



**World Health
Organization**

REGIONAL OFFICE FOR **Europe**

Third Moscow intersectoral NCD training course: “Alcohol as a risk factor for road safety and noncommunicable diseases”

**12–15 March 2018
Moscow, Russian Federation**

TRAINING COURSE REPORT

ABSTRACT

The third Moscow intersectoral NCD training course, "Alcohol as a risk factor for road safety and noncommunicable diseases", was held on 12–15 March 2018 in Moscow, Russian Federation. The training was organized by the WHO Regional Office for Europe in collaboration with the I.M. Sechenov First Moscow State Medical University, Russian Federation (a WHO collaborating centre) and international experts. The four-day course aimed to support Member States in improving national action and collaborative work to promote the co-benefits of legislative, enforcement and social marketing practices in the prevention of NCDs and drink-driving, and to explore the co-benefits of emergency care services and sustainable transport. Forty-five participants from nine countries of central Asia and eastern Europe attended: Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan and Uzbekistan. This report captures the main point from lectures, roundtable discussions and groupwork during the four days.

Keywords

ALCOHOLIC BEVERAGES - ADVERSE EFFECTS
ALCOHOL DRINKING - ADVERSE EFFECTS, LEGISLATION AND
JURISPRUDENCE, PREVENTION AND CONTROL
ACCIDENTS, TRAFFIC - PREVENTION AND CONTROL
NONCOMMUNICABLE DISEASES
SOCIAL MARKETING

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Acronyms

BAC	blood alcohol concentration
BrAC	breath alcohol concentration
CIS	Commonwealth of Independent States
CVD	cardiovascular disease
EAEU	Eurasian Economic Union
EU	European Union
GAPPA	(WHO) Global Action Plan on Physical Activity
NCDs	noncommunicable diseases
NGO	nongovernmental organization
NIS	newly independent states
PEN	Package of Essential Noncommunicable Disease Interventions for Primary Health Care in Low-resource Settings
RTI	road traffic injury
SBI	screening and brief counselling interventions
SDGs	(United Nations) Sustainable Development Goals
THE PEP	Transport, Health and Environment pan-European Programme

Background and introduction to the course

The *Global action plan for the prevention and control of noncommunicable diseases 2013–2020*, endorsed by the Sixty-sixth World Health Assembly in May 2013, recognizes alcohol as a leading risk factor for the development of noncommunicable diseases (NCDs) such as cancer, cardiovascular disease (CVD), liver disease and cerebrovascular disease. The importance of considering comprehensive measures to tackle this avoidable cause of premature mortality have also been reflected in relevant European regional strategies and action plans, including fiscal, legislative and health service measures. The United Nations Decade of Action of Road Safety and the associated United Nations resolution also recognize driving under the influence of alcohol as a key risk factor leading to death and disability on the roads. Evidence suggests that among the interventions necessary to control this, the priorities would be enactment of comprehensive legislation, enforcement, product and environment modifications, and health service response.

Common approaches to these two areas are lacking, but they are unified by common public health approaches – strategies, surveillance, risks and interventions. To address this need for common approaches, the WHO Regional Office for Europe organized the third Moscow intersectoral NCD training course as a capacity-building event for a small group of Member States from the WHO European Region. The main focus of the course was alcohol as a common risk factor for road crashes and NCDs. The control of drink–driving requires the use of legislation and enforcement. It is recognized, however, that capacity to develop and implement such laws and regulations may be limited in many Member States. To support countries, legislative reviews of laws, institutional capacity and enforcement practices of drink–driving were conducted prior to the workshop. There are co-benefits to legislative, enforcement and social marketing practices. Other co-risks, co-benefits and common approaches, including the co-benefits of efficient emergency medical services and sustainable transport solutions, were also explored, as were the burden of alcohol-related NCDs and injuries, in particular CVD and road traffic injuries (RTIs).

Introduction to the training course

The third Moscow intersectoral NCD training course, "Alcohol as a risk factor for road safety and noncommunicable diseases", was held on 12–15 March 2018 in Moscow, Russian Federation. The training was organized by the Regional Office in collaboration with the I.M. Sechenov First Moscow State Medical University, Russian Federation (a WHO collaborating centre) and international experts. The course was held in the context of the Project on the Prevention and Control of NCDs, financed through a voluntary contribution from the Ministry of Health of the Russian Federation.

The four-day course aimed to support Member States in improving national action and collaborative work to promote the co-benefits of legislative, enforcement and social marketing practices in the prevention of NCDs and drink–driving, and to explore the co-benefits of emergency care services and sustainable transport.

Forty-five participants from nine countries of central Asia and eastern Europe attended: Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan and Uzbekistan. A full list of participants is shown in Annex 1.

The course was launched with an official ceremony hosted by Dr Ruslan Khalifin, Director of the Higher School of Health Administration, First Moscow State Medical University. Welcoming speeches were made by: Dr Tatyana Litvinova, Vice Rector for Academic Affairs, First Moscow State Medical University; Dr Igor Kagramanyan, First Deputy Chairman of the Social Policy Committee, Federal Assembly of the Russian Federation; Dr Nikolay Gerasimenko, Health Care Committee, State Duma of the Russian Federation; Dr Sergei Maravyev, Director of International Cooperation and Public Health Department, Ministry of Health of the Russian Federation; Dr Artem Tarasenko, Deputy Director, Department of Medical Education and Human Resources Policy in Health Care, Ministry of Health of the Russian Federation; Professor Victor Kondratiev, Chief Specialist, Main Office for Road Safety, Ministry of the Interior of the Russian Federation; and Dr Melita Vujnovic, WHO Representative and Head of the WHO country office in the Russian Federation. Dr Joao Breda, Head of WHO European Office for Prevention and Control of Noncommunicable Diseases, and Dr Dinesh Sethi, Programme Manager, Violence and Injury Prevention, WHO Regional Office for Europe, introduced the course to participants.

All speakers highlighted the relevance of the course, the multisectoral nature of which would contribute to further development of common approaches to NCDs and RTI prevention. It was stated that the course provided an opportunity for joint action that would lead to synergistic gains in both these areas of health. There are common risk factors and societal and health responses that would be beneficial to both priority areas. Key among them are the control of harmful alcohol use and health services' response to this critical risk factor.

The opening session was followed by a tour of the Museum of the History of Medicine at Sechenov University.

About the course

The training course was designed to build capacity by providing an overview of the burden of NCDs, debating the burden of CVD and RTIs related to alcohol, discussing case studies of legislative analyses of drink-driving conducted in key newly independent states (NIS), delivering best practice in policy, laws and enforcement approaches to drink-driving, and debating how health, legal and enforcement practices could be strengthened in NIS countries. The co-benefits of emergency care services and sustainable transport for NCDs and RTIs were also explored. The course aimed to explore ways to achieve effective multisectoral collaboration and improve policy coherence for NCD and RTI prevention, notably between the health and interior sectors.

Course structure and objectives

The course was designed as a four-day training programme that included lectures, roundtables, moderated discussions and six groupwork activities aimed at developing country roadmaps for common approaches to drink-driving, reducing harmful alcohol use and NCDs.

