Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

ALCOHOL POLICY SCORING

Assessing the level of implementation of the WHO Global strategy to reduce the harmful use of alcohol in the Region of the Americas.

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Foreword

Monitoring progress is a key component whenever planning and committing to implement health strategies, as it can help guide needed improvements and identify and respond to gaps in the public health response. Thus, in any given society, it becomes a mechanism for accountability to governments and other stakeholders involved. This report describes the construction of a series of composite indicators developed for evaluating the level of implementation of the ten policy areas of the WHO *Global strategy to reduce the harmful use of alcohol (1)* adopted in 2010 at the World Health Assembly (WHA)—and furthermore adopted in 2011 by all Member States in the Region of the Americas (hereafter referred to as "the Region" or simply "the Americas") through the *Regional plan of action (2)* of the Pan American Health Organization, Regional Office of the World Health Organization (PAHO/WHO).

The composite indicators comprise 34 summary indicators and reflect the 10 action areas in the global strategy. They measure whether a Member State has implemented a policy measure and has considered the level of empirical support for the measure's effectiveness, as well as the measure's level of strictness and comprehensiveness. As such, the composite indicators allow monitoring to go beyond solely tracking whether a Member State has a specific alcohol policy, to a more fine-grained approach of evaluating its individual components.

The methodology used in this report was developed by the WHO Regional Office for Europe (WHO/EURO). The data used were derived from the responses made by Member States in the Americas to the last WHO *Global survey on alcohol and health* in 2016 *(21)* and *ATLAS on Substance Use (ATLAS-SU): resources for the prevention and treatment of substance use disorders* in 2014 *(22)*. The report also includes an annex with a profile for each of 33 Member States in the Americas covering all ten areas of the WHO global strategy. The report serves as a useful guide in areas where alcohol policies and actions need strengthening in order to reduce the harmful use of alcohol at the national level. Despite caution being needed in the interpretation of some of the results, given the caveats identified, this report constitutes the first comparative assessment of alcohol policy implementation in the Americas. It thus provides a comprehensive overview of the various regional and national scenarios, as well as essential elements to further improve methods for evaluating the implementation of alcohol policy.

Acknowledgments

This publication would not have been possible without the contribution of many partners. We would especially like to acknowledge the work of the individuals listed below:

Lars Moller, International Consultant, authored the first draft of the report, adapting the methodology from the WHO Office in Europe and analyzing the data from the Region.

Pamela Trangenstein, Fellow at the Alcohol Research Group, revised the document and contributed technical expertise for its finalization.

Maristela Monteiro, Department of Noncommunicable Diseases and Mental Health (NMH) of the Pan American Health Organization (PAHO), revised the report and provided guidance and vision, as well as technical expertise on the data presented throughout the process.

Devora Kestel, Department of Noncommunicable Diseases and Mental Health (NMH) of the Pan American Health Organization (PAHO), revised the report and provided guidance for its completion.

Lalla-Arkia Maiga, Department of Noncommunicable Diseases and Mental Health (NMH) of the Pan American Health Organization (PAHO), contributed to the production of this report by revising and editing the document.

Natalia Toscano, Department of Noncommunicable Diseases and Mental Health (NMH) of the Pan American Health Organization (PAHO), designed the cover page and contributed to the publication process of this document.

A special thanks to Suzanna Stephens, PAHO retiree, for professionally editing and formatting the document for publication.

List of acronyms

APC	Adult per capita consumption
ATLAS-SU	ATLAS on Substance Use: resources for the prevention and treatment of substance use disorders
BAC	Blood alcohol content
cL (cl, CL)	Centiliter(s) (all versions appear on the Internet, so the case used appears to be irrelevant)
g	Gram(s)
GISAH	Global information system for alcohol and health
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Revision
NCDs	Noncommunicable diseases (also known as chronic diseases)
PAHO/WHO	Pan American Health Organization, Regional Office of the World Health Organization
PPP	Purchasing power parity
SI	Summary indicator
WHA	World Health Assembly
WHO	World Health Organization
WHO/EURO	World Health Organization, Regional Office for Europe

Part I: Implementation status in the Americas of the WHO *Global strategy to reduce the harmful use of alcohol*

Global and regional context of alcohol policy

Momentum in international alcohol policy has gained pace slowly but surely. In May 2010, the World Health Assembly (WHA) of the World Health Organization (WHO) adopted Resolution WHA63.13, which endorsed the *Global strategy to reduce the harmful use of alcohol* (hereafter referred to as the "global strategy") *(1)*. Through a broad consultation process involving multiple stakeholders, all 193 WHO Member States arrived at this historical consensus on ways to reduce alcohol-related harm. The aims of the global strategy are to increase governments' commitment, strengthen the knowledge base, enhance capacity in Member States, foster partnerships and coordination, and improve monitoring and surveillance systems. The overarching goal is to curb the harmful use of alcohol.

The strategy also includes a set of evidence-based interventions grouped into 10 areas for action (see Table 1). The Pan American Health Organization, Regional Office of the World Health Organization (PAHO/WHO) subsequently developed its regional *Plan of action to reduce the harmful use of alcohol* (hereafter referred to as the "regional action plan"), which all its Member States adopted in September 2011 *(2)*. The regional action plan called for implementing technical cooperation activities at the country level, focusing on the ten target areas proposed by the global strategy, for a period of ten years (2012–2021).

However, several policy measures can contribute to a single target area; a policy can vary in the degree of rigor or severity applied in its regulation, its comprehensiveness in covering the target area, and its ability for continual alignment with changing circumstances (e.g., adjusting taxes for inflation or cost of living). Therefore, without a standard method for assessing policies, it is difficult to know how a country is doing in terms of implementing the target areas proposed by the global strategy and assessing progress made in implementing the plan of action, both at the country and regional levels. Therefore, this report utilized a methodology developed and validated by the WHO Regional Office for Europe (WHO/EURO) to generate summary indicators for use in alcohol policy assessment. Given that the countries of the Americas used the same questionnaires,

during the same years, to collect the same data on alcohol policies, most countries in the Americas were able to generate summary indicators.

Table 1: The *Global strategy to reduce the harmful use of alcohol*—areas for policy options and interventions

Target areas	Options for policies and interventions
1. Leadership, awareness, and commitment	Political commitment through adequately funded, comprehensive, and multisectoral national policies that are evidence based and tailored to each local context
2. Health services' response	Providing preventive services and treatment to individuals and families at risk of, or affected by, alcohol use disorders and associated conditions
3. Community and workplace action	Harnessing the local knowledge and expertise of communities to change collective behavior
4. Drink-driving policies and countermeasures	Introducing measures to deter people from driving under the influence of alcohol; creating a safer driving environment to minimize the likelihood and severity of alcohol-involved road traffic crashes
5. Availability of alcohol	Preventing easy access to alcohol for vulnerable and high-risk groups; reducing the social availability of alcohol so as to change social and cultural norms that promote the harmful use of alcohol
6. Marketing of alcoholic beverages	Protecting young people by regulating both the content of alcohol marketing and the amount of exposure to that marketing
7. Pricing policies	Increasing the prices of alcoholic beverages to reduce underage drinking, halt progression towards drinking large volumes of alcohol and/or episodes of heavy drinking, and influence consumers' choices
8. Reduction of the negative consequences of drinking and alcohol intoxication	Reducing the harm from alcohol intoxication by managing the drinking environment and informing consumers
9. Reduction of the public health impact of illicit alcohol and informally produced alcohol	Reducing the negative consequences of informal or illicit alcohol through good market knowledge, an appropriate legislative framework, and active enforcement of measures
10. Monitoring and surveillance	Developing surveillance systems to monitor the magnitude of and trends in alcohol-related arms, to strengthen advocacy, to formulate policies, and to assess the impact of interventions

Source: World Health Organization (WHO) *(1)*

Aims of the composite indicators

Despite the policy resources that PAHO has made available, the countries of the Americas continue to experience alarming levels of alcohol-attributable harm. A gap is suggested by this disconnect, one that lies between what is known and what is practiced. Under these circumstances, there is a need for a standardized method of determining the extent to which governments have adopted the recommended best practices as reflected in the global strategy and the regional action plan. One way of measuring multidimensional phenomena (e.g., countries' level of alcohol policy development) is to construct composite indicators based on an underlying model *(3)*. For WHO Member States in the Americas, this report describes 10 novel composite indicators that quantify national alcohol strategies and plans (that is, the number of policies present and the degree to which each policy meets certain prescribed standards). In addition, it describes the extent to which individual Member States have implemented the strategies outlined in the regional action plan, as well as the strengths and limitations of the composite indicators.

Methods

Data sources

The main data sources for this analysis were the Global Information System on Alcohol and Health (GISAH) *(23)* and the *ATLAS on Substance Use (ATLAS-SU): resources for the prevention and treatment of substance use disorders (22)*. Data for this project are largely based on WHO's *Global survey on alcohol and health,* conducted in 2016 *(21),* and the ATLAS-SU questionnaire utilized in 2014 *(22)*.

Construction of the scoring scheme

The purpose of developing the scoring scheme was to establish a logical and consistent process for condensing a large volume of policy information collected by the global survey, so that it produced a score for each country and for each of the 10 action areas in the regional action plan. Important considerations during this phase were as follows:

- All 10 action areas of the global strategy must be represented in the scores.
- It should be possible in theory for all Member States in the Americas to attain the maximum score.
- Policy options that are more actively promulgated by WHO should receive higher scores.
- More effective policies should receive higher scores than less effective policies.
- The scoring scheme should be grounded in scientific evidence and reflect current best practices.

WHO/EURO was behind the initial development of the process, where an expert advisory group selected a subset of survey questions from the WHO/GISAH questionnaire to form an appropriate foundation for policy benchmarking and for evaluating the implementation of the global strategy. The experts then thematically grouped the selected questions to form summary indicators (SIs), where each SI measured one dimension of alcohol control. In the end, the 34 SIs were categorized into one of each of the 10 action areas (see Figures 1 and 2, Table 2). The complete list of survey questions used in this study is presented in Annex I.

Figure 1: Three-step process for creating summary indicators and composite indicators

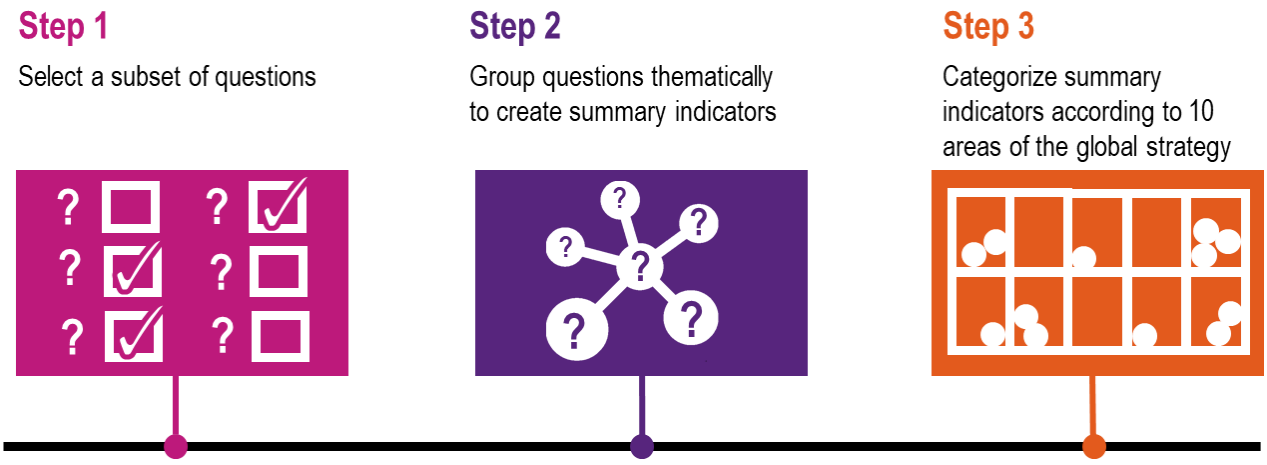


Figure 2: Ten composite indicators

Table 2: Composite and summary indicators

Composite Indicators	Summary Indicators
1. Leadership, awareness, and commitment	1.1 National policy document on alcohol 1.2 Definition of an alcoholic beverage 1.3 Definition of a standard drink 1.4 Awareness activities
2. Health services' response	2.1 Screening and brief interventions for harmful and hazardous alcohol use 2.2 Special treatment programs 2.3 Pharmacological treatment
3. Community and workplace action	3.1 School-based prevention and reduction of alcohol-related harm 3.2. Workplace-based prevention of and counseling for alcohol problems 3.3 Community-based interventions to reduce alcohol-related harm
4. Drink–driving policies and countermeasures	4.1 Maximum legal blood alcohol content (BAC) limit when driving a vehicle 4.2 Enforcement using sobriety checkpoints 4.3 Enforcement using random breath-testing 4.4 Penalties
5. Availability of alcohol	5.1 Lowest age limit for alcohol service on the premises and sale of alcohol for consumption off the premises 5.2 Control of retail sales 5.3 Restrictions on availability by time 5.4 Restrictions on availability by place 5.5 Restrictions on sales at specific events 5.6 Alcohol-free public environments
6. Marketing of alcoholic beverages	6.1 Legally binding restrictions on alcohol advertising 6.2 Legally binding restrictions on product placement 6.3 Legally binding restrictions on industry sponsorship for sporting and youth events 6.4 Legally binding restrictions on sales promotions by producers, retailers and owners of pubs and bars
7. Pricing policies	7.1 Adjustment of taxation level for inflation 7.2 Affordability of alcoholic beverages 7.3 Other price measures
8. Reducing the negative consequences of drinking and alcohol intoxication	8.1 Server training 8.2 Health warning labels
9. Reducing the public health impact of illicit alcohol and informally produced alcohol	9.1 Use of duty-paid or excise stamps on alcohol containers 9.2 Estimates of unrecorded alcohol consumption 9.3 Legislation to prevent illegal production and sale of alcoholic beverages
10. Monitoring and surveillance	10.1 National system for monitoring 10.2 National surveys

After creating the summary and composite indicators, the group introduced scales to quantify the number of policies implemented by each country, as well as the level of scientific support for the chosen policies. The scales depended on the topic and reflected the following criteria, where appropriate:

- **Stringency:** The degree of rigor or severity of the corresponding regulations (e.g., a higher minimum legal purchase age)
- **Comprehensiveness:** The degree to which the regulation covers the dimension completely or comprehensively (e.g., a monitoring system that includes consumption and related harms)
- **Recency:** The degree to which the regulation is aligned with current circumstances (e.g., adjusting excise taxes for inflation)

Annex II provides more details on the construction of summary indicators for various policy areas.

Generation of scores

Of the 35 Member States in the Americas, 33 submitted data appropriate for use in generating the composite indicators. Member States' responses were first retrieved from the datasets compiled by WHO and then validated by the respective focal points at the respective ministries of health who had been nominated as contact persons for WHO. The most recent available data were used. Missing values were replaced with zero points. Composite indicators were not calculated if data were missing for two or more data points in two or more SIs in a Member State. Figure 3 shows the number of composite indicators generated for each action area by the countries of the Americas.

Scoring scheme

The finalized scoring scheme consisted of 34 SIs categorized into the 10 action areas contained in the global strategy (see Table 3). Most of the SIs encompassed more than one policy variable. Annex II further presents detailed scoring rubrics that show the precise composition of each SI.

Figure 3: Number of Member States participating in each action area

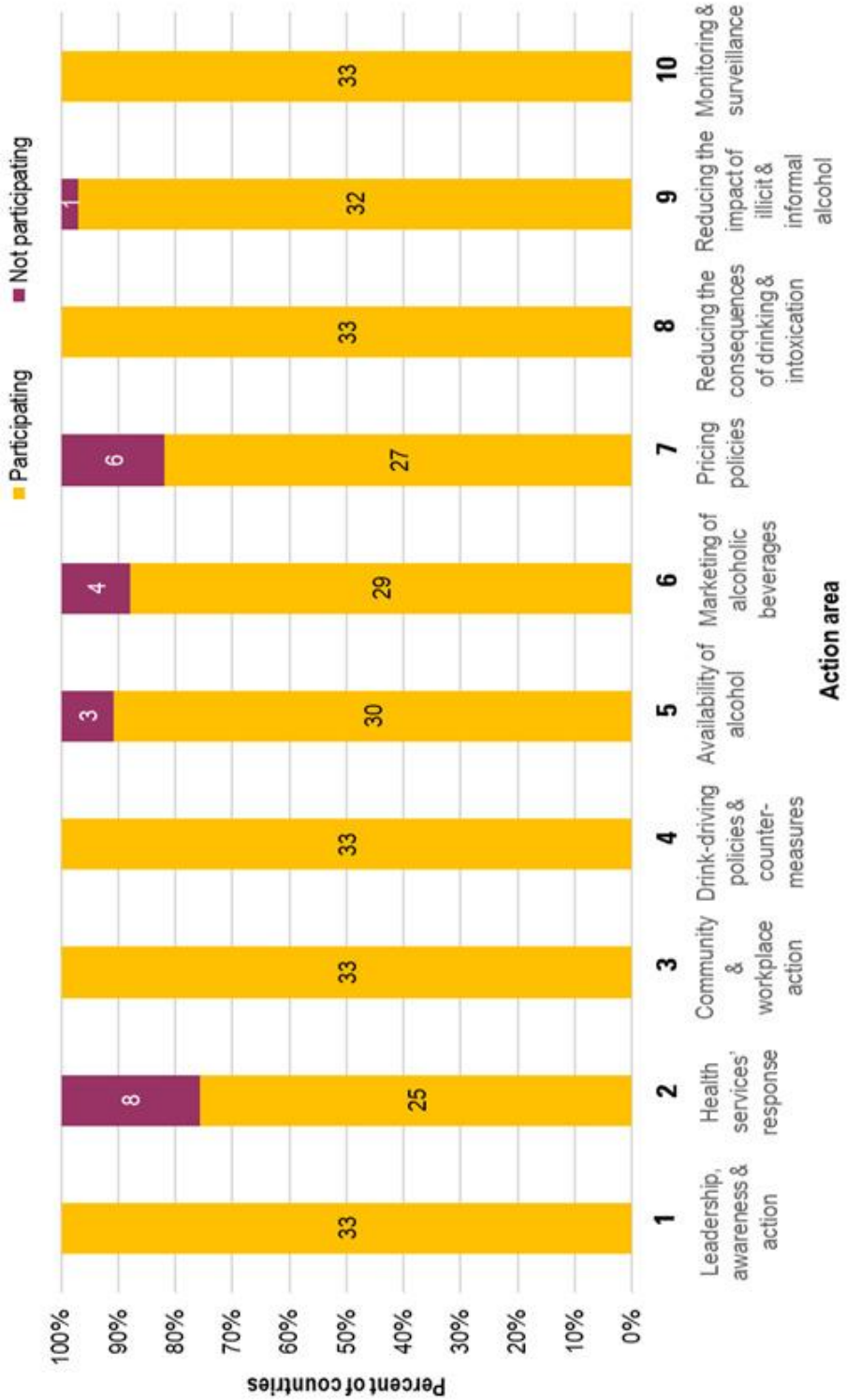


Table 3: Overview of scoring scheme for the composite indicators

	Maximum raw score	Multiplier level	Weighted score
1. *Leadership, awareness, and commitment*			
1.1 National policy document on alcohol	4	3	12
1.2 Definition of an alcoholic beverage	1	2	2
1.3 Definition of a standard drink	1	1	1
1.4 Awareness activities	4	2	8
	Total possible points [a]		*23*
2. *Health services' response*			
2.1 Screening and brief interventions for harmful and hazardous alcohol use	8	3	24
2.2 Special treatment programs	4	2	8
2.3 Pharmacological treatment	4	3	12
	Total possible points		*44*
3. *Community and workplace action*			
3.1 School-based prevention and reduction of alcohol-related harm	2	2	4
3.2. Workplace-based prevention of and counseling for alcohol problems	6	2	12
3.3 Community-based interventions to reduce alcohol-related harm	3	2	6
	Total possible points		*22*
4. *Drink-driving policies and countermeasures*			
4.1 Maximum legal BAC limit when driving a vehicle	5	5	25
4.2 Enforcement using sobriety checkpoints	3	3	9
4.3 Enforcement using random breath-testing	4	4	16
4.4 Penalties	4	4	16
	Total possible points		*66*
5. *Availability of alcohol*			
5.1 Lowest age limit for alcohol service on the premises and sale of alcohol for consumption off the premises	4	4	16
5.2 Control of retail sales	4	3	12
5.3 Restrictions on availability by time	4	3	12
5.4 Restrictions on availability by place	4	3	12
5.5 Restrictions on sales at specific events	3	3	9
5.6 Alcohol-free public environments	11	3	33
	Total possible points		*94*

		Maximum raw score	Multiplier level	Weighted score
6.	*Marketing of alcoholic beverages*			
6.1	Legally binding restrictions on alcohol advertising	4	3	12
6.2	Legally binding restrictions on product placement	4	3	12
6.3	Legally binding restrictions on industry sponsorship for sporting and youth events	4	3	12
6.4	Legally binding restrictions on sales promotions by producers, retailers, and owners of pubs and bars	4	3	12
			Total possible points	*48*
7.	*Pricing policies*			
7.1	Adjustment of taxation level for inflation	4	3	12
7.2	Affordability of alcoholic beverages	4	4	16
7.3	Other price measures	14	3	42
			Total possible points	*70*
8.	*Reducing the negative consequences of drinking and alcohol intoxication*			
8.1	Server training	3	2	6
8.2	Health warning labels	5	2	10
			Total possible points	*16*
9.	*Reducing the public health impact of illicit alcohol and informally produced alcohol*			
9.1	Use of duty-paid or excise stamps on alcohol containers	3	3	9
9.2	Estimates of unrecorded alcohol consumption	3	3	9
9.3	Legislation to prevent illegal production and sale of alcoholic beverages	6	2	12
			Total possible points	*30*
10.	*Monitoring and surveillance*			
10.1	National system for monitoring	23	3	69
10.2	National surveys	4	3	12
			Total possible points	*81*

[a] Total possible points after weighting by the multiplier level.

Results

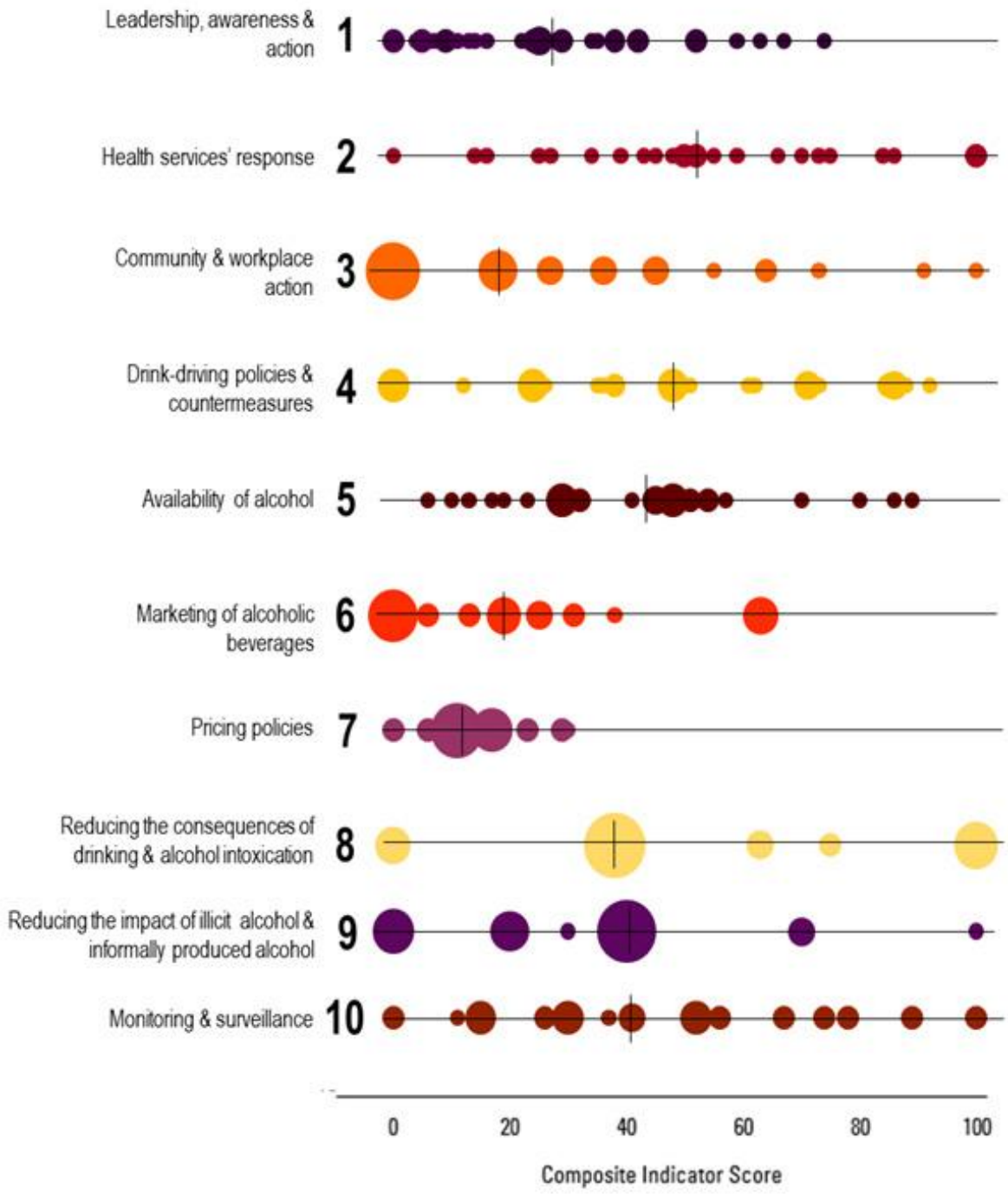
Regional Scores and rankings

The composite indicators were calculated for 33 of the 35 Member States in the Americas with sufficient data. Rescaling of country scores for each action area used a scale that ranged from 0 to 100 for ease of comparison. The mean, median, minimum, and maximum scores observed for the Americas are presented in Annex III.

