or HIV, single topic data quality assessment, conducted by donor partners. The multiplicity of data collection systems and disjointed efforts in data analysis and use further compounds the country situation and reporting burden.

Quality control is essential. Global Fund and GAVI may increase budgets based on certain epidemiological trends (e.g. 5% increases in budget if HIV, TB or malaria incidence has been increasing in the past 5 years) or programme performance (e.g. numbers of children immunized). Such policies need to be supported by strict data quality control measures which are not necessarily done in a way to strengthen country systems. While full integration is not always the best option, countries could benefit much more with better alignment and greater efficiency of these investments.

Problems notwithstanding, there have been successful efforts towards harmonization. The best example is the alignment of the USAID-supported Demographic and Health Survey (DHS) and the UNICEF-led Multiple Indicator Cluster Survey (MICS) in terms of contents and timing. More recently, the efforts to come up with a harmonized facility survey instrument for multiple purposes (namely the Service Availability and Readiness Assessment) is an effort of multiple agencies. GAVI is reducing GAVI-specific reporting requirements and increasing their use of existing country and global reporting mechanisms where possible (e.g., participation in and utilisation of joint annual reviews (JARs), and extracting data from existing country reports and the WHO/UNICEF Joint Reporting Form rather than asking countries to report through a separate GAVI-specific mechanism). Efforts are also underway by WHO, Global Fund and GAVI to harmonize and align on a set of data quality assessment tools for countries.

The Global Fund with the New Funding Model is expecting a decrease in the total number of required indicators by approximately 30%. Global Fund, PEPFAR, USAID, JICA among others are increasingly jointly investing in the District Health Information System (DHIS 2.0) platform that is rapidly becoming a standard for facility reporting systems in low and middle income countries. Through the UNAIDS Monitoring and Evaluation Reference Group (MERG), PEPFAR and 18 other international multi-lateral organizations (including UNAIDS, WHO, UNICEF, GFATM, etc.) and other bilateral donors, agreed on a minimum set of standard indicators. This core set of indicators has been incorporated into the new PEPFAR HIV indicators.

**Table 5: Current practices and suggested improvements for more harmonized data collection systems**

Data collection system	Bad practice	Needed improvements
Household surveys	Disease-specific surveys that are costly	Harmonized survey plan that can meet the main information of multiple programs
Facility surveys	Single program facility survey that provide information for only one specific program	A regular system of independent assessment of facility services that assesses all service delivery components holistically
Civil registration and vital statistics (CRVS)	“Pilotitis” in the use of mobile technology in community based reporting of births and deaths	- Consolidation of pilot efforts in community based reporting systems that use mobile technology under one umbrella
Facility reporting system (Health Management Information System (HMIS))	Parallel facility reporting systems for specific programmes (e.g. EPI, ART)	Investment in one strong national health management information that collects facility information for all programs or unique program-specific systems that are inter-operable with the national HMIS
Health facility data quality	Unsystematic and uncoordinated program-specific data assessment efforts	A systematic, regular and harmonized system of facility data quality assessment
Health accounts	Separate uncoordinated efforts to map health financing activities	Standard harmonized system of accounts with program-specific sub-accounts

Regular reviews, evaluations and health system performance assessments are all forms of assessments of the progress and performance the national health system that require that data are brought together and analyzed. The experience from sector-wide approaches (SWAs)<sup>3</sup> and multisectoral AIDS strategies, among others, has shown that periodic progress and performance reviews are critical for updating all stakeholders on programme progress, discussing problems and challenges, and developing a consensus on corrective measures or actions needed.

While programme data should be used on an ongoing basis, programme-specific reviews are critical points when programme specific data is evaluated to review the progress and performance within a programme. However, programme reviews often happen at timelines not coordinated with the national review process. These programme-specific reviews are often conducted as separate, parallel activities instead of being linked to the overall health sector review and contributing to it. These parallel review efforts can directly contribute to the proliferation of uncoordinated data collection efforts.

<sup>3</sup> Sector-wide approaches: <http://www.who.int/trade/glossary/story081/en/>

Country experiences document a lack of coordination among partners in supporting the data sources and institutional capacity for health information systems.

#### Excerpts from Nepal's policy on development cooperation with partners

The transaction costs of receiving foreign aid are high, and though it is difficult to quantify these in a meaningful manner, it is clear that high transaction costs lower the real value and effectiveness of foreign aid. Development Partners continue to place significant demands on the Government in terms of time, reporting needs, and use of other resources through numerous missions and meetings.

With recent increases in the volume of aid assigned to Nepal, the average number of sectors supported by each donor has increased, and so has the average number of donors per sector. This burden consequently exacerbates the capacity problems faced by the Government, and there is clearly some scope for better division of labor among External Development Partners (EDPs). Differing modus operandi of development partners often creates difficulties for the district government institutions responsible for coordinating activities. Agency-specific reporting requirements can also tax the limited capacity of local government institutions.

The Ministry of Health and Population and (EDPs) have agreed to work together under a shared vision and on agreed-upon priorities. The EDPs will ensure that all the assistance to the health sector will be consistent with and supportive of the priorities of the new orientation in Nepal's health policy. EDPs will harmonize their support to annual planning, joint reviews and reporting, and will share relevant information with all partners to facilitate their contributions to health sector development.

The Government encourages development partners to use country system and institutions, including accounting, auditing, procurement system, common reporting system and national M&E system.

