Sund By Netværksdage
Vores unge – vores fremtid!
Holeby, 3.-4. April 2019

HEALTH PROMOTING community
Wellbeing for All

Health and wellbeing of (young) Icelanders
Examples of successes and challenges

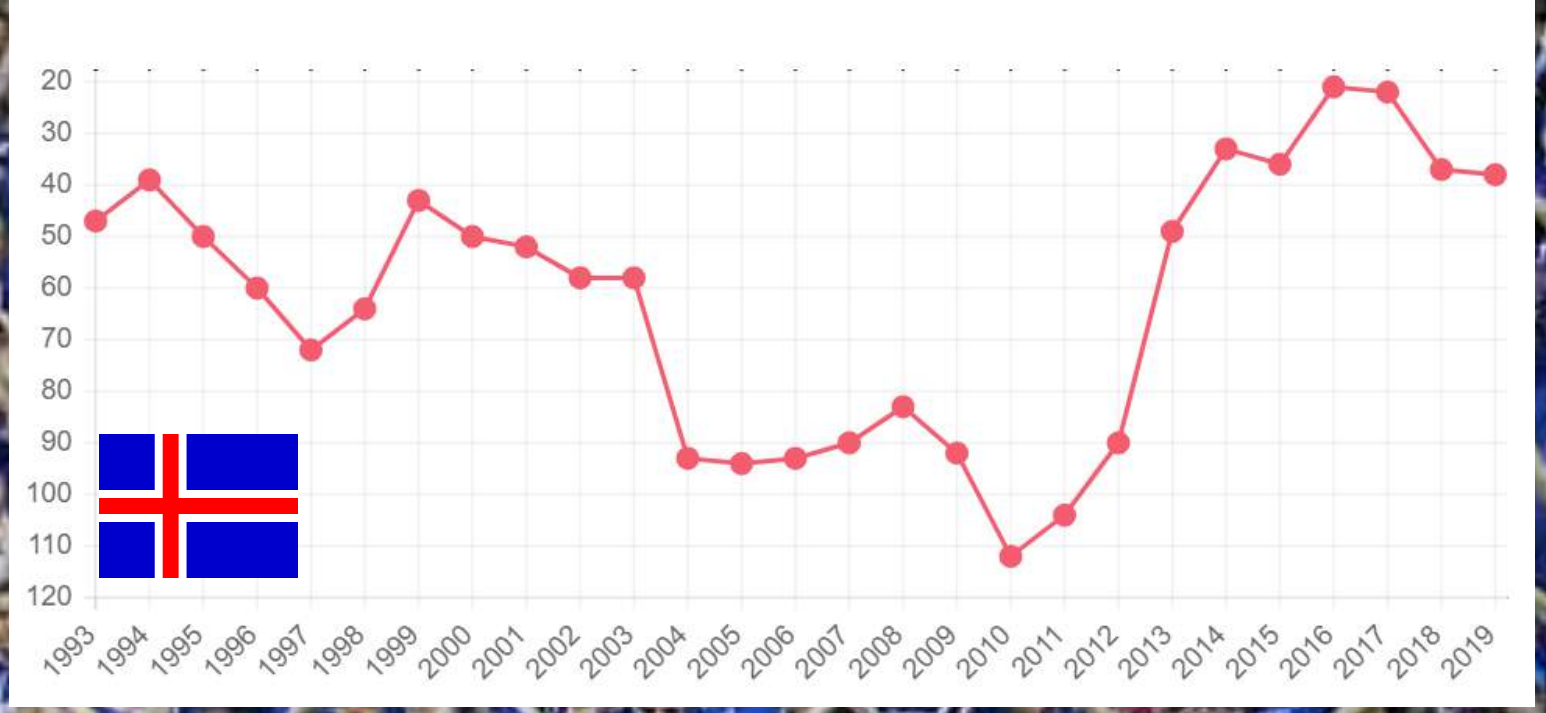
Department Determinants of Health and Wellbeing

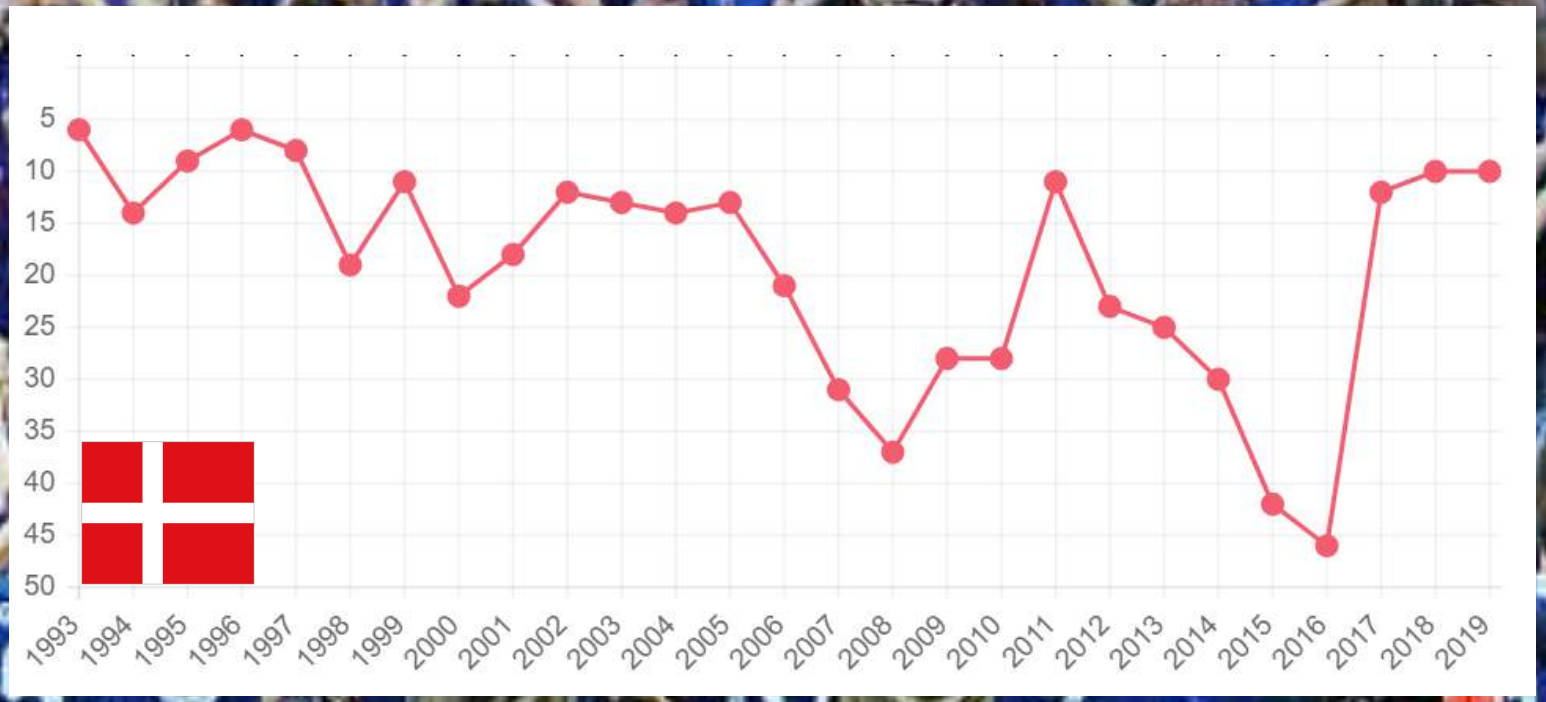
Gígja Gunnarsdóttir

Rafn M. Jónsson

Embætti landlæknis
Directorate of Health

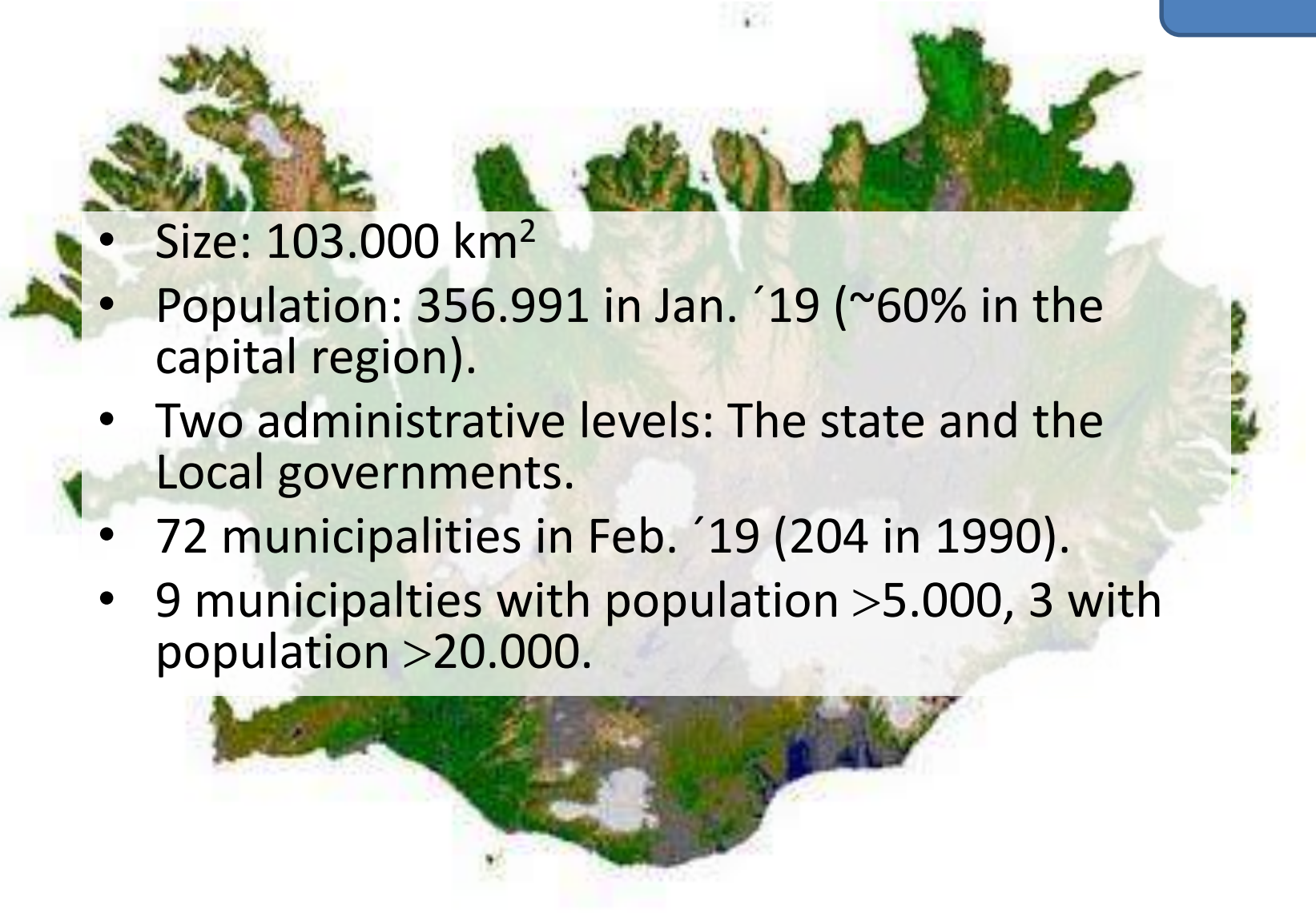
FIFA World Ranking - Men





Iceland

~Arhus + Esbjerg



- Size: 103.000 km^2
- Population: 356.991 in Jan. ´19 (~60% in the capital region).
- Two administrative levels: The state and the Local governments.
- 72 municipalities in Feb. ´19 (204 in 1990).
- 9 municipalties with population >5.000, 3 with population >20.000.

