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Standardization and harmonization of data and data collection initiatives

Report of the Convention Secretariat

INTRODUCTION

1. At its third session (Durban, South Africa, 17–22 November 2008) the Conference of the Parties requested the Convention Secretariat to compile a report on data collection measures, in decision FCTC/COP3(17). The decision outlined the fact that this should be undertaken under the guidance of the Bureau, and with the assistance of competent authorities within WHO, in particular WHO's Tobacco Free Initiative, as well as relevant intergovernmental and nongovernmental organizations with specific expertise in this area. Paragraph 6 of the decision stated that the report should cover measures: to improve the comparability of data over time; to standardize[1] collected data within and between Parties; to develop indicators and definitions to be used by Parties' national and international data collection initiatives; and to further harmonize[2] with other data collection initiatives.

2. The request to provide such a report is in line with Article 23.5 of the Convention, which requires the Conference of the Parties to "keep under regular review the implementation of the Convention" and to "promote and guide the development and periodic refinement of comparable methodologies for research and the collection of data, in addition to those provided for in Article 20, relevant to the implementation of the Convention".

[1] Standardization: the adoption of generally accepted uniform technical specifications, criteria, methods, processes or practices to measure an item.

[2] Harmonization: the adjustment of differences and inconsistencies between different measurements, methods, procedures, schedules, specifications or systems to make them uniform or mutually compatible. Harmonization also aims to avoid duplication of effort or place an undue burden on informants.

3. Two expert meetings were convened in June 2009 and February 2010. The draft outlines that were produced following these meetings were reviewed in November 2009 and April 2010 by the Bureau of the Conference of the Parties, which provided guidance on the further development of the report.[1]

4. The present report is based on a review of the most relevant international literature and other sources of information on tobacco-related data collection, documents considered by previous sessions of the Conference of the Parties related to reporting and exchange of information,[2] as well as the expert contributions received during the process described above. That process also included an in-depth comparative review of existing data sources and data collection systems and identification of possible steps for standardization and harmonization, performed in cooperation with relevant WHO departments, in particular the Tobacco Free Initiative.

5. The report contains an overview of international data collection initiatives. It discusses the extent to which further standardization and harmonization among them would be desirable, and the areas in which this should take place. The report places particular emphasis on harmonization between the reporting mechanism of the Convention and the survey of the WHO Global Tobacco Control Report (GTCR). Finally, the report concludes with recommendations on future steps concerning standardization and harmonization between tobacco-related data collection initiatives.

OVERVIEW OF INTERNATIONAL DATA COLLECTION INITIATIVES ON TOBACCO CONTROL AND RELATED DATABASES

6. This section of the report provides an overview of international data collection initiatives on tobacco control and databases that are dedicated, in whole or in part, to storing data related to tobacco.

7. Tobacco control is probably one of the most researched areas in public health. A significant amount of information and knowledge is available on tobacco-related behaviours and measures to control tobacco use. Monitoring patterns and trends of tobacco use, the variety of policies and programmes countries implement to control tobacco use and the impact of such efforts is essential if informed decisions are to be made on future implementation of the Convention.

8. Reports of Parties to the Convention indicate that research to assess the use of tobacco in various forms has been conducted by the majority of Parties. According to the 2009 summary report on global progress in implementation of the Convention,[3] 84% of Parties had provided data on adult tobacco use and 79% had provided data on tobacco use by youth. In addition, around half of the Parties reported that they had implemented various research programmes in accordance with Article 20 of the Convention.

[1] All background documents used during the deliberations of the two expert meetings, which also served as important sources of information for this report, are available on a protected web site to which all interested Parties can obtain access. Requests for information can be sent to copreporting@who.int.

[2] These include an earlier report of the interim secretariat (document A/FCTC/COP/1/INF.DOC./2).

[3] *2009 Summary Report on global progress in implementation of the WHO Framework Convention on Tobacco Control*. Geneva, Convention Secretariat to the WHO Framework Convention on Tobacco Control, 2009 (http://www.who.int/fctc/FCTC-2009-1-en.pdf).

9. WHO, either alone or in collaboration with international agencies and donors, has proposed surveys to its Member States for the collection of tobacco-related information. WHO also recommends that such surveys are conducted regularly so that their repetition contributes to the creation of tobacco-related national surveillance systems as envisaged in Article 20.3(a) of the Convention.[1] Data from the 2009 summary report indicate that around half of the Parties repeat their surveys/research programmes regularly so that they may be considered to have a system in place for the epidemiological surveillance of tobacco consumption and related social, economic and health indicators.

10. WHO regularly recommends standardized questionnaires, definitions, indicators and methodologies for tobacco-related data collection. In 1998, it developed guidelines for monitoring the tobacco epidemic.[2] The information systems that WHO has promoted have produced comparable national data on tobacco use and tobacco control in many countries.

11. There are two main types of international data collection systems currently in use. The first, **population-based surveys** (surveys of individuals or **primary data collection systems**), facilitate collection of epidemiological data on tobacco use. In several cases they go further and also collect information on knowledge, attitudes and beliefs concerning tobacco use and particular tobacco control policies among individuals.

12. The second group can be referred to as **policy monitoring surveys/systems** (hereinafter referred to as "monitoring systems"); they can also be labelled **secondary data collection systems** in order to distinguish them from primary systems, which target individuals. Secondary systems target key informants in countries, who report data collected either by themselves or through primary data collection initiatives undertaken by the country. The main purpose of these secondary systems is to collect data on tobacco control measures.

13. However, making a clear distinction between the two types of survey is difficult. Many population-based surveys also contain questions on certain aspects of tobacco-control measures. On the other hand, monitoring systems may also look at various tobacco-control policies from an individual perspective (e.g. gathering information on individuals' knowledge, attitudes and beliefs towards tobacco-control policies) or include questions on the prevalence of tobacco use.

14. Following the adoption of the Convention, data collection efforts have been strengthened by increasing their geographical coverage or adding new systems to existing ones. The reporting mechanism of the Convention is one of the new data collection systems.

Population-based international data collection systems

15. There is a variety of international data collection systems currently in use. Some of the surveys are tobacco specific, while others refer to a number of health determinants, including tobacco (non-tobacco specific surveys). They target either adults or young people. Some of them are global and some regional; some are one point in time surveys and some are repeated periodically; some are inexpensive surveillance systems, others are costly research projects. The majority are either

[1] Apart from the repeatability and frequency of the survey, other criteria that characterize a good national surveillance system include: comparability; validity and reliability; mechanisms to translate findings into action; and sustainability (of financial and human resources).

[2] Guidelines for controlling and monitoring the tobacco epidemic. Geneva, World Health Organization, 1998.

coordinated by various departments of WHO or the Organization is a key collaborative partner in their implementation.

16. In addition to these international initiatives many countries design and implement their own national health surveys, which do not directly relate to any of the international systems, although some elements of design and content may be similar to those used in the international systems. However, analysis of such national surveys is beyond the scope of this report.

17. Implementation of population-based surveys may have important benefits for the Parties to the Convention. First, the surveys help Parties to monitor tobacco use. Second, they can provide information on people's perceptions of tobacco-control policies. Third, they provide information that can be translated into policy action by serving as advocacy tools during the promotion of stronger tobacco-control measures. Last but not least, they enable Parties to provide and exchange up-to-date information through the reporting instrument of the Convention.

18. Population-based international data collection systems can be categorized by:

(a) their tobacco specificity (e.g. **tobacco-specific surveys,** such as the Global Youth Tobacco Survey (GYTS), and surveys **with broader coverage that include tobacco** within their scope, such as the WHO STEPwise survey);

(b) age groups. These systems may target adults, e.g. the Global Adult Tobacco Survey (GATS); or young people, e.g. the GYTS; the Global School-based Student Health Survey (GSHS), the European School Survey Project on Alcohol and other Drugs (ESPAD), or the Health Behaviour in School-aged Children (HBSC) study, among others.

19. In addition, some of the surveys have already reached global coverage, while others mainly concern only one or a few WHO regions. A brief overview of the major data collection initiatives implemented in a number of countries is provided in Annex 1.

20. Analysis of the implementation reports of the Parties allows assessment of the range of the most frequently used surveys and international data collection systems. Using the example of surveys that collect data on smoking habits, the most frequently cited international data collection initiatives are the WHO STEPwise survey, the World Health Survey and the Demographic Health Survey. Many Parties report data collected through their national health surveys. In the case of tobacco use by youth, the GYTS is the survey most often referred to in Parties' reports, with 47 out of the 93 Parties reporting data on tobacco use by youth using data from that survey.

