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EUROPEAN SOCIAL CHARTER

18th National Report on the implementation of the European Social Charter

submitted by

THE GOVERNMENT OF NORWAY

Articles 3, 11, 12, 13, 14, 23 and 30.

for the period 01/01/2017 - 31/12/2020

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CYCLE 2020

NORWAY'S 18TH NATIONAL REPORT 2020 RELATING TO THE APPLICATION OF THE EUROPEAN SOCIAL CHARTER

The report includes replies to the conclusions of non-conformity as well as replies to the questions raised and information about changes since the last report on Articles 3, 11, 12, 13, 14, 23 and 30.

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Article 3 - The right to safe and healthy working conditions

Article 3, section 1 - occupational safety, occupational health and the working environment

Question a)

Please provide information about policy formulation processes and practical arrangements made to identify new or emerging situations, that represent a challenge to the right to safe and healthy working conditions; also provide information on the results of such processes and of intended future developments.

The Nordic Future of Work Group was commissioned by the Norwegian Labour Inspection Authority and the other Nordic labour inspectorates to produce a new report in 2020 that identifies and analyses working environment challenges in the light of the future of work. The report, entitled 'Work today and in the future', includes recommendations on how the various labour inspectorates can prepare for a number of future challenges, such as platform work (e.g. Foodora, Uber), digitalisation, social dumping, climate change, pandemics, home office working and labour migration from a working environment perspective.

Together with the Nordic labour inspectorates, the social partners and our international partners, the Norwegian Labour Inspection Authority will continue to work on the recommendations in terms of how the inspectorates can guard against future working environment challenges. A summary of the report is given below, and the full version is appended to this report.

Executive summary

This report was commissioned by the Nordic Director Generals to better prepare the Nordic LIs (labour inspectorates) for the future of work. The report itself has been written by the Nordic Future of Work Group. The group started its work in 2016 and since then has given important insights into how each country looks at specific national challenges regarding the future of work and what measures have been taken to deal with them. The present report is the second of two reports published by the Nordic Future of Work Group.[1]

[1] Nordic Future of Work Group: *Diversity of the future workforce and work tasks - challenges to OSH.* 2016.

This report delivers a diverse set of perspectives on the future of work and OSH (occupational safety and health) based on published literature and active engagement with national and international stakeholders as well as the research community. However, the authors of the report have made conclusions and predictions based on the existing material and are solely responsible for all the claims made in this report.

The report is not intended to be an oracle that covers all possible areas as they relate to the future of work, and instead extracts the central themes for LIs that concern the future of work and OSH.

The purpose of this report is to identify and analyse the challenges faced by Nordic LIs in the light of the imminent future of work. Furthermore, it provides general and specific recommendations to better prepare the LIs for meeting the challenges of the near and distant future.

Three main aspects make this report unique. First, the report focusses on occupational safety and health and labour inspection. This perspective is not common in future of work studies and analyses. Second, the report gives practical recommendations for LIs. Third, the report provides a unique Nordic perspective on themes of regional and global importance in the context of labour inspection.

It is anticipated that the future of work will be influenced by four drivers: the changes in technology, demographics, globalisation, and environment and climate. These drivers can potentially impact OSH, either independently or in combination.

- Digital technologies such as AI (artificial intelligence), robotics, 3-D printers and smart wearables have the potential to enhance productivity and efficiency to produce goods and services. However, these rapidly evolving technologies have associated OSH risks as they concern the physical and psychosocial work environment. These range from the risk of getting injured by a robotic arm attributed to a sensor failure in an environment where robots and workers are deployed together, to the constant psychological stress of performance reviews by customers who use digital platform-based taxi services. 3-D printers and smart wearables are significant technological leaps for productivity, innovation and OSH, but these devices are also accompanied by foreseeable OSH risks that need to be carefully addressed.

- In fact, new technologies are evolving at such a rapid pace that it might stretch our biological limits, leading to serious health and safety consequences. Certainly, the regulators are unable to keep up to speed with dynamic changes in working life that may have significant implications for OSH. The advent of the platform economy, its OSH implications, and the difficulties of regulating it is a clear example of the pace of newness where LIs have not yet been able to understand and address the phenomenon comprehensively.

- Surveillance in OSH was typically conceived in terms of monitoring workers' health through OSH indicators. However, with new forms of working and the technologies at hand, constant visual and digital surveillance of the worker is a reality. This is made possible by video cameras, apps and mobile devices including smart wearables. Although these technologies enable employers to improve efficiency and monitor the safety of workers, they also provide the opportunity for constant control and incessant

performance evaluations. Such ceaseless intrusion of privacy could be detrimental to the psychosocial health of workers.

- Migrant labour is gradually increasing in the Nordic countries. The proportion of elderly people is also increasing in the general population. Thus, migrant labour is necessary to support the Nordic welfare models and at the same time it is necessary to extend the working careers of all people and especially of elderly people. It is also necessary to be inclusive of workers with varying degrees of capacity for work. There are some factors that require LIs to take special actions to guarantee equal and safe working conditions for women in particular. There is a large proportion of female workers in the health and social care sector, which in turn entails a range of OSH exposures at work. For example, musculoskeletal disorders are and will remain a major challenge for workers in the health care sector, and by default will impact disproportionally on a large number of women compared to men. Young workers are the ones who will embrace the future of work, but they are seemingly lacking the skills and education to meet the new economy in terms of securing employment. Moreover, much of the data suggest that young workers remain vulnerable to OSH risks, and these risks may be compounded because of the unknown risk of newer technologies and new forms of working that the young workers will encounter. The aforementioned diverse groups of workers are critical to the future of work but remain vulnerable in terms of enduring OSH risks, and a better inclusion and protection strategy is therefore required to prepare for the future.

- The future of work brings new ways and means of organising work. This has certainly led to complex employer-worker relationships and a growing tendency towards individual contracts, and through that an individualisation of OSH risks. Consequently, there has been a gradual fall in unionisation rates among workers and a simultaneous growth of precarious and atypical forms of working. In combination, these factors are threatening the traditional Nordic model in working life, as the acceptance or rather the space of the traditional social partners is shrinking. This means collective agreements, including those that impact OSH, are increasingly compromised. These developments do not bode well for OSH, and are certainly an impending challenge for achieving OSH compliance. Not surprisingly, there has been a remarkable rise in malicious phenomena like social dumping, undeclared work and work-related crime in the Nordic countries, necessitating broad measures from the governments. However, it must be underscored that these phenomena are in many ways the extension of precarious working arrangements. Although undeclared work and related issues deal with tax evasion, trafficking and fraudulent enterprises, such developments have a direct and deleterious impact on OSH.

- The future of work is bringing technologies that enable flexibility for the worker and the employer. But in many cases, this means that work can be done in living rooms, kitchens and bedrooms, and in that sense is boundless and boundaryless. This development has far-reaching implications for health and social well-being as it impacts on aspects of OSH, but also creates a conflict between working life and family life. Long working hours and shift work have been amply documented to have negative effects on health. Technologies paired with new forms of employee-worker arrangements create situations where work time is also becoming a challenging proposition. In fact, technological solutions make it possible to have the worker on-demand through devices used by the employer, but the advent of new individualised

contracts also means that the employer and worker could agree on working hours outside of the tripartite agreements. Moreover, globalisation has led to developments that suggest we are fast becoming a 24/7 society, further compromising healthy work time arrangements.

- Office space is expensive, and there has been a gradual shift towards open plan offices, and extended use of home offices as a solution as we move into the future. Both of these approaches to organising work present OSH challenges vis-a-vis the psychosocial working environment, but also in terms of productivity and infection prevention. Although open plan office and home office solutions might be intuitively cost-saving in the short term, the long-term OSH implications are potentially detrimental given our limited insight into this problem.

- Manual and physically demanding work is gradually receding, and there is a concurrent increase in sitting time, including screen time. These changes to working life are already being manifested in psychosocial and musculoskeletal disorders, but conceivably also conditions like obesity, hypertension and diabetes, which are the highest health cost drivers in the Nordic countries. A significant proportion of these aforementioned conditions are increasingly considered to be attributed to work, and fall under the category of non-communicable diseases (NCDs). Work-related NCDs will pose significant OSH challenges as we move towards a more automated and digitalised working life.

- A polarised working life is a harbinger of occupational health inequalities. The drivers influencing the future of work in combination attribute to the polarisation and fragmentation of working life, with significant contrasts between the haves and have-nots of the working population. The gradual rise in precarious and atypical work, the decline of tripartism and the non-congruent uptake and application of technological innovations by different groups of workers (young, elderly, migrants) will lead to significant differences in qualifications, competence and incomes. Such differences will perpetuate sub-standard working conditions for the most vulnerable workers and increase the inequalities in occupational health in the working population.

- COVID-19 has launched the LIs into a turbo phase with regard to the level of preparedness vis-à-vis OSH in the Nordic countries. The pandemic revealed a significant lack of preparedness among national authorities including OSH agencies for handling such situations. There were areas of concern with regards to lack of PPE (personal protective equipment), risk assessments for health care workers, swift introduction of home office solutions, and coordination and collaborations with relevant national and international agencies.

- Climate and environmental change have two distinct pathways in terms of influencing OSH. One is the direct impact of climate changes such as extreme temperatures, floods and natural disasters, which entail OSH risks for outdoor workers including emergency responders. The other pathway is the response to climate and environmental change with the emphasis on a circular economy and green jobs. While technologies to support the circular economy and green jobs are desirable and much needed, the associated OSH risks must be profiled and addressed. Moving forward,

the emphasis on a green economy should also consider including and addressing aspects of safe and decent work.

Although the Nordic LIs traditionally have a very close cooperation and shared values, the legislation and mandates of the different LIs are rather different. Thus, the recommendations might apply somewhat differently across the five Nordic countries. Given the global nature of the challenges vis-à-vis future of work, the recommendations may also provide an impetus for policy discussions as they concern OSH and labour inspection in the European and global context.

The report concludes with **general** and **specific recommendations** based on the deliberations of the challenges of the future of work for OSH. It is a starting point for a Nordic dialogue to collaboratively find solutions for the OSH challenges of the future in order to secure a safe, healthy, and decent working life for all.

Question b)

With particular reference to COVID-19, provide specific information on the protection of frontline workers (health-care staff including ambulance crews and auxiliary staff; police and other first responders; police and military personnel involved in assistance and enforcement; staff in social-care facilities, for example for older people or children; prison and other custodial staff; mortuary services; and others involved in essential services, including transport and retail; etc.). Such information should include details of instructions and training, and also the quantity and adequacy of personal protective equipment provided to workers in different contexts. Please provide analytical information about the effectiveness of those measures of protection and statistical data on health outcomes.

