



Europe Summary
for 31 countries



EuroSafe

How safety conscious
are European Countries
towards children



Message by John Dalli, European Commissioner for Health and Consumer Policy

Injuries are the leading cause of death and disability for children in the European Union. Its incidence, however, varies widely, with a five-fold difference in child injury mortality rates between EU Member States.

I believe we must do everything we can to ensure the safety of the youngest and most vulnerable members of our society across Europe. This is why the EU Health programme supports initiatives to reduce accidents and injuries.

The Child Safety Report Card 2012: Europe Summary for 31 countries is one such successful initiative. Its assessment of the current level of safety in Member States and of evidence-based actions makes a valuable contribution in reducing child deaths and disability.

Deaths caused as a result of childhood injury cause unimaginable suffering for the families left behind. The European Union and its Member States must cooperate and act to ensure the right of all children to safety. This initiative provides support to raise the level of health, well being and growth for children in Europe.



Message by Malcolm Harbour, MEP, Chair of Internal Market and Consumer Protection Committee

As European politicians we have a responsibility to ensure that we provide the highest level of consumer protection for our most vulnerable citizens.

Children need our very special attention. Injuries are the number one cause of childhood deaths and disabilities across Europe. So we need to understand the causes, and devise and implement injury reduction policies and programmes.

The Child Safety Report Card 2012 provides an invaluable tool to encourage new policy initiatives. It uses 100 evidence based measures, across 31 countries, to show how safety consciousness is embodied in national plans. It assesses the impact of current actions being taken to improve child safety and highlights "best practice".

The Report Card also shows the need for better monitoring of safety standards and consistent implementation of regulations at both the EU and Member State levels.

I am pleased to support the European Child Safety Alliance and thank them for their work on this very important initiative.

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What are child safety report cards?

Child injury is a leading cause of death for children in Europe and the #1 leading cause for children and adolescents 5-19 years of age. Deaths are the 'tip of the injury burden iceberg' with many more children suffering enormous long-term consequences in terms of physical disability and psychological effects, which in turn represents a large cost to society. The child safety report cards are a tool that was specifically designed to bring attention to this deadly and debilitating threat.

There are large differences in rates of injury between countries and within countries and injury has a steeper social class gradient than any other cause of childhood death or long-term disability. As such, child injury is a major public health issue – one that is killing and injuring members of the next generation of adults and wage earners who should provide social and economic funding for countries in Europe in the future. Yet for some reason child injury does not provoke the response one might expect, given the heavy burden and the length of time this critical issue has existed.

Child safety report cards were devised to allow:

- a comparative assessment of the burden of unintentional child injury
- a comparative assessment of the adoption, implementation and enforcement of national level policy measures that are known to work
- a within country review of strengths, weaknesses and gaps; thereby providing guidance on where to focus action
- a benchmarking exercise both within countries over time and across countries, which can serve to inspire and motivate further progress
- an important mechanism to identify, share, utilise and adapt the experience gained from across Europe
- a first insight into the links between effective policies and health outcomes.

The child safety report cards for 2012 are an overview that summarise countries' levels of safety provided to their youngest and most vulnerable citizens through national policy up to July 2011. They are based on an examination of evidenced good practice policies to support child and adolescent safety in each country and include policies in nine areas of unintentional injury in addition to leadership, infrastructure and capacity actions that support child injury prevention efforts. The 2012 report cards represent first time report cards for four countries and updates for the remaining 27.¹ This Europe Summary for 31 countries provides an overview and summary of the report card results of all 31 countries that participated in the child safety report cards in 2012.

What is new in 2012?

In this round of report cards, produced as part of Tools to Address Childhood Trauma, Injury and Children's Safety (TACTICS) project, we have assessed several new policies related to unintentional injury in addition to those that were assessed in 2007 and 2009. As a result, we present three sets of scores in this European summary report – one for the newly expanded set of indicators for the 31 countries that participated in 2012 (pages 6-7), one based on the original set of indicators from 2007 for the 16 countries that participated in both the 2007 and 2012 report cards (pages 8-9) and one based on the expanded set of indicators used in 2009 for the 24 countries that participated in both 2009 and 2012 (pages 10-11). In addition, we examine whether there have been statistically significant changes in overall performance scores over the five years since the first report cards were produced.

As part of TACTICS we are also beginning to look more closely at the issue of inequalities and inequity as they relate to child injury. Although a more comprehensive report on child injury and inequity will be released in 2014, we begin to explore the issue in this report including looking at the related report card results (pages 46-48).

¹ First report cards: Bulgaria, Croatia, Romania and Slovakia; 31 countries includes England, Scotland and Wales as constituent countries of the United Kingdom.

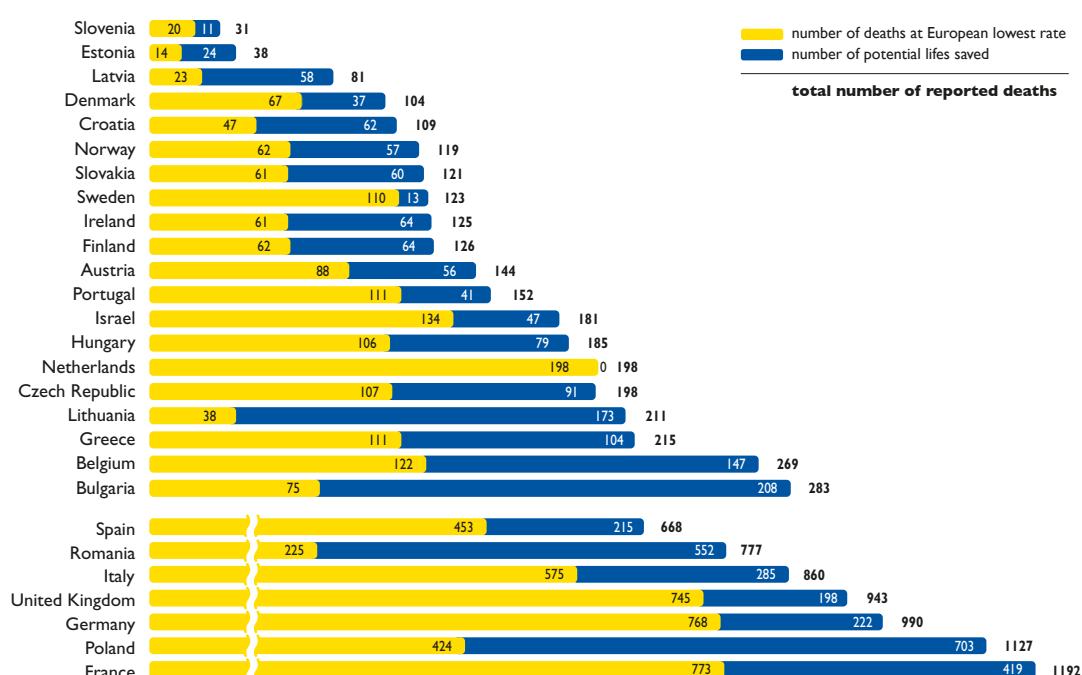
How do the countries measure up?

Despite the injury reductions and safety improvements over the last 20 to 30 years, injury remains a leading cause of death for children and adolescents in every Member State in Europe. **More children aged 5-19 years die of injuries than all other causes combined.**

It has been estimated by researchers that **if strategies known to be effective were uniformly implemented up to 90% of injuries could be prevented.** One way to quantify the potential gains for injury prevention in Europe is to examine the deaths in excess of what would have been expected if all countries had the same child injury death rate as the EU Member State with the lowest rate. **It is estimated that in 2010 alone, there would have been over 3800 fewer deaths to children and adolescents in the 31 countries participating in the TACTICS report cards if rates in all countries had matched the Netherlands's injury rate.²** And beyond that, there are still gains to be had in the Netherlands, which means the potential life savings across the countries are even greater:

Potential for life saving in children and adolescents in participating TACTICS countries

(number of deaths using the EU MS with the lowest rate)



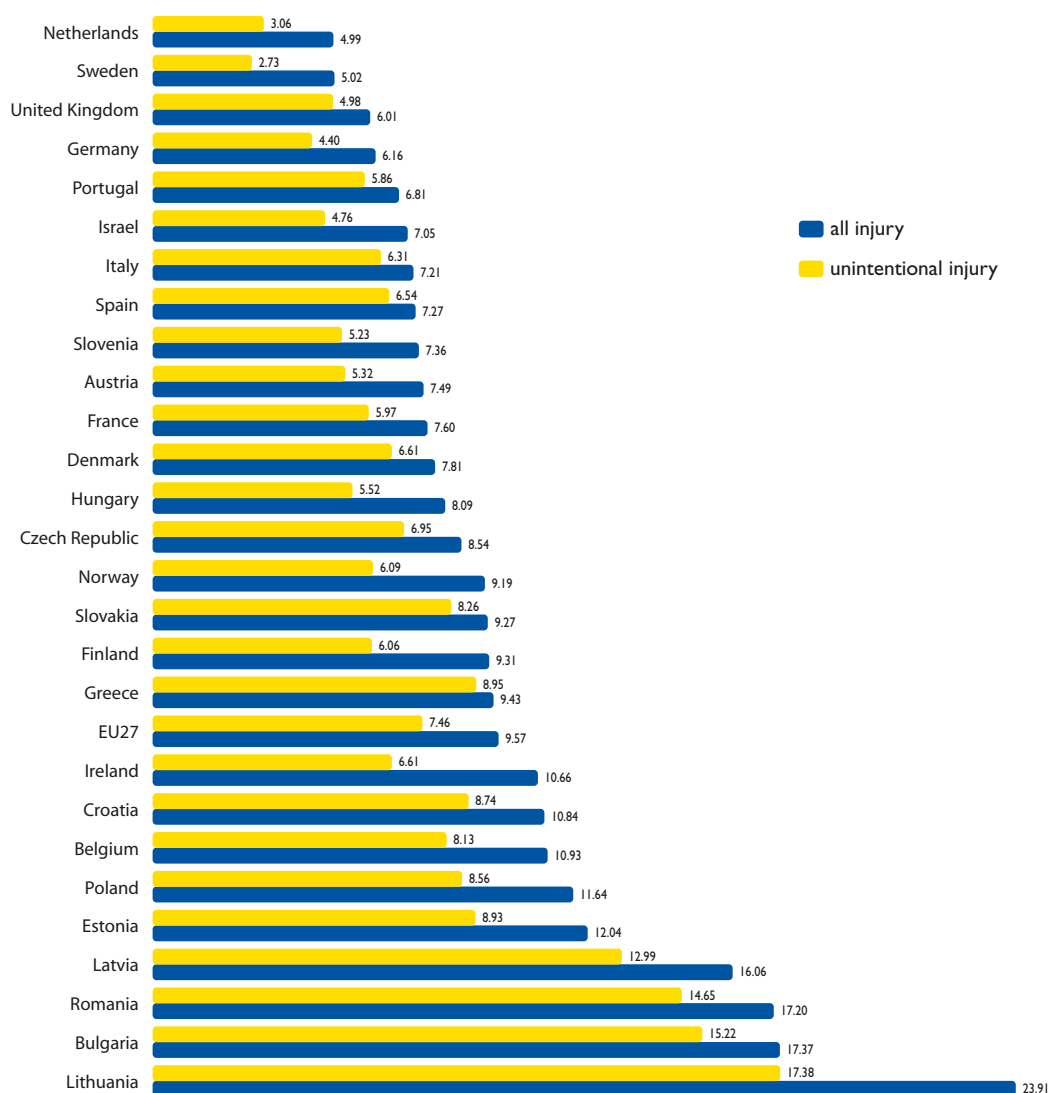
Source: WHO European Detailed Mortality Database (EDMD); 2010 or most recent year available; Cyprus, Iceland, Luxembourg and Malta excluded because of small numbers.

Of the 35,000+ children and adolescents under age 20 years who die each year in the EU, about 24% or roughly 9,100 deaths are due to injuries. Over two thirds of these are unintentional injuries (those injuries which occur without intent of harm). There is great variability between the best performing countries compared to poorer performing countries with just under a 5 times difference in 'all injury' rates and over a 6 times difference in 'unintentional injury' rates between the countries with the highest and lowest rates. Of the 31 countries that participated in these report card assessments, the highest rates for both 'all injury' and 'unintentional injury' are found in Lithuania, Bulgaria and Romania.

² The measure for potential life savings (avoidable deaths) compares countries using the most recent year of data available to the EU Member State with the lowest overall injury rate in the reference year: for this report the Netherlands rate of 5.05/100,000

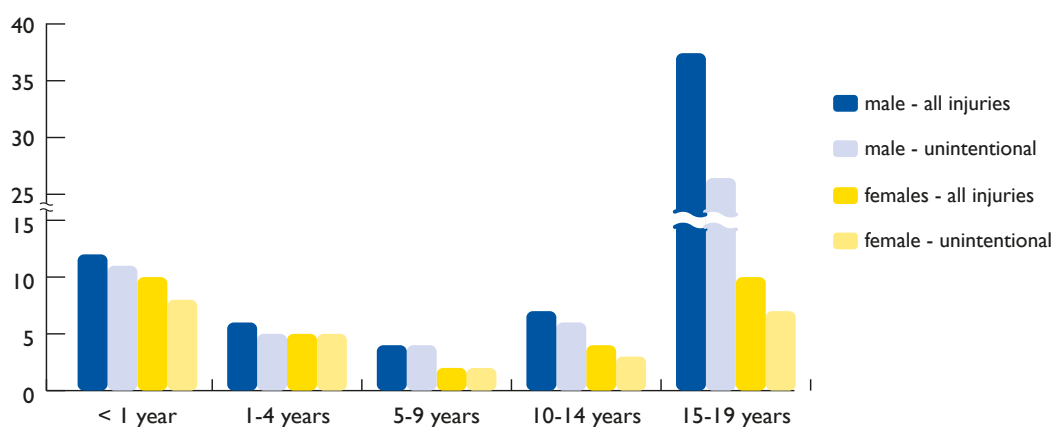
All injury and unintentional injury deaths for children and adolescents

(Europe age adjusted rate per 100 000 population 0-19 years)



Source: WHO European Detailed Mortality Database (EDMD) for 2010 or most recent year of data; Cyprus, Iceland, Luxembourg and Malta excluded due to small numbers.

Further there are significant differences in injuries by age and gender; the youngest and the oldest in the age group experiencing higher rates.



Source: WHO European Detailed Mortality Database (EDMD); EU average for 2008-2010 or most recent three years of data.

Overall child safety grades

All countries in Europe have adopted, implemented and enforced some policy actions that support child and adolescent safety, but this third set of Child Safety Report Cards signals that much more can be done to make life safer for children and adolescents. The overall level of safety provided to children and adolescents with respect to unintentional injuries in the 31 countries participating in these report cards was assessed by examining and grading the level of adoption, implementation and enforcement of evidenced based national policies in:

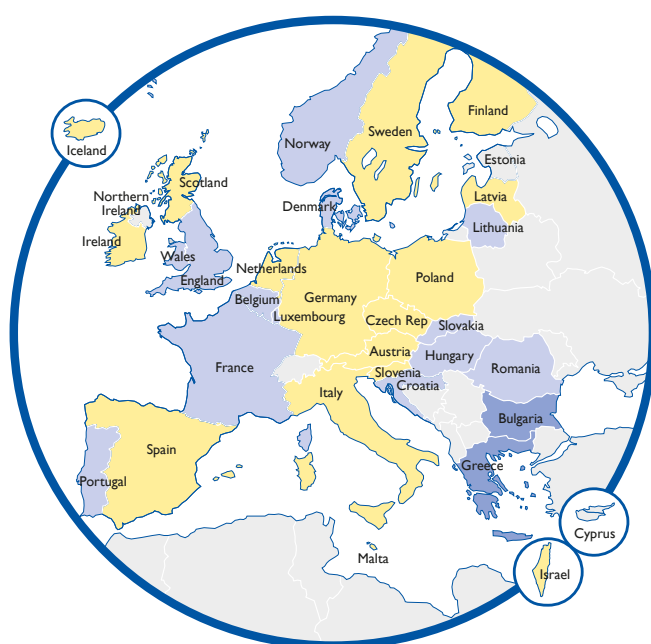
1) nine areas of safety relevant to children and adolescents

- moped/motor scooter safety,
- passenger/driver safety,
- pedestrian safety,
- cycling safety,
- water safety/drowning prevention,
- fall prevention,
- poisoning prevention,
- burn/scald prevention, and
- choking/strangulation prevention.

2) three areas looking at strategies to support child safety efforts

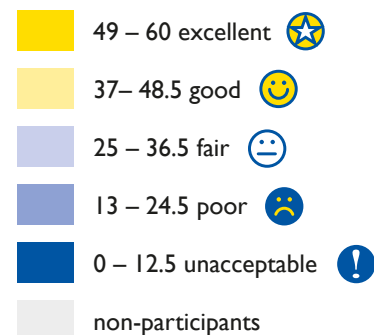
- leadership,
- infrastructure and
- capacity.

Countries were given a score out of 5 stars, where 5 stars was the best possible score for each of these 12 areas based on their adoption, implementation and enforcement of national policy specific to each area. An overall grade was calculated by adding together the number of stars over the 12 areas out of a total of 60.



Overall child safety grades in Europe (31 countries)

Performance grade out of 60 stars



TACTICS average: 35.0 stars 😐

Key findings

- Countries that participated in the report card assessments received grades in the middle of the scale, with none receiving a grade of excellent, indicating room for improvement in all countries. Sixteen countries (Austria, Czech Republic, Finland, Germany, Iceland, Ireland, Israel, Italy, Latvia, Malta, Netherlands, Poland, Scotland, Slovenia, Spain and Sweden) received an overall grade of good performance, thirteen received an overall grade of fair performance (Belgium, Croatia, Denmark, England, France, Hungary, Lithuania Luxembourg, Norway, Romania, Portugal, Slovakia and Wales) and two received an overall grade of poor performance (Bulgaria and Greece).
- Generally speaking child safety grades based on adoption, implementation and enforcement of evidenced good practice policy correspond reasonably well to the overall rate of unintentional injury deaths (i.e., countries with lower injury rates achieved higher safety grades in this assessment; Pearson correlation coefficient -0.462 , $p < 0.01$).
- There is room for improvement in all countries, as none have adopted and implemented all the recommended evidence-based policies.

The detailed results for individual policies for each injury area are not included in this summary report card but are available in the country specific report cards, which can be downloaded from the European Child Safety Alliance website at www.childsafetyeurope.org

Child Safety Scores in 31 countries

The table on the following page provides the overall safety performance grade and the scores out of 5 stars for each of the 12 issues in the 31 participating countries for policies up to July 2011.

- The scores for the individual issue areas and overall score and grade differ between countries.
- None of the participating countries have adopted and implemented all of the recommended evidence-based policies for all sub-areas examined. However, nine countries (Austria, Denmark, Finland, Iceland, Ireland, Latvia, Romania, Slovenia and Spain) have adopted all the moped/ motor scooter safety measures; three countries (Czech Republic, Germany and Slovenia) have adopted all the pedestrian safety measures; five countries (Austria, Croatia, Czech Republic, Latvia and Slovenia) have adopted all the cycling safety measures and two (Czech Republic and Sweden) have adopted all the capacity-related actions to support child safety.
- Countries with lower scores in a specific sub-area can look to the experiences and successes of countries with stronger scores to assist in making their countries safer for children and adolescents.

Child Safety Scores in 31 countries

	Pedestrian safety	Passenger/ driver safety	Moped/motor scooter safety	Cycling safety	Water safety/ drowning prevention	Fall prevention	Poisoning prevention	
Austria	4.5	3.5	5	5	2.5	1.5	3	
Belgium	3.5	3	4	2.5	1.5	2	3	
Bulgaria	3.5	2.5	4	3.5	2.5	1.5	0.5	
Croatia	4.5	2.5	3.5	5	0.5	0.5	1.5	
Czech Republic	5	3	3.5	5	4	2	3	
Denmark	3.5	2	5	2.5	1	3	3.5	
England	3.5	3.5	4	1	1	3	3.5	
Finland	4.5	4	5	4.5	3	3	3.5	
France	3.5	2.5	4.5	2.5	3.5	1.5	2	
Germany	5	3	3.5	3.5	1	2	4.5	
Greece	0.5	0	3	0	1.5	0	1	
Hungary	4.5	2.5	4.5	3	1.5	1.5	3	
Iceland	4	4.5	5	4.5	3.5	3.5	4.5	
Ireland	4	4	5	3.5	3	2.5	3	
Israel	3.5	3.5	4.5	4.5	3.5	1	3	
Italy	1.5	2	4.5	2.5	3.5	3	4.5	
Latvia	3.5	4	5	5	2	1.5	3	
Lithuania	3.5	2.5	4.5	2.5	2	2	2	
Luxembourg	4	2.5	4	2.5	2	1	1	
Malta	4	3	4.5	4.5	2.5	2	3	
Netherlands	4	3	4.5	3.5	2.5	4	4.5	
Norway	2.5	3	4	2.5	2	2.5	3	
Poland	4	3	4.5	4	3.5	2	4	
Portugal	1.5	3	4	1	2	2	3.5	
Romania	3.5	3	5	2.5	1.5	1	0.5	
Scotland	4	3.5	4.5	3.5	1	2	2.5	
Slovakia	3.5	2.5	4.5	3.5	1	1	1.5	
Slovenia	5	3.5	5	5	4	2	2.5	
Spain	2.5	3	5	4.5	3	1.5	3.5	
Sweden	3	2	4.5	3.5	1.5	3	3.5	
Wales	2	3	4	1	1	1.5	2.5	
TACTICS average	3.5	3.0	4.5	3.5	2.0	2.0	3.0	

🌟 = 49-60 stars – excellent performance, 😊 = 37-48.5 stars – good performance, 😐 = 25-36.5 stars – fair performance,

	Burn/scald prevention	Choking/strangulation prevention	Child safety leadership	Child safety infrastructure	Child safety capacity	Overall score	Overall grade	
	2.5	2.5	1.5	3	3	37.5	😊	Austria
	2.5	2.5	1	1	2	28.5	😐	Belgium
	1	1	1	1.5	0.5	23	😞	Bulgaria
	1	1.5	3	3.5	2.5	29.5	😐	Croatia
	2.5	2.5	4	4	5	43.5	😊	Czech Republic
	3	3	1	2	2.5	32	😐	Denmark
	3	3	4	3.5	3	36	😐	England
	3.5	3	3	3.5	4.5	45	😊	Finland
	2.5	2	2	3	2	31.5	😐	France
	2.5	4	4	3	3	39	😊	Germany
	0.5	0.5	2.5	2	3	14.5	😞	Greece
	1.5	2	3.5	3.5	4	35	😐	Hungary
	3.5	2.5	3.5	3	2.5	44.5	😊	Iceland
	3.5	2.5	3	3.5	3	40.5	😊	Ireland
	2	1	3.5	4	4	38	😊	Israel
	3	4	3	3.5	3.5	38	😊	Italy
	3	3	2.5	3.5	3	39	😊	Latvia
	3	3	2	2	3	32	😐	Lithuania
	2	2	2	2	2.5	27.5	😐	Luxembourg
	3	2.5	2	3	4.5	38.5	😊	Malta
	3.5	2.5	4.5	4	3	43.5	😊	Netherlands
	2.5	3	3	3.5	3.5	35	😐	Norway
	3	2.5	4.5	4	4.5	43.5	😊	Poland
	2.5	2	3	2	3.5	30	😐	Portugal
	2	2	2.5	2	0.5	26	😐	Romania
	3	3	4	3	3.5	37.5	😊	Scotland
	1	2	1.5	1.5	3.5	27	😐	Slovakia
	2	2.5	4.5	3.5	2.5	42	😊	Slovenia
	2.5	2.5	3.5	3	4.5	39	😊	Spain
	4	3	3.5	4.5	5	41	😊	Sweden
	3	2.5	3	4.5	3	31	😐	Wales
	2.5	2.5	3.0	3.0	3.0	35	😐	TACTICS average

😞 = 13-24.5 stars – poor performance, ! = 0-12.5 stars – unacceptable performance

Comparison of report card scores 2007-2012 and 2009-2012

Changes 2007-2012

Thirteen countries participated in all three sets of report cards (2007, 2009 and 2012) and three others participated in 2007 and 2012 allowing a comparison of scores based on the original 94 indicators in 16 countries (see table below).

