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IFMSA Policy Document Road Safety and Health

Proposed by Team of Officials

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Policy Commission

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Policy Statement

Introduction

Road crashes are the chief killer of youth aged 15-29 globally. The majority of road traffic fatalities are seen in low and middle-income countries posing an imperative social equity issue. Road Traffic Injuries lead to devastating health and economic impacts on victims and their families, yet they are preventable with policies available to reduce the risks, protect vulnerable road users and ensure a safe mobility system that puts people's needs at the centre. Such measures exist in the United Nations Decade of Action for Road Safety and the Sustainable Development Agenda with ambitious targets for countries to halt and reverse the accelerating trend of road traffic deaths and injuries. The global health community must now mobilize to make road safety an imminent priority across all levels.

IFMSA position

The IFMSA firmly recognizes the global burden of mortality and morbidity resulting from road traffic crashes, including the broad range of health, social and economic consequences that cost countries 3% of their annual Gross Domestic Product (GDP) and hinder their progress towards sustainable development. IFMSA believes that governments, and multinational, regional and national bodies must strengthen their efforts to advance the cause of road safety and implement pragmatic measures to reduce road traffic deaths and injuries. IFMSA calls on medical students and young healthcare professionals to address the road injury epidemic and advocate for concrete changes through effective interventions and local efforts.

Call to Action

Governments to:

1. Adopt and enforce new road safety laws on risks including the enforcement of low-speed zones limits particularly around schools and neighbourhoods where high volume pedestrians and motorized vehicles combine, and effective monitoring of compliance;
2. Redesign roads with protective infrastructure that prioritize the needs of vulnerable road users and marginalized groups including open public spaces, cycling lanes, wider sidewalks, protective bollards in pedestrian zones and equitable access to spaces for walking, cycling, and other physical activities;
3. Strengthen and enforce the implementation of legislations such as blood-alcohol concentration (BAC) limits, random drug testing, seatbelt and child restraints, motor vehicle safety standard, and helmet laws and helmet standards regulations;
4. Develop and fund a national road safety strategy dedicated to research and advocacy initiatives that focus on the reduction of road traffic deaths and injuries, and the provision of the most updated data and statistics.
5. Invest in a post-crash care system and response protocols to avoid preventable death and disability, limit the severity of the injury and the suffering caused by it, and ensure the crash survivor's best possible recovery and reintegration into society;
6. Develop best practice communication campaigns with a focus on promoting behavioural change among drivers on key risk-factors by collaborating with civil society organizations and media outlets;



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7. Invest in the expansion, safety and sustainability of public transportation with special attention to the needs of those in vulnerable situations and provide equitable access to these services.

The United Nations and the World Health Organization to:

1. Collaborate with governments, non-governmental and youth-led organizations to shape and ensure the implementation of the Decade of Action for Road Safety 2021-2030;
2. Expand road safety efforts and advocate for the investment in best practices including the Road Safety Grants Programme, the World Bank's Global Road Safety Facility and the United Nations Road Safety Fund;
3. Provide countries with evidence-based measures to fulfill the commitments and adopted targets to reduce road traffic deaths and injuries in the short and long-term;
4. Provide technical assistance, particularly through regional and country offices, and ensure the continuous monitoring, updating and sharing of data and risk communication for countries to effectively reduce road traffic crashes.

Non-Governmental Organizations to:

1. Advocate for the design and implementation of road safety policies and evidence-based measures in collaboration with governments and research institutions;
2. Raise awareness and public support for road safety through education and campaigns in alignment with the UN Global Road Safety Week, with a focus on preventative and mitigating factors;
3. Advocate for the use of alternative sustainable means of transportation to reduce carbon emissions and improve air quality;
4. Educate and inform policymakers, practitioners and the public about the road safety risk factors and prevention measures using social marketing campaigns aimed at changing behaviour and attitude.

Education and Higher-Education Institutions to:

1. Implement educational road safety programs in high-schools and universities;
2. Ensure the safety of educational institution zones and surrounding infrastructures through the establishment of drop-off and pick-up zones, pedestrian crossing, speed limit reduction.

