# SDG indicator metadata

**(Harmonized metadata template - format version 1.1)**

## 0. Indicator information (SDG_INDICATOR_INFO)

### 0.a. Goal (SDG_GOAL)

Goal 3: Ensure healthy lives and promote well-being for all at all ages

### 0.b. Target (SDG_TARGET)

Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

### 0.c. Indicator (SDG_INDICATOR)

Indicator 3.5.1: Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders

### 0.d. Series (SDG_SERIES_DESCR)

SH_SUD_ALCOL - Alcohol use disorders, 12-month prevalence (%) [3.5.1]

SH_SUD_TREAT - Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders (%) [3.5.1]

### 0.e. Metadata update (META_LAST_UPDATE)

2024-05-24

### 0.f. Related indicators (SDG_RELATED_INDICATORS)

3.5.2: Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol

### 0.g. International organisations(s) responsible for global monitoring (SDG_CUSTODIAN_AGENCIES)

World Health Organization (WHO)

United Nations Office on Drugs and Crime (UNODC)

## 1. Data reporter (CONTACT)

### 1.a. Organisation (CONTACT_ORGANISATION)

World Health Organization (WHO)
United Nations Office on Drugs and Crime (UNODC)

## 2. Definition, concepts, and classifications (IND_DEF_CON_CLASS)

### 2.a. Definition and concepts (STAT_CONC_DEF)

**Definitions:**

The coverage of treatment interventions for substance use disorders is defined as the number of people who received treatment in a year divided by the total number of people with substance use disorders in the same year. This indicator is disaggregated by two broad groups of psychoactive substances: (1) drugs, (2) alcohol and other psychoactive substances.

Whenever possible, this indicator is additionally disaggregated by type of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services). The indicator is accompanied and can be analysed together with contextual information such as prevalence of alcohol and drug use disorders and availability coverage, i.e. Service Capacity Index for Substance Use Disorders (SCI-SUD) [1] that reflects the capacity of national health systems to provide treatment for substance (alcohol, drugs and other psychoactive substances) use disorders, in terms of the proportion (%) of available health system elements in a given country from a theoretical maximum.

**Concepts:**
The central concept of "substance abuse" in the SDG health target 3.5 implies the non-medical, hazardous, harmful or dependent pattern of use of psychoactive substances that, when taken in or administered into one's system, affect mental processes, e.g. perception, consciousness, cognition or affect. The concept of "substance use disorders" includes both "drugs use disorders" and "alcohol use disorders" according to the International Classification of Diseases (ICD-10 and ICD-11)[2].

The term "drugs" refers to controlled psychoactive substances as scheduled by the three Drug Control Conventions (1961, 1971 and 1988), substances controlled under national legislations, new psychoactive substances (NPS) and some other that are not controlled under the Conventions, but may pose a public health threat. "Alcohol" refers to ethanol - a psychoactive substance with dependence producing properties that is consumed in ethanol-based alcoholic beverages or their surrogates.

People with substance use disorders are those with harmful patterns of substance use or substance dependence. Harmful pattern of substance use is defined in the ICD-11 as a pattern of use of substances that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. According to ICD-11, dependence arises from repeated or continuous use of psychoactive substances. The characteristic feature is a strong internal drive to use psychoactive substance, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences.

Within this context treatment interventions for substance use disorders include any structured intervention that is aimed specifically to a) reduce substance use and cravings for substance use; b) improve health, well-being and social functioning of the affected individual, and c) prevent future harms by decreasing the risk of complications and relapse. These may include pharmacological treatment, psychosocial interventions and rehabilitation and aftercare. All evidence-based used for treatment of substance use disorders are well defined in WHO and UNODC related documents. Though hazardous substance use is not included in the concept of "substance use disorder", such patterns of substance use are important targets for prevention interventions in health systems, and such interventions are included in the overall scope of comprehensive health system responses to "substance abuse" as defined in SDG 3.5.1 indicator.

