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Priorities for

CHILD SAFETY

in the European Union:



Agenda for Action



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A close-up photograph of a hand holding a single white daisy flower with a dark center. The hand is positioned in the lower right quadrant of the frame. The background is a soft, out-of-focus light gray. The overall mood is contemplative and poignant.

In the European Union more children die of injuries than all other childhood diseases combined.

Let's deal with what is killing our children today.

Who is the Alliance?

The European Child Safety Alliance is an initiative of the European Consumer Safety Association to advance **child injury prevention** throughout Europe.

The Alliance serves as the European catalyst through which national and international networks and activities in child injury prevention are facilitated firstly to enhance advocacy for policy and funding changes and secondly to serve as a communications network to share best practices, successful programming and information needs. To achieve these goals, the Alliance undertakes activities including research studies on child injury issues, publication of reports, and recommendations that ultimately could enhance the quality of children's lives in Europe. The direction for the Alliance is provided by a steering group composed of representatives of the 25 Member States of the European Union (EU) and affiliated organisations; observers also participate from EU applicant and associated countries.

It is our ambition to make life
safer for children in
Europe.

What do we want to achieve?



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This Agenda for Action on “Priorities for Child Safety in the European Union” has been prepared to achieve the following four objectives:

1. To increase the awareness and knowledge of the magnitude of child injuries in the EU and the opportunities to assist in their reduction.
2. To provide an overview of the current structures, standards, and regulations already in place in the EU to deal with child injury, and the present limitations and challenges.
3. To outline the required infrastructure, processes and support needed to manage child injury in the EU effectively and efficiently.
4. To make specific recommendations to the European Parliament, European Commission and Member States to support child injury prevention in the EU.

For the purpose of this report we will be referring to statistics from 1996-2000 for unintentional and intentional child injury deaths for the ages 0 to 14 years, based on WHO mortality codes predominantly in the EU Member States (1996 - 2000 data is the most recent injury data available and currently no age group data for children 0-18 years exists from the World Health Organization). Data is currently unavailable for Cyprus in the WHO database.

Children are our youngest and most vulnerable members of society, and often their voices are left unheard.

Why action for child safety?

The United Nations Convention on the Rights of the Child initiated a new understanding of respect for children and their needs and rights from birth to 18 years. The Convention underlines the social responsibility to protect children, and to provide necessary support and service for them. This should also hold true for the leading cause of death and disability for children, injury.

The Convention states that the child has the right to the highest attainable level of health, and the right to a safe environment.¹ Therefore, we have a duty to ensure children's rights to safety, and in particular for the following reasons:

- Children do not have access to adequate information, and are not capable of understanding all the implications of such information even if they had it, about the products they use and the environments in which they live, play and travel.
- Very often, many of the environments they have to be in, like roads, schools, playgrounds, and even homes, are not by their own choice or their parents'. The socio-economic conditions they live in determine these options to a large extent.
- It is not possible for children or their parents to judge the potential hazards of many of the modern technological products, especially chemicals.


Therefore, it becomes imperative for society to ensure the safety of children as a fundamental human right.

INJURY

Injuries are currently a major cause of death and disability throughout the developed world.

According to the World Health Organization (WHO), almost 6 million people died worldwide from injury in 2002 and this figure is expected to rise to 8.4 million in the year 2020, escalating the seriousness of injuries for all populations. In the European Union, approximately 200,000 deaths are caused by injuries each year and many more non-fatal injuries result in either permanent or temporary disability.

Injury is the leading cause of death for children in Europe and between the ages of 1 and 14 years, an injury death occurs at twice the rate of a death from cancer, or 8 times that of a respiratory-related death.² Injury is the largest environmental burden for children compared to outdoor/indoor contaminants, water, sanitation and hygienic issues, or lead contaminants.³ How many more days and lives will it take until we finally make a joint commitment to change this?



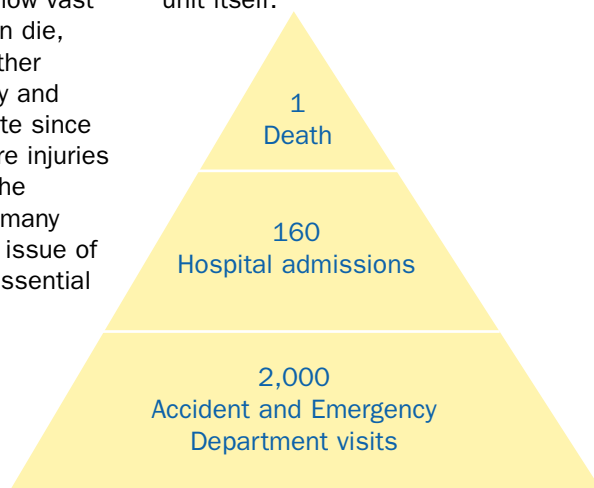
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The **impact** of child injury beyond deaths

It is even more concerning to realise that a death due to injury is only the tip of the iceberg, and when we look deeper into the true size of the problem it multiplies exponentially. Co-ordinated and comparable data within the EU is currently non-existent for hospitalisation and emergency and accident visits, but research in The Netherlands reveals that for every child death that occurs just from a home and leisure injury, another 160 children are admitted to a hospital with a severe traumatic injury, and another 2,000 children are treated at the accident and emergency departments. Furthermore, many more thousands of children visit paediatricians and family physician offices or health clinics to deal with less severe injuries.⁴ If we apply this injury ratio throughout the EU, we have a better appreciation to see how vast the problem really is. Every day 14 children die, 2,240 are admitted to a hospital and another 28,000 receive treatment in an emergency and accident department. This is a low estimate since the ratio is based only on home and leisure injuries and is calculated on child injury rates in The Netherlands, which has less injuries than many other EU-member countries. With a health issue of this magnitude, co-ordinated actions are essential to achieve any level of success.

The burden of child injury death is also multi-level. There are the economic impacts of managing and treating injuries. Calculations to determine total child injury costs in the EU have not been completed yet, but it has been estimated that the overall socio-economic burden of all injuries in Europe is almost 400 billion Euro annually. That is an enormous cost to the European economy each year due to injuries, which is more than 4 times the entire EU budget.⁵

With the death of a child also comes the loss of the youngest in society and those who had the greatest number of years to contribute as healthy, able individuals. Yet most importantly, the tragic death of a young child has devastating effects on their immediate family, often destroying the family unit itself.



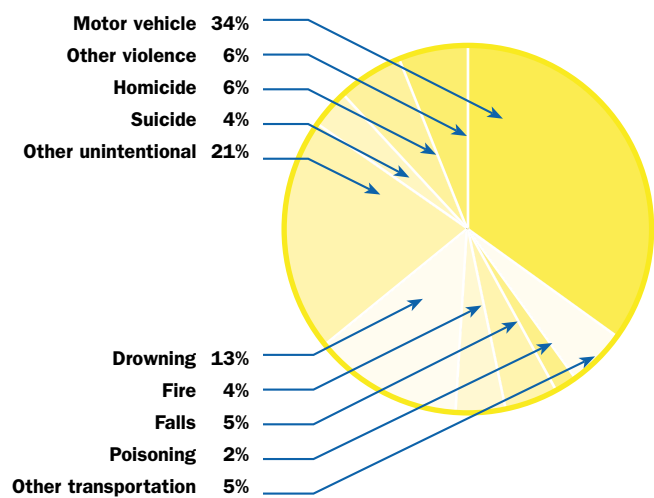
Source: Consumer Safety Institute 2000

The Injury “Pyramid”

The leading causes of injury deaths in the EU are the same in all Member States: road accidents, drowning, homicide, falls, fire and suicide. But it is the distribution of injuries within each category and how these injuries occur that determines the unique profiles of each EU Member State.