National Member Organizations to:

1. Build the capacity of members on road safety through workshops and campaigns to expand their advocacy efforts and local actions;
2. Collaborate with other health student organizations, governments and civil society, to raise awareness on road safety and enforce the implementation of legislations;
3. Encourage medical students to engage in the formulation and enforcement of road safety frameworks and policies within their governmental and non-governmental bodies.



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Position Paper

Background information

Road Traffic Injuries (RTIs) and Deaths

More than 1.35 million people are lost every year due to road traffic accidents. Between 20 and 50 million more people suffer non-fatal injuries, with many living with significant disabilities. Furthermore, Road Traffic Injuries (RTIs) lead to major economic consequences to individuals, their families, and to countries as a whole. Such losses are incurred due to the considerable costs of treatment and lost productivity due to lives lost and disabilities for individuals, and for family members who are forced to leave their work to provide care for those injured. Road traffic crashes cost most countries 3% of their gross domestic product [1].

An average of 3,700 people are killed globally on a daily basis in road traffic crashes. The majority of those killed are pedestrians, motorcyclists, or cyclists. RTIs are considered by the World Health Organization (WHO) to be the eighth leading cause of death globally for all age groups and the main cause of death for children and young people aged 5–29 years. More people now die in crashes than from HIV/AIDS, tuberculosis and malaria [2].

Best Practice from Different Stakeholders on Road Safety

Firstly, Rochelle Sobel, President, Association for Safe International Road Travel, United States of America said that “There are not many roads, there is a single road that extends across the length and breadth of our vast planet. Each of us is responsible for a segment of that road. The road safety decisions that we make or do not make, ultimately have the power to affect the lives of people everywhere. We are one road – one world.” Similarly, the Chairman of Drive Alive in South Africa quoted that “The human suffering for victims and their families of road traffic-related injuries is incalculable. There are endless repercussions: families break up; high counseling costs for the bereaved relatives; no income for a family if a breadwinner is lost; and thousands of rands to care for injured and paralysed people.” [3]

Most road traffic deaths and fatal injuries are preventable because the crash risk is largely predictable. Therefore, many countermeasures can be enforced. RTIs respond well to effective interventions that prevent injuries, minimize their severity, and reduce the preceding complications. Although no blueprint for road safety exists, a broad consensus exists on diverse best practices such as addressing risk factors such as speeding, drinking, and driving, and implementing legislations related to the use of seat belts, child restraints and helmets. In addition, enhancing post-crash care from life-saving measures to rehabilitation.

In addition to these effective interventions, political will and commitment are essential to reducing the burden of RTIs. The first and most imperative action to mitigate RTIs is the strict and efficient implementation of legislations that follow safety principles and discipline unsafe behavior. Presently, national laws that address the key risk factors, including speeding; driving under influence; and failing to use helmets, seat belts, and child restraints, are implemented by 91 out of 180 countries. Since 2011, 17 countries have amended their laws on one or more key risk factors for RTIs to bring them in line with best practices. However, little progress has



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been made globally in extending the coverage of national laws to include all key risk factors [4].

To promote and ensure the adoption of safe road behavior and principles not only demands enforcement of legislations, but also building public awareness of such implementation. A large body of research, yet a few are based from low and middle-income country (LMIC) experiences demonstrate that:

- Implementing speed limits according to designated functions of the roads can reduce RTIs by up to **34%**;
- Enforcing blood alcohol concentrations (BAC) limits at 0.05 grams per deciliter (g/dl) and conducting random breath tests can significantly reduce alcohol-related RTIs.
- Enforcing the use of motorcycle helmets and helmets standards can reduce the risk of death by **40%** and the risk of serious head injuries by more than **70%**
- Ensuring the use of seat belts can reduce the risk of fatal injuries by up to **50%** for front-seat occupants and **75%** for rear seat occupants. Although most countries have mandatory seatbelt laws, the legislation often does not extend to rear-seat occupants.
- Mandating the use of child restraints can reduce the likelihood of a fatal crash for children by up to **80%**. However, such laws are evidently lacking in LMICs. For example, only 1 out of 10 South-East Asian countries has a law requiring child restraints [4].