Pharmacological treatment refers to evidence-based interventions that include administration of pharmacological agents or medicines in the context of different treatment modalities and interventions, including withdrawal management; treatment of alcohol use disorders with baclofen, naltrexone, acamprosate and disulfiram; management of opioid dependence with opioid agonists (methadone, buprenorphine) and antagonists (naltrexone); and prevention and management of opioid overdose with naloxone (WHO/UNODC International Standards for the treatment of drug use disorders[3], 2020 and WHO Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders, 2023[4] ).

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[1] https://onlinelibrary.wiley.com/doi/10.1002/mpr.1950
[2] https://icd.who.int/browse/2024-01/mms/en#1676588433
[3] https://iris.who.int/handle/10665/331635
[4] https://iris.who.int/handle/10665/374250

Psychosocial interventions refer to programs that address motivational, behavioral, psychological, social, and environmental factors related to substance use and have been shown to improve quality of life and well-being, reduce psychoactive substance use, promote abstinence and prevent relapse. For different substance use disorders, the evidence from clinical trials supports the effectiveness of treatment planning, screening and brief intervention (SBI), counselling, peer support groups, cognitive behavioral therapy (CBT), motivational interviewing (MI), community reinforcement approach (CRA), motivational enhancement therapy (MET), family therapy (FT) modalities, contingency management (CM), counselling, insight-oriented treatments, housing and employment support among others. (UNODC/WHO International Standards for the Treatment of Drug Use Disorders, 2020 and WHO Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders, 2023).

Rehabilitation and aftercare (Recovery Management and Social Support) refers to interventions that are based on scientific evidence and focused on the process of rehabilitation, recovery and social reintegration. (UNODC/WHO International Standards for the Treatment of Drug Use Disorders, 2020 and WHO Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders, 2023).

## 2.b. Unit of measure (UNIT_MEASURE)

Percent (%)

## 2.c. Classifications (CLASS_SYSTEM)

The International Statistical Classification of Diseases and Related Health Problems (ICD)[5] is used to define substance use disorders, both for drugs and alcohol.

# 3. Data source type and data collection method (SRC_TYPE_COLL_METHOD)

## 3.a. Data sources (SOURCE_TYPE)

Numerator (people who received treatment):
Treatment registries are the main source of data for the number of people receiving treatment. They are expected to cover the entire national territory and be linked to all relevant agencies providing treatment services.

Denominator (people with substance use disorders):
To estimate the number of people with drug use disorders, the sources include:
- Household surveys
- Surveys among people using substances – using for instance respondent driven sampling
- Indirect methods such as capture/recapture or multiplier benchmark method

Surveys should be nationally representative, with a sample size sufficiently large to capture relevant events and compute needed disaggregation, and they should be based on a solid sample design. The use of indirect questions for network scale-up methods in household surveys is encouraged.
When data at the national level are not available, estimates on the number of people with drugs use disorders produced by the Institute for Health Metrics and Evaluation (IHME), and published through the Global Burden of Disease (GBD) study[6], can be used for the denominator of the indicator.

To estimate the number of people with alcohol use disorders, preferred data sources are population-based surveys targeting the adult population (15+ years) and using standardized diagnostic

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[5] See https://www.who.int/standards/classifications/classification-of-diseases
[6] https://www.healthdata.org/research-analysis/gbd

instruments. International surveys such as World Health Survey (WHS), WHO STEPwise approach to surveillance (STEPS), Gender, Alcohol, and Culture: An International Study (GENACIS), and The European Cancer Anaemia Survey (ECAS) represent good practices.