Figure 4 shows the distribution of country scores by action area, with the size of each circle representing the number of countries with a given score (with larger circles indicating that greater numbers of countries have that score) and the vertical lines representing the median. In general, Member States' average scores were highest in health services' response (mean: 53; range: 0–100); reducing the negative consequences of drinking and alcohol intoxication (mean: 52; range: 0–100); drink-driving policies and countermeasures (mean: 48; range: 0–92); monitoring and surveillance (mean: 46; range: 0–100); and physical availability of alcohol (mean: 43; range: 6–89), which is one of WHO's "best buys."[1] However, WHO's two other best buys—pricing policies (mean: 14; range: 0–30) and marketing of alcoholic beverages (mean: 21; range: 0–63)—had the lowest average scores. Average scores were also low for leadership, awareness, and commitment (mean: 28; range: 0–74); community and workplace action (mean: 27; range: 0–100); and reducing the public health impact of illicit alcohol and informally produced alcohol (mean: 32; range: 0–100).

[1] WHO identified three "best buys" in Appendix 3 of the *Global regional action plan for the prevention and control of NCDs 2013–2020 (24)*. In the fight to combat the epidemic of chronic noncommunicable diseases, these policies are both effective and cost-effective in low- and middle-income countries. The "best buys" for alcohol are (a) restricting availability of alcohol, (b) pricing policies, and (c) regulations on the marketing of alcoholic beverages.

Figure 4: Distribution of composite indicators



Geographic distribution of scores for the most cost-effective policies

Figure 5 includes three maps displaying scores for the WHO "best buys": physical availability of alcohol, marketing of alcoholic beverages, and pricing policies.

Physical availability of alcohol

In Figure 5-A, Costa Rica (89), Ecuador (86), and Chile (80) had the highest scores for the composite indicator on physical availability of alcohol; the lowest scores were from Argentina (5), Suriname (10), and Barbados (13).

Marketing of alcoholic beverages

Colombia, Dominica, the Dominican Republic, Mexico, and Saint Kitts and Nevis all had the highest score on the composite indicator for marketing of alcoholic beverages (63, shown in Figure 5-B). Ten countries (Barbados, Cuba, El Salvador, Grenada, Guatemala, Peru, Saint Lucia, Saint Vincent and the Grenadines, the United States of America, and Venezuela) had a score of 0 (see Figure 5-B).

Pricing Policies

Peru (30), Costa Rica (29), and the Dominican Republic (29) had the highest scores on the composite indicator for pricing policies, while Saint Vincent and the Grenadines and the United States of America both received no points (see Figure 5-C). Noteworthy is that the composite indicator for pricing policies had the highest levels of missing values; and six countries (Antigua and Barbuda, Barbados, Cuba, Ecuador, Guyana, and Honduras) did not have enough information to calculate this composite indicator.

Figure 5: Maps of composite indicator scores for "best buys," by country

A. Marketing of alcoholic beverages

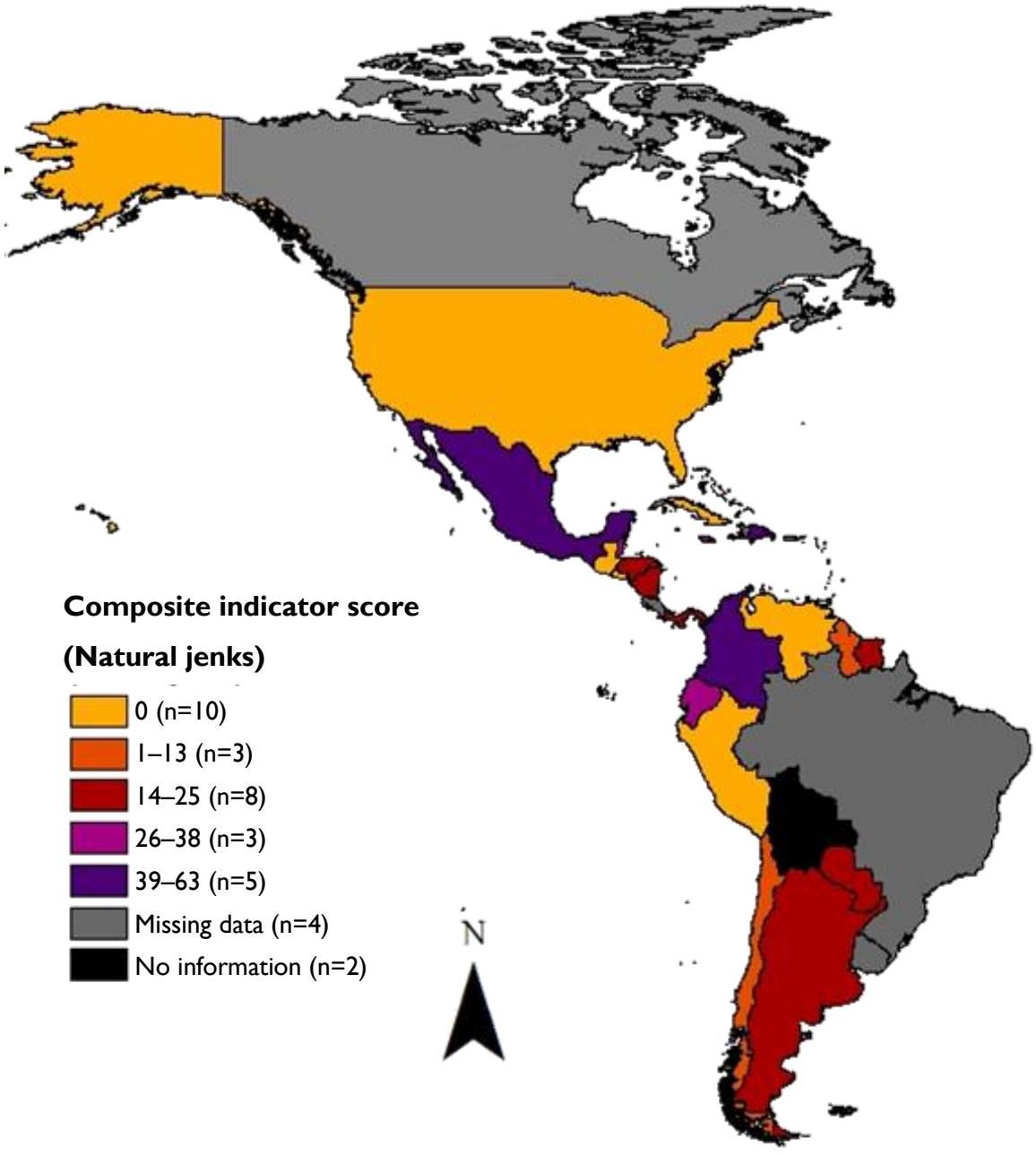


Figure 5: Maps of composite indicator scores for "best buys," by country (cont'd)

B. Physical availability of alcohol

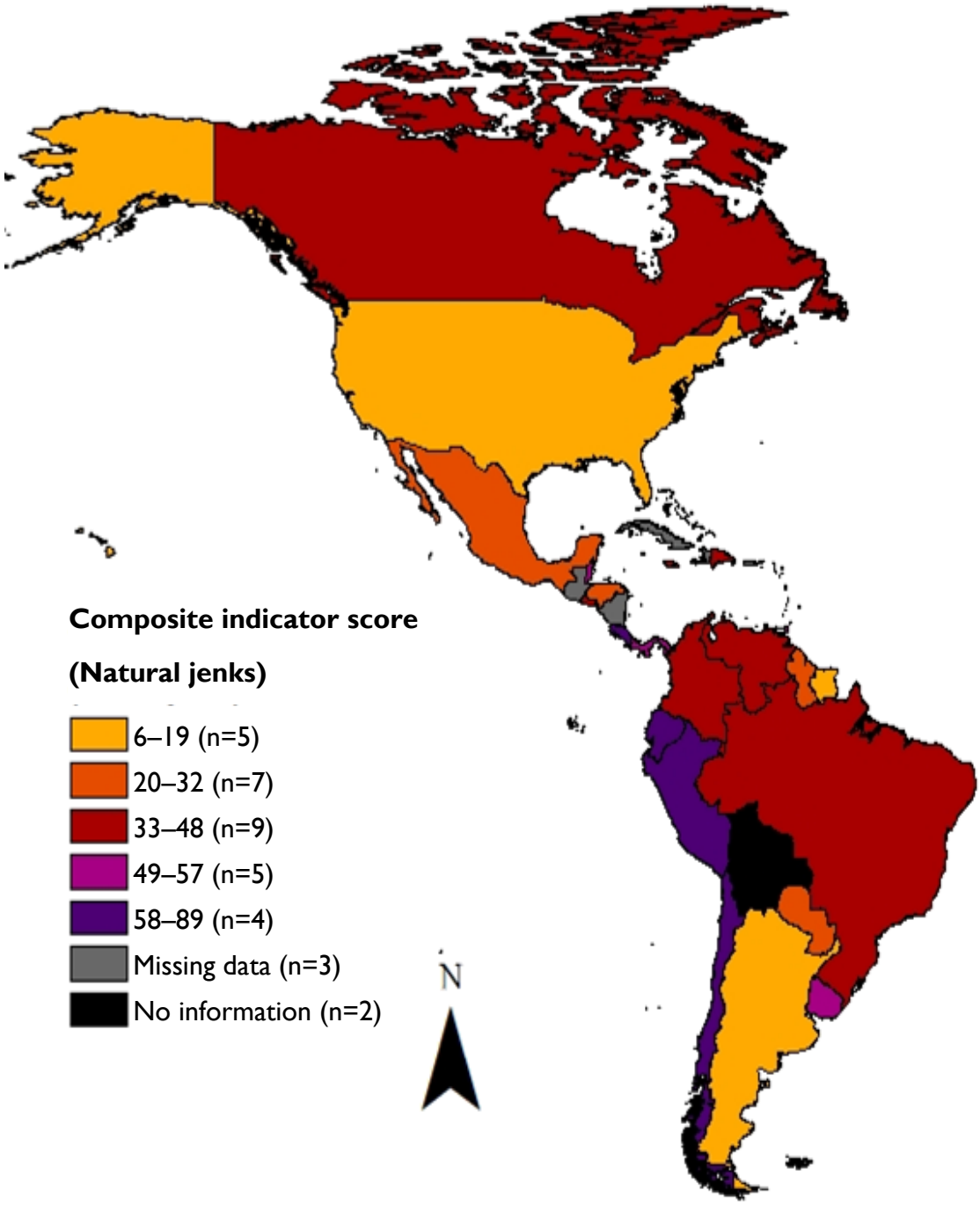
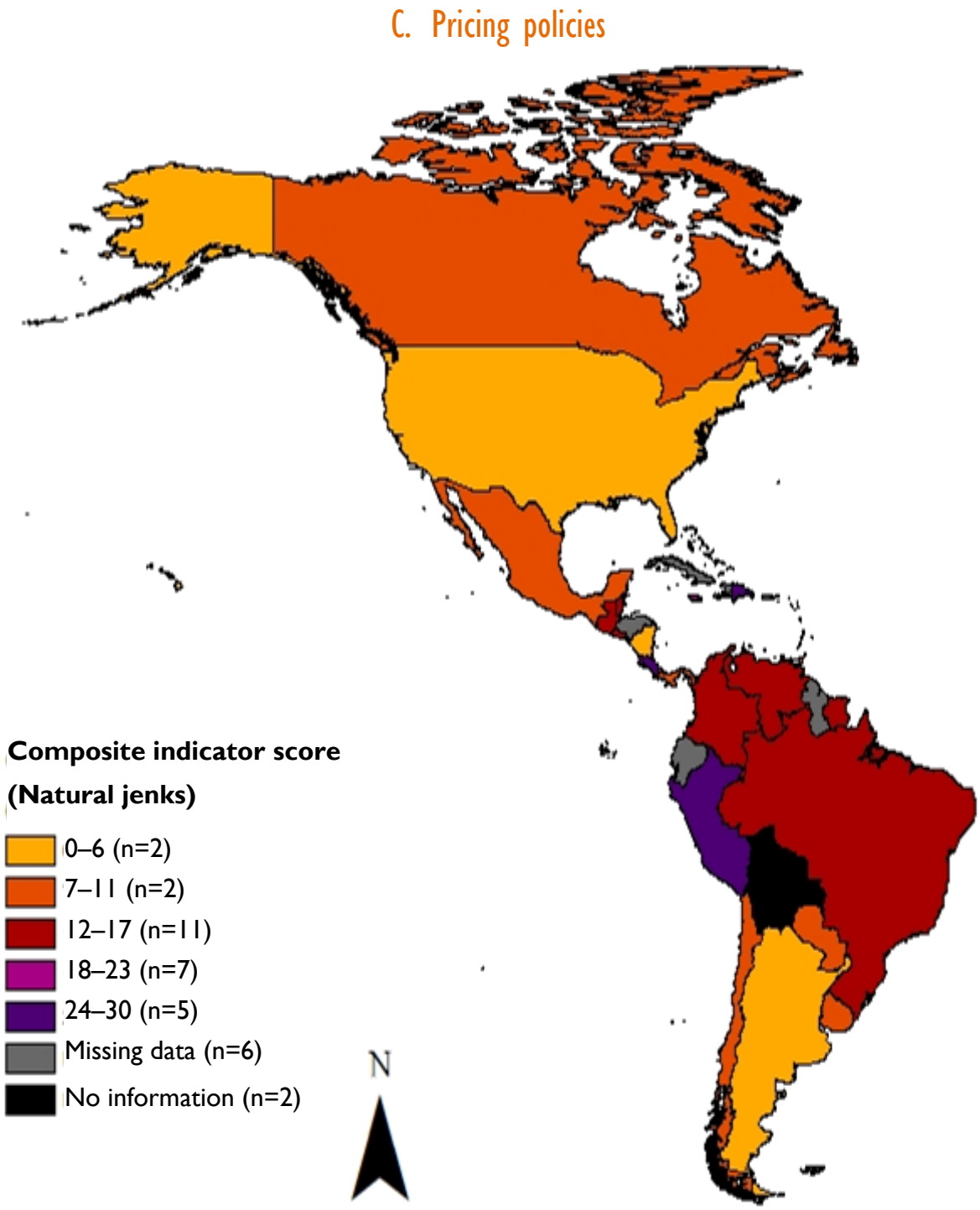


Figure 5: Maps of composite indicator scores for "best buys," by country (cont'd)



Geographic distribution of scores for the other policy areas

Figure 6 shows the geographic distribution of scores for the other seven alcohol policy areas in the countries in the Americas.

Argentina (74), Colombia (67), and Brazil (63) had the highest scores for leadership, awareness, and action (see Figure 6-A). Antigua and Barbuda, as well as Saint Vincent and the Grenadines, received no points for leadership, awareness, and action. In addition, Saint Lucia (4), Nicaragua (5), Honduras (5), Canada (7), Dominica (9), and Venezuela (9) had scores of less than 10 for leadership, awareness, and action.

Health services' response, community and workplace action, reducing the harmful consequences of drinking and intoxication, reducing the public health impact of illicit and informally produced alcohol, and monitoring and surveillance had the largest range of scores, with at least one country receiving both the maximum (100) and minimum (0) possible scores. For health services' response, El Salvador and Brazil received the maximum 100 points (see Figure 6-B), and the United States received the maximum 100 points for community and workplace action (see Figure 6-C). Costa Rica (92), Uruguay (88), Brazil (86), Colombia (86), and Paraguay (86) had the highest scores on drink-driving policies and countermeasures; at the same time, Barbados, Dominica, Guatemala, and Mexico had the lowest scores for drink-driving policies and countermeasures (0) (see Figure 6-D).

Reducing the harmful consequences of drinking and intoxication resulted in the most countries having maximum scores (with a total of eight countries: Argentina, Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, Guatemala, and Panama; see Figure 6-E). Venezuela received 100 points for reducing the public health impact of illicit and informally produced alcohol (see Figure 6-F). Trinidad and Tobago, along with the United States, received 100 points for monitoring and surveillance (see Figure 6-G). Grenada received no points for health services' response, and 12 countries (Argentina, Antigua and Barbuda, Brazil, Canada, Costa Rica, Dominica, Guatemala, Guyana, Honduras, Jamaica, Saint Kitts and Nevis, and Saint Vincent and the Grenadines) received no points for community and workplace action. Five countries (Barbados, Canada, Jamaica, Saint Lucia, and Saint Kitts and Nevis) received no points for reducing the harmful consequences of drinking and intoxication. Seven countries (Argentina, Barbados, Guatemala, Guyana, Mexico, Saint Lucia, and Uruguay) received no points for reducing the public health impact of illicit and informally produced alcohol. Finally, two countries (Saint Kitts and Nevis and Saint Vincent and the Grenadines) received no points for monitoring and surveillance.

Across all policy areas, Ecuador (68), Costa Rica (57), Brazil (54), and Colombia (54) had the highest average scores. Belize, Jamaica, and Venezuela had average scores that were equal to the median overall score (35). Saint Vincent and the Grenadines (13), Guyana (16), Antigua and Barbuda (19), and Guatemala (19) had the lowest average scores.

Figure 6: Maps of composite indicator scores by country for other policy areas

A. Leadership, awareness, and action

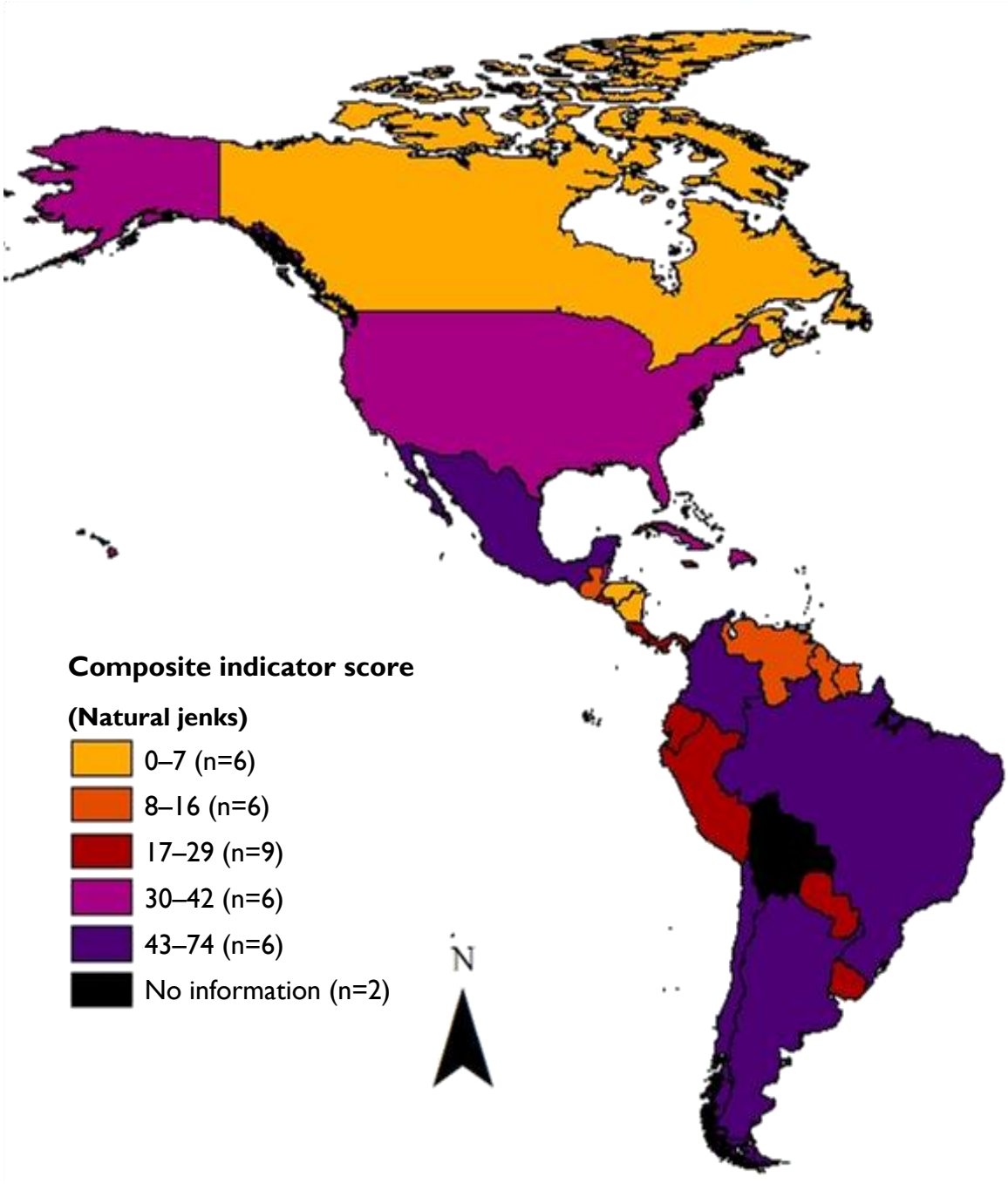


Figure 6: Map of composite indicator scores by country and other policy areas (cont'd)

B. Health services' response

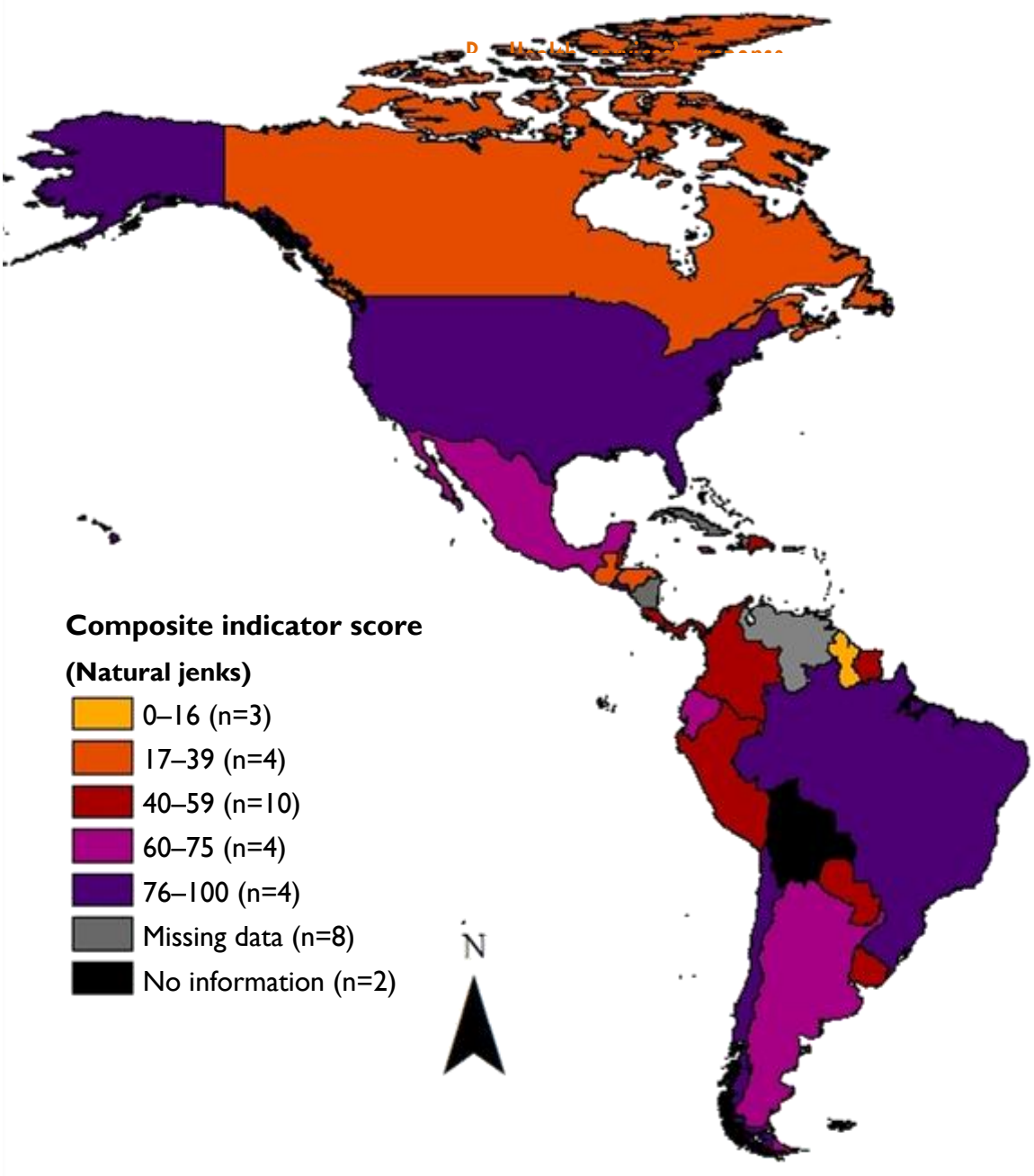


Figure 6: Map of composite indicator scores by country and other policy areas (cont'd)

C. Community and workplace action

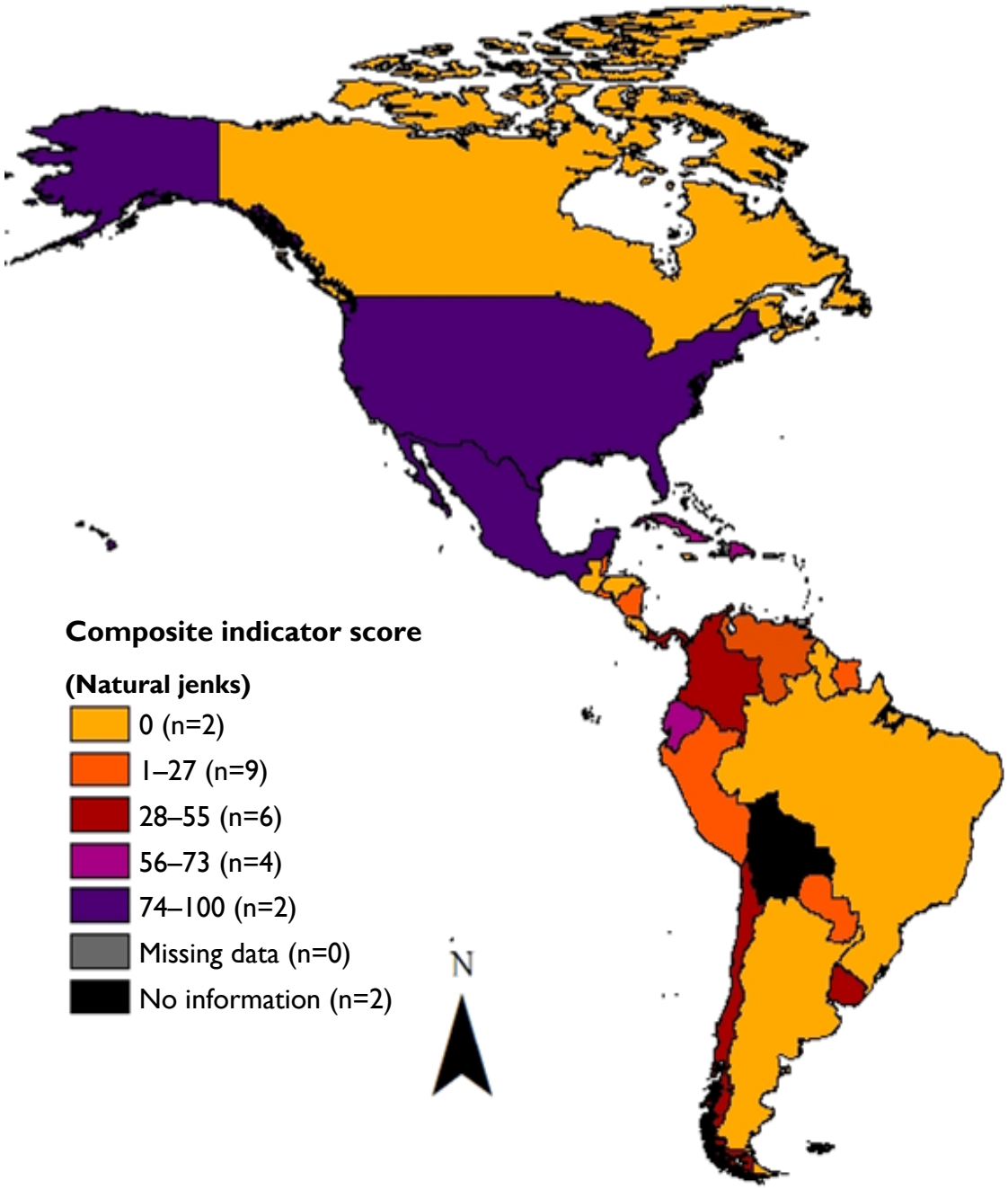


Figure 6: Map of composite indicator scores by country and other policy areas (cont'd)