Disparities in Road Safety

Around 1.35 million people die due to traffic accidents, or equal to 3700 lives lost every day [5]. Nearly 93% of these fatalities occurred in low- and middle-income countries (LMIC) where only less than half of the global registered vehicles are documented [6]. Road traffic crashes are the 10th most frequent causes of death in the world with children and young people between the ages of 5 and 29 as the most vulnerable group [7]. In fact, the mortality rates are increasing rapidly in 104 countries and showed no reduction in any low-income country between 2013 and 2016. [8] Despite the fact that the financial burden of road traffic injury and death accounts for 2-7% in LMIC [6], funding remains to be considered as the main barrier to ensure road safety. [9]

Thus, Road Safety has been integrated into many global agendas such as the Sustainable Development Goal (SDGs) target 3.6 and 11.2. Five pillars comprising building road safety and management capacity, improving the safety of roads and transport networks, improving vehicle safety, improving the behaviour of road users, and improving post-crash response were adopted at the UN General Assembly in 2010 as 2011-2020 the Decade of Action for Road Safety [7]. As the Decade of Action for Road Safety ends, the SDG targets 3.6 to halve all deaths due to road traffic injuries and death by 2020 unlikely to be achieved. This wasn't unfortunately accomplished by most countries. Multisectoral work in urban governance needs to be implemented in ensuring the links of the health sector with the stakeholders involved including but not limited to education and transportation [10]. Rather than seeing road traffic accidents as human errors, it should be seen as a public health crisis for which road users, designers and policy-makers are held accountable [11].

Discussion

Global Governance in Road Safety



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Lack of Representation in the Global Health Scene

Road deaths and injuries have had a significant global health burden due to the implications it has on the various governmental sectors [12]. However, the importance of addressing road safety within the global health advocacy scene was emphasized in September 2015 at the United Nations General Assembly (UNGA) with the adoption of the Sustainable Development Goals 2030 [12]. 17 SDGs have been adopted with 169 targets [13][14]; however, of those 169 targets only 2 have been attributed to road safety representing 1.18% of the commitment the UN's Member States towards advocating towards road safety [13]:

- SDG 3: **Ensure healthy lives and promote well-being for all at all ages:** target 3.6: by 2020, halve the number of global deaths and injuries from road traffic accidents [13][14].
- SDG 11: **Make cities and human settlements inclusive, safe, resilient and sustainable:** target 11.2: by 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, people with disabilities and older people [13][14].

Moreover, in the 2010 UN General Assembly, the Member States announced that 2011-2020 would be the Decade of Action for Road Safety [15]. It entails a global plan composed of five main pillars: enhancing road safety management, building safer roads and transport systems, improving vehicle safety, improving the road users' behavior and attitude towards road safety, and improving post-crash response on a national level [15].

According to the 2018 WHO's Global Status Report on Road Safety, with 80% of the decade passing, there was no reduction in the incidence of road traffic deaths in any low-income country between 2013 and 2016 [8]. It was reported in the 2009 initial report for the global action plan that over 90% of the world's deaths on the roads occur in low-income and middle-income countries even though these countries have only 48% of the world's vehicles [15]. According to the 2018 Global Status report, the worldwide death toll increased in 104 countries; only 48 countries of high to middle-income status witnessed a reduction [8]. When it comes to the fifth pillar in the action plan: improving the post-crash response, it was found that when comparing low-income to high-income countries, the low-income countries had twice the number of road traffic victims die before reaching healthcare facilities compared to those in high-income countries [8]. This 2018 Global Status report shows that the target 3.6 within the SDG 2030 to half the road-related deaths is farfetched. Thus, more action is required and needed in order to address this global health issue.

Moving forward with initiatives in the global health scene and global governance with regards to funding opportunities, starting in 2005, the World Bank's Global Road Safety Facility was launched with the objectives to increase funding and technical assistance for implementation of road safety programmes for low- and middle-income countries [16]. In 2011, with the adoption of the Global Plan for the Decade of Action for Road Safety 2011-2020, The Road Safety Fund was created to support programs aiming to prevent road traffic injuries [16].