- All countries increased their scores in at least one sub-area (range 1-11).
- All sub-area averages showed an increase of at least 0.5 stars over the 16 countries except for moped/motor scooter; passenger; pedestrian and water safety. However the variation for each sub-area across the different years was too small to undertake trend analyses of individual sub-areas.
- The sub-area with the most countries reporting an improved score was falls (12/16) and this was for the most part the result of establishing an action plan, educational programme and/or a media campaign addressing the issue. Other areas with a greater number of countries reporting an increased score were burns/scalds (11/16) and pedestrian safety (10/16), child safety leadership (10/16) and child safety capacity (10/16).

Changes in scores 2007 to 2012

	Pedestrian safety			Passenger safety			Moped/motor scooter safety			Cycling safety			Water safety/drowning prevention			Fall prevention			Poisoning prevention			
	2007	2009	2012	2007	2009	2012	2007	2009	2012	2007	2009	2012	2007	2009	2012	2007	2009	2012	2007	2009	2012	
Austria	3	5	5	2.5	3	3	4	4.5	4.5	1	4	5	2	3	2.5	1.5	2.5	2	1	3	3	
Belgium	3.5	4	3.5	2.5	3	2.5	3	3	3.5	1	1	2.5	2.5	2.5	2	3	2.5	2	3.5	4	2.5	
Czech Republic	3	4	3.5	3.5	3	3	3	5	5	3	4.5	5	2	3.5	4	0.5	2	2	1.5	2.5	2.5	
Denmark	4	-	3.5	3.5	-	2	4.5	-	4.5	4	-	2.5	2	-	1	1.5	-	3.5	2.5	-	3.5	
France	3.5	4	3.5	3	3.5	2.5	4.5	5	4.5	3	4	2.5	2.5	3.5	3.5	3	3	1.5	3.5	2.5	1.5	
Germany	4	4	5	3	3	3	3.5	3.5	3.5	4	4	3.5	1	1	1	1.5	1.5	3	2.5	2.5	4	
Greece	1.5	4	0.5	3	4.5	0.5	4	4	2.5	1	0	0	1.5	2	1	1.5	1	0	0	1.5	0	
Hungary	3	4	4.5	3	3	2.5	5	4.5	4.5	4	3	3	1.5	1.5	2	1.5	2	2	2.5	3.5	3	
Italy	1.5	1.5	1.5	2	2	3	4	4	4.5	1	0	2.5	2.5	3	3.5	2	2	3	1.5	3.5	4.5	
Netherlands	3.5	3.5	4	3	3	3.5	4.5	5	4.5	2.5	4	3.5	2	2	2.5	2.5	3	4.5	4	4.5	4	
Norway	3.5	-	2.5	3.5	-	3.5	4	-	3.5	4	-	2.5	2	-	2	2	-	2.5	1.5	-	2.5	
Poland	3.5	-	4	3.5	-	3	4.5	-	4.5	3	-	3.5	3	-	3.5	2	-	2	1.5	-	3.5	
Portugal	1	1.5	1.5	3	3	3	3	3.5	3.5	1	1	1	0.5	2	2	0.5	1	2	1.5	2.5	3.5	
Scotland	3.5	3.5	4	3	3	3	4	4.5	4.5	1	2.5	3.5	1	1.5	1	1	2	2	3	3	2	
Spain	1.5	1.5	2.5	3.5	4	3	5	5	5	2	2	4.5	2	2	3	0	0.5	2	3.5	4	3.5	
Sweden	1.5	1	3	3.5	3.5	2	5	4.5	4.5	5	5	3.5	2	2	1.5	2	2	3	4	4	3.5	
TACTICS average	3	3	3	3	3	2.5	4	4.5	4	2.5	2.5	3	2	2.5	2	1.5	2	2.5	2.5	3	3	

★ = 49-60 stars – excellent performance, 😊 = 37-48.5 stars – good performance, 😊 = 25-36.5 stars – fair performance,

- Eleven out of the 16 countries appear to have made progress in the five years between assessments, with the greatest improvements in score found in Spain and the Czech Republic.
- In 2007 the 16 countries represented a ratio of good:fair:poor performance of 3:11:2 and in 2012 this has improved to 7:9:1, demonstrating a marked improvement.
- The average overall safety performance score increased from 31.5 in 2007 to 36 in 2012. The average increase of 5.09 was statistically significant ($p=0.019$; 95% confidence interval 0.96,9.22).

Changes 2009-2012

Twenty-four countries participated in both the 2009 and 2012 allowing a comparison of scores based on 102 indicators - the original 94 plus the eight indicators added in 2009 (see table on next page).

- All countries increased their scores in at least one sub-area (range 0-9 sub-areas) except France.
- There were only three sub-areas where the average score increased (cycling, burns/scalds and choking/strangulation).
- The sub-area with the most countries reporting an improved score was burn/scald prevention (16/24 countries showed an improvement) and this is most likely the result of the introduction of policy at the EU level addressing child resistant lighters and reduced ignition propensity (RIP)

	Burn/scald prevention			Choking/strangulation prevention			Child safety leadership			Child safety infrastructure			Child safety capacity			Overall score			
	2007	2009	2012	2007	2009	2012	2007	2009	2012	2007	2009	2012	2007	2009	2012	2007	2009	2012	
	1	2.5	2.5	2	2.5	2.5	1	1.5	1	4	3	3.5	4	4	4	27	38.5	38.5	Austria
	3	3	2.5	2.5	2.5	2.5	1	1	0	1.5	1.5	1	1	1.5	2	28	29.5	26.5	Belgium
	1.5	3	2	2	2	2.5	3	4.5	4.5	4	4	5	4	4	5	31	42	44	Czech Republic
	2.5	-	3	2.5	-	3	2.5	-	1	5	-	2.5	5	-	3	39.5	-	33	Denmark
	3	3.5	2.5	3	3	2	2	2	1	2	3	3	4	3	2.5	37	40	30.5	France
	2	2.5	3	2.5	3	4.5	3.5	4.5	4	3	3	3	5	5	4.5	35.5	37.5	42	Germany
	0.5	0.5	0.5	1.5	1.5	0.5	0	1.5	2	3.5	4	3	3	4	4	21	28.5	14.5	Greece
	1	2	1.5	2	2	2	2	2.5	3.5	2.5	4.5	4	4	5	5	32	37.5	37.5	Hungary
	1	1.5	3	2	2	4	2	4	2	3	4	3.5	4	4	3.5	26.5	31.5	35.5	Italy
	3	3	3.5	2.5	2.5	2.5	4.5	4.5	4.5	4	4.5	5	4	5	5	40	44.5	47	Netherlands
	2.5	-	2.5	2.5	-	3	2	-	3	4	-	3.5	4	-	4	35.5	-	35	Norway
	2	-	3	2.5	-	2.5	1	-	4	3.5	-	3.5	2	-	4.5	32	-	41.5	Poland
	0.5	1.5	2.5	0.5	2	2	1.5	1.5	3	2.5	2.5	2.5	3.5	4	4	19	26	30	Portugal
	3	3	2.5	2.5	2.5	3	1.5	1.5	3.5	2.5	3.5	3.5	5	5	5	31	35.5	37.5	Scotland
	1.5	2	3	0.5	1.5	2.5	1	1.5	3.5	1	2.5	3.5	1	3	5	22.5	29.5	41	Spain
	3	4	4	3	3	3	2.5	4	3.5	4.5	4.5	4.5	4	5	5	40	42.5	41	Sweden
	2	2.5	2.5	2	2.5	2.5	2	2.5	2.5	3	3.5	3.5	3.5	4	4	31.5	35.5	37	TACTICS average

☹ = 13-24.5 stars – poor performance, ! = 0-12.5 stars – unacceptable performance

cigarettes that benefited from action at the Member State level. Other areas with a greater number of countries reporting an improved score were leadership (15/24), water safety (14/24) and choking strangulation (13/24).

- Eighteen countries reported progress in the two years between assessments, with the greatest improvements in score found in Spain, Ireland, Italy and Latvia. Of the six countries whose scores decreased, the governments of two (Iceland and Greece) have faced financial crises during the period.

Changes in scores 2009 to 2012

	Pedestrian safety		Passenger safety		Moped/motor scooter safety		Cycling safety		Water safety/drowning prevention		Fall prevention		Poisoning prevention		
	2009	2012	2009	2012	2009	2012	2009	2012	2009	2012	2009	2012	2009	2012	
Austria	5	5	4	3.5	4.5	4.5	4	5	3	2.5	3	2	3	3	
Belgium	4	3.5	3.5	3	3	3.5	1	2.5	2.5	2	2	2	4	3	
Czech Republic	4	5	3	2.5	5	5	4.5	5	3.5	4	2.5	2.5	3	3	
England	4	3.5	3.5	3.5	4	3.5	4	1	1.5	1.5	3	2.5	2.5	3.5	
Finland	4	4.5	3.5	4	5	5	4.5	4.5	2	2.5	3	3	3	3.5	
France	4	3.5	3.5	3	5	4.5	4	2.5	3.5	3.5	2.5	1.5	3	2	
Germany	4	3.5	3.5	3.5	3.5	3.5	4	3.5	1	1	2	3	3	4	
Greece	4	0.5	3.5	0	4	2.5	0	0	2	1	1	0	2	1	
Hungary	4	4.5	3.5	2.5	4.5	4.5	3	3	1.5	2	1.5	2	3.5	3	
Iceland	4	4	4	4.5	4.5	5	4.5	4.5	4	3.5	4	3.5	4.5	4.5	
Ireland	4	4	2.5	4	4.5	5	2	3.5	2.5	3	2	2	1	3	
Israel	2	3.5	3	3	4	4.5	3	4.5	3	4	1.5	1	2	3	
Italy	1.5	1.5	2	3	4	4.5	0	2.5	3	3.5	2	3	3.5	4.5	
Latvia	3.5	3.5	4.5	4.5	4	5	3	5	1.5	2.5	1.5	2	2	3	
Lithuania	2.5	3.5	3.5	3	4.5	4.5	4	3.5	2	2	1.5	2	2.5	2	
Luxembourg	4	4	3	3	4	3.5	2.5	2.5	2	2.5	1	1	0.5	1	
Malta	3.5	4	3	3	4.5	4.5	4.5	4.5	2	2.5	1	2	2	3	
Netherlands	3.5	4	3.5	3.5	5	4.5	4	3.5	2	2.5	3.5	4.5	4.5	4.5	
Portugal	1.5	1.5	3.5	3	3.5	3.5	1	1	2	2.5	1	1.5	3	3.5	
Scotland	3.5	4	3.5	3.5	4.5	4.5	2.5	3.5	1.5	1	2	2	3	2.5	
Slovenia	5	5	3.5	3.5	4.5	5	5	5	3.5	4	2.5	2.5	2.5	2.5	
Spain	1.5	2.5	3.5	3.5	5	5	2	4.5	2	3	0.5	1.5	4.5	3.5	
Sweden	1	3	3.5	2	4.5	4.5	5	3.5	2	2	2.5	3	4.5	3.5	
Wales	3	2	3	2.5	3.5	3.5	2.5	1	0.5	1.5	1	1.5	2.5	2.5	
TACTICS average	3.5	3.5	3.5	3	4.5	4	3	3.5	2.5	2.5	2	2	3	3	

🌟 = 49-60 stars – excellent performance, 😊 = 37-48.5 stars – good performance, 😐 = 25-36.5 stars – fair performance,

- In 2009 these 24 countries represented a ratio of good:fair:poor performance of 9:14:1 and in 2012 this has improved to 16:7:1, demonstrating an increase in adoption, implementation and / or enforcement of evidence-based good practices.
- The average overall safety performance score based on the enhanced set increased from 35 in 2009 to 37.5 in 2012. The average difference of 2.08 was not quite statistically significant ($p=0.082$; 95% confidence intervals -0.29, 4.46).

	Burn/scald prevention		Choking/strangulation prevention		Child safety leadership		Child safety infrastructure		Child safety capacity		Overall score		
	2009	2012	2009	2012	2009	2012	2009	2012	2009	2012	2009	2012	
	2.5	2.5	2.5	2.5	2	1.5	3	3	4	4	40.5	39	Austria
	3	2.5	2.5	2.5	1.5	0.5	1	0.5	1.5	2	29.5	27.5	Belgium
	2.5	2.5	2	2.5	4.5	5	3.5	4.5	4	5	42	46.5	Czech Republic
	2.5	3	2.5	3	4	3	3.5	3	4.5	5	39.5	36	England
	2.5	3.5	2.5	3	1.5	2.5	3	4	4	4	38.5	44	Finland
	3	2.5	3	2	2.5	1.5	3	3	3	2.5	40	32	France
	2.5	2.5	3	4.5	4.5	4	3	3	5	4.5	39	40.5	Germany
	0.5	0.5	1.5	0.5	1	2	3.5	2.5	4	4	27	14.5	Greece
	1.5	1.5	2	2	2	3	4.5	4.5	5	5	36.5	37.5	Hungary
	4.5	3.5	3	2.5	2.5	3	4	3	5	3	48.5	44.5	Iceland
	2	3.5	2.5	2.5	1	2.5	3	3.5	4	4	31	40.5	Ireland
	1.5	2	1.5	1	2.5	3.5	4	4	3.5	4	31.5	38	Israel
	1	3	2	2.5	4	2.5	3	4	4	4	30	38	Italy
	2	3	2.5	3	2.5	2.5	4	3.5	3	5	34	42.5	Latvia
	2	3	3	3	1.5	1.5	3	3	2.5	3	32.5	34	Lithuania
	1	2	2	2	0.5	1	1	2	2.5	2.5	24	27	Luxembourg
	2	3	1.5	2.5	1	1.5	2.5	2.5	4	4	31.5	37	Malta
	3	3.5	2.5	2.5	4.5	4.5	4.5	5	5	5	45.5	47.5	Netherlands
	1.5	2	2	2	2	3	2	2	4	4	27	29.5	Portugal
	2.5	3	2.5	3	1.5	4	3.5	3.5	5	4.5	35.5	39	Scotland
	1.5	2	2	2.5	3	4	4	4.5	3.5	3	40.5	43.5	Slovenia
	2	2.5	1.5	2.5	1.5	3.5	2	3.5	3	5	29	40.5	Spain
	4	3.5	3	3	4	3.5	4	4.5	5	5	42.5	41.5	Sweden
	2.5	3	1.5	2.5	1	2.5	4	4.5	4.5	4.5	29.5	31.5	Wales
	2	2.5	2	2.5	2.5	2.5	3	3.5	4	4	35	37.5	TACTICS average

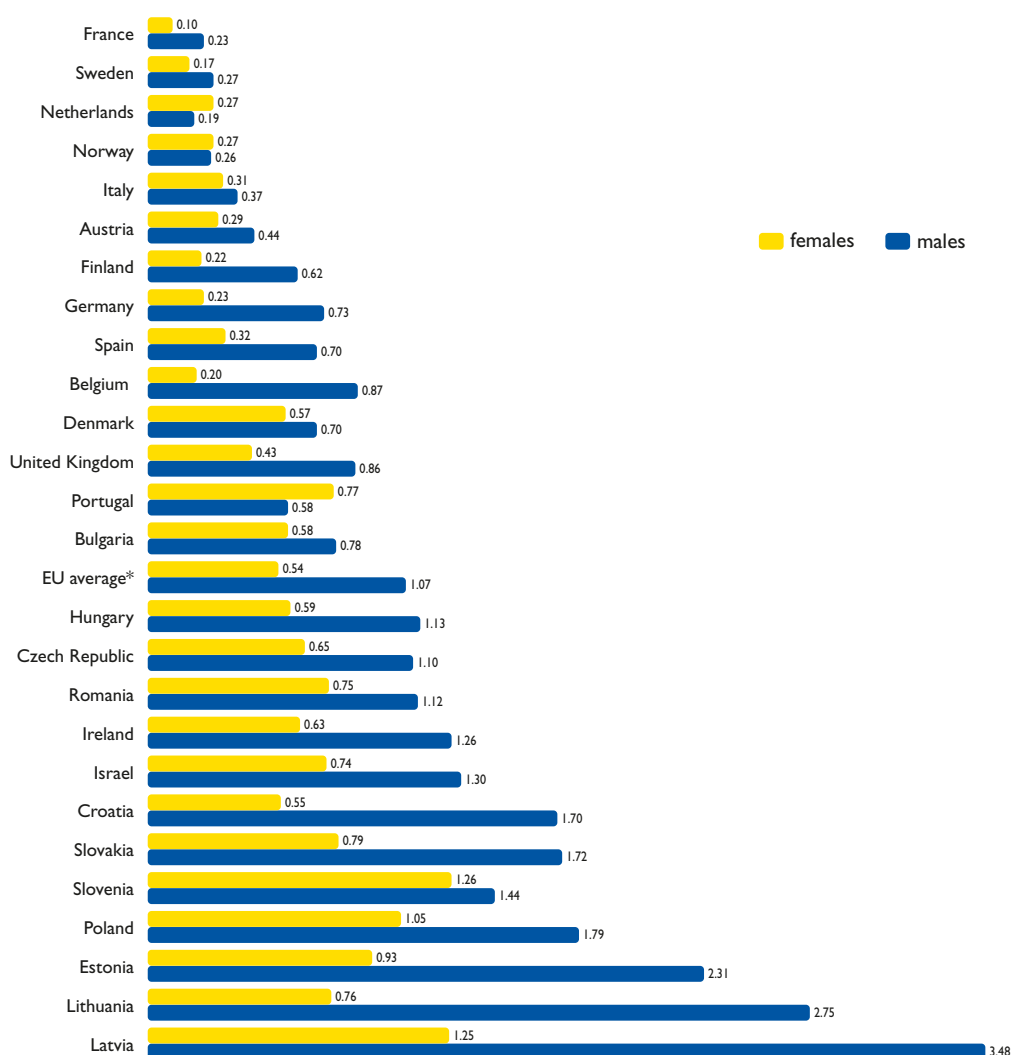
Pedestrian safety

Walking is encouraged as part of the battle against the obesity epidemic. Children are increasingly encouraged where feasible to walk to and from school. At the same time, countries continue to become more motorised, and the environment is becoming less friendly for pedestrians, particularly child pedestrians.

Inequality in pedestrian deaths for children and adolescents shows over a 14 times greater risk in the lowest performing country compared to that of the best performing country participating in the report card assessment for whom data were available. Rates for males are higher than females for all countries except for the Netherlands, Norway and Portugal. The highest rates were seen in Latvia, Lithuania, and Estonia for males and Slovenia, Latvia and Poland for females.

Pedestrian related deaths for children and adolescents

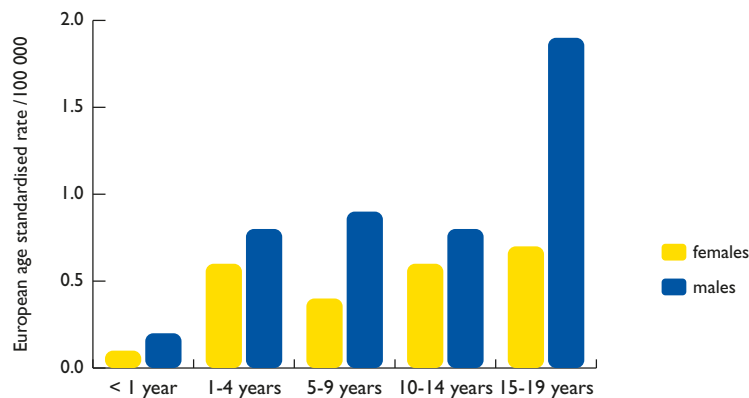
(Europe age standardised rate per 100 000 0-19 years by sex)



Source: WHO European Detailed Mortality Database (EDMD); 3 year averages for 2008-2010 or 2007-2009 or most recent three years of data; Cyprus, Iceland, Luxembourg and Malta excluded due to small numbers and resulting rate variability; Greece is excluded as ICD-9 codes do not allow breakdown of road traffic injuries so EU average presented represents remaining 26 countries of the EU.

Children are at increased risk of injury due to their small size, inability to judge distances and speeds, and lack of experience with traffic rules. Pedestrian injury rates increase from the time children begin to walk until their development advances enough that they can manage to safely manoeuvre in traffic. However the highest rates are seen in adolescents, which likely relates to exposure and risk taking behaviours.

EU average rate of pedestrian related deaths for children and adolescents by age and sex



Source: WHO European Detailed Mortality Database (EDMD), EU average based on 2008-2010, 2007-2009 or most recent three years of data for all EU countries except Greece as ICD-9 codes do not allow breakdown of road traffic injuries.

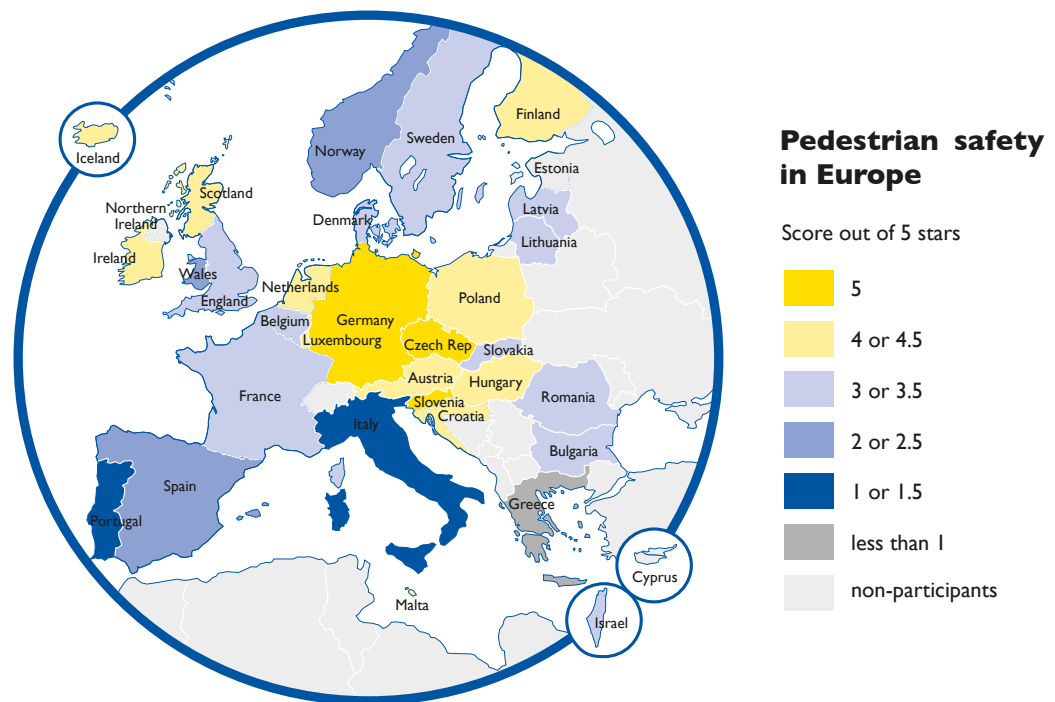
Comparison of pedestrian safety scores

The level of pedestrian safety for children and adolescents was assessed based on the adoption, implementation and enforcement of evidence-based national level policies relating to pedestrian safety that included:

- a national law requiring reduced speed in residential areas (e.g. areas near schools and playgrounds)
- a national law assuming driver responsibility in a crash involving a child pedestrian (e.g., places the burden of proof on the driver)
- a national policy providing specific supports for vehicle redesign to reduce risk of pedestrian injury
- a national ministry/ government department with mandated responsibility for child and adolescent pedestrian safety
- a government approved national injury prevention strategy with specific targets and timelines related to child and adolescent pedestrian safety
- a national media campaign at least once in past five years targeting child and adolescent pedestrian safety.

