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EUROPEAN SOCIAL CHARTER

22nd National Report on the implementation of
the European Social Charter

submitted by

THE GOVERNMENT OF ICELAND

(Articles 3, 12 and 13
for the period 01/01/2005 – 31/12/2007 ;
Articles 11 and 14
for the period 01/01/2003 – 31/12/2007)

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CYCLE XIX-2 (2009)

EUROPEAN SOCIAL CHARTER

22nd report on the implementation of the European Social Charter

Submitted by
THE GOVERNMENT OF ICELAND
Ministry of Social Affairs
(for the period 1st January 2005 to 31st December 2007)

REPORT

on the application of Articles 3, 11, 12, 13, 14 for the period 1st January 2005 to 31st December 2007 made by the Government of ICELAND in accordance with Article 21 of the European Social Charter and the decision of the Committee of the Ministers, taken at the 573rd meeting of Deputies concerning the system of submission of reports on the application of the European Social Charter.

Article 3
The right to safe and healthy working conditions

Article 3, para. 1 – Issue of safety and health regulation.

I. On land.

Act No. 46/1980 on Working Environment, Health and Safety in Workplaces, with subsequent amendments.

Act No. 46/1980 on Working Environment, Health and Safety in Workplaces was amended by Act No. 138/2005 which entered into force in December 2005. The Act stipulates that provisions on working hours, as provided for in Chapter IX of the Act, shall also apply to doctors undergoing occupational training. This Act was passed to implement Council Directive 2003/88/EC, concerning certain aspects of the organisation of working time, to which reference is made in item 32h of Annex XVIII to the Agreement on the European Economic Area, as amended by Decision of the EEA Joint Committee No. 45/2004, *cf.* also Council Directive 2000/34/EC, amending Council Directive 93/104/EC, concerning certain aspects of the organisation of working time, so as to make it cover the occupations and activities excluded by that directive. The provisions on maximum working hours, however, did not fully enter into force until 31 July 2009, as authorisations provided in the Directive for a transitional period were utilised. Thus the Act provided that the maximum working hours of doctors undergoing occupational training (interns) should not exceed 58 hours a week, on average, during each four-month period until 31 July 2007. During the period from 1 August 2007 to 31 July 2009, the maximum working hours of doctors undergoing occupational training (interns) was not to exceed 56 hours a week, on average during each four-month period. The Act shall be fully applicable to doctors undergoing occupational training as of 1 August 2009.

Regulation No. 430/2007 prohibiting the use of asbestos in workplaces.

The object of the Regulation is to prevent occupational illnesses that can be caused by breathing in asbestos dust. According to the Regulation, the use of asbestos in workplaces is prohibited. However, the Administration of Occupational Safety and Health in Iceland may grant permission for the demolition of buildings, parts of buildings, machines or other equipment containing asbestos. In the event of any doubt as to the presence of asbestos during demolition or other

work, an analysis shall be made of the material or equipment in question so that the appropriate actions may be taken if asbestos proves to be present.

The Regulation was passed to implement Council Directive 83/477/EEC, as amended by Council Directives 91/382/EEC and 2003/18/EEC, on the protection of workers from the risks related to exposure of asbestos at work.

Regulation No. 160/2007 on the control of major-accident hazards involving dangerous substances.
The object of the Regulation is to promote safety in workplaces, to prevent major accidents involving dangerous substances and to reduce their impact on people and the environment. The Regulation stipulates that operators who employ dangerous substances in significant quantities, specified in the Annex to the Regulation, must prepare a major-accident prevention schedule and ensure that such schedule is properly implemented. The major-accident prevention schedule established by the operator shall be designed to guarantee a high level of protection for people and the environment by appropriate means, including the preparation of management systems.

The Regulation was passed to implement Council Directive 96/82/EC of 9 December 1996 on the control of major-accident hazards involving dangerous substances and Directive 2003/105/EC of the European Parliament and of the Council of 16 December 2003 amending Council Directive 96/82/EC.

Regulation No. 922/2006 on the prevention of stress due to exposure to mechanical vibration in workplaces.
The object of the Regulation is to ensure safety and protect the health of workers who are at risk or may become at risk of suffering stress due to exposure to mechanical vibration in the course of their work.

The Regulation was passed to implement Council Directive 2002/44/EC on the minimum health and safety requirements regarding the exposure of workers to the risks arising from physical agents (vibration).

Regulation No. 921/2006 on the prevention of stress due to exposure to noise in workplaces.
The object of the Regulation is to ensure the safety and protect the health of workers who are at risk or may become at risk of suffering stress due to exposure to noise in the course of their work and, in particular, exposure that may lead to loss of hearing.

The Regulation was passed to implement Council Directive 2003/10/EC on the minimum health and safety requirements regarding the exposure of workers to the risks arising from physical agents (noise).

Regulation No. 920/2006 on the organisation and implementation of health and safety at workplaces.
The Regulation provides mainly for the obligation of employers to prepare a written schedule on health and safety in the workplace, i.e. describe and evaluate any hazards posed to the health and safety of their workers. Among other things, the schedule must contain a risk assessment and health protection schedule containing schedule for preventive measures. The substance of the

Regulation is discussed in greater detail in the discussion in the second paragraph of Article 3 of this report.

Regulation No. 367/2006 on the use of equipment.
The object of the Regulation is to ensure the safety and protect the health of workers when they use equipment in the workplace. According to the Regulation, the employer shall inter alia ensure that employees receive the necessary education and training to perform their work in a manner that does not entail risk. Employees shall, among other things, receive training in how to react to any risks that the use of equipment may pose.

The Regulation was passed to implement Council Directive 89/655/EEC concerning the minimum safety and health requirements for the use of work equipment by workers at work, Directive 95/63/EC amending Directive 89/655/EEC concerning the minimum safety and health requirements for the use of work equipment by workers at work and Directive 2001/45/EC amending Directive 89/688/EEC concerning the minimum safety and health requirements for the use of work equipment by workers at work.

Regulation No. 384/2005 on working in refrigerated areas in food production.
The Regulation applies to work in refrigerated areas where foodstuffs are manufactured and where work must be carried out at temperatures below 16°C for health reasons relating to the manufacture of the goods. The object of the Regulation is to ensure the safety and protect the health of employees who work in refrigerated areas in foodstuffs manufacture. According to the Regulation, the employer is under obligation to ensure the use of manufacturing, working and processing methods that ensure that employees do not suffer health problems due to low temperatures in the performance of their work.

II. At sea.
Regulation No. 200/2007 on measures to encourage improvements in the safety and health of workers on vessels.
According to the Regulation, the employer must have a risk assessment of safety and health in the workplace, together with the risks to which particular groups of employees may be exposed. The employer must decide what preventive measures must be employed and, if necessary, what protective equipment must be used. The employer must maintain a record of any occupational accidents causing an employee to be absent from work for longer than three working days. Moreover, he or she must prepare a report on any occupational accidents that his or her employees suffer and deliver such report to the Icelandic Maritime Accident Investigation Board (IMAIB).

The Regulation was passed to implement Directive 89/391/EEC on the introduction of measures to encourage improvements in the safety and health of workers at work as well as other Directives issued by the EU which also apply to the health and safety of seafarers.

III. In the air.
No new regulations have been passed in the field of the health and safety of aircraft crew. As a result, reference is made to the previous report issued by Icelandic authorities.

Article 3, para. 2 – Provision for the enforcement of safety and health regulations by measures of supervision.

In 2006, Regulation No. 920/2006 on the organisation and implementation of health and safety at workplaces was passed. The Regulation was passed to supplement Chapter XI of Act No. 46/1980 on Working Environment, Health and Safety in Workplaces, with subsequent amendments. The object of the Regulation is to establish systematic health and safety efforts in workplaces and to ensure effective preventive measures that promote the health, safety and well-being of employees in the workplace.

According to the Regulation, establishments are under obligation to prepare a written schedule on health and safety in the workplace. This means, among other things, that employers are responsible for preparing a written risk assessment for the workplaces in their establishments. The risk assessment involves describing and evaluating the risks posed to the health and safety of any employees who may be present in the workplace. Moreover, they are to prepare a health protection schedule containing, among other things, plans for preventive measures against the risks found in the risk assessment to reduce the incidence of occupational illnesses and accidents.

Holding presentations on health and safety efforts was Administration of Occupational Safety and Health's main task in 2007. At the same time, presentations on the methods used in risk assessment were held in a large number of establishments and at Administration of Occupational Safety and Health's courses for workers' safety representatives and safety managers. In addition, many entities have sought information on these matters from Administration of Occupational Safety and Health. There was considerable demand for courses on the preparation of risk assessments. Fourteen courses were held in various parts of Iceland.

Furthermore, Administration of Occupational Safety and Health inspectors spent a great deal of effort promoting risk assessments during their inspection tours to workplaces. They also followed up on the implementation of the Regulation. Approximately 20% of all issued instructions and recommendations to establishments during the year involved the preparation of risk assessments and schedule for preventive measures.

Table 1. Number of courses and participants in courses for workers' safety representatives and safety managers.

Year	Number of courses	Number of participants
2006	16	296
2005	18	279

Source: Administration of Occupational Safety and Health

In 2007, 19 courses were held for workers' safety representatives and safety managers.

Table 2. Courses held for workers' safety representatives and safety managers.

Certification courses	**2005**		**2006**		**2007**	
Machine operation courses	**Course**	**Particip.**	**Course**	**Particip.**	**Course**	**Particip.**
Machine operation	52	949	59	1173	60	1205
Construction crane operation	5	66	6	95	6	91
Other courses	6	95	17	271	60	1045
Total	**63**	**1,110**	**82**	**1,539**	**126**	**2,341**
ADR course[1)]						
Basic course	7	93	9	112	10	117
Cont. education	3	36	6	85	9	76
Advanced course	12	92	14	118	11	96
Cont. edu. for advanced course	6	41	11	94	15	90
Total	**28**	**262**	**40**	**409**	**45**	**379**

Source: Administration of Occupational Safety and Health

1) ADR courses are for those who transport hazardous cargo. Courses for such persons are held on a regular basis. These consist of basic courses (providing certification to transport piece goods, although not explosive or radioactive substances) and advanced and continuing education courses. ADR certificates are valid for 5 years.

Establishment inspections – Adapted inspections.

In the autumn of 2007, work began on implementing a new method of inspection, i.e. adapted inspection. This method is used for establishments employing 30 employees or more. The inspector notifies the establishment of his/her intention to inspect the establishment. This is done to ensure that the inspector can meet with the key parties responsible for the establishment's health and safety efforts. At the beginning of the inspection, the inspector meets with the manager and safety committee. Together, they systematically review the arrangement of health and safety efforts in the establishment. One of the basic issues examined is whether a written schedule has been prepared on safety and health together with a risk assessment and schedule for preventive measures. It is also examined whether the establishment has workers' safety representatives and safety managers and whether such persons have received the requisite health and safety training. Inspectors also examine employees′ working conditions according to the working environment checklist for the profession in question.

General establishment inspections.

According to the records of Statistics Iceland, there were 50,316 establishments registered in Iceland in 2005. By the year 2006, this number had risen to 52,994, and in 2007, the number of registered establishments in Iceland was 55,719. It should be noted that not all registered establishments are in operation.

The frequency of inspection visits to an establishment depends to some extent to the risk assumed to be present in the workplace. Other aspects such as employee complaints, accidents and mishaps, initiative projects in sectors, risk aspects receiving particular focus in inspections each year or follow-ups on the implementation of new regulations also have an impact on what workplaces are examined.

Table 3. Registered establishments according to risk categories.

	2005	**2006**	**2007**
Category 1, annual inspection	2,709	2,461	2,388
Category 2, inspection every two years	3,030	3,146	3,261
Category 3, inspection every four years	2,093	2,451	2,565
Category 4, irregular inspections	6,588	6,906	7,154
Total	**14,420**	**14,964**	**15,368**

Source: Administration of Occupational Safety and Health

In 2005, Administration of Occupational Safety and Health implemented the use of sector-based working environment checklists. Working environment checklists are a part of Administration of Occupational Safety and Health's quality handbook and are intended to promote harmonised working practises in establishment inspections. The working environment checklists throw a light on the principal problems which can be expected to arise in the sector in question, and specify applicable acts of law, regulations and criteria used as a basis.

Workplaces are examined according to sector-based working environment checklists. This is done, as previously stated, to ensure comprehensive and standardised inspections. Experience has shown that these are useful to many establishments in their own health and safety efforts, e.g. in the preparation of risk assessments. In 2006, all working environment checklists were updated in tune with amendments to the regulatory framework. Working environment checklists have been prepared for a total of 27 sectors. These are listed in Table 4.

Table 4. Working environment checklists for sectors in 2009.

1. Automobile workshops
2. Construction industry
3. Slipways, ship lifts and floating docks
4. Chemical and pharmaceutical industries
5. Fish meal factories
6. Fish, prawn and salt fish processing plants
7. Hairdressing and beauty salons
8. Tunnelling operations
9. Agriculture
10. Agriculture – checklist for tractors and agricultural machinery
11. Nursery schools
12. Police, ambulance personnel and fire brigades
13. Grocery stores
14. Metal-working
15. Metallurgic operations
16. Power plants and transmission systems
17. Printing industry
18. Cleaning services
19. Schools
20. Offices
21. Slaughterhouses and meat processing establishments
22. Carpentry shops
23. Care work
24. Restaurants and cafeterias
25. Goods transport – distribution and warehouses
26. Laundries and dry cleaners
27. Diverse food industries

Source: Administration of Occupational Safety and Health

Inspectors of establishments within the Administration of Occupational Safety and Health fall into eight regional inspection area groupings, the largest of which is in Reykjavík. The number of inspectors in each area depends on the size of the area and the number of establishments located there. In 2005, there were 15 inspectors in Reykjavík and 18 inspectors outside Reykjavík. In 2007, there were 21 inspectors working outside Reykjavík and 16 within the city. By the end of 2007, there were seven inspectors working in Administration of Occupational Safety and Health's industrial machines department, together with a department manager.

Table 5. Inspection visits to establishments.

Establishment inspections – number and type	**2005**	**2006**	**2007**
Regular inspections	2,179	2,312	2,284
Partial inspections	946	936	983
Regular re-inspections	226	92	115
Re-inspections following on from partial inspections	12	2	6
Inspections, total	**3,363**	**3,342**	**3,388**
Other visits to establishments	810	590	570
Visits to establishments, total	**4,173**	**3,932**	**3,958**
Measurements and tests performed	633	547	393
Noise measurements (included in the figure above)	229	103	95
Call-outs due to accidents	228	225	289

Source: Administration of Occupational Safety and Health

Once Administration of Occupational Safety and Health has completed its visit, a report is prepared describing conditions and issuing instructions on what improvements should be made, making reference to acts of law, rules and regulations. The report is in writing and is delivered to the establishment. There are, however, exceptions in the case of acute problems that must be addressed without delay. Administration of Occupational Safety and Health has increasingly focused on following-up on its instructions. If notifications are not received from establishments within the deadline given to make the improvement, written reminders are sent which lead to reassessment and enforcement measures if a reply is not received from the establishment in question. Administration of Occupational Safety and Health also visits the place to investigate whether the improvements have been made if it considers such a visit necessary.

Table 6. Measures taken by Administration of Occupational Safety and Health due to non-compliance in establishments.

Establishment inspection	**2005**	**2006**	**2007**
Instructions and recommendations made following inspection			
Instructions on improved health standards	1,382	1,611	1,370
Instructions on improved safety standards	2,554	2,510	3,040
Instructions on improvements to facilities	715	625	531
Instructions on health and safety efforts	373	407	1,051
Other instructions	5	11	26
Instructions issued, total	**5,026**	**5,164**	**6,018**
Recommendations on improved health standards	733	569	612
Recommendations on improved safety measures	516	679	643
Recommendations improved facilities	177	140	87
Recommendations for health and safety efforts	289	688	518
Other recommendations	3	41	14
Recommendations, total	**1,714**	**2,117**	**1,874**
Instructions and recommendations, total	**6,740**	**7,281**	**7,892**
Use prohibited	21	85	119
Premises/equipment sealed	0	0	0
Per diem fines imposed	1	0	0
Total measures to achieve compliance	**22**	**85**	**119**

Source: Administration of Occupational Safety and Health

Instructions issued after establishment inspections increased by just under 17% between 2006 and 2007. Instructions relating to safety were over half of all issued instructions in 2007, increasing by 21% from 2006. Considerable efforts were spent on inspections in the construction industry, with a greater number of inspectors carrying out construction inspections than previously. This can be traced to the increased scope in this field in 2007. Proportionately, the increase was greatest in instructions relating to health and safety efforts, which increased by approximately 650 from 2006, when instructions for health and safety efforts were 407, i.e. instructions issued in 2007 numbered 1051, which is an increase of 150% between years. Of greatest consequence are instructions to establishments for the preparation of risk assessments and schedule for preventive measures.

Administration of Occupational Safety and Health's enforcement measures increased in number by 40% in 2007 when compared with 2006. This may in part be traced to increased focus on inspection and follow-up in the construction and civil engineering sector, where the majority of accidents occurred.

In 2007, four cases were reported to the police due to violations of the Regulation on the employment of children and young people.

Table 7. Safety and health categorised according to inspection issues in 2005–2007.

	Number of instructions			**Number of recommendations**		
Health and safety inspection issues	**2005**	**2006**	**2007**	**2005**	**2006**	**2007**
Work space	240	220	173	152	88	94
Air quality inside	396	337	252	151	136	153
Chemicals and chemical effects	366	624	601	193	202	236
Carcinogenic substances	3	5	4	0	2	1
Biological risk agents	3	2	9	1	2	6
Lighting	134	134	40	30	24	37
Noise	46	64	119	175	44	19
Workstations – physical strain / ergonomics	171	199	157	20	27	50
Psychosocial working environment	23	26	15	11	10	16
Total	**1,382**	**1,611**	**1,370**	**733**	**535**	**612**

Source: Administration of Occupational Safety and Health

Table 7 shows the division of inspection issues that fall under health and safety. In 2007, instructions and recommendations relating to health and safety were most common in the field of chemicals and chemical effects. Moreover, there was a considerable increase in instructions relating to noise and noise prevention between 2006 and 2007.

Administration of Occupational Safety and Health's initiative projects.

Year 2005

A targeted occupational safety campaign is mounted every year. The focus in 2005 was on noise in the workplace, an issue addressed by the European Week for Safety and Health at Work that year. The goal of the Week for Safety and Health at Work was to draw attention to the consequences of noise in the workplace and to encourage establishments to reduce noise and to employ active noise prevention. A large number of articles were published in newspapers to draw attention to noise in the workplace and its possible harmful effects. Among other things, articles were written on the sound design of workplaces, the hearing loss of musicians, tinnitus, ear protectors, risk assessment, hearing loss, etc. Administration of Occupational Safety and Health created a separate website[1] dedicated to noise, where some of the above articles can be found, as can diverse information on noise in the workplace and its consequences. During the Week for Safety and Health at Work itself, Administration of Occupational Safety and Health inspectors visited workplaces for the purpose of drawing particular attention to the possible harmful effects of noise in the workplace. The inspectors met with establishment managers and employees, delivered documentation on the effects of noise and measured noise levels.

In October and November 2005, a survey of personal protection equipment was carried out in co-operation with the Consumer Agency. Shops and wholesalers were visited during the survey, and attention was directed to disposable dust masks. Sixteen establishments were visited, and 58 different types of dust masks were examined. The survey was carried out taking the ÍST EN 149-2001 standard into account. An examination was made of whether the dust masks available met the main requirements stated in rules on personal protection equipment. A leaflet about the project and its object was delivered to the sales outlets in question. The results were that only seven types of dust masks met the standard's requirements in full. CE markings were lacking in 16% of cases, the sell by date was missing in 21% of cases, there were no Icelandic instructions in 85% of cases and EU conformity specifications were missing in 74% of cases. Administration of Occupational Safety and Health and the Consumer Agency took the appropriate restraining measures for the purpose of getting sales entities to arrange matters in accordance with laws and regulations applicable to dust masks.

In 2005 saw the completion of the collaborative project on risk assessment which began in 2003 between Administration of Occupational Safety and Health and establishments in various parts of Iceland. Its goal was to present new legislative provisions that obligate establishments to prepare a written schedule for safety and health. Moreover, the goal was to have specific establishments in all parts of Iceland prepare a risk assessment to allow the establishments and the employees of Administration of Occupational Safety and Health to gain experience in this field.

Administration of Occupational Safety and Health provided a method entitled *Six steps in the preparation of a risk assessment* which provides good guidance in the preparation of a risk assessment. Four meetings were held at each part of Iceland, once a month, over the period between January and April 2005, with the representatives of the establishments. The status was examined every four weeks when the establishments reported on their progress, and discussions were held on various aspects in the risk assessment preparation. The opportunity arose to monitor the manner in which risk assessments are prepared in the actual working environment, where

[1] vinnueftirlit.is/havadi

time and money are often limited. In the opinion of Administration of Occupational Safety and Health, valuable experience and knowledge was gained from this process.

Year 2006

The European Week for Safety and Health at Work in 2006 was dedicated to young people in the labour market, aged 25 and younger, and was entitled *Safe Start* (*Örugg frá upphafi)*. The goal of the European Week for Safety and Health at Work was first to increase young people's awareness of health and safety and to promote their "safety" from the very beginning of their working life. The use of the term "safe" refers to safety issues as well as to confidence and well-being at work. Second, the goal was to raise awareness in society as regards the rights, obligations and special position of young people in the labour market. Furthermore, an inspection effort was mounted as regards grocery stores and fast food outlets in the greater Reykjavík area in the summer of 2006. Information was obtained about the age, tasks and working hours of young people. The results showed that in 14% of cases, staff operating cash drawers were younger than 15 and had not, therefore, reached an age to be permitted to carry out such work. Administration of Occupational Safety and Health took the appropriate steps to ensure that this did not happen again.

In the autumn of 2006, posters were published containing messages directed at young people. Also published were two leaflets, one for young people and the other for employers. The leaflets focused on the rights, obligations, risks, preventive measures and the well-being of new recruits at work. The Week for Safety and Health at Work was held on 22–27 October 2006. During that week, Administration of Occupational Safety and Health inspectors visited workplaces and distributed various informative and educational material.

In 2005, the decision was made to launch a health and safety initiative in primary schools to be implemented during the 2005–2006 school year. The goal of the project was to inform primary school supervisors of their duties as regards health and safety in schools, to encourage them to establish active internal health and safety efforts and to help them to get started. The initiative was divided into two parts: an information initiative and a supervisory initiative. In the information initiative, a website on the school environment was created, checklists were prepared, articles written, etc. The supervisory initiative performed in February and March in 2006 involved the normal visit of inspectors to the majority of primary schools in Iceland. In these visits, requirements were made for the election of workers' safety representatives and the appointment of a safety manager and, moreover, that these parties attend a course on health and safety in the workplace.