D. Drink-driving policies & countermeasures

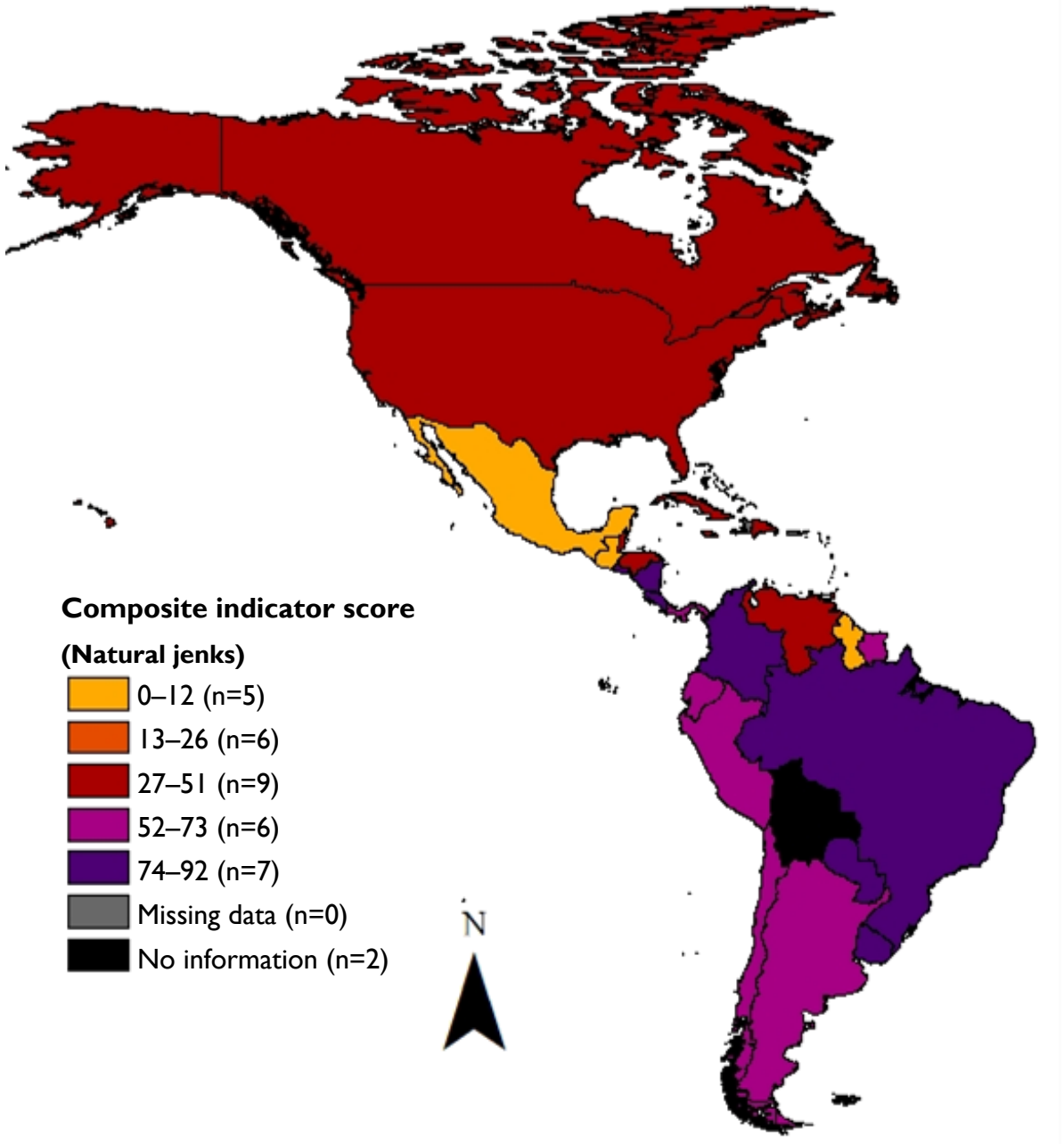


Figure 6: Map of composite indicator scores by country and other policy areas (cont'd)

E. Preventing the public health impact of illicit and informally produced alcohol

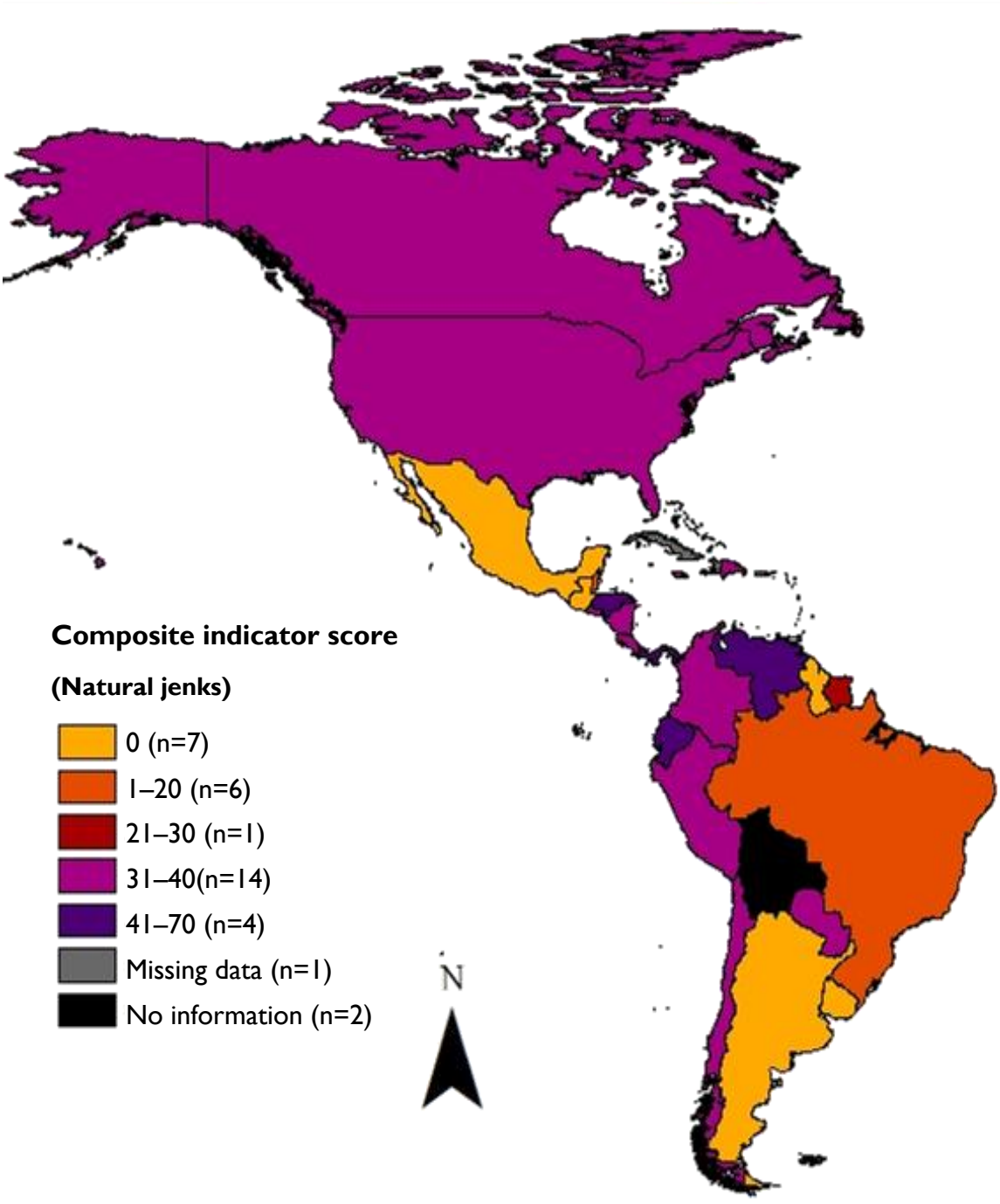


Figure 6: Map of composite indicator scores by country and other policy areas (cont'd)

F. Reducing the negative consequences of drinking and intoxication

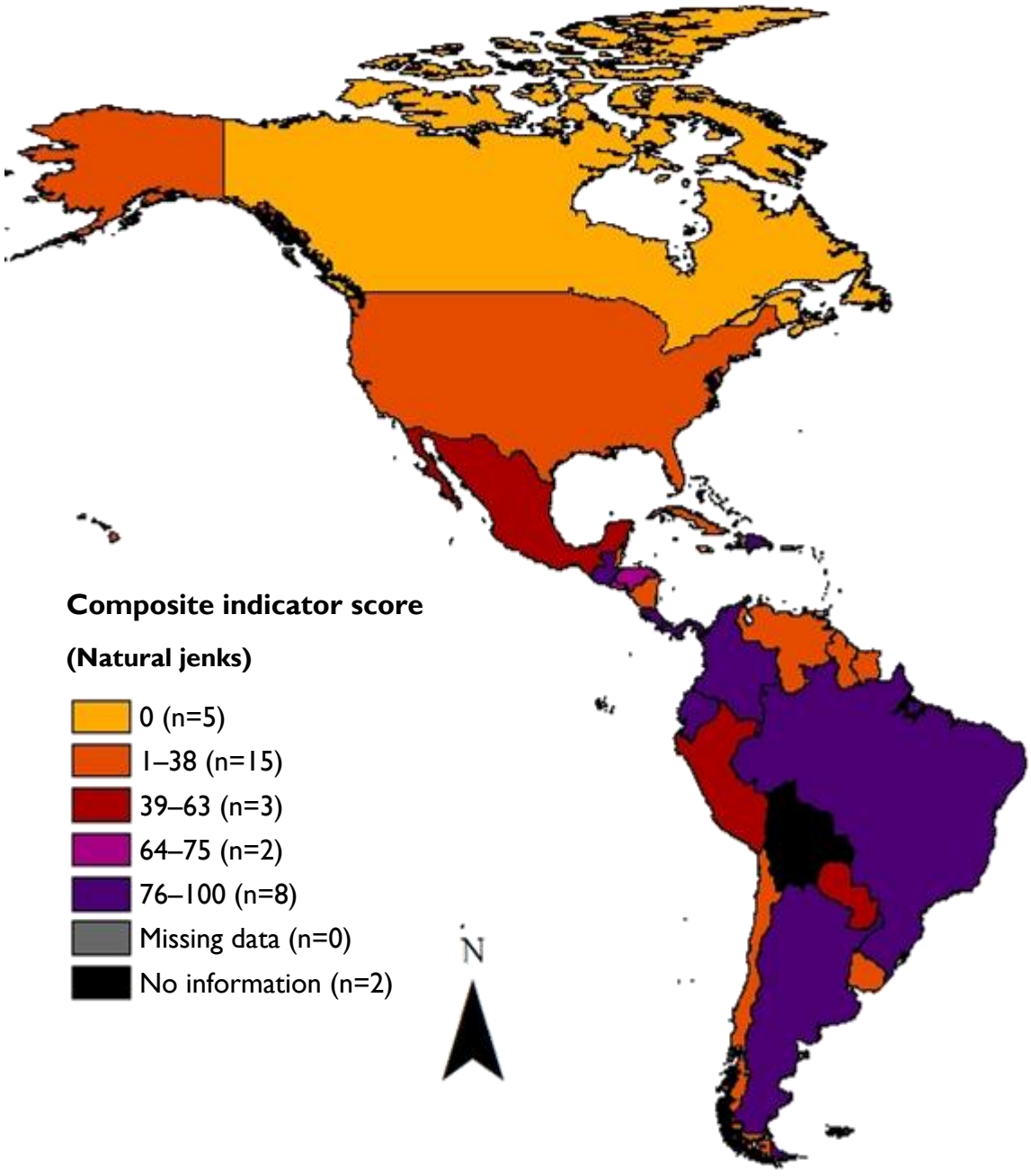
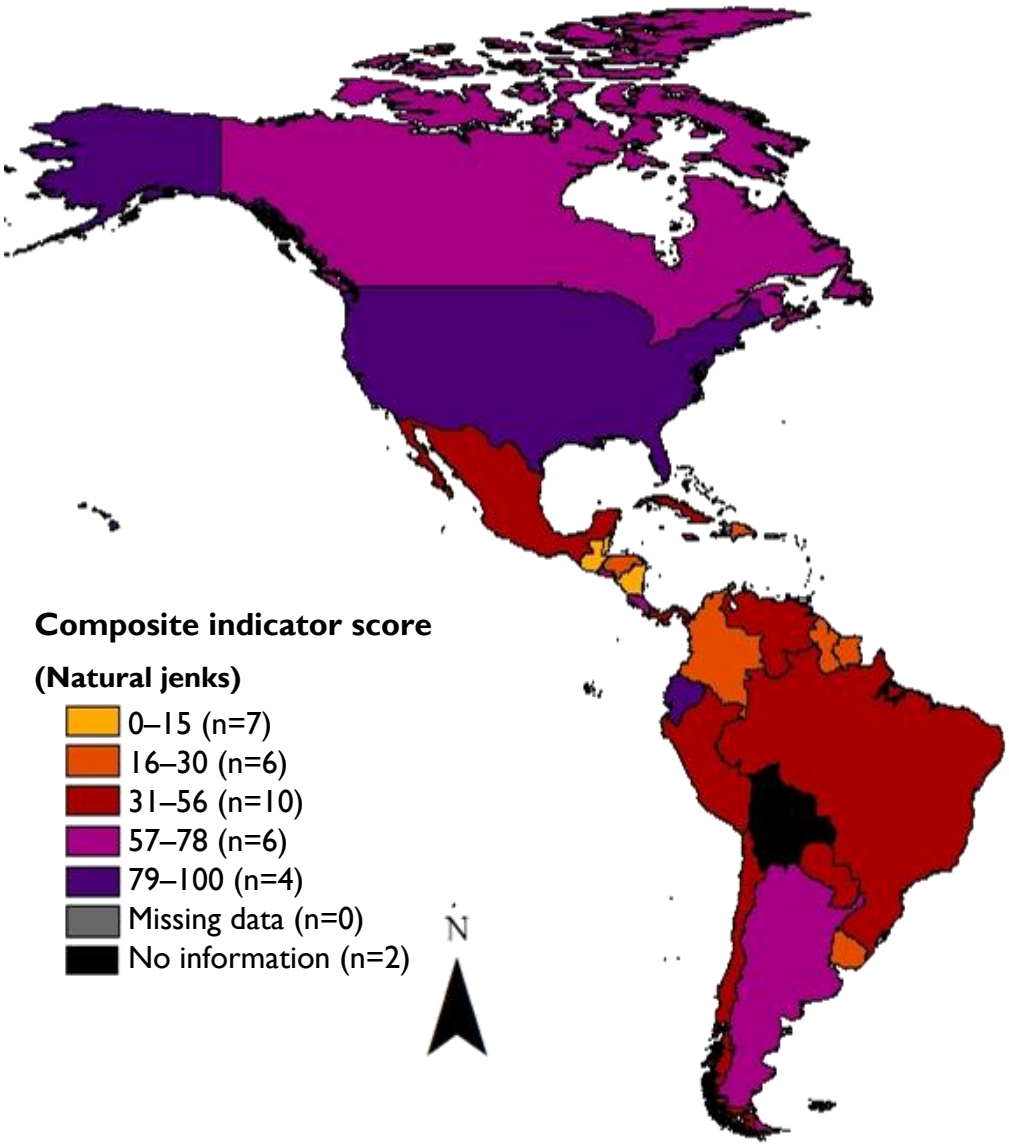


Figure 6: Map of composite indicator scores by country and other policy areas (cont'd)

G. Monitoring & surveillance



Part II of this report presents country profiles for each of the 33 Member States. It shows the composite scores for each alcohol policy area and compares them with the respective median regional score.

Discussion

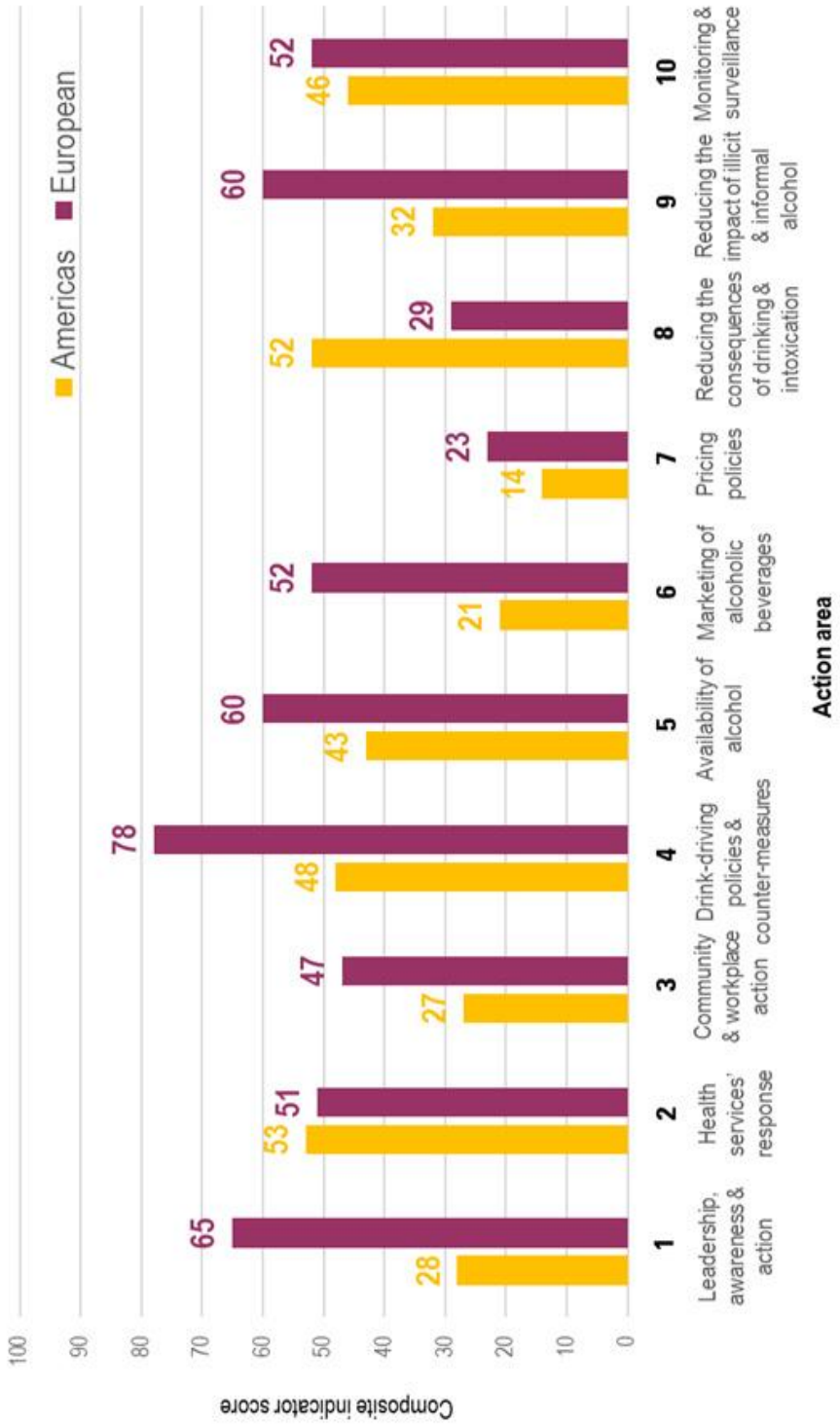
Summary of findings

The composite indicators were designed to assist Member States by indicating where they might make improvements in their alcohol policies, consistent with the global strategy and the regional action plan as well as the best evidence available from scientific studies. The final scoring scheme comprised 34 SIs spanning the 10 action areas described in the global strategy. The wide range of scores suggests that the composite indicators are sensitive enough to capture the different levels of alcohol policy implementation across the Americas.

Overall, there is room for every Member State to develop more comprehensive and stringent alcohol policies. Overall, the highest average scores (54–68) fall just above the midpoint of the scales, which demonstrates this margin for improvement. The greatest opportunity for improvements are in pricing (14, 11); marketing of alcoholic beverages (21, 19); community and workplace action (27, 18); leadership, awareness, and action (28, 25); and reducing the public health impacts of illicit and informally produced alcohol (32, 40). The justification lies in the fact that these areas have the lowest average and median scores, respectively. We encourage countries to use the scoring provided in this report as a benchmark to plan further work on alcohol policy, so as to achieve a measurable reduction in the harmful use of alcohol. As countries plan future policies, we also encourage them to use this report to identify fellow Member States that have adopted similar policies, in order to enable them to learn lessons from the process others have followed. Along with the global and regional status reports, which contain country-level data on alcohol consumption and harms, governments can use this report to assess the aforementioned ten action areas with the greatest opportunity to advance alcohol policies and establish a baseline for monitoring progress in years to come.

Scores were computed and analyzed for 33 of the 35 PAHO/WHO Member States, and they can be compared to the analyses done by WHO/EURO *(4, 5)*. This comparison is interesting because alcohol consumption and the harms related to alcohol are highest in the European Region, followed by the Americas. Therefore, alcohol policy implementation in these two regions might do well to proceed in accordance with the respective ranking. Indeed, when comparing the final scores for the two WHO regions, the scores for the Americas tended to be lower than those for Europe (see Figure 7).

Figure 7: Mean-scaled scores (0–100) for the WHO Americas and European Regions



This suggests that countries in the Americas have implemented fewer of the evidence-based approaches highlighted in both the global strategy and the regional action plan. For example, the average score for marketing of alcoholic beverages in the European Region (52) was more than twice the average score for the Americas (19). Only the mean scores for health services' response (53) and reducing the negative consequences of drinking and alcohol intoxication (52) were higher in the Americas than in Europe (51 and 29, respectively); and these were the two composite indicators with the highest mean scores in the Americas. At the same time—given the very high treatment gap for alcohol use disorders reported for the Americas *(6)*, the lower level of access to health services in general *(7)*, and high levels of alcohol-related violence *(11)*—it is likely that the questions related to these policy areas are not truly capturing each country's reality. While the mean score for drink-driving policies and countermeasures was among the highest in the Americas (48), it was well below Europe (78). Despite pricing policies being the best buy where the largest percentage of countries around the world reported making progress since 2010 *(5)*, both the Americas Region (9) and the European Region (21) had low average scores.

Robustness of the composite indicators

This analysis is intended to be the first step in a long-term process that will support evidence-based alcohol policy implementation. Future research calls for conducting a thorough sensitivity analysis to test several key aspects and assumptions made while calculating these composite indicators.

- First, the cut points used to calculate the SIs should be both varied and compared, because different thresholds may produce considerable changes to the final scores. Using the affordability of alcoholic beverages (Indicator 7.2) as an example to determine the final score, the lowest price level rather than the average price level might better account for cross-beverage substitution.
- Second, the research basis for assigning the multiplier levels was current as of 2010 *(8)*, though the process did incorporate expert feedback. Future analyses could generate and test policy weights that systematically incorporate all research to date. Alternatively, researchers could build country-specific weights that incorporate evidence of policy effectiveness specific to each country's context (e.g., income level, consumption level), similar to the approach used by Brand et al. *(9)*.

- Third, future analyses could handle missing data using advanced methods like regression or nearest neighbor imputation.
- Finally, some composite indicators—despite having gained maximum scores for some countries—may indicate that the original questions behind their formulation are not succeeding in capturing each country's reality. One example is the area of health services, where many studies indicate a huge treatment gap for alcohol problems and dependence. Even when countries do not extend full coverage to all people in need, a score of 100 can indicate no further need to work in that area. The same could be concluded regarding the area of negative consequences of drinking and alcohol intoxication, as this is an area weakly addressed in most countries. Meanwhile, questions currently used in the global survey may not succeed in capturing a country's current situation, either.

Strengths and limitations of the composite indicators

The composite indicators presented in this report could be used as a baseline to monitor future policy trends. They could be recalculated when each WHO survey is undertaken, and additionally recalculated over the lifespan of the global strategy and plan of action, so as to quantify and compare countries' policy changes. Such trend data could help identify which countries in the Americas are implementing the evidence-based alcohol policies recommended by the global strategy and making progress in reducing the harmful use of alcohol. Countries implementing new evidence-based policies can provide lessons learned and inspiration to other countries in the Region that face similar problems and implementation barriers.

The explicit link to the global strategy and to the regional action plan constitutes an important foundation because all Member States in the Americas have endorsed them. Nevertheless, future iterations should consider additional methods to obtain and synthesize feedback from ministries of health. These data could help establish the face validity of the composite indicators—that is, their acceptance as measures that are both useful and valid *(10)*.