Leading causes of injury deaths for children (0-14 years) in the EU

Source: WHO World Health Statistics Annual 1996-2000



What is **killing** our children?

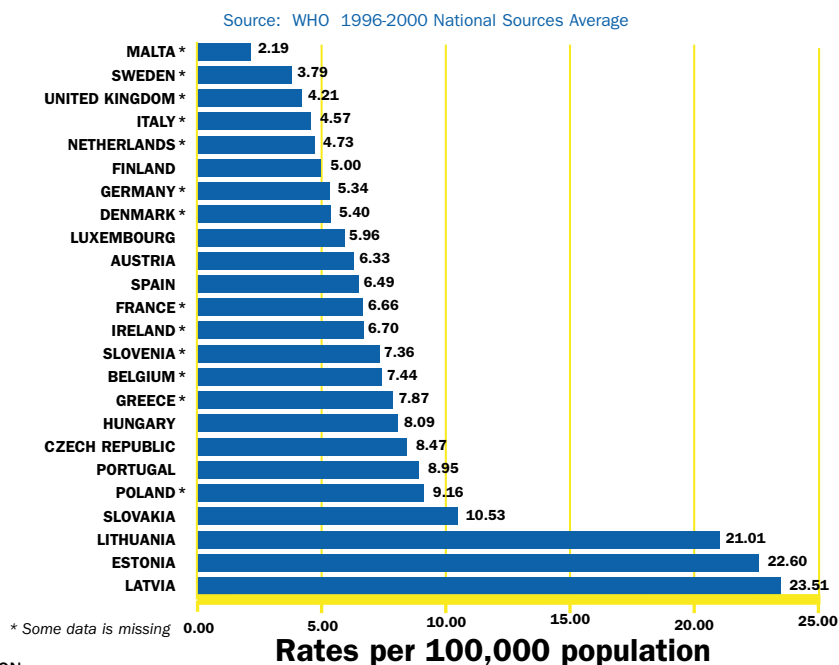
Child injury across Europe; how do we compare?

In the expanded EU of 25 Member States there is great variability between the best performing countries compared to the injury rates that are 10 times higher in the countries at the bottom of the scale.

The newest EU-members in general display higher child injury rates with the exception of Malta and Slovenia. Overall child injury death rates have been reduced over the past 20 years, but not at the same speed in many countries and certainly not as rapidly as we have seen in the past with the eradication of many childhood diseases.⁶

If the EU is committed to reducing disparities in living standards between its members, serious commitments will need to be made to ensure child injury deaths will be reduced in the immediate future throughout Europe. For most countries road accidents are the leading cause of injury deaths, yet in some countries in Central and Eastern Europe drowning is the number one cause of child injury deaths. The third leading cause for countries varies between homicide, falls and fires.

Injury deaths for children (0-14 years) in the EU



Leading causes of child injury deaths (0-14 years) in each country

Source: WHO 1996-2000 National Sources Average

	Motor vehicle	Other unintentional	Drowning	Homicide	Other violence	Falls	Suicide	Fire	Other transportation	Poisoning	
AUSTRIA	27%	20%	14%	10%	10%	6%	4%	4%	3%	1%	(1996-2000)
BELGIUM	34%	15%	11%	8%	8%	5%	3%	9%	2%	4%	(1996)
CZECH REPUBLIC	17%	24%	15%	4%	6%	5%	4%	2%	19%	3%	(1996-2000)
DENMARK	52%	15%	7%	7%	1%	3%	3%	3%	6%	2%	(1996-1998)
ESTONIA	22%	25%	26%	5%	1%	4%	5%	10%	1%	2%	(1996-2000)
FINLAND	28%	13%	22%	10%	1%	3%	6%	4%	12%	0%	(1996-2000)
FRANCE	37%	25%	9%	6%	10%	4%	3%	4%	1%	1%	(1996-1999)
GERMANY	34%	17%	13%	9%	4%	5%	5%	6%	6%	1%	(1996-1999)
GREECE	51%	28%	9%	3%	0%	3%	1%	2%	1%	2%	(1996-1999)
HUNGARY	26%	22%	17%	11%	2%	4%	4%	4%	7%	3%	(1996-2000)
IRELAND	47%	16%	9%	2%	0%	4%	5%	9%	4%	3%	(1996-1999)
ITALY	47%	24%	8%	3%	2%	7%	3%	1%	3%	2%	(1996-1999)
LATVIA	20%	17%	32%	7%	4%	2%	3%	9%	2%	4%	(1996-2000)
LITHUANIA	23%	20%	28%	6%	3%	3%	3%	5%	3%	6%	(1996-2000)
LUXEMBOURG	50%	23%	4%	0%	8%	8%	8%	0%	0%	0%	(1996-2000)
MALTA	43%	29%	14%	14%	0%	0%	0%	0%	0%	0%	(1996-1999)
NETHERLANDS	36%	15%	19%	10%	1%	5%	6%	3%	5%	0%	(1996-1999)
POLAND	37%	17%	17%	4%	5%	4%	6%	2%	5%	3%	(1996-2000)
PORTUGAL	39%	17%	3%	3%	28%	4%	1%	4%	1%	1%	(1996, 1999, 2000)
SLOVAKIA	1%	32%	2%	3%	6%	2%	4%	0%	49%	1%	(1996-2000)
SLOVENIA	16%	9%	31%	3%	0%	21%	6%	7%	3%	4%	(1996-1999)
SPAIN	48%	21%	13%	2%	0%	6%	2%	3%	2%	2%	(1996-2000)
SWEDEN	37%	18%	13%	6%	3%	2%	5%	8%	6%	0%	(1996-1999)
UNITED KINGDOM	33%	21%	7%	9%	11%	4%	1%	9%	3%	2%	(1996-1999)

How do we compare?

Timely, comprehensive and co-ordinated data at a national and European level is essential to access the injury picture in each country and measure future progress.

Great variability lies within the 25 Member States' injury collection systems and the availability and accuracy of data is dependent on each country's commitment to good monitoring. Co-ordinated reporting of data to the WHO is an outdated 4 years old or more. It is difficult to access the current state of affairs or convince politicians for needed action with information that is so outdated. Could you manage your bank account with a statement that was 4 years old?

An all injuries database, representative nationally and standardised throughout the EU for deaths, hospitalisations and physician visits is needed. An all injury classification already exists, but funding has not been provided for it to operate at the EU level or in all Member States.

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Preventable and profitable

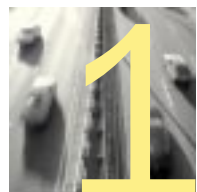
Not only is injury preventable, but safety measures can provide a “Return On Investment” (ROI). Proven injury prevention strategies have been shown to be a good investment not just for the benefit of health and protection, but also from a financial gain. Injury prevention makes good business sense!⁷

€ 1 spent on smoke alarms	saves € 69
€ 1 spent on bicycle helmets	saves € 29
€ 1 spent on child safety seats	saves € 32
€ 1 spent on road safety improvements	saves € 3
€ 1 spent on prevention counselling by paediatricians	saves € 10
€ 1 spent on poison control services	saves € 7

Source: CDC, 2000

Yet injury is a major health problem that is preventable

There are prevention strategies that have been successful in injury prevention and reduction of deaths and hospitalisations. The most effective strategies tend to be those that involve a combined approach of public health policies supported by well-designed products and environments that are widely communicated to the public through a variety of educational methods.



