# Annexes

# Use of Norwegian Municipal Public Health Profiles and Data Bank: A qualitative study

DL Public Health MSc PHM 305

Candidate Number: J09639

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Submitted: September 30 2014

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## Annex A. Ethical Approval from RCMHRE, Norway

[RCMHRE – Regional Committee for Medical and Health Research Ethics]

**UNIVERSITETET I OSLO**
**DET MEDISINSKE FAKULTET**

[redacted]

Regional komité for medisinsk og helsefaglig forskningsetikk Sør-Øst C (REK Sør-Øst C)
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**Date: 30.04.14**
**Your ref.:**
**Our ref.: IRB 0000 1870**

**To whom it may concern**

**Exemption from ethics approval regarding the study:**
***Use of Norwegian Municipal Health Profiles and Data Bank: A qualitative study***

With reference to your email of 9th of April, we hereby confirm that the Regional Committee for Medical and Health Research Ethics, section South-East C, Norway has assessed the project *Use of Norwegian Municipal Health Profiles and Data Bank: A qualitative study.*

The ethics committee system consists of seven independent regional committees, with authority to either approve or disapprove medical research studies conducted within Norway, or by Norwegian institutions, in accordance with ACT 2008-06-20 no. 44: Act on medical and health research (the Health Research Act).

The abovementioned study is exempt from review in Norway, cf. § 4 of The Act. The project can be implemented without the approval by the Regional Committee for Medical Research Ethics.

Please do not hesitate to contact the Regional Committee for Medical and Health Research Ethics, section South-East C (REK Sør-Øst C) if further information is required.

Yours sincerely,

Britt-Ingjerd Nesheim MD, PhD
Professor of Medicine,
University of Oslo

Chair Regional Committee
for Medical and Health Research Ethics,
section South-East C

Marianne Eidem
Higher executive officer

Regional Committee for
Medical and Health
Research Ethics, section
South-East C

| Author/year | Institution | Title | Product evaluated | Publicatio | What kind of survey? | Respondents | Results |
|---|---|---|---|---|---|---|---|
| Lester, N. & Gartner, A. (2012) | Public Health Wales Observatory | Measuring inequalities: an example of developing a profile | Report: Measuring Inequality, Trends in Mortality and Life Expectancy in Wales, 2011 | 1 report, 1 Powerpoint presentation | Questionnaire with space for free text, personally administered | 23 end users | Information about how the original report was used |
| I2SARE Project Team (2011) | I2SARE (Health Inequalities Indicators in the | Evaluation report. Work package 3 | 168 regional health reports for Europe | Report | Internal evaluation of EU project | Project participants | Information on whether project benchmarks had been met |
| Statistics Canada (2009) | Statistics Canada | Consultation survey on health indicators | Health Indicators, indicator set used in many different settings | Report | Qualitative interviews | 49 end user interviews | Information about intended users' awareness and usage of Health Indicators product, and how |
| Statistics Canada (2005) | Statistics Canada | Consultation study. External clients of health statistics division | Health Indicators, indicator set used in many different settings | Report | Web survey, posted to contacts | 187 completed surveys | Information about usage of the Health Indicators, the specific indicators, difficulties and suggestions |
| Galbraith, L. (2010) | Scottish Public Health Observatory | Evaluation of Scottish health and wellbeing profiles 2008 | Health and Wellbeing Profiles | Report | Online questionnaire, sent to several different kinds of lists/networks | 83 completed surveys | Information about usage of the Health and Wellbeing Profiles, some specific indicators, difficulties and |
| Helgesen, M.K., Hofstad, H. & Vestby, G.M. (2008) | Norwegian Institute for urban and regional research | Kommunehelseprofiler. Kommunenes bruk av Helsedirektoratets nettsted | Webpage: Kommunehelseprofiler | Report | Questionnaire distributed to all public health coordinators and planners in the municipalities, qualitative interviews with ten municipalities | 514 questionnaires, 20 interviews | Information about knowledge about and usage of the webpage, evaluation of indicators |
| Shared Intelligence (2009) | South East Public Health Observatory | Health profiles evaluation. Final report | Health Profiles: Regional Profiles and online Interactive Tool | Report | Online survey, interviews with stakeholders, focus groups | 270 questionnaires, 10 interviews, 2 focus groups | Information about knowledge about and usage of Health Profiles, discussion of indicators, |
| Statskontoret, Sweden (2013) | Statskontoret, Sweden | Utvärdering av uppföljningssystemet för den nationalla folkhälsopolitiken | 2 reports, Folkhälsopolitisk rapport and Årsrapport, 1 webpage: Folkhälsodata | Report | Questionnaires, interviews with selected high-level stakeholders | 413 questionnaires, ca 30 interviews | Information about the varying usage and knowledge about the three products. |

## Annex C. Information Letter and Consent Form

[These have been translated from the original in Norwegian.]


(Address municipality)

(date)

**Survey on the use of the Public Health Profiles for Municipalities and the Municipal Health Statistics bank**

May we interview the Municipal Physician and Public Health Coordinator in your municipality ?

Background :
Municipalities and counties are in accordance with the regulations laid down in the Public Health Act required to monitor the health status and determinants for health.
According to § 5 of this regulation the NIPH will annually distribute processed statistics from central registries to assist the municipalities.
In January 2014, the updated Municipal Public Health Profiles and information about the Municipal Data Bank were distributed for the third time. The NIPH is interested in studying whether and how these products are used in the municipalities and whether there are deficiencies that should be corrected. In this context, we would like to conduct interviews with the Municipal physician and the Public Health Coordinator in a limited number of municipalities.
The interview is expected in itself to provide useful practical knowledge about the use of the public health profile for each municipality, and there will be allocated time for questions and additional briefings at the request of the interviewee after the interview. If the municipality wishes, we can also provide training in the use of the municipal health statistics bank to all municipal employees who are available the same day as the interview takes place.

Interview Form :
The interview has three parts. First, a structured interview, which will be recorded, then a short questionnaire, and finally, the municipal employees get some short practical tasks to be solved using the MDB.

All interviews will be carried out in the period April-June 2014.

Confidentiality:
The person / persons being interviewed will not be asked personal questions beyond age and educational background. The final report, which is the only thing that will be publicly available in this study, will not make it possible to identify individuals or specific municipalities, and notes and audio recordings will be erased when the report is completed. The person / persons being interviewed will be asked to sign a consent form (attached).

Practical points:
Please provide a phone number and a time when I might call to make an appointment , alternatively you can call me directly on mobile (deleted) . If the municipality is far from Oslo I'd prefer to interview both the Municipal physician and the Public Health Coordinator on the same day, but this is not an absolute requirement.

Sincerely,

(name)

(title)


**Consent Form for Survey on the use of Municipal Public Health Profiles and the Municipal Data Bank**

I have read the information sheet with information about this investigation and agree that the information I provide in an interview with the Norwegian Institute of Public Health employee may be used in the survey anonymously.

I agree that I may be contacted one time after the interview to clear up any misunderstandings or correct the data collected. (yes / no)

Name: _____

Municipality: _____

Identity number (11 digits): _____

Phone: _____

Date: _____ Signature: _____

## Annex D. Interview Guide

[These have been translated from the original in Norwegian.]

1) Demographic questions (to be filled in in advance)
    a. The Municipality
        i. Name
        ii. Population
        iii. District index, Centrality
        iv. The specific MPHP (to be brought)
        v. Downloads (how many times)
        vi. Main industries (if available on municipal web page)
        vii. How public health work is organised (if available on municipal web page)

    b. The Informant
        i. Name
        ii. Gender
        iii. Age
        iv. Education
        v. Job title
        vi. Time in position

2) About the Municipal Public Health Profile (MPHP)

a. How/when did you find out about the MPHP?
b. What kind of work do you have where statistics can be of use?
c. Do you use the MPHP at all?
d. How much?
e. When did you last use the MPHP?
f. For what purpose? Result?
g. In general: How often?
h. For what?
i. Example?
j. Easy/hard compared to other data sources?
k. What do you think about the presentation form?
l. Do you use the MPHP with others?
m. Have you shared the MPHP with anyone? Who? What and how?
n. Does anyone else in the municipality use the MPHP?
o. Effect of the MPHP locally?
p. Do you check the MPHP every year regarding municipal developments?
q. Is the MPHP mirrored in municipal policy/strategy?
r. How COULD one use the MPHP?
s. What kind of work do you have where the MPHP might be of use?
t. Do you/your municipality produce your own statistics?
u. Do you/your municipality use other sources of statistics?
v. Does the MPHP reflect your reality?
w. Reflection page 1?
x. Reflection page 2?
y. Reflection page 3?
z. Reflection page 4/the barometre?
aa. What do you think about the length of the MPHP?
bb. Comments user friendliness/functionality?
cc. Comments data provided/indicators? Are they relevant?
dd. Are you satisfied with the MPHP?

