Addendum 2010

Child Safety Good Practice Guide:
Good investments in unintentional child injury prevention and safety promotion
Introduction

New evidence statements

New Good Practice Case Studies from Europe


Child Safety in Cars - Traveling Information Center, Portugal

Take your 20s to Heart, Scotland

Fife Cares Child Safety Scheme, Scotland

TIP TIPAT BETICHUT - the Injury Prevention Program in Well-Baby Clinics, Israel
Introduction

This document is an addendum to the Child Safety Good Practice Guide: Good Investments in unintentional child injury prevention and safety promotion, originally published in 2006.

From 2008 to 2009, the European Child Safety Alliance, EuroSafe’s Effective Measures in Injury Prevention (EMIP) initiative and the WHO Office for Europe collaborated on an expert review of evidence in child injury prevention involving experts in the field of injury prevention and the analysis of scientific evidence. The review, led by WHO, was part of the preparations for the Fifth Ministerial Conference on Environment and Health, which was held in Parma, Italy in March 2010. The process involved reviewing injury prevention related actions in the initial table of evidence for Regional Priority II produced as part of the Child Health and Environment Action Plan for Europe (CEHAPE) in 2004 and updating it. CEHAPE Regional Priority Goal II states “we aim to prevent and substantially reduce health consequences from accidents and injuries and pursue a decrease in morbidity from lack of adequate physical activity, by promoting safe, secure and supportive human settlements for all children.” The core structure of the review process involved a) formulation of the interventions to be examined, b) the identification and collection of evidence and c) the analysis of collected evidence (quality appraisal and synthesis). The final synthesis of the evidence for prevention interventions was carried out through expert consensus meetings and email consultations.

In reviewing the evidence, three additional prevention measures not previously included in the Good Practice Guide were deemed to meet the definition of evidence-based good practice used in 2006 and are included here as additional evidence statements.

In addition, this addendum includes five additional case studies of evidence-based good practice in action in Europe. Two deal with child passenger safety, one with child pedestrian safety and the remaining two with general home safety.
**Good practice for child driver / passenger safety**

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<thead>
<tr>
<th>Evidence statement</th>
<th>Transfer and Implementation points</th>
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<tr>
<td>Graduated driver licensing (GDL) systems reduce the risk of motor vehicle crashes</td>
<td>- Graduated driver licensing (GDL) is a training system that gradually introduces young drivers to higher risk driving situations. Restrictions vary across programs (e.g., extra passengers, night driving, and roadways).&lt;sup&gt;4,5&lt;/sup&gt;</td>
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<td>and road traffic injuries among young drivers.&lt;sup&gt;1,3&lt;/sup&gt;</td>
<td>- Graduate licensing systems introduced in several American States, Canadian Provinces and other countries have found crash risk reductions from 19 to 40%.&lt;sup&gt;1,2&lt;/sup&gt;</td>
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<td>- The most effective components of GDL systems appear to be nighttime restrictions, passenger restrictions and extended learner periods.&lt;sup&gt;2,5-6&lt;/sup&gt;</td>
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<td>- Extending the time for which a learner permit must be held prior to licensure is considered the most significant single contributor to the reductions observed among licensed drivers aged 16 years.&lt;sup&gt;1,4-6&lt;/sup&gt; As driver licensing occurs at later ages in Europe – 18 years in most countries, the applicability of GDL in the European setting would benefit from further evaluation.</td>
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Good practice for general child home safety

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<td><strong>Enforcement</strong></td>
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| Non-voluntary building codes for new dwellings (legal standards to address hazards related to falls, fire injuries, other thermal injuries, collisions, entrapment, cutting and piercing, drowning, electrocution and poisoning [i.e., lockable cupboard]) leads to reduction in children’s exposure to hazards. | - The quality and quantity of the evidence varies across different hazards types and for different ages of children. It is weaker in some areas, such as for electrocution, because of the small number of incidents. What is clear is that within each hazard type the direction of the evidence is consistent.  
- Effectiveness of non-voluntary building codes is dependent on formulation, application and enforcement.  
- Building codes fall within the mandate of the housing ministries but the formulation should involve collaboration between sectors including health.  
- Need to consider capacity and mechanism for enforcement.  
- Building codes should be hazard related regardless of the setting, take into account the special needs of children and be understandable to those applying and enforcing the codes. |
| Non-voluntary building codes for existing dwellings (legal standards to address hazards related to falls, fire injuries, other thermal injuries, collisions, entrapment, cutting and piercing, drowning, electrocution and poisoning [i.e., lockable cupboard]) leads to reduction in children’s exposure to hazards. | - Building codes that apply to only new dwellings are likely to miss the children most at risk, who are more likely to be living in older more hazardous buildings, thus it is better if building codes apply to all dwellings.  
- The quality and quantity of the evidence varies across different hazards types and for different ages of children. It is weaker in some areas, such as for electrocution, because of the small number of incidents. What is clear is that within each hazard type the direction of the evidence is consistent.  
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References


Israel

**Background**

The Buckle Up program was based on a multifaceted approach, using multiple strategies for injury prevention. Most of the strategies (see below) commenced in 2002.