## 3.b. Data collection method (COLL_METHOD)

WHO and UNODC  use well-established data collection tools and procedures to gather available statistics from member states:
- UNODC Annual Report Questionnaire ;
- WHO Global Survey on Progress with attainment of SDG Health Target 3.5;

**Drugs:**
- Data on people with drug use disorders and the number of people in treatment are collected through a standardised questionnaire sent to countries, the Annual Report Questionnaire (ARQ). This questionnaire provides specific definitions of data to be collected and it collects a set of metadata to identify possible discrepancies from standard definitions and to assess overall data quality (e.g. sample size, target population, agency responsible for the data collection, etc.). At the national level, countries are required to have standardized treatment reporting system.
- A revised ARQ is currently in use since 2021, with data being collected through the newly developed Data eXchange Platform (DXP). Data on drug use disorders and treatment, with the relevant disaggregations are collected through this tool. The revision of the questionnaire took into consideration the disaggregation and data quality needs emerging from the SDG data exercise.
- Countries are requested to nominate national focal points to ensure technical supervision at country level
- Automated and substantive validation procedures are in place to assess data consistency and compliance with standards
- When data from national official sources are missing or not complying with methodological standards, data from other sources are also considered and processed by using the same quality assurance procedures.

**Alcohol and other substances:**
- Data on prevalence of alcohol and other substance use disorders, the number of people in treatment as well as on development of treatment systems for substance use disorders are collected through the periodical WHO global surveys addressed to the national focal points officially nominated by the Ministries of Health.
-  These focal points provide national government statistics and data or links or contacts through which the data can be accessed.
- In addition, data are accessed from country-specific industry data sources in the public domain and other databases as well as systematic literature reviews.
- WHO global surveillance activities include population-based national surveys that allows to generate country data used for estimation of the number of people with substance use disorders in populations (such as World Mental Health Survey and STEPS surveys)
- Data on service utilization and contextual information are being collected by periodical WHO Global Survey on Progress with SDG Health Target 3.5 and through specific activities such as service mapping surveys implemented in collaboration with UNODC.
- The collected, collated and analysed data is included in the process of country consultations.
After the validation process, the data are sent to national focal points for their review before publication.

## 3.c. Data collection calendar (FREQ_COLL)

Countries are encouraged to conduct general population surveys on substance use regularly, but at least every four-five years. Also, countries are encouraged to use less costly alternatives to estimate the number of people with substance use disorders and service utilization, taking advantage of the availability of administrative data through the use of indirect estimation methods. Collection of data from countries is planned on annual or biannual basis.

## 3.d. Data release calendar (REL_CAL_POLICY)

Data on relevant SDG indicators are collected, compiled and sent back to countries for data review annually by UNODC, and every 3-4 years by WHO. Data are then reported to United Nations Statistics Division (UNSD) through the regular reporting channels annually.

## 3.e. Data providers (DATA_SOURCE)

Data are collected through national focal points. Data providers vary by country and they can be institutions such as Drug Control Agencies, National Drug Observatories, Ministries of Health and/or National Statistical Offices.

## 3.f. Data compilers (COMPILING_ORG)

Data will be compiled by the co-custodians for this indicator (UNODC and WHO).

## 3.g. Institutional mandate (INST_MANDATE)

The United Nations Office on Drugs and Crime (UNODC) is a global leader in the fight against illicit drugs, transnational organized crime, terrorism and corruption, and is the guardian of most of the related conventions, particularly:

- The United Nations Convention against Transnational Organized Crime and its three protocols (against trafficking in persons, smuggling of migrants and trafficking in firearms)
- The United Nations Convention against Corruption
- The international drug control conventions

UNODC is specifically mandated by the three international drug conventions to collect drug-related data on annual basis from Member States through the Annual Report Questionnaire (ARQ)[7]. In addition, the Convention on Narcotic Drugs (CND) has overseen the process for the latest revision of the ARQ and endorsed the questionnaire in its 63rd session in March 2020[8].

The World Health Organization (WHO) is a specialized agency of the United Nations responsible for international public health. WHO's activities are implemented in accordance with the mission set out in the Organization's Thirteen General Programme of Work: to promote health, keep the world safe and serve the vulnerable. It is structured around three interconnected strategic priorities (to ensure healthy lives and well-being for all at all ages: achieving universal health coverage, addressing health emergencies and promoting healthier populations) and WHO's six core functions: (1) Providing leadership on matters critical to health and engaging in partnerships where joint action is needed; (2) shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge; (3) setting norms and standards and promoting and monitoring their implementation; (4) articulating ethical and evidence-based policy options; (5) providing technical support, catalysing change, and building sustainable institutional capacity; and (6) monitoring the health situation and assessing health trends.