3) About the Municipal Data Bank (MBD)

a. What kind of work do you have where statistics can be of use?
b. Do you use statistics banks, such as Statistics Norway's data bank, NorHealth, WHO-HfA etc in your daily work ?
c. How/when did you find out about the MDB?
d. Do you use the MDB at all?
e. When did you last use the MDB? Result?
f. How much do you use the MDB?
g. In general: How often?
h. For what? Example use?
i. Easy/hard compared to other data sources?
j. What do you think about the presentation form?
k. Do you use the MDB with others?
l. Have you shared the MDB with anyone? Who? What and how?
m. Does anyone else in the municipality use the MDB?
n. Effect of the MDB locally?
o. Is the MDB mirrored in municipal policy/strategy?
p. How COULD one use the MDB?
q. What kind of work do you have where the MDB might be of use?
r. Do you/your municipality produce your own statistics?
s. Do you/your municipality use other sources of statistics?
t. Does the MDB reflect your reality?
u. Comments user friendliness/functionality?
v. Comments data provided/indicators? Are they relevant?
w. Are you satisfied with the MDB?

4) For the future
    a. What can be improved in the MPHP?
    b. Data selection/indicators in the MPHP?
    c. Othe data sources for the MPHP?
    d. User friendliness in the MPHP?
    e. What can be improved in the MDB?
    f. Data selection/indicators in the MDB?
    g. Othe data sources for the MDB?
    h. User friendliness in the MDB?

    i. How can the MPHP and MDB better serve your needs and the municipality's needs?
    j. Is there a need for other products for data presentation?
    k. Is the NIPH sufficiently active in promoting the MPHP/MDB?
    l. What should the NIPH be doing?

5) Any other issues you would like to raise?

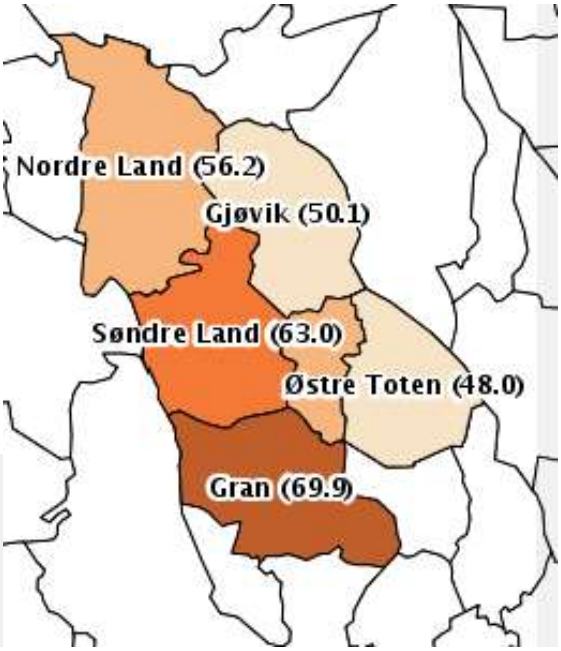
Handouts:

1) Municipal Public Health Profile (as in Annex H,
   but the 2014 version, in Norwegian, of the relevant municipality)
2) (after interview): short questionnaire (Annex F)
3) Three simple tasks to be solved using the MDB (Annex E)

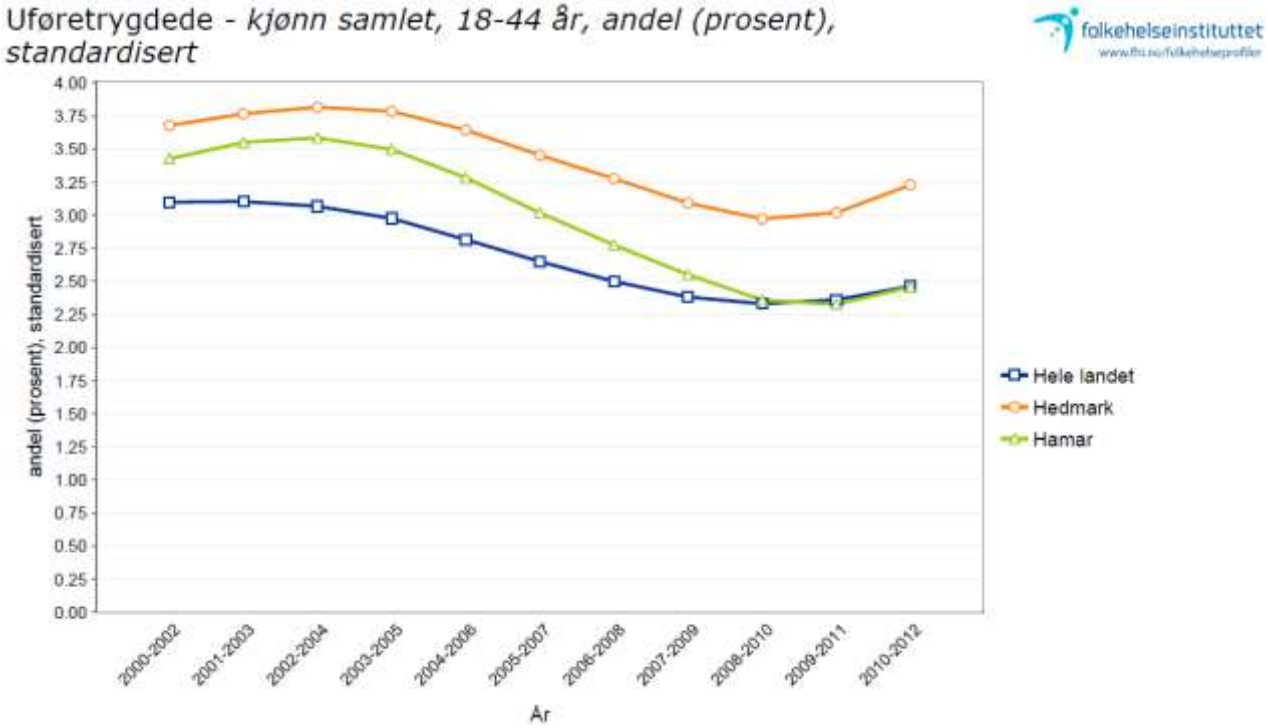
## Annex E. Tasks to be solved using the Municipal Data Dank

[These have been translated from the original in Norwegian.]

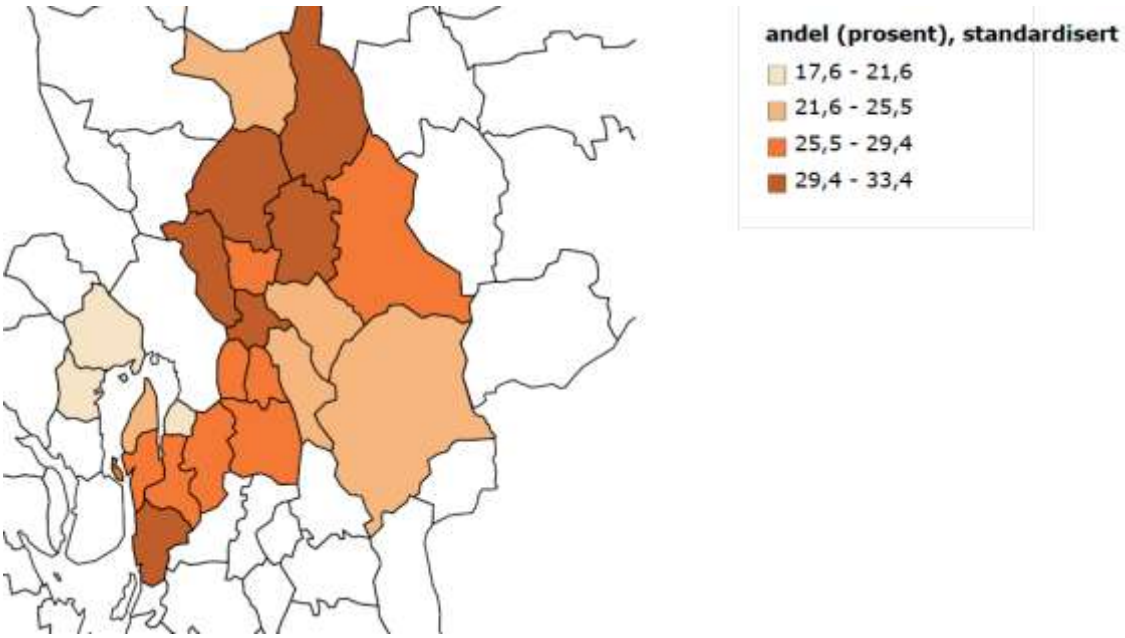
1) Make a **map** showing the percentage using **primary health care services** for the symptoms **anxiety and depression in your municipality** and **some neighbouring municipalities.**




2) Make a **timeline** showing the percentage of **young people on disability benefits** over **as long a time span as possible** in **Norway, your county and your municipality**.