1. **Capacity building**: Training of professionals including child passenger safety instructor and technician training courses based on the National Highway Transportation System Administration (NHTSA) programme in the US; training of 80% of all maternity wards and public health nurses in Israel; training of thousands of teachers, kindergarten teachers, and daycare professionals.

2. **Public education**: Instruction of thousands of parents in maternity wards and well-baby clinics, and the development of educational programmes targeted at children 4-9 years old. An information hotline regarding child passenger safety for parents and car seat 'check up' events.

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<td>SETTING</td>
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<td>TARGET AUDIENCE</td>
<td>Government officials, medical professionals, police, teachers and daycare professionals, businesses, community, parents and children 4-9 years old</td>
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<td>RESOURCE IMPLICATIONS</td>
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<td>EVIDENCE BASE:</td>
<td>Community-based interventions combining information dissemination on child passenger restraint safety with enhanced enforcement campaigns lead to increase use of child passenger restraints.</td>
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3. **Social Marketing**: Promotion of booster seats as appropriate restraint for older children, increasing availability of booster seats in toy stores, drugstores and hardware stores, and redesigning booster seat fabric to be more appealing for older children. Annual national media campaigns directed at parents and economic incentives through 30% discount offerings on child safety seats and booster seats by local dealers during the annual campaign period.

4. **Legislation**: Changes in the mandatory transportation regulations concerning child passenger safety incorporated into national legislation in November 2004 including specifying the safest ways to drive with children.

5. **Enforcement**: Police trained in child passenger safety and implementation of police led highly visible enforcement campaigns that including positive messaging and issuing citations.


**Policy Background/ Driving Force**

Motor vehicle crashes are one of the leading causes of death and injury to children in Israel. In 2001 in Israel, the overall paediatric injury rate for children 0-14 years of age traveling as passengers in cars was 160 per 100,000 population.

Child-restraint systems (CRS) have been proven to be life-saving measures in reducing death and injury to children in motor vehicle crashes.

Baseline measures of public knowledge regarding child passenger safety (CPS) in Israel established that knowledge levels were low and led to the inception of a multifaceted series of interventions to increase safe behaviour.
Partners
• National Road Safety Authority
• Ministry of Transport and Road Safety
• Ministry of Health
• Ministry of Education
• Businesses
• Communications Media
• Parliamentary Committee on the Rights of the Child
• Non-governmental organisations
• National and Local Police
• Local Authorities
• Hospitals and family health centres

Aims & Objectives
• To reduce injuries and injury severity in road crashes among children in Israel
• To increase child passenger safety and use of restraints among children age 0-15 years

Evaluation
Specific, uncontrolled observational behavioural studies have been conducted annually since 2002. The evaluation has also included telephone surveys regarding knowledge, attitudes, and behaviour.

Observational data show a significant decrease in the percentage of children 0-15 years riding unrestrained from 21% in 2002 to 10% in 2005 (p<0.0001), as well as a slight increase in the percentage of children 0-15 years riding appropriately restrained during the same time period (39% to 43%, p<0.05). A closer examination of the appropriately restrained children by age shows a significant increase in appropriately restrained infants less than one year (40% to 59%, p<0.001). Other significant changes include an increased from 17% to 23% for 5-9 year olds (p<0.05) and an increase from 50% to 59% for 10-15 year olds (p<0.01). No significant change was noted for 1-4 year olds.

Data also revealed a large decrease from 16% to 7.6% (p<0.0001) in the percentage of children riding in the front seat. The age groups most affected were 5-9 year olds (8% to 3.4%, p<0.0001) and 10-15 year olds (39% to 11.4%, p<0.0001). Again no significant change was noted for 1-4 year olds.

The telephone surveys of knowledge, attitudes and behaviours found a significant improvement in parents’ knowledge concerning child passenger safety. Parents’ knowledge of the proper CRS for children aged <1, 4-5 and 6-8 years significantly increased from 2002-2005 (57% to 71%; 62% to 72% and 16% to 35%, respectively; p<0.01). Parents’ knowledge concerning child positioning in the car (front or back seat) also significantly increased for children aged <1 and 1-3 years during the study period 2002-2005 (49% to 63%, and 83% to 91%, respectively; p<0.01).

Initially designed and promoted by Beterem, the observational survey is now conducted annually by the National Road Safety Authority.

Key Steps
• Legislation and Enforcement: changes in legislation and regulations, and enforcement by the police in special campaigns increased public awareness of the topic, as well as the demand for further information on the subject.
• Training professionals from various fields to facilitate capacity building within different sectors. Modelling of training activities on existing standardised programme (NHTSA programme from the US).
• Media Campaigns to increase public awareness of the importance of the use of correct CRS. Booster seats, previously unfamiliar to the public, received publicity and became common place.
• Cooperation with private companies to modify CRS products to make them more acceptable to target audience, promote safety equipment sales and provide funding for the production of informational materials to raise awareness.
• Research and evaluation to examine the knowledge, attitudes and behaviour of parents and children regarding CPS. Engagement of partners in local communities regarding proposed local activities, timeframes, etc.

