March 2022

EUROPEAN SOCIAL CHARTER (REVISED)

European Committee of Social Rights

Conclusions 2021

NORWAY

This text may be subject to editorial revision.

The function of the European Committee of Social Rights is to rule on the conformity of the situation in States with the European Social Charter. In respect of national reports, it adopts conclusions; in respect of collective complaints, it adopts decisions.

Information on the Charter, statements of interpretation, and general questions from the Committee, is contained in the General Introduction to all Conclusions.

The following chapter concerns Norway, which ratified the Revised European Social Charter on 7 May 2001. The deadline for submitting the 18th report was 31 December 2020 and Norway submitted it on 22 March 2021.

The Committee recalls that Norway was asked to reply to the specific targeted questions posed under various provisions (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter). The Committee therefore focused specifically on these aspects. It also assessed the replies to all findings of non-conformity or deferral in its previous conclusions (Conclusions 2013).

In addition, the Committee recalls that no targeted questions were asked under certain provisions. If the previous conclusion (Conclusions 2013) found the situation to be in conformity, there was no examination of the situation in 2020.

In accordance with the reporting system adopted by the Committee of Ministers at the 1196th meeting of the Ministers' Deputies on 2-3 April 2014, the report concerned the following provisions of the thematic group II "Health, social security and social protection":

- the right to safe and healthy working conditions (Article 3);
- the right to protection of health (Article 11);
- the right to social security (Article 12);
- the right to social and medical assistance (Article 13);
- the right to benefit from social welfare services (Article 14);
- the right of elderly persons to social protection (Article 23);
- the right to protection against poverty and social exclusion (Article 30).

Norway has accepted all provisions from the above-mentioned group except Articles 3§1 and 3§4.

The reference period was from 1 January 2016 to 31 December 2019.

The conclusions relating to Norway concern 13 situations and are as follows:

– 8 conclusions of conformity: Articles 3§2, 11§1, 11§2, 12§2, 12§3, 14§1, 14§2 and 30.

– 3 conclusions of non-conformity: Articles 12§4, 13§1 and 23.

In respect of the other two situations related to Articles 3§3 and 11§3, the Committee needs further information in order to examine the situation.

The Committee considers that the absence of the information requested amounts to a breach of the reporting obligation entered into by Norway under the Revised Charter.

The next report to be submitted by Norway will be a simplified report dealing with the follow up given to decisions on the merits of collective complaints in which the Committee found a violation.

The deadline for submitting that report was 31 December 2021.

Conclusions and reports are available at www.coe.int/socialcharter.

Article 3 - Right to safe and healthy working conditions

Paragraph 2 - Safety and health regulations

The Committee takes note of the information contained in the report submitted by Norway.

The Committee recalls that for the purposes of the present report, States were asked to reply to targeted questions for Article 3§2 of the Charter as well as, where applicable, previous conclusions of non-conformity or deferrals (see the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection").

The Committee notes that previously, pending receipt of the information requested, the Committee found the situation in Norway to be in conformity with the Charter (Conclusions 2013). The assessment of the Committee will therefore only concern the information provided by the Government in response to the targeted question.

Content of the regulations on health and safety at work

In its targeted question on Article 3§2, the Committee asked for information on regulations adopted to improve health and safety in evolving new situations such as in the digital and platform economy by, for example, strictly limiting and regulating electronic monitoring of workers, by recognising a right to disconnect, right to be unavailable outside agreed working and standby time, mandatory digital disconnection from the work environment during rest periods. It also requested information on regulations adopted in response to emerging occupational risks.

The report indicates that under Working Environment Act (LOV-2005-06-17, No. 62), work-related stress is regulated and that the Norwegian Labour Inspection Authority previously had guidance on it. Harassment and other inappropriate behaviour at the workplace are also regulated by the Working Environment Act and the employer has the duty to prevent it. Violence and threats at workplace are regulated by the Working Environment Act and by Regulations concerning the performance of work and is supervised by the Norwegian Labour Inspection Authority. As for substance abuse, there is a website dedicated to the challenges of remote work related to the substance abuse that indicates steps to be taken by the employee in that regard. As for work-related illnesses, they are regulated by the Working Environment Act and the employer has a general duty to cater for employees with different health challenges. As for mandatory digital disconnection from the work environment during rest periods, under the relevant legislation, employees must not be at the employer's disposal during those periods.

The Covid-19 pandemic has changed the way many people work, and many workers now telework or work remotely. Teleworking or remote working may lead to excessive working hours.

The Committee considers that, consistent with States Parties' obligations in terms of Article 3§2, in order to protect the physical and mental health of persons teleworking or working remotely and to ensure the right of every worker to a safe and healthy working environment, it is necessary to enable fully the right of workers to refuse to perform work outside their normal working hours (other than work considered to be overtime and fully recognised accordingly) or while on holiday or on other forms of leave (sometimes referred to as the "right to disconnect").

States Parties should ensure there is a legal right not to be penalised or discriminated against for refusing to undertake work outside normal working hours. States must also ensure that there is a legal right to protection from victimisation for complaining when an employer expressly or implicitly requires work to be carried out outside working hours. States

Parties must ensure that employers have a duty to put in place arrangements to limit or discourage unaccounted for out-of-hours work, especially for categories of workers who may feel pressed to overperform (e.g. those during probationary periods or for those on temporary or precarious contracts).

Being connected outside normal working hours also increases the risk of electronic monitoring of workers during such periods, which is facilitated by technical devices and software. This can further blur the boundaries between work and private life and may have implications for the physical and mental health of workers.

Therefore, the Committee considers that States Parties must take measures to limit and regulate the electronic monitoring of workers.

Establishment, alteration and upkeep of workplaces

The Committee previously found the situation to be in conformity in this respect (Conclusions 2013).

Protection against hazardous substances and agents

The Committee previously found the situation to be in conformity in this respect (Conclusions 2013).

Personal scope of the regulations

The Committee previously found the situation to be in conformity in this respect (Conclusions 2013).

Consultation with employers' and workers' organisations

The Committee previously found the situation to be in conformity in this respect (Conclusions 2013).

Conclusion

The Committee concludes that the situation in Norway is in conformity with Article 3§2 of the Charter.

Article 3 - Right to safe and healthy working conditions

Paragraph 3 - Enforcement of safety and health regulations

The Committee takes note of the information contained in the report submitted by Norway.

The Committee recalls that for the purposes of the present report States were asked to reply to targeted questions for Article 3§3 of the Charter as well as, where applicable, previous conclusions of non-conformity or deferrals (see the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection").

The Committee had deferred its previous conclusion pending receipt of the information requested (Conclusions 2013).

Assessment of the Committee will therefore concern the information provided by the Government in response to the deferral and to the targeted questions.

Accidents at work and occupational diseases

The Committee previously examined the situation regarding accidents at work and occupational diseases (Conclusions 2013). It considered that due to unreliable data for the reference period, it was not in a position to determine trends in occupational accidents and cases of occupational diseases, and to make the necessary comparison with the previous reference period. Pending receipt of the information requested concerning: reliable data regarding accidents at work; data on cases of occupational diseases in all sectors of economy, including the petroleum sector, the Committee deferred its conclusions. In its targeted question on Article 3§3 with regard to accidents at work and occupational diseases, the Committee asked for information on statistical data on prevalence of work-related death, injury and disability including as regards suicide or other forms of self-harm, PTSD, burn-out and alcohol or other substance use disorders, as well as on epidemiological studies conducted to assess the long(er)-term health impact of new high-risk jobs (e.g. cycle delivery services, including those employed or whose work is managed through digital platform; performers in the sports entertainment industry, including in particular contact sports; jobs involving particular forms of interaction with clients and expected to use potentially harmful substances such as alcohol or other psychoactive products; new forms of high-yield high-stress trading; military and law enforcement; etc.) and also as regards the victims of harassment at work and poor management.

In reply to the first targeted question concerning the new high-risk jobs and as regards the victims of harassment at work and poor management, the report limits its submission to stating that the authorities do not have the capability to easily identify the accidents and diseases which occur in the performance of new high-risk jobs, as these types of businesses (such as Uber, Foodora, Wolt and cycle delivery firms) are not registered under the standard industrial classification codes that would typically be a gateway to identify them. In relation to various occupations within the police and other emergency services, the report indicates that the data related to such operations are not registered and Statistics Norway/the Norwegian Labour and Welfare Administration do not have this data neither.

The report does not provide any figures on the number of accidents at work or incidence rates of such accidents. The Committee reiterates its request for data regarding accidents at work and incidence rates of such accidents. The Committe also reiterates its request for information on epidemiological studies conducted to assess the long(er)-term health impact of new high-risk jobs (cycle delivery services, jobs involving particular forms of interaction with clients and expected to use potentially harmful substances such as alcohol or other psychoactive products). The Committee also reiterates its request as regards the victims of harassment at work and poor management. The Committee considers that if the requested

information is not provided in the next report, there will be nothing to establish that accidents at work and occupational diseases are monitored effectively.

According to EUROSTAT data, the number of non-fatal occupational accidents decreased in comparison to the previous reference period (from 10,150 in 2016 to 9,943 in 2019, whereas this number was 26,998 in 2008), as did the incidence rate for such accidents (373.85 in 2016 and 326.94 in 2019). This rate is significantly below the average rate in the EU-27 (1,718.32 in 2016 and 1,659.09 in 2018). The number of fatal accidents decreased during the reference period (45 in 2016 and 33 in 2019), although there is no significant difference with the figures of the previous reference period (38 in 2008). The incidence rate of such accidents (1.66 in 2016, 1.31 in 2018 and 1.09 in 2019) remain below the EU-27 average (1.84 in 2016 and 1.77 in 2018).