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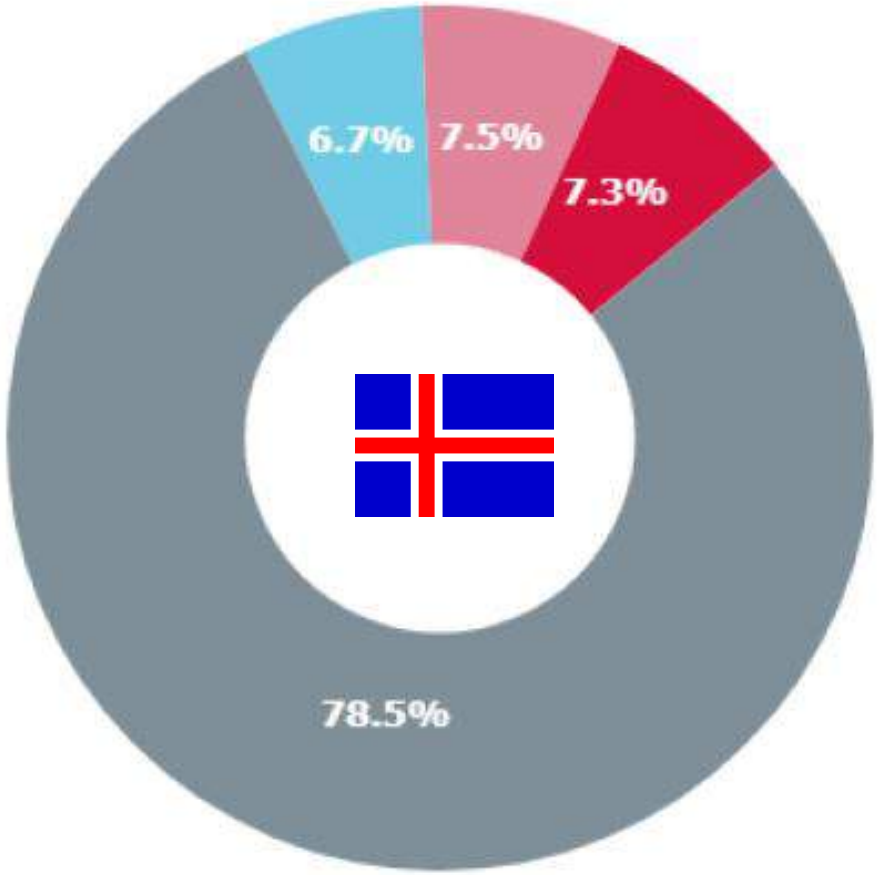
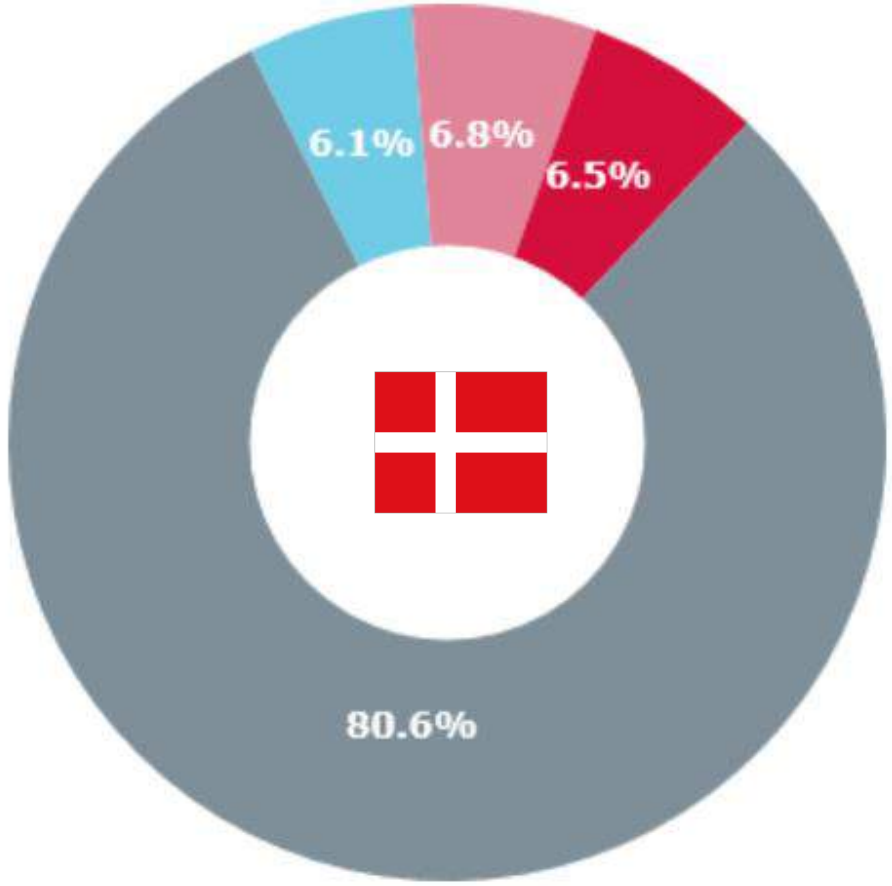
Young people, % of the population 2017





Age group 15-19

Age group 20-24

Age group 25-29

Other age groups

EACEA National Policies Platform – Youth Wiki
www.eacea.ec.europa.eu/national-policies/en/youthwiki

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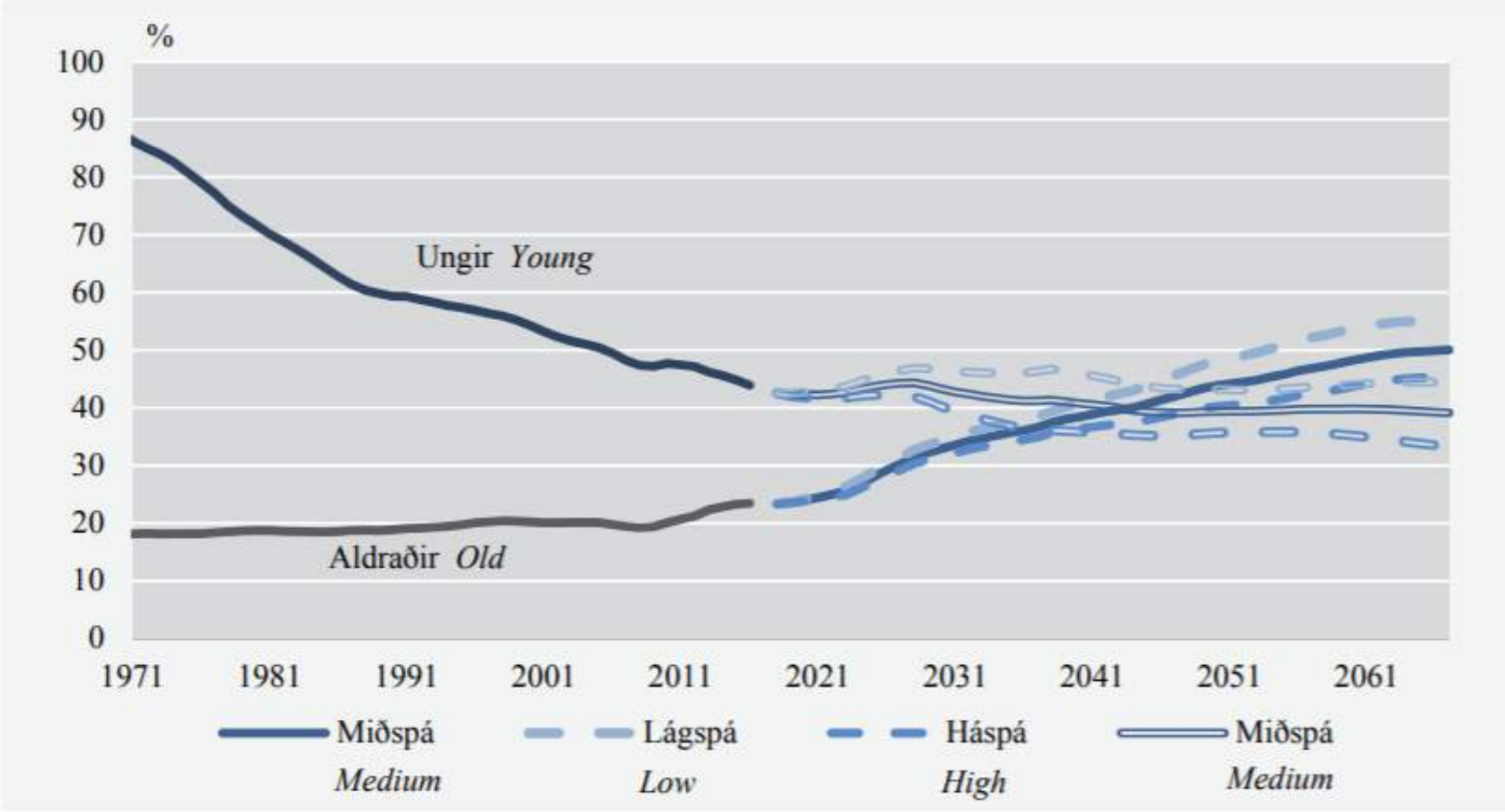
Opportunities & challenges for national and local governments

Mynd 9. Framfærsluhlutfall ungs fólks og eldra en 65 ára 1971–2067
Figure 9. Old and young dependency ratios (% per year) 1971–2067



Dependency ratio = number of <20 years or >65 years, divided by number of 20-65 years old (working age).

Statistics Iceland. (2018). Population projections 2018-2067

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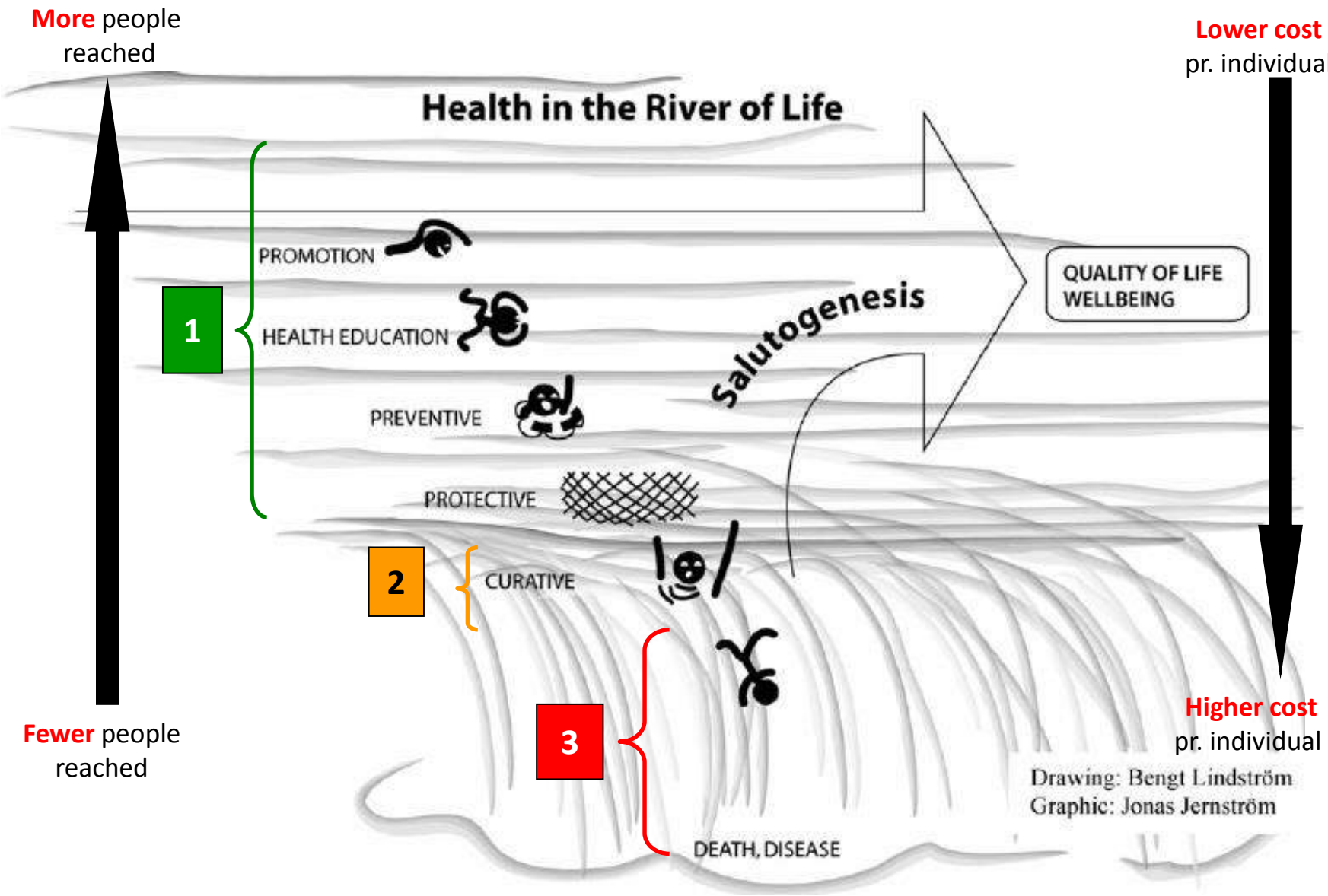

Biggest bang for the buck

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What you measure affects what you do...