Lessons Learned

Barriers:
• As child passenger restraint is not one of law enforcement’s top priorities (speeding and driving under the influence are), enlisting their interest and cooperation as part of the program and more specifically their special operations to enforce the law including issuing citations to adults when children are not restrained properly, was challenging and required specific and ongoing efforts.
• Positioning booster seats as the accepted CRS for older children among parents and children age of 5-9 years and as a desired safety product in the car was challenging and required changing the public’s concept of booster seats (that they are only for toddlers) as well as convincing CRS producers to change the look of the boosters.

• The effect of legislation can take time, mainly due to the lag in law enforcement implementation and the period needed for the public to assimilate the behavior into everyday use.

Facilitators:

• Scientific evidence concerning CRS as a life-saving measure in motor vehicle crashes, greatly facilitated the recruitment of partners for the initiative.

• The cooperation of both the government sector as well as the business sector, were a key facilitator to success as they provided complementary components in the programme. While the government had the law passed, enforced and had extensive campaigns, the importers of CRS had to have in their stocks enough boosters and encourage retail stores other than baby products stores to sell them.

• Coordinating work of all relevant bodies (government, business and media) had a great effect on the success of the program by making the effect synchronized. For example, having the television and radio campaign synchronized with education at schools and reduced costs of CRS by retailers, communicated the booster seat message via multiple channels and enabled people to understand that booster seats are necessary.

Advice to Countries/ Transferability

• Consider conducting an initial survey to capture the current situation and problems of child passenger safety before starting the programme. This step is crucial in order to identify the most appropriate interventions to address local problems.

• The use of several coordinated and complimentary strategies is crucial, and it also allows synchronization over time between education and capacity building, media campaign, sales promotion and enforcement.

• The work undertaken should be systematic and include a long term commitment in order to see positive results.

• Although legislation is important, creating social norms is the foundation of the whole process. The police can be a partner for creating a new social norm, even before the law comes into effect, through positive reinforcement activities.

• Monitoring and evaluation demands a substantial amount of resources and effort, but of key to success in partnership building in design and ongoing improvement of the intervention and in demonstrating impact. Scientific findings also serve as a media hook and the basis for the creation of social norms.

References, Additional Information


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Child Safety in Cars -
Traveling Information Center
Portugal

Background
The main idea of this community-based educational campaign addressing the use and misuse of child restraint systems (CRS) for transporting children in cars was the creation of an “traveling information centre” or road show running in all districts of Continental Portugal to support existing legislation. The road show was supported by a strong media campaign (TV spot and programmes, radio spot and programmes, press advertisements), which slogan was “Don’t let this be the last goodbye”.

The educational campaign led by APSI, the Portuguese Association for Child Safety Promotion, was developed at a national level and included community-based actions in the 18 districts of Continental Portugal. In each district, a main city was selected and the “traveling information centre” was installed and run over a two-day period. This included:

- **Educational sessions for children ages 8-9 years, developed in local schools and leisure centres and facilitated by APSI staff.**

The sessions started with a film of an automobile crash followed by a discussion where booster seats, booster cushions and reflective vests were available for demonstration and experimentation. At the end of the session, all children were weighed and measured and a prescription with the recommended CRS for their age and size was provided.

- **Seminars for families and professionals**
  These were held in the evenings and involved a standard PowerPoint presentation about road accidents and the importance of a correct choice and use of CRS. The local police, emergency and hospital services were invited to participate as speakers and share local reality and concerns related with protection of children in cars.

- **Child Restraint Systems (CRS) Check Points**
  Checkpoints were held at strategic locations using trained inspectors who checked appropriateness of CRS including misuse and provided direct feedback to families including teaching them how to correctly install CRS in their cars and whenever necessary give advice on criteria to choose a new CRS. Before leaving the checkpoint an informative leaflet with recommendations for the choice of CRS for different ages was given to all families.

Policy Background/Driving Force
In Portugal, despite the reductions in road related deaths from 75/1,000,000 children to 18/1,000,000 children in in the last 10 years, road accidents are the main cause of death or permanent disability in children and adolescents. Up to the age of 14 years, almost half (46%) of these traffic deaths affect child passengers.

The number of deaths with child passengers has decreased in all age groups (0-5, 6-9, 10-14) between 1998 and 2006 with a parallel increase in the rate of CRS use by families. Studies carried out by APSI between 1996 and 2007 show increasing CRS usage rates for children under 3 years of age. However, misuse rates have not changed, with misuse ‘severe
enough to reduce significantly the level of protection’ still observed in 50% of all cases examined.

Over the years, APSI has developed several campaigns to promote CRS use and reduce misuse. Considering this experience, a model community-based educational campaign was undertaken during 2007 in support of the current legislation. The campaign was also the basis for a study on CRS use and misuse patterns in urban settings, as the only existing systematic studies in Portugal were the annual APSI surveys on CRS use conducted in the highway setting.