In 2006, a separate supervisory and information initiative was implemented in the EU directed at work with asbestos and its treatment. Administration of Occupational Safety and Health was responsible for the initiative in Iceland. The goal of the initiatives was to draw attention to the fact that employee health must be protected wherever maintenance, demolition, transportation or disposal of materials that contain asbestos takes place. Moreover, the goal was to monitor compliance with the rules on asbestos that apply within the EEA.

Year 2007

The 2007 European Week for Safety and Health at Work addressed the causes of musculoskeletal disorders (MSDs), e.g. affecting the back, neck, shoulders and upper limbs. The European Agency for Safety and Health at Work in Bilbao, Spain, recommended that attention be drawn to,

on the one hand, how best to prevent musculoskeletal disorders and, on the other, how to retain workers and rehabilitate them. Letters of encouragement containing a list of ideas for action were sent out to establishments with 100 employees or more. E-mails were sent containing educational material to interior and furniture designers, architects, construction engineers, industrial designers, technical engineers and engineers. In Iceland, the slogan for the Week for Safety and Health at Work was *Suitable Loads are Healthiest* (*Hæfilegt álag er heilsu best*). Here the term *suitable* was considered highly important, as work loads should not be too heavy, but neither should they be too light. The Icelandic slogan, therefore, is broader than the original slogan of the European Week for Safety and Health at Work, i.e. *Lighten the Load.* The conference *Suitable Loads are Healthiest* was held on 23 October 2007. The conference's agenda was varied and addressed, among others, subjects such as risk assessment, workplace design and ergonomics. During the Week for Safety and Health at Work, Administration of Occupational Safety and Health inspectors visited 229 establishments, or 10–20 establishments on average in each region. Meetings were held with managers and employees in transportation and distribution establishments, warehouses, large inventory buildings and shops, and published educational materials and checklists on physical strain were distributed.

In 2007, the focus was on providing information on the new provisions contained in Regulation No. 920/2006, on the organisation and implementation of health and safety at workplaces, on examining whether risk assessments and schedule for preventive measures had been prepared for the workplace and whether there were safety managers and workers' safety representatives in place. Considerable attention was also paid to construction sites, in particular that health and safety schedules had been prepared for such workplaces and that work was carried out in accordance thereto. Particular attention was paid to fall prevention and work at a height.

Furthermore, Administration of Occupational Safety and Health focused on the workplace health and safety of foreign workers employed in the Icelandic labour market. An illustrated pamphlet was published on safety issues on construction sites in four languages. These were distributed by inspectors to managers and employees during visits to construction sites where there were foreign workers. Moreover, the pamphlet was sent with circulars to a large number of interested parties to call the attention of their management to the importance of employing systematic preventive measures and training and educating their employees. In addition, Administration of Occupational Safety and Health inspectors distributed a new information leaflet intended to inform foreign workers about health and safety in the workplace and of their rights and duties in this respect in Iceland. This leaflet was issued in nine languages.

Administration of Occupational Safety and Health held a seminar on preventive measures and actions against bullying and sexual harassment in the workplace on 5 December 2007; attendees were approximately 90. The goal of the seminar was to shine a light on the status of this issues in Icelandic society, to focus on the responsibility and position of different entities, to discuss how to increase the number of preventive measures in the workplace as regards bullying and sexual harassment and how to make responses more effective and provide better services to victims. The seminar was intended for service providers in health and safety in the workplace, administrative representatives, healthcare workers, workplace managers and employees and others interested in the issue. Three meetings were held during preparations for the seminar to obtain different views on the issue. The first was with service providers in the field of psychosocial working

environment components, the second was with trade unions and the third meeting was with victims of bullying. The results of the meetings were presented at the seminar.

Health and safety at sea.
Comment by the Committee of Independent Experts.
Conclusions XVIII-2 p. 9
The Committee asks whether the measures announced by the Government in the previous report to reduce the number of accidents in the fishing industry were implemented, and whether additional ones are envisaged in view of the continuing high number of accidents.

The Programme on the Safety of seafares 2007-2010.
The main objective of the Programme on the Safety of Seafarers is to reduce the number of maritime accidents. The aim is to achieve a safety levels on board Icelandic ships, comparable to the best in other countries.

The main points of emphasis for the long-term programme focused on seafarers' education, promotion campaigns, ship stability, development of educational material and guidelines, dissemination of information to seafarers and research in the field of maritime safety. The Ministry of Transport and Communications decided to advance the programme and put it before the Parliament in the form of a proposal for a resolution on a long-term programme on the safety of seafarers. In the proposal, which was adopted by the Parliament on 19 May 2001, the Parliament concluded that a campaign on the safety of seafarers would be in progress during the period 2001 to 2003. The aim of the programme was to enhance the safety of Icelandic ships and their crews as well as passengers travelling on board Icelandic ships and ships navigating within the Icelandic exclusive economic zone (EEZ). The aim should be to define the role of those who are involved in the safety of seafarers and to reduce the number of accidents at sea to at least one third until the year 2004 and, likewise, to reduce damage to property due to maritime accidents. Today, according to the Transport Policy Act, the issue of safety of seafarers has become a part of the transport policy in the form of a Programme on the Safety for Seafarers.

With the support of the Programme on the Safety of Seafarers, miscellaneous educational material for seafarers has been published in the form of handbooks, DVD discs and brochures, which has been distributed on board all Icelandic ships. In addition, a weeklong programme dedicated to the safety of seafarers, including a conference, has been on the agenda in September every two years and during the year when the safety week is not on the agenda, meetings dedicated to a campaign on the safety of seafarers have been held throughout the country. Examples of educational material 2001 - 2005:

Brochures: Hoisting safety, on-board safety drills, fire prevention on board ships, safety of small fishing vessels, passenger safety (in Icelandic, English, Danish and German), on-board familiarization training for new seafarers, safety in port and the danger of falling on board ships.
*DVD discs: "*Safety of Seafarers" (two DVD discs, a total of 6 hours of new and republished material), "Safety of Seafarers 2" (emphasis on small boats as well as new and republished material) and "Safety of Passenger Ships" (instructions on crowd management on board passenger ships, medical first-aid, resuscitation techniques and the use of defibrillators.

*Books, publications and promotional material: "*Medical Manual for Seafarers", "Ergonomics for Seafarers", "Stability of fishing vessels", "Guidelines on the Stability of Decked Vessels" and "Conduct of Ships and Navigation - Collision Regulations".

Among other important issues that have been implemented in recent years is the new Marine Accident Investigation Board Act and the reorganisation of the Board's role and work as well as the establishment of the Maritime Traffic Service in Skógarhlíð Reykjavík where the central administration of search and rescue operations in the sea area around Iceland is now located. Furthermore, the increased number of rescue vessels owned and operated by the Icelandic Association for Search and Rescue (ICE-SAR) in various locations along the whole coastline has enhanced the safety of seafarers and the new coast guard ship and aircraft that will soon be taken into operation by the Icelandic Coast Guard will also serve to improve safety.

Vision of future developments in the years to come.
The programme on the safety of seafarers 2007 to 2008 contains some proposals for amendments to the programme. The amendment means that the projects will focus more on safety management on board ships. The purpose of safety management on board ships is to ensure that safety aspects are safely managed and that the ship's equipment and competence of the crew is as good as possible at any one time. Efficient safety management on behalf of shipowners and on board their ships will entail enhanced safety awareness of all employees on land and at sea which will lead to increased overall safety. Efficient safety management is likely to urge shipowners and crews to implement surveys and checks on board their ships due to the fact that these parties are the ones who are most familiar with their ships. This methodology is called "own surveys" and in this case the Icelandic Maritime Administration would control whether the surveys are appropriately conducted. Safety management systems and security assessments are an integral part of safety management. Also included are scheduled instructions and training of the crew as well as the registration of accidents and incidents (*near-accidents*) and analyses of their causes. Under the auspices of the Programme on Safety of Seafarers 2003-2006, work commenced on preparing the promotion of formal safety management as a general practice on board Icelandic fishing vessels. This includes the development of educational material on hazard assessment on board ships and the use of manuals on service, training and safety at work on board fishing vessels. Emphasis will be placed on conducting hazard assessment on board each ship with a view to analysing job hazard and to prevent or lessen the hazard. Also, it has been proposed that safety management systems will be introduced on board all Icelandic fishing vessels. According to IMO rules, all passenger ships, oil and chemical tankers and other cargo ships of 500 gross tonnage and above are required to be operated in accordance with the safety management system, the so-called ISM Code. The need for formal management of safety aspects is not less on board other ships as on board merchant ships. Preparations for this project have been carried out for some time and further work will be based on a safety management system developed for fishing vessels and financed by the Ministry of Transport and Communications. Parallel to these projects there is interest in carrying out an actuarial assessment of maritime accident and their costs and to compare the outcome to the development in neighbouring countries. New emphases will be put forward as to the analysis of main projects and the costs involved. In the programme on the safety of seafarers 2001 - 2003 / 2005 - 2008, projects were divided into nine points of emphasis but those will be compacted into four points of emphasis with regard to harmonisation and the experience gained from 2001. The basis for the programme, which was specified in the year 2000, will be re-evaluated. An attempt will be made to evaluate seafarers' attitudes to their own

safety issues and the programme as was done in 2005 as well as in 2000 when the points of emphasis of the long-term programme were chosen. Also a theoretical assessment of accident, serious accidents and fatal accidents is on the agenda.

Accidents at work.
The number of notified accidents at work is similar in the years 2005–2007. Accidents in the construction industry are by far the most common accidents among men and underscores the risk related to that sector and how important it is to respond. The majority of women who are injured are employed in public services. These include various types of care work which is both physically demanding and difficult.

Table 8. Number of work accidents on land in 2005 to 2007.

	Total	Men	Women
2005	1,627	1,219	408
2006	1,709	1,310	399
2007	1,828	1,395	433

Source: Administration of Occupational Safety and Health

Table 9 shows a summary of the number of fatal accidents at work in Iceland in 2005 to 2007.

Table 9. Number of fatal work accidents on land in 2005 to 2007.

2005	3
2006	6
2007	4

Source: Administration of Occupational Safety and Health

In comparison, in 2001 to 2004, seven people had fatal accidents at work on land. The number of fatal accidents, therefore, has almost doubled during this period, and as is shown in Table 9, 13 people died during the three-year period that this report covers. It must be noted, however, that the total number of fatal accidents had never been lower than during the period 2001 to 2004, a rate of 2.25 individuals per year. Nevertheless, the Administration of Occupational Health and Safety has taken notes of this negative development and has the object to influence on that development with the aim to reduce the number of fatal work accidents and work accidents in general.

In 2005, there were three fatalities in work accidents on land.

1. An employee of a concrete paving establishment was dislodging sand in a sand silo. He had gone through an opening in the safety frame, into the silo down to the bottom. The sand from the sides of the silo dislodged and fell over him.
2. A fencing contractor engaged in drilling for fence posts with an auger drill was caught in the drive shaft that propelled the auger drill by means of a tractor shaft input.
3. An industrial worker who was working on the roof of a potroom at an aluminium plant slipped down the roof and fell 15.6 metres to the ground. He was equipped with a safety belt attached to a line that had either not been fastened or had come loose from the fastenings.

In 2006, there were six fatalities in work accidents on land.

1. A driver died when he was run over by the trailer of a towing vehicle. The trailer had been backed up onto ramps in a parking area near a residential building. The trailer rolled off the ramps, with the consequence that he was crushed under the trailer.
2. There was an explosion at a borehole – an employee was hit by rocks that fell after the explosion.
3. A mechanical digger tipped onto its side, the digger's control house landed on a large rock, with the result that it collapsed and the worker operating the digger died.
4. An employee working at a height of 8.5 metres on a switching station at Hellisheidi Power Plant fell to the ground off a pallet that was on the fork of a forklift that tipped over.
5. A driver was employed in transporting blasted rocks. When he backed up to empty his load from the edge of a soil mound, the vehicle went over the edge and rolled down backwards over a slope with large boulders. It is believed that the man jumped out of the vehicle and may have been run over by it and died as result.
6. An insulation chain fell from a high-voltage pylon and landed on an employee who was working on the pylon.

In 2007, there were four fatalities in work accidents on land.

1. A driver died when he was connecting a trailer to a vehicle in a storage area and was crushed between the vehicle and the trailer.
2. An employee working in the powerhouse of a power plant died when he fell five metres onto a concrete floor.
3. A welder working in a floating dock was crushed between a steel door and a steel pillar.
4. A builder working on constructing foundations for a floor slab in a new construction fell 2.6 metres between floors when the end of the beam in the foundation fell from under him. He died from the accident 24 hours later.

Accidents involving seafarers.
The table below shows the categories of accidents to befall seafarers in 2006. As shown, accidents involving falls of various types are the most common, or 26.

Table 10. Types of accident that befell seafarers in 2006.

	During fishing	During sailing	Releasing fishing gear	Hauling in fishing gear	Tied up in dock	Other	Total
Fatal accident	1	2					3
Falls	5	8	2	2	8	1	26
Man overboard	1						1
Injured when embarking or disembarking					1		1
Injured on falling from a ladder		1			3		4
Injured at mooring					2		2
Injured when loading, unloading, lashing (merchant vessel)		1			5		6
Injured when unloading catch					2		2
Injured when working in hold	3				3		6
Injured when working in engine room	1	2					3
Accidents caused by surge	2						2
Total	**13**	**14**	**2**	**2**	**24**	**1**	**56**

Source: The Icelandic Marine Accident Investigation Board

Table 11. Types of accidents that befell seafarers in 2007.

Burn injuries – Caused by acids and other chemicals	1
Chemical accidents	2
Falls	12
Man overboard	2
Injured when embarking or disembarking	2
Injured at mooring	1
Injured when loading, unloading, lashing (merchant vessel)	4
Injured when working in hold	2
Accidents caused by surges	1
Total	**27**

Source: The Icelandic Marine Accident Investigation Board

Table 12. Fatal accidents within the Icelandic continental shelf.

2005	3
2006	2
2007	5

Source: The Icelandic Marine Accident Investigation Board

There were three fatal accidents at sea in 2005. A crew member died when he was crushed between a trawl board and a mast when fishing in Faxaflói bay. Moreover, two sailors died in an accident when a pleasure craft ran aground on a reef within the harbour area of the Associated Icelandic Ports in Faxaflói bay in Reykjavík.

In 2006, two crew members died when a fire broke out in a tanning bed on-board a trawler that was fishing in the fishing grounds off the Westfjords. One person died while kayaking in Hvalfjördur, and a Danish sailor from a Danish coast guard vessel died during a rescue mission at Stafnes. The Danish authorities were responsible for investigating the last-mentioned incidence.

In 2007, there were five fatalities at sea. Two crew members died on a boat that was hit by a surge and capsized. A crew member was dragged overboard when he became entangled in fishing gear. In addition, two crew members died as a result of oxygen deprivation.

The Icelandic Marine Accident Investigation Board proposed, as a result of the oxygen deprivation accident, that provisions be passed in a regulation that in vessels where there is a risk of oxygen deprivation in areas where crew members generally work, it would be mandatory to have oxygen meters and/or oxygen sensors and to have proper ventilation in defined risk areas. Furthermore, the Board proposed the publication of guidance posters and leaflets on hazardous substances, how to behave near such substances and possible chemical formations on-board vessels. Moreover, that all areas where there is risk of chemical reaction should be defined conspicuously and the crew properly informed of such risks. Finally, the Board proposed that specific measures be included in response plans on-board vessels, in the event of an accident caused by lack of oxygen.

The Icelandic Maritime Administration addressed the proposals of the Icelandic Marine Accident Investigation Board as follows:

1. The Regulation on the safety of fishing vessels that are 24 m and longer has been amended, *cf.* Article 13 of Section VI on equipment and measures to protect the crew, as proposed by the Icelandic Marine Accident Incestigation Board. There is now special provisions on the use of gas and oxygen meters.
2. Regulation No. 200/2007 on measures that promote improved safety and health of employees on board vessels was passed. The object of this Regulation is to take measures to ensure that the safety and health of employees on-board vessels will be improved. The Regulation sets forth general principles for preventive actions against risks when working, the protection of safety and health, the elimination of aspects that give rise to risk or cause accidents, information, collaboration, normal participation of employees and their representatives, together with general criteria for the implementation of the principal rules.
3. The Icelandic Maritime Administration, in co-operation with the project management of the long-term plan on issues relating to seafarers' safety, issued the *Seafarers' Medical Manual.* This contains, in Chapter 17 on poisonings, a description of how to analyse and treat poisonings.
4. An information leaflet on hazardous substances in vessels was issued.
5. An information leaflet and other informative material are currently being prepared as regards specific measures to be included in action plans on-board vessels when accidents involving oxygen deprivation occur.

Occupational diseases.
Table 13 shows notification of occupational diseases on land.

Table 13. Notifications of occupational diseases.

2005	12
2006	14
2007	17

In 2005, the majority of notifications relating to occupational diseases could be traced to the careless use of chemicals, e.g. where there was a lack of ventilation and use of personal protection equipment. In two cases, the notifications lead to extensive action in the workplaces in question. Five notifications were submitted regarding skin diseases, and there were five notifications of communicable diseases.

A total of 14 notifications of occupational diseases were submitted in 2006. Five notices involved skin diseases, three were cases where there was a direct link to the use of chemicals in the workplace where the disease could be traced to a particular chemical, while in two cases, it was clear that the disease was caused by substances in the workplace, although it was not possible to find out exactly what the substance was. There were four notifications of lung diseases. Two of these were serious diseases that could be traced to asbestos. This underscores how important it is to continue preventive measures with respect to working with asbestos, and it must be pointed out how vital it is that workers have the appropriate certification if they are to

work with asbestos. Moreover, there were five notifications relating to occupation-linked communicable diseases.

In 2007, 17 notifications of occupational diseases were submitted. Of these, 11 were from construction work at the Kárahnjúkar Power Plant and were first and foremost individuals with respiratory problems. The reason for the illnesses was considered to be air pollution from diesel engines deep in the tunnels, where the ventilation was not sufficient for the employees who worked there. Work on the tunnelling was halted temporarily while the matter was investigated. The case was unique and Administration of Occupational Safety and Health responded immediately when it received notification, by halting the work. As regards the other six notifications, three can be traced to temporary air pollution in the workplace. Suspected lead poisoning lead to an examination of a group of employees, but the results were negative, and it was assumed that there had been no risk of health damages.

Administration of Occupational Safety and Health, moreover, has encouraged those who prepare risk assessments for establishments and healthcare employees to familiarise themselves with the EU's list of occupational diseases, since better awareness of occupational diseases on the part of all is important as regards improved working environment in workplaces in the country.

Protection against dangerous agents and substances.

Protection of workers against asbestos.

As regards working with asbestos, Regulation No. 750/2008 on the registration, evaluation, authorisation and restriction of chemicals (REACH) applies, as does Regulation No. 430/2007 prohibiting the use of asbestos in workplaces which repealed the rules No. 379/1996 on asbestos was repealed.

The object of the Regulation prohibiting the use of asbestos in workplaces is to prevent occupational illnesses that breathing in asbestos dust can involve. According to Article 4 of the Regulation, the use of asbestos in workplaces is prohibited. However, the Administration of Occupational Safety and Health in Iceland may grant permission for the demolition of buildings, parts of buildings, machines or other equipment containing asbestos. In the event of any doubt as to the presence of asbestos during demolition or other work, an analysis shall be made of the material or equipment in question so that the appropriate actions may be taken if asbestos proves to be present.

Regulation No. 430/2007 establishes clearer provisions than Rule No. 379/1996 that the use of asbestos in workplaces is prohibited. However, Administration of Occupational Safety and Health can, as previously stated, grant permission for demolition where asbestos may be present. Moreover, a provision has been added to Regulation No. 430/2007 listing the variants of asbestos and their CAS Numbers.

Protection against ionising radiation.

As regards protection against ionising radiation, it should be noted that as of 2003, supervision began with the use of equipment and substances rather than only monitoring the equipment and substances per se. Also started were audits of internal controls and research into patient radiation exposure rather than only technical supervision as previously.

In other respects, reference is made to the discussion under the third paragraph of Article 3 on monitoring arrangements pursuant to Act No. 44/2002.

Article 3, para. 3 – Consultation with employers' and workers' organisations on questions of safety and health.

Comment by the Committee of Independant Experts.
Conclusions XVIII-2 p. 10
The Committee asks if there are any statutory provisions requiring the Minister and/or Director of the Administration to consult the board of the Administration of Occupational Safety and Health in relation to the preparation of new legislation. It also wishes to know if other social partners, whether or not on the Board, are consulted on draft legislation.

The Government has, for quite some time, placed great importance on cooperation with the social partners on labour market issues, including in the field of occupational health and safety.

As a general rule, when bills for new legislation are to be created or amendments made to legislation applicable to the labour market, the Minister of Social Affairs and Social Security will appoint a committee in which the social parners have a representative.

According to Act No. 46/1980 on Working Environment, Health and Safety in Workplaces, the Minister of Social Affairs and Social Security appoints the nine-member Board of Administration of Occupational Safety and Health for a term of four years. The Minister appoints the chairman without nomination, two Board members are nominated by the Icelandic Confederation of Labour, one by the Association of Academics, one by the Confederation of State and Municipal Employees, one by the Ministry of Finance, one by the Association of Local Authorities in Iceland and two are nominated by the Confederation of Icelandic Employers. The same Act assumes that the Minister will seek comments from the Board when preparing to issue legislation, regulations and other rules on matters covered by the Act. The Minister, therefore, is at all times under obligation to submit draft bills or regulations to the Board for comment. Furthermore, as a general rule, attempts are always done in order to have consensus on the substance of individual bills before they are submitted to the Althingi or regulations before they are passed.

The principal social partners on the Icelandic labour market have representatives on the Board of Administration of Occupational Safety and Health and, as result, seeking further collaboration has not been the norm. When regulations apply to specific sectors, it is assumed that it is the role of the appropriate association to guard the interests of individual unions or employers, and in such cases, as appropriate, further collaboration may be requested.

Article 11
The right to protection of health

Article 11, para. 1 – Removal of the causes of ill-health.

The Icelandic healthcare service's role is to improve the general health of the nation. All people living lawfully in Iceland have the right to receive state-of-the-art healthcare irrespective of gender, religion, political views, age, national origin, colour, economic circumstances, origin and position. This entails that the healthcare services that are accessible for people must be as good as possible and must be of a comparable standard for all. In order to meet the aims of the services, all inhabitants in Iceland must be ensured equal access to efficient healthcare services and must be provided easy direct access to the services. In this context, it is particularly important to consider the social groups in the poorest circumstances with respect to health, as some studies show that social status has an impact on the health of people; this can be seen from a strong correlation between the health, education, income and social class.

