



alcohol & drugs

Report on the meeting on indicators
for monitoring alcohol, drugs and other
psychoactive substance use, substance-
attributable harm and societal responses

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WHO would like to express its gratitude to the experts from national institutions and international organizations who participated in the meeting on indicators for monitoring alcohol, drugs and other psychoactive substance use, substance-attributable harm and societal responses in Valencia, Spain in October 2009. Their knowledge and expertise were invaluable in driving the discussions forward. The list of invited experts engaged in this process is provided at the end of this report.

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INTRODUCTION

Background

Information on the consumption of alcohol and drugs, related harms and associated treatment and policy responses are lacking from many parts of the world, as many surveillance and monitoring systems do not include indicators on psychoactive substance use. The ongoing systematic collection, collation, and analysis of data would lead to the accumulation of substantial information on a country's disease burden, the number of people at risk, and whether effective policy and treatment measures are being effectively implemented. Monitoring or the process of continuous data collection requires the use of standardized and comparable indicators to reliably and comparably capture change and to establish trends. Monitoring of alcohol and other psychoactive substance use is greatly needed as it generates valuable data to provide health professionals and policy makers at the national level with the information required to drive program development, policy and legislation.

At the regional and global level there is also a growing demand for effective systems to monitor trends on psychoactive substance use, substance-attributable harm and societal responses. Regional and global frameworks for reducing alcohol and drug-related harm require comparable data on key indicators to evaluate progress made at the regional and global level, and are also essential to perform meaningful within-country and cross-country comparisons. Comparable and reliable data on levels and patterns of alcohol and drug use in populations, prevalence of substance use disorders and magnitude of other health consequences are also necessary for improving estimates of alcohol and drug-attributable burden at regional and global levels.

Several regional and global organizations, including those at the UN system, as well as some national institutions and organizations and research groups have accumulated substantial experience in developing different sets of indicators and therewith associated data collection and analysis procedures, which could be also recommended for implementation at the sub-national and national level. The World Health Organization

(WHO) has a constitutional mandate within the UN system to monitor the health situation and to assess health trends, including those related to alcohol and other psychoactive substance use. This work is being implemented in collaboration and in partnership with relevant UN agencies, other intergovernmental organizations and national authorities.

In this context, the WHO Department of Mental Health and Substance Abuse, Management of Substance Abuse convened a technical meeting on indicators for monitoring alcohol, drugs and other psychoactive substance use, substance-attributable harm and societal responses from 19-21 October 2009 in Valencia, Spain, with the support of the Government of Valencia.

Objective and purpose

The purpose of the technical meeting in Valencia was to discuss a relevant set of indicators to effectively assess and monitor alcohol, drugs and other psychoactive substances regarding consumption, harm, treatment and policy responses respectively.

As agreed by the participants of the technical meeting, objectives of the meeting were as follows:

- To present and discuss a suggested set of core, expanded and additional indicators for monitoring alcohol consumption and drug use in populations;
- To present and discuss a suggested set of core, expanded and additional indicators for monitoring alcohol- and drug-attributable harm;
- To present and discuss a suggested set of core, expanded and additional indicators for monitoring responses at the level of treatment and treatment systems;
- To present and discuss a suggested set of core, expanded and additional indicators for monitoring societal responses for alcohol and drug use at the population level.

Guiding principles

Consensus among the meeting participants about the selection of core, expanded and additional indicators on monitoring consumption, harm, and societal responses of psychoactive substance use have been driven by the following guiding principles.

- All indicators on alcohol, drugs and other psychoactive substance use as presented in this meeting report have to be mainly related to the health or wellbeing of the individual or populations.
- Indicators have to be consistent with current recognized international data collection practices and standards, and take into consideration WHO activities in this area such as the WHO Global Survey on Alcohol and Health, the ATLAS Survey on Resources for the Prevention and Treatment of Substance Use Disorders, the WHO Global Information System on Alcohol and Health, and other WHO activities such as the development of the WHO Global Health Observatory.
- The burden on countries in collecting and compiling data shall be minimized by harmonizing indicators on psychoactive substance use with data collected by other specialized international agencies (e.g. EMCDDA, UNAIDS, UNODC) in that area.
- Guidance for indicator operationalization or possible data sources will be provided, but additional effort is required at the national level to adjust and refine indicators according to national needs, resources and data collection mechanisms.

Indicators

The indicators proposed in this meeting report cover consumption, harm, as well as treatment and policy responses for alcohol and other psychoactive substances. The level and pattern of both consumption and harm indicators provide useful information on the current and prospective disease burden, and morbidity and mortality resulting from psychoactive substance use. Policy and treatment indicators reflect the availability of different treatment and policy measures and the capacity of the country to respond to the burden of alcohol and other psychoactive substance use.

The suggested list of "Core" indicators are those which are regarded as essential for alcohol and other psychoactive substance use monitoring. Core indicators are indicators which can be measured in a reliable manner and represent basic but essential information on alcohol and other psychoactive substance use, substance-related harm, and treatment and policy responses.

"Expanded" indicators are suggested as complementing core indicators and build upon them through expanding and shifting their focus on different aspects of the core indicator or on other population groups. They are regarded as having universal applicability, but not the first priority in resource poor settings.

"Additional" indicators are distinct from core and expanded indicators and offer the possibility to open up new areas of exploration or may represent indicators which are specific for certain countries or regions. Furthermore, this indicator category has been created to allow the inclusion of unique national indicators, acknowledging the existence of specific country needs to measure and follow typical country occurrences.

After providing a short overview in Table 1 and listing the suggested core, expanded, and additional indicators for alcohol and other psychoactive substance use in the

respective areas, each indicator is described and itemized in detail according to the requirements of indicator specification requested from the WHO Global Health Observatory – providing an indicator definition, possible data source, nominator, denominator, possible operationalization, suggested data collection frequency, and indicator disaggregation. While some possible data sources or guidance concerning the measurement and possible operationalization of the indicators are suggested in this meeting report, it is emphasized that refining and adjustment of indicators at the national level may be required.

In this regard, the meeting participants noted that the availability, reliability and quality of different data sources vary across countries. A "one size fits all" prescription on possible data sources is unlikely to be the best approach, and could even lead to a reduction in the number of indicators available for cross-country comparisons as not all data sources may be nationally available. To enhance data quality it is suggested that the precise definitions and most reliable data sources for each indicator be identified and selected by experts at the national level.

Similarly, the serving sizes and definitions of a standard drink of alcohol differ across countries, making cross-country comparisons based on standard drink measures more difficult. There is no international consensus on the usage of the phrase "standard drink" or "standard alcoholic drink". The alcohol content varies from 6 to 20 grams of alcohol in different countries' definitions of "standard drinks" (although most countries use definitions in the 8-14 grams range). However, the concept of the "standard drink" based measurement was supported by the meeting participants as being an essential way to measure consumption, with "standard drink" sizes being defined at the national level.

In measuring other psychoactive substance use, it was highlighted that the focus of this effort lies on non-medical use of illicit drugs and psychoactive medicines and to problems related to their abuse. It has been suggested to measure non-medical drug use

according to different drug categories such as heroin or other opiates, amphetamine type stimulants, cocaine, cannabis, or prescription medicines. However, within each drug category different types of drugs may be specified and selected at the national level, allowing also the possibility to integrate colloquial terms for different types of drugs. Drug use should therefore always be further specified, constructing at least one indicator for each drug category. For example, if it is possible to further categorize indicators relating to the non-medical use of prescription medicines by the class of prescription medicines (heroin or other opiates, stimulants, benzodiazepines, and so on). This would enable the pooling of measures related to illicit opioid use with measures related to the non-medical use of prescription opioids, which in some situations may be desirable, while still enabling the separation of illicit opioids from the non-medical use of prescription opioids in other situations.

Indicators monitoring alcohol, drugs and other psychoactive substance use may be measured among different population groups. For the reference adult population, internationally recognized age ranges have been chosen (the population 15+ years for alcohol consumption, for drug consumption the population 15-64 years), acknowledging and aligning with existing practices in this field. For the adolescent population it was however observed that there is no such accepted age range for measuring alcohol and drug use among the younger population group. Although WHO defines adolescents as being 10-19 years of age, it was concluded that among this age group a subpopulation may be selected at the national level, responding to age ranges of already existing national data collection activities (such as school surveys).

Finally, it has been stressed that the indicators suggested in this meeting report may be incorporated into already existing health information systems or can be used as a complete set of indicators, focusing exclusively on alcohol and other psychoactive substances.

This meeting report builds on a number of other WHO documents and activities. Further information and methodological guidance on epidemiology and monitoring of alcohol and other psychoactive substance use can be obtained from the WHO International Guide for Monitoring Alcohol Consumption and Related Harm or the WHO Guide to Drug Abuse Epidemiology to be accessed at the WHO Management of Substance Abuse website:

http://www.who.int/substance_abuse/en/

The suggested list of indicators and conclusions which have been drawn from the meeting on indicators for monitoring alcohol, drugs and other psychoactive substance use, substance-attributable harm and societal responses will be taken into consideration for normative guidance and further development of WHO documents and technical tools in the respective areas. Any feedback on these indicators is welcomed and will also be taken into consideration in further work on this topic.

INDICATOR OVERVIEW

Table 1: List of core, expanded and additional indicators for alcohol and other psychoactive substance use (indicators on consumption, harm, treatment and policy responses respectively)

Indicators: Alcohol and other psychoactive substance use			
	Core	Expanded	Additional
Alcohol Consumption	[1.1.1] Recorded adult (15+ years) per capita consumption (in litres of pure alcohol)	[1.2.1] Unrecorded adult (15+ years) per capita consumption (in litres of pure alcohol)	[1.3.1] Age at first drinking
	[1.1.2] Lifetime abstainers (15+ years)	[1.2.2] Total (recorded and unrecorded) adult (15+ years) per capita consumption (in litres of pure alcohol)	[1.3.2] Drinking with meals among adults (15+ years) during the last 30 days
	[1.1.3] Past-year abstainers (15+ years)	[1.2.3] Total (recorded and unrecorded) adult (15+ years) per capita consumption per drinker (in litres of pure alcohol)	
	[1.1.4] Heavy episodic drinking among adults (15+ years)	[1.2.4] Lifetime abstainers among adolescents	
	[1.1.5] Drinking among adolescents during the last 12 months	[1.2.5] Heavy episodic drinking among adolescents during the last 30 days	
	[1.1.6] Drinking among adolescents	[1.2.6] Yesterday's alcohol consumption	

during the last 30 days

[1.2.7] Drinking frequency among adult drinkers during the last year (15+ years)

[1.2.8] Very heavy drinking among adult drinkers during the last 12 months (15+ years)

[1.2.9] Largest number of drinks consumed among adult drinkers (15+ years) during the last 12 months

Alcohol-Related Harm

[2.1.1] Age-standardized death rates for liver cirrhosis (per 100,000)

[2.1.2] Age-standardized death rates for road traffic accidents (per 100,000)

[2.2.1] Alcohol-attributable years of life lost (YLL)

[2.2.2] Age-standardized death rates for poisoning (per 100,000)

[2.2.3] Age-standardized death rates for violence (per 100,000)

[2.2.4] Age-standardized death rates for alcohol liver cirrhosis (per 100,000)

[2.2.5] Age-standardized death rates for alcohol-related road traffic accidents (per 100,000)

[2.2.6] Age-standardized death rates for

[2.3.1] Prevalence of fetal alcohol syndrome (FAS)

[2.3.2] Social cost attributable to alcohol consumption

[2.3.3] Disease burden of alcohol-related harm to others (DALYs)

[2.3.4] Proportion of infectious diseases attributable to alcohol consumption

[2.3.5] Alcohol-attributable disability-adjusted life years (DALYs)

alcoholic poisoning (per 100,000)

[2.2.7] Age-standardized death rates for alcohol-related violence (per 100,000)

[2.2.8] Alcohol dependence, 12-month prevalence

[2.2.9] Alcohol-use disorders, 12-month prevalence

Alcohol Treatment

[3.1.1] Availability of treatment for alcohol use disorders in primary health care

[3.1.2] Beds for alcohol use disorders (per 100,000)

[3.2.1] Outpatient treatment slots for alcohol use disorders (per 100,000)

[3.2.2] Waiting period to receive alcohol detoxification treatment

[3.2.3] Waiting period to receive short-term treatment for alcohol dependence

[3.2.4] Waiting period to receive long-term care and after care for alcohol dependence

[3.2.5] Inpatient treatment admissions due to alcohol use disorders

[3.3.1] Screening and brief interventions for alcohol use disorders

[3.3.2] Availability of workplace alcohol prevention or counselling programs (for employees with alcohol problems)

[3.3.3] Availability of pharmacological treatment for the management of alcohol use disorders

[3.3.4] HIV-testing among persons in treatment for alcohol use disorders

[3.3.5] Counselling to family members with alcohol problems

[3.3.6] Counselling to pregnant

women with alcohol use disorders or alcohol problems

[3.3.7] Percentage of persons who have seen a treatment provider and who have been asked about their alcohol problems

[3.3.8] Availability of gender-specific treatment services for alcohol use disorders within the health care system

Alcohol Policy

[4.1.1] Presence of a national total ban of alcohol

[4.2.1] Presence of a multisectoral alcohol policy

[4.3.1] Provision of consumer information on alcohol's impact on health at points of alcohol sale (supermarkets, pubs/bars)

[4.1.2] Availability of a written national policy on alcohol

[4.2.2] National maximum legal blood alcohol concentration (BAC) when driving a vehicle for young/novice drivers

[4.3.2] Provision of server training

[4.1.3] National maximum legal blood alcohol concentration (BAC) when driving a vehicle for the general population

[4.2.3] National maximum legal blood alcohol concentration (BAC) when driving a vehicle for professional/commercial drivers

[4.3.3] Training of health professionals: screening and brief intervention for alcohol use disorders

[4.1.4] Excise tax on alcoholic beverages

[4.3.4] Provision of community based interventions/projects involving non-governmental organizations

[4.1.5] Availability of special legislative provisions pertaining to treatment and rehabilitation of persons with alcohol use disorders

[4.1.6] Availability of policy documents regulating pharmacological treatment of alcohol use disorders

[4.3.5] Provision of interventions/projects actively involving young persons and the civil society

[4.3.6] School-based programmes which prevent the harmful use of alcohol

[4.3.7] Presence of a treatment registry for alcohol use disorders

[4.3.8] Provision of publicly funded alcohol research and monitoring programs

[4.3.9] National legal minimum age for off-premise sales of alcoholic beverages

[4.3.10] National legal minimum age for on-premise sales of alcoholic beverages

[4.3.11] Administrative fines and license suspension for drink driving

Drug Consumption

*Drug use (non-medical): As agreed by the meeting participants, the focus of drug monitoring lies on non-medical drug use related to substance abuse, and measurement of drug use indicators as presented below is suggested according to different drug categories: 1) heroin and other illicit opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug.