Policy change depends on successful communication among diverse stakeholders. Currently, regular reports are produced both regionally *(11, 12)* and globally *(13, 14, 15)*. All of them describe trends in alcohol consumption, alcohol-related harm, and policy responses. These reports comprehensively analyze a broad range of indicators. The composite indicators described in this report complement regional efforts by condensing and translating the massive amount of

information collected into a simpler assessment of progress made at the country level.

The strengths and limitations of the composite indicators depend on the data used to calculate them. The surveys used for this study currently document legislation and policies in a categorical fashion that does not always capture the continuum of stringency, funding, implementation, and/or enforcement. This means that the survey data may or may not be reflective of what is practiced in the real world. This presents problems when policy restrictions (e.g., excise taxes, partial bans on advertising, and limits on hours/days of sale) become dichotomized and do not reflect policy stringency. Using pricing policies as an example, the global survey asks Member States if they implement an alcohol excise tax in a binary (yes/no) fashion that treats taxes paid by the consumer, retailer, distributor, wholesaler, and/or producer as the same. This is challenging because the global strategy itself emphasizes that such excise taxes reduce consumption when they increase the relative price paid by consumers *(1, 16)*.

The composite indicators in this report attempt to address this issue by using more specific pricing data taken from ATLAS-SU to calculate an affordability index. Based on the *Cost of Living Index,* these data document the price of several common brands of beer, wine, and spirits products by volume. While such measures are more nuanced than a binary measure, they still contain measurement errors and do not capture variations in quality across alcohol products *(17)*. This is critical, because there is substantial variation in the price of production, taxes, and retailer costs for different beverage categories and brands *(8, 9)*. To address this gap, PAHO is now working to develop a tax share indicator. This would serve to generate regular data collection that would in turn assist countries in determining alcohol affordability and the progress they make towards taxing alcoholic beverages for public health purposes, and not only to generate revenue.

In addition, previous efforts demonstrate that policies intended to advance public health can be unenforceable if they contain unanticipated loopholes. Policy implementation at the local level may also require long-term regulatory changes *(18, 19)*. To address this limitation, the global survey asks national experts to provide policy enforcement ratings for certain policies. While these experts may be knowledgeable in the area of policy enforcement, their ratings are nonetheless subjective. This means that such questions might introduce bias and complicate interpretation of scores across countries. In the end, such enforcement ratings were deemed too unreliable for incorporation into the composite indicators reported here. An alternative proxy for enforcement is the level of competitive

funding for each policy, as was used by Thomas et al. *(19)* in California (United States of America). This approach is both innovative and feasible, but scaling it to work at the international level presents challenges. Thus, the current composite indicators do not incorporate objective enforcement ratings; and future research should consider methods to overcome this limitation.

An additional limitation of this analysis is the vast amount of missing data for some indicators, which was comparable to the level of missing values encountered when Ferreira-Borges et al. calculated composite indicators for the WHO African Region *(20)* using a different method (based on another alcohol policy index). The number of missing values in the present analysis was particularly problematic for pricing policies, which reinforces the need to strengthen monitoring indicators related to taxes. Table 4 provides a summary of the strengths and limitations of the composite indicators.

Table 4: Strengths and limitations of the composite indicators

Strengths	Limitations
• The role of governments in reducing population exposure to modifiable risk factors is emphasized. • Political accountability is promoted. • Regional/global solidarity is fostered. • A rounded evaluation of national alcohol strategies is provided. • A big picture for each overarching policy area is presented, which is easier to grasp than separate trends across many different indicators. • Comparisons between countries are facilitated. • Monitoring of a country's progress over time is facilitated. • Communication with stakeholders is simplified.	• Enforcement of policies is not measured. • Informal controls and contextual determinants of alcohol consumption are not accounted for. • Other data and/or methods could be used for some aspects (such as policy weights). • Data for some indicators (such as pricing estimates) are less reliable. • Large amounts of data are missing in some policy areas (such as screening and brief interventions). • Adjustments may be needed *vis-à-vis* the details of a composite indicator as newer research evidence becomes available. • Subnational variations in alcohol policies are not reflected in aggregated information. • Summary measures are prone to misinterpretation.

Future work

The composite indicators presented in this report are the first step in a long-term, iterative process that aims to generate an accurate and evidence-based method for quantifying Member States' progress in implementing the global strategy and regional action plan. Interpreting the results requires caution, because the Member States did not validate the scores calculated. Future work should develop a streamlined process to solicit feedback from Member States early on in the score construction process, so that scores can reliably reflect national efforts in all areas of alcohol policy implementation.

Conclusion

The process of developing the composite indicators tied to the global strategy and regional action plan aimed to measure not only the presence of a range of alcohol policies, but also the extent to which they meet recommended standards of strictness and comprehensiveness. This was done via a stepwise approach to selecting, scaling, weighting, and recoding relevant policy variables. The composite indicators can be used for performance benchmarking, monitoring trends over time, comparing policy options, and communicating with stakeholders and the public alike. Further work can be done to ascertain the robustness of the composite indicators and their political acceptability.

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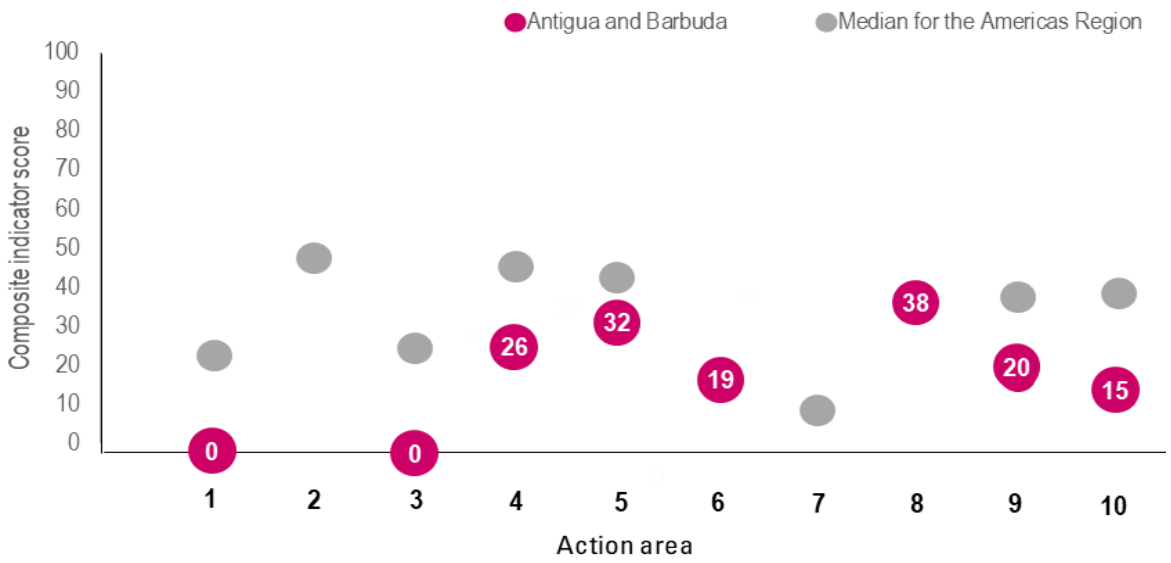
Part II: Alcohol policy implementation—country profiles

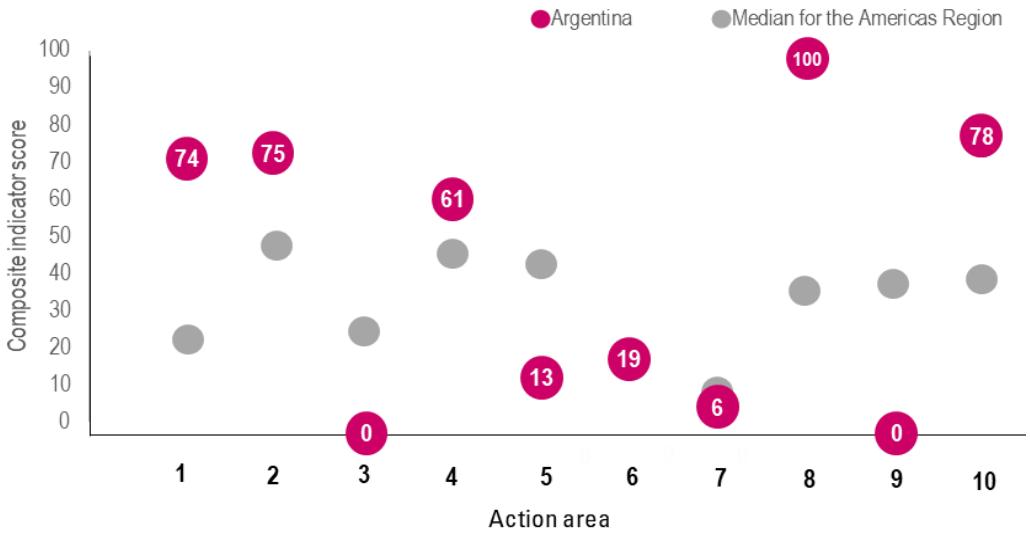
Composite indicator–scaled scores (0–100) for Member States of the Americas, 2016

Antigua and Barbuda



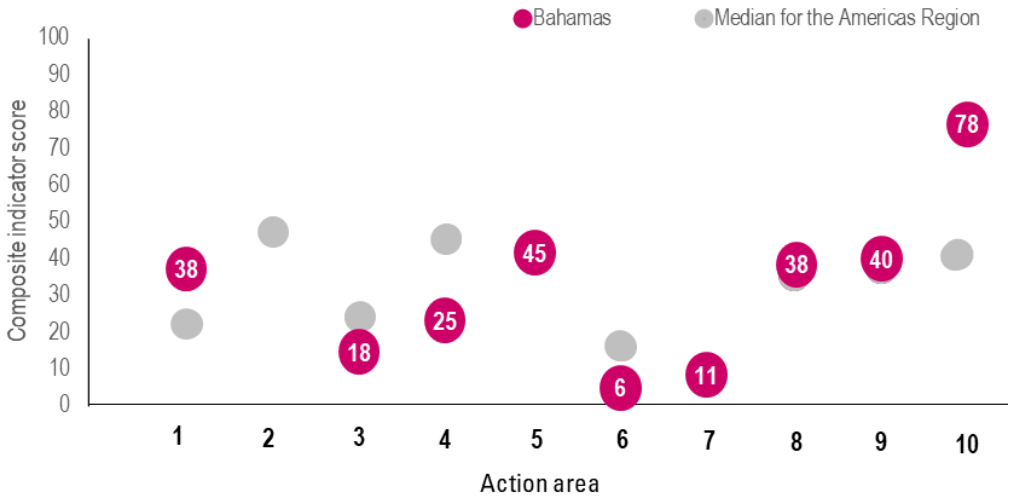
Note: Antigua and Barbuda did not have enough data to calculate composite indicators for health services' response or pricing policies. Antigua and Barbuda were also missing data from leadership, awareness, and commitment; community and workplace action; and reducing the public health impact of illicit alcohol and informally produced alcohol. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Argentina



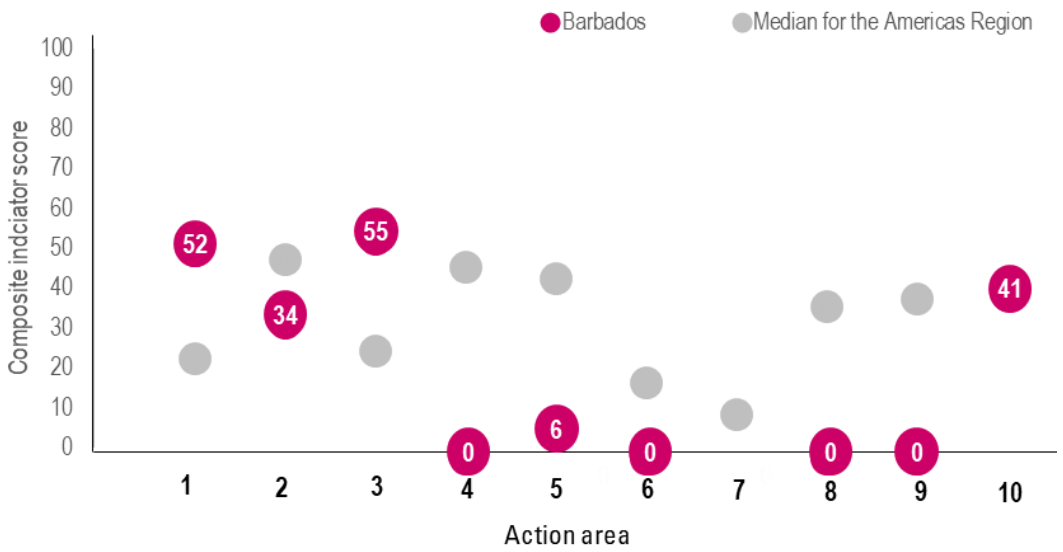
Note: Argentina was missing data from community and workplace action as well as from pricing policies. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Bahamas



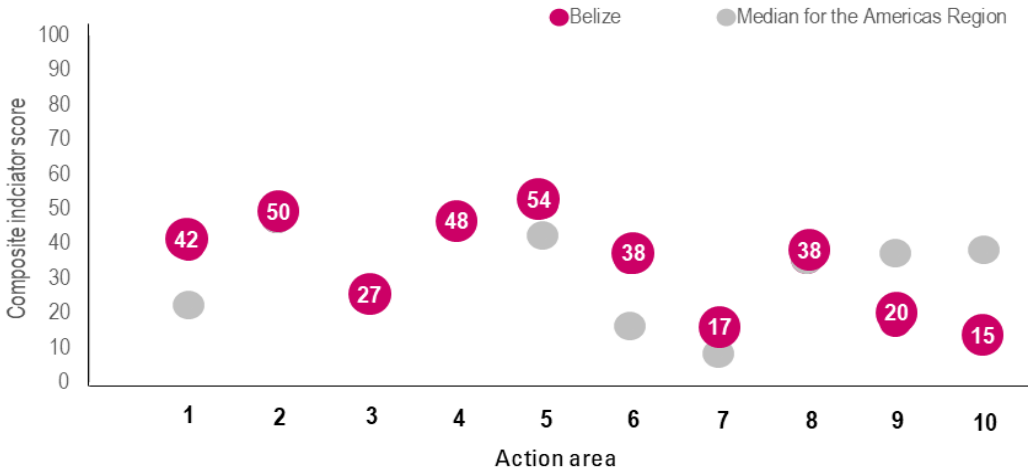
Note: The Bahamas did not have enough information to calculate a composite indicator for health services' response. The Bahamas was missing data from leadership, awareness, and commitment; community and workplace action; drink-driving policies and countermeasures; and marketing of alcoholic beverages. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Barbados



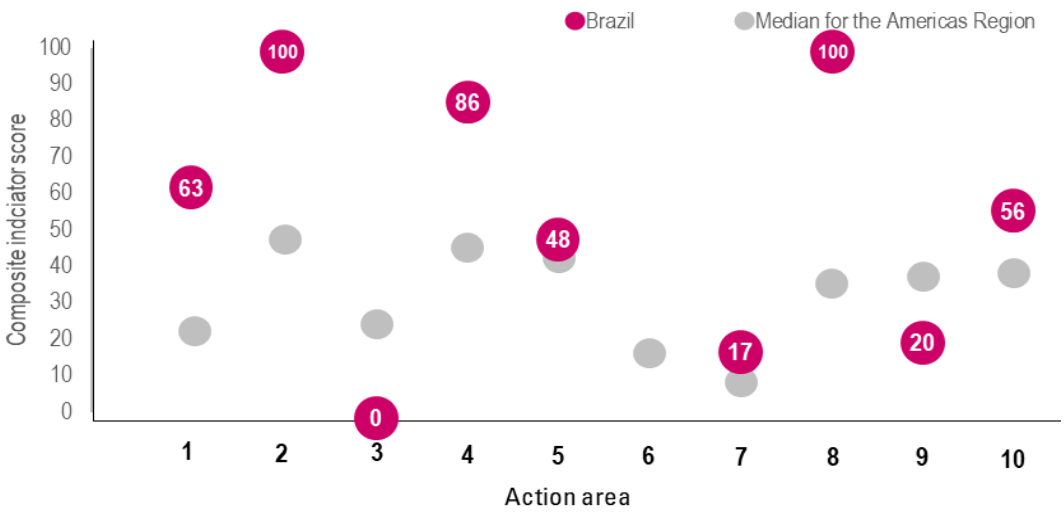
NOTE: Barbados did not have enough information to calculate the composite indicator for pricing policies. Barbados was also missing data from community and workplace action; reducing the public health impact of illicit alcohol and informally produced alcohol; and monitoring and surveillance. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Belize



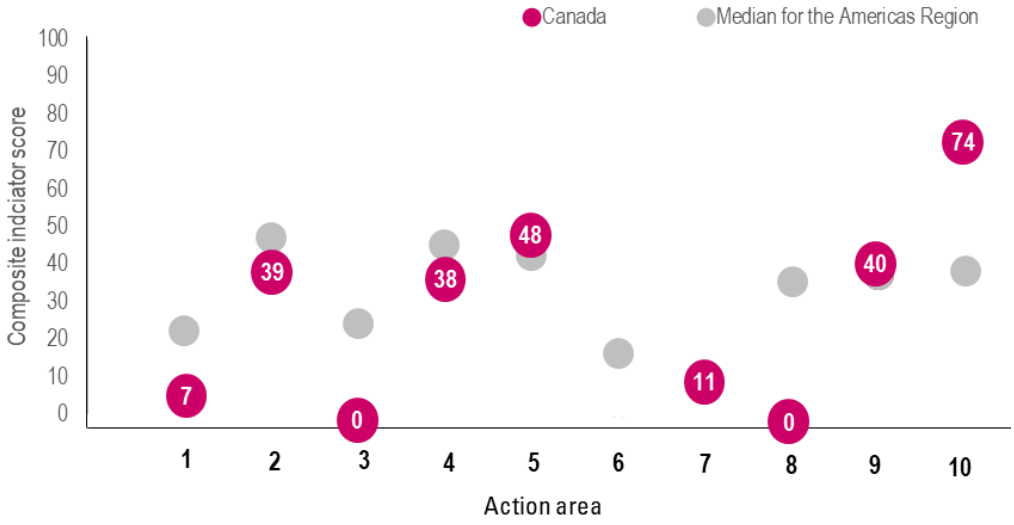
Note: Belize was missing data from community and workplace action but had enough data to calculate this composite indicator. It is possible that the score for this composite indicator would be higher if these data were available.

Brazil



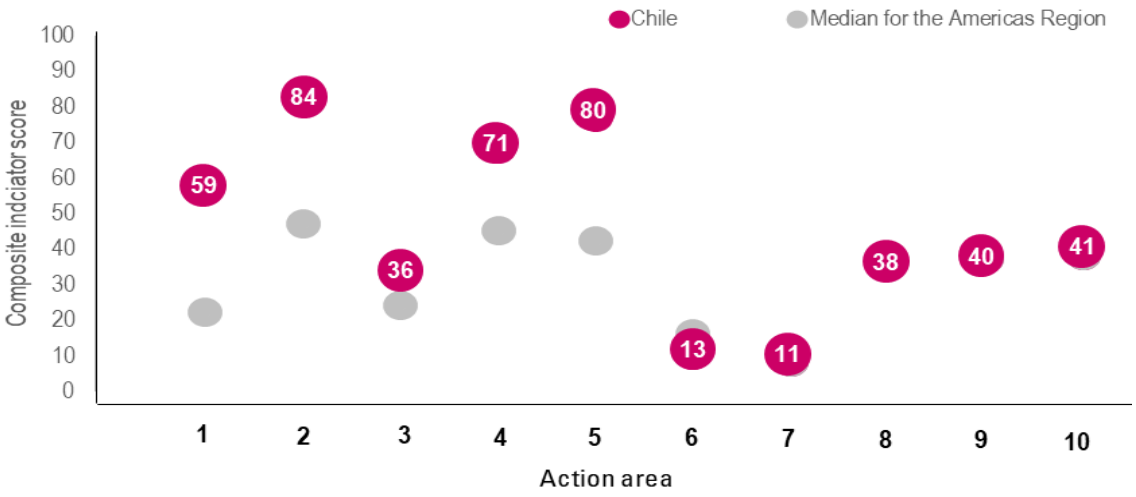
Note: Brazil did not have enough data to calculate the composite indicator for marketing of alcoholic beverages. Brazil was also missing data from community and workplace action but had enough data to calculate this composite indicator. It is possible that the score for this composite indicator would be higher if these data were available.

Canada



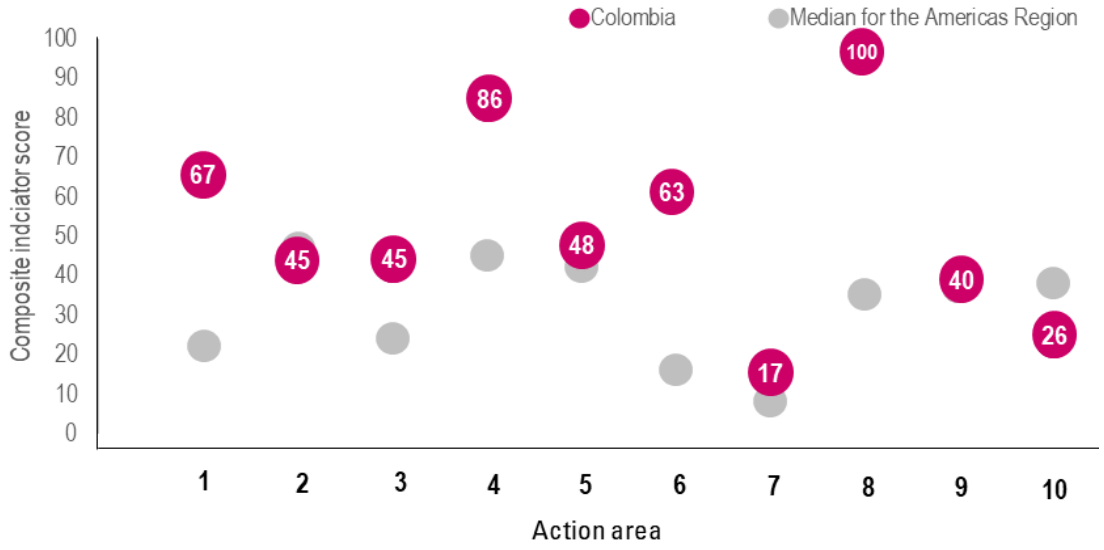
Note: Canada did not have enough data to calculate the composite indicator for marketing of alcoholic beverages. Canada was also missing data from leadership, awareness, and commitment; health services' response; and community and workplace action. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Chile



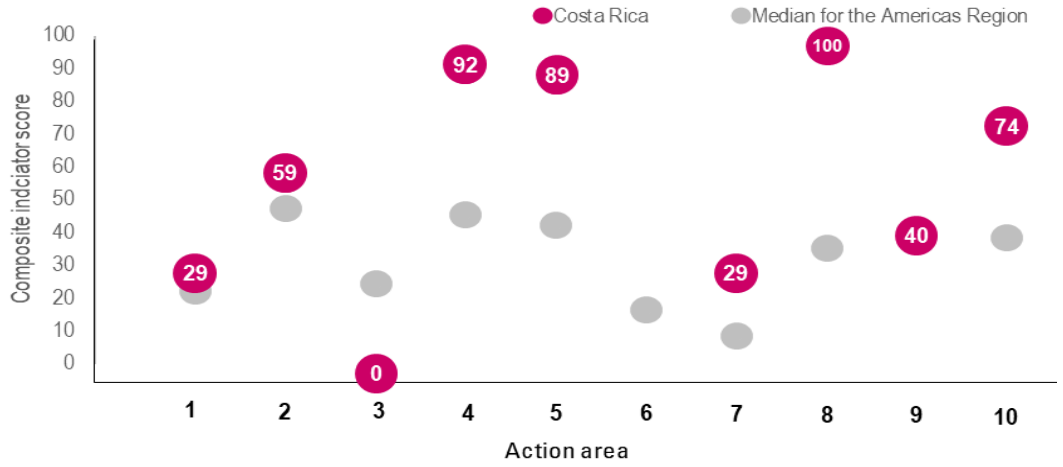
Note: Chile was missing data from community and workplace action but had enough data to calculate this composite indicator. It is possible that the score for this composite indicator would be higher if these data were available.

Colombia



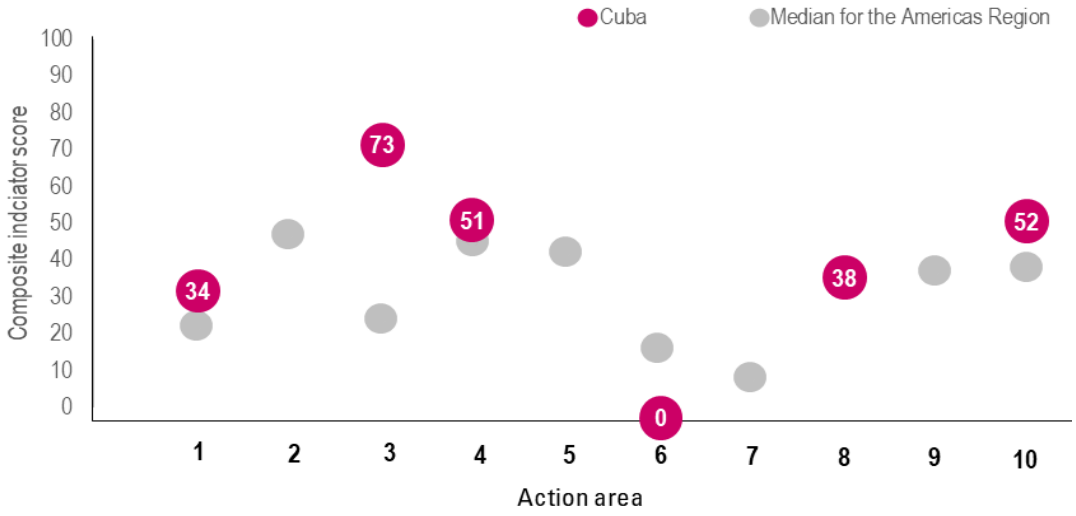
Note: Colombia was missing data from community and workplace action as well as from pricing policies. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Costa Rica



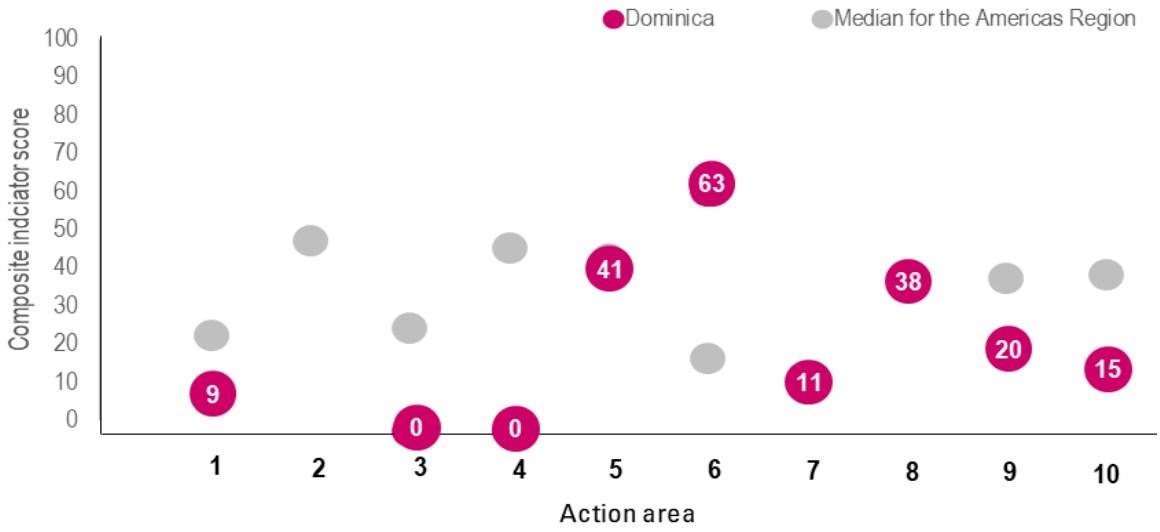
Note: Costa Rica did not have enough data to calculate the composite indicator for marketing of alcoholic beverages. Costa Rica was also missing data from community and workplace action but had enough data to calculate this composite indicator. It is possible that the score for this composite indicator would be higher if these data were available.