Legislative amendments in the field of healthcare services.
The Healthcare Services Act.
The Healthcare Services Act No. 40/2007 repealed Act No. 97/1990 on Healthcare Services, as legislation on healthcare services was considered to be in need of a comprehensive revision. According to Article 1 of Act No. 40/2007, the purpose of that Act is to provide all inhabitants in Iceland with access to the most advanced state-of-the-art healthcare services available at any particular time for the maintenance of their mental, physical and social health in accordance with the Social Security Act, the Patients' Rights Act and other legislation as applicable.

Under this Act, Iceland is divided into health regions for which the Minister of Health shall provide further details through the issuing of regulations. Furthermore, for each health region, there shall be a health institution operated or health institutions that are responsible for the provision of general healthcare services in the region. The Minister shall at the same time be authorised to issue regulations with further provisions on the operation of health institutions in each region. The Act provides that, in the organising of healthcare services, every effort should be made to ensure that the services provided at any time are of a proper service level and that the Primary Health Care Clinics (*heilsugæslan)* will, as a rule, be the first place visited by patients. The healthcare service is classified on the one hand into a general healthcare service or a basic service, where Primary Health Care Clinics are included, and on the other hand into a specialised healthcare service. The Act clearly provides for the position and responsibility of the director of a health institution as the head of each institution. Furthermore, the role of hospitals and health institutions are further defined in the Act, including that the Landspítali University Hospital located in Reykjavík is defined as the main hospital in Iceland. The Minister of Health has issued Regulation No. 786/2007 on supervision by the Medical Director of Health of the operation of healthcare services and professional minimum requirements which include the professional minimum requirements for the operation of a healthcare service.

The Healthcare Services Act clearly prescribes that the Medical Director of Health shall at all times oversee that the healthcare service meets the professional standards. It states that it is not permitted to start operating a healthcare service unless there is a prior attestation from the Medical Director of Health that the intended operation meets the requirements laid down in the health legislation as well as all professional requirements.

The Act on the Medical Director of Health No. 41/2007.
The Medical Director of Health Act was enacted in 2007, but prior to the enactment, there were provisions on the operation of the office of the Medical Director of Health in the Healthcare Service Act and in the Physicians' Act. Due to the enactment of the Act, there is a more clear prescription on the position and role of the Medical Director of Health as a supervisory and administrative agency under the authority of the Minister of Health. Furthermore, there is a more clear provision on the authority of the Medical Director of Health to maintain national health records as well as for the preparation of reports in the area of health. Now it is clearly prescribed that the Medical Director of Health shall oversee that the healthcare service meets professional standards at any particular time. The permission of the public to submit complaints to the Medical Director of Health because of healthcare services have been strengthened and are currently further elaborated upon. There are provisions for the obligation of healthcare service providers to record unexpected events that occur in the course of the provision of services and about the requirements concerning notification to the Medical Director of Health in the event of serious incidents There are provisions on the role of the Medical Director of Health concerning quality development within the healthcare services.

Comment by the Committee of Independent Experts.
Conclusions XVII-2 – p. 5.
The Committee refers to its last conclusion for a general description of the health care system (Conclusions XV-2, pp. 268-269). It notes the current reforms approved by Parliament in 2001 set out in the health programme to 2010 and in the health and social security ministry's official policy statements, and asks for information in the report on their implementation, in law and in practice.

The National Health Plan
The National Health Plan applies until 2010, but a special revision was performed of its main targets in the beginning of year 2007. The Ministry of Health and Social Security conducts the administrative implementation and revision of the targets of the Plan, and the Medical Director of Health makes provisions for the collection and processing of information and professional monitoring. District physicians, health care employees and boards, as well as directors of institutions, work towards reaching the set targets and to ensure the monitoring of the implementation of the plan at a local level.

In the autumn of 1998, the regional committee of WHO in Europe adopted a health plan which in most areas covers the period until 2020, with its emphasis on 21 health targets. The basis for the National Health Plan is formed by the 21 targets of the WHO European health plan. The National Health Plan specifically defines seven priority targets until the year 2010 but it also describes all the European targets, circumstances in Europe and in Iceland, and the specific Icelandic targets up until 2010. It also covers fields where the situation is unsatisfactory, or less clear.

Furthermore, the Plan uses the appropriate type of statistical measurement tools, thereby endeavouring to present a reasonably accurate picture of the development of health care matters and of the effectiveness of the country's health care services.

Priority projects of the Health Plan until 2010 cover the following seven sectors:
• Prevention of alcohol, drug, and tobacco use
• Children and adolescents
• Senior citizens
• Mental health
• Heart and brain disease prevention
• Cancer prevention
• Prevention of accidents

During the revision of the Icelandic Health Plan in 2007 a decision was taken to add to the main objectives, new objectives concerning overweight and obesity and also concerning cancer prevention.

Priority projects and main objectives.
I. Alcohol, Other Drugs and Tobacco.

a) Reduced alcohol consumption of inhabitants 15 years and older to an annual average of no more than 5,0 litre of pure alcohol and almost none under that age. (Baseline: In 1998 the alcohol consumption was 5.56 litres per inhabitant 15 years and older, in 2004 the alcohol consumption was 7.2 litres per inhabitant 15 years and older).

b) Reduced consumption of alcohol and other drugs of those who are under age by 40% (under 18 years) (this target was 25% before the revision). (Baseline: According to studies from 2004, 56% adolescents in 2nd year, and 53% in 1st year of secondary school, 26% of pupils in the 10th grade, 11% in the 9th grade and 4% in the 8th grade said they had been drinking 3 - 6 times in the last 30 days before these studies were carried out, and that year 15% adolescents in 2nd year and 13% in 1st year of secondary school, 9% of pupils in the 10th grade, 5% in the 9th grade and 2% in the 8th grade said they had smoked hash).

c) Reduced smoking among people 18 - 69 years of age to prevalence less than 12% (was 20% before the revision). (Baseline: In 1999 27% of males and 28% of females smoked daily, in 2006 23% of males and 18,3% of females smoked daily)

d) Reduced smoking among children and adolescents 14 - 17 years of age to prevalence less than 5%. (Baseline: In 2004 16% of adolescents in 2nd year and 15% in 1st year of secondary school, 12% of pupils in the 10th grade, 6% in the 9th grade and 2% in the 8th grade smoked).

II. Children and Adolescents.

a) Measures should be taken to reduce by 25% health differences among children linked to social position of parents. (Baseline: In 1991 - 1995 an index of long-term diseases among children linked to the education of the father was as follows: university education 1, secondary education 1.17 and primary education 1.47).

b) Extend the psychiatric service to reach on an annual basis to at least 2% of all children and adolescents in the age group 0 - 18 years. (Baseline: In 1997 psychiatric service covered 0,4% of the age group 0 - 18 years, in 2005 psychiatric service covered 1,8% of the age group 0 - 18

years).

c) Reduced by 30% accidents and accidental deaths among children. (Baseline: In the period 2001 - 2005, 3,6 per 100,000 boys in the age group 0 - 14 years died an accidental death and comparable figure for girls in the same age group were 6,8 per 100,000.

d) Reduced prevalence of dental caries (DMFT) among 12 years old to 1,0. (Baseline: In 1996 the DMFT among 12 years old was 1,5, in 2005 the DMFT among 12 years old was 2,1).

e) Reduce the prevalence of overweight below 15% and obesity below 3% among 9 years old. (A new objective added during the revision in 2007 - baseline: In 2004 23% of 9 years old were overweight and 5% suffered from obesity).

III. Older Adults.

a) Reduced waiting time for people in great need for a place in a nursing home to maximum of 90 days. (Baseline: In 2004 the average waiting time in Iceland was 191 days, in 2006 it was 138 days).

b) Over 80% of people 80 years and older should be in so good health that they can with an appropriate support live in their own home (was over 75%). (Baseline: In 2003 75% of people 80 years and older were living at home, in 2004 75,7% were living at home).

c) Reduced prevalence of breaking coxal bones and back bones by 25%. (Baseline: In 2003 the prevalence of breaking coxal bones and back bones was 374,8 per 100.000 65 years and older).

d) Over 50% of people 65 years and older should have at least 20 healthy teeth in a bite. (Baseline: In 1995 25% of those in age group 65 and older had 10 or more upper teeth and in 2000 this proportion had risen to 34%).

IV. Mental Health.

a) Reduce the prevalence of suicides by 15% (was 25%). (Baseline: In 1991 - 1995, 10,8% per 100.000 per year committed suicide, in 2001 – 2005 the number was the same).

b) Reduce the prevalence of mental disorders by 10%. (Baseline: In 1994 was the total prevalence of mental disorders was estimated 22%, in 2001 it was estimated to be 21%).

V. Cardiovascular Disease and Stroke.

a) Reduce cardiovascular disease deaths in the age group 25 - 74 years, men by 30% (was 20%) and women by 20% (was 10%). (New age-adjusted baseline: Annually in 2001 – 2005 males: 117 deaths per 100.000, and females: 38,8 per 100.000 – the former age-adjusted baseline was 1991 - 1995, males: 131 deaths per 100,000, and females: 76 deaths per 100.000).

b) Reduce stroke events by 25%. (Age-adjusted baseline: Annually in 1991 - 1995, males: 44,1 deaths per 100,000, and females: 30.4 deaths per 100,000).

c) Reverse the growing trend in overweight and obesity in people older than 20 years of age. (A new objective added during the revision in 2007 - baseline: In 2002, 56% of people older than 20 years of age were overweight and 16% suffered from obesity).

VI. Cancer.

a) Cancer mortality rate among people younger than 75 years of age should be reduced by 10%. (Age-adjusted baseline: Annually in 2001-2005, males: 95,7 deaths per 100,000 younger than 75 years, and females 94,7 deaths per 100,000).

b) Prostate cancer mortality rate among men younger than 75 years of age should be reduced by 30%. (A new objective added during the revision in 2007 - age-adjusted baseline: Annually in 2001–2005 10,3 males younger than 75 years of age died of prostate cancer).

c) Breast cancer mortality rate among women younger the 75 years of age should be reduced by 30%. (A new objective added during the revision in 2007 - age-adjusted baseline: Annually in 2001–2005 16,6 per 100,000 females younger than 75 years of age died of breast cancer).

d) Reduce by 50% the use of sunbeds (A new objective added during the revision in 2007 - baseline: In 2005 the sunbed use of people aged 12 – 75 years old was 39%).

VII. Accidents.

a) Reduce accidents by 25%. (Base line: In 1997 the total number of accidents was estimated at 60,000, in 2004 the total number of accidents was estimated to be 50,000).

b) Reduced deaths by accident by 25%. (Baseline: annually in 1996-2000, 21,9 per 100.000 died by accident and in 2001-2005, 23,5 per 100.000 died).

Comment by the Committee of Independant Experts.
Conclusions XVII-2 – p. 6
To enable it to decide whether the situation is in compliance with the Charter, the Committee asks for up-to-date information and statistics on access to care for the most disadvantaged groups.

Under Article 1 of the Health Insurance Act No. 112/2008, the purpose of the Act is to ensure assistance for health-insured individuals for the protection of health and for the equal access to healthcare services irrespective of an individual's economic circumstances. Information concerning the availability of healthcare services for different groups in society is not available. All have access to Primary Health Care Clinics (*heilsugæslan*) as well as to hospital emergency wards and services. In addition the health insurance system is meant to equalise access to other medical services.

Health-insured persons are charged ISK 1,000 for visits to Primary Health Care Clinics or to a GP during normal working hours, but old age pensioners and disability pensioners are charged ISK 500 for visits to health services or to a GP. Health-insured persons are charged ISK 4,600 for visits to accident or emergency wards, but old age pensioners and disability pensioners are charged ISK 2,300. The charge for general and specialised healthcare services at an outpatient ward, a day ward, an accident ward and an emergency ward in a hospital without hospitalisation is lower for the elderly, disabled and children. The charge covers i.a. the cost of registration and cost of medical services and the services of other healthcare workers.

Article 15 of Regulation No. 1204/2008 on the proportional share of health-insured individuals in the cost of healthcare services, with subsequent amendments, relates to health-insured individuals between 18 and 70 years of age the right to discount cards when the individuals have paid ISK 25,000 during the same calendar year for visits to Primary Health Care Clinics or to a GP, for doctors' visits, hospitalisations, visits to the accident ward, the hospital outpatient ward, the day ward and to the hospital emergency rooms, visits to medical specialists outside the hospitals, laboratory tests, radio diagnosis, imaging and measurement of bone density.

Children under 18 years of age having the same family registration code number according to the definition of the National Registry shall be considered one person. The custodians of children are entitled to a discount card when payments of ISK 8,100 have been made on behalf of these children during the same calendar year with regard to children under the age of 18 in the same family to medical specialists outside hospitals, doctors' visits, laboratory tests, radio diagnosis, imaging and measurement of bone density.

When old age pensioners 70 years and older, disability pensioners and old age pensioners 67–70 years of age who received disability pension until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension have paid ISK 6,100 during the same calendar year because of visits to a Primary Health Care Clinic or to a GP, doctors' visits, hospitalisations, visits to the accident ward, the hospital outpatient ward, the day ward and to the hospital emergency room, visits to specialists outside the hospitals, laboratory tests, radio diagnosis, imaging and measurement of bone density, they shall be entitled to hold a discount card.

The holders of discount cards shall pay as follows for healthcare services for the remainder of the calendar year:

1. For visits to a Primary Health Care Clinic or to a GP pursuant to Article 4 during normal working hours:
    a. For health-insured persons in general: ISK 580.
    b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 400.

2. For a visit to a Primary Health Care Clinic or to a GP pursuant to Article 5 outside normal working hours:
    a. For health-insured persons in general: ISK 1,500.
    b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 700.

3. For doctors' visits, i.e. the service of a GP outside of Primary Health Care Clinics during normal working hours:
    a. For health-insured persons in general: ISK 1,600.
    b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 700.
    c. Children under the age of 18 and children with caretaker cards pursuant to Regulation No. 504/1997 on Financial Aid to the Providers of Disabled Children and Children suffering from Long-Term Illnesses: ISK 300.

4. For a doctor's visit, i.e. the service of a GP outside of the Primary Health Care Clinics outside of normal working hours:
    a. For health-insured persons in general: ISK 2,300.
    b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 900.
    c. Children under the age of 18 and children with caretaker cards pursuant to Regulations No. 504/1997 on Financial Aid to the Providers of Disabled Children and Children Suffering from Long-Term Illnesses: ISK 400.

5. For visits to the accident ward and the emergency ward of hospitals:
    a. For health-insured persons in general: ISK 2,300.
    b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 800.
    c. Children under the age of 18: ISK 400.

6. For visits to hospitals on account of hospitalisation:
    a. For health-insured persons in general: ISK 3,000.
    b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 60–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 1,000.

7. For visits to the outpatient ward of hospitals because of services from others than medical doctors:
    a. For health-insured persons in general: ISK 1,300.
    b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 60–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 650.

8. For a visit to a hospital day ward pursuant to paragraph 4 of Article 9:
    a. For health-insured persons in general: ISK 800.
    b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 60–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 400.

9. For a visit to a specialist outside a hospital and to a specialist in the outpatient ward of a hospital:
    a. For health-insured persons: ISK 1,300 plus one-third of 40% of the agreed or determined total charges upon arrival which is in excess, however with a maximum of ISK 25,000. For conal surgery, a maximum charge of ISK 2,400.
    b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: 1/9 of 3,600 plus 40% of the agreed or determined total charges upon arrival which is in excess, with a minimum, however, of ISK 650 and a maximum of ISK 25,000. For conal surgery, there is a maximum charge of ISK 900.
    c. Children under the age of 18 pay 1/9 of 3,600 plus 40% of the agreed or determined total charges upon arrival which is in excess, with a minimum, however, of ISK 450 and a maximum of ISK 25,000, and no charge for a visit to a specialist at the outpatient ward of a hospital.

10. For laboratory tests and for the testing of samples sent for testing to a laboratory:
    a. For health-insured persons in general: ISK 700.
    b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 230.
    c. Children under the age of 18: ISK 120.

11. For radio diagnosis, imaging and measurement of bone density:
    a. For health-insured persons: ISK 700 and an additional one-third of 40% of the agreed or the determined total charges at arrival for that which is in excess however to a maximum of ISK 25,000. For coronary angioplasty and cardiac catherisation, the maximum charge is ISK 2,400.
    b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension shall pay 1/9 of the charge that health-insured persons generally pay, i.e. ISK 2,000. However, the minimum shall be ISK 350 and the maximum shall be ISK 25,000. For coronary angioplasty and cardiac catherisation, the maximum charge is ISK 800.
    c. Children under the age of 18 shall pay 1/9 of the charge that health-insured individuals generally pay, i.e. ISK 2,000 with a minimum, however, of ISK 230 and a maximum of ISK 25,000.

For visits and revisits to hospital outpatient wards for services other than those of medical doctors where an anaesthesiologist will administer anaesthesia for a surgeon's operation, the health-insured individual shall pay a maximum of ISK 25,000.

It is permissible to decide that discount card holders must pay the same consultation fee that others pay but will then later get the balance reimbursed through the health insurance against their showing of a doctor's receipt. Fees that are paid at the Primary Health Care Clinics and at the hospital will go to the operation of these institutions. A consultation fee is deducted from a contractual doctor's fee for consultation.

Under the Regulation, an individual who has been unemployed for six consecutive months or more according to the confirmation of the Directorate of Labour is entitled to healthcare services under the same terms as old age pensioners who are 70 years or older, disability pensioners 67–70 years who have received disability pension until the age of 67 and old age pensioners who are 60–70 years of age who receive full old age pension. The confirmation of the Directorate of Labour shall be renewed every three months.

It should be pointed out that pre-natal care during pregnancy, birth and infant care services are free of charge for parents who are health insured.

Comment by the Committee of Independant Experts.
Conclusions XVII-2 – p. 6
The Committee notes the detailed information in the report on waiting times for treatment. Patients' waiting times have fallen in the various sectors, with the exception of orthopaedic surgery. However, the information in the report does not allow it to assess the system for managing waiting lists in the light of the principles of the Council of Europe's Committee of Ministers Recommendation (99) 21 on criteria for the management of waiting lists and waiting times in health care. The next report should therefore clarify this point.

The system for managing waiting lists in the light of the principles of the Council of Europe's Committee of Ministers Recommendation (99) 21 on criteria for the management of waiting lists and waiting times in health care is the following. The Directorate of Health of Iceland has been collecting and monitoring information on waiting lists and waiting time since 1986. This collection and monitoring is mandatory by the Act of Medical Director of Health No. 41/2007. Information on waiting lists and waiting times is collected three times per year and the information is made available on the web-page of the Directorate of Health http://www.landlaeknir.is/Pages/915. By the Act on the Rights of Patients No. 74/1997 doctors shall provide their patients with information on the estimated waiting time and if it is possible to receive the necessary treatment sooner elsewhere. If it is necessary to place the patient waiting for treatment in order of priority, the order should be based on medical grounds first and foremost and other professional criteria, as the case may be.

Comment by the Committee of Independant Experts.
Conclusions XVII-2 – p. 6
The Committee asks for detailed and up-to-date information in the next report on the number of hospital beds per 1,000 population and the number of general practitioners, specialists and dentists.

As can be seen from the table below, there are 6.21 hospital beds for every 1,000 inhabitants. The proportion of GPs is 0.58 for every 1,000 inhabitants. The ratio of specialists is 2.98 for every 1,000 inhabitants, and the number of dentists is 0.93 for every 1,000 inhabitants.

Table 14. The number of hospital beds, GPs, specialists and dentists for every 1,000 inhabitants.

Number of beds (per 1,000 population)	6,21
General practitioners (per 1,000 population)	0,58
Specialists (Other doctors) (per 1,000 population)	2,98
Dentist (per 1,000 population)	0,93

Pregnancy care.
Objectives of pregnancy care:

- To promote the health of the mother and the child.
- To provide professional care, support and training.
- To analyse risk factors and respond to them.
- To provide instruction on pregnancy and birth.

Pregnancy care is open to all expectant mothers and fathers and is free of charge for them. Pregnancy care is performed by midwives and GPs at Primary Health Care Clinics and obstetricians are consulted if need be. It is emphasised that service is continuous and the expectant mother and father will therefore see the same midwife during the pregnancy.

All Primary Health Care Clinics in the Reykjavik area provide pregnancy care and have further information concerning the services on their websites. Each Primary Health Care Clinic serves those who live in the clinic's service area or who have their GP at the clinic. Assistance by telephone is offered by a midwife at each clinic.

Table 15. Numbers of women who died as a result of complications in pregnancy, birth or during confinement in the period 2005 – 2007.

	Total
2005 Complications during pregnancy, birth and confinement	0
2006 Complications during pregnancy, birth and confinement	0
2007 Complications during pregnancy, birth and confinement	0

As is shown in Table 15, there were no fatalities among women due to events that were caused by pregnancy, birth or their associated complications during the years of 2005–2007.

Table 16. Number of live births during the period 2005–2007.

	Total	**Girls**	**Boys**
2005	4,280	2,097	2,183
2006	4,415	2,157	2,258
2007	4,560	2,201	2,359

Table 16 provides information concerning the number of live births during the period 2005–2007 which means 2.1 children per woman on the average according to Statistics Iceland.

Table 17. Infant mortality in the period 2005 – 2007.

	Total	**Girls**	**Boys**
2005	3.3	3.3	3.2
2006	4.1	3.7	4.4
2007	2.6	2.3	3.0

Figures for the period are annual averages
Infant mortality is the frequency of deaths during the first year of life per 1,000 live births.
Source: Statistics Iceland

Table 17 provides an overview over infant mortality during the period 2005–2007. Infant mortality is the frequency of deaths during the first year of life per 1,000 live births.

In 2006, life expectancy of males at birth was 79.4 years and the life expectancy of women was 83 years. In 2007, life expectancy of males at birth was 79.4 years and the life expectancy of women was 82.9 years.

Infant care services.
A nurse administers infant care services in collaboration with GPs and paediatricians.

Regular infant and child healthcare is performed from the time when the child returns home from the maternity ward. During the first weeks following the birth, nurses will visit the children in their homes. The first medical examination takes place at the age of six weeks and takes place at the Primary Health Care Clinic / Centre for infant care services. The growth and development of children is regularly monitored. When everything is normal, a child will visit the infant and child healthcare control centre at a Primary Health Care Clinic every other month until the age of twelve months, and following this, the child will return at the age of eighteen months. Regular vaccinations are made according to the current instructions by the health authorities at any particular time. Vaccinations start at the age of three months. Parents receive education and consulting as needed at any particular time. Vaccinations are discussed in greater detail in the discussion in the second paragraph of Article 11.

Examples of points of instruction are*:* breast feeding / bottle feeding, the effects of passive smoking on children, accident prevention, exercising and resting for the mother and nutrition and pelvic floor exercises, as well as the well-being of the mother and the father – a change in roles. Additional points include screening for maternal postnatal depression, stimulation and the

development of children, postnatal sex and contraception, ad-vitamin drops, information on vaccinations, motor development in children, teething and dental care, language stimulation, sleep, discipline and loving guidance. Selection of children's footwear, hygiene habits, TV watching, physical harassment, outdoor activities and exercising will also be discussed.