Monitoring systems

21. Two monitoring systems were established after the Convention entered into force, one of which was the reporting system of the Convention. The two systems are presented below.

22. **The reporting system of the Convention.** The system was established by the Conference of the Parties at its first session in 2006, in line with Article 21 of the Convention. A Party is requested to report on implementation of the Convention for the first time two years after the Convention has entered into force for that Party and by the end of the fifth and the eighth years thereafter. The format

for submission of reports by Parties was first provisionally adopted by the first session of the Conference of the Parties in 2006[1] (phase 1 (Group 1) questions of the reporting instrument). The decision also envisaged that reporting arrangements would be graduated, with the first report covering core items of data, legislation, taxation, and funding for implementation activities while more complex questions or more detail would be included in later reports. In 2007, the second session of the Conference of the Parties further considered the reporting arrangements and called for revision of the format of phase 1 of the reporting instrument, based on Parties' feedback, while maintaining the content. It also initiated the elaboration of phase 2 (Group 2 questions) of the reporting instrument to serve as the format for the five-year reports of the Parties.[2] Both questionnaires were adopted at the third session of the Conference of the Parties and they are available to the Parties for the preparation of their respective reports.

23. The aim of the reporting instrument is to collect data already available in the countries at the time of reporting. Therefore, for the purposes of reporting to the Conference of the Parties, Parties do not need to implement new (population-based) surveys. However, those Parties which have not previously implemented such population-based surveys will be required to do so since it is a requirement under the treaty (Article 20.3(a)) to *"establish progressively a national system for the epidemiological surveillance of tobacco consumption and related social, economic and health indicators"*. Having a national surveillance system also assumes that such data collection is repeated regularly.

24. The Convention Secretariat provides feedback to reporting Parties' focal points after a review process (that includes checking the content of the report for any missing information; checking the suitability of supporting documentation submitted; carrying out a cross-check between answers and the content of supporting documentation and checking for possible logical inconsistencies in the reports), which often assists in the finalization of the report. Parties' reports are then made available through the web-based database maintained by the Convention Secretariat. Finally, Party reports are analysed and used to prepare annual global summary reports on implementation of the Convention. The reports of Parties thus serve as the basis for the regular review of the implementation of the Convention by the Conference of the Parties, in accordance with Article 23.

25. The reporting instrument of the Convention, through the comparison of subsequent data sets reported by the Parties (Parties started submitting their second implementation reports in February 2010) allows for trend analysis concerning tobacco use and implementation of legislative and other measures by individual Parties. Reporting schedules dependent on date of entry into force, however, still display limitations concerning international comparability of data. The full capacity of the reporting system of the Convention to provide globally comparable data could be realized if Parties were requested to report preferably at the same point in time.

26. **The survey of the WHO Report on the Global Tobacco Epidemic.** In mid-2005 WHO decided to periodically collect a set of country-specific data for all WHO Member States regarding tobacco consumption and the progress countries are making towards implementing demand-reduction tobacco-control policies. This process was then launched in 2007. Data are collected annually and data collection is coordinated by the WHO Tobacco Free Initiative. Reported data on tobacco use originate

[1] Decision FCTC/COP1(14).

[2] Decision FCTC/COP2(9).

from previously implemented national surveys, while data on policy and legislation originate from key informants in the government. The design of the GTCR survey includes: a capacity building element (regional coordinators provide technical support to the process of data collection by national data collectors); a data validation mechanism (internal, within WHO; and external, by the country's informant) that compares the answers to questions with existing legislation and regulation; and a mechanism to assess enforcement of policies, which assumes the participation of five experts in assessing compliance with policies.

27. Verified data are analysed by the WHO Tobacco Free Initiative and the information collected is disseminated as the GTCR, which has been published twice (in 2008 and 2009) since the introduction of this data collection system. The GTCR also reports adjusted and age-standardized prevalence rates based on the WHO InfoBase system, which enable intercountry comparison of prevalence data and interpretation of the trend in prevalence of smoking.

28. The GTCR survey focuses on tobacco-control policies consistent with the MPOWER package. These include the monitoring of tobacco use and prevention policies (corresponding to Article 20 of the Convention) and demand-reduction measures, such as: protecting people from environmental tobacco smoke (Article 8); offering help to quit tobacco use (Article 14); warning about the dangers of tobacco use (Articles 11 and 12); enforcing bans on tobacco advertising, promotion and sponsorship (Article 13); and raising taxes on tobacco (Article 6). It also contains a section on "National Tobacco Control Programmes" which corresponds to the requirements of Article 5 (General obligations) of the treaty, although it does not tackle the issue of interference by the tobacco industry in public health policies on tobacco control.[1]

29. The third international monitoring system, the **noncommunicable disease country capacity assessment** is coordinated by the WHO Department of Chronic Diseases and Health Promotion. This assessment, launched in 2000, is reaching its third wave of data collection in 2010. The survey has a broad focus and includes assessment of the policies, action plans, strategies and programmes concerning all risk factors of noncommunicable diseases. In relation to tobacco control, the questionnaire focuses on the existence of tobacco-control strategies, action plans or programmes as well as on existing capacities and financial resources dedicated to their implementation, thus reflecting the content of Articles 5 and 26 of the Convention. It also requires reporting of the outcome indicators and the target populations and settings used in these strategies and programmes.

Databases with information on tobacco

30. Worldwide there is an impressive number of databases which make tobacco-related information available, including several databases within WHO (operated at headquarters or in the regions) containing and providing access to information on tobacco use and its impact on health and tobacco-control policies worldwide. Some of them are linked to specific data collection systems, while others only re-package the information collected through other initiatives. Private databases add to the variety of available data concerning various aspects of tobacco control.

31. One comprehensive source, specific to the Convention, is the database of Parties implementation reports maintained by the Convention Secretariat. Initiatives focused on regional and

[1] However, WHO's Tobacco Free Initiative does have a tobacco industry monitoring system that is independent from the GTCR.

thematic data include the databases developed by the regional offices of WHO, the database on pictorial health warnings recently completed by WHO's Tobacco Free Initiative, and the tobacco-control legislation database maintained by the International Legal Consortium based at the Campaign for Tobacco-Free Kids. Tobacco is also included in international databases with broader coverage, such as CancerMondial and the WHO Statistical Information System (WHOSIS) among others. Further databases are being maintained by WHO regional offices. A brief overview of major databases containing tobacco-related data is provided in Annex 1.

STANDARDIZATION AND HARMONIZATION: OVERVIEW OF THE STATUS, CHALLENGES AND OPPORTUNITIES

32. In general, population-based surveys employ standard methodologies and use standard questions and definitions maintained from survey to survey to ensure comparability over time and across countries implementing the same survey. There are some similarities and some differences in the methodologies employed by different surveys.

33. First, the majority of surveys are non-tobacco specific and therefore they do not focus in such detail on tobacco-related matters as tobacco-specific surveys. However, though limited in number, the tobacco-related questions may still be useful in providing basic understanding of patterns of tobacco use. They can also be broadly indicative – if attitudes towards implementation of selected tobacco-control policies are also measured – of the tobacco-control policies that would be likely to meet the demands and enjoy the support of the majority of the population.

34. Second, since patterns of tobacco use and policy-related beliefs can differ according to age, the parallel use by countries of data collection tools specifically designed for youth and adults is advisable.

35. Third, individual surveys use their own standard definitions and indicators. Some of the indicators are similar across surveys. For example, lifetime cigarette use is measured in the ESPAD, the GYTS and the HBSC study. Cigarette smoking during the past 30 days is sought in the ESPAD, the GSHS and GYTS, along with the use of other tobacco products in the past 30 days (the ESPAD, GSHS, GYTS). Both the age of initiation of cigarette smoking and daily cigarette smoking is captured in the ESPAD and the GSHS. Many of the definitions and indicators are, however, different, making cross-survey analysis of data impossible. Repeated implementation of the same survey, would allow collection of comparable data sets.

36. Fourth, different population-based surveys reached different levels of geographical coverage. For example, the GYTS reached the widest coverage, but fewer European countries have actually implemented this survey. Almost all European countries have implemented either the European School Survey Project on Alcohol and other Drugs and HBSC at least once.

37. Fifth, although they have a different purpose and there are differences with respect to employing some methodological approaches, monitoring systems present significant repetitions and overlaps.