In 2012, The Road Safety Grants Programme, supported by Bloomberg Philanthropies and managed by the Global Road Safety Partnership, was created to support initiatives aiming to advocate for improved road safety policies with their relevant action plans [17]. As for the United Nations Road Safety Fund (UNRSF) established in 2018, it aims to empower low- and middle-income countries to develop national road safety systems to decrease the



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number of deaths and injuries from road accidents and thus to reduce economic losses due to road-related burdens [16]. Thus, indirectly excluding mitigation risk, first-aid efforts, health system amendments, emergency transport upgrade, improving treatment, trauma care, and ICU,

The Framework of Causes for Road Injuries

The framework of these action plans highlights the diversity of the causes of road-related injuries of death. The 2009 Global Status Report on Road Safety set the determinants of road safety mortality [8]. It listed 3 independent variables [8]:

1. Exposure Factors
2. Risk Factors, Preventative or Moderating Measures
3. Mitigating Factors

The exposure factors are relevant to the vehicle density and the road density [8]. The risk factors, preventative or moderating measures include policies on specific interventions and their enforcements such as laws and regulations on alcohol, speed, and investment in public transport [5]. As for the mitigating factors, this tackles the load and the strength a country's healthcare system has with relevance to pre-hospital care such as primary healthcare centers and emergency care such as in post-crash situations [8]. It was found that the exposure factors and preventative or moderative measures were the categories dependent and varying on a country's income level [8].

Road Safety Legislations and Regulations

Regardless of the presence or absence of laws and/or policies, if there isn't a systematic change with regards to the perception of road safety, no impact would be done. There should be an increase in the awareness of road safety. Sampling different countries, in South India, a cross-sectional study was done on medical students and it was found that the participants and a significantly low level of awareness when it comes to the usage of seatbelts (20% of participants), alcohol and driving (4.2%), and usage of mobile phones (6.1%) [18]. This shows that there is a lack of awareness portrayed.

A similar study in a different region was conducted in Lagos, Nigeria where the cross-sectional study yielded that only 1% of drivers had the correct information regarding the driver's license authorities in Nigeria. In addition, only 41% of the drivers had knowledge of road signs with 100% lack of knowledge of the maximum speed limits [19]. It was found that the eldest, least educated, and the least experienced drivers had the lowest levels of knowledge on road safety [19]. As for a study that occurred in New Zealand, 49% and 32% of males and females respectively reported driving under the influence of alcohol (within 2 hours of drinking alcohol) 30 days before the study; 19% and 8% of males and females respectively reported that they have consumed alcohol to a level they would not be able to drive safely [20]. It was also reported that 38% of males and 11% of females have reported that they have been driving "often" at a speed higher than 120 kph [20]. A cross-sectional study was done on medical students in Egypt that showed that 40% of the students had had an injury within the previous year of the study with 15.2% of those due to driving; of note, of those 15.2% injured drivers, only 9.6% had a valid driving licence [21]. However, one conclusive outcome is that 89.2% of students reported that road traffic injuries are preventable [21].



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The Economic Burden of Road Traffic Injuries

Road injuries have an important impact on the economy of the governments and the families since they need to cover expenses like rescue management, acute trauma care, rehabilitation, cost of property damage, and in some cases there are economic losses regarding DALYs (Years Lived with Disability). [22]

According to a study published in 2019, the road injuries macroeconomic burden for 166 countries between 2015 and 2030 will cost \$1.8 trillion due to health care expenditures and losses in employment as a result of mortality or morbidity. [23]

The high-income countries bear a greater economic burden compared with the middle and low-income countries, where HICs deal with \$963 billion and a per capita loss of \$779 while LMICs \$11 billion in total and \$14 per person[23]. However, it is important to note that the economic burden is not proportionally distributed with population size and DALYs since the disease burden measured as DALYs in the LMICs corresponds to 89% of the global DALYs[2]. This means that health care and treatments account for a great proportion of the economic burden and due to a better health system and access roads and infrastructure that allows a time ambulance response the DALYs and the mortality related to road injuries are lower in HICs. [23]