Cuba



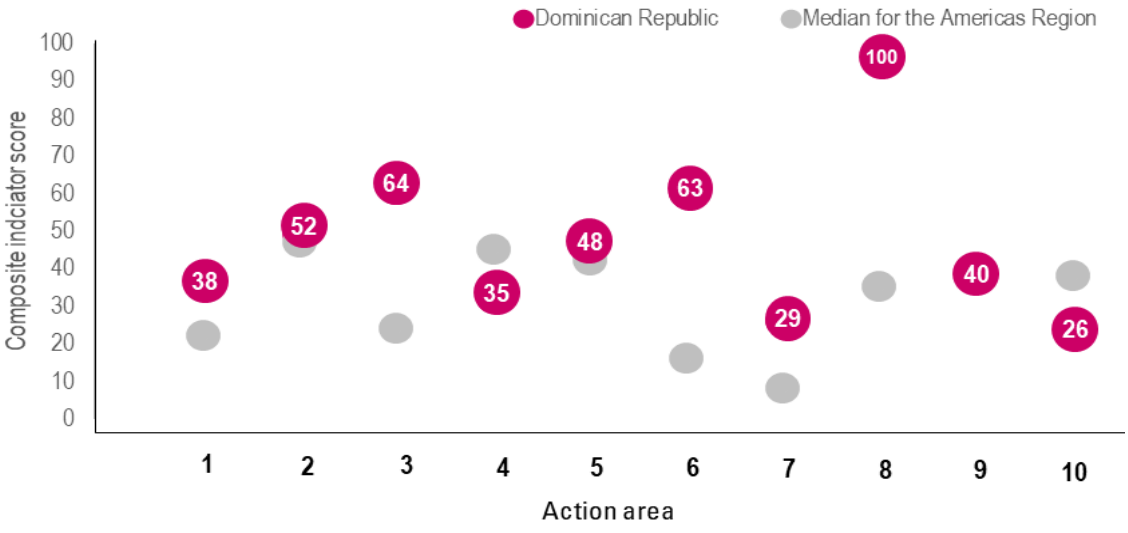
Note: Cuba did not have enough data to calculate the composite indicators for health services' response; availability of alcohol; pricing policies; and reducing the public health impact of illicit alcohol and informally produced alcohol. Cuba was also missing data from health services' response; community and workplace action; and drink-driving policies and countermeasures. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Dominica



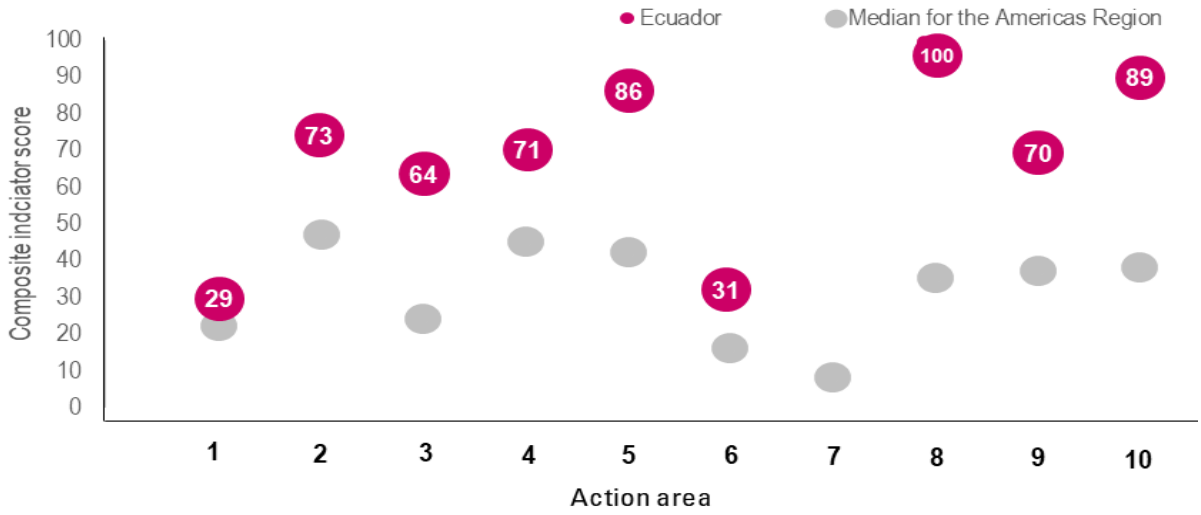
Note: Dominica did not have enough data to calculate the composite indicator for health services' response. Dominica was missing data from leadership, awareness, and commitment as well as from community and workplace action; nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Dominican Republic



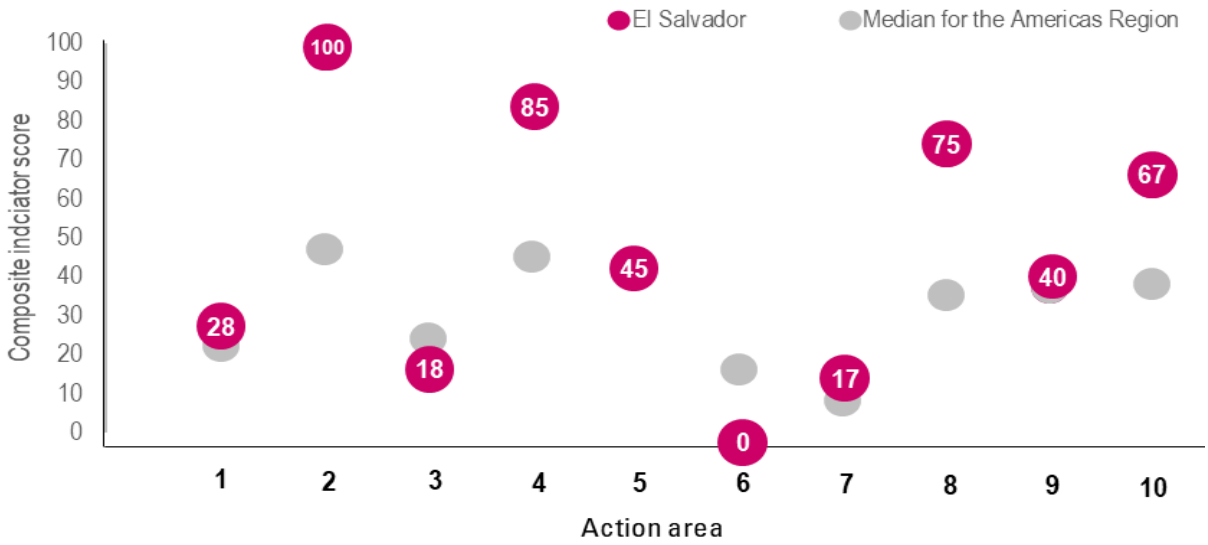
Note: The Dominican Republic was missing data from community and workplace action but had enough data to calculate this composite indicator. It is possible that the score for this composite indicator would be higher if these data were available.

Ecuador



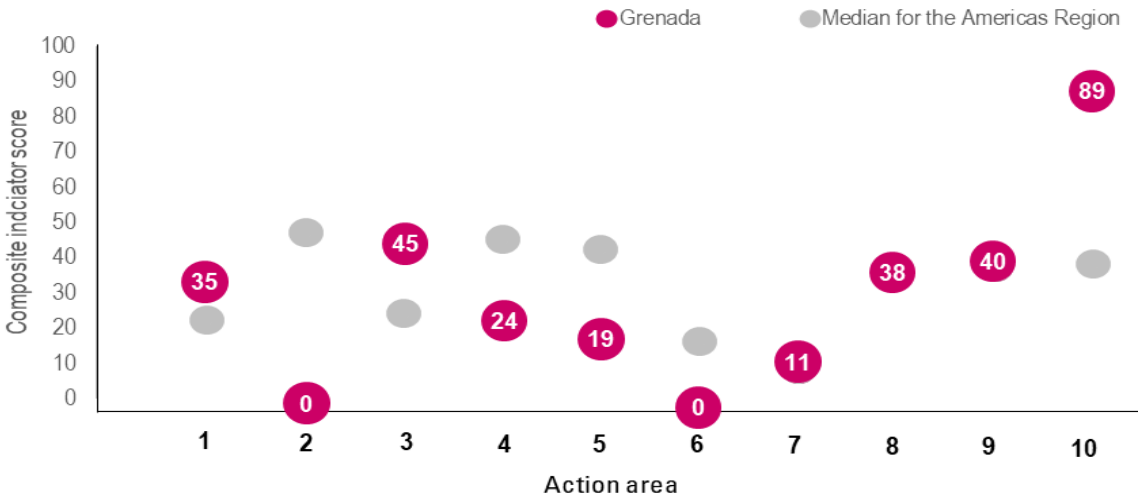
Note: Ecuador did not have enough data to calculate the composite indicator for pricing policies. Ecuador was also missing data from community and workplace action but had enough data to calculate this composite indicator. It is possible that the score for this composite indicator would be higher if these data were available.

El Salvador



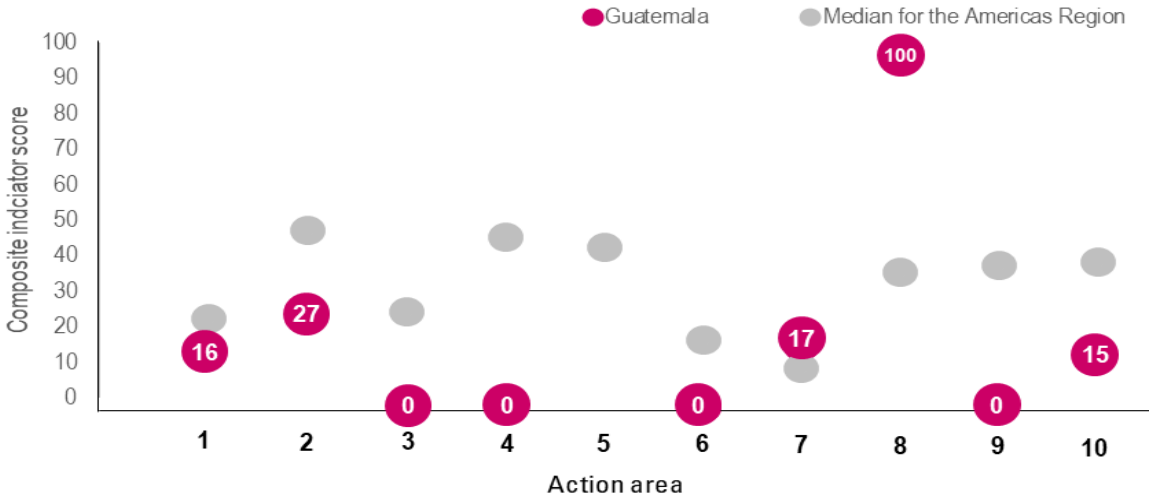
Note: El Salvador was missing data from community and workplace action but had enough data to calculate this composite indicator. It is possible that the score for this composite indicator would be higher if these data were available.

Grenada



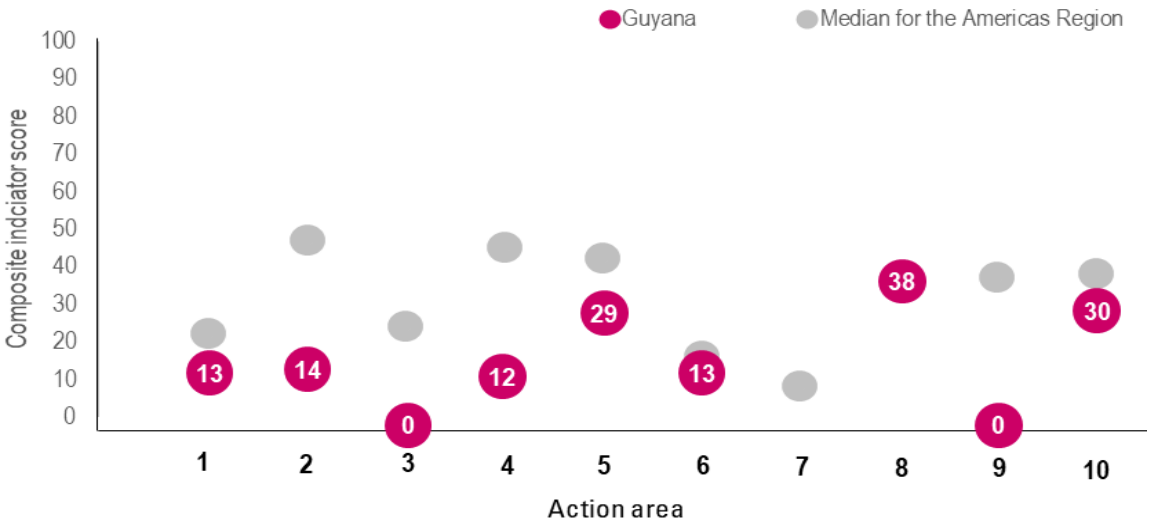
Note: Grenada was missing data from community and workplace action but had enough data to calculate this composite indicator. It is possible that the score for this composite indicator would be higher if these data were available.

Guatemala



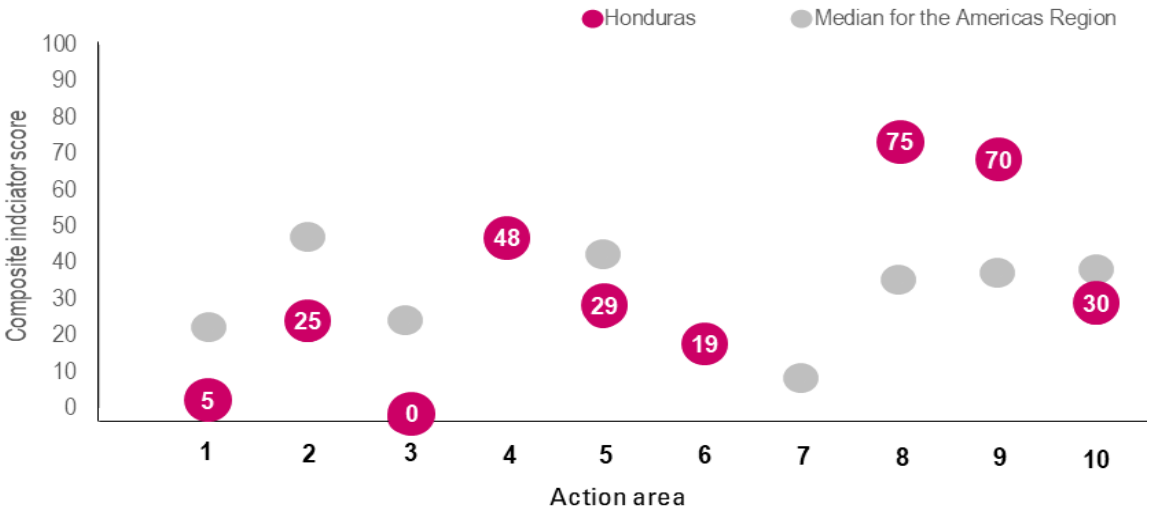
Note: Guatemala did not have enough data to calculate the composite indicator for availability of alcohol. Guatemala was missing data from leadership, awareness, and commitment; community and workplace action; drink-driving policies and countermeasures; and reducing the public health impact of illicit alcohol and informally produced alcohol. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available

Guyana



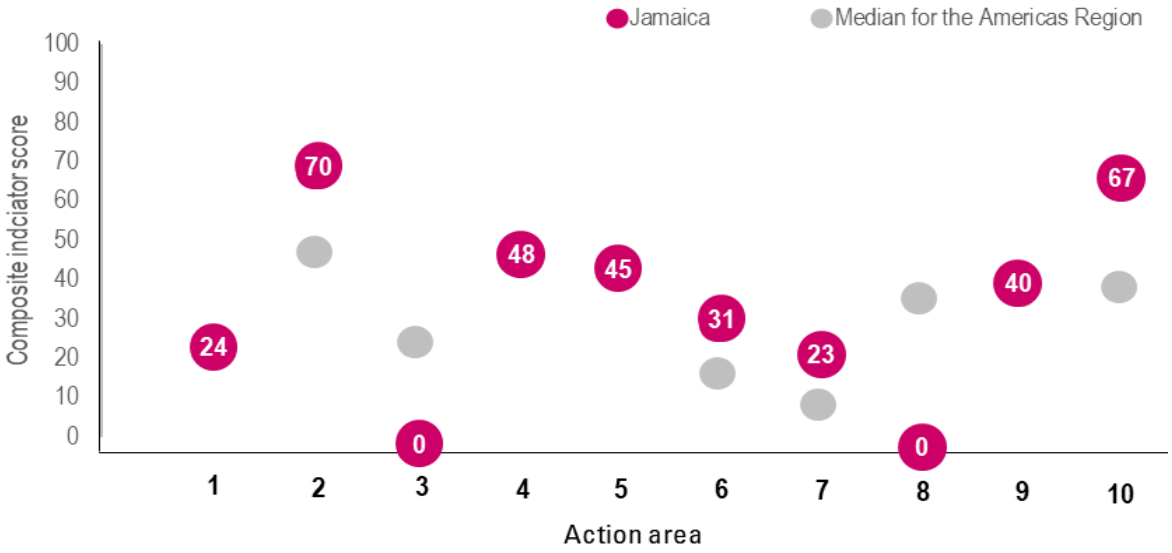
Note: Guyana did not have enough data to calculate the composite indicator for pricing policies. Guyana was missing data from leadership, awareness, and commitment as well as from community and workplace action. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Honduras



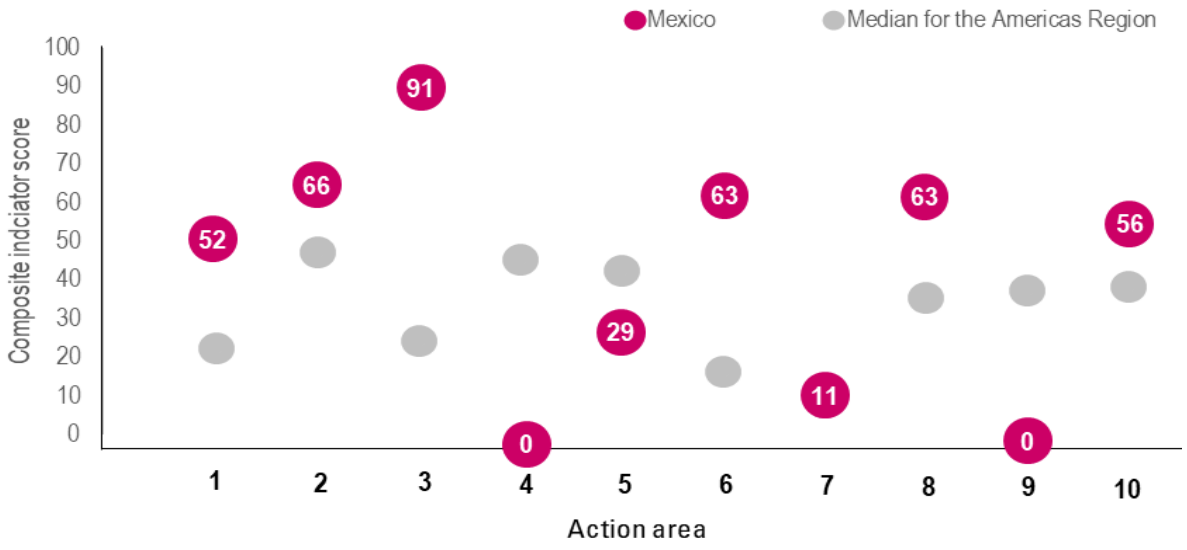
Note: Honduras did not have enough data to calculate the composite indicator for pricing policies. Honduras was missing data from leadership, awareness, and commitment as well as from community and workplace action. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Jamaica



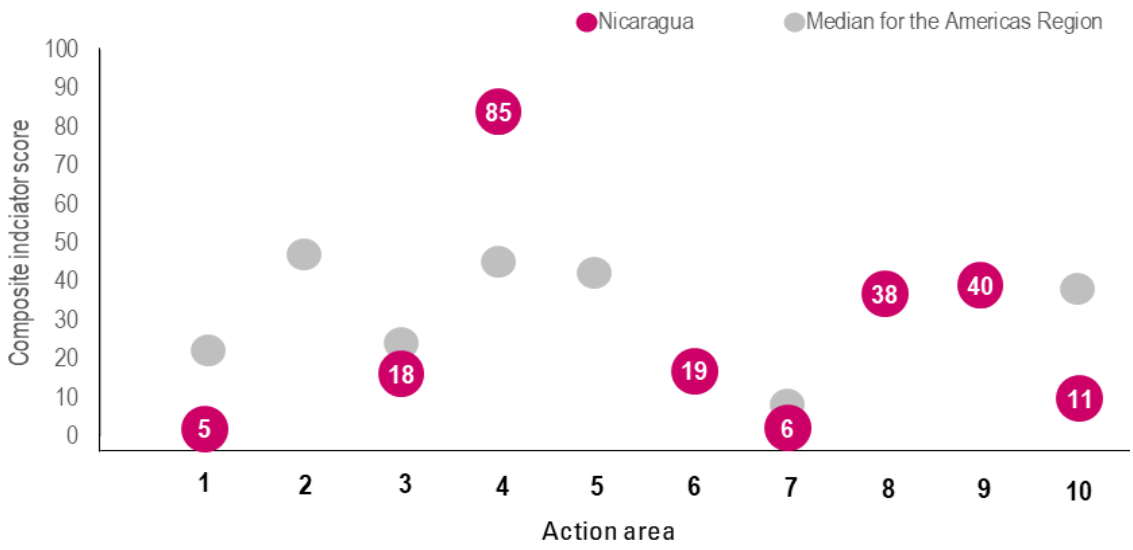
Note: Jamaica was missing data from community and workplace action but had enough data to calculate this composite indicator. It is possible that the score for this composite indicator would be higher if these data were available.

Mexico



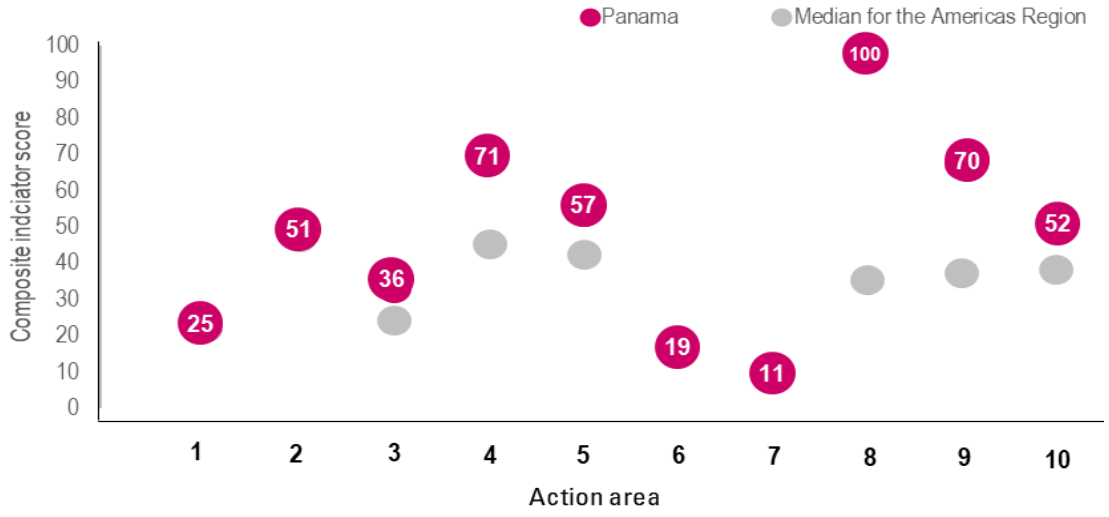
Note: Mexico was missing data from community and workplace action but had enough data to calculate this composite indicator. It is possible that the score for this composite indicator would be higher if these data were available.