38. In the case of population-based surveys, further standardization of methodologies, indicators and definitions would enable countries to collect more and comparable data sets on the prevalence of tobacco use and knowledge, and on attitudes and beliefs concerning tobacco-control policies. In the case of monitoring systems, harmonization, which is an area of concern to many Parties, remains the principal challenge and one that should be addressed as early as possible.

Standardization of data

39. Standardization enables research to be used as a measurement tool and gives it scientific credibility. From an international point of view, the need for cross-country comparisons and trend analysis encourages further efforts in the area of standardization within and across surveys, to an extent that is appropriate and allows the individual character of each survey to be maintained.

40. The 1998 WHO Guidelines for Controlling and Monitoring the Tobacco Epidemic promotes standardized approaches concerning methods for data collection (such as sampling techniques); indicators and their definitions; and for data preparation, analysis and presentation. In line with WHO recommendations, population-based surveys are characterized by standardized methodologies, including timing/periodicity of the application of the survey, sampling, data collection, data analysis and the dissemination of findings.

41. Some work has already been done to reach a certain level of standardization across different data collection tools. For example, the school-based surveys of the Global Tobacco Surveillance System – GYTS, GSPS and Global Health Professions Students Survey (GHPSS) – employ the same standard methodology. Furthermore, these school-based surveys have many design elements in common with the latest element of this global system, the GATS.

42. Efforts are currently in place to encourage countries to include core questions from the GATS into their national health surveys. This is to ensure that an increasing number of Parties are able to provide comparable data on adult prevalence of tobacco use even if they do not implement a full GATS. Similarly, national censuses may include tobacco-related questions if resources for independent tobacco-related surveys are scarce.

43. While some efforts to standardize across surveys have been successful in practice, experts have warned that, owing to the different objectives and geographical scope of population-based surveys, standardization across surveys, especially with regard to the content, would not necessarily be beneficial. Variations lead to a wider diversity of questions, which result in the collection of a broader set of information. The variety of information collected not only enhances Parties' ability to promote stronger tobacco-control measures in their jurisdictions or to evaluate their programmes, but they also assist Parties in fulfilling their reporting obligations. Therefore, complete standardization across surveys may not be the ultimate goal.

44. To ensure that Parties collect data allowing for trend analysis, it is advisable that some level of consistency across data collection systems is maintained in countries where multiple systems are in use. For example, different systems can be applied in different time frames. Consistency across surveys can also be ensured by using a set of core questions and related indicators, as well as by using the same definitions and indicators for the same surveyed item.

45. Taking into account the considerations outlined above, the following aspects of survey design/methodology can benefit from standardization across surveys:

Timing and periodicity

46. Individual population-based surveys have their own recommendations concerning periodicity, which takes into account data needs and the level of resources available in the country. Based on experience of established international data collection systems, repetition of the same survey is recommended as often as practical, but at least every three to five years. Some countries with established surveillance systems provide for continuous data collection and analysis, enabling the elaboration of new figures each year.

47. If multiple population-based surveys are implemented in the same jurisdiction, Parties can ensure, by carefully selecting the timing of the surveys, that consecutive data sets allowing comparison and trend analysis are produced.

Use of standard methods of estimation

48. Data on tobacco use can originate from a variety of surveys that frequently span several years and do not employ a standard set of questions, indicators and definitions. In such cases, different methods to estimate the prevalence of tobacco use can be employed to ensure cross-country comparability of data, thus resulting in an accurate global picture of tobacco use. A standard methodology for producing comparable estimates has been developed as part of the WHO Infobase project,[1] but no information is available on the use of this methodology by the WHO Member States. In general, experience indicates that more comparable estimates are being produced in the case of tobacco than in the case of other behavioural risk factors.

49. For example, WHO's Tobacco Free Initiative has been collecting data on four principal indicators (current and daily tobacco smoking; current and daily cigarette smoking), which are then adjusted and age-standardized to produce comparable estimates. Adjustments are made for missing indicators, coverage, age groups and the year of survey, to arrive at a set of estimates that can be compared across countries at one point in time as well as within a country over time. Such adjustments are particularly useful in the case of countries with relatively weak tobacco use prevalence data,[2] at least as a temporary option until a national surveillance system is established.

Age ranges and age groups

50. Individual surveys use standard **age ranges** (sample frame) and age groups. The lower limit of the age range for "adult" tobacco use prevalence surveys is usually set at 15 years of age, but may be set at 18 years or even higher.

51. **Age groups** also vary across surveys. The WHO STEPwise Approach to Surveillance (STEPS) uses 10-year age categories, such as 25–34 and 35–44 years. The GATS uses the following age groups: 15–24, 25–44, 45–64, and 65 years and over. The reporting instrument of the Convention, like STEPS, promotes the use of age groups broken down by 10-year categories, e.g. 25−34 and 35−44 years.

[1] https://apps.who.int/infobase/help.aspx?typecode=hp.tc.001#297.

[2] For a more detailed description of estimation procedures see: *WHO report on the global tobacco epidemic, 2009. Implementing smoke-free environments*. Geneva, World Health Organization, 2009: 76–77 (http://whqlibdoc.who.int/publications/2009/9789241563918_eng_full.pdf).

52. Standardization in this area can be achieved by:

(a) promoting a standard age range and age groups (for example, those used by the most widely embraced international data collection systems); or

(b) promoting the use of standard estimation methods (for example, the one recommended by WHO). Countries may also choose to use the method regularly used by their statistical agencies to create data sets for age groups.

53. If the first approach is chosen, it should be borne in mind that many of the international surveys are being coordinated by WHO, or that WHO is one of the key partners in their implementation. Thus, WHO may also play a key role in initiating, coordinating or continuing such efforts to improve comparability of the collected data across countries. At country level, an effort to promote standard age groups may eventually lead to the newly collected raw data becoming incomparable with previously collected data. Therefore, this change will not be beneficial in well-established surveys. It should also be taken into account that such a change will necessarily have cost implications, which the country and/or the management of such national and international systems may not wish to bear.

54. If the second approach is chosen, WHO capacities can be used to create estimates for tobacco use prevalence rates for the required age ranges to promote comparability of prevalence data reported by the Parties.

Definitions and indicators

55. Clear definitions and indicators are crucial as far as the quality of collected data is concerned. Surveys apply various definitions of a "user" of tobacco products. Such variability in the definition of a "user" may result in different figures. For example figures for "current smoking" will necessarily be different from those for "current daily smoking". Also, in countries where many forms of tobacco (including smoking and smokeless forms) are used, figures reflecting "tobacco use" may substantially differ from figures on "tobacco smoking". The same observation applies to figures on "tobacco smoking" or "cigarette smoking". This great variability of definitions subsequently results in limited comparability.

56. There is also a great variation in the use of indicator across the surveys, especially in the case of monitoring systems. The indicators used largely depend on the scope and on the level of detail in the data collected in relation to selected areas of tobacco control. The reporting instrument of the Convention and the GTCR survey employ the highest number of indicators. Indicators used in the reporting instrument of the Convention reflect the content of specific treaty articles, without using combined indicators. Maintaining the indicators in the different phases of the reporting instrument will also ensure comparability of data across the Parties and will make trend analysis possible.

57. The 1998 WHO guidelines provide options for relevant indicators for **tobacco use** (e.g. prevalence of smokers; prevalence of daily and occasional smoking; prevalence of smokeless tobacco use; prevalence of ex-smokers; prevalence of cessation; and per capita cigarette consumption) and for the **health effects of tobacco use** (such as: incidence and prevalence of diseases attributable to tobacco use; cause-specific mortality; and absolute or relative risk of lung cancer death). The International Agency for Research on Cancer also suggests a set of prevalence indicators of tobacco

use behaviours.[1] A more recent effort to create a set of core and expanded indicators concerning tobacco for international surveys is being undertaken as part of the implementation of the WHO 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases (objective 6). An expert-led process is under way to look into measuring and reporting morbidity and mortality across a range of noncommunicable disease risk factors, including tobacco.

