



TACTICS

Mandated responsibility for Intentional and Unintentional Child Injury Prevention in Europe

Focusing on Road Safety, Water Safety,
Home Safety and Intentional Injury

EPHA Briefing – December, 2014



EPHA Briefing

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The *European Public Health Alliance (EPHA)* is the European Platform **bringing together public health** organisations representing health professionals, patients groups, health promotion and disease specific NGOs, academic groupings and other health associations. Our membership includes representatives at international, European, national, regional and local level.

EPHA's mission is **to protect and promote public health in Europe**. EPHA brings together organisations across the public health community, to share learning and information and to bring a public health perspective to European decision-making. We help build capacity in civil society participation across Europe in the health field, and work to empower the public health community in ensuring that the health of European citizens is protected and promoted by decision-makers. **Our aim is to ensure health is at the heart of European policy and legislation.**

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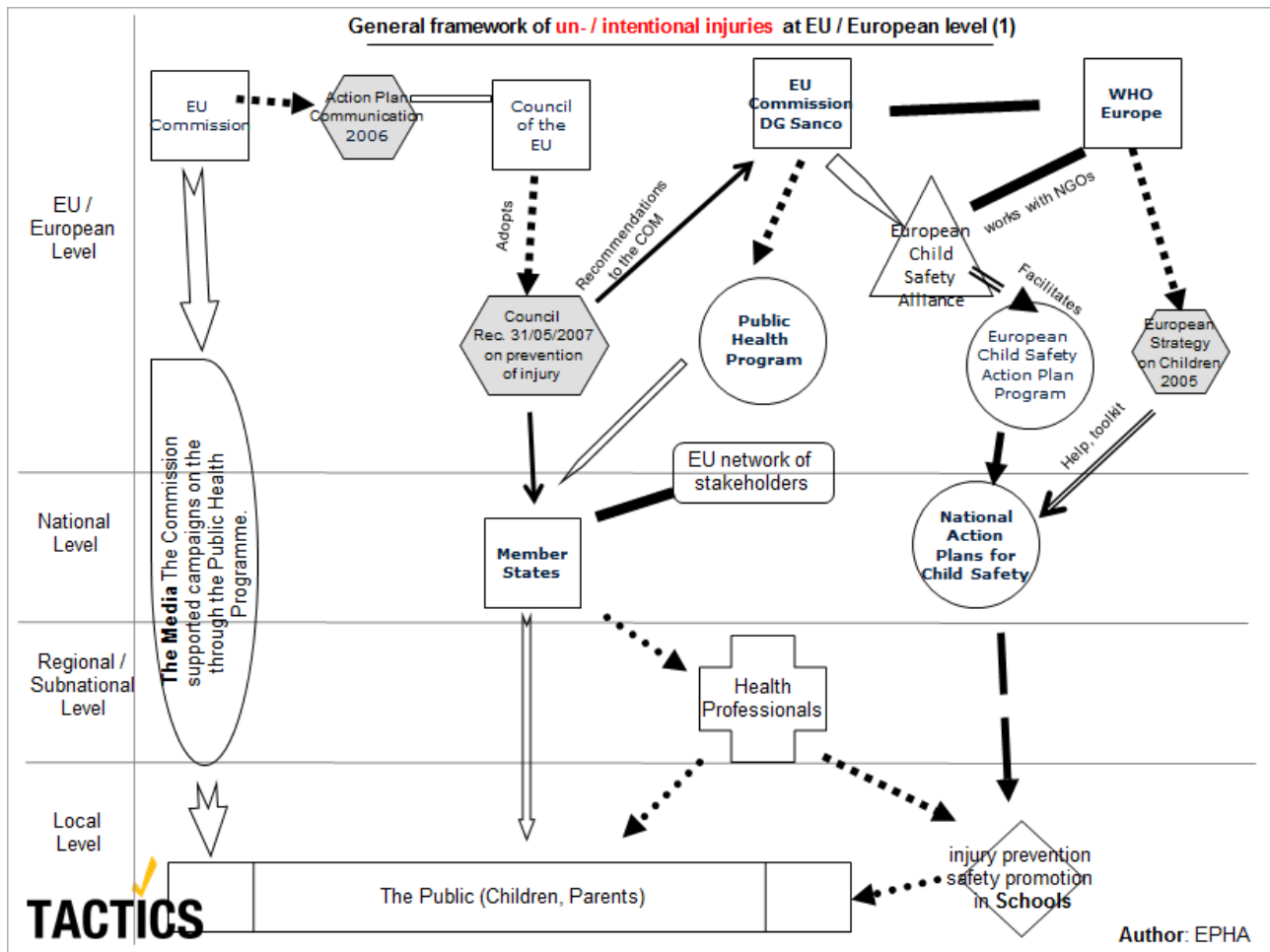
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1 Introduction

Due to the complexity of intentional and unintentional child injury in Europe the first part ([I. General Framework for Intentional and Unintentional Injury of Children](#)) describes the general policy and legal framework which applies **both for intentional and unintentional child injury** (see [1. organigraph](#)).



Organigraph 1. – General framework of un- / intentional injuries at EU / European level (1)

Within this general framework, this analysis focuses on sector specific legislations under part two ([II. European and EU legislation tackling Intentional and Unintentional Injury of Children](#)). In that part the European legislation on **Road Safety** of Children (see [2. organigraph](#)), **Water Safety** of Children ([3. organigraph](#)), **Home Safety** of Children (see [4. organigraph](#)), and **Intentional Injury** of Children (see [5. organigraph](#)) will be presented.

Our short analysis takes into account the **WHO Europe Region**¹ on the one hand, and more specifically the existing **EU legislation** on the other.

¹ The Region comprises 53 countries in an area stretching from the Arctic Ocean in the north and the Mediterranean Sea in the south and from the Atlantic Ocean in the west to the Pacific Ocean in the east.

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1.1 General Framework for Intentional and Unintentional Injury of Children

The **universal legal basis** of any policy action at European level was **the Convention on the Rights of the Child**² (hereinafter referred to as ‘the Convention’) adopted in 1989. The Convention became the first legally binding international convention to affirm human rights for all children. As a binding treaty of international law, it codifies principles that Member States of the United Nations agreed to be universal.³

1.1.1 WHO action at European level

At its fifty-third session in 2003, the WHO Regional Committee for Europe established **child and adolescent health** and development as a top priority. The Environmental and Health Ministers adopted the **Children’s Environment and Health Action Plan for Europe (CEHAPE)**⁴ in 2004 in which Ministers reaffirmed their commitment to attaining the Regional Priority Goals referred to in the CEHAPE.

The **European Regional Office for Europe of the World Health Organization (the WHO Regional Office)** was charged with developing a **European strategy** on the issue to be presented at the fifty-fifth Session of the Regional Committee, and the Regional Director was asked to support Member States in their endeavours to improve the health of children and adolescents. The WHO Regional Office has adopted a **European strategy for child and adolescent health and development in 2005**, which gave an impetus to and influenced the respective European decision making process concerning child injury.

The purpose of this strategy was to assist Member States in formulating their own policies and programmes. It identifies **the main challenges** to child and adolescent health and development and, most importantly, provides guidance based on evidence and the experience gathered over recent years.

The strategy for child and adolescent health and development is designed to help Member States achieve the following **objectives**:

1. to **develop a framework for an evidence-based review** and improvement of national child and adolescent health and development policies, programmes and action plans, from a lifecourse perspective;
2. to **promote multisectoral action** to address the main health issues related to child and adolescent health;
3. to identify **the role of the health sector** in the development and coordination of policies and in delivering services that meet the health needs of children and adolescents.

According to that strategy, **WHO supports Member States** in their endeavours to improve child and adolescent health and development. This includes advocacy at the highest level, both internationally and nationally.

² <http://www2.ohchr.org/english/law/crc.htm>

³ <http://www.childsafetyeurope.org/publications/europeanpolicy/index.html>

⁴ http://www.euro.who.int/_data/assets/pdf_file/0006/78639/E83338.pdf

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The WHO Regional Office built on existing international partnerships with the European Union, and it **worked closely with NGOs** to promote a coordinated approach to child and adolescent health.

By way of technical assistance, the WHO Regional Office has produced a **toolkit** of resources for use by Member States. The toolkit includes guidance on the assessment and review of existing policies and strategies. It highlights the essential **elements in promoting child and adolescent health** and directs decision-makers to technical advice and evidence-based action plans. WHO also manages a very efficient information and surveillance system that can be used to assist Member States in identifying current and emerging priorities.

Specifically, the WHO Regional Office supports Member States in the following areas:

- reviewing and developing comprehensive child and adolescent **health policies** and strategies;
- **building capacity** for and supporting the implementation of child and adolescent health strategies and integrated intervention packages at national and regional levels;
- developing and providing **standards and guidelines** for child and adolescent health policies, strategies, interventions and services;
- providing **technical support** in surveillance, monitoring and evaluation;
- facilitating the development of **intersectoral collaboration** and structures.

1.1.2 EU action

The Commission first work on injuries begun within the framework of **the Injury Prevention Programme** which started in **1999** and ended in **2003** when the Public Health Programme came into force.

According to the available data in 2007, every year, about **235 000 citizens of the EU died** as a result of an accident or violence. Injuries were, after cardiovascular diseases, cancer and respiratory diseases, the fourth most common cause of death in the Member States. In children, adolescents and young adults accidents and injuries were the leading cause of death.

Many survivors of severe injuries **suffered life-long impairments**. Accidents and injuries were a main cause of chronic disability among younger people leading to a heavy and largely avoidable loss of life years in good health.

On average, injuries accounted for about **6,8 million hospital admissions**, which represented **11 % of all hospital admissions** in the European Union. Injuries represented a huge financial burden on health and welfare systems, causing about **20 % of sick leave** and constituting a major factor for reduced productivity.⁵

1.1.2.1 European Commission

The major directions for the injury related actions under the Public Health Programme are now being provided by **the Communication on 'Actions for a Safer Europe'** that the **Commission**

⁵ Council Recommendation on the prevention of injury and the promotion of safety on 31 May 2007, recitals (1)-(5) <http://www.childsafetyeurope.org/publications/europeanpolicy/info/council-recommendation.pdf>

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has adopted in May 2006.⁶ This communication focuses on the prevention of accidents and injuries in Europe by public health actions. It is intended to provide a strategic framework which is needed to help all Member States prioritise their actions to reduce accidents and injuries.