Countries were assessed based on the above good practice measures and given a score out of a possible 5 stars.

Pedestrian safety



Key findings

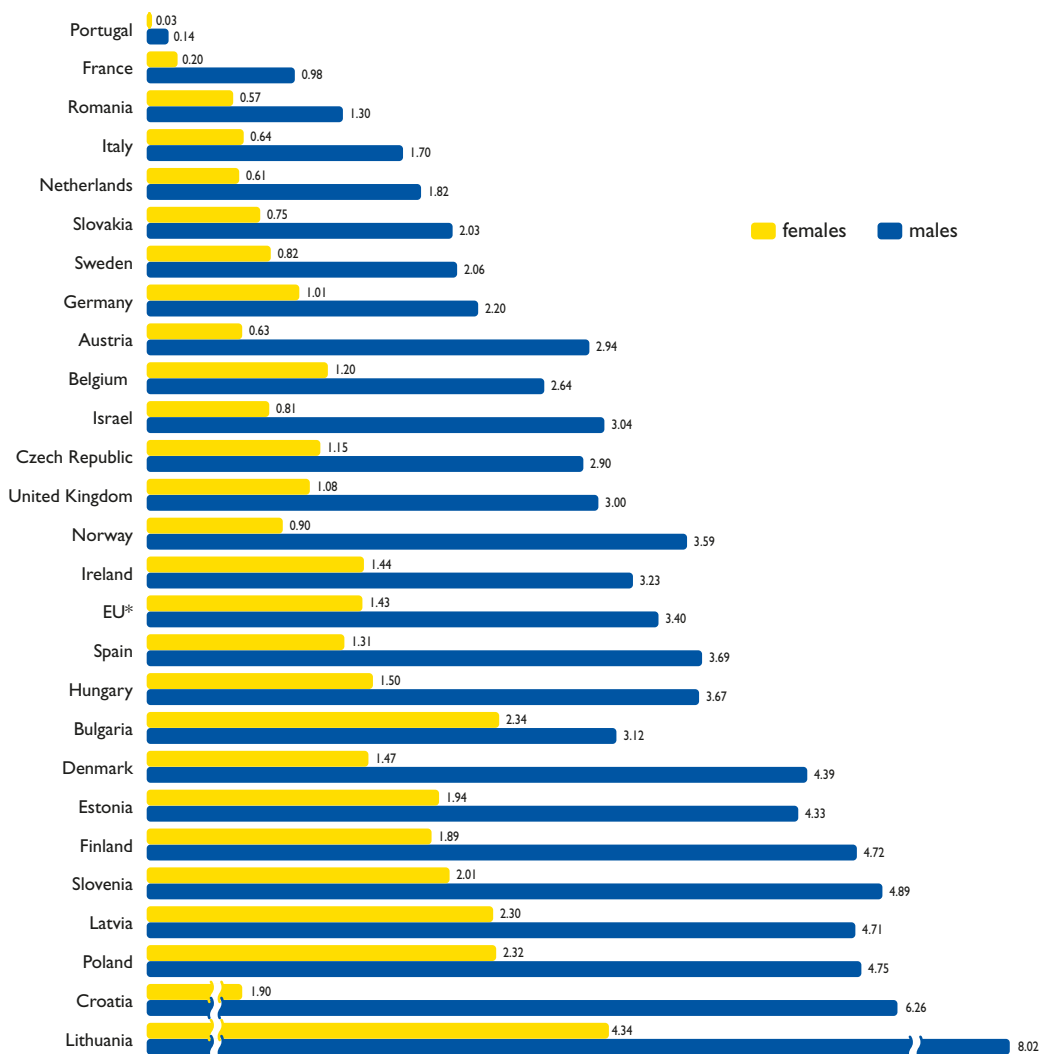
- Currently many of the recommended evidence-based national level policies in pedestrian safety are adopted, implemented or enforced in the majority of countries assessed. However scores ranged from 1.5 to 5 stars with an average score of 3.5 out of 5 stars.
- Pedestrian safety scores did not correspond to pedestrian deaths for all countries. For example, Sweden who had one of the lower pedestrian safety scores also had one of the lowest death rates. However Sweden has invested heavily in local infrastructure in the last 25 plus years and this is not captured in the policy measures assessed. It is therefore reasonable to assume that the lack of correspondence between pedestrian death rates and safety scores may reflect in part that only national level policies were assessed and that there can be differing levels of implementation and enforcement of adopted policy measures between the countries. In addition, it is likely that there are differing levels of exposure for child pedestrians between countries that would also account for differences in death rates.
- All countries but three, Croatia, Portugal and Sweden, report a national law requiring reduced speed in residential areas, although in Sweden municipal level laws do exist. In addition, Greece, Israel, the Netherlands and Wales report their national laws are only partly implemented or enforced.
- Thirteen countries (Austria, Belgium, Croatia, Denmark, Finland, France, Germany, Hungary, the Netherlands, Poland, Slovakia, Slovenia and Sweden) report a national law that assumes driver responsibility in a crash involving a child pedestrian, although most laws are not specific to children and the law in Poland is only partly implemented or enforced.
- For the countries where a historical comparison in sub-area scores was possible between 2007 and 2012, improved scores reflected increased adoption of national laws requiring reduced speeds in residential areas and addressing liability in the event of a child pedestrian incident and the introduction of national media campaigns targeting child pedestrian safety.

Children and adolescents spend an increasing amount of time in motor vehicles as family car ownership in Europe has increased. In some countries and/or regions children are more likely to be driven to school than to walk, cycle or take public transport. Fatal injuries occur in all age groups, but are highest in males aged 15-19 years, likely reflecting increased risk in novice drivers due to inexperience or increased risk due to driving with a novice driver.

Inequality in motor vehicle passenger or driver deaths for children and adolescents shows over 10 times greater risk in the lowest performing country compared to that of the best performing country participating in the report card assessment for whom data were available. The highest rates occur in Lithuania, Croatia and Slovenia for males and Lithuania, Bulgaria and Poland for females.

Motor vehicle passenger or driver deaths for children and adolescents

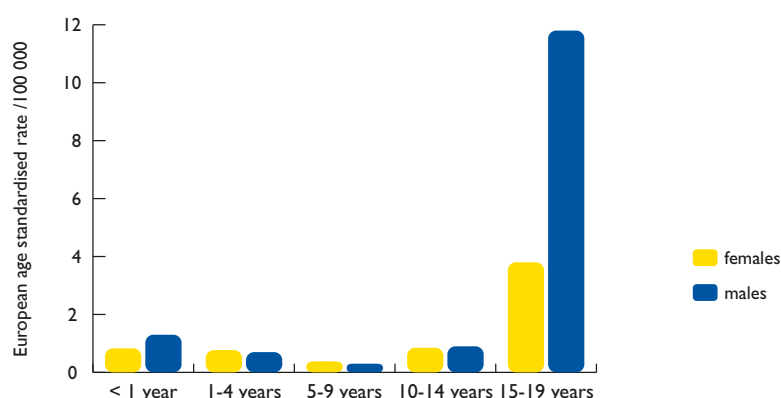
(Europe age standardised rate per 100,000 population 0-19 years by sex)



Source: WHO European Detailed Mortality Database (EDMD); 3 year averages for 2008-2010 or 2007-2009 or most recent three years of data; Cyprus, Iceland, Luxembourg and Malta excluded due to small numbers and resulting rate variability; Greece is excluded as ICD-9 codes do not allow breakdown of road traffic injuries so EU average presented represents remaining 26 countries of the EU.

Passenger/driver safety

EU average rate of motor vehicle passenger/driver deaths for children and adolescents by age and sex



Source: WHO European Detailed Mortality Database (EDMD), EU average based on 2008-2010, 2007-2009 or most recent three years of data for all EU countries except Greece as ICD-9 codes do not allow breakdown of road traffic injuries.

Comparison of passenger/driver safety scores

The level of passenger safety for children and adolescents was assessed based on adoption, implementation and enforcement of evidence-based national level policies relating to passenger/driver safety that included:

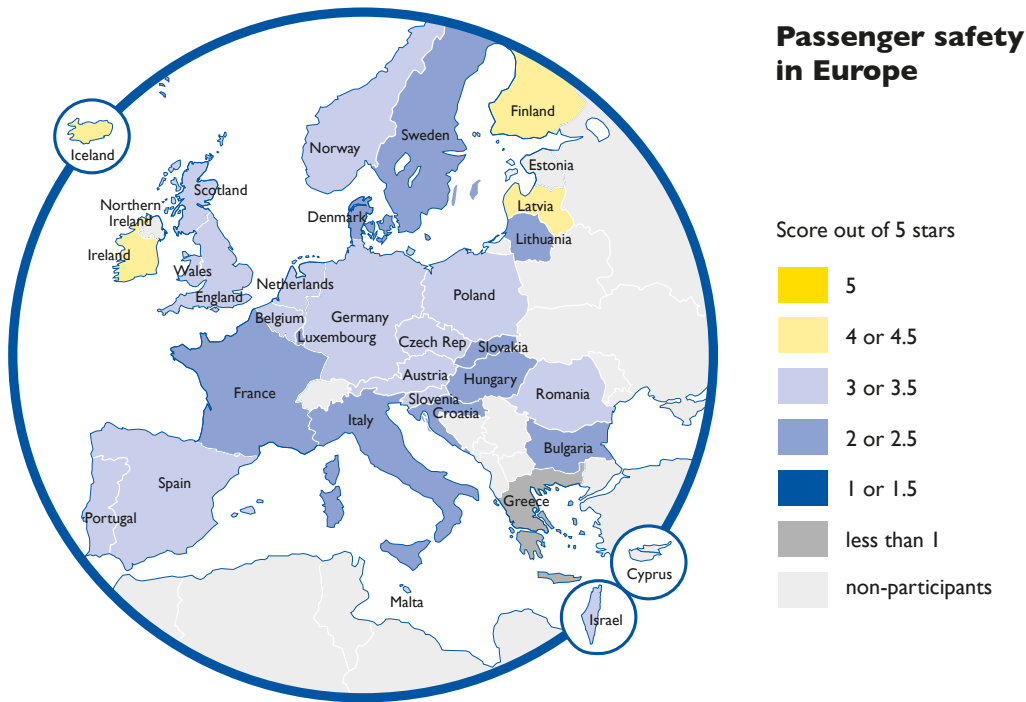
- a national law requiring use of appropriate child and adolescent passenger restraint
- a national law requiring children to remain seated rear facing in car seats until age 4 years
- a national law requiring children to remain seated in the back seat until age 13 years
- a national policy aimed at increasing access to child passenger restraint systems (CPRS) by disadvantaged families (new policy measure in 2012)
- a national law requiring graduated licensing for new drivers
- a national law banning children from riding/driving farm tractors
- a national law banning children from riding/driving all terrain vehicles (ATVs, 3- or 4-wheelers)
- a national ministry/ government department with mandated responsibility for child and adolescent passenger safety
- a government approved national strategy with specific targets and timelines related to child and adolescent passenger safety
- a national programme of child home visits that includes education on child passenger safety
- a national media campaign at least once in past five years targeting passenger safety.

Countries were assessed based on the above good practice measures and given a score out of a possible 5 stars.

Key findings

- Currently many of the recommended evidence-based national level policies in passenger safety are adopted, implemented or enforced in the majority of countries assessed and scores ranged from 0 to 4.5 stars. The average score across the participating countries was 3 out of 5 stars.
- Interestingly, passenger safety policy scores do not correspond to motor vehicle related deaths. For example, Latvia has a high policy score but ranks towards the bottom in terms of passenger/driver related injury deaths. This likely reflects different levels of exposure to risk and preventive interventions, and implementation and enforcement of existing laws between the countries.

Passenger/driver safety



- All countries reported legislation requiring use of appropriate child passenger restraints although Greece, Hungary and Israel indicate increased enforcement was needed.
- Although several countries have laws that require children to remain seated rear facing until older than a year, no country reported a law requiring children to remain seated rear facing until age 4 years; the age that research suggests would keep them safest. Of note, although there is no law, the norm in Sweden is to keep children seated rear facing until age 4 years and the country has reduced their child passenger death rate in very young children to almost zero.
- No country requires children to stay seated in the back seat of a motor vehicle to age 13 years. Twelve countries (Bulgaria, Czech Republic, France, Hungary, Iceland, Ireland, Latvia, Poland, Portugal, Romania, Slovakia and Spain) reported a law requiring children to remain seated in the back seat of the motor vehicle until age 12 and / or 150 cm in height. However, in most countries exceptions are made if the child is considered properly restrained in the front seat, and several countries indicated that this law is not well enforced.
- Twelve countries reported a policy designed to increase access to child passenger restraints by disadvantaged families (Belgium, Czech Republic, England, Finland, Iceland, Ireland, Israel, Malta, Portugal, Scotland, Slovenia and Wales), with most favouring a reduced tax on the restraints. Several countries that had other subsidy-type programmes indicated that the funds were not easily obtained, and so questioned whether the policies really increase access.
- While many countries have phased licensing policy for new drivers, only 16 have multi-stage programmes with graduated privileges that allow new drivers on-road experience under conditions of reduced risk such as: zero tolerance for alcohol, no driving at night, limiting passengers, speed, and so on. However, several countries are in progress of reviewing current laws.
- All countries except Greece have a law banning children from riding/driving farm tractors, but age limits vary and in some countries it only applies to driving on official roads.
- All countries except Bulgaria and Greece have laws banning children from riding/driving all terrain vehicles (ATVs), although several indicated the law is only partially implemented or enforced and only a few have laws that govern off-road riding.
- For the countries where a historical comparison in sub-area scores was possible, improved scores reflected increased enforcement of existing passenger restraints laws and the introduction of national media campaigns targeting child passenger safety.

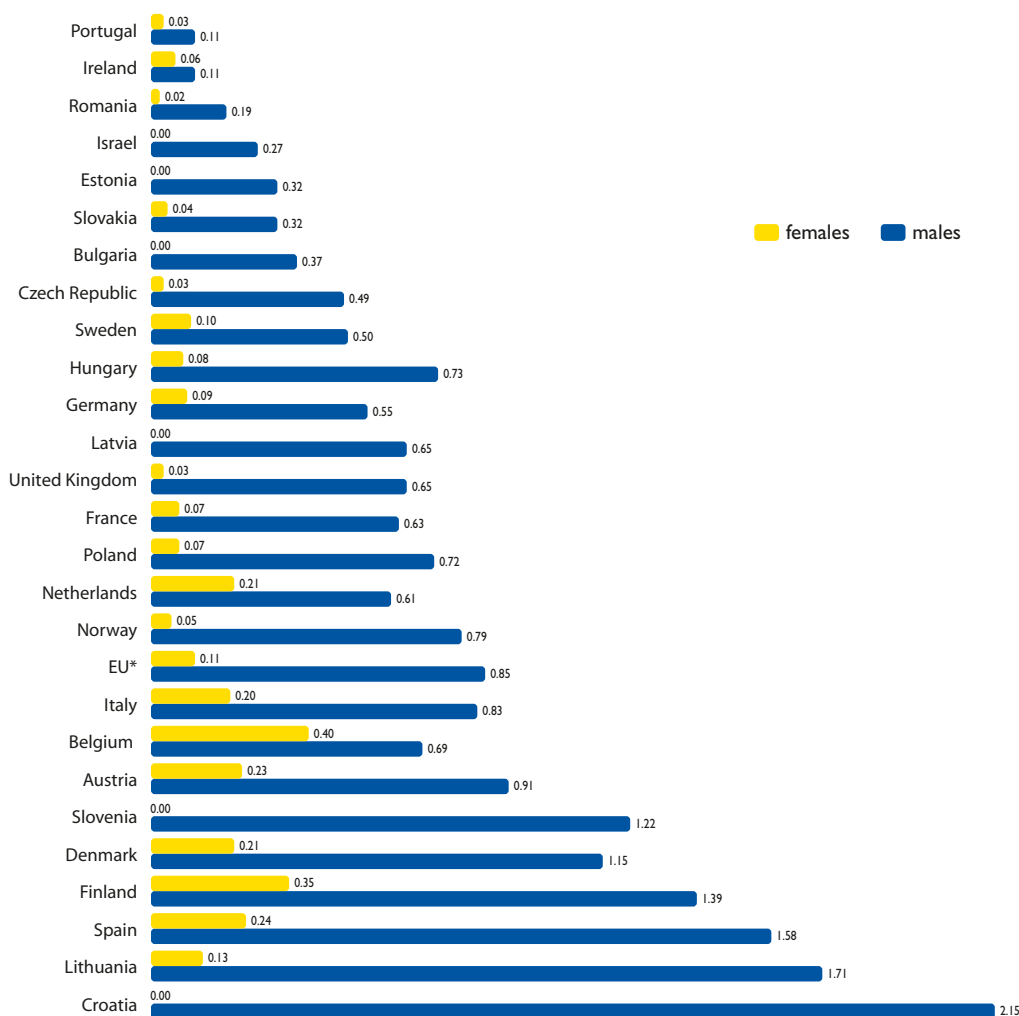
Moped/motor scooter safety

Mopeds and motor scooter use by adolescents is very common in southern Europe and is increasing across the EU as the density of road traffic increases, and mopeds are seen as an economic alternative to a car. In several countries mopeds are the major means of transportation to school, work and social events for adolescents.

Inequality in deaths due to motorised two-wheelers for children and adolescents shows a 36 times greater risk for moped or motor scooter injury in the lowest performing country compared to that of the best performing country participating in the report card assessment for whom data are available. While the highest rates are found in Croatia, Lithuania and Spain for males and Belgium, Finland and Spain for females, males are killed in accidents on motorised two-wheelers in much greater numbers than females (nearly 8x the risk using the EU average). Deaths due to motorised two-wheelers are for the most part an issue for males aged 15-19 years.

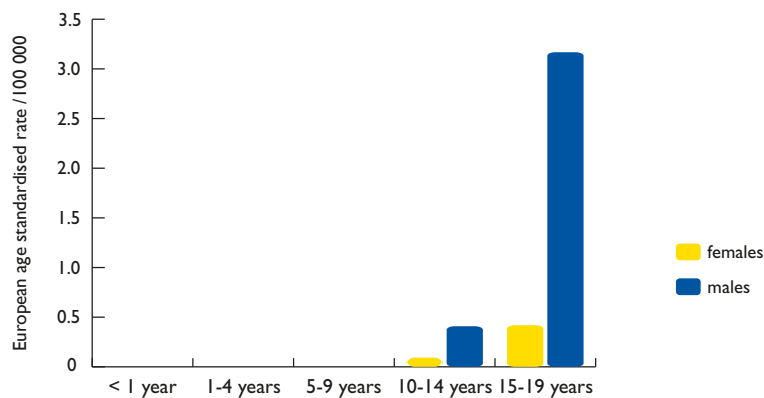
Deaths due to motorised two-wheelers for children and adolescents

(Europe age standardised rate per 100 000 population 0-19 years by sex)



Source: WHO European Detailed Mortality Database (EDMD); 3 year averages for 2008-2010 or 2007-2009 or most recent three years of data; Cyprus, Iceland, Luxembourg and Malta excluded due to small numbers and resulting rate variability; Greece is excluded as ICD-9 codes do not allow breakdown of road traffic injuries so EU average presented represents the remaining 26 countries of the EU

EU average rate of deaths due to motorised two-wheelers for children and adolescents by age and sex



Source: WHO European Detailed Mortality Database (EDMD), EU average based on 2008-2010, 2007-2009 or most recent three years of data for all EU countries except Greece as ICD-9 codes do not allow breakdown of road traffic injuries.

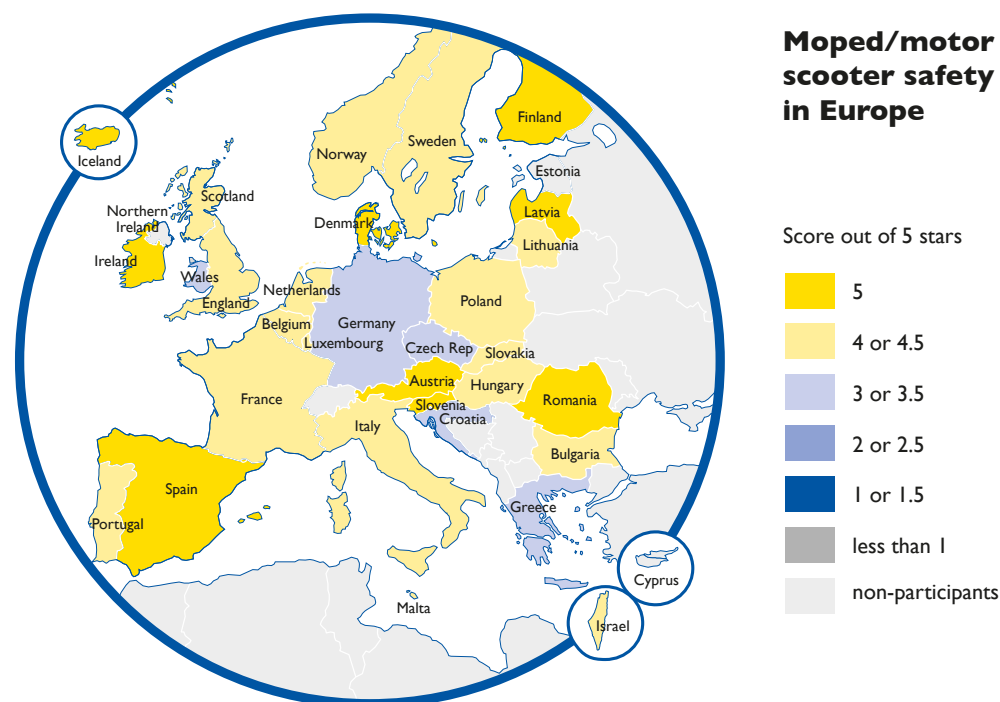
Comparison of moped/motor scooter scores

The level of moped/motor scooter safety for children and adolescents was assessed based on a country's adoption, implementation and enforcement of evidence-based national level policies relating to moped/motor scooter safety including:

- a national law limiting legal age to drive a moped/motor scooter (small engine motorcycle)
- a national law requiring a minimum qualification for riding a moped/motor scooter (e.g., formal exam prior to receiving riding permit)
- a national law limiting age or number of child and adolescent passengers on mopeds/motor scooters
- a national law limiting speeds for mopeds/motor scooters
- a national law requiring compulsory use of a helmet by moped/motor scooter riders and passengers
- a national law addressing drinking and driving of licensed vehicles by young drivers (e.g., specified allowable blood alcohol level when driving a scooter) (new policy measure in 2012)
- a national ministry/ government department with mandated responsibility for child and adolescent moped or motor scooter safety
- a government approved national injury prevention strategy with specific targets and timelines related to child and adolescent moped or motor scooter safety
- a national media campaign at least once in past five years targeting child and adolescent moped or motor scooter safety.

Countries were assessed based on the above good practice measures and given a score out of a possible 5 stars.