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[7] See https://www.unodc.org/unodc/en/data-and-analysis/arq.html
[8] See https://documents-dds-ny.un.org/doc/UNDOC/GEN/V19/117/68/PDF/V1911768.pdf?OpenElement

WHO is one of the four treaty bodies to the international drug control conventions. As part of the United Nations system, WHO's role under the conventions is to protect individuals and societies from harm due to drug use and to promote public health interventions to reduce harm.  WHO focuses on prevention of substance use (including all psychoactive substances), treatment of substance use disorders (including both harmful pattern of use and dependence), monitoring trends in substance use and its health consequences, prevention and management of associated health and social conditions and public health problems in order to reduce the health and social burden attributable to substance use. In addition to the international drug conventions, WHO 's work related to psychoactive substances is guided by the WHO Constitution and by the Organization's governing bodies (chiefly through resolutions of the World Health Assembly and WHO's regional committees), such as the WHO Global Alcohol Action Plan 2022–2030 endorsed by the Seventy-fifth World Health Assembly in May 2022 to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority.

# 4. Other methodological considerations (OTHER_METHOD)

## 4.a. Rationale (RATIONALE)

According to United Nations Office on Drugs and Crime (UNODC) and World Health Organization (WHO) data, around 296 million people aged 15 to 64 years worldwide used an illicit drug at least once in 2021, about 2.3 billion people are current drinkers of alcohol, some 35 million of people suffer from drug use disorders and 289 million from alcohol use disorders.

Substance use disorders are serious health conditions that present a significant burden for affected individuals, their families and communities. Untreated substance use disorders trigger substantial costs to society including lost productivity, increased health care expenditure, and costs related to criminal justice, social welfare, and other social consequences. Strengthening treatment services entails providing access to a comprehensive set of evidence-based interventions (-laid down in the international standards and guidelines) that should be available to all population groups in need. The indicator will inform the extent to which a range of evidence-based interventions for treatment of substance use disorder are available and are accessed by the population in need at country, regional and global level.

Even though effective treatment exists, only a small amount of people with substance use disorders receive it. For instance, it is estimated that globally one out of 7 people with drug use disorders have access to or provided drug treatment services (World Drug Report 2019). WHO ATLAS-Substance Use data showed that in 2014 only 11.9 % (out of 103 responding) countries reported high coverage (40% or more) for alcohol dependence. SDG indicator 3.5.1 is crucial for measurement the progress towards strengthening the treatment of substance abuse worldwide as formulated in the Target 3.5.

## 4.b. Comment and limitations (REC_USE_LIM)

The two main challenges in terms of computing the SDG 3.5.1 indicator are the limited availability of household surveys on substance use and the under-reporting of use among survey respondents. Data reported from household surveys are one of the sources of information on of the number of people with substance use disorders. There are issues of under-reporting for certain psychoactive substances, in countries where stigma is associated to substance use and when a considerable proportion of the drug or alcohol using population is institutionalized, homeless or unreachable by population-based surveys. Additionally, being a relatively rare event, household surveys on substance use disorders require a large sample and can be costly. In order to address these issues, additional approaches (e.g. scale up methods) are increasingly used in household surveys to address undercount issues. These can be used in conjunction with special studies and/or additional information, in order to obtain reasonable estimates via indirect methods, such as benchmark/multiplier or capture-recapture methods.

Given these challenges, often national officially produced estimates on the number of people with drug use disorders are not available. In this context, additional sources are considered, such as the estimates produced by the Institute for Health Metrics and Evaluation (IHME), and published through the Global Burden of Disease (GBD) study. Data on treatment of drug use disorders is more widely available at the national level, as it relies on administrative records.