The report does not provide any information nor data on occupational diseases. The Committee reiterates its request for data and information on cases of occupational diseases in all sectors of the economy, including specifically the petroleum sector.The Committee considers that if the requested information is not provided in the next report, there will be nothing to establish that accidents at work and occupational diseases are monitored effectively.

Activities of the Labour Inspectorate

The Committee previously examined the situation regarding the activities of the Labour Inspectorate (Conclusions 2013). It considered that the absence of the information required amounted to a breach of the reporting obligation entered into by Norway under the Charter. It considered therefore that the Government had an obligation to provide the requested information in the next report. Pending receipt of the detailed information concerning the amendments implemented by Act No. 39/2009, and any legislation and regulation relevant to the scope of inspection services and powers of labour inspectors; figures on inspection visits conducted by the Petroleum Safety Authority (PSA); complaint investigations and accident investigations conducted by all competent bodies; the number of workers covered by inspection visits performed by the PSA and the Maritime Authority (NMA).- explanation for the low ratio of the labour force covered by the Labour Inspection Authority’s (LIA) inspection visits and administrative measures which the PSA and the NMA may adopt, as well as the overall amount of fines collected by the competent bodies, and the outcome of reports to the Police, the Committee deferred its conclusions. The targetted questions with regard to the activities of the Labour Inspectorate concern the organisation of the Labour Inspectorate, and the trends in resources allocated to labour inspection services, including human resources; number of health and safety inspection visits by the Labour Inspectorate and the proportion of workers and companies covered by the inspections as well as the number of breaches to health and safety regulations and the nature and type of sanctions; whether inspectors are entitled to inspect all workplaces, including residential premises, in all economic sectors.

In reply to the targeted questions raised by the Committee regarding the activities of the Labour Inspectorate, the report indicates that on 1 January 2020 (which is outside the reference period), the Norwegian Labour Inspection Authority introduced its new organisational model, which entails a shift from a regional organisational model to a functional organisational model with departments that have nationwide responsibility within their own areas. According to the report, the number of inspections carried out during the reference period slightly decreased (15,265 inspections in 2016 and 12,362 inspections in 2019) as well as the number of entities inspected (from 13,650 in 2016 to 10,918 in 2019) and the proportion of companies covered by the inspections (7% in 2016 and 5% in 2019). The total number of employees which were covered by the inspections increased (192,515 in 2016 and 202,101 in 2019), but the proportion of employees covered by the inspections to the total number of employees decreased (16% in 2016 and 14% in 2019).

During the inspections, 42,371 breaches were found in 2016 and 26,361 in 2019. In 2019, 5,605 orders were issued following the inspections and in 367 cases, decision to halt activities as means of pressure have been adopted (this number 607 in 2016). 991 fines have been imposed in 2019 (858 in 2018, 997 in 2017 and 1050 in 2016). In 2019, 543 fines for breach of safety and health regulations have been imposed (658 in 2018, 279 in 2017 and 97 in 2016). The report also indicates that the sample provided is limited to registered employees in companies inspected at corporate level: any entities inspected outside this group are not included in the calculation. The Committee asks that the next report include figures concerning unregistered employees as well.

In reply to the targeted question on whether inspectors are entitled to inspect all workplaces, including residential premises, in all economic sectors, the report states that all companies with employees fall within the scope of the Working Environment Act, regardless of industry or sector. In special cases, the regulations also apply to companies with no employees. The Norwegian Labour Inspection Authority supervises legislative compliance. The Petroleum Safety Authority Norway supervises petroleum activities and onshore facilities. With regard to the Norwegian Labour Inspection Authority's access to companies, the Working Environment Act stipulates that the inspectorate has unfettered access to any premises covered by the Act. This includes work premises, construction sites, staff accommodation provided by the employer, and places where, for example, hazardous chemicals are stored.

The report does not provide information with regard to the targeted question concerning trends in resources allocated to labour inspection services, including human resources. Therefore, the Committee reiterates its request for information in these regards and, in particular, on the total number of labour inspectors (excluding the administrative staff) and the number of inspectors per 10,000 employed persons. It also requests information on the annual number of inspection visits per inspector. In addition, the Committee reiterate its request for information in its previous conclusions, on the amendments implemented by Act No. 39/2009, and any legislation and regulation relevant to the scope of inspection services and powers of labour inspectors. The Committee considers that if the requested information is not provided in the next report, there will be nothing to establish that the activities of the Labour Inspectorate are effective.

Conclusion

Pending receipt of the information requested, the Committee defers its conclusion.

Article 11 - Right to protection of health

Paragraph 1 - Removal of the causes of ill-health

The Committee takes note of the information contained in the report submitted by Norway.

The Committee recalls that for the purposes of the present report, States were asked to reply to targeted questions for Article 11§1 of the Charter, as well as, where applicable, previous conclusions of non-conformity or deferrals (see the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group “Health, social security and social protection”).

In its previous conclusion, the Committee concluded that the situation in Norway was in conformity with Article 11§1 of the Charter (Conclusions 2013). The assessment of the Committee will therefore only concern the information provided by the Government in response to the targeted questions.

The Committee wishes to point out that it will take note of the reply to the question relating to Covid-19 for information purposes only, as it relates to developments outside the reference period (i.e. after 31 December 2019). In other words, the information referred to in the Covid-19 section below will not be assessed for the purposes of Charter compliance in the current reporting cycle.

Measures to ensure the highest possible standard of health

In reply to the Committee’s targeted question on statistical data on life expectancy across the country and different population groups, the report indicates that, according to Statistics Norway, life expectancy at birth was 84.69 years for women and 81.19 for men in 2019.

The report further indicates that the Norwegian Institute of Public Health (‘NIPH’) has found differences across the counties of up to 2.5 years, with the highest life expectancy in western Norway and the lowest in the former counties of Finnmark, Østfold and Hedmark. When comparing the municipalities with the lowest life expectancy and the highest one, the NIPH found differences of up to 10 years. In some districts in Oslo, the difference in life expectancy is up to 8 years. The report states that these differences can mainly be attributed to socio-economic inequality. The level of education is a major factor in the large variation in life expectancy in Norway. Men and women with higher education are expected to live 6.4 years and 5 years longer respectively than those with only compulsory education.

The Committee notes that, according to the report, the findings of the NIPH are based on figures corresponding to 2015 which is outside the reference period. It asks that the next report provide updated data relevant to the reference period in question on life expectancy across the country and different population groups identified in the report.

The report further states that according to the Norwegian Directorate for Children, Youth and Family Affairs (‘Bufdir’), some immigrants have a lower mortality rate compared to the rest of the population, such as: those who immigrated before the age of 3 or after 45 years of age; those with a short period of residence in Norway; those who immigrate to Norway for work or education purposes, as well as refugees and family reunification. Some groups of immigrants have a somewhat higher mortality rate than the general population, such as: those who immigrated to Norway between the ages of 3 and 18; those who have lived in Norway more than 30 years or at least 40% of their life; immigrants from the Nordic region.

The report indicates that life expectancy is somewhat lower in the STN area (the Sami Parliament’s business support scheme) north of the Saltfjellet mountains than in other areas north of this.

The report also provides statistical data on the number of new cases of HIV annually which is reported to have fallen from 100 in 2009 to 28 in 2019.

Access to healthcare

In a targeted question, the Committee asked for information about sexual and reproductive healthcare services for women and girls (including access to abortion) and statistical information about early (underage or minor) motherhood, as well as child and maternal mortality.

The report indicates that the Norwegian health policy is based on the premise that sexual and reproductive health and rights are an important part of public health. The government's sexual health strategy, 'Talk about it!' (2017–2022) highlights the importance of the topic and provides a basis for a comprehensive effort to protect the population's sexual health and reproductive health and rights. The report states that good sexual health is important for the individual's quality of life. Children, young people and adults need knowledge and confidence to set boundaries and to make independent choices about their own body and sexuality.

The report further indicates that children and the under 20s, pregnant women and post-partum women have a legal right to free primary health services that safeguard their sexual and reproductive health. The national guidelines for child health centres and school health services, and the national guidelines for ante-natal care aim to ensure that the services are of a professional standard. The health centre for youths is a statutory, free municipal service for young people up to the age of 20. Many local authorities have decided to increase the age limit to 25. These centres offer consultations adapted to the needs of young people on sexual health, contraception and sexually transmitted infections. Women over the age of 25 go to a GP, a private doctor or a midwife for consultations related to sexual and reproductive health. Pregnant and post-partum women can receive contraceptive advice and help with sexual and reproductive health from a midwife or public health nurse.

The report provides detailed information on the access to contraception (including emergency contraception and sterilisation as a method of contraception) and access to information. In addition to doctors, qualified public health nurses and midwives can prescribe all types of contraceptives to women over the age of 16. Contraceptives for girls under 16 must be prescribed by a doctor. As regards the costs of contraception, the report indicates that women between the ages of 16 and 22 receive financial support to cover all or part of them. The degree of cover varies according to the product and the woman's age. Women up to the age of 19 do not pay for an intratrauterine device (IUD) or contraceptive implants, while women who are 20 or 21 years old have to pay a small charge. Emergency contraception is not free, but it can be purchased without a prescription at pharmacies and supermarkets. The age limit for emergency contraception in shops is 18, but there is no age limit in pharmacies.