…if you don´t measure the right thing,

you don´t do the right thing.“ Joseph Stiglitz, 2009

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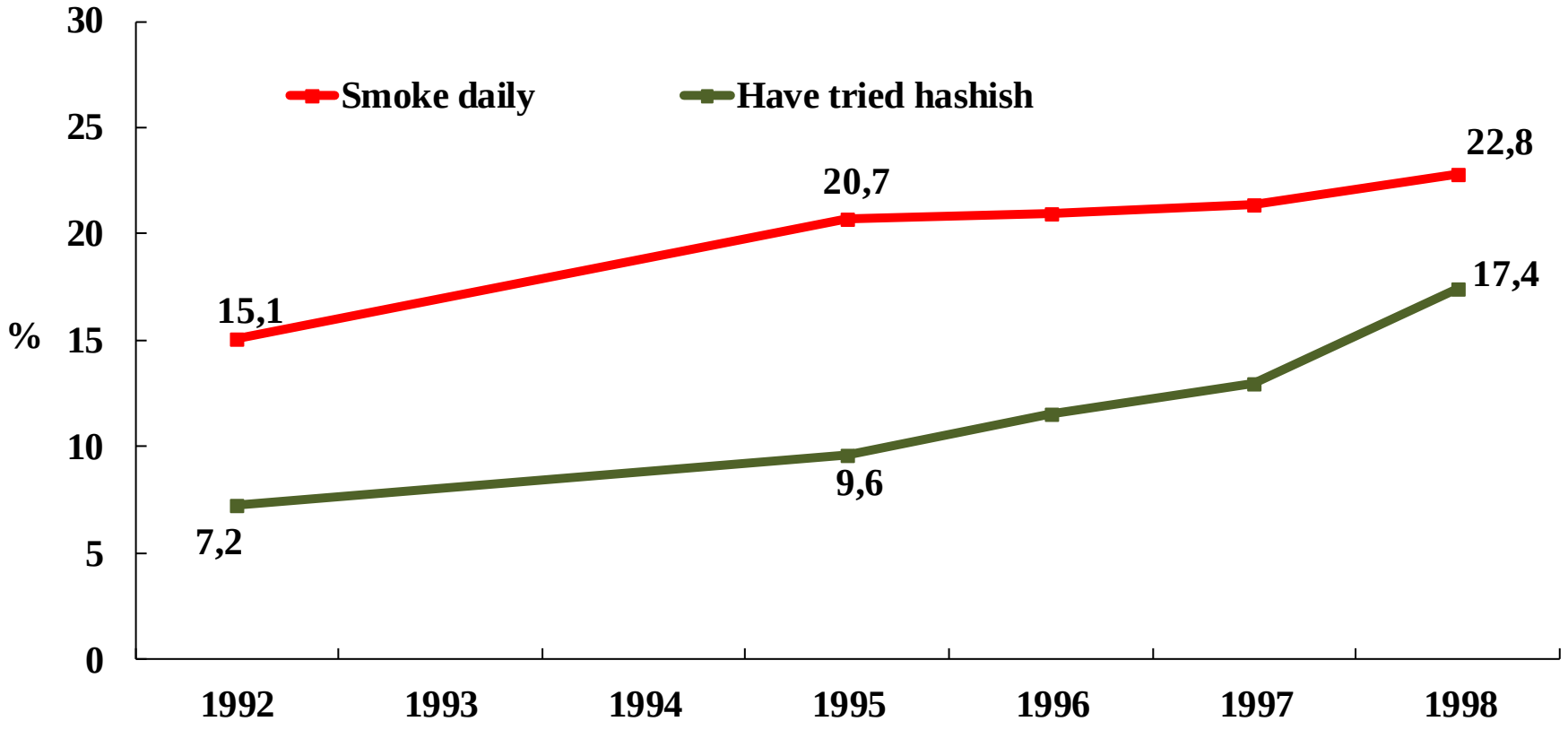
Upward trend 1992 – 1998
10th grade (15-16 years)



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„VIÐ HÖFUM ENGAN STAÐ — svo við förum niður á Halló í kvöld"

No secure location for young people to „hang out"

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BÓNUS
MYNDIR

„Áttu eld, mamma?“ Preben Elkjær fær eld hjá mömmu sinni.

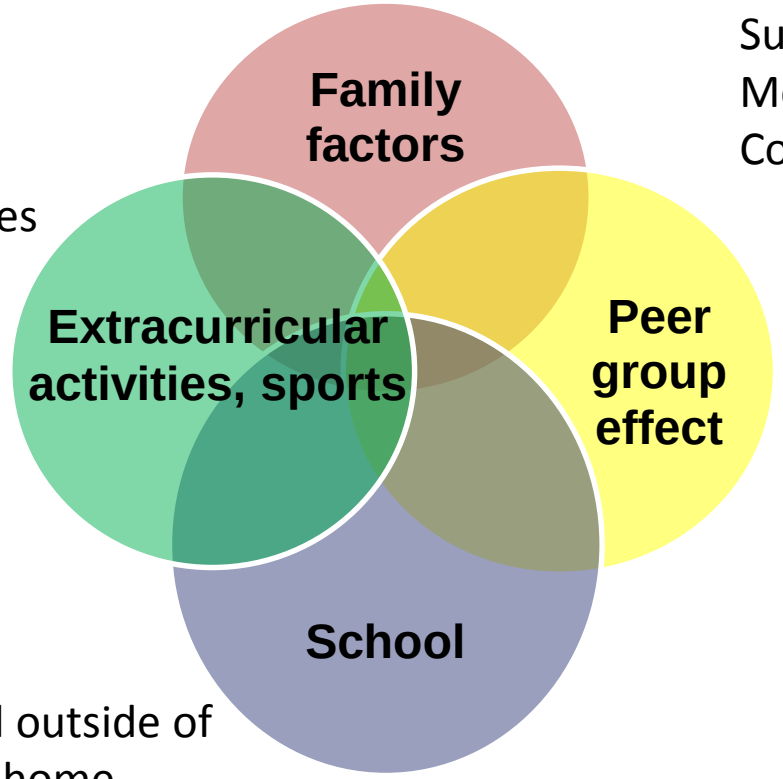
Skorar mörk og reykir pakka á dag

Preben Elkjær Larsen, knattspyrnukappinn kunni, er alveg búinn að gefa upp á bátinn að hætta að reykja. Elkjær, eins og hann er oftast kallaður, reykir pakka af hinum rótsterku Prins sígarettum en þær eru danskar eins og knattspyrnusnillingurinn.

DV, 9. december 1985

How were the findings used?

Model based on Icelandic youth research



Time spent with parents
Support
Monitoring
Control

Organized activities
vs.
unorganized

Positive and negative effects.
How we as parents approach the peer group
Staying outside late
Hanging out in malls

Inside and outside of school, at home, bullying e.t.c.

Protective factors vs. Risk factors?

Present results to relevant stakeholders

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Drug-free Iceland 1997-2002

- At this time, a totally new (for us) approach in prevention
- To change the actual behaviour of youth, not only their attitudes.
- To gain public consensus on this ambitious aim
- Change the environment of our children so that they would be in lesser risk of substance use.
- Strengthen and combine of different professions.
- To initiate and support research in this field to improve preventive work at each given time.

The Drug-free Iceland, actions

- Experts visited municipalities, information about data and support to create prevention policy and action plans.
- Cooperation, groups against drugs nationwide and in local communities all around the country, bringing together and combining the strengths of many stakeholders (police, social services, school…) – discussions, informations.
  - Activate non-governmental organizations - “Who does what?”
  - Joint forces with parents organizations
- Activated and motivated young people, what do you think, what do you need?
- Young people at risk - Encouraged improved assistance

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Posters in alcohol outlets

- DON’T DO A BAD DEAL!

Buying alcohol for teenagers is an illegal offence!

DON’T DO A BAD DEAL!

Teenagers want clear messages – let’s not buy alcohol for them!

DON’T DO A BAD DEAL!

Intoxicated teenagers are in danger!

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The Drug-free Iceland action plan cont.

→ Establishment of the Alcohol and Drug Prevention Council in 1998

– The main aim, to build up and strengthen measures to prevent the abuse of alcohol and drugs, particularly among children and young people, and to combat the consequences of the consumption of alcohol and other intoxicants.

Several projects/programs

- Stop youth drinking – started before Drug-free Iceland
  - Parents in 1994
- Outdoor hours
- Leisure activity card
- Parental agreement
- Live your life – support to municipalities
- Drug prevention school
- SAMAN-hópurinn – information to parents
- Náum áttum – information meetings
- Seminars and conferences
- Regular data collection, population surveys in compulsory and uppersecondary schools.

Outdoor hours limits for children by law since 2002

Parents let's work together!

During the school period

- Children, 12 years old or younger, may not be outside their home after 20:00 pm.
- Children, 13 to 16 years of age, may not be outside their home after 22:00 pm.

During the summer

- Children, 12 years old or younger, may not be outside their home after 22:00 pm.
- Children, 13 to 16 years of age, may not be outside their home after 24:00 pm.

- Parents and caregivers have absolute rights to reduce these outdoor hours. These rules are in accordance with the Icelandic Child Protection laws and forbid children to be in public places after the stated hours without adult supervision. These rules can be exempted if children 13 to 16 years of age are on their way home from an official school, sports, or youth centre's activity. The child's birth year rather than its birthday applies.

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The leisure card – Constructive leisure time for all

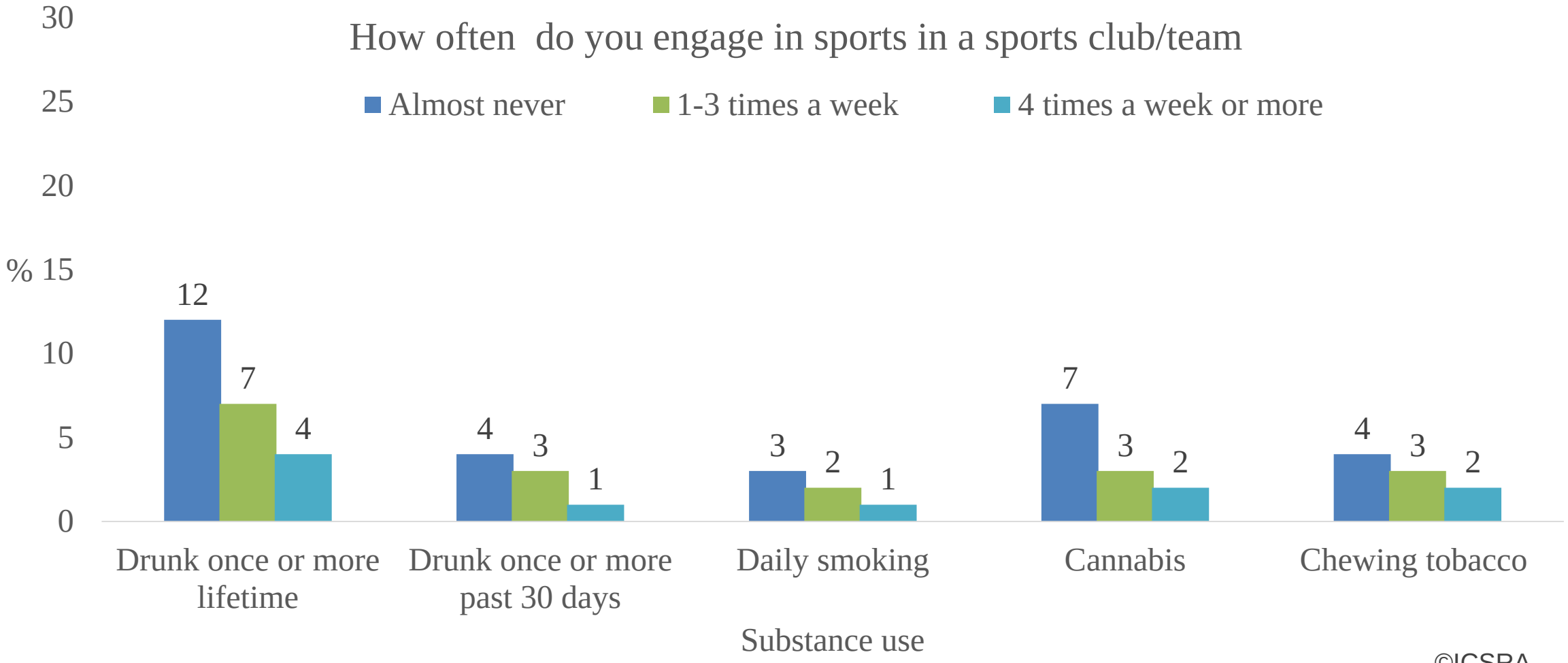
- Grant for all children, available in many municipalities in Iceland, usually 6-16/18 years old.
- Also examples of leisure card for older adults.