This communication identified **safety of children and adolescents**, as one of the seven priority areas. Children and adolescents have been chosen as a priority because injuries and their disabling consequences have a tremendous impact on health in this age group in particular.

The Commission supported this initiative and campaigns on the priority areas through the **Public Health Programme**.

Under a project of the Community Public Health Programme, **the European Child Safety Alliance** currently facilitates **the establishment of national action plans for child safety** in the majority of Member States. The main priority is to integrate the remaining Member States and candidate countries into the process and to prepare the implementation of the national child safety action plans. The implementation of these plans must be evaluated and further enhanced.

EU wide campaigns are being conducted on priority issues. These EU public health campaigns informed the public about the quantity of the problems, demand for better primary prevention, disseminate good practices, support networks, provide health administrations of Member States with policy tools for national action.

In order to be successful in injury prevention, an **EU network of stakeholders** has been established which enables the consolidation of expertise, efforts and outputs to deal with the immediate needs for preventing accidents and injuries effectively in the EU. The Commission work with the authorities of the Member States, in particular the ministries of health and consumer protection, to enhance public health actions in favour of injury prevention and to ensure synergy with other relevant policy domains.

1.1.2.2 Council of the European Union

Following this Communication, **the Council of the European Union** has adopted a **Council Recommendation on the prevention of injury and the promotion of safety** on 31 May 2007.⁷

The Council Recommendation recommends Member states to

1. Make better use of existing data and develop, where appropriate, representative **injury surveillance** and reporting instruments to obtain comparable information, monitor the evolution of injury risks and the effects of prevention measures over time and assess the needs for introducing additional initiatives on product and service safety and in other areas.;
2. Set up **national plans** or equivalent measures, including the promotion of public awareness of safety issues, **for preventing accidents and injuries**. Such plans and measures should initiate and promote interdepartmental and international cooperation and use funding opportunities effectively for preventive actions and promoting safety. In their

⁶ COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL on Actions for a Safer Europe http://ec.europa.eu/health/ph_determinants/environment/IPP/documents/com_328_en.pdf

⁷ Council Recommendation on the prevention of injury and the promotion of safety on 31 May 2007 <http://www.childsafetyeurope.org/publications/europeanpolicy/info/council-recommendation.pdf>

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implementation, particular attention should be paid to gender aspects and to vulnerable groups such as children, elderly people, persons with disabilities, vulnerable road users, and to sports and leisure injuries, injuries caused by products and services, violence and self-harm.

3. Encourage the introduction of injury prevention and safety promotion, **in schools and in training of health and other professionals, so that these groups can serve as competent actors and advisors in the field of injury prevention.**

The Council Recommendation invites the European Commission to

1. **Gather, process and report Community-wide injury information** based on national injury surveillance instruments.
2. **Facilitate the exchange of information** on good practices and on policy actions in the identified priority areas and the dissemination of the information to relevant stakeholders.
3. **Support Member States** in the inclusion of injury prevention knowledge into the training of health and other professionals.
4. Carry out **Community actions** as outlined above by using the resources provided for in the Community Public Health Programme and successor programmes, the general framework for financing Community actions in support of consumer policy⁸, the Framework Programme for Research⁹ and any other relevant Community programmes.
5. Carry out **an evaluation report** four years after the adoption of this Recommendation to determine whether the measures proposed are working effectively and to assess the need for further actions.

1.1.2.3 Other EU actors

European NGOs, alliances and organisations play an important role in the EU decision making process, although their role is merely informal. They use advocacy strategies and lobbying tools to influence the European decision makers (**European Commission, Council, European Parliament**). However, their role is more than just influencing the political decision: due to their expertise, NGOs can influence the general public at European and national/regional/local level concerning the importance of child injury prevention.

⁸ Decision No 20/2004/EC of the European Parliament and of the Council of 8 December 2003 establishing a general framework for financing Community actions in support of consumer policy for the years 2004 to 2007 (OJ L 5, 9.1.2004, p. 1).

⁹ Decision No 1513/2002/EC of the European Parliament and of the Council of 27 June 2002 concerning the sixth framework programme of the European Community for research, technological development and demonstration activities, contributing to the creation of the European Research Area and to innovation (2002-2006) (OJ L 232, 29.8.2002, p. 1).

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2 European and EU legislation tackling Intentional and Unintentional Injury of Children

2.1 Towards specific EU legislation tackling unintentional and intentional child injuries

As a matter of principle, **EU Member States are provided with the competence to regulate** the main safety aspects of children injury prevention. However, the EU may contribute to these efforts within the limits of the Treaties by adopting binding measures seeking harmonisation and by coordinating Member States' action by.

Children are affected by different products circulating freely within the European Single Market. Thus, the EU could intervene in this regard by adopting specific legislations regulating **common safety standards** for products used by/for children. In order to achieve to common aims of the internal Market, the EU adopts its legal acts merely based on **Article 114 of the Treaty on the Functioning of the European Union (TFEU)**.¹⁰

However, there are different legal ways to approach the safety of children based on different articles of the Treaties. TFEU Article 168 ensures that *'1. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.'* This is the so-called **Health in All Policies [HIAP] approach**.

Since children can be regarded as especially vulnerable customers, the relevant customer protection EU policy contributes to their overall legal protection since **TFEU Article 169** lays down that *'In order to promote the interests of consumers and to ensure a high level of consumer protection, the Union shall contribute to protecting the health, safety and economic interests of consumers, as well as to promoting their right to information, education and to organise themselves in order to safeguard their interests.'*

Nevertheless, **TFEU Article 36 allows Member States** to adopt national legislations which go beyond the limits set up by EU legislation if they consider that the protection of health and life of human requires such an action. However, such legislations containing prohibitions or restrictions shall not constitute a means of arbitrary discrimination or a disguised restriction on trade between Member States.

Based on the above mentioned basis of the primary law of the Union, the EU adopted specific pieces of the secondary EU legislation, regulating the four examined aspects of unintentional children injury (water, road and home safety) and intentional children injury. The potential national measures adopted on the basis of TFEU Article 36 are beyond the scope of this analysis.

2.2 General process applicable to all relevant acts of the secondary law at the Union aiming at preventing children injuries

The European decision making process is extremely complicated and it takes many times several years when a legislative proposal became finally European law.

¹⁰ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2010:083:0047:0200:EN:PDF>

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The monopoly of making initiatives lies within the **European Commission**. Before drafting a proposal, the European Commission may publish White Papers or Green Papers. White Papers aims to guide readers to better understand an issue, solve a problem, or make a decision. In order to collect further inputs, the Commission can publish Green Papers aiming to identify successful practices and policies. The public consultations offer a direct possibility not only for interested stakeholders but also for ordinary citizens to send input to the European Commission.

The Lisbon Treaty confirmed the roles of the official advisory bodies: the **Committee of the Regions** and the **European Economic and Social Committee**.

The Committee of the Regions (CoR) has to be consulted throughout the legislative process involving the European Parliament and the Council of the European Union in areas such as health, civil protection or the environment.

The European Economic and Social Committee (EESC) is a consultative body that gives representatives of Europe's socio-occupational interest groups, and others, a formal platform to express their points of views on EU issues. Its opinions are forwarded to the larger institutions - the Council, the Commission and the European Parliament.

Based on the inputs received in previous procedures, **the European Commission** elaborates its legislative proposals to the co-legislators: to the Council of the European Union and to the European Parliament.

The appropriate **General Directorate of the European Commission** drafts a proposal. The most important for child safety are the General-Directorate Health and Consumer (DG-SANCO), the General-Directorate Enterprise (DG-ENT) and the General Directorate dealing with Transport and Energy (DG-TREN). At the final political phase within the Commission, all proposals are transmitted to the College of Commissioners who agree on the final proposal, before sending them to the co-legislators.

The Council of the European Union composed of the representatives of the Member States, and **the European Parliament** work together in the framework of the ordinary legislative procedure ('codecision')¹¹. The Lisbon Treaty reinforced the competences of the European Parliament aiming at making its role equivalent to the Council.

All of the above mentioned decision making bodies are subject to lobbying from **NGOs** and the **industry**.

The described EU decision making procedure applies to the different patterns on child injury prevention. Bearing in mind this general legal and procedural framework, we focus on the specific important pieces of legislation of unintentional (water, road, home safety) and intentional child injury prevention.

2.3 Common rules for unintentional child injury prevention

After screening the different EU legislation aiming at protecting vulnerable costumers, the most important piece of legislation is the general framework of **the General Product Safety Directive**

¹¹ The ordinary legislative procedure are regulated by TFEU Article 294

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(GPSD) and the respective rules on **European Standards (the new EU Regulation on European Standardization (1025/2012/EC))** which can be considered as common rules for unintentional child injury prevention. In each part, the most important articles subjects of EU legislation and European Standards are listed under the 3 sub-sections (home, road and water safety).

2.4 General Product Safety Directive (GPSD) 2001/95/EC

The **General Product Safety Directive 2001/95/EC (GPSD)**¹² is intended to protect consumer health and safety and to ensure the proper functioning of the internal market. The **GPSD** is intended to ensure **a high level of product safety** throughout the EU for consumer products that are not covered by specific sector legislation (**e.g. toys, chemicals, cosmetics, machinery**). The Directive also complements the provisions of sector legislation which do not cover certain matters, for instance in relation to producers' obligations and the authorities' powers and tasks. This can be particularly relevant for children, providing a general level of safety.