The health authorities have drawn up a number of guidelines for the protection of workers during the COVID-19 pandemic, some of which are highlighted below. A more exhaustive account of guidelines and training in all the relevant occupational groups can be forwarded if necessary. The COVID-19 Commission has been set up to conduct a thorough and comprehensive review and assessment of the Norwegian authorities' handling of the COVID-19 pandemic. The Commission will consider both the government's preparedness prior to the pandemic and how it dealt with the crisis. The Commission plans to conclude its work by the end of March 2021.[2]

The Norwegian Institute of Public Health (NIPH) has drawn up the following guidelines to protect specialist health service staff:[3]

Management's responsibilities and duties:

[2] Link to the Commission's mandate: https://www.regjeringen.no/no/aktuelt/dep/smk/pressemeldinger/2020/regjeringen-oppnevner-koronakommisjon/koronakommisjonens-mandat/id2699477/

[3] https://www.fhi.no/nettpub/coronavirus/helsepersonell/tiltak-i-spesialisthelsetjenesten-ved-mistenkt-og-bekreftet-smitte-med-nytt/

- The risk of infection during the pandemic will vary, and can also differ from region to region. The infection control advice below should always be followed. In the event of an increased risk of community transmission, more stringent infection control measures should also be considered.
- Provide clear information at the hospital entrance about where patients and their families should report upon arrival.
- Devise a screening and triage plan that is appropriate for the current level of community transmission of SARS-CoV-2.
- Devise a plan for reporting and managing situations where a staff member or patient unexpectedly develops symptoms of COVID-19. Instruct all employees with symptoms to stay at home and to get tested as quickly as possible.
- Ensure that all specialist health service staff in the relevant unit are aware of the COVID-19 advice.
- Implement a system for informing new employees and temporary staff of the COVID-19 advice before their start date.
- Implement a system for recording whether employees and temporary staff with close patient contact have been exposed to SARS-CoV-2 (if they have been a 'close contact') or have travelled outside Norway in the last 10 days. This also applies to trips to and stays in regions and countries outside Norway that are exempt from the quarantine rule ('yellow countries').
- Ensure that staff, patients and their families are able to maintain a distance (of at least 1 metre) from each other in waiting rooms, treatment rooms, day rooms and staff rooms.
- Ensure that clear information is provided on cough etiquette and good hand hygiene for staff, patients and their families.
- Ensure that healthcare personnel have access to the necessary training in the correct use of personal protective equipment and have the opportunity to practise using it.
- Maintain an overview of visitors to the hospital for the purposes of tracking and tracing if this becomes necessary.
- In the event of a rising community transmission rate, have a plan in place for escalating efforts and redistributing resources.
- Establish routines for monitoring and addressing the needs of staff at risk of developing severe symptoms of COVID-19.

Advice for specialist health service staff:

- All staff with symptoms of COVID-19 must stay at home and get tested as quickly as possible.
- Staff members, including new employees and temporary staff, who have been in 'red countries' in the last 10 days must quarantine.
- Staff and patients who are defined as close contacts must receive further follow-up in line with the advice in Follow-up of close contacts.
- Staff can go to work even if they have household members with symptoms of a respiratory infection, provided that the household members are *not* in home isolation. It is important that staff monitor their own symptoms.
- Staff must follow basic infection control routines and general advice on cough etiquette and good hand hygiene. Hands should be cleaned before entering and leaving the hospital, wards, patient rooms and other rooms, such as examination/treatment rooms.
- Staff should maintain a distance (of at least 1 metre) from others in waiting rooms, treatment rooms, day rooms and staff rooms. Remember to maintain a distance between colleagues if possible.
- Consultations should be timed so that as few patients as possible are in the waiting room at the same time, for example by allocating time between each patient.
- There should be no hand-shaking or unnecessary physical contact.
- Staff should closely monitor all in-patients who may have been exposed to SARS-CoV-2. In the event of symptoms developing, including mild ones, follow the advice for patients with confirmed COVID-19.
- When interacting with patients who have been abroad in the last 10 days, staff should be particularly watchful for symptoms of COVID-19.
- Advice has also been issued for healthcare personnel at risk of developing severe symptoms of COVID-19.
- Staff must facilitate visits by patients' families to the greatest extent possible. Staff must consider whether permission can be granted in consultation with the patient or their family, and provide information on applicable infection control measures.

The NIPH has drawn up the following guidelines to protect GPs and staff at A&E units:[4]

Infection control advice:

[4] https://www.fhi.no/nettpub/coronavirus/helsepersonell/tiltak-i-primarhelsetjenesten-ved-mistenkt-eller-bekreftet-smitte-med-nytt-/?term=&h=1

- Staff must carefully consider whether they may be at risk of transmitting the infection, and must stay at home if they have symptoms of acute respiratory infection or other symptoms consistent with COVID-19 (including mild symptoms) and get tested as soon as possible. If they develop symptoms of acute respiratory infection while at work, they should leave the workplace immediately. If they are unable to maintain a distance of 2 metres before leaving the building or on the way home, they should wear a face mask. It is important to convey this to temporary staff, students and new employees.
- Staff can go to work even if they have household members with symptoms of respiratory infection, provided that the household members are *not* in home isolation. It is important that staff monitor their own symptoms.
- The employer should have a system for recording whether employees, including new employees and temporary staff, who work closely with patients are defined as close contacts or have travelled outside Norway in the last 10 days.
- Staff members, including new employees and temporary staff, who are defined as close contacts or have been in 'red countries' during the last 10 days are required to quarantine, and must be followed up further in line with the advice in Follow-up of close contacts.
- Staff in risk groups should, in consultation with their employer, assess the need to adapt work duties according to individual risk.
- Common areas (waiting rooms etc.) must be arranged so that a distance of at least 1 metre can be maintained. In waiting rooms, unnecessary items such as reading material should be removed and food should not be served.
- Consultations should be timed so that as few patients as possible are in the waiting room at the same time.
- Maintain a distance of at least 1 metre from others and avoid physical contact as much as possible. This particularly applies to face-to-face contact.
- The importance of basic infection control procedures, including cough etiquette, must be conveyed and these must always be followed. Provision must be made to facilitate good hand hygiene (washing hands with soap and water or hand disinfection).
- Everyone should wash their hands when they arrive at and leave health service facilities.
- Daily cleaning is recommended, and cleaning (with standard cleaning agents) surfaces and contact points such as door handles, computer keyboards and such like (mobile phones) several times a day will reduce the spread of infection.

- Cash should not be used in payment transactions.
- Advice on infection control in training courses and meetings is given in Advice for the specialist health service.

Advice for managing patients with suspected COVID-19:

- Obtain the patient's medical history and details of exposure via telephone. Find out if the patient meets the criteria for testing. If so, establish where they should go to be examined and tested for coronavirus. Consideration should be given to whether the patient should be tested at home or in the primary health care service. If a clinical assessment indicates a need for testing or hospitalisation, the doctor on duty at the nearest hospital should be contacted and informed of the suspected COVID-19 case.
- When interacting with patients who have been abroad in the last 10 days, staff should be particularly watchful for symptoms of COVID-19.
- If clinically justifiable, consultations with patients displaying symptoms of acute respiratory infection should be carried out at the end of the working day.
- Patients arriving at the doctor's office should wash their hands and be given a face mask, which they themselves must put on as instructed by staff, unless the patient is unable to wear a mask due to medical reasons.
- The patient should not stay in common areas, but be shown into a separate room where only the necessary health personnel enter.
- If the patient has to remove their face mask to be examined or tested, this must not be removed until they are in the examination room and the healthcare personnel have put on PPE.
- The patient should wash their hands and put on their face mask before leaving the doctor's office.

PPE:

Healthcare personnel who examine, treat or have close contact (closer than 2 metres) with patients who may have COVID-19 must wear the following protective equipment:

- Medical grade face mask (type II or IIR)
- Long-sleeved gown
- Gloves
- Eye protector (protective glasses or a visor)

Respirator masks (FFP2 or FFP3) are only required during aerosol-generating procedures.

All healthcare personnel must be trained in the correct use of PPE, including how to put it on and critical points during use and removal.

Advice for healthcare personnel on how to use PPE and on what to do in the event of a potentially looming or actual shortage of PPE can be found here:

- Personal protective equipment

In the primary healthcare service, it is the district medical officer who assesses which measures should be implemented in the event of an increased risk of infection (infection risk level 3-5).

Article 3, section 2 – safety and health regulations

Question a)

Please provide detailed information on the regulatory responses adopted to improve occupational safety and health in connection with known and also evolving or new situations (including as regards stress and harassment at work; work related substance use and employer responsibility; strictly limiting and regulating electronic monitoring of workers; mandatory digital disconnection from the work environment during rest periods also referred to as "digital detox"; health and safety in the digital and platform economy; etc.) and about regulatory responses to newly recognised forms of professional injury or illness (such as work related self-harm or suicide; burn out; alcohol or other substance use disorders; post-traumatic stress disorders (PTSD); injury and disability in the sports entertainment industry, including in cases when such injury and disability can take years or even decades to become apparent, for example in cases of difficult to detect damage to the brain; etc.).