**Partners**

- National Ministry with the Responsibility for Road Safety
- Brandia Central (a Portuguese Communication Agency)
- National media
- Local media
- Local authorities (Municipalities, Police, Emergency Services, Hospitals), universities and non-governmental organisations (Fire prevention NGOs)
- Local schools and leisure centres

**Aims & Objectives**

- To increase the rate of use of CRS
- To reduce misuse of CRS
- To raise awareness of the importance of correct choice and use of CRS amongst families, professionals and institutions
- To characterise the rate of CRS use and misuse in urban settings and compare and monitor CRS use and misuse patterns in Portugal

**Evaluation**

A survey of CRS use and misuse rates was conducted before and after each site intervention to evaluate the impact of the campaign on behaviour change regarding protection of children in cars. This survey also allowed the characterisation of the use and misuse of CRS in urban settings. The ‘before’ survey was conducted on the morning of the first day at each site with the ‘after’ survey conducted 3 or 4 weeks after the intervention. The surveys were carried out by staff and volunteers specifically trained for the purpose and took place near schools when families were leaving children for the day.

The before and after surveys were compared with each other and with results of previous studies. While use rate did not significantly change, CRS misuse was found to significantly decrease from 40% to 30%. In addition several specific misuse patterns were observed to decrease, including the prevalence of ‘very serious misuse’ of the CRS harness. Finally the number of children travelling rearward facing increased for both children aged 9-12 months (from 30% to 53%) and those aged 13-18 months (from less than 8% to 21%).

**Key Steps**

- Obtain official support from the Government, not only financial, but also institutional
- Obtain involvement of local community stakeholders in the evaluation studies (police, health professionals, university students, municipal technicians and NGOs)
- Develop programme materials
- Engage participation of the local authorities (municipalities, police authorities, local government, local health services, schools) in the promotion of the initiative and in the seminar with the presentation of local needs and reality
- Explore possibilities to work directly with families in each community
- Encourage active involvement of national and local media in advertising and reporting on the events
- Implement programme and monitor impact

**Lessons Learned**

- The involvement and the participation of local authorities and organisations in the different actions from the beginning of the initiative promoted greater acceptance of the "traveling information centre" coming to a community and increased involvement in organising and promoting the event. Inviting these organisations to participate actively in planning and implementing the actions fostered a sense of ownership and ensured that their work, needs and concerns were valued and taken into account.
- The training of local community stakeholders already working with families and community organisations as observers for the CRS surveys builds capacity and specific knowledge about the transport of children in cars that can then be applied
in their daily activities fostering greater spread of information to families in the future.

- Direct interaction with families, and in particular hands on education as part of CRS checkpoints, is more likely to create a climate of trust that fosters acceptance of counselling, uptake of new knowledge and resulting behavioural change.

- The information given to families represents the best evidence for providing the highest levels of protection for children in cars; however currently the CRS market in Portugal has few models to offer that provide the safest solutions for children from 1 to 4 years old, such as a CRS that would allow rearward facing to 3 or 4 years of age.

Advice to Countries/Transferability

- Consider allocating regular financial resources to the development of this type of campaign to guarantee a systematic, coordinated and harmonised work with populations and free permanent CRS checkpoints all over the country.

- Consider including in the community activities training sessions for local professionals that have a role in counselling to families (health professionals, CRS sellers).

- Consider holding seminars in the evening and free CRS checkpoints during weekends when parents are not working.

- Before the actions on site, provide training to police officers to enhance misuse detection and effective law enforcement following the community interventions.

- Before starting the campaign, try to encourage suppliers to expand CRS models that allow children to remain rearward facing up to 3 or 4 years of age.

- Implement systematic monitoring of CRS use and misuse in different traffic settings and as possible consider having fixed teams of observers so that observations will be more homogeneous over time.

- Consider starting with a smaller pilot and if successful extending to other parts of the country.

References, Additional Information

1. ETCS, European Transport Safety Council (2009), Pin Flash 12 “Reducing Child Deaths on European Roads”. February: Brussels
2. APSI, Portuguese Association for Child safety Promotion (2007). Analysis of the number of road traffic deaths up to 14 years, during 1998-2006. Lisbon

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### Take your 20s to Heart

Scotland

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**EVIDENCE BASE:**
Area wide engineering solutions to reduce pedestrian risk lead to reduction in injuries and are cost effective.

### Background

The introduction of 20mph (32 kph) speed limits in residential areas and at schools has increased significantly since 1997, in response to growing concern about the problem of inappropriate speed and its contribution to Scotland’s poor record on child pedestrian casualties.

The Scottish Executive commissioned a three-year programme of research to examine the situation. The research considered speed data from 75 trial sites throughout Scotland where advisory 20s (speed limits are set for reasons of safety but are not legally enforceable) had been introduced as part of a campaign entitled ‘20’s Plenty’. At the majority of sites the results proved to be extremely positive prompting the Scottish Executive to issue guidance to Local Authorities permitting not only the introduction of advisory 20s limits but also the introduction of mandatory 20mph limits and zones. Mandatory 20mph limits and zones were required to be self enforcing and generally involved the introduction of traffic calming measures.

Prompted by Scottish Executive funding and a mandate that 20mph limits should be introduced outside all schools, in 2003/2004 Fife embarked on a comprehensive consultation and evaluation process to determine how this could be best achieved. Early findings proved that children were most at risk in the vicinity of their own homes, only occasionally on route to and from school but more often when at play in the evenings, at weekends or during school breaks. It was also found that parents and vulnerable groups including a high percentage of elderly people supported the introduction of 20mph zones in their community rather than simply 20mph limits being introduced outside schools. Studies within Fife and UK wide indicated that a 20mph mandatory limit with traffic calming features would achieve a higher rate of return in the long term.