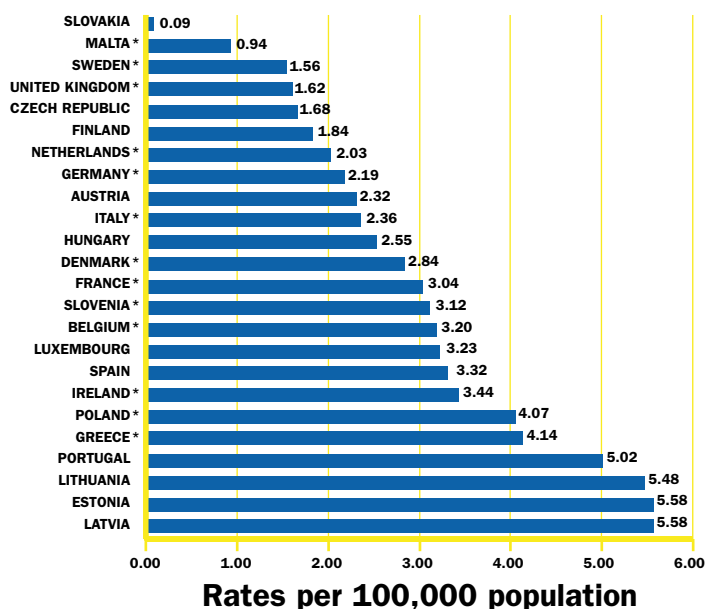
Road Accidents

In the EU as a whole, 34% of child injury deaths are due to a road accident. Road accidents include child injury deaths to pedestrians, cyclists and motor vehicle passengers and the distribution of these injuries varies greatly by country.² Overall there is almost 10 times greater risk of a road death in Lithuania, Estonia and Latvia than the best performing countries. As road accidents are the largest cause of child injury deaths for most Member States, it is clear that those who can successfully manage the road area will achieve great gains in reducing their overall child injury and death rates.

A great deal of intervention and prevention work has been done in the area of road accidents in a variety of countries around the world. It is always difficult to simply transfer an injury prevention strategy from one geographic location to another without culturally adapting it while still assuring its effectiveness. Yet there is evidence that more lives could be saved on roads throughout Europe if the following strategies were implemented, taught to the public and enforced:

Road accident deaths for children (0 - 14 years) in the EU

Source: WHO 1996-2000 National Sources Average



- **Reduced speed limits** - in the UK, introduction of 20 mph speed limit zones resulted in local reductions of 48% in child road accidents involving cyclists and a reduction of 70% in fatal child road accidents involving pedestrians;⁸
- **Traffic calming** - has shown accident savings of 60% in 30 km/hr zones;⁹
- **Safer car fronts for pedestrians and cyclists** - estimates up to 2,100 deaths and 18,000 serious pedestrian and cyclist casualties of all ages could be prevented annually in the EU;⁹
- **Child passenger restraints** - when used properly have shown to have an injury reducing factor of 90-95% for rear-facing systems and 60% with forward facing systems.⁹
- **Stay rearward facing longer** - children transported rearward in child passenger restraints up to the age of 3 have shown almost 5 times greater protection than those in forward facing restraints;¹⁰
- **Bicycle helmets** - correctly fitted, bicycle helmets reduce the risk of head and brain injury by 63 to 88%;¹¹
- **Education campaigns** - targeted communication messages for use of child passenger restraints and bicycle helmets have shown positive behaviour change.¹²



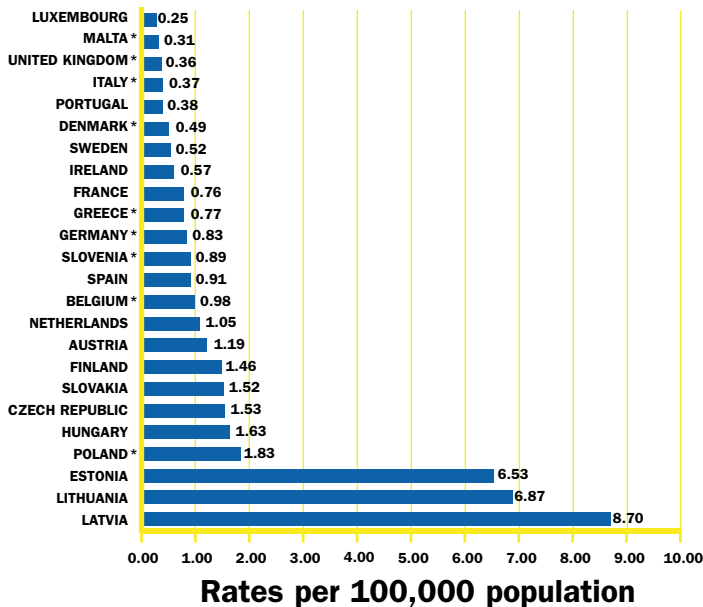
Drowning

Drowning is the second leading cause of death for children of the EU. More than 70% of the victims are boys and the most vulnerable are children aged 1 to 4.² A drowning incident takes many people by surprise, as it happens silently within seconds, in as little as 2 cm of water. In The Netherlands, it has been estimated that for each childhood drowning fatality, about 140 children are hospitalised and another 20 are seen in the emergency department and released.¹³

However, among those sustaining immersion and losing consciousness, the mortality rate is as high as 50%. Prompt resuscitation following immersion is critical to survival. The likelihood that a child will survive a drowning is largely determined by events occurring in the first 10 minutes. Consciousness is lost after approximately 2 minutes; irreversible brain damage occurs after 4 to 6 minutes. The outcome for most children with immersion is determined by their status on arrival to the emergency department; medical and ICU care appear to have relatively little impact on outcome.¹⁴ Therefore, prevention is key to reducing hospitalisations and deaths from drowning. Thus in 2003 the Alliance launched an European water safety drowning prevention campaign in 18 countries.

Drowning deaths for children (0-14 years) in the EU

Source: WHO 1996-2000 National Sources Average



* Some data is missing

The drowning event varies by age and geographical regions throughout Europe, but the common locations include bathtubs, pools, ponds, streams, lakes, rivers, and the sea. Drowning prevention is an area where more work is needed. While many studies have been done on the incidence and epidemiology of drowning, few studies have evaluated intervention programs for their effectiveness. A few strategies have been proven to be effective. Prevention measures that show promise include:

- **Swimming pool fencing** - private pools that are fenced provide 95% more protection against a drowning event.¹⁴
- **Personal floatation devices, detection systems, swimming lessons, parental supervision and lifeguards** - these prevention strategies still require more research to determine their true level of effectiveness.