[5.1.1] Drug use* among adults (15-64 years) during their lifetime	[5.2.1] Drug use* among adolescents during the last 30 days	[5.3.1] Age at first drug use
[5.1.2] Drug use* among adults (15-64 years) during the last 12 months	[5.2.2] Cannabis use among adolescents during the last 30 days	[5.3.2] Perception about availability of drugs ("by drug category") among adolescents
[5.1.3] Drug use* among adults (15-64 years) during the last 30 days	[5.2.3] Injecting drug use (IDU) among adults (15-64 years) during the last 30 days	[5.3.3] Perception about harm of drugs ("by drug category") among adolescents
[5.1.4] Drug use* among adolescents during the last 12 months	[5.2.4] Drug use* among the elderly (64+ years) during the last 12 months	
[5.1.5] Use of any illicit drug among adults (15-64 years) during their lifetime	[5.2.5] Drug use* among the elderly (64+ years) during the last 30 days	
[5.1.6] Injecting drug use (IDU) among adults (15-64 years) during the last 12 months		

Drug-Related Harm

[6.1.1] Drug dependence, 12-months prevalence	[6.2.1] Drug use disorders, 12-months prevalence	[6.3.1] Imprisonment due to drug-related crime
[6.1.2] Infectious diseases among injecting drug users (IDUs): HIV prevalence	[6.2.2] Non-fatal drug-related poisoning (per 100,000)	[6.3.2] Drug-related crime
[6.1.3] Infectious diseases among injecting drug users (IDUs): Hep C prevalence	[6.2.3] Infectious diseases among injecting drug users (IDUs): Hep B prevalence	[6.3.3] Drug-attributable disability-adjusted life years (DALYs)
[6.1.4] Infectious diseases among injecting drug users (IDUs): TB incidence	[6.2.4] Infectious diseases among non-injecting drug users: Hep B prevalence	[6.3.4] Disease burden of drug-related harm to others (DALYs)
[6.1.5] Infectious diseases among non-injecting drug users: HIV prevalence	[6.2.5] Drug-attributable years of life lost (YLL)	[6.3.5] Drug use among HIV-infected people
[6.1.6] Infectious diseases among non-injecting drug users: TB incidence	[6.2.6] Needle sharing among injecting drug users (IDUs)	[6.3.6] Drug-related traffic arrests
[6.1.7] Age-standardized death rate for drug-related poisoning (per 100,000)	[6.2.7] Sexually transmitted infections (STIs) among drug users	[6.3.7] Drug-related traffic injury

Drug Treatment

[7.1.1] Outpatient treatment slots for drug use disorders (per 100,000)	[7.2.1] Percentage of opioid-dependent persons on opioid substitution therapy (OST) at census date	[7.3.1] Mandatory treatment for drug use disorders
[7.1.2] Opioid substitution therapy (OST) sites per 1,000 opioid injectors	[7.2.2] Beds for drug use disorders (per 100,000)	[7.3.2] Treatment for persons with drug use disorders in prisons
[7.1.3] Needle and syringe programme (NSP) sites per 1,000 IDUs	[7.2.3] Percentage of patients in treatment: Methadone maintenance	[7.3.3] HIV-testing among IDUs
[7.1.4] Syringes distributed per injecting drug user (IDU) per year	[7.2.4] Percentage of patients in treatment: Buprenorphine maintenance	[7.3.4] Polysubstance dependence
	[7.2.5] Waiting period to receive drug detoxification treatment	[7.3.5] Mental health conditions among persons in treatment for drug use disorders
	[7.2.6] Waiting period to receive short-term treatment for drug dependence	[7.3.6] Opioid substitution therapy (OST) sites per 1,000 opioid dependent persons
	[7.2.7] Waiting period to receive long-term care and after care for drug dependence	[7.3.7] Availability of drugs (medication) for pharmacological treatment for opioid dependence for detoxification
	[7.2.8] Inpatient treatment admissions due to drug use disorders	[7.3.8] Availability of drugs (medication) for pharmacological treatment for opioid dependence for maintenance
		[7.3.9] Availability of gender-specific treatment services for drug

use disorders within the health care system

Drug Policy

[8.1.1] Availability of a written national policy on drugs

[8.1.2] Availability of special legislative provisions pertaining to treatment and rehabilitation of persons with drug use disorders

[8.1.3] Availability of policy documents regulating pharmacological treatment of drug use disorders

[8.2.1] Presence of drug courts in the country

[8.2.2] Availability of programmes for drug use disorders which divert clients from the criminal justice system towards treatment

[8.3.1] Provision of drug-testing among traffic drivers

[8.3.2] Provision of treatment after drug driving

[8.3.3] Policy of integrating treatment for drug use disorders into primary health care

[8.3.4] Training of health professionals: screening and brief intervention for drug use disorders

[8.3.5] Availability of a national treatment registry for drug use disorders

[8.3.6] Provision of publicly funded drug research and monitoring programs

I ALCOHOL CONSUMPTION INDICATORS

1.1 ALCOHOL CONSUMPTION: CORE INDICATORS

1.1.1 Recorded adult (15+ years) per capita consumption (in litres of pure alcohol)

Definition	Recorded adult per capita consumption is defined as the total consumption of recorded alcohol (measured in litres of pure alcohol) per person in the population (15+ years) in a 12 month period, which is based either on the country's production of alcohol, import and export data, or on sales/taxation data.
Possible data sources	Production, import, export, sales/taxation data, administrative reporting systems.
Numerator	The amount of recorded alcohol consumed (in litres of pure alcohol) during a calendar year, either from alcohol production, alcohol imports and exports, or from alcohol sales/taxation.
Denominator	Midyear resident population (15+ years), UN World Population Prospects, medium variant.
Measurement	Estimated amount of pure ethanol in litres of total alcohol, and separately, beer, wine and spirits consumed per person (15 years and older) in the country during a calendar year, as calculated from official statistics on production, sales, import and export, taking into account stocks whenever possible.
Suggested data collection frequency	Every 3 years.
Disaggregation	By type of alcoholic beverages (e.g. beer, wine, spirits, or any other alcoholic beverage), age, and sex.
Annotation	Recorded adult per capita consumptions captures recorded consumption, including consumption by tourists, which is deducted, where possible and relevant. It does not take into account unrecorded alcohol consumption (such as home made or informally produced alcohol, smuggled alcohol or alcohol obtained through cross border shopping). Recorded adult per capita consumption reports the alcohol consumption level of the adult population, irrespective of the number of abstainers (i.e. people who do not drink alcohol) in the country. Estimates of recorded adult per capita consumption in litres of pure alcohol are calculated either from data on alcohol production, import and export data, or from sales data. In order to disaggregate recorded adult per capita consumption by sex other data sources such as survey data are needed. The alcohol content of beer is considered to be 5%, wine 12% and spirits 40% by volume. Tourist consumption is relevant if there is a large difference between the amount of alcohol consumed by tourists in the country and the amount of alcohol consumed by residents while overseas.

1.1.2 Lifetime abstainers (15+ years)

Definition	The proportion of people in the population (15+ years) who did not consume an alcoholic drink (other than a few sips) during their lifetime.
Possible data source	Survey data.
Numerator	The number of lifetime abstainers (i.e. the number of persons in the population (15+years) who have not consumed an alcoholic drink during their lifetime).
Denominator	The total population (aged 15+ years).
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	Information regarding lifetime abstainers can be gained by asking respondents whether a standard alcoholic drink has ever been consumed during lifetime such as e.g. beer, wine, spirits, fermented cider or any other local alcoholic beverage.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age, sex, and relevant special population groups.
Annotation	<u>Indicator:</u> The number of alcohol lifetime abstainers quantifies the population aged 15 years and older in each country who did not drink a standard alcoholic drink during their lifetime. The indicator provides important information about the pattern of drinking in a population. <u>Data source:</u> Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex.

1.1.3 Past-year abstainers (15+ years)

Definition	The proportion of people in the population (15+ years) who did not consume an alcoholic drink (other than a few sips) during the past 12 months.
Possible data source	Survey data.
Numerator	The number of past-year abstainers (i.e. the number of persons in the population (15+ years) who have not consumed an alcoholic drink during the past 12 months).
Denominator	The total population (aged 15+ years).
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	Information regarding past-year abstainers can be gained by asking respondents whether an alcoholic drink such as beer, wine, spirits, fermented cider or any other local alcoholic beverage, has been consumed within the last 12 months.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age, sex, and relevant special population groups
Annotation	<u>Indicator:</u> The number of alcohol abstainers quantifies the population aged 15 years or older in each country who did not drink a standard alcoholic drink during the last 12 months. The indicator identifies the size of the alcohol consuming population and provides important information about the pattern of drinking in a population. <u>Data source:</u> Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex.

1.1.4 Heavy episodic drinking among adults (15+ years)

Definition	The proportion of the population (15+ years) who have had episodes of heavy drinking (equivalent of 60 grams pure alcohol or more) at least once per week on average over the past 12 months.
Possible data source	Survey data.
Numerator	Respondents who report to have had episodes of heavy drinking (equivalent of 60 grams pure alcohol or more) at least once per week on average over the past 12 months.
Denominator	The total population (aged 15+ years).
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	Information regarding heavy episodic drinking can be gained by asking respondents e.g. how often five or more standard alcoholic drinks have been consumed in a day during the last year (e.g. using the response options: every day, 5-6 times a week, 3-4 times a week, once or twice a week, 1-3 times a month, 3-11 times a year, once or twice a year, not at all in the last year, never), displaying examples of a standard alcohol drink in different drink classes.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age, sex, and relevant special population groups
Annotation	<u>Indicator:</u> The indicator identifies heavy episodic drinkers among the population 15+ years and provides important information about the pattern of drinking. <u>Standard alcoholic drink:</u> On average a standard alcoholic drink is containing 10-12 grams of pure alcohol. If the standard alcohol drink size is outside this range, then a different number of standard drinks, equating to 60 grams pure alcohol, should be used to indicate an episode of heavy drinking. <u>Data source:</u> Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex.

1.1.5 Drinking among adolescents during the last 12 months

Definition	Drinking among adolescents during the last 12 months is defined as the proportion of adolescents who report to have consumed alcohol (other than a few sips) during the last 12 months.
Possible data source	Survey data.
Numerator	The number of adolescents who have consumed an alcoholic beverage (other than a few sips) during the last 12 months.
Denominator	The total adolescent population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	By asking respondents whether an alcoholic beverage (other than a few sips) has been consumed during the last 12 months, or by asking more specifically about the number of occasions or times during the last 12 months in which an alcoholic beverage has been drunk.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age and sex.
Annotation	<u>Data source</u>: Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Study population</u>: According to WHO, adolescence is defined as the age period between 10-19 years of age.

1.1.6 Drinking among adolescents during the last 30 days

Definition	Drinking among adolescents during the last 30 days (i.e. current drinking) is defined as the proportion of adolescents who report to have consumed alcohol (other than a few sips) during the last 30 days.
Possible data source	Survey data.
Numerator	The number of adolescents who have drunk any alcoholic beverage (other than a few sips) during the last 30 days.
Denominator	The total adolescent population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	By asking respondents whether an alcoholic beverage (other than a few sips) has been consumed during the last 30 days, or by asking more specifically about the number of occasions, times or days during the past 30 days in which an alcoholic beverage has been consumed.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age and sex.
Annotation	<u>Data source:</u> Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Study population:</u> According to WHO, adolescence is defined as the age period between 10-19 years of age.