Example – Guðjón and friends 8 years old

- Reykjavík, Sport club KR
- Training 3 times pr week + friendly games and other activities that does not cost extra.
- Bus from school to the training site.
- Annual fee: 67.000 ISK (3.600 DKK)
  Leisure card: 50.000 ISK (2.700 DKK)

Total cost for parents: 17.000 ISK (900 DKK)

Sports and substance use (ages 14-15), year 2018



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Parental agreement - compulsory schools

Agreement between parents to follow and uphold regulations and to be active in the children's education in several areas.

The Home and School – National Parents Association, since 1992

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The prevention-day
lead by the president of Iceland – since 2006

Encouraging children and parents to spend more time together

http://www.forvarnardagur.is

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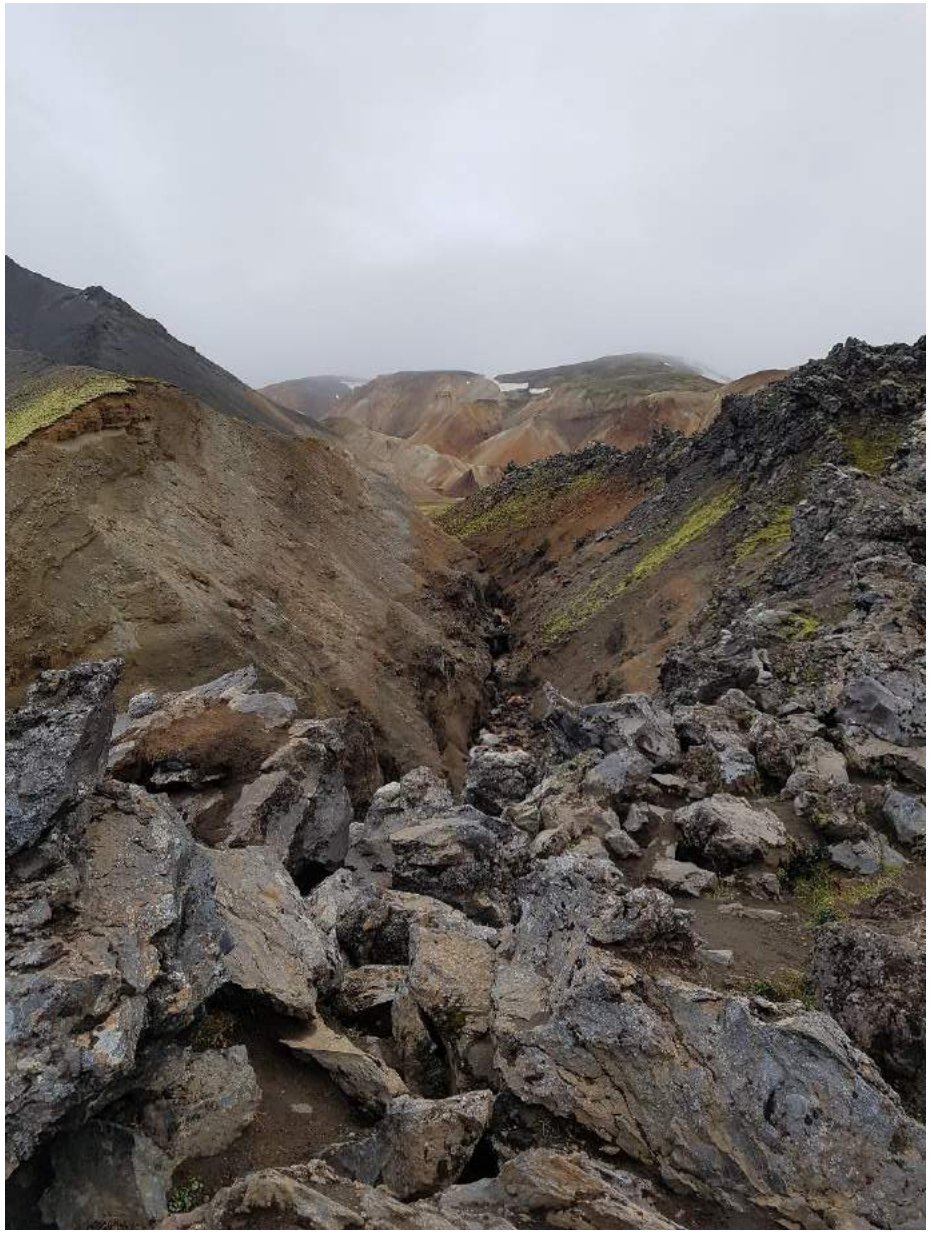
What changed?



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In short

In cooperation we:

Strengthened preventive factors

Weakened risk factors

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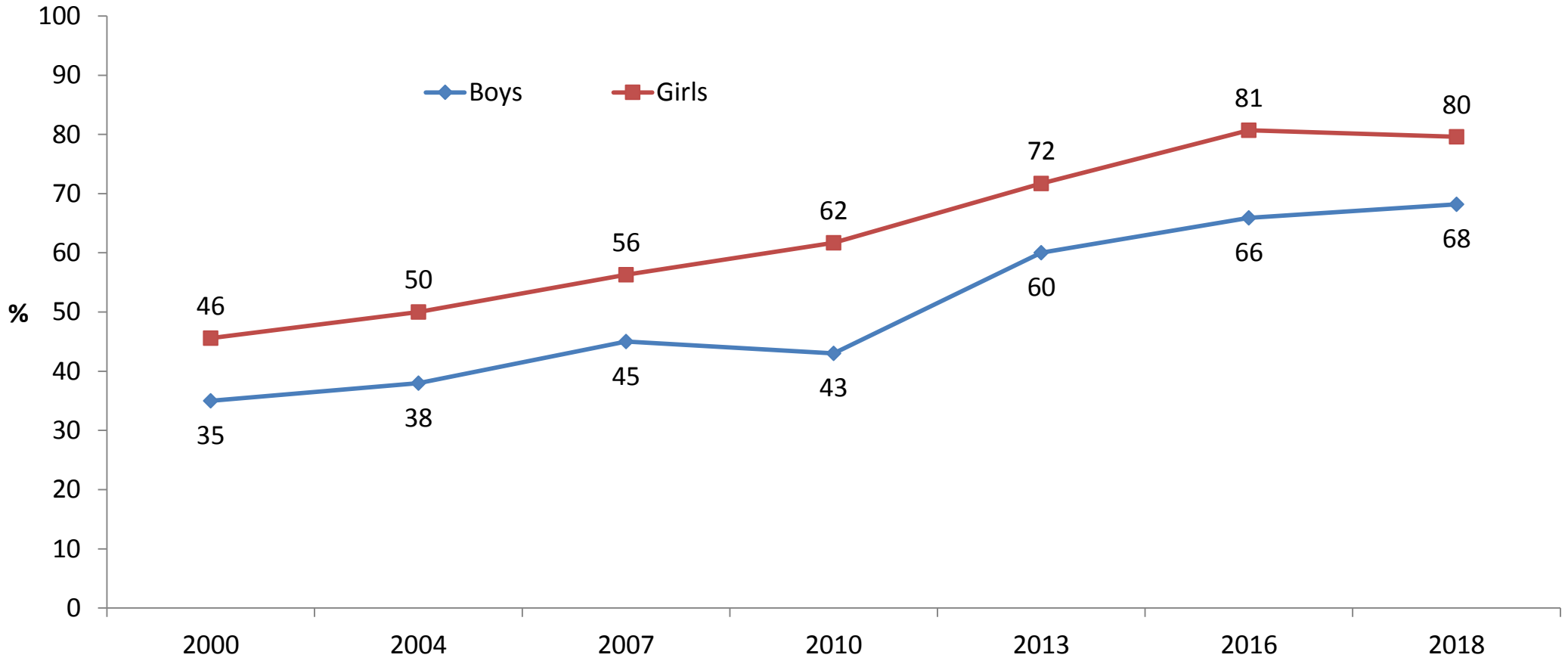
My parents know where I am in the evening

Students who report this statement applies rather or very well to them



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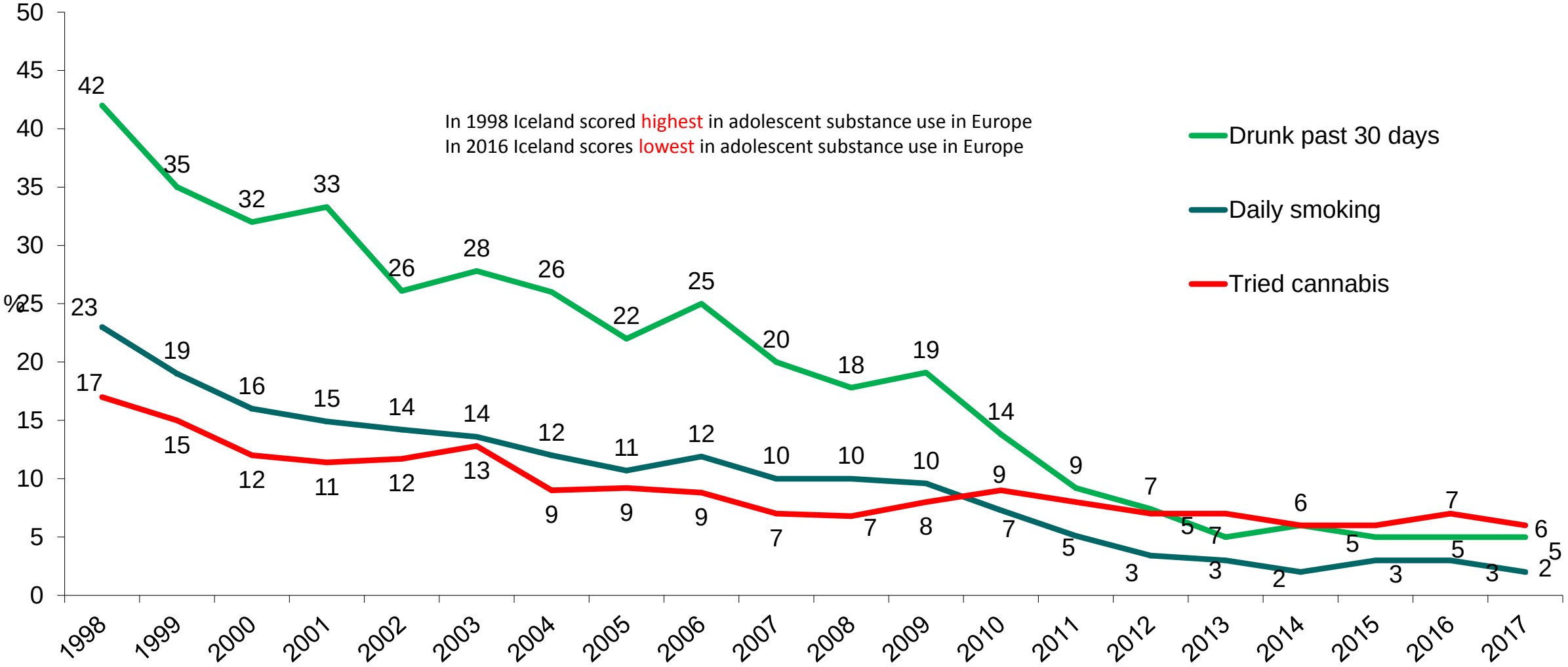
From highest to lowest in substance use – 15/16 year old students