Moped/motor scooter safety



Key findings

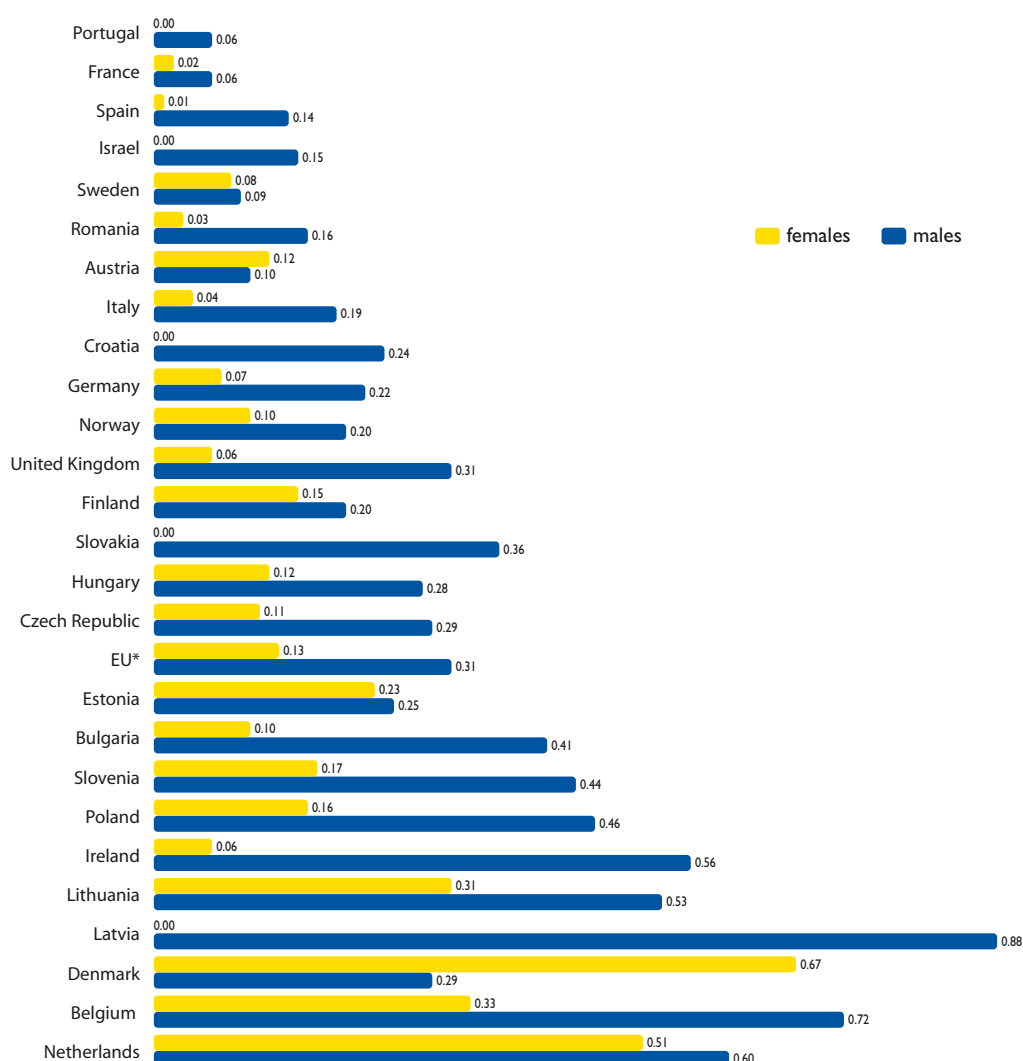
- Road safety related policies related to moped/motor scooters were the most likely to have been adopted and implemented compared to all other injury areas and while the ranges in scores was 3 to 5 stars, the average score across the 31 countries was 4.5 out of 5 stars with 10 countries reporting receiving 5 out of 5 stars. It is likely that more countries have adopted these laws as they are for the most part specified under EU Directives, whereas for other areas (e.g., passenger/driver safety), the measures investigated are not.
- Moped/motor scooter safety scores do not correspond to motorcycle related deaths for all countries. For example, Lithuania with the highest death rate also has a high safety score. This lack of correspondence between mortality rate and score likely reflects that the category used to calculate the mortality rates includes more than just moped/motor scooter-related incidents. Current coding of death data in some countries does not allow for a breakdown to examine moped/motor scooter related injuries separately, which makes European level comparisons difficult. In addition levels of exposure to risk both in terms of moped ownership and use and driving conditions and implementation and enforcement of policy measures vary between the countries.
- All countries had a law limiting the legal age to drive a moped/motor scooter and all required use of a helmet, although the legal age limit was reported as not well enforced in Poland.
- All countries require minimum qualifications, although in Bulgaria this was reported as only partly enforced, and all had specific speed limits, although Greece, Israel and Portugal reported that the speed limits are not well enforced.
- All countries but the Netherlands reported a law limiting the age or number of child passengers on mopeds/motor scooters, but Germany, Greece, Poland and Portugal reported that the law was not fully enforced.
- For the countries where a historical comparison in sub-area scores was possible, improved scores reflected increased enforcement of existing laws and the introduction of national media campaigns addressing moped/motor scooter safety.

As with walking, cycling is encouraged to promote physical activity and to battle the obesity epidemic. Children are being encouraged to use non-motorised transportation more often. Unfortunately, few countries have invested in infrastructure (such as separate bicycle lanes) to make the environment friendlier for cyclists, particularly in urban and suburban localities.

Inequality in cycling deaths for children and adolescents shows an over 40 times greater risk in the lowest performing country compared to that of the best performing country participating in the report card assessment for whom data were available. The highest rates were seen in Latvia, Belgium and the Netherlands for males and Denmark, the Netherlands and Belgium for females. Rates were higher for males than females in all countries except Austria and Denmark, the latter being notable in that rates for females were over twice that for males.

Deaths due to cycling for children and adolescents

(Europe age standardised rate per 100 000 population 0-19 years by sex)

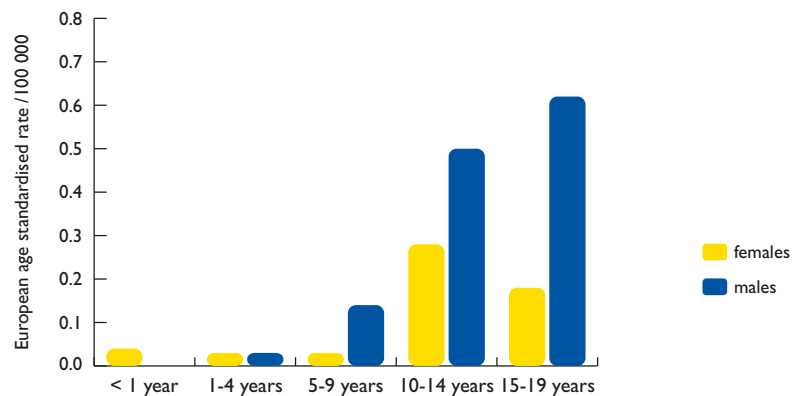


Source: WHO European Detailed Mortality Database (EDMD); 3 year averages for 2008-2010 or 2007-2009 or most recent three years of data; Cyprus, Iceland, Luxembourg and Malta excluded due to small numbers and resulting rate variability; Greece is excluded as ICD-9 codes do not allow breakdown of road traffic injuries so EU average presented represents remaining 26 countries of the EU.

Cycling safety

The rates of death due to cycling are for the most part and issue for children over age 5 years, with the highest rates found in children and adolescents over the age of 10 years, particularly males.

EU average rate of deaths due to cycling for children and adolescents by age and sex



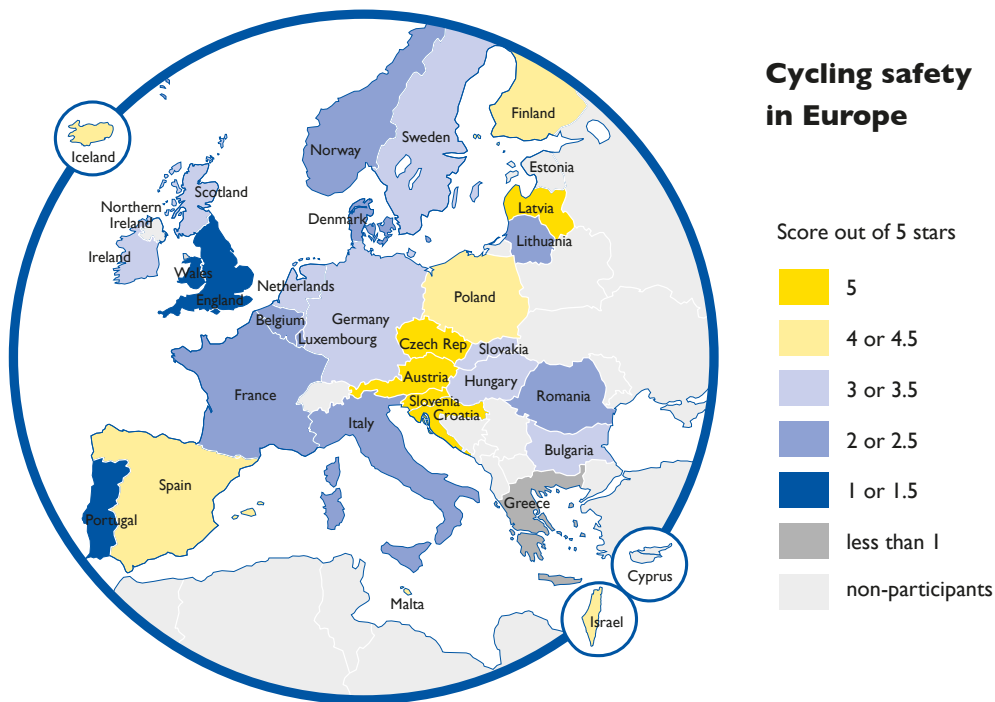
Source: WHO European Detailed Mortality Database (EDMD), EU average based on 2008-2010, 2007-2009 or most recent three years of data for all EU countries except Greece as ICD-9 codes do not allow breakdown of road traffic injuries.

Comparison of cycling safety scores

The level of cycling safety for children and adolescents was assessed based on a country's adoption, implementation and enforcement of evidence-based national level policies relating to cycling safety that included:

- a national law requiring use of bicycle helmet while cycling
- a national ministry/government department with mandated responsibility for child and youth cycling safety
- a government approved national strategy with specific targets and timelines related to child and adolescent cycling safety
- a national media campaign at least once in past five years targeting child and adolescent cycling safety.

Countries were assessed based on the above good practice measures and given a score out of a possible 5 stars.



Key findings

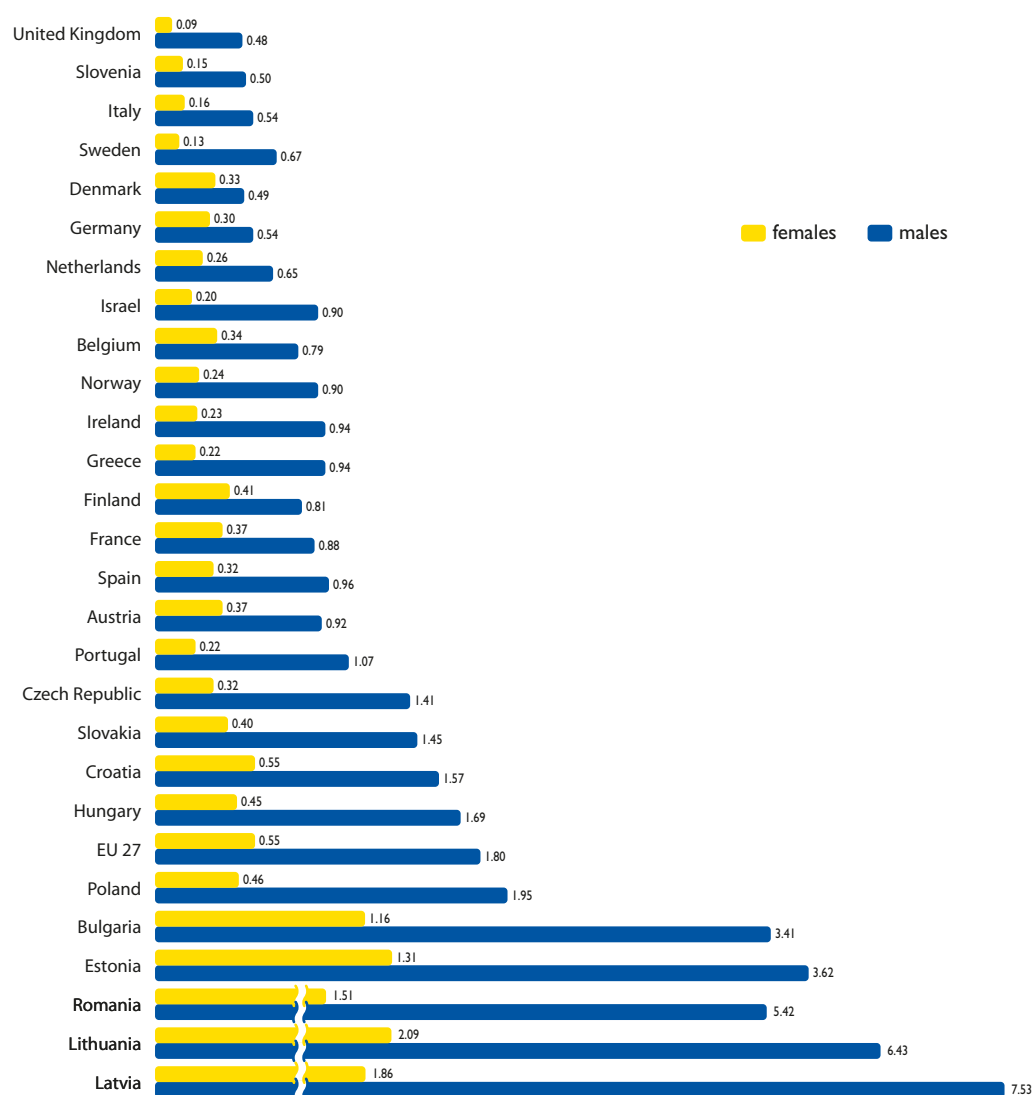
- Many of the countries have road safety plans that include specific targets for cyclists and have carried out extensive educational and media campaigns to prevent cycling-related accidents. The scores ranged from 1 to 5 stars with an average score across the participating countries of 3.5 out of 5 stars.
- We note that the policy assessment did not examine environmental modifications such as cycling lanes, as these strategies are most often implemented at the local level and the assessment focused on policies at the national level.
- Cycling safety scores did not correspond to cycling deaths for all countries. For example, the Netherlands, which has a higher cycling safety score, also had high death rates. This finding reflects the different levels of exposure as cycling is more widely undertaken in the Netherlands, but may also reflect levels of implementation and enforcement of policy measures between the countries. Another example is Latvia, which had the highest death rate for males and 5 out of 5 stars for policy uptake, however their helmet law just came into effect in 2008 and the 3-year average presented includes data from 2007-2009.
- Thirteen countries (Austria, Croatia, Czech Republic, Finland, Iceland, Israel, Latvia, Lithuania, Malta, Slovakia, Slovenia, Spain and Sweden) reported a national law requiring use of a bicycle helmet while cycling. The age up to which a helmet is required varies between countries from 12 years to all ages and five of the countries (Finland, Iceland, Israel, Malta and Spain) indicate that enforcement is an issue.
- For the countries where a historical comparison in sub-area scores was possible, improved scores reflected introduction or enhanced implementation / enforcement of existing laws requiring helmet use and the introduction of national media campaigns addressing cycling safety.

Water safety/drowning prevention

Drowning is the second leading cause of unintentional injury death for children and adolescents in the EU. Drowning often happens silently within seconds and can occur in as little as 2 cm of water:

Drowning deaths for children and adolescents

(Europe age standardised rate per 100 000 0-19 years by sex)

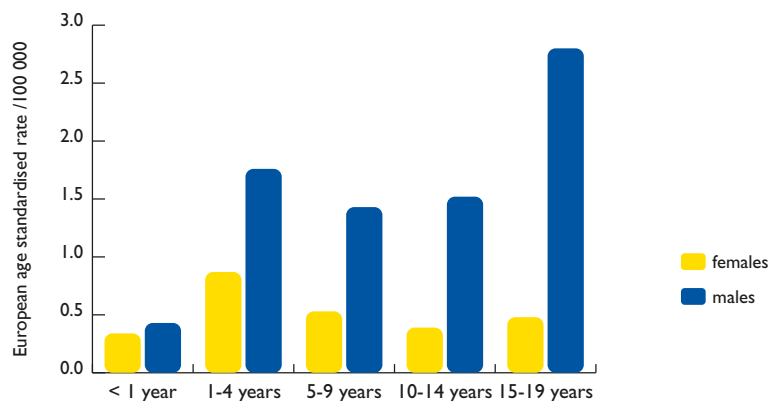


Source: WHO European Detailed Mortality Database (EDMD); 3 year averages for 2003-2005 or most recent three years of data. Cyprus and Iceland excluded due to small populations and data for the constituent countries of the United Kingdom not available so presented together as the United Kingdom.

Inequality in drowning deaths for children and adolescents shows an almost 18 times greater risk in the lowest performing country compared to that of the best performing country participating in the report card assessment for whom data are available. The highest rates were seen in new member states, Latvia, Lithuania and Romania for both males and females. However, it is also important to note that many drownings occur to children who are tourists in another country, and the drowning deaths reported here by country do not include tourist deaths, which are attributed to country of residence. As a result drowning deaths occurring in some countries may underestimate the true magnitude of the issue.

Drowning deaths occur across the age groups, with deaths being significantly higher for males than females after the first year of age. The highest rates occur in males aged 15-19 years.

EU average rate of deaths due to drowning for children and adolescents by age and sex



Source: WHO European Detailed Mortality Database (EDMD), EU average based on 2008-2010, 2007-2009 or most recent three years of data.

Water Safety/Drowning Prevention Scores

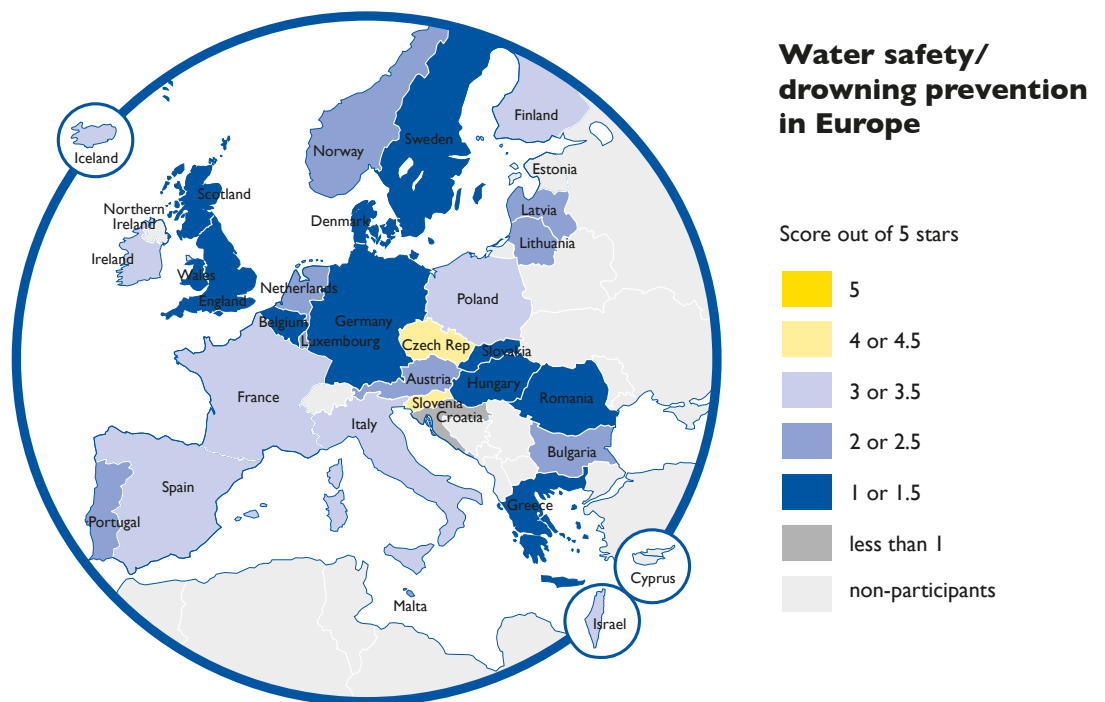
The level of water safety/drowning prevention for children and adolescents was assessed based on a country's adoption, implementation and enforcement of evidence-based national level policies relating to water safety/drowning prevention that included:

- a national law requiring barrier fencing for public pools
- a national law requiring barrier fencing for private pools (domestic pools; those associated with a residence or dwelling)
- a national law requiring national recertification for lifeguards on a regular basis
- a national law stating minimum number of lifeguards required on beaches or other areas specifically specified for water leisure activities
- a national law stating minimum number of lifeguards required at public pools
- a national standard for public swimming pools that mandates water depth markings, step edges marked with contrasting colours, onsite safety equipment, suction outlet covers and chemical standards
- a national standard for water safety signs and symbols (e.g., no diving signs, red flag indicating 'do not enter water', etc.)
- a national policy requiring qualified risk assessment of all designated public water recreational areas (e.g., assessment conducted by qualified inspector) (new policy measure in 2012)
- a national policy governing water safety for leisure/ recreational programming at the community level (e.g., minimum levels of supervision, training or safety equipment, etc.)
- a national policy making water safety education, including swimming lessons, a compulsory part of the school curriculum
- an investment programme (either national or regional with national coverage) to renew infrastructure to provide equitable access to public swimming pools for swimming lessons for school age children (new policy measure in 2012)
- a national law requiring mandatory use of personal floatation device/lifejacket while on the water (e.g., while boating, sailing, etc.)

Water safety/drowning prevention

- a national ministry/government department with mandated responsibility for child and adolescent water safety
- a government approved national injury prevention strategy with specific targets and timelines related to child and adolescent water safety
- a national programme of child home visits that includes education on child water safety
- a national media campaign at least once in past five years targeting child and adolescent water safety.

Countries were assessed based on the above good practice measures and given a score out of a possible 5 stars.



Key findings

- Currently the recommended evidence-based national level policies in water safety are not adopted, implemented or enforced in the majority of countries assessed. Scores ranged from 0.5 to 4 stars with an average score across the participating countries of only 2 out of 5 stars.
- Water safety/drowning prevention scores did not correspond to drowning deaths for all countries with no clear pattern of reduced mortality for those countries with higher water safety scores. Again this lack of correspondence likely reflects different levels of exposure and implementation and enforcement of policy measures between the countries.
- In addition, for several countries, many of the water safety/drowning prevention policies are addressed at the regional level. Germany is one example of a country with regional policy for water safety/drowning prevention and this may explain why their score was low.
- Only eight countries Bulgaria, France, Iceland, Israel, Italy, Lithuania, Norway and Sweden have a law that requires barrier fencing for private pools. Only France reported that their law was well implemented and enforced, however compliance is satisfied by several measures in addition to barrier fencing, so its impact on fencing is unknown.