An additional step in data validation and country capacity building for monitoring treatment coverage for substance use disorders will be implemented during the next couple of years for in-depth data generation in a sample of countries from different regions and representing different levels of health system development. A rapid assessment tool for in-depth data generation is in the process of development by WHO.

The indicator stresses on type, availability and coverage of services but does not necessarily provide information on the actual quality of the interventions/services provided. To address this, the proposed treatment indicator is accompanied with contextual information on availability coverage produced by WHO and using Service Capacity Index for Substance Use Disorders (SCI-SUD)[9] that reflects the capacity of national health systems to provide treatment for alcohol and drug use disorders, in terms of the proportion (%) of available service elements in a given country from a theoretical maximum.

## 4.c. Method of computation (DATA_COMP)

The indicator will be computed by dividing the number of people receiving treatment services at least once in a year by the total number of people with substance use disorders (SUD) in the same year:

$$Coverage_{SUD} = \frac{\text{number of people in treatment for SUD}}{\text{number of people with SUD}} X \ 100$$

Where: SUD – Substance use disorders

## 4.d. Validation (DATA_VALIDATION)

**Drugs**
Data on people in treatment for SUD and people with SUD collected through the ARQ and other sources go through a thorough validation process that involves identification of outliers, consistency with previous reported data, consistency with data reported by other countries, direct communication with technical counterparts providing data through the DXP, as well as exploring other sources of data. In addition, once a year data available through the ARQ and other sources are shared with ARQ Focal Points for their review in a pre-publication process related to UNODC's flagship publication, the World Drug Report. Finally, data compiled for the SDG indicator 3.5.1 are shared with SDG Focal Points for their feedback and review, during the SDG pre-publication process before submission to UNSD every March. All feedback received by Member States related to these data are incorporated.

**Alcohol and other psychoactive substances**
WHO Global Survey on Progress with SDG Health Target 3.5 collects data from WHO focal points in Ministries of Health, nominated by their governments to participate in the survey. The WHO's LimeSurvey

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[9] https://onlinelibrary.wiley.com/doi/10.1002/mpr.1950

platform is used to collect information. Respondents are encouraged to contact and consult additional experts from the following areas: (1) persons in charge of or involved in alcohol/drug control in the Ministry of Health, Ministry of Justice or other ministry, or the most senior government official in charge of alcohol control or alcohol-related conditions, or drug demand reduction programmes; (2) the head of a prominent non-governmental organization dedicated to alcohol/drug control; (3) a health professional (e.g., medical doctor, nurse, pharmacist, social worker, psychologist) who specialized in alcohol-related conditions and conditions due to other SU; (4) a faculty member of a public health or other relevant university department; (5) a police or other law enforcement officer; (6) a person at the Ministry of Finance, tax agency or statistical office; (7) a researcher, civil servant, or faculty member with expertise in treatment systems for SUD and treatment/service coverage. Adjusted for comparability, country summaries with data points are validated through the established network of WHO focal points to ensure data accuracy prior to their publication. Data validation processes include checking of internal consistency, identification of outliers and checking consistency with previously reported data, and discrepancies in data are communicated to the focal points for clarification.

## 4.e. Adjustments (ADJUSTMENT)

Adjustments may take place to fit the age group requirements of the indicator (people 15 years of age and older), depending on the national data available.

## 4.f. Treatment of missing values (i) at country level and (ii) at regional level (IMPUTATION)

**At country level**
For drug use disorders, data will be reported for countries where information is available for both numerator and denominator, either via data reported by the government or produced by other sources mentioned in this document. No data estimates will be published at the national level.

For alcohol, when information on service utilization is missing in a country, several approaches are used to produce estimates based on all available contextual service capacity data in the country and regionally. Link to be established between service availability and service utilization to get rough understanding on number of people who might be using services for countries where no direct information on number of people using services is available.

**At regional and global level**
Sub-regional and regional aggregates are produced when enough data at the country level are available (a minimum number of countries and a minimum percentage of population coverage). When data are available, sub-regional estimates are created first and then aggregated at regional level. The global level is computed as aggregation of regional estimates.