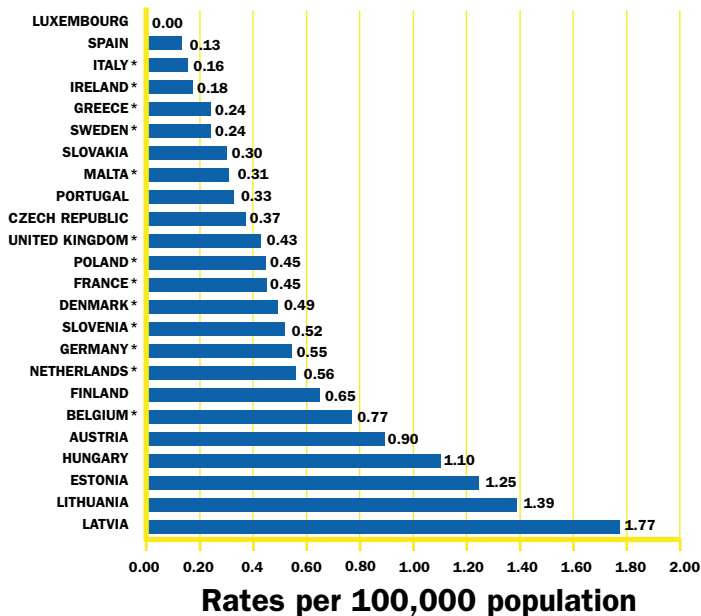
Homicide

Homicide is the 3rd leading cause of injury death for children 0 to 14 years of age throughout the EU. The WHO defines homicide as fatal injuries inflicted by another person with intent to injure or kill, by any means. Homicide rates may be attributed to many factors, including socio-economic inequalities, availability of lethal weapons and cultural beliefs and attitudes.² The prevalence of homicide exposure of children is relatively unexplored in European communities, but two common profiles of child homicides emerge. The first is one of the parents shooting all of the children and committing suicide afterwards.

The second is defined as a 'fatal child abuse' and involves very young children whose cause of death is the result of a cranio-cerebral trauma from battering or shaken baby syndrome. Regarding newborn homicides, when the identity of the mother is known, she is identified as the perpetrator. With non-new born homicides, the majority of victims are killed at home and knew the offender.¹⁵ Parental socio-economic status is the single most important parental determinant for child homicide.¹⁶ The number of child violence related deaths in the European Union is unacceptably high. Co-ordinated prevention and control efforts are urgently needed. Best practice and strategies that show promise of reducing homicides worldwide that should be implemented throughout Member States include:

Homicide deaths for children (0-14 years) in the EU

Source: WHO 1996-2000 National Sources Average



* Some data is missing

- **Implementing surveillance systems** to monitor the incidence and prevalence of violence related events.
- **Establishing an international network** to share information and resources on prevention research and programs.
- **Developing a global agenda** to identify and prioritise research needs.
- **Conducting national research** to better understand risk protective factors for violence.
- **Implementing interventions and policies** that reduce the risk of exposure to violence and promote non-violence.¹⁷

4 Falls

Falls are the fourth leading cause of child injury deaths in the EU.² Yet in European countries where hospitalisation and emergency department data is available, we see that falls for children are the leading cause of admissions and emergency visits. The most common type of fall leading to hospitalisation is from one level to another, such as from change tables, stairs, chairs, beds/bunkbeds, windows, balconies and playground equipment.

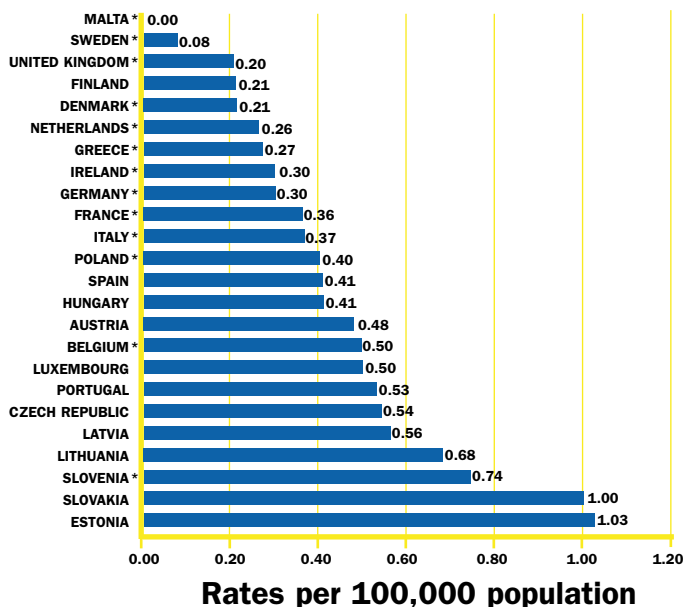
Baby walkers are also common causes of injuries in young children, due to extra mobility and speed, in which children in walkers fall down stairs, or suffer burns due to pulling hot foods or liquids from stoves and counters on themselves. Efforts have been made to redesign walkers, but all attempts to date still leave a product on the market that is very dangerous to children. Elimination of baby walkers is being promoted as the safest strategy at present.¹⁴

Falls resulting in severe or fatal injuries are usually due to falls from second storey or higher windows, balconies and stairs.¹²

While much is known about fall injuries, few strategies have been examined to prevent these injuries from occurring for children. As the leading cause of children's hospitalisations, more efforts should be made throughout Europe to adopt common sense practices, such as changing diapers on a floor mat and the following proven measures to reduce fall injuries:

Deaths due to falls for children (0-14 years) in the EU

Source: WHO 1996-2000 National Sources Average



* Some data is missing

- **Stair gates** - have been shown to assist in the reduction of falls down stairs to young children when used at the top of stairs.¹²
- **Playground interventions** - ensuring absorbing surface material and appropriate height of play equipment for various ages provides an improvement in serious fall injuries.¹²
- **Window bars** - have shown a 35% decrease in deaths from window falls and a 31% decrease in reported falls.¹⁴
- **Strengthening of motor skills** to prevent falls is a strategy that has promise for fall prevention, but requires more research.



Burns and Scalds

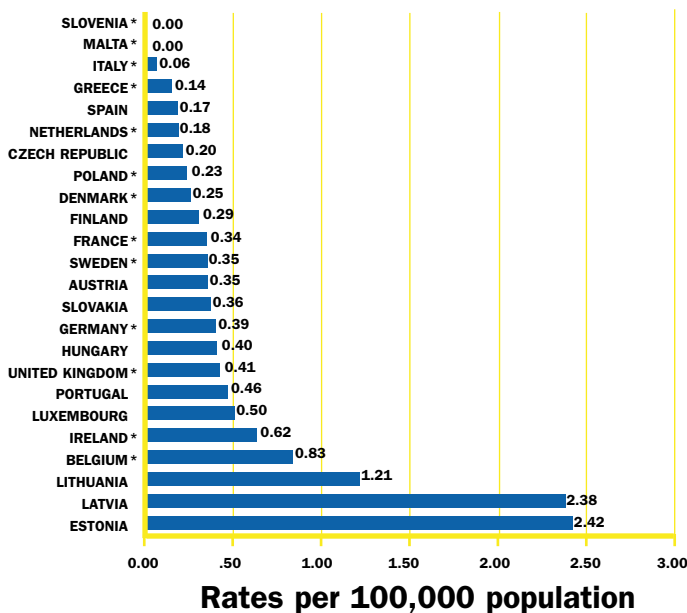
Burns and scalds share the fifth leading cause of death in the EU for children with suicide. Severe burn injuries require multiple hospitalisations and lengthy treatment and may result in permanent disability and disfigurement. More than 55% of burn injuries occur to boys, with scalds and contact burns occurring predominantly to toddlers under the age of 2 years.² The major cause of burn deaths is house fires. Though hundreds more children suffer burns and scalds injuries due to spilling of hot liquids and tap water, touching hot appliances, and misuse of matches and cigarette lighters.

In the UK for example, more than 5000 fires are caused annually by children under 10 years old. In Europe, it is estimated that annual fatal fires for children from cigarette lighters alone cost the tax-payers of Europe 95 million Euro each year.⁵ Hospitalisations due to burns and their life long scars are even more costly and remain forever devastating.