Thus since early 2005 Fife has been committed (subject to available funding) to roll out a community safety programme to achieve the introduction of a mandatory 20mph limit within all residential areas by year end 2011 or earlier. Currently 80% of Fife’s residential streets are subject to a mandatory 20 mph limit supported by appropriate traffic calming features.

### Policy Background/ Driving Force

Road accidents are the leading cause of accidental injury amongst children and young people. However in looking at solutions, children need the freedom to use the roads for their social development and through exercise for their general health and fitness and therefore should be able to walk and cycle in safety. A pedestrian has a 1 in 5 chance of being killed if hit by a vehicle travelling at 30 mph but at 20 mph this chance reduces to 1 in 40.

The UK Government’s Road Safety Strategy Document ‘TOMORROW’S ROADS – SAFER FOR
EVERYONE’ (published 2000) set challenging targets for year 2010: to reduce by 40% the number of people killed or seriously injured, to reduce by 50% the number of children killed or seriously injured and to achieve a 10% reduction in the slight casualty rate. Fife's Road Safety Targets and Objectives were presented originally in Fife Council's ‘Road Safety Strategy for Fife 2003 – 2007’ and are continued in the current ‘Safer Travel Strategy 2008 – 2011’.

Fife is currently engaged in the promotion of ‘Safer Routes to School’ and the development of ‘School Travel Plans’ at all schools. Intervention at an early age seeks to achieve a healthier and more sustainable life style for today's children and future adults. Fife aims to achieve a target of 60% of children walking and cycling to school by 2012.

**Partners**
- The Scottish Government
- Fife Council
- Local Councillors & Community Groups
- Fife Constabulary including Road Safety Officers
- Fife Fire and Rescue Service
- National Health Service
- Local Bus Companies & Taxi Firms
- Schools and Teachers
- Parents, guardians and children

**Aims & Objectives**
- To reduce vehicle speeds and promote safer driving
- To reduce the number and severity of road casualties within residential areas
- To promote a community spirit and healthier safer lifestyle for all

**Evaluation**
The residential 20mph zones in Fife are proving to be a great success with a significant reduction in speeds and associated improved safety.

Surveys have found that, on average, around 81% of vehicles in these zones now travel below 25mph compared to 58% before the zones were introduced. This in itself represents a significant improvement in the quality of life for communities which, in turn, is helping to support other initiatives aimed at encouraging a greater share of the street space for walking, cycling and play. For example, Fife currently has 143 primary and 19 secondary schools with around 35% having a formal “Travel Plan” in place. Our target is to increase this to 100% by 2013.

Outcomes to date show that over the period in which 20 mph zones have been introduced there are indications of increasing numbers of children cycling to school, with an increase from 1.2% to 3.5% between 2007 and 2009 alone against a local target of 2%. This improvement is considered to be in part related to the reduced speed zones which are helping to make the implementation of school travel plans more effective. Changing children’s’ travel habits in this way will contribute to reversing the health issues associated with obesity and a less active life. Around 37% of Fife's schools are currently involved in cycle training and efforts are being made through Fife’s Cycling Charter, which will hopefully be further enhanced through the awaited Cycling Action Plan for Scotland, to increase the number of children receiving this training to 100% by 2011. 20mph zones, in conjunction with these other sustainable travel initiatives, will help Fife work towards the Government’s target to increase the modal share of journeys undertaken by bicycle to 10%.

In terms of road accidents and associated casualties, whilst a number of years’ worth of data is essential to help identify trends (requiring further evaluation work to be done), an analysis of the number of road deaths within a cluster of 60+ established 20mph zones in part of Fife shows the number has fallen from one person killed per year from 2000 to 2003 (before period) to zero in 2005, 2006, 2007, 2008 and 2009 (after period). Further work is being undertaken to establish correlations to show a corresponding reduction in the severity of non-fatal casualties.

Overall, there is a growing acceptance of 20 mph limits throughout Fife, evidenced by the small number of objections received against their introduction in contrast to the substantial number of requests for limits to be introduced.

**Key Steps**
- Approval given to introduce three trial 20mph limits as part of Scottish Executive Study (1999/2002) – two advisory limits and one mandatory limit introduced.
- Results of trail evaluated to determine the best way forward examining the merits of advisory limit verses mandatory limit with traffic calming features.
• Assess the most appropriate traffic calming features to suit the local environment/ available budget and any specific problems.

**Funding Considerations:**
• Single set of Speed Cushions - £1000
• Full set of Road Humps/ Junction Tables - £5,000-£10,000
• Road Narrowings - £5,000
• Signing – Cheaper for zones than individual streets

**Features:**
• Speed cushions adopted as the favoured traffic calming feature on existing roads based on effectiveness, practicality of provision and cost.
• Full Road Humps/Junction Tables recommended for use on new development roads.
• Road Narrowings recommended for use where there are road noise issues or layout/on site benefits.

Determine availability of budget based on phased scheme projection costs.

From evidence based casualty data determine a realistic programme.

Seek appropriate Local Committee approval recognising the availability of Scottish Executive funding.

Engage with Local Communities regarding individual scheme proposals, timescale etc.