Topic/factor	As a result of	Regulated by	Comments
Work-related stress	Organisation of the work, adaptation and management	Working Environment Act: • S. 4-1 (1) and (2) • S. 4-2 (2) b	Work-related stress is often a result of: • how the work is organised, adapted and managed • can also be a result of how it is adapted to the individual's capabilities Supervision: • The Norwegian Labour Inspection Authority

			previously had guidance on work-related stress
Harassment and other inappropriate behaviour at the workplace		Working Environment Act: • S. 4-3 (3)	The employer has a duty to prevent harassment and other inappropriate behaviour
Violence and threats at the workplace		Working Environment Act: • S. 4-3 (4) Regulations concerning the Performance of Work • Chapter 23 A	• Not mentioned in the list, but a relevant problem • Supervision in health and social care by the Norwegian Labour Inspection Authority over several years
Substance abuse and employer's liability			• Employer's duty of care? • https://akan.no/english-information-about-akan/
Electronic monitoring at the workplace		Working Environment Act: • S. 9-1 • S. 9-2 • S. 9-5 • S. 9-6	• Control measures; both under labour law and privacy law. The privacy law aspect falls under the regulations administered by the Norwegian Data Protection Authority
Mandatory digital disconnection from the work environment during rest periods			• During rest periods, employees must not be at the employer's disposal
Work-related illnesses: • self-harm or suicide; • burnout; • alcohol or other substance use disorders; • post-traumatic stress disorders (PTSD); • injury and disability in the sports		Working Environment Act: S. 4-1, 4-2 and 4-6	The employer has a general duty to cater for employees with different health challenges.

entertainment industry			

Many of the circumstances mentioned are possible consequences, i.e. a result of conditions (factors) in the working environment. The employer has various tools to prevent harm to health, ensure safety and rectify problems:

- systematic health and safety work, section 3-1 of the Working Environment Act, sections 7-1 and 7-3 and 10-1 and 10-2 of the Regulations concerning Organisation, Management and Employee Participation, and section 5 of the Internal Control Regulations
- participation by employees (collective participation and individual participation), cf. chapters 6 and 7, and section 3-1 (1) of the Working Environment Act, chapters 2 and 3 of the Regulations concerning Organisation, Management and Employee Participation (safety representatives and working environment committees)
- an approved occupational health service, cf. section 3-3 of the Working Environment Act and chapter 13 of the Regulations concerning Organisation, Management and Employee Participation
- information and staff training, including information on potential consequences for health, cf. section 3-2 (1) of the Working Environment Act and chapters 8 and 9 of the Regulations concerning Organisation, Management and Employee Participation

In collaboration with the Norwegian Data Protection Authority, the Petroleum Safety Authority Norway and the social partners, the Norwegian Labour Inspection Authority issued a guide in 2019 on controls and monitoring in the workplace; https://www.arbeidstilsynet.no/contentassets/04ec2eb566d44942bd6693e9e3a0c99e/veileder-om-kontroll-og-overvaking-2019.pdf

A national working environment initiative has been established in which the Norwegian Labour Inspection Authority has strengthened its efforts to ensure preventive working environments in the context of the inclusive working life agreement (IA agreement). The aim is to strengthen businesses' efforts in the areas that cause the most sick leave and the highest staff turnover rates.

Another of the Norwegian Labour Inspection Authority's priority areas is to provide employees and employers with appropriate guidance and information on reporting wrongdoing, reporting procedures and regulations that provide protection against retaliation after reporting wrongdoing, cf. Proposition to the Storting 74 L (2018-2019). The Norwegian Labour Inspection Authority has also been developing a separate service function for reporting wrongdoing. This work to develop national guidelines will be completed in 2020.

The Norwegian Labour Inspection Authority must take an offensive approach to developing and revising the body of rules, and is now considering its options for digitisation, removing outdated rules, removing 'unnecessary' rules and simplifying the language. It is also considering the rules in the context of the workplace of the future. This will take place in consultation with the Ministry of Labour and Social Affairs and the social partners. The work relating to the workplace of the future will be viewed in conjunction with the work of committees in this area, whose findings will be published in an Official Norwegian Report by 1 June 2021. The work will also be considered in the context of the attached report from the Nordic Future of Work Group, which the Norwegian Labour Inspection Authority has participated in.

Article 3, section 3 – the enforcement of such regulations by measures of supervision

Question a)

Please provide 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 highstress trading; military and law enforcement; etc.) and also as regards the victims of harassment at work and poor management.

Linking aggregate data to so-named new high-risk jobs is a challenge as we do not have the capability to easily identify these accidents/injuries/illnesses in our source data. 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 our gateway to identifying them.

This problem is also highlighted in the attached Nordic report on challenges for the labour inspectorates in the future of work, where the challenges of categorising companies, as well as the concept of employer and employee are discussed. In relation to various occupations within the police and other emergency and emergency preparedness services, the feedback is that we do not register data related to such occupations, and Statistics Norway/ the Norwegian Labour and Welfare Administration (NAV) do not have data on this either.

Question b)

Please provide updated information on the organisation of the labour inspectorate, and on the trends in resources allocated to labour inspection services, including human resources. Information should also be provided on the 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 on the number of breaches to health and safety regulations and the nature and type of sanctions.

On 1 January 2020, 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. See further details about the new organisational model on the inspectorate's website:

https://www.arbeidstilsynet.no/nyheter/ny-organisering-av-arbeidstilsynet/

The table below gives an overview of the number of inspections carried out, the number of breaches and the sanctions applied by the Norwegian Labour Inspection Authority in the

reference period 2016–2019. The data include all inspections carried out by the Norwegian Labour Inspection Authority in the period 2016–2019.

Item	2016	2017	2018	2019
No. of inspections carried out	15 265	13 877	13 412	12 362
No. of breaches found in inspections	42 371	39 394	32 043	26 361
No. of inspections – orders issued	7 158	6 516	5 889	5 605
No. of inspections – decision to halt activities as means of pressure	607	573	542	367
No. of inspections – coercive fine order	1 050	997	858	991
No. of inspections – decision to halt activities due to imminent danger	736	1 117	1 388	971
No. of inspections – infringement fine order	97	279	658	543
Proportion of companies covered	7%	6%	6%	5%
Proportion of employees covered	16%	13%	17%	14%

The Norwegian Labour Inspection Authority primarily inspects companies at the corporate level with employees. The proportion of companies and employees covered is calculated on the following basis:

Year	No. of entities inspected	Total no. of companies (with employees)	Proportion of companies covered
2016	13650	192515	7%
2017	12501	195424	6%
2018	11899	200016	6%
2019	10918	202101	5%

Year	No. of employees in entity inspected	Total no. of employees	Proportion of employees covered
2016	423963	2591899	16%
2017	353985	2625554	13%
2018	448415	2676956	17%
2019	379763	2700491	14%

The following applies to the calculation of coverage:

Proportion of companies covered = No. of entities inspected / Total no. of companies (with employees)

No. of entities inspected: the number of companies that the Norwegian Labour Inspection Authority has inspected in the relevant year.

Total no. of companies (with employees): the number of companies with employees in the relevant year (Statistics Norway, Table 10309). This includes all industries, regardless of which supervisory authority they fall under.

Proportion of employees covered = No. of employees in the entity inspected / Total no. of employees

No. of employees in entity inspected: the number of employees registered in the companies inspected by the Norwegian Labour Inspection Authority at the time of inspection in the relevant year. The sample is limited to registered employees in companies inspected at corporate level. Any entities inspected outside this group are not included in the calculation.

Total no. of employees: the number of register-based employees in the relevant year (SSB Table 07984). This includes all industries.

Question c)

Please indicate whether Inspectors are entitled to inspect all workplaces, including residential premises, in all economic sectors. If certain workplaces are excluded, please indicate what arrangements are in place to ensure the supervision of health and safety regulations in such premises.

All companies with employees fall within the scope of the Working Environment Act, cf. section 1-2, regardless of industry or sector. In special cases, the legislation (regulations) also applies to companies with no employees, see section 1-4 of the Working Environment Act. The Norwegian Labour Inspection Authority supervises legislative compliance, cf. section 18-1 of the Working Environment Act. The inspectorate supervises land-based activities. The Petroleum Safety Authority Norway supervises petroleum activities and onshore facilities (see, for example, the framework regulations).

With regard to the Norwegian Labour Inspection Authority's access to companies, section 18-4 of 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.

Article 11 – The right to protection of health

Article 11, section 1 - to remove as far as possible the causes of ill-health

Question a)

Please provide overall and disaggregated statistical data on life expectancy across the country and different population groups (urban; rural; distinct ethnic groups and minorities; longer term homeless or unemployed; etc.) identifying anomalous situation (e.g. particular areas in the community; specific professions or jobs; proximity to active or decommissioned industrial or highly contaminated sites or mines; etc.) and on prevalence of particular diseases among relevant groups (e.g. cancer) or blood borne infectious diseases (e.g. new cases HIV or Hepatitis C among people suffering from substance use disorders or who are held in prison; etc.).

Differences in life expectancy in Norway

In 2019, life expectancy at birth was 84.69 years for girls and 81.19 years for boys. (Statistics Norway)

Based on 2015 figures, the 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. In a comparison of the municipalities with the lowest and highest life expectancy, the NIPH found differences of up to 10 years. In some districts in Oslo, the difference in life expectancy is up to 8 years. These differences can mainly be attributed to socioeconomic inequality. Level of education is a major factor in the large variation in life expectancy in Norway. Men and women with a higher education are expected to live 6.4 years and 5 years longer respectively than those with only a compulsory education (FHI, 2015).

According to Bufdir, studies show that immigrants as a group have a lower mortality rate than the general population. The Bufdir.no website states the following:

Some immigrants have a particularly low mortality rate compared to the rest of the population:

- Those who immigrated before the age of 3 or after 45 years of age.
- Those with a short period of residence in Norway. The shorter the period of residence in Norway and the smaller the proportion of a person's life that is spent in Norway, the lower the mortality rate.
- Those who immigrate to Norway for work or education purposes, as well as refugees and family reunification immigrants have a lower mortality rate than the general population.

Some groups of immigrants have a somewhat higher mortality rate than the general population:

- 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.

Life expectancy is somewhat lower in the STN (the Sami Parliament's business support scheme) area north of the Saltfjellet mountains than for other areas north of this (Bufdir.no).

Pollution from industry
According to the NIPH, industry generally causes little air pollution in the cities, while emissions in towns and urban areas can constitute a significant part of the pollution.

HIV and hepatitis among drug users and prisoners
Overall, the number of new cases of HIV reported annually in Norway has fallen from 100 in 2009 to 28 in 2019. Increased testing among vulnerable groups, shorter waits for treatment following diagnosis, the introduction of PrEP (pre-exposure prophylaxis), and easy access to condoms are assumed to be the main reasons for the decline.

In 2017, seven of the new HIV cases were due to injecting drugs (NIPH).

Hepatitis can be transmitted through the sharing of needles among drug users. According to the Norwegian Surveillance System for Communicable Diseases (MSIS), there were 5 cases of acute hepatitis B in 2015 and 10 cases of chronic hepatitis B among drug users. With regard to hepatitis C, the estimate is about 1000–1500 new cases annually, of which 80% are due to intravenous drug use (rop.no, 2013).

Question b)

Please also provide information about sexual and reproductive health-care services for women and girls (including access to abortion services) and include statistical information about early (underage or minor) motherhood, as well as child and maternal mortality. Provide also information on policies designed to remove as far as possible the causes for the anomalies observed (premature death; preventable infection by blood borne diseases; etc.).

Reproductive rights of women and girls, including access to abortion
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. Good sexual health is important for the individual's quality of life. Children, young people and adults need knowledge and the confidence to set boundaries and to make independent choices about their own body and sexuality.

An important part of the work in safeguarding sexual and reproductive health is ensuring easy access to information, guidance, contraception and services. 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 on sexual health, contraception and sexually transmitted infections that are

adapted to the needs of young people. Women over the age of 25 use a GP, private doctor or 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.