The objectives were to:

- provide an overview of the burden of NCDs and RTIs;
- consider the cross associations of risks and benefits between NCDs and drink-driving, and debate the burden of NCDs and RTIs related to alcohol;
- review case studies of legislative analyses conducted in Eurasian Economic Union (EAEU) countries on drink-driving;

- consider effective policy options and legal approaches to drink–driving and how health, legal and enforcement practices can be strengthened;
- explore the co-benefits of common approaches such as sustainable transport and emergency care services; and
- establish and deepen professional capacity and networks for making progress on reducing the burden of NCDs and RTIs due to alcohol.

The course included several country presentations from NIS as well as best practice from across the Region. Cross benefits of tackling alcohol-related RTIs and NCDs were debated and common approaches explored.

The programme of the course is presented in Annex 2. Course presentation materials can be found on the Sechenov University website.¹

¹ The Sechenov University website can be accessed at: <http://hsha.ru/materialyi-4/> using the password WHO2018.

Day 1

Lecture. Burden and risk factor of NCDs and CVDs, by Dr Joao Breda (40 minutes)

Lecture. Problems and risks of alcohol, by Dr Carina Ferreira-Borges (40 minutes)

Lecture. Road traffic injury attributed to alcohol, by Dr Dinesh Sethi (40 minutes)

In this session, the speakers provided an overview of the global and European burden of disease due to NCDs and RTIs and the increased importance being given to these conditions. The importance of alcohol as a risk factor for NCDs and RTIs, as well as other injuries (both unintentional and due to violence), was discussed. The session also set the scene on the relationships between CVD, alcohol and road safety.

NCDs and the area of road safety have been identified as major challenges to sustainable development. Consequently, the United Nations Summit on Sustainable Development adopted the Sustainable Development Goals (SDGs) to reduce premature mortality from NCDs by one third (SDG target 3.4) by 2030 and reduce the number of global deaths and injuries from road traffic crashes by 50% (SDG target 3.6) by 2020. Alcohol is a risk factor common to NCDs and RTIs, as well as other injuries, and this is recognized in SDG target 3.4. Most countries in the European Region and globally have developed national strategies to combat NCDs, road safety and alcohol misuse, and global and European regional policies have also been developed. More could be gained, however, by exploring the linkages between these standalone policies. Inequalities across the Region were emphasized.

Lecture. Alcohol as a co-risk factor for NCD, injuries, CVDs and RTIs, by Professor Jürgen Rehm (40 minutes)

The associations between alcohol-related NCDs and injuries, and between CVDs and RTIs, were explored. Mortality from alcohol-attributable NCDs and injuries, and CVDs and RTIs, was high in the Region, particularly in the NIS. There is a strong correlation between CVDs and RTI mortality. The variance could not adequately be explained by either total consumption or pattern of consumption (binge drinking = more than five drinks at one sitting). There is a need for better survey data with more detailed information on patterns of drinking.

Roundtable 1. Country experiences: what is the burden, inequalities and differences? Facilitated by Professor Jürgen Rehm and Dr Artem Gil (40 minutes)

Participants were asked:

- which diseases/groups of diseases have the biggest impact on the generation of the burden of NCDs in their country;
- what are the leading NCD risk factors that determine the burden of NCDs in their country;
- whether the burden of diseases is evenly distributed between different population groups in their country and, if so, among which population groups; and
- whether there are differences in distribution of NCD risk factors between various population groups in their country, and which risk factors are most unevenly distributed among the population in their country.

With reference to *Armenia*, it was highlighted that the leading diseases are CVDs, cancer and diabetes mellitus, but the prevalence of injuries has been increasing due to various reasons,

including motorization. Risk factors have been studied since 2007, and the STEPS NCD Risk Factors survey has shown a relatively high prevalence of smoking, obesity, lack of physical activity, hypertension, high cholesterol and glucose levels, and high consumption of salt. The problem of smoking is more problematic than alcohol consumption, and the prevalence of obesity is a real concern. The risk group for alcohol is people aged 30–55, with a correlation between drinking and income (lower income correlates to higher drinking) and education (groups with lower education drink more). The RTI mortality level is relatively low. Random breath checks are performed only if there are other violations. Alcohol consumption is higher in men.

Kazakhstan reported on NCDs being the leading cause of death, though alcohol and tobacco consumption are decreasing. The STEPS survey is only at the planning stage, so alcohol-related data cannot yet be provided. Data from national surveys on behaviour changes show that alcohol consumption was highest in Almaty oblast and North Kazakhstan in 2015, and North Kazakhstan and Kostanay oblast in 2012. There seems to be no correlation between drinking patterns and socioeconomic status, unlike in the Russian Federation, where poor groups consume surrogate alcohol.

Tajikistan stated that the leading diseases in 2017 were CVDs, cancer, injuries and poisonings. More than 30% of the population drinks alcohol, and the STEPS survey showed that more than 15% drink daily. Among the risk factors are tobacco use, high consumption of salt and animal fats, drinking and lack of physical activity. Drinking is more prevalent in urban areas. Much has been done to address the issue of RTIs, but the problem of road crashes is severe, as is the issue of drink-driving.

According to the Federal State Statistics Service, 81.4% of overall mortality in the *Russian Federation* is caused by NCDs.² The leading causes of death are CVDs, oncological diseases and diseases of the digestive system. Mortality from external causes in 2016 was 8.8%, which included mortality from accidents, injuries and suicides. Road traffic deaths are often alcohol related. According to the Ministry of Internal Affairs of the Russian Federation, the number of alcohol-related road crashes has increased in the last seven years, while the number of road crashes not related to alcohol has been decreasing. Starting from 2012–2014, there has been a tendency of decrease in rates of RTIs and deaths, but RTII associated with alcohol require strengthened prevention measures.

Belarus reported that CVDs cause 56% of deaths, and cancer 19–20%. Third place belongs to external causes. Alcohol is one of the most significant risk factors, with 37% of men and 17% of women drinking regularly. The alcohol-attributable proportion of deaths among the working male population is 28% (most deaths are caused by CVDs). There is an up to 20-times disparity in male and female mortality in low-income districts. The mortality rate for men is five times as high than that for women. The STEPS survey showed that 53% of respondents had consumed alcohol within the past 30 days. Answering a question on geographical differences, the Belarus representative stated that no such differences were observable due to the small size of the country, but that age was a big contributing factor. Belarus noted restrictions on alcohol use, including hours of sale and type of outlets.

² See: http://www.gks.ru/free_doc/doc_2017/zdrav17.pdf

Uzbekistan stated that due to the country being Islamic, alcohol is not a significant risk factor, and the number of alcohol-related road crashes is very low. Drink-driving is a criminal offence regardless of the blood alcohol concentration (BAC) level. The leading NCDs are CVD, cancer, diabetes and injuries (with household injuries most prevalent).

In *Azerbaijan*, 50% of morbidity and 80% of mortality are CVD-related. The major risk factor is tobacco. The STEPS 2017 survey showed that 50% of the male population currently smokes. New legislation on smoking was introduced in 2017 to tackle the problem. Alcohol-related road crashes now comprise 1.4% of all road crashes, down from 2.1%. The corresponding legislation is very strict, with a \$8000–9000 penalty and up to 12 years imprisonment for violations.