The Directive provides a generic definition of a **safe product**. Products must comply with this definition. If there are no specific national rules, the safety of **a product is assessed in accordance with European standards**, Community technical specifications, codes of good practice, the state of the art and the expectations of consumers. The Directive provides for an alert system (this is the so-called **RAPEX system**) between Member States and the Commission. The RAPEX system ensures that the relevant authorities are rapidly informed of dangerous products. Subject to certain conditions, Rapid Alert notifications can also be exchanged with non-EU countries. In the case of serious product risks, the Directive provides for temporary Decisions to be taken on Community-wide measures.¹³

The GPSD provides for the following **key obligations and possibilities**:

- obligation for producers and distributors to **market only safe products** and to take the **necessary corrective actions** and to inform the relevant national authorities if they have put on the market an unsafe product (Articles 3 and 5);
- obligation for **national authorities** to carry out **market surveillance and enforcement activities** to ensure that only safe products are put on the market (Articles 6-9);
- obligation for **national authorities** to **notify each other and the Commission via the RAPEX system** of measures taken in order to restrict the marketing or use of dangerous products (Articles 11-12);
- possibility for the **Commission** under specific circumstances to take **temporary, urgent measures** to restrict the marketing or use of products posing a serious risk to the health and safety of consumers (Article 13);

The GPSD contains **a list of conformity assessment criteria** in Article 3(2) and (3). These are relevant also in the risk assessment and guide the thinking as to what could be considered as dangerous under this Directive. It is noteworthy that the GPSD **does not subject** products in a general manner **to prior safety assessment and marketing authorisation** by the national authorities before they are placed on the market. However, if it is considered that a certain product could pose a risk or be dangerous, national authorities can make its marketing **subject to prior conditions so as to make it safe or suspend the marketing of a product for the period needed for safety evaluations**. The GPSD is applied in a **complementary way to sector specific legislations**.

¹² <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CONSLEG:2001L0095:20100101:EN:PDF>

¹³ http://ec.europa.eu/consumers/safety/prod_legis/index_en.htm

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2.4.1 European Standards (Regulation 1025/2012/EC)

The new EU Regulation on European Standardization (1025/2012/EC)¹⁴ entered into force as from 1 January 2013. It provides the legal framework within which the European Standards Organisations (CEN, CENELEC, ETSI) operate. **European Standards** play an important role in product safety so in order to make the procedure more smoothly running. **The GPSD delegates the elaboration of most of the technical details of product specifications to the European standards bodies.**

2.4.2 The European Committee for Standardization (CEN)

The **European Committee for Standardization (CEN)** was officially created as an international non-profit association based in Brussels on 30 October 1975. CEN's 33 National Members work together to develop voluntary **European Standards (ENs)**. These standards have a unique status since they also are national standards in each of its 33 Member countries. With one common standard in all these countries and every conflicting national standard withdrawn, a product can reach a far wider market with much lower development and testing costs. ENs help build a European Internal Market for goods and services and position Europe in the global economy.¹⁵

2.4.3 Sector Specific legislations

As highlighted before, in general, **the GPSD applies in a complementary way** to products and/or risks covered by sector-specific product safety legislation applicable on areas such as **chemicals, toys personal protective equipment, cosmetics, pharmaceuticals, machinery, recreational craft, liability for defective products**. The GPSD can be considered as the main rule if there is no sector specific legislation. However, if such a special legislation exists than the GPSD shall be interpreted in the light of the specific sector specific legislation. The European Commission has published a guide to clarify the relationship between the GPSD and the horizontal rules on market surveillance.¹⁶

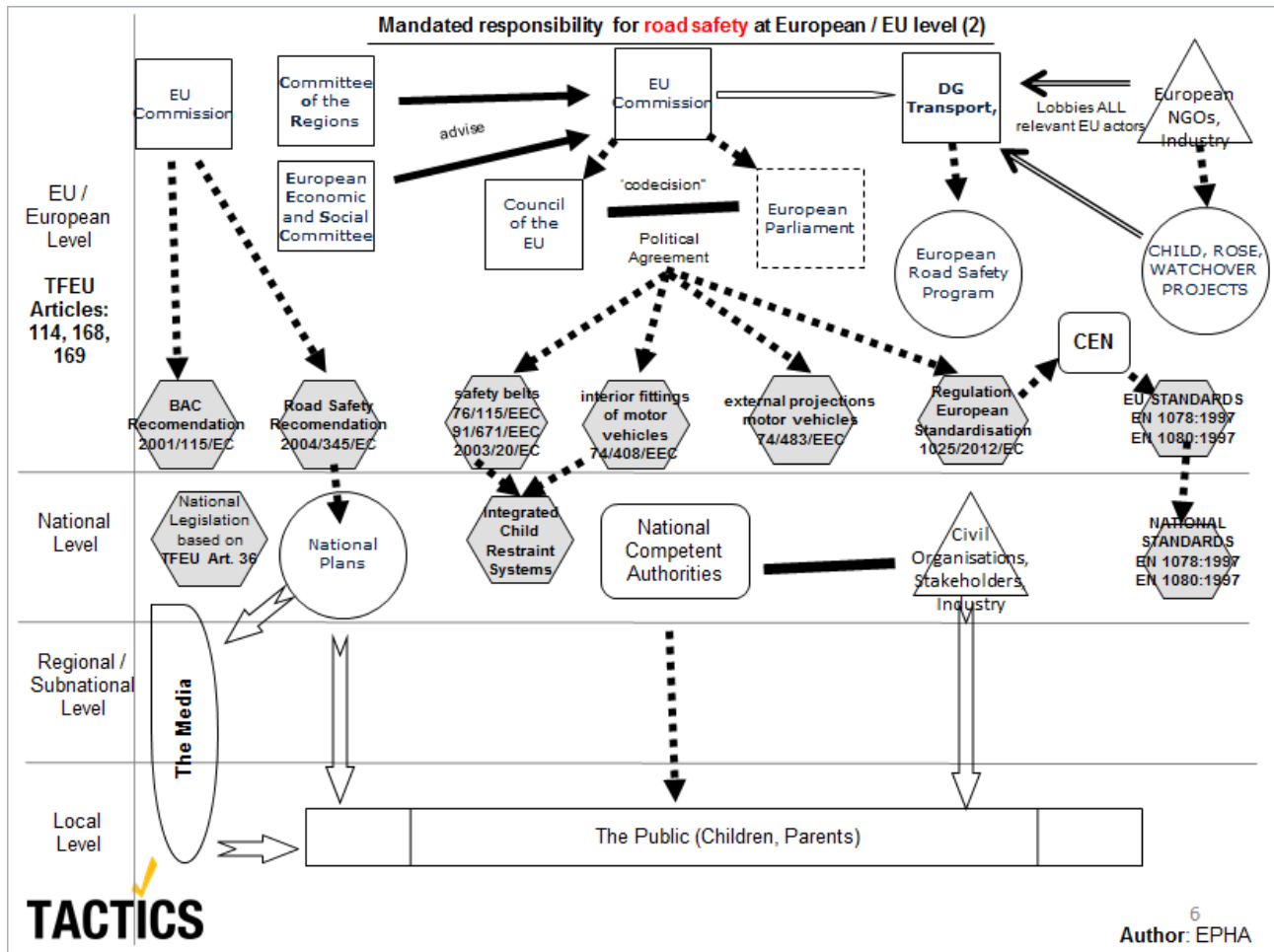
¹⁴ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2012:316:0012:0033:EN:PDF>

¹⁵ <http://www.cen.eu/cen/aboutus/pages/default.aspx>

¹⁶ http://ec.europa.eu/consumers/safety/prod_legis/docs/20100324_guidance_gspd_reg_en.pdf

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3 Road Safety of Children



Organigraph 2. - Mandated responsibility for road safety at European / EU level

3.1 Background information at European level

According to the WHO analysis in 2004, **Road traffic injuries (RTIs) were the leading cause of death in those aged 5–19 years in the WHO European Region.** In 2004, they were estimated to have **killed 16 400 young people aged 0–19 years.** RTIs also result in traumatic brain and limb injuries, leading to long-term disability. Mortality in the country in the Region with the highest rate was three times that in the country with the lowest rate. Children from deprived backgrounds are at increased risk of death, especially as pedestrians and cyclists; the poorest may have over 20 times the risk of the richest, because of exposure in unsafe environments.¹⁷

Children are particularly vulnerable. **Each year, more than 1100 children under the age of 15 are killed on European roads and 100 000 are injured.**¹⁸

¹⁷ http://www.euro.who.int/_data/assets/pdf_file/0003/83757/E92049.pdf

¹⁸ http://ec.europa.eu/transport/road_safety/users/children/index_en.htm

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3.1.1 General Framework: non-binding Commission Recommendation 2004/345/EC on Road Safety

The **Commission Recommendation 2004/345/EC** of 6 April 2004 on enforcement in the field of road safety makes proposes different actions to be taken for Member States. In order to make an effective planning of the measures to be taken following the Recommendation, Member States should establish **a national enforcement plan** which they should evaluate at regular intervals and if necessary adapt. In order to enable effective sanctioning also in cases of serious and/or repeated violations that are committed in another Member State than the Member State where the car is registered, the Recommendation provides for a mechanism for cross-border enforcement. The Commission should draw up **a report every two years** on the basis of this information provided by the Member States.¹⁹

3.1.2 The most relevant areas of EU legislation and European Standards

In the light of the above mentioned data, the following objects may be subject of legislation at European level:

Motor Vehicle:

- Appropriate restraint systems by children of all ages
- Placement of children in the rear seats to avoid air bag injuries and head on impacts
- Child restraints
- Development of universal child restraint systems using rigid or semi-rigid vehicle anchorages
- Redesign child restraint systems to allow toddlers to travel rearward facing for a longer period (or up to the age of 4)
- Alcohol limits
- Seat belts
- Vehicle crashworthiness
- Children banned from riding/driving farm tractors

Pedestrian:

- Design of motor vehicles considering pedestrian protection
- Speed limits in urban areas
- Traffic calming of road ways Bicycles: Brakes on bicycles for children
- Mandatory use of helmets
- Separate lanes for bicycles²⁰

Bicycles:

- Brakes on bicycles for children
- Mandatory use of helmets
- Separate lanes for bicycles

¹⁹ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:111:0075:0082:EN:PDF>

²⁰ <http://www.childsafetyeurope.org/publications/alliance-fact-and-tip-sheets.html>

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3.1.3 EU legislation on motor vehicles

Fatalities and injuries to child car occupants under 10 years of age remain high in Europe, and this can be attributed to the fact that nearly half of these injuries are caused by the child riding unrestrained in the car.