1.2 ALCOHOL CONSUMPTION: EXPANDED INDICATORS

1.2.1 Unrecorded adult (15+ years) per capita consumption (in litres of pure alcohol)

Definition	Unrecorded adult per capita consumption is defined as the total consumption of unrecorded alcohol (such as home or informally produced alcohol, smuggled alcohol or alcohol obtained through cross-border shopping) in litres of pure alcohol, per person (15+ years) per year.
Possible data sources	Representative surveys, specific empirical investigations, expert opinion.
Numerator	The amount of unrecorded alcohol consumed during a calendar year in litres of pure alcohol among the population 15+ years.
Denominator	Midyear resident population 15+ years for the same calendar year. UN World Population Prospects, medium variant.
Suggested data collection frequency	Every 3 years.
Annotation	<u>Indicator</u> : In many countries unrecorded alcohol consumption is an important source of consumption. Unrecorded adult per capita consumption complements the indicator on recorded adult per capita consumption. Adding unrecorded and recorded adult per capita consumption and deducting tourist consumption (if possible and relevant), estimates the total amount of alcohol consumed per person (15+ years) per year. Tourist consumption is relevant if there is a large difference between the amount of alcohol consumed by tourists in the country and the amount of alcohol consumed by residents while overseas.

1.2.2 Total (recorded and unrecorded) adult (15+ years) per capita consumption in (litres of pure alcohol)

Definition	Total adult per capita consumption is defined as the total amount of recorded and unrecorded alcohol consumed per person (15+ years) in litres of pure alcohol, per year.
Possible data sources	Production data, export, import, sales data (for recorded); representative surveys, specific empirical investigations, expert opinion (for unrecorded); administrative reporting systems.
Numerator	Recorded + unrecorded (- tourist consumption, if possible and relevant).
Denominator	Midyear resident population 15+ years for the same calendar year. UN World Population Prospects, medium variant.
Suggested data collection frequency	Every 3 years.
Disaggregation	By type of alcoholic beverage (e.g. beer, wine, spirits, any other alcoholic beverage).
Annotation	<u>Indicator:</u> Total adult per capita consumption in litres of pure alcohol captures the total amount of alcohol consumed within a country among the population 15+ years, considering recorded and unrecorded consumption. Total adult per capita consumption aggregates the total amount of alcohol consumed per person (15+ years) per country, irrespective of the abstaining population. Tourist consumption is relevant if there is a large difference between the amount of alcohol consumed by tourists in the country and the amount of alcohol consumed by residents while overseas.

1.2.3 Total (recorded and unrecorded) adult (15+ years) per capita consumption per drinker (in litres of pure alcohol)

Definition	Total adult per capita consumption per drinker is defined as the total amount of alcohol consumed per person who is drinking alcohol (15+ years) (including both recorded and unrecorded consumption) in litres of pure alcohol.
Possible data sources	Production data, export, import, sales data (for recorded); representative surveys, specific empirical investigations, expert opinion (for unrecorded); survey data for abstainer data.
Numerator	Recorded + unrecorded (- tourist consumption, if possible and relevant).
Denominator	The total population (15+ years) which is drinking alcohol (i.e. not abstaining).
Suggested data collection frequency	Every 3 years.
Disaggregation	By sex.
Annotation	<u>Indicator:</u> Total adult (15+ years) per capita consumption per drinker in litres of pure alcohol captures the total amount of alcohol consumed within a country, including both recorded and unrecorded consumption. Total adult per capita consumption per drinker aggregates the total amount of alcohol consumed per drinker per country. Tourist consumption is relevant if there is a large difference between the amount of alcohol consumed by tourists in the country and the amount of alcohol consumed by residents while overseas.

1.2.4 Lifetime abstainers among adolescents

Definition	The proportion of adolescents who have not consumed an alcoholic drink (other than a few sips) during their lifetime.
Possible data source	Survey data.
Numerator	The number of lifetime abstainers among adolescents (i.e. the number of adolescents who have not consumed an alcoholic drink during their lifetime).
Denominator	The total adolescent population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	Information regarding lifetime abstainers among adolescents can be gained by asking respondents whether they have ever consumed an alcoholic drink such as beer, wine, spirits, fermented cider, or any other local alcoholic beverage during their lifetime.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age and sex.
Annotation	<u>Indicator:</u> This indicator quantifies the adolescent population in each country who have not consumed an alcoholic drink during their lifetime. It separates out the drinking population and provides important information about the pattern of drinking among adolescents. <u>Data source:</u> Surveys should be fully representative of the adolescent general population, and/or weighted to account for the distribution of the population by age and sex.

1.2.5 Heavy episodic drinking among adolescents during the last 30 days

Definition	The proportion of adolescents who have had episodes of heavy drinking (equivalent of 60 grams pure alcohol or more) on one drinking occasion or on one day at least once during the last 30 days.
Possible data source	Survey data.
Numerator	Adolescents who report to have who have had episodes of heavy drinking (equivalent of 60 grams pure alcohol or more) on one drinking occasion (or in a day) at least once during the last 30 days.
Denominator	The total adolescent population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	Information regarding heavy episodic drinking among adolescents can be gained by asking respondents about the number of times e.g. 5 or more standard alcoholic drinks have been consumed on one drinking occasion during the last 30-days.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age and sex.
Annotation	<u>Data source:</u> Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Standard alcoholic drink:</u> On average a standard alcoholic drink is one containing 10-12 grams of pure alcohol. <u>Study population:</u> According to WHO, adolescence is defined as the period between 10-19 years of age.

1.2.6 Yesterday's alcohol consumption

Definition	The population distribution of yesterday's alcohol consumption ¹ .
Possible data source	Survey data.
Numerator	The number of people in the population (e.g. 15+ years) who abstained, had one standard drink, two standard drinks, three standard drinks, etc. on the day before the survey/interview was conducted.
Denominator	The total population (e.g. 15+ years).
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	Information about yesterday's alcohol consumption can be gained by asking respondents about the number of standard alcoholic drinks which they consumed "yesterday" (i.e. the day before the survey/interview was conducted).
Suggested collection frequency	Every 3 years.
Disaggregation	By age, sex, and relevant special population groups
Annotation	<u>Standard alcoholic drink</u> : On average a standard alcoholic drink is containing 10-12 grams of pure alcohol. <u>Data source</u> : Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex.

¹ As opposed to most of the other indicators in this document, there is no suggested cut off for monitoring the amount of consumption in the indicator on "Yesterday's Alcohol Consumption". Asking the question about yesterday's alcohol consumption will enable the plotting of a distribution which is then used in comparisons with other time points or other places.

1.2.7 Drinking frequency among adult drinkers during the last year (15+ years)

Definition	The frequency distribution of alcohol consumption among the population (15+ years) during the last year ² .
Possible data source	Survey data.
Numerator	The number of people within the population (15+ years) who are consuming any alcohol (more than a few sips) at different frequencies e.g. twice or more every day, once a day, 5-6 times a week, 3-4 times a week, 1-2 times a week, 1-3 times a month, 3-11 times a year, 1-2 times a year, not at all in the last year.
Denominator	The total population (15+ years).
Measurement	For all categories, numerator divided by the denominator and multiplied by 100. Population distribution of frequency categories.
Possible operationalization	Information on drinking frequency among the population (15+ years) can be gained by asking respondents how often alcoholic beverages have been drunk during the last year (e.g. twice or more every day, once a day, 5-6 times a week, 3-4 times a week, 1-2 times a week, 1-3 times a month, 3-11 times a year, 1-2 times a year, not at all in the last year).
Suggested data collection frequency	Every 3 years.
Disaggregation	By age, sex, and relevant special population groups
Annotation	<u>Data source</u> : Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex.

² As for the indicator on "Yesterday's Alcohol Consumption", this indicator is a distribution, not a single figure.

1.2.8 Very heavy drinking among adult drinkers (15+ years) during the last 12 months

Definition	The proportion of people among the adult population (15+ years) who have consumed more than 140 grams of alcohol (approximately 12 or more standard alcoholic drinks, depending on the definition of the standard drink used) on one drinking occasion or on any day during the last 12 months.
Possible data source	Survey data.
Numerator	The number of persons (15+ years) among the population who have consumed more than 140 grams of alcohol (approximately 12 or more standard alcoholic drinks, depending on the definition of the standard drink used) on one drinking occasion or on any day during the last 12 months.
Denominator	The total population (e.g. 15+ years).
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	Information about very heavy drinking can be gained by asking respondents about the number of times 12 or more standard drinks have been consumed on one drinking occasion during the last 12 months.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age, sex, and relevant special population groups
Annotation	<u>Data source</u>: Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Standard alcoholic drink</u>: On average a standard alcoholic drink is one containing 10-12 grams of pure alcohol.

1.2.9 Largest number of drinks consumed among adult drinkers (15+ years) during the last 12 months

Definition	The distribution of the average highest amount of alcohol consumed on any single day/occasion among the alcohol drinking population (15+ years) during the last 12 months.
Possible data source	Survey data.
Numerator	The number of people among the alcohol drinking population (15+ years) who consumed " <i>number of drinks</i> " (e.g. 1, 2, 3, 4, 5, 6, 10, 20 standard alcoholic drinks, etc), that being their highest number of drinks consumed on any single day/occasions during the last 12 months.
Denominator	The total population (15+ years) who is drinking alcohol (i.e. who is not abstaining).
Measurement	Numerator divided by the denominator and multiplied by 100 for each category of number of drinks. Population distribution of number of drinks.
Possible operationalization	Information on the largest number of drinks consumed on a single day among drinkers (15+ years) can be gained by asking respondents about the largest number of drinks which were consumed on a single day during the last 12 months.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age, sex, and relevant special population groups
Annotation	<u>Data source</u> : Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Standard alcoholic drink</u> : On average a standard alcoholic drink is one containing 10-12 grams of pure alcohol.

1.3 ALCOHOL CONSUMPTION: ADDITIONAL INDICATORS

1.3.1 Age at first drinking

Definition	Age at first drinking measures the age of drinking onset (other than a few sips only) among the population.
Possible data source	Survey data.
Numerator	The number of people in the population reporting to have had their first alcoholic drink at a certain age.
Denominator	The total population.
Measurement	Numerator divided by the denominator and multiplied by 100. Population distribution of ages of onset.
Possible operationalization	Information regarding the onset of drinking can be gained by asking respondents to name their age when the first drink of alcohol (other than a few sips) was consumed.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sex.
Annotation	<u>Indicator:</u> Age of first drinking elicits information about alcohol consumption among the population, and enables establishments of changing trends in alcohol initiation by collecting data consecutively. Age at first drinking is an important risk factor for later substance abuse problems and dependence. <u>Data source:</u> Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex.

1.3.2 Drinking with meals among adults (15+ years) during the last 30 days

Definition	Prevalence of drinking with meals is defined as the proportion of persons within the population (15+ years) who report to have consumed an alcoholic drink while having a meal during the last 30 days.
Possible data source	Survey data.
Numerator	The number of persons (15+ years) drinking alcohol while having a meal during the last 30 days.
Denominator	The total population (15+ years).
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	Information on drinking alcohol together with meals can be gained by asking respondents about the number of times an alcoholic drink was consumed while having a meal (i.e. a proper meal, not snacks) during the last 30 days.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age and sex.
Annotation	<u>Data source</u> : Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex.

II ALCOHOL-RELATED HARM INDICATORS

2.1 ALCOHOL-RELATED HARM: CORE INDICATORS

2.1.1 Age-standardized death rates for liver cirrhosis (per 100,000)

Definition	The number of people in the total population who died during a calendar year from liver cirrhosis. Death rates should be age-standardized by the WHO standard population, and reported per 100,000 people.
Possible data sources	Hospital record data (e.g. ICD-10 codes), national registers, death certificates.
Numerator	The number of liver cirrhosis deaths among the total population during a calendar year.
Denominator	Midyear resident population for the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator. The age-standardized mortality rates should be measured as a weighted average of the age-specific mortality rates per 100,000 persons. The weights are the proportions of persons in the corresponding age groups of the WHO standard population.
Suggested data collection frequency	Annually.
Disaggregation	By age and sex.
Annotation	<u>Indicator:</u> Liver cirrhosis is associated with long-term excessive alcohol consumption, and its prevalence in a given population can indirectly measure the number of persons dying due to heavy alcohol use.

2.1.2 Age-standardized death rate for road traffic accidents (per 100,000)

Definition	The number of people in the total population who died during a calendar year from road traffic accidents. Death rates should be age-standardized by the WHO standard population, and reported per 100,000 people.
Possible data sources	Hospital record data (e.g. ICD-10 codes), death certificate data, national registers, police record data.
Numerator	The number of road traffic deaths among the total population during a calendar year.
Denominator	Midyear resident population for the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator. The age-standardized mortality rates should be measured as a weighted average of the age-specific mortality rates per 100,000 persons. The weights are the proportions of persons in the corresponding age groups of the WHO standard population.
Suggested data collection frequency	Annually.
Disaggregation	By age and sex.
Annotation	<u>Indicator:</u> Fatal road traffic accidents measure the total amount of deaths due to road traffic accidents. Alcohol and drugs are frequently involved in fatal accidents with elevated blood alcohol levels being the main cause. The age-standardized death rate for road traffic accidents can therefore be considered as an indirect measure for alcohol and drug-related mortalities as road traffic accidents may also arise from other reasons besides alcohol.