Technology has shown to be successful in the design of a number of products that assist tremendously in the reduction of burn deaths and injuries, but as in many injury issues, we need to ensure their proper and continued use. Burns and scald injuries could be reduced in Europe if the following prevention measures were implemented, promoted and enforced with the public:

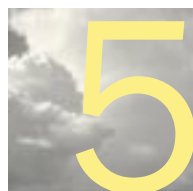
Burn deaths through fires for children (0-14 years) in the EU

Source: WHO 1996-2000 National Sources Average



* Some data is missing

- **Smoke detectors** - effective, reliable and inexpensive early warning devices that have assisted in reducing residential fires by 71% when batteries are operational.¹⁴
- **Water temperature regulation** - legislation requiring a safe pre-set temperature (54°C) for all water heaters has proven to be a more effective method of reducing scalds burns than education to encourage parents to turn down water heaters.¹⁴
- **Child resistant cigarette lighters** - fire deaths associated with cigarette lighters dropped 43% with the adoption of child resistant designs and annual savings of \$125 million were made by United States taxpayers.¹⁴
- **Flame retardant fabrics** - a 75% reduction in burn unit admissions due to sleepwear was realised following the passage of the Flammable Fabrics Act of 1972 in the United States.¹⁴



Suicide

Suicide shares the 5th place as a leading cause of injury deaths for children with burns and scalds in the European Union. Suicide is defined as death from injury where there is evidence that the injury was self-inflicted and that the individual intended to kill himself or herself.²⁰

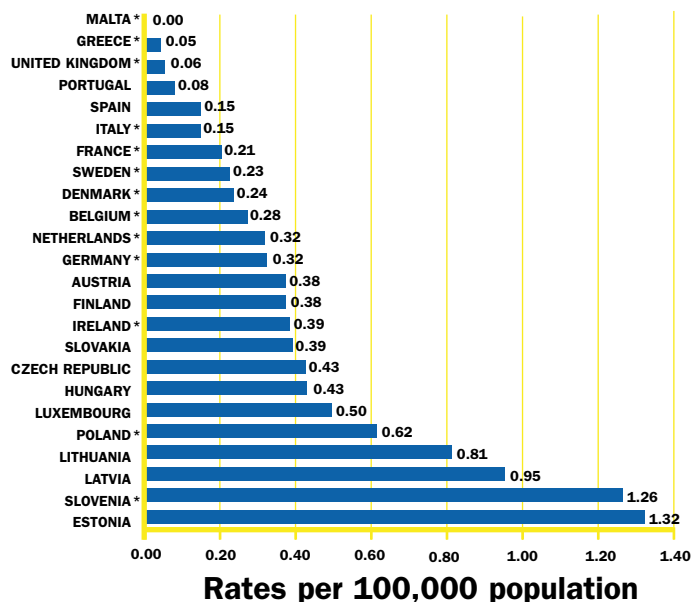
Females are most likely to attempt suicide, but males are much more likely to succeed in their suicide attempt. A child or youth attempting suicide is often so distressed that they are unable to see that they have other options and better choices they could make.²¹

Their emotional pain can be linked to conflicts with family, school, or interpersonal relationships, sexual and emotional abuse and stress.²² Research suggests that exposure to suicide or suicidal behaviour of relatives and friends appears to be a significant factor influencing a vulnerable young person to suicide.²³ Young people use suicide methods like hanging, being run over by a train or jump from a height, in addition to self poisoning and gassing by domestic supplies or car fumes.^{21,22}

Over 90% of countries have no mental health policy that includes children and adolescents.²⁴ The WHO has made the following recommendations for countries to implement to reduce mental health issues like suicide:

Suicide deaths for children (0-14 years) in the EU

Source: WHO 1996-2000 National Sources Average



* Some data is missing

- Provide treatment in primary care.
- Make the best drugs to treat conditions available.
- Give community care, it has a better outcome than institutional treatment.
- Public health and awareness campaigns should be launched in all countries.
- Communities, families and consumers should be included in the development and decision making of policies, programmes and services.
- Establish national policies, programmes and legislation to support mental health.
- Provide training to increase and support mental health workers.
- Sectors other than health, such as education, labour, welfare, and law and nongovernmental organisations, should be involved in improving the mental health of communities.
- Monitor the mental health of communities by including mental health indicators in health information and reporting systems.



Poisoning

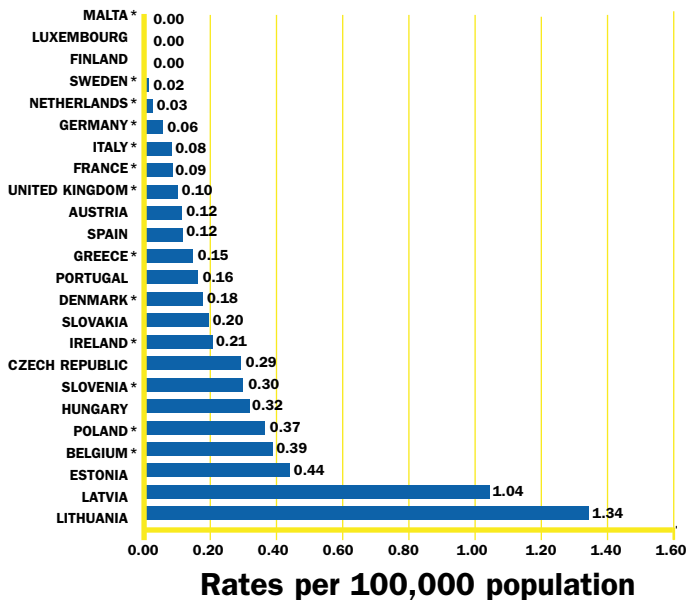
Poisoning is the sixth ranked cause of injury death for young children in Europe. The youngest children are naturally at greatest risk. Children 5 years and under account for the majority of all poison exposures; children 9 months to 2 years and under are especially vulnerable.² Curiosity and the desire to put everything in their mouths place children at considerably greater risk for poison exposure than adults. More than 90% of all poisonings occur in homes, or within the home environment.

Many common household products can poison children, including cleaning supplies, alcohol, pesticides, medicines, and cosmetics.¹⁸ When exposed to poison, children are more likely to suffer serious consequences because they are smaller, have faster metabolic rates and their bodies are less capable of neutralising toxic chemicals.