Meanwhile, the total costs of road crashes measured in terms of percentage of GDP are found to be 2.7% of GDP in the HICs and 2.2% of GDP in the LMICs (unweighted averages) [25]. The higher cost within the HICs groups is probably related to the “willingness to pay (WTP)”[24,25]. However, half of the cost in both HICs and LMICs are related to injuries; 23% of the cost in HICs and 30% in LMICs are linked to fatalities, the difference between them is explained by the higher number of fatalities within LMICs compared to the number of injuries. [24]

The major number of fatalities associated with road injuries in LMICs are also related to road infrastructure and a greater number of vulnerable road users like pedestrians, cyclists, and motorcyclists which comprise more than half of all global deaths, with pedestrians and cyclist representing 26% of all deaths, motorcyclist 28%, car occupants 29%, and unidentified road users the remaining 17%. [8,25]

Road Safety and Marginalized Groups

Marginalized groups that are ethnic minorities, with low income or unemployed, with low educational status or low-status occupations often have an increased risk of traffic accident-related mortality and morbidity. This risk is aggravated by multiple variables such as the absence of vehicle safety features, residing in remote places without hospital trauma center or efficient emergency transport or being unable to pay for healthcare and rehabilitation which implies an economic loss for the victim and their families for the loss of a breadwinner or for not being able to work due to disability or for caring a disabled family member. [25, 26] Also, people with differing abilities (wheelchair users, people with auditory, visual or mental differing abilities, etc) and elderly people are at greater risk of RTIs and deaths. The environment, the means of transport and human factors (drivers, accompanying persons, medical staff, etc) play a decisive role in the number of lives lost due to road crashes. [28, 29]



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Road Safety and Air Pollution

Traffic emissions are a major source of air pollution due to the release of carbon monoxide (CO), oxides of nitrogen (NOx), benzene, and particulate matter (PM), including fine particles (PM2.5) and elemental carbon (EC) which are related to respiratory tract infection and asthma among children and young people, cardiovascular problems, impaired lung function circulatory deaths and non-accidental mortality within the elderly population [25, 30, 31]. Also, these emissions contribute to climate change that may not affect health directly yet its consequences such as heatwave, floods droughts, air pollution, aeroallergens, and vector-borne diseases impact largely global health [30, 31]. Furthermore, disadvantaged groups tend to live near roadway sources or closer to industrial fabrics and to be more exposed to emissions due to this residential segregation [25].

Road injuries, traffic emissions, and economic burden affect the whole world especially LMICs. Therefore, there is a need to improve road access equity vertically by providing quality public transport that allows all income people to reach workplaces with an affordable budget and safely with alternative transport initiatives such as carpooling and bike-sharing which can effectively reduce the use of private gasoline and in turn carbon emissions per individual [25].

Current Legislations on Road Safety and the Role of Media

To reduce RTIs, the formulation and effective implementation of legislations on major behavioural risk factors including speed, driving under influence and failing to use motorcycle helmets, seat-belts and child restraints are vital. Currently, 123 countries, representing nearly six billion people, have laws that meet best practices for at least one of the five key behavioural risk factors [8].

The results of a global survey held by the WHO suggest that the legislation on these risk factors is not comprehensive in many countries, and enforcement is often lacking. Similarly, many countries lack the institutional mechanisms and resources that would allow them to implement planned activities in a coordinated fashion – including adopting and enforcing laws – which may result in a “piecemeal” approach to road safety efforts that are seen in many countries [32].

Road traffic is often covered in the media as an event and not as an enormous drain on a country's health resources or a leading killer of its citizens in most countries. By framing traffic safety as a health story, journalists have the opportunity to impact the way these stories are told, and potentially help shift policy and public reaction [33]. When media outlets report stories about road traffic crashes without using specific statistical data, they are regarded by the public and policymakers as one-time incidents. When they are reported with data, crashes that result in injuries can manifest a broader concern in public health and development that requires urgent attention [34].

The media has tremendous power to influence social change – reporting on policies and government action on such things as creating and enforcing speed limits, seat belt and drunk driving laws; spending on infrastructure projects and even street lighting; the massive cost to already overburdened health care systems; and the loss of productivity in society due to millions of injuries[32].