Promote required Traffic Regulation Orders prior to the commencement of any works.

Record for evaluation pre scheme speeds.

Publicise works programme within local community.

**Lessons Learned**
• Ensure the Local Community fully understand the reason for speed changes and support the measures to be introduced.
• Ensure any residents who will be directly affected by traffic calming features are consulted.
• Initial problems of the severity of road humps and cushions resolved by improved quality control and the introduction of standard practices (development & use of road cushion template etc)
• Where there are problems on distributor roads 20mph limits can be applied within zones (i.e mass treatment 20mph village)

**Advice to Countries/ Transferability**
• A small sample of results may not always produce significant benefits.
• Listen to individual concerns and introduce design changes where appropriate.
• Engage with Communities & Schools after the completion of works and speed changes not just before.

**References, Additional Information**
1. Road Hump Regulations and Studies (various)
2. A Road Safety Good Practice Guide (1st edition) - DTLR
3. Scotland’s Road Safety Framework to 2020 (‘GO SAFE on Scotland’s Roads it’s EVERYONE’S RESPONSIBILITY)
4. ‘Put the HEART back into our COMMUNITIES’ – leaflet Fife Community Safety Partnership
5. Safer Travel Strategy 2008 to 2011 – Fife Community Safety Partnership

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Fife Cares Child Safety Scheme
Scotland

Background

The Fife Cares Home Safety Scheme is a Fife Community Safety Partnership initiative that was developed between 2002 and 2005 and launched in 2006. It serves as part of the Partnership’s drive to reduce the number of accidents in the home involving children.

The Fife Cares Child Safety Service is an integral part of Fife Community Safety Partnership’s work to improve the safety of vulnerable residents and to deliver the community safety outcome ‘Fewer injuries and losses of life at home and on the roads’. By visiting individuals and families in their own homes, the service addresses specific needs and provides tailored advice and assistance.

The Partnership’s Fife Cares Child Safety Service offers families with children aged five and under a free home risk assessment. Assessments are undertaken by two Home Safety Advisers who visit families in their homes and conduct a room by room check for hazards. As appropriate safety advice and education is supported through the provision, and sometimes installation, of child safety equipment tailored to a family’s individual needs. There is no form filling, no waiting list and all the equipment is fitted free of charge.

Policy Background/Driving Force

A recent report from the Scottish Child Safety Alliance has revealed that every year one in five children in Scotland attend accident and emergency departments as the result of an injury — that is approximately 200,000 visits per year. In addition, death rates from accidents among children in the lowest earning homes in Scotland are three times higher than those living in the wealthiest households.

In the Fife region the Community Safety Partnership is leading work to help reduce the likelihood of children being involved in an accident.

Evidence confirms that accidents are more likely to happen to children within the most deprived areas of Fife. For example in the period 2007/2008 the admission rate for children per 1000 in Fife’s data zones that are included in Scotland’s 15% most deprived areas was 10.65%, compared with 6.37% for other less deprived areas.

The work of Fife Cares is set within an agreed national context, as led by agencies such as Royal Society for the Prevention of Accidents (RoSPA) and SAPC — whereby home injury prevention work is a key policy priority.

The Fife Cares Service in an integral part of the Partnerships work to reduce home accidents and to meet the community safety outcomes within the:

- Community Safety Strategy
- Fife Community Plan
- Single Outcome Agreement between Fife Partnership and The Scottish Government

The work of Fife Cares is supported nationally by ROSPA who oversee the work of Fife Cares via the Safer Homes Task Group. The programme has been

<table>
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<tr>
<th>IMPLEMENTATION LEVEL</th>
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<td>Education, Safety Equipment</td>
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<td>TARGET AUDIENCE</td>
<td>Vulnerable families with at least one child under 5 years of age</td>
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<td>RESOURCE IMPLICATIONS</td>
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<tr>
<td>EVIDENCE BASE:</td>
<td>Home safety counselling can reduce the risk of child injury.</td>
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successfully transferred to several other regions in Scotland since its inception.

**Partners**
- Fife Community Safety Partnership
- Fife Council
- Fife Constabulary
- Fife Fire & Rescue Service
- National Health Service (NHS) Fife
- Voluntary Sectors (CVS Fife)

**Aims & Objectives**
- To educate and raise awareness regarding child home safety and security amongst vulnerable families through home risk assessments
- To ensure access to safety and security equipment, including where necessary installation.

**Evaluation**

Figures from NHS Fife indicate that the number of emergency hospital admissions involving children aged 16 and under following a home accident for the years 2006-2009 was 23% lower than the number for the three years preceding the launch of the programme. Reductions were even greater for children 5 and under, where a 29% reduction was found.

Service benefits are measured using a range of outcome measures, the number of people visited and feedback from clients and partner services. Figures for total visits achieved the Fife Cares Child Safety Service for the 2009/2010 fiscal year indicate that there were 256 child safety visits within the targeted data zones with the highest rates of accidents and 780 child safety visits outside of the targeted data zones.

For the fiscal year 2008/2009 Fife Cares conducted a customer survey and used the feedback collated to examine possible improvements to existing service delivery.