2.2 ALCOHOL-RELATED HARM: EXPANDED INDICATORS

2.2.1 Alcohol-attributable years of life lost (YLL)

Definition	Alcohol-attributable years of life lost (YLL) is the average years lost due to alcohol-related deaths, summing the number of years each person dying from an alcohol-related cause would have lived, if they had not died prematurely due to alcohol.
Possible data source	Mortality data.
Measurement	$YLL = \sum \text{alcohol-attributable death} \times \text{remaining life-expectancy}$
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By disease category (e.g. cancer, neuropsychiatric disorders, unintentional injuries, intentional injuries, cardiovascular diseases, cirrhosis of the liver). By sex.
Annotation	For comparability, rates of YLL per 1,000 or standardized rates of YLL per 1,000 should be calculated as well. For public health purposes, often discounted YLLs are used.

2.2.2 Age-standardized death rate for poisoning (per 100,000)

Definition	The number of people in the total population who died during a calendar year from poisoning. Death rates should be age-standardized by the WHO standard population, calculated by 100,000 people.
Possible data sources	Hospital record data (e.g. ICD-10 codes), death certificate data, national registers.
Numerator	The number of deaths from poisoning among the total population during a calendar year.
Denominator	Midyear resident population for the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator. The age-standardized mortality rates should be measured as a weighted average of the age-specific mortality rates per 100,000 persons. The weights are the proportions of persons in the corresponding age groups of the WHO standard population.
Suggested data collection frequency	Annually.
Disaggregation	By age and sex.
Annotation	<u>Indicator:</u> Deaths due to fatal poisoning can be used as an indirect indicator for alcohol and drug-related overdose resulting in mortality, since the ICD-10 codes for poisoning do also consider other poisonings due to other toxic substances, besides overdose of alcohol and drugs.

2.2.3 Age-standardized death rate for violence (per 100,000)

Definition	The number of people in the total population who died during a calendar year from acts of violence (i.e. physical violence). Death rates should be age-standardized by the WHO standard population, and reported per 100,000 people.
Possible data sources	Hospital record data (e.g. ICD-10 codes), death certificate data, national registers.
Numerator	The number of deaths from physical violence among the total population during a calendar year.
Denominator	Midyear resident population for the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator. The age-standardized mortality rates should be measured as a weighted average of the age-specific mortality rates per 100,000 persons. The weights are the proportions of persons in the corresponding age groups of the WHO standard population.
Suggested data collection frequency	Annually.
Disaggregation	By age and sex.
Annotation	<u>Indicator:</u> Deaths due to acts of violence measures the total amount of deaths due to physical violence. The intake of alcohol or drugs can facilitate involvements in physical violence, being a perpetrator or a victim. The age-standardized death rate for physical violence can be considered as an indirect measure for alcohol and drug-related mortalities.

2.2.4 Age-standardized death rates for alcoholic liver cirrhosis (per 100,000)

Definition	The number of people in the total population who died during a calendar year from alcoholic liver cirrhosis. Death rates should be age-standardized by the WHO standard population, and reported per 100,000 people.
Possible data sources	Hospital record data (e.g. ICD-10 codes), national registers, death certificates.
Numerator	The number of alcoholic liver cirrhosis deaths among the total population during a calendar year.
Denominator	Midyear resident population for the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator. The age-standardized mortality rates should be measured as a weighted average of the age-specific mortality rates per 100,000 persons. The weights are the proportions of persons in the corresponding age groups of the WHO standard population.
Suggested data collection frequency	Annually.
Disaggregation	By age and sex.
Annotation	<u>Indicator:</u> Alcoholic liver cirrhosis is associated with long-term excessive alcohol consumption, and its prevalence in a given population reflects the number of persons dying from heavy alcohol use. Alcoholic liver cirrhosis needs to be separated from other unspecified liver cirrhosis, and figures might suffer from underreporting due to false diagnosis and/or incomplete death certificates.

2.2.5 Age-standardized death rate for alcohol-related road traffic accidents (per 100,000)

Definition	The number of people in the total population who died during a calendar year from alcohol-related road traffic accidents. Death rates should be age-standardized by the WHO standard population, and reported per 100,000 persons.
Possible data sources	Police record data, national registers.
Numerator	The number of alcohol-related road traffic deaths among the total population during a calendar year.
Denominator	Midyear resident population for the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator. The age-standardized mortality rates should be measured as a weighted average of the age-specific mortality rates per 100,000 persons. The weights are the proportions of persons in the corresponding age groups of the WHO standard population.
Suggested data collection frequency	Annually.
Disaggregation	By age and sex.
Annotation	<u>Indicator:</u> Alcohol-related road traffic accidents measure the total amount of deaths due to alcohol-related road traffic accidents solely. Alcohol and drugs are frequently involved in fatal accidents with elevated blood alcohol levels being the main cause. The age-standardized death rate for road traffic accidents can therefore be considered as a direct measure for alcohol and drug-related mortalities.

2.2.6 Age-standardized death rate for alcoholic poisoning (per 100,000)

Definition	The number of people in the total population who died during a calendar year from alcoholic poisoning. Death rates should be age-standardized by the WHO standard population, and reported per 100,000 persons.
Possible data sources	Hospital record data (e.g. ICD-10 codes), death certificate data, national registers.
Numerator	The number of deaths from alcoholic poisoning among the total population during a calendar year.
Denominator	Midyear resident population for the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator. The age-standardized mortality rates should be measured as a weighted average of the age-specific mortality rates per 100,000 persons. The weights are the proportions of persons in the corresponding age groups of the WHO standard population.
Suggested data collection frequency	Annually.
Disaggregation	By age and sex.
Annotation	<u>Indicator:</u> Deaths due to fatal alcoholic poisoning can be used as a direct indicator of alcohol-related overdose resulting in mortality.

2.2.7 Age-standardized death rate for alcohol-related violence (per 100,000)

Definition	The number of people in the total population who died during a calendar year from acts of alcohol-related violence (i.e. physical violence due to alcohol consumption). Death rates should be age-standardized by the WHO standard population, and reported per 100,000 persons.
Possible data sources	Hospital record data (e.g. ICD-10 codes), death certificate data, national registers.
Numerator	The number of deaths from alcohol-related violence among the total population during a calendar year.
Denominator	Midyear resident population for the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator. The age-standardized mortality rates should be measured as a weighted average of the age-specific mortality rates per 100,000 persons. The weights are the proportions of persons in the corresponding age groups of the WHO standard population.
Suggested data collection frequency	Annually.
Disaggregation	By age and sex.
Annotation	<u>Indicator:</u> Deaths due to alcohol-related violence can be considered as a direct indicator of alcohol-related mortality.

2.2.8 Alcohol dependence, 12 month prevalence

Definition	The proportion of people in the population (15+ years) with alcohol dependence as defined by ICD-10.
Possible data sources	Diagnostic interviews, treatment data, data from household surveys for indirect prevalence estimates.
Numerator	The number of people in the population (15+ years) who are dependent on alcohol.
Denominator	Midyear resident population (15+ years) over the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age, sex, and special population groups.
Annotation	In the absence of data on alcohol dependence, data on daily use of alcohol can be reported considering also the quantity of alcohol consumed per day.

2.2.9 Alcohol use disorders, 12 month prevalence

Definition	The proportion of people in the population (15+ years) during a calendar year who are suffering from either alcohol dependence or harmful use of alcohol as defined by ICD-10.
Possible data sources	Diagnostic interviews, treatment data, data from household surveys for indirect prevalence estimates.
Numerator	The number of people in the population (15+ years) with alcohol use disorders.
Denominator	Midyear resident population (15+ years) over the same calendar year. UN World Population Prospects, medium variant.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age, sex, and special population groups.
Annotation	In the absence of data on alcohol use disorders, data on daily use of alcohol can be reported considering also the quantity of alcohol consumed per day.

2.3 ALCOHOL-RELATED HARM: ADDITIONAL INDICATORS

2.3.1 Prevalence of fetal alcohol syndrome (FAS)

Definition	The number of newborns' diagnosed with fetal alcohol syndrome in the population as defined by ICD-10.
Possible data sources	Hospital record data (e.g. ICD-10 codes), national registers.
Numerator	The number of FAS cases among the newborn during a calendar year.
Denominator	The total number of newborn during a calendar year.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3 years.
Disaggregation	By the age and the socio-economic status of the mother.

2.3.2 Social cost attributable to alcohol consumption

Definition	Social cost attributable to alcohol consumption comprises the total amount of economic costs to the society as a whole attributable to the negative effects of alcohol consumption.
Possible data sources	National authorities or special research studies measuring e.g. "health care costs", "law enforcement costs", "other direct social costs" (e.g. property damage and loss), "direct administrative costs" or "social work services" and "other indirect costs" attributable to alcohol consumption.
Suggested data collection frequency	Every 3 years.
Annotation	For further information on social cost attributable to alcohol consumption: Single, E., Collins, D., Easton, B., Harwood, H., Lapsley, H., Kopp, P., Wilson, E. (2003). International Guidelines for Estimating the Costs of Substance Abuse. Second Edition. Geneva, World Health Organization.

2.3.3 Disease burden of alcohol-related harm to others (DALYs)

Definition	The burden of disease to persons affected by the alcohol consumption of others (e.g. the effects of drinking on the health of others, on violence and injuries, on family life), measures in DALYs.
Possible data sources	Special research studies, surveys.
Measurement	$DALY = YLL + YLD$ $YLL = \sum \text{alcohol-attributable death} \times \text{remaining life-expectancy}$ $YLD = I$ [the number of incident cases for the reference period] $\times DW$ [the disability weight in the range 0 – 1] $\times L$ [the average duration of disability (measured in years)].
Suggested data collection frequency	Every 3 years.
Disaggregation	By age and sex.
Annotation	For comparison purposes, DALYs are often expressed as a rate or a standardized rate.

2.3.4 Proportion of infectious diseases attributable to alcohol consumption

Definition	The proportion of infectious diseases (HIV, TB, pneumonia) which is attributable to alcohol consumption.
Possible data sources	Special research studies.
Measurement	Alcohol-attributable fractions: Calculated from the prevalence of drinking in the society and the relative risk for the infectious disease (e.g. HIV, TB, pneumonia) associated with drinking alcohol.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age, sex, and the type of infectious disease.

2.3.5 Alcohol-attributable disability-adjusted life years (DALYs)

Definition	Alcohol-attributable "Disability-Adjusted Life Years" (DALYs) is a measure of overall disease and injury burden and quantifies mortality and morbidity due to alcohol consumption in a single disease measure.
Possible data sources	Mortality data, disease incidence by age and sex, age of disease onset, disease duration in years, and degree of disability.
Measurement	$DALY = YLL + YLD$ $YLL = \sum \text{alcohol-attributable death} \times \text{remaining life-expectancy}$ $YLD = I$ [the number of incident cases for the reference period] $\times DW$ [the disability weight in the range 0 – 1] $\times L$ [the average duration of disability (measured in years)].
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By age and sex.
Annotation	For comparison purposes, the DALYs are often expressed as a rate or a standardized rate. Alcohol-attributable "Disability-Adjusted Life Years" excludes the disease burden of alcohol-related harm to others (see indicator 2.3.3).

III ALCOHOL TREATMENT INDICATORS

3.1 ALCOHOL TREATMENT: CORE INDICATORS

3.1.1 Availability of pharmacological treatment for alcohol use disorders in primary health care

Definition	Presence and integration of pharmacological treatment for alcohol use disorders in primary health care in the country.
Possible data sources	National authorities, service providers.
Suggested data collection frequency	Annually.
Disaggregation	By sub national-region.

3.1.2 Beds for alcohol use disorders (per 100,000)

Definition	The number of inpatient beds available for treatment of alcohol use disorders.
Possible data sources	National authorities, service providers.
Numerator	Total number of alcohol-specific inpatient beds.
Denominator	Midyear resident population (15+ years), UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator. Data presented by 100,000 persons.
Suggested data collection frequency	Annually.
Disaggregation	By settings (e.g. general hospital, mental hospital, specialized treatment services, etc).

3.2 ALCOHOL TREATMENT: EXPANDED INDICATORS

3.2.1 Outpatient treatment slots for alcohol use disorders (per 100,000)

Definition	The number of patients that can be seen in the treatment system as an outpatient at any given time.
Possible data sources	National authorities, service providers.
Numerator	The total number of outpatient treatment slots for alcohol use disorders.
Denominator	Midyear resident population for the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator. Data presented by 100,000 persons.
Suggested data collection frequency	Annually.

3.2.2 Waiting period to receive alcohol detoxification treatment

Definition	Average number of days a patient has to wait to receive alcohol detoxification treatment.
Possible data sources	National surveys on waiting time, service providers, national authorities. The average number of days a person has to wait before receiving alcohol detoxification treatment, from when they first contact a treatment agency to the first day of detoxification.
Suggested data collection frequency	Annually.
Disaggregation	By treatment setting: by inpatient treatment; by outpatient treatment.
Annotation	To differentiate alcohol detoxification from regular short-term treatment for alcohol dependence, alcohol detoxification treatment is defined here in time lasting from less than a week until 10 days at most.