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Social marketing campaigns that are based on extensive research and testing have a better chance of changing people's perceptions. It was scientifically proven that showcasing real-life and storytelling campaigns on RTIs are more impactful and hard-hitting because they are more likely to be recalled by the target audience. It was demonstrated by the WHO that, in diverse countries such as Brazil, Cambodia, Kenya and Mexico, the implementation of hard-hitting campaigning strategies, instead of using the "feel-good" approach, is significantly more effective for behavioural change by chiefly shedding light on the life-threatening consequences of irresponsible behaviour and lack of proper enforcement of road safety legislations [37].

Since 2007, with the technical support of WHO and its partners, the Government of Vietnam has continuously improved its laws and regulations to promote helmet-wearing by motorcyclists [34]. Helmet-wearing rates increased from 40% in 2007 to more than 95% in 2008 and have remained above 90% since the introduction of the motorcycle helmet law in 2007[34]. The use of seat-belts can reduce the risk of serious and fatal injury by between 43% and 65%. Seat-belts are most effective in frontal crashes, which are the most common kind of crashes and often result in serious head injuries. The mandatory use of seat-belts is also highly cost-effective[35].

Legislation on the use of safety restraints must be accompanied by strict enforcement in order to be effective. Korea showed a dramatic increase in the rates of using safety restraints among drivers from 23% to 98% in less than a year after raising the penalty for not following safety restraints by two-fold, which was additionally accompanied by a widespread national enforcement campaign by the government [35]. In Russia, thanks to enhanced enforcement and mass media campaigns, the rate of seat-belt wearing in Lipetsk Oblast increased between 2010 and 2013 from around 50% to nearly 80%; and from below 50% to 90% in Ivanovo Oblast. In addition, the use of child restraints has quadrupled in both oblasts, jumping from 20% to above 80% in Ivanovo Oblast, for example [37].

Similarly, highly visible and well-publicized enforcement of mandatory seat-belt laws is effective at increasing seat-belt use. Seat-belt compliance increased by 15% within one year of strict enforcement in several provinces in Canada and France [5]. In low-income countries, seat-belt use legislation is still not universal and will become increasingly important as car traffic levels rise in these countries [35].

Poor Quality of Public Transportation

As public transportation gathers more than one passenger in one means of transport, it carries a greater risk of compromise of safety. The problem becomes worse in developing countries because of the lack of suitable and integrated approaches [36]. Because of the low percentage of crashes involving buses and the assumption that public transport improves road safety by reducing vehicular traffic, bus safety is far less important to public interest than the safety of other types of vehicles. It is possible that less attention is paid to the significance of crashes involving buses because the safety level of bus systems is considered to be adequate [37].

Quality and Safety of Roads Infrastructures

Road infrastructure is a key risk factor to fatal road injuries which has been confirmed by many studies that demonstrated the critical role played by improvements to road infrastructure, especially design standards that prioritize the needs and safety of all road users. In a review



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that was done by the WHO, 112 countries have national design standards for the management of speed. National design standards for creating isolated and safe spaces for pedestrians and cyclists from motorized traffic have been seen in 91 countries. Moreover, 132 countries have national design standards for the provision of safe crossings for pedestrians and cyclists [8].

The Insurance Policies Related to RTIs

Implementing awareness of the society and child education as well as providing innovation to learn such as workshops and innovation awards, are the main focus to achieve the sub-targets of the SDGs. Moreover, the success indicators such as the number of people targeted, the number of events and studies conducted as well as the budget will be utilized to measure the impact [38][39].

According to the FIA Foundation Deputy Director, Avi Silverman: "These targets are essential if there is to be global progress towards the SDG agenda on road safety. They provide a clear set of actions to be prioritized by governments worldwide. And importantly, they take into account the needs of children and the vulnerable, setting the key objectives to save lives on the world's roads." [39]

In addition, it is extremely important to note that these targets are in direct line with the Decade of Action for Road Safety and its five pillars; "road safety management, safer roads and mobility, safer vehicles, safer road users, and post-crash response". [39] The fifth pillar of the Decade of Action for Road Safety highly supports the implementation of appropriate and necessary road user insurance schemes to finance rehabilitation services for crash victims through the introduction of mandatory third-party liability and International mutual recognition of insurance, for instance, the green card system. [15]

From this point, a collaborative initiative, Insurance for Safer Roads, was implemented to look at new levers and hence, improve road safety from the perspective of the insurance industry, with a special focus on low- and middle-income countries [40].