The Committee asks for information on the proportion of the cost of contraceptives that is not covered by the State (in cases where the cost is not fully reimbursed by the State).

With regard to access to abortion, the report indicates that since 1979, women in Norway have had the right to decide whether they want to have an abortion during the first twelve weeks of pregnancy. A period of reflection is not required. Healthcare personnel have a duty to inform the woman about how the abortion will be performed and about the risk of complications, as well as offer further guidance and support. For girls under the age of 16, parents/guardians are given the opportunity to express their opinion, unless there are special reasons why they shouldn't. For women with a mental disability, their next of kin are given the opportunity to have their say. In cases where the woman has a serious mental illness or mental disability, their next of kin can request an abortion on the woman's behalf. The woman's consent must be obtained if it can be assumed that she has the ability to understand the significance of the procedure.

The report further indicates that women who wish to have an abortion after the end of the 12th week of pregnancy must send a substantiated request to an abortion board. The criteria for granting an abortion become more stringent as the pregnancy progresses. The Abortion Act was amended in 2019, whereby a request to reduce the number of foetuses must be determined by a board. Since 1 January 2020 (outside the reference period), 26 hospitals in Norway have had an abortion board.

With regard to the costs of abortion, the report states that abortions are free for women who are residents in Norway. Women who are not residents, but who are members of the National Insurance Scheme or are covered by a reciprocal agreement with another country, can have their expenses covered by the National Insurance Scheme. Other women have to pay for the abortion themselves.

The report indicates that the abortion rate in Norway is falling, and it was at its lowest in 2019 since the Abortion Register was established in 1979. According to the statistics presented in the report, the decline has been sharpest in the youngest age groups (women aged 15-19) and the abortion rate is highest in the age group 25–34 years.

The report provides statistical data on teenage births, infant mortality and stillbirths. It also provides information on measures taken to prevent infant mortality such as the Early Intervention training programme for services and professionals in local authorities. The goal is to empower practitioners in sensitive conversations and increase the likelihood of identifying risks and providing early intervention to pregnant women and families. An important topic in the programme covers monitoring and talking with pregnant women and parents about alcohol, mental health difficulties and violence in close relationships. A total of 163 municipalities have so far participated in the training programme.

The Committee asks that the next report contain information on the public health expenditure as a share of GDP.

As regards the right to protection of health of transgender persons, the Committee in its previous conclusion took note of the submissions from the International Lesbian and Gay Association (European Region) (ILGA) stating that "in Norway there is a requirement that transgender people undergo sterilisation as a condition of legal gender recognition". The Committee asked whether legal gender recognition for transgender persons requires (in law or in practice) that they undergo sterilisation or any other invasive medical treatment which could impair their health or physical integrity (Conclusions 2013, General Introduction). The Committee notes from Transgender Europe (TGEU) that in July 2016, a Gender Recognition Act was adopted in Norway which allows one to change legal gender (male/female) without the previously required sterilisation.

In a targeted question, the Committee asked for information on measures to ensure informed consent to health-related interventions or treatment (under Article 11§2). The report indicates that according to Section 3-1 [on the patient's right to participation] of the Patients' Rights Act, the service user is entitled to participate in the implementation of his/her healthcare. This includes the right to participate in the choice between available and medically safe services, methods of examination and treatment. According to the report, the form of participation shall be adapted to the individual patient's ability to give and receive information. Children who are able to form their own opinions must be given information and heard. The child's opinion should be weighted according to his/her age and maturity.

Covid-19

In the context of the Covid-19 crisis, the Committee asked the States Parties to evaluate the adequacy of measures taken to limit the spread of virus in the population as well as the measures taken to treat the ill (under Article 11§3).

For the purposes of Article 11§1, the Committee considers information focused on measures taken to treat the ill (sufficient number of hospital beds, including intensive care units and equipment, and rapid deployment of sufficient numbers of medical personnel).

With regard to treating those who are ill, the report states that all those infected with Covid-19 have received necessary and good healthcare, but patients with health problems other than Covid-19 were given a lower priority than those infected with Covid-19. For example, elective surgeries were postponed for a brief period in order to ensure that sufficient healthcare resources were available to treat Covid-19 patients, should the need arise. No excess mortality has been recorded during the pandemic. Preliminary figures from the NIPH show that 190 deaths per 100,000 inhabitants were registered from March to May this year, while in the same period the year before, the corresponding figure was 192. However, healthcare personnel consider the infection control measures in their work situation to be stressful, all the more so as time passes. It has also been reported that vulnerable groups in the population have had a more difficult time during the pandemic. For example, there are reports of increased isolation and loneliness, with the accompanying mental health challenges.

The Committee recalls that during a pandemic, States Parties must take all necessary measures to treat those who fall ill, including ensuring the availability of a sufficient number of hospital beds, intensive care units and equipment. All possible measures must be taken to ensure that an adequate number of healthcare professionals are deployed (Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020).

The Committee recalls that access to healthcare must be ensured to everyone without discrimination. This implies that healthcare in a pandemic must be effective and affordable to everyone, and States must ensure that groups at particularly high risk, such as homeless persons, persons living in poverty, older persons, persons with disabilities, persons living in institutions, persons detained in prisons, and persons with an irregular migration status are adequately protected by the healthcare measures put in place. Moreover, States must take specific, targeted measures to ensure enjoyment of the right to protection of health of those whose work (whether formal or informal) places them at particular risk of infection (Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020).

During a pandemic, States must take all possible measures as referred to above in the shortest possible time, with the maximum use of financial, technical and human resources, and by all appropriate means both national and international in character, including international assistance and cooperation (Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020).

Conclusion

Pending receipt of the information requested, the Committee concludes that the situation in Norway is in conformity with Article 11§1 of the Charter.

Article 11 - Right to protection of health

Paragraph 2 - Advisory and educational facilities

The Committee takes note of the information contained in the report submitted by Norway.

The Committee notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter with respect to the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

In its previous conclusion, the Committee found that the situation in Norway was in conformity with Article 11§2 of the Charter (Conclusions 2013).

Education and awareness raising

In its targeted questions, the Committee asked for information about health education (including sexual and reproductive health education) and related prevention strategies (including through empowerment that can serve as a factor in addressing self-harm conducts, eating disorders, alcohol and drug use) in the community, on a lifelong or ongoing basis, and in schools.

The report indicates that a national health awareness strategy has been adopted for the period 2019-2023. It aims, among others, to ensure that health competence is incorporated into the planning, development, implementation and evaluation of health and care services and public health work at all service and administrative levels; help the Norwegian Directorate of Health to be a health competence-friendly organisation; devise a knowledge base for targeted interventions that foster more informed health choices, including a national survey of health-literate organisations; introduce health competence as a competence objective and learning outcome in all health and social care programmes of professional study; value and encourage voluntary organisations to help improve the population's health competence.

The Committee asks that more detailed information be provided in the next report about health education and related prevention strategies (including through empowerment that can serve as a factor in addressing self-harm conducts, eating disorders, alcohol and drug use) in the community, on a lifelong or ongoing basis.

As regards health education in schools, the report indicates that the national curriculum forms the framework and governs the content in Norwegian schools. Local authorities and schools have considerable autonomy in deciding how they want to organise the education process in order to achieve the objectives of the curriculum. Schools and teachers determine what curricula and learning materials are used. In its previous conclusion (Conclusions 2009), the Committee noted that the work of the school health services covers various topics, such as sexuality, relationships and contraception, protection against communicable diseases, diet, dental health, anti-smoking, drinking and drug campaigns, physical activity, and preventing accidents and injury.

The report indicates that a new curriculum was developed in the 2016–2019 period, which was planned to be introduced in schools in autumn 2020 (outside the reference period).

Moreover, the Norwegian Directorate of Education and Training has created an online resource that addresses the prevention of self-harm and suicide. It is recommended that schools adopt an interdisciplinary approach and work with other disciplines and sectors on these themes.

With regard to sexual and reproductive health education, the report indicates that different aspects of these issues are covered in social studies, science, physical education, religious and ethical education. The Committee takes note of the examples of relevant competence objectives in the syllabuses for the different subjects provided in the report. In social studies, for example, sexual orientation, setting boundaries and sexual abuse are central topics. Natural science focuses on reproductive health, bodily changes during puberty and the potential effects of puberty on emotions. Drugs and alcohol are also covered in the science syllabus.

In its targeted questions, the Committee also asked for information about awareness-raising and education with respect to sexual orientation and gender identity (SOGI) and to gender-based violence. In response, the report provides some examples of learning resources that relate to education and awareness-raising on sexual orientation and gender identity (SOGI) and on gender-based violence. The Committee takes note of the digital learning resource "*Jeg Vet*" ("I know"), which was launched in 2018 to prevent violence and acquire life skills in kindergartens and schools. In particular, its purpose is to provide children with age-appropriate, quality-assured knowledge about what violence, bullying and sexual abuse are, what rights they have, and where they can get help. It also provides support material for teachers. Another learning tool "*Snakke sammen*" ("Talk together") was also launched in 2018. It is a digital information and simulation portal aimed at increasing adults' confidence when addressing important issues with children they are concerned about.

Counselling and screening

In its previous conclusion, the Committee found that the situation in Norway was in conformity with Article 11§2 with respect to counselling and screening services available to pregnant women and children (Conclusions 2017).