The goal of infant care services is to monitor and encourage a wholesome growth and development in children until school age and the welfare of the family as a whole. The role of infant care services is also to guide and advise and to find ways to solve problems that may arise.

Health services in school.
The objective of health services in school is to make students able to develop under the best mental, physical and social conditions that are available at any particular time.

School nurses administer health services in the primary schools in Iceland and in some secondary schools. The job is particularly versatile because the children vary in age, and their needs vary.

Children contact the school nurses through the children's own initiative with various problems such as wounds, sprains, fatigue and nausea. There are also children in the schools who have chronic health issues, such as asthma, diabetes, behavioural problems or cancer that must be treated in different ways so that they will be able benefit from attending school. The number of disabled children is increasing in the general primary schools, and it will be the task of the school nurses to attend to their interests. In order to meet the needs of these children in the most beneficial manner, there must be very good collaboration between the school nurse, the parents, the teachers and the school administration.

School nurses also administer various health training and preventative measures to individual children and to whole classes. The following may also be mentioned: accident prevention, hygiene, nutrition, rest, smoking and drug abuse prevention, sexual development and sexual behaviour. It must not be forgotten that school nurses administer physical examinations such as measuring hearing, sight, height and weight.

School nurses need to be endowed with an extensive knowledge in their work, and there is a lot of responsibility attached to it. They operate according to the law, regulations and recommendations from the Medical Director of Health, but the versatility of the job provides a lot of opportunities for initiative, research and different specialisation.

Article 11, para. 2 – Advisory and educational facilities.
Public Health Institute.
The Public Health Institute of Iceland was founded in 2003 under the provisions of Act no. 18/2003. Since that time, the Institute has been working on its policy and vision, together with an action plan.

The work of the Public Health Institute has above all been guided by the principle that the people of Iceland be provided with opportunities to live a healthy life. Health education carried out by the healthcare system, schools and other agencies plays an important role. The Public Health Institute thus places emphasis on collaboration with various bodies and organisations, and support for them, in various educational programmes. Health-enhancing conditions and facilities,

whether at work, at home or during leisure hours, are also of vital importance to public health. These are affected by decisions made by government, employers and other influential parties – decisions which can enhance life and health, or alternatively lead to unforeseen damage, in the short or the long term.

Priority is given to collaboration with local government, and support for programmes in the fields of prevention and health promotion. But knowledge of risk factors has little significance unless efforts are made to apply the best knowledge and tried-and-tested methods to promote health. The Public Health Institute thus places emphasis on being a centre of knowledge for effective methods in public health, and of research in the field.

Health.
Health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.

Public health.
The science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society. Public health is concerned with maintaining and enhancing the health, wellbeing and conditions of peoples and social groups through general health care and health services, health promotion, research and social responsibility. Public health work is grounded in extensive collaboration and multi-disciplinary approaches, and is concerned with e.g. social, environmental and economic issues.

Health in Iceland.
The people of Iceland enjoy better health today than ever before. Infant mortality very low, and life expectancy, not least life expectancy in good health, is high. Many infectious diseases have been all but eliminated by means of inoculation, improved hygiene and medications, and efforts to combat the major cause of death in Iceland, cardiovascular disease, have led to a considerable reduction in cases of illness and death from this cause. Increased prosperity, improved health services, technical advances, and an equalising social system are probably the major factors in these improvements in public health. At the same time, threats to health have become increasingly noticeable, especially those consequent upon longer life and the changing age composition of society.

The project: Everything has an effect, in particular we ourselves!
Everything affects us, especially ourselves! is a project of the Public Health Institute of Iceland and municipalities that has the goal of promoting healthy lifestyles of children and their families by emphasizing increased physical activity and improved diet. The program began formally in the fall of 2005; the first part of the project concluded in 2007 the second part will conclude in 2010.

The prevalence of overweight and obesity among Icelandic children has increased dramatically in the last decades. Changes in physical activity and eating behavior are factors that are considered to be related to increased body weight among children in Iceland.

24 local governments have decided to participate. Inhabitants in participating municipalities account for 78% of the population in Iceland. It is emphasised that the municipalities that participate, work towards a policy and action plan regarding these two subject categories. The purpose of the project is to encourage a healthy lifestyle of children, young people and their families with an emphasis on increased exercising and an improved diet. Efforts are made to increase the knowledge of individuals regarding the factors that have an impact and to encourage improvements of the facilities and the environment with regards to exercise and the diet in each municipality. That way the project will be applied in order to ensure a more health-oriented environment. The success of the project will be assessed on the basis of possible adjustments regarding the inner work of the schools and the conditions of the students, as the school is an excellent venue where all children can be reached.

It has been pointed out that the lifestyle, health and well-being of young people is much better in those municipalities that have formulated a policy, action plan and working procedures in the affairs of children and adolescents, mobilising parents for collaboration and following up words with actions so that adolescents will know their limits and will be met everywhere with the same message, rather than in the municipalities where this has not been the case. The municipalities operate the schools (nursery schools and primary schools) in Iceland, and therefore, there is a call upon municipalities regarding collaboration with the project. Education (nursery school and primary school education) is an excellent venue for the general health improvement of children, because there one will be able to reach almost all children of school age. In order to make this health improvement project become a reality, there will need to be a collaboration of all in the school community, i.e. the students, the employees, the Primary Health Care Clinics and, as the need may be, parties outside the school.

Support to the school system, the teaching professions and education as a whole is a probable way to improve the health and well-being. School health services are always intended to monitor the health, development, well-being and conditions of children of primary school age. This system offers regular physical examinations, interviews and education. The role of the school health services is to encourage the physical, mental and social health of school children and to analyse and administer health issues that affect the welfare of students and their learning abilities, as well as to assess those factors in the environment and the conditions of children that affect their health and well-being.

There is continually placed a greater emphasis on having a good human resources policy at the workplace that provides people with room to co-ordinate work and family life, and this also applies to the schools. A good family policy and a policy that encourages improved health and well-being of people at the workplace is very important. The attitude of the managers towards these factors is important. It is also important that there is the same emphasis on a healthy lifestyle at the workplace as there is in the school system.

The implementation of the project is directed towards two risk factors in the lifestyle of people, i.e. lack of exercise and a poor diet. In any preventive work and health improvement work, it is important to ensure a comprehensive approach with multifarious actions which, in this instance, have an impact on the nutrition and the exercise of the general public and which have relevance to the social, political and cultural factors of children as well as of adults. There will be an endeavour to make people aware of their own health and welfare, to support children and

adolescents to take responsibility for themselves and to make them better able to reach decisions that promote improved health. Such an approach that aims at increasing knowledge, influencing attitudes and changing behaviour requires education and information campaigns as well as action in schools, nursery schools and leisure activities facilities. That way action will be aimed at making the healthy choice become the easy choice. The World Health Organisation increasingly urges that preventive measures are directed towards reducing factors in the environment that contribute to lack of exercise and a poor diet. The most important factor in this connection is the contribution of the government towards increased exercising and towards improving the quality of food along with access to wholesome food.

Evaluation of results.
The Public Health Institute of Iceland will check the projects' results by doing an initial status assessment and follow-up evaluations after two and six years. The research will have two parts:
1.Schooling-related matters. Questionnaires will be sent to school administrators emphasizing the following elements:

- Availability of physical activity and sports at the school and the degree of students' participation.
- Availability of food in schools, wholesomeness of the food and the degree to which students eat the food offered by the school.
- Instruction on healthy lifestyle in schools for students and parents.
- Environment of schools, walking and biking paths, instructions from the schools on modes of travel to and from school.
- Schools' instructions about sack/box lunches.

2. Matters related to children and families

- Survey of health-related lifestyles of children and youths, aged 11, 13 and 15.
- Mental well-being of the child
- Physical well-being of the child
- Food habits and utilisation of the school cafeteria
- Child's leisure time habits with the family and friends
- Attitudes toward leisure time, games and sports.
- Mode of travel to and from school

The height and weight of children will then be obtained from the school nurse's files and related to the previously mentioned points

Here below is a brief overview of the evaluation of the project that was done in 2007.

Regarding human resources, 90% of municipalities had representatives from agencies/associations in the municipality participating in policy formation for the municipality. 100% of school nurses had received the information material. About 90% of the participating municipalities have representatives from different areas (schools, preschools, sport associations, parents associations, youngsters representatives and school nurses) sitting in the steering committee. Collaboration workshops are held with the school health care service once a week to work on the information material. Twice a year workshops are held with the municipality steering committees.

Municipalities work.
80% of the participating municipalities have a specific policy and action plan regarding the project. Furthermore 80% of the participating municipalities are applying the methods on which the project manager's policy formation is based and have accepted offered courses. 85% of participating elementary schools follow largely or completely the Public Health Institute guidelines on nutrition for schoolchildren, compared to 65% in 2005. Increased knowledge and changing attitudes by all the participants has led to a more strategic focus on physical activity and nutrition.

Examples of outcome**:**

Table 18. Nutrition.

Standards	**2005**	**2007**
The percentage of primary schools that daily offer fruits during the morning break.	**27%**	**37%**
The percentage of primary schools that daily offer vegetables with the lunch meal.	**23%**	**60%**
The percentage of primary schools that offer fish two times or more every week.	**59%**	**62%**
The percentage of primary schools that follow the advice of the Public Health Institute of Iceland to a greater extent or entirely.	**60%**	**85%**
The percentage of nursery schools that daily offer fruits during the morning break.	**76%**	**84%**
The percentage of nursery schools that daily offer vegetables with the lunch meal.	**55%**	**51%**
The percentage of nursery schools that offer fish two times or more every week.	—	**82%**
The percentage of nursery schools that follow the advice of the Public Health Institute of Iceland to a greater extent or entirely.	—	**67%**

Table 19. Exercise.

Standards	2005	2007
Percentage of nursery schools where the school employees participate in the physical play of children outdoors twice every week or more.	**51%**	**57%**
Percentage of nursery schools where the school employees participate in the physical play of children indoors twice every week or more.	**17%**	**37%**
The percentage of nursery schools that daily offer children with special needs a special physical training programme.	**72%**	**85%**
The percentage of primary schools that systematically encourage playing games during breaks.	**37%**	**66%**
The percentage of primary schools that offer children with special needs a special physical training programme.	**66%**	**65%**
The percentage of primary schools that have three or more sports classes.	**95%**	**95%**

The Public Health Institute has led the work of the municipalities that participate in the project, in terms of policymaking and creating a plan of action. The results of the surveys have been analysed for each separate municipality, to assess the need for action and also to assess the outcome of the project in the different municipalities. Those results have formed the basis of the work carried out in the steering groups operating in each municipality. The outcome has also been presented to local authorities and public officials in the municipalities and towns. Most of the participating municipalities have made a lot of progress in policymaking and planning. This work will be presented to town or municipal authorities for approval, and then used as a frame of reference in the municipalities' financial planning work each year.

Comment by the Committee of Independant Experts.
Conclusions XVII-2 – p. 6
As part of the systematic teaching of health in schools, new curricula were published in 1999. The Committee asks for information in the next report on the precise topics covered.

A fully revised national curriculum guide of the primary schools in sports and physical fitness programmes was published in 1999 and with minimal changes in 2007. According to the national curriculum guide, the field of studies called sports – physical fitness programme is divided into two parts: on the one hand into school sports and, on the other hand, into school swimming. It is important to view the subjects in this field of studies or to view the two subjects, school sports and school swimming, as one whole where the final goal is i.a. to promote the overall development of every student, to strengthen his/her state of health and to increase his/her productivity. Systematic sports and movement studies not only have a beneficial influence on the physical health of each student, but also a positive effect on mental and social well-being. It is not only in the interest of each student to receive a systematic training in the field of sports, but it can also be an important determining factor regarding the health of the nation. Thorough exercising

and games that appeal to both sexes and to all age groups are factors upon which good sports teaching is built. Swimming lessons in the primary school in Iceland have enjoyed a special status for a number of years and will continue to do so. There are several reasons that swimming lessons hold this special position. The main reasons are that swimming is an important safety factor – to be considered able to swim is a key point for all the inhabitants of an island where fishing in the ocean, in rivers or lakes is widely practiced. The swimming is a cultural heritage which it is important to minister to and to cultivate, as the Icelanders were among the first nations in the world that adopted mandatory swimming classes in their schools. The Icelanders live under very good conditions for swimming, and in addition, swimming is considered an excellent physical fitness activity that most people are able to practice. Such things must be preserved and should be increasingly cultivated in the coming years. It is important to link a theoretical input on sports and physical fitness programmes with the implantation of physical exercises and games. Physical education is well adapted to strengthen this integration. This methodology also has the advantage of frequently inducing the students to think about the value of athletics and igniting an interest in regular physical exercises and athletic practices.

The goals of school athletics and school swimming classes are classified into four different subject categories. The first category is sensory and motor development; the second category is physical and aesthetic development; the third category is social, emotional and moral development; the fourth category is cognitive development.

The national curriculum guide for primary schools in domestic science which was published in 1999 and slightly revised in 2007 also refers to health. Domestic science deals with the person, his/her life and living conditions and his/her physical and spiritual needs. This subject is intended to promote good health, economy and the protection of the environment. The Public Health Institute of Iceland has introduced recommendations regarding a reasonable diet that must be adhered to in all education. Studies done by the Icelandic National Nutrition Council (The Public Health Institute of Iceland) on the consumption of inhabitants in Iceland have shown that the consumption of fats and sugar is too high in Iceland. There must be a reaction to this in a systematic manner, for instance by keeping students and the general public well informed with respect to national nutrition and to have a positive attitude towards healthy consumption and lifestyle. This should result in the better health of the nation.

Comment by the Committee of Independant Experts.
Conclusions XVII-2 – p. 7
The Committee asks for information on agency activities, particularly in the field of alcoholism and drug prevention, that have helped to increase public awareness.

Each year the Public Health Institute allocates grants to *preventive programmes for primary and secondary school*. Many of these programmes involve visits to schools by the organisers of the programmes, who provide education on the harmfulness of alcohol and other substances, and urge pupils to say No. The Public Health Institute is also a more active participant in various programmes, such as *Flott án fíknar* (Smart, Drug Free). This programme, aimed at primary and secondary schools, has the objective of supporting youngsters and their parents against substance abuse. The programme aims to be conducive to creating a positive youth culture, so that young people will not start using tobacco, drugs or other substances, and will not drink alcohol until they are of an age to do so legally (age 20).

Each year *grants* are allocated from *the Prevention Fund* for programmes and research in the field of alcohol and substance use, which may contribute to future work in the field. The Fund especially solicits applications from large-scale long-term programmes.

Vertu til (Be prepared) follows on from the programme *Drug-free Iceland*. It is a collaborative programme of many bodies, which has been in progress since 2003. *The Drug- free* Iceland programme was a collaborative programme of many bodies, including national and local government. Lasting from 1997 to 2002, the programme had the principal aim of uniting the nation against illegal substances, and strengthening preventive work. In the *Be Prepared* programme, policy on prevention has been in formation, based on collaboration between local governments, the police, healthcare, church etc. The intention is to continue the programme, perhaps as part of the programme *Allt hefur áhrif – einkum við sjálf!* (Everything affects us – especially ourselves!) sem var fjallað um hér að framan.

The Public Health Institute operates education programmes on the harmful effects of alcohol consumption for young people and adults. Two information booklets have been published on the effects of alcohol consumption, one for young people, and the other for adults. At times when alcohol consumption is known to be high, e.g. in the summer, and at Christmas and the New Year, the Institute campaigns in the press, encouraging Icelanders to change their patterns of alcohol consumption, which are typified by binge drinking, generally at weekends. Educational material has also been published on the effects of substance abuse: *Höldum heilanum heilum* (Keep the Brain Safe).

The SAMAN group (saman = together) is a collaborative group working in prevention, with the backing of the Public Health Institute. All Iceland's largest communities are now members of the group, as are the leading non-government organisations involved in the welfare of children and young people. The SAMAN group works on prevention, focussing on the family, in relation to events which are likely to lead to increased alcohol and substance abuse by young people, such as the spring when 16-year-olds graduate from compulsory education, National Day on 17 June, the August Bank Holiday weekend, and the New Year.

Article 11, para. 3 – Prevention of diseases.

Smoking and alcohol consumption.
Comment by the Committee of Independant Experts.
Conclusions XVII-2 – p. 7
The Committee asks that the next report provide information on all measures taken to combat alcoholism and drug addiction, and, in particular, it wishes to be informed of the follow up to the 2002 "Iceland without Drugs" programme.

The slogan *Iceland without Drugs* became well-known and it was regarded a valuable asset. It was measured by survey that approximately 86% of the population had heard of the slogan. Two third of those who had heard the slogan, said it supported well the prevention of illegal drug use and the younger people was more positive for the slogan than the elderly.

Research have shown that the program, *Iceland without drugs*, generated positive results in less use of illegal drug and less alcohol consumption among young people. Furthermore, research show that increased parent's awareness about illegal drugs and the using consequences has increased.

The program was an important factor in combining all parties which are operating preventions programs against illegal drug use and alcohol consumptions among young people.

There was done an evaluation in 2002 about the program, *Iceland without drugs*. The results of the evaluation showed that the program had been more successive if certain parties had been more involved with the program, like school administrations and the health sector, mainly the primary health care sector.

On 1 June 2007, an Act of law entered into force placing a total prohibition on smoking in the service areas of restaurants and clubs. The main purpose of the Act is to protect the health and safety of the employees with reference to applicable occupational health and safety laws and smoking ban laws and the protection of the public with reference to a rapidly increasing compilation of scientific evidence that shows that passive smoking is detrimental to health and causes deaths. When this main objective is met, one may expect a variety of other benefits from the smoking ban, both for the society and for individuals.

Table 20. Smoking habits 15-69 ára 2005 – 2007.

	Number of participants	Total	Have never smoked	Stopped more than a year ago	Stopped less than a year ago	Smoke occasionally	Smoke daily
2005	841	100.0	46.7	26.5	4.8	3.6	20.5
2006	2583	100.0	45.8	27.6	4.5	3.3	18.8
2007	3394	100.0	46.6	27.1	3.9	3.5	19.0

Source: The Public Health Institute of Iceland.

As is shown in Table 20, there is a slight decrease in the number of those who smoke on a daily basis, and for comparison, one could mention that in 1987, 33% of the participants of a similar survey were smokers. See also Table 9 in the 18th report of the Icelandic Government.

The results of the ESPAD[2] study in 2007 shows that, notwithstanding that one of every nine students in the 10th class of the primary school is a smoker, the percentage of students who smoke every day has decreased by close to 50% in twelve years, from 21% in 1995 down to 11% in 2007. According to this ratio, one may expect that 500 students in the 10th class smoke on a daily basis. According to the results of the survey, this change in the proportion of students in the 10th class may be explained by, first, an increasing suppression by the government through laws and regulations and an increased pressure by society, school management and parents. Second, preventive projects by various parties such as non-governmental organisations, municipalities and

[2] European School Survey Project on Alcohol and Other Drugs, which is a joint project of scholars from over forty countries.

agencies have all played a part in contributing to a reduction in the numbers of smokers among 10th class students.

Table 21. Consumption of alcaholic beverages 2005 – 2007.

	Litres of pure alcohol	Beer		Wine		Spirits	
		Litres sold	Litres of pure alcohol	Litres sold	Litres of pure alcohol	Litres sold	Litres of pure alcohol
Quantity total, 1,000 litres							
2005	1.624,8	17.044,0	854,9	3.564,5	449,4	806,4	306,7
2006	1.721,6	18.160,3	903,2	3.744,7	471,8	863,4	325,9
2007	1.852,0	19.443,6	970,6	4.000,5	502,7	948,3	358,3
Litres per inhabitant							
2005	5,49	57,61	2,86	12,05	1,52	2,73	1,04
2006	5,66	59,67	2,97	12,30	1,55	2,84	1,07
2007	5,95	62,44	3,12	12,83	1,61	3,05	1,15

Source: The Public Health Institute of Iceland.

If Table 21 is compared to a similar table in the 18th report of the Icelandic Government, one can see that alcohol consumption is steadily increasing, as according to that table, there were 1,254.8 litres of pure alcohol sold in 1999, compared to 1,852.0 litres in 2007, which is an increase of 47% over a seven-year period.

According to the results of the ESPAD survey discussed above, the intoxication of adolescents was greatly reduced during the years 1995–2007, and the percentage of students in the 10th class who had been intoxicated during their lifetime decreased from 64% to 42% between the years 1995 and 2007. Changes in the proportion of students in the 10th class who had been intoxicated during the previous 30 days decreased from 56% in 1995 to 21% in 2007. These results may primarily be credited to effective preventive work.

Vaccinations.
Vaccinations have been common in Iceland for decades, and participation is high, particularly regarding the vaccinations of children. This is extremely important, as epidemics cannot be restrained unless the majority of the population is vaccinated. It is important that the vaccination of children covers all children in each age group. That way it is possible to form a so-called herd immunity against virulent contagious diseases, which means that immunity against these becomes sufficient enough throughout the country to be able to prevent the spreading of the diseases even though individual cases may appear.

Due to the general participation of the inhabitants in the vaccinations, there has not been considered any need to make vaccinations mandatory. The vaccinations of children are free of charge for people, but adults and tourists pay for vaccinations. Special vaccinations due to official measures against communicable diseases are free of charge for people.

Table 22. Organisation of the vaccination of children in Iceland after 1 January 2007.

Age:	Vaccination against:
3 months	Pertussis, diphtheria, tetanus, Haemofilus influenzae type b (Hib) and polio in one shot
5 months	Pertussis, diphtheria, tetanus, Haemofilus influenzae type b (Hib) and polio in one shot
6 months	Neisseria meningitidis C
8 months	Neisseria meningitidis C
12 months	Pertussis, diphtheria, tetanus, Haemofilus influenzae type b (Hib) and polio in one shot
18 months	Measles, mumps and rubella in one shot
5 years	Diphtheria, tetanus and pertussis in one shot
12 years	Measles, mumps and rubella in one shot
14 years	Diphtheria, tetanus and pertussis with polio in one shot

Comment by the Committee of Independant Experts.
Conclusions XVII-2 – p. 7
Air pollution – The Committee notes that local authority health committees and the environment agency are responsible for the application of the Health and Anti-Pollution Act, No. 7/1998, as amended. Five percent of the agency's budget is devoted to monitoring such pollution. The Committee asks to be kept informed of any developments in law and in practice.

No signifcant changes have been made in law or in practice of the Health and Anti-Pollution Act, No. 7/1998, with subsequent amendments.

Comment by the Committee of Independant Experts.
Conclusions XVII-2 – p. 8
Ionising radiation - The Committee asks for details in the next report on the monitoring arrangements laid down in the Radiation Protection Act, No. 44/2002.