Nicaragua



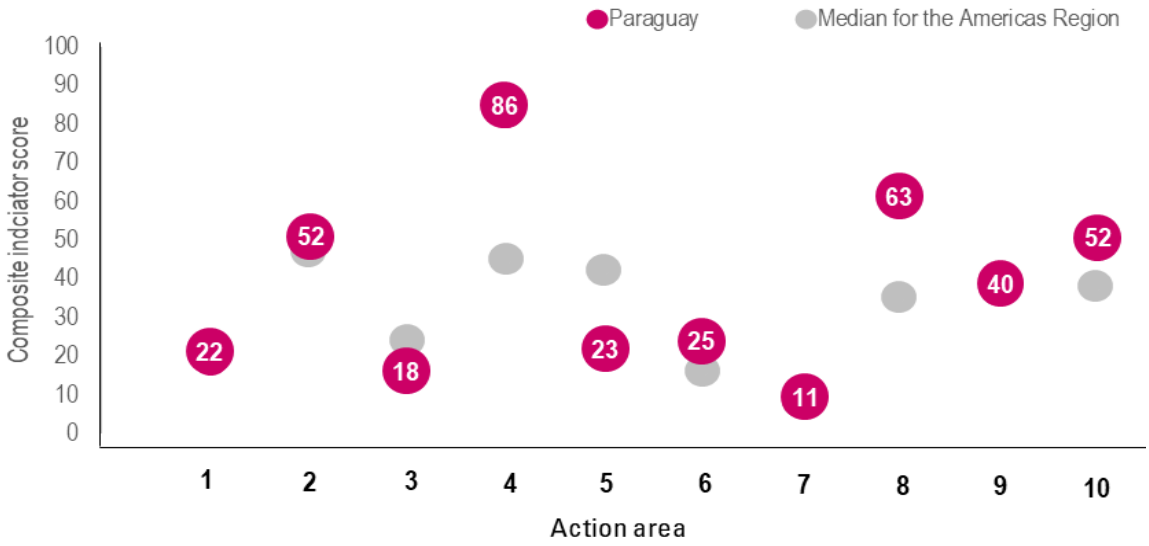
Note: Nicaragua did not have enough data to calculate the composite indicators for health services' response and availability of alcohol. Nicaragua was also missing data from leadership, awareness, and commitment; community and workplace action; drink-driving policies and countermeasures; and pricing policies. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Panama



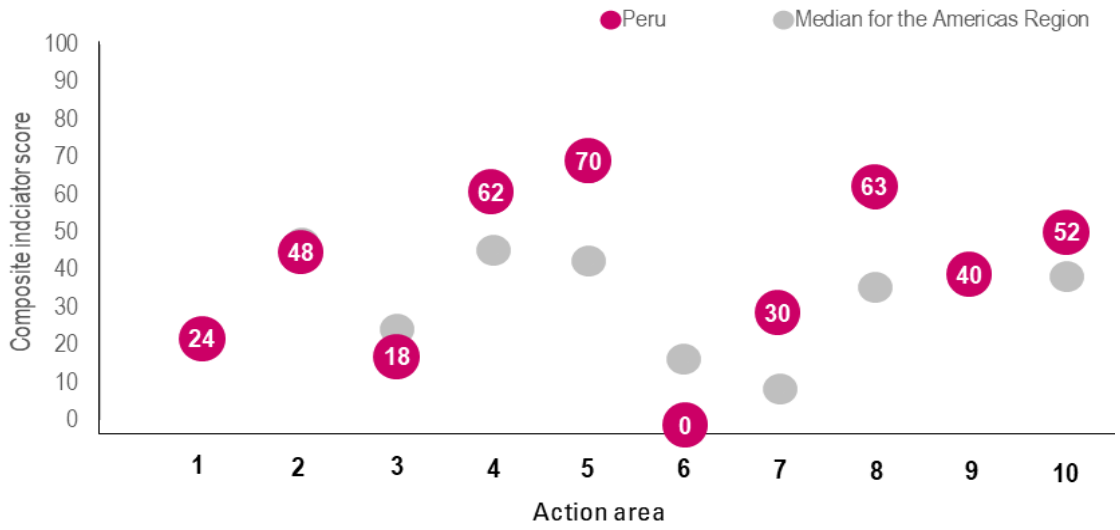
Note: Panama was missing data from health services' response as well as community and workplace action but had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Paraguay



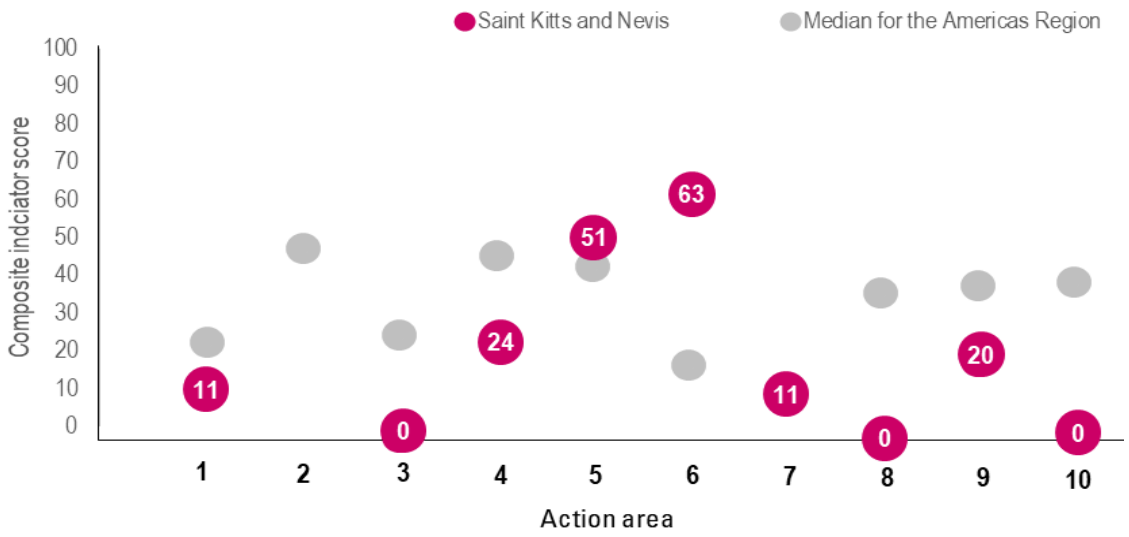
Note: Paraguay was missing data from community and workplace action but had enough data to calculate this composite indicator. It is possible that the score for this composite indicator would be higher if these data were available.

Peru



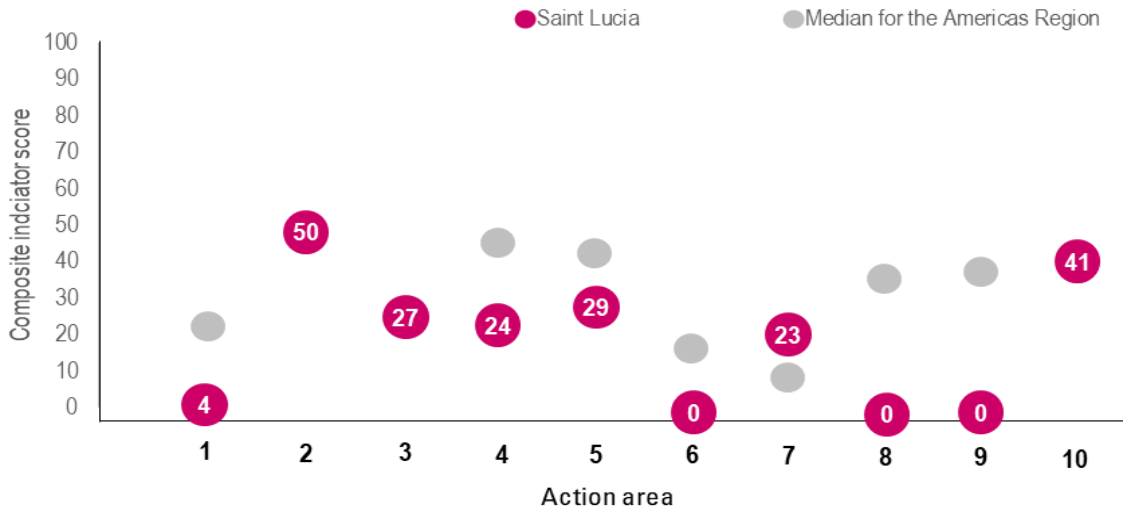
Note: Peru was missing data from community and workplace action; drink-driving policies and countermeasures; and pricing policies. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Saint Kitts and Nevis



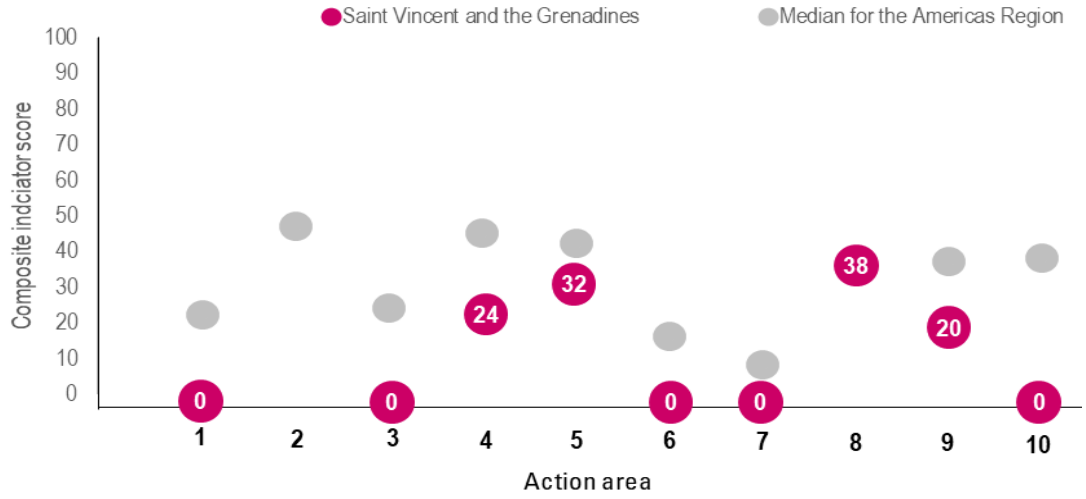
Note: Saint Kitts and Nevis did not have enough data to calculate the composite indicator for health services' response. Saint Kitts and Nevis was also missing data from leadership, awareness, and commitment as well as from community and workplace action. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Saint Lucia



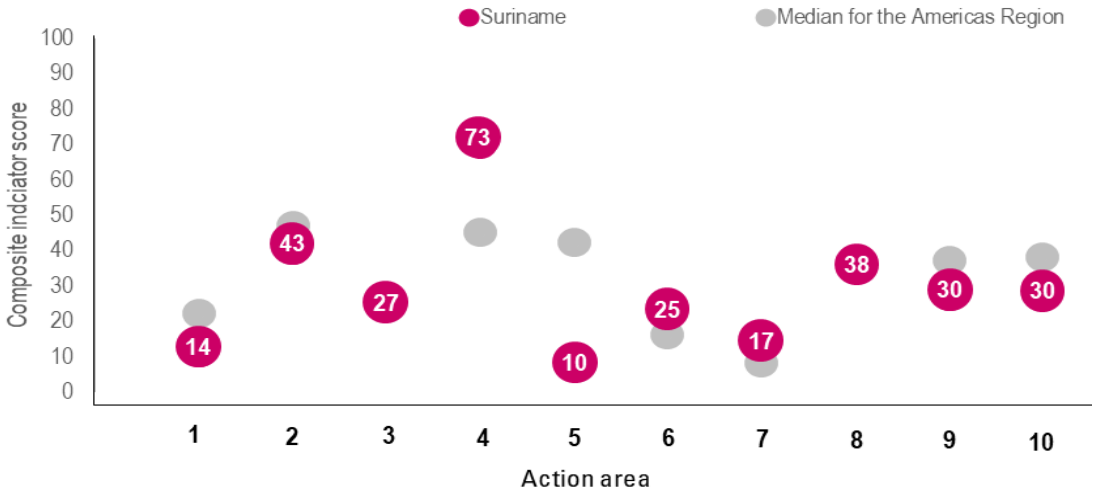
Note: Saint Lucia was missing data from community and workplace action but had enough data to calculate this composite indicator. It is possible that the score for this composite indicator would be higher if these data were available.

Saint Vincent and the Grenadines



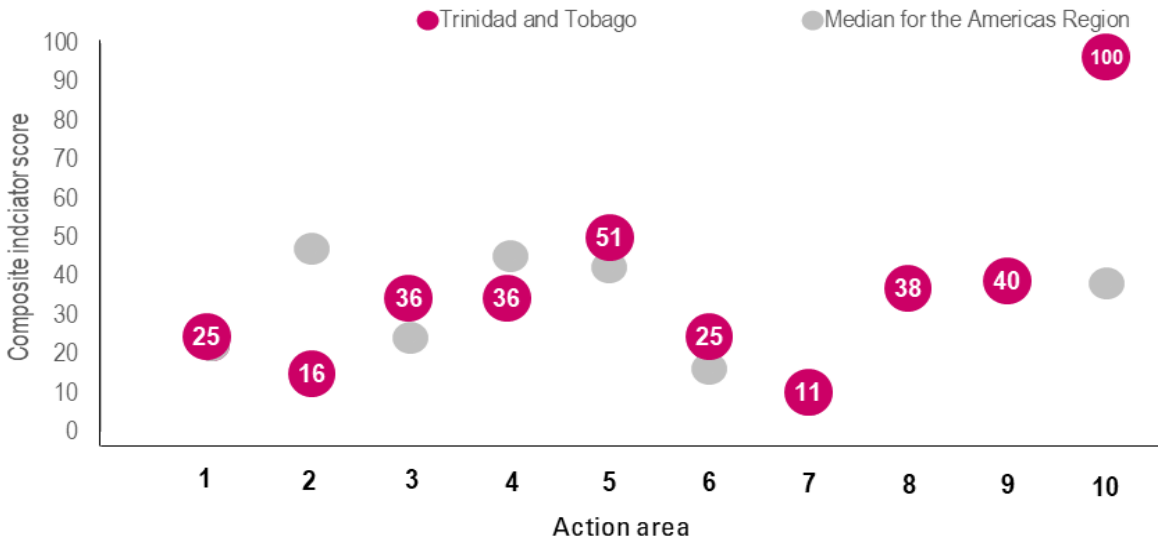
Note: Saint Vincent and the Grenadines did not have enough data to calculate the composite indicator for health services' response. Saint Vincent and the Grenadines was missing data from leadership, awareness, and commitment; community and workplace action; and pricing policies. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Suriname



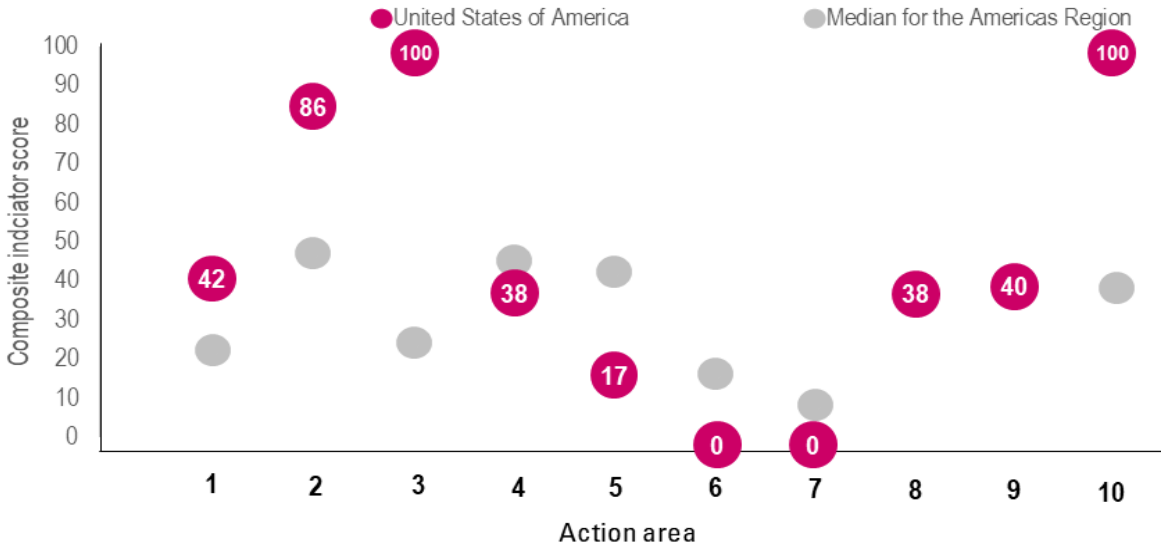
Note: Suriname was missing data from leadership, awareness, and commitment; community and workplace action; and pricing policies. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Trinidad and Tobago



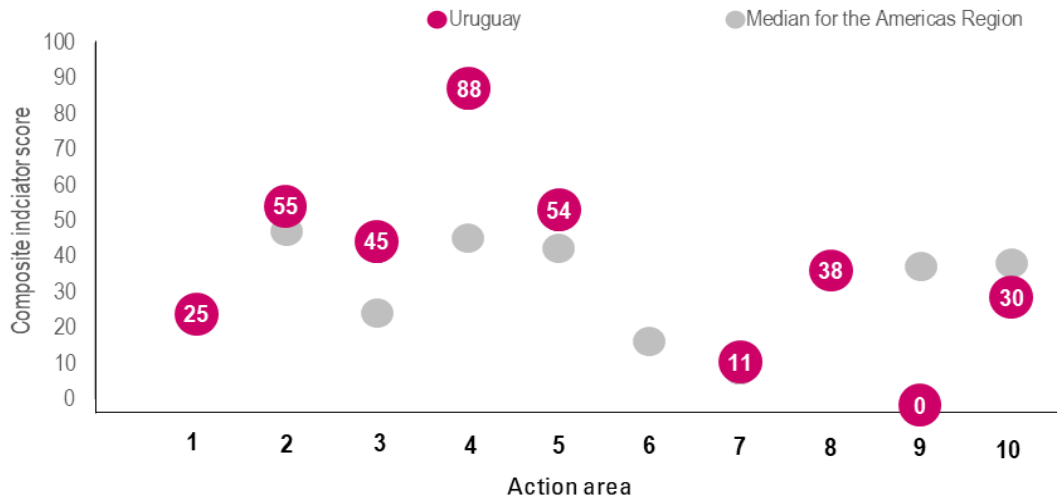
Note: Trinidad and Tobago were missing data from the composite indicator for health services' response. Trinidad and Tobago were also missing data from community and workplace action but had enough data to calculate this composite indicator. It is possible that the score for this composite indicator would be higher if these data were available.

United States of America



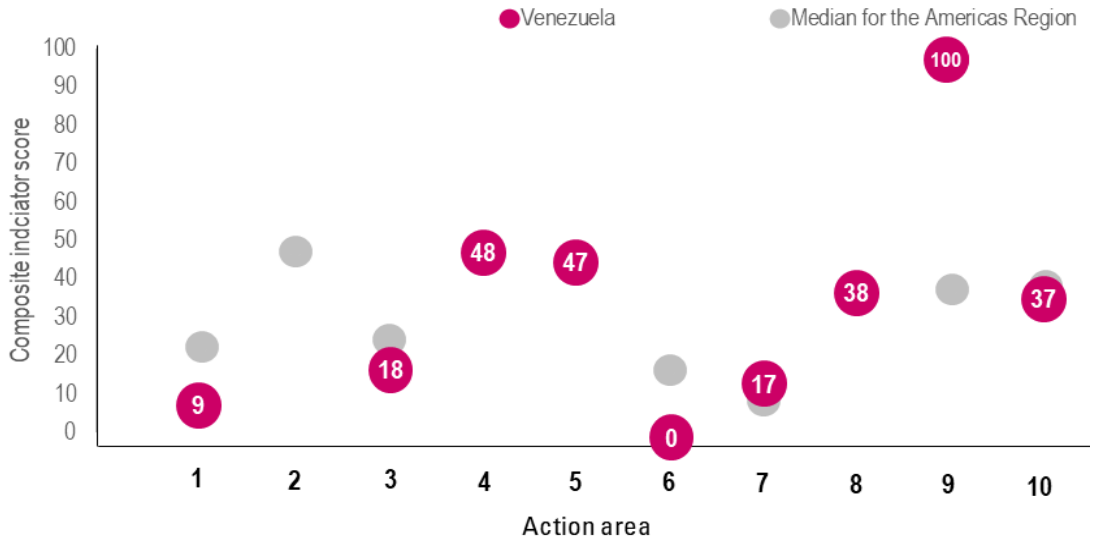
Note: The United States of America was missing data from community and workplace action and pricing policies but had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Uruguay



Note: Uruguay did not have enough data to calculate the composite indicator for marketing of alcoholic beverages. Uruguay was also missing data from community and workplace action as well as from pricing policies. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Venezuela (Bolivarian Republic of)



Note: Venezuela did not have enough data to calculate the composite indicator for health services' response. Venezuela was also missing data from community and workplace action as well as from pricing policies. Nonetheless, the country had enough data to calculate these composite indicators. It is possible that the scores for these composite indicators would be higher if these data were available.

Annexes

Annex I: List of survey questions used for the composite indicators arranged by SI

1.	Leadership, awareness, and commitment
1.1	**National policy on alcohol**
Is there a written national policy on alcohol specific to your country? *A written national policy on alcohol is an organized set of values, principles and objectives for reducing the burden attributable to alcohol in a population which is adopted at the national level.* ☐ National policy ☐ Subnational: description of subnational policy/regional variations: ☐ No	
Is the written national policy on alcohol multisectoral? ☐ No ☐ Yes	
For the implementation of the written national policy on alcohol, is there a national action plan? ☐ No ☐ Yes	
Is there currently a process of developing a written national policy on alcohol or of revising the adopted one? *Check (✓) one only.* ☐ No ☐ Yes, revising the adopted one ☐ Yes, developing a written national policy on alcohol	

1.2 Definition of alcoholic beverage
In your country, is there a standard legal definition of an alcoholic beverage that is used by your government? ☐ No ☐ Yes
If YES, what is the standard legal definition of an alcoholic beverage in your country? *Please include the % alcohol by volume if applicable, e.g. "All types of beverages over 0.5% alcohol by volume".*
1.3 Definition of a standard drink
In your country, is there a definition of a standard drink used at the national level? ☐ No ☐ Yes
If YES, how much is a standard drink in grams of pure alcohol?
1.4 Awareness activities
In the last three years, did you have any nationwide awareness-raising activities? ☐ No ☐ Yes. *Please specify. Check (✓) all that apply.* ☐ Young people's drinking ☐ Drink–driving ☐ For indigenous peoples ☐ Impact of alcohol on health ☐ Social harms (harms to others than the drinker) ☐ Other, please specify ☐ Illegal/surrogate alcohol ☐ Alcohol and pregnancy ☐ Alcohol at work

In your country, which of the following tools/programmes are used for prevention of substance use and substance use disorders? *Please answer for alcohol use and alcohol use disorders. Please precise the estimated level of coverage (%) of the target population.*

☐ There are no tools/programs

	Mass media (audiovisual)	Mass media (print)	Advertisements in public places (posters)
None (0%)	☐	☐	☐
Some (1–30%)	☐	☐	☐
High (31–60%)	☐	☐	☐
Very high (61–100%)	☐	☐	☐

2. Health services' response

2.1 Screening and brief interventions for harmful and hazardous alcohol use

In your country are there clinical guidelines for brief interventions that have been approved or endorsed by at least one health care professional body?

☐ No ☐ Yes

What is the proportion of primary health care services that have implemented *screening* and brief interventions for harmful and hazardous substance use at the national level? *Specify for alcohol use. Screening can be simply by asking about substance use and not necessarily involving standardized screening questionnaires or testing.*

	Routine screening (for majority of patients)	Selective screening (for minority of patients)
None (0)	☐	☐
Few (1-10%)	☐	☐
Some (11–30%)	☐	☐
Many (31–60%)	☐	☐
Most (61–100%)	☐	☐
Unknown	☐	☐

What is the proportion of ante-natal services that have implemented screening and brief interventions for harmful and hazardous substance use at the national level? *Specify for alcohol use. Screening can be simply by asking about substance use and not necessarily involving standardized screening questionnaires or testing.*

☐ None (0)
☐ Few (1-10%)
☐ Some (11–30%)
☐ Many (31–60%)
☐ Most (61–100%)
☐ Unknown

2.2 Special treatment programs

In your country, are there special treatment programmes for women as well as for children and adolescents with substance use disorders? *Please specify for alcohol use disorders and in which area of the country they are located. Please tick all that apply.*

	Special treatment programs for women	Special treatment programs for children and adolescents
No	☐	☐
Yes, in the capital city	☐	☐
Yes, in other major cities[a]	☐	☐
Yes, in other areas [b]	☐	☐

a Major cities refers to cities with relatively large population and available tertiary and higher levels of health care that includes highly specialized facilities such as university hospitals or highly specialized treatment centres such as for neurosurgery or radiology.
b Other areas refers to urban and rural areas outside the capital and major cities.

2.3 Pharmacological treatment

In your country, which of the following medications are available? *Specify if it is registered, available in publicly funded treatment services and if the dosing is supervised. Check (✓) all that apply*

Medication	*Formulation*	*For the treatment of*	*Registered in the country*		*Is it available for use in publicly funded treatment services for this indication?*		*Is outpatient dosing generally supervised?* [a]	
			Yes	*No*	*Yes*	*No*	*Yes*	*No*
Acamprosate	Tablets	Alcohol dependence	☐	☐	☐	☐	N/A	
Bupernorphine	Sublingual tablets	Opioid dependence	☐	☐	☐	☐	☐	☐
Buprenorphine/ naloxone	Sublingual tablets	Opioid dependence	☐	☐	☐	☐	☐	☐
Buprenorphine/ naloxone	Sublingual film	Opioid dependence	☐	☐	☐	☐	☐	☐
Diazepam (or other long-acting benzodiazepines)	Tablets	Alcohol withdrawal	☐	☐	☐	☐	☐	☐
Diazepam (or other long-acting benzodiazepines)	Tablets	Benzodiazepine withdrawal	☐	☐	☐	☐	☐	☐
Clonidine	Tablets	Opioid withdrawal	☐	☐	☐	☐	N/A	
Disulfiram	Tablets	Alcohol dependence	☐	☐	☐	☐	☐	☐
Lofexidine	Tablets	Opioid withdrawal	☐	☐	☐	☐	N/A	
Methadone	Liquid	Opioid dependence	☐	☐	☐	☐	☐	☐
Methadone	Tablets	Opioid dependence	☐	☐	☐	☐	☐	☐
Naloxone	For injection	Opioid overdose	☐	☐	☐	☐	N/A	
Naltrexone	Tablets	Alcohol dependence	☐	☐	☐	☐	N/A	
Naltrexone	Tablets	Opioid dependence	☐	☐	☐	☐	☐	☐

a Supervision for methadone, buprenorphine, diazepam, disulfiram and naltrexone dosing for outpatients: tick YES if outpatients are required to have doses supervised daily unless an individual assessment determined that daily supervision of dosing is not necessary. In supervised methadone treatment, for example, patients come each day for their dose at the beginning of treatment until they are assessed as suitable to receive take-home methadone.

3. Community and workplace action

3.1 School-based prevention and reduction of alcohol-related harm

In your country, do you have national guidelines for the prevention and reduction of alcohol-related harm in school settings?