Overall, responses were positive with clients expressing satisfaction with the service, welcoming not only the equipment but also, importantly, the child safety advice. Informal feedback to Fife Cares is also positive, with many referrals being made following recommendations from family and friends.

**Key Steps**

**2002-2005**

- A consultation around the issue of home safety with the existing programmes (Safe and Sound schemes, Home Start and the Fife Council Social Work and Council for Voluntary Services Fife) identified that action was needed to ensure the continuation of the service provided by these valued projects. All partners were fully supportive of a proposed initiative, which would mainstream provision within the Fife Cares Service.

- Specific targeting criteria were developed so that home visits and risk assessments would be offered to people who live in communities experiencing high levels of crime and accidents in the home and the most vulnerable. Criteria include:
  - A child is known to have had an injury within the home
  - The family is on a low income or experiencing financial difficulties
  - Family problems exist - e.g., marital breakdown, domestic violence.
  - Parent or child has special needs (emotional, social or disability)
  - House is overcrowded
  - House is in poor state of repair
  - Parents are unemployed or receiving benefits.
  - Multiple occupancy accommodation

- Other aspects of the new service included:
  - Educating and raise awareness regarding home safety and ensuring access to safety and security equipment.
  - Promoting the service to local staff from local partner agencies not only to increase awareness of the service but to also increase knowledge of safety and security issues and try and get everyone to think with home safety and security in mind.
  - Providing a one-stop shop approach, so that while the initial visit focuses on home safety, if it apparent that the family or individual has other needs that appropriate linkages to other services will be seamlessly made.
2006 - present

- Launch of scheme and promotional efforts regarding the service that target all services across all sectors of Fife region. Fife Cares aims to learn about what other agencies do so they can offer the best advice to clients on any other issues that are highlighted.

- Examination of best way to work, with conclusion that joint working is more effective, more productive and a safer method of working

- Review of the lone working procedure, the child protection procedure and the child protection incident reporting form as they relate to the scheme

- Working with the Safer Homes Task Group Fife Cares works hard to make sure that home safety remains a priority within the community safety and community planning agenda

- Process evaluation and monitoring

Lessons Learned

Barriers

- Home safety is not necessarily viewed as a priority within partner agency service plans. Fife Cares therefore works hard via the Safer Homes Task Group to ensure continued partner support for the service.

- Some of the families visited cannot or will not prioritise the purchase of child safety equipment. In these cases the service installs equipment, while at the same time educating parents or carers and highlighting risks.

- Funding is an ongoing issue. Although the core service is funded, additional funding has to be found each year to ensure that the service can be targeted at the areas where it is most needed.

- The collection of data to measure service performance and impact is also important. To date, this has been limited to hospital admissions and accident and emergency data.

Facilitators

- The service is open to home owners or to families living in either council or privately owned rented properties.

- Ongoing commitment and financial support from partners is crucial. For example, NHS Fife and Fife Council’s Housing Service have maintained their funding for the service at a time when other budgets have been reduced.

- The Safer Homes Task Group is one of five strategic community safety groups in the region. The group oversees the work of Fife Cares and is responsible for delivering the Making Homes Safer and More Secure outcome within Fife’s community safety strategy. This link ensures that changes can be made to policy and working practices as required following feedback from the service.

Advice to Countries/Transferability

- When deciding where to place programme, look for situations where strategic direction and governance structures are a fit and monitoring systems and processes already exist in order to increase chances for sustainability.

- Modify the programme as needed to make it work within local and regional context.

- Start with a smaller pilot to identify what works and what needs improvement before expanding implementation of the programme.

- Implement processes to monitor and evaluate the programme, including customer surveys, in order to establish whether the programme processes are working as planned and whether there is an impact on child injuries.

References, Additional Information

1. Fife Direct (Fife Council website) http://www.fifedirect.org.uk/

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TIP TIPAT BETICHUT - the Injury Prevention Program in Well-Baby Clinics Israel

**Implementation Level**  
Local

**Approach**  
Education, training

**Setting**  
Well-Baby Clinics

**Target Audience**  
Parents of children 0-5 years old during visits at Well-Baby Clinics

**Resource Implications**  
\( \text{€ €} \)

**Evidence Base:**  
There is indirect evidence that individual-level educational/counselling in the clinical setting are effective measures to reduce many childhood unintentional injuries.

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**Background**

TIPP TIPAT BETICHUT, the Injury Prevention Program in Well-Baby Clinics in Israel is a national programme that focuses on training and empowerment of health professionals and public education strategies at the local level.

Nurses at Well-Baby Clinics are trained to review safety messages with parents during the 10 standard visits that are made with the child from infancy through to toddler age. Each visit is designed for the age and developmental stage of the child. Safety messages for each stage are provided in a 2-3 minute presentation that includes a training kit with illustrative pictures as well as safety devices.

The program, which was developed during 1998 and launched in 1999, is based on TIPP (The Injury Prevention Program) designed by the American Academy of Paediatrics.

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**Policy Background/ Driving Force**

Unintentional injuries are a leading cause of mortality and morbidity in children in Israel. Children up to 4 years of age are at greatest risk for death and injuries due to accidents.

Parents lack knowledge and are unaware of the risks of unintentional injuries and methods to prevent injuries. Health professionals play an important role in addressing these knowledge gaps by educating parents.