The Icelandic Radiation Safety Authority monitors employees' effective radiation doses and maintains a record of the results. The Icelandic Radiation Safety Authority is responsible for the regular assessment of radiation to which the public is exposed from operations[3] to which the Act applies, as well as a separate assessment of radiation levels to which patients are exposed from medical irradiation. An assessment is made of the usefulness and risk of new types or categories of types where ionising radiation is used.

[3] Operations pursuant to Act No. 44/2002 involve manufacture, imports, exports, delivery, ownership, installation, use, handling and disposal of radioactive materials and radiological equipment, *cf.* the fourth paragraph of Article 13.

Those who operate under the Act must take precautions and organise responses to radiation accidents.

The Icelandic Radiation Safety Authority may require the removal or disposal of radioactive materials or radioactive materials no longer in use.

A separate assessment is made of the usefulness and risk of medical irradiation.

All new types or categories of activities that can cause ionising radiation to people must be pre-evaluated taking into account economic, social or other usefulness as compared to the risk of the harmful health effects the radiation may have.

The Act provides for a dose register to be maintained by the Icelandic Radiation Safety Authority on the results of individual radiation monitoring. The registry is subject to the provisions of the Act on Protection of Privacy as regards the Processing of Personal Data. The results shall be stored for the entire period during which the worker is subjected to ionising radiation at work, and until such time he/she reaches the age of 75 and, in any event, for not less than 30 years after the worker ceases working in the position causing exposure to ionising radiation. A special account shall be given of results that are not based on individual monitoring. The effective dose of a radiation accident shall be especially recorded, as well as the circumstances of the radiation and the measures taken.

Comment by the Committee of Independant Experts.
Conclusions XVII-2 – p. 8.
Noise – The Committee notes that there are a number of general noise prevention measures, such as regulations Nos. 933/1999 and 941/2002, as well as regulation relating to specific areas, such as road and air traffic and industry. The Committee asks for practical information in the next report on methods used, as well as information on data collection.

Regulation No. 933/1999 was repealed by Regulation No. 724/2008 on Noise.

According to the Regulation, a health committee may issue recommendations to operators for specific equipment at places of assembly, outdoor festivals and other places where people gather for short periods to prevent people from suffering discomfort or hearing damage caused by noise, and to inform guests of the level of noise in the location.

The responsible party is required to notify the health committee of events where it may be expected that the level of noise is higher than the limits that are specified in the appendix of the Regulation concerning noise levels for social gatherings with reasonable notice, and that party shall carry the cost of supervision at the concert, including sound measuring according to price list. The health committee may issue recommendations to the party responsible for the venue in question that he/she offer guests earplugs and display special warning signs in prominent locations warning of high levels of noise, establish age limits for guests, provide information of the location of loudspeakers and on other items that the health committee considers necessary to prevent noise levels that are detrimental to health.

The Environment Agency of Iceland issues, in co-operation with the Planning Agency and other authorities as is appropriate, guidance on the treatment of noise reduction requirements in planning, criteria for noise reduction requirements in nursery and primary schools and elsewhere where children spend time and where there is considered to be a risk that noise could cause them inconvenience or be detrimental to their health, and methods for measuring noise levels for supervising purposes.

Health committees are responsible for the implementation of the Regulation on Noise under the oversight of the Environment Agency of Iceland. Health committees shall, as needed, carry out or have carried out, noise monitoring measurements.

A health committee may, in order to enforce the implementation of measures pursuant to the Regulation on Noise, issue reprimands and grant a reasonable period for improvement, or halt or limit the activities in question or any use, when appropriate, to prevent noise levels detrimental to health, such as the traffic of noisy transport vehicles on any particular roads through residential areas and in the neighbourhood of hospitals or other healthcare institutions in consultation with the police.

If an entity does not heed the instructions of the health committee to reduce noise levels that are detrimental to health, or does not comply with noise level limits, within the deadline given, the health committee may impose daily fines of up to ISK 500,000 until the matter has been remedied.

Violations of the provisions of the Regulation may be subject to fines irrespective of whether committed intentionally or through gross negligence. In the event of gross or repeated intentional violations, such violations, moreover, shall be punishable by imprisonment of up to four years.

New Regulations No. 921/2006 on the Prevention of Stress due to Exposure to Noise in Workplaces, entered into force in 2006 following the special attention that the Administration of Occupational Safety and Health in Iceland had brought to bear on the possible harmful effects of noise in the workplace in 2005. This matter is discussed in greater detail in Article 3 of this report.

Article 12
The right to social security

Article 12, para. 1. – Existence of a system of social security

The Social Security System.

The Government which took office in the year 2007 decided to reorganise the division of tasks in the field of social security. According to a new legislation that entered into force on 1 January 2008 the responsibility and supervision of the social pension scheme and state social assistance was transferred from the Ministry of Health and Social Security to the Ministry of Social Affairs. The two ministries were given new names accordingly, the first mentioned was given the name Ministry of Health and the second the Ministry of Social Affairs and Social Security. In addition the affairs of the elderly was transferred to the Ministry of Social Affairs and Social Security from the Ministry of Health. The Ministry of Health is from 1 January 2008 only responsible for health care and health insurance, occupational injuries insurance and occupational diseases insurance. The Ministry of Social Affairs and Social Security is responsible for national pension insurance and the social assistance from the state in addition to the issues the Ministry was responsible for, such as the unemployment insurance, maternity/paternity leave cash benefits, payments to the parents of long term sick or severly disabled children and adoption benefits. The objective of this reorgination was to streamline and strenghten the administration. The policy emphasises also strengthening the position of senior citizens and the disabled.

The Prime Minister established a committee with government representatives and representatives from the Association of the Elderly in Iceland in the year 2005. The task of the committee was to propose a new plan for the next few years regarding old age benefits from the national pension scheme and social services at home when the elderly decide to live in their own houses. The committee made proposals to the Prime Minister in July 2006. In accordance with the proposals the amounts of the pension benefits were increased on 1 July 2006 by 5.5% and a special supplement was paid for the period July to December 2006. Other proposals needed changes in the Act on Social Security and Act on the Affairs of the Elderly and entered into force 1 January 2007. The changes in the legislation included simplification of the national pension scheme and increases in pension benefits. The changes also included a new definition of "other income" of a pensioner, minimizing the influence of the spouses' income and allowing pensioners to have a certain amount of income before pension is reduced. Various proposals were made as regards the social services, nursing and institutions for long-term residence of the elderly.

The Parliament passed various changes to the Act on Social Security, which was reissued as Act No. 100/2007, regarding the national pension scheme that entered into force in stages during 2007 and 2008. The objective was to improve the situation of the elderly and the disabled. Further changes were made to the calculation of the income-testing of the national pension benefits, increasing the maximum income levels or free brackets, (i.e. a part exempt from income-testing) for employment earnings, occupational earnings and financial earnings.

Legislation on old age and invalidity pensions was simplified, income testing was decreased and pension amounts increased. A person can defer old age pension until he or she is 72 years of age with yearly increase in pension amount. Persons aged 70 years and older can earn income from employment without affecting the amount of the national pension. The aim of this legislation is to enable or encourage the elderly to stay at the labour market longer should they wish so. The Government reduced according to the policy the general ratio of income that affects the national pension amount from 39.95% to 35%.

Furthermore, specific actions were taken to minimise overpayment and underpayment of insurance benefits as of 1 April 2008, for instance, by establishing an ISK 90,000 deduction-free capital gains income limit. The personal allowance of residents in care institutions, moreover, was increased by almost 30% from 1 April 2008, and the deduction-free income allowance was discontinued. As of 1 April 2008, the curtailment ratio of old age pensions was decreased from 30% to 25%. The deduction-free income allowance with regard to income from employment for old age pensioners aged 67–70 was also increased to ISK 100,000 per month as of 1 July 2008. As of 1 July 2008, the amount of the age-related disability pension supplement was increased. As of 1 July 2008, an ISK 300,000 deduction-free income allowance was introduced for disability pension recipients receiving income from pension funds. Moreover, the curtailment of pension payments due to withdrawals from private pension funds was discontinued from 1 January 2009.

The emphasis in the social security system in the year 2006 was, as in the year 2005, on the affairs of the elderly. The Minister of Health and Social Security issued a new plan for the future where the main principle is to give domiciliary care priority over residential care. There is a growing emphasis on providing nursing and care to chronically ill people in their homes to enable them to live as long as possible in their own homes. Persons who are unable to continue living in their own homes as a result of chronic illness, notwithstanding support, shall be ensured other recourses, such as hospitalisation or other institutionalisation in institutions intended for the long-term residence of people who are not capable of living at home, even with support.

Development of nursing facilities for 400 senior citizens will be expedited and the number of single dwellings increased. Round-the-clock services will be strengthened and individual-based services increased. Means testing and curtailment of social security benefits will be scaled down.

Number of benefit recipients and total allocations to social security.
According to information from Statistics Iceland, 307,672 individuals were domiciled in Iceland on 31 December 2007. The age spread was as follows: 70,024 were 15 or younger, 205,986 were aged between 16 and 66 and 31,665 were over 67. This total figure includes those who had been in the country for less than six months. Under the Social Security Act, No. 100/2007, with subsequent amendments, six months' domicile in Iceland confers the right of medical insurance and three years' domicile confers the right to pension insurance, providing other conditions are met.

In 2007, 62.601 individuals, or 20% of the population, received payments of some type from the Social Security Administration. Of the recipients of payments 2007 from the Social Security Administration 7,352 received only child support. 50,339 received social security benefits or benefits based on the law on social assistance and additional 4,910 received payment based on

both schemes. The largest group of recipients, 27,397, consist of old-age pensioners and about 13,616 disabled persons received disability benefit.

Under the budget for 2007, social expenditure was ISK 111,4 billion or 8.61 of GDP. Thereof, payments from the public pension funds, i.e. olde age pension, invalidity pension and child pension, accounted for ISK 37,265 million, or 2.9% of GDP. Expenditure for social security health insurance was ISK 17,707 million in 2007.

Social Security Benefits.
Tables 23-25 shows the benefit sums to which individuals may be entitled under the Social Security Act, No. 100/2007, the Social Assistance Act, No. 99/2007, the Maternity/Paternity Leave and Parental Leave Act, No. 95/2000 and the Unemployment Insurance Act, No. 54/2006.

Table 23. Benefits according to the Social Security Act, No 100/2007, and the Social Assistance Act, No. 99/2007.

Benefits according to the Social Security Act, No 100/2007		
Pension benefits		**Monthly benefits January 1st 2007**
Old age pension (basic pension)	ISK	24.831
Pension supplement on old age pension	ISK	78.542
Invalidity pension (basic pension)	ISK	24.831
Pension supplement on invalidity pension	ISK	79.674
Pension supplement for each maintained child under age 18	ISK	18.284
Personal allowance, hospital and nursing home residents	ISK	28.591
Sickness benefits		
Per diem sickness benefits, individual	ISK	966
Per diem sickness benefits, for each maintained child	ISK	264
Occupational injury benefits		
Per diem occupational injury benefits, individual	ISK	1.184
Per diem occupational injury benefits, for each maintained child	ISK	253
Widow/widower benefits (occupational injuries, 8 years)	ISK	27.429
Other		
Child maintenance for one child	ISK	18.284
Benefits according to the Social Assistance Act, No. 18/1993		
Household supplement (only to those who live alone)	ISK	23.164
Supplement for the operating costs of an automobile	ISK	9.092
Single parent allowance for 2 children (single parent)	ISK	5.325
Single parent allowance for 3 or more children	ISK	13.846
Death allowance 6 months	ISK	27.429
Death allowance 12-48 months	ISK	20.565
Home care allowance to parents taking care of disabled or chronically ill children	max. ISK	96.978

Source: Statistics Iceland

Table 24. The Maternity/Paternity Leave Cash Benefits.

	2005	2006	2007
The maximum monthly payments from the Maternity/Paternity Leave Fund* to parents who have been active on the labour market.	480.000 kr.	504.000 kr.	518.600 kr.
The minimum monthly payment from the Maternity/Paternity Leave Fund* to parents who have been active on the labour market in 25-49% jobs.	67.184 kr.	72.543 kr.	72.589 kr.
The minimum monthly payment from the Maternity/Paternity Leave Fund* to parents who have been active on the labour market in 50-100% jobs.	93.113 kr.	97.769 kr.	100.604 kr.
Parental allowances for parents outside the labour market or in less than 25% job**	41.621 kr.	42.662 kr.	43.889 kr.
Parental allowances for students (75%-100%)	93.113 kr.	95.441 kr.	98.209 kr.

*Employees who have been working at least six months on the labour market are entitled to 80% of their average wages with certain minimum and maximum payments.
**Maternity/Paternity benefits for those who are not active on the labour market or are in school.

Table 25. The Unemployment Benefits.

	2005	2006	2007
The maximum monthly payments from the Unemployment Insurance Fund for the first three months*	___	185.400 kr.	185.400 kr.
The basic unemployment benefits to the unemployed who was in full employment last twelve months	91.426 kr.	111.015 kr.	114.244 kr.

*Employees who have been working twelve months on the labour market are entitled to 70% of their average wages with certain maximum payments.

Comment by the Committee of Independant Experts.
Conclusions XVIII-1 p. 15
The Committee asks the next report to provide figures, for the period of reference, for any branch in percentage in order to be able to assess the effective coverage of the population (health care, sickness insurance and family benefits) and of the active population (sickness and maternity benefits, unemployment benefits, pensions, and work accidents or occupational diseases benefits).

Health care and sickness insurance.
Everyone who has had domicile in Iceland longer than six months is sickness insured in Iceland and therefore has access to the health care system.

Table 26. Number of patients in a specific cost interval by specialites 2005 – 2007. Cost interval in ISK.[1]

	0.-.3.500	**3.501– 7.000**	**7.001 – 10.000**	**10.001 – 30.000**	**30.001 – 50.000**	**50.001<**
2005	38.278	105.456	38.392	109.334	21.450	11.698
2006	25.277	98.561	41.427	92.943	19.711	12.769
2007	15.205	97.592	50.581	94.678	20.3931	16.085

1) The cost-interval refers to total cost, i.e.patient payment of cost plus the health insurance payment/reimbursement to the specialists.

Table 27. Number of recipients with unreduced invalidity pensions and allowances 2005.

Recipients in each category	**Basic pension**	**Pension supplement**	**Household supplement**
Old age pensioners	25.282	9.566.	4.056
Invalidity pensioners	11.706	6.367	2.702
Rahabilitation pensioners	757	511	201
Total number of recipients with unreduced pensions and allowances	37.745	16.445	6.959
Total number of pensioners in each category	40.254	34.756	11.968

Source: Social Security Administration.

Table 28. Number of recipients with unreduced invalidity pensions and allowances 2007.

Recipients in each category	Basic pension	Pension supplement	Household supplement
Old age pensioners	25.924	364	212
Invalidity pensioners	12.195	2.218	999
Rahabilitation pensioners	866	391	165
Total number of recipients with unreduced pensions and allowances	38.985	2.973	1.376
Total number of pensioners in each category	41.955	37.179	12.485

Source: Social Security Administration.

Table 29. Number of recipients with unreduced monthly old age pensions 2005 – 2007

	Retirement pension	Pension supplement, lump sum payments	Basic pension and supplement with lump sum payments	Household supplement/additonal household supplement/Additional pension supplement	Samtals greiðslur frá TR
2005	21.993	47.065	69.058	40.978	110.036
2006	23.502	53.577	77.079	42.616	119.695
2007	24.831	81.815	106.646	24.129	130.775

Source: Social Security Administration.

The Maternity/Paternity Leave.

The Act on Maternity/Paternity Leave and Parental Leave applies to the rights of parents working in the domestic labour market to be granted maternity/paternity leave and parental leave. When parents have been active on the labour market six months or longer before the date of birth they have the right to payments according to the act.

Table 30. Payments to parents during maternity/paternity leave 2005-2007.

	2005			2006			2007		
	Males	Felmales	Total	Males	Females	Total	Males	Females	Total
Numbers									
Maternity /paternity leave	5.455	5.366	10.821	5.514	5.452	10.966	5.881	5.827	11.708
Maternity /paternity allowences	414	1.221	1.635	393	1.280	1.673	374	1.307	1.681
Total	**5.869**	**6.587**	**12.456**	**5.907**	**6.732**	**12.639**	**6.255**	**7.134**	**13.389**
Million ISK									
Maternity /paternity leave	2.823	3.320	6.143	2.926	3.457	6.383	3.412	4.125	7.537
Maternity /paternity allowences	96	355	451	93	378	471	93	383	476
Total	**2.919**	**3.675**	**6.594**	**3.019**	**3.835**	**6.854**	**3.505**	**4.508**	**8.013**

Family benefits.
In Iceland, child benefit is paid to parents for children who they support under 18 years of age.

Table 31. Child benefits.

	2005	2006	2007
Number of parents having child benefits	53.871	55.481	63.691
Proportion of parents having child benefits from the population registered with the tax authorities.	23,0%	23,0%	25,1%

Unemployment Insurance.
People who have been working twelve months on the domestic labour market before the date they get unemployed are fully insured according to the Act on Unemployment Insurance.

Table 32. The average monthly registered unemployment 2005 – 2007.

Percentage	**2005**	**2006**	**2007**
Monthly registered unemployment	2,5%	1,3%	1,0%
Women	2,8%	1,8%	1,4%
Men	1,8%	0,9%	0,8%
Numbers			
Monthly registered unemployment	3.120	2.017	1.632
Women	1.777	1.150	911
Men	1.343	866	721

Source: Directorate of Labour.

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The report provides information on the level of social security benefits. The Committee completed this information with information from MISSOC1. However, the Committee was unable to assess the adequacy of such benefits because information on the poverty threshold defined as 50% of median equivalised income and as calculated on the basis of the Eurostat at-risk-of-poverty threshold value, is not available. It asks the next report to provide this information.

In the years 2003 to 2006 just under 10% of the population living in private households was at risk of poverty according to the EU-SILC definition. This was based on a sample survey; the confidence-interval indicators given in Table 33 show the uncertainty in this assessment.

Table 33. At-risk-of-poverty rate by age and gender.

	Rate				2006	
	2003	2004	2005	2006	*CI*	*Estimated number*
All ages						
Total	10.0	9.7	9.6	9.9	+/- 1.2	29,500
Males	9.6	9.8	9.1	8.9	+/-1.3	13,400
Females	10.5	9.6	10.1	11.0	+/- 1.5	16,100
18 and over						
Total	9.5	9.6	8.9	9.3	+/- 1.1	20,400
Males	8.9	9.6	8.2	8.3	+/- 1.3	9,100
Females	10.1	9.6	9.6	10.4	+/- 1.4	11,300
18-64 years						
Total	9.3	9.6	8.4	8.4	+/- 1.1	15,500
Males	8.9	9.6	7.8	8.0	+/- 1.3	7,500
Females	9.8	9.6	8.9	8.8	+/- 1.3	8,000
65 and over						
Total	10.3	9.2	11.8	14.7	+/- 3.6	4,900
Males	8.8	8.6	10.0	10.1	+/- 4.0	1,600
Females	11.7	9.8	13.5	18.8	+/- 5.2	3,300

Source: Statistics Iceland.

Analysed by age and gender, the rate below the poverty threshold in the year 2006 was highest (just over 15%), among women aged between 18 and 24 and among women aged 65 and older (just below 19%). Among men aged 65 and above, the rate was 10.1%; however, the sample was not sufficiently large to enable us to state that there is a significant difference between the sexes in this age group, since the confidence levels overlap. The rate below the threshold was lowest (5-6%) among people aged 50 to 64. Among the 0-17 age group, the at-risk-of-poverty rate in 2006 was 11.7%.

The low-income limit in 2006 was ISK 126,000 per month for households consisting of a single individual; this was 60% of the median value of disposable income per consumption unit (*cf.* Table 34). Thus, those living alone with disposable income under ISK 126,000 per month fell below the at-risk-of-poverty threshold according to the definition. The corresponding income figure for a household consisting of two adults and two children under the age of 14 was ISK 265,000 per month.

Table 34. At-risk-of-poverty threshold (illustrative values).

ISK per month	2003	2004	2005	2006	*CI* 2006
One person houshold	96.900	103.200	111.400	126.000	+/-17.700
Two adults and two children	203.500	216.700	233.900	264.500	+/- 37.100

Source: Statistics Iceland.

Article 12, para. 2. – Maintenance of social security system at a satisfactory level at least equal to that required for ratification of International Labour Convention No. 102.

Reference is made to previous reports.

Article 12, para. 3. – Development of the social security system.
Reference is made to the previous report and to Article 12, para. 1 of this report.

Article 12, para. 4. – Social security of persons moving between states.

Comment by the Committee of Independant Experts.
Conclusions XVIII-1 p. 18
The Icelandic report fails to provide the information *requested by the Committee in its previous conclusion (Conclusions XVI-I, p. 323). The Committee reiterates its question on the States with which Iceland concluded multilateral or bilateral agreements. The Committee recalls that it previously concluded for the non-conformity of the situation on the following grounds:*

- *the payment of family benefits is conditional on the claimant's children being resident in Iceland, subject to any bilateral or multilateral agreements that may be applicable;*
- *retention of accrued benefits is not guaranteed where persons move to a state party not bound by Community regulations or by an agreement with Iceland;*
- *Icelandic legislation does not provide for the accumulation of insurance or employment periods completed by the nationals of States party not covered by Community regulations or bound by agreement The Icelandic report fails to provide the information requested by the Committee in its previous conclusion.*

According to the Social Security Act, the Government may negotiate with foreign States and the Minister of Social Affairs and Social Security may negotiate with foreign insurance institutions on reciprocal rights to benefit under Social Security legislation. Such agreements may include provisions stating that the period of residence, period of employment or period of insurance in another contracting State shall be equivalent to the period of residence in Iceland, whether or not the persons involved are Icelandic citizens or citizens of other contracting States. Such agreements may, furthermore, provide a right to benefit payments under the Social Security Act with respect to residence in another contracting State.

The Icelandic authorities have been making agreements with authorities in other countries and have decided to negotiate with countries where the most exchange takes place between nationals of the countries. It has to be borne in mind that Iceland has a very small administration and cannot negotiate with all countries concerned, especially if these countries show little or no initiative in making agreements with Iceland.

Since 1 January 1994, Iceland has been a member of the Agreement on the European Economic Area and applies EU Regulations No. 1408/71 and 574/72 on Social Security for Migrant Workers. The Agreement on the European Economic Area has been extended twice, in 2004 and 2007. The other members of the Agreement are Austria, Belgium, Bulgaria, Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Liechtenstein, Lithuaina, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal,

Romania, Slovakia, Slovenia, Spain, Sweden and the United Kingdom. Iceland has made additional agreements on social security for those who are not covered by the two EU regulations with Austria, Denmark, Finland, Luxembourg, Norway, Sweden and the United Kingdom.