The use of child car seats and seat belts is critical to injury prevention in the case of an accident. Youths age 15 to 19 make up a high risk group as both drivers and passengers, due to the lack of experience driving and increased risk taking. Boys make up 75% of road traffic fatalities for this age group.²¹

Concerning seat belts and child restraints, under EU law, seat belts must be used in all vehicles. Children over 1.35 m can use an adult seat belt. Those under 1.35 m must use equipment appropriate to their size and weight when travelling in cars or lorries. It is now against the law to use a rear-facing child seat on the front passenger seat – unless the airbag has been deactivated.²²

The Council Directive of 16 December 1991 relating to the compulsory use of **safety belts** and **child-restraint systems** in vehicles (**91/671/EEC**) lays down the basic rules to protect children in vehicles²³.

One of the aims of the common **EU transport policy** is effectively to reduce the number of traffic accidents and casualties. The wearing of safety belts and the use of restraint systems for children are essential protective factors as vehicle occupancy. In order to achieve this, this directive aimed at making it mandatory to wear safety belts throughout the EU in all of the seats fitted to vehicles weighing less than 3.5 tonnes. This directive accepted the principle of the compulsory use of restraint devices for children aged less than 12 years, and contains provisions for the compulsory use of child restraint systems on seats fitted with safety belts.²⁴

This directive has been amended by Directive **2003/20/EC** of the European Parliament and of the Council of 8 April 2003 which extended the scope of application of the Directive 91/671/EEC to require the use of seat belts where provided by all motor vehicle occupants and for children to be restrained by an appropriate child restraint system conforming to **UN-ECE standard Regulation 44.03**) when travelling in passenger cars and light vans (M1 and N1 vehicles). This rule had to be transposed into National law of Member states by 9 May 2006. **The main safety benefit** of the new Directive was that it recognised that **children**, like adults, **have the right to be protected** when travelling in cars and therefore requires the adults responsible to ensure that the children are restrained by child restraints that are designed for their age and size.²⁵

There is no minimum standard for the **safety of child restraint systems (CRS)** in European legislation other than integrated CRS. The following two directives deal with aspects of the fitment of CRS:

²¹ <http://www.childsafetyeurope.org/injurytopics/roadsafety/passenger-safety.html>

²² http://ec.europa.eu/transport/road_safety/users/children/index_en.htm

²³ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CONSLEG:1991L0671:20030509:EN:PDF>

²⁴ <http://aei.pitt.edu/3977/>

²⁵ <http://www.childsafetyeurope.org/injurytopics/roadsafety/passenger-safety.html>

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Council Directive **74/408/EEC** of 22 July 1974 on the approximation of the laws of the Member States relating to the **interior fittings of motor vehicles** (strength of seats and of their anchorage) (OJ L 221 12.08.1974 p.1) This Directive has been amended by Council Directive of 20 July 1981, by Commission Directive 96/37/EC of 17 June 1996, by Directive 2005/39/EC of the European Parliament and of the Council of 7 September 2005, and by Council Directive 2006/96/EC of 20 November 2006.²⁶

Council Directive **76/115/EEC** of 18 December 1975 on the approximation of the laws of the Member States relating to **anchorage for motor-vehicle safety belts** (OJ L 024 30.01.1976 p.6)²⁷

The following legislations contain further technical specifications in that matter.

Concerning **seat belts**:

Council Directive **77/541/EEC** of 28 June 1977 on the approximation of the laws of the Member States relating to **safety belts and restraint systems of motor vehicles** (OJ L 220 29.08.1977 p.95) Includes three point anchorage in the centre rear position and in minibuses and two point belts in larger coaches.²⁸

Concerning **vehicle crashworthiness**:

Directive **96/27/EC** of the European Parliament and of the Council of 20 May 1996 on the protection of occupants of motor vehicles **in the event of a side impact** and amending Directive 70/156/EEC (OJ L 169 08.07.1996 p.1)²⁹

Directive **96/79/EC** of the European Parliament and of the Council of 16 December 1996 on the protection of occupants of motor vehicles **in the event of a frontal impact** and amending Directive 70/156/EEC (OJ L 018 21.01.1997 p.7)³⁰

It has been estimated that that at least 10000 drivers, passengers, pedestrians and cyclists are killed every year in road accidents in which a driver's competence was impaired due to alcohol on roads in the EU. Most Member States have already adopted 0,5 mg/ml as their maximum permissible BAC limit.

Thus, the Commission has been adopted its **Recommendation 2001/115/EC** of 17 January 2001 on the **maximum permitted blood alcohol content (BAC)** for drivers of motorised vehicles³¹. The primary aim of a more uniform maximum BAC limit within the Community is to provide a clearer and more consistent message to drivers of passenger and freight vehicles that, above a certain limit, alcohol and driving is a dangerous activity and that different limits in different Member States are potentially confusing and weaken the message that driving under the influence of alcohol is dangerous.

²⁶ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CONSLEG:1974L0408:20070101:EN:PDF>

²⁷ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CONSLEG:1976L0115:20051020:EN:PDF>

²⁸ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CONSLEG:1977L0541:20070101:EN:PDF>

²⁹ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CONSLEG:1996L0027:19960728:EN:PDF>

³⁰ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CONSLEG:1996L0079:20000202:EN:PDF>

³¹ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2001:043:0031:0036:EN:PDF>

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3.1.4 CHILD (Child In Car Safety Research Project) project (2002-2005)

The **CHILD project** looked into the ways children are injured in accidents. Its findings should help to improve the design of child restraints.

A Strong Partnership

The Consortium included **a good geographical representation** within Europe, relying on the skill of experts in child protection -and more generally in safety- and a balance between Research, Industry, Regulation and Testing Institutes.

Expected impact

The main goal of CHILD was **to improve the child safety in road accidents**. CHILD will enable the investigation of injury mechanisms and tolerances for different ages of children and to establish injury criteria and risk curves.

Project summary

CHILD aimed towards a more comprehensive understanding of the injury mechanisms experienced by children of different ages in road accidents, through innovative tools and methods, in order to contribute to revised or improved standards and more efficient design of child restraint systems. The CHILD project started in September 2002 and took place over 3 years.³²

3.1.5 Pedestrian and cyclist related EU legislation

Both child pedestrians and cyclists usually suffer **the most severe injuries as a result of road traffic collisions**. Children up to age 15 are most at risk for road traffic injuries while cycling. Use of a bicycle helmet can reduce the risk of head or brain injury up to 88%.³³

Teachers and parents can teach children about road safety as pedestrians (learning by doing). But children should have some formal training on basic traffic rules before they're allowed to cycle on the road. Like adults, children should wear a helmet at all times when cycling.

Some basic safety features – brakes, bell and reflectors – are compulsory for all bicycles. Some EU countries have additional rules – on visibility, helmets, children's seats and the minimum age for cycling on public roads.

Vehicle design

Improving the design of cars and heavy vehicles can reduce the risk of injury to any cyclists or pedestrians that they hit. For instance, **crash-friendly car fronts and blind spot mirrors** on lorries could save up to 2 000 pedestrian and cyclist lives each year.

The **APROSYS project** developed new test methods for vehicle fronts to assess their impact on pedestrians and cyclists. It also examined laminated materials that can fracture without losing their

³² <http://www.casper-project.eu/child%20web%20site/index2.htm>

³³ <http://www.childsafetyeurope.org/injurytopics/roadsafety/cyclist-safety.html>

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shape or falling apart. These would be especially useful for cycling helmets. The WATCH-OVER³⁴ project promotes the development of new communication and video-sensing technologies – to help drivers detect cyclists and pedestrians in complex traffic.

Traffic management

Separating bikes from motorised traffic by **using uninterrupted cycling lanes** helps to reduce collisions between cars and bicycles. Traffic-calmed areas with a low speed limit (30 kph or 20 mph) can also reduce the risk and seriousness of accidents.³⁵

Council Directive **74/483/EEC** of 17 September 1974 on the approximation of the laws of the Member States relating to the **external projections of motor vehicles** (OJ L 266 02.10.1974 p.4) as amended deals with minor projections on vehicle fronts.

3.1.6 ROSE Project

In **September 2003** the European Commission tendered a project to investigate the situation of **Road Safety Education (RSE)** in all 25 Member States. It is evident that the differing development paths of school systems and the differences in traffic, mentalities, cultures and administrations have all led to a fascinating variety of RSE initiatives. With this project the European Commission emphasises **the need to collect and exchange good practice** in order to launch a discussion on RSE Guidelines at the European level. This effort to strengthen European RSE networks, as well as to create synergies in RSE research and development, is an important investment for the benefit of the young generation.

The results of the **ROSE 25 project**³⁶ include a booklet with European guidelines on road safety education for young people. The guidelines are based on the experiences of 25 EU countries.³⁷

The main purpose of the project was **collecting measures of good practice** in Road Safety Education (RSE) for children and teenagers in the Member States and compiling European guidelines for best practice (the European Booklet).

Target groups were children and teenagers aged 3 to 17 and moped users and pre-drivers are also included. Parents (especially parents of "smaller" children, aged 0 to 3) were included, too.

3.1.7 European Standards

European standards addressing bicycles **avoid issue of brakes due to conflicting national theories regarding hand brakes versus back-pedal brakes**. No European regulation mandating the wearing the helmets. Voluntary standards exist governing the performance of helmets. In line with the above mentioned European mechanism of standards, the following standards apply to the cyclists:

EN 1078:1997 Helmets for pedal cyclists and for users of skateboards and roller skates

EN 1080:1997 Impact protection helmet for young children

³⁴ <http://www.watchover-eu.org/objectives.html>

³⁵ http://ec.europa.eu/transport/road_safety/users/cyclists/index_en.htm

³⁶ http://ec.europa.eu/transport/rose25/index_en.htm

³⁷ http://ec.europa.eu/transport/road_safety/users/children/index_en.htm

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3.1.8 EU road safety plan for next 10 years

According to a recent EU-wide survey, **Europeans think more should be done to reduce accidents**. Most people surveyed thought government action should focus on improving roads and enforcing traffic laws. Only four countries – Latvia, Spain, Estonia and Portugal - have managed to reduce their annual road death toll by 50% compared with 2001. The number of fatalities has increased in Romania and Malta. The UK, the Netherlands and Sweden had the lowest death tolls in 2009. Greece and Romania had the highest.

In 2009, 35 000 people died in road accidents across the EU – 36% less than in 2001, when the commission first set its target of cutting the annual death rate by 50%. Young people and motorcyclists are among those most at risk.