58. With regard to **policy-related definitions**, the Convention itself provides definitions for a number of terms.[2] The guidelines already adopted by the Conference of the Parties provide further definitions, and the step-by-step instructions accompanying both phase 1 and phase 2 questionnaires promote the use of additional definitions.[3] Experts who participated in the process leading to the elaboration of this report agreed that there is a need for further consideration of the definitions and indicators that will derive from specific articles of the treaty or related implementation guidelines adopted by the Conference of the Parties. The ongoing and future intergovernmental working groups established by the Conference of the Parties on other articles could also be encouraged to include the required definitions in their respective draft guidelines. For the articles/areas where there is no such intergovernmental process in place, establishing a special intergovernmental process for the identification of relevant definitions and indicators could be considered by the Conference of the Parties.

Harmonization between international data collection initiatives

59. Given the number of population-based surveys and monitoring systems currently implemented at national and global levels, the participation in such data collection exercises imposes a burden on available capacities in many countries, particularly those with limited resources. Harmonization between the systems[4] is therefore desirable to ensure better use of available resources in both data collection and management, analysis and dissemination.

60. A precedent also exists for harmonization between the reporting instruments of different international treaties. In the case of reporting to the five global biodiversity-related treaties[5] their respective secretariats are engaged in the process of investigating whether there is scope for harmonizing reporting procedures by making use of common formats and datasets.

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[1] *IARC Handbooks of Cancer Prevention, Tobacco Control, Vol. 12: Methods for Evaluating Tobacco Control Policies*. Lyon, International Agency for Research on Cancer, 2008 (http://www.iarc.fr/en/publications/pdfs-online/prev/handbook12).

[2] These include: “illicit trade”, “economic integration organization”, “tobacco advertising and promotion”, “tobacco control”, “tobacco industry”, “tobacco products”, and “tobacco sponsorship”.

[3] These are: “smoking tobacco products”, “smokeless tobacco products”, “other tobacco products”, “complete” and “partial” (in relation to the extent of the ban of smoking in public places in questions related to Article 8 of the Convention and its guidelines); “comprehensive ban on all tobacco advertising”, “promotion and sponsorship” (in relation to Article 13 of the Convention and respective guidelines).

[4] In the international literature terms such as “standardization across surveys” and “harmonization between surveys” are used interchangeably. Experts participating in this process consider attempts to use standard questions, definitions and indicators, even standard methodologies across surveys as belonging to the first category. These efforts may be complemented by more substantial adjustments between different surveys, including those concerning data collection, analysis and use of collected data for purposes of policy development. This “standardization” with a broader scope can be defined as “harmonization”.

[5] The Convention on Biological Diversity, the Convention on Wetlands, the Convention on International Trade in Endangered Species, the Convention on Migratory Species and the World Heritage Convention.

61. **With respect to population-based surveys**, harmonization has already been achieved among various international data collection systems on a few methodological matters. For example, most of the surveys employ sampling strategies aimed at maximizing the representativeness of the population. Both the GATS and STEPS aim to obtain representative samples and try to use the best sampling frame (such as the latest census or best available administrative list) to generate the sample. With respect to the questions they use, most of the existing surveys formulate their questions to yield data on specific indicators of interest, but even questions that refer to the same indicator are not necessarily similar in different questionnaires. The noncommunicable disease country capacity assessment instrument was recently harmonized with the GTCR questionnaire to avoid duplication of questions. Discussions are ongoing to harmonize questions used in STEPS and the GATS. Consideration is being given to the inclusion a core set of questions from the GATS survey into the set of expanded questions of STEPS and even promotion of such a core set of questions with a view of their inclusion in national health surveys.

62. Surveys coordinated within WHO are likely to continue to be harmonized, a process that aims to improve support to Parties in fulfilling their reporting obligations under the Convention. Harmonization among other surveys would also be desirable, although it would not easily be achieved in every case.

63. **With respect to reporting/monitoring systems**, the main concern for governments is the overlap between the reporting instrument of the Convention and the GTCR survey. The need to harmonize the two instruments, and, ideally, to have only a single data collection instrument, has already emerged during the development of phase 2 (Group 2 questions) of the reporting instrument. Initial efforts to compare the content of the two instruments have started with respect to prevalence of tobacco use and taxation and price of tobacco products. Parties and experts have however voiced their support for a full alignment in process and content so as to eliminate the need for double reporting. The expert group proposed that the following steps should be undertaken, each point being examined in subsequent paragraphs:

1. amending the content of the Convention reporting instrument, which will serve as the single international instrument, to include the treaty-specific questions of the GTCR questionnaire and reviewing selected questions with a view to assisting Parties in providing the relevant information;

2. aligning Parties' reporting cycle with the cycle of Conference of the Party sessions;

3. amending the step-by-step instructions to provide a full list of standard definitions so that each Party is aware of the standards and specifications of the information requested;

4. including a process to support, when requested, quality assurance in the reporting process;

5. collating information from different databases of tobacco-control laws and regulations, and promoting their use by Parties.

64. First, proposals were developed for amending the Convention reporting instrument to incorporate treaty-specific questions referred to in the GTCR that are not covered in sufficient detail in the reporting instrument, as per the request and with the contribution of the experts participating in the process. These are included in Annex 2 of this report. Cross-analysis of phase 2 (group 2 questions) of the reporting instrument and the latest questionnaire in use served as the basis for the development of

these proposals. The amended phase 2 questionnaire would then serve as the basis for Parties' reports and could also be used by WHO's Tobacco Free Initiative in monitoring progress in tobacco control in Member States which are not yet Parties to the Convention.

65. Second, harmonization of the reporting cycle of the Convention would also be beneficial since it would ensure that all Parties to the Convention report at the same time. Transition to a two-year reporting cycle linked to sessions of the Conference of the Parties is recommended, to replace the current link between reporting dates and the dates of entry into force of the Convention for a Party, which has been an important factor during the first years of treaty operations but may be standardized after the submission of second reports by the majority of Parties. If convening the sessions of the Conference of the Parties during the last quarter of the year remains the practice as so far established, reports of the Parties could be submitted in the early months of that year, for example by the end of April, to allow for timely preparation of the global progress report by the Secretariat for submission to the Conference of the Parties. The transition from the existing reporting timeline could start after the fourth session of the Conference of the Parties and could be completed by its fifth session in 2012.[1]

66. Harmonization of the reporting cycle would also ensure a high level of traceability of policy changes and allow a thorough interpretation and analysis of global trends in the implementation of policies and of tobacco use prevalence, etc. To ensure a degree of flexibility in the instrument (for example, timely inclusion of proposals from Parties on its amendment), and in line with decision FCTC/COP3(17), the Bureau could be mandated to adopt substantiated changes, as appropriate, to the reporting instrument.

67. Third, the process of harmonization would also include amending the step-by-step instructions issued by the Convention Secretariat in relation to phase 2 (Group 2 questions) of the reporting instrument. Special emphasis should be given to including all definitions available not only in the Convention but also in the guidelines for implementation of specific articles of the Convention. There is also a need to clarify notions appearing in various questions in the reporting instrument, especially those related to the implementation of policies (e.g. "complete" and "partial" bans of tobacco use in public places in relation to Article 8 of the Convention; "complete" and "partial" bans on advertising, promotion and sponsorship in relation to Article 13 of the Convention). This would promote a common understanding of the respective questions and notions among the Parties, eventually leading to more accurate and comparable answers. The step-by-step instructions could also provide a list of national and international data collection initiatives (for example that included in Annex 1 of this report), which the Party may have implemented. Such a reminder may facilitate collection of data and coordination among different government sectors during the preparation of the report. The Convention Secretariat would issue the above amendments in early 2011 and take into account the new implementation guidelines that may be adopted by the fourth session of the Conference of the Parties.

[1] If the change in the reporting cycle falls between the fourth and fifth sessions of the Conference of the Parties, then Parties would be required to send their reports during the early months of 2012. Since this year would be the year of inception of the new reporting cycle, those Parties which reported in 2011 (either for the first or second time) will not be required to report again in 2012. They will have to submit their next implementation reports in 2014. According to this schedule, the 60 Parties which report in 2011 will not report in 2012, but all remaining Parties will be required to do so. In the year 2014, the transition to the new two-year reporting cycle would be completed. The existing phase 2 questionnaire, with amendments as proposed, would serve as the single instrument for future biennial reports. For new Parties (potentially becoming Party to the Convention after the fourth session of the Conference of the Parties) the minimum period between the entry into force of the Convention for a Party and the submission of its first report should be at least one year.

68. Fourth, ensuring completeness and improving quality, accuracy and of the data reported is a major objective to be addressed during the harmonization process. The experience of different Parties indicates that reporting is a resource-demanding process both with respect to human and – if the data required to be reported are not available – financial resources. Consultation with experts and Parties also indicated that this should be done in conjunction with establishing, sustaining and/or strengthening national capacities for performing research and other data collection initiatives by government departments other than health.