The EFTA/EEA (Iceland, Norway and Lichtenstein) states have made an agreement with Switzerland under which EU Regulations 1408/71 and 574/72 are made applicable. The agreement with Switzerland entered into force on 1 June 2002.

No other bilateral or multilateral agreements apply to the social assistance and Iceland has not received requests from countries that are members of the Social Charter but not members of the EEA Agreement to make such agreements.

Reference is made to the 17th report of the Iclandic Government.

Comment by the Committee of Independant Experts.
Conclusions XVIII-1 p. 18
However since not all countries apply such a system, states applying the 'child residence requirement' are under the obligation, in order to secure equal treatment within the meaning of Article 12§4, to conclude within a reasonable period of time bilateral or multilateral agreements with those states which apply a different entitlement principle. The Committee therefore asks the next report to indicate whether such agreements exist with the following countries: Albania, Armenia, Georgia and Turkey, or, if not, whether it is envisaged to conclude them and in what time delay.

No, there are no such agreements with Albania, Armenia, Georgia and Turkey and Iceland has not received requests from these countries to make such agreements so the Government has not take any decision on making such agreements.

Comment by the Committee of Independant Experts.
Conclusions XVIII-1 p. 18
The Committee notes from another source that non-EU/EEA nationals of States party to the Charter or the Revised Charter must be in possession of a permanent work permit in order to be entitled to unemployment benefits. It asks what are the conditions governing the grant of such a permit.

According to the Foreign Nationals' Right to Work Act, No. 97/2002, a foreign national may be granted an unrestricted work permit when the following conditions are met:

a. the foreign national has acquired a permanent residence permit under the Foreign Nationals Act,
b. a written employment contract between the foreign national and an employer has been made and signed, and
c. the foreign national has previously been granted a temporary work permit under Article 8, or a temporary work permit in connection with a temporary residence permit granted on humanitarian grounds under Article 11.

According to the Act an immediate family member of a foreign national who holds an unrestricted work permit meeting the requirements of items *a* and *b* may be granted an unrestricted work permit. Children who have acquired permanent residence permits in Iceland under the Foreign Nationals Act before the age of eighteen years may be granted unrestricted work permits when they reach the age of eighteen years.

An unrestricted work permit shall expire if the foreign national lives abroad continuously for a period of more than eighteen months. The Directorate of Labour shall take the decision on cancelling such permits. However, the Directorate of Labour may, after receiving comments, grant exemptions from the restriction imposed, with the result that the foreign national shall retain an unrestricted work permit despite living abroad for a longer period.

Foreign nationals that have received residence permit in Iceland have to register their domicile in The National Register. As soon as they have registered their domicile they have a right of social service from the municipality that their domicile is in**.**

Article 13
The right to social and medical assistance

Article 13, para. 1. – Adequate assistance for every person in need.
There has not been changes in the legislation on the local authorities' social services so reference is made to the 17th report of the Icelandic Government.

Table 35 shows the number of households that sought social assistance from the local authorities in the period 2005-2007 according to the records of Statistics Iceland. During this period, between 4-5,000 households received financial assistance from the local authorities each year. The largest group receiving financial assistance, 37% on average, were single men without children; the second-largest group (34% on average) consisted of single mothers.

Table 35. Municipal income support, by age of recipients 2005–2007.

	Total	*Capital area*			*Municipalities with over 300 inhabitants 1)*
		Total	Reykjavík	*Other municipal-ities*	
2005					
Households, total	**4,825**	**3,639**	**2,963**	**676**	**1.186**
Age of recipients					
24 years and under	1,385	1,060	858	202	325
25–39 years	1,885	1,412	1,147	265	473
40–54 years	1,138	868	707	161	270
55–64 years	265	189	161	28	76
65 years and over	152	110	90	20	42
18 years or older, total 1)	5,246	3,896	3,167	729	1,350
2006					
Households, total	**4,579**	**3,395**	**2,715**	**680**	**1,184**
Age of recipients					
24 years and under	1,238	940	747	193	298
25–39 years	1,847	1,382	1,110	272	465
40–54 years	1,103	798	632	166	305
55–64 years	263	183	153	30	80
65 years and over	128	92	73	19	36
18 years or older, total 1)	4,958	3,623	2,894	729	1,335
2007					
Households, total	**4,280**	**3,120**	**2,509**	**611**	**1,160**
Age of recipients					
24 years and under	1,126	842	660	182	284
25–39 years	1,815	1,335	1,086	249	480
40–54 years	957	679	549	130	278
55–64 years	248	169	137	32	79
65 years and over	134	95	77	18	39
18 years or older, total 1)	4,678	3,345	2,693	652	1,333

1) Total number of recipients of income support, 18 years or older, is found by doubling the number of households of married/cohabiting couples.

In 2007, financial assistance provided by the City of Reykjavík could amount to ISK 95,325 per month for an individual and ISK 152,520 per month to a married or cohabiting couple. This assistance was independent of the number of children, as it was assumed that child benefit, child maintenance and child pension payments would suffice to meet the needs of the children.

Table 36. Number of households receiving financial services of the Reykjavik Social services.

	2005	2006	2007
Total number of households.	2.929	2.685	2.491

Table 37. Types of financial assistance in Reykjavik in 2007 – number of cases.

Types of financial assistance	Total
Financial assistance	1.656
Special occupational assistance.	294
Financial assistance for students for fees and books	262
Special financial assistance for students	252
Counselling	207
Assistance to families with children	156
Assistance because of special difficulties	154
Grants for housing deposit	126
Tentist financial assistance	77
Grants for furniture	71
Financial assistance regarding funerals	45
Financial assistance to storage furniture from the household.	20
Trauma assistance	17
Other assistance	336
Total number of households	**2.421**

Financial assistance provided by the Kópavogur Social Services amounted to ISK 100.950 per month for an individual in 2007. The support base for an individual aged 18 or older is rated as 1.0; that for a couple (married or cohabiting) is 1.6. As in Reykjavík, the monetary amount of financial assistance is independent of whether or not a child or children live in the home. An individual living with his or her parents receives half the basic sum each month, less the deduction of his or her personal income. Financial assistance paid for an individual by Akureyri, a municipality in the northeast of Iceland, could amount to ISK 96.000 per month in 2007. The basic level of support there is the same as in Kópavogur.

Persons living in rented accommodation may be entitled to rent benefit; the aim of this is to cut the housing costs of low-income renters and reduce inequalities in their position on the housing market.

In the wake of the onset of the economic recession in autumn 2008, the Minister of Social Affairs and Social Security appointed a steering committee to monitor welfare issues; this was in accordance with the resolution by the government of 10 February 2009. The committee is expected to monitor systematically the social and financial consequences of the economic situation for families and individuals and to propose measures to be taken to meet the needs of households. The committee consists of sixteen members, including representatives of the social partners, the government ministries, NGO's and the local authorities. The role of the committee is to gather information on the social and financial consequences of the economic situation for families and individuals, to gather information on the experience of other nations of dealing with economic recessions, to identify means that the state, the local authorities and NGO's can use to respond to the situation and to stimulate consultation and collaboration between those who can make a contribution in view of their skills and experience.

The steering committee monitoring welfare issues has set up a number of task forces to examine various matters that are regarded as urgent. The main focus in this is on the welfare of children; it is regarded as a priority to find means of providing the best possible protection for children's interests. In addition, the steering committee is giving particular attention to the position of children and young people in the 15-25 year-old age group. There is also a task force which is giving special attention to the position of those who were particularly vulnerable before the collapse in October 2008, as it can be expected that this group will also be particularly badly affected by the deterioration in the economic environment. Other task forces are concerned with the unemployed, with the financial position of households and the use made of the health services.

The steering committee to monitor welfare issues has submitted two interim reports to the Minister, one in March and one in August 2009. It was on the basis of the first of these that the government adopted its plan of action on welfare issues. This plan is intended to promote effective and dynamic welfare and social services. It outlines the government's priorities regarding welfare over the coming one or two years; these include the establishment of a fund which is intended to finance research on welfare issues and special measures aimed at helping specific groups which are worst affected by the recession. It is also planned that experts will be engaged to construct social indicators for use in the systematic monitoring of the social and economic consequences of the economic crisis on the family in Iceland. Resources will also be made available from the fund for special studies of the consequences of the economic situation on children, and whether the increase in the number of reports of abuse, neglect, etc. to the child welfare authorities can be attributed to the crisis. The work of the NGO's will also be examined, and efforts will be made to coordinate it. The steering committee also makes it a priority to ensure easy access to the welfare services and that effective remedies will be available to households that are in serious debt. It is also regarded as important that those who have lost their jobs should remain active as far as possible, and that a variety of openings be explored for creating new jobs.

The second report states, amongst other things, that many of the local authorities have made special efforts to adapt their social service programmes to the changed circumstances and to assess the extra need for services. Collaboration between departments within the local authorities, and also between the local authorities and state agencies, has been enhanced. Work is in progress on establishing closer collaboration between the Directorate of Labour and the local authorities'

social service departments. In many places, social centres have been opened and NGO's have been active in assisting people in the local communities. Parallel with these developments, the government has advanced a number of remedies for households facing solvency problems, and launched new labour-market measures. The revival of the economy is seen as the prerequisite for having all the organs of society function at their full strength, and until this stage is achieved, care is to be taken to ensure that spending cuts and savings measures will have the smallest possible effect on children and young people. At the same time, active labour-market measures will continue to be a priority; these will include means of looking after and supporting the long-term unemployed and young people who are unemployed. This group includes a large number of people who have completed only compulsory schooling or comparable levels of education. Up to now, little change has taken place in the pattern of use of the health services that can be attributed to the economic crisis.

The steering committee on welfare issues will continue to monitor developments and make proposals to the government on possible measures designed to tackle the situation and its effects on Icelandic society.

Comment by the Committee of Independant Experts.
Conclusions XVIII-1 p. 21
The Committee is unable to determine whether the level of assistance is in conformity with Article 13§1 of the Charter as it has no information on the poverty threshold (defined as 50% of median equivalised income and as calculated on the basis of the Eurostat at-risk-of-poverty threshold value). It therefore asks for information in the next report to enable it to determine the poverty threshold, together with full details of any other benefits (allowances, supplements, reimbursements) to which persons living alone are entitled in addition to the basic financial assistance.

Reference is made to the information given on at-risk-of-poverty rate in the discussion of the Article 12, para 1.

At-risk-of-poverty rate of persons by household type.
A relatively high proportion of single people, with or without children, are below the poverty threshold compared to other household types. Persons living alone who are 65 or older are those who are most at risk of falling below the threshold, with a rate of 41.7%. The next largest group consists of women living alone (31.3%) and single parents (23.3%). The confidence interval in statistics on these groups is broad because of the small numbers sampled; this means that the differences recorded from one year to the next are not statistically significant.

Table 38. At-risk-of-poverty rate of persons by households type.

	Rate				2006	
	2003	2004	2005	2006	*CI*	*Estimated number*
Households without dependent children	10.2	11.2	8.9	10.8	+/- 1.8	11,800
One person household, under 65 years	20.9	24.2	12.6	17.7	+/- 4.9	3,900
One person household, 65 and over	24.3	22.6	27.6	41.7	+/- 8.9	4,400
One person household, female	24.0	22.9	19.4	31.3	+/- 7.0	4,600
One person household, male	20.4	24.4	15.6	20.7	+/- 5.8	3,700
Two adults under 65 years, no children	8.1	9.7	6.8	7.0	+/- 2.5	2,600
Two adults, at least one 65+, no children	3.0	2.3	3.6	2.3	+/- 1.8	600
Other no dependent children	1.8	3.0	4.6	2.2	+/- 2.1	300
Households with dependent children	10.0	8.9	10.0	9.4	+/- 1.6	17,600
Single parent, one or more dependent child	21.9	14.7	27.1	23.3	+/- 7.6	4,600
Two adults, 1 dependent child	7.5	7.6	9.5	6.3	+/- 2.4	2,800
Two adults, 2 dependent child	7.2	8.3	6.2	7.1	+/- 2.6	3,800
Two adults, 3 dependent child or more children	12.1	10.9	10.1	11.7	+/-3.9	4,900
Other households with dependent children	6.7	4.4	5.3	5.6	+/- 3.0	1,500

Source: Statistics Iceland.

There are only special supplements or allowances within the social security system to people living alone who have invalidity or old age pension.

Comment by the Committee of Independant Experts.
Conclusions XVIII-1 p. 21
The Committee wishes to receive information that would enable it to determine whether the Social Services Appeals Committee is independent both from the executive and from the parties. It accordingly wishes to know what safeguards are in place to protect its members against outside pressure (rules on removal from office, revocation, instructions, requisite qualifications for members appointed by the Ministry of Social Affairs, etc.)

The Icelandic administrative system is structured in such a way that it is possible to have an administrative decision reviewed by an authority other than the one that took the original decision. One purpose of this is to increase the security of citizens under the law. Thus, a party to a case, or another person who has the right to appeal against a decision, can lodge an appeal with a higher authority, which is then obliged to re-examine the decision. The general principle is that appeals against decisions taken by individual government bodies may be lodged with the relevant specialist ministry that is responsible for the overall management of a particular class of issues. In the case of decisions by local authorities, it follows from the provision on their autonomy that their administrative decisions may not be the subject of an appeal to the minister unless there is a provision in law permitting this. This point is addressed in Article 103 of the Local Government Act, which states that, all other things being equal, decisions taken by local authorities may be referred to the Ministry of Communication.

It has also been customary in public administration in Iceland to entrust, by law, ministerial power of adjudication in instances of complaint to special complaints committees. These are independent administrative committees appointed to function in parallel with the ordinary administrative systems of the ministries. Thus, it is decided in legislation that instead of it being possible to lodge appeals with the relevant specialist ministries against the decisions of specific institutions, such appeals must be referred to the appropriate complaints committee. The decisions of such committees may not subsequently be referred to the minister or any other authority and are therefore final decisions in the executive structure.

This last-mentioned method was adopted in connection with the Local Authorities' Social Services Act (*cf.* Article 63 of the Act). This means that instead of decisions by a local authority on the granting of its social services being the subject of an appeal to the Ministry of Communication, which is the case with most of their decisions, a special complaints committee with adjudicatory powers was established to deal with them. Thus, the Social Services Complaints Committee is regarded as a superior authority, whose decisions can not be referred to other authorities within the executive structure (*cf.* paragraph 3 of Article 65 of the Local Authorities' Social Services Act). Its rulings are therefore final executive decisions, in the same way as rulings by the Ministry of Communication on local government issues that are referred to it under Article 103 of the Local Government Act.

The Social Services Complaints Committee consists of three people, one of them nominated by the Supreme Court of Iceland who shall be the chairperson of the committee and shall be qualifed lawyer, one nominated by the Minister of Social Affairs and Social Security and one nominated by the Association of Local Authorities in Iceland.

The qualification of the members of the complaint committee, both regarding the party and the concerned local Authority, shall be determined by the rules of Article 3 of the Administrative Procedure Act, No. 37/1993, with subsequent amendments. The Article 3 reads as followed:

1. if he/she is either a party to a case, or the spokesman or the representative of such a party;
2. if he/she is, or has been, a party's spouse, a relative in the descending or ascending line, whether natural or adoptive or by marriage, or a first cousin;
3. if he/she is related to a spokesman or a representative of a party according to the Act;
4. when a complaint has come under review, if he/she has previously taken part in dealing with the case at a lower administrative level. The same shall apply to an official in whom are vested powers of supervision or inspection if he/she has previously been associated with the case in this capacity;
5. if the case concerns to a substantial degree either himself/herself, his/her relatives, his/her immediate superiors in their personal capacity, or an agency or a privately owned company for which he/she has responsibility;
6. if, finally, such circumstances obtain as are likely to cast reasonable doubt upon his/her impartiality.

The question of disqualification shall not, however, arise if what is at stake is negligible, if the nature of the case is such, or if the role of the official or board member in the handling of the case is so trivial as to rule out any danger of ulterior motives influencing the decision.

There are no special safeguards in place to protect its members against outside pressure other than the Administrative Procedure Act.

A party to a case may refer rulings by the Social Services Complaints Committee, including its procedures, to the Parliamentary Ombudsman, as may be done regarding the procedure of other government authorities in other matters. The role of the ombudsman is to exercise, as the agent of the Althingi (parliament), monitoring functions over public administration by the state and the local authorities in the manner further specified by the Parliamentary Ombudsman Act, No. 85/1997. In this way, an attempt is made to guarantee the rights of citizens vis-à-vis the government authorities. The ombudsman is required to ensure that the principle of equality is observed in public administration and that administrative functions are exercised in other respects in accordance with law and good administrative practice. If the ombudsman comes to the conclusion that there were deficiencies in the procedure followed in a case handled by a particular government authority, he may recommend that the authority re-examine the substance of the case.

If a party to a case does not accept the conclusion reached by the Social Services Complaints Committee, she/he may also institute proceedings before the ordinary courts.

Comment by the Committee of Independant Experts.
Conclusions XVIII-1 p. 21
Is the reference to a six-month residence period after being granted resident status or is it to a six-month stay required for domiciliation, which is a condition for obtaining resident status?

There is a six month stay period required before persons moving to the country are fully covered by medical insurance. This requirement applies equally to Icelandic people who have lived abroad and would like to move back home to Iceland and to foreigners who would like to live in Iceland.

The six month stay period starts when the person concerned has registered by the National registry. There is no waiting time to register by the National registry when a person has a permit to stay in the country.

Foreigners, other than nationals of the EEA member states, who would like to live in Iceland have to apply for a permit to stay before they enter the country. When they receive their permits, they can come to the country and register by the National registry the same day. From that day the six month stay period according to the Social Security Act will begin.

According to the Act on Foreign Nationals Right to Work, from 2002, which entered into force on 1 January 2003, employers are obliged to insure foreign workers for the first six months they are living in Iceland. This should preclude the possibility that foreign workers in Iceland will be uninsured during this six-months' period. The Foreigners Nationals Act, also from 2002, has a medical insurance for the first six months in Iceland as a condition for the first permit to stay. The medical insurance for foreigners is not expensive; this costs ISK 50,000-70,000 per person for the whole period.

There are special rules based on the EEA agreement. According to agreement, having held medical insurance in one of the EEA countries for the last six months is considered equivalent to the six-month stay period in Iceland. Thus, if a person from one of these countries, who has held insurance there for the prescribed period, takes up residence in Iceland, he or she is fully covered by medical insurance in Iceland from the first day of stay.

Furthermore, a governmental regulation provides for waiving the requirement of six-month stay period. This is done, for example, when there is an urgent need for medical service in the case of an acute illness, when a kidney patient needs regular treatment, when a person has communicable disease and the Directorate General of Public Health has ordered treatment, etc. These are all reasons of a humanitarian nature.

As stated in the last reports, the six month stay period is required to avoid misuse of the services. People could, and did, take up residence in Iceland mainly to use the medical insurance as it had such wide coverage. A requirement of the six month stay period was thus introduced to protect the system from abuse.

Medical assistance is very expensive services and the health insurance system in Iceland is tax-financed. The aim is not to discriminate between people rather to make sure that the people who actually live in the country and pay their taxes, receive and enjoy the services.

However, it should be emphasised that doctors and hospitals in Iceland are required to treat those in need of urgent care. Individuals who have no medical insurance in Iceland always receive medical services, but must pay for them afterwards. In fact no one would be refused medical attention in emergency cases even if it were revealed that he/she was unable to pay.

Comment by the Committee of Independant Experts.
Conclusions XVIII-1 p. 22
The Committee previously concluded that the situation was not in conformity, on the grounds that nationals of States party which are not also parties to the Nordic Agreement on Social Assistance and Social Services receive no social assistance unless domiciled in Iceland. The Committee understands that at least six months residence is required to be deemed to be domiciled in Iceland, but that social assistance is then payable from the first day to persons who satisfy the residence condition. The Committee asks whether this is correct. If so, it considers that, under the Appendix to the Charter on personal scope, the situation may be considered to be in conformity with Article 13§1. In the mean time, it reserves its position on this point.

There is no requirement for six-month residence or stay period for domiciliation before persons moving to the country are fully covered by Local Authorites' Social Services. Therefore, there is no waiting period to qualify for social services from the local authorities once an individual, irrespective of his/her nationality, has registered by the National registry.

It should also be underlined that there is no waiting time to register by the National registry when a person has a permit to stay in the country. Foreigners, other than nationals of the EEA member states, who would like to live in Iceland have to apply for a permit to stay before they enter the country. When they receive their permits, they can come to the country and register by the National registry the same day. From that day they have the same rights regarding local authorities' social services in the municipality where their homes are as other residents of their local government areas.

Consequently, when a foreigner has registered by the National registry the same condition regarding the social services applies to the Icelandic people and foreigners, irrespective they are nationals of the Nordic countries, the EEA member states or other contracting state of the Social Charter.

Article 13, para. 2. -Non-discrimination in the exercise of social and political rights.
Referene is made to the government of Iceland's previous reports.

Article 13, para. 3. -Prevention, abolition or alleviation of need.
Reference is made to the previous reports; the Statistic in the present report have been updated.

In 2007, the number of active social workers working at the Social Services Unit in Reykjavík, which, with 116,642 inhabitants, is by far the largest local authority in the country, was 190. There were 14 social workers, two psychologists, 48 nurses, three pre-school teachers, four social pedagogues, four occupational therapists, four lawyers, 15 university-trained counsellors and 96 other employees. Kópavogur, the second largest authority, with 27.525 inhapitants employed 8.45 social workers, one psychologists, 2.8 nurses, 12 university-trained counsellors, 12.8

parametic and 89.7 other employees. The third largest local authority, Hafnarfjörður, with 23,751 inhabitants, had in its service 13 social workers, two psychologists, seven university-trained counsellors and 99 other employees. Akureyri, the fourth largest local authority, with 17,253 inhabitants, employed three social workers, one nurse, one social pedagogues, four occupational therapists, three university-trained counsellors and 48 other employees. In smaller municipalities the number of staff varied. For example, Reykjanesbær, with 13,256 inhabitants, had eleven social workers, one specialist in the affairs of the applicants of asylum, and one specialist in housing, Árborg, with 7,565 inhabitants, had in its service two social workers, one social pedagogue, one psychologist, one lawyer and one specialist in the affairs of the elderly.

Table 39. Social protection expenditure 2005 – 2006.

