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Public Health Measures Enacted by the Norwegian Political Leadership to Protect the Elderly in Response to the SARS-CoV-2 Pandemic Crisis

ABSTRACT: *The SARS-CoV-2 pandemic crisis is ongoing, and the elderly are still affected by the virus, sometimes with fatal consequences. The political leaders are, inter alia, focussed on protecting citizens, including this vulnerable group. This article aims to describe the response of the Norwegian political leadership, with a focus on the public health measures enacted to protect the elderly during the SARS-CoV-2 pandemic crisis in the years 2020 and 2021. This study has a descriptive qualitative research design using thematic-content analysis as a methodology to evaluate data collected from official documents, national statistics and public health documents from Norway. Statistics show that the elderly mortality rate per 100,000 person-weeks during the first wave of the SARS-CoV-2 pandemic was 2.69 in Norway; during the second wave of the pandemic, it was 1.43. The public health measures the Norwegian political leadership instigated were more effective in containing the crisis when compared to other European countries, and this paper investigates the reasons. The results of our study provide public health policy decision-makers with insights into analytical material showing the usefulness of different measures enacted by the Norwegian government. The Norwegian government's responses to the crisis, such as the public health measures, restrictions, social consequences for vulnerable groups such as the elderly, as well as cross-government and cross-community cooperation, will need further in-depth analysis.*

KEYWORDS: elderly, mortality rates, Norway, SARS-CoV-2 pandemic, political response, public health measures

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INTRODUCTION

SARS-CoV-2, the causative agent of the COVID-19 pandemic, carries a disproportionate risk of infection, disease, morbidity and higher mortality rates in the elderly because of the direct risks caused by their increased vulnerability when considering their latent or indirect risks from sociocultural and demographic factors (Khan et al., 2020; D'Cruz & Banerjee, 2020). Public health measures (such as mask covering, social distancing, vaccination, the duration of quarantine and lockdown, the approach to and frequency for testing, hospital and long-term care visitor policies) and concrete interventions are necessary for reducing fatal consequences for all citizens, including the elderly. Williamson et al. (2021) state that the elderly are clearly among the groups most at risk of serious illness and death from COVID-19. The pandemic and responses to it limit the extent to which the elderly's voices are heard and restrict the considerable contributions they can make to our global response and recovery.

During the pandemic, it was very important to disseminate the information about public health measures in a comprehensible manner to the entire public. As an example, when Norway enforced a lockdown, 5.4 million text message alerts were sent to its citizens and to 300,000 foreign visitors to inform them about lockdown restrictions (NIPH, 2020); these messages were written in all the local and minority languages. Additionally, all the relevant information about health measures was published online in 44 languages, along with short animated films and picture posters, by the Norwegian Institute of Public Health. The country continued to maintain the lockdown, and every Friday, political leaders, standing a significant distance apart and wearing face masks, held open

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conferences in professional, clear and calm voices and shared the importance of compliance with the public health measures. In this way, the political leadership of Norway was an example of ‘good practice’ for their citizens. The SARS-CoV-2 pandemic has brought structural and social issues to light, including the erosion of public trust in government and expert advice, which was compounded by a wave of mis- and disinformation (OECD, 2022). As a result of a pandemic’s dynamic nature, complete transparency concerning the potential risks was – and still is – necessary to ensure a clear definition of, and the quality of, the resulting societal and political response (Nicola, 2020). Additionally, Aasland and Braut (2022) stressed that the collaboration and the method and delivery of communication are crucial factors in handling crises such as the SARS-CoV-2 pandemic.

Haslam et al. (2021) focussed on how political leaders mobilise the population and disseminate public health measures. They used the identity leadership approach to explain how leaders can represent and advance the shared interests of group members and create and embed a sense of shared social identity among them. Several researchers emphasised that the states with female governors who issued early stay-at-home orders had fewer SARS-CoV-2-related deaths than those with male governors who issued the same orders. Subsequent qualitative analyses revealed that female governors cultivated more empathy and confidence through their SARS-CoV-2-related briefings than male governors; for example, the female governors forged deeper connections with their constituents by exhibiting empathy and showing compassion in expressions of concern and care for citizens’ welfare (Sergent & Stajkovic, 2020; Aldrich & Lotito, 2020; Bruce et al. 2022). The principal executive authorities at the national level in Norway during the SARS-CoV-2 pandemic crisis were the Ministry of Health and Care Services (national responsibility for health preparedness; declares a health crisis, thus activating roles of other authorities), the Directorate of Health (coordinates mitigation efforts and implements infection control measures) and the Institute of Public Health (monitors the pandemic situation and supervises and advises state and local authorities on infection control). Many of the political leaders in important positions were female – Prime Minister Erna Solberg and the head of the Norwegian Institute of Public Health Camilla Stoltenberg, together with the Divisional Director of Public Health and Prevention by Norwegian Directorate of Health Linda Granlund. Each leader had an important role and responsibility to convey health measures to citizens. As Boin et al. (2013) explained, the leader’s success in crisis situations depends to a great extent on exercising good judgment; further, Sturm et al. (2017, p. 350) stressed that having sound judgment is an important aspect of effective leadership. Norway’s Directorate of Health was given responsibility for coordinating the health-sector response which started on 31st January 2020, and it kept this role into 2021. When the pandemic crisis turned into a full-blown crisis in March 2020, the Directorate temporarily had extraordinarily extensive decision-making responsibilities due to emergency procedures in the Infection Control Act. Out of convenience, 12th March lockdown decisions were formally enacted by the Directorate, even though the Prime Minister, other government ministers and the Ministry of Health were actively involved in the decision-making process (Askim & Bergström, 2022).

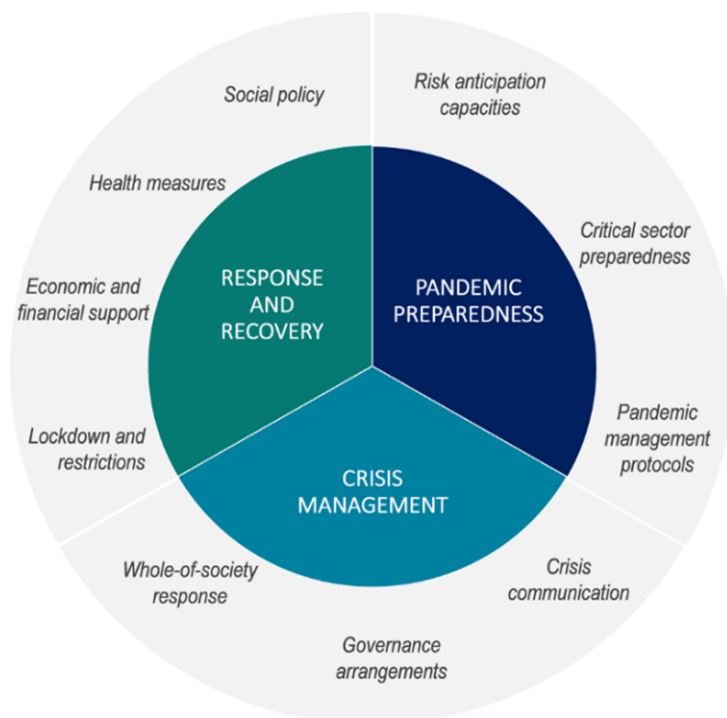
The present article aims to describe the response of the Norwegian political leadership with a focus on the public health measures enacted to protect the elderly during the SARS-CoV-2 pandemic crisis during 2020 and 2021. The following research question was investigated: *How did the Norwegian political leadership respond to the SARS