3.2.3 Waiting period to receive short-term treatment for alcohol dependence

Definition	The average number of days a patient has to wait to receive short-term treatment for alcohol dependence.
Possible data sources	National surveys on waiting times, service providers, national authorities. The average number of days a person has to wait before receiving short-term treatment for alcohol dependence, from when the person first contacts the agency to when treatment commences.
Suggested data collection frequency	Annually.
Disaggregation	By treatment setting: by inpatient treatment; by outpatient treatment.
Annotation	Short-term treatment for alcohol dependence is defined here as treatment lasting up to 4 months.

3.2.4 Waiting period to receive long-term care and after care for alcohol dependence

Definition	The average number of days a patient has to wait to receive long-term care and after care for alcohol dependence.
Possible data sources	National surveys on waiting times, service providers, national authorities. The average number of days a person has to wait before receiving long-term care and after care for alcohol dependence, from when the person first contacts the agency to when treatment commences.
Suggested data collection frequency	Annually.
Disaggregation	By treatment setting: by inpatient treatment; by outpatient treatment.
Annotation	Long-term care and after care for alcohol dependence is defined here as treatment lasting 4 months and longer.

3.2.5 Inpatient treatment admissions due to alcohol use disorders

Definition	The proportion of all inpatient treatment admissions due to alcohol use disorders in the population accumulating within a calendar year.
Possible data sources	Hospital data/records, national registers, service providers.
Numerator	The number of inpatient treatment admissions due to alcohol use disorders during a calendar year.
Denominator	Midyear resident population (15+ years), UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Annually.
Disaggregation	By age and sex. By treatment settings (e.g. Specialized treatment centres, mental hospitals, general hospitals).
Annotation	<u>Indicator:</u> The number of inpatient treatment admissions for alcohol use disorders during a calendar year is susceptible to double-counting as the same person can be admitted several times to different inpatient treatment facilities within a country. Although the term "admission" is used in the title, often it is the separation or discharge which is measured.

3.3 ALCOHOL TREATMENT: ADDITIONAL INDICATORS

3.3.1 Screening and brief intervention for alcohol use disorders

Definition	The presence and routine provision of screening and brief interventions for alcohol use disorders within the health care system at the national or sub-national level.
Possible data sources	National authorities, service providers, national surveys.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.
Annotation	Screening and brief interventions for alcohol use disorders is a measure of health promotion and disease prevention.

3.3.2 Availability of workplace alcohol prevention or counselling programs (for employees with alcohol problems)

Definition	Systematic availability of workplace alcohol prevention or counselling programs (i.e. for employees with alcohol problems including harmful use of alcohol and alcohol dependence).
Possible data sources	National authorities, service providers, national surveys.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.
Annotation	Workplace alcohol prevention programmes can be said to be available when most workplaces with more than a few employees have some alcohol prevention or counselling programmes in place.

3.3.3 Availability of pharmacological treatment for the management of alcohol use disorders

Definition	National availability of medication used for the treatment of alcohol use disorders within the country. This indicator should be disaggregated by types of pharmacotherapy. Pharmacotherapy for alcohol use disorders may include the following: benzodiazepines for detoxification, acamprosate, naltrexone, disulfiram.
Possible data sources	National authorities, survey providers, national surveys.
Suggested data collection frequency	Every 3 years.
Disaggregation	By type of medication and sub-national region.

3.3.4 HIV-testing among persons in treatment for alcohol use disorders

Definition	The proportion of persons who were tested for HIV/AIDS while being treated for alcohol use disorders during a calendar year.
Possible data sources	National authorities, service providers, national surveys.
Numerator	Number of persons who were tested for HIV/AIDS while being treated for alcohol use disorders during a calendar year.
Denominator	Number of persons in treatment for alcohol use disorders during a calendar year.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age and sex.

3.3.5 Counselling to family members with alcohol problems

Definition	The proportion of families with alcohol problems in which one or more family members (e.g. children, adolescents, adults) received counselling during a calendar year, because of the other family member's alcohol use disorder.
Possible data sources	Service providers, national authorities, national surveys.
Numerator	The total number of families with alcohol problems from which one or more family members (e.g. children, adolescents, adults) received counselling one or more times during a calendar year because of the other family member's alcohol problem.
Denominator	Estimated number of families with alcohol problems.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age and sex.

3.3.6 Counselling to pregnant women with alcohol use disorders or alcohol problems

Definition	The proportion of pregnant women with alcohol use disorders in the total population (e.g. harmful use of alcohol, or alcohol dependence) who received counselling during a calendar year.
Possible data sources	Service providers, national authorities, national surveys.
Numerator	The total number of pregnant women with alcohol use disorders (harmful use of alcohol, or alcohol dependence) who received counselling one or more times during a calendar year.
Denominator	Estimated number of pregnant women with alcohol use disorders.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3 years.
Disaggregation	By age.

3.3.7 Percentage of persons who have seen a treatment provider and who have been asked about their alcohol problems

Definition	The proportion of persons who were in primary health care treatment during a calendar year and who were asked by the treating health professional about problems related to alcohol use.
Possible data sources	National authorities, service providers, national surveys.
Numerator	Number of persons who were in primary health care treatment during a calendar year and who were asked about problems related to alcohol use.
Denominator	Number of persons who were in primary care treatment during a calendar year.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3 years.

3.3.8 Availability of gender-specific treatment services for alcohol and drug use disorders within the health care system

Definition	Availability of gender-specific treatment services for alcohol and drug use disorders within the health-care system (e.g. availability of gender-specific treatment programmes for women which are tailored and respond to their specific needs).
Possible data sources	National authorities, service providers.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.

IV ALCOHOL POLICY INDICATORS

4.1 ALCOHOL POLICY: CORE INDICATORS

4.1.1 Presence of a total ban of alcohol

Definition	A total ban of alcohol is defined as the governmental prohibition of production, transportation, sales and consumption of alcohol.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.

4.1.2 Availability of a written national policy on alcohol

Definition	Presence of a written national policy on alcohol in the country. An alcohol policy is defined by an organized set of values, principles and objectives for reducing the burden attributable to alcohol consumption in the population.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.

4.1.3 National maximum legal blood alcohol concentration (BAC) when driving a vehicle for the general population

Definition	The maximum legal concentration of alcohol in a person's blood (measured as mass per volume) allowed while driving a vehicle for the general population.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.

4.1.4 Excise-tax on alcoholic beverages

Definition	Existence and level of excise tax (i.e. the amount of tax charged on alcohol, in terms of percentage of the retail price) imposed on alcohol products.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By type of alcoholic beverage (e.g. beer, wine, spirits, other).

4.1.5 Availability of special legislative provisions pertaining to treatment and rehabilitation of persons with alcohol use disorders

Definition	Presence of special legislative provisions in the country which pertain to treatment and rehabilitation of persons with alcohol use disorders. Special legislative provisions for alcohol treatment and rehabilitation can exist on their own, or can be integrated or be a part of the general health legislation (or mental health legislation, or social care legislation).
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.

4.1.6 Availability of policy documents regulating pharmacological treatment of alcohol use disorders

Definition	Availability of policy documents in the country which regulate the pharmacological treatment of alcohol use disorders. Documents on pharmacological treatment of alcohol use disorders can exist as a part of an overall document on treatment of substance use disorders, or can be focused on the pharmacological treatment of alcohol use disorders only.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.

4.2 ALCOHOL POLICY: EXPANDED INDICATORS

4.2.1 Presence of a multisectoral alcohol policy

Definition	Presence of a written policy on alcohol in the country, which is multisectoral in nature (i.e. an alcohol policy which involves and is represented by multiple sectors such as the health sector, the social sector, the justice sector, education, employment, law enforcement, etc). An alcohol policy is defined by an organized set of values, principles and objectives for reducing the burden attributable to alcohol consumption in the population.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.

4.2.2 National maximum legal blood alcohol concentration (BAC) when driving a vehicle for young/novice drivers

Definition	The maximum legal concentration of alcohol in a person's blood (measured as mass per volume) allowed while driving a vehicle for young/novice drivers.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.

4.2.3 National maximum legal blood alcohol concentration (BAC) when driving a vehicle for professional/commercial drivers

Definition	The maximum legal concentration of alcohol in a person's blood (measured as mass per volume) allowed while driving a vehicle for professional/commercial drivers.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.

4.3 ALCOHOL POLICY: ADDITIONAL INDICATORS

4.3.1 Provision of consumer information on alcohol's impact on health at points of alcohol sale (supermarkets, pubs/bars)

Definition	Provision of consumer information on the impact of drinking alcohol on health in places where alcohol is sold and/or served.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.

4.3.2 Provision of server training

Definition	Provision of server training on a regular basis (i.e. to alcohol servers in bars, pubs and restaurants) to reduce the harm due to alcohol and to prevent intoxication, drink driving and sales to minors.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.

4.3.3 Training of health professionals: screening and brief intervention for alcohol use disorders

Definition	Systematic provision of training to health professionals for screening and brief interventions for alcohol problems and alcohol use disorders.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.

4.3.4 Provision of community based interventions/projects involving non-governmental organizations

Definition	Systematic provision (i.e. at local, regional, or federal level) of community-based projects for the prevention and treatment of alcohol use disorders involving stakeholders such as non-governmental organizations.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.

4.3.5 Provision of interventions/projects actively involving young persons and the civil society

Definition	Systematic provision (i.e. at the local, regional, or federal level) of interventions/projects addressing alcohol use which are actively involving young persons and the civil society in the country.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.

4.3.6 School-based programmes which prevent the harmful use of alcohol

Definition	Systematic provision (i.e. at the local, regional, or federal level) of school-based educational programmes which have been shown to reduce levels of student's alcohol use and related harm.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.
Annotation	Although there are effective school-based programmes which have been shown to prevent the harmful use of alcohol, evaluation of many other school based programmes has shown them to be ineffective. To meet this criteria, there should be the systematic implementation of programmes with proven effectiveness, allowing for cross-cultural adaptations.

4.3.7 Presence of a treatment registry for alcohol use disorders

Definition	Presence of a government treatment registry for alcohol use disorders in the country.
Possible data source	National and sub-national authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.

4.3.8 Provision of publicly funded alcohol research and monitoring programs

Definition	Provision of publicly funded alcohol research and monitoring programs at the national or regional level.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.

4.3.9 National legal minimum age for off-premise sales of alcoholic beverages

Definition	The legal minimum age for off-premise sales of alcoholic beverages is defined as the age at which a person can be sold alcoholic beverages by off premises alcohol outlets, i.e. alcoholic beverages cannot be sold to a person under this age.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region, by type of alcoholic beverage (beer, wine, spirits).
Annotation	Off-premise sale: Consumers buy products for later consumption away from the point of sale (e.g. store, shop, supermarket).

4.3.10 National legal minimum age for on-premise sales of alcoholic beverages

Definition	The legal minimum age for on-premise sales of alcoholic beverages is defined as the age at which a person can be served alcoholic beverages on premises, i.e. alcoholic beverages cannot be served to a person under this age.
Possible data source	National authorities.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region, by type of alcoholic beverage (beer, wine, spirits).
Annotation	On-premise sale: Consumers buy products for immediate consumption at the point of sale (e.g. cafe, pub, bar, restaurant).

4.3.11 Administrative fines and license suspension for drink driving

Definition	Provision of administrative fines with license suspension (i.e. administered at the regional or national level) imposed on the driver for disregarding drink-driving laws (e.g. for driving a vehicle when alcohol was consumed).
Possible data sources	National authorities, police data.
Suggested data collection frequency	Every 3 years.
Disaggregation	By sub-national region.
Annotation	The impact on administrative fines with license suspension might be reflected in the number of road-traffic deaths occurring within the country since the adoption of the policy measure (i.e. administrative fines with license suspension). The total numbers of road-traffic deaths might then be compared to the total number of road-traffic deaths which occurred the years before the adoption of the policy measure (administrative fines with license suspension). However, if several other policy measures were implemented concurrently (besides license suspension), road traffic deaths need to be adjusted for the influence of those other policy measures.

V DRUG CONSUMPTION INDICATORS

5.1 DRUG CONSUMPTION: CORE INDICATORS

5.1.1 Drug use ("by drug category") among adults (15-64 years) during their lifetime

Definition	The proportion of the population (15-64 years) who ever used ("type of drug by drug category") during their lifetime. [Note: Separate indicators may be created for each type of drug. The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug]
Possible data source	Survey data, treatment data, registry data, indirect prevalence estimates.
Numerator	The number of persons in the population (15-64 years) having ever used ("type of drug") during their lifetime.
Denominator	The total population (15-64 years).
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	By asking respondents whether ("type of drug") has ever been used during their lifetime.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of drug, age, sex, and any special population groups.
Annotation	<u>Data source</u> : Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Drug categories</u> : The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug. People should be counted once, according to their main category of non-medical drug use.