The leading NCDs in the *Republic of Moldova* are CVDs, cancers and chronic diseases of the digestive system. Cases of alcohol-related liver cirrhosis are many. Mortality among the working-age population is higher in men. The fourth-leading cause of death is injuries and poisonings. Alcohol-related road crashes amount to 6% of all road crashes. The corresponding legislation has been toughened. As a wine-producing country, consumption of alcohol in the Republic of Moldova is high: the STEPS survey of 2015 showed that 60% of respondents had consumed alcohol within the past 30 days.

Professor Rehm concluded that the NCD situation is very different among countries, and the differences in distribution of injuries is even higher. Prevalence of injuries has been increasing in several countries and, as the countries acknowledge, the role of enforcement is key. Some countries name tobacco as the leading NCD risk factor, and some alcohol. Solutions will therefore have to be adapted to 2–3 groups of countries. Among the cited differences are those related to rural/urban settings, geographic region, religion, age, gender (Russian Federation and Belarus) and education (Armenia).

In the following discussion, it was stated that legislation to improve the drink-driving situation must be strict and enforcement must be strong, with drivers realizing that punishment for drink-driving would be unavoidable. Random breath testing helps to reduce overall alcohol consumption. Some countries seem to prefer restrictive measures, such as limiting sale times of alcohol, and some prefer restraining measures, such as licence suspension. Decreases in overall consumption might nevertheless be insufficient to reduce alcohol-related injuries.

Professor Rehm suggested that while discussing the corresponding measures, participants should consider the country context. The recommended best buys were:

- strictly enforcing a drink-driving law;
- setting laws for drink-driving limits at 0.05 g/dl for the general population and 0.02 g/dl for young/novice drivers;
- increasing excise taxes on alcoholic beverages;
- enacting and enforcing bans on comprehensive exposure to alcohol advertising; and
- enacting and enforcing restrictions on the physical availability of retailed alcohol via reduced hours of sale.

Lecture. Co-benefits of common approaches to addressing alcohol, NCDs and RTIs, by Dr Carina Ferreira-Borges (40 minutes)

Effective policy options and legal approaches to drink-driving, along with how health, legal and enforcement practices can be strengthened, were considered. Ways to achieve effective

multisectoral collaboration, especially between the health and interior sectors, were identified to improve policy coherence for NCD and road safety.

**Groupwork 1. Countries' experiences of alcohol as a risk factor for CVD and RTI.
Facilitated by WHO national professional officers Professor Andrei Demin, Ms Victoria Madyanova, Dr Artem Gil and Dr Elena Yurasova (40 minutes)**

This groupwork was aimed at providing an epidemiological snapshot of the problem of alcohol-attributed disease, CVD and road injury. It also offered an opportunity for each participant to discuss and understand the multisectoral nature of policies relating to alcohol. The group exercise emphasized the importance of interministerial working and roles and the need to share relevant information. By the end of the session, participants better understood that the prevention of RTIs and related diseases requires a systematic, collaborative approach.

Day 2

Professor Khalfin and Professor Kondratiev provided a flashback to the 1990s, when the Russian Federation addressed alcohol through an anti-drinking campaign. Though the effect of the campaign was only temporary, it resulted in a dramatic reduction in deaths from injuries, including RTIs. Restricting access to alcohol is a proven measure to reduce alcohol-related harm. These aspects were recommended for consideration.

Lecture. What are we looking for in legislation, enforcement and technology? Presented by Ms Evelyn Murphy (40 minutes)

Lecture. Overview of legislation and enforcement practices in drink-driving in the Russian Federation, by the Ministry of the Interior (30 minutes)

Discussion (10 minutes)

Leading interventions for addressing drink-driving were considered, including legislation, enforcement, social marketing and advocacy. In particular, the specific role of legislation, the essential elements of a drink-driving law, and facts to consider when setting a BAC limit were examined. The challenges of developing a drink-driving law were debated, as well as implementing drink-driving legislation through enforcement practices and having penalties appropriate to the level of the offence. The importance of enhanced enforcement and linked social marketing campaigns to change public behaviour was discussed, and monitoring of the proper enforcement of laws was emphasized.

Answering a question on tougher sanctions for drink-drivers, such as cancellation of the driver's licence and forfeiture of the car, Ms Murphy recommended that the requirements of the country's legal system be followed. The more severe the offence, the tougher the sanctions should be, but prevention is more important. Discussing the opportunity of equipping every vehicle with an alcohol ignition interlock, Ms Murphy stated that no country in the world has introduced this in every vehicle so far. Countries that have introduced the locks on commercial vehicles, such as Sweden, have found it challenging administratively (deciding under what circumstances to require its use) and in terms of enforcement. In some cases, this has led to reversal of laws and their implementation.

There was also a question on the size of the drink-driving fine, potentially 2–3 times higher than the offender's salary. Ms Murphy reminded participants that a fine is a way of penalizing and high fines alone do not prevent drink-driving behaviour. Without random breath testing, for example, such fines will hardly act as deterrents. Enforcement is crucial.

Representatives from Armenia suggested that the BAC limit should be 0 g/dl. Ms Murphy outlined the challenges to a zero-BAC law; there can be many other reasons unrelated to alcohol consumption for BAC to be higher than 0; and the kind of equipment needed and its proper use, as well as resources to administer a zero-BAC law, could be challenging for many countries. She provided the example of some Australian states in which there is zero BAC for some populations and in which enforcement resources around drink-driving include the use of mobile alcohol and drug testing buses (known as booze buses), and discussed the differences between screening and evidentiary tests. She emphasized that the so-called zero tolerance concept, where every offender knows they will be punished while still having a BAC limit of 0.05 g/dl for the general

population or 0.02 g/dl for novice/young drivers, was better.

The Russian Federation provided data on alcohol-related road crashes in the country and reported on activities performed to reduce drink-driving. These include: stricter administrative sanctions; introduction of criminal liability for repeated drink-driving; medical examination for intoxication of all those involved in a road crash which caused light-to-medium harm to human health; returning the driver's licence after being tested for knowledge of the traffic code and undergoing a medical examination for intoxication; and implementation of mass checks for intoxication.

Some activities to reduce drink-driving are being planned. These include: introducing a deposit for the detained vehicle; using BAC tests (in addition to breath alcohol concentration (BrAC) levels); toughening the sanctions for refusal to undergo a medical examination; simplifying the procedure of alcohol-related offence registration; and other measures within the framework of the Russian Federation road safety strategy, 2018–2024.

The question of whether driverless cars could reduce the number of crashes and consequently the number of RTIs was then discussed. Autopiloted cars are being produced, but the process might take decades.

Another issue discussed was that of corruption risks in reference to alcohol breath testing. Such risks cannot completely be avoided in any kind of enforcement activities, but the final decision is made not by the police officer but by the judge. Another way to address this issue is to equip every police car with a dash camera.