Speeding, driving after drinking alcohol and not wearing a seatbelt are some of the leading causes of road deaths. But unsafe vehicles and poorly maintained roads also pose unnecessary risks. The new **EU Road Safety programme**³⁸ addresses all these issues.

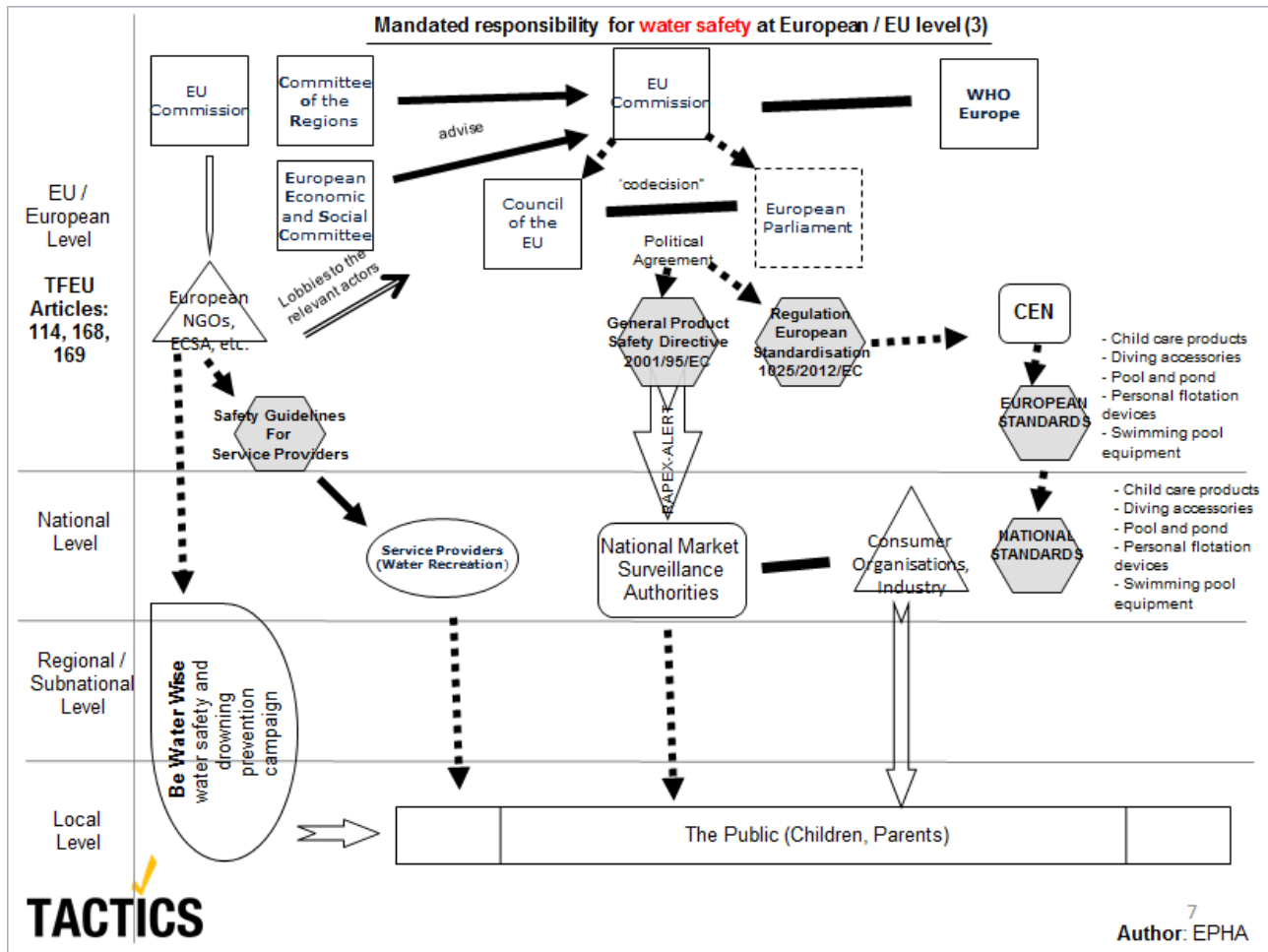
Over the next 10 years:

- new rules will come into force requiring **more vehicles to be equipped with automatic warning systems**, including for speeding or leaving a lane.
- EU funding will only go to road-building projects that **comply with EU road safety laws**.
- the EU will work with national authorities to **devise a common education and training strategy** for road users.
- more effort will be made to make **motorcyclists safer**. Recent years have seen a drop in road deaths for all modes of transport except this category. Every year, some 17% of fatalities involve motorbike or moped riders even though they make up just 2% of road users.

³⁸ http://ec.europa.eu/transport/road_safety/pdf/com_20072010_en.pdf

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4 Water Safety of Children



Organigram 3. - Mandated responsibility for **water safety** at European / EU level

4.1 Background information at European level

The respective WHO report made in 2004 demonstrates, that drowning was the leading cause of injury deaths in children aged 1–4 and results in over 5000 deaths per year in the Region. Children who survive may be severely disabled through brain damage and require lifelong financial and health care support. Again, **inequalities were enormous**, with a twentyfold difference in mortality between countries with the highest and lowest rates, and a nearly elevenfold difference in risk for the poorest groups within countries.³⁹

On July 14, 2008 the European Child Safety Alliance, EuroSafe launched a new resource entitled "**Protecting children and youth in water recreation: safety guidelines for service providers**"⁴⁰.

³⁹ http://www.euro.who.int/_data/assets/pdf_file/0003/83757/E92049.pdf

⁴⁰ http://ec.europa.eu/consumers/safety/serv_sectors/docs/water_recreation_en.pdf

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This water safety resource is specifically tailored towards people working in the water recreation and tourism sectors to assist them in offering safe water related activities and services for children and families throughout Europe.

Developed with the support of the European Commission and in collaboration with professional water recreation associations and injury prevention experts across Europe, these guidelines provide informative facts on injuries and hazards, and outline specific safety recommendations for water recreation service providers (hotel managers, rental providers, tour operators, etc.).

The recommendations include: checking the risks linked to the water-related area and activity, particularly for vulnerable users such as children; providing the appropriate equipment, such as floatation devices; communicating the risks and hazards clearly; and having well-trained staff and an emergency plan in place. Specific recommendations are also set out for certain water-sports, including snorkelling, scuba diving, sailing, motor-boating and kite-surfing.⁴¹

4.1.1 European Standards

The following categories shall be taken into account for water safer:

Drowning prevention:

- Child care products
- Diving accessories
- Pool and pond fencing, natural barriers, locked gates
- Personal flotation devices
- Swimming pool equipment

For **Child care products**, the **EN13822:2000** standard applies on bath seats.

For **Diving accessories**, the **following** standards apply:

- **EN 1972:1997** - Diving accessories - Snorkels - Safety requirements and test methods
- **EN 13319:2000** - Diving accessories - Depth gauges and combined depth and time measuring devices - Functional and safety requirements, test methods

There are no European regulatory requirements for the provision of pool fencing or other safety equipment and only voluntary standards govern the construction of related products. For **pool and pond fencing, natural barriers, locked gates**, the **following** standards apply:

- **EN 393:1993/A1:1998** Lifejackets and personal buoyancy aids - Several standards
- **EN 60335-2-60:1997** Safety of household and similar electrical appliances - Part 2: Particular requirements for whirlpool baths and similar equipment
- **EN 1069-1:2000** Water slides over 2m height - Part 1: Safety requirements and test methods
- **EN 1069-2:1999** Water slides over 2m height - Part 2: Instructions

⁴¹ http://ec.europa.eu/consumers/safety/serv_sectors/watersafety_en.htm

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For **personal flotation devices**, the **following** standards apply:

- **EN 393:1993/A1:1998** Lifejackets and personal buoyancy aids- Buoyancy aids - 50N
- **EN 395:1993/A1:1998** Lifejackets and personal buoyancy aids - Lifejackets - 100N
- **EN 396:1993/A1:1998** Lifejackets and personal buoyancy aids - Lifejackets - 150N
- **EN 399:1993/A1:1998** Life jackets and personal buoyancy aids - 275 N
- **EN 394:1993** Lifejackets and personal buoyancy aids - Additional items
- **EN 13138-2:2002** Buoyant aids for swimming instruction - Part 2: Safety requirements and test methods for buoyant aids to be held
- **EN 13138-1:2008** Buoyant aids for swimming instruction - Part 1: Safety requirement and test methods for buoyant aids to be worn.

For **swimming pool equipment**, the **following** standards apply:

- **EN 13451- 1: 2001** - Swimming pool equipment - Part 1: General safety requirements and test methods
- **EN 13451- 2: 2001** - Swimming pool equipment - Part 2: Additional specific safety requirements and test methods for ladders, stepladders and handle bends
- **EN 13451- 3: 2001** - Swimming pool equipment - Part 3: Additional specific safety requirements and test methods for pool fittings for water treatment purposes
- **EN 13451- 4: 2001** - Swimming pool equipment - Part 4: Additional specific safety requirements and test methods for starting platforms
- **EN 13451- 5: 2001** - Swimming pool equipment - Part 5: Additional specific safety requirements and test methods for lane lines
- **EN 13451- 6: 2001** - Swimming pool equipment - Part 6: Additional specific safety requirements and test methods for turning boards
- **EN 13451- 7: 2001** - Swimming pool equipment - Part 7: Additional specific safety requirements and test methods for water polo goals
- **EN 13451- 8: 2001** - Swimming pool equipment - Part 8: Additional specific safety requirements and test methods for leisure water features⁴²