3) Make a **map** showing **high school drop out rates** in all **municipalities in your county.**



## Annex F. Questionnaire

[These have been translated from the original in Norwegian.]

To which extent do you agree/disagree with the following statements about the Municipal Public Health Profiles (MPHPs) and the Municipal Data Bank (MDB)?

| **The Municipal PHP…** | **Strongly agree** | **Agree** | **Disagree** | **Strongly disagree** | **Don't know** |
|---|---|---|---|---|---|
| present data clearly | | | | | |
| help to prioritise within public health | | | | | |
| are helpful in planning new services | | | | | |
| raise consciousness about social inequalities in health | | | | | |
| have changed my views about public health problems | | | | | |
| are useful in my daily work | | | | | |

| **The Municipal Data Bank…** | **Strongly agree** | **Agree** | **Disagree** | **Strongly disagree** | **Don't know** |
|---|---|---|---|---|---|
| presents data clearly | | | | | |
| helps to prioritise within public health | | | | | |
| is helpful in planning new services | | | | | |
| raises consciousness about social inequalities in health | | | | | |
| has changed my views about public health problems | | | | | |
| is useful in my daily work | | | | | |

**For which purposes have you used, respectively, the Municipal Public Health Profile (MPHP) and the Municipal Data Bank (MDB)?**

| | **MPHP** | **MDB** |
|---|---|---|
| Public health interventions/campaigns | | |
| Surveillance, for use in my daily work | | |
| Municipal planning (incl. regulating, area plans, expansion) | | |
| Professional skills development | | |
| Personal interest | | |
| To illustrate a talk | | |
| To illustrate a report | | |
| To examine inequalities in my municipality | | |
| | | |
| | | |

| **My relationship to** | **MPHP** | **MDB** |
|---|---|---|
| I have never really used (x) | | |
| I don't understand very well what it's about | | |
| I have talked to people who don't understand what it's about | | |
| I understand what it's about, but it is of no use to me | | |
| | | |
| | | |
| | | |

| | Municipality/ Informant | Fjordby/ S | Fjordby/ H | Granbygd/ J | Urban/ M | Urban/ H | Strandbygd/ A | Strandbygd/ M | Strandbygd/ G | Kystby/ I | Kystby/ S | Skogsby/ K | Bjørkebygd/ J | Sum Yes/ Agree | Sum No/ Disagree | Sum Unknown/ Don't know |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MPHPs are:** | clear | y | y | y | y | y | y | y | y | y | y | y | y | 12 | 0 | 0 |
| | help prioritise | y | n | y | n | n | y | y | y | y | y | y | u | 8 | 3 | 1 |
| | help plan | y | u | y | n | n | y | y | u | y | u | y | u | 6 | 2 | 4 |
| | show social inequalities | y | n | y | y | n | y | n | y | y | u | y | u | 7 | 2 | 3 |
| | changed my views | n | n | n | n | n | y | n | y | n | n | n | u | 2 | 9 | 1 |
| | useful | y | u | y | n | y | y | y | y | y | n | y | y | 9 | 2 | 1 |
| **MDB is:** | clear | y | y | u | y | u | y | y | y | y | y | y | y | 10 | 0 | 2 |
| | helps prioritise | y | n | u | y | u | y | y | y | y | y | y | y | 9 | 1 | 2 |
| | helps plan | y | u | u | y | u | y | y | y | y | u | y | u | 7 | 0 | 5 |
| | shows social inequalities | y | y | u | y | u | y | n | y | y | u | y | y | 8 | 1 | 3 |
| | changed my views | n | u | u | n | u | y | n | y | n | n | n | u | 2 | 6 | 4 |
| | useful | y | y | u | y | y | y | y | y | y | n | y | y | 10 | 1 | 1 |
| **MPHP uses:** | intervention | n | n | n | n | n | n | n | y | n | n | y | n | 2 | 10 | 0 |
| | surveillance | n | n | n | n | n | y | y | y | n | n | y | n | 4 | 8 | 0 |
| | planning | y | y | y | y | y | y | y | y | n | n | y | n | 9 | 3 | 0 |
| | skills development | y | y | n | n | n | n | y | y | y | n | n | n | 5 | 7 | 0 |
| | personal interest | n | n | n | n | n | n | n | y | y | n | n | n | 2 | 10 | 0 |
| | illustrate talk | y | n | n | y | y | y | y | y | y | n | y | n | 8 | 4 | 0 |
| | illustrate report | n | y | n | y | n | y | y | y | y | n | n | n | 6 | 6 | 0 |
| | examine inequalities | n | y | n | n | n | y | y | y | n | n | n | n | 4 | 8 | 0 |
| **MDB uses:** | intervention | n | n | n | n | n | n | n | n | n | n | y | n | 1 | 11 | 0 |
| | surveillance | n | n | n | y | n | y | y | n | n | n | y | n | 4 | 8 | 0 |
| | planning | y | y | y | y | n | y | y | y | n | n | y | n | 8 | 4 | 0 |
| | skills development | y | y | n | n | n | n | y | y | y | n | y | n | 6 | 6 | 0 |
| | personal interest | n | n | n | y | n | n | n | n | y | n | y | n | 3 | 9 | 0 |
| | illustrate talk | y | n | n | n | n | y | y | n | n | n | y | n | 4 | 8 | 0 |
| | illustrate report | n | y | n | y | n | y | y | n | n | n | y | n | 5 | 7 | 0 |
| | examine inequalities | n | y | n | n | n | y | y | y | n | n | y | n | 5 | 7 | 0 |
| **MPHP** | never used | n | n | n | n | n | n | n | n | n | y | n | y | 2 | 10 | 0 |
| **relationships:** | don't understand | n | n | n | n | n | n | n | n | n | n | n | u | 0 | 11 | 1 |
| | others don't understand | y | y | n | y | n | n | n | n | n | n | n | u | 3 | 8 | 1 |
| | no use for me | n | n | n | n | n | n | n | n | n | y | n | u | 1 | 10 | 1 |
| **MDB** | never used | n | n | y | n | y | n | n | n | n | y | n | y | 4 | 8 | 0 |
| **relationships:** | don't understand | n | n | u | n | u | n | n | n | n | u | n | u | 0 | 8 | 4 |
| | others don't understand | n | y | u | y | u | n | n | n | n | u | n | u | 2 | 6 | 4 |
| | no use for me | n | n | u | n | u | n | n | n | n | y | n | u | 1 | 8 | 3 |

## Annex H. Municipal Public Health Profile for Tromsø 2013

# PUBLIC HEALTH PROFILE 2013

# Tromsø

**The public health profile is a contribution to the municipality's efforts to gain an overview over the health status of the population and the factors that influence this, as required by the Public Health Act. The statistics are from the last available time period, October 2012, and are based on the municipal boundaries as of January 1st 2013.**

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## Some features of municipal public health

The topics were selected to provide opportunities for health promotion and prevention. The indicators take into account the municipality's age and gender composition, but all statistics must also be interpreted with local conditions in mind.

### About the population

- Life expectancy for women is not clearly different from what is expected in the country as a whole.
- The proportion of over-80s is lower than in the country as a whole.
- The proportion of single - person households is higher than the proportion in the country.

### Living conditions

- The proportion with high school or higher education is higher than the country level.
- The proportion of people in low-income households is lower than in the country as a whole.
- The proportion of disability pensioners under the age of 45 is lower than the national level.
- The proportion of children with single parents is higher than in the country as a whole.

### Environment

- The proportion of people supplied by waterworks with 12 analysed samples and with satisfactory E. coli results appears to be higher than the national level. This concerns the part of the population connected to waterworks where reporting is required.
- The proportion of the population who are injured in accidents is lower than in the country as a whole, based on hospital admissions.

### Schools

- The proportion of 10th graders who enjoy school is lower than in the country as a whole.
- The proportion of 5th graders at the lowest level of reading proficiency is lower than in the country as a whole.
- The rate of high school dropouts is higher than in the country as a whole.

### Lifestyle

- Smoking seems to be a bigger problem than in the country as a whole, based on the proportion of pregnant women who smoke at first prenatal check-up. We have no figures for the rest of the population.
- Obesity seems to be a bigger problem than in the country as a whole, based on the proportion of men with BMI > 25 kg / m² at the military assessment.

### Health and disease

- The proportion of the population with psychiatric symptoms and disorders is lower than in the population as a whole, based on data from general practitioners and emergency departments.
- The proportion of cardiovascular disease is not clearly different from the country level, based on hospital admissions.
- The proportion of people with type 2 diabetes appears to be lower than the country level, based on data from general practitioners and emergency departments.
- Musculoskeletal ailments and diseases appear to be more prevalent than in the country as a whole, based on data from general practitioners and emergency departments.