Groupwork 2. Country group work on legislative review of drink-driving and next steps. Facilitated by WHO national professional officers Professor Andrei Demin, Ms Victoria Madyanova, Dr Artem Gil and Mrs Evelyn Murphy (120 minutes)

This session provided an opportunity for each participating country to discuss its national road safety legislation and enforcement practices in relation to drink-driving. Participants were asked to review the recommendations in the "Preliminary institutional and legislative assessment in the countries of Eurasian Economic Union". Each country received a brief draft legislative review for drink-driving prior to the training workshop.

The best safety requirements pertaining to drink-driving as well as enforcement and compliance practices were discussed. Each group appointed a rapporteur to present the highlights of the group discussion. Countries of the EAEU (Armenia, Belarus, Kazakhstan, Kyrgyzstan and the Russian Federation) formed country-specific groups. Participants from other Commonwealth of Independent States (CIS) countries not belonging to the customs union (Azerbaijan, the Republic of Moldova, Tajikistan, Turkmenistan and Uzbekistan) discussed the problem collectively.

Feedback from country groups and discussion (80 minutes, seven minutes each)

Azerbaijan reported that alcohol-related crashes were 1.4% in 2017 (2.1% in 2014). There is no stated limit in the legislation. The corresponding sanctions are strict, including deprivation of the right to drive vehicles for a period of 3–5 years, fines amounting to \$3500–4700 and imprisonment for 3–12 years (Article 263.1 of the Criminal Code), or deprivation of the right to drive vehicles for a period of six months to two years, fines of \$60–8800 and administrative

arrest for 15 days to three months (articles 333, 334, 336 and 337 of the Administrative Code). The police have the right to stop and test any driver, including randomly. The law states that if the police officer suspects a driver to be drunk, the driver can be sent for a medical examination; if the driver refuses to undergo the examination, they may be required to do so. The same procedure applies to road crash participants. Police cars have equipment that allows tracing of the history of violations.

The drink-driving law is based on BAC/BrAC, but BAC can be tested only at a health facility. The blood alcohol level cited in Azerbaijan's presentation was 0.03 g/dl. Regular raids are performed to detect drunk drivers (near restaurants, on roadsides and at accident black spots). The car fleet of the police has been renovated, and motorcycles are also involved. All roads have been reconstructed and equipped with speed cameras.

Other activities include monitoring and evaluation performed by Baku Transport Agency, police officers receiving a certain percentage of collected fines (to address corruption) and two emergency telephone numbers (112 and 103). Strengths and weaknesses are covered by national road safety legislation. There is a need to increase alcohol prices and increase penalties for violation of the rules of alcohol sales. Restrictions on alcohol sales at certain times of the day could also be effective. It was considered that further activities in the frame of the national NCD strategy would be composed, including alcohol restrictions, and would have a strong emphasis on controlling drink-driving.

Kazakhstan reported that national legislation can already effectively prevent drink-driving. Almost everything is covered, including the legal age and restrictions on selling alcohol at night and in defined places. The evidence shows that all the measures taken in 2014 and 2015 have proved to be effective, with 947 alcohol-related road crashes in 2013 and only 509 in 2015. Drink-driving is punished with licence suspension for 3–5 years. Sometimes that leads to driving without a licence, which is a criminal offence. Such strict measures are supported by the public, with the aim that longer-term sentences prevent recidivism.

Answering a question on whether alternative sanctions may give way to bribery, the representative of the country stated that Kazakhstan removed all alternatives from the law, so there are no longer fines for drink-driving – just licence suspension and vehicle impoundment. The violator must attend court. Future national policy suggestions should aim to limit sales of alcohol in evening hours and according to age.

Kyrgyzstan reported that national strengths include all types of sanctions for drink-driving: fixed fines, administrative arrest prior to a court hearing, imprisonment and public works. The law is based on BrAC, but enforcement is suboptimal due to reasons such as inadequate human resources and equipment. The BAC limit is 0.03 g/dl for all drivers. Random breath tests are not performed. In the case of a road crash, all those involved are tested for intoxication. Fines are not high enough, and there are no remedial courses for violators. The next steps should include equipping all police officers with breathalysers, installing speed cameras all over the city and adopting a national road safety strategy.

Tajikistan claimed to have legislation similar to that of Kyrgyzstan, but with much tougher fines. Medical examination for intoxication is obligatory in cases of road crashes. Alcohol-related crashes are criminal offences punishable by up to eight years of imprisonment. "Safe City"

technology has been introduced, and there are sobriety check points and random breath checks. The legislation was amended less than a year ago, so there is no evidence on fine recovery.

In *Uzbekistan*, the sanctions for drink-driving are tough, and fines are high. The minimum wage is 173 000 som, but drink-driving is punished with a fine of 3 million som and may lead to imprisonment. Police perform raids in the morning and during school time, and at night near restaurants and cafes. All road intersections are equipped with cameras. Starting from 2017, the legislation has been revised to incorporate international best practice and expert knowledge. The "Safe City" project has already started.

In 2017, 135 000 drivers underwent medical examination for intoxication, but only 75 000 cases were proved. The problem is that not all police cars are equipped with breathalysers, so they send all suspected drivers to be medically tested for intoxication. There is a need for police officers to be trained in identifying signs of intoxication.

Armenia reported drink-driving legislation being based on BrAC, with a limit of 0.04 g/dl for all drivers. A different limit for young and novice drivers will have to be considered. There are continuous checks, including random breath testing. All road intersections have cameras. They are of two types: speed cameras, and cameras recording all types of violations. A drunk driver can also be identified by the manner of their driving. Fines are between \$300 and \$827. There is also the option of licence suspension or, in case of a repeated violations, imprisonment (6–12 months). Answering Dr Sethi's question on the BrAC limit (0.08 g/dl or 0.04 g/dl), the representative of the country explained that the limit had been toughened quite recently.

The *Republic of Moldova* adopted a national road safety strategy in 2012. It covers everything and aims to reduce road traffic mortality by 50% (according to the objectives of the Decade of Action); currently, it is approximately 20%. After introducing law enforcement and a number of deterrents, a general reduction in car crashes and number of deaths was achieved, but the reduction is not high (5–7% among various groups). Among the strengths is the police being equipped to perform breath checks on site, with raids, both planned and spontaneous, performed at different times of the day. Random breath checks are covered by law. Among the weaknesses, country participants mentioned the need to revise sanctions depending on the severity of the violation. There is also a need for repeated social marketing campaigns. Education programmes in schools were proposed.

The drink-driving law in *Belarus* is based on both BAC and BrAC. The BAC limit is 0.029 mg/dl and 0.03 mg/dl is already a violation. A different limit for young and novice drivers is being considered, as is lifetime licence deprivation for drink-driving. The number of deaths in alcohol-related road crashes has been decreasing, and the number of alcohol-related RTIs decreased by 5.8% in the last year. Repeated drink-driving is a criminal offence punishable by car forfeiture. The test is performed by a police officer, though a health professional might be involved. The final decision is made by the police officer.

There is a need for a clearer procedure for biological sampling; this would avoid many lawsuits. A government decree allows forced examination; in practice, a police officer would arrive at a conclusion based on external signs. If the car is forfeited, a person may purchase another one; the forfeited vehicles are sold, with the money going to the state budget. Drivers are not be able to get their licence back for five years. It was suggested that the duration made for permanent suspension of driving of those who violate the existing law or temporary suspension was 15 days

to six months if crashes caused by drink-driving did not result in severe injuries. National holidays are a risk factor for drink-driving and should be targeted.