4.1.2 Be Water Wise

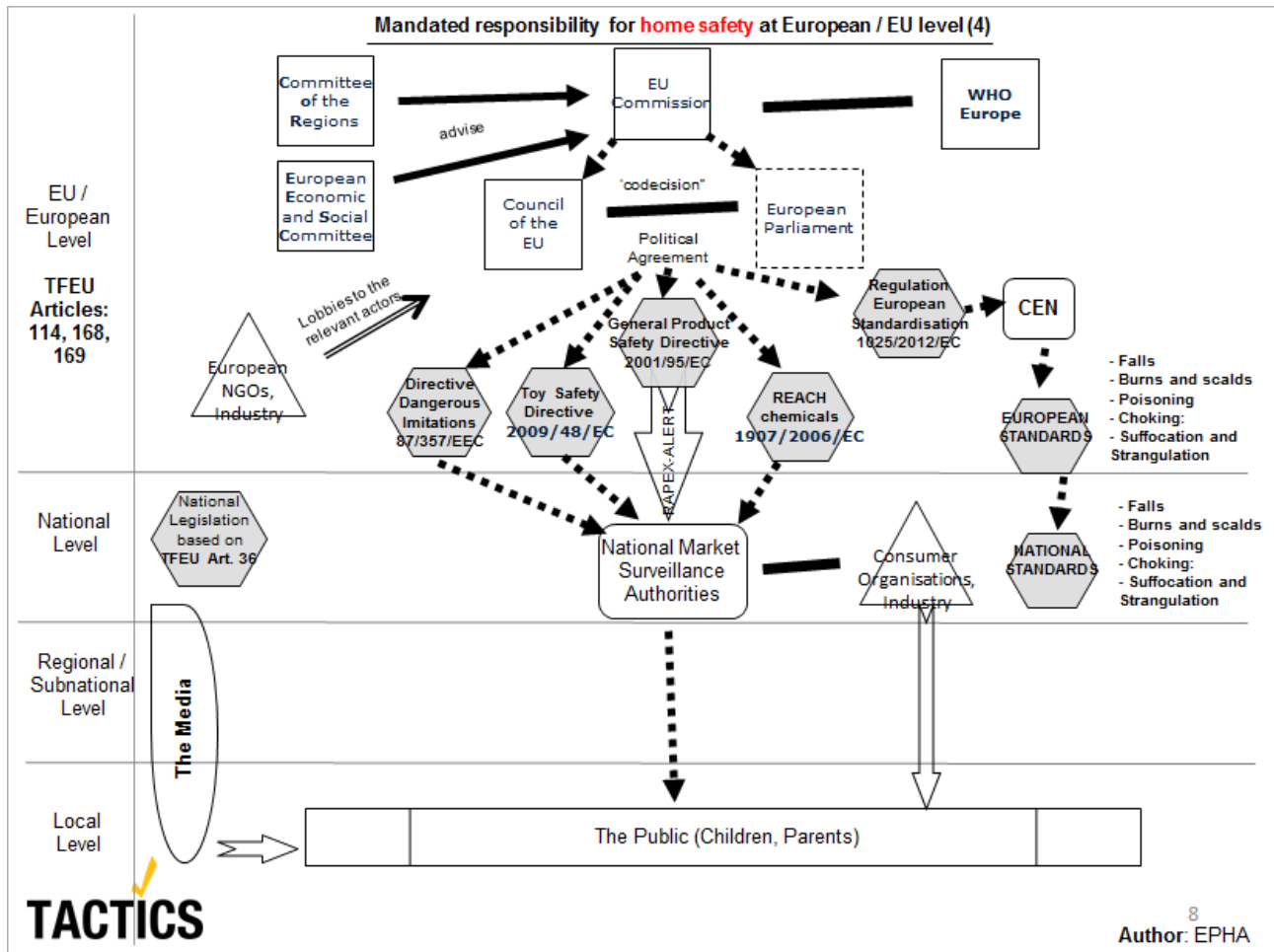
Last, but not least, all policy and legal efforts are reinforced by an action called '**Be Water Wise**', which is a water safety and drowning prevention campaign of the European Child Safety Alliance in partnership with Johnson & Johnson - Europe, Middle East and Africa.⁴³

⁴² <http://www.childsafetyeurope.org/publications/alliance-fact-and-tip-sheets.html>

⁴³ <http://www.childsafetyeurope.org/injurytopics/drowningwatersafety/index.html>

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5 Home Safety of Children



Organigram 4. - Mandated responsibility for home safety at European / EU level

5.1 Background information at European level

The WHO provided alarming data in 2004 concerning different aspects of home safety, such as poisoning, burning or falls.⁴⁴

Poisoning remained the third leading cause of injury death. In 2004, acute poisoning caused 3000 deaths in the European Region, with a thirtyfold difference between the countries with the highest and lowest rates. The home was the most common setting for childhood poisoning and children were particularly at risk when harmful substances are stored in easily opened containers or within easy reach. The agents in most fatal poisonings were pharmaceuticals, household agents, pesticides and plants. Acute intoxication with alcohol is a growing concern in adolescents.

Burns killed 1700 young people aged 0–19 years in 2004 in the European Region; survivors could be permanently scarred or disabled. Again, there were great inequities between and within

⁴⁴ http://www.euro.who.int/_data/assets/pdf_file/0003/83757/E92049.pdf

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countries. Deaths in the countries with the highest rates were 85 times those in the countries with the lowest, and the poorest people in countries have up to 38 times the risk of the richest. Deaths and injuries from burns were linked to unsafe environments and products, especially at home.

More than 1500 young people aged 0–19 died from **falls** each year in the European Region, with a twentytwofold difference in deaths between the countries with the highest and lowest rates. Many more non-fatal fall injuries were a leading cause of disability. As with other injury types, poor children were at increased risk.

5.1.1 The directive on dangerous imitations (87/357/EEC)

The Directive on dangerous imitations prohibits the marketing, import and manufacture of products that look like foodstuffs but that are not in fact edible. These products may be particularly relevant for children who are most likely to be victim of such imitations.

The Directive (87/357/EEC)⁴⁵ applies to products which are not edible, but could easily be confused with foodstuffs by their appearance, smell or packaging. Member States must carry out checks to ensure that no such products are marketed. If a Member State bans a product under the terms of this Directive, it must inform the Commission and provide the details needed to inform the other Member States.

As examples, some products imitating soaps, candles and other decorative articles can be all food-imitating and as a consequence pose a risk of **choking, poisoning** or **perforation** of the digestive tract, **in particular to young children**, because they can be mistaken for food and be sucked or ingested given their shape, colour, appearance and size.

In these cases, the main corrective measure taken by the national authorities (or sometimes on a voluntary basis by the producer or distributor) to prevent the risk to consumers has been the withdrawal of the food-imitating products from the market.

Directive 87/357/EEC on dangerous imitations **prohibits** the marketing, import and manufacture of products that look like foodstuffs but that are not edible.

5.1.2 The old Toy safety directive (88/378/EEC)

The original directive on toy safety (88/378/EEC⁴⁶) was adopted in the context of the achievement of the internal market. The aim of this harmonisation measure was also to guarantee an equally high level of toy safety across the whole Community. Directive 88/378/EEC sets the essential safety requirements that toys placed on the market in the Community have to fulfil.

Technical details are left to be fixed by standardisation organisations, which mean that toys that comply with the harmonised standards are presumed to be in conformity with the essential safety requirements of the Directive.

⁴⁵ <http://eur-lex.europa.eu/Notice.do?checktexts=checkbox&checktexte=checkbox&val=129356%3Acs&pos=2&page=1&lang=en&pgs=10&nbl=2&list=129357%3Acs%2C129356%3Acs%2C&hwords=&action=GO&visu=%23texte>

⁴⁶ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CONSLEG:1988L0378:20090112:EN:PDF>

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Directive 88/378/EC has, in general, worked well during its almost 20 years of existence. However, the **technological developments in the toys market** have raised new issues with respect to the safety of toys, and made consumers express increased preoccupations in this regard. The experience made with the operation of the existing Directive on the safety of toys led to the conclusion that there is a need to update and complete the safety requirements, in particular in areas such as noise and chemicals in toys. The 'old' Directive, therefore, needed to be adapted to these developments.⁴⁷

5.1.3 The new directive on Toy safety (2009/48/EC)

On 30 June 2009 the **new Toy Safety Directive** was published.⁴⁸ It substantially amends the old Directive across virtually all safety aspects, fulfils to the highest level the newest health and safety standards and improves the existing rules for the marketing of toys that are produced in and imported into the EU in view to reducing toy related accidents and achieving long-term health benefits.

Directive 2009/48/EC **applies to toys defined as "products designed or intended, whether or not exclusively, for use in play by children under 14 years of age"**. It foresees 19 products not to be considered as toys within the meaning of the Directive and 5 toys the Directive is not applying to (for example, toy steam engines, slings).

The new Directive brings in particular more references on **chemicals** by limiting the amounts of certain chemicals that may be contained in materials used for toys. Chemicals that are susceptible to provoke cancer, change genetic information or harm reproduction, so-called **CMR (Carcinogenic, Mutagenic or toxic for Reproduction)** substances, are no longer allowed in accessible parts of toys. For certain substances like nickel tolerable limit values have been introduced and certain heavy metals which are particularly toxic, like lead, may no longer be intentionally used in those parts of toys that are accessible to children.

Allergenic fragrances are either completely forbidden, if they have a strong allergenic potential, or have to be labeled on the toy if they are potentially allergenic for some consumers.

This new Directive came into force on 20 July 2009, Member States had to implement into national legislation by 20 January 2011, and they began apply the new measures from 20 of July 2011, except for annex II part III (chemical requirements). Recognizing that this is a more complicated area, the parts of the Directive relating to chemical content will come into force on 20 July 2013. During this transitional period, part III of annex II of Directive 88/378/EEC will continue to apply.⁴⁹

The Commission elaborated, in cooperation with **Toy Industry of Europe**, a brochure on toys safety, available in all EU languages. The brochure is intended to all parties directly or indirectly concerned by the new Toy safety directive 2009/48/EC⁵⁰.

⁴⁷ http://ec.europa.eu/enterprise/sectors/toys/documents/directives/index_en.htm

⁴⁸ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2009:170:0001:0037:EN:PDF>

⁴⁹ http://ec.europa.eu/enterprise/sectors/toys/documents/directives/index_en.htm

⁵⁰ http://ec.europa.eu/enterprise/sectors/toys/files/toys-safety-brochure/w-toys-safety-brochure_en.pdf

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Authorities, consumer organisations and industry, in collaboration with the Commission, made toy safety tips addressed to consumers in order to make the best choices when buying toys providing adequate toys to our children.⁵¹

5.1.4 REACH regulation (1907/2006/EC)

The REACH Regulation⁵² is the main legislation at EU level on Registration, Evaluation, Authorisation and Restriction of Chemicals. It entered into force on 1st June 2007. It streamlines and improves the former legislative framework on chemicals of the European Union (EU).