Norwegian Institute of Public Health

# Disease patterns reflect lifestyle, environment and living conditions

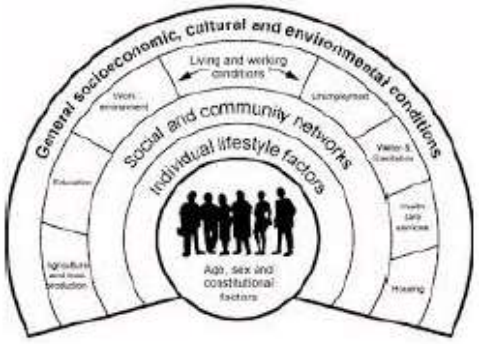
**Many municipalities ask for statistics about diet, physical activity and other lifestyle habits. In many cases it is necessary to use disease patterns and other indirect measures in the public health profiles to obtain information about the lifestyle of the population.**

At present, there are no national registries with reliable data on lifestyle so the public health profiles mostly feature statistics related to health targets, such as disease and causes of death. These statistics can still be useful for assessing the living habits of the population.

Several chronic diseases are largely a result of the living habits over time. We can indirectly obtain information about lifestyle in the municipality by "reading" patterns of disease. Lifestyle refers to diet, physical activity, smoking and other health-related behaviours. Lifestyle is not only the result of personal choice. The choices individuals make are also the result of environmental and living conditions, and disease patterns may therefore provide an indication of conditions in the municipality.

Figure 1 shows the factors that affect health. These range from personal characteristics such as age and gender, to social conditions such as culture, employment, housing and local environment, education and social networks.

**Figure 1.** Factors influencing health (after Dahlgren and Whitehead (1))




The underlying factors may either promote health or increase the risk of disease. Lack of social support is a factor that increases the risk of both mental and physical health problems. Conversely, social support promotes health and well-being, because the support of friends, schoolmates, colleagues and family acts as a "buffer" against various stresses.

Education is an example of a factor that has an impact on health throughout adulthood.

## Significant health disparities

Studies show that lifestyle often follows education and income levels. This means that groups with longer education and higher income have, on average, more favourable lifestyles and better health than groups with shorter education and lower income.

Reducing social inequalities in health is an important objective of public health. Efforts to improve living conditions, such as work and education, can help to promote health and reduce social inequalities. Preventing children from dropping out of high school will promote health because it provides greater opportunities for work and active participation in society. Mastery and well-being in primary school lays a good foundation for completion of high school.

## One initiative, multiple gains

The municipality's efforts against one risk factor may reduce the incidence of several diseases. For example, measures to combat smoking reduce the incidence of diseases such as cardiovascular disease, chronic obstructive pulmonary disease (COPD) and cancer. Likewise, efforts to promote physical activity affect the incidence of health problems such as obesity, cardiovascular disease and type 2 diabetes. In addition, physical activity improves well-being and physical and mental health.

Preventive measures may be directed towards high-risk groups or the total population. Initiatives towards groups with particularly high risks may be effective, but measures directed at the entire population may provide greater overall gains. This is because population-oriented measures reach a large number of people with intermediate risk, and because more cases of disease occur in this group than in the high-risk group. Although the individual risk is much higher in the high-risk group, more cases of illness occur in the group with moderate risk, because this group is larger.

There is no conflict between population-related measures and measures directed towards high-risk groups as, they can complement each other. For example, reducing salt in processed foods lowers blood pressure a little in everyone, and thus lowers the risk of cardiovascular disease in the general population. Health services will continue to treat individuals with hypertension to reduce their risk.

Population-oriented measures aim at "small changes among many," so that the entire population moves towards a lower risk.

## Short term and long term health gains

It may take many years before current prevention efforts provide results. However, some results may also come quickly. For example, physical activity is important for wellbeing and mental health, and smoking cessation reduces the risk of heart attack already in the first year of not smoking. Another example is injury prevention, which can quickly be demonstrated by reduced injury incidence.

Through the design of the physical environment the municipality can encourage physical activity and social interaction between people. Planning the physical environment in terms of health promotion can contribute to better physical and mental health. Meeting places in the community may have an impact on mental health, while it is easier to be physically active if the neighbourhood is safe and inviting.

## Smoking and smokeless tobacco

The proportion of smokers in the Norwegian population has declined, but still 17 per cent smoke daily. Smoking is the habit that has the greatest negative impact on public health. Prevalence of smoking-related diseases such as COPD, lung cancer and cardiovascular disease can provide information on people's smoking habits over time. Statistics on these smoking-related diseases can be found in the public health barometer.

There are great social differences in smoking behaviour. Figure 2 shows daily smoking in different educational groups, with data provided by the nationwide Survey of Living Conditions in 2008 (SSB).

There is a higher proportion of smokers in groups with shorter education than in groups with longer education. These differences explain a large part of the social inequalities in morbidity and mortality.

Many of the people using tobacco as adults became addicted at a young age. It is therefore vital to prevent tobacco use among adolescents - both smoking and smokeless tobacco use. Smokeless tobacco is as addictive as cigarettes and contains harmful and carcinogenic substances and the number of users is increasing Initiatives in middle school may be particularly effective, and should be followed with measures in high school. Enforcement of the age limit for tobacco purchases and the establishment of smoke-free areas are appropriate measures.

## Physical activity and diet

Physical activity and a balanced diet promote health and protect against a variety of diseases throughout life.

Several of the indicators under health and disease in the public health barometer can provide information about the population's diet and physical activity. These include indicators of obesity, high blood pressure and cholesterol, cardiovascular disease, cancer and type 2 diabetes. Regular physical activity can also improve mental health.

Figure 3 shows the proportion of the population who achieve the recommended minimum level of activity in different age groups, as measured by activity monitors. Numbers in the figure are derived from population surveys of activity in the population conducted by the Norwegian Directorate of Health in 2008-2011 (2.3). Adults and the elderly are recommended to be physically active for at least 30 minutes daily, while children and adolescents are recommended at least 60 minutes of daily physical activity. The figure shows that there is considerable variation between the different age groups in terms of the extent to which they achieve their recommended levels of activity.

Overweight and obesity are major health problems in most countries, including Norway. Figure 4 shows the prevalence of overweight including obesity in men, measured at military inscription, shown as an average for the period 2003-2009. When the basis for data is small, municipal values may not be displayed.

Habits related to diet and physical activity are set early in life. The development of overweight and obesity can be delayed by directing measures towards children and their physical and social environment. The municipality, as the owner of schools and kindergartens, has a unique opportunity to encourage children to have positive experiences of healthy eating and physical activity. Public health clinics are another arena in which the municipality can make a difference through contact with children and their families.

References: 1. Dahlgren G, Whitehead M. Policies and Strategies to Promote Social Equity in Health. Stockholm 1991. 2. Fysisk aktivitet blant voksne og eldre i Norge. Resultater fra en kartlegging i 2008-2009. Oslo: Hdir; 2009. 3. Fysisk aktivitet blant 6-, 9- og 15-åringer i Norge. Resultater fra en kartlegging i 2011. Oslo: Hdir; 2012.

**Figure 2:** Daily smokers by educational background (country figures)

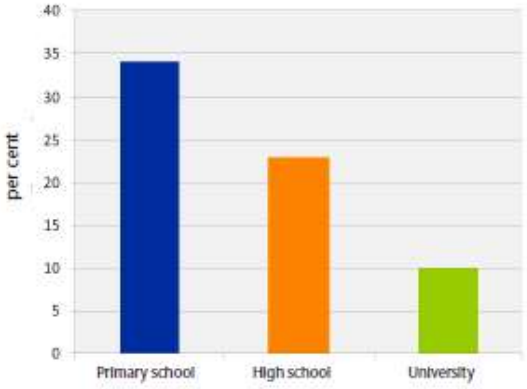



**Figure 3:** Proportion who achieve recommended levels of physical activity (country figures)

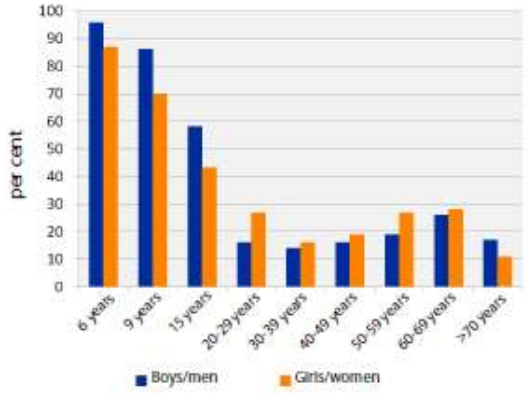
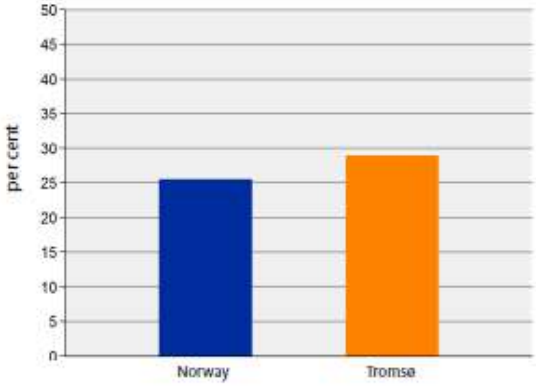