The estimated annual global cost of road crashes is US\$ 1,855 billion. This accounts for around 1-3% of Countries' GDP and may even reach 5% in low-and-middle-income countries (LMICS), thus, road accidents have significant consequences on the insurance sectors. This causes a strong business case for the insurance sector to try to contribute to the reduction of road risks and encouragement of safer driving; hence reducing road accidents and their costs [40].

The key role of insurance industries in road safety is motor insurance. It protects road users who depend on insurers to cover any financial losses in case of an accident. This is a major issue in countries that do not have compulsory motor third-party liability (MTPL) or fail to implement and control it; which is the case in many LMICs, thus, individuals are obligated to cover the majority of the road crash costs. Tackling the road safety challenge in LMICs is a high priority, although they account for only half of the vehicles in the world (54%), they contribute to more than 90% of global road fatalities. Insurance industries can thus contribute to road safety through the motor vehicle insurance value chain, which may be divided into three phases:

- **Phase 1: Preventing and reducing road risks.**



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This step may be achieved through advocacy, prevention, and education programs. In addition to conducting studies on the risks related to road uses and driving behavior.

- **Phase 2: Insuring road risks.** By assessing the risks and adopting motor policies with a special focus on vehicle users in LMICs, insurers can integrate road safety incentives into their products and services to promote responsible driving behavior.
- **Phase 3: Supporting the customers throughout the insurance cycle.** Road safety is a good motivator for insurers to ensure a good, strong relationship with their customers throughout the insurance cycle. Moreover, new technologies and innovations allow them to have a better understanding of customers' driving behaviors, and thus, share personalized feedback to the customers to reduce road risks. Fairness and transparency to insurance claims must be ensured to all customers by insurers under all circumstances [40].



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Bylaws Paragraphs concerning Policy

17.2 Definitions

- a) **Policy Statement:** Short and concise document highlighting the position of IFMSA for specific field(s). A policy statement does not include background information, discussion related to the policy, a bibliography and neither does it quote facts and figures developed by outside sources. The maximum length of a policy statement is 2 pages, including introduction, IFMSA position and call to action.
- b) **Position Paper:** A detailed document supporting the related policy statement that contains background information and discussion in order to provide a more complete understanding of the issues involved and the rationale behind the position(s) set forth. A position paper must cite outside sources and include a bibliography.
- c) **Policy commission:** A policy commission is composed of three people, with 2 representatives of the NMOs and one Liaison Officer. The proposer of the draft is part of the policy commission and is responsible of appointing its members. The tasks of the policy commission are the following:
 - a. They are responsible of the quality of the policy document with the approval of the proposal.
 - b. Ensuring the content is based on global evidence.
 - c. Collecting and incorporating NMO feedback after the call for input.
 - d. Coordinating the discussion during the General Assembly.

Adoption of policies

17.3. A draft policy statement, position paper and the composition of the policy commission must be sent to the NMO mailing list by the proposer and in accordance with paragraph 9.4. Input from NMOs is to be collected between submission of the draft and submission to the General Secretariat.

17.4. The final policy statement and position paper are to be sent in accordance with paragraph 9.4, using the template provided in the call for proposals. The proposal must be co-submitted by two NMOs from different regions or the Team of Officials. A corrected version of this document may be submitted according to paragraph 9.5. Correction may not be used to add members to the policy commission.

17.5. Policy statements and position papers must be presented to NMOs during the first working day of the IFMSA General Assembly.

17.6. A motion to adopt the policy statements and position papers must be submitted the day before the relevant plenary by two NMOs from different regions or an IFMSA Official, the IFMSA Team of Officials or the IFMSA Executive Board. Adoption requires $\frac{2}{3}$ majority.

17.7. Amendments may be sent to the proposer in accordance with Annex 1. Amendments made during a General Assemblies or after the deadline stipulated in Annex 1, shall be submitted to the Chair at the latest 23:59 observed in the time zone of the relevant General Assembly on the day before the scheduled start of the session in which the policy will be voted on. These amendments require $\frac{2}{3}$ majority to pass.