Easy access to contraception: easy access to safe contraception is a core part of the efforts to promote sexual and reproductive health. In addition to doctors, qualified public health nurses and midwives can prescribe all types of contraceptives for women over the age of 16. They can also insert and remove long-acting reversible contraceptives (LARCs) such as contraceptive implants and intrauterine devices (coils). Contraceptives for girls under 16 must be prescribed by a doctor.

Women between the ages of 16 and 22 receive financial support to cover all or part of the costs of contraception. 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 the coil or contraceptive implants, while women who are 20 or 21 years old have to pay a small charge. The requirement to have a female personal identification number has recently been removed, and there is therefore no longer a requirement to be a woman by law in order to have the costs of hormonal contraception covered. There has been a marked increase in the number of users of LARCs in the 15–35 age group in recent years, particularly among 15–24-year-olds. In 2019, about 150 people under the age of 15 obtained at least one prescription for a LARC and 1800 people obtained at least one prescription for short-acting or long-acting contraception.

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. Sales of emergency contraception are declining. In 2009, more than 166 000 defined daily doses of emergency contraception were sold. In 2019, the number had fallen to about 115,300 doses. Five per cent were sold in supermarkets.

Sterilisation: sterilisation is a permanent and safe method of contraception, but is a low-priority health service that can be expensive for the patient. Over the past two decades, the number of sterilised women has been falling, from 5000 annually in 2002 to about 1000 in 2018. The reason for the decline is partly due to new, safer contraceptives and probably also the rise in sterilisation costs for the patient from 2002.

Easy access to information: easy access to quality-assured information is another core element of the efforts to promote sexual and reproductive health. Child health centre staff assist in the teaching of sex education at primary and lower secondary schools, as well as at upper secondary schools if this is requested. They also offer adapted teaching outside the classroom for children and young people with special needs. The purpose of the teaching is to strengthen children and young people's sexual health knowledge and autonomy, help them to build a positive relationship with their own body, develop a safe sexual identity, and ensure safe sexual behaviour and prevent sexual abuse.

The website www.zanzu.no provides information on sexual health in various languages. The aim is that people who have not lived in Norway very long and have limited knowledge of Norwegian have an easily accessible tool for learning about sexual health and finding out about their rights and obligations in Norway. Zanzu is also a tool that can be used by various professionals to introduce themes relating to the body, reproductive health and sexuality in connection with teaching, counselling or consultations.

On the website www.ung.no, young people can get quality-assured answers to their questions and read editorial content about sexual and reproductive health. The website www.helsenorge.no provides service users with information about sex and relationships.

Access to abortion: 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. There is no requirement to have a period of reflection. 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. The woman makes direct contact with a hospital that has a gynaecology department. 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.

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. As of 1 January 2020, 26 hospitals in Norway have an abortion board.

All women living in Norway have the right to an abortion which is either decided by themselves or by an abortion board. Abortions are free for women who are resident 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.

Abortion statistics: the abortion rate in Norway is falling, and in 2019 was the lowest since the Abortion Register was established in 1979. The decline has been greatest in the youngest age groups. The abortion rate is now highest in the age group 25–34 years. Among women between the ages of 15 and 49, 9.7 abortions were performed per 1000 women in 2019, compared with 11.0 per 1000 women in 2016. Among women aged 15–19, 4.9 abortions were performed per 1000 women in 2019. The same year, 0.5 abortions were performed per 1000 among the under 16s.

Overview of the infant mortality rate and underage mothers

Teenage births: there are few teenage births in Norway, and the proportion is falling. In the period 2016–2019, there were 225,147 births in Norway. Of these, 315 women were 17 years or younger when they gave birth, and 1655 were 19 years or younger. This corresponds to 0.1 per cent and 0.7 per cent of all births respectively. In 2010, this share was 0.4 per cent and 1.8 per cent respectively.

Infant mortality in Norway: In the period 2016–2018, there were 172,860 live births in Norway. Of these, 379 infants died in the first year of life. This corresponds to an infant mortality rate of 2.2 per live birth. In 2010, the infant mortality rate was 2.5 per live birth. We do not have data for 2019 because infant mortality requires a 1-year follow-up period.

Stillbirths: In the period 2016–2019, 228,692 children were born, and 765 of these were stillbirths. This corresponds to 3.3 per 1000 births.

Measures to prevent infant mortality

Evidence shows that pregnant women and parents who are struggling with mental health challenges or drug/alcohol use, or who live in families with violence, can expose the child to

stress and injury. Pregnancy and the early years are an important period for brain development and psychological and/or social development.

The competence centres (KoRus, RBUP/RKBU, RVTS) and the Office for Children, Youth and Family Affairs (Bufetat)) have created a joint training programme, Early Intervention (*Tidlig inn*) for services and professionals in local authorities. The programme includes specific tools, conversation methods and exercises to strengthen individual skills. Recommendations related to cross-sectoral interactions, guidelines and the exchange of experience between services and professionals are also included. The training programme uses motivational interviews as a method of establishing dialogue about sensitive topics. The goal is to identify risk and motivate change.

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. Talking about sensitive topics and identifying risk factors can be a challenge for services. The Early Intervention training programme is a national initiative, funded by the Norwegian Directorate of Health and the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir). 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. Competence in identifying and conversing with pregnant women and parents about alcohol use, psychological difficulties and violence will increase the likelihood that the goals of early intervention will be achieved. A total of 163 municipalities have so far participated in the training programme.

Improved interdisciplinary efforts and the Early Intervention training programme complement and support each other. Improved interdisciplinary efforts provide an organisational framework that emphasises processes and relationships between the municipal services and complement them with knowledge and practical work. Early Intervention provides employees in services with tools and methods to improve their skills. Overall, improved interdisciplinary efforts and early intervention will increase the quality of a comprehensive and coordinated service and enable it to identify risks and implement appropriate measures.

(National guidelines for child health centres and school health services. Norwegian Directorate of Health, 2019).

Article 11, section 2 – to provide advisory and educational facilities for the promotion of health and the encouragement

Question a)

Please provide 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 (life-long or ongoing) and in schools. Please also provide information about awareness and education in respect of sexual orientation and gender identity (SOGI) and gender violence.

The national curriculum forms the framework and governs the content in Norwegian schools. It also reflects the values and principles of the education, and the syllabuses for the individual subjects set overarching learning outcomes. The local authorities and the schools have a large degree of autonomy to decide how they want to organise the education in order to achieve the

goals of the curriculum. It is the schools and the teachers who determine which teaching plans and teaching materials are used.

In order to understand the framework and priorities that form the basis for teaching topics related to health, including reproductive health and sexuality, we must look to the national curriculum.

In the period 2016–2019, a new curriculum was developed in Norwegian schools (LK20), which was planned for introduction in schools in the autumn of 2020.

The new curriculum contains three interdisciplinary themes: public health and life skills, sustainable development, and democracy and citizenship. These are not separate subjects, but they represent prioritised societal challenges that require competence spanning different subject areas.

Competence related to physical and mental health falls under the interdisciplinary theme of public health and life skills. Life skills relate to the ability to understand and influence factors that have a bearing on mastering one's own life. This theme will teach pupils how to best deal with success and adversity and personal and practical challenges. Relevant areas within the theme include lifestyle choices, sexuality and gender, drugs, media use, consumption and personal finances. Value choices and the importance of living a meaningful life, interpersonal relationships, being able to set boundaries and respect others, and being able to deal with thoughts, feelings and relationships are also covered in this theme.

Different aspects of health and sexuality are covered in social studies, science, religious and ethical education and physical education. We have received a lot of input on these themes, and have tried to ensure a holistic approach in the different subjects. 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.

Critical thinking and source evaluation are core elements of the competence in all syllabuses. In natural science, this includes explaining the significance of vaccines in public health, and being able to assess the reliability of various sources of information on health and lifestyle issues.

Examples of learning resources

Jeg Vet (I know) is a digital learning resource for violence prevention and life skills in kindergartens and schools that was launched in 2018.[5] The aim 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. *Jeg Vet* also provides support material for teachers, such as guides that show the individual resources' relevance to the framework plan and learning objectives, in addition to material that can be used to inform parents and information about what teachers should do if they are worried about a child. The resource has been developed in collaboration with experts in bullying, violence and abuse,

[5] https://www.jegvet.no/

and in consultation with the Norwegian Directorate for Education and Training and the Norwegian Directorate of Health.

The learning tool *Snakke sammen* (Talk together) was also launched in 2018,[6] and is a digital information and simulation portal aimed at increasing adults' confidence when addressing important issues with children they are concerned about. The core content of *Snakke sammen* is a recently developed simulation game that enables users to practise such conversations and helps them to talk to children and young people about difficult issues. Implementation of *Snakke sammen* and *Jeg Vet* will be coordinated where this is appropriate.

The Norwegian Directorate for Education and Training has created an online resource that addresses the prevention of self-harm and suicide.[7] It is recommended that schools adopt an interdisciplinary approach and work with other disciplines and sectors on these themes.

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. In 2019, a total of NOK 1.3 billion was allocated to this area, including earmarked funds of NOK 330 million.

Appendices

The following are examples of relevant competence objectives in the syllabuses for the different subjects:

Competence objective in natural science, year 4

- Discuss similarities and differences between the genders, gender identity and human reproduction

Competence objective in natural science, year 7

- Explain the physical and mental changes that take place during puberty and discuss how this can impact on feelings, behaviour and sexuality

Competence objectives in natural science, year 10

- Discuss issues relating to sexual and reproductive health
- Compare the nervous system and the endocrine system, and describe how drugs and alcohol, medicines, environmental toxins and anabolic steroids affect the body's communication systems
- Describe the body's immune system and how vaccines work, and explain the importance of vaccines in public health

Competence objective in natural science, year 10

- Discuss relevant health and lifestyle issues and consider the reliability of information from different sources

Competence objective in social studies, year 4

- Discuss boundaries related to the body, what constitutes violence and sexual abuse, and where to seek help in the event of exposure to violence and sexual abuse

Competence objective in social studies, year 7

[6] https://www.snakkemedbarn.no/om-snakke-sammen/

[7] https://www.udir.no/kvalitet-og-kompetanse/sikkerhet-og-beredskap/skolens-selvmordsforebyggende-arbeid/

- Reflect on variations in identities, sexual orientation and gender expression, and own and others' boundaries related to feelings, body, gender and sexuality, and discuss what to do if boundaries are crossed

Competence objective in social studies, year 10

- Reflect on how identity, self-image and own boundaries are developed and challenged in different circumstances, and suggest ways to handle influence and undesirable behaviour
- Reflect on what impacts on one's own and others' boundaries in terms of the body, sexuality and substance use, and understand how important it is to respect boundaries

Competence objective in religious and ethical education, after year 10

- Explain and reflect on different viewpoints on gender, sexuality and sexual ethics in Christianity and other religions and beliefs

Competence objective in physical education, after year 10

- Reflect on how body image in the media and in society impact on physical activity, body identity and self-image

Question b)

Provide information on measures to ensure informed consent to health-related interventions or treatment and on specific measures to combat pseudoscience in respect of health issues.