The representative of the *Russian Federation* reported that in the last 10 years the number of road traffic deaths due to violations convicted by drunk drivers has increased by 1.8 times (an increase by 78.8% in 2016 in comparison to 2007), while the total number of road traffic deaths decreased by 39% in the corresponding period. This trend can inter alia be explained through the quality of registering such information and the introduction in 2013 of a requirement for each and every driver involved in a traffic crash to undergo a medical examination for alcohol. Sanctions for drink-driving are severe, including criminal liability for drink-driving crashes. Repeated drink-driving is punishable by a fine amounting to \$3000–5000, but when alternative sanctions are available, the applied sanction is usually the least severe; sanctions therefore seem not to work as a sufficient deterrent. The BrAC limit is 0.16 g/l; the BAC limit is 0.3 g/l. There is no differentiation between the limits for all drivers and for young and novice drivers, because such a small difference in concentration is not supported by the corresponding achievements in narcology (detection methods) and is absorbed by permissible error. Those refusing to be tested for alcohol might have been drug-driving, so there is a need for tests to detect drug intoxication. Drunk driving is punished with both a fine and cancellation of the driver's licence.

Roundtable 2. Next steps to improve legislation and enforcement for drink-driving

Discussion focused on random breath testing. Professor Kondratiev encouraged participants to debate the legal grounds for random tests. If it is for the police officer to decide which car to stop, what are the criteria, and are they fully objective? If the car's trajectory looks strange, the suspicion of something being wrong with the driver is grounded. If random tests mean that a group of police officers stops every vehicle, then those vehicles are stopped without any evident reason, and that should be covered by law.

In the Russian Federation, police officers usually check for signs of intoxication when stopping the car for other reasons or while performing spot checks, and after receiving information from third parties, including the personnel of gas stations, cafes and restaurants. Eighteen per cent of violations are detected thanks to such information.

Another measure is the so-called mass checks, when ways in and out of an area are blocked by police cars and police officers check for visual signs of intoxication, making drivers causing suspicion undergo a breath test. The challenge, however, is testing effectively for drugs. In either case, in the Russian Federation there should be objective reasons to ask the driver to undergo a test (external signs of intoxication).

Some countries (Tajikistan, Kazakhstan) reported that their governments had had to ban random checks due to numerous drivers' complaints of corruption. Mass checks are legal and enable effective detection of drunk drivers. In Belarus, however, debate is taking place on whether mass checks represent an efficient use of police resources. They focus on regularly and randomly testing commercial drivers for intoxication during their working hours. In Armenia, the police can stop any driver, anywhere, anytime, if there is a suspicion. Police in Armenia and Uzbekistan perform raids linked to such events as the beginning of the school year and harvesting.

Mrs Murphy reminded participants that random breath tests have proved to be an effective preventive measure, as they help to form the concept of punishment being inevitable.

Participants agreed that strict sanctions can be a deterrent only if enforcement is strong. Prevention is very important. Every road user should realize the risk of drink–driving, and everyone should be intolerant to drunk drivers. Continuous toughening of legislation without enforcement and education is not productive; there should always be activities in the area of social prevention. Uzbekistan and Armenia reported that the use of drink–driving simulation goggles had proven to be effective; the Russian Federation is planning to introduce them in driving schools.

Day 3

Dr Russovich reported back on Day 2 before participants spent 20 minutes catching up upon groupwork from the previous day.

Lecture. Role of the Eurasian Economic Union (EAEU): drawing parallels of tobacco and other initiatives in EAEU and European Union (EU) countries, by Professor Andrei Demin (40 minutes)

Roundtable 3 (40 minutes)

EAEU goals and economic potential, as well as the regulatory role the EAEU could play in strengthening drink-driving legislation in the Region, were discussed. Success stories of policy implementation in the EAEU were highlighted and examples for public health, such as tobacco control and nutrition, explored. Part of the lecture was devoted to the development of single transport policy.

The following recommendations were made.

- In the structure and functioning of the EAEU, it is necessary to ensure priority for public health interests over trade and business interests, and protection of consumer rights and involvement of civil society.
- It is time to intensify cooperation between the EAEU and WHO, taking into account the experience of participation of supranational organizations, including the EU and EU–EAEU cooperation in the field of public health.
- It is necessary to analyse and disseminate the best practices of supranational organizations, particularly the EU, to maximize the EAEU's potential to prevent and control NCDs, particularly in the field of alcohol and road accidents.

The presentation was followed by a roundtable discussion that welcomed the forthcoming memorandum of understanding between WHO and EAEU. The importance of WHO's support to countries was highlighted. The EAEU would be expanding and its prospects might include a single currency union with single citizenship and common social protection.

Supranational regulation is a good lever in advocating for public health issues. It would be beneficial if there was a common parliament, though at the moment the EAEU is an economic union, not a political one. Dr Sethi encouraged countries to search for new options to identify public health champions in parliaments, including the Global Network of Road Safety Legislators. The coming debate at the United Nations General Assembly will be attended by some parliamentarians from countries like Armenia and the Republic of Moldova. It is good to work with peers to address global legislative aspects.

The issue of common traffic laws for EAEU countries was also debated. Participants agreed that harmonization with a special focus on alcohol use was necessary.

Social marketing: benefits of social marketing and enhanced enforcement and parallels with tobacco control

Introduction. Basic principles and theory of social marketing, by Dr Elena Yurasova (15 minutes)

Lessons learned on the success of tobacco and social marketing, by Ms Olga Manukhina (15 minutes)

Russian experiences RS10, by Dr Elena Yurasova (15 minutes)

Examples of drink–driving advertisements, by Dr Yongjie Yon (15 minutes)

This session consisted of four parts. The first provided an outline of the basic principles and theory of social marketing and developed an understanding of the benefits of social marketing in empowering the public to change health behaviours. The importance of a joint strategic approach with enhanced enforcement was discussed. The second part focused on the use of social marketing and legislation and enforcement to influence tobacco control and achieve lower smoking prevalence in the Russian Federation. The third drew from the Road Safety in 10 Countries project in the Russian Federation to illustrate the use of social marketing, using the examples of seatbelt-wearing, child restraints and speed. The fourth considered examples of drink–driving campaigns from around the Region (videos were shown). It was highlighted that social marketing campaigns should go in parallel with enforcement activities.

Groupwork 3. Design and strategy for the development of social marketing

The groupwork provided participants with the opportunity to develop a social marketing campaign on drink–driving. A video developed by the Republic of Moldova as part of a major campaign against drink–driving was shown. Three videos were made: one, which was chosen by focus groups, initially was broadcast by all TV channels for two years, but is now broadcast by a channel aimed at the young population.