☐ No ☐ Yes

In your country, is there a legal obligation for schools to carry out alcohol (or broader alcohol and other substance use) prevention as part of the school curriculum or as part of school health policies?

☐ No ☐ Yes

3.2 Workplace-based alcohol problem prevention and counselling

In your country, are there any national guidelines for alcohol problem prevention and counselling at workplaces?

In your country, is there legislation on alcohol testing at workplaces?

☐ No ☐ Yes

In your country, are workplace programs used for the prevention of substance use and substance use disorders? *Please answer for alcohol use and alcohol use disorders. Please precise the estimated level of coverage (%) of the target population.*

☐ There are no tools/programs

None (0)	☐
Few (1-10%)	☐
Some (11–30%)	☐
Many (31–60%)	☐
Most (61–100%)	☐

3.3	Communitv-based interventions to reduce alcohol-related harm

In your country, are there national guidelines for implementing effective community-based interventions to reduce alcohol-related harm?

☐ No ☐ Yes

In your country, are there any community-based interventions/projects involving stakeholders (nongovernmental organizations, economic operators, others)?

☐ No ☐ Yes *Please specify the most important sectors involved. Check (✓) all that apply*.

☐ Nongovernmental organizations
☐ Economic operators
☐ Local government bodies
☐ Others Please specify:

In your country, are there community-based programs used for prevention of substance use and substance use disorders? *Please answer for alcohol use and alcohol use disorders. Please precise the estimated level of coverage (%) of the target population.*

☐ There are no tools/programs

None (0%)	☐
Some (1–30%)	☐
High (31–60%)	☐
Very high (61–100%)	☐

4. Drink-driving policies and countermeasures

4.1 Maximum legal blood alcohol concentration (BAC) limit when driving a vehicle

At the national level, what is the maximum legal BAC when driving a vehicle, for each of the following groups? (e.g., 0.05%; usually, from 0% to 0.10%). *Enter the BAC in % or "None" if there is no maximum legal BAC.*

General population: 0. __ __ %
Young/novice drivers: 0. __ __ %

4.2 Enforcement using sobriety checkpoints

Do you have sobriety checkpoints? *Sobriety checkpoints are checkpoints or roadblocks established by the police on public roadways to control for drink–driving.*

☐ No ☐ Yes

4.3 Enforcement using random breath-testing

Do you have random breath testing? *Random breath testing means that any driver can be stopped by the police at any time to test the breath for alcohol consumption*.

☐ No ☐ Yes

4.4 Penalties

What are the penalties for drink–driving in your country? *Check (✓) all that apply*.

☐ Fines ☐ Penalty points ☐ Short-term detention ☐ Vehicle impounded ☐ Mandatory treatment ☐ Mandatory education and counselling	☐ Driving licence suspension ☐ Driving licence revoked ☐ Imprisonment ☐ Community/public service ☐ Ignition interlock ☐ None

5. Availability of alcohol

5.1 Lowest age limit for on-premise alcohol service and off-premise alcohol sale

What are the legal age limits at the national level, for the following? *Enter age limit (in years) or "None" if there is no age limit. Legal age limit means that alcoholic beverages cannot be served/sold to a person*

	Beer	Wine	Spirits
On-premise sales (serving) (café, pub, bar, restaurant)	_____ years	_____ years	_____ years
Off-premise sales (selling) (take-away from, for example, shop, supermarket)	_____ years	_____ years	_____ years

5.2 Control of retail sales

If the control for production and sale of alcohol is at the national level, do you have government monopoly? *Please check (✓) the appropriate answer(s). Government monopoly means full or almost complete government control.*

	Beer	Wine	Spirits
Monopoly on production	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Monopoly on retail sales	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If the control for production and sale of alcohol is at the national level, do you have licensing? *Please check (✓) the appropriate answer(s). Licensing means partial government control where a license is required.*

	Beer	Wine	Spirits
Licence for production	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Licence for retail sales	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

5.3 Restrictions on alcohol availability by time			
Please provide information on existing restrictions for the on-premise sales of beer, wine and spirits at the national level. *Check (✓) the appropriate answers. On-premise sales means serving in, for example, a cafe, pub, bar, restaurant.*			
	Beer	Wine	Spirits
Hours of sale	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Days of sale	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Please provide information on existing restrictions for the off-premise sales of beer, wine and spirits at the national level. *Check (✓) the appropriate answers. Off-premise sales means selling as take-away in, for example, a shop or supermarket.*			
	Beer	Wine	Spirits
Hours of sale	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Days of sale	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5.4 Restrictions on alcohol availability by place			
Please provide information on existing restrictions for the on-premise sales of beer, wine and spirits at the national level. *Check (✓) the appropriate answers. On-premise sales means serving in, for example, a cafe, pub, bar, restaurant.*			
	Beer	Wine	Spirits
Locations of sales	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Density of outlets	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Please provide information on existing restrictions for the off-premise sales of beer, wine and spirits at the national level. *Check (✓) the appropriate answers. Off-premise sales means selling as take-away in, for example, a shop or supermarket.*			
	Beer	Wine	Spirits
Locations of sales	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Density of outlets	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

5.5 Restrictions of sales at specific events

Please provide information on existing restrictions for the on-premise sales of beer, wine and spirits at the national level. *Check (✓) the appropriate answers. On-premise sales means serving in, for example, a cafe, pub, bar, restaurant.*

	Beer	Wine	Spirits
Sales at specific events (e.g., football games)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please provide information on existing restrictions for the off-premise sales of beer, wine and spirits at the national level. *Check (✓) the appropriate answers. Off-premise sales means selling as take-away in, for example, a shop or supermarket.*

	Beer	Wine	Spirits
Sales at specific events (e.g., football games)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

5.6 Alcohol-free public environments

Please provide information on the extent to which different public environments are alcohol-free in your country. *Check (✓) the appropriate column. Partial statutory restriction means that certain alcoholic beverages are forbidden or some offices/ buildings/places are alcohol-free. Voluntary agreement/self-regulation means that local governments and municipalities have their own regulations or the alcoholic beverage industry follows its internal voluntary rules.*

	Ban	Partial statutory ban	Voluntary/self-regulated	No restriction
Educational buildings	☐	☐	☐	☐
Public transport	☐	☐	☐	☐
Parks, streets	☐	☐	☐	☐
Sporting events	☐	☐	☐	☐

6. Marketing of alcoholic beverages

6.1 Legally binding restrictions on alcohol advertising

Are there legally binding restrictions on alcohol advertising at the national level?

☐ No ☐ Yes

If YES, please specify the restrictions on alcohol advertising. Use letters to indicate the type of beverage (B=BEER), (W=WINE) and (S=SPIRITS) for which there are restrictions. *Partial statutory restriction means that the restriction applies during a certain time of day or for a certain place, or to the content of events, programs, magazines, films and so on. Voluntary agreement means that the alcoholic beverage industry follows its internal voluntary rules.*

	Ban	Partial restriction: time/place	Partial restriction: content	Voluntary/self-regulated	No restriction
Public service/national TV					
Commercial/private TV					
National radio					
Local radio					
Print media (newspapers					
Billboards					
Points of sale					
Cinema					
Internet					
Social media (Facebook etc.)					

6.2 Legally binding restrictions on product placement

Are there legally binding restrictions on alcohol product placement at the national level? *Product placement means that economic operators sponsor TV or film productions if their product is shown in these productions.*

☐ No ☐ Yes

If YES, please specify the restrictions on product placement. Use letters to indicate the type of beverage (B=BEER), (W=WINE) and (S=SPIRITS) for which there are restrictions. *Partial statutory restriction means that the restriction applies during a certain time of day or for a certain place, or to the content of events, programs, magazines, films and so on. Voluntary agreement means that the alcoholic beverage industry follows its internal voluntary rules*

	Ban	Partial restriction: time/place	Partial restriction: content	Voluntary/ self-regulated	No restriction
Public service/national TV					
Commercial/private TV					
Films/movies					

6.3 Legally binding restrictions on industry sponsorship for sporting and youth events

Are there legally binding restrictions on alcoholic beverage industry sponsorship at the national level?

☐ No ☐ Yes

If YES, please specify the restrictions on industry sponsorship. Use letters to indicate the type of beverage (B=BEER), (W=WINE) and (S=SPIRITS) for which there are restrictions. *Partial statutory restriction means that the restriction applies during a certain time of day or to some events, programs, magazines, films and so on. Voluntary agreement/ self-regulation means that the alcoholic beverage industry follows its internal voluntary rules*.

	Ban	Partial statutory regulations	Voluntary/ self-regulated	No restrictions
Industry sponsorship of sporting events				
Industry sponsorship of youth events such as concerts				

6.4 Legally binding restrictions on sales promotions by producers, retailers and owners of pubs and bars

Are there legally binding restrictions on sales promotion from producers, retailers (including supermarkets) and owners of pubs and bars at the national level?

☐ No ☐ Yes

If YES, please specify the restrictions on sales promotion. Use letters to indicate the type of beverage (B=BEER), (W=WINE) and (S=SPIRITS) for which there are restrictions. *Partial statutory restriction means that the restriction applies during a certain time of day or to some events, programs, magazines, films and so on. Voluntary agreement/ self-regulation means that the alcoholic beverage industry follows its internal voluntary rules*.

	Ban	Partial statutory regulations	Voluntary/ self-regulated	No restrictions
Sales promotion from producers (for example, parties and events)				
Below costs sales promotions from retailers (including supermarkets)				
Free drinks sales promotions from owners of pubs and bars				

7. Pricing policies

7.1 Adjustment of taxation level for inflation

Is the level of taxation (excise tax or special tax on alcohol other than excise tax) for alcoholic beverages adjusted for inflation in your country? *Please specify how often the level of taxation is adjusted for inflation (e.g. every 3 months/ every year):*

Beer	☐ No ☐ Yes ➔	every |__| months/every |__| years
Wine	☐ No ☐ Yes ➔	every |__| months/every |__| years
Spirits	☐ No ☐ Yes ➔	every |__| months/every |__| years
Other (most popular country-specific alcoholic beverage), please specify % alcohol by volume: __ __ % and name:	☐ No ☐ Yes ➔	every |__| months/every |__| years

7.2 Affordability of alcoholic beverages

Please specify the average retail price for alcoholic beverages.

	Quantity in cL	Reference brand (market leader)	Average retail price (in local currency)
Beer: most popular brand of beer			
Wine: table wine/ordinary wine			
Spirits: most popular local brand			
Spirits: most popular imported brand			
Other (most popular country-specific alcoholic beverage), please specify % alcohol by volume: __ __ % and name: _____			

7.3 Other price measures

Do you have any price measures other than taxation in your country? *Price measures other than taxation means, for example regulation of the price of non-alcoholic and alcoholic beverages, such as making a non-alcoholic beverage cheaper than an alcoholic beverage.*

☐ No ☐ Yes *Please check (✓) all that apply*.

☐ Minimum price policy
☐ Requirement to offer non-alcoholic beverages at a lower price
☐ Additional levy on specific products (for example, on alcopops), *please specify:*
☐ Price measures to discourage underage drinking or high-volume drinking.
Please specify:
☐ Ban on below-cost selling
☐ Ban on volume discounts
☐ Other, *please specify:*

8. Reducing the negative consequences of drinking and alcohol intoxication

8.1 Server training

In your country, is there any systematic alcohol server training (for servers of pubs, bars, restaurants) on a regular basis? *Check (✓) all that apply. Server training means a form of occupational training provided to people serving alcohol such as bar and restaurant staff, waiting staff or people serving at catered events. Alcohol server training promotes the safe service of alcoholic beverages to customers (such as not serving to intoxication, not serving to those already intoxicated or to minors). Alcohol server training can be regulated and mandated by state or local laws.*

☐ No
☐ Yes, organized by enforcement agencies
☐ Yes, organized by the private sector
☐ Yes, organized by other.
Please specify:

8.2 Health warning labels

Are health warning labels legally required on alcohol advertisements in your country at the national level?

☐ No ☐ Yes

Are health warning labels legally required on the containers/bottles of alcoholic beverages in your country at the national level?

☐ No ☐ Yes

9. Reducing the public health impact of illicit alcohol and informally produced alcohol

9.1 Use of duty paid or excise stamps on alcohol containers

Do you use duty-paid, excise or tax stamps or labels on alcoholic beverage containers/bottles in your

Beer:	☐ No	☐ Yes
Wine:	☐ No	☐ Yes
Spirits:	☐ No	☐ Yes

9.2 Estimates of unrecorded alcohol consumption

What are the main components of the national system of monitoring alcohol consumption? *Check (✓) all that apply*.

☐ Regular estimation of consumption of unrecorded (informally/illegally produced) alcohol based on expert opinion
☐ Regular estimation of consumption of unrecorded (informally/illegally produced) alcohol based on research focused on unrecorded alcohol consumption
☐ Regular estimation of consumption of unrecorded (informally/illegally produced) alcohol based on indirect estimates using government data on confiscated/seized alcohol
☐ Regular estimation of consumption of unrecorded (informally/illegally produced) alcohol based on indirect estimates using survey data
☐ Regular estimation of consumption of unrecorded (informally/illegally produced) alcohol based on indirect estimates using other data. *Please specify other data for estimation of unrecorded:*

9.3 Legislation to prevent illegal production and sale of alcoholic beverages

Do you have any national legislation in your country to prevent illegal production and/or sale of home- or informally produced alcoholic beverages?

☐ No
☐ Yes, to prevent illegal production
☐ Yes, to prevent illegal sale

10. Monitoring and surveillance

10.1 National monitoring system

In your country, do you have a national system for monitoring alcohol consumption, its health and social consequences? *Check (✓) all that apply. A national system for monitoring alcohol consumption, its health and social consequences refers to a data repository including a range of population-based and health facility data. The main population-based sources of health information are censuses, household surveys and (sample) vital registration systems. The main health facility-related data sources are public health surveillance, health services data and health system monitoring data.*

☐ Yes, with data collected on alcohol consumption
☐ Yes, with data collected on health consequences of alcohol consumption
☐ Yes, with data collected on social consequences of alcohol consumption
☐ Yes, with data collected on alcohol policy responses
☐ No

What are the main components of the national system of monitoring alcohol consumption? *Check (✓) all that apply*.

☐ Sales data for alcoholic beverages
☐ National population-based surveys including questions on alcohol consumption.
Please specify:
(i) how often these types of survey are implemented (e.g. every 3 years): every _ _ years; and
(ii) the last year of survey implementation (e.g. year 2011):

Are there regular reports available?

☐ Yes.
Please specify/indicate the year of last publication/release and web link or reference.
Year:
Web link or reference:
☐ No

What resources are secured for the national monitoring system?

☐ Institution/organization/department with the mandated function of a national monitoring centre. *Please provide the name and location of the institution/organization/department with such a monitoring function:*

☐ A person with the mandated function of monitoring the situation on alcohol and health.

10.2 National surveys
What are the main components of the national system of monitoring alcohol consumption? ☐ National youth (including school-based) surveys including questions on alcohol consumption. *Please specify:* *(i) how often these types of surveys are implemented (every _ _ years); and* *(ii) the last year of survey implementation (_ _ _ _):*
Do you have national surveys on the rates of heavy episodic drinking (binge drinking)* among adults (15+ years)? *The definition of heavy episodic drinking/binge drinking here should be 60+ g of pure alcohol on at least one occasion weekly during the past 12 months.* ☐ No ☐ Yes

Annex II: Detailed methodology to generate indicators and their scoring rubrics

Nested banded approach

Some SIs required a different scoring approach because the corresponding policies contained a nested structure. For example, the marketing SIs 6.1–6.4 contained policy options for beverage types nested within media types; and pricing policies SI 7.2 contained policy options for beverage types nested within price indices. A nested banding approach was employed for these indicators following the methods of Esser & Jernigan *(i)*. This approach first defined the number of bands a priori, which equaled the number of categories that define policy restrictiveness. Individual scores were then calculated and totaled for each question in the SI. The next step was to divide the maximum possible score by the number of bands,[1] in order to determine the cut points used to assign the final score value.

Table II-A outlines how to calculate the nested banded scores for product placement scores, which nests beverage types within media types. In this example, the band was set at four, as there are four levels of policy restrictiveness (i.e., none, voluntary, partial statutory, and ban). There are nine survey questions, each worth up to three points. Dividing the total points possible (9x3=27) by the number of bands* determines the ranges for each SI score (27/4=6.75): 1 (0–7 points), 2 (8–14 points), 3 (16–20 points), and 4 (21–27 points). The country in this example would be assigned a score of 4 because its score (19) fell within the 21–27 range.

* World Health Organization, Regional Office for Europe (WHO/EURO). *Status report on alcohol and health in 35 European Countries 2013* [Internet]. Copenhagen: WHO/EURO; 2013. Available from: http://www.euro.who.int/__data/assets/pdf_file/0017/190430/Status-Report-on-Alcohol-and-Health-in-35-European-Countries.pdf?ua=1 (accessed 1 Oct 2018).

Table II-A: Example of a score for legally binding restrictions on product placement (indicator 6.2) following the nested banding approach

Question of interest: Are there any restrictions on product placement?			
Item	Beverage type	Restriction	Points (level of restriction)
National television	Beer	Ban	3
	Wine	Partial statutory	2
	Spirits	Voluntary	1
Cable television	Beer	None	0
	Wine	Ban	3
	Spirits	Ban	3
Films	Beer	Ban	3
	Wine	Ban	3
	Spirits	Ban	3
		Total points	*21*
		Band	*4*
		Final score range	*4*
		Multiplier	*3*
		Final score for indicator	***12***

Marketing SIs following a nested banded approach contained a categorical structure used to define the band (i.e., policy restrictiveness levels of none, voluntary, partial ban, and total ban). However, the band for pricing policies SI 7.2 was ascertained according to the price indices of different beverage types. The price index used was a modified version of the affordability measure first introduced by Brand et al. *(ii)*. It is defined as follows:

$$10{,}000 \times \frac{\text{Price (calculated based on standard containers of 50 cl beer, 75 cl wine, and 70 cl spirits) (€)}}{\text{Gross national income at PPP per capital (current international \$)}}$$

Sub-policy indicators

Other variables were recoded because they were composed of several sub-policy indicators. For example, the questions on restrictions on hours and days of alcohol sales contained 12 binary variables that separated policies by policy type (i.e., hours or days of sale), outlet type (i.e., on- or off-premise outlets[**]) and beverage type (i.e., beer, wine, or spirits). Researchers determined all permutations of outlet, beverage, and policy type reported by countries in the Americas. Researchers then sorted these permutations based on whether the reporting countries had restrictions for all three beverage types (labeled "comprehensive restrictions") or, at most, for two beverage types (labeled "partial restrictions"). They then assigned scores using Table II-B below as a guide. These variables were subsequently merged into a single SI (Indicator 5.3) and recoded following the ordered categories (i.e., 0, 1, 2, 3, 4) delineated in the scoring scheme shown in Table II-C.

Table II-B: Scoring scheme for an SI—Indicator 5.3

Points	Criteria
IIII Four	Comprehensive restrictions on *either* days or hours of sale for *both* on- and off-premise locations
III Three	Comprehensive restrictions on *either* days or hours of sale for *either* on- or off-premise locations
II Two	Partial restrictions on *either* days or hours of sale for *both* on- and off-premise locations
I One	Partial restrictions on *either* days or hours of sale for *either* on- or off-premise locations
None	No restrictions

[**] "On-premise service" refers to alcoholic beverages that bars, cafés, or restaurants sell for people to consume within the setting of their premises; in contrast, "off-premise sale" refers to alcoholic beverages that people purchase in shops (such as supermarkets, liquor stores, convenience stores, or petrol kiosks) for consumption elsewhere.

Table II-C: Example of a recoded SI

Question of interest: Are there any restrictions on alcohol availability by time?												
Combination	*Comprehensive restrictions*						*Partial restrictions*					
	A	*B*	*C*	*D*	*E*	*F*	*G*	*H*	*I*	*J*	*K*	*L*
On-premise / hours / beer	✓	-	✓	-	-	-	✓	-	-	-	-	-
On-premise / hours / wine	✓	-	✓	-	-	-	✓	-	-	✓	-	-
On-premise / hours / spirits	✓	-	✓	-	-	-	-	-	-	✓	-	-
On-premise / days / beer	-	✓	-	✓	-	-	-	-	✓	-	-	-
On-premise / days / wine	-	✓	-	✓	-	-	-	✓	-	-	-	-
On-premise / days / spirits	-	✓	-	✓	-	-	-	✓	-	-	-	-
Off-premise / hours / beer	✓	-	-	-	✓	-	✓	-	-	-	-	-
Off-premise / hours / wine	✓	-	-	-	✓	-	✓	-	-	-	-	-
Off-premise / hours / spirits	✓	-	-	-	✓	-	-	-	-	-	✓	-
Off-premise / days / beer	-	✓	-	-	-	✓	-	-	✓	-	-	-
Off-premise / days / wine	-	✓	-	-	-	✓	-	✓	-	-	-	-
Off-premise / days / spirits	-	✓	-	-	-	✓	-	✓	-	-	-	-
Points for indicator 5.3	***4***	***4***	***3***	***3***	***3***	***3***	***2***	***2***	***2***	***1***	***1***	***0***

Multipliers

Because the scoring scheme needed to align with the scientific evidence, multiplier levels were used to weight scores based on the strength of the underlying research. In the process followed by WHO/EURO, members of the expert advisory group carried out the first round of input-gathering on the multiplier levels via e-mail consultations in June 2015. WHO/EURO and the WHO Collaborating Center on Alcohol Policy Implementation and Evaluation jointly developed the final rubric based on the experts' feedback and on information derived from the publication, *Alcohol: no ordinary commodity (iii)*. This book evaluated several policy measures and assigned each policy a rating of 0–3 based on dimensions of effectiveness, breadth of research support, and extent of cross-national testing. These quantitative ratings, which represent the consensus of the 15 authors, served as instruments for use in defining the five multiplier levels shown in Table II-D.

Table II-D: Description of tool used for weighting SIs

Multiplier Level	Description	Effectiveness	Breadth of Research Support and Cross-National Testing	OR	Effectiveness	Breadth of Research Support and Cross-National Testing
5x	High level of effectiveness demonstrated consistently across different populations OR fundamental public health infrastructure needed to initiate and sustain an effective response	✓✓✓ 3	✓✓✓ 2 or 3			
4x	High level of effectiveness demonstrated in a limited number of studies and populations OR moderate effectiveness demonstrated consistently across different populations	✓✓✓ 3	✓✓ 1 or 2		✓✓ 2	✓✓✓ 2 or 3
3x	High level of effectiveness demonstrated in a limited number of studies and populations OR moderate effectiveness demonstrated consistently across different populations	✓✓ 2	✓✓ 1 or 2			
2x	Moderate effectiveness demonstrated in a limited number of studies and populations	✓ 1			? unknown	
1x	Not shown on its own to be effective but may be valuable as part of a package of policy measures	0				

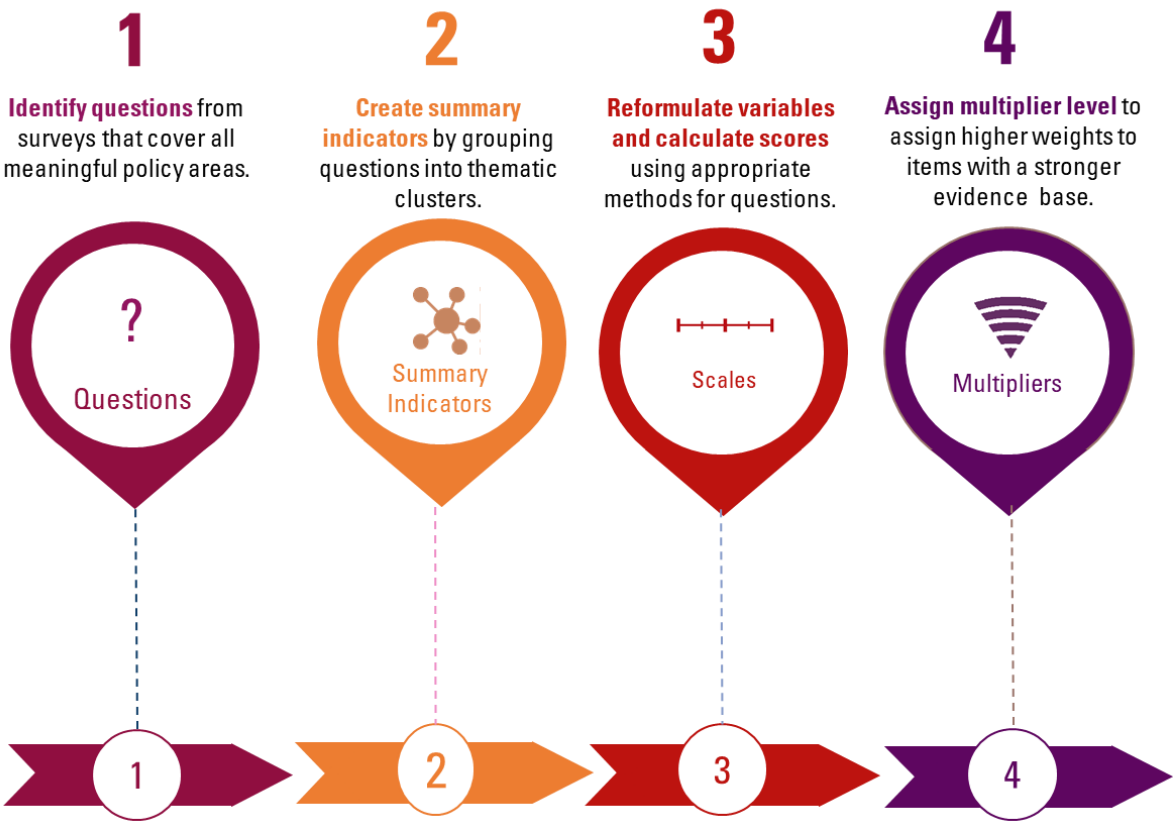
Note: The source for the effectiveness, breadth of research, and cross-national testing rankings was Babor et al. *(9)*

The authors also used other publications providing a synthesis of available evidence to guide the allocation of multiplier levels *(iv)*. The scoring rubric was submitted to the expert advisory group for final review in October 2015.

Policies encompassing more rigorous scientific evidence called for assigning higher scores to them. To this end, weighted SI scores were calculated as the product of each raw SI score and the corresponding multiplier level. Composite indicators were then calculated as the sum of all weighted SIs.