There is increasing evidence that the following prevention measures to reduce poisonings to children should be implemented, enforced and communicated to the European public:

Poisoning deaths for children (0-14 years) in the EU

Source: WHO 1996-2000 National Sources Average



* Some data is missing

- **Child resistant packaging** - introduction of regulations enforcing the compulsory use of child resistant packaging for all children's aspirin and paracetamol preparations led to a dramatic fall in the number of children admitted to hospital with unintentional poisoning as a result of these medications in England, The Netherlands and the United States. This type of packaging would also be beneficial for specific non-pharmaceutical products.¹⁹
- **Safe storage** - control of household cleaners and chemicals has been an effective means of preventing poisoning.¹⁴
- **Education** - educational strategies aimed at children and parents have been associated with increased knowledge of poisons and poison prevention.¹⁴



Choking, Suffocation and Strangulation

Airway and breathing-related injuries occur less frequently than other injury causes, but often are fatal injuries. Choking occurs most commonly on small attractive products, including balloons, coins, small toy parts, round and cylinder food pieces and inedibles in food products. Studies in Greece, Germany and Israel all confirm that food products containing inedibles are inherently unsafe and that labelling is not an adequate protection. It is estimated that 2,000 injuries occur annually in the EU due to inedibles in food products alone.²⁵ It has been identified that four main product characteristics should be considered when evaluating these products for safety, including: size (usually in diameter), compressibility, flexibility and configuration. Suffocation is often defined as death due to oxygen deprivation from external causes like plastic bags, entrapment in sealed containers and spaces, or fallen earth/snow. Strangulation is death due to lack of oxygen from pressure on the trachea from items like clothing drawstrings, crib bars, window blinds and drapery cords.¹⁴

Product modification and legislation have shown to be successful in reducing fatal deaths from choking, suffocation and strangulation, yet specific research needs to be done to determine the level of effectiveness for this prevention measures. Several legislative measures that should be implemented, enforced and communicated to the public include:

- **Warning labels** - labels placed on products that explain the hazard, not just a label stating “for children ages 3 years and up” have provided greater knowledge for parents.¹⁴
- **Entrapment** - lowering the minimum force that is required to open a lid or door to a sealed container allows children to escape trapped locations.¹⁴
- **Product bans** - prepare regulations that remove latex balloons, inedibles in food products and drawstrings on clothing. All these strategies have reduced deaths in countries that introduced bans on these items.¹²
- **Product modification** - regulations on slat spacing for crib designs, balconies, and outdoor fencing have been effective to reduce strangulation. But old crib models not modified need to be removed from homes and not passed to other families, especially immigrants and poorer families purchasing used cribs.¹⁴

Trends affecting child injury

Europe, like other continents, has undergone **significant changes** in the past few decades.

Child injury rates have been slowly improving over the past 2 decades, but it is still a long road ahead to control the leading killer of children in Europe. We must recognise that our behaviour is influenced by a variety of factors and that it cannot be isolated from the given social, cultural and environmental, context of the country we live in and its place in Europe.

With the recent and continuing expansion of Europe, the challenge to deal with the larger range of inequities between countries and the injuries that come with that will be a growing concern. Proven best practices can be shared, but the development of data systems, trained staff and policy implementation for these strategies will take years before success will be seen.

We are also experiencing a globalisation of product availability, not just throughout Europe, but in the industrialised world, emphasising the need for consistency in the safety performance of products.

Europe and the entire world has become a smaller place as technology has made the opportunity for mobility so much more accessible for many. With travel and exposure to new environments there is an increased risk of injuries. This applies to the great number of migrants that came to the EU community in the past three decades and are now permanent residents. There will also now be new migration that will occur as more European borders open with the expanded EU, as well as for tourists travelling abroad. We have also seen a growth in urbanisation in Europe where some cities are becoming larger to accommodate the growing work force. That workforce includes more women than in earlier years, leaving them less dedicated time to supervise their children directly.

The traditional family unit and extended families are also rapidly changing with the increase of divorce over the past two decades, leaving very high numbers of single parent families to raise children often in less well off conditions. All these changes have an effect on child injury and prevention and must be taken into consideration when determining prevention strategies.

Low income and childhood injury

There is a strong association between low income and poor health across higher income countries. This may partially explain the association between poor health and ethnicity. Not only is the standard of living important, but also how income is distributed in society. Some of the greatest social gradients occur for child injury deaths in some countries, but the evidence that the poorest in society are at far greater risk is not consistent for all types of injury or in all countries.²⁶

Poverty can affect injury in a number of ways. Economic poverty can increase the risks to children. In the road environment, poorer children are more likely to live in areas with a high traffic density, to live in homes which open directly onto the street, where there are less safe areas to play, and are more likely to travel on foot or by bicycle than by car. Where children are transported by cars, more affluent families can provide newer cars that incorporate more safety features, such as side impact protection bars. In the home environment, more affluent families are able to install a range of safety devices such as smoke detectors, safety gates and fireguards. People living in poorer housing conditions may increase their risk of fire with older furniture, heating equipment, and electrical appliances. Social factors may influence the parents' abilities to supervise children: such factors include single parent families, parent maturity, awareness and experience, depression and family illness, large family size.²⁷

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Studies have shown higher risks of injury for children from poorer families:²⁸

- In England and Wales, children of parents from unskilled manual jobs were three to four times more likely to die of an injury than children whose parents were skilled non-manual workers.
- In England and Wales, the risk of children dying from fire was 16 times greater for the lowest occupational group compared to the highest, and for pedestrian injuries the risk was five times higher.
- In Germany, poorer families were twice as likely to be involved in traffic accidents.

There have been relatively few injury prevention initiatives that have been designed to meet the needs of the most deprived communities. Some possible strategies include:

- Provision of free or low cost safety equipment.
- Installation of equipment by professionals.
- Specific advice, relevant to the needs of the target groups.
- Provision of materials which take low literacy levels into account.

- Less reliance on written media.
- Provision of free crèche facilities/provision of transport etc. for families attending safety training.
- Use of home visits to provide support and advice.
- Recruit and train lay workers from the same community as the target group.
- Target specific groups or injuries, e.g. window guards provided for tenants of high rise flats to prevent window fall injuries.
- Modify programmes for specific groups, e.g. equipment loan schemes with free equipment for those in receipt of state benefits.

Prevention strategies to assist in the reduction of injuries within poorer families need to be enhanced throughout Europe. They should determine best practices that will benefit this population.¹² Injury risks for children from different ethnic groups should also be investigated, as research is indicating higher injury rates in this group in some countries.²⁹

Economic poverty can increase the risks to children.

Parents' (lack of) concern

The European Commission 2003 Eurobarometer survey included questions to European consumers and parents in the 15 Member States at the time, regarding their attitudes and behaviours towards personal safety.³⁰

Attitudes

Overall, Europeans agree fairly strongly on a range of statements concerning children's safety and product manufacturing. They agree that manufacturers should bear the responsibility for the safety of their products and that they should take children's safety into account when designing play areas, child related products and other products. Europeans agree that the EU should enforce standards and regulations to help reduce accidental injury. Still well above "tend to agree" are the statements that most accidental injuries concerning children can be avoided and that many products designed for child safety have unclear or complicated instructions. There was little variation from Member States or socio-demographic groups on these statements.