**Figure 4:** Overweight including obesity among men, measured at military assessment



# Public health barometers for your municipality

The table below compares some key figures on a municipal and county level with national figures. Municipalities and counties may have an age and gender composition that differs from the national average. This may affect the statistics and is taken into account in the figure and number columns. Statistics without age and gender standardisation are available in the Municipal Health data bank, khs.fhi.no . The differences between the municipality and the country are tested for statistical significance, see www.fhi.no/folkehelseprofiler

- Green value - can state with a high degree of certainty that the municipality is in a better position than the country as a whole
- Red value - can state with a high degree of certainty that the municipality is in a worse position than the country as a whole
- Yellow value - not possible to state for certain how the municipality compares to the country as a whole
- Not tested for statistical significance
- The value for the county (not tested for statistical significance)
- The value for the country as a whole
- The variation between the municipalities in the county

**Semicircles**: Municipal values that are more than double or half the country value are shown as a semicircle on the perimeter of the field.

A «green» value means that the municipality is better placed than the country as a whole. However, the indicator may still be a major health challenge for the municipality, as the country level may not necessarily represent a desired level. For a more comprehensive list of municipal developments, you can create charts in the Municipal Health Data Bank.

| Topic | | Indicator | Municipality | County | Norway | unit (*) | Public health profile for Tromsø |
|---|---|---|---|---|---|---|---|
| About population | 1 | Population growth | 1.3 | 0.7 | 1.3 | per cent | |
| | 2 | Population over 80 years | 2.7 | 4.1 | 4.4 | per cent | |
| | 3 | Life expectancy, men | 77.3 | 76.7 | 77.2 | years | |
| | 4 | Life expectancy, women | 82.3 | 81.9 | 82.2 | years | |
| | 5 | One-person households | 19 | 18 | 18 | per cent | |
| | 6 | Number of immigrants and children of immigrant parents | 9.6 | 7.5 | 13 | per cent | |
| Living conditions | 7 | Upper secondary / higher education | 86 | 82 | 83 | per cent | |
| | 8 | Low income | 8.6 | 8.6 | 9.4 | per cent | |
| | 9 | Income disparity, P90/P10 | 2.5 | 2.4 | 2.6 | - | |
| | 10 | Unemployed | 2.2 | 2.2 | 2.7 | per cent | |
| | 11 | Disability pension, 18-44 years | 1.8 | 2.5 | 2.3 | per cent (a,k*) | |
| | 12 | Child of single parents | 19 | 19 | 16 | per cent | |
| Environment | 13 | Drinking water, E. coli analyses | 97 | 73 | 94 | per cent | |
| | 14 | Hospital-treated injuries | 12 | 13 | 13 | per 1000 (a,k*) | |
| Schools | 15 | Enjoys school | 82 | 79 | 84 | per cent (k*) | |
| | 16 | Bullied at school | 9.5 | 10 | 8.9 | per cent (k*) | |
| | 17 | Lowest level reading skills | 20 | 25 | 26 | per cent (k*) | |
| | 18 | Drop out from high school | 32 | 32 | 25 | per cent (k*) | |
| Life-style | 19 | Smoking, women | 22 | 24 | 20 | per cent (a*) | |
| | 20 | Overweight incl. obesity, men | 29 | 31 | 25 | per cent | |
| Health and disease | 21 | Mental illness and symptoms, primary care | 125 | 130 | 135 | Per 1000 (a,k*) | |
| | 22 | Mental illness, users of medication | 109 | 112 | 131 | Per 1000 (a,k*) | |
| | 23 | Hypertension, primary care | 54 | 62 | 65 | Per 1000 (a,k*) | |
| | 24 | Cholesterol lowering agents, users of medication | 63 | 75 | 77 | Per 1000 (a,k*) | |
| | 25 | Cardiovascular disease, hospital treatment | 18 | 18 | 18 | Per 1000 (a,k*) | |
| | 26 | COPD and asthma, users of medication | 93 | 101 | 97 | Per 1000 (a,k*) | |
| | 27 | Type 2 diabetes, users of medication | 30 | 34 | 32 | Per 1000 (a,k*) | |
| | 28 | Type 2 diabetes, primary care | 30 | 36 | 39 | Per 1000 (a,k*) | |
| | 29 | Cancer total, new cases | 525 | 517 | 554 | Per 100 000 (a,k*) | |
| | 30 | Cancer of colon and rectum, new cases | 77 | 73 | 76 | Per 100 000 (a,k*) | |
| | 31 | Lung cancer and COPD, mortality | 40 | 38 | 38 | Per 100 000 (a,k*) | |
| | 32 | Hip fractures, hospital treatment | 2 | 2.1 | 2.2 | Per 1000 (a,k*) | |
| | 33 | Musculoskeletal disorders, primary care | 272 | 285 | 254 | Per 1000 (a,k*) | |
| | 34 | Vaccination coverage | 95.2 | 94.0 | 94.1 | per cent | |

**Explanation (numbers indicate line in the table above):**

* = standardised values, a = age standardised and k = standardised by gender

1. 2011. 2. 2012. 3/4. 1997-2011, calculated based on age-specific mortality, 15 year average. 5. 2011, in per cent of the population. 6. 2012. 7. 2011, highest level of education (of all with stated education). 8. 2010, persons living in households with income below 60 % of national median. 9. 2010, the ratio between the income of a person who is in the 90th percentile and one who is in the 10th percentile. 10. 2011, of persons in the labour force. 11. 2008-2010. 12. 2009-2011, 0-17 years, of all children for whom child benefit is paid. 13. 2011, proportion of persons connected to water utilities with satisfactory analytical results regarding E. coli, as a percentage of population connected to water utilities requiring reports. At least 12 samples must be analysed. For more data, see khs.fhi.no. 14. 2009-2011. 15. 2008-2012. 16. 2008-2012. 17. 2010-2011. 18. 2009-2011. 19. 2002-2011, woman at first prenatal check. 20. 2003-2009, BMI over 25 kg/m², men at military assessment interview. 21. 2010-2011, 0-74 years, users of primary care physician and emergency services. 22. 2009-2011, 0-74 years, medicines to treat psychiatric disorders, including hypnotics. 23. 2010-2011, 0-74 years, users of primary care physician and emergency services. 24. 2009-2011, 0-74 år. 25. 2009-2011. 26. 2009-2011, 45-74 years. 27. 2009-2011, 30-74 years, users of blood glucose lowering drugs, excl insulins. 28. 2010-2011, 30-74 years, non-insulin dependent diabetes, users of primary care physician and emergency services. 29. 2001-2010. 30. 2001-2010. 31. 2002-2011, 0-74 years. 32. 2009-2011. 33. 2010-2011, 0-74 years, musculoskeletal complaints and illnesses (excl fractures and injuries), users of primary care physician and emergency services. 34. 2007-2011, vaccine against measles, mumps and rubella. Missing numbers are mainly due to privacy considerations, and are often in a small municipality with a high vaccination coverage.

**Data Sources:** Data sources: Statistics Norway, Cause of Death Registry, Norwegian Labour and Welfare Administration, Norwegian Directorate for Education and Training, The Norwegian Water Works Registry, Norwegian Patient Registry, Medical Birth Registry of Norway, primary care physician and emergency services (KUHR database, owned by the Directorate of Health), Cancer Registry of Norway, Norwegian Immunisation Registry (SYSVAK), and the Norwegian Prescription Database. For more information about the indicators, see www.fhi.no/folkehelseprofiler