Behaviour-change conversations in trauma and primary care settings

Lecture. Screening and brief behaviour-change interventions in primary care and trauma settings: part 1, by Dr Niamh Fitzgerald (60 minutes)

Discussant. Experiences from the primary medical care setting and emergency trauma care setting, by Dr Konstantin Vyshinskiy (10 minutes)

Moderated discussion 1. Behaviour-change conversations in trauma and primary care settings: part 2 (Dr Niamh Fitzgerald) (40 minutes)

Evidence on the use of screening and brief counselling interventions (SBI) on alcohol in health-care settings, both primary care and trauma care, was presented. The overview of brief interventions included a detailed description of what they are and how they might be adapted to different settings. The contents of new training materials for health professionals developed by WHO were outlined, and the potential use of the SBI materials in trauma settings was discussed. Successful SBI implementation requires political will, institutional support and a change in practitioner behaviour.

A comprehensive approach to preventing alcohol-related harm required the following:

1. leadership
2. health service response, involving SBI

3. specialist treatment
4. community and workplace action (with media advocacy)
5. effective action to control drink–driving
6. reduced availability of alcohol
7. restrictions to advertising
8. pricing policies to increase alcohol price
9. reduced impact of illicit alcohol
10. monitoring and surveillance

The SBI alcohol brief intervention manual for primary care was published in Russian at the workshop. The SBI alcohol brief intervention training manual for trauma care would be forthcoming.

Groupwork 4. Country implementation on alcohol screening and brief interventions

Participants continued working at their roadmaps, aiming to include the SBI component.

Day 4

Lecture. Emergency care services and benefits to CVD and road crashes, by Dr Teri Reynolds (40 minutes)

The WHO emergency care system framework for providing integrated approaches to early recognition and management of trauma and other emergencies such as acute CVD and RTIs was introduced. The lecture provided key elements of post-crash care, including the development of organized and integrated prehospital and facility-based emergency care systems, the training of all frontline providers in basic emergency care and the promotion of lay first-responder training. The lecture also provided an overview of the standardized WHO tools to conduct national assessments of emergency care systems.

A short questions and answers session followed. Several models of an ambulance team were discussed, including the advanced option (staffed by a physician, a feldsher and a driver) common in the NIS, and a team staffed with paramedics only, which seems to be common in countries in western Europe. Dr Reynolds explained that staffing of ambulance teams is country-specific, but it is very expensive to staff them with doctors, since too many ambulance calls are inappropriate – only a small proportion are true emergencies, and many cases could be dealt with by primary care. Proper triage to emergency care units is the solution.

The representative of Armenia inquired whether the WHO triage tool was available in Russian. It is being translated in Kazakhstan and will be ready within a month, after which it will undergo piloting.

Answering a question on ways to adapt the emergency care system framework to the national context of Kazakhstan, with its low population density, large territory and lack of health professionals at district level, Dr Reynolds reminded the audience that the framework had been successfully used in sub-Saharan Africa, where conditions are much worse. The goal is early detection, resuscitation and referral. The triage tool was developed specifically for primary level. Professor Khalfin praised the framework, highlighting the importance of timely and adequate referral of an injured person. First responders are sometimes unable to provide first aid and try to carry the injured person to the nearest hospital, not considering the severity of the trauma or the capacity of the hospital. Appropriate training in triage and appropriate organization of services were necessary.

Lecture. The experience of the Russian Federation of emergency care services, by Dr Mikhail Bystrov (15 minutes)

An overview of emergency trauma care systems in the Russian Federation was provided, with its organizational structure, including the definition of its components (such as trauma centres), discussed in detail.

The following discussion of co-benefits to CVD and RTI from an effective emergency care response system highlighted the importance of intersectoral cooperation among the legislature and the interior and health sectors to ensure that emergency teams could reach the site in the shortest possible time.

Lectures.

SDGs, reduced air pollution and physically active transport, by Ms Nino Sharashidze (40 minutes)

Promoting urban cycling in the Russian Federation: the role of mass events, by Dr Vladimir Kumov (10 minutes)

Healthy Cities, Klin, Moscow region, by Dr Ekaterina Ivanova, and Dr Elena Chinkova, (10 minutes)

National policy on active transport, Kazakhstan, by Dr Saltanat Mukasheva

Subnational policy on active transport, Dr Elena Boleac, Deputy Head for Health

Determinants Control, National Agency for Public Health, the Ministry of Health, Labour and Social Protection, Republic of Moldova

Moderated discussion. Sustainable transport (moderated by Dr Nino Sharashidze) (30 minutes)

This session provided an overview of the significant burden caused by the transport sector on environment, health, national economies and well-being in the Region through emissions of air pollutants, greenhouse gases and noise, land-taking, traffic congestion, injuries and reduced opportunities for physical activity. The importance of integration of health, environment and other social concerns into transport policies to achieve more efficient, equitable and healthy transport systems was emphasized.

The role of regular physical activity for the prevention and treatment of the leading NCDs was discussed. Active mobility (walking, cycling and the use of public transport) as a means of transportation was mentioned as a highly promising approach to integrate physical activity into individuals' daily lives and meet the WHO global recommendation, which is 150 minutes of moderate-intensity physical activity per week. It was also underlined that investment in policy action on promoting active mobility offers great socioeconomic benefits and can contribute directly to achieving the SDGs.

Policy frameworks and supportive tools to promote sustainable transport, as well as policy developments such as the Transport, Health and Environment pan-European Programme (THE PEP), jointly managed by the United Nations Economic Commission for Europe and the WHO Regional Office for Europe, and the WHO Global Action Plan on Physical Activity 2018–2030 (GAPPA) were also discussed. The interlinked benefits of road safety and physically active transportation were debated as part of a Healthy Cities approach to reduce traffic injuries, air pollution, congestion and NCDs. Changes to infrastructure were needed to facilitate more cycling. Examples of the successful promotion of cycling in Moscow and other cities, with the engagement of civil society, were presented.

Case studies were presented from the Russian Federation (promoting urban cycling and healthy urban planning), Kazakhstan and the Republic of Moldova (active transport policies). The following discussion was devoted to the issues of funding, and it was suggested that one way to fund sustainable transport may be through public–private partnerships. Enforcing slower and safer speeds in urban areas was also essential to reducing pollution and promoting safety, with participants agreeing on the need to reduce speed limits in urban areas to at least 50 km/h.

Groupwork 5. Finalizing country roadmaps

The benefits of common approaches and synergies between NCDs, alcohol and road safety, and sustainable transport and emergency care services were debated for inclusion in the country roadmaps. Each group appointed a rapporteur to present the roadmaps.

Country roadmaps and next steps

Armenia

The NCD share of overall mortality is about 80%, with CVD accounting for 48%, cancer 20% and injuries 4.6%.

The country has a national NCD prevention strategic plan, a national strategy and action plan on healthy lifestyle, and a national strategy and action plan on injury prevention. Alcohol is articulated as a health-risk factor. Corresponding legislative documents include an administrative code, a law on traffic safety and road safety rules. The national legal minimum age for sales of alcoholic beverages is 18, and alcohol advertising is banned. The BAC limit is 0.04 g/dl.