5.1.2 Drug use ("by drug category") among adults (15-64 years) during the last 12 months

Definition	The proportion of the population (15-64 years) who consumed ("type of drug by drug category") during the last 12 months. [Note: Separate indicators may be created for each type of drug. The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug]
Possible data source	Survey data, treatment data, registry data, indirect prevalence estimates.
Numerator	The number of persons (15-64 years) in the population consuming ("type of drug") at least once during the last 12 months.
Denominator	The total population (15-64 years).
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	By asking respondents whether ("type of drug") has ever been used during the last 12 months, or by enquiring more specifically about the number of times ("type of drug") has been used during the last 12 months.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of drug, age, sex, and any special population groups.
Annotation	<u>Indicator:</u> Compared to lifetime drug use, 12 month prevalence of drug use is generally more useful because it reflects more current patterns of use rather than use that may have occurred many years ago. Lifetime prevalence estimates are also likely to be affected by recall and other biases as persons grow older. <u>Data source:</u> Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Drug categories:</u> The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug. People should be counted once, according to their main category of non-medical drug use.

5.1.3 Drug use ("by drug category") among adults (15-64 years) during the last 30 days

Definition	The proportion of the population (15-64 years) who consumed ("type of drug by drug category") during the last 30 days. [Note: Separate indicators may be created for each type of drug. The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug]
Possible data source	Survey data, treatment data, registry data, indirect prevalence estimates.
Numerator	The number of persons (15-64 years) in the population consuming ("type of drug") at least once during the last 30 days.
Denominator	The total population (15-64 years).
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	By asking respondents whether ("type of drug") has ever been used during the last 30 days, or by enquiring more specifically about the number of times or days ("type of drug") has been used during the last 30 days.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of drug, age, sex, and any special population groups.
Annotation	<u>Indicator:</u> Compared to 12 month prevalence, prevalence of past 30-days drug use provides more information about current and/or regular drug use in a given population. <u>Data source:</u> Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Drug categories:</u> The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug. People should be counted once, according to their main category of non-medical drug use.

5.1.4 Drug use ("by drug category") among adolescents during the last 12 months

Definition	The proportion of the adolescent population who consumed ("type of drug by drug category") during the last 12 months. [Note: Separate indicators may be created for each type of drug. The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug]
Possible data source	Survey data, treatment data, registry data, indirect prevalence estimates.
Numerator	The number of adolescents in the population consuming ("type of drug") at least once during the last 12 months.
Denominator	The total adolescent population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	By asking respondents whether ("type of drug") has ever been used during the last 12 months, or by enquiring more specifically about the number of times ("type of drug") has been used during the last 12 months.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of drug, age, and sex.
Annotation	<u>Indicator:</u> 12 month prevalence of drug use gives a more accurate indication of drug consumption within a given population as lifetime prevalence captures also adolescents who have experimented drugs for only a few times in life (or a long time ago). <u>Data source:</u> Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Study population:</u> According to WHO, adolescence is defined as the period between 10-19 years of age. <u>Drug categories:</u> The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug. People should be counted once, according to their main category of non-medical drug use.

5.1.5 Use of any illicit drug among adults (15-64 years) during their lifetime

Definition	The proportion of the population (15-64 years) who ever used any illicit drug during their lifetime.
Possible data source	Survey data, treatment data, registry data, indirect prevalence estimates.
Numerator	The number of persons in the population (15-64 years) having ever used any illicit drug during their lifetime.
Denominator	The total population (15-64 years).
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	By asking respondents whether any illicit drug such as (<i>"list different type of illicit drugs"</i>) have ever been used during lifetime.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of drug, age, sex, and any special population groups.
Annotation	<u>Data source</u> : Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex.

5.1.6 Injecting drug use (IDU) among adults (15-64 years) during the last 12 months

Definition	The proportion of the population (15-64 years) who have injected drugs one or more times during the last 12 months.
Possible data sources	Research studies (indirect prevalence estimation), treatment data, registry data.
Numerator	The number of persons (15-64 years) in the population who have injected drugs one or more times during the last 12 months.
Denominator	Midyear resident population (15+ years) over the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of drug, age, sex, and any special population groups.

5.2 DRUG CONSUMPTION: EXPANDED INDICATORS

5.2.1 Drug use ("by drug category") among adolescents during the last 30 days

Definition	The proportion of the adolescent population who consumed ("type of drug by drug category") during the last 30 days. [Note: Separate indicators may be created for each type of drug. The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1 heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug]
Possible data source	Survey data, treatment data, registry data, indirect prevalence estimates.
Numerator	The number of adolescents in the population consuming ("type of drug") at least once during the last 30 days.
Denominator	The total adolescent population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	By asking respondents whether ("type of drug") has ever been used during the last 30 days, or by enquiring more specifically about the number of times or days ("type of drug") has been used during the last 30 days.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of drug, age, and sex.
Annotation	<u>Data source</u> : Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Study population</u> : According to WHO, adolescence is defined as the age period between 10-19 years of age. <u>Drug categories</u> : The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug. People should be counted once, according to their main category of non-medical drug use.

5.2.2 Cannabis use among adolescents during the last 30 days

Definition	The proportion of the adolescent population who consumed cannabis during the last 30 days.
Possible data source	Survey data, treatment data, registry data, indirect prevalence estimates.
Numerator	The number of adolescents in the population consuming cannabis at least once during the last 30 days.
Denominator	The total adolescent population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	By asking respondents whether cannabis has ever been used during the last 30 days, or by enquiring more specifically about the number of times or days cannabis has been used during the last 30 days.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By age and sex.
Annotation	<u>Data source</u> : Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Study population</u> : According to WHO, adolescence is defined as the age period between 10-19 years of age.

5.2.3 Injecting drug use (IDU) among adults (15-64 years) during the last 30 days

Definition	The proportion of the population (15-64 years) who have injected drugs one or more times during the last 30 days.
Possible data sources	Research studies (indirect prevalence estimation), treatment data, registry data.
Numerator	The number of persons (15-64 years) in the population who have injected drugs one or more times during the last 30 days.
Denominator	Midyear resident population (15+ years) over the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By age, sex, and any special population groups.

5.2.4 Drug use ("by drug category") among the elderly (64+ years) during the last 12 months

Definition	The proportion of the population (64+ years) who consumed ("type of drug by drug category") during the last 12 months. [Note: Separate indicators may be created for each type of drug. The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug]
Possible data source	Survey data, treatment data, registry data, indirect prevalence estimates.
Numerator	The number of persons (64+ years) in the population consuming ("type of drug") at least once during the last 12 months.
Denominator	The total population (64+ years).
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	By asking respondents whether ("type of drug") has ever been used during the last 12 months, or by enquiring more specifically about the number of times ("type of drug") has been used during the last 12 months.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of drug, age, sex, and any special population groups.
Annotation	<u>Data source</u> : Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Drug categories</u> : The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug. People should be counted once, according to their main category of non-medical drug use.

5.2.5 Drug use ("by drug category") among the elderly (64+ years) during the last 30 days

Definition	The proportion of the population (64+ years) who consumed ("type of drug by drug category") during the last 30 days. [Note: Separate indicators may be created for each type of drug. The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug]
Possible data source	Survey data, treatment data, registry data, indirect prevalence estimates.
Numerator	The number of persons (64+ years) in the population consuming ("type of drug") at least once during the last 30 days.
Denominator	The total population (64+ years).
Measurement	Numerator divided by the denominator and multiplied by 100.
Possible operationalization	By asking respondents whether ("type of drug") has ever been used during the last 30 days, or by enquiring more specifically about the number of times or days ("type of drug") has been used during the last 30 days.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of drug, age, sex, and any special population groups.
Annotation	<u>Data source:</u> Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Drug categories:</u> The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug. People should be counted once, according to their main category of non-medical drug use.

5.3 DRUG CONSUMPTION: ADDITIONAL INDICATORS

5.3.1 Age at first drug use

Definition	Distribution of the age at first drug use among the population [Note: Separate indicators may be created for each type of drug (<i>e.g. any drug, and/or cannabis, or other type of drugs</i>).]
Possible data source	Survey data.
Numerator	The number of persons in the population reporting to have used drugs (<i>e.g. any drug, or any single drug like e.g. cannabis or any other type of drug</i>) at a certain age.
Denominator	The total population.
Measurement	Numerator divided by the denominator and multiplied by 100. Population distribution of ages of onset.
Possible operationalization	Information regarding the onset of drug use among the population can be gained by asking respondents to name their age when drug(s) (<i>e.g. any drug, or any single drug like e.g. cannabis or any other type of drug</i>) has/have been used for the first time.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By age and sex.
Annotation	<u>Indicator:</u> Age of first drug use elicits information about drug use among the population, and enables establishments of changing trends in drug initiation by collecting data consecutively. Age at first drug use is an important risk factor for later substance abuse problems and dependence. <u>Data source:</u> Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Drug categories:</u> The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug.

5.3.2 Perception about availability of drugs ("by drug category") among adolescents

Definition	Perception about availability of drugs is defined as the perceived access of drugs (i.e. perceived difficulty of obtaining drugs) among adolescents. This indicator is the distribution of perceived availability for each drug type. [Note: Separate indicators may be created for each type of drug. The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug specified]
Possible data source	Survey data.
Numerator	The number of adolescents in the population who feel that it would be (e.g. probably impossible, very difficult, fairly difficult, fairly easy) to obtain drug (s) ("by drug category") if they wanted to.
Denominator	The total adolescent population.
Measurement	Numerator divided by the denominator and multiplied by 100. Population distribution.
Possible operationalization	By asking respondents how difficult they think it would be to obtain drugs ("by drug category") if they wanted to. [Response categories: e.g. probably impossible, very difficult, fairly difficult, fairly easy, cannot say drug not known].
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sex.
Annotation	<u>Data source</u>: Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Study population</u>: According to WHO, adolescence is defined as the age period between 10-19 years of age. <u>Drug categories</u>: The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug.

5.3.3 Perception about harm of drugs ("by drug category") among adolescents

Definition	Perception about harm (physically or in any other way) by using ("types of drugs by drug category") among adolescents. [Note: Separate indicators may be created for each type of drug. The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine, type stimulants 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug specified].
Possible data source	Survey data.
Numerator	The number of adolescents in the population who feel that people risk harming themselves by using ("types of drugs by drug category") e.g. once or twice during life, occasionally or regularly.
Denominator	The total adolescent population.
Measurement	Numerator divided by the denominator and multiplied by 100. Population distribution of different levels of harm associated with different drug types.
Possible operationalization	By asking adolescents how much they think people risk harming themselves by using ("type of drugs by drug category") once or twice during life, occasionally or regularly. [Response categories: e.g. no risk, slight risk, great risk, cannot say drug not known].
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sex.
Annotation	<u>Data source</u> : Surveys should be fully representative of the study population, and/or weighted to account for the distribution of the population by age and sex. <u>Study population</u> : According to WHO, adolescence is defined as the age period between 10-19 years of age. <u>Drug categories</u> : The monitoring focus lies on non-medical drug use, and measurement of drug use is suggested according to different drug categories: 1) heroin or other opiates, 2) amphetamine type stimulants, 3) cocaine, 4) cannabis, 5) non-medical use of psychoactive prescription medicines, 6) any other drug.

VI DRUG-RELATED HARM

6.1 DRUG-RELATED HARM: CORE INDICATORS

6.1.1 Drug dependence, 12 month prevalence

Definition	The proportion of persons (15-64 years) in the total population who are drug dependent as defined by ICD-10.
Possible data sources	Diagnostic interviews, treatment data, police data, or data from household surveys for indirect prevalence estimates.
Numerator	The number of persons (15-64 years) in the total population who are dependent on drugs.
Denominator	Mid year resident population over the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator and multiplied by 100. Dependence is defined by ICD-10 as "a cluster of physiological, behavioral, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviors that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take the psychoactive drugs (which may or may not have been medically prescribed)".
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of drug, age, sex, and any special population groups.
Annotation	In the absence of data on drug dependence, data on daily use of drugs can be reported.

6.1.2 Infectious diseases among injecting drug users (IDUs): HIV prevalence

Definition	The proportion of injecting drug users (IDUs) in the total population (IDUs are defined as injecting at least once in the past 12 months) who are infected with HIV.
Possible data source	Studies specifically designed to look at IDU populations.
Numerator	The number of IDUs infected with HIV.
Denominator	The number of IDUs in the total population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3-5 years.
Annotation	<u>Indicator:</u> Data on infectious diseases among IDUs reported from research studies might not be nationally representative, so data might need to be aggregated at the national level to estimate the total number of HIV infected IDUs within the country. As estimates of the denominator may vary it is recommended to report the numerator and the denominator separately.

6.1.3 Infectious diseases among injecting drug users (IDUs): Hepatitis C prevalence

Definition	The proportion of injecting drug users (IDUs) in the total population (IDUs are defined as persons having injected at least once in the past 12 months) who are infected with Hepatitis C.
Possible data source	Studies specifically designed to look at IDU populations.
Numerator	The number of IDUs infected with Hepatitis C.
Denominator	The number of IDUs in the total population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3-5 years.
Annotation	<u>Indicator:</u> Data on infectious diseases among IDUs reported from research studies might not be nationally representative, so that data might need to be aggregated at the national level to estimate the total number of Hep C infected IDUs within the country. As estimates of the denominator may vary, it is recommended to report the actual numbers as well as the proportion.