The report indicates that school health services have been strengthened. The period 2014 to 2019 saw a gradual increase in funding for school health services and child health centres.

The report identifies some of the measures undertaken, *inter alia*, to combat pseudoscience with respect to health issues. The Committee notes that the official healthcare website (*Helsenorge.no*) has been developed for residents of Norway in order to improve and simplify the interaction between the individual patient, his/her family and the healthcare service, to promote life skills, strengthen the patients' role and improve their health. It aims to simplify the search for and selection of a treatment provider, provide access to users' own health information, provide quality information and advice on good health and lifestyle choices, symptoms, illness, treatment and rights.

Conclusion

The Committee concludes that the situation in Norway is in conformity with Article 11§2 of the Charter.

Article 11 - Right to protection of health

Paragraph 3 - Prevention of diseases and accidents

The Committee takes note of the information contained in the report submitted by Norway.

The Committee notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

Therefore, it will focus on the Government's replies to the targeted questions, namely about healthcare services in prison; community-based mental health services; drug abuse prevention and harm reduction; healthy environment; immunisation and epidemiological monitoring; Covid-19; and any previous deferrals or non-conformities.

The Committee wishes to point out that it will take note of the information provided in reply to the question relating to Covid-19 for information purposes only, as it relates to developments outside the reference period (namely, after 31 December 2019). In other words, the information referred to in the Covid-19 section will not be assessed for the purposes of Charter compliance in the current reporting cycle.

In its previous conclusion, the Committee concluded that the situation in Norway was in conformity with Article 11§3 of the Charter (Conclusions 2013).

Healthcare services in places of detention

In a targeted question, the Committee asked for a general overview of healthcare services in places of detention, in particular prisons (under whose responsibility they operate/which ministry they report to, staffing levels and other resources, practical arrangements, medical screening on arrival, access to specialist care, prevention of communicable diseases, mental health-care provision, conditions of care in community-based establishments when necessary, etc.).

The report notes that prison healthcare is based on the principle of equivalence with the level of care available in the community, and that it must be adapted to individual needs. The report further notes that the responsibility for providing prison healthcare is distributed between local and county authorities, regional health authorities, the Correctional Service, and the police.

The Committee refers to the latest report on Norway by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT, 2018), which noted a persistent problem in that prisoners suffering from a severe mental disorder were denied access to an appropriate psychiatric unit/hospital for as long as required by their state of health. The Norwegian Government indicated at the time that it was planning to construct a new regional psychiatric security department in the Oslo area to address these needs. In its latest concluding observations concerning Norway, the United Nations Committee against Torture (CAT, 2018) similarly noted the severe insufficiency of mental healthcare services and of the capacities of inpatient psychiatric wards to accommodate prisoners with serious mental illnesses, which often result in their placement in isolation, including security cells, which leads to a further deterioration of their health.

In light of the foregoing, the Committee asks for information regarding the measures taken with a view to ensuring that prisoners with mental health problems benefit from appropriate psychiatric care..

Community-based mental health services

In a targeted question, the Committee asked for information regarding the availability and extent of community-based mental health services and on the transition to community-based mental health from former large-scale institutions. The Committee also asked for statistical information on outreach measures in connection with the mental health assessment of vulnerable populations and on proactive measures adopted to ensure that persons in need of mental healthcare are not neglected.

The report provides an outline of measures taken with a view to supporting people with substance abuse and addiction disorders in the context of the Covid-19 pandemic, outside the reference period, and not directly related to the targeted question.

Consistent with the World Health Organisation (WHO) Comprehensive Mental Health Action Plan 2013-2030, and other relevant standards, the Committee considers that a human rights-compliant approach to mental health requires at a minimum the following elements: a) developing human rights-compliant mental health governance through, inter alia, mental health legislation and strategies that are in line with the Convention on the Rights of Persons with Disabilities and other relevant instruments, best practice and evidence; b) providing mental health in primary care community-based settings, including by replacing long-stay psychiatric hospitals with community-based non-specialised health settings; and c) implementing strategies for promotion and prevention in mental health, including campaigns to reduce stigmatisation, discrimination and human rights violations.

The Committee notes that the information requested is not provided, namely with regard to the availability and extent of community-based mental health services and on the transition to community-based mental health from former large-scale institutions. The Committee also asked for statistical information on outreach measures in connection with the mental health assessment of vulnerable populations and on proactive measures adopted to ensure that persons in need of mental healthcare are not neglected. Therefore, the Committee reiterates the request and considers that if the requested information is not provided in the next report, there will be nothing to establish that the situation in Norway is in conformity with Article 11§3 of the Charter.

Drug abuse prevention and harm reduction

In a targeted question, the Committee asked for information about drug-related deaths and transmission of infectious diseases among people who use or inject psychoactive substances both in the community and in custodial settings. The Committee also asked for an overview of the national policy designed to respond to substance use and related disorders (dissuasion, education, and public health-based harm reduction approaches, including use or availability of WHO listed essential medicines for opioid agonist treatment) while ensuring that the "available, accessible, acceptable and sufficient quality" criteria (WHO's 3AQ) are respected, subject always to the exigency of informed consent. This rules out, on the one hand, consent by constraint (such as in the case of acceptance of detox and other mandatory treatment in lieu of deprivation of liberty as punishment) and, on the other hand, consent based on insufficient, inaccurate or misleading information (i.e. not based on state of the art scientific evidence).

The report provides information about the trends with regard to drug-related deaths during the reference period, which have remained relatively stable (286 deaths in 2018, 249 in 2017, and 284 in 2016). The report otherwise focuses on prevention policies, which are described in some detail. The guidelines "Tackling it together – local efforts in mental health and substance use in adults" list health and social interventions addressing the needs of different groups of users. Lastly, the National Overdose Strategy 2019-2022 entails measures aimed at saving lives and limiting damage to health.

The Committee notes from other sources that the number of newly diagnosed cases of HIV and acute Hepatitis B among people who inject drugs remains relatively stable and low during the reference period (European Monitoring Centre for Drugs and Drug Addiction,

Norway Country Drug Report 2019). In terms of harm reduction intervention, low-threshold facilities offer a broad range of services, such as health checks, vaccinations (including the provision of free Hepatitis A and B vaccines), distribution of clean injecting equipment and foil, overdose prevention interventions, nutritional and hygiene guidance, follow-up and referral to other parts of the health service, and supervised injection rooms. Drug treatment encompasses a range of services including assessment, detoxification, stabilisation, short- and long-term residential treatments and medication-assisted treatment, such as opioid agonist treatment.

Healthy environment

In a targeted question, the Committee asked for information on the measures taken to prevent exposure to air, water or other forms of environmental pollution, including proximity to active or decommissioned (but not properly isolated or decontaminated) industrial sites with contaminant or toxic emissions, leakages or outflows, including slow releases or transfers to the neighbouring environment, nuclear sites, mines, as well as on the measures taken to address the health problems of the populations affected, and to inform the public, including pupils and students, about general and local environmental problems.

The report provides an outline of selected provisions of the Pollution Control Act concerning waste management, permits and regulations for pollution-generating activities, emergency measures during acute pollution events, the attributions of the Pollution Control Authority, and on access to information.

Immunisation and epidemiological monitoring

In a targeted question, the Committee asked States Parties to describe the measures taken to ensure that vaccine research is promoted, adequately funded and efficiently coordinated across public and private actors.

The report provides a list of national and international vaccine research initiatives that Norway contributes to.

Covid-19

The Committee asked States Parties to evaluate the adequacy of measures taken to limit the spread of the Covid-19 virus in the population (testing and tracing, physical distancing and self-isolation, provision of surgical masks, disinfectant, etc.).

The report provides an overview of the preventive measures taken in the context of the Covid-19 pandemic, including by imposing a lockdown, testing and tracing, a quarantine regime for international arrivals or public communication campaigns. The report states that the measures implemented proved to be effective, with Norway recording a relatively low level of fatalities and hospitalisations. At the same time, healthcare personnel experienced hardship as a result of additional pressure brought to bear by the pandemic, while members of vulnerable groups reported increased isolation and loneliness, leading to mental health challenges.

The Committee recalls that States Parties must take measures to prevent and limit the spread of the virus, including testing and tracing, physical distancing and self-isolation, the provision of adequate masks and disinfectant, as well as the imposition of quarantine and 'lockdown' arrangements. All such measures must be designed and implemented having regard to the current state of scientific knowledge and in accordance with relevant human rights standards (Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020). Furthermore, access to healthcare must be ensured to everyone without discrimination. This implies that healthcare in a pandemic must be effective and affordable to everyone, and that groups at particularly high risk, such as homeless persons, persons living in poverty, older persons, persons with disabilities, persons living in

institutions, persons detained in prisons, and persons with an irregular migration status must be adequately protected by the healthcare measures put in place (Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020).

Conclusion

Pending receipt of the information requested, the Committee defers its conclusion.

Article 12 - Right to social security

Paragraph 1 - Existence of a social security system

The Committee notes that no targeted questions were asked under this provision. As the previous conclusion found the situation to be in conformity there was no examination of the situation in 2021.

Article 12 - Right to social security

Paragraph 2 - Maintenance of a social security system at a satisfactory level at least equal to that necessary for the ratification of the European Code of Social Security

The Committee takes note of the information contained in the report submitted by Norway.

The Committee recalls that Norway ratified the European Code of Social Security and its Protocol on 25 March 1966, and has accepted Parts II-VII, IX and X of the Code.