Information to ensure informed health choices

The Patients' Rights Act, section 3-1, the patient's right to participation: the service user is entitled to participate in the implementation of his or her health care. This includes a right to participate in choosing between available and medically sound services and examination and treatment methods. 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 views must be given information and heard. The child's opinion should be weighted according to their age and maturity.

The government's strategy for increasing health competence in the population (2019–2023) shall include, but is not limited to the following:

- 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, i.e. where health competence is an integral part of the directorate's organisation, management and authority, as well as grant management
- 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 National Health and Hospital Plan (2020-2023) describes the patient as an active participant. One of the measures aimed at fostering participation is the simplification of appointment notifications and letters about the right to health care. A review of the learning and coping services in the specialist health service and primary health and care services is also planned.

National guidelines on communication via an interpreter have been drawn up for managers and personnel in the health and care services (Norwegian Directorate of Health, 2011).

Measures to combat the spread of pseudoscience in respect of health issues

Helsenorge.no is the official health website for residents of Norway. The content is provided by various actors in the health sector. Helsenorge.no has been designed to improve and simplify the interaction between the individual patient and their family and the health service, and to stimulate mastery of life skills, strengthen the patient's role and improve their health.

Helsenorge.no aims to:

- Make it easier to find and choose a treatment provider.
- Provide access to users' own healthcare information.
- Serve as a self-service portal and enable self-help.
- Provide quality-assured information and advice on good health and lifestyle choices, symptoms, illness, treatment and rights.

Research: SAMRISK is a research programme managed by the Research Council of Norway aimed at improving the knowledge base for societal security work. The programme will shed light on vulnerabilities and dilemmas, help prevent unwanted incidents, maintain important societal functions, safeguard the life, health and basic needs of citizens before, during and after highly stressful events. SAMRISK covers various types of major stressors that may be due to misguided actions, accidents or natural disasters. A total of 45 projects have been listed under SAMRISK II in the project database, such as 'Fakespeak – the language of fake news. Fake news detection based on linguistic cues'.

Knowledge-based service development: Helsebiblioteket.no provides free access to professional procedures, reference material, databases, journals and other knowledge resources for healthcare personnel.

Guide for developing knowledge-based guidelines (Norwegian Directorate of Health, 2012): Knowledge-based professional guidelines containing systematically prepared advice and recommendations related to prevention, diagnostics, treatment and/or follow-up within the health and care services. The advice and recommendations given must be specific, and must help healthcare personnel and patients to make good decisions. They must also reduce unwanted variation and promote good quality in health and care services.

Other: Several actors in the health sector hold courses on knowledge-based practice. The NIPH has been holding workshops in knowledge-based practice for the past 20 years.

Article 11, section 3 - to prevent as far as possible epidemic, endemic and other diseases, as well as accidents

Question a)

Please describe the measure taken to ensure that vaccine research is promoted, adequately funded and efficiently coordinated across public and private actors.

Measures to ensure adequate funding for vaccine research by private and public sector actors
Research Council of Norway: the Research Council of Norway provides funding for research projects and environmental support (centre initiatives) through open competitions. In 2020, there were calls for research proposals related to COVID-19, but probably none with a specific focus on vaccine research, either in 2020 or earlier. The Project Databank (Research Council of Norway) contains 190 projects with the Norwegian word for 'vaccine' (*vaksine*). The corresponding figure where SkatteFUNN (offers business support in the form of tax deductions for R&D) is the source is 74, and under the EU there are 19 projects with the keyword 'vaccine'. The projects listed include basic research for testing in both human and animal health.

GLOBVAC: Between 2006 and 2020, the Research Council of Norway managed a programme initiative within Global Health and Vaccination Research (GLOBVAC). The future focus of this work is now being developed. In recent years, the initiative has had an annual budget of approximately NOK 100 million, with 90/10 per cent of the funding coming from Norad/the Ministry of Health and Care Services. Several of the vaccine projects in the Project Databank have received funding from GLOBVAC. GLOBVAC has also funded numerous projects that are not related to vaccine research.

EDCTP2: The European & Developing Countries Clinical Trials Partnership (EDCTP) is a Euro-African study aimed at helping to combat infectious diseases that particularly affect Africa. The initiative started in 2006. A further initiative under the Horizon Europe research and innovation framework programme is also planned. Vaccine research is one of several areas funded by the EDCTP. Norway has been a member of the EDCTP from the beginning. The GLOBVAC programme has funded Norway's participation.

The regional health authorities (RHAs) receive earmarked research funding. All four RHAs hold competitions within their area of responsibility. They also collaborate on joint programmes aimed at major multi-regional projects and other collaborative projects, including research on vaccines.

CEPI: Launched in Davos in 2017, CEPI is an innovative global partnership between public, private, philanthropic and civil society organisations aimed at developing vaccines to stop future epidemics. The mission is to accelerate the development of vaccines against emerging infectious diseases and enable equitable access to these vaccines for people during outbreaks. Norway is a major contributor in CEPI.

Norad (PDPs): Over time, Norad has supported a number of non-commercial actors (NGOs and foundations) whose purpose is to develop, among other things, vaccines for under-prioritised infectious diseases. This support has been based on framework grants to support

the objectives of activities, including the development of vaccines. Norad's financial support to most of these Product Development Partnerships (PDPs) has now come to an end.

International organisations: Norway provides funding for international organisations that also fund vaccine research (e.g. WHO). These are not earmarked funds from Norway for vaccine research as is the case for PDPs.

The Norwegian Institute of Public Health (NIPH) is a competent authority within vaccines, and conducts vaccine research.

Universities and university colleges conduct vaccine research. This research does not receive earmarked funds.

Other research funding: There are several initiatives that involve research commissioned by both the public and private sector – such as the regional research funds, the Barents collaboration, various foundations, etc. Some of these may play a role in funding vaccine research.

Question b)

Please provide a general overview health care 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.).

Healthcare services in prisons and other detention institutions, including who is responsible for ensuring that prisoners' right to health care is protected

The Norwegian Directorate of Health's guidelines for health and care services for prisoners states that prisoners must receive the same standard of care as the rest of the population. Services for prisoners must be adapted to their individual needs following an individual assessment. It is crucial that prisoners have access to qualified personnel who have special competence in matters related to prisoners' special living conditions, life circumstances, functional ability and health problems.

In accordance with section 3-1 of the Health and Care Services Act, the local authority must ensure that people who reside in the municipality are offered the necessary health and care services. This also applies to prisoners. The local authority determines the organisational structure of health and care services for prisoners. The regional health authorities must ensure that the inhabitants in their region can access the necessary specialist health services in and outside the institution, e.g. hospital services, laboratory services, radiological services and ambulance services. The county authority is responsible for the public dental health service, cf. the Dental Health Services Act, and must ensure reasonable availability of dental health services, including specialist dental services, for everyone living permanently or temporarily in the county. Together with other public agencies, including the health and care service, the Norwegian Correctional Service and the police have a duty to ensure that prisoners have access to the services they are entitled to under law, cf. section 4 of the Execution of Sentences Act (Norwegian Directorate of Health, 2016).

Question c)

Please provide information on the availability and extent of community-based mental health services and on the transition to community-based mental health from former large-scale institutions. Please provide statistical information on outreach measures in connection with the mental health assessment of vulnerable populations, including those in a situation of poverty or exclusion, the unemployed (especially long-term unemployed). Provide also information on proactive measures adopted to ensure that persons in need of mental health care are not neglected. Please also provide information from prison healthcare services on the proportion of inmates who are deemed as having mental health problems and who, according to health-care professionals, do not belong in the prison system or would have possibly been spared of such a situation should suitable mental health services been available to them in the community or in specialised establishments.

Availability and extent of mental health services, especially in the transition from institutions to community-based services, including information on proactive measures to ensure that persons in need of mental health care are not neglected

(Information on healthcare services for prisoners is given under Article 11, section 3 (b).)

Many people with substance abuse and addiction disorders can be considered to lack resources. The efforts made towards this population during the coronavirus pandemic can serve as an example of measures that can provide them with social and medical assistance during a crisis. The measures that were implemented can be divided into information measures, professional measures and financial measures.

Information measures: The Norwegian Directorate of Health established regular weekly electronic meeting points between the Norwegian Directorate of Health, the Ministry of Health and Care Services and the user organisations in the field of mental health and the field of substance abuse and addiction. The purpose was to gather and exchange information in order to be able to monitor situations and implement the necessary measures. The Norwegian Directorate of Health used the already established networks in different municipalities, and was given help to send a weekly form recording how people in the service apparatus perceive the situation in their local drug environment and how the municipal services address challenges related to COVID-19 and substance use. The surveys showed the status of how the respondents assess the situation in their municipality and provided an opportunity to follow developments during the pandemic.

Information about the symptoms of COVID-19 and about infection control was disseminated to users by the health services, research institutions and service user organisations, both through direct contact and via social media. In a survey of drug addicts in three Norwegian cities (Welle-Strand 2020), it was found that 65.9% of the sample were familiar with common COVID-19-related symptoms and that 91.2% were willing to test for COVID-19. Users who were receiving opioid substitution treatment were three times more likely to be familiar with COVID-19 symptoms than users who were not receiving such treatment.

Professional measures: In the period March-June 2020, the Norwegian Directorate of Health developed a guide with national professional recommendations for the health service for simultaneous care of infection control considerations and treatment of patients with mental illness or substance abuse and addiction disorders. The recommendations were aimed at ensuring that the target group received the necessary infection control whilst also receiving the necessary professional health care. Separate recommendations were developed for substitution treatment for opioid addiction, with a focus on maintaining substitution treatment, repatriation of drugs, individual assessment when choosing a substitution drug and

reduced control measures, as well as easy access to substitution treatment for people with opioid dependence outside treatment.

The Norwegian Directorate of Health prepared for various scenarios within the spread of infection in the drug environment, and assessments were initiated to provide a knowledge base for substitution treatment for addictions to drugs other than opioids. This work formed the basis for assessing whether such treatment could have positive treatment effects and at the same time reduce the risk and spread of infection.