6.1.4 Infectious diseases among injecting drug users (IDUs): TB incidence

Definition	The number of injecting drug users (IDUs) in the total population (IDUs are defined as persons having injected at least once in the past 12 months) who develop TB disease (active TB) during a calendar year.
Possible data sources	Studies specifically designed to look at IDU populations (cohort studies).
Numerator	The number of IDUs who develop TB disease during a calendar year.
Denominator	The number of IDUs in the total population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3-5 years.
Annotation	<u>Indicator:</u> Data on infectious diseases among IDUs reported from research studies might not be nationally representative, so that data might need to be aggregated at the national level. As estimates of the denominator may vary it is recommended to report the numerator and the denominator separately.

6.1.5 Infectious diseases among non-injecting drug users: HIV prevalence

Definition	The proportion of non-injecting drug users in the total population who are infected with HIV.
Possible data source	Studies specifically designed to look at HIV prevalence rates among non-injecting drug users.
Numerator	The number of non-injecting drug users infected with HIV.
Denominator	The number of non-injecting drug users in the total population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3-5 years.
Annotation	<u>Indicator:</u> Data on infectious diseases among non-injecting drug users reported from research studies might not be nationally representative, so that data might need to be aggregated at the national level to estimate the total number of HIV infected non-injecting drug users within the country. As estimates of the denominator may vary it is recommended to report the numerator and the denominator separately.

6.1.6 Infectious diseases among non-injecting drug users: TB incidence

Definition	The number of non-injecting drug users in the total population who develop TB disease (active TB) during a calendar year.
Possible data source	Studies specifically designed to look at TB prevalence rates among non-injecting drug users (cohort studies).
Numerator	The number of non-injecting drug users who develop TB disease during a calendar year.
Denominator	The number of non-injecting drug users in the total population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3-5 years.
Annotation	<u>Indicator:</u> Data on infectious diseases among non-injecting drug users reported from research studies might not be nationally representative, so that data might need to be aggregated at the national level. As estimates of the denominator may vary it is recommended to report the numerator and the denominator separately.

6.1.7 Age-standardized death rate for drug-related poisoning (per 100,000)

Definition	The number of persons in the total population who died during a calendar year due to drug-related poisoning. Death rates are age standardized by the WHO standard population, reported per 100,000 persons.
Possible data sources	Hospital record data (e.g. ICD-10 codes), death certificate data, national registers.
Numerator	The number of deaths due to drug-related poisoning among the total population occurring during a calendar year.
Denominator	Midyear resident population for the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator. The age-standardized mortality rates are measured as a weighted average of the age-specific mortality rates per 100,000 persons. The weights are the proportions of persons in the corresponding age groups of the WHO standard population.
Suggested data collection frequency	Annually.
Disaggregation	By type of drug, age, and sex.

6.2 DRUG-RELATED HARM: EXPANDED INDICATORS

6.2.1 Drug use disorders, 12 month prevalence

Definition	The proportion of persons (15-64 years) in the total population who are suffering from drug use disorders by showing dependency syndromes and a pattern of psychoactive substance use that is causing damage to physical or mental health.
Possible data sources	Diagnostic interviews, treatment data, police data, or data from household surveys for indirect prevalence estimates.
Numerator	The number of persons in the total population (15-64 years) who have drug use disorders.
Denominator	Midyear resident population for the same calendar year. UN World Population Prospects, medium variant.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of drug, age, and sex.
Annotation	In the absence of data on drug use disorders, questions on daily use of different types of drugs can be reported.

6.2.2 Non-fatal drug-related poisoning (per 100,000)

Definition	The number of persons in the total population who were diagnosed with drug-related poisoning during a calendar year, reported per 100,000 persons.
Possible data source	Treatment data (e.g. data from emergency departments).
Numerator	The number of persons diagnosed with drug-related poisoning in the total population during a calendar year.
Denominator	Midyear resident population (15+ years) over the same calendar year. UN World Population Prospects, medium variant.
Measurement	Numerator divided by denominator. Rate presented per 100,000 persons.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of drug, age, and sex.

6.2.3 Infectious diseases among injecting drug users (IDUs): Hepatitis B prevalence

Definition	The proportion of injecting drug users (IDUs) in the total population (IDUs are defined as injecting at least once in the past 12 months) who are infected with Hepatitis B (surface antigen +ve).
Possible data source	Studies specifically designed to look at IDU populations.
Numerator	The number of IDUs infected with Hepatitis B.
Denominator	The number of IDUs in the total population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3-5 years.
Annotation	<u>Indicator:</u> Data on infectious diseases among IDUs reported from research studies might not be nationally representative, so that data might need to be aggregated at the national level to estimate the total number of Hep B infected IDUs within the country. As estimates of the denominator may vary it is recommended to report separately the numerator and the denominator and the proportion. As estimates of the denominator may vary it is recommended to report the numerator and the denominator separately.

6.2.4 Infectious diseases among non-injecting drug users: Hep B prevalence

Definition	The proportion of non-injecting drug users in the total population who are infected with Hepatitis B (surface antigen +ve).
Possible data source	Studies specifically designed to look at Hepatitis B prevalence rates among non-injecting drug users.
Numerator	The number of non-injecting drug users infected with Hepatitis B in the population.
Denominator	The number of non-injecting drug users in the total population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3-5 years.
Annotation	<u>Indicator:</u> Data on infectious diseases among non-injecting drug users reported from research studies might not be nationally representative, so that data might need to be aggregated at the national level to estimate the total number of HIV infected non-injecting drug users within the country. As estimates of the denominator may vary it is recommended to report the numerator and the denominator separately.

6.2.5 Drug-attributable years of life lost (YLL)

Definition	Drug-attributable years of life lost (YLL) is a summary measure of the effect of illicit drug use. As a measure of premature mortality it estimates the average years a person would have lived if not dying prematurely due to illicit drug use.
Possible data source	Mortality data.
Measurement	$YLL = \sum \text{drug attributable death} \times \text{remaining life-expectancy}$.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sex. By disease category (e.g. overdose, HIV).
Annotation	For comparison, YLLs should be expressed as a general population rate, either crude or age-standardized.

6.2.6 Needle sharing among injecting drug users (IDUs)

Definition	The proportion of IDUs in the total population who have shared needles one or more times during the last 12 months.
Possible data sources	Special research studies, surveys.
Numerator	The number of IDUs in the total population who have shared needles (one or more times) during the last 12 months.
Denominator	The number of IDUs in the total population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By age and sex.
Annotation	As estimates of the denominator may vary it is recommended to report the numerator and the denominator separately.

6.2.7 Sexually transmitted infections (STIs) among drug users

Definition	The proportion of drug users in the total population who have any sexually transmitted infection (STI).
Possible data sources	Special research studies, treatment data.
Numerator	The number of drug users in total population who have any sexually transmitted infection.
Denominator	The number of drug users in the total population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Annually.
Disaggregation	By age and sex.
Annotation	As estimates of the denominator may vary it is recommended to report the numerator and the denominator separately.

6.3 DRUG-RELATED HARM: ADDITIONAL INDICATORS

6.3.1 Imprisonment due to drug-related crime

Definition	The proportion of prisoners who have been imprisoned due to a drug-related crime (e.g. drug-dealing, drug possession, etc) during a calendar year.
Possible data sources	Police records; Prison records.
Numerator	The number of prisoners who are imprisoned during a calendar year due to a drug-related crime.
Denominator	The total number of persons who are imprisoned during a calendar year.
Suggested data collection frequency	Every 3-5 years.

6.3.2 Drug-related crime

Definition	The proportion of crime which is drug-related (e.g. drug-dealing, drug possession, etc) accumulating within a calendar year in the total population.
Possible data source	Police records.
Numerator	The total number of drug-related crime within a calendar year: - Offences for drug trafficking (by type of drug), - Arrests for drug trafficking (by type of drug and sex of the person), - Arrests for drug possession/use (by type of drug and sex of the person), - Offences for drug possession/use (by type of drug).
Denominator	The number of crimes (any crime) accumulating within a calendar year.
Suggested data collection frequency	Every 3-5 years.

6.3.3 Drug-attributable disability-adjusted life years (DALYs)

Definition	Drug-attributable "Disability-Adjusted Life Years" (DALYs) is a measure of overall disease burden and quantifies mortality and morbidity due to illicit drug use in a single disease measure.
Possible data sources	Mortality data, illicit drug use incidence by age and sex, age of illicit drug use onset, illicit drug use: duration in years, and degree of disability.
Measurement	$DALY = YLL + YLD$ $YLL = \sum \text{alcohol-attributable death} \times \text{remaining life-expectancy}$ $YLD = I [\text{the number of incident cases for the reference period}] \times DW [\text{the disability weight in the range } 0 - 1] \times L [\text{the average duration of disability (measured in years)}]$
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By age and sex.
Annotation	For comparison purposes, the DALYs are often expressed as a rate or a standardized rate. Drug-attributable "Disability-Adjusted Life Years" excludes the disease burden of drug-related harm to others (see indicator 6.3.4).

6.3.4 Disease burden of drug-related harm to others (DALYs)

Definition	Drug-related harm to others quantifies the adverse effect of drug use on persons other than the drug-user (e.g. the effects of drug use on the health of others, on violence and injuries, on family life).
Possible data sources	Special research studies, surveys.
Measurement	$DALY = YLL + YLD$ $YLL = \sum \text{drug-attributable death} \times \text{remaining life-expectancy}$ $YLD = I [\text{the number of incident cases for the reference period}] \times DW [\text{the disability weight in the range } 0 - 1] \times L [\text{the average duration of disability (measured in years)}]$
Suggested data collection frequency	Every 3 years.
Disaggregation	By age and sex.
Annotation	For comparison purposes, the DALYs are often expressed as a rate or a standardized rate.

6.3.5 Drug use among HIV-infected persons

Definition	The proportion of HIV-infected persons who are using drugs (injecting and/or non-injecting) at least once during the last 12 months.
Possible data sources	Special research studies, treatment data.
Numerator	The total number of HIV-infected persons who have used drugs (injecting and non-injecting) at least once during the last 12 months.
Denominator	The number of HIV-infected persons in the total population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Annually.
Disaggregation	By age and sex.
Annotation	As estimates of the denominator may vary it is recommended to report the numerator and the denominator separately.

6.3.6 Drug-related traffic arrests

Definition	The proportion of traffic arrests who have been drug-related (i.e. traffic arrests due to drug-driving or due to illegal carriage of illicit drugs).
Possible data sources	Police data.
Numerator	The total number of drug-related traffic arrests accumulating within a calendar year.
Denominator	The total number of all traffic arrests accumulating within the same calendar year.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

6.3.7 Drug-related traffic injury

Definition	The proportion of all traffic injuries accumulating within a calendar year among the total population which are drug-related (i.e. occurred due to drug use of one of the participating parties).
Possible data sources	Police data.
Numerator	The total number of all drug-related traffic injuries accumulating within a calendar year among the total population.
Denominator	The total number of all traffic injuries accumulating within a calendar year among the total population.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Annually.
Disaggregation	By type of traffic-injury.

VII DRUG TREATMENT INDICATORS

7.1 DRUG TREATMENT: CORE INDICATORS

7.1.1 Outpatient treatment slots for drug use disorders (per 100,000)

Definition	The number of patients that can be seen in the treatment system as an outpatient at any given time.
Possible data sources	National authorities, service providers.
Numerator	The total number of outpatient treatment slots for drug use disorders.
Denominator	Mid-year resident population for the same calendar year. UN World Population Prospects, medium variant.
Suggested data collection frequency	Annually.

7.1.2 Opioid substitution therapy (OST) sites per 1,000 opioid injectors

Definition	The number of opioid substitution therapy (OST) sites available in the country by opioid injectors.
Possible data source	Service providers.
Numerator	The number of OST sites in the country.
Denominator	Total number of opioid injectors/1,000.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub national-region.
Annotation	Countries and sub-national regions with an office-based treatment model should count each office based practice as a separate site.

7.1.3 Needle and syringe programme (NSP) sites per 1,000 IDUs

Definition	Needle and syringe programme (NSP) sites (including pharmacy sites providing no-cost needles and syringes) per 1,000 IDUs in the country.
Possible data source	National authorities, service providers.
Numerator	Number of NSP sites (including pharmacy sites providing no-cost needles and syringes).
Denominator	Total number of IDUs/1,000.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

7.1.4 Syringes distributed per injecting drug user (IDU) per year

Definition	The total number of syringes distributed per injecting drug user (IDU) per year.
Possible data source	National authorities, service providers.
Numerator	Number of syringes distributed during a calendar year.
Denominator	Total number of IDUs in the country during the same calendar year.
Suggested data collection frequency	Annually.
Annotation	Targets: Low: ≤ 100 per 100 per IDU per year; Medium: $>100 \leq 200$; High: >200 . These levels are based upon studies in developed countries settings investigating the levels of syringe distribution and impact on HIV transmission. In most cases only data on the number of syringes distributed via NSPs but not pharmacy sales will be available.

7.2 DRUG TREATMENT: EXPANDED INDICATORS

7.2.1 Percentage of opioid-dependent persons on opioid substitution therapy (OST) at census date

Definition	The proportion of opioid dependent persons who are on opioid substitution therapy (OST) in the country.
Possible data source	National authorities, service providers.
Numerator	Number of persons on OST at census date.
Denominator	Number of opioid-dependent persons (including both injectors and non-injectors).
Suggested data collection frequency	Annually.
Annotation	Target: $\leq 20\%$; Medium: $<20\text{--}\leq 40\%$; High: $>40\%$. High target level based on levels of coverage achieved in countries with well-established OST programmes.