69. Training of the identified data collectors may also be required. This can be achieved by way of a variety of interventions (updating and strengthening the step-by-step instructions accompanying the reporting instrument; workshops to promote understanding of the content and of underlying definitions; clear guidance concerning possible sources of information and the process which needs to be put in place nationally for data collection, etc.). Additional support to reporting officers can be provided via more interactive electronic tools such as a "message board" (a password-protected web site where all interested Parties can post questions and receive answers after a registration process, which includes an internet-based support tool for "troubleshooting") or a list of "frequently asked questions" to be developed and published on the Internet. The current system of feedback to Parties on the reports received should be maintained.

70. Measures to ensure quality and a high level of data accuracy should also be considered during the process leading to the submission of the official Party report. The necessary assistance should be made available and offered, on demand, by either the Convention Secretariat, WHO's Tobacco Free Initiative or WHO regional and country offices, whatever is the most accessible for the Party, and which has the necessary expertise on the respective item. The Convention Secretariat should promote and coordinate such assistance. Working with civil society may also contribute to improving data quality, because some data may have only been collected by nongovernmental organizations. Parties to the Convention, where subnational jurisdictions have the authority to regulate some aspects of tobacco control, may also consider incorporating or strengthening quality control efforts at subnational levels.

71. Fifth, collating information from different legal databases with a view to promoting the use of such information by the Parties (e.g. the WHO database on health legislation, the WHO regional tobacco-control databases and the international legal database initiative of the Campaign for Tobacco-Free Kids). The web-based database of Party reports maintained by the Convention Secretariat also provides access to texts of relevant laws and regulations submitted by Parties as part of their implementation reports.

Reflection of implementation guidelines in the reporting instrument

72. Implementation guidelines adopted by the Conference of the Parties have already been taken into account during the development of phase 2 (Group 2 questions) of the reporting instrument, either by adding new questions or by adding new answer options to the already existing questions to reflect the level of detail contained in the guidelines. Guidelines on the implementation of Articles 8, 11 and 13 of the Convention also provide definitions for terms not defined in the Convention itself. These definitions were inserted into the step-by-step instructions that accompany phase 2 of the reporting instrument. In addition to the definitions, the guidelines for implementation of Article 8 recommend indicators for consideration by Parties when monitoring the implementation of the guidelines in their jurisdictions.

73. All four guidelines adopted so far by the Conference of the Parties emphasize the need for effective enforcement of the proposed measures. This again underlines the importance of referring to the various enforcement mechanisms Parties may have put in place in the reporting instrument.

74. The content of guidelines adopted by the Conference of the Parties should continue to be considered for inclusion in the Convention reporting instrument. Consideration could be given to creating separate modules attached to the core questionnaire of the reporting instrument on specific requirements of the guidelines. Relevant questions on compliance and on the enforcement mechanisms in place would be inserted in the questionnaire in all sections referring to legislation and regulation.

75. Organizations and institutions responsible for other international data collection initiatives should be advised to reflect on the content and recommendations of these initiatives, with a view to helping Parties monitor the implementation of guidelines. Efforts should be made to inform these organizations and institutions of the adoption of guidelines by the Conference of the Parties, and of their content. Moreover, Parties should be advised to reflect the content of the guidelines in their national data collection initiatives.

CONCLUSIONS AND RECOMMENDATIONS

76. There are several international data collection initiatives relevant to tobacco control and a number of databases that are dedicated, in part or in whole, to storing data related to this area. The need for standardization within and across data collection initiatives, and for harmonization between them, emerged once tobacco-related data collection instruments increased in number following the adoption of the Convention and they became important components of national and international public health efforts. Many Parties to the Convention implement national data collection initiatives and/or participate in international data collection systems.

77. All international data collection systems employ standard methodologies, questions, definitions and indicators. There are also overlaps in the content of such surveys, especially in the case of monitoring systems. Initial efforts have been made to ensure standardization across the surveys and harmonization of some of their content.

78. In the case of population-based surveys, design and content elements that may benefit from further standardization include: timing and periodicity of the surveys; age range and age groups used; definitions and indicators; and the use of standard methods of estimation, if appropriate. Further standardization across these surveys, in cooperation with WHO, as called for in Article 20 of the Convention, would contribute to better comparability of data, both at national and international levels.

79. Experts consulted during the development of this report indicated that further consideration should be given to the development of definitions and indicators that will ultimately be recommended to Parties to the Convention for their use in collecting data. Further guidance is sought from the Conference of the Parties in this regard. All working groups established by the Conference of the Parties for elaboration of further implementation guidelines could be requested to recommend definitions and indicators for specific areas to facilitate data collection through the reporting instrument. A special intergovernmental process could be envisaged for the definitions and indicators related to treaty areas not covered by ongoing and future working groups.

80. When designing national research programmes, including survey questionnaires, Parties should ensure that, at a minimum, these programmes enable collection of data which Parties are expected to

include in their implementation reports to the Conference of the Parties. Parties should also ensure that those data are collected regularly and, if possible, in a timely manner, given the reporting deadlines. This minimum or core set of data should include items such as adult prevalence data on tobacco use, broken down by gender, age and ethnicity, if appropriate; and data on prevalence of tobacco use among youth. Forthcoming WHO recommendations (initiated by the NCD Reference Group) may also support the inclusion of tobacco-related morbidity and mortality in the core set of data.

81. Regarding harmonization in relation to the reporting instrument of the Convention and the GTCR survey, emphasis should be given to a fully aligned process through a single internationally agreed instrument. Such alignment would be in line with requests received from Parties and was supported by the experts participating in the elaboration of this report. The recommended steps, taking into account the reporting obligations of Parties under Article 21 of the Convention and for the consideration by the Conference of the Parties, include the following:

- reviewing and amending selected questions in the Convention's reporting instrument in view of details contained in the WHO GTCR questionnaire to ensure they better assist Parties in providing relevant information (Annex 2 provides the outcome and recommendations of such a review undertaken jointly by the Convention Secretariat and WHO's Tobacco Free Initiative)

- aligning the treaty reporting cycle with the cycle of sessions of the Conference of the Parties;

- amending the step-by-step instructions to provide a full list of standard definitions so that each Party is aware of the standards and specifications of the information requested;

- promoting and offering assistance to Parties, particularly developing country Parties and Parties with economies in transition, in the process of reporting to ensure completeness and quality of data reported;

- collating information on tobacco-control laws and regulations from different existing databases, completion of such information, if necessary and promoting its use. This would enable governments and research groups to access relevant information in one place.

82. As part of harmonization efforts, a single reporting instrument, namely the reporting instrument of the Convention, should be uniformly applied by all Parties. Reporting cycles could be linked to the review of global progress made in the implementation of the Convention by the Conference of the Parties. Parties could all be required to report at the same time, every second year, in tandem with the biennial cycle of the regular session of the Conference of the Parties. A report could be submitted, for example, in the first quarter of the year of the regular sessions of the Conference of the Parties, to be followed by the preparation of the summary report by the Convention Secretariat for consideration by the Conference of the Parties later in that year. This would allow better international comparability of data and promote a thorough assessment of the global progress by the Conference of the Parties at its regular sessions.

83. The reporting system of the Convention should also take into account the evolution of the treaty and the development of new treaty instruments (protocols and guidelines). The Conference of the Parties could decide that future possible updates of the reporting instrument take into account and refer to the implementation guidelines. In parallel with the streamlining of the reporting instrument, the Convention Secretariat could be mandated to develop proposals for specific modules reflecting the

content of the guidelines, following the adoption of such guidelines by the Conference of the Parties. These modules could then be applied in conjunction with the core questionnaire.

ACTION BY THE CONFERENCE OF THE PARTIES

84. The Conference of the Parties is invited to note this report and provide further guidance on the conclusions and recommendations contained in paragraphs 76–83.

ANNEX 1

OVERVIEW OF MAJOR INTERNATIONAL DATA COLLECTION INITIATIVES AND DATABAES WITH INFORMATION ON TOBACCO USE AND TOBACCO-CONTROL POLICIES

INTERNATIONAL DATA COLLECTION INITIATIVES[1]

Surveys are divided in this section according to their tobacco specificity (tobacco-specific and non-tobacco-specific surveys) and also by the age groups they target (adults or young people).