The local authorities in Oslo and Bergen established their own 24-hour units and offered temporary housing in hotels for the care of patients in quarantine or isolation, who due to a difficult housing situation, other social conditions and/or general illness burden could not be quarantined/isolated at home. Oslo also established a testing unit in the drug community so that people who frequent these environments can easily be tested.

With the closure of injecting rooms and shelters for drug addicts, outpatient schemes were established in many municipalities that continued to ensure that vulnerable people had access to clean user equipment, food and social contact.

No treatment institutions for people with drug and addiction disorders in the specialist health service were closed down, but in many places, video consultations were introduced for outpatient treatment. Infection control measures were implemented.

Financial measures: The financial measures were aimed at both the health services and the individual user. The Ministry of Health and Care Services established a subsidy scheme of NOK 50 million to help local authorities maintain the operation of low-threshold services. Effort-driven financing (ISF) was reorganised in the form of online consultations. Some health trusts removed the requirement for deductibles for vulnerable patients. Free disinfectants were distributed to users in a substance abuse environment.

More specific measures to ensure service provision:

- Individuals with mental, somatic and substance abuse-related conditions are not able to visit pharmacies for medications, can apply for assistance from their local authority.
- A number of local authorities have an outreach health service for this purpose – some local authorities have special premises for drug users in order to ensure them a safe place to inject the drug.
- All Norwegian municipalities have an obligation to provide clean equipment for drug users.
- A number of municipalities have outreach teams to assist the target group. The team provides health-related services (ACT/FACT team).
- Most of the bigger municipalities have premises with social services staffed with health/social work providers. Some of these services also provide food for the target group.
- Many NGOs work with the target group(s) and often have staff with a background from health/social work.
- Municipalities also provide support to the families of the target group(s) as well as guidance to the users themselves.

From institution to municipal service provision:

- Efforts are ongoing to link the data from primary health services and specialist health services in order to be able to follow individuals across the service levels.
- The responsibility, roles and routines for the follow-up of the patients across the levels are regulated in the statutory framework as well as in clinical guidelines.
- https://lovdata.no/dokument/SF/forskrift/2011-11-18-1115
- https://pasientsikkerhetsprogrammet.no/om-oss/innsatsomrader/trygg-utskrivning
- National plan for health and hospitals https://www.regjeringen.no/contentassets/e353a5d022d84deabd969a5fe043783e/no/pdfs/i-1194_b_kortversjon_nasjonal_helse.pdf

An important new measure is the establishment of 'health communities'. The specialist health providers will develop and plan services together with the primary health services. Individuals with severe mental disorders or/and substance abuse are one of the prioritised target groups, in addition to children and young people, individuals with chronic somatic conditions and the elderly with special needs.

Question d)

Please also provide 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. Provide 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, which 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).

<u>Statistics on fatal overdoses, transmission of infectious diseases among drug users</u>

The total number of drug-related deaths (also known as fatal overdoses) in 2018 was 286. This is an increase from 2017, but is on a par with previous years. There were 22 such deaths in the former county of Hordaland in 2018, which is the lowest figure for more than ten years. The county of Trøndelag had 29 fatal overdoses, which was the highest figure for more than 20 years. For the third year in a row, opioids other than heroin (morphine, codeine, oxycodone, etc.) were the most common cause of death.

In 2018, the number of deaths was at the same level as in 2015 and 2016. In 2017, the figure was 17 per cent lower. The figures for fatal overdoses are as follows:

- 2018: 286 deaths, 29 per cent women
- 2017: 249 deaths, 29 per cent women
- 2016: 284 deaths, 30 per cent women

In the period 2003–2018, we found that:

- the average number of deaths varied at around 266 per year, see Figure 1
- the age-adjusted rate for fatal overdoses was 5.4 per 100 000 inhabitants in 2018
- all figures apply to residents in Norway at the time of death

Drug-related deaths can be divided into three main groups: accidental poisoning, suicide, and mental illness and behavioural disorders as a result of substance use.

Of the 286 fatal overdoses in 2018, 210 were due to accidental poisoning, 51 were suicides and 24 related to mental illness and behavioural disorders. The breakdown for these three groups is 73, 18 and 8 per cent respectively. These rates have remained relatively stable in recent years.

Policies aimed at preventing substance use

IS-2076 Tackling it together – local efforts in mental health and substance use in adults (Sammen om mestring – lokalt psykisk helse- og rusarbeid for voksne)

The guide describes prevention at three levels:

- Prevention aimed at individuals who have risk factors or have developed problems (mild and temporary problems)

The main efforts of the services should be directed at those who are considered likely to develop significant health problems or impairments. Services for people with mental health or substance use problems must, to a far greater extent than in the case of somatic diseases, be proactive in providing information and need to organise the services in a way that makes them easily accessible to service users.

Child health centres, school health services, outreach teams, the child welfare service, GPs and psychologists in the primary health and care service are important contributors in the individual preventive measures. Easily accessible information on mental health and substance abuse problems and treatment options, including teaching programmes in schools, can reduce stigmatisation, make it easier to seek help and increase the probability of necessary measures being initiated at an early stage. In addition to the health and care services, public health coordinators and the team that coordinates local crime prevention measures play an important role in the local authorities' work on prevention.

- Prevention aimed at users with established problems (temporary serious problems/disorders and long-term milder problems/disorders)

The preventive efforts are aimed at reducing the harmful effects of substance use or the mental disorder, and the consequence of the problems. In cases where the preventive work is successful, it is often possible to limit the extent of the problems, and this can help to reduce the stigma of, for example, breaching social norms.

The preventive measures are aimed at alleviating the health problems, ensuring a better outcome, preventing relapses and counteracting complications. Effective treatment can

relieve troublesome symptoms such as anxiety, depression and emotional lability, and has a major impact on functional ability, quality of life and interpersonal relationships. Long-term problems are associated with more extensive negative consequences. Many people do not manage to hold down a job and their social network is eroded, which can lead to isolation and loneliness. Others drop out of the labour force and have poor finances. Some people experience homelessness as a result of their tenancy being terminated. Prevention of such problems should form part of the treatment in the primary health services, such as GPs, psychologists or mental health and substance use services, in collaboration with the specialist health service, preferably as part of a tailored plan.

- Prevention aimed at people with long-term problems/disorders (serious and long-term problems/disorders)

In the case of serious and long-term problems/disorders, the main focus will be on preventing additional problems and guiding the individual on to a path towards improvement and mastering their own life circumstances. Prevention can also entail reducing the risk of exposure to stigmatisation and discrimination, preventing exacerbation and recurrence of the problems, limiting the negative consequences of the problem and working towards long-term improvement.

People with serious and long-term problems/disorders are often subjected to stigmatisation and discrimination. Some are easily recognisable due to their appearance or demeanour, they can attract attention, and people can feel unsafe or afraid around them. Factual information can help to reduce fear and the dramatic perception of the problem. Public information campaigns, educational programmes for specific target groups, information meetings to introduce new institutions, housing provisions and other measures can all help to reduce prejudice and stigmatisation. Medication-assisted rehabilitation can reduce breaches of norms associated with the financing and sale of illegal drugs.

Many people with severe and long-term mental disorders and/or substance use problems are at risk of losing or lacking access to life’s basic needs, such as housing, employment and social networks. The situation can be a direct consequence of a mental illness or substance use problem that has hindered normal development and the opportunity to master everyday life. The primary health and care services and NAV provide services aimed at improving the life circumstances of the individual.

National overdose strategy (2019-2022)

The national overdose strategy provides direction for the overdose prevention effort, and highlights areas that can play a role in meeting the associated challenges. Overdose prevention work entails measures aimed at saving lives and limiting damage to health. This work must be viewed in conjunction with other health and welfare efforts aimed at people with substance use problems.

The local action plans for the prevention of fatal overdoses are a key tool in this work. Local mental health and substance use services play a central and important role, and the target group of the national guidelines is therefore all local authorities with overdose issues. These local authorities should implement measures to prevent overdoses and drug-related deaths.

The main objective of the national overdose strategy is an annual reduction in fatal overdoses, with a long-term vision of zero cases.

National guidelines – overdoses – local preventive work

The Norwegian Directorate of Health has drawn up national guidelines for local overdose prevention work. Some of the guidelines/recommendations are summarised below:

- The basis for all health work is the collaboration with patients and service users. This also applies to overdose prevention work. Before the local authority initiates work in this area, it is sensible to establish a collaboration with relevant organisations and individuals.
- The Norwegian Directorate of Health recommends local mapping of the overdose situation as a basis for developing action plans and procedures in the local authority.
- Systematic efforts are a particularly important goal in the work to reduce fatal overdoses. Specific action plans based on mapping local conditions and which are linked to other municipal plans will be a useful starting point for this work.
- Overdose prevention work requires close cooperation. Cooperation is necessary at both the system and individual level. Local authorities often initiate arenas in which cooperation on overdose prevention work is developed. Services such as the ambulance service, the specialist health service, the police, patient and family organisations and voluntary/non-profit actors are relevant partners.

Question e)

Please provide information on 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 measures taken to address health problems of the populations affected. Please provide also information about measures taken to inform the public, including pupils and students, about general and local environmental problems.

Protection against damage and nuisance as a result of pollution and waste is regulated in the Pollution Control Act. Section 7 of the Act states that 'No person may possess, do, or initiate anything that may entail a risk of pollution unless this is lawful pursuant to section 8 or 9 or permitted by a decision made pursuant to section 11'. Under section 28, it is prohibited to empty, leave, store or transport waste in such a way that it is unsightly or may cause damage or nuisance to the environment. Persons responsible for unlawful pollution and contamination have a duty to implement measures to counteract the pollution and clean up the contamination.

Pollution-generating activities are regulated in permits and/or regulations. Permits and regulations set out the thresholds for noise and emissions to air and sea, and requirements for monitoring and reporting. The EU's Industrial Emissions Directive is incorporated into Norwegian law under chapter 36 of the Pollution Control Regulations, cf. the EEA Agreement, and these regulations set out special requirements for the activities covered by the directive.

Chapter 6 of the Pollution Control Act includes requirements for emergency preparedness in the event of acute pollution in order to ensure that measures are implemented quickly. The

responsibility for the emergency response is shared between private companies, the local authority and the government.

In order to ensure compliance with the Pollution Control Act and the requirements therein, the companies responsible must establish internal controls that comply with the regulations on systematic health, environment and safety work (the Internal Control Regulations). The regulations governing companies that use or store large quantities of hazardous chemicals also impose a requirement on such companies to control such activity. New regulations relating to such companies were adopted in 2016 in order to incorporate the EU's Seveso III Directive in Norwegian law. These regulations also include a requirement for the public to be informed, see section 12.