## 6. Summary of findings

Global health agency leaders agreed to critically review respective agency reporting requirements from countries with the aim of reducing country reporting burden. A rapid stock-taking of reporting requirements at the global level and country level revealed a picture of heavy reporting burden for countries. Key points that emerged from this assessment include the following:

### Global overview

- The agency reports indicate that efforts are being made to focus and rationalize the set of indicators on which data are collected. No organization considers that it is collecting lots of unnecessary information, and there is fairly good agreement around which indicators should be used.
- While most agencies agree on the benefits of harmonization and rationalization of indicators and many have or are supporting harmonization efforts, the cumulative reporting burden in countries is still very heavy, especially those with weak institutional capacity and poor accountability systems.
- A review across only a selected number of partners, programs and resolutions revealed that countries are requested to report on as many as 600 indicators. This is a conservative estimate of the reporting requirements as many programs and partner reporting requirements are not included in the calculation.
- The global reporting requirements have given rise to a significant number of challenges for countries. Countries must not only deal with a huge volume of indicators, but also in many cases, with diverse indicator definitions, reporting periodicities and formats. This is often seriously compounded by parallel, vertical data collection efforts, and limited capacity in-country.
- While in principle agencies agree that there is a need to use country systems rather than separate donor reporting systems, if the quality is sufficient. Since country health information systems are often weak, however, partners tend to invest in parallel and vertical data collection efforts, supported by different donors and programmes.

### Country overview

- In addition to the external demands for information, a country also collects many additional indicators to monitor its programs. National monitoring and planning processes in country are guided by both the M&E plans of the national health sector strategic plans, as well as by specific disease and programme national plans.
- National sector and disease specific plans sometimes use internationally recommended indicators and definitions, and sometimes they do not. There are many more indicators in programme specific plans than in national plans and these are often driven by donor project requirements.
- There is a disconnect between the national health sector strategic plan and the disease specific plans in terms of indicators and definitions, and data collection systems.
- Country evidence reveals that partners only use a fraction of the information generated through the national monitoring and evaluation systems, and add significant reporting burden to country systems.
- This multiplicity of data collection systems supported by partners and disjointed efforts in data analysis and use further compounds the country situation and reporting burden.

There is ample evidence of an overload of data collection through forms, registers and reports for frontline health workers.

## 7. Conclusions and possible actions

Measuring results is a central element in accounting for progress of societies and development efforts and is likely to be a prominent element of the post-2015 development agenda. In health, leaders of global health agencies and many countries have endorsed the IHP+ approach and its seven principles, which include accountability. Measurement of results and accountability is considered a particularly good area for focus to translate the IHP+ principles into concrete and meaningful actions amongst all partners.

This rapid assessment of the burden of indicators and reporting for health illustrates how global investments in disease and program specific M&E programmes have resulted in very large numbers of indicators, fragmented data collection, uncoordinated efforts to strengthen country institutional capacity, causing unnecessary reporting burden to countries and inefficiencies, and hampering overall analysis and decision-making.

Although there has been some progress in global efforts to harmonize data collection and minimize the reporting burden on countries, there is ample scope for further streamlining of data requests, for harmonization of partner investments in strengthening the underlying country data systems and in the development of comprehensive a high quality country M&E platform that become the basis for all reporting.

The accountability framework, developed by the Commission on Accountability for Women's of Children's Health in the context of the UN Global Strategy for Women's and Children's Health, provides an important step in the right direction. Efforts to implement the framework are now underway in over 70 countries in a way that builds upon and strengthens the IHP+ approach for strengthening one national health plan with strong M&E framework but needs much broader support. New approaches to information generation and dissemination in health facilitated by e- and m-technologies hold the promise of a new generation of real-time health information that bridges individual health records with population health assessment as well as data on the supply of services with feedback from patient's encounters with the health system.

These challenges and opportunities can come together around the emerging post-2015 development agenda in health that is extending the MDG agenda with new targets as well as embracing new challenges such as the NCDs and UHC. The time is now to bring greater alignment and efficiency in investments in health information around country-led plans to strengthen the measurement of results and accountability. Possible actions for global partners to move forward include:

1. Rationalize existing measurement efforts to arrive at a unified results measurement framework with a limited, core set of indicators. Each development partner agency continues to identify measures it can do without and are willing to forego in the interest of better alignment.
2. Agree upon a global core set of indicators that are prioritized in results monitoring. A common list of indicators for results monitoring should lead to reduced reporting requirements and better investments in data sources and analyses to obtain high quality data for the indicators. It should also facilitate better alignment with and greater investment in one country-led health sector platform for results and accountability.
3. Work together not only on harmonizing reporting requirements and indicators, but also on strengthening country monitoring and evaluation plans ensuring better alignment with global standards and harmonization across plans.
4. Joint investments in country data systems, including births, deaths and cause of death reporting, harmonized regular surveys, facility and administrative data reporting systems and strengthening of institutional capacity for measurement of results.

### Annex 1: World Health Resolutions

World Health Resolutions	Indicator monitoring requirements	Total number of targets
HIV/AIDS	12	4
Tuberculosis	5	6
Malaria	6	6
Maternal and Child Health (MCH) & Reproductive Health	6	4
Nutrition	7	7
Non-communicable Diseases	25	9
Mental Health	2	2
Immunization	15	17
Neglected Tropical Diseases	19	25
Sexually Transmitted Infections (STIs)	16	12
Influenza	1	2
Eye Health	3	1
Water and Sanitation	2	0
Official Development Assistance (ODA)	1	2
Health Financing and Universal Coverage	2	1
Research for Health	2	2
International Health Regulations	20	
<b>TOTAL</b>	<b>144</b>	<b>100</b>