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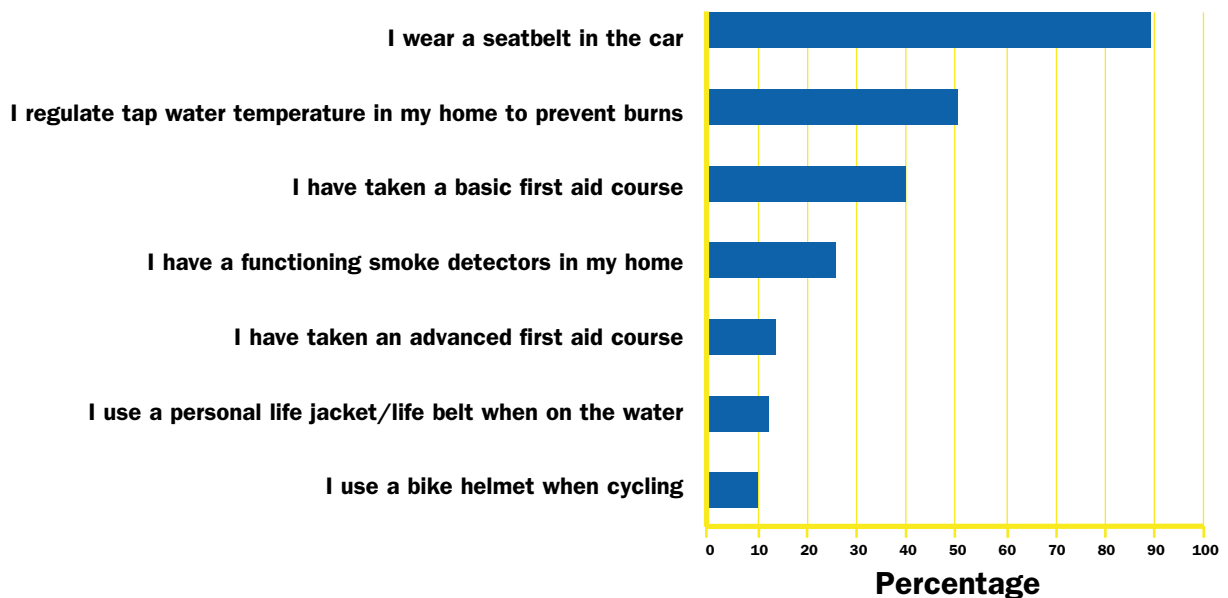
Behaviours

In terms of measures taken to protect personal safety, the wearing of a seatbelt is the measure most often taken, with nearly 90% Europeans saying that they do so. Just about half of all Europeans say that they regulate the temperature of tap water in their homes to prevent burns, while just fewer than 40% have taken a basic first aid course. Fewer than 10% of Europeans use a bicycle helmet when cycling. Overall parents and caregivers of children under 10 years in Europe most commonly help children cross the road (85%), put medicines and poisons out of reach (81%) and keep an eye on children while cooking (78%).

The attitudes of European consumers and parents indicate they are concerned about safety, but when it comes to taking action and using safety measures many people just do not bother. In Italy and Greece more than 20% of the public does not use a seat belt, throughout Europe more than 75% do not use a smoke detector and there is 90% non usage of bicycle helmets. Simple, proven, cost effective measures are not adopted. Concerted action and commitment is needed from Member States, the European Commission and public health authorities to educate, regulate and enforce measures to reduce injuries.

European's Personal Safety Measures, 2003

Source: European Commission Eurobarometer 2003 Survey



Government departments' views

The ECOSA research conducted in 2001 among EU Member States' government departments revealed weak commitment and a basic lack of consistency in approach to child safety. In most countries, a variety of government departments are managing some component of child safety, and officials are often unsure where the prime responsibility for child safety lies.

Overall, government interviews made it evident that a more cohesive and integrated approach to child safety is required with a lead ministry for child safety nationally. Greater communication is needed, both within countries and across Europe. In fact, it is clear that before there can be an integrated approach to child safety across the EU, there needs to be one within each individual Member State.

Very few government staff are employed to address child safety issues and no dedicated budget exists for child injury and prevention.

National child safety action plans

As of 2004, 18 Member States have agreed to participate with the European Child Safety Alliance with support of the European Commission to develop national child safety action plans. Standard assessments will be made in each country to determine the level of child safety and then each Member State will prepare a plan of action to address its national issues using proven best practices for child safety. By 2006 national plans with targets and benchmarks to address the leading cause of death for children will be in place.

This action provides a direct output for the declaration and action plan approved by the WHO co-ordinated Ministers of Health and Environment Conference in Budapest, June 2004 by 52 countries in Europe, in which child injury is addressed as the greatest burden to children's environmental health.³¹ It is hoped that this commitment to injury reduction by national governments will lead to implementation of policies, education campaigns and engineering designs to increase safety for children and their families throughout Europe.

National legislation and enforcement: a snapshot

Legislation of proven injury prevention measures and their enforcement is one of the most effective ways to create a safer environment.¹² In Europe, policies and laws occur at various levels including municipal, national and EU-wide. There are differences that exist in countries throughout Europe, not only in child injury rates, but also as to how individuals and communities decide to control injuries.

Large variation has been identified in prevention measures enforced in a number of countries that have been proven to assist with reduction of childhood injury deaths and serious injuries in the EU. Whilst no EU member has adopted all ten prevention policy measures that were conducted in recent research,³² Sweden, Spain and the Czech Republic do show commitment to using policy to influence the reduction of child injury by having adopted most of the identified measures. Many other countries have adopted 5 or 6 measures. The most common measures adopted are related to motor vehicles (including: child safety seats/restraints, seat belt wearing, and reduced speed limits and restriction of fireworks sales). The lowest adopted prevention measures include bicycle helmets for children and smoke detectors in private residences. Even though Germany and the UK introduced child resistant packaging for pharmaceuticals more than 25 years ago, only another 8 countries use this proven safety measure. Even in those cases where European directives exist, it is reported through other studies that there is great variation in how EU Member States enact these directives in their domestic law.

The level of enforcement for these measures is difficult to assess, but it is reported that stronger enforcement appears to occur for the areas of urban speed limits, seat belts, fireworks and child resistant packaging all, which have fines, associated with them. Many countries within the EU lack even a basic structure for enforcing regulations and standards for consumer products such as child care articles. Co-ordination at national and European levels is most deficient. In order to get a complete picture of how national legislation and enforcement is affecting injury reduction, more research is needed.

Effective measures in reducing childhood deaths and serious injuries in Europe

Source: updated from Towner and Towner, 2004

	Bicycle helmets for children	Child safety seats/restraints in cars	Seat belt wearing by children	Speed limits-roads in urban areas	Child resistant packaging: pharmaceuticals	Smoke detectors in home	Barrier fencing: domestic swimming pools	Children banned from riding/driving farm tractors	Adoption of playground standards	No sale of fireworks to children
AUSTRIA		1994	1994	1994	1996		✓	1995	1974	
BELGIUM		1996	1975	✓	1998			2001	2000	
CZECH REPUBLIC	2000	2000	2000	✓	1999		2000	1999	2000	
DENMARK		✓	✓	✓	✓		✓		✓	
ESTONIA		2003	2003	2003			2003		2004	
FRANCE		1992	✓	1972		2003		1994		
GERMANY		1992	1993	1952	1976		✓		✓	
GREECE		1999	1977	1962			✓	✓	✓	
HUNGARY		2000	2000	✓						
ICELAND	1999	1990	1981	1988		1993	✓	1998	✓	
IRELAND		✓	1993	✓		1994	✓			
ITALY		1988	1989	✓	1984			1996	✓	
LUXEMBOURG		✓	2000	✓			✓	✓		
NETHERLANDS		✓	1992	✓	1986	2003*	✓	1997	1995	
NORWAY		✓	1979	✓		1990	1997	✓	1996	
POLAND		1997	1997	1997		2002		1997		✓
PORTUGAL		1995	1994	✓	✓		✓	1998	✓	
SPAIN	1999	1992	1974	1990			✓	✓	✓	
SWEDEN		1988	1988	1936	✓		1973	✓		
SWITZERLAND		1981	1981	1959			1976		1988	
UNITED KINGDOM		1989	1989	1934	1994	1999		1998	1998	1997

* New homes only

✓ Indicates legislation enacted but year not known

YEAR Indicates date legislation enacted if known

Blank No legislation measure enacted

What is needed for Europe-wide regulations and standards

Regulation is the single most effective means of intervention. Within the EU, in pursuit of the establishment of the Single Market in goods and services between Member States, many existing regulations have been harmonised at some level of common safety denominator. Member States may initiate further safety measures, but always have to justify why they need to exceed the safety levels as laid down in European law since these measures could affect trade with other Member States and therefore may present technical barriers, i.e. import barriers to interstate trade.