The Pollution Control Authority is responsible for monitoring the general pollution situation and pollution from individual sources and for monitoring waste management. By providing advice, guidance and information, the Pollution Control Authority seeks to combat pollution and waste problems and ensure compliance with the provisions of the Pollution Control Act and relevant decisions. In order to enforce the Act, the Pollution Control Authority may impose measures, obtain information and order investigations to be carried out. It can monitor any business or activity that may cause pollution, impose coercive fines to ensure that obligations and orders are carried out, and can implement measures on behalf of the party responsible. Violation of the Pollution Control Act and decisions made pursuant to the Act is a criminal offence.

When processing cases pursuant to the Pollution Control Act, the Pollution Control Authority must adhere to the requirements in individual decisions and regulations in the Public Administration Act. Chapter 36 of the Pollution Control Regulations also sets out special procedural rules for applications for permits under the Pollution Control Act. Both the Public Administration Act and chapter 36 of the Pollution Control Regulations include requirements for advance notification and consultation with affected parties and the general public.

In Norway, the main rule is that public undertakings are open and transparent. According to the Freedom of Information Act, case documents, case records and similar registers can be freely inspected unless otherwise provided for by law or regulations. Environmental information is also subject to the Environmental Information Act, which incorporates the international Convention on Access to Information, Public Participation in Decision-making and Access to Justice in Environmental Matters into Norwegian law.

Information to the general public about pollution and environmental status in Norway is available at www.miljøstatus.no and on the Norwegian Environment Agency's website. Data on emission permits are freely accessible on the website www.norskeutslipp.no, and information on ground pollution is available at www.grunnforurensning.miljodirektoratet.no.

Question f)

In the context of the COVID-19 crisis, please evaluate the adequacy of measures taken to limit the spread of virus in the population (testing and tracing, physical distancing and self-isolation, provision of surgical masks, disinfectant, etc.) as well as the 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 while ensuring that their working conditions are healthy and safe – an issue addressed under Article 3 above). Please indicate the measures taken or foreseen as a result of this evaluation.

Evaluation of infection control measures, including treating those with symptoms (personnel resources)

The following report on the infection control strategy and measures was written in October 2020. It does not therefore give information about the subsequent tightening of measures, nor of the developments in mortality and infection rates.

On 12 March, the Norwegian government implemented the most stringent measures in peacetime. National measures were introduced in which kindergartens, schools, education institutions and workplaces were closed. A maximum limit was set for how many people could meet both privately and in public, and travel restrictions were imposed for a defined period. Healthcare personnel involved in the treatment of patients were not permitted to travel abroad. Elective operations were postponed. The population was encouraged to work from home and quarantine was introduced for travellers arriving from abroad. All public and private health and care institutions introduced access controls, and visitors were not permitted. These are all examples of the national measures that were introduced. The number of COVID-19 cases was quickly brought under control, and by 7 April the government announced a gradual reopening of society and an end to the most restrictive measures. In May/June, the country was almost back to normal and in mid-July travel was once again allowed to many EU/EEA countries.

The goal of the government's strategy has been to reduce the infection rate and keep it low. Tracking and tracing was implemented in cases of local outbreaks in order to stop the transmission, and this strategy is still being followed. When the government introduced the national measures, infections were still at a relatively low level and the measures that were implemented have proven to be very effective. It is difficult to know which individual measures have had the greatest effect as they were all introduced at the same time. In early summer, June/July, there were very few cases in Norway, and Norway still has one of the lowest infection rates in Europe, despite also now experiencing a slight increase in the total number of infections. As of early October, we still have fewer mortalities and cases of illness than comparable countries.

The Norwegian authorities put a great deal of trust in the population, and advice and recommendations are largely followed. The Prime Minister used the term ‘national collective effort’ at an early stage of the pandemic in order to emphasise the need to work together and share the responsibility. The population has been kept informed and given responsibility, and this has been well received by the population. The order in which restrictions have been removed has been a political decision, and has been communicated clearly in weekly press conferences. Restrictions relating to schools and children were the first to be removed. Measures affecting jobs were prioritised next, before other measures were removed. On 12 October, the national measures were removed, and since then local measures have been implemented for specific periods based on the infection situation.

All those infected with COVID-19 have received necessary and good health care, but patients with health problems other than COVID-19 were given a lower priority. 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, and particularly over time. 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.

Article 12 – The right to social security

Article 12, section 2 and 3

Question a)

Please provide information on social security coverage and its modalities provided to persons employed or whose work is managed through digital platforms (e.g. cycle delivery services).

The Norwegian National Insurance Scheme is a comprehensive system which in practice covers all persons who are residing or employed in Norway, i.e. for all practical purposes 100 per cent 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 the provisions of a bilateral or multilateral social security coordination instrument in force between Norway and the country in question. However, a certain number of people residing abroad will have a similar affiliation to the Norwegian National Insurance Scheme. We have no precise statistics on these groups.

The Norwegian National Insurance Scheme, seen in conjunction with the family allowance scheme, comprises all branches of social security as set out in the European Code of Social Security. Reference is made to the survey 'The Norwegian Social Insurance Scheme', updated in January 2020, which also gives relevant information as to the more specific nature of the system and its various branches, its financial arrangement, the level of the different benefits and the conditions for entitlement to them. The survey is available online:

https://www.regjeringen.no/contentassets/03b0e088c8f44a8793ed0c0781556b11/a-0008-e-the-norwegian-social-insurance-scheme-2020.pdf

Question c)

Please provide information on any impact of the COVID-19 crisis on social security coverage and on any specific measures taken to compensate or alleviate possible negative impact.

<u>Sickness benefit</u>

The following changes were introduced for sickness benefit as from Monday 16 March 2020 as a consequence of the COVID-19 pandemic:

Changes in entitlement criteria: The right to sickness benefits applies correspondingly when a person must be absent from work due to COVID-19 or suspected COVID-19 (quarantine). Persons who act contrary to national travel advice and have a duty to quarantine when returning to Norway may be denied sick pay.

Amendments to the sickness benefit scheme:

The employers' period for paying compensation for sick leave as a result of the coronavirus pandemic has been reduced to 3 days (normally 16 days).

Self-employed and independent workers will have sick leave compensated from day 4 of their leave, on the same basis for coverage as before (normally from the 17th day).

Care benefit

The following changes have been introduced for care benefit under the sickness benefit scheme, coming into effect on Friday 13 March 2020 as a consequence of the COVID-19 pandemic:

Changes in entitlement criteria: Broadening of the scope of the benefit, enabling use of the benefit when kindergartens or schools are closed due to the pandemic and to parents of children who cannot attend kindergarten/school due to the health condition of the child or a family member. Medical confirmation is necessary.

Amendments in the care benefit scheme

Care benefit is paid without any confirmed sickness, if kindergartens/schools are closed.

The number of days with paid care benefit was doubled for the first half of 2020 for all parents. For the last half of 2020, all parents got the same number of days they normally have for one year, regardless of the use of days during the first half.

Parents with children who should not attend kindergarten or school due to the health condition of the child or a family member get as many days with care benefit as is needed.

When a school or kindergarten is closed due to the pandemic, parents get as many days with care benefit as is needed. One parent may transfer his/her right to care benefit to the other parent.

The employer's obligation to pay care benefit was reduced from ten to three days in the period from 13 March to 30 June. It returned to the normal ten days as of 1 July. The Labour and Welfare Service (NAV) reimburses care benefit paid by the employer after the third day.

The waiting period for care benefits from NAV for the self-employed and freelancers was reduced from ten to three days in the period from 13 March to 30 June. It returned to the normal ten days as of 1 July.

Article 13 – The right to social and medical assistance

Article 13, section 1 – ensure that any person who is without adequate resources be granted adequate assistance

Question a)

Please describe any reforms to the general legal framework. Please provide pertinent figures, statistics or any other relevant information, in particular: evidence that the level of social assistance is adequate, i.e. the assistance should enable any person to meet his/her basic needs and the level of the benefits should not fall below the poverty threshold. Information must therefore be provided on basic benefits, additional benefits and on the poverty threshold in the country, defined as 50% of the median equivalised income and calculated on the basis of the poverty risk threshold value published by

Eurostat.

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 2109 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.

Financial benefits are allocated in line with the needs of the individual. The support can be the main income or can be paid as a supplement to other income – for example income from work, or from social assistance benefits or the qualification programme benefit.

Since the benefit is calculated according to needs rather than on the basis of accrual or fixed rates, the amounts paid will vary. A single person can receive a small monthly amount as a supplement to other income, or a family may have the benefit as its primary income. The benefit can also be paid as a lump sum grant in special situations, such as moving home, upgrading necessary equipment in the home, short-term loss of income and the like. The applicant's income, expenses, assets and debts are taken into consideration when assessing applications and calculating the amount of the benefit or grant. Everyone is ensured a modest but acceptable level of subsistence, and special account is taken of the needs of children and young people to participate in activities at school and in their leisure time.

All the facts mentioned above mean 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 general indicator of poverty in Norway is an income which is persistently less than 60 per cent of the annual median disposable equivalised household income over a three-year period. 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 EU and the OECD weigh economies of scale differently (using equivalence scales). Here we have used the EU's equivalence scale for the conversion of economies of scale both for the low income limit set at 50 and 60 per cent of the median income, and for persistently low incomes.

Low income limits in Norwegian kroner (50 and 60 per cent of the median income after tax per consumption unit, EU equivalence scale):

	50% of the median income (EU equivalence scale)	**60% of the median income (EU equivalence scale)**
2016	180,700	215,300
2017	185,900	221,300

2018	192,100	228,400
2016-2018*	-	226,800

Source: Statistics Norway, Statbank
09593: Low income limits in Norwegian kroner (annual income) based on distances to the median income
* Average for a three-year period. Source: Statistics Norway, Finances and low incomes for low-income groups

Question b)

Please indicate any specific measures taken to ensure social and medical assistance for persons without resources in the context of a pandemic such as the COVID-19 crisis. Please also provide information on the extent and modalities in which social and medical assistance was provided to people without a residence or other status allowing them to reside lawfully in your country's territory.

Measures to ensure medical assistance for persons without legal residence in Norway, and how measures safeguard such persons

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.

People without legal residence can be found throughout Norway. 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 we know from surveys conducted by the Norwegian Medical Association that GPs throughout much of Norway treat patients without legal residence.

No other special measures have been taken to guarantee medical assistance for persons without legal residence in connection with COVID-19, other than the measure that entitles them to free health care and treatment.