Tobacco-specific surveys

The **Global Tobacco Surveillance System**[2] has four components: the GYTS; the Global School Personnel Survey; the GHPSS; and more recently, the GATS. The GYTS and GATS are described in more details below. The GSPS is a survey of all school personnel working in schools selected to participate in the GYTS. The GHPSS is a school-based survey of third-year students pursuing advanced degrees in dentistry, medicine, nursing, and pharmacy.

The Global Tobacco Surveillance System was developed in late 1998 and initiated in 1999 to assist countries in planning, developing, implementing, and evaluating their tobacco-control programmes. Leading agencies in the implementation of these surveys include WHO, the US Centers for Disease Control and Prevention, and the Canadian Public Health Association.

The system uses a common survey methodology, similar field procedures for data collection, and similar data management and processing techniques across countries. It is flexible and allows countries to include important unique information at their discretion to the core of the questionnaires.

Global Youth Tobacco Survey[3]

- The GYTS was developed and initiated by WHO and the US Centers for Disease Control and Prevention in 1999.[4] It focuses on epidemiology and policy, and helps implementing countries to regularly collect data on tobacco use among youth. It also provides information in relation to five articles of the Convention (Articles 8, 12, 13, 14 and 16). It is a widely used survey: by the end of 2008, 154 WHO Member States and 13 other areas (territories, commonwealths, geographic regions, United Nations' administered areas and special

[1] More details on some of the surveys referred to here can be found in the following publication: IARC Handbooks of Cancer Prevention, Tobacco Control, Vol. 12: Methods for Evaluating Tobacco Control Policies (2008: Lyon, France) http://www.iarc.fr/en/publications/pdfs-online/prev/handbook12

[2] http://www.cdc.gov/tobacco/global/gyts/datasets/policy/00_pdfs/data_release_school_based.pdf.

[3] http://www.who.int/tobacco/surveillance/gyts.

[4] The WHO Tobacco Free Initiative is the focal point within WHO for a number of international data collection efforts, including the survey of the GTCR and components of the Global Tobacco Surveillance System.

administrative areas) had completed at least one round of the GYTS. Of these, 107 countries have completed a second round and 10 countries have completed a third round of the GYTS.

- Owing to its repeated implementation, the GYTS serves as a good basis for analysing the trends in tobacco use among the target age group. The GYTS is also the only survey on tobacco use among youth that covers all the six WHO regions.

- The Office on Smoking and Health of the US Centers for Disease Control and Prevention, has funded the GYTS annually since 1999 and is committed to further support its implementation. The level of funding for the GYTS is over US$ 1 million per year.

Global Adult Tobacco Survey[1]

- The GATS is a national household survey of adults aged 15 years and older. It aims to collect data on adult tobacco use and key tobacco-control measures by using a standard global protocol. The GATS is designed to collect data on tobacco use, exposure to second-hand smoke, quit attempts among adults, and indirectly to measure the impact of tobacco-control and prevention initiatives.

- Substantial funds from Bloomberg Philanthropies, supplemented by resources and contributions from WHO, the US Centers for Disease Control and Prevention and participating national governments, have contributed to the implementation of the GATS. So far, the GATS has been implemented in 14 countries (Bangladesh, Brazil, China, Egypt, India, Mexico, Philippines, Poland, Russian Federation, Thailand, Turkey, Ukraine, Uruguay and Viet Nam).

The International Tobacco Control Policy Evaluation Project (ITC Project)[2] aims to evaluate the psychosocial and behavioural effects of national-level tobacco control policies. The project follows adult smokers over five or more years from the survey start date in their respective countries. The start dates are strategically chosen to follow changes in national-level tobacco policies required to be implemented under the Convention. The study focuses not only on whether a given policy has its desired effect, but also on how and why those policy effects are achieved. The first wave of longitudinal cohort surveys in each country is administered just before a large policy change takes place. The surveys continue over a five year period in order to monitor the impact of likely Convention-based policy changes as they are implemented. The survey measures the same variables across countries in the case of the ITC, and retains participants from year to year to monitor changes in overall attitudes, knowledge or behaviour within the population over time.

The ITC Policy Evaluation Project started in 2002 with the ITC Four-Country Project (in Australia, Canada, the United Kingdom of Great Britain and Northern Ireland, and the United States of America). The ITC team is currently undergoing a seventh wave of data collection. Other ITC countries joined the project at different times after the Four-Country project had begun, and therefore they are in different waves of data collection.

[1] http://www.cdc.gov/tobacco/global/gats.

[2] http://www.itcproject.org/.

The **Organization for Economic Co-operation and Development (OECD)** regularly collects data and monitors trends, analyses and forecasts economic developments and researches social changes or evolving patterns in such areas as trade, environment, agriculture, technology and taxation. It also maintains a statistical database[1] with information on tobacco consumption in OECD countries.

Non-tobacco-specific surveys

Surveys targeting the adult population

The **WHO STEPwise Approach to Surveillance (STEPS)[2]** is a population-based survey developed by WHO and first implemented in 2001. It supports countries with a simple adult-targeted surveillance system that uses standardized tools enabling comparisons over time and across countries. It is wide in scope, targeting both behavioural risk factors (tobacco use, harmful alcohol consumption, unhealthy diet, physical inactivity) and biological risk factors (overweight and obesity, raised blood pressure, raised blood glucose and abnormal blood lipids). It employs a stepwise approach in terms of data collection methods (first step: questionnaire; second step: physical measurements; third step: blood samples) and also on the complexity of questions on a given subject (five core and nine expanded questions on tobacco use). Technical support and tools for data entry and analysis are provided by WHO. Around 120 countries are active in STEPS and around 60 have completed data collection. Key results are reported on STEPS fact sheets.[3]

The **WHO Study on Global Ageing and Adult Health (SAGE)[4]** is part of the Longitudinal Study Programme of WHO which attempts to compile comprehensive longitudinal data on the health and well-being of adult populations and the ageing process across different countries, through primary data collection and secondary data analysis.

The core Study on Global Ageing and Adult Health collects data on respondents aged 18 or more years, with an emphasis on populations aged more than 50 years, from nationally representative samples in six countries (China, Ghana, India, Mexico, Russian Federation and South Africa). A further set of countries in Latin America and Europe are considering joining future rounds of the Study. The survey instruments and methods were adapted from those used by the World Health Survey and/or from 16 national surveys on ageing.

SAGE baseline data (Wave 0, 2002–2004) was collected as part of WHO's World Health Survey. A second round of data collection (Wave 1, 2007–2009) is currently being carried out and has expanded the sample sizes in each participating country.

Since 1984, the **Demographic and Health Surveys project[5]** has provided technical assistance to more than 240 surveys in over 85 countries, advancing global understanding of health and population trends in developing countries. It has earned a worldwide reputation for collecting and disseminating

[1] http://stats.oecd.org/index.aspx.

[2] http://www.who.int/chp/steps.

[3] http://www.who.int/chp/steps/reports.

[4] http://www.who.int/healthinfo/systems/sage.

[5] http://www.measuredhs.com/aboutsurveys/search/listmodules_main.cfm.

accurate, nationally representative data on fertility, family planning, maternal and child health, gender, HIV/AIDS, malaria, and nutrition. Tobacco was referred to in the questionnaires used in 61 countries. The main funder of the project is the United States Agency for International Development, but contributions from other donors and countries' own resources are also being used.

The main purposes of the project include, among others, the subsequent use of collected data in policy formation, programme planning, and monitoring and evaluation; fostering and reinforcing host country ownership of data collection, analysis, presentation, and use; increasing the capacity of host-country partners to collect and use data for programme and policy purposes.

The **Eurobarometer**[1] is a series of surveys regularly performed on behalf of the European Commission since 1973. These surveys monitor the evolution of public opinion in European Union Member States. The major topics covered by surveys include: European Union enlargement, poverty and social exclusion, health, culture, information technology, the environment, the Euro, defence and climate change. Each survey is based on approximately 1000 face-to-face interviews per Member State. Reports are published twice yearly.

Specific tobacco-related surveys are also conducted as part of the Eurobarometer with some regularity. The latest tobacco-related survey was published in December 2008. In this survey, 26 500 Europeans were asked about issues concerning their tobacco consumption and knowledge, attitudes and beliefs on tobacco policy matters. Previous tobacco-related surveys were implemented in 2005 and 2006.