The Committee notes from Resolution CM/ResCSS(2020)13 of the Committee of Ministers on the application of the European Code of Social Security and its Protocol by Norway (period from 1 July 2018 to 30 June 2019) that the law and practice in Norway continue to give full effect to all Parts of the Code and the Protocol which have been accepted.

Conclusion

The Committee concludes that the situation in Norway is in conformity with Article 12§2 of the Charter.

Article 12 - Right to social security

Paragraph 3 - Development of the social security system

The Committee takes note of the information contained in the report submitted by Norway.

The Committee recalls that States were asked to reply to two targeted questions for Article 12§3 of the Charter as well as, where applicable, the previous conclusions of non-conformity or deferral (see the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection").

In its previous conclusion, the Committee found that the situation in Norway was in conformity with Article 12§3 of the Charter (Conclusions 2013). It will therefore restrict its consideration to the Government's replies to the two targeted questions, namely:

- social security coverage, and its modalities, provided to persons employed by digital platforms or whose work is managed via such platforms; and
- any impact of the Covid-19 crisis on social security coverage, and any specific measures taken to compensate for or alleviate any possible negative impact.

The Committee wishes to point out that it will take note of the reply to the second question for information purposes only, as it relates to developments that occurred outside the reference period (i.e. after 31 December 2019). In other words, the information referred to in the Covid-19 section below will not be assessed for the purposes of Charter compliance in the current reporting cycle.

Platform workers

The Committee recalls that it has posed a targeted question to all States on social security cover for persons employed or whose work is managed by digital platforms. The emergence of these new forms of employment has had a negative impact on certain rights of these workers, as explained in the General Introduction. In matters of social security, compliance with Article 12§3 of the Charter requires that the existing social security systems be adapted to the specific situation and needs of the workers concerned, in order to guarantee that they enjoy the social benefits included within the scope of Article 12§1. The Committee is keenly aware that there are significant gaps in the social coverage of workers in new forms of employment such as platform workers. It considers that the States Parties are under an obligation to take all the necessary measures to address these shortcomings.

In particular States Parties must take steps to ensure that all workers in new forms of employment have an appropriate legal status (employee, self-employed or other category) and that this status is in line with the actual situation thus avoiding abuse (such as the use of "bogus" or "false" self-employed status to circumvent the applicable social security regulations) and conferring adequate social security rights as guaranteed by Article 12 of the Charter on the platform workers.

In its report, the Government states that the Norwegian national insurance scheme is a comprehensive system which covers all persons who are residing or employed in Norway, i.e. 100% of the population. Exemptions are limited to categories such as foreign diplomats stationed in Norway or workers posted in Norway who remain insured in their home country under bilateral or multilateral social security co-ordination instruments. Some people residing abroad may have a similar affiliation to the Norwegian national insurance scheme. There are no precise statistics on these groups. The Government further states that the Norwegian national insurance scheme, taken in conjunction with the family allowance scheme, comprises all branches of social security as set out in the European Code of Social Security; in this respect, it refers to the survey on the Norwegian Social Insurance Scheme (published on its website) which also gives relevant information as to the nature of the system and its

various branches, its financial arrangement, the level of the benefits and the eligibility criteria.

Other sources indicate that the platform economy was the focus of developments, and debate, during the reference period. In particular, in 2016 the Government set up the Sharing Economy Committee to evaluate the opportunities and challenges presented by the sharing economy and draw up proposals for adapting Norway's policies and legislation. According to the conclusions of the 2017 report, a majority of the committee members considered that the sharing economy did not challenge the term "employee" as it was understood in the current Working Environment Act and that the current national insurance and pension schemes for the self-employed were well founded, and therefore proposed that the Working Environment Act and the insurance/pension rights of the self-employed (national schemes) should not be changed. In contrast, other studies and publications point out that the status of digital platform workers is unclear and that the social security coverage of digital platform workers has shortcomings and needs to be improved (e.g. Protection of platform workers in Norway, Part 2 Country report, Marianne Jennum Hotvedt – Nordic future of work project 2017-2020: Working paper 09, Pillar VI, Fafo 2020).

The Committee takes note of this information, which is useful but does not give it a full picture of the social security coverage of digital platform workers. The Committee asks for updated and detailed information in the next report on the number of digital platform workers (as a percentage of the total number of workers), their status (employees, self-employed and/or other category), the number/percentage of these workers by status and their social security protection (by status).

Covid-19

In response to the second question, the Government states that owing to the pandemic, changes were introduced in March 2020 concerning sickness benefits and care allowances (to entitlement criteria and the benefit scheme). For example, entitlement to sickness benefits was expanded to include persons who had to be absent from work due to Covid-19 (including in cases of quarantine, i.e. suspected illness); in addition, the period during which employers pay compensation for sick leave due to Covid-19 (before it begins to be paid by the national insurance system) was reduced from 16 to three days, and self-employed workers and freelancers received compensation from the fourth day of their sick leave (instead of from day 17). The scope of care allowances was also extended to include childcare in the event of school/nursery closures due to the pandemic and childcare when children cannot attend school/nursery due to illness (of the child or a family member). In both cases (closure of the facilities; illness of child or family member), parents receive childcare benefits for as many days as required. In addition, the number of childcare allowance days was increased for all parents in 2020.

Conclusion

Pending receipt of the information requested, the Committee concludes that the situation in Norway is in conformity with Article 12§3 of the Charter.

Article 12 - Right to social security

Paragraph 4 - Social security of persons moving between States

The Committee notes that the report does provide any information concerning this provision of the Charter. Therefore, it reiterates its previous findings of non-conformity.

Conclusion

The Committee concludes that the situation in Norway is not in conformity with Article 12§4 of the Charter on the grounds that:

- the length of residence required of persons no longer resident in Norway or not resident in a country with which Norway has an agreement in order to be able to benefit from the exportability of non-contributory old-age, invalidity and survivors' benefits is excessive;
- the accumulation of periods of insurance or employment is not guaranteed for nationals of all States Parties.

Article 13 - Right to social and medical assistance

Paragraph 1 - Adequate assistance for every person in need

The Committee takes note of the information contained in the report submitted by Norway.

The Committee notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

Therefore it will focus on the Government's replies to the targeted questions, namely about measures taken to ensure that the right to social and medical assistance is ensured and any previous deferrals or non-conformities.

The Committee wishes to point out that it will take note of the information provided in reply to the question relating to Covid-19 for information purposes only, as it relates to developments outside the reference period (i.e. after 31 December 2019). In other words, the information referred to in the Covid-19 section will not be assessed for the purposes of Charter compliance in the current reporting cycle.

The previous conclusion (2013) considered that the situation in Norway was not in conformity with Article 13§1 of the Charter on the ground that the level of social assistance was inadequate.

General legal framework, types of benefits and eligibility criteria

The Committee takes note that the report states that there were no reforms to the legal framework for social services in the period 2016-2019. Minor adjustments have been made to the regulations, such as the introduction of a duty for social security recipients under the age of 30 to engage in work-related activity from 2017, and changes in the regulations for the Qualification Programme in 2019 in order to make it more accessible and flexible. Persons who cannot support themselves through earned income are entitled to financial support. The support should aim to make the person concerned able to support themselves. The Ministry can issue recommended guidelines regarding the level of support and has done so since 2001. Government guidelines for the level of financial support for certain basic living expenses are adjusted annually in line with inflation.

Levels of benefits

To assess the situation during the reference period, the Committee takes into account the following information:

- Basic benefit: the Committee notes from MISSOC that according to the Government guidelines that exist in this respect, defining the expenses for which support should be given and the reasonable monthly amounts for subsistence allowance (taking into account the most ordinary expenses in daily life but excluding housing allowance, electricity, housing insurance etc., which are paid separately, depending on the actual needs), it stood at NOK 6,250 on 1 January 2020 (€573) for a single person (NOK 6,150 in 2019), NOK 10,450 (€959) for a married couple or couple cohabiting and NOK 5,250 (€482) for persons living in common households.
- Medical healthcare: according to MISSOC, public health care services are available to all residents. When access is dependent on co-payment this will be taken into consideration, when determining the amount of the financial assistance. Consequently, there is no need for special access to healthcare for this group of people. The frequency of payment is dependent of the need. The

governments guidelines are based on a presumption of the needs per month. But if the recipient has additional needs within this period the person can apply for more financial assistance at any time.

- Poverty threshold: the report states that statistics showing the average monthly payment do not give an accurate picture of the benefit recipient's actual financial situation. When assessing the benefit recipient's total financial situation, a number of important services must also be taken into consideration, such as the fact that day-care centres, schools and health and care services are either free or require a small personal contribution. Norway has no official poverty line. The report considers that the EU's equivalence scale used in this measurement stipulates that the poverty line should be set at 50 per cent of the median income. Eurostat mainly uses 60 per cent of median income as an at-risk-of-poverty indicator. The report states that in 2018, the 50% of the median income was NOK 192,100 (€18,702). According to Eurostat, in 2019 it stood at €1,630 per month.

The Committee takes note of all the explanations about the fact that each situation is to be assessed individually. It further notes from MISSOC that here are certain housing allowances provided by the Housing Bank (Husbanken). Housing costs are to be considered on a concrete and individual basis by the municipality. All those who cannot afford his/her housing costs can apply for financial assistance. However, these amounts still fall well below the poverty threshold.