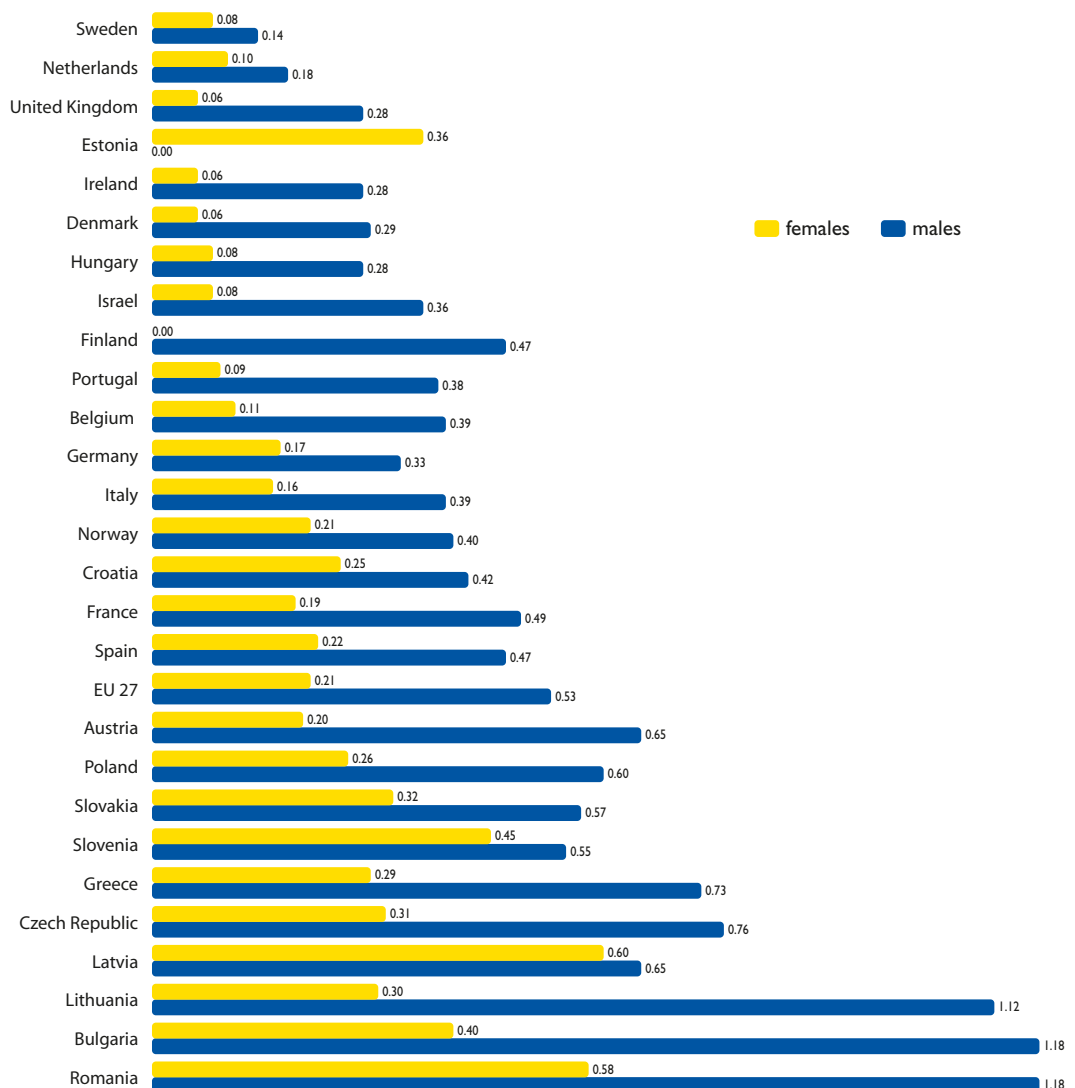
Water safety/drowning prevention

- Seven countries reported laws requiring barrier fencing around public pools (Austria, Bulgaria, Czech Republic, Iceland, Israel, Italy, Norway, Poland, Slovenia, Spain and Sweden). In a number of countries the fences are just required around the perimeter of the whole property and in Bulgaria, Italy and Sweden the law is only partially enforced.
- Laws regarding lifeguard certification and minimum numbers required in different settings were reported to vary greatly both across countries and within countries and several countries reported only having guidelines. This may be an area where consensus at a European level would benefit the injury prevention field.
- Nineteen countries report a policy that makes water safety education (including swimming lessons) a compulsory part of the school curricula but implementation varies greatly within and between countries and is often limited by lack of facilities. Only ten countries (Czech Republic, Finland, Hungary, Iceland, Lithuania, Malta, Norway, Poland, Slovenia and Spain) reported some form of national or regional investment programmes to increase and / or renew infrastructure.
- Only four countries (Bulgaria, Ireland, Latvia and Poland) require and enforce use of personal floatation devices (PFD) while on the water: Portugal also has legislation but it is not fully implemented and enforced (Portugal) and 18 others (Austria, Czech Republic, Denmark, Finland, France, Greece, Hungary, Iceland, Israel, Italy, Lithuania, Luxembourg, Malta, Norway, Romania, Slovakia, Slovenia and Spain) have existing legislation that requires only that the PFD be present while on the water and does not specify that it should be worn. This is not seen as providing adequate protection for children.
- For the countries where a historical comparison in sub-area scores was possible, improved scores reflected introduction or enhanced implementation / enforcement of existing laws addressing personal floatation device use, pool fencing, lifeguard supervision and recertification and the introduction of national media campaigns addressing water safety.

Fall prevention

Falls are the third leading cause of unintentional death for children and adolescents in the EU. Yet in countries where data are available for hospitalisations and emergency department visits, falls are frequently the leading cause of admissions and emergency department visits for children and adolescents. Inequality in deaths due to falls for children and adolescents shows over a 9 times greater risk in the lowest performing country compared to that of the best performing country participating in the report card assessment. Rates were higher for males in all countries except Estonia and overall the highest rates for males were seen in Romania and Bulgaria and Lithuania and for females in Latvia, Romania and Slovenia.

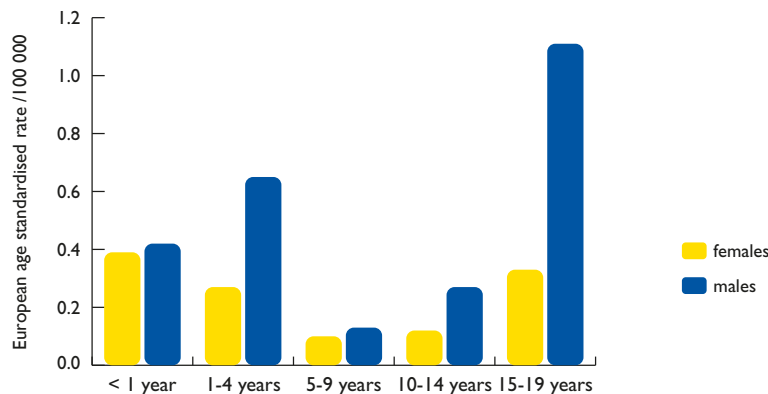
Deaths due to falls for children and adolescents
(Europe age standardised rate per 100 000 population 0-19 years by sex)



Source: WHO European Detailed Mortality Database (EDMD); 3 year averages for 2008-2010 or 2007-2009 or most recent three years of data; Cyprus, Iceland, Luxembourg and Malta excluded due to small numbers and resulting rate variability.

Falls occur across the age range, with higher rates in very young children and older adolescent males. The causes of fall-related injury differ with infants more likely to fall from furniture or as a result of being dropped; children aged 1-4 years are more likely to fall from stairs and steps, windows, balconies, furniture or play equipment; and older children and adolescents are more likely to fall from playground equipment and heights such as fire escapes, roofs and balconies.

EU average rate of deaths due to falls for children and adolescents by age and sex



Source: WHO European Detailed Mortality Database (EDMD), EU average based on 2008-2010, 2007-2009 or most recent three years of data.

Comparison of fall prevention scores

The level of fall prevention for children was assessed based on a country's adoption, implementation and enforcement of evidence-based national level policies relating to fall prevention that included:

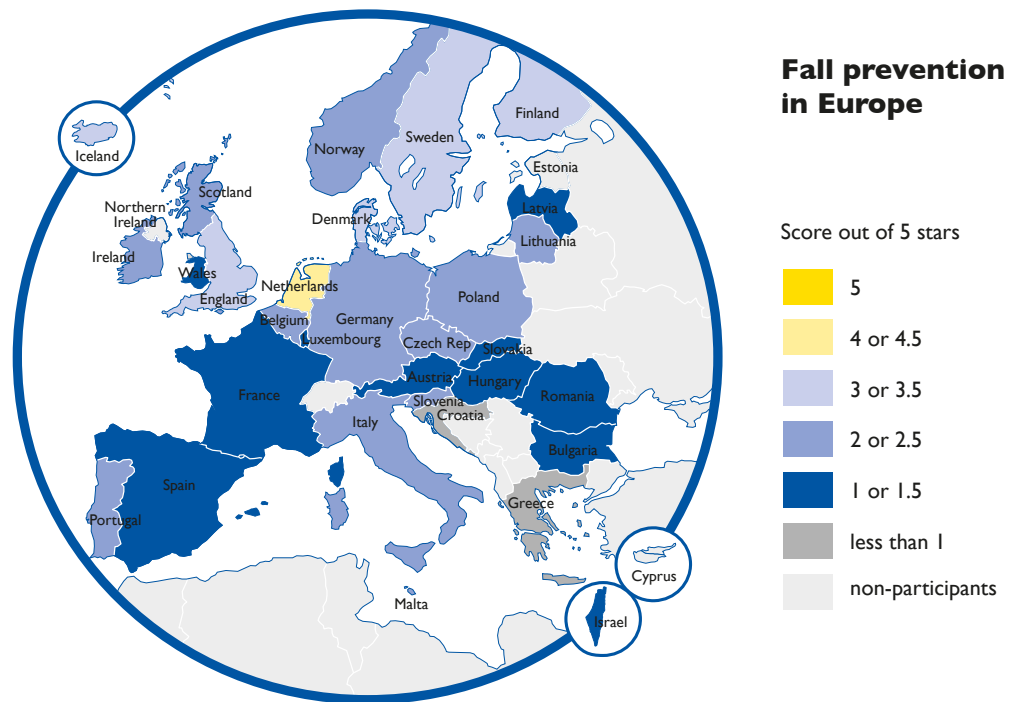
- a national policy requiring playground equipment and landing surfaces to meet safety standards
- a national law banning the marketing and sale of baby walkers
- a national law requiring environmental changes to prevent children from falling out of windows in buildings with more than one storey/level (e.g., window guards or locks)
- a national regulation for private and public buildings requiring safe design for guardrails to prevent falls from balconies and stairs
- a national policy aimed at increasing access to childcare equipment [e.g., stair gates] for disadvantaged families (national equipment give-away programme or loaner scheme OR policy making childcare equipment such as stair gates essential childcare articles i.e., taxed at a lower rate) (new policy measure in 2012)
- a national ministry/ government department with mandated responsibility for child and adolescent fall prevention
- a government approved national injury prevention strategy with specific targets and timelines related to child and adolescent fall prevention
- a national programme of child home visits that includes education on child fall prevention
- a national media campaign at least once in past five years targeting child and adolescent fall prevention.

Countries were assessed based on the above good practice measures and given a score out of a possible 5 stars.

Key findings

- Currently the recommended evidence-based national level policies in fall prevention are not adopted, implemented or enforced in the majority of countries assessed. Scores ranged from 0-4 stars with an average score for countries participating of 2 stars out of 5. It is interesting to note that the highest scores occur in the Nordic countries and the Netherlands, countries with longer-term investments in child injury prevention.

Fall prevention



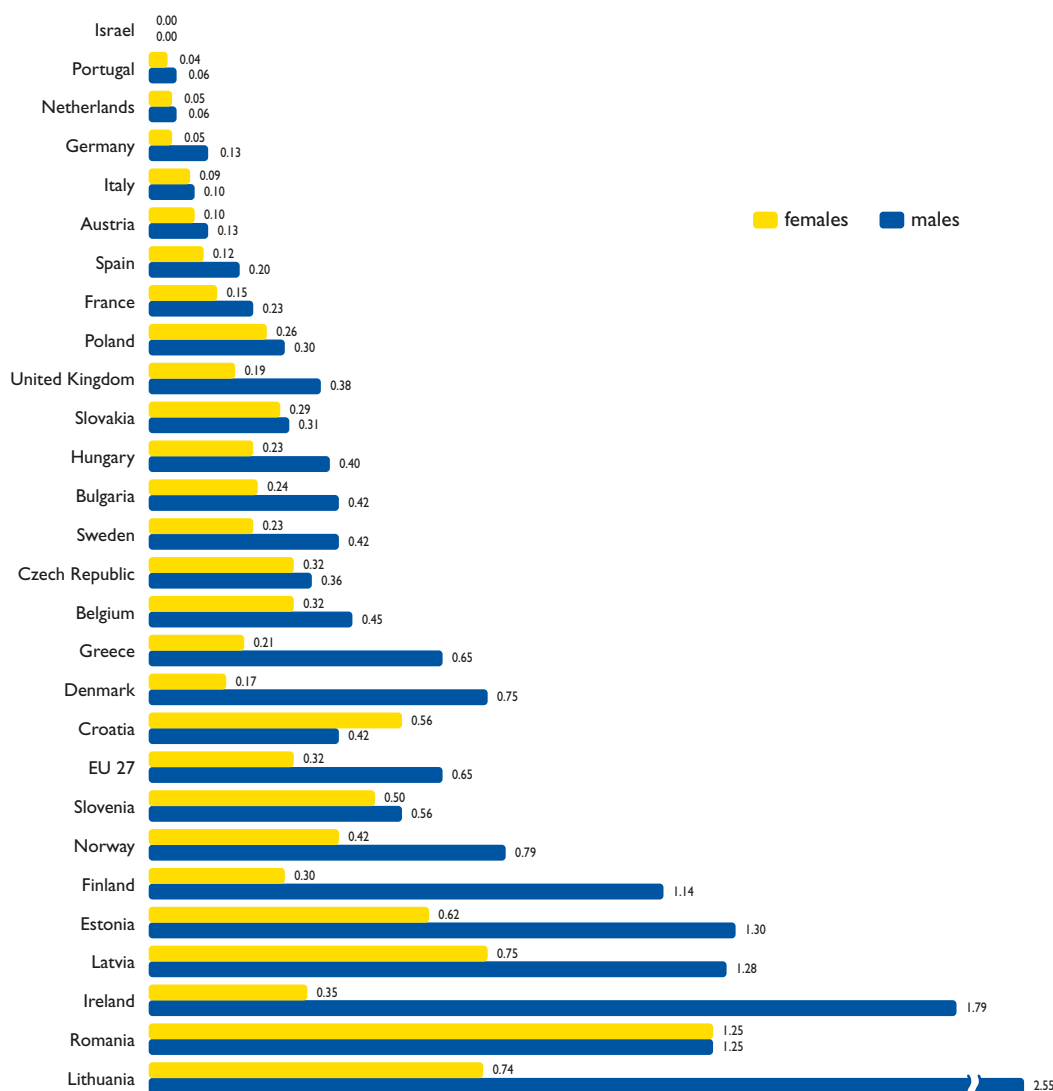
- Fall prevention scores more closely correspond to rates of deaths due to falls than other injury issues. However, there are still differences likely reflecting different levels of exposure and implementation and enforcement of policy measures between the countries.
- Every country except Greece reported a policy requiring playground equipment and landing surfaces to meet safety standards, but seven others indicated that the standard was only partially implemented or enforced (Bulgaria, Croatia, Israel, Latvia, Portugal, Romania and Spain).
- Sixteen countries (Bulgaria, Denmark, England, Finland, Hungary, Iceland, Ireland, Lithuania, Luxembourg, Netherlands, Norway, Romania, Scotland, Slovenia, Sweden and Wales) have a national law requiring environmental changes to prevent children from falling out of windows in buildings with more than one storey or level, but in many cases these are building codes that apply only to new buildings or refurbishments, meaning that older buildings that do not meet standards are not required to be upgraded to be made safe. This may increase inequities, in that the most vulnerable families are the least likely to live in buildings impacted by the requirement.
- All but nine countries (Belgium, Bulgaria, Croatia, Greece, Hungary, Latvia, Malta, Portugal and Spain) report a national regulation for public and private buildings requiring safe design for guardrails to prevent falls from balconies and stairs, although again these tend to apply only to new buildings or refurbishments and in several countries are reported not to be well enforced.
- Very few countries (Belgium, England, Iceland, Ireland, Lithuania and Malta) reported a national policy aimed at increasing access to childcare equipment for disadvantaged families and the mechanisms varied by country.
- For the countries where a historical comparison in sub-area scores was possible, improved scores reflected establishment of a national ministry/ government department with mandated responsibility or national injury prevention strategy with specific targets and timelines for the issue, enhancement of laws related to playground equipment and landing surfaces and the introduction of national falls prevention campaigns and programmes educating new parents.

Poisoning is the fifth leading cause of unintentional death for children and adolescents in the EU. The youngest children are at greatest risk since curiosity and a natural tendency to put things in their mouths means they are at increased risk of poisoning over older children and adults. However, issues such as alcohol poisoning emerge with older children and adolescents.

Inequity in poisoning deaths for children and adolescents shows a 40+ times greater risk for poisoning in the lowest performing country compared to that of the best performing country participating in the report card assessment. The highest rates were seen in Lithuania, Ireland and Estonia for males and Romania, Latvia and Lithuania for females.

Poisoning deaths for children and adolescents

(Europe age standardised rate per 100 000 population 0-19 years by sex)

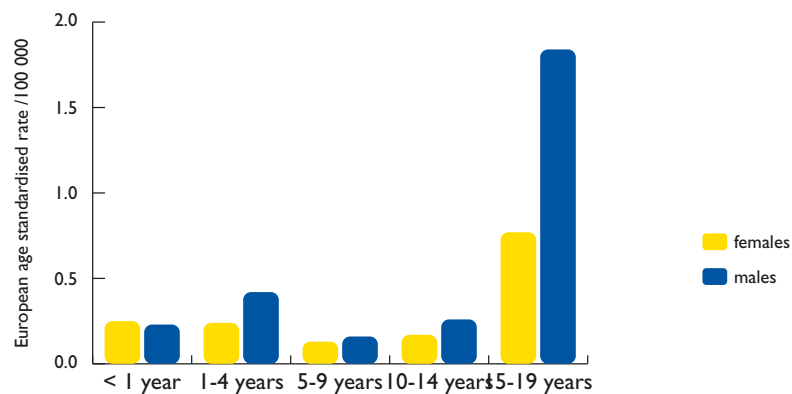


Source: WHO European Detailed Mortality Database (EDMD); 3 year averages for 2008-2010 or 2007-2009 or most recent three years of data; Cyprus, Iceland, Luxembourg and Malta excluded due to small numbers and resulting rate variability.

Poisoning prevention

Fatal poisonings occur across the age range. The highest rates are found in 15-19 year olds where acute alcohol poisoning and misuse of medications and other illicit drugs are common causes.

EU average rate of deaths due to falls for children and adolescents by age and sex



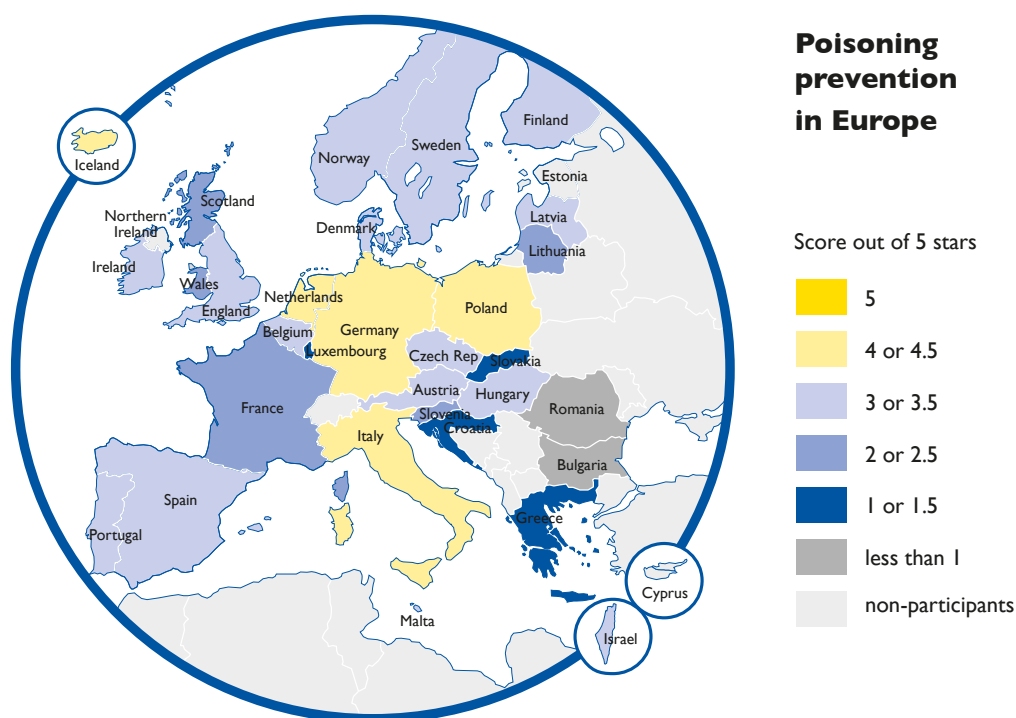
Source: WHO European Detailed Mortality Database (EDMD), EU average based on 2008-2010, 2007-2009 or most recent three years of data.

Comparison of poisoning prevention scores

The level of poisoning prevention for children was assessed based on the country's adoption, implementation and enforcement of evidence-based national level policies relating to poisoning prevention that included:

- a national law requiring child resistant packaging of medications
- a national law requiring child resistant packaging of household cleaners
- a national policy regarding poison control centres (e.g., funding or support for national or regional poison control centre)
- a national ministry/ government department with mandated responsibility for child and adolescent poisoning prevention
- a government approved national injury prevention strategy with specific targets and timelines related to child and adolescent poisoning prevention
- a national programme of child home visits that includes education on child poisoning prevention
- a national media campaign at least once in past five years targeting child and adolescent poisoning safety.

Countries were assessed based on the above good practice measures and given a score out of a possible 5 stars.



Key findings

- Although slightly better than the other areas of non-traffic injury, the recommended evidence-based national level policies in poisoning prevention are still not adopted, implemented or enforced in the majority of countries assessed. The average score for countries participating was 3 stars out of 5, scores ranged from 0.5 to 4.5 stars.
- Poisoning prevention scores correspond reasonably well to poisoning deaths. However, there are still examples where they do not correspond and this likely reflects different levels of exposure and implementation and enforcement of policy measures between the countries. In addition alcohol poisoning in adolescents may also play a role in those countries with higher rates of unintentional poisoning.
- While 21 countries have one or more educational strategies in place, only 12 countries report having well enforced laws requiring child resistant packaging of both medications and household cleaners (Austria, England, Germany, Hungary, Iceland, Israel, Italy, Poland, Scotland, Spain, Sweden and Wales). Three countries (Belgium, Bulgaria and Romania) report laws that are not fully implemented or enforced and Greece reports no national law for either.
- All countries except Bulgaria and Romania have a national policy regarding poison control centres, although Israel indicated more could be done to support the efforts in their country.
- For the countries where a historical comparison in sub-area scores was possible, improved scores reflected establishment of a national ministry/ government department with mandated responsibility or national injury prevention strategy with specific targets and timelines for the issue and the introduction of a national media campaign and programmes educating new parents.