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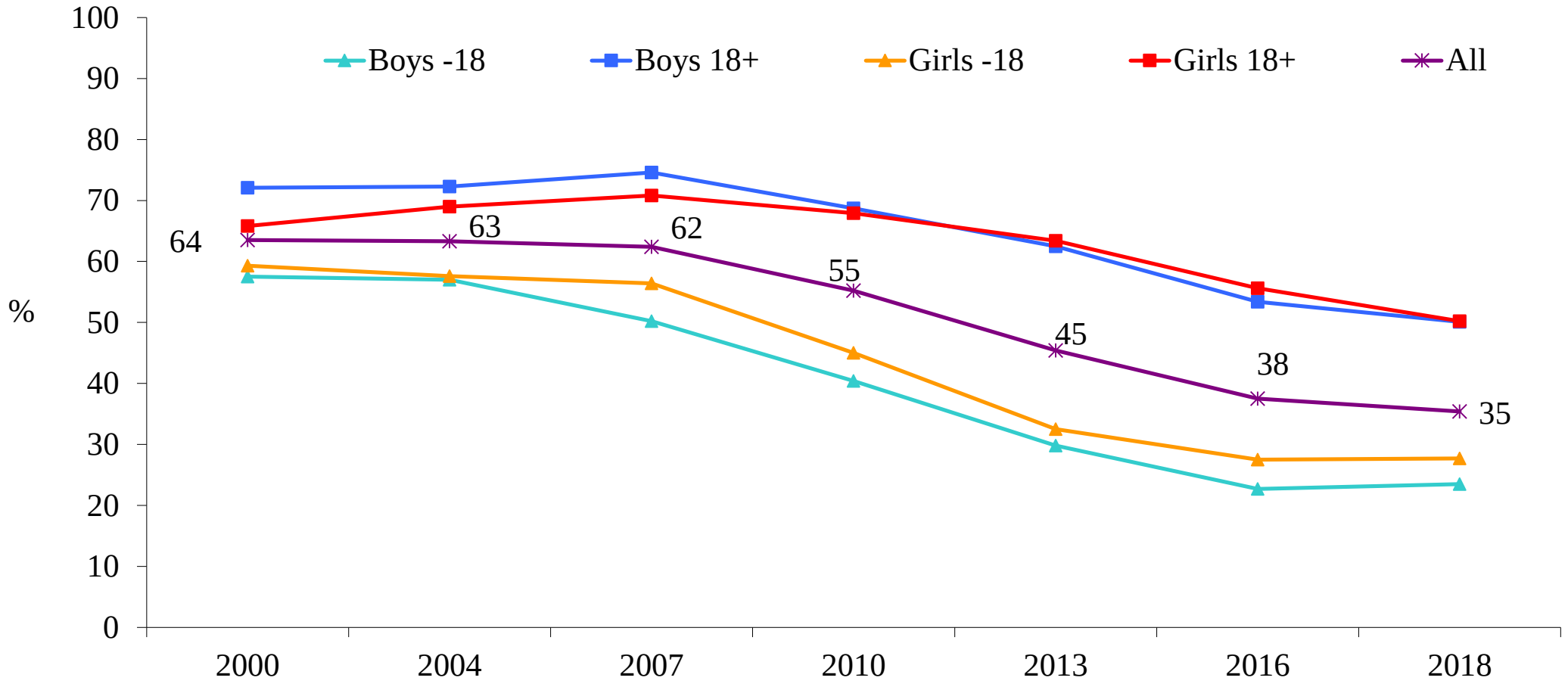
Proportion of uppersecondary school students that have **been drunk** 1x ≤ last 30 days



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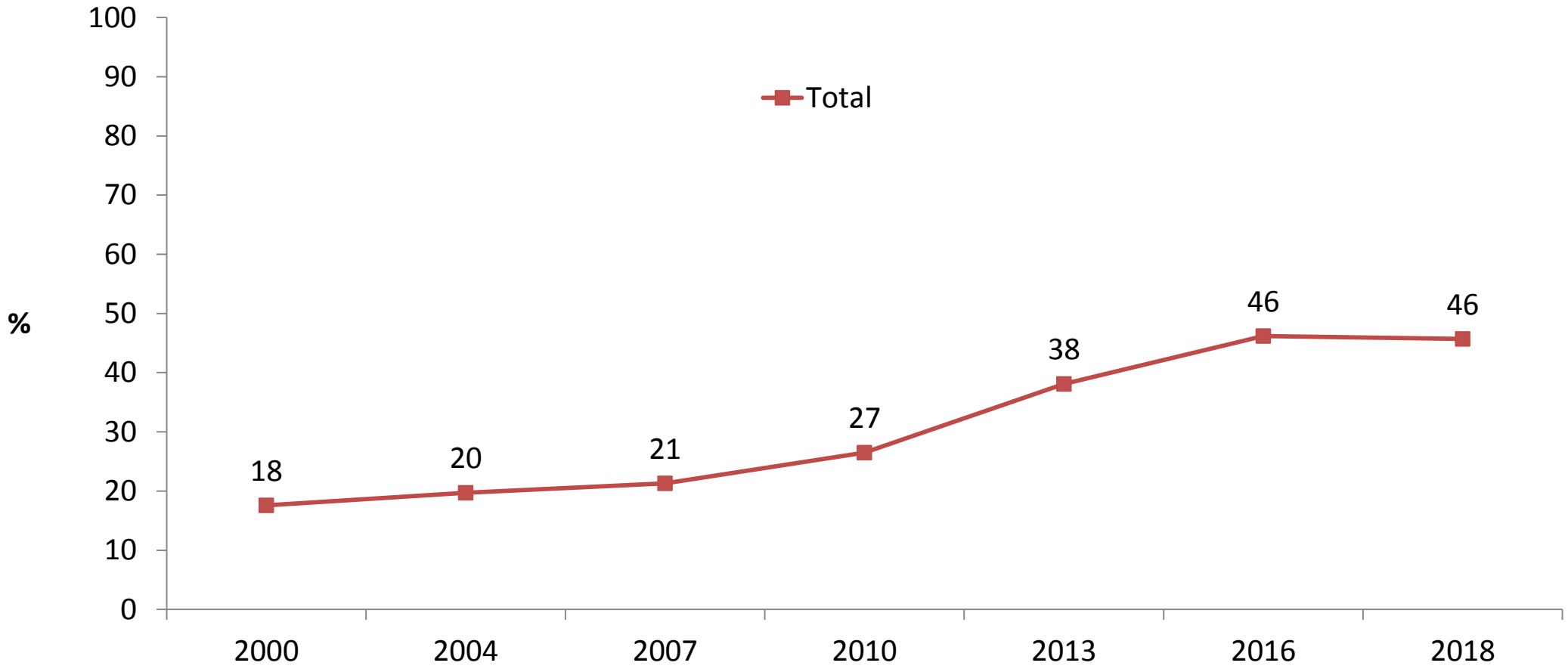
Never been drunk in lifetime
Uppersecondary school students (16 - 20 year old)



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Development of adult drinking in Iceland

Margrét Valdimarsdóttir, Rafn M. Jónsson og Stefán Hrafn Jónsson (2009)

Mynd 2. Hlutfall karla sem drekka áfengi vikulega eða oftar

Mynd 3. Hlutfall kvenna sem drekka áfengi vikulega eða oftar

Funding

- Public health fund – for health promotion and prevention programs
  - 1% alcohol taxes and 0,9% of gross sale of Tobacco and – cigarettes
- Contracts between treatment service, municipalities and government.

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Comprehensive approach – *universal actions* to decrease youth drinking and promote health and wellbeing

The State

- **Act on how long children can stay outside – outdoor time limits (2002)**
- Taxes on alcohol
- Age limit, access to places selling alcohol.
- High age limit for buying alcohol and alcohol monopoly.

Municipality

- **Data driven intervention**
- Information to parents and other stakeholders – **magnets with the outdoor hours** published and distributed.
- Encourage parents/caregivers to comply with the law.
- Organise search in collaboration with Police.
- Access to organised sports and other constructive leisure time activities – "**The leisure card**".

Schools- youth centres – sports clubs and others providing constructive leisure time options for children

- Alcohol-free gatherings, **in line with the outdoor hours law.**
- Education to parents and students
- Support parent-groups (education, provide facilities for their work).
- Availability, access and quality

Parents

- Parents-walks around neighbourhoods to **follow up on the outdoor hours** (social capacity, share information).
- Parent contracts on **outdoor hours etc**.
- **Joint family time -> encouraged to spend more time with their children.**
- Support participation in healthy recreational activities like organised sports via the **leisure card.**

Youth

- **Informed about laws** and regulations.
- **Spending more time with parents/family**.
- Increased participation in organised sports and other organised leisure time activities via the **leisure card.**

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Current work

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HEALTH PROMOTING community

Wellbeing for All

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Determinants of health and wellbeing
= the backbone of the HPC and HPS work

DOHI addapted from Dahlgren & Whitehead, 1991

Why printing posters is not enough?

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HEALTH IN THE SDG ERA

World Health Organization

WWW.WHO.INT/SDGS

SUSTAINABLE DEVELOPMENT GOALS

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Foundation for the HPC and schools work

- **Directorate of Health,** act and policy:

  Good health and wellbeing with health promotion and prevention work and accessible and safe health care services based on best available knowledge and experience.

  ⇒ Comprehensive approach, relying on active participation across sectors and levels is effective.

- **Public Health Policy 2030** (2016):

  All municipalities should become Health promoting communites, incluting preschools, compulsory schools, upper secondary schools and workplaces

- **National curriculum guides (2011)**

  Health and welfare one of six pillars of education.

- **The Association of Local Authorities strategy 2018-2022:**

  3.3.19: The Associaton collaborates with the Directorate of Health to support and encourage municipalities to become Health promoting communities and guards their interests.

  3.2.10: The Associaton collaborates with the Directorate of Health to implement the Public health policy, i.e. Health promoting schools and the Mental health strategy, with special focus on wellbeing and welfare of children.

- **The UN Sustainable Development Goals 2030**
- **National Health Policy,** being developed
- **Other policies and plans at national and local level.**

The background of the HPC and HPS programs

- The Ottawa Charter for Health Promotion (1986)
- Health in All Policies (HiAP)
- Schools for Health in Europe (SHE)
- Healthy Cities, WHO
- Previous health promotion and prevention work in Iceland, Nordic countries, Europe, the world ← Conferences, meetings, networks, European projects etc.

CHRODIS+

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Main aim

The main aim of the HPC programme is to **support communities to create supportive environments and conditions** that promote healthy behavior and lifestyle, health and **well-being of all**.

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Addressing Health Determinants with comprehensive settings approach

HEILSUEFLING
eldri borgara

HEILSUEFLANDI
leikskóli

HEILSUEFLANDI
grunnskóli

HEILSUEFLANDI
framhaldsskóli

HEILSUEFLANDI
vinnustaður

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Intersectoral collaboration – National level

- **The HPC high level steering group**
  - Prime ministers office
  - Ministry of Health
  - Ministry of Social affairs
  - Ministry of Education and Culture
  - Association of Local Authorities
  - Development Centre of the Primary health care
  - Directorate of Health

- **The HPC and SDGs Consultation platform**

Ministry of Transport and Local Government, Ministry for the Environment and Natural Resources, Directorate of Education, Environment Agency, National Planning Agency, Icelandic Transport Authority, National Commissioner of the Icelandic Police, The Office of Ombudsman for Children, Icelandic Food and Veterinary Authority, Administration of Occupational Safety and Health, VIRK – Vocational Rehabilitation Fund, Organisation of Disabled in Iceland, UN Association in Iceland, UNICEF, Youth Work Iceland, The Multicultural Centre, National Olympic and Sports Association of Iceland, Icelandic Youth Association, Association 78 and National Association for the elderly. More stakeholders are joining.

Guiding principles

- **Active participation of all stakeholders** across sectors and levels.
- Work is based on **best knowledge and experience** available.
- ***Do no harm***.
- **Equity** in health, universal measures and additional effort to meet the needs of vulnearable groups.
- **Sustainability**. Long term approach.