In the light of the above information, the Committee concludes that the level of social assistance is inadequate and therefore the situation is not in conformity with Article 13§1 of the Charter.

Right of appeal and legal aid

The situation was previously in conformity with the Charter. The Committee asks the next report to provide for updated information on the appeals and remedies available in this field.

Personal scope

The specific questions asked in relation to Article 13§1 this year do not include an assessment of assistance to nationals of States parties lawfully resident in the territory. Therefore, this particular issue will only be assessed if there was a request of information or a non-conformity in previous cycle.

Foreign nationals unlawfully present in the territory

The Committee recalls that persons in an irregular situation must have a legally recognised right to the satisfaction of basic human material need (food, clothing, shelter) in situations of emergency to cope with an urgent and serious state of need. It likewise is for the States to ensure that this right is made effective also in practice (European Federation of National Organisations working with the Homeless (FEANTSA) v. the Netherlands, Complaint No. 86/2012, decision on the merits of 2 July 2014, §187).

The report states that all persons without legal residence in Norway are entitled to immediate medical assistance, cf. Regulations relating to the right to health and care services for persons without permanent residence in Norway. Persons without legal residence in the country are entitled to free health care and treatment for infectious diseases, including COVID-19. Oslo and Bergen have dedicated health centres for undocumented immigrants which provide health care for a limited number of days and hours a week. In Trondheim, those without legal residence receive health care via the refugee health team. There are no dedicated health centres for this group elsewhere in the country, but from surveys conducted by the Norwegian Medical Association GPs throughout much of Norway treat patients without legal residence. The report states that foreign citizens who do not have legal

residence in Norway are not entitled to individual services under the Social Services Act, with the exception of information, advice and guidance from the local authority. If a person without legal residence is unable to provide for himself and is not entitled to government-funded accommodation, they nevertheless have a right to financial support and help in finding temporary accommodation for a short period in the event of an emergency. Help shall be provided until the person can in practice leave the country.

The Committee considers that the situation in this respect is in conformity with the Charter.

Medical and social assistance during the Covid-19 pandemic

The Committee takes note that there have been some amendments in the social assistance scheme as a consequence of the Covid-19 pandemic, such as introducing a legal basis to regulate temporary exceptions from using activity as eligibility criteria during a serious communicable disease, in order to receive financial assistance. Participants in the qualification programme will not lose the right to a benefit or to time in the programme due to the Covid-19 pandemic. This includes situations where participants are not able to go through with their planned activity due to the Covid-19 pandemic, where this was initially a prerequisite for receiving the benefit.

The Committee asks the next report to produce further information on social assistance and specific measures taken during the Covid-19 pandemic.

Conclusion

The Committee concludes that the situation in Norway is not in conformity with Article 13§1 of the Charter on the ground that the level of social assistance is not adequate.

Article 13 - Right to social and medical assistance

Paragraph 2 - Non-discrimination in the exercise of social and political rights

The Committee notes that no targeted questions were asked under this provision. As the previous conclusion found the situation to be in conformity there was no examination of the situation in the current cycle.

Article 13 - Right to social and medical assistance

Paragraph 3 - Prevention, abolition or alleviation of need

The Committee notes that no targeted questions were asked under this provision. As the previous conclusion found the situation to be in conformity there was no examination of the situation in the current cycle.

Article 13 - Right to social and medical assistance

Paragraph 4 - Specific emergency assistance for non-residents

The Committee notes that no targeted questions were asked under this provision. As the previous conclusion found the situation to be in conformity there was no examination of the situation in the current cycle.

Article 14 - Right to benefit from social welfare services

Paragraph 1 - Promotion or provision of social services

The Committee takes note of the information contained in the report submitted by Norway.

The Committee recalls that Article 14§1 guarantees the right to benefit from general social welfare services. It notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

Therefore, it will focus on the Government's replies to the targeted questions, namely how and to what extent the operation of social services was maintained during the COVID-19 crisis and whether specific measures were taken in view of possible similar crises arising in the future. The Committee wishes to point out that it will take note of the information provided in reply to the question relating to COVID-19 for information purposes only, as it relates to developments outside the reference period (i.e. after 31 December 2019). In other words, the information referred to in the COVID-19 section will not be assessed for the purposes of Charter compliance in the current reporting cycle.

As regards the description of general organisation of social services, the Committee refers to its previous conclusion (Conclusions 2013) in which it found the situation to be in conformity with the Charter. The report does not indicate any changes in this respect.

In response to the targeted questions, the report provides that social service case processing has worked well during the pandemic, and the availability of services has largely been maintained. The Directorate of Labour and Welfare has drawn up a guide to simplify the processing of decisions on financial social assistance as a result of the pandemic. It provides guidance on how NAV can ensure proper case processing in a time of significant pressure on the social services. A solution for online applications for social assistance (DIGISOS) during the period was also implemented in all local authorities. The solution has made NAV more accessible to those who need to apply for social assistance. It has also helped to simplify the processing of applications for financial social assistance.

The report does not contain information on any specific measures taken in anticipation of possible crises of such nature.

Conclusion

The Committee concludes that the situation in Norway is in conformity with Article 14§1 of the Charter.

Article 14 - Right to benefit from social welfare services

Paragraph 2 - Public participation in the establishment and maintenance of social services

The Committee takes note of the information contained in the report submitted by Norway.

The Committee recalls that Article 14§2 requires States Parties to provide support for voluntary associations seeking to establish social welfare services. The "individuals and voluntary or other organisations" referred to in paragraph 2 include the voluntary sector (non-governmental organisations and other associations), private individuals, and private firms.

The Committee further notes that for the purposes of the current examination, States were asked to reply to the specific targeted questions posed to States in relation to this provision (questions included in the appendix to the letter of 3 June 2020, in which the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the scope of the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals. States were therefore requested to provide information on user involvement in social services ("co-production"), in particular on how such involvement is ensured and promoted in legislation, in budget allocations and decision-making at all levels, as well as in the design and delivery of services in practice. Co-production is understood here to mean that social services work together with users of the services on the basis of fundamental principles, such as equality, diversity, accessibility and reciprocity.

The Committee has previously found the situation in conformity with the Charter (Conclusions 2013 and precedent). The report provides that Under the Social Services Act, the administration has a duty to consult with the service user. The service shall, as far as possible, be designed in collaboration with the service user, whose opinion must be weighted heavily. In 2008, a contact committee was appointed for contact between the government and representatives of the socially and financially disadvantaged. The contact committee is a platform for dialogue and gives the authorities access to service users' perceptions and experiences of poverty and social exclusion, which can be used to inform social policy. Three meetings a year are held. Financial support is provided to the Co-operation Forum against Poverty, which is a nationwide network of service user organisations. Operating grants are also given to user- driven organisations that are working to improve the situation of the socially and financially disadvantaged. A central service user committee is in place in NAV, as well as regional and local service user committees. A strategy for service user participation in NAV has been devised, which deals with participation at system and service level.

Conclusion

The Committee concludes that the situation in Norway is in conformity with Article 14§2 of the Charter.

Article 23 - Right of the elderly to social protection

The Committee takes note of the information contained in the report submitted by Norway.

The Committee notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

Therefore, it will focus on the Government's replies to the targeted questions, namely about measures taken to ensure that the social and economic rights of older persons are respected and Covid-19 and any previous deferrals or non-conformities.

The Committee wishes to point out that it will take note of the information provided in reply to the question relating to Covid-19 for information purposes only, as it relates to developments outside the reference period (namely, after 31 December 2019). In other words, the information referred to in the Covid-19 section will not be assessed for the purposes of Charter compliance in the current reporting cycle.

The previous Conclusion found the situation not to be in conformity on the grounds that the scope of the legal framework to combat age-discrimination outside employment was not sufficiently wide (Conclusions 2013).

Autonomy, inclusion and active citizenship

Legislative framework

The Committee recalls that Article 23 of the Charter requires State Parties to undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular to enable older persons to remain full members of society for as long as possible. The expression "full members of society" used in Article 23 requires that older persons must suffer no ostracism on account of their age. The right to take part in society's various fields of activity should be ensured to everyone active or retired, living in an institution or not.

The Committee takes due account of contemporaneous definitions of ageism which refer to the stereotypes, prejudices and discrimination directed towards other or oneself based on age (see for example WHO report on Ageism, 2021, p. XIX) As the World Health Organisation has noted, "… ageism has serious and far-reaching consequences for people's health, well-being and human rights"(WHO report on Ageism, 2021, p. XVI).

The Covid-19 crisis has exposed and exacerbated a lack of equal treatment of older persons. This has included in the healthcare context, where there have been instances of rationing of scarce resources (e.g. ventilators) based on stereotyped perceptions of quality of life, vulnerability and decline in old age.

Equal treatment calls for an approach based on the equal recognition of the value of older persons' lives in all the areas addressed by the Charter.

Article 23 of the Charter requires the existence of an adequate legal framework for combating age discrimination in a range of areas beyond employment, namely in access to goods, facilities and services, such as insurance and banking products, allocation of resources and facilities. Discrimination against older persons in terms of social rights enjoyment, is also contrary to Article E.