Burn prevention

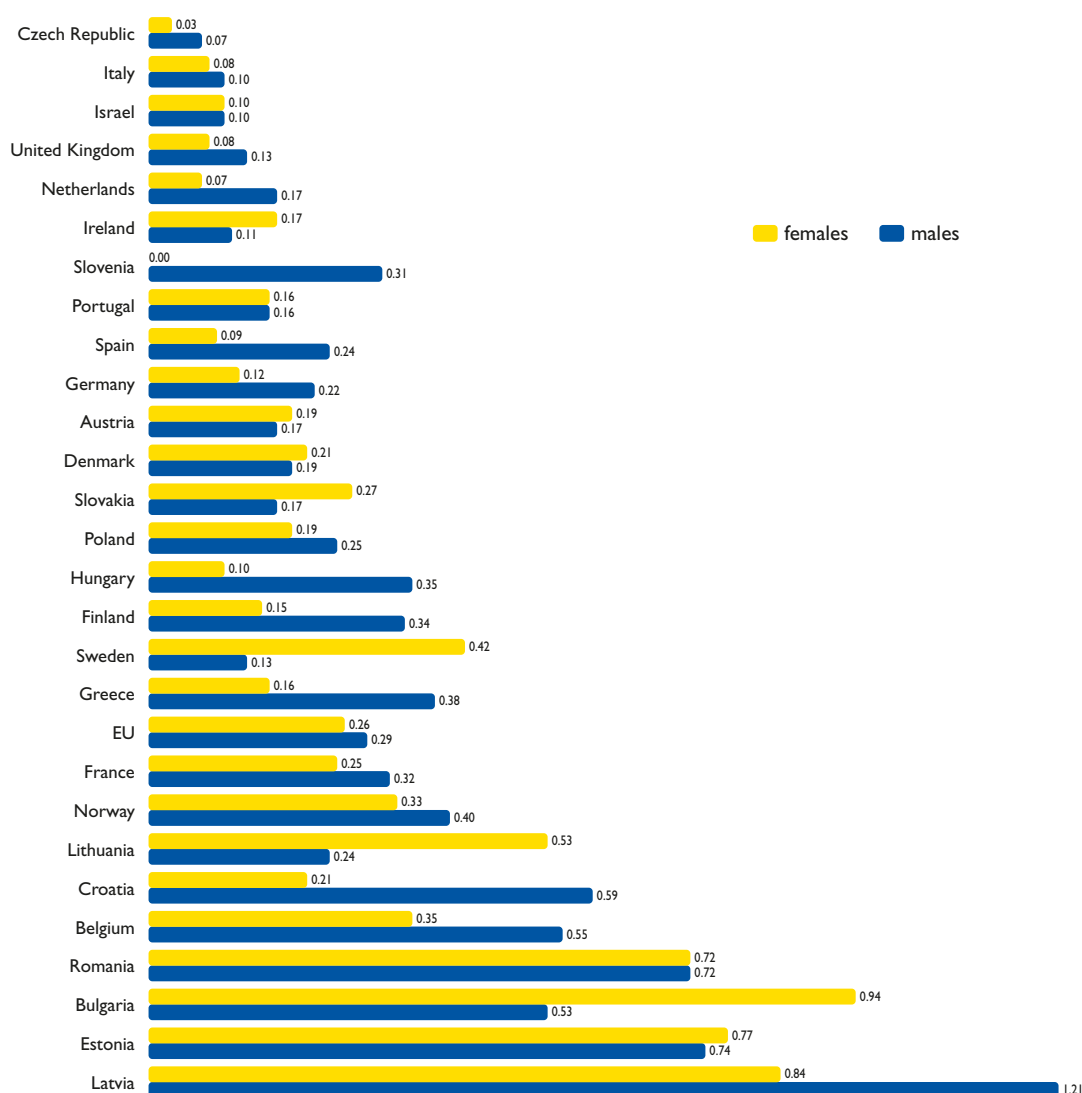
Burns, scalds and fire make up the fourth leading cause of unintentional injury death for children and adolescents in the EU. In addition to deaths, non-fatal burn injuries are life-altering events, requiring extended hospital stays and multiple surgeries and often resulting in permanent disability and disfigurement.

Inequality in burns and scald deaths for children and adolescents shows over a 21 times greater risk for burns and scalds in the lowest performing country compared to that of the best performing country participating in the report card assessment. The highest rates were seen in Latvia, Estonia and Romania for males and Bulgaria, Latvia and Estonia for females. Rates for females were either lower than males or similar for all countries except Sweden, Lithuania and Bulgaria.

Deaths due to burns, scalds and fire occur across all age groups of children and adolescents. The highest rates occur in children under five years of age, likely reflecting higher rates of fatality in house fires given that they are less likely to be able to escape in the event that a house fire occurs.

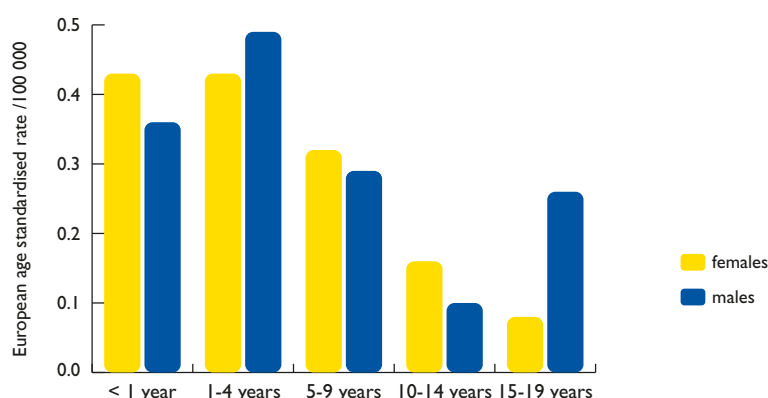
Deaths due to burns, scalds and fire for children and adolescents

(Europe age standardised rate per 100 000 population 0-19 years by sex)



Source: WHO European Detailed Mortality Database (EDMD); 3 year averages for 2008-2010 or 2007-2009 or most recent three years of data; Cyprus, Iceland, Luxembourg and Malta excluded due to small numbers and resulting rate variability.

EU average rate of deaths due to burns, scalds and fire for children and adolescents by age and sex



Source: WHO European Detailed Mortality Database (EDMD), EU average based on 2008-2010, 2007-2009 or most recent three years of data.

Comparison of burn/scald prevention scores

The level of burn/scald prevention for children and adolescents was assessed based on a country's adoption, implementation and enforcement of evidence-based national level policies relating to burn/scald prevention that included:

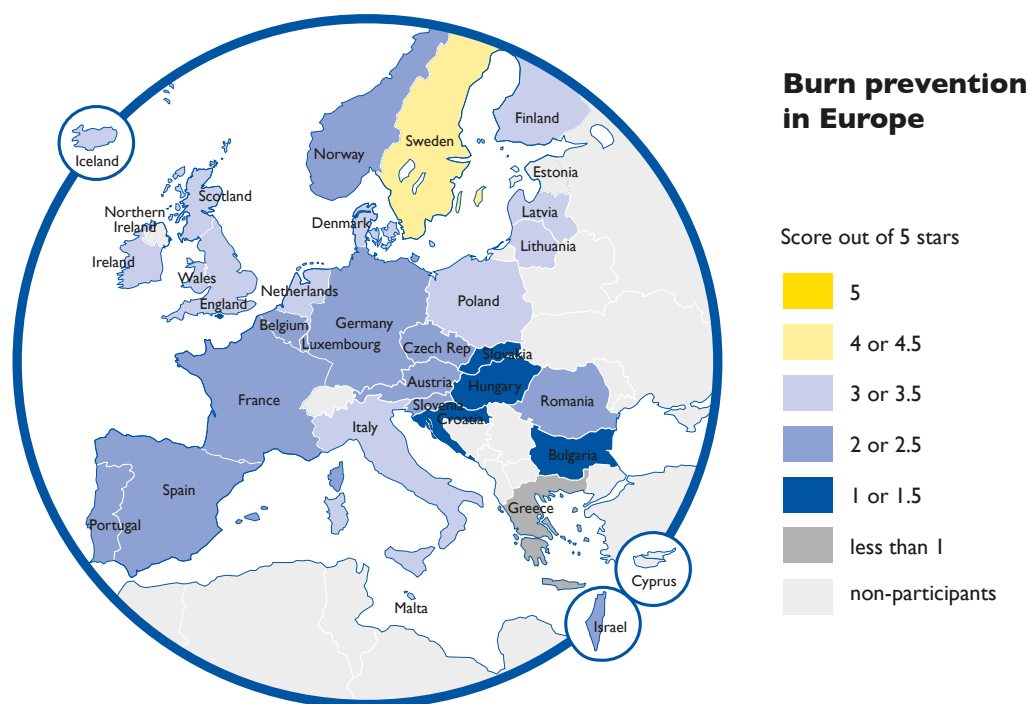
- a national law requiring a scald preventing maximum temperature (not higher than 50°C) for tap water in domestic settings
- Building codes requiring working smoke detectors in all private dwellings
- Building codes requiring working smoke detectors in all public dwellings (e.g., hospitals, schools and day-care centres)
- a national policy requiring sale of reduced ignition propensity (RIP) cigarettes (e.g., "fire-safe" cigarettes designed to reduce risk of igniting upholstered furniture, mattresses and bedding)
- a national regulation requiring child resistant design for cigarette lighters
- a national law requiring use of flame retardant fabrics in children's nightwear
- a national law controlling the sale of fireworks
- a national ministry/ government department with mandated responsibility for child and adolescent burn/scald prevention
- a government approved national injury prevention strategy with specific targets and timelines related to child and adolescent burn/scald prevention
- a national programme of child home visits that includes education on child burn/scald prevention
- a national media campaign at least once in past five years targeting child and adolescent burn/scald prevention.

Countries were assessed based on the above good practice measures and given a score out of a possible 5 stars.

Key findings

- Currently the recommended evidence-based national level policies in burn prevention are still not adopted, implemented or enforced in the majority of countries assessed. Scores ranged from 0 to 4 stars with an average score for countries participating of 2.5 stars out of 5.

Burn prevention



- Burn prevention scores correspond reasonably well to the rates of deaths from burns, scalds and fire. Again, this may reflect different levels of exposure and implementation and enforcement of policy measures between the countries and the fact that these types of injuries are less likely to be fatal.
- Only one country, Iceland, reported requiring a scald preventing maximum temperature (not higher than 50°C) for tap water in domestic settings. While several others have legislation requiring a safe hot water temperature (England, France, Israel, Scotland, Sweden, Wales), the legislation does not apply to all dwellings. Still others have legislation that specifies a temperature that is not scald preventing, but exists for bacterial deterrent purposes or applies only to day-care centres and thus reflect no decreased risk of scalds for children in the home.
- Only Finland, France, Iceland and Sweden reported requiring working smoke detectors in all public and private dwellings. Most other countries have legislation that requires smoke detectors for only new buildings or only public buildings, a situation that does not adequately protect children and families from lower socio-economic settings. Bulgaria, Croatia, Greece, Hungary and Israel have no legislation regarding smoke detectors.
- All countries but Croatia, Czech Republic and Iceland report a regulation requiring child resistant designs for cigarette lighters, but several countries reported that there is still an issue with unsafe designs on the black market.
- While the new EU standard for reduced ignition propensity (RIP) cigarettes only came into effect after the cut-off for the current assessment, several countries had already introduced policies on the topic as of July 2012 (Austria, Czech Republic, England, Finland, France, Italy, Lithuania, Luxembourg, Poland, Scotland and Wales).
- All countries have a law controlling the sale of fireworks to children, but the laws vary widely and are reported as not well enforced in Bulgaria, Greece and Portugal.
- For the countries where a historical comparison in sub-area scores was possible, improved scores reflected establishment of a national injury prevention strategy with specific targets and timelines for the issue, introduction of policies related to child resistant lighters and reduced ignition propensity cigarettes and the introduction of a national media campaign and programmes educating new parents.

Choking/strangulation prevention

INJURY AREA SCORES Choking/strangulation prevention

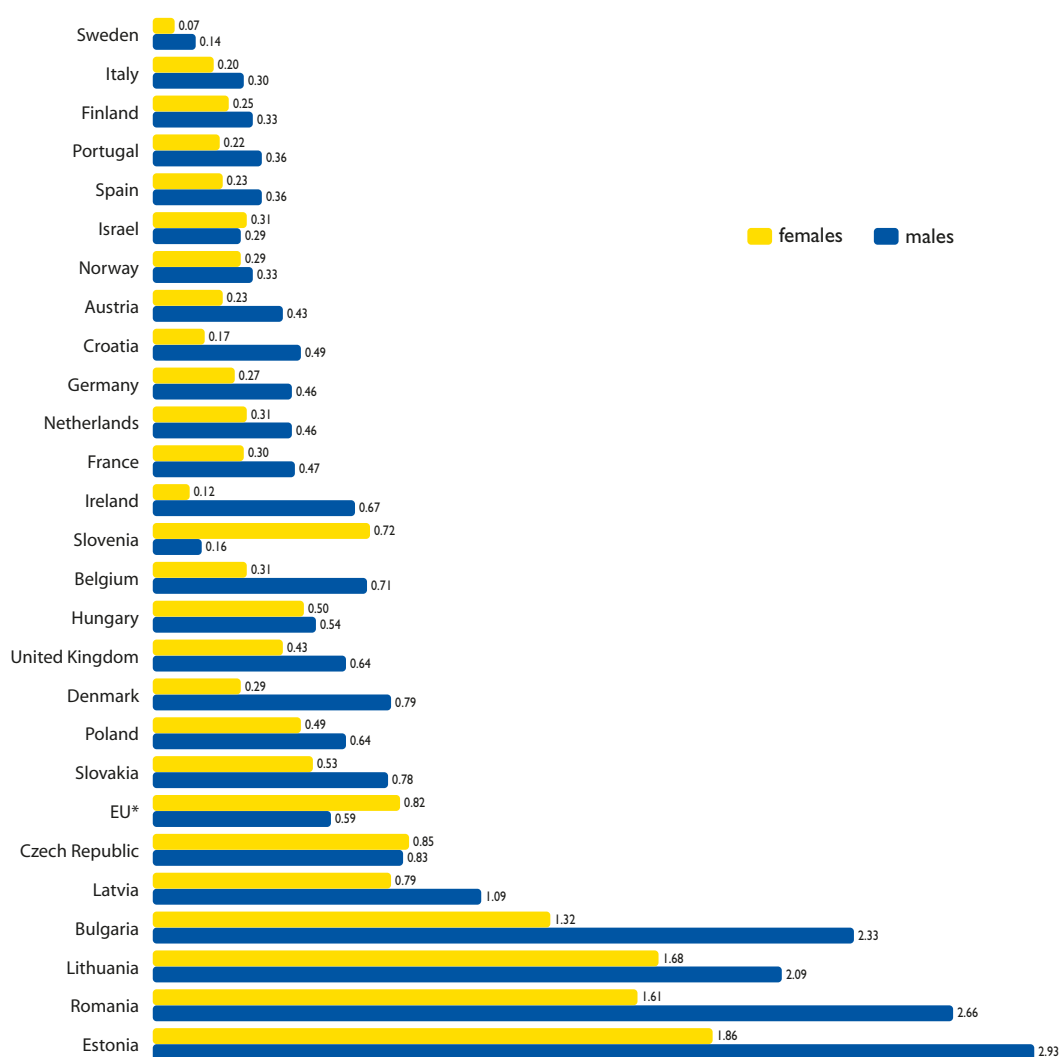
Although they occur less often than other causes of injury death, airway and breathing related injuries, such as strangulation with blind cords or choking on small parts, are often fatal injuries.

Inequality in choking/strangulation deaths for children and adolescents shows over a 20 times greater risk for choking/strangulation in the lowest performing country compared to that of the best performing country participating in the report card assessment. The highest rates were seen in Estonia, Romania and Bulgaria for males and Estonia, Lithuania and Romania for females.

Choking/strangulation deaths are predominately an issue in children under one year of age, where again natural curiosity and a tendency to put things in their mouths increases their risk of choking. In addition, should they become entangled, they are also less likely to be able to disentangle themselves.

Deaths due to choking/strangulation for children and adolescents

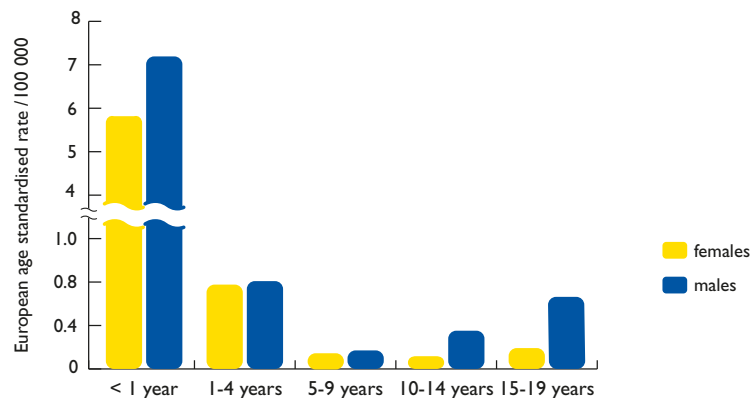
(Europe age standardised rate per 100 000 population 0-19 years by sex)



Source: WHO European Detailed Mortality Database (EDMD); as 3 year averages for 2008-2010 or 2007-2009 or most recent three years of data. Cyprus, Iceland, Luxembourg and Malta excluded due to small numbers and potential variability; Greece excluded as unavailable so EU average presented represents remaining 26 countries of the EU.

Choking/strangulation prevention

EU average rate of deaths due to choking/strangulation for children and adolescents by age and sex



Source: WHO European Detailed Mortality Database (EDMD), EU average based on 2008-2010, 2007-2009 or most recent three years of data for all EU countries except Greece.

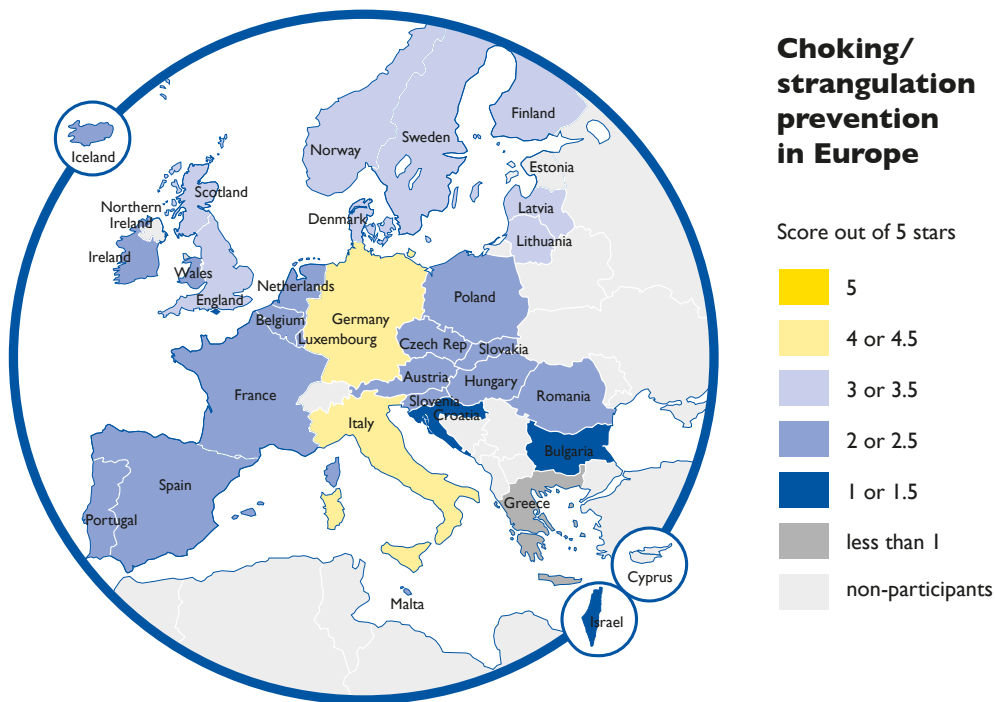
Comparison of choking/strangulation prevention scores

The level of choking/strangulation prevention for children was assessed based on a country's adoption, implementation and enforcement of evidence-based national level policies relating to choking/strangulation prevention that included:

- a national law that enables restriction or banning of unsafe products
- a national law requiring informative warning labels on products (e.g., toys) to prevent choking, suffocation or strangulation
- a national law that bans the production and sale of latex balloons
- a national law that prohibits the use of inedible materials in food products
- a national law that regulates design and sale of blind cords
- a national standard that regulates safe crib design
- a national law that prohibits the use of drawstrings in children's clothing
- a national ministry/ government department with mandated responsibility for child and adolescent choking/strangulation prevention
- a government approved national injury prevention strategy with specific targets and timelines related to child and adolescent choking/strangulation prevention
- a national programme of child home visits that includes education on child choking/strangulation prevention
- a national media campaign at least once in past five years targeting child and adolescent choking/strangulation prevention.

Countries were assessed based on the above good practice measures and given a score out of a possible 5 stars.

Choking/strangulation prevention



Key findings

- Currently the recommended evidence-based national level policies in choking/strangulation prevention are still not adopted, implemented or enforced in the majority of countries assessed. The average score for countries participating was 2.5 stars out of 5 (range 0.5 to 4.5 stars).
- Choking/strangulation prevention scores do not currently correspond well to the rates of choking deaths for all countries. This likely reflects different levels of exposure to risks for choking and strangulation and of implementation and enforcement of policy measures between the countries, and also the fact that policies examined cover only a small proportion of the causes of choking.
- All countries except Italy report a law that enables restriction or banning of unsafe products.
- Although many report they are following the new EU standard for the use of inedible materials in food products, few countries have a law that actually prohibits the use of inedible materials in food products.
- Ten countries (Denmark, England, Finland, Ireland, Lithuania, Malta, Norway, Scotland, Slovenia and Wales) regulate the design and sale of blind cords, while several others have voluntary standards.
- All countries except Croatia, Luxembourg and Romania report a national standard regulating safe crib design, however Bulgaria, Finland, Greece, Italy, Latvia and Portugal all note the need for stronger enforcement.
- For the countries where a historical comparison in sub-area scores was possible, improved scores reflected establishment of a national injury prevention strategy with specific targets and timelines for the issue and work related to window blind safety, national media campaigns and programmes educating new parents.

ACTIONS TO SUPPORT CHILD SAFETY EFFORTS

LEADERSHIP, INFRASTRUCTURE AND CAPACITY are essential to supporting child and adolescent safety prevention and promotion efforts at a national level. With the recent economic crisis, leadership becomes even more crucial as countries struggle to do more with less. Creative broad thinking will become increasingly important to ensure that austerity measures do not result in a halt in the progress of child injury prevention and / or increases in existing disparities within and between countries.

Commitment of top political and government leaders is critical to ensuring that injury is established as a priority issue and that the requisite resources, both human and financial, are allocated at levels commensurate with the size of the injury problem. National leadership is important to both sustaining and building on initial child injury prevention efforts and to achieving successful partnerships and service delivery at regional and local levels. Basic infrastructure tools such as adequate data to describe the issue, monitor progress and identify new threats or trends are also essential. In addition organisations with a clear mandate and capacity to support prevention efforts are necessary to ensure effective use of scarce resources. A knowledgeable and connected group of stakeholders is also needed to provide the necessary capacity in a country to carry out effective planning, implementation and evaluation of prevention strategies, to ensure exchange of knowledge on what works and coordination of efforts between national, regional and local levels.