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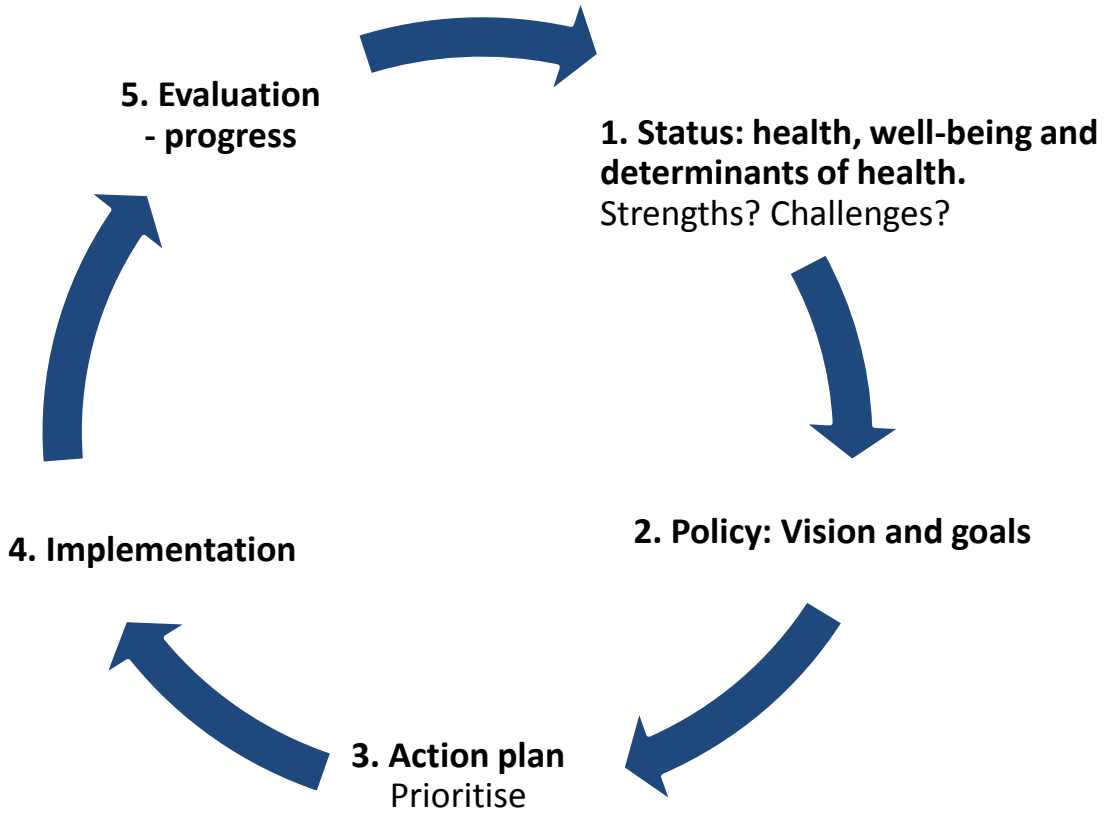
Key elements of HPC

- Voluntary participation, application signed by the director of the municipality.
- Appoint coordinator, contact to DOHI.
- Structure for systematic PH work: Steering group, ensure involvement of key stakeholders.
- Contract signed by the director of the municipality and Director of health.
  - Systematic public health work in line with the main aim and the guiding principles.
  - Use the on-line working area when available.

Systematic public health work in HPC and S

1. **HPC steering group**, other key stakeholders.
2. **Systematic public health work,** from data to policy and action:



Status – how?

- Public health indicators, other indicators and data
- Own data and inside knowledge of the community.

Interactive working area, heilsueflandi.is being developed

- Check-lists
- HPS reports.

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Public health indicators since 2016

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Suðurnes

LÝÐHEILSUVÍSAR 2017

Lýðheilsuvísar eftir heilbrigðisumdæmum á Íslandi

Hvers vegna lýðheilsuvísar?

Lýðheilsuvísar eru safn mælikvarða sem gefa vísbendingar um heilsu og líðan þjóðarinnar. Birting lýðheilsuvísa eftir heilbrigðisumdæmum á Íslandi er liður í því að veita yfirsýn yfir lýðheilsu í hverju umdæmi fyrir sig í samanburði við landið í heild. Lýðheilsuvísum er ætlað að auðvelda sveitarfélögum og heilbrigðisþjónustu að greina stöðuna í eigin umdæmi, finna styrkleika og veikleika og skilja þarfir íbúanna þannig að hægt sé að vinna að því að bæta heilsu og líðan.

Hvað hefur áhrif á heilsu og líðan?

Fjölmargir þættir hafa áhrif á heilsu og líðan einstaklinga. Sumum áhrifaþáttum heilsu er ekki hægt að breyta, t.d. aldri og erfðum. Margir aðrir áhrifaþættir heilbrigðis eru hins vegar þess eðlis að hafa má áhrif á þá og stuðla þannig að bættri heilsu og velliðan einstaklinga og minnka líkur á sjúkdómum. Má þar nefna lífnaðarhætti á borð við áfengis- og tóbaksneyslu, mataræði og hreyfingu og samskipti við fjölskyldu og vini. Lífsskilyrði eins og framboð og aðgengi að menntun, atvinnu, húsnæði, heilbrigðis- og félagsþjónustu hafa einnig mikil áhrif á heilsu og líðan svo fátt eitt sé nefnt (Dahlgren G, Whitehead M, 1991). Með því að hafa heilsu og líðan að leiðarljósi í allri stefnumótun og aðgerðum má skapa umhverfi og aðstæður, t.d. í skólum, á vinnustöðum og almennt í samfélögum, sem stuðla að heilbrigðari lífnaðarháttum, betri heilsu og líðan og minnka ójöfnuð m.t.t. heilsu.

Dahlgren G, Whitehead M. 1991. Policies and Strategies to Promote Social Equity in Health. Stockholm, Sweden: Institute for Futures Studies.

Svæðisbundinn munur á heilsu – ójöfnuður

Svæðisbundinn munur á heilsu og líðan er þekktur um allan heim. Til þess að draga úr svæðisbundnum mun á heilsu og líðan þarf að fylgjast með mælikvörðum sem gefa þennan mun til kynna og miðla upplýsingum til þeirra sem starfa á vettvangi. Hjá Embætti landlæknis er unnið að heilsueflingu á heildrænan hátt í gegnum Heilsueflandi samfélag og Heilsueflandi leik-, grunn- og framhaldsskóla þar sem áhersla er lögð á að skapa aðstæður sem stuðla að heilsu og velliðan allra. Á grundvelli svæðisbundinna lýðheilsuvísa og Heilsueflandi samfélags geta sveitarfélög og heilbrigðisþjónusta unnið saman að því að bæta heilsu og líðan íbúanna.

Suðurnes

Hér eru dæmi um lýðheilsuvísa þar sem tölur fyrir Suðurnes eru frábrugðnar tölum fyrir landið í heild.

- Fjölgun íbúa yfir landsmeðaltali
- Ölvunardrykkja framhaldsskólanema undir landsmeðaltali
- Hlutfall framhaldsskólanema sem hefur prófað kannabis er undir landsmeðaltali
- Gosdrykkjaneysla bæði framhaldsskólanema og fullorðinna er hæst á landinu
- Streita fullorðinna er yfir landsmeðaltali
- Fleiri sjúkrahúslegur vegna langvinnrar lungnateppu

Val á lýðheilsuvísum

Við val á lýðheilsuvísum var sjónum beint að þeim áhrifaþáttum heilsu og líðanar sem fela í sér tækifæri til heilsueflingar og forvarna. Einnig var leitast við að velja þá þætti í sjúkdómabyrði sem mikilvægt er að heilbrigðisþjónusta hvers umdæmis geri sér grein fyrir og bregðist við eftir föngum. Mikilvægar stefnur og aðgerðaáætlanir á sviði lýðheilsu eru hafðar til hliðsjónar. Þar má nefna stefnu velferðarráðuneytisins um lýðheilsu og aðgerðir sem stuðla að Heilsueflandi samfélagi frá 2016, stefnu Evrópudeildar Alþjóðaheilbrigðismálastofnunarinnar um heilsu kvenna frá 2016, aðgerðaráætlun Alþjóðaheilbrigðismálastofnunarinnar vegna langvinnra sjúkdóma frá 2013 og árlegar starfsáætlanir Embættis landlæknis.

Gögn

Margvísleg gögn liggja til grundvallar útreikningum lýðheilsuvísa. Notuð eru gögn úr heilbrigðisskrám og könnunum landlæknis, gögn úr könnunum Rannsókna og greininga og Háskólans á Akureyri og gögn frá Hagstofu Íslands og Sjúkratryggingum Íslands. Birtar eru upplýsingar úr gögnum sem nýjust eru hverju sinni.

Suðurnes

LÝÐHEILSUVÍSAR 2017

- Heilbrigðisumdæmið er marktækt frábrugðið landinu öllu
- Heilbrigðisumdæmið er ekki marktækt frábrugðið landinu öllu
- Ekki er prófað fyrir marktækni
- Landið allt
- Dreifing heilbrigðisumdæmanna sjö

	Lýðheilsuvísir	Ár	Umdæmi	Ísland	Eining
Samfélag	1 Íbúafjöldi	2016	23.251	335.439	
	2 Íbúafjöldi (fjölgun/fækkun)	2012-16	9,6	4,6	%
	3 Íbúar ≥ 80 ára	2016	2,4	3,6	%
	4 Kynjahlutfall	2016	1,08	1,02	kk/kvk
	5 Fæðingartíðni	2012-16	55,6	54,1	Á 1.000
	6 Lesskilningur (10. b.)	2015	71,1	77,8	%
	7 Háskólamenntaðir	2016	20,6	37,8	%
	8 Ráðstöfunartekjur	2015	3.251	3.352	1.000 kr
Lífnaðarhættir	9 Hamingja fullorðinna	2016	61,3	61,0	%
	10 Hamingja (8.-10. b.)	2016	83,5	84,2	%
	11 Líkamsmynd stúlkna (8.-10. b.)	2016	56,1	56,0	%
	12 Ofbeldi og stríðni (5.-7. b.)	2017	16,5	14,8	%
	13 Einmanaleiki framhaldsskólanema	2016	10,0	10,7	%
	14 Stuttur svefn framhaldsskólanema	2016	71,1	70,3	%
	15 Streita fullorðinna	2016	29,0	22,2	%
	16 Virkur ferðamáti í vinnu/skóla, fullorðnir	2016	10,4	20,3	%
	17 Þátttaka í skipulögðu íþróttastarfi (8.-10. b.)	2016	55,1	55,3	%
	18 Grænmetis- og ávaxtaneysla fullorðinna	2016	8,9	10,1	%
	19 Gosdrykkjaneysla framhaldsskólanema	2016	33,0	24,1	%
	20 Gosdrykkjaneysla fullorðinna	2016	25,3	18,0	%
	21 Áhættudrykkja fullorðinna	2016	27,4	28,0	%
	22 Ölvunardrykkja framhaldsskólanema	2016	36,4	38,3	%
	23 Reykingar fullorðinna	2016	12,5	10,2	%
	24 Tóbaksnotkun í vör, framhaldsskólanemar	2016	22,2	19,7	%
	25 Prófað kannabis, framhaldsskólanemar	2016	17,1	20,0	%
Heilsa og sjúkdómar	26 Meta andlega heilsu sæmilega/lélega, fullorðnir	2016	30,4	27,6	%
	27 Þunglyndislyfjanotkun, kk	2016	81,9	94,2	DÞD
	28 Þunglyndislyfjanotkun, kvk	2016	160,7	168,3	DÞD
	29 Blóðsykurslækkandi lyf, önnur en insúlín	2016	40,8	33,5	DÞD
	30 Háþrýstingslyfjanotkun	2016	282,5	261,6	DÞD
	31 Blóðfitulækkandi lyf	2016	85,1	87,6	DÞD
	32 Langv. lungnateppa, sjúkrahúslegur, kk	2012-16	292,1	155,9	Á 100.000
	33 Langv. lungnateppa, sjúkrahúslegur, kvk	2012-16	399,0	234,2	Á 100.000
	34 Ótímabær dauðsföll v/ langv. sjúkdóma	2012-16	28,9	22,7	%
	35 Dánartíðni vegna krabbameina	2012-16	248,0	187,1	Á 100.000
	36 Sýklalyfjaávísanir < 5 ára	2016	1.362	1.269	Á 1.000
	37 Bólusetningar barna, 12 mán.	2016	87,6	87,9	%
	38 Inflúensubólusetning ≥ 60 ára	2016-17	17,3	22,6	%
	39 Leghálskrabbameinsskoðun	2015	62,0	71,0	%
	40 Brjóstamyndataka	2015	48	58	%
	41 Loftslagsaðgerðir á mjöðm	2012-16	208	233	Á 100.000
	42 Biðlisti eftir hjúkrunarrými, ≥ 67 ára	2016	12,1	7,6	Á 1.000
	43 Heilsugæsluheimsóknir	2015	3,1	2,7	Á íbúa
	44 Sérfræðingsheimsóknir	2016	1,3	1,5	Á íbúa