**With regards to the contextual information related to the .Service Capacity Index**
For countries that do not submit any data or have levels of missingness deemed as very high through WHO Global Survey on Progress with SDG Health Target 3.5, WHO employs multivariate imputation by chained equations method (van Buuren, 2018) to impute SCI-SUD assuming that the data are missing at random (MAR) and using the predictive mean matching method (Krupchanka et al., 2022).

## 4.g. Regional aggregations (REG_AGG)

Regional and global aggregations are produced for the indicator on substance use disorders related to "Any drug". After data are validated by Member State, estimates by year and sub-region are produced. These are later aggregated to the regional and global levels.

Data aggregation is also possible for contextual information for the indicator (i.e. Service Capacity Index), both at global and regional levels.

## 4.h. Methods and guidance available to countries for the compilation of the data at the national level (DOC_METHOD)

UNODC has published a series of methodological guidelines on several issues related to the drug problem, entitled "Global Assessment Program (GAP)". These guidelines consist of 8 modules, covering different aspects of monitoring the drug situation including setting up drug information systems, estimating drug prevalence using indirect methods, setting up treatment monitoring and reporting systems, etc. The modules can be found at: https://www.unodc.org/unodc/en/GAP/. It is planned to update these guidelines in the near future.

As part of the Annual Report Questionnaire (ARQ) review process, UNODC is planning to enhance its capacity building tools by complementing regional and national capacity building activities with:
- E-learning training modules with incorporated training curricula
- Creating methodological guidelines and tools on drug-related issues, including drug use disorders and treatment
- promoting national coordination mechanisms on drugs data, including national drug observatories

WHO has published series of documents on alcohol monitoring in populations (e.g. International Guide for Monitoring Alcohol Consumption and Related Harm), and established a Global Information System on Alcohol and Health (GISAH) that provides easy and rapid access to a wide range of alcohol-related health indicators. It is an essential tool for assessing and monitoring the health situation and trends related to alcohol consumption, alcohol-related harm, and policy responses in countries. Data on prevalence of alcohol use disorders at national, regional and global levels have been regularly reported by WHO and included among the key indicators in periodic WHO publications such as global status reports on alcohol and health. GISAH is a further development of the Global Alcohol Database which has been built since 1997 by the WHO Department of Mental Health and Substance Use. The main purpose of GISAH is to serve WHO Member States and governmental and nongovernmental organizations by making alcohol-related health data available. These data can help to analyse the state of the health situation related to alcohol in a country, a WHO region or sub-region, or the world. The Indicator Code Book has been prepared to assist countries in collecting the data.

## 4.i. Quality management (QUALITY_MGMNT)

The prepublication processes conducted for most UNODC and WHO data collections as described in the Validation section above allow to properly manage the quality of the data submitted. In particular, as data for the SDG indicator 3.5.1 are shared with different Focal Points (from the drugs and the SDG sides), often representing different institutions within the national system, this allows for consolidating a national figure on the indicator and other key drug-demand indicators, such as people in treatment and people with alcohol/drug use disorders.

## 4.j Quality assurance (QUALITY_ASSURE)

At UNODC, quality assurance measures are in place to collect, process and disseminate statistical data. They build on the 'Principles governing international statistical activities' and regulate the collection, processing, publication and dissemination of data.

All data for SDG indicators as compiled by the Office are sent to countries (through the relevant national focal points) for their review before statistical data are officially released by UNODC. When countries provide feedback/comments on the data, a technical discussion is conducted to identify a common position.

At WHO quality assurance measures are in place for producing the health statistics that include the main indicators on alcohol consumption and its health consequences. WHO Technical Advisory Group on Alcohol and Drug Epidemiology provides technical advice and input to WHO activities on monitoring alcohol consumption and treatment capacity for substance use disorders in its Member States.

Data compilation is to be performed centrally by WHO and UNODC based on data collected from countries that later will be validated through official focal points.