7.2.2 Beds for drug use disorders (per 100,000)

Definition	The number of inpatient beds available for treatment of drug use disorders, per 100,000 persons.
Possible data sources	National authorities, service providers.
Numerator	The total number of drug-specific inpatient beds.
Denominator	Midyear resident population (15+ years), UN World Population Prospects, medium variant/100,000.
Measurement	Numerator divided by the denominator. Data presented by 100,000 persons.
Suggested data collection frequency	Annually.
Disaggregation	By setting (e.g. general hospitals, mental hospitals).

7.2.3 Percentage of patients in treatment: Methadone maintenance

Definition	Percentage of patients in opioid agonist maintenance treatment with methadone at any given time during a calendar year in the total population.
Possible data sources	National authorities, treatment data, service providers.
Numerator	The total number of patients in opioid agonist maintenance treatment with methadone at any given time during a calendar year.
Denominator	Number of opioid dependent persons in the total population during the same calendar year.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Annually.
Annotation	As estimates of the denominator may vary it is recommended to report the numerator and the denominator separately.

7.2.4 Percentage of patients in treatment: Buprenorphine maintenance

Definition	Percentage of patients in opioid agonist maintenance treatment with buprenorphine at any given time during a calendar year in the total population.
Possible data sources	National authorities, treatment data, service providers.
Numerator	The total number of patients in opioid agonist maintenance treatment with buprenorphine at any given time during a calendar year.
Denominator	Number of opioid dependent persons in the total population during the same calendar year.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Annually.
Annotation	As estimates of the denominator may vary it is recommended to report separately the numerator and the denominator and the proportion.

7.2.5 Waiting period to receive drug detoxification treatment

Definition	The average number of days a patient has to wait to receive drug detoxification treatment.
Possible data sources	National surveys on waiting time, service providers, national authorities.
Suggested data collection frequency	Annually.
Disaggregation	By treatment setting: by inpatient treatment; by outpatient treatment.
Annotation	To differentiate drug detoxification from regular short-term treatment for drug dependence, drug detoxification treatment is defined here in time lasting from less than a week until 10 days at most.

7.2.6 Waiting period to receive short-term treatment for drug dependence

Definition	The average number of days a patient has to wait to receive short-term treatment for drug dependence.
Possible data sources	National surveys on waiting time, service providers, national authorities.
Suggested data collection frequency	Annually.
Disaggregation	By treatment setting: by inpatient treatment; by outpatient treatment.
Annotation	Short-term treatment for drug dependence is defined here as treatment lasting up to 4 months.

7.2.7 Waiting period to receive long-term care and after care for drug dependence

Definition	The average number of days a patient has to wait to receive long-term care and after care for drug dependence.
Possible data sources	National surveys on waiting time, service providers, national authorities.
Suggested data collection frequency	Annually.
Disaggregation	By treatment setting: by inpatient treatment; by outpatient treatment.
Annotation	Long-term care and after care for drug dependence is defined here as treatment lasting 4 months and longer.

7.2.8 Inpatient treatment admissions due to drug use disorders

Definition	The proportion of all inpatient treatment admissions due to drug use disorders in the population accumulating within a calendar year.
Possible data sources	Hospital data/records, national registers, service providers.
Numerator	The total number of inpatient treatment admissions due to drug use disorders during a calendar year.
Denominator	Midyear resident population (15+ years), UN World Population Prospects, medium variant.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Annually.
Disaggregation	By age and sex. By treatment settings (e.g. Specialized treatment centres, mental hospitals, general hospitals), By type of drug.
Annotation	<u>Indicator:</u> The number of inpatient treatment admissions for drug use disorders during a calendar year is susceptible to double-counting as the same person can be admitted several times to different inpatient treatment facilities within a country. Admission may also refer to either separation or discharge.

7.3 DRUG TREATMENT: ADDITIONAL INDICATORS

7.3.1 Mandatory treatment for drug use disorders

Definition	Proportion of the population receiving treatment for drug use disorders in the past year for whom any part of that treatment has been mandatory. Mandatory treatment requires a legislative provision for the compulsory treatment for persons with drug use disorders in the country.
Possible data source	National authorities.
Numerator	Number of persons who received mandatory treatment for drug use disorders during a calendar year.
Denominator	Total number of persons receiving drug treatment during a calendar year.
Suggested data collection frequency	Every 3-5 years.
Annotation	As estimates of the denominator may vary it is recommended to report the numerator and the denominator separately.

7.3.2 Treatment for persons with drug use disorders in prisons

Definition	The proportion of prisons where treatment (i.e. pharmacotherapy, counselling, etc) for persons with drug use disorders is available.
Possible data source	National authorities.
Numerator	The number of prisons where treatment (i.e. pharmacotherapy, counselling, etc) for persons with drug use disorders is offered.
Denominator	The total number of prisons in the country.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of treatment. By remand prisons and penitentiaries. By sub-national region.

7.3.3 HIV-testing among IDUs

Definition	The percentage of IDUs who received an HIV test during a calendar year and know the results.
Possible data sources	National authorities, service providers.
Numerator	Number of IDUs who have been tested for HIV/AIDS and are aware of their status during a calendar year.
Denominator	Total number of IDUs in the country during a calendar year.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Annually.
Disaggregation	By age and sex.
Annotation	As estimates of the denominator may vary it is recommended to report the numerator and the denominator separately.

7.3.4 Polysubstance dependence

Definition	The proportion of persons in treatment who are dependent on more than one drug (e.g. alcohol and any other illicit substance, or two illicit substances) during a calendar year.
Possible data sources	Special research studies, treatment data.
Numerator	The number of persons who are in treatment and are dependent on more than one drug during a calendar year.
Denominator	The total number of persons in treatment for alcohol and drug use disorders during a calendar year.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By age and sex.

7.3.5 Mental health conditions among persons in treatment for drug use disorders

Definition	The proportion of persons in treatment for drug use disorders who are diagnosed with an additional mental health problem/psychiatric condition according to ICD-10 criteria during a calendar year.
Possible data sources	Special research studies, treatment data.
Numerator	The number of persons in treatment for drug use disorders who are diagnosed with an additional mental health problem/psychiatric condition according to ICD-10 criteria during a calendar year.
Denominator	The total number of persons in treatment for drug use disorders during a calendar year.
Measurement	Numerator divided by the denominator and multiplied by 100.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By age and sex.

7.3.6 Opioid substitution therapy (OST) sites per 1,000 opioid dependent persons

Definition	The total number of opioid substitution therapy (OST) sites available in the country by opioid dependent persons (injecting and non-injecting).
Possible data source	Service providers.
Numerator	Number of OST sites in the country.
Denominator	Total number of opioid dependent persons/1,000
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

7.3.7 Availability of drugs (medication) for pharmacological treatment for opioid dependence for detoxification

Definition	National availability of drugs (i.e. medication) used for treatment of opioid dependence for detoxification within the country. The indicator should be disaggregated by type of pharmacotherapy. Pharmacotherapy for treatment of opioid dependence for detoxification may include the following (methadone, buprenorphine, buprenorphine/naloxone, clonidine tablets/patches, lofexifine, guanfacine, and other medication).
Possible data sources	National authorities, survey providers.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of medication. By sub-national region.

7.3.8 Availability of drugs (medication) for pharmacological treatment for opioid dependence for maintenance

Definition	National availability of drugs (i.e. medication) used for treatment of opioid dependence for maintenance within the country. The indicator should be disaggregated by type of pharmacotherapy. Pharmacotherapy for treatment of opioid dependence for maintenance may include the following (methadone solution/syrup, methadone tablets, buprenorphine, buprenorphine/naloxone).
Possible data sources	National authorities, survey providers.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By type of medication, by sub-national region.

7.3.9 Availability of gender-specific treatment services for drug use disorders within the health care system

Definition	Availability of gender-specific treatment services for drug use disorders within the health-care system (e.g. availability of gender-specific treatment programmes for women which are tailored and respond to their specific needs).
Possible data sources	National authorities, service providers.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

VIII DRUG POLICY INDICATORS

8.1 DRUG POLICY: CORE INDICATORS

8.1.1 Availability of a written national policy on drugs

Definition	Presence of a written national or sub-national policy on drugs in the country. A drug policy is defined by an organized set of values, principles and objectives for reducing the harm and burden attributable to drug use in the population.
Possible data source	National authorities.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

8.1.2 Availability of special legislative provisions pertaining to treatment and rehabilitation of persons with drug use disorders

Definition	Presence of special legislative provisions in the country which pertain to treatment and rehabilitation of persons with drug use disorders. Special legislative provisions for drug treatment and rehabilitation can exist on their own, or can be integrated or be a part of the general health legislation (or mental health legislation, or social care legislation).
Possible data source	National authorities.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

8.1.3 Availability of policy documents regulating pharmacological treatment of drug use disorders

Definition	Availability of policy documents in the country which regulate the pharmacological treatment of drug use disorders. Documents on pharmacological treatment of drug use disorders can exist as a part of an overall document on treatment of substance use disorders, or can be focused on the pharmacological treatment of drug use disorders only.
Possible data source	National authorities.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

8.2 DRUG POLICY: EXPANDED INDICATORS

8.2.1 Presence of drug courts in the country

Definition	Presence of drug courts in the country. Drug courts are judicially supervised courts in which persons with substance use disorders who committed a crime are sentenced, but which ensures that persons with substance use disorders also receive help from other sectors like e.g. the health sector (e.g. treatment), or the social service sector.
Possible data source	National authorities.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

8.2.2 Availability of programmes for drug use disorders which divert clients from the criminal justice system towards treatment

Definition	Availability of programmes within the country which divert clients (i.e. offenders with substance use disorders) towards treatment and away from the criminal justice system and thus offer alternatives to criminal sanctions.
Possible data source	National authorities.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

8.3 DRUG POLICY: ADDITIONAL INDICATORS

8.3.1 Provision of drug-testing among traffic drivers

Definition	Provision of a legislation to randomly test drivers in traffic for drug use (e.g. testing for the presence of an active component of cannabis) in the country.
Possible data source	National authorities.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

8.3.2 Provision of treatment after drug-driving

Definition	Availability of programmes or provisions within the country which divert clients towards treatment (and counselling) after having been tested positively for drug-driving.
Possible data source	National authorities.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

8.3.3 Policy of integrating treatment for drug use disorders into primary health care

Definition	Availability of a national or sub-national policy or legislative framework to integrate treatment for drug use disorders into primary health care.
Possible data source	National authorities.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

8.3.4 Training of health professionals: screening and brief intervention for drug use disorders

Definition	Availability of screening and brief interventions for drug use disorders as a measure of health promotion and disease prevention within the health care system at a national or sub-national level.
Possible data source	National authorities.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

8.3.5 Availability of a national treatment registry for drug use disorders

Definition	Availability of national or sub-national treatment registry for drug use disorders in the country.
Possible data source	National authorities.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

8.3.6 Provision of publicly funded drug research and monitoring programs

Definition	Provision of publicly funded drug research and monitoring programs at the national or sub-national level.
Possible data source	National authorities.
Suggested data collection frequency	Every 3-5 years.
Disaggregation	By sub-national region.

APPENDIX A: MEETING AGENDA

Monday, 19 October 2009

12:30 – 14:00	Registration
14:00 – 15:00	Welcome, introductions, objectives of the meeting.
15:00 – 15:30	Introduction of the background paper
15:30 – 16:00	Break
16:00 – 17:30	Review of the core, expanded and additional indicators

Tuesday, 20 October 2009

09:00 – 9:15	Summary and conclusions of the first day
09:15 - 10:30	Introduction and review of indicators for monitoring alcohol consumption: definitions, sources of data, data collection, interpretation
10:30 – 11:00	Break
11:00 – 12:30	Introduction and review of indicators for monitoring drug and other psychoactive substance use consumption: definitions, sources of data, data collection, interpretation
12:30 – 13:30	Lunch
13:30 – 15:00	Introduction and review of indicators for alcohol-attributable harm: definitions, sources of data, data collection, interpretation
15:00 – 15:30	Break
15:30 – 17:30	Introduction and review of indicators for drug-attributable harm: definitions, sources of data, data collection, interpretation

Wednesday, 21 October 2009

09:00 – 09:30	Summary and conclusions of the second day
09:30 - 10:30	Introduction and review of indicators for societal responses at population level: definitions, sources of data, data collection, interpretation
10:30 – 11:00	Break

11:00 – 12:30	Introduction and review of indicators for societal responses at prevention and treatment system level: definitions, sources of data, data collection, interpretation
12:30 – 13:30	<i>Lunch</i>
13:30 – 15:00	Revisiting core, expanded and additional indicators
15:00 – 15:30	<i>Break</i>
15:30 – 16:30	Next steps and implications for monitoring systems at different levels
16:30 – 17:30	Conclusions and closure of the meeting

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The harmful use of alcohol and illicit drugs is the third leading risk factor for premature deaths and disabilities in the world. It is estimated that 2.5 million people worldwide died of alcohol-related causes in 2004, including 320 000 young people between 15 and 29 years of age.



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