The roadmap recommendations presented by the country team included the following legislative and operative changes:

- defining lower BAC limits for young and commercial drivers;
- suspending licences for first-time violation/BAC more than 1 g/dl;
- improving intersectoral collaboration among, for instance, ministries of transport, health, emergency situations and the police;
- communicating and sharing information;
- implementing joint awareness-raising events and prevention measures;
- strengthening evaluation and monitoring;
- incorporating key legislative components into monitoring programmes;
- taking forward population-wide and targeted social marketing/advocacy;
- delivering SBI consultations;
- improving alcohol culture/policy in the workplace;
- using the WHO emergency care assessment tool to conduct an evaluation and develop emergency care triage protocols; and
- promoting safe infrastructures and safe transport within the context of Healthy Cities.

Azerbaijan

The country's goal is stabilization and further reduction of alcohol-related RTI mortality by 2030, with the focus on public health measures in the area of NCDs.

Objectives include: further implementation of the multisectoral national strategy on NCDs 2015–2020 and the development concept "Azerbaijan–2020: look into the future"; setting a target for reducing the number of alcohol-related accidents, morbidity and mortality; further strengthening managerial infrastructure and capacity-building to implement activities in the area of road safety, NCDs and alcohol; enhancing the quality of data collection on road safety, NCDs and alcohol; monitoring progress and outcomes on indicators related to road safety, NCDs and alcohol; better using existing resources; and encouraging funding activities aimed at prevention of alcohol-related road crashes.

Recommended activities include:

- improving the system of data collection and analysis in reference to monitoring progress in alcohol-related road crash injuries and mortality;
- improving the system of monitoring and evaluation of alcohol-related RTI exposure and NCDs;
- setting realistic and long-term indicators based on analysis of national alcohol-related road crash data;
- strengthening partnerships between agencies (such as governmental agencies, nongovernmental organizations (NGOs) and businesses);
- developing and implementing innovative projects on alcohol-related road crashes and NCD prevention;
- promoting increased commitment to road safety among traffic police and drivers;
- assisting in the introduction of a system of graduated licences for novice drivers;
- supporting the introduction of SBIs in trauma and primary care settings;
- introducing innovative approaches to training and testing of trainee drivers to help them realize the risks of drink-driving;
- supporting the equipping of police vehicles with innovative technical means of drink-driving prevention;
- identifying black spots in relation to alcohol-related road crashes and introducing corresponding remedial activities;
- implementing targeted social marketing events and campaigns and including them in new comprehensive state programmes, including those in the health sector;
- strengthening legislation based on BAC/BrAC;
- enhancing the responsiveness of health systems and the Ministry of Emergency Situations to emergencies and strengthening their capacity to provide the necessary care and rehabilitation for victims;
- improving the work of the 112 and 103 hotlines;
- supporting targeted checks on roads and black spots;
- strengthening control over the sale of alcohol to minors;
- increasing alcohol taxation and improving pricing policies; and
- using social marketing more widely.

Indicators to 2030 are to be considered, but due to better enforcement, RTI mortality has already decreased from 31% in 2015 to 15% in 2017.

The Republic of Moldova

The main goal is gradually to reduce the number of alcohol-related road traffic deaths and severe injuries through a combination of passive and active road safety measures, and improving road infrastructure and the behaviour of road users through training, raising awareness and enhanced compliance with traffic regulations.

Objectives include: a 30% reduction in alcohol consumption by 2030; reduction of RTIs and deaths; increased awareness of risks and negative consequences of alcohol use, including among road users; and creating safer road traffic environments.

Actors should include sectors such as the interior, health (emergency care, primary care, trauma service, narcology), education, economy and infrastructure, agriculture, regional development

and the environment, the mass media, local authorities, NGOs (Autoclub Moldova) and other professional organizations. A working group involving all these actors should be established.

Existing policies include: national health policy; national road safety policy; national strategy on prevention and control of NCDs; national programme on alcohol control; and regulation on road traffic rules.

Priority areas include the following.

1. Revision of drink–driving legislation to:
 - a) increase the effectiveness of legal sanctions for drink–driving; sanctions should differ depending on the degree of intoxication and repetitive violations (two-year period);
 - b) introduce a zero limit for novice drivers;
 - c) ensure enforcement can effectively be carried out by supplying equipment and other resources; and
 - d) enhance legislative measures regarding the consumption of alcohol by pedestrians, drivers and cyclists when they move along public roads.

2. Raising awareness through social marketing campaigns to warn about the road traffic risks of alcohol consumption to:
 - a) develop zero tolerance to drink–driving by means of the education system;
 - b) include “no drink–driving” topics in drivers’ training;
 - c) systematically implement anti-drink–driving campaigns;
 - d) raise awareness of cyclists and pedestrians about the higher probability of involvement in a traffic crash if moving along public roads while drunk;
 - e) limit access to alcohol (depending on time, age and location) and banning the sales of alcohol at gas stations; and
 - f) ban all kinds of alcohol advertisements.

3. Monitoring the introduction of changes to:
 - a) equip road police with breathalysers
 - a) make random alcohol tests routine
 - b) increase the number of alcohol checks by the police.

Barriers are national traditions, accessibility (unregistered alcohol and home-brewed alcohol), the alcohol lobby (Association of Alcohol Manufacturers), lack of intersectoral cooperation, and the unstable economic, political and social situation.

Uzbekistan

Goals and objectives include strong drink–driving enforcement and reduction of RTI mortality.

Among the important indicators and components are:

- reducing the urban speed limit from 70 km/h to 60 km/h;
- equipping police cars with breathalysers;
- introducing the Package of Essential Noncommunicable Disease Interventions for Primary Health Care in Low-resource Settings (PEN) protocol in all districts of the republic;
- developing tougher drink driving sanctions for pedestrians;
- introducing social advertisements on a massive scale, explaining the risks of drink–driving; and

- implementing preventive measures, with public involvement.

Key action areas include enhanced coordination and stronger interagency cooperation (involving parliament, the Government and all interested ministries). The focus should also be on emergency care for injuries, with a shared delivery platform; this will require family medicine centres to be equipped to provide emergency care.

Belarus

The goal is to reduce alcohol-related RTI and NCD mortality.

Objectives are: reduction of alcohol consumption; enhancement of legislation and enforcement; development and introduction of a mechanism for social marketing; and enhancement of care (SBIs and emergency care).

To reduce alcohol consumption by 10% by 2020, it is necessary to:

- increase the age limit for alcohol sales (Scandinavian model);
- limit times and places for sales of alcohol (including banning sales of spirits at gas stations);
- increase excise taxes (spirits); and
- introduce SBIs (in primary care, trauma and admission rooms).

Enhancement of legislation and enforcement should include:

- introducing the 0.19 g/ml limit for young and professional drivers;
- making use of roadsides by emergency services legal;
- clearly defining the obligatory medical examination for intoxication;
- investing in public transport (reducing bus fares to encourage drivers to use public transport, and separating pedestrian and cycle lanes); and
- imposing urban speed limits of 50 km/h.

Introducing the social marketing mechanism would require target-group identification (young drivers, family members and professional drivers) and would aim to change drinking behaviour.

Better care for injured people should include: training first responders in providing first aid; ensuring enhanced medical care (SBIs and emergency care); and further developing emergency care (district emergency care centres, better transportation, reforming admission rooms and capacity-building).