People without legal residence constitute a very vulnerable group as a result of poor living conditions and life circumstances etc. It should be possible to test them at A&E units or testing stations, but because they have no personal identity number, this presents challenges in relation to test results, and special follow-up is required by the relevant health centre or health service.

The following amendments have been made to the *social assistance scheme* as a consequence of the COVID-19 pandemic:

- 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.

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.

Persons who have legal residence but no fixed abode in Norway are, in principle, not entitled to services under the Social Services Act, with the exception of information, advice and guidance from the local authority. If a person is in an emergency situation and is unable to provide for himself, they are entitled to help. The person in question may be entitled to financial support and temporary accommodation until such time as they can reasonably be expected to receive assistance from sources in their own country.

Article 14 – Everyone has the right to benefit from social welfare services

Article 14, section 1 - The right to benefit from social welfare services

Question a)

Please explain how and to what extent the operation of social services has been maintained during the COVID-19 crisis and whether specific measures have been taken in view of possible future such crises.

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.

Article 14, section 2 – to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services.

Question a)

Please 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 and in the design and practical realisation of services. Co-production is here understood as social services working together with persons who use the services on the basis of key principles, such as equality, diversity, access and reciprocity.

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.

Article 23 – Every elderly person has the right to social protection

Question a)

Please provide detailed information on measures (legal, practical and proactive, including as regards supervision and inspection) taken to ensure that no older person is left behind in terms of access to and enjoyment of their social and economic rights.

The Norwegian Directorate of Health has updated its guidance on visits to health and care institutions, with the most recent amendment on 9 October:

https://www.helsedirektoratet.no/veiledere/koronavirus/besok-i-helse-og-omsorgsinstitusjoner-og-tiltak-mot-sosial-isolering

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. The Storting has allocated money for activities in nursing homes and for older people living at home. The voluntary sector has been given a significant role in the new measures, and this will require broad mobilisation and extensive organisation.

Question b)

Please provide information on specific measures taken to protect the health and well-being of the elderly, both in their home and in institutional settings, in the context of a pandemic crisis such as the COVID-19 crisis.

<u>Pandemic measures implemented for the elderly</u>

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. This includes 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.

In connection with the lockdown on 12 March, 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 in particular. A letter from the Norwegian Directorate of Health on 14 March 2020 explained that the requirements in the health legislation pertaining to safe practice made it necessary to introduce temporary access controls in all public and private health and care institutions and to stop all visits.

On 7 April 2020, the government announced the gradual return of some health services, but these had to be well prepared and closely controlled. The hospitals were asked to prepare for gradual escalation to normal operations and the local authorities were asked to restore normal activity in the health and care services. The Norwegian Directorate of Health then began preparing guidelines for visits to health and care institutions, 'Visits to Health and Care Institutions and Measures to Combat Social Isolation', which include measures and assessment criteria to ensure safe visits to residents in institutions where local infection numbers are low, and to ensure adequate protection in cases of local outbreaks.

The Norwegian Directorate of Health's COVID-19 guide also includes separate chapters covering, for example:

- Home-based services, which includes recommendations on infection control and protection of vulnerable groups, both with and without COVID-19, such as people with dementia or intellectual disabilities, those who need user-controlled personal assistance, service users with complex needs, family members with a considerable care responsibility etc. 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.
- Nursing homes, which includes infection control measures, plans for dealing with a high infection rate and/or high levels of staff absence etc.
- The GP service, which includes a recommendation on how GPs can prioritise the most at-risk patients by means of systematic risk assessments.
- Mental disorders, substance use problems and addiction, which includes how the local authority monitors the risk of a worsening situation and the need for follow-up.

The Norwegian Directorate of Health has issued advice on the prioritisation of health and care services during COVID-19 pandemic. This includes both general advice for prioritising health care in Norway during the pandemic and advice on prioritisation in nursing homes and home-based services (COVID-19).

Measures to combat social isolation and stimulate physical activity:

- The chapter covering visits to health and care institutions and measures to combat social isolation in the COVID-19 guide provides guidelines on measures to limit social isolation in a scenario with visitor restrictions.
- 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.

Training measures:

- Staff must be highly competent in infection control so as to ensure best practice during the pandemic. The Norwegian Directorate of Health's COVID-19 guide therefore gives recommendations on training measures in the municipal health and care services.
- Palliative care for COVID-19 patients is challenging, and knowledge from other areas cannot be directly transferred. The Norwegian Directorate of Health has therefore commissioned the Norwegian National Advisory Unit on Ageing and Health to devise a plan for e-learning on palliative care for COVID-19.

COVID-19 web pages:

- As mentioned, the Norwegian National Advisory Unit on Ageing and Health has been commissioned by the Norwegian Directorate of Health to provide information about COVID-19 on its website, with a special focus on follow-up and services for the elderly. The aim is to disseminate information about effective measures for the elderly during the pandemic. The website also includes information on training resources.
- The National Institute on Intellectual Disability and Community (NAKU): the Norwegian Directorate of Health has provided information on its website about people with intellectual disabilities and COVID-19. The web pages were developed by NAKU in collaboration with the Norwegian National Advisory Unit on Ageing and Health and the SOR Foundation, which promotes the rights of people with intellectual disabilities.

Article 30 – The right to protection against poverty and social exclusion

Question a)

Please provide detailed information on measures (legal, practical and proactive, including as regards supervision and inspection) taken to ensure that no person drops under the poverty threshold, and provide also information on the impact of the measures taken. Please indicate how many people in your country are at risk of poverty, how many in a situation of poverty, and how many in extreme poverty, including specific data for children.

Labour force participation leads to financial independence, social belonging and participation in a community. A weak attachment or no attachment to the labour market typically involves a low income, and can lead to poorer living conditions, health and quality of life. Broad participation in the labour force helps to counteract socioeconomic inequalities.

The government strives for broad participation in the labour force, and has therefore initiated the Inclusion Initiative with the aim of increasing employment among those with disabilities and/or gaps in their CV. Collaboration with relevant actors and investment in measures that make it easier for employers to hire people in the target group are an important part of this work.

The government also escalated its efforts aimed at the under 30s in 2017. Young people who are not in work, education or other meaningful activity within eight weeks of registering with NAV are offered tailored employment-oriented support.

In March 2019, the government submitted a white paper to the Storting on Opportunities for all – Distribution and Social Sustainability (Report to the Storting 13 (2018–2019). The white paper presents the government's efforts to contribute to social sustainability and counteract inequality and the consequences of inequality, including the importance of the labour market, education and social welfare schemes for wealth distribution and opportunities. The white paper also addresses inequalities in health, and democratic and social participation.

In October 2020, the government presented a new cooperation strategy for children and young people in low-income families (2020–2023), 'Equal Opportunities for Children'. The strategy emphasises the importance of increased participation and equal opportunities for the development of children and young people in low-income families. The goal is to stimulate social mobility and break the generational cycle of poverty and low income. The cooperation strategy is a follow-up to the government's strategy 'Children Living in Poverty (2015–2017)'.

The government's integration reform aims to enable more immigrants to secure employment and become active members of society. One of the goals of the government's integration strategy (2019–2022) is for more immigrants to gain a stable and firm foothold in the labour market. The National Insurance income guarantee scheme provides financial security for the unemployed and those who are unable to work. The main purpose of the National Insurance Scheme is to give all citizens financial security, contribute to more equality in income levels and living conditions throughout the individual's life time and between groups of people, as well as to stimulate self-help with a view to financial independence and mastering daily life to the greatest extent possible.

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 authority makes an assessment of the person's overall situation, taking into account any income and income opportunities, necessary living expenses and personal circumstances. The local authority has both a right

and a duty to make discretionary assessments in each individual case. In all assessments, an emphasis is placed on upholding the purpose of the legislation in the best way possible.

The right of appeal against decisions regarding municipal social services and government regulation of the services helps protect the population's legal rights and ensures that the services are run properly. The County Governor is the executive appeal body and supervisory authority and this supervisory role is directly subordinate to the Norwegian Board of Health Supervision. The Norwegian Board of Health Supervision monitors the County Governors' case processing and reports, draws up guidelines and provides regular feedback to the offices in order to ensure that inspections and appeals are carried out appropriately, correctly and quickly throughout Norway. In addition, central government authorities help ensure that local authorities are able to effectively fulfil their responsibility for social services, through measures for skills enhancement and facilitation. Experiences from supervisory work and appeals processes are an important basis for the design of such measures.

Statistics on those at risk of poverty:

	Annual low income 50 per cent (EU equivalence scale)				Annual low income 60 per cent (EU equivalence scale)			
	Population excluding students*		Children under 18 years**		Population excluding students*		Children under 18 years**	
	%	Number	%	Number	%	Number	%	Number
2016	5.5	280 000	6.5	73 000	11.0	560 000	12.3	138 000
2017	5.6	287 000	6.8	76 000	11.2	575 000	12.8	143 000
2018	5.6	289 000	6.9	77 000	11.2	579 000	12.8	142 000

Source: Statistics Norway, Statbank

*Table 06947: Persons in private households with annual after-tax income per consumption unit, by distance to the median income. Excludes students.

**Table 08764: Persons under 18 years of age in private households with annual after-tax income per consumption unit, by distance to the median income.

The general indicator of poverty in Norway is an income which is persistently less than 60 per cent of the annual median disposable equivalised household income over a three-year period, according to the EU's equivalence scale. In the three-year period 2016–2018, 9.8 per cent of the population, about 486 000 people, excluding students, had an income below 60 per cent of the median. In the period 2016–2018, 11.3 per cent of all children lived in households with persistently low incomes. This corresponds to about 111 000 children.

No one lives in extreme poverty in Norway.

Question b)

Please provide information on measures taken to assist persons affected by poverty, social exclusion and homelessness during the COVID crisis, or after the crisis to mitigate its effects.

The objectives of the Social Security Act are to improve living conditions for disadvantaged persons, to promote financial and social security, including giving individuals opportunities to live and reside independently, and to promote the transition to work, as well as social inclusion and an active and meaningful existence in a community with others. The Act shall also help to ensure that vulnerable children and young people and their families are offered uniform and coordinated services. In addition, it is intended to promote greater equality of human worth and social status and to prevent social problems.

The social services aim to uphold the purpose of the law and serve as society's final safety net for individuals facing difficult life circumstances, including during a pandemic. Means-tested financial benefits are provided to cover a reasonable subsistence level. The local authority has both a right and a duty to make discretionary assessments in each individual case. The information, advice and guidance provided by the services shall help to resolve or prevent social problems and shall also be adapted to individual needs. The local NAV administration shall help provide housing for disadvantaged people who are unable to take care of their own interests in the housing market. The local authority has a duty to find temporary housing for those who are unable to do so themselves.