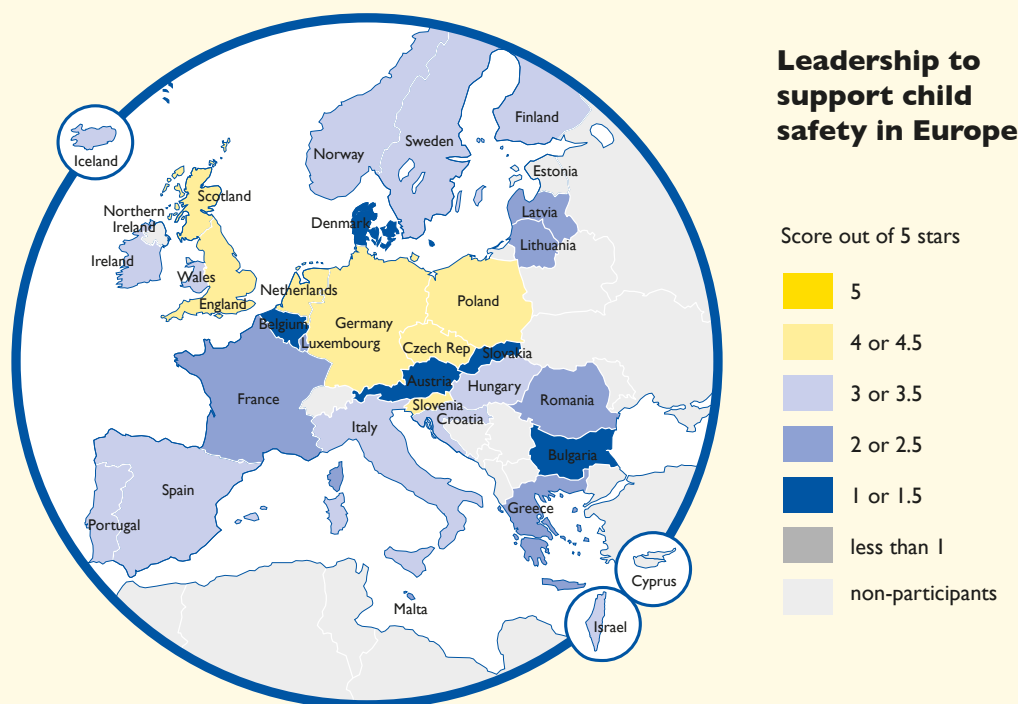
Leadership to support child safety

A country's level of child safety leadership was assessed based on its adoption and implementation of evidence-based national level policy action to support child injury prevention related to leadership and included:

- establishing responsibility for lead on national coordination of child and adolescent safety activities within a government department/ministry
- establishing a specific contact or focal point identified for child and adolescent safety for each of the departments/ministries involved in the issue
- identifying injury prevention as a national priority by government (e.g., listed as a priority issue within a government document or health plan)
- establishing a government led national injury prevention strategy with specific targets relating to child and adolescent safety
- existence of a national ombudsman for children (new policy measure in 2012)
- existence of a national law protecting the employment rights of young workers under legal age particularly as they relate to health and safety (new policy measure in 2012)
- existence of a nationally coordinated early childhood development programme (a programme with national coverage whose purpose is to facilitate achievement of the many skills and milestones that children are expected to reach by the time they reach the age of five (e.g., Safe Start, Sure Start) (new policy measure in 2012)
- existence of a national alcohol policy
- committing dedicated funds within government budget for the development / support of national prevention programmes, research, capacity building, a national steering group or a network or organisation to coordination activities related to child and adolescent safety
- identifying and supporting an organisation responsible for national coordination of child and adolescent safety activities.


Countries were assessed based on the above good practice measures and given a score out of a possible 5 stars.





Key findings

- Leadership scores ranged from 1 to 4.5 with an average of 3 stars out of 5.
- Encouragingly all but four countries (Belgium, Germany, Hungary and Sweden) reported that injury prevention has been identified as a national priority by the government.
- All but nine countries (Belgium, Denmark, England, France, Lithuania, Norway, Slovakia, Sweden and Wales) indicated that a government-led national injury prevention strategy existed. However a number of countries focus on road traffic safety only; and in others injury is an element of several different strategies, and there is no coordination between them to cover gaps and minimize duplication of efforts; and in 11 countries there are no child and adolescent specific targets.
- About half of the countries reported having a government department/ministry that is responsible for national coordination of child and adolescent safety activities, although all countries indicated that they had government departments/ministries with some responsibility for child and adolescent safety activities. However only about a third of the countries (England, Germany, Iceland, Israel, Latvia, Norway, Portugal, Romania, Scotland, Slovenia and Sweden) indicated that a specific focal point had been identified for child safety within each of the departments/ministries involved in the issue. It is certainly more challenging to take a multi-sectoral approach at the national level if potential partners cannot identify key individuals within government carrying the injury portfolio.
- All countries except Austria, Bulgaria, Czech Republic, Denmark, Israel, Portugal and Spain reported having a national ombudsman for children
- All countries reported a law protecting young workers and all but Croatia, Denmark and Greece reported a national alcohol policy, although several of the policies do not include specific mention of risks and solutions for children and youth.
- 18 countries reported having a nationally funded early childhood development programme
- 19 countries reported that government departments have a dedicated budget for the development/support of national prevention programmes related to child and adolescent safety, but for many of those countries programmes are specific to only one area of child injury prevention (e.g., traffic safety).

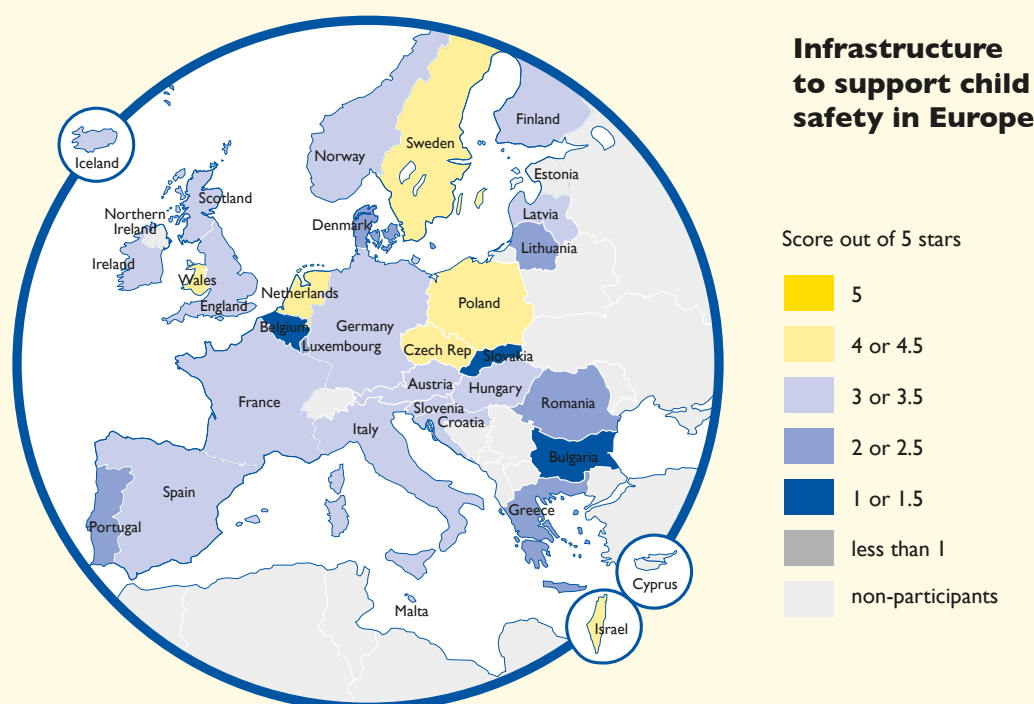
- 
- About a third of countries report dedicated funding from government for a national steering group/task force to address national child and adolescent safety (in many cases related to developing a Child Safety Action Plan) and 13 report dedicated funding for a coordinating network/organisation, although again for many of these the coordination was only occurring in one area of child injury prevention (e.g., traffic safety).
 - 15 countries reported some dedicated budget for research (again often related to traffic safety) and 15 some dedicated funding for capacity building related to child and adolescent safety.
 - For the countries where a historical comparison in sub-area scores was possible, improved scores reflected increased identification of a government department / ministry responsible for national coordination of child safety activities, progress towards national injury prevention strategies with child specific targets and increased funding for programmes, coordination and national steering committees / task forces.

Infrastructure to support child safety

A country's level of child safety infrastructure was assessed based on its adoption and implementation of national level policy action to support child injury prevention related to infrastructure and included:

- mandating an organisation (e.g., government department, NGO or other agency) with specific responsibility to coordinate injury data and produce reports to support action
- producing an annual or biannual report that includes minimum information on all child and adolescent injury deaths
- conducting studies to explore link between the risk of child and adolescent injury death with the social and economic circumstances of the family, rural / urban residence or other factors
- publishing a burden of injury report that includes data on children and adolescents
- ensuring the necessary data to perform an analysis of the burden of child and adolescent injury (e.g., mortality data, estimates of duration of disability, etc.)
- ensuring data for child and adolescent (0-17 years) accidents and injuries are reasonably available at the national level (e.g., mortality and morbidity data)
- participating in the next Health Behaviour in School-aged Children survey (2014) including the injury prevention module (new policy measure in 2012)
- establishing a national programme of child death reviews/death review committee (a multi-disciplinary team using data from multiple sources to investigate unnatural deaths in children, examine patterns and make specific prevention-related recommendations) (new policy measure in 2012)
- ensuring a mechanism to allow early identification of and rapid response to emerging safety hazards.

Countries were assessed based on the above good practice measures and given a score out of a possible 5 stars.



Key findings

- Scores for infrastructure ranged from 1 to 4.5 stars out of 5 with an average of 3 stars.
- All countries except Belgium, Bulgaria, England, Germany, Lithuania, Poland, Romania and Slovakia indicated the existence of an organisation whose mandate specifically includes coordinating injury data and producing reports to support action and all but Belgium, Bulgaria, Denmark and Iceland reported producing a regular report that includes at least minimum information on injury deaths in children and adolescents.
- All countries have population-based mortality data, but access, availability, coding and coverage of hospitalisation and emergency department data vary greatly by country.
- A number of countries have published a burden of injury report that included children and adolescents, however these reports most often express injury burden in strict terms of mortality and do not include burden of injury-related disability, therefore the true burden of childhood injury is not calculated to show the large impact injury has. Others that include injury related disability have not presented data separately for children and adolescents.
- While a number of countries will participate in the 2014 Health Behaviour in School-Aged Children Survey, or are at least considering it, only eight have confirmed that the optional injury module will be included (Austrian, Czech Republic, Iceland, Israel, Italy, Latvia, Luxembourg and Poland).
- Only 10 countries have a national programme of child death reviews/death review committee and in four of those reviews are done of only one sub-group of child deaths (e.g., traffic related, school related deaths). Given the rich source of prevention information that these reviews can provide and the specific recommendations that can be produced it is unfortunate that more countries have not adopted this practice.
- 21 countries reported a mechanism that allows early identification of and rapid response to emerging safety hazards, with most referring to their involvement with the Rapex system.
- For the countries where a historical comparison in sub-area scores was possible, improved scores reflected enhancement of existing data and establishment of an organisation with specific mandate to coordinate injury data and publishing of injury reports including data on children.

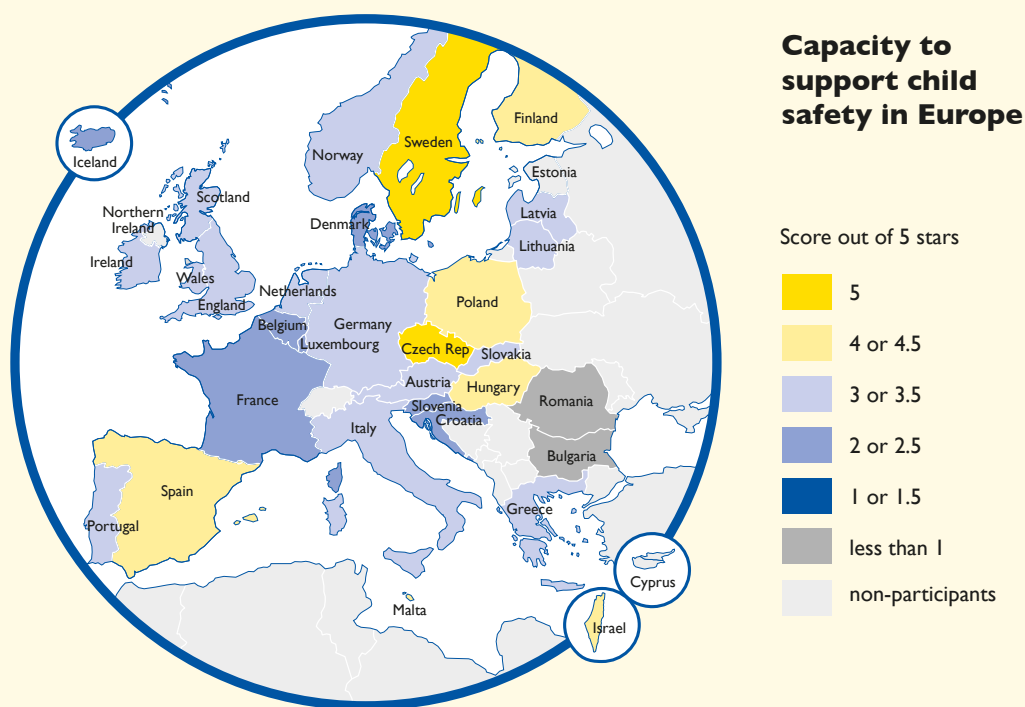


Capacity to support child safety

A country's level of child safety capacity was assessed based on its adoption and implementation of national level policy action to support child injury prevention related to capacity building and included:

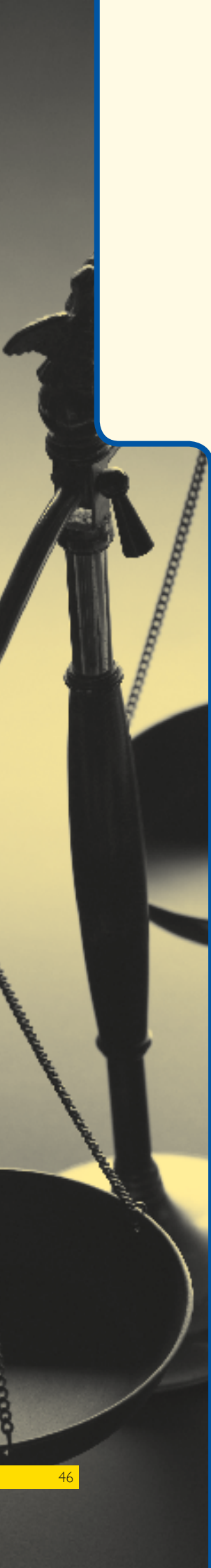
- mandating one or more organisations (e.g., government department, NGO or other agency) with responsibility to distribute information on evidenced good practice and / or facilitate or encourage uptake of evidenced good practice in the area of injury prevention or safety promotion
- establishing a network/structure or healthcare system that can facilitate accident prevention education for expectant parents and / or parents of children 0-4 years old and is currently using it for that purpose
- establishing national capacity building initiatives for those working in the area of injury prevention that are either specific to injury prevention or include injury prevention content
- establishing a network for child and adolescent injury prevention practitioners and researchers
- establishing a national conference or regional meeting on child and adolescent injury prevention or a national conference where child and adolescent injury is part of a larger agenda
- establishing a national policy making injury prevention education a mandatory part of elementary or school education curricula, including a standardised injury prevention education curriculum (new policy measure in 2012)
- establishing a national policy making first aid education a mandatory part of elementary or secondary school education curricula, including a standardised first aid education curriculum (new policy measure in 2012)
- establishing a national policy making life skills education a mandatory part of elementary or secondary school education curricula (a large group of psycho-social and interpersonal skills which can help people make informed decisions, communicate effectively, and develop coping and self-management skills that may help them lead a healthy and productive life), including a standardised life skills education curriculum (new policy measure in 2012).

Countries were assessed based on the above good practice measures and given a score out of a possible 5 stars.



Key findings

- Scores for capacity ranged from 0.5 to 5 stars out of 5, with an average of 3 stars.
- All countries except Bulgaria report one or more organisations whose mandate includes distributing information on evidenced good practice and / or facilitating or encouraging uptake of evidenced good practice for injury prevention or safety promotion.
- All countries except Belgium, Denmark and Romania report the existence of national capacity building initiatives for those working in the area of injury prevention that are either specific to child and adolescent injury prevention, or include child and adolescent injury prevention content. However these vary greatly in target group and content and only one of two countries reported attempts to comprehensively address basic levels of knowledge in key groups of stakeholders working on child and adolescent injury prevention.
- All countries except Bulgaria, France, Greece, Lithuania, Romania, and Slovakia report a network/ structure or healthcare system that can facilitate accident prevention education for expectant parents and / or parents of children 0-4 years old; although the degree to which it is used for that purpose varies, as does the capacity of those delivering the education.
- Less than half of the countries report the existence of a national network to facilitate exchange of information on injury prevention for children and adolescents. Given the value in sharing experience, particularly related to sharing issues that might be key to successful transfer of a strategy from one setting to another; and sharing of emerging results, it is concerning that networks do not exist in over half of the countries.
- All countries except Austria, Belgium, Bulgaria, Iceland, Luxembourg and Romania have hosted a regional meeting or conference in the past five years that contained some content on child and adolescent injury. Some of these were specific to child and adolescent injury, but most were broader events where child and adolescent injury was included as one of many issue areas covered.
- For the countries where a historical comparison in sub-area scores was possible, improved scores reflected enhanced learning opportunities for professionals and development of national networks for child safety injury prevention, often as part of child safety action plan development.



Child injuries, inequalities and inequity

Unintentional injuries are the leading cause of inequality in childhood deaths, for both males and females.³ Data show that across all age groups, the greatest inequalities are found for children, re-emphasising their vulnerability to socioeconomic factors. The mortality data presented previously in this report illustrate the huge variation between countries, with up to 6 times the difference in rates of unintentional injury overall between countries and an approximately 40 times the difference between the highest and lowest rates for some specific types of injury (such as cycling or poisoning). Studies have also been conducted within countries and demonstrate that the differences are not limited to between countries but also occur between regions, ethnic groups and socio-economic strata within countries. For example, in the Rhône area of France, the greatest disparity of injury rates between the rich and the poor occur with pedestrian injuries, with the incidence of casualties was almost twice as high in poor areas as compared to wealthy areas.⁴ A review of inequalities in the United Kingdom found that lowering the speed limit for traffic in London to 20 miles per hour (≈ 32 kph) reduced road casualties of all ages including children and adolescents by 40%; cycling casualties by 17% and pedestrian injuries by 33%.⁵

“The social class gradient in child injury is steeper than for any other cause of childhood death or long-term disability.”

Marmot, 2010

In the case of the child, the inequalities in injury rates that exist are most often attributable to their external environment and conditions that are for the most part outside of their control. The uneven distribution of injuries between and within countries is therefore, for the most part, unnecessary and avoidable, as well as unjust and unfair. The result of this is that the inequalities lead to inequities.

Inequity is a very complex issue. The gradient between the poor and the affluent, or the ‘haves’ and the ‘have-nots’, is the main factor that needs altering to lessen the disparities in injury risk present in European society. Research to identify what it is that increases both the risk of injury and the risk of increasing inequity continues, with the majority of European examples coming from the United Kingdom and Sweden. Studies examining the injury mechanisms contributing to this social pattern indicate that one of the major risk factors is increased exposure to unsafe home, play and road environments for children and adolescents living in deprived areas. This suggests that modifying these unsafe environments through a combination of engineering, education and enforcement should make a difference.

One approach to this is encouraging the uptake, implementation and enforcement of more passive prevention strategies – strategies that do not require a lot of action on behalf of the group being targeted, such as enforced laws and regulations, which make unsafe environments safer. These help address

“To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.”

Marmot, 2010

inequities by applying a legal requirement across the population. However, in situations where laws and regulations do not apply retroactively, this can lead to widening of inequities. For example, a requirement for smoke detectors that only applies to new or refurbished buildings may actually increase inequities in that the most vulnerable families are the least likely to live in buildings impacted by the requirement.

Unfortunately few of the policies introduced are actively monitored to assess their impact on actual injury rates or other measures of inequity, and in the few cases where this is attempted a lack of data has limited efforts. Further, introduction of laws and regulations in the absence of education is also not ideal, and mainstream public awareness campaigns

3 Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. When these differences are unnecessary and avoidable, and as a consequence unjust and unfair, they result in inequity in health (WHO definition available at <http://www.who.int/hia/about/gloss/en/index1.html>)

4 Licaj I, Haddak M, Hours M, Chiron M. (2011) Deprived neighbourhoods and risk of road trauma (incidence and severity) among under 25 year olds in the Rhône Département (France).

5 Marmot M (Chair) (2010) Fair Society Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England post 2010. <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

and brochures may not be the best strategies to engage families in deprived areas.

There are therefore also strong arguments in favour of addressing inequities by targeting the most deprived in communities. These are often more active strategies, which involve the on-going promotion of safe behaviours and the specific targeting of the more vulnerable audiences (i.e., children, migrants, low income families, repetitive generations of family poverty) and adaptations for the setting in which they are to be applied (i.e., inner city, rural) either on their own or as a sub-set within a greater audience.

Studies have suggested that without this more specific targeting, there is often a gradient in participation and uptake of safe behaviours in broader campaigns, with actions more commonly adopted in affluent areas than in deprived areas. However, it should be noted that even with specific targeting of injury prevention strategies, the evidence of improvements in injury incidence as a result of these interventions is somewhat limited – although again these results are often restricted by lack of data and / or small sample sizes. It is clear that more research is required to understand why these efforts are less successful and additional strategies need to be explored, including addressing some of the broader determinants of inequities in partnership with other child health issues.

It is likely however that the countries who are further ahead in addressing inequities in child injuries are those who have begun to study the issue to better understand the risks and then adopt actions that address the specific risks. As noted above, this can take the form of national law, regulation or policy intended to increase the safety of all children or specific programmes or policies targeted at the most vulnerable (e.g., policies or programmes that reduce the cost of safety equipment). The 2012 child safety report card measures include several indicators attempting to capture practices that if adopted and implemented may contribute to reducing inequities.

- Nineteen countries (61%) reported that studies have been conducted to explore links between the risk of child and adolescent injury death with the social and economic circumstances of the family, rural/urban residence or any other factors (e.g., teenage parenthood or drug and alcohol use)
- Twelve (39%) indicated that there is a national policy aimed at increasing access to child passenger restraint systems (CPRS) by disadvantaged families (e.g., CPRS included as essential child-care articles and taxed at lower rate, subsidies offered through programmes targeting disadvantaged families). However several noted that the reduced tax is a more general measure that would apply across the population.
- Six (19%) indicated there was a national policy aimed at increasing access to childcare equipment [e.g., stair gates] for disadvantaged families such as a national equipment give-away programme or loaner schemes, specific funds that can be applied for to purchase safety equipment (often complex processes that discourage application) or a policy change to make childcare equipment such as stair gates essential childcare articles so they are taxed at a lower rate.
- Eighteen countries (58%) reported they had a nationally coordinated early childhood development programme. Given the strong link between level of physical and mental development and injury, interventions that facilitate achievement of young children's developmental skills and milestones may reduce the risk of injury. As these programmes are often targeted at lower socioeconomic groups or vulnerable populations they may also address inequities. In addition, getting information into parent/caregiver hands at appropriate moments may also reduce risks, particularly if paired with environmental modifications, and 25 countries (81%) reported a network/structure or healthcare system that is being used to facilitate accident prevention education for expectant parents and / or parents of children 0-4 years old. Several also indicated the programme is more intensive for vulnerable populations.
- Twenty countries (65%) have a national policy that makes water safety education, including swimming lessons, a compulsory part of the school curriculum, thereby theoretically increasing the likelihood of equal access to swimming lessons. However, only 13 (42%) reported it is well implemented and few programmes have been evaluated as to their coverage. Further 10 (32%) also reported either a national or regional investment programme to renew infrastructure to increase the number of pools thereby providing more equitable access to public swimming pools for swimming lessons amongst school age children.