Russian Federation

The goals are to reduce RTI mortality to 4 per 100 000 population by 2024, and to reduce alcohol consumption to 10 litres per capita by 2020.

Existing legislative documents include: the concept of a state policy to reduce the scope of alcohol abuse and prevent alcoholism among the population to 2020; a national road safety strategy, 2018–2024; and the Russian Federation State Healthcare Development Programme.

Key activity areas are to:

- simplify the procedure of registration of drink–driving cases;
- further enhance drink–driving legislation;
- strengthen intersectoral cooperation;

- improve mechanisms for economic incentivizing of road traffic compliance (taxation, licensing and insurance);
- develop zero tolerance for drink–driving through involvement of the public and the media;
- enhance first-aid provision to road traffic victims; and
- develop re-training programmes for violators (first-time and repeated) and educate trainee drivers on the risks of drink–driving.

Road safety influencing factors include safer urban speed, back-seat passenger safety, correspondence of safety standards for new cars with those of the EU, and social marketing. Corresponding indicators will include the number of alcohol-related RTIs and alcohol-related RTI deaths, drink–driving prevalence and reduction of mortality caused by alcohol-related diseases.

Steps will be taken to further introduce SBIs, including further cooperation between the Sechenov University, where 40 trainers were trained last year, and the Serbski Institute (also trained 40 trainers), develop improved scratch cards and education videos, and support those already using SBIs in their routine practice.

Kyrgyzstan and Tajikistan

Both countries see the need to revise and amend legislation to exclude alternative sanctions and toughen fines. They also recognize the need to equip traffic police with breathalysers and badges to conduct random breath testing.

Key activity areas should include social marketing accompanied by effective enforcement. Opinion leaders (religious leaders) should be involved in media campaigns. Education activities should include SBI, for which it is necessary to identify institutions (in the capital and regions) to take responsibility for training and monitoring, and effective emergency care provision. Active transport should be developed through the Healthy Cities network: at the moment, three big cities in Kyrgyzstan are ready to join the network.

Kazakhstan

Goals include safety on the roads and reduction of the alcohol-related RTI burden.

The following activities are proposed:

- increasing excise tax on alcohol;
- introducing health warnings on alcohol containers and bottles, and in alcohol-selling stores;
- toughening control over illegal or unorganized manufacturing and sales of alcohol;
- introducing the limit of 0.05 g/dl for all drivers and 0.02 g/dl for young drivers;
- making medical examination for intoxication of drivers involved in a road crash obligatory, with corresponding prevention, treatment and rehabilitation, if applicable;
- introducing legislation on alcohol ignition interlocks;
- enhancing social marketing, based on best practices, to identify the most effective methods of changing behaviours and environments, with the client-oriented approach and existing barriers considered;
- introducing legislation covering regular implementation of social marketing campaigns;
- training national trainers in SBI;
- introducing the WHO SBI manual and adapting it to the national context; and

- monitoring and evaluating implementation of the SBI manual.

Indicators will include reduction of per capita alcohol consumption, reduction of alcohol-related road crashes and their consequences for all road users and raised awareness of drink–driving risks.

Closing ceremony

Closing remarks were made by Dr Migliorini, who thought the training course was highly productive and expressed gratitude to all participants and contributors. The course was evaluated by participants and was rated highly in terms of content, materials, delivery and mode of working (see Annex 2). Dr Svetlana Axelrod expressed her appreciation of the course. A letter of gratitude to the Ministry of Interior from the Ministry of Health was delivered, and certificates were awarded.

Annex 1

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Interpreters/translators/rapporteur

Mrs Lyudmila Yurastova
Interpreter

Mrs Tatiana Polunina
Interpreter

Mrs Elena Labtsova
Rapporteur and translator

Annex 2

COURSE EVALUATION FORM

Course outline and content

Please give you overall evaluation of the Course, according to a 5-scale system

Unsatisfactory	Satisfactory	Good	Very good	Excellent
0	0	3 (9%)	13 (38%)	18 (53%)

Did you meet your objectives during the course of the Course?

No	Not completely	Yes
0	0	34 (100%)

In general, did you enjoy the teaching approach used during the Course?

No	Not completely	Yes	Very much so
0	0	16 (47%)	18 (53%)





How would you rate the programme of the Course? Please choose one option for every question below:

Content of the Course was	Easy	Optimal	Complicated
	1 (3%)	32 (94%)	1 (3%)
Number of lectures was	Insufficient	Optimal	Excessive
	3 (9%)	30 (88%)	1 (3%)
Number of round tables/moderated discussions was	Insufficient	Optimal	Excessive
	2 (6%)	31 (91%)	1 (3%)
Number of group tasks was	Insufficient	Optimal	Excessive
	2 (6%)	29 (85%)	3 (9%)
Number/duration of breakes was	few/short	normal/ optimal	many/long
	0	33 (97%)	1 (3%)
In whole, duration of the course program (5 days) was	Not sufficient	Optimal	Too long
	3 (9%)	29 (85%)	2 (6%)

How useful for you was participation in the group work?	Useless	Quite useful	Very useful
	0	5 (15%)	29 (85%)

How useful for you was participation in the round tables/moderated discussion focused on countries experience?	Not useful	Quite useful	Very useful
	0	12 (35%)	22 (65%)

Would you recommend to your colleagues, friends to receive training on this course?

			
No	Not sure	Yes	Will definitely recommend
		11 (31%)	23 (69%)

Please, describe three elements of the programme you'd liked the most:

Note: Elements of program identified by participants as the most liked were as follows:

- Lectures and round tables, as well as moderated discussions 13 (38%)
- Participation in Working Groups 9 (26%)
- Analysis of the regulatory and legal framework 9 (26%)
- The role of alcohol abuse in NCDs 4 (12%)
- Analysis of the burden of NCDs and risk factors 1 (3%)
- Alcohol as a common risk factor 1 (3%)
- The role of Eurasian Economic Union (holding parallels on tobacco control) 1 (3%)
- Healthy cities, districts and cities 1 (3%)
- Brief consultations 1 (3%)
- The experience of countries in reducing the death rate of crash 1 (3%)
- Intersectoral approach 2 (6%)
- Elements of a road safety strategy 1 (3%)
- Social Marketing 4 (12%)
- Control of alcohol consumption 1 (3%)
- Effective measures of activity 1 (3%)
- NCD burden and CVD risk factors 1 (3%)
- The burden of alcohol on the development of NCDs and the improvement of road accidents 1 (3%)
- Motivational counseling 1 (3%)

Please, describe three elements of the programme you'd liked the least:

Note: Elements of program identified by participants as the least liked were as follows:

23 participants did not indicate elements of the program that they disliked. There were 11 responses of the following:

- Motivational counselling 1 (3%)

- Sustainable transport 1 (3%)
- General approaches 1 (3%)
- Bad simultaneous translation 2 (6%)
- Healthy cities 1 (3%)
- Some presentations were very long 1 (3%)
- Instructions to working groups are not sufficient 1 (3%)
- Too much time was given to work in groups 1 (3%)
- Little time has been spent to discuss the harm of alcohol on health in general 1 (3%)
- Too much time has been devoted to short interventions on alcohol (one could organize separately on this topic) 1 (3%)