Skýringar

1. Hagst. 2. Hagst. 3. Hagst. 4. Hagst. 5. Fs. Lífandi fædd börn á 1.000 konur 15-49 ára. 6. Mms. Lágmarkshæfni í lesskilningi í PISA. 7. Hagst. 25-74 ára. 8. Hagst. Vegið meðgildi ráðstöfunartekna skattgr. ≥ 16 ára. 9. Vöktun. Svara 8-10 á hamingjukvarða (1-10). 10. R&G. Mjög/nokkuð hamingjusöm. 11. R&G. Mjög/nokkuð ánægðar með líkama sinn. 12. R&G. Beitt(ur) ofbeldi og/eða stríðni og/eða skilin(n) útundan í skóla ≥ 2 í sán. 13. R&G. Oft einmana síl. viku. 14. R&G. ≤ 7 klst/nóttu. 15. Vöktun. Finna oft/mjög oft fyrir mikilli streitu. 16. Vöktun. Ganga/hjóla ≥ 3x í viku. 17. R&G. Æfa íþróttir ≥ 3x í viku. 18. Vöktun. Borða grænmeti og ávexti ≥ 5x/dag. 19. R&G. Sykraðir og/eða sykurlausir ≥ daglega. 20. Vöktun. Sykraðir og/eða sykurlausir ≥ daglega. 21 Vöktun. AUDIT-C samræmingur eftir kyni. 22. R&G. ≥ 1x síl. mán. 23. Vöktun. Daglega. 24. R&G. 1x síl. mán. 25. R&G. Prófað ≥ 1x um ævina. 26. Vöktun. 27. Lgg. ATC: N06A. Aldurst. 28. Lgg. ATC: N06A. Aldurst. 29. Lgg. ATC: A10B. Aldurst. 30. Lgg. ATC: C02, C03, C07, C08, C09. Aldurst. 31. Lgg. ATC: C10. Aldurst. 32. Vss. ICD-10: J40-J44.9, J47 (ekki Asmi). Aldurst. ≥ 15 ára. 33. Vss. ICD-10: J40-J44.9, J47 (ekki Asmi). Aldurst. ≥ 15 ára. 34. Dms. ICD-10: I00-I99, C00-C97, E10-E14, J30-J98. 35. Dms. ICD-10: C00-C97. Aldurst. 36. Lgg. ATC: J01. Aldurst. 37. Bss. Uppsafnað, árg. 2015. DTaP-IVP-Hib. 38. Bss. Uppsafnað, ≥ 60 ára. 39. Krs. Uppsöfnuð 3,5 ára mæting 23-65 ára. 40. Krs. Uppsöfnuð 2 ára mæting 40-69 ára. 41. Vss.

The society is developing fast → New challenges

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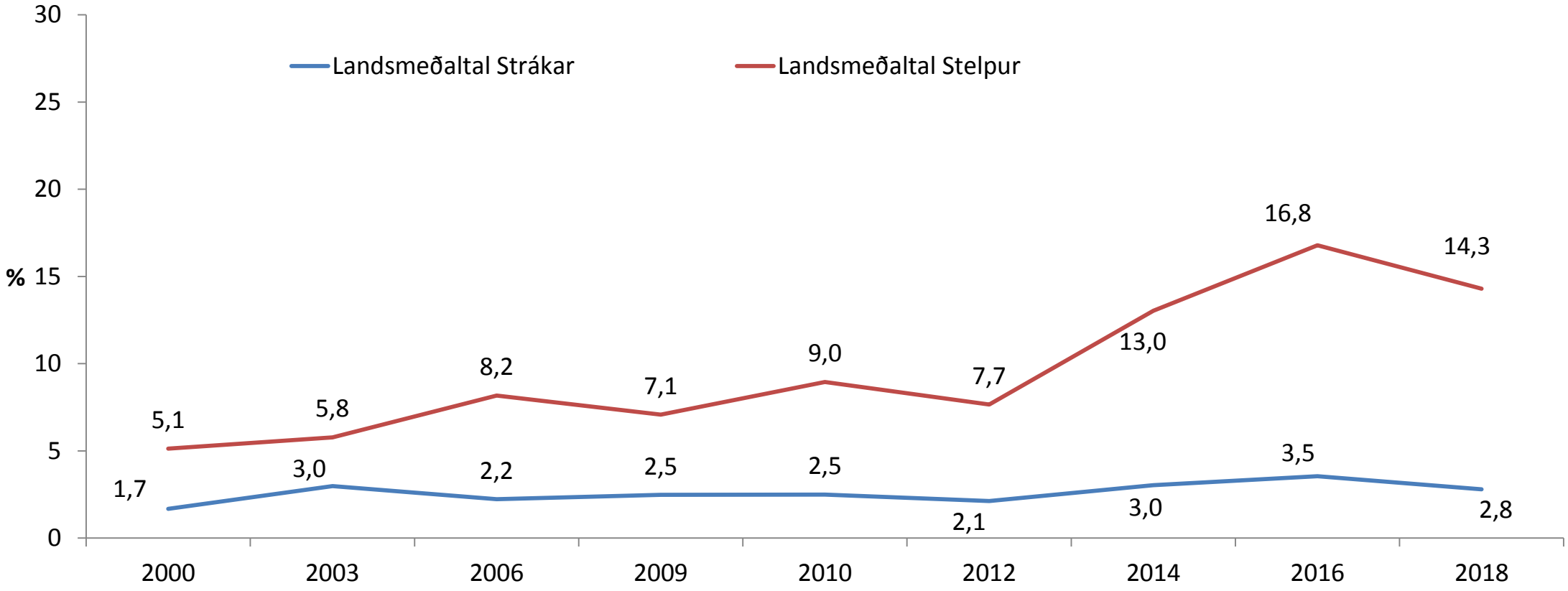
Proprtion of boys and girls in 9. og 10. grade compulsory school that mark the highest score on the anxiety scale 1997 - 2018



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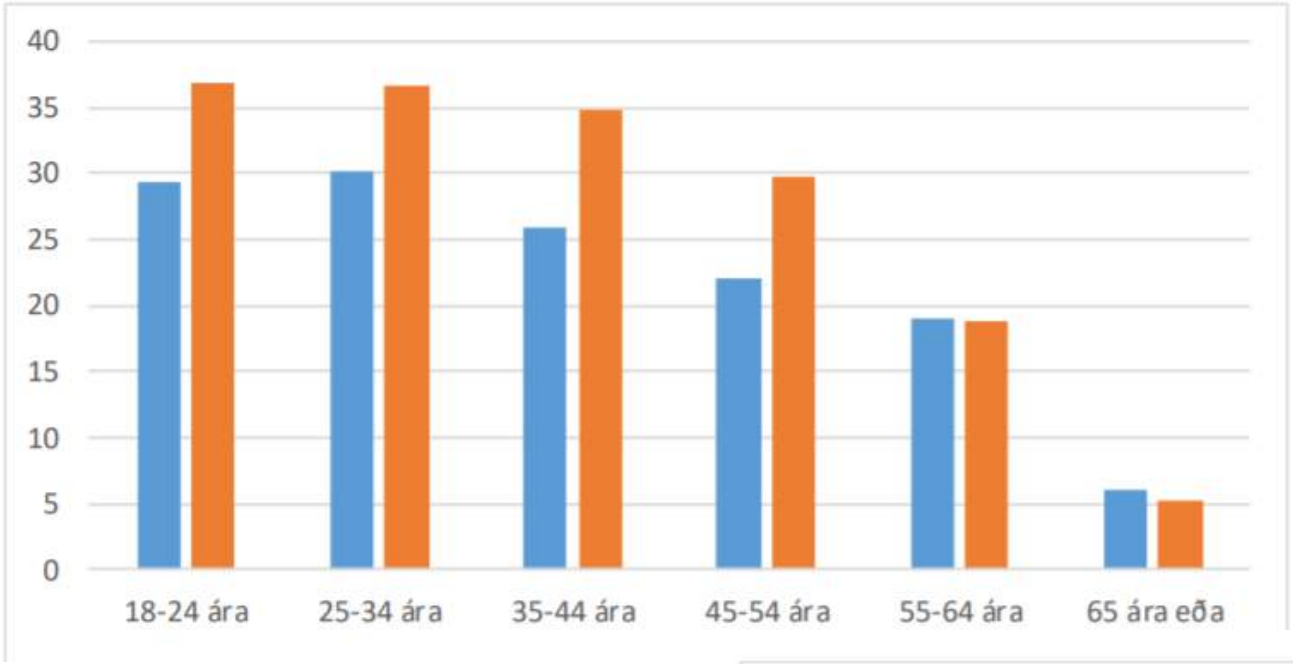
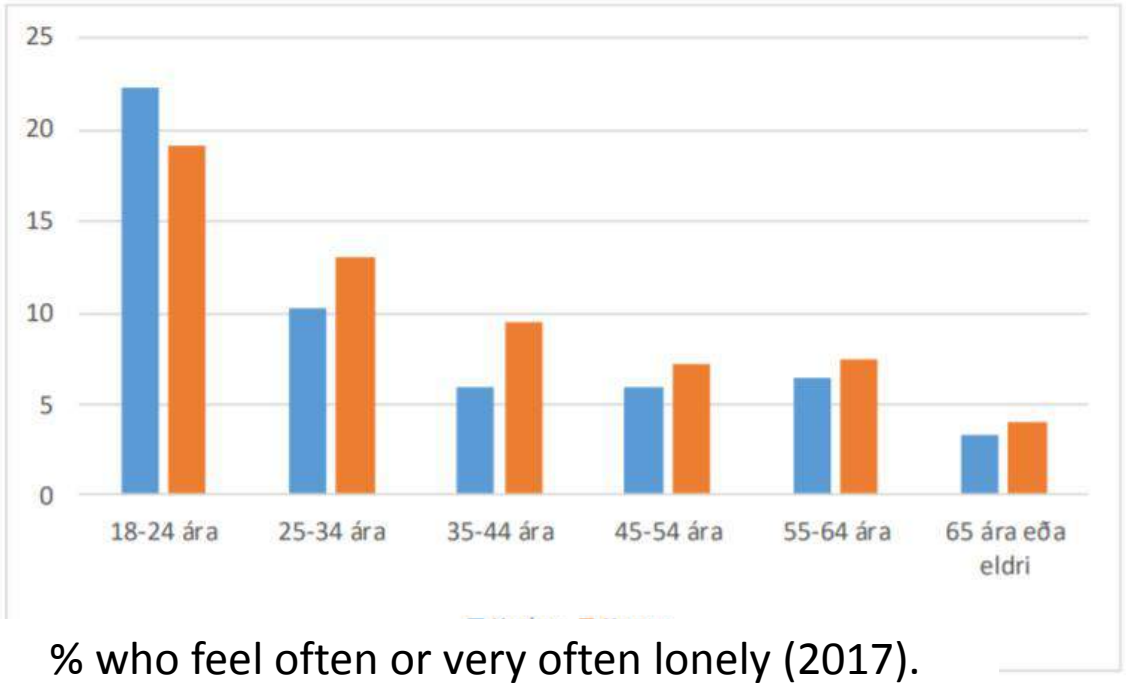


% who feel often or very often high levels of stress (2017).



% who feel often or very often lonely (2017).