## Annex I. Code List

| Code Description | Theme Description |
|---|---|
| 01. Differences within municipalities are not covered | E) Municipality Size and MDB/MPHP Suitability |
| 02. Presence of indicators in the MPHPs rules what the municipalities notice or measure | I) MDB/MPHP Indicators and Policy |
| 03. The municipality has little/no experience using the MDB | D) Municipality Present Use of MDB/MPHP |
| 04. Interacting with legal frameworks | F) Municipal Roles and Leadership |
| 04. Interacting with legal frameworks | I) MDB/MPHP Indicators and Policy |
| 05. No interest in the MPHP midsection | C) MPHP Midsection Wishlist |
| 06. Discussions about specific problematic indicators | I) MDB/MPHP Indicators and Policy |
| 07. Offering regular physical training courses | D) Municipality Present Use of MDB/MPHP |
| 07. Offering regular physical training courses | F) Municipal Roles and Leadership |
| 07. Offering regular physical training courses | H) NIPH Actions Wishlist |
| 07. Offering regular physical training courses | I) MDB/MPHP Indicators and Policy |
| 08. The municipality needs/all municipalities need to have more MDB users | D) Municipality Present Use of MDB/MPHP |
| 09. Need for practical information about interventions and priorities | D) Municipality Present Use of MDB/MPHP |
| 10. Making better use of NIPH e-mail communication to municipalities | H) NIPH Actions Wishlist |
| 11. User friendliness of the map function | A) MDB Functionality Wishlist |
| 12. Using a positive slant on more indicators | B) MDB/MPHP Indicator Wishlist |
| 12. Using a positive slant on more indicators | C) MPHP Midsection Wishlist |
| 13. Adding indicators on health promotion | B) MDB/MPHP Indicator Wishlist |
| 13. Adding indicators on health promotion | C) MPHP Midsection Wishlist |
| 14. Providing a MPHP midsection on mental health | C) MPHP Midsection Wishlist |
| 15. Discussing the role of the Chief Municipal Officer | F) Municipal Roles and Leadership |
| 16. Not having to use the plus sign to expand the indicator list | A) MDB Functionality Wishlist |
| 17. User friendliness of showing name and values on the map | A) MDB Functionality Wishlist |
| 18. Not having to select «Show table» after every change in the pop-up screen | A) MDB Functionality Wishlist |
| 19. Potential municipal mergers | E) Municipality Size and MDB/MPHP Suitability |
| 20. Being frustrated over own municipal role/position | F) Municipal Roles and Leadership |
| 21. Use of MDB/MPHP in multisectorial municipal working groups | D) Municipality Present Use of MDB/MPHP |
| 21. Use of MDB/MPHP in multisectorial municipal working groups | F) Municipal Roles and Leadership |
| 21. Use of MDB/MPHP in multisectorial municipal working groups | D) Municipality Present Use of MDB/MPHP |

| | |
|---|---|
| 22. Use of MDB/MPHP in collaborating with other municipalities | E) Municipality Size and MDB/MPHP Suitability |
| 22. Use of MDB/MPHP in collaborating with other municipalities | F) Municipal Roles and Leadership |
| 23. One-sided focus on red and green lights | I) MDB/MPHP Indicators and Policy |
| 24. Adding reasons for inclusion of indicator/MPHP midsection subjects | B) MDB/MPHP Indicator Wishlist |
| 24. Adding reasons for inclusion of indicator/MPHP midsection subjects | C) MPHP Midsection Wishlist |
| 24. Adding reasons for inclusion of indicator/MPHP midsection subjects | H) NIPH Actions Wishlist |
| 25. Adding indicators for kindergarten/school indoor environment | B) MDB/MPHP Indicator Wishlist |
| 26. Ensuring that indicators correspond with the NDH handbook | B) MDB/MPHP Indicator Wishlist |
| 26. Ensuring that indicators correspond with the NDH handbook | G) Central Health Authority Roles (and leadership) |
| 26. Ensuring that indicators correspond with the NDH handbook | H) NIPH Actions Wishlist |
| 27. Adding indicators from school nurses | B) MDB/MPHP Indicator Wishlist |
| 28. Working with and consulting central health authorities | G) Central Health Authority Roles (and leadership) |
| 29. Providing NIPH support with analysis/interpretation | D) Municipality Present Use of MDB/MPHP |
| 29. Providing NIPH support with analysis/interpretation | H) NIPH Actions Wishlist |
| 30. Lacking a public health coordinator in municipality | F) Municipal Roles and Leadership |
| 31. Working with municipal politicians | F) Municipal Roles and Leadership |
| 31. Working with municipal politicians | I) MDB/MPHP Indicators and Policy |
| 32. Showing more than one indicator at a time | A) MDB Functionality Wishlist |
| 33. Adding indicators from Ungdata | B) MDB/MPHP Indicator Wishlist |
| 34. Adding indicators for education level of people who move into and out of the municipality | B) MDB/MPHP Indicator Wishlist |
| 35. Adding indicators from local municipal surveys | B) MDB/MPHP Indicator Wishlist |
| 35. Adding indicators from local municipal surveys | E) Municipality Size and MDB/MPHP Suitability |
| 36. Prioritizing within municipal public health | I) MDB/MPHP Indicators and Policy |
| 37. Offering regular online trainings/video lectures | H) NIPH Actions Wishlist |
| 38. Using MDB/MPHP for evaluations of municipal activities | D) Municipality Present Use of MDB/MPHP |
| 39. Using MPHPs/MPH for training within the municipality | D) Municipality Present Use of MDB/MPHP |
| 40. External media use of the MDB/MPHP toolsets | D) Municipality Present Use of MDB/MPHP |
| 41. Planning municipal work; mapping/measurements | D) Municipality Present Use of MDB/MPHP |
| 42. Add indicators/MPHP midsection on social inequalities in health | C) MPHP Midsection Wishlist |
| 43. Large municipalities want more data to be made | E) Municipality Size and MDB/MPHP Suitability |

| | |
|---|---|
| available | |
| 44. User friendliness of select all/remove all | A) MDB Functionality Wishlist |
| 45. Adding more age groups | B) MDB/MPHP Indicator Wishlist |
| 45. Adding more age groups | E) Municipality Size and MDB/MPHP Suitability |
| 46. Location of the indicator descriptions | A) MDB Functionality Wishlist |
| 47. Taking no interest in the MPHPs because of munipality size. Only MDB gives relevant information | E) Municipality Size and MDB/MPHP Suitability |
| 48. Providing a MPHP midsection on young people, stress and substance abuse | C) MPHP Midsection Wishlist |
| 49. Adding indicators for sick leave | B) MDB/MPHP Indicator Wishlist |
| 50. Adding indicators for overweight in children | B) MDB/MPHP Indicator Wishlist |
| 51. Adding indicators for purchasing power | B) MDB/MPHP Indicator Wishlist |
| 52. Adding indicators/MPHP midsection for smoking/snus | B) MDB/MPHP Indicator Wishlist |
| 53. Adding indicators/MPHP midsection for smoking/snus | C) MPHP Midsection Wishlist |
| 53. Adding indicators for fertility | B) MDB/MPHP Indicator Wishlist |
| 54. Supporting multicultural municipalities (not used in report) | J) Other issues |
| 55. Adding indicators for sick leave for mental distress | B) MDB/MPHP Indicator Wishlist |
| 56. Adding indicators for bathing water quality | B) MDB/MPHP Indicator Wishlist |
| 57. Adding indicators for possibility of outdoor exercise/distance to footpath | B) MDB/MPHP Indicator Wishlist |
| 58. Adding indicators for language testing in kindergarten/early schooling | B) MDB/MPHP Indicator Wishlist |
| 59. Adding indicators from health stations | B) MDB/MPHP Indicator Wishlist |
| 60. Adding indicators/MPHP midsection for substance abuse | B) MDB/MPHP Indicator Wishlist |
| 60. Adding indicators/MPHP midsection for substance abuse | C) MPHP Midsection Wishlist |
| 61. Praise for existing NIPH fact sheets (not used in report) | J) Other issues |
| 62. Adding indicators for overweight in adults | B) MDB/MPHP Indicator Wishlist |
| 63. Adding a new NIPH fact sheet for ISO-BMI (not used in report) | J) Other issues |

## Annex J. Theme List

| Theme Description | Code Description |
|---|---|
| A) MDB Functionality Wishlist | 11. User friendliness of the map function |
| A) MDB Functionality Wishlist | 16. Not having to use the plus sign to expand the indicator list |
| A) MDB Functionality Wishlist | 17. User friendliness of showing name and values on the map |
| A) MDB Functionality Wishlist | 18. Not having to select «Show table» after every change in the pop-up screen |
| A) MDB Functionality Wishlist | 32. Showing more than one indicator at a time |
| A) MDB Functionality Wishlist | 44. User friendliness of select all/remove all |
| A) MDB Functionality Wishlist | 46. Location of the indicator descriptions |
| B) MDB/MPHP Indicator Wishlist | 12. Using a positive slant on more indicators |
| B) MDB/MPHP Indicator Wishlist | 13. Adding indicators on health promotion |
| B) MDB/MPHP Indicator Wishlist | 24. Adding reasons for inclusion of indicator/MPHP midsection subjects |
| B) MDB/MPHP Indicator Wishlist | 25. Adding indicators for kindergarten/school indoor environment |
| B) MDB/MPHP Indicator Wishlist | 26. Ensuring that indicators correspond with the NDH handbook |
| B) MDB/MPHP Indicator Wishlist | 27. Adding indicators from school nurses |
| B) MDB/MPHP Indicator Wishlist | 33. Adding indicators from Ungdata |
| B) MDB/MPHP Indicator Wishlist | 34. Adding indicators for education level of people who move into and out of the municipality |
| B) MDB/MPHP Indicator Wishlist | 35. Adding indicators from local municipal surveys |
| B) MDB/MPHP Indicator Wishlist | 45. Adding more age groups |
| B) MDB/MPHP Indicator Wishlist | 49. Adding indicators for sick leave |
| B) MDB/MPHP Indicator Wishlist | 50. Adding indicators for overweight in children |
| B) MDB/MPHP Indicator Wishlist | 51. Adding indicators for purchasing power |
| B) MDB/MPHP Indicator Wishlist | 52. Adding indicators/MPHP midsection for smoking/snus |
| B) MDB/MPHP Indicator Wishlist | 53. Adding indicators for fertility |
| B) MDB/MPHP Indicator Wishlist | 55. Adding indicators for sick leave for mental distress |
| B) MDB/MPHP Indicator Wishlist | 56. Adding indicators for bathing water quality |
| B) MDB/MPHP Indicator Wishlist | 57. Adding indicators for possibility of outdoor exercise/distance to footpath |
| B) MDB/MPHP Indicator Wishlist | 58. Adding indicators for language testing in kindergarten/early schooling |
| B) MDB/MPHP Indicator Wishlist | 59. Adding indicators from health stations |
| B) MDB/MPHP Indicator Wishlist | 60. Adding indicators/MPHP midsection for substance abuse |
| B) MDB/MPHP Indicator Wishlist | 62. Adding indicators for overweight in adults |
| C) MPHP Midsection Wishlist | 05. No interest in the MPHP midsection |