However, the Treaty of Maastricht has extended the European Commission's authority significantly with respect to the protection of health and safety of European citizens. It empowers the Commission to initiate regulatory actions in order to ensure the safety of products and services in Member States. The Commission must also ensure consumer protection is of greater importance than protection of the free market. The revised General Product Safety Directive rightfully reflects a stronger role for the European Commission, but it still is to be seen whether Member States give room for such a steering role for the Commission to be developed. A further challenge is to expand European regulations towards services such as housing, day care, education, holiday accommodation and sports facilities. These are areas that are also most relevant for child safety.

Standards play a key role in regulating safety in the EU today because they provide technical specifications for existing framework legislation; compliance with standards also gives manufacturers a legal presumption of conformity with European regulations. Standards also have the unique potential to draw on technical expertise for design and manufacturing, to implement solutions through legislation, and to educate through provisions for instructions, warnings, illustrations, and symbols.³³

Currently, EU standards and legislation related to child safety are still incomplete and the following actions need to be taken if we want to achieve real reductions in child injury in Europe.³⁴

What is needed ...

- That a reform of the standardisation system is initiated, as it is very much dominated by industry at the moment. There is a need to strengthen the participation and influence of consumer representatives.
- That standardisation is not the only option to establish detailed requirements for products. They could be also established by the Commission and the Member States after stakeholder consultation.
- That current regulations and standards are controlled and enforced to ensure compliance. Some European regulations and standards addressing child safety (e.g. child resistant packaging) are not implemented properly or are not providing the safety measures that are presently needed by many Member States.
- That child safety is addressed in all standards for products with which children come into contact.
- That more flexible regulations are developed which allow to respond quickly to market changes (new dangerous products).
- That highly political issues are settled at the political level and are not deferred to the standards bodies.
- That the current voluntary standards are incorporated in a legislative framework in all Member States across the EU for the areas like child care articles, playground equipment, hot surfaces, and sport equipment.
- That standards should be recognised as harmonised standards giving a presumption of conformity to requirements in directives only after careful scrutiny to ensure that safety levels are adequate.
- That European regulations and standards are developed for the areas like inedibles in food products, building code requirements for pool fencing, window and balcony railings, amusement/riding devices, swimming pools, cords on children's clothes, and second hand products.
- That a revision of the regulation on child restraint systems is undertaken in order to provide appropriate protection for children in today's cars (e.g. side impact testing, usage of universal ISOFIX attachment systems).
- That amendments are made to the current low voltage directive to ensure that child safety is taken into account in all standards for electrical appliances.
- That new directives be developed for pedestrian and cyclist protection through safer car fronts and child-resistant packaging for pharmaceuticals.

In order to ensure harmonised enforcement of injury prevention measures throughout Europe, we need a co-ordinating centre in the EU. Such a centre should have the competencies for risk assessment and for concerted actions among Member States and may build on the current voluntary network of ProSafe (Product Safety Forum in Europe).

Building commitment

Legislation is most effective when it is followed by education and training to enable consumers to understand the purpose the new policy serves. Such communication actions should be part of an overall child safety promotion plan which involves all stakeholders, including business, non-governmental organisations, and professional groups such as paediatricians, paediatric surgeons, emergency physicians, public health professionals, teachers, architects, designers, urban planners, engineers and consumer organisations. Given the fragmented infrastructures for child safety communications and policy, the first priority should be to create a sense of urgency among potential partners and stakeholders within these countries to make a commitment to reduce the leading killer of children. The national and regional departments of health are the most suitable public agencies to take the lead in this.

At the European level, much can be done to foster this process by giving guidance and direction to Member States in this respect. Promoting efficient exchange of good practices, adopting legislation to promote implementation of proven prevention measures, facilitating European collaboration and concerted actions such as joint campaigning should be undertaken.

The leading cause of death and disability to children can be significantly reduced in Europe if Member States, the European Parliament, the European Commission, industry and child safety organisations work together and make a joint commitment to address this issue. Enacting the following recommendations would create the way ahead for children in Europe and begin to give them their rights to safety.

Recommendation # 1

That each Member State's Health Department produces bi-annual report cards of child accidents and preventive measures taken. That it ensures timely and co-ordinated injury data delivery at a national level for risk identification, prioritisation of actions, strategies used and benchmarking of performance. The establishment of an interministerial taskforce lead by Ministries of Health for child safety is a prerequisite for enabling co-ordinated action in Member States.

Recommendation # 2

That Member States and the European Parliament establish a dedicated fund for child injury research to identify best practices for communities, taking into account vulnerable groups such as poorer families and immigrants. In addition, a real-time and shared database of child injury prevention measures and best practice should be established and maintained, encouraging a forum to exchange results throughout Europe that enables practitioners to build on each other's work.

Recommendation # 3

That the European Commission evaluates European level regulations, standards and directives to ensure they are providing safety to children effectively, regularly enforced with strict penalties given for non-compliance, and adopted as national laws in Member States. This would provide needed harmonisation across Europe and the spread of good practice in all countries. Priority areas for improving European regulations and standards are child restraint systems in cars, pedestrian protection, building safety, childcare articles, clothing flammability, cords on clothing, playground and fairground equipment, sport equipment and electrical appliances.

Recommendation # 4

That the European Commission and Member States' public health authorities, educational institutions and media collaborate to increase the awareness and knowledge of child injury prevention.

- An annual child safety campaign communicating proven actions should be planned and implemented in Member States and co-ordinated throughout the European Union to provide a consistent message to consumers and provide the needed information to educate parents about child safety.
- Professional training for injury prevention should be promoted as part of academic curricula in health, education, urban planning, architecture, engineering, landscaping, and law for appropriate use of best practices in their work.

Recommendation # 5

That the European Commission together with the Member States' public health authorities develop and implement national action plans to address child injury that incorporate:

- A four year plan for child safety promotion in the EU, including operational targets with regard to measures and actions as well as strategic targets related to the reduction of deaths and injuries due to accidents (as part of the Health and Consumer Protection Directorate's Fact and Figures Profile).
- Allocation of resources and the establishment of a European taskforce for child safety, including a dedicated support structure that ensures competencies, consistency and continuity in co-ordinated actions for child safety throughout Europe.
- Annual updates of achievements in Member States and in Europe overall, benchmarking of Member States' performance and focused directions for European actions.

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European Child Safety Alliance of the European Consumer Safety Association (ECOSA)

Injuries are the leading cause of death and disability for children in the European Union. This ECOSA 2nd edition white book on "Priorities for Child Safety in the European Union" presents an overview of the child injury issue within the European Union, including the size of the problem, opportunities for improvement, environmental trends and policies affecting child injury.

The report is based on statistics provided by the World Health Organisation as well as through research centres in EU Member States. Results of parental attitudes and behaviours toward safety were provided from the 2003 Eurobarometer of the European Commission.

In the conclusions to the report, ECOSA's European Child Safety Alliance makes a plea for a stronger commitment of public authorities, in particular the Member States' health departments and European Commission, to reduce the toll of premature deaths and disabilities to children due to injuries.

This white book was prepared under the review of the European Child Safety Alliance Steering Committee, an initiative of the European Consumer Safety Association. For more information about the Alliance and other technical reports please visit the website: www.childsafetyeurope.org



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