The main aims of REACH are to ensure **a high level of protection of human health and the environment** from the risks that can be posed by chemicals, the promotion of alternative test methods, the free circulation of substances on the internal market and enhancing competitiveness and innovation.

REACH makes industry responsible for assessing and managing the risks posed by chemicals and providing appropriate safety information to their users. In parallel, the European Union can take additional measures on highly dangerous substances, where there is a need for complementing action at EU level.⁵³

REACH foresees a **restriction** process to regulate the manufacture, placing on the market or use of certain substances, either on their own or in mixtures or articles, within the EU territory if they pose an unacceptable risk to health or the environment. Such activities may be limited or even banned, if necessary. The restriction is designed to manage risks that are not addressed by the other REACH processes or by other EU legislation. **The main restrictions** are listed in Annex XVII.

5.2 European standards on home safety of children

There is significant number of adopted standards which ensure the highest attainable safety level of relevant products.

Falls:

- Furniture
- Mandatory use of helmets during sports
- Playgrounds with regulated shock absorbing surfaces to comply with the playground standards
- Fairground equipment and leisure attractions
- Stair gates
- Window Bars and Balconies
- Sports equipment
- Supermarket trolleys

⁵¹ http://ec.europa.eu/enterprise/sectors/toys/files/toys-safety-tips/toy_safety_tips_en.pdf

⁵² http://ec.europa.eu/enterprise/sectors/chemicals/documents/reach/index_en.htm

⁵³ http://ec.europa.eu/enterprise/sectors/chemicals/reach/index_en.htm

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Burns and scalds:

- Child resistant lighters and matches
- Flammability of furniture and other products
- Flame resistant clothing
- Smoke alarms
- Temperature regulators on water heaters to prevent tap water scalds
- Surface temperatures
- Fireworks

Poisoning:

- Child resistant packaging
- Labelling of dangerous products
- Phthalates in toys and child care products
- Chemicals in Toys
- Safe storage
- Nickel allergy

Choking:

- Inedibles in food
- Small parts size enforcement for child products and toys/warning labels
- Pen Caps

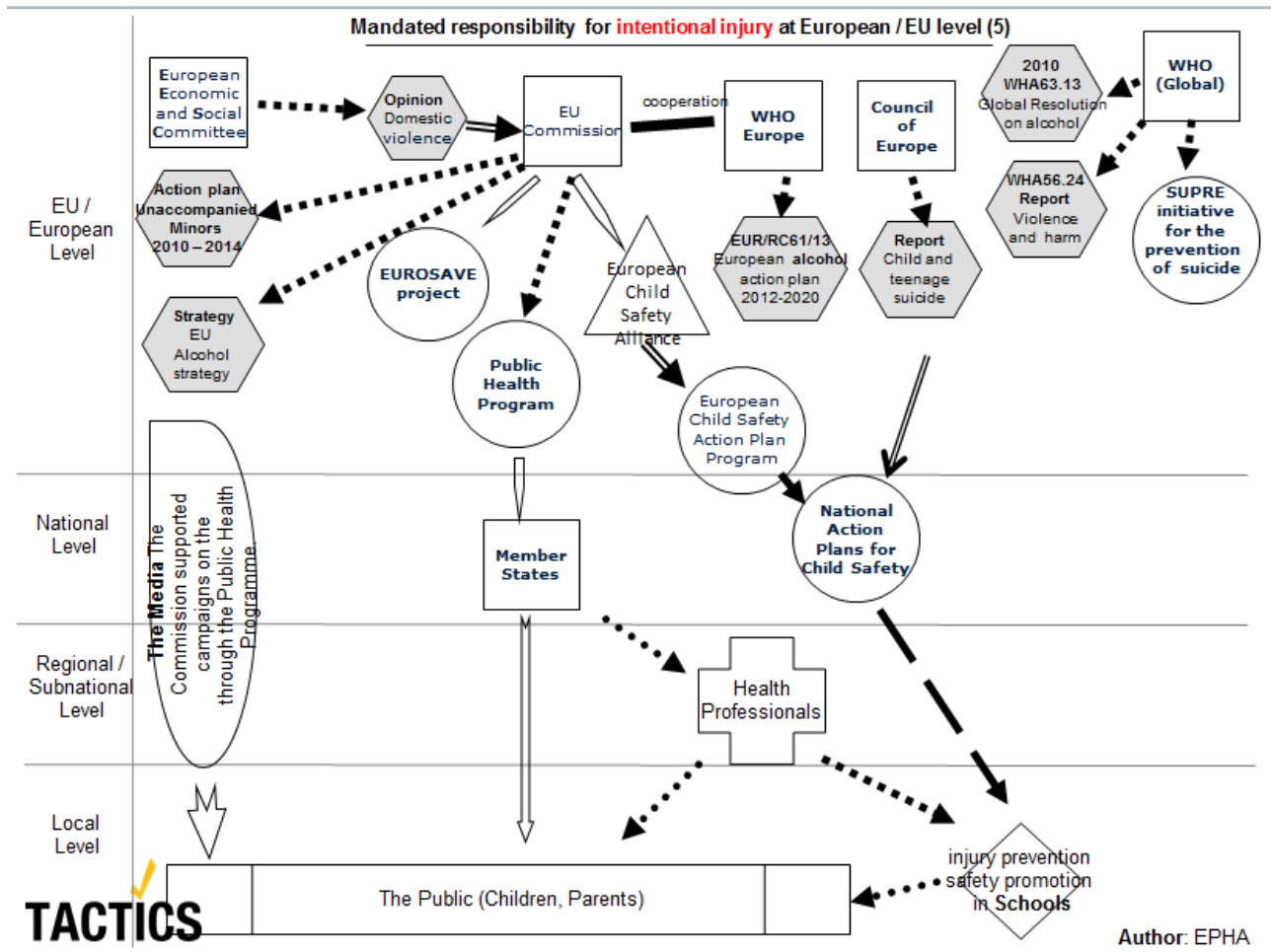
Suffocation and Strangulation:

- Blind cords on windows
- Requirements on measurements in standards for products
- Removal of drawstrings on children's clothing
- Pen caps⁵⁴

⁵⁴ <http://www.childsafetyeurope.org/publications/alliance-fact-and-tip-sheets.html>

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6 Intentional Injury of Children



Organigram 5. - Mandated responsibility for intentional injury at European / EU level

6.1 Introduction

The analysis relies on the WHO approach to intentional injury. **The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in injury, death, psychological harm, maldevelopment or deprivation.**⁵⁵ An injury which is judged to have been purposely inflicted, either by the self or another (Rice et al., 1989).⁵⁶

⁵⁵ WHO World report on violence and health -

http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf

⁵⁶ SOPHE Unintentional Violence / Intentional Injury <http://www.sophe.org/ui/injury-violence.cfm>

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6.1.1 The main forms of intentional injuries of children

Child Maltreatment

- Data on the confirmed number of U.S. child maltreatment cases in 2002 are available from child protective service agencies; but these data are generally considered underestimates (DHHS 2005):
- 905,000 children were victims of maltreatment in 2006 (HHS 2006)
- 64 percent of the children were classified as victims of child neglect; 7 percent as victims of emotional abuse; 9 percent as victims of sexual abuse; and 16 percent as victims of physical abuse (HHS 2006).
- An estimated 1,500 children were confirmed to have died from maltreatment; 36% of these deaths were from neglect, 28% from physical abuse, and 29% from multiple maltreatment types (HHS 2006).
- Shaken-baby syndrome (SBS) is a form of child abuse affecting between 1,200 and 1,400 children every year. SBS is a collection of signs and symptoms resulting from violently shaking an infant or child (National Center on Shaken Baby Syndrome 2007).⁵⁷

Youth Violence

- 5,686 young people age 10 to 24 were murdered-an average of 16 each day-in 2005 (CDC 2008).
- Over 720,000 violence-related injuries in young people age 10 to 24 were treated in U.S. emergency rooms in 2006 (CDC 2008).
- Among 10 to 24 year-olds, homicide is the leading cause of death for African Americans; the second leading cause of death for Hispanics and Asian/Pacific Islanders; and the third leading cause of death for American Indians and Alaska Natives (CDC 2008a)
- Of the 5,958 homicides reported in 2006 among 10 to 24 year olds, 86% were males and 14% were females (CDC 2006).
- Direct and indirect costs of youth violence (e.g., medical, lost productivity, quality of life) exceed \$158 billion every year (Children's Safety Network Economics & Data Analysis Resource Center 2000).⁵⁸

6.1.2 European policy action at WHO level tackling the main risk factors of intentional injury of children

Alcohol

The World Health Assembly approved a resolution to endorse a global strategy to reduce the harmful use of alcohol endorsed by **the World Health Assembly in May 2010**. The strategy gives

⁵⁷ Child Maltreatment: Facts at a Glance http://www.cdc.gov/violenceprevention/pub/CM_datasheet.html

⁵⁸ Youth Violence <http://www.cdc.gov/ViolencePrevention/youthviolence/index.html>

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guidance to Member States and defines priority areas for global action and represents a unique consensus among our 193 Member States on ways to tackle harmful use of alcohol at all levels.

Recommended approaches through which Member States can **reduce harm by alcohol include**⁵⁹:

- regulating marketing of alcohol beverages, particularly to young people;
- regulating and restricting availability of alcohol;
- enacting appropriate drink-driving policies;
- Reducing demand through taxing and pricing mechanisms;
- Raising awareness and support for policies;
- Providing accessible and affordable treatment for people with alcohol use disorders;
- Implementing screening programmes and brief interventions for hazardous and
- harmful use of alcohol.