| | |
|---|---|
| C) MPHP Midsection Wishlist | 12. Using a positive slant on more indicators |
| C) MPHP Midsection Wishlist | 13. Adding indicators on health promotion |
| C) MPHP Midsection Wishlist | 14. Providing a MPHP midsection on mental health |
| C) MPHP Midsection Wishlist | 24. Adding reasons for inclusion of indicator/MPHP midsection subjects |
| C) MPHP Midsection Wishlist | 42. Add indicators/MPHP midsection on social inequalities in health |
| C) MPHP Midsection Wishlist | 48. Providing a MPHP midsection on young people, stress and substance abuse |
| C) MPHP Midsection Wishlist | 53. Adding indicators/MPHP midsection for smoking/snus |
| C) MPHP Midsection Wishlist | 60. Adding indicators/MPHP midsection for substance abuse |
| D) Municipality Present Use of MDB/MPHP | 03. The municipality has little/no experience using the MDB |
| D) Municipality Present Use of MDB/MPHP | 07. Offering regular physical training courses |
| D) Municipality Present Use of MDB/MPHP | 08. The municipality needs/all municipalities need to have more MDB users |
| D) Municipality Present Use of MDB/MPHP | 09. Need for practical information about interventions and priorities |
| D) Municipality Present Use of MDB/MPHP | 21. Use of MDB/MPHP in multisectorial municipal working groups |
| D) Municipality Present Use of MDB/MPHP | 21. Use of MDB/MPHP in multisectorial municipal working groups |
| D) Municipality Present Use of MDB/MPHP | 29. Providing NIPH support with analysis/interpretation |
| D) Municipality Present Use of MDB/MPHP | 38. Using MDB/MPHP for evaluations of municipal activities |
| D) Municipality Present Use of MDB/MPHP | 39. Using MPHPs/MPH for training within the municipality |
| D) Municipality Present Use of MDB/MPHP | 40. External media use of the MDB/MPHP toolsets |
| D) Municipality Present Use of MDB/MPHP | 41. Planning municipal work; mapping/measurements |
| E) Municipality Size and MDB/MPHP Suitability | 01. Differences within municipalities are not covered |
| E) Municipality Size and MDB/MPHP Suitability | 19. Potential municipal mergers |
| E) Municipality Size and MDB/MPHP Suitability | 22. Use of MDB/MPHP in collaborating with other municipalities |
| E) Municipality Size and MDB/MPHP Suitability | 35. Adding indicators from local municipal surveys |
| E) Municipality Size and MDB/MPHP Suitability | 43. Large municipalities want more data to be made available |
| E) Municipality Size and MDB/MPHP Suitability | 45. Adding more age groups |
| E) Municipality Size and MDB/MPHP Suitability | 47. Taking no interest in the MPHPs because of munipality size. Only MDB gives relevant information |
| F) Municipal Roles and Leadership | 04. Interacting with legal frameworks |
| F) Municipal Roles and Leadership | 07. Offering regular physical training courses |
| F) Municipal Roles and Leadership | 15. Discussing the role of the Chief Municipal Officer |
| F) Municipal Roles and Leadership | 20. Being frustrated over own municipal role/position |

| | |
|---|---|
| F) Municipal Roles and Leadership | 21. Use of MDB/MPHP in multisectorial municipal working groups |
| F) Municipal Roles and Leadership | 22. Use of MDB/MPHP in collaborating with other municipalities |
| F) Municipal Roles and Leadership | 30. Lacking a public health coordinator in municipality |
| F) Municipal Roles and Leadership | 31. Working with municipal politicians |
| G) Central Health Authority Roles (and leadership) | 28. Working with and consulting central health authorities |
| G) Central Health Authority Roles (and leadership) | 26. Ensuring that indicators correspond with the NDH handbook |
| H) NIPH Actions Wishlist | 07. Offering regular physical training courses |
| H) NIPH Actions Wishlist | 10. Making better use of NIPH e-mail communication to municipalities |
| H) NIPH Actions Wishlist | 24. Adding reasons for inclusion of indicator/MPHP midsection subjects |
| H) NIPH Actions Wishlist | 26. Ensuring that indicators correspond with the NDH handbook |
| H) NIPH Actions Wishlist | 29. Providing NIPH support with analysis/interpretation |
| H) NIPH Actions Wishlist | 37. Offering regular online trainings/video lectures |
| I) MDB/MPHP Indicators and Policy | 02. Presence of indicators in the MPHPs rules what the municipalities notice or measure |
| I) MDB/MPHP Indicators and Policy | 04. Interacting with legal frameworks |
| I) MDB/MPHP Indicators and Policy | 06. Discussions about specific problematic indicators |
| I) MDB/MPHP Indicators and Policy | 07. Offering regular physical training courses |
| I) MDB/MPHP Indicators and Policy | 23. One-sided focus on red and green lights |
| I) MDB/MPHP Indicators and Policy | 31. Working with municipal politicians |
| I) MDB/MPHP Indicators and Policy | 36. Prioritizing within municipal public health |
| J) Other issues | 54. Supporting multicultural municipalities (not used in report) |
| J) Other issues | 61. Praise for existing NIPH fact sheets (not used in report) |
| J) Other issues | 63. Adding a new NIPH fact sheet for ISO-BMI (not used in report) |

## Annex K. Recommendations

Hoping to reach what Silverman (2013, p 436) describes as the policy-making audience, clear recommendations are crucial. I want to stress that these are derived from the (prospective) users of the MPHPs and the MDB in a bottom-up manner.

The following discussion comes from Urbankommune, where M wanted the NIPH to construct a new indicator. It illustrates how many of these recommendations arose (lines 522-537, abbreviated):

(The interviewer, I, demonstrates population figures in the MDB)

> *M … it will not tell me much about fertility, will it? ... Because that's a more complicated concept. Compared to the numbers that are here* [in the MDB]*, namely the population of working age compared to people who are over retirement age, right, and* [we could] *compare them.*
>
> *M ...* [we] *should be working towards increasing fertility, and when one thinks nationally as well, should something be done about it? That's a bit interesting when we demonstrate why it's OK having immigrants* (laughs)*. Which is something that not everyone thinks ...* (laughs)
>
> *I: That should be fairly straight forward. I'll take that* [idea] *with me.*
>
> *M Yes, and it is a complex indicator, so it is fine that someone does the job.*

In writing this chapter, I am split between the desire to present the wish lists of my informants and presenting what I think the municipalities actually need. If I'm to do the first, to which degree should I evaluate, or even censor, their wishes?

I have decided to present, but annotate, the wishes of my informants, and to a certain degree allow the Themes I constructed in the Results chapter to order my thoughts. The code numbers from the first coding exercise are maintained for ease of reference.

39 of the 63 codes led to recommendations, which are listed in this annex.

## 1.1. Theme A: MDB Functionality Wishlist

| **Code 11. User friendliness of the map function** |
|---|
| **Recommendation:** Make the map button more visible. |

This was, overwhelmingly, the greatest technical challenge. The small globe on the menu line signifying "Map" was terribly difficult to find, and even practised users had no idea where to look. It needs to be made more visible.

| **Code 17. User friendliness of showing name and values on the map** |
|---|
| **Recommendation:** Increase reliability of this function. |

For the majority of users, this function did not work. Work is needed on the IT side to make it work on all browser platforms.

| **Code 18. Not having to select «Show table» after every change in the pop-up screen** |
|---|
| **Recommendation:** Ask IT specialist if this is necessary for the system to function, and if there are alternative solutions. |

| **Code 32. Showing more than one indicator at a time** |
|---|
| **Recommendation:** Show multiple indicators. |

Some users who had been working in the field for a long time remembered this function from NorHealth, where one could show two different indicators with the same denominator on the same graph. This was something they missed and would like to have re-instated.