	2005	**2006**
Total	**222,271**	**247,998**
Direct expenditure, total	**218,842**	**244,487**
Families and children	**30,320**	**36,318**
Cash benefits	12,916	14,154
Maternity benefits	6,594	6,854
Familyor child allowance	5,674	6,661
Child maintenance	648	638
Benefits in kind	17,404	22,165
Day-care for children	12,005	15,793
Summer camping and youth activities	2,902	3,367
Child and youth welfare	2,398	2,904
Home-help services for families with children	98	100
Unemployment insurance and employment agencies	**4,021**	**3,367**
Unemployment benefits	3,153	2,370
Vocational training allowances etc.	133	138
Employment agencies	735	859
Health insurance	**76,086**	**85,057**
Cash benefits	15,578	17,690
Per-diem sickness benefits	923	1,152
Wages and salaries during sickness	14,368	16,328
Short-term occupational injury insurance	287	210
Benefits in kind	60,508	67,368
Hospitals and health care	59,294	66,119
Hospital care	35,782	39,741
Consultations, physiotherapy etc., outside hospitals	21,400	24,198
Other expenditures	2,111	2,180
Dental care	1,214	1,249
Old age	**62,589**	**69,985**
Retirement pension	43,636	48,653
Social security scheme (basic pension)	19,993	20,943
Compulsory private pension funds	23,643	27,711

Benefits in kind	18,953	21,332
Retirement homes and nursing homes	16,417	18,665
Home-help services for the elderly	882	1,068
Day-care for the elderly	1,654	1,599
Disability	**33,111**	**38,169**
Cash benefits	22,589	26,086
Disability pension	22,392	25,862
Social security scheme (basic pension)	16,236	17,832
Compulsory private pension funds	6,156	8,031
Long-term occupational injury insurance	197	224
Benefits in kind	10,522	12,083
Rehabilitation and employment for the disabled	5,273	5,623
Residential homes and flats for the diabled	4,702	5,482
Home-help services for the disambled	214	316
Other services	333	662
Survivors	**5,625**	**4,820**
Widow's/widower's benefits	5,576	4,745
Social security scheme (basic pension)	327	309
Compulsory private pension funds	5,249	4,436
Death grants	48	75
Housing	**2,150**	**2,192**
Rent benefit	2,150	2,192
Social housing	517	557
Other rent benefit	1,633	1,634
Other social benefits	**4,947**	**4,572**
Cash benefits	2,385	2,067
Income support etc.	1,692	1,615
State guaranteed wages in insolvency's	694	453
Benefits in kind	2,562	2,505
Rehabilitation of alcohol and drug abusers	771	875
Other assistance	1,791	1,630
Administration costs	**3,429**	**3,511**

Source: Statistics Iceland.

Article 13, para. 4 - Specific emergency assistance for non-residents.
Reference is made to the previous reports of the Icelandic Government and also to the discussion under Article 13, para 1 in this report.

Comment by the Committee of Independant Experts.
Conclusions XVIII-1 p. 23
The Committee asks the Government to reply to the question posed in the General Introduction to these Conclusions on the social assistance to which foreign nationals unlawfully in the country are entitled.

Foreign nationals who have not registered by the National registry but stay in the country for some reasons, such as travellers or people staying unlawfully in the country, do not have the right to social services. If such individuals are in financial or social difficulties during their stay, they are to apply to their embassies or consuls. Nevertheless, foreign nationals in such a situation in Iceland are to be given social assistance in special cases under Article 15 of the Local Authorities' Social Services Act, as amended in 1997.

This provision covers these emergency instances in which a foreign national is without money in Iceland. The explanatory notes to the bill that became the Act No. 34/1997 states that Article 15 constitutes a special rule. It also states: "First and foremost, what is involved here is assistance to return to the home country. Also, in exceptional cases, it may involve financial assistance for urgent needs for a short period." This assistance is to be given by the local authority of the area in which the person is staying, in consultation with the Ministry of Social Affairs and Social Security, providing that assistance has previously been sought from the person's home country.

In practice, foreigners in such situations are given financial assistance for a short period and get assistance to return to the home country. In 2006 there were 58 foreigners receiving financial assistance under Article 15 of the Local Authorities' Social Services Act and in 2007 there were 40 foreigners.

Article 14
The right to benefit from social welfare services

Article 14, para. 1. – Provision or promotion of social welfare services

There has not been changes in the legislation on the local authorities' social services so reference is made to the 18th report of the Icelandic Government but the statistics has been updated.

In 2004 there were 6,846 households receiving municipal social home assistance, thereof 75.7% were the homes of the elderly, 15.5% people with disabilities in households and 8,8% other households according to Statistics Iceland. In 2005 there were 7,496 households receiving municipal social home assistance, thereof 75.9% were the homes of the elderly, 14.9% people with disabilities in households and 9,2% other households. In 2006 there were 7,532 households receiving municipal social home assistance, thereof 76.4% were the homes of the elderly, 17.6% people with disabilities in households and 6,1% other households. Reference is also made to the discussion on municipal financial assistance under Article 13 in this report, *cf.* table 35.

As before the Reykjavik Social Services are taken here as a reference example, being by far the largest social service unit in the country. In 2007, 116,642 inhabitants lived in Reykjavik.

Table 40. Number of households receiving services of the Reykjavik Social Services, by type of service in 2006 and 2007.

	2006	2007
Social Home Assistance[1]	3.646	3.710
Financial assistance	2.685	2.491
Rent Benefits	6.005	5.815
Special Rent Benefits	590	647
Personal assistance		
Number of people receiving personal assistance or supervision	299	344
Number of children receiving assistance from support families	140	152
Child welfare of Reykjavík		
Number of notifications	3.411	3.762
Number of children in child welfare cases	2.329	2.384
Number of families	1.875	1.901
Rent apartments		
Number of rent apartments	1.597	1.748
Number of housing allocations	162	175
Number of people on the waiting list at the end of each year	727	761
Service apartment for the elderly		
Number of service apartments	339	342
Number of housing allocations	52	52
Number of people on the waiting list at the end of each year	385	368
Home delivered food to the elderly or patients		
Number of people	913	989
Number of meals	94.989	105.636

1 Under the social home assistance scheme, people living in their own homes who are not capable of housekeeping tasks or looking after themselves without assistance are provided with such assistance. The idea behind this is to enable them to live in their own homes despite difficulties such as illness, strain, old age, disability or family problems. Many different types of service are involved, all adapted to the individuals' needs. For example, workers in this home assistance scheme carry out ordinary housekeeping tasks such as cleaning and washing clothes. They seek to meet people's individual requirements, and the social support, encouragement and company that they provide are an important part of their work.
Source: Annual Reports of the Reykjavik Social Services for 2006 and 2007.

Comment by the Committee of Independant Experts.
Conclusions XVII-2 p. 12
The Committee asks whether social services are subject to fees and if they are evenly distributed on the Icelandic territory.

The aim of the local authorities' social services is to guarantee their inhabitants' financial and social security and to contribute towards their well-being on the basis of mutual assistance and equal entitlement to the quality of life. This means that individuals who are in difficulty have the right to assistance in order to improve their standard of living and in order to enable them to lead independent lives and take an active part in their community.

The main principle is that the social services are not subject to fees except under the Art. 29 of the Local Authorities' Social Services Act, No. 40/1991, the local authorities are allowed to charge fees for social home assistance according to their scale of charges. Thus, the situation may vary from one local government area to another. According to the Reykjavik's scale of charges for the social home assistance the people who have only financial support from the Social Insurance Administration, i.e. old age pension, invalidity pension and pension supplements, are not subject to fees. The same applies to people having monthly wages or other financial support lower than ISK 148,977 for individual and ISK 243,470 for couple in January 2009. The amounts is reviewed 1. January each year in conformity with the changes in the amounts of the pensions according to the Social Security Act. Similar rules apply in other municipalities.

As stated in the last report of the Icelandic Government, access to social services provided by the local authorities is very easy, and all persons are entitled to seek assistance, irrespective of the nationality or standing in other respects.

In 2007 the Social Services Complaints Committee received 36 cases and 27 cases in 2008.

Regarding the information on staff levels and qualifications, reference is made to the discussion of Article 13, para 3, in this report. Reference is also made to table 39 in this report regarding social portection expenditure 2005-2006.

Retirement homes and nursing homes.
Table 41 shows the numbers of people who received placements in retirement homes and nursing homes in 2004-2007. Nursing homes are state-run.

Table 41. Numbers of people placed in retirement homes and nursing homes in the years 2004 – 2007.

	Total[1]	64 years and younger	65-69 years	70-79 years	80 years and over
2004	3,341	83	100	828	2,330
Males	1,241	46	48	364	783
Females	2,100	37	52	463	1,547
2005	3,290	75	142	773	2,300
Males	1,213	32	66	329	786
Females	2,077	43	76	444	1,514
2006	3,244	73	83	677	2,411
Males	1,174	38	43	304	789
Females	2,070	35	39	374	1,621
2007	3,235	72	83	677	4,404
Males	1,167	36	42	295	795
Females	2,068	36	41	383	1,609

1 Number of people refers to those living in retirements and nursing homes and the elderly in nursing care and geriatric wards at hospitals.
Source: Statistics Iceland.

Table 42 shows the number of persons supporting children who were entitled to mother's or father's allowance and care-givers' allowance under the Social Assistance Act, No. 99/2007.

Table 42. Number of persons supporting others who received allowances under the Social Assistance Act, No. 99/2007, during the period 2004-2007.

Number	**Expenditure, ISK millions**
Single parent's allowance	
2004 – 3,517	2004 - 291
2005 – 3,491	2005 - 300
2006 – 3,225	2006 - 290
2007 – 3,132	2007 – 303
Benefits and allowances for carers of sick and disaled children	
2004 – 1,978	2004 - 907
2005 – 2,034	2005 – 965
2006 – 2,000	2006 – 1,015
2007 – 2,111	2007 – 1,155
Spouse's and attendance benefits	
2004 – 107	2004 -
2005 – 125	2005 – 81
2006 – 125	2006 – 92
2007 – 130	2007 – 143

Source: Statistics Iceland.

In 2005, 7,927 children were supported by single parent's allowances paid to their parents, 7,349 children were supported in 2006 and 7,109 children were supported in 2007.

In 2005, 2,661 sick and/or disabled children were supported by carer's allowances, 2,629 children were supported in 2006 and 2,704 children were supported in 2007.

Services related to alcohol and drug abuse
Table 43 shows the numbers registered for treatment at the National Center of Addiction Medicine (SÁÁ).

Table 43. Numbers of individuals registered in treatment for alcohol and drug abuse in institutions run by SÁÁ, 2004-2006.

Year	***Number***
2004	4,032
2005	2,828
2006	3,062

State expenditure on treatment for alcohol and drug abusers at the National Center of Addiction Medicine amounted to ISK 471,3 in 2005, ISK 507.3 in 2006 and ISK 610 million in 2007.

Trafficking in human beings.
The Icelandic Government has continued its emphasis on taking preventive measures against trafficking and prostitution.

In November 2004, the Minister of Justice appointed a working group to examine the experience gained of the various types of legislation in force in Europe against prostitution, the pornography industry and trafficking in human beings. In particular, the group was commissioned to examine the effects of this legislation in Sweden, where purchasing the service of prostitutes is a criminal offence, and to evaluate the pros and cons of this legislation. The group submitted its findings to the minister, and its report was published in February 2006.

The Minister of Justice presented a bill to the Althingi in February 2006, proposing amendments to the Police Act, which were aimed in part at fighting organized crime, including trafficking in human beings (an issue explicitly mentioned by the Minister when presenting the Bill in the Althingi). The bill was passed as law on 2 June 2006.

A special punitive provision had earlier been introduced into the General Penal Code, as Article 227 *a*, by the Act No. 40/2003. The explanatory notes accompanying the bill that became the Act No. 40/2003 stated that in the light of international agreements, it was proposed to enact a special provision in the penal code criminalising trafficking in human beings. Although the actions described in the bill were already criminal, the notes stated that the bill was intended to highlight these offences and to increase the punitive provisions to deal with them, as the offences were directed against the most sacrosanct of personal rights, including freedom.

It should be mentioned in this connection that the provision of the second paragraph of Article 226 of the General Penal Code can apply to trafficking in human beings when its conditions are

met regarding deprivation of freedom for a long period of time, or of deprivation of freedom for motives of profit. The punitive provisions of this provision are much broader than those of Article 227 *a*, under the former, imprisonment of not less than 1 year, and up to 16 years, is prescribed.

The Government approved an action plan against trafficking in human beings in March 2009 and the Minister of Social Affairs and Social Security submitted a report to the Parliament to introduce the action plan. The action plan was made in a close cooperation with NGO's. The objective of the Action Plan is to enhance the coordination of actions that are necessary in order to prevent human trafficking in Iceland, and to further study trafficking in human beings. Furthermore, it specifies actions that are aimed at prevention and education regarding this matter and ensure that aid and protection to victims is provided. There is also an emphasis placed on actions that aim at facilitating the prosecution of the perpetrators. At the same time, the intention is to initiate necessary legislative amendments, so that the United Nations 2000 Convention against Transnational Organised Crime and its Protocol on Human Trafficking, the Council of Europe 2005 Convention on Action against Human Trafficking, and the Council of Europe 2007 Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse may be ratified, and actions taken to implement these conventions. In addition, bills will be introduced with the goal of criminalising the demand for prostitution and deleting the exemption provision in paragraph 4, Article 4 of Act No. 85/2007 to operate strip clubs.

Prostitution.

In April 2006, the Minister of Justice submitted a bill to the Parliament proposing amendments to several provisions on Sexual Offences in the General Penal Code, including the provisions on prostitution. The bill had previously been publicised on the Ministry's web-site in February 2006. The bill was not discussed, but the minister resubmitted it to the Althingi in its 2006-2007 sitting. It became law on 27 March 2007 as the Act No. 61/2007 amending the General Penal Code, No. 19/1940 (sexual offences).

With the passing of this act, engaging in prostitution as a means of supporting oneself is no longer a criminal offence. The decriminalisation of prostitution is based on the view that prostitution is always resorted to as a result of dire need and that it is consequently more sensible to offer those who sell themselves as prostitutes social, medical and financial assistance instead of punishing them. The aim is to help individuals who are the victims of difficult circumstances instead of punishing them. Thus, they no longer need to fear prosecution if they decide to bring charges for violent treatment or coercion that they have suffered, and will be more likely to give evidence against procurers and more willing to seek assistance for themselves, both from the social services and the health services.

The Act No. 61/2007 enshrined in law new provisions making it punishable to offer, arrange or request sexual relations with another person in return for payment if this is done by means of a public advertisement. The aim of this is to prevent prostitution from becoming more visible following the abolition of provisions making it a criminal offence to support oneself by prostitution. The provisions of the General Penal Code regarding offences against people's sense of decency could serve the same purpose in the case of prostitution practised in the street.

The General Penal Code contains provisions on the criminal liability of those who exploit prostitution practised by others in various ways. Firstly, the act states that it is a criminal offence to base one's economic activity or means of subsistence on prostitution practised by others. Secondly, it is a criminal act to entice, encourage or assist a child under the age of 18 years to engage in prostitution. Thirdly, it is a criminal offence to encourage any person from moving from Iceland or to Iceland in order to engage in prostitution as a means of support. Fourthly, it is a criminal offence to encourage other persons, by enticements, exhortations or acting as an agent, to have sexual intercourse or other sexual relations in return for payment or to derive income from prostitution practised by others, e.g. by renting them premises or in other ways.

The explanatory notes to the bill which became the Act No. 61/2007 present various arguments for and against criminalising the purchase of the services of prostitutes. It is stated that it is necessary to take account of social attitudes and circumstances at any given time. Further studies of prostitution in Iceland and its extent and nature are needed, and also of the best methods of addressing it, before proposing legislative amendments of the type that have been adopted in Sweden, where it has been made a criminal offence to purchase sexual services. The notes state that it would also be a good idea to examine why prostitution features so rarely in cases in the criminal justice system, not least in view of the fact that it is known to be practised in Iceland to some degree. Furthermore, other remedies exist which are probably far more effective in reducing the incidence than making it an offence to purchase the service of prostitutes. In itself, punishment has never proved to be a good method of solving social problems, and if other courses of action are available, then they should rather be followed. The root causes of the problem should be found and measures should be taken to prevent people from indulging in prostitution. Children and young people who are the victims of sexual abuse, neglect or other maltreatment constitute a risk group which experience shows may become involved in prostitution, both as sellers and purchasers. The commercialisation of sex increases the likelihood that persons in such risk groups will start practising prostitution. Thus, it is necessary to make a priority of preventive measures, to try to protect these children and young people, to address the functions of strip-tease clubs and other night spots and to work against the attitudes towards sex which they embody. As stated in the notes it is not unlikely that, with positive and healthy education and information about sex, attitudes in society could be changed, so reducing the demand for prostitution. With reference to the foregoing, it was not proposed in the bill that the purchase of the service of prostitutes should be criminalised.

Committee on violence against women.

The Committee on measures to combat violence against women is still working, having been reappointed in 2007 for a period of four years. By a resolution adopted by the Government on 18 October 2005, it was entrusted with the task of discussing measures against violence against children and also to prepare an action plan in connection with domestic violence and sexual violence. This was done at the instigation of the Minister of Social Affairs and the Minister of Justice and Ecclesiastical Affairs.

The committee worked on an action plan which was approved by the Government at its meeting of 26 September 2006. This plan is intended to run until 2011, and the main task of the committee will be to monitor the plan dealing with domestic violence and sexual violence. In drawing up the plan, attention was given to, amongst other things, a draft action plan on gender-

related violence that had been drawn up by a non-governmental organisation and sent to some of the government ministers in April 2005.

The main aim of the action plan is to work against domestic violence and sexual violence which is directed against women and children, and also to improve the care facilities available for those who have suffered such violence or are at risk of doing so. It is divided into two parts. One covers measures against violence in the homes and sexual violence against children; the other covers domestic violence and sexual violence against women. In each part, there are four main guiding principles. The first of these is to increase preventive measures aimed at stimulating public discussion of violence against children and gender-related violence and to encourage a change of public attitudes. Secondly, the aim is to give support to staff of institutions so as to enable them to identify the signs and consequences of violence against children and gender-based violence, and to assist the victims. Thirdly, the aim is to ensure suitable assistance for the victims of domestic violence and sexual violence, and the fourth aim is to strengthen methods designed to provide treatment for the perpetrators in order to break the vicious circle which is often a feature of this violence.

The action plan is wide-ranging, comprising 37 separate measures covering all aspects of the problem that are considered likely to have an affect in reducing violence in the homes of children and sexual violence, including preventive measures, support to employees in public institutions so as to enable them to identify indications of violence, measures to ensure appropriate assistance and, last but not least, to break the vicious circle in which violence often thrives. Each measure, together with the aims involved, is described in detail. The project is administered by the Ministry of Justice and Ecclesiastical Affairs, the Ministry of Social Affairs, the Ministry of Health and Social Security and the Ministry of Education, Science and Culture, and the Union of Local Authorities in Iceland participates in some of the individual parts.

Furthermore, the committee has published a small card (of the same size as a credit card) with the telephone numbers of the principal institutions and organisations that offer assistance to victims of sexual abuse. It is intended to be carried in a wallet or pocket, the aim being to give simply accessible and useful information for those in need of it. This was done because victims often take time before making up their minds to seek assistance and frequently are not in a position to find out for themselves where it can be found.

The committee has also made a priority of consulting non-governmental organisations and others concerned with these issues; one or two consultative meetings have been held each year, in addition to informal consultations.

Protection of victims.
Reference should be made to the previous reports by the Government of Iceland.

Training of the police.
Reference should be made to the previous reports by the Government of Iceland.

Domestic violence.
A bill to amend the General Penal Code, No. 19/1940, was presented to the Althingi at the 132nd legislative session in 2005-2006; this was designed to amend the provisions of the code dealing

with domestic violence. The bill was part of the campaign by the Ministry of Justice and Ecclesiastical Affairs against domestic violence, and it was passed on 11 April 2006 as the Act No. 27/2006, amending the General Penal Code, No. 19/1940 (domestic violence). The Minister of Justice decided to concentrate more effort on measures to combat domestic violence in reaction to information he had received on the matter and public discussion that had taken place. In addition, appeals had been received from non-governmental organisations calling for a comprehensive action plan against sexual abuse.

The aim of the amendments was to make the legal remedies available in cases of domestic violence more effective. It was considered necessary to have Icelandic legislation reflect more clearly the view of the legislature, which was that offences committed between persons in an intimate relationship are of a special nature. The bill called for the introduction of authorisation in law for heavier punishments in cases where it is considered that the close relationship between perpetrator and victim has led to grosser violations. Furthermore, it was proposed to introduce a new provision in the General Penal Code, Article 233 b, replacing Article 191 of the code and providing for up to two years' imprisonment in cases where a person insults or vilifies his or her spouse or former spouse, child or another person closely related to the perpetrator and the action is seen as constituting gross defamation. The intention behind the enactment of this new provision was to give a clearer embodiment to the provision for punishment that had already existed in the first paragraph of Article 191 of the code. The aim was also to give individuals better protection against offences committed by close related in a marriage or within the family and to give better protection against gross defamation so as to make it more realistic to achieve the procedural and political legal aims that it is normal to apply in this context. Finally, it was proposed that violations of Article 233 b should be liable to public indictment.

With the passing of the Act No. 61/2007, amending the General Penal Code, No. 19/1940, with subsequent amendments (sexual offences), the provision of Article 205 of the code was abolished; this had provided for the waiving of punishment for certain sexual offences if the persons between whom the intercourse took place continue to live together, enter into a cohabitation or marry. There is no record of this provision ever having been applied in practice in Iceland; it was seen as embodying an outdated attitude towards women. Furthermore, there was thought to be no reason for the legislature to support the maintenance of marriages in which one party committed acts of violence or abuse towards the other. The repeal of this provision is also seen as being in better conformity with the amendments, described above, that were made to the General Penal Code by the Act No. 27/2006, in which the message is clearly that offences committed between people in a close relationship, e.g. in a marriage or within the family, are viewed more seriously than might otherwise be the case. The procedural rules issued to the police by the National Police Commissioner for the registration of cases of domestic violence, which took effect on 20 October 2005, include definitions of categories of offence; one of these covers sexual offences. Thus, it is clear that a lapse of punishment applying to sexual offences committed towards a person's spouse or partner would be opposed to the views that are now receiving general acceptance both in legislation and in the application of criminal law.

The second part of the Government's action plan of 26 September 2006 to tackle domestic violence and sexual violence addresses measures that the Government intends to take over the period in order to prevent offences against women.

The action plan prioritises public awareness raising about gender-based violence, including domestic violence. Provision has been made for regular publicity campaigns in collaboration with local authorities, the media and NGOs aimed at putting across the message that gender-based violence is not to be tolerated. The aim is to rouse people to awareness of the existence of domestic and sexual violence, what it involves and where victims can seek help and support. Furthermore, it is important to examine how traditional gender roles and stereotypes may contribute to violence towards women.

Domestic violence is one type of gender-based violence which it is often difficult to observe and identify. It takes many forms which it is important to be aware of and to recognise. The aim of one of the projects in the action plan is to produce and distribute posters, both in Icelandic and in a number of foreign languages, in order to raise public awareness regarding domestic violence. These are to contain information as to what constitutes domestic violence, whether what is involved is physical violence, mental cruelty or sexual abuse. Also, it is intended to put across information on where victims can seek assistance and counselling.