The **European Health Interview Survey** is a community-wide harmonized survey[2] which is implemented and managed by Eurostat.[3] The survey is planned to be conducted every five years, with the first wave implemented in the period 2006–2010. The health interview survey usually covers the following topics: height and weight, which form the basis for the calculation of body mass index; self-perceived health; activities that have been reduced because of health problems; long-standing illnesses or health problems; smoking behaviour; and alcohol consumption.

Surveys targeting young people

The **Global School-based Student Health Survey (GSHS)**[4] was developed by WHO in collaboration with UNICEF, UNESCO and UNAIDS; and with technical assistance from the US Centers for Disease Control and Prevention. It is conducted primarily among students aged 13–15 years. It is a population-based survey covering the same age range as the GYTS and following the same school-based methodology. The two surveys differ in content: while the GYTS aims to collect detailed data on tobacco consumption as well as on various tobacco-control measures, the GSHS focuses on collecting basic prevalence data on 10 behaviours (alcohol and drug use, dietary behaviours, etc.), tobacco also being one of the behaviours. Implementation of the GSHS started in 2003 and it has been completed in 43 countries so far.

[1] http://ec.europa.eu/public_opinion/index_en.htm.

[2] http://ec.europa.eu/health/ph_information/dissemination/reporting/ehss_01_en.htm.

[3] Eurostat is the statistical office of the European Union. Its task is to provide the European Union with statistics at European level that enable comparisons between countries and regions. It also has a database with information on smoking: http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database.

[4] http://www.who.int/chp/gshs.

The **European School Survey Project on Alcohol and Other Drugs (ESPAD)**[1] is a collaborative effort of independent research teams in about forty European countries and the largest cross-national research project on adolescent substance use in the world.

Data have been collected every fourth year since 1995 and the ESPAD has now completed four cycles of data collection: 1995, 1999, 2003 and 2007. In 2007–2008, surveys were completed in 40 countries. The latest results were published in March 2009. Data collection in individual countries is funded by national sources.

To reach the goal of providing data that are cross-nationally comparable, the methodology of the ESPAD project is strictly standardized with regard to the target population, data collection instrument, field procedure, timing and data processing. A searchable database is available with the data collected from participating countries.

The **Health Behaviour of School-aged Children (HBSC)**[2] was adopted in the mid-1980s by the WHO Regional Office for Europe as a WHO collaborative cross-national study. It was developed by a multi-disciplinary network of researchers from countries in Europe and North America. It was first conducted in 1983/84 (4 countries), then in 1985/86 (13 countries), and then every four years: 1989/90 (16 countries), 1993/94 (26 countries), 1997/98 (30 countries), 2001/02 (36 countries), and 2005/06 (41 countries). The questionnaire includes questions on tobacco use. Data from the HBSC study have been used to influence health promotion and health education policies at national and international levels.

An international data file is created from all national data for each HBSC survey and stored at the Norwegian Social Science Data Services. The international data file is restricted for the use of member country teams for a period of three years from its completion. After this time the data is available for external use by agreement with the International Coordinator and the Principal Investigators.

DATABASES WITH INFORMATION ON TOBACCO

Databases in this section are divided into two categories: tobacco-specific and non-tobacco specific.[3] Within these categories, reference is made to databases that contain global data and to those that concern only one or two WHO regions. In addition to these databases, population-based international data collection systems usually maintain a database for the publication of survey reports and also make possible searches for collected data. Such databases can be accessed through the respective survey web sites and these are not repeated in the listing below.

[1] http://www.espad.org.

[2] http://www.hbsc.org.

[3] The list presented here is not exhaustive, especially with respect to private and commercial databases maintained by several agencies.

Tobacco-specific databases

Databases with global data

- **A web-based database of Parties' implementation reports.** The Convention Secretariat maintains a database of Parties' implementation reports on the WHO FCTC web site that provides access to the reports, as well as to additional information (including the texts of national legislation and national tobacco control programmes) submitted by the Party as part of their report. Currently, the database is searchable by name of Party; it will be further developed and, by the fourth session of the Conference of the Parties, it will also allow progress on the implementation of the Convention to be tracked by its different provisions, both regionally and globally, and it will integrate the database on available resources for implementation of the Convention.

- **Global Information System on Tobacco Control (GISTOC).**[1] WHO's Tobacco Free Initiative is currently working to set up this system, in order to provide brief information on and links to various global and regional databases with statistical information on tobacco-related issues. Some of these databases are maintained by WHO's Tobacco Free Initiative itself and other WHO departments, while others are housed by its partners and other international agencies.

- **International database on health warnings**. In line with decision FCTC/COP3(10) the Convention Secretariat invited WHO's Tobacco Free Initiative to establish and maintain, in consultation with those Parties that wish to share with other Parties the pictorial health warnings and messages they use, a central international database of such warnings and messages. This database is now available and is being regularly updated.[2]

- The **International Legal Consortium at the Campaign for Tobacco-Free Kids** is developing a proposed worldwide legislation database that aims to serve as a repository of tobacco control laws and to offer analysis of these laws in terms of obligations under the Convention and its guidelines, with a focus on Articles 8, 11 and 13. The project began in 2008 and the database is planned to be operational and launched, with a limited number of countries, by the end of 2010. The database will be online and searchable by country and/or using key policy terms.

Databases with regional data

WHO regional offices also operate databases that provide information on Member States' tobacco control efforts. However, the volume and level of detail of such information varies greatly from region to region.

[1] http://www.who.int/tobacco/global_data/.

[2] http://www.who.int/tobacco/healthwarningsdatabase/en/index.html.

- The web site of the **WHO Regional Office for Africa** provides access to reports on tobacco-related surveys carried out by countries in the region.[1]

- In the **WHO Region of the Americas**, the Pan American Tobacco Information Online System (PATIOS)[2] is a searchable web-based information system containing country-specific data from different sources on a wide variety of tobacco control topics. PATIOS provides standardized and reliable tracking and assessment of the tobacco-related situation within and across countries. The database covers 53 indicators on tobacco use and control policies in all Member States in the Region.

- The web site of the **WHO Regional Office for South-East Asia** features a Regional Tobacco Control Database.[3] It is searchable, and allows for in- and cross-country comparisons. The database is part of the regional Integrated Data Analysis System.

- The **WHO Regional Office for Europe** manages a Tobacco Control Database,[4] which contains data on smoking prevalence and various aspects of tobacco control policies in the countries of the region that also allows comparisons across countries regarding policies. It has a special section on tobacco control legislation and also contains information on the implementation of the Convention in Europe.

- On the web site of the **WHO Regional Office for the Eastern Mediterranean,** profiles of the countries in the region are available.[5]

- The **WHO Western Pacific Region** operates a Tobacco Control Data Centre[6] containing searchable sets of information on tobacco from the countries from the region.

Non-tobacco specific databases

- **CancerMondial**[7] provides access to information on the occurrence of cancer worldwide held by the International Agency for Research on Cancer. The aim of the project is to provide online access to data on cancer incidence, prevalence, survival and mortality rates worldwide.

- The statistical database of **Eurostat**[8] provides information concerning European Union Member States on diverse areas linked to tobacco, including smoking rates, trade (exports and imports of tobacco), consumer price indices, etc.

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[1] http://www.afro.who.int/en/divisions-a-programmes/dnc/tobacco/tob-country-profiles.html.

[2] http://www.paho.org/tobacco/PatiosHome.asp.

[3] http://www.searo.who.int/EN/Section1174/Section2469/Section2481.htm.

[4] http://data.euro.who.int/tobacco/.

[5] http://www.emro.who.int/TFI/CountryProfile-Part6.htm.

[6] http://www.wpro.who.int/health_topics/tobacco/data.htm.

[7] http://www-dep.iarc.fr/.

[8] http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/themes.

- The **Global Health Observatory** and establishing **national noncommunicable disease surveillance systems** are ongoing WHO projects.

- **The WHO database on health legislation.**[1] The database contains approximately 100 texts of national and subnational legislation.

- The **WHO Global Infobase and Regional noncommunicable disease (NCD) Infobases.** The WHO Global InfoBase and Regional NCD Infobases are online tools containing noncommunicable disease risk factor data. These data are subsequently used to develop estimates of national prevalence for each risk factor. It also contains data on tobacco use[2] from the following surveys: the GSHS, GYTS, STEPS and World Health Survey.