Directorate of Health Iceland. Annual monitoring of determinants of health, data from 2017

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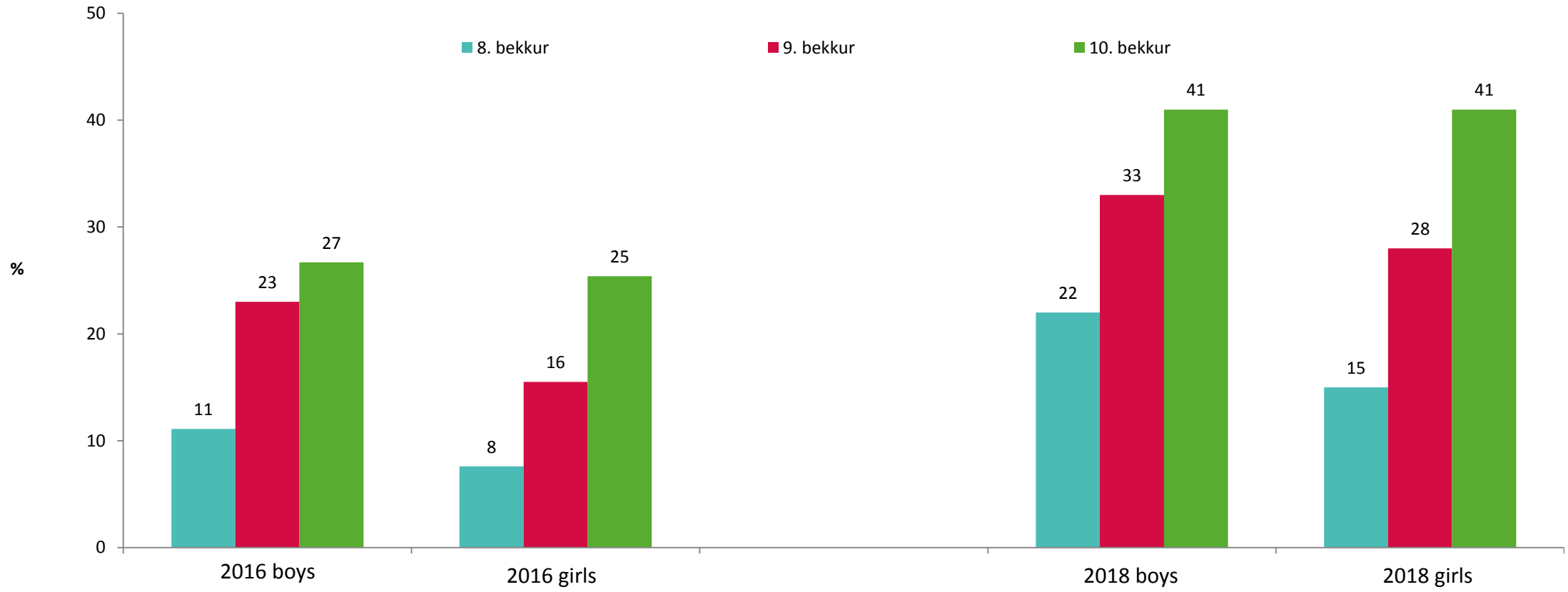
Directorate of Health

Proportion of boys and girls in 8., 9. og 10. grade that have used e-cigarettes 1x≤ over lifetime, 2016 and 2018



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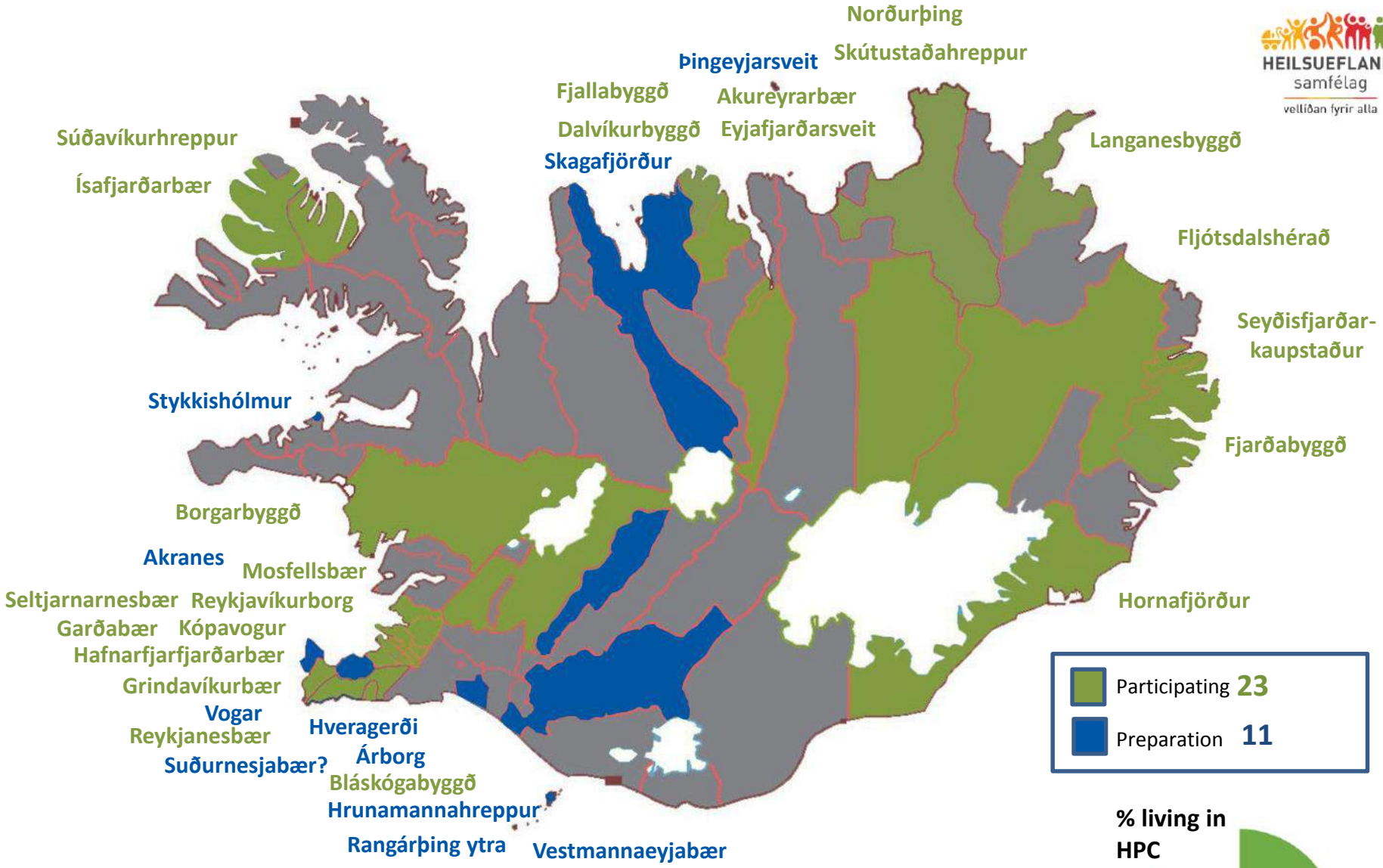
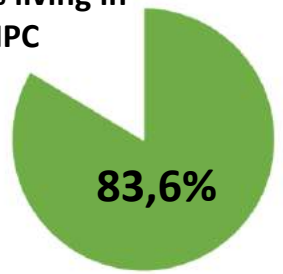


HEILSUEFLANDI
samfélag
vellíðan fyrir alla

Health promoting communities

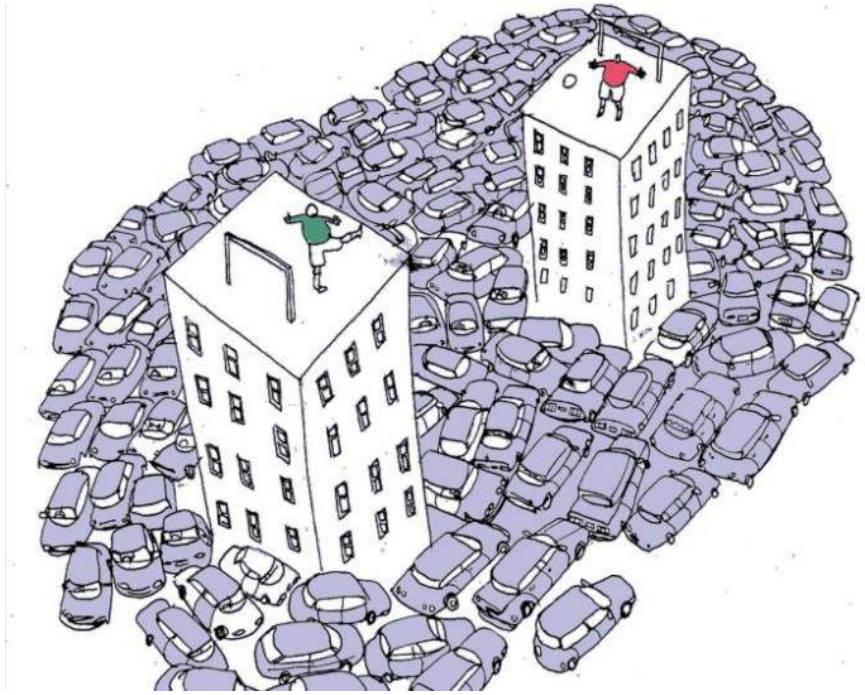
April 2019

% living in HPC



Public health is in the end a question of **in what kind of society we want to live**

Agren, G. (2003). *Sweden´s new public health policy: National Public Health Objectives for Sweden.*



Mynd: http://boardvoice.ca/public/2016/07/28/visions-of-a-healthy-community/

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Conclusion

- Parents/society: Big change in attitudes, beliefs
  …not OK for adolescents to drink alcohol.
- Don´t buy alcohol for you children
- No unsupervised parties – Know how children spend their leisure time and be active participant.
- Constructive leisure time activities can counteract negative effects of difficulties in other areas.
- Monitoring: environment, behaviour, health and well-being.
- Local community based approaches supported with laws and regulations including regulated availability of alcohol – monopoly
- Success in delaying onset of drinking in young people but other attitudes regarding adult drinking.
- Ban on advertising alcohol but not on marketing.
- What that works in one context has to be adapted to other.

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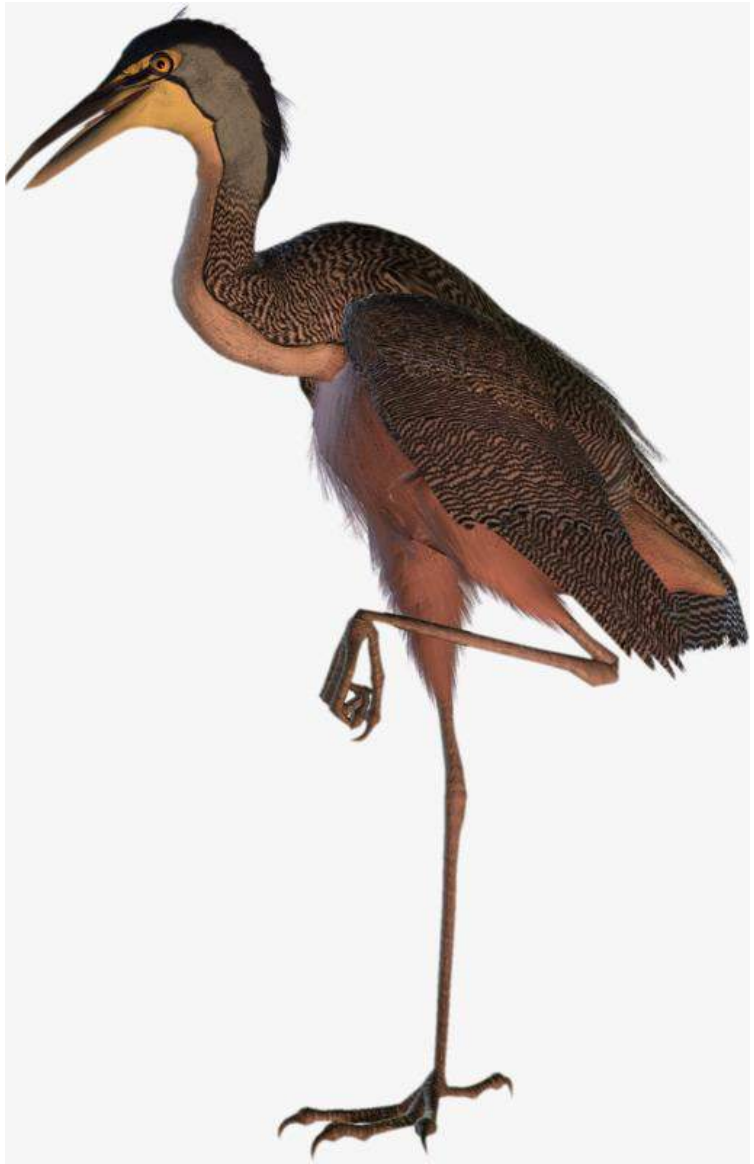
Conclusions cont.

- Fast changing world, health promotion and prevention work has to develop accordingly – including parents. The core protective factors seems to be constant.
- ,,Learn how to play FIFA”
- Connection, belonging, social interaction etc. is the key.
- Majority of young people is doing fine, celebrate it and avoid hysteria (do no harm).
- The SDG´s are great window of opportunity.
- Data and evidence – community - dialogue
- U can do it!

When new challenges and limited evidence for the practice …

STAY or GO ?



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There´s no I in TEAM ;)

- Margrét Lilja Guðmundsdóttir ICSRA and University of Reykjavík.

And collegues from DoH:

- Rafn Jónsson
- Sveinbjörn Kristjánsson
- Dóra G. Guðmundsdóttir
- Ingibjörg Guðmundsdóttir
- Jenný Ingudóttir
- Sigga Stína
- Viðar Jónsson

… and all the others

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It takes a whole,
healthy village…

Thank you

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Don´t assume – ask!