The overall emphasis in the Charter on using social rights to underpin personal autonomy and respect the dignity of older persons and their right to flourish in the community requires a commitment to identifying and eliminating ageist attitudes and those laws, policies and

other measures which reflect or reinforce ageism. The Committee considers that States Parties, in addition to adopting comprehensive legislation prohibiting discrimination on grounds of age, must take a wide range of measures to combat ageism in society. Such measures should include reviewing (and as necessary amending) legislation and policy for discrimination on grounds of age, adopting action plans to ensure the equality of older persons, promoting positive attitudes towards ageing through activities such as society-wide awareness campaigns, and promoting inter generational solidarity

Further Article 23 requires that States parties provide for a procedure of assisted decision making.

The Committee previously concluded that the situation in Norway was not in conformity with Article 23 of the Charter on the grounds that the legislative framework prohibiting discrimination on grounds of age outside of employment was inadeqaute (Conclusions 2013). No information was provided on this issue. Therefore the Committee reiterates its previous conclusion.

The Committee also previously asked for information on the legal framework related to assisted decision making for older persons (Conclusions 2013). No information is provided on this issue. The Committee repeats its request for this information

The Committee recalls that there should be a national legal framework related to assisted decision making for older persons guaranteeing their right to make decisions for themselves. Older persons must not be assumed to be incapable of making their own decision just because they have a particular medical condition or disability, or lack legal capacity.

An older person’s capacity to make a particular decision should be established in relation to the nature of the decision, its purpose and the state of health of the older person at the time of making it. Older persons may need assistance to express their will and preferences, therefore all possible ways of communicating, including words, pictures and signs, should be used before concluding that they cannot make the particular decision on their own.

The Committee recalls that there should be a national legal framework related to assisted decision making for older persons guaranteeing their right to make decisions for themselves. Older persons must not be assumed to be incapable of making their own decisions just because they have a particular medical condition or disability.

States Parties must take measures to replace regimes of substituted decision-making by supported decision-making, which respects the person’s autonomy, will and preferences. These may be formal or informal.

Older persons may need assistance to express their will and preferences, therefore all possible ways of communicating, including words, pictures and signs, should be used before concluding that they cannot make the particular decision on their own.

In this connection, the national legal framework must provide appropriate safeguards to prevent the arbitrary deprivation of autonomous decision making by older persons. It must be ensured that any person acting on behalf of older persons interferes to the least possible degree with their wishes and rights (Statement of Interpretation 2013).

Prevention of abuse of older persons

The Committee asks for updated information to be provided in the next report, on measures taken to combat abuse of older persons including measures to raise awareness of the need to eradicate older abuse and neglect (beyond the insitutional care context), and any legislative or other measures. It also asks whether data has been collected which would indicate the prevalence of abuse of older persons.

Independent living and long term care

The Committee asks whether steps have been taken to move way from the institutionalisation of older persons and adopt a long term care and support in the community

model. The Committee recalls that Article 23 provides that measures should be taken to enable older persons to lead independent lives in their familiar surroundings therefore it considers that older persons requiring long term care should be able to choose their living arrangements. In particular, this requires states to make adequate provision for independent living, including housing suited to their needs and state of health, as well as the necessary resources and supports needed to make independent living possible.

Institutionalisation is a form of segregation, often resulting in a loss of autonomy, choice and independence. The Covid-19 pandemic has put the spotlight on the shortcomings of institutionalised care. The Committee refers in this respect to its Statement on Covid-19 and social rights (adopted march 2021) where its stated that enabling older persons to remain in their familiar surroundings as required by Article 23 of the Charter has become even more important in view of the heightened risk of contagion in the congregated settings of nursing homes and other long-term institutional and residential facilities and to the human rights-based argument for investment in the community to give reality to the right to community living is now added a public health argument in favour of moving away from residential institutions as an answer to long term care needs.

The Committee asks the next report to provide updated information on the progress made in providing care in the community, it asks in particular how many older persons reside in institutions -residential care and trends in the area.

Services and facilities

The Committee asks the next report to provide updated information on the range of services and facilities available to older persons, including long term care, in particular those enabling them to remain active members of their community and to remain in their home as well as information on the costs of such services. It also asks whether there is an adequate supply of care services, including long term care services and whether there are waiting lists for services.

It also asks the next report to provide updated information on what support is available for informal carers.

The Committee notes that many services (and information about services) are increasingly accessible online. Digitalisation provides opportunities for older persons. However older persons may have more limited access to the internet than other groups and may lack the necessary skill to use it. Therefore the Committee asks what measures have been taken to improve the digital skills of older persons, ensure the accessibility of digital services for older persons, and ensure non-digital services are maintained.

Housing

The Committee recalls that older persons are eligible for grants for adapting their own houses so that they can live at home longer after their health begins to decline. Grants can be accompanied with a loan (Conclusions 2013).

The Committee asks the next report to provide information on how the needs of older persons are taken into account in national or local housing policies and strategies as well as information on the supply of sheltered/supported housing and the range of accommodation options for older persons.

Health care

The Committee asks that the next report provide information on healthcare programmes specifically designed for older persons

The Committee notes that the pandemic has had devastating effects on older persons' rights, in particular their right to protection of health (Article 11 of the Charter), with consequences in many cases for their rights to autonomy and to make their own decisions and life-choices, their right to continue to live in the community with adequate and resilient

supports to enable them to do so, as well as their right to equal treatment in terms of Article E when it comes to the allocation of health care services including life-saving treatments (e.g., triage and ventilators). Whether still living independently or not, many older persons have had their services removed or drastically reduced. This has served to heighten the risk of isolation, loneliness, hunger and lack of ready access to medication.

Further the Covid-19 crisis has exposed examples of a lack of equal treatment of older persons, too much space was allowed for implicit judgments about the 'quality of life' or 'worth' of lives of older persons when setting the boundaries for such triage policies. Equal treatment calls for an approach based on the equal recognition of the value of older persons' lives.

The Committee also asks whether decisions around the allocation of medical resources may be made solely on the basis of age, and asks whether triage protocols have been developed and followed to ensure that such decisions are based on medical needs and the best scientific evidence available.

Institutional care

The Committee refers to its statement above on the importance of moving away from institutional care and towards care in the community.

The Committee considers that the overall emphasis in the Charter on personal autonomy and respect for the dignity of older persons, results in a pressing need to re-invest in community-based supports as an alternative to institutions.The Committee considers that the overall emphasis in the Charter on personal autonomy and respect for the dignity of older persons and their right to flourish in the community, results in a pressing need to re-invest in community-based supports as an alternative to institutions.

Where, in the transition period, institutionalisation is unavoidable, Article 23 requires that living conditions and care be adequate and that the following basic rights are respected: the right to autonomy, the right to privacy, the right to personal dignity, the right to participate in decisions concerning the living conditions in the institution, the protection of property, the right to maintain personal contact (including through internet access) with persons close to the elderly person and the right to complain about treatment and care in institutions. This also applies in the Covid-19 context.

Due to the specific Covid-19 related risks and needs in nursing homes, States Parties must urgently allocate sufficient additional financial means towards them, organise and resource necessary personal protective equipment and ensure that nursing homes have at their disposal sufficient additional qualified staff in terms of qualified health and social workers and other staff in order to be able to adequately respond to Covid-19 and to ensure that the above mentioned rights of older people in nursing homes are fully respected.

Adequate resources

When assessing adequacy of resources of older persons under Article 23, the Committee takes into account all social protection measures guaranteed to older persons and aimed at maintaining income level allowing them to lead a decent life and participate actively in public, social and cultural life. In particular, the Committee examines pensions, contributory or non-contributory, and other complementary cash benefits available to older persons. These resources will then be compared with median equivalised income. The Committee will also take into consideration relevant indicators relating to at-risk-of-poverty rates for persons aged 65 and over.

The Committee previously concluded that Norway was in conformity with Article 23 of the Charter on this point, but noted from Eurostat that in 2011, 0.9% of persons aged 65 and over received income falling below 40% of median equivalised income (compared to 0.5% in 2010 and 0.6% in 2007) and asked the Government what measures are being taken to address the situation of this group (Conclusions 2013).

The Committee recalls that as a general rule, all residents of Norway, irrespective of nationality, will qualify for a minimum old-age pension/guaranteed pension when reaching the age of 67. A three-year residence requirement is imposed for the acquisition of entitlement to an old-age pension. In order to receive a full minimum pension/guaranteed pension, the person concerned must have lived in Norway for at least 40 years. The minimum pension is non-contributory.

A pension supplement is available for persons who reached the age of 67 and have low income (persons who receive a small or no earnings-related old-age pension, or a low non-contributory pension because they have less than 40 years' residence in the country) (Conclusions 2013).

The Committee notes from MISSOC that for a single pensioner who has at least 40 years of insurance based only on residence, the annual minimum pension was NOK 194,192 (€20,052) in 2019.

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, was estimated at €1,630 per month 19,560 annually) in 2019. The Committee notes that the full minimum pension/guaranteed pension is above the poverty line. However it asks the next report to provide updated information on the guaranteed minimum income for older persons, and information on the percentage of persons having an income falling below 40% of the median equivalised income as well as on measures taken to address their situation.

Covid-19

The Committee asked a targeted question on measures taken to protect the health and well-being of older persons in the context of a pandemic crisis such as Covid-19.

According to the report since the start of the Covid-19 pandemic, the Norwegian Directorate of Health has been issuing recommendations, making decisions, giving advice and providing training resources etc. for health and care services. Guidance has been provided on infection control, capacity planning and dealing with challenges in the local authorities in order to ensure that the health and care needs are met for people who require support and help in general, and vulnerable groups in particular. This includes covering their basic needs and protecting them from infection.