Parents and their children in Israel visit Well-Baby Clinics on a regular basis until the age of 5 for developmental follow-up. Beterem and the Israeli Ministry of Health developed TIP TIPAT BETICHUT, a programme for the Well-Baby Clinics, with the idea that prevention of unintentional injuries is a basic healthcare issue that should be included in the guidance parents receive at the clinics.

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**Partners**

- Israel Ministry of Health
- Tel Aviv Regional Health Offices
- Well Baby Clinics
- Health Maintenance Organisations (HMO)

**Aims & Objectives**

- Reduce injuries and injury severity among young children in Israel
- Raise awareness among parents that injuries are a central cause of morbidity and mortality and it is possible to prevent them
- Provide parents with knowledge on injury prevention for infants and children
• Bring about a change in parent attitudes regarding child safety
• Promote the use of low budget safety devices in and around the home to create safer environments for infants and children
• Encourage adoption of safe behaviours to prevent injury

Evaluation
1. Pilot evaluation study including a survey of parents' knowledge, attitudes, and behaviour, a survey of nurses' knowledge and focus groups.

Data showed that most parents received child safety training as part of the pilot programme (81.4% of the participants). The proportion of parents able to report changes that they can make in the home surroundings to help prevent accidents at home increased from 81.6% to 91.8%. Most parents indicated that the training accompanied by the coloured kit with illustrative pictures and safety devices helped them understand the safety messages. 88.5% of the parents said they intend to adopt safety habits after exposure to the program.

The results from a focus group with nurses indicated that they found training kit with illustrative pictures and safety devices to be an important aspect of executing the program. Most of the nurses stated that the targeted professional training helped increase their own knowledge and awareness to child safety and this was backed up by results.

The results of the survey of nurses knowledge indicated that the programme had increased nurses' knowledge about child safety. For example, before training only 25.9% of the nurses knew that installing a hot water heater thermostat and limiting the water temperature to no more than 52°C reduces the risk of a scald and only 33.6% knew that a hotdog is one of the most common foods causing choking, compared to 65.5% and 85.2%, respectively, after training.

2. As part of programme evaluation process, Maccabi Healthcare Services performed a survey in its Well-Baby Clinics. Results of the study indicated that nurses' knowledge improved by more than 10% after the program started. In the first year of programme implementation the occurrence of safety training during parents' visits to the clinics increased by 18.3% (p<0.00).

3. In 2005-2006 a parents' knowledge, attitude, and behaviour survey took place in Well-Baby Clinics in several regions in Israel. The results indicate that 64.3% of the parents are exposed to the programme, and 58.5% of them received more than one safety training session (p<0.001). Parents who received the training scored higher in reported safety behaviours than parents who did not receive the training (p<0.001).

Key Steps
• Commitment of the Ministry of Health and Well-Baby Clinics' nurses to the programme including an understanding that it is their responsibility to train parents in child safety as part of basic child development and health education.
• Programme development, including the professionals' training programme and coloured kits with illustrative pictures and safety devices in both Hebrew and Arabic.
• Programme implementation as a pilot along with process evaluation in Tel-Aviv County. Results and recommendations based on the pilot programme, led to the revision of the professionals' training programme and the coloured kit with illustrative pictures and its distribution at a national level, as well as the development of an Arabic language version.
• Implement revised programme broadly across country.

Lessons Learned

Barriers:
• A change in knowledge and safety habits is only an intermediate phase in the injury prevention process and the nurses often complain that they don't see how their work influences the prevention of the injuries. This influences their motivation in carrying out the programme. This concern was addressed by adding an additional unit in to the training that deals specifically with barriers to change. The unit combines theoretical models and practical tools in order to give the nurses the ability...
to deal with parents' barriers as well as their own difficulties.

- The programme requires the cooperation of Health Maintenance Organizations (HMO) to ensure wide adoption of the programme and supervision of its implementation at the Well-Babies Clinics.
- There is a need for a systematic method to insure inclusion of safety education during visits and to continue monitoring the programme, this takes resource and support from high levels of administration.

Facilitators:
- The pre-existence of a Ministry of Health regulation that mandates Well-Baby Clinics to conduct developmental follow-up of children on a regular basis until 5 years of age. The regulation also requires that the programme provide optimal accessibility to parents.
- Government cooperation was a key facilitator to success as their commitment resulted in financial resources as well as the obligation for the nurses to be trained and use the materials in educating parents.

Advice to Countries/ Transferability
1. The TIP TIPAT BETICHUT programme in Israel is based on The Injury Prevention Program (TIPP) of The American Academy of Pediatrics program, which has been proven to be a cost-effective programme in the US.
2. In adopting programmes from elsewhere it is important to take into account the cultural and language compatibility and modify programmes to suit the unique characteristics of the different communities.
3. Working in cooperation with the implementing body and associated professionals (in this case, Well-Baby Clinic nurses) from the very beginning of the process is key to their buy-in and compliance with the programme.
4. Success in implementation in the long-term is dependant on regularly bringing new aspects of the subject to the professionals implementing the programme to keep things fresh or by making it a compulsory standard by the Government Ministry.

References, Additional Information


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