## 1.2. Theme B: MDB/MDPH Indicator Wishlist

| **Code 13. Adding more indicators on health promotion** |
|---|
| **Recommendation:** Find more positive indicators on health promotion. |

| **Code 25. Adding indicators for kindergarten/school indoor environment** |
|---|
| **Recommendation:** Today this is collected by around 70% of all municipalities. Start publishing these indicators, and more municipalities will start collecting and reporting. |

| **Code 27. Adding indicators from school nurses** |
|---|
| **Recommendation:** School nurses collect large amounts of data for municipal data servers. Find or compute good indicators. |

| **Code 33. Adding indicators from Ungdata** |
|---|
| **Recommendation:** Today most municipalities take part in these surveys. Start publishing these indicators, and more municipalities will take part. |

| **Code 34. Adding indicators for education level of people who move into and out of the municipality** |
| --- |
| **Recommendation:** Requires data linkages, but might be a feasible indicator. |
| **Code 45. Adding more age groups** |
| **Recommendation:** When possible, add more age groups, at least for larger municipalities. |

| **Code 51. Adding indicators for purchasing power** |
| --- |
| **Recommendation:** Find good indicators for this. |

| **Code 50. Adding indicators for overweight in children** |
| --- |
| **Recommendation:** Use the Barnevekst study to publish data where this is available. Data from school nurses may also be useful here. |

| **Code 52. Adding indicators/MPHP midsection for smoking/snus** |
| --- |
| **Recommendation:** Find a way to include an indicator on this, possibly from school surveys. |

| **Code 53. Adding indicators for fertility** |
| --- |
| **Recommendation:** Publish an indicator at municipal level. |

| **Code 55. Adding indicators for sick leave for mental distress** |
| --- |
| **Recommendation:** When possible, publish this indicator in the MDB. |

| **Code 56. Adding indicators for bathing water quality** |
| --- |
| **Recommendation:** This indicator is published for many bathing areas, and could be included in the MDB if it can be calculated for the relevant municipalities. |

| **Code 57. Adding indicators for possibility of outdoor exercise/distance to footpath** |
| --- |
| **Recommendation:** Such an indicator is already collected in many municipalities. Find a way to include it in the MDB, and more municipalities will start collecting it. |

| **Code 58. Adding indicators for language testing in kindergarten/early schooling** |
| --- |
| **Recommendation:** Results from these tests are currently collected. Find a way to make good indicators. |

| **Code 60. Adding indicators/MPHP midsection for substance abuse** |
| --- |
| **Recommendation:** Find feasible indicators. |

| **Code 62. Adding indicators for overweight in adults** |
| --- |
| **Recommendation:** Look for ways to include an indicator on overweight, at least at county level. |

## 1.3. Theme C: MPHP Midsection Wishlist

| **Code 13. Adding more indicators on health promotion** |
|---|
| **Recommendation:** Find a way to include more about health promotion within all fields of Public Health. |

| **Code 14. Providing a MPHP midsection on mental health** |
|---|
| **Recommendation:** This topic is growing in importance, and a midsection dealing with mental health would be an important policy signal. |

| **Code 24. Adding reasons for inclusion of indicator/MPHP midsection subjects** |
|---|
| **Recommendation:** Write explicitly why specific topics are included. This is needed because municipal public health officials need such arguments to influence their politicians on which interventions and other measures should be prioritised and what they should involve. |

For code 24, H in Kystby agrees (lines 181-183 ):

> *Yes, it is educating the general public. Why is it important? Because when we "preach" about education and why we should work on this, it's not always so easy to justify. And then of course we have these hideous graphs showing the numbers ... like life expectancy ... and ...*[tapers off]

| **Code 42. Add indicators/MPHP midsection on social inequalities in health** |
|---|
| **Recommendation:** Ensure this this topic is regularly covered. |

| **Code 52. Adding indicators/MPHP midsection for smoking/snus** |
|---|
| **Recommendation:** Tobacco use remains an important health determinant, and snus use is growing. The municipalities need more information in these fields. |

| **Code 60. Adding indicators/MPHP midsection for substance abuse** |
|---|
| **Recommendation:** Ensure this topic is regularly covered. |

## 1.4. Theme D: Municipal Use of MDB/MPHP

This theme is descriptive of what the informants do today and did not generate any recommendations.

## 1.5. Theme E: Municipality Size and MDB/MPHP Suitability

| **Code 01. Differences within municipalities are not covered** |
|---|
| **Recommendation:** Strengthen and speed up ongoing work to add data at lower geographical levesl; consider doing this for all municipalities above a certain size, not just biggest cities. |

| **Code 43. Large municipalities want more data to be made available** |
|---|
| **Recommendation:** Work with the bigger municipalities to add extra datasets. |

## 1.6. Theme F: Municipal Roles and Leadership

This theme mainly describes what the municipal informants do today and did not generate any direct recommendations. (The NIPH could make recommendations for how the municipalities should irganise their inner workings in this area, but that would be beyond the scope of this report.)

## 1.7. Theme G: Central Health Authority Roles (and Leadership)

This highly political theme is how I sorted all descriptions and desires of national authorities interacting with municipal public health work. See codes 26 (Theme H) and 28 (Theme I).

## 1.8. Theme H: NIPH Actions Wishlist

| **Code 07. Offering regular physical training courses** |
|---|
| **Recommendation:** Organise courses at as many venues and in as many forms as possible. |

| **Code 10. Making better use of NIPH e-mail communication to municipalities** |
|---|
| **Recommendation:** Include information about the MPHPs and the MDB in more mailings. |

It is possible to subscribe to different NIPH newsletters, but MDB/MPHP tools are rarely/never mentioned. The mailings should have short instructions on how to use in particular the MDB, not just inform people that there is a new version available, and the regular mailings could also be used to reach different municipal roles.

Regarding code 10, S in Kystby comments (lines 474-477):

> *It arrives in the general municipal e-mail. And I guess there's some kind of regular distribution list. But I'm very uncertain of whether it reaches the Municipal Head of Education, and the Head of Education certainly doesn't know there are training courses, and that this might be something for them, to give an example.*

| **Code 26. Ensuring that indicators correspond with the NDH handbook** (Norwegian Directorate of Health 2013, pp19-21). |
|---|
| **Recommendation:** Ensure that the municipal public health workers know how these subject areas are covered by the MDB and the MPHPs. Consider discussing a revised version of the handbook with NDH to make it more in line with the intended users' expectations. |

| **Code 29. Providing NIPH support with analysis/interpretation** |
|---|
| **Recommendation:** Include links to analysis and other forms of interpretations when possible. |

| **Code 37. Put video lectures on the NIPH web pages** |
|---|
| **Recommendation:** Video lectures should be provided on NIPH's website. |

## 1.9. Theme I: MDB/MPHP Indicators and Policy

| **Code 02. Presence of indicators in the MPHPs rules what the municipalities notice or measure** |
|---|
| **Recommendation:** This implies that the NIPH must work with other authorities to ensure that the set of indicators selected are practical for prevention and health promotion, and that municipal political leaders must be trained in using health indicators for what they are. |

| **Code 04. Interacting with legal frameworks** |
|---|
| **Recommendation:** Include training on different frameworks in both video lectures and other training packages. |

| **Code 15. Discussing the role of the Chief Municipal Officer** |
|---|
| **Recommendation:** This is the person informants think the NIPH should attempt to communicate more with, to emphasize his/her role in public health. Training was also mentioned. Ways should be found to reach and engage these officials, to ensure they know and understand the important part they play. |

As stated by I in Fjordby (lines 245-251, abbreviated):

> *They have often their own networks, chief municipal officer networks. If you* [the NIPH] *are ever there and say something, and somehow showcase them as the most important public health people ... then maybe…*[it will] *help eventually (laughs). It's very different, many of us are located deep in an organization. And er... some might be ... I feel maybe not even that I am invisible, to the Chief Municipal Officer level, but many might almost be so, as public health coordinators. One is located so far down in an organization.*

| **Code 36. Prioritizing within municipal public health** |
| --- |
| **Recommendation: T**he 2014 Public Health Act moves more responsibility to the municipal level, leaving the municipalities with responsibilities for areas few of them are trained in, and where procedures, measurements, plans and targets are under rapid development. |

| **Code 28. Working with and consulting central health authorities** |
| --- |
| **Recommendation:** Encourage all relevant institutions to communicate more and better with the municipalities. Due to requirements in the new Public Health Act (NMHCS 2012), more contact points and information systems may need to be developed. |