- The **WHO Statistical Information System (WHOSIS)** is the WHO guide to health and health-related epidemiological and statistical information providing access to statistical information on most WHO technical programmes. Data, searchable by keywords within WHOSIS or throughout the entire WHO site, are available under the following categories: core health indicators; statistics by country or region; statistics by topic; burden of disease statistics. The system also provides links to other sources of health related information.

- **World Health Statistics 2009**[3] is a publication containing WHO's annual compilation of data from its Member States, and which includes a summary of progress towards the health-related Millennium Development Goals and the relevant targets. The contents of this book have been collated from publications and databases produced and maintained by WHO's technical programmes and regional offices. Indicators have been included on the basis of their relevance to global health, the availability and quality of the data and the reliability and comparability of estimates. This set of indicators provides a comprehensive summary of the current status of national health and health systems, including: mortality and burden of disease, causes of death, reported infectious diseases, health service coverage, risk factors, health systems resources, health expenditures, inequities and demographic and socioeconomic statistics. Two tobacco-related indicators are included: prevalence of current tobacco use among adults (aged 15 years and over) and prevalence of current tobacco use among adolescents (aged 13 to 15 years).

- The web site of the **ERC Group**[4] has a commercial database containing the latest news and information on the tobacco industry, including market and company analysis, regulatory information, changes in taxation and pricing as well as data on smoking prevalence and

[1] http://idhlrils.who.int/frame.cfm?language=english. The Health Law unit of the Information, Evidence and Research cluster is involved in data collection for the WHO database on health legislation.

[2] https://apps.who.int/infobase/report.aspx?rid=112&ind=TOB.

[3] http://www.who.int/whosis/whostat/2009/.

[4] http://erc-world.com/tobacco/ (Founded in 1961, ERC is one of Europe's longest established independent market research organizations.). Access to documents only for subscribers.

numbers of smokers. Other web sites with similar information on the economics of tobacco also exist.[1]

- The **Euromonitor International**[2] is a commercial database containing a section on tobacco research. The site provides in-depth analysis of tobacco markets worldwide, including market size, contraband sales, retail distribution and pricing trends; information on the leading tobacco companies and their brand shares; insight into key sectors including: cigarettes, cigars, smoking tobacco and smokeless tobacco; but also per capita expenditure for tobacco products and consumption trends.

[1] The Tobacco Merchants Association databases (http://www.tma.org/tmalive/FrmMain) and the Economist Intelligence Unit price database (http://store.eiu.com/product/1990000199.html?ref=Products).

[2] http://www.euromonitor.com/tobacco. Access to full documents only to subscribers.

ANNEX 2

PROPOSALS FOR AMENDMENTS TO THE REPORTING INSTRUMENT OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

Current question(s)	Type of review proposed	Suggested amendment	Rationale/comments
A. Proposals in relation to Article 8 of the Convention (*Protection from exposure to tobacco smoke*)			
3.2.2.1, 3.2.2.3 and 3.2.2.5	Merging questions and technical revision [The following questions are merged: – protection from exposure to tobacco smoke in indoor workplaces? – protection from exposure to tobacco smoke in public transport? – protection from exposure to tobacco smoke in indoor public places?]	Questions to be merged as follows: 3.2.2.1 – banning tobacco smoking in indoor workplaces, public transport, indoor public places and, as appropriate, other public places?	The questions are merged for editorial reasons and undergo technical revision, by changing the focus from "protection from exposure" (outcome of a specific measure) to the banning of tobacco smoking in a particular setting (the specific measure itself). The wording of Article 8.2 of the Convention is also reflected in full. The new formulation is easier to interpret and may improve the precision and validity of the data received.
3.2.2.1	Adding detail to an existing question	Sub-question to be added: 3.2.2.2 If you answered yes to question 3.2.2.1, what is the type/nature of the measure providing for that ban? • National law • Subnational law(s) • Administrative and executive orders • Voluntary agreements • Other measures Phrase to be added: 3.2.2.3 Please provide a brief explanation of the type/nature and content of the measures providing for the ban.	Parties are asked to specify the type of the measure(s) (legislative, executive, administrative or other measures) banning tobacco smoking in indoor workplaces, public transport, indoor public places and, as appropriate, other public places. Additional space is provided to enter details. The additional space is inserted with particular focus on Parties with subnational jurisdictions that have the authority to regulate tobacco use in public places.

Current question(s)	Type of review proposed	Suggested amendment	Rationale/comments
3.2.2.2	Adding detail to an existing question	Sub-question to be added: 3.2.2.4 If you answered yes to any options in 3.2.2.2, do any of these measures provide for a mechanism/ infrastructure for enforcement? Phrase to be added: 3.2.2.5 If you answered yes to question 3.2.2.4 please provide details of this system.	This question refers to an important component of the implementation of policies under Article 8 of the Convention and also reflects the content of the guidelines on Article 8. Additional space is provided to enter details concerning the answer to question 3.2.2.4.
3.2.2.2, 3.2.2.4 and 3.2.2.6	Merger of questions and adding details [The following questions are merged: "If you answered yes to question 3.2.2.1, how comprehensive is the protection from exposure to tobacco smoke in the following – … indoor workplaces – … types of public transport – … indoor public places:"]	Question to be merged as follows: 3.2.2.5 If you answered yes to question 3.2.2.1 please specify the settings and extent/comprehensiveness of measures applied in indoor workplaces, public transport, indoor public places and, as appropriate, other public places? The following answer options to be added to the original list: universities; shopping malls; pubs and bars (instead of bars only); private vehicles; and ferries.	Questions are merged and the options for answering them are combined to reflect a list of settings in which the smoking ban could apply. The rationale for collapsing the questions is that all indoor workplaces, public transport facilities and indoor public places are also workplaces. The revision of question 3.2.2.1 also reflects this fact. In addition, new answer choices are provided, and the answer options ("complete", "partial" and "none") are retained.
B. Proposal in relation to Article 11 of the Convention (*Packaging and labelling of tobacco products*)			
3.2.5.6	Adding detail to an existing question	Sub-question to be added: If you answered yes to question 3.2.5.6, does your law mandate, as a minimum, a style, size and colour of font to render the warning clear, visible and legible?	This additional question may improve the accuracy of answers, by explicitly looking into some of the content of the legislation.

Current question(s)	Type of review proposed	Suggested amendment	Rationale/comments
C. Proposals in relation to Article 14 of the Convention (*Demand reduction measures concerning tobacco dependence and cessation*)			
3.2.8.2	Adding detail to an existing question	Revision of answer choices as follows: • programmes specially designed for – **underage girls and young women** – women – pregnant women • **telephone quitlines**?	Answer options were separated and new answer options ("underage girls and young women", "telephone quitlines") are added to allow for more accurate answers. Reference to gender is also in conformity with decision COP2(9).
3.2.8.10	Adding detail to an existing question	Sub-question to be added: If you answered yes to question 3.2.8.10, where and how can these products be legally purchased in your country?	A new open-ended question is added requiring information on the accessibility of treatment of tobacco dependence as referred to in Article 14.2(d) of the Convention.
3.2.8.11	Technical revision	If you answered yes to question 3.2.8.10, which pharmaceutical products are **legally** available for the treatment of tobacco dependence in your jurisdiction?	The word "legally" is added to make reference to the legal market within the Parties' jurisdiction, as opposed to products which may be available on the illegal market, to which product regulation or other regulation do not apply.
3.2.8.12	Technical revision	If you answered yes to question 3.2.8.10, are the costs of these products covered by public funding or reimbursement?	The words "treatment with" are deleted. The change adds clarity to the question, by not implying that the cost of the cessation *service* should also be taken into account when answering this question. The reimbursement of cessation services is covered by question 3.2.8.7.
D. Proposals in relation to Article 20 of the Convention (*Research, surveillance and exchange of information*)			
3.4.3.3	Adding detail to an existing question	Phrase to be added: If you answered yes to question 3.4.3.3, please list all surveys, including the year of the survey, that you have undertaken in the past. Sub-question to be added: In reference to question 3.4.3.3, does your country have any plans to repeat any of the above or to undertake a new tobacco survey within three to five years of your last survey?	This new phrase refers to Article 21.1(d). It allows the "yes" answer provided to 3.4.3.3 to be checked. Parties will also be required to provide a copy of the surveys in question. This question also helps, with reference to Article 21.1(d) of the Convention, in assessing whether the surveys repeated by the Party could be termed a state-of-the-art "surveillance system". It will also raise expectations regarding the content of the next report of the Party.

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