Based on this initiative, taking into due into account the fact that **the European Region has the highest levels of alcohol consumption and alcohol related harm in the entire world**,⁶⁰ the Regional Committee for Europe in its Sixty-first session adopted the EUR/RC61/R4 Resolution about a European action plan to reduce the harmful use of alcohol 2012–2020.⁶¹

This Resolution is based on **10 recommended target areas** consistent with those within the WHO global strategy to reduce the harmful use of alcohol:

1. Leadership, awareness, and commitment;
2. Health services´ response;
3. Community and workplace action;
4. Drink-driving policies and countermeasures;
5. Availability of alcohol;
6. Marketing of alcoholic beverages;
7. Pricing policies;
8. Reducing the negative consequences of drinking and alcohol intoxication;
9. Reducing the public health impact of illicit alcohol and informally produced alcohol; and
10. Monitoring and surveillance.

6.1.2.1 Preventing youth suicide and deliberate self harm

According to WHO Mortality Database, a comparison of the most recent data up to 2004 from 90 countries including the European region showed that **suicide was the 4th leading cause of death among young males ages 15 to 19**, and 3rd leading cause among females ages 15 to 19, and

⁵⁹ A global strategy to reduce the harmful use of alcohol

http://ec.europa.eu/health/alcohol/docs/open191110_co05_en.pdf

⁶⁰ World Health Organisation Regional Office for Europe. European action plan to reduce the harmful use of alcohol 2012-2020- 2020. EUR/RC161/13. June 2011. <http://www.euro.who.int/en/who-we-are/governance/regional-committee-for-europe/sixty-first-session/documentation/working-documents/wd13-european-action-plan-to-reduce-the-harmful-use-of-alcohol-20122020>.

⁶¹ http://www.euro.who.int/_data/assets/pdf_file/0018/150552/RC61_R4.pdf

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accounts for 9.1% of all fatalities in this age group.⁶² In 21 of the 30 European countries covered, suicide rates for youth have been increasing.⁶³

6.1.2.2 WHA56.24 WHO Resolution Implementing the recommendations of the World report on violence and health

In 2003, in response to the 2002 World report on violence and health (WRVH), the World Health Assembly passed **Resolution WHA 56.24**, recalling that **WHO** is a core partner, with **UNICEF and the Office of the United Nations High Commissioner for Human Rights**, of a working group to support the United Nations Study on Violence against Children, and that WHO is active in the prevention of violence against young people, women, the disabled and the elderly.

The Resolution urged Member States to promote the report, appoint a ministry of health focal point for violence prevention, and prepare a national report on violence and violence prevention. The resolution also requested the Director-General to cooperate with Member States in supporting implementation of the WRVH recommendations. As of April 2005, over 40 countries have launched the WRVH, over 50 have nominated health ministry focal points, and nearly 30 countries are developing national reports and plans of action for 2005-2006.

After publication of the WRVH demand for assistance with implementing its recommendations increased rapidly. In response to this demand VIP has developed several tools and technical guidelines.⁶⁴

6.1.2.3 WHO SUPRE Prevention of suicidal behaviours: a task for all

The overall objective of the SUPRE project is to reduce mortality and morbidity due to suicidal behaviours, to break the taboo surrounding suicide, and to bring together national authorities and the public in an integrated manner to overcome the challenges.

Specific objectives are:

- To bring about a **lasting reduction in the number of suicides and suicide attempts**, with emphasis on developing countries and countries in social and economic transition.
- To **identify, assess and eliminate** at early stages, as far as possible, **factors** that may result in young people taking their own lives.
- **To raise the general awareness** about suicide and provide psychosocial support to people with suicidal thoughts or experiences of attempted suicide, and to their relatives and close friends, as well as to those of people who committed suicide.

⁶² Wasserman D, Cheng Q, Jiang. GX. Global suicide rates among young people aged 15 – 19. World Psychiatry 4: 2 – June 2005.

⁶³ Mittendorfer R, Wasserman D. Trends in adolescent suicide mortality in the WHO European Region. European Child Adolescent Psychiatry 2004; 13:321 – 31.

⁶⁴ <http://www.who.int/nmh/wha5624/en/index.html>

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The SUPRE project is managed by the WHO Department of Mental Health and Substance Abuse. The work is conducted in coordination with different clusters and departments at headquarters (i.e. Health Systems, Child and Adolescent Health and Development, Chemical Safety), WHO Regional Offices, sister UN agencies (e.g. UN, ILO, UNICEF and UNESCO), relevant NGOs and WHO Collaborating Centres.⁶⁵

6.1.3 Council of Europe

Child and teenage suicide in Europe: A serious public-health issue

Teenage suicide has become a serious public-health issue. The importance of the problem is often underestimated, yet there are tens of thousands of suicides every year, i.e. more deaths than are caused by road accidents. The underlying causes of suicide are often both psychological and social. In addition to ending young lives prematurely, suicide leaves an enormous amount of damage in its wake. Its effects ripple out to impact on those close to the death of a young person.

For many adolescents, **suicide is linked to failure or fear of failure.** Moreover, alcohol and drug misuse have both been found to be associated with youth suicide and intoxication often provides the context for suicide in young people.

The report adopted by the Council of Europe about child and teenage suicide reaffirms the importance of fighting against all forms of discrimination (ethnic, religious and sexual) which could have an influence on young people and calls for a better educational role of the media in their coverage of youth suicides.

This report also insists on **the risk-detection and prevention of repeated attempts** in all of its medical, psychological and social components and urges the member states of the Council of Europe to provide youth-appropriate psycho-social measures in order to address this problem.⁶⁶

6.1.4 Policy actions in the EU

6.1.4.1 Domestic violence

Although there is **little EU law dealing specifically with domestic violence**, the obligations imposed by the EU legal framework (including the **European Social Charter**) regarding violence against women governs Member States' obligations with regard to domestic violence. Additionally, all EU Member States took part in the 1995 Beijing Conference on Violence against Women and adopted the Declaration and Platform for Action emerging from it.

European Economic and Social Committee

Although it is not binding, an **Opinion of the European Economic and Social Committee** in May 2006 (**2006/C 110/15**) reiterated the need for continued vigilance on the issue of domestic violence and called for a pan-European strategy, reflecting concerns that the responses of individual European countries vary widely. The Committee particularly **called for an EU-wide study** on the prevalence of domestic violence against women, its impact on individuals and society, and the

⁶⁵ http://www.who.int/mental_health/prevention/suicide/information/en/index.html

⁶⁶ <http://assembly.coe.int/ASP/Doc/XrefViewHTML.asp?FileID=11917&Language=EN>

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financial costs. This was to reflect concerns that, although in many European countries data is more readily available on violence, there are still countries that do not systematically collect data and additionally, even where data is collected, that the parameters used differ considerably and do not allow for Europe-wide analysis or comparison.⁶⁷

6.1.4.2 Action Plan on Unaccompanied Minors (2010 – 2014)

Protecting children from violence and when they are vulnerable

Children when they are vulnerable can lack opportunities in society and access to quality services in education or health. They can also experience physical and emotional violence or abuse and exploitation, which are detrimental to their well-being, physical and mental health, and may even be life-threatening. Some categories of children who can face greater threats to their rights and well-being are, for example:

- children at risk of poverty and social exclusion;
- children with disabilities;
- children seeking asylum;
- unaccompanied or separated children;
- Roma children;
- those exposed to cyber criminality or bullying;
- victims of sexual exploitation and trafficking;
- missing children.

EU actions also extend to **children outside the EU**, for example in cases where children are subject to:

- child sex tourism ;
- child labour ; and
- when they are involved in armed conflicts.⁶⁸

The challenge of unaccompanied minors is growing: a considerable number of third-country nationals or stateless persons below the age of 18 arrive on EU territory unaccompanied by a responsible adult, or are left unaccompanied after they have entered EU territory. Although some Member States experience this far more than others, all are affected.

The reasons behind the arrival of this particularly vulnerable category of children are manifold: to **escape from wars and conflicts, poverty or natural catastrophes, discrimination or persecution**; to be sent by their family in the expectation of a better life or in order to access education and welfare, including medical attention; to join family members; as victims of trafficking destined for exploitation.

The Commission therefore produced a **Communication: Action Plan on Unaccompanied Minors (2010-2014)**. It helps coping with the considerable number of third-country nationals or stateless minors arriving or left unaccompanied within the EU's territory.⁶⁹

⁶⁷ http://ec.europa.eu/justice_home/daphnetoolkit/files/others/booklets/05_daphne_booklet_5_en.pdf

⁶⁸ http://ec.europa.eu/justice/fundamental-rights/rights-child/protection-action/index_en.htm

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6.1.4.3 EU Alcohol Strategy

On 24 October 2006, the European Commission adopted the long awaited **Communication setting out a strategy to support Member States in reducing alcohol-related harm (EU Alcohol Strategy)**. The EU Alcohol strategy has been awaited since in June 2001 the Council invited the Commission to put forward proposals for a comprehensive Community strategy aimed at reducing alcohol-related harm to complement national policies.

As part of the implementation of the Alcohol Strategy the Commission has set up the following **bodies**:

- **An EU Alcohol and Health Forum**, a multistakeholder platform composed of NGOs and economic operators. Members of the Forum have made a series of commitments aimed at reducing alcohol-related harm.
- **A Committee for national alcohol policy** and action that brings together representatives from the national governments to share information, knowledge and good practice on reducing harmful alcohol consumption.
- **A Committee on data collection**, indicators and definitions whose aim is to develop key indicators for monitoring overall performance of the strategy.

The current EU Alcohol Strategy comes to an end in 2012.

6.1.4.4 EUROSAVE project

EUROSAVE was a project that was built on the foundation of the earlier EC funded EURORISC project (European Review of Injury Surveillance and Control). As a result, the two projects could be combined to provide a series of useful and important results concerning the entire spectrum of unintentional and intentional injuries in the EU.

6.2 Conclusions and recommendations (policy oriented and other)

To facilitate international comparisons, standardisation of suicide and parasuicide definitions, classification and reporting methods are required across the EU. The means of committing suicide should be specified in routine national data. Risk and exposure variables should be included in routine suicide data. Consideration should be given to the setting up of **national parasuicide registers**. Non-total sampling strategies (e.g. random, systematic) should be investigated as an alternative means of collecting data on parasuicide. An EU wide suicide prevention strategy that encompasses data issues should be developed within the context of the new EU Public Health Programme.⁷⁰

⁶⁹ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:0213:FIN:en:PDF>

⁷⁰ <http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/9A49C7F8B7E00847C1257473003926C5?openDocument&context=B6E7502F91706720C125773F003B8452>

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