## 4.k Quality assessment (QUALITY_ASSMNT)

As for certain regions there could be different data published at the international level on the indicators used for the calculation of the indicator, i.e., people in treatment for alcohol/drug use disorders and people with alcohol/drug use disorders, there is an exercise of data exchange taking place with key actors, including WHO regional offices and other regional organizations such as the European Monitoring Center for Drugs and Drug Addiction (EMCDDA). This exercise, together with the validation and prepublication processes described before, allows to produce the most accurate data as possible. It is important to note that in cases the production of these indicators at the national level, especially for the estimation of people with alcohol/drug use disorders, can differ in definition from country to country depending on the methodology used. While UNODC and WHO strives to publish data that is as comparable as possible, cases that differ from the standard definitions are clearly identified in the corresponding footnotes.  Ideally, this would require additional activities that would allow in-depth data collection in selected countries: a future direction for strengthening the indicator.

## 5. Data availability and disaggregation (COVERAGE)

**Data availability:**

Data on treatment of people with alcohol/drug use disorders is widely available countries as it relies on administrative data. While data on the estimated number of people with drug use disorders can be scarce in certain regions as it relies in data from surveys or indirect methods, external sources such as the ones mentioned in this document can provide a coverage for almost all countries in the world. As a consequence, data on this indicator is available for over 100 countries globally. The indicator can also be disaggregated by gender and substance based on the data available.

Data on prevalence of alcohol use disorders  are currently available for 188 Member States (for 2012, 2016, 2019) and validated through the process of country consultation. Data are regularly updated and presented through WHO Global Health Observatory. For utilization of treatment by people with alcohol use disorders, data are currently available for at least 30 countries and further data collection is ongoing For contextual information on treatment services, WHO has collected data from 145 countries for 2019 and extended to all countries using multiple imputation (described above). New round of data collection is taking place in 2023-2024..

**Time series:**

During 2015-2021, data are available for over XX countries for at least two years for both numerator and denominator necessary for the calculation of the SDG indicator on drug use disorders.   For the alcohol, data on denominator are available for a long period since establishment of GISAH in 1997 and the

indicator has been tentatively calculated for at least 30 countries in 2019, with contextual comparable information available for 188 countries.

**Disaggregation:**

Given the policy importance, the indicator will be disaggregated to provide data for drugs and alcohol. Depending on data availability, it will be additionally disaggregated by following:

- by treatment interventions (pharmacological, psychosocial, rehabilitation and aftercare)
- by sex
- by age groups

In relation to drug use disorders, the following types of drugs should be considered:

- cannabis (including herb and resin)
- opioids (opium, heroin, medicinal products containing opioids and other opioids)),
- cocaine type,
- amphetamines (amphetamine, methamphetamine, medicinal products containing ATS),
- ecstasy-type substances,
- sedatives and tranquilizers,
- hallucinogens
- solvents and inhalants
- new psychoactive substances (NPS)

# 6. Comparability / deviation from international standards (COMPARABILITY)

**Sources of discrepancies:**

Given the heterogeneity of national data collection systems, there is potential for discrepancies related either to the differences in recording the number of people in treatment and for people with substance use disorders. For this purpose, the Annual Report Questionnaire (ARQ) as well as the relevant WHO data collection tools have recently been improved to allow for countries to specify the nature of the data reported and to enable UNODC and WHO to assess the accuracy and comparability of data.

Apart from evaluating the consistency of data and addressing data discrepancies by using additional sources, UNODC and WHO are in continuous communication and discusses technical issues with reporting countries in order to minimize discrepancies and inconsistency of data.

# 7. References and Documentation (OTHER_DOC)

**URLs:**

https://www.who.int/data/gho/data/themes/resources-for-substance-use-disorders
https://wdr.unodc.org/wdr2019/
https://www.who.int/data/global-health-estimates
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5608813/
https://icd.who.int/browse10/2016/en
https://icd.who.int/en
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