In summary, a systematic evidence-based approach was used to define the component SIs and their attached weights. Alternative statistical techniques for constructing composite indicators were initially considered. For example, principal components analysis and factor analysis may be employed to "[group] together individual indicators that are collinear to form a composite indicator that captures as much as possible of the information common to individual indicators" *(v)*. The authors used these methods for reasons of parsimony and for preventing possible double counting of overlapping variables. They decided, however, that such a statistical approach was not suitable for the end goal of political advocacy, because statistical correlations "do not necessarily correspond to the real-world links and underlying relationships between the indicators and the phenomena being measured" *(vi)*. Moreover, a composite indicator that is based on current science and accompanied by a transparent scoring system is more likely to resonate with policy-makers than abstract statistical constructs. Thus, the final scoring system retained all meaningful items of the global strategy—regardless of their statistical contribution to the overall variance—as an indication of their practical importance. The steps involved in constructing the scoring scheme are illustrated in Figure II-A that follows.

Figure II-A: Steps taken to construct the scoring scheme



Detailed scoring rubrics for the composite indicators

1.	**Leadership, awareness, and commitment**				
1.1	**National policy on alcohol** *An adopted written national policy on alcohol is defined as a written organized set of values, principles and objectives for reducing the burden attributable to alcohol in a population.*				
	Written national policy on alcohol	☐ Adopted (2 p.)	☐ In development (1 p.)	☐ No (0 p.)	
	Written national policy on alcohol is multisectoral	☐ Yes (1 p.)	☐ N/A (0 p.)	☐ No (0 p.)	
	Written national policy on alcohol policy is accompanied by a national action plan for implementation	☐ Yes (1 p.)	☐ N/A (0 p.)	☐ No (0 p.)	
	Multiplier	x3			
1.2	**Definition of alcoholic beverage** *A beverage over a certain percentage of alcohol by volume is defined as an alcoholic beverage.*				
	An alcoholic beverage is legally defined as a beverage over 0.1–2.8% alcohol by volume	☐ Yes (1 p.)	☐ No (0 p.)		
	Multiplier	x2			
1.3	**Definition of standard drink** *A definition of a standard drink (in grams of pure alcohol) is used at the national level.*				
	A standard drink is defined as 8–12 g of pure alcohol	☐ Yes (1 p.)	☐ No (0 p.)		
	Multiplier	x1			
1.4	**Awareness activities** *Awareness activities are provided pertaining to the following topics: young people's drinking, drink–driving, indigenous peoples, impact on health, social harms, illegal/surrogate alcohol, alcohol at work, or pregnancy and alcohol.*				
	Implementation of national awareness activities within last three years	☐ 6 or more topics (3 p.)	☐ 4–5 topics (2 p.)	☐ 1–3 topics (1 p.)	☐ None (0 p.)
	Tools/programs used for the prevention of alcohol use and alcohol use disorders (audiovisual mass media, print mass media *or* advertisements in public places) cover at least 31% of the target population	☐ Yes (1 p.)		☐ No (0 p.)	
	Multiplier	x2			
Rubric 1 = maximum 23 points					

2.	**Health services' response**					
2.1	**Screening and brief interventions for harmful and hazardous alcohol use** *Screening and short-term interventions are implemented for harmful and hazardous alcohol use. Screening can consist of simple questions about alcohol use and does not necessarily involve standardized screening questionnaires or testing.*					
	Proportion of primary health care services that have implemented routine (for a majority of patients) and/or selective (for a minority of patients) screening and brief intervention	☐ Most (61–100%) (4 p.)	☐ Many (31–60%) (3 p.)	☐ Some (11–30%) (2 p.)	☐ Few (1–10%) (1 p.)	☐ None (0 p.)
	Proportion of antenatal services that have implemented screening and brief interventions for harmful and hazardous alcohol use at the national level	☐ Most (61–100%) (4 p.)	☐ Many (31–60%) (3 p.)	☐ Some (11–30%) (2 p.)	☐ Few (1–10%) (1 p.)	☐ None (0 p.)
	Multiplier			x3		
2.2	**Special treatment programs**					
	Special treatment programs for women with alcohol use disorders are available in major cities or other areas			☐ Yes (2 p.)		☐ No (0 p.)
	Special treatment programs for children and adolescents with alcohol use disorders are available in major cities or other areas			☐ Yes (2 p.)		☐ No (0 p.)
	Multiplier			x2		
2.3	**Pharmacological treatment** *Medications are available for the treatment of alcohol dependence or alcohol withdrawal.*					
	Pharmacological treatment	☐ Acamprosate (1 p.) ☐ Diazepam (or other long-acting benzodiazepines) (1 p.) ☐ Disulfiram (1 p.) ☐ Naltrexone (1 p.)				☐ No (0 p.)
	Multiplier			x3		
	Rubric 2 = maximum 44 points					

3.	**Community and workplace action**		
3.1	**School-based prevention and reduction of alcohol-related harm**		
	National guidelines are available for the prevention and reduction of alcohol-related harm in school settings	☐ Yes (2 p.)	☐ No (0 p.)
	Multiplier		x2
3.2	**Workplace-based alcohol problem prevention and counselling**		
	National guidelines are available for prevention and counselling for alcohol problems at workplaces	☐ Yes (2 p.)	☐ No (0 p.)
	Legislation is in place on alcohol testing at workplaces	☐ Yes (1 p.)	☐ No (0 p.)
	Workplace programs for the prevention of alcohol use and alcohol use disorders cover at least 31% of the target population	☐ Yes (3 p.)	☐ No (0 p.)
	Multiplier		x2
3.3	**Community-based interventions to reduce alcohol-related harm**		
	Community-based programs for the prevention of alcohol use and alcohol use disorders cover at least 31% of the target population	☐ Yes (3 p.)	☐ No (0 p.)
	Multiplier		x2
	Rubric 3 = maximum 22 points		

4.	**Drink–driving policies and countermeasures**			
4.1	**Maximum legal blood alcohol concentration (BAC) limit when driving a vehicle** *This is the legal maximum BAC (measured as mass per volume) allowed while driving a vehicle in a country.*			
	General BAC limit	☐ ≤0.02% (3 p.)	☐ >0.02% but ≤ 0.05% (2 p.)	☐ >0.05% (0 p.)
	BAC for young/novice drivers	☐ ≤0.02% (2 p.)	☐ >0.02% but ≤ 0.05% (1 p.)	☐ >0.05% (0 p.)
	Multiplier	x5		
4.2	**Enforcement using sobriety checkpoints** *Police checkpoints are used to enforce alcohol laws. Sobriety checkpoints are checkpoints or roadblocks established by the police on public roadways to control for drink–driving.*			
	Sobriety checkpoints are used	☐ Yes (3 p.)	☐ No (0 p.)	
	Multiplier	x3		
4.3	**Enforcement using random breath-testing** *Random breath-testing is used to enforce alcohol laws. Random breath-testing is defined as a test given by the police to drivers chosen by chance. It means that any driver can be stopped by the police at any time to test the breath for alcohol consumption.*			
	Random breath-testing is used	☐ Yes (4 p.)	☐ No (0 p.)	
	Multiplier	x4		
4.4	**Penalties** *Penalties include: community/public service, short-term detention, fines, penalty points, licence suspension, licence revocation, imprisonment, impounding of vehicle, ignition interlocks (alcolocks), mandatory treatment, and mandatory education and counselling imposed on drivers for disregarding drink–driving laws.*			
	Penalties	☐ At least 4 different types of penalty implemented (4 p.)	☐ 1–3 different types of penalty implemented (2 p.)	☐ None (0 p.)
	Multiplier	x4		
	Rubric 4 = maximum 66 points			

5.	Availability of alcohol					
5.1	**Lowest age limit for on-premise alcohol service and off-premise alcohol sale** *These are the lowest ages at which a person can be served alcoholic beverages on premises in a country (alcoholic beverages cannot be served to a person under this age) and sold alcoholic beverages for consumption off the premises in a country (alcoholic beverages cannot be sold to a*					
	Lowest age limit	☐ ≥20 years (4 p.)	☐ 18–19 years (3 p.)	☐ <18 years (0 p.)		
	Multiplier	x4				
5.2	**Control of retail sales** *Licensing refers to partial government control of the sale of alcoholic beverages. A monopoly refers to a government monopoly (full control) of the sale of alcoholic beverages.*					
	Control of retail sales	☐ Full monopoly (beer and wine and spirits) (4 p.)	☐ Partial monopoly (beer or wine or spirits) (3 p.)	☐ Full licensing (beer and wine and spirits) (2 p.)	☐ Partial licensing (beer or wine or spirits) (1 p.)	☐ None (0 p.)
	Multiplier	x3				
5.3	**Restrictions on alcohol availability by time** *There are regulated limits on the time (hours/days) of sales of alcoholic beverages.*					
	Restrictions on alcohol availability by time	☐ Comprehensive restriction on either days or hours of sales (beer and wine and spirits) for <u>both</u> on-premises and off-premises sales (4 p.)	☐ Comprehensive restriction on either days or hours of sales (beer and wine and spirits) for <u>either</u> on-premises or off-premises sales (3 p.)	☐ Partial restriction on either days or hours of sales (beer or wine or spirits) for <u>both</u> on-premises and off-premises sales (2 p.)	☐ Partial restriction on either days or hours of sales (beer or wine or spirits) for <u>either</u> on-premises or off-premises sales (1 p.)	☐ None (0 p.)
	Multiplier	x3				
5.4	**Restrictions on alcohol availability by place** *There are regulated limits on the location (places/density) of sales of alcoholic beverages.*					
	Restrictions on alcohol availability by place	☐ Comprehensive restriction on either location or density of sales (beer and wine and spirits) for <u>both</u> on-premises and off-premises sales (4 p.)	☐ Comprehensive restriction on either location or density of sales (beer and wine and spirits) for <u>either</u> on-premises or off-premises sales (3 p.)	☐ Partial restriction on either location or density of sales (beer or wine or spirits) for <u>both</u> on-premises and off-premises sales (2 p.)	☐ Partial restriction on either location or density of sales (beer or wine or spirits) for <u>either</u> on-premises or off-premises sales (1 p.)	☐ None (0 p.)
	Multiplier	x3				

5.5	**Restrictions on sales at specific events** *There are regulated limits on the sales of alcoholic beverages during specific events (such as football games)*			
	Restrictions on sales at specific events	☐ Comprehensive restrictions (beer and wine and spirits) (3 p.)	☐ Partial restrictions (beer or wine or spirits) (2 p.)	☐ None (0 p.)
	Multiplier	x3		
5.6	**Alcohol-free public environments** *Alcohol use is restricted in public places such as public transport, parks and streets, educational buildings and sporting events.*			
	Restriction on alcohol consumption on public transport	☐ Partial restriction or ban (2 p.)	☐ None or voluntary agreement/self-regulation (0 p.)	
	Restriction on alcohol consumption in public areas (such as parks or streets)	☐ Partial restriction or ban (3 p.)	☐ None or voluntary agreement/self-regulation (0 p.)	
	Restriction on alcohol consumption in educational building	☐ Partial restriction or ban (3 p.)	☐ None or voluntary agreement/self-regulation (0 p.)	
	Restriction alcohol consumption at sporting events	☐ Partial restriction or ban (3 p.)	☐ None or voluntary agreement/self-regulation (0 p.)	
	Multiplier	x3		
Rubric 5 = maximum 94 points				

6. Marketing of alcoholic beverages (see also Rubric 6a)

6.1 Legally binding restrictions on alcohol advertising

Alcohol advertising is defined as the promotion of alcoholic beverages by the alcohol industry through a variety of media: national television, cable television, national radio, local radio, print media, cinemas, billboards, points of sale, internet and social media. The level of restriction may be a total ban, partial statutory restriction or voluntary agreement/self-regulation. (Partial statutory restriction means that the restriction applies during a certain time of day or to some events, programs, magazines, films or suchlike. Voluntary agreement/self-regulation means that the alcoholic beverage industry follows its internal voluntary rules.)

	Legally binding restrictions on alcohol advertising	☐ Total ban (3 p.)	☐ Partial statutory restriction (2 p.)	☐ Voluntary agreement/self-regulation (1 p.)	☐ None (0 p.)
	Multiplier	*See Rubric 6a*			

6.2 Legally binding restrictions on product placement

Product placement refers to the sponsorship of, for example, television productions by economic operators if their alcoholic beverage is shown in these productions. Media include: public service/national television, commercial/private television and films. The level of restriction may be a total ban, partial statutory restriction or voluntary agreement/self-regulation.

	Legally binding restrictions on product placement	☐ Total ban (3 p.)	☐ Partial statutory restriction (2 p.)	☐ Voluntary agreement/self-regulation 1 p.)	☐ None (0 p.)
	Multiplier	*See Rubric 6a*			

6.3 Legally binding restrictions on industry sponsorship for sporting and youth events

Sponsorship refers to the support of an event financially or through the provision of products or services as part of brand identification and marketing.

	Legally binding restrictions on industry sponsorship for sporting and youth events	☐ Total ban (3 p.)	☐ Partial statutory restriction (2 p.)	☐ Voluntary agreement/self-regulation (1 p.)	☐ None (0 p.)
	Multiplier	*See Rubric 6a*			

6.4 Legally binding restrictions on sales promotions by producers, retailers and owners of pubs and bars

Restrictions are legally enforced on the promotion of alcohol sales in a country by, for example, producers (parties and events), retailers (including supermarkets) in the form of sales below cost (for example, two for the price of one, happy hours), or owners of pubs and bars (serving alcohol free). Sales promotion refers to marketing practices designed to facilitate the purchase of a product.

	Legally binding restrictions on sales promotions by producers, retailers and owners of pubs and bars	☐ Total ban (3 p.)	☐ Partial statutory restriction (2 p.)	☐ Voluntary agreement/self-regulation (1 p.)	☐ None (0 p.)
	Multiplier	*See Rubric 6a*			

6a.	Marketing of alcoholic beverages					
	A nested banding approach is employed. Points are awarded for multiple items (such as various advertising platforms) based on the level of restriction applied to different types of beverage. The sum of points across the items corresponds to a band, which in turn determines the final score for the indicator. Using a 3-2-1 point scale for total ban, partial statutory restriction, and voluntary agreement/self-regulation, respectively, there is a maximum number of 30 points for each beverage type (3 points x 10 advertising platforms), or a total of 90 points for beer, wine and spirits combined. Bands are then created (for example, band 0: 0 points, band 1: 1–22 points, band 2: 23–44 points, band 3: 45–67 points, band 4: 68–90 points) and points assigned to each band.					
6.1	**Legally binding restrictions on alcohol advertising**					
	Legally binding restrictions on alcohol advertising	☐ Band 4 (68–90 points) (4 p.)	☐ Band 3 (45–67 points) (3 p.)	☐ Band 2 (23–44 points) (2 p.)	☐ Band 1 (1–22 points) (1 p.)	☐ Band 0 (0 points) (0 p.)
	Multiplier			x3		
6.2	**Legally binding restrictions on product placement**					
	Legally binding restrictions on product placement	☐ Band 4 (68–90 points) (4 p.)	☐ Band 3 (45–67 points) (3 p.)	☐ Band 2 (23–44 points) (2 p.)	☐ Band 1 (1–22 points) (1 p.)	☐ Band 0 (0 points) (0 p.)
	Multiplier			x3		
6.3	**Legally binding restrictions on industry sponsorship for sporting and youth events**					
	Legally binding restrictions on industry sponsorship for sporting and youth events	☐ Band 4 (68–90 points) (4 p.)	☐ Band 3 (45–67 points) (3 p.)	☐ Band 2 (23–44 points) (2 p.)	☐ Band 1 (1–22 points) (1 p.)	☐ Band 0 (0 points) (0 p.)
	Multiplier			x3		
6.4	**Legally binding restrictions on sales promotions by producers, retailers and owners of pubs and bars**					
	Legally binding restrictions on sales promotions by producers, retailers and owners of pubs and bars	☐ Band 4 (68–90 points) (4 p.)	☐ Band 3 (45–67 points) (3 p.)	☐ Band 2 (23–44 points) (2 p.)	☐ Band 1 (1–22 points) (1 p.)	☐ Band 0 (0 points) (0 p.)
	Multiplier			x3		
	Rubric 6 = maximum 48 points					

7.	**Pricing policies (See also Rubric 7a)**				
7.1	**Adjustment of taxation level for inflation** *This is to indicate whether the level of taxation (excise tax or special tax on alcohol other than excise tax) for alcoholic beverages is adjusted for inflation.*				
	Adjustment of taxation level for inflation	☐ At least two types of beverage (4 p.)	☐ One type of beverage (beer, wine or spirits) (2 p.)	☐ No (0 p.)	
	Multiplier	x3			
7.2	**Affordability of alcoholic beverages**				
	Affordability of alcoholic beverages	*See Rubric 7a*			
	Multiplier	*See Rubric 7a*			
7.3	**Other price measures** *This is to indicate whether there are any price measures other than taxation in a given country. Price measures other than taxation mean, for example, by regulation of the price of non-alcoholic and alcoholic beverages, such as making a non-alcoholic beverage cheaper than an alcoholic beverage. They include: minimum price policy, additional levy on specific products (such as alcopops), requirement to offer non-alcoholic beverages at a lower price, ban on below-cost selling, or ban on volume discounts.*				
	Minimum price policy	☐ Yes (3 p.)	☐ No (0 p.)		
	Additional levy on specific products	☐ Yes (3 p.)	☐ No (0 p.)		
	Requirement to offer a non-alcoholic beverage at a lower price than an alcoholic beverage on the premises	☐ Yes (2 p.)	☐ No (0 p.)		
	Ban on below-cost selling	☐ Yes (3 p.)	☐ No (0 p.)		
	Ban on volume discounts	☐ Yes (3 p.)	☐ No (0 p.)		
	Multiplier	x3			
7a.	**Pricing policies**				
7.2	**Affordability of alcoholic beverages** *A band is ascertained according to the price indices of different types of beverage.* *The price index is a modification of the affordability measure first introduced by Brand et al. (2007), and is defined as follows:* *Price index=10 000 × (Price (calculated based on standard containers of 50 cl beer,75 cl wine and 70 cl spirits)(€))/(Gross national income at PPP per capita (current international $))* *The price index is calculated separately for beer, wine and spirits, and an overall score for the affordability indicator is determined using the banding approach.*					
	Affordability of alcoholic beverages	☐ Band 4 (13–16 points) (4 p.)	☐ Band 3 (10–12 points) (3 p.)	☐ Band 2 (7–9 points) (2 p.)	☐ Band 1 (4–6 points) (1 p.)	☐ Band 0 (≤ 3 points) (0 p.)
	Multiplier	x4				
	Rubric 7 = maximum 70 points					

8.	**Reducing the negative consequences of drinking and alcohol intoxication**		
8.1	**Server training** *Server training is provided on a regular basis to bar staff and staff at special events to give them skills and knowledge about alcohol harm and safe serving practices.*		
	Server training is offered on a regular basis	☐ Yes (3 p.)	☐ No (0 p.)
	Multiplier	x2	
8.2	**Health warning labels** *Health warning labels are present with information on the dangers associated with the use of the product.*		
	Health warning labels are legally required on alcohol advertisements	☐ Yes (2 p.)	☐ No (0 p.)
	Health warning labels are legally required on containers/bottles of alcoholic beverages	☐ Yes (3 p.)	☐ No (0 p.)
	Multiplier	x2	
	Rubric 8 = maximum 16 points		
9.	**Reducing the public health impact of illicit alcohol and informally produced alcohol**		
9.1	**Use of duty paid or excise stamps on alcohol containers** *Excise stamps on alcohol containers are used by national customs to signify that the excise tax has*		
	Duty paid or excise stamps are used	☐ Yes (3 p.)	☐ No (0 p.)
	Multiplier	x3	
9.2	**Estimates of unrecorded alcohol consumption** *Unrecorded alcohol is alcohol that is not taxed and is outside the usual system of governmental control, such as home- or informally produced alcohol (legal or illegal), smuggled alcohol, surrogate alcohol (alcohol not intended for human consumption), or alcohol obtained through cross-border shopping which is recorded in a different jurisdiction.* *Regular estimates of the consumption of unrecorded alcohol may be available in a country based on expert opinion, research focused on unrecorded alcohol consumption, indirect estimates using government data on confiscated/seized alcohol, indirect estimates using survey data or indirect estimates using other data.*		
	Estimates of unrecorded alcohol consumption are available	☐ Yes (3 p.)	☐ No (0 p.)
	Multiplier	x3	
9.3	**Legislation to prevent illegal production and sale of alcoholic beverages** *National legislation is in place to prevent the illegal production and/or sale of home- or informally produced alcoholic beverages.*		
	Legislation exists to prevent illegal production of alcoholic beverages	☐ Yes (3 p.)	☐ No (0 p.)
	Legislation exists to prevent illegal sale of alcoholic beverages	☐ Yes (3 p.)	☐ No (0 p.)
	Multiplier	x2	
	Rubric 9 = maximum 30 points		

10.	**Monitoring and surveillance**		
10.1	**National monitoring system** *This is to indicate whether there is a national system for monitoring alcohol-related harm.*		
	National system for monitoring includes data on:	☐ alcohol consumption (including regular national surveys of consumers and abstainers in the general population) (3 p.) ☐ health consequences (3 p.) ☐ social consequences (3 p.) ☐ alcohol policy responses (3 p.) ☐ sales data (3 p.)	☐ No national monitoring system (0 p.)
	Regular reports are published using data from national monitoring system	☐ Yes (4 p.)	☐ No (0 p.)
	An institution/organization/ department has the mandated function of a national monitoring centre *or* a person has the mandated function of monitoring the situation on alcohol and health	☐ Yes (4 p.)	☐ No (0 p.)
	Multiplier	x3	
10.2	**National surveys** *This is to indicate whether there are national surveys of the rates of heavy episodic drinking (binge drinking) among adults and of alcohol consumption among young people (including school-based surveys).*		
	Surveys of heavy episodic drinking are carried out	☐ Yes (4 p.)	☐ No (0 p.)
	Multiplier	x3	
	Rubric 10 = maximum 81 points		

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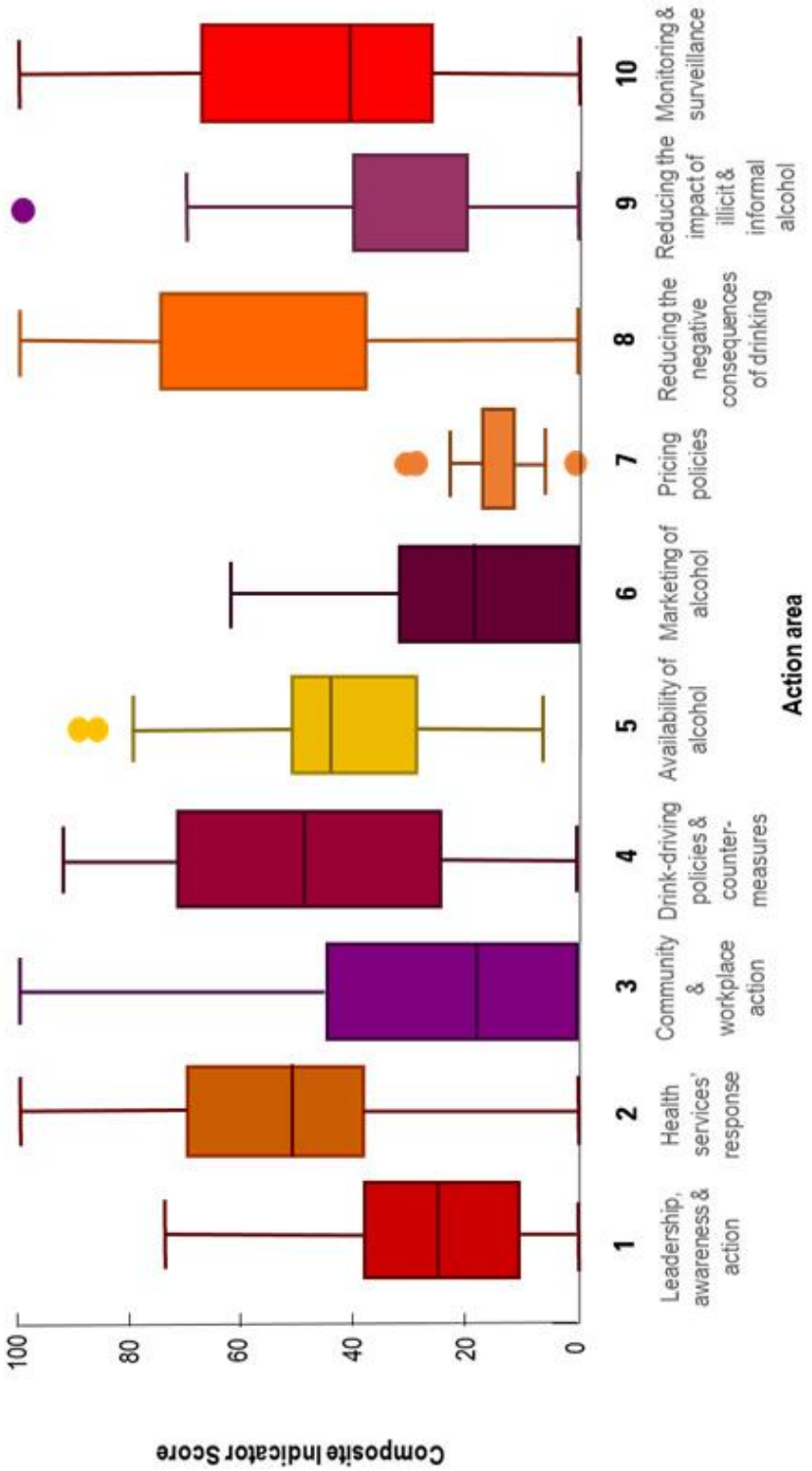
Annex III: Descriptive statistics for scaled composite indicators

Table III-A: Descriptive statistics for scaled composite indicators

Action area	Mean	Median	Minimum observed	Maximum observed
Leadership, awareness, and commitment	28	25	0	74
Health services' response	53	51	0	100
Community and workplace action	27	18	0	100
Drink-driving policies and countermeasures	48	48	0	92
Availability of alcohol	43	45	6	89
Marketing of alcoholic beverages	21	19	0	63
Pricing policies	14	11	0	30
Reducing the negative consequences of drinking and alcohol intoxication	52	38	0	100
Reducing the public health impact of illicit alcohol and informally produced alcohol	32	40	0	100
Monitoring and surveillance	46	41	0	100

Figure III-A: Box and whiskers plot of the composite indicators



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