- Finally, including information and skill building as part of school curricula is another way to try and ensure all children have access to knowledge that will either help them avoid or prevent an injury or know what to do in the event an injury incident occurs. Nineteen (61%) countries report a national policy making injury prevention education a mandatory part of elementary or school education curricula with a standardised injury prevention education curriculum. However the curricula are often limited to road traffic safety. Eleven (35%) reported that first aid education using standardised curricula is a mandatory part of elementary or secondary school education. As well 15 countries (48%) reported they have a national policy making life skills education using standardised curricula that is a mandatory part of elementary or secondary school education curricula. Life skills education is one tool that can help young people begin to understand risk and to make informed decisions.

While the indicators above provide just a few examples of national/regional level measures that can be taken to address inequities, it is clear that more needs to be done to address the issue across Europe. It is likely that this will require a mix of population level and targeted interventions, but a good starting place would be consistent uptake, implementation and monitoring of evidence-based measures across all Member States along with careful analysis of data to understand the specific needs of vulnerable populations. In addition, if data on exposure to both hazards and prevention strategies were improved, the inequities, particularly those seen between countries could be better understood. It will be important that the issue of child injury is included as health inequities are studied and addressed by international organisations, the EU and national governments. The current economic downturn is likely to increase risks and disparities so on-going investment will be important to continue to decrease child injury rates and begin to narrow the mortality gaps across and within countries. This will also support countries in meeting their commitment to children's rights as laid out in the UN Convention on the Rights of the Child.⁶

“The true measure of a nation’s standing is how well it attends to its children - their health and safety, their material security, their education and socialisation, and their sense of being loved, valued, and included in the families and societies into which they are born.”

UNICEF

6 UN Convention on the Rights of the Child. United Nations General Assembly resolution 44/25 of 20 November 1989. (accessed June 2012) Available at: <http://www2.ohchr.org/english/law/crc.htm>

SUMMING UP

Action to address child and adolescent injury is happening, and progress has been made since 2009, but it is clear that still more can be done to reduce the burden that injury places on countries in Europe. Although some countries have improved scores, others have taken steps backward compared to previous report card assessments, and as highlighted in all three of the European report cards released to date, the investment in the child and adolescent injury issue is not commensurate with the size of the problem. The price of doing nothing continues to be a huge loss in the number of Europe's youngest citizens each year and the untold heartache for the families left behind. Deaths are the tip of the iceberg with thousands more children being treated in hospitals or emergency departments and many going on to live with lifelong disabilities, which remain a burden to the individual, their family and society as a whole. **With an ageing tax base and population structure, each young life becomes more precious to the societal and economic well being of a country.** With that in mind, what investment are countries willing to make to ensure their youngest and most vulnerable citizens are adequately protected from injury and grow up to be healthy contributors to their community and country? We know a lot about what works to prevent child and adolescent injuries; we need greater commitment and further action now, as stated in the 2010 World Health Assembly Resolution on Child Injury Prevention.⁷

As noted in the previous section inequalities between countries in terms of injury rates are large, as is the range in terms of policy action with overall performance scores for unintentional injury ranging from 14.5 to 45 out of a possible 60. Encouragingly, most countries have made progress since the report cards were initiated in 2007, with some of the greatest improvements seen in countries where investment has been made (e.g., Czech Republic, Finland, Hungary, Scotland and Spain). The decrease in performance grade in Greece since 2009 probably reflects the economic crisis in the country and may signal the likelihood of an erosion of progress in other countries as austerity measures are put into place. Funds for promotion, and in this case safety promotion, are often the first to be cut, followed by prevention and it will be important to continue to monitor progress (or its lack) over this period of government cutbacks, not only overall, but from the perspective of a widening gap with respect to inequalities.

However the news is not all bad. It is also important to acknowledge the cross cutting multi-sectoral nature of injury and the opportunities that provides, particularly during these times of economic restraint and reduced spending. While the healthcare sector treats injury, prevention often involves other sectors (e.g., transport, environment, justice, education). Activities that reduce injuries can also have other benefits that in turn can help advance the goals of those sectors. For example, reducing motor vehicle use and kilometres travelled by car can reduce a child's exposure to vehicles and therefore reduce the risk of motor vehicle injuries. By redesigning the environment and putting in place supporting policies and education we can encourage more bicycling, walking and motor vehicle-free zones. These actions also improve the climate, air quality, urban vitality, and recreational goals; they result in reduced risk of obesity, heart disease and cancer; save money for government and businesses; reduce demand on health institutions; improve quality of life, and so on. Another example where benefits of a concerted prevention effort will be cross-cutting is alcohol and substance abuse. Alcohol use has been linked with increase risk of injury with respect house fires, road traffic accidents and drowning. Actions to reduce alcohol and substance abuse and the resulting harm will not only reduce risks of child injury but will also reduce risk of liver cirrhosis, cancers, heart disease and psychological problems, family disruption, crime, violence increased health care costs and economic loss. Thus injury prevention and society as a whole, has a great deal to gain from collaborating with other sectors and fields.

7 World Health Organization. World Health Assembly Resolution 64.27 Child Injury Prevention, 24 May 2011. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_R27-en.pdf

However progress is hampered and this report card assessment not only highlights progress and gaps within participating countries, but also allows for a look across countries within the EU from which guidance to address barriers to progress can be drawn, including:

The need to focus on home safety with a similar intensity as has been seen for road safety:

The higher policy scores across countries for road safety in the report card assessments reflect the fact that more resources have been invested in road safety – an investment that has resulted in major reductions over the past 20-30 years. While injury death rates for other areas of child injury are not as high (with the exception of drowning), many children are dying each year and many more are hospitalised or treated in ambulatory settings for injuries more likely to occur in or around the home environment, yet policy scores for these areas are lower for most countries. Given the success of the concerted efforts in the area of road safety between transport, health and education, a commensurate investment on actions to prevent drownings, falls, burns/scalds, poisonings and choking/strangulation would go a long way to reducing these injuries.

The need for information on the cost of injury and its prevention to make stronger arguments for critical investment:

Data on the burden of child injury in Europe, including the financial cost is lacking and the few existing estimates are outdated. What is clear is that investment in injury prevention does lead to a reduction in costs. For example, recent estimates from the Children's Safety Network in the U.S. indicate that every dollar spent on a child resistant lighter results in \$72 savings and every dollar spent on bicycle helmets results in \$48 savings.⁸ There is a need to highlight the financial arguments and this will require greater involvement of economists, and investment in specific projects to identify a clearer picture of the actual cost and benefits of actions to reduce child injury. A good first step would be a burden of disease/injury study specifically addressing children and adolescents, so that resources can be invested commensurate with burden.

The need for improved data systems that include timely and complete injury data:

Most injury experts from the EU Member States have identified challenges with data as a major barrier to progress. Better data will support better decisions with respect to identifying priorities – including a better understanding of inequities, and facilitate evaluation of policies and programmes so countries are both doing more of what works and avoiding unsound investments. Better quality data (standardised, reliable, timely, relevant, representative) are needed, as are increased capacity to use data and increased access to those data by those developing, implementing and evaluating injury prevention and safety promotion programmes and policies. Coordination and cooperation between organisations managing such data and a central repository both nationally and at the European level would greatly facilitate quality, timeliness and access and should be developed with parallel processes to increase capacity. Efforts proposed under the EU funded initiative JAMIE (Joint Action on Injury Monitoring in Europe) will be most successful if uptake is across the EU and all levels of government support the necessary actions to ensure that all hospitals collect the JAMIE minimum data set. This would also support local prevention efforts, as local data are very important to stimulating local prevention.

Monitoring and evaluation are major gaps: Few policies are monitored as to their impact on interim measures (e.g., do they reduce risk by reducing harmful exposures to hazards or increasing beneficial exposures to protective equipment or other preventative measures) or longer-term outcomes (e.g., do they reduce fatal injuries or disabilities). This is in great part related to gaps in data systems, particularly with respect to data related to products and the distribution and determinants of both harmful and beneficial exposures. To provide useful information monitoring needs to be planned before a policy or programme is put into place so that baseline data are collected against which impact can be measured after implementation. A combination of

8 The Children's Safety Network. Injury Prevention: what works? A summary of cost-outcome analysis for injury prevention programs (2010 update). (accessed May 2012). Available from: <http://www.childrenssafetynetwork.org/sites/childrenssafetynetwork.org/files/ChildhoodinjuryCostprevention.pdf>

administrative data, market research and population-based surveys are likely needed to achieve this, thus careful consideration as to injury data needs is required both overall and as each new initiative is planned. Without these investments much learning that could be transferred across countries is being lost as a result of failure to monitor impact in those settings where action has been taken. Success in this area will require collaboration and cooperation between the public, academic and private spheres.

The need for more focus on inequity issues within and between countries:

Better data and more targeted research should assist with ensuring a better understanding of existing inequities and suggest effective ways to begin to address them. Work on child injury and inequity would be greatly facilitated if a standardised set of key indicators of disparity was developed and adopted across the European Union and broader European region to allow comparative data, as would many other areas of child health. Interventions designed to address either inequalities or inequities need to be evaluated as to their impact, and this information needs to be shared so that decision makers can make more informed choices that are more likely to be successful.

Capacity is lagging behind need: A lack of investment in the child injury issue means that few professional programmes include the issue as part of professional education – both in terms of education and skill building. Leaders at regional or local level who could adopt, implement and monitor action to promote safety and prevent injuries do not receive adequate training, nor do those who are charged with delivery of programmes to the public. Furthermore, educational interventions aimed at increasing the knowledge and skills of families and children vary greatly across Europe and within individual countries. This adds to existing disparities. Investment in standardised curricula for professionals in the many sectors involved in injury prevention, such as health visitors, urban planners, police, engineers and architects and for children would begin to build the critical mass necessary to support successful action to address this tragically unnecessary epidemic.

In closing, Child Safety Report Cards are a useful tool in that they benchmark progress and highlight gaps where action is needed. They have limitations in that they apply a set of standardised indicators against a heterogeneous group of countries. Due to differences in geography, governance structures and size, not all measures are as applicable to some countries as others. As such, the report cards are a crude measure; however, not applying the items consistently to all countries would mean standardised assessments are not possible. The absence of European-wide timely and reliable mortality, morbidity and exposure data and a lack of monitoring and evaluation of many of the policies and programmes implemented also makes it difficult to show a direct correlation between performance grades and outcome data, however as data systems improve this will become easier. Another limitation is that the report cards only reflect actions at the national level and many policy and programme decisions are made at a regional and /or local level and most action is implemented and / or enforced at those levels. Thus there is also a need for other tools to support efforts at sub-national levels. This is the goal of the TACTICS project of which these report cards are part.

Despite these limitations, the Child Safety Report Cards have been very valuable in: raising awareness among the public, media and other key stakeholders; engaging government across sectors and other national and regional stakeholders; identifying gaps where action is needed and benchmarking progress. They have supported the development of national child safety action plans in individual countries, and in some cases they are used as indicators to monitor progress of those plans. The Child Safety Report Cards and the methods used to create them have been recognised as an important health action internationally and received the Health Award from the European Health Forum Gastein in 2011. With this set of report cards in 2012, we now have a baseline for all 27 EU Member States from which future progress can be measured.

Recommendations for action on child safety

Overall the country report card grades for leadership, infrastructure and capacity indicate that despite increased awareness of the child injury issue as a leading cause of death, disability, burden and inequity for children in the EU, the commitment and resources put towards it still do not correspond with the magnitude of the issue. Given that often the first areas to be cut during times of economic crisis are promotion and prevention, it is important that current levels of investment at least be maintained so that progress made in the EU in reducing child injuries is not eroded and current trends in reduction continue. Protecting children is an investment that will save money now and in the future.

The way forward begins now and needs to continue by focusing on...

Leadership

- The European Commission, Member States and EU institutions need to make child injuries a priority. They need to provide leadership on issues affecting the safety of the children and youth of Europe by bringing together the sectors necessary to address child and adolescent injuries and determine who will be responsible for specific injury issues and coordinate the actions and resources needed.
- Despite the economic downturn, Member States need to continue developing and implementing national action plans to prevent injury to children. These can be stand-alone plans or goals; or objectives, targets and actions related to child injury prevention that are integrated into other strategies within health or other related sectors. Along with the establishment and endorsement of a plan is the need to ensure that adequate resources are targeted to build and maintain infrastructure and the capacity to support prevention activities. Member States should benchmark their performance and measure and monitor their progress towards achieving action plan goals and targets.
- The European Commission and international organisations such as WHO, UNICEF and OECD can encourage and support Member State efforts in building leadership, infrastructure and capacity to support child and adolescent safety. Examples of this include the WHO regional resolution and European Commission recommendation calling for national plans and improved data systems and capacity to support injury prevention, the WHO led World and European reports on child injury prevention and the 2010 World Health Assembly Resolution on Child Injury Prevention.
- Member States need to provide leadership by adopting, implementing, enforcing and evaluating policy measures that have been shown to work at a national level; and encouraging and supporting uptake and enforcement of good practice strategies that have been shown to be effective at the regional or local level. Furthermore, as prevention efforts move from national to regional and local levels, a multi-sectoral approach (e.g., working with health, transport, environment, and education) becomes more important and should be encouraged. There is also a need to evaluate interventions as to their impact and to share the results of evaluation so that other Member States can benefit from their experience.
- The European Commission needs to continue to work with appropriate parties to develop EU level policy where European level action will reduce the risk of injury and provide equitable protection to children across the EU. Results of the Report Cards suggest that where a EU Directive is in place, Member States are more likely to have taken action. The development of EU level policies should be followed by timely publication and follow-through with countries to assess adoption, implementation and enforcement within national policy frameworks and to evaluate their impact.
- The European Commission and international organisations such as WHO and UNICEF can encourage and support Member State efforts in adopting, implementing and enforcing evidence-based policies to support child injury prevention.

- The European Commission and international organisations such as WHO, UNICEF and the OECD need to work with Member States to develop an action-oriented research agenda that identifies outstanding questions to support current and emerging injury issues and provide clear guidance on effective action to decision makers. Better coordination of research efforts addressing both 'what works' and 'how do we effectively transfer what works' in various settings, should reduce duplication, provide opportunities for stronger studies and ultimately provide the necessary evidence to support smarter investments.

Infrastructure

- Member States should ensure that mortality data are annually submitted to the WHO so that timely data are available within the WHO Health for All Database and Eurostat and the European Commission and international organisations such as WHO and UNICEF should encourage and support this practice.
- Data should be made available in age classifications that match the UN definition of children (children below age 18 years) by all countries in Europe and European databases managed by WHO (e.g., Health For All database) and Eurostat should also work to provide data for this age group. Currently due to standard age groupings 15-19 year olds are grouped together and individual years are not available, which means data to examine injury deaths for children and adolescents using the UN definition of the child are not available.
- This report has just begun to touch on the issue of child injury as it relates to inequities, but it is clear that the identification and adoption of a standardised set of key indicators of disparity would benefit child injury and many other areas of child health. The European Commission should work with Member States to investigate, select and use standard measures for socio-economic status that are relevant to child and adolescent injuries across the European Union and broader European region to allow comparative data.
- Member States and the European Commission should support efforts to conduct a burden study examining the well being of children that includes injury and additional efforts should be made to bring together economists with stakeholders in the injury field to encourage calculations looking at cost effectiveness, return on investment for effective prevention strategies and cost of treatment versus prevention.
- Member States and the European Commission should make the necessary investments to ensure that comparable injury morbidity (non-fatal injury) data including coding of external cause of injury (e.g., the minimal dataset proposed within the JAMIE (Joint Action on Injury Monitoring in Europe) initiative are collected and that consistent estimation methods are developed and used for making estimates using the more detailed Injury Database (IDB) dataset. Ideally these data should be kept as part of the Eurostat data systems to increase ease of access.
- Member States and the European Commission should support research into injury hazards, including tracking/reporting of dangerous products, and invest in the collection of exposure data, to allow a better understanding of the variation in injury risk within and across countries. In addition, more research should be conducted to better understand the influence of socio-demographic and economic status as determinants of child injury, particularly with respect to allowing comparisons within and between countries.

Capacity building

- It would facilitate communication and action requests greatly if each Member State would establish and support an inter-sectoral committee with participants from the relevant departments/ministries involved in child safety (e.g., health, transport, education, justice) to deal with the crosscutting nature of injury. The establishment of a focal or contact point within each department/ministry would also assist.

- Member States should support the development of child safety expertise in their countries and the establishment and / or enrichment of national child safety networks to enhance prevention efforts, dissemination of evidence-based good practice and exchange of knowledge and experience.
- Education and skill building are required at all levels and priority should be given to integrating injury prevention and safety promotion education and skill building into existing educational mechanisms (e.g. professional programmes, continuing education programmes, primary and secondary school curricula). The existence of tools such as TEACH VIP (WHO's modular curriculum for the teaching of core and advanced public health competencies in the area of injury prevention and control), with its newly released module on child safety, provide an opportunity for consistent preparation of stakeholders across and within Member States. There is also opportunity for sharing examples of effective tools and approaches, particularly for school age children, between countries and this could be facilitated with the support of the European Commission, WHO and UNICEF.
- Member states and the European Commission should support research into effective transfer of evidence-based good practices, including demonstration research and case studies of examples of both effective and ineffective transfer; to increase knowledge of what is needed to ensure effective adoption, implementation and evaluation of child injury prevention efforts. Stronger efforts are also required to ensure that the results of such efforts make it into the hands of decision makers so that programmes and policies developed are evidence based.

Our commitment from the European Child Safety Alliance

To continue supporting action for child safety in Europe the European Child Safety Alliance commits to:

- seeking resources to allow the assessment of the child safety policies, including those examining leadership, infrastructure and capacity, to be repeated periodically to allow for the on-going measurement of progress and benchmarking both for Member States and across the EU and exploring other means of supporting and monitoring progress,
- continuing to work cooperatively with UNICEF, WHO and the European Commission to advance the recommended actions in this report and the recent UN World Assembly Resolution on child injury prevention in order to move child safety forward in Member States and Europe overall,
- continuing to support Member States and their child safety networks as they work to develop, implement and evaluate Child Safety Action Plans,
- continuing to promote evidence-based good practices, advocate for their adoption, implementation and enforcement and develop decision-making tools and resources to assist Member States with action at the national, regional and local levels.

METHODS TO PREPARE COUNTRY AND SUMMARY REPORT CARDS

The Child Safety Report Card concept was originally developed as part of the Child Safety Action Plan Project, a European initiative led by the European Child Safety Alliance which ran from 2004-2007 (Phase I) and 2007-2010 (Phase II). Measures for the injury preventing policies examined were initially developed in 2006 from current evidence of effective policies with a focus at the national level.⁹ Policy strategies known to be effective, but more likely to be established at regional or local levels (e.g., traffic calming measures to reduce risk of pedestrian or cycling injuries), were not included. Indicators addressing leadership, infrastructure and capacity were taken from measures proposed by other indicator initiatives or described in the literature. Additional policy strategies were added for the 2009 Child Safety Report Cards and again in the current set in 2012. In particular questions addressing additional policies to reduce inequities and build capacity were added for 2012.

The assessment conducted to produce this Summary report card and the individual country report cards covers both written and practical policies. It focuses on those policies where there is good evidence that adoption, implementation and enforcement at the national level has a positive impact on child safety (children were defined as ≤ 17 years of age, however as mortality data on this age group are not readily available, data presented within this report are for children 0-19 years). Country partners contact the relevant government departments to assess whether each of the policies existed, had been partially or wholly implemented and was being partially or wholly enforced. As such the assessment provides an indication of current levels of policy but should not be considered absolutely definitive as it is subject to the availability of data. Further, the assessment examines what countries have done to address child and adolescent safety, but does not extend to an assessment of how well those policy actions are working. Data on deaths due to the various injury causes are included as a reference point to assist in interpreting the policy scores. However it is important to note that many other factors, including governance structures, exposure to hazards and prevention measures and socio-demographic determinants, need to be considered when attempting to understand the relationship between injury rates and policy scores. The uncertainties in interpreting the results merely stress that the information can still be improved with better data and increased understanding of the determinants of injury at the population level.

Data on injury deaths and hospitalisations and socio-demographic determinants used in this Summary report card and / or the individual country report cards and profiles were obtained from existing international databases managed by several organisations including WHO, Eurostat and the United Nations Development Programme in early 2012. The exception is data for Wales and England, which were obtained from Public Health Wales and the Office for National Statistics, respectively. Mortality and morbidity indicators were compiled and / or calculated by Collaboration for Accident Prevention and Injury Control (CAPIC) at Swansea University in Wales. Data presented are for the most recent year(s) available from the data sources at the time of data collection. Mortality data are for ages 0-19 as data for ages 0-17 are not available. All rates are European age-standardised and morbidity rates for countries with less than 100% coverage of collection of data from hospitals were adjusted to 100% coverage assuming a proportionate number of hospitalisations for the percent not covered by the database. In addition, three-year age adjusted average rates were used to examine mortality trends and the rates of external causes of injury (e.g., falls, drowning) where because of small numbers less stable rates were anticipated. Countries with a small population of less than 1 million (Cyprus, Iceland, Luxembourg and Malta) were excluded from mortality comparisons in this report. Charts showing rates by sex were constructed in order of rank using overall average.

⁹ MacKay M, Vincenten J, Brussoni M, Towner L. Child Safety Good Practice Guide: Good investments in unintentional child injury prevention and safety promotion. Amsterdam: European Child Safety Alliance, Eurosafe; 2006..

Data for the policy indicators included in the 2012 report cards were obtained during 2011-2012 from TACTICS project partners using English language assessment tools. The primary data collection required the project partner in each country to contact the appropriate government departments to ascertain correct information regarding current policies; policy information is accurate to July 2011.

The ratings out of five stars for each of the sub-areas were calculated by multiplying the composite score for each area (sum of allotted points (😊 = 2, 😐 = 1, ☹ = 0) for all questions in the sub-area with no weighting of items, divided by total possible points) by five and rounded off to the nearest half star. The overall safety grade was based on a summation of the sub-area scores (😊 = 49-60 stars, 😊 = 37-48.5 stars, 😐 = 25-36.5 stars, ☹ = 13-24.5 stars, ! = 0-12.5 stars). Weighting of individual items and sub-area scores was not done as this would require data on exposure to specific injury hazards and / or studies comparing the effectiveness of the various policies within a given area, neither of which is available consistently across injury areas or countries involved in the TACTICS project. Comparisons between the 2012, 2009 and 2007 assessments were made for common indicator items using paired sample t-tests in order to determine whether the average difference between the years was significantly different from zero (after checking that data were normally distributed).

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The Child Safety Report Card Europe 2012 - Summary for 31 Countries was developed as part of the Tools to Address Childhood Trauma, Injury and Children's Safety (TACTICS) project, a large scale multi-year initiative that is working to provide better information, practical tools and resources to support the adoption and implementation of evidence-based good practices for the prevention of injury to children and youth in Europe. The initiative is led by the European Child Safety Alliance of EuroSafe, with co-funding and partnership from the European Commission, RoSPA, the Nordic School of Public Health, Maastricht University, Swansea University, Dublin City University, the European Public Health Alliance, and partners in more than 30 countries.

One of the objectives of the project was to review and expand the set of Child Safety Action Plan indicators and standardised data collection tools to continue to monitor and benchmark progress in reducing child and adolescent injury as countries moved from planning to implementation. The Child Safety Report Cards 2012, Child Safety Profiles 2012 and Child Safety Report Card 2012 – Europe Summary for 31 countries are the result of this activity.

For more information on the TACTICS initiative, the child safety report cards and profiles for the 31 participating countries go to the European Child Safety Alliance website at: www.childsafetyeurope.org



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