The action plan also covers methods aimed at raising the knowledge and skills of workers who in the course of their jobs deal with the victims of gender-based violence, and to increase collaboration among them. For example, the production of a manual on domestic violence for professionals involved in these cases, with material on the victims and perpetrators; also the making of a study of gender-based violence, and the making of surveys of the extent of gender-based violence among certain groups of women and of the extent of domestic violence against men. It is also intended to make a further examination of ways of supporting the Emergency Reception Centre for victims of rape and the Post-Trauma Assistance Centre in the National and University Hospital, how to increase collaboration between these two bodies and how to expand their scope so as to have them address both domestic and sexual violence. This includes plans to examine ways of working for more efficient collaboration with the social services, the child welfare agencies, the health services, NGOs and others involved in treating the victims of gender-based violence.

The action plan also provides for measures aimed at providing the victims of domestic violence and sexual abuse with individually-tailored treatment, and also for treatment for the perpetrators of gender-based offences. The aim is that perpetrators who have abused women should have an opportunity to undergo treatment aimed at breaking the repetitive pattern of violence. The project *Karlar til ábyrgðar* (Male Responsibility) is to be expanded and given further support, and attention is to be given to whether the same methods applied and support given to the perpetrators of domestic violence would be of benefit to the perpetrators of sexual offences.

The Women's Refuge (Kvennaathvarfið.)

The aim of the organization running the Women's Refuge (*Kvennaathvarfið*) is to provide refuge facilities both for women and their children when the situation in the home makes it impossible for them to go on living there because of domestic violence, whether in the form of physical assaults or mental cruelty, practised by the husband or cohabiting partner or other persons in the home, and also for women victims of rape. It is also the organization's aim to provide counselling and information and to stimulate publicity and discussion of the problem of domestic violence. Table 44 shows a survey of admissions to the refuge for the period 2000-2005.

Table 44. Admissions to the Women's Refuge 2000–2005.

Year	2000	2001	2002	2003	2004	2005
Total admissions	347	503	435	388	531	557
Interviews	252	406	380	315	443	465
Stay periods	95	97	55	73	88	92
Number of children	61	74	41	59	55	76
Phone calls to emergency line	1635	1880	1614	1402	1612	1855

The number of admissions in 2005 was a record (557). Many women are admitted more than once, either for interviews or periods spent in the refuge; this figure represents 283 women who sought admission to stay there during the year, including 143 (51%) who had not previously applied to the refuge. The number of women who stayed there rose by 5% from 88 to 92, and the number of children by 38%, from 55 to 76, compared with the previous year. The number of days spent in the refuge in each period considerably, the average rising from 12 to 14 days for women and from 10 to 16 for children; this goes a long way to explaining the increase in the number of days spent there, both in terms of the larger number of children and the longer periods they spent in the refuge. On average, there were four women and three children in the refuge every day during 2005. The number of interviews taken during the year, 465, was also a record; on average, each woman registered at the centre came for two interviews during the year.

The number of women applying to the Women's Refuge indicates not so much the extent of gender-based violence in Iceland but rather whether or not the victims know of the services provided by the refuge and whether they are prepared to use them. Studies indicate that the actual extent of violence is far greater than the statistics from the Women's Refuge suggest, and it is therefore seen as a positive thing that the number seeking assistance there should be large rather than small. The increase in the number of supportive interviews (counselling sessions) held there in recent years also suggests that women are making more use of the services of the refuge than they used to, i.e. that they are turning to the refuge for advice and support before actually being compelled to go for protection from violent situations. It is to be hoped that the increase in the number of admissions is also an indication that women no longer hesitate so long before applying to the refuge for help when they need it. In addition to offering supportive interviews, a telephone service and facilities for temporary stays, the Women's Refuge has offered self-help therapy groups for more than a year. The first of these was launched in autumn 2004, consisting of eight women with a leader and deputy leader from among the staff of the refuge. Two groups were operated in 2005, each consisting of seven women in addition to the group leaders. Record applications to the Women's Refuge two years in a row can probably be attributed to the high level of public discussion of gender-based violence that has taken place. The interviews (counselling sessions) offered by the Women's Refuge have clearly become established; they are sought after by women who are in violent situations and by those who are getting over the consequences of earlier experiences of violence. The rise in the number of children attending the centre is more difficult to explain; it should be pointed out, however, that the number of children accompanying their mothers in the refuge in 2004 was unusually low, so that an increase the following year was natural. The average length of stay periods was considerably longer, this being explained by the fact that more women needed longer time than before in safety and security.

On arrival at the Women's Refuge, either to stay or to attend a counselling session, the women are asked the reason for their visit. Most give more than one reason; for example, mental cruelty is generally found together with physical violence. In most cases, they are also seeking support to get through a difficult phase in their lives. It is much more commonly the case that women apply to the Women's Refuge because of mental cruelty than because of physical violence; mental cruelty can be no less serious a situation. It can take the form of threatening behaviour, financial dominance, isolation and degradation. More women give mental cruelty, physical violence and sexual abuse as the reasons for their visits to the refuge than used to be the case; in the same way, more now come to the centre because of threats and persecution than before. This is worrying, as it seems that violence is assuming a harsher form, but the reason may also be increased awareness of gender-based violence and the forms that it can take. Little discussion has taken place about sexual abuse within marriages or partnerships; however, it is frequently encountered as an accompaniment to other forms of violence.

More women have been applying to the Women's Refuge because of incest; this is attributed to an enormous amount of public discussion of incest that took place in 2005 following the publication of a book in Iceland in which a woman described her experience of sexual abuse and ill-treatment as a child. As *Stígamót* (the Counselling and Information Centre for Victims of Sexual Violence) had difficulty in providing sufficient counselling services in the latter part of the year, many women applied to the Women's Refuge in connection with incest.

The project Karlar til ábyrgðar ("Male Responsibility").
The "Male Responsibility" project was re-launched in May 2006. This involves the offer of specialised treatment for men who indulge in violence in the home in Iceland. Treatment of this type has proved effective both in Iceland and abroad. It is estimated that about 1,100 women suffer domestic violence at the hands of their husbands/partners or ex-husbands/partners each year in Iceland.

Treatment is provided by psychologists; the aim of the project is to provide male perpetrators of domestic violence with assistance and treatment if they are prepared to seek it. It is regarded as a priority that perpetrators should seek treatment voluntarily and accept their responsibility for committing violence. Treatment is based on individual counselling, and may last between six months and two years.
Parallel with this treatment project, a special project management team is at work, consisting of representatives of the Gender Equality Centre, the Ministry of Health and Social Security and the Women's Refuge; it is directed by the representative of the Gender Equality Centre. Its role includes the definition of how the project is to be developed in the future in consultation with those who provide the treatment and the monitoring of the day-to-day functions and an assessment of the effectiveness of the project.

Sexual offences.
As has been stated above, the Act No. 61/2007 introduced amendments to the section of the General Penal Code (No. 19/1940, with subsequent amendments) dealing with sexual offences. Amendments were made to Articles 194-199 of the code, covering rape and other offences against the sexual freedom of the individual (*cf.* Article 205) and also Articles 200-202, dealing with sexual offences against children (*cf.* Article 204).

One of the reasons for the review of these provisions was the public discussion that has taken place concerning sexual abuse of children and gender-based violence. Increasing criticism of some of the provisions had been expressed, as it was felt that they did not give the victims sufficient legal protection, and some people took the view that they embodied outdated attitudes towards women. In addition, it was felt that the sentences handed down by the courts for offences of this type were too lenient.

When the legislation was drafted, attention was given to studies made by the author of the draft which dealt both with the legislation itself and its application. Secondly, attention was given to surveys of legislation covering sexual offences in other countries, and thirdly, data from various social and criminological studies was taken into consideration. Finally, the author of the draft took steps to find out about the experience of various parties who had worked with victims of offences of this type.

Furthermore, attempts were made to have the amendments proposed to these provisions in line with the framework already existing in the General Penal Code. It was regarded as a priority to have the proposed amendments based on a sound legal basis, taking account both of international trends in this area and also of Icelandic legal tradition. Another guiding principle was to increase the legal protection given to women and children, to make the provisions more modern and to strive to ensure respect for privacy, self-determination, sexual freedom and freedom of action for all individuals.

One of the innovations introduced into the code was a broadening of the definition of rape, with the result that "rape" in Article 194 of the code now includes other forms of sexual coercion and the exploitation of the victim's poor mental condition or inability to resist the action or to realise its significance. As a result of the amendment, offences in this category now carry far heavier punishments than before: imprisonment of 1-16 years, instead of a maximum of six years previously. Furthermore, circumstances leading to the imposition of heavier punishments for rape are defined in the law. Allowance is made for heavier punishments, firstly, if the victim is a child under the age of 18, secondly if the violence committed by the perpetrator is of major proportions and thirdly if the offence is committed in a way that inflicts particularly serious pain or injury.

Authorisation was introduced by the amendment providing for consideration to be given to repeated offences within the broad category of sexual offences; thus, a previous conviction for an offence of this type may lead to a heavier punishment being imposed for a subsequent offence. Allowance is made for an increase of up to one half in the punishment imposed.

The minimum age of consent for sexual acts was raised from 14 to 15, and the provision for punishment for having sexual intercourse or other sexual relations with a child under the age of consent was expanded so that these offences qualify for the same punishment as rape, i.e. 1-16 years' imprisonment. This emphasises the gravity of such offences when the victims are children; rape, sexual intercourse or other sexual relations involving children under the age of 15 now constitute the most serious types of offence within the category of sexual offences, a position that used to be reserved for rape only. Nevertheless, provision is made for a reduction or waiver of punishment in cases where the perpetrator of acts involving sexual intercourse or other sexual relations with a child under the age of 15 is him- or herself of the same age or level of

mental maturity as the child. It was also stated in the amendment that liability for offences under Article 194 (rape), the first paragraph of Article 200 (sexual intercourse or other sexual relations with one's own child or other descendant) and the first paragraph of Article 201 (sexual intercourse or other sexual relations with a child under the age of 18, to whom the offender is related or connected in a particular way) does not lapse over time (i.e. is not subject to any statute of limitations) in cases where the child is under the age of 18. Regarding other sexual offences, an amendment was introduced stating that the period over which liability expires is to begin running from the time when the victim reaches the age of 18 and not 14 as used to be the case.

The Centre for Sexual Abuse Victims (Stígamót).
About 1468 individuals came to the Centre for Sexual Abuse Victims, (*Stigamót*), in the period 2003–2005; 496 did so in 2003, of which 251 were making their first visit to the centre. In 2004, 429 individuals came to the centre, including 228 who were seeking help for the first time. In 2005 the total number was 543, of which 249 were seeking assistance for the first time. The breakdown by sex for the years 2003-2005 is presented in Table 45 (referring to those applying to the centre for the first time).

Table 45. Persons received by Stigamót for the first time: breakdown by sex.

	2003		**2004**		**2005**	
	Number	Proportion	Number	Proportion	Number	Proportion
Women	224	89,2%	209	91.7%	223	89.6%
Men	27	10.8%	19	8.3%	26	10.4%

There are many reasons why individuals turn to the Centre for Sexual Abuse Victims: rape, prostitution, incest and their consequences and also sexual harassment. One hundred and fifty individuals contacted the centre in 2005 in connection with incest and its consequences and ninety-eight in connection with incest and its consequences. Nine contacted the organization in connection with prostitution and sixteen in connection with sexual harassment.

The Emergency Reception Centre.
In the period 2003-2005, 17 of the women who contacted the Stígamót Centre in connection with rape also went to the Emergency Reception Centre for rape victims: seven in 2003, seven in 2004 and three in 2005. About 353 individuals, of which 98% were women, came to the Emergency Reception Centre in the period 2003–2005: 119 did so in 2003, 104 in 2004 and 130 in 2005.

Altogether, 1,284 individuals applied to the Emergency Reception Centre for rape victims from the time when it opened in 1993 up to the end of 2005. As can be seen from the following Figure, the largest group, 395, consists of persons in the 19-25 age group.

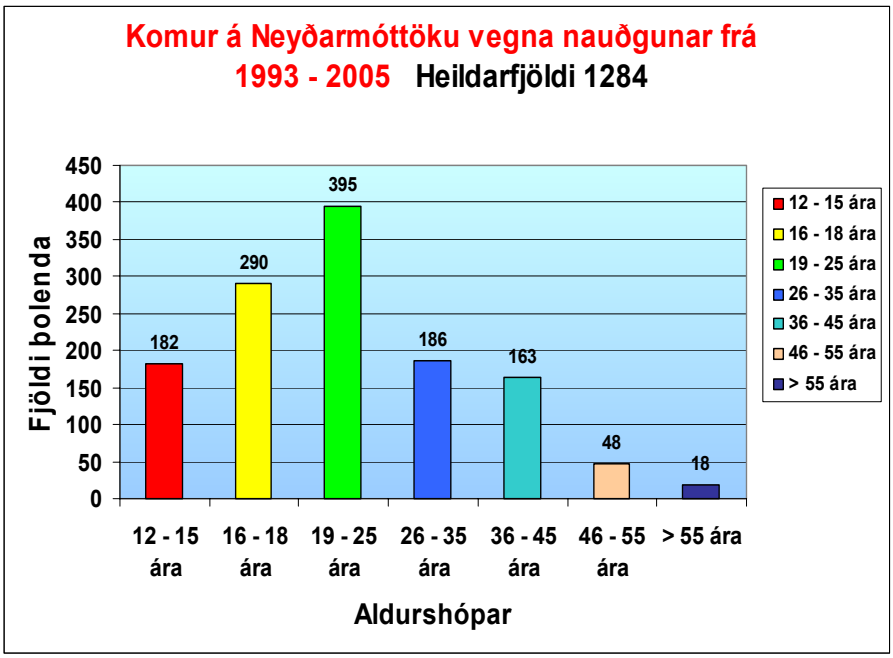

Fig. 1. Persons applying to the Emergency Reception Centre for the victims of rape and sexual abuse, 1993-2005.

Translation from the figure: "Komur á Neyðarmóttöku vegna nauðgunar frá 1993-2005" = Persons applying to the Emergency Centre following rape, 1993-2005; "Fjöldi þolenda"= Number of victims; "Aldurshópar"= Age groups; "Ára"= years.

Figure 2 presents a further breakdown of the cases attended to by the Emergency Reception Centre. This shows that the victims report the incidents to the police in fewer than half of the cases. It also seems to have become more common for more than one perpetrator to be involved in cases of rape.

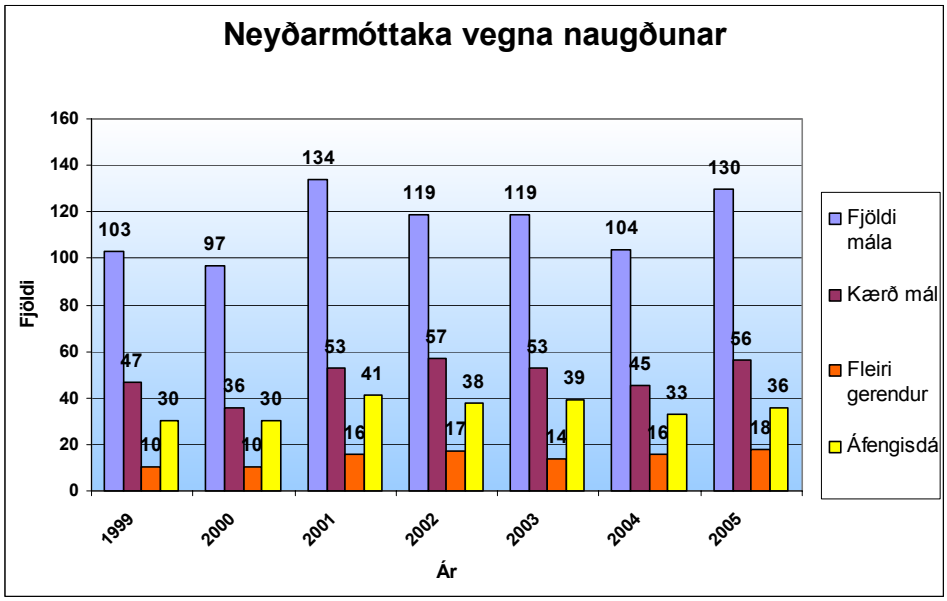

Figure 2. Further breakdown of the cases attended to by the Emergency Reception Centre for the victims of rape and sexual abuse.

Translation from the figure: "Neyðarmóttaka vegna nauðgunar"= Emergency Reception Centre for rape victims; "Fjöldi mála"= Number of cases; "Kærð mál"= Cases reported to the police; "Fleiri gerendur"= More than one perpetrator; "Fjöldi"=Number; "Ár"=Year.

Violence against children.
The first part of the plan of action on violence in homes and sexual abuse, which was approved by the government on 26 September 2006, covered measures that the government intended to take in order to prevent violence against children, and also to assist those who have suffered violence and abuse. The fundamental assumption is that it is always the adult who is responsible if a child suffers violent treatment, and that the perpetrator should suffer the consequences, since this type of conduct cannot be tolerated. The projects in the plan of action are based on this, and are therefore primarily concerned with adults.

Measures are set forth in the plan and designed to prevent children from being exposed to violence in their homes or sexual abuse. Part of these focus on sleep disturbance and restlessness among young children and infants; sleeping problems may have a negative effect on relations between parents and their children. It is also proposed to hold meetings describing methods of working with children of kindergarten and junior school age who have behavioural problems. The publication of a publicity booklet in Icelandic and foreign languages on the consequences of violence against children is also planned.

In order to help child victims of violence, it is important that professionals employed by institutions such as the kindergartens and junior schools, the health services and the child welfare committees, should have a knowledge of how to recognise the signs of violence and be aware of its consequences.

This involves, amongst other things, extending the educational training of these professions; the Ministry of Education, Culture and Science intends to issue instructions to those educational institutions which, in the course of their work, are involved with children and their families, to include teaching and awareness-raising on violence against children as part of the syllabus in both the basic training and retraining and extension courses attended by their professional staff. Furthermore, it is planned to prepare a manual for workers in the health services with a checklist and procedural guidelines on carrying out medical examinations of children who may have suffered violence. It is also planned to hold annual educational meetings with persons who, in the course of their work, are involved in the care and education of children. Preventive measures and the causes and consequences of violence against children will be examined, the aim being to increase these persons' awareness and skills.

The action plan also embraces measures aimed at providing individually-tailored treatment for children who have suffered violence in the home or sexual abuse. These include an emphasis on supporting and developing the work of the Children's House (*Barnahús*), publicising its service and seeking ways to do more to meet the needs of children who have suffered violence or abuse of any type.

Last but not least, emphasis is placed on enabling the perpetrators of violence against children to undergo treatment in order to break the pattern of repeated violence. Amongst other things, it is planned to establish a professional team of experts specialising in the treatment of young offenders who have committed acts of mental cruelty, physical violence or sexual abused against other children.

Article 14, para. 2. – Public participation in the establishment and maintenance of social welfare services.

The state has continued to support institutions active in the sphere of social services. Total allocations under the budget for 2007 amounted to ISK 310 millions, divided as shown in table 46. This is not necessarily an exhaustive list of public support grants to NGO's.

Table 46. State grants to institutions active in the sphere of social services 2007 (Thousands ISK).

Name	
1. ADHD-association	2,000
2. Multicultural Center	3,500
3. *Barnaheill* (child welfare)	1,000
4. *Blátt áfram*, preventive project	3,000
5. National Association of the Blind	8,500
6. National Associaltion of the Deaf and Blinds	1,000
7. National Association of the Deaf	9,200
8. *EKRON* – rehabilitation	4,000
9. Society of Responsible Fathers	1,500
10. Single Parents' Society..	3,000
11. Parent-teachers' association of *Öskjuhlíðarskóli* (a school for children with disabilities)	6,000
12. Education for the families of the disabled	700
13. Municipality Hafnarfjörður, radio for immigrants	200
14. The Charity of the Church	2,000
15. *Hlutverk* – Association of rehabilitation	500
16. *Hósanna-group*	200
17. Women's Counselling Service	800
18. *Landsbyggðin lifi*	1,600
19. National Senior Citizens' Association	1,200
20. *Þroskahjálp* (the National Federation for the Aid of the People with Disabilites	5.000
21. *Höndin* Charity organization	1,500
22. *Mæðrastyrksnefnd Reykjavíkur* Charity organization	4,200
23. New Dawn (association for the bereaved)	700
24. *Regnbogabörn* (rainbow children)	3,000
25. *Samfés*	500
26. *Krossgötur,* rehabilitation home	23,400
27. Association against poverty	200
28. Samtökin 78 (Gay People Association)	3,000
29. *Sjálfsbjörg,* National federation of people with disabilities	4,000
30. *Sjónarhóll*	16,500
31. *Sorgin og lífið*	500
32. *Systkinasmiðjan*	500
33. Society for persons who care for autistic people	1,200
34. *Vernd* (rehabilitation for ex-prisoners)	1,500
35. Drug-free youth..	6,500
36. The Centre for Sexual Abuse Victims (*Stígamót)*	31,600
37. The Women's Refuge (*Kvennaathvarfið*)	32,600
38. *Geðhjálp* (support association for the mentally disturbed	21,000
39. *Geysir,* work exchange for the mentaly disturbed	28,000
40. Other	74,800
Total	**310,100**

Comment by the Committee of Independant Experts.
Conclusions XVII-2 p. 13
The Committee repeats its question about supervision of social services. In particular it asks what criteria public and private providers must fulfil to provide these services and what are the supervisory procedures in place to ensure that they are met in practice.

The legislature has set a legal framework for securing the aim of the social service (the Local Authorities' Social Services Act, No. 40/1991), which the local authorities are then responsible for implementing. The local authorities are expected to serve all social groups, including both non-disabled and disabled, the elderly, the sick and others who may need social services. Under Article 3 of the Local Authorities' Social Services Act, the Ministry of Social Affairs and Social Security is responsible for monitoring the provision by local authorities of the legally-prescribed services to their inhabitants. The ministry has issued guideline rules on the implementation of social services; these were revised in 2003 in collaboration with the Union of Local Authorities and the Association of Directors of Social Affairs in the municipalities.

Decisions by a local authority on the granting of its social services are being the subject of an appeal to a special complaints committee with adjudicatory powers was established to deal with them. Thus, the Social Services Complaints Committee is regarded as a superior authority, whose decisions can not be referred to other authorities within the executive structure (*cf.* paragraph 3 of Article 65 of the Local Authorities' Social Services Act). Its rulings are therefore final executive decisions.

Article 23
Consultations and communication of copies of the report

In the preparation of this report, consultations were held with the Icelandic Confederation of Labour and the Icelandic Confederation of Employers, which are, respectively, the main organizations of workers and employers in Iceland.

Copies of this report have been communicated to the following national organizations of employers and trade unions:

The Icelandic Confederation of Labour.
The Confederation of Icelandic Employers.
The Federation of State and Municipal Employees.
The Alliance of Graduate Civil Servants.