A Covid-19 guide was immediately drawn up by the Norwegian Directorate of Health when the country went into lockdown in mid-March. Many of the recommendations are about how to prioritise in the event of a critical infection rate. It became clear that many patients in Norway's health and care institutions were at a high risk of severe illness and death from Covid-19, and that measures were therefore needed to protect these groups hence all visits to all public and private health and care institutions were stopped. Guidelines on measures to limit social isolation in a scenario with visitor restrictions were also issued.

The Norwegian Directorate of Health subsequently updated its guidance on visits to health and care institutions. The recommendation for visitor restrictions has been revised to make it clearer that residents in municipal health and care institutions have the right to receive visitors, and that any bans on visits must have a legal basis.

Two subsidy schemes with a combined value of NOK 332 million have been established to stimulate more activity for vulnerable elderly people in the current pandemic. The subsidies are managed by the County Governor on behalf of the Norwegian Directorate of Health.

The Norwegian National Advisory Unit on Ageing and Health has been commissioned by the Norwegian Directorate of Health to publish information about Covid-19 on its website, with a special focus on follow-up and services for the elderly and people with dementia. The website also provides information about physical activity in daily life.

The Norwegian Directorate of Health's Covid-19 guide also includes separate chapters covering, inter alia, home-based services, which includes recommendations on infection control and protection of vulnerable groups, both with and without Covid-19. One recommendation is that the local authority must have a plan for service users living at home and their families in various phases of the pandemic. Other chapters cover General Practitioner services, which includes a recommendation on how GPs can prioritise the most at-risk patients by means of systematic risk assessments. and palliative care for Covid-19 patients.

The Committee recalls Article 23 requires that older persons and their organisations be consulted on policies and measures that concern them directly, including on ad hoc measures taken with regard to the current crisis. Planning for the recovery after the pandemic must take into account the views and specific needs of older persons and be firmly based on the evidence and experience gathered in the pandemic so far.

Conclusion

The Committee concludes that the situation in Norway is not in conformity with Article 23 of the Charter on the ground that there is no legislation prohibiting discrimination on grounds of age outside employment.

Article 30 - Right to be protected against poverty and social exclusion

The Committee takes note of the information contained in the report submitted by Norway.

The Committee notes that for the purposes of the present report, States were asked to reply to the specific targeted questions related to this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter with respect to the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

Therefore, it will focus on the Government's replies to the targeted questions, namely about measures (legal, practical and proactive, including some concerning supervision and inspection) taken to ensure that no person falls below the poverty threshold, during or after the Covid-19 crisis, the impact of these measures and any previous deferrals or non-conformities.

The Committee wishes to point out that it will take note of the information provided in reply to the question relating to Covid-19 which relates to developments outside the reference period (namely, after 31 December 2019) for information purposes only. In other words, the information referred to in this section – "Poverty and social exclusion in times of the Covid-19 crisis" – will not be assessed for the purposes of Charter compliance in the current reporting cycle.

In its previous conclusion, the Committee found that the situation in Norway was in conformity with Article 30 of the Charter (Conclusions 2013).

Measuring poverty and social exclusion

The Committee recalls that, under Article 30, States Parties must provide detailed information on how they measure poverty and social exclusion. The main indicator used by the Committee to measure poverty is the relative poverty rate. This corresponds to the percentage of people living under the poverty threshold, which is set at 60% of the equivalised median income.

The report indicates that the general indicator of poverty in Norway is an income which, over a three-year period, remains below 60% of the annual median disposable equivalised household income, as calculated using the EU's equivalence scale. In the three-year period 2016–2018, 9.8% of the population (about 486,000 people, excluding students) had an income below 60% of the median, and 11.3% of all children (about 111,000 children) lived in households with persistently low incomes. According to the report, no one lives in extreme poverty in Norway.

The Committee notes that since the report does not provide all the necessary data on poverty, they have been taken from Eurostat.

The Committee notes that the at-risk-of-poverty rate (cut-off point: 60% of the median equivalised income after social transfers) increased slightly, from 12.2% in 2016 to 12.7% in 2019. It also observes that the difference in the at-risk-of-poverty rate (after social transfers) between the sexes was very small during the reference period (fluctuating between around 1.6% and 3%).

The at-risk-of-poverty rate of the unemployed (aged 16 to 64) increased significantly, from 38.8% in 2016 to 48.5% in 2019. Moreover, the at-risk-of-poverty rate of the employed (aged 16 to 64) also increased during the reference period (5.9% in 2016 and 6.4% in 2019).

The at-risk-of-poverty rate (cut-off point: 60% of the median equivalised income after social transfers) among persons over 65 decreased from 9.1% in 2016 to 8.1% in 2019 (compared to 9.8% in 2014 and 11.3% in 2011).

Concerning the risk of poverty and social exclusion (AROPE), which according to Eurostat methodology, corresponds to the sum of the persons who are (1) at risk of poverty; and/or (2) face severe material deprivation; and/or (3) live in a household with very low work intensity, the Committee observes that 15.3% of the population was at risk of poverty and social exclusion in 2016, 16% in 2017, 16.2% in 2018 and 16.1% in 2019.

As regards children (younger than 16), the risk of poverty and social exclusion increased during the reference period, from 14.4% in 2016 to 16% in 2019 (compared to 11.5% in 2012).

The Committee notes that all the indicators measuring poverty and income inequalities are very low. Moreover, there is no person living in extreme poverty.

Approach to combating poverty and social exclusion

The Committee notes from the report that the government continues to pursue diverse objectives such as, among others, broad participation in the labour force, social resilience and improving the living conditions of vulnerable groups in its approach to combating poverty and social exclusion.

In the employment sphere, the government launched the Inclusion Initiative which aims to increase employment of persons with disabilities by investing in measures that make it easier for employers to hire them and by working with relevant stakeholders. In 2017, the government also stepped up its efforts to target people under the age of 30: young people who are not in employment, are not following an educational curriculum or other meaningful activities within eight weeks of registering with the Norwegian Labour and Welfare Administration are offered tailored employment-oriented support. The report also indicates that the government's integration strategy, adopted for the 2019-2022 period, aims to enable more immigrants to secure employment and become active members of society.

According to the report, the government submitted a white paper to the *Storting* on "Opportunities for all – Distribution and Social Sustainability" (Report No. 13, 2018–2019) in March 2019. This document presents the government's efforts to contribute to social sustainability and fight inequality and its consequences.

As regards children and young people in low-income families, the report indicates that the Government's strategy, "Children Living in Poverty" for the 2015-2017 period, was followed by a new cooperation strategy, "Equal Opportunities for Children" for the 2020-2023 period (outside the reference period). The new strategy emphasises the importance of increasing the participation of children and young people from low-income families with other children and young people allowing them to develop on an equal footing, with a view to stimulating social mobility and breaking the generational cycle of poverty and low incomes. The Committee asks that the information on the implementation of this strategy be provided in the next report.

Furthermore, the report states that the National Insurance Income Guarantee Scheme provides financial security for unemployed persons and those who are unable to work. The main purpose of this scheme is to give all citizens financial security, contribute to greater equality in income levels and living conditions throughout a person's life and between groups of people, as well as to strengthen people's ability to help themselves with a view to maximizing their financial independence and the acquisition of skills for everyday life.

The report also indicates that anyone who does not have enough money to cover their living expenses from earned income, their own funds or welfare benefits, is entitled to social security. Assistance for necessary subsistence is means-tested. The local authorities assess the person's overall situation, taking into account any income and income opportunities, necessary living expenses and personal circumstances. The local authorities have both a right and a duty to make discretionary assessments in each individual case. The Committee takes note of the information provided in the report on the right of appeal against decisions

regarding municipal social services and governmental regulation of these services. The Committee requests that the results of this assessment (in figures) be provided in the next report.

The Committee also refers to its conclusions of non-conformity regarding other relevant provisions of the Charter for an assessment of conformity with Article 30 (see Conclusions 2013 and the Statement of interpretation on Article 30). It refers in particular to Article 13§1 and its conclusion that the level of social assistance was not adequate (Conclusions 2021).

In view of all the above-mentioned points, and in particular the comparatively low poverty rates, the Committee considers that the situation remains in conformity with Article 30.

Monitoring and evaluation

In its previous conclusions, the Committee examined how individuals and voluntary associations take part in assessing measures to combat poverty and found that the situation was in conformity on this point (Conclusions 2013).

The Committee asks for the updated information on monitoring and evaluation of the effort to combat poverty and social exclusion to be provided in the next report.

Poverty and social exclusion in times of the Covid-19 crisis

The report indicates that the objectives of the Social Security Act are to improve living conditions for disadvantaged persons, to promote financial and social security, the transition to work, social inclusion, and an active and meaningful existence in society. The Act ensures that vulnerable children, young people and their families receive uniform and coordinated services.

The social services aim to uphold the Act's objectives and serve as a final safety net for individuals facing difficult situations, including during the Covid-19 crisis. Means-tested financial benefits are provided to ensure a reasonable level of subsistence. Local authorities have both a right and a duty to make discretionary assessments in each individual case. The information, advice and guidance provided by the services must help to resolve or prevent social problems and must also be adapted to individual needs. The local Labour and Welfare Administration allocates housing to disadvantaged people who are unable to defend their own interests in the housing market. The local authorities also have a duty to find temporary accommodation for those who are unable to do so themselves.

Conclusion

Pending receipt of the information requested, the Committee concludes that the situation in Norway is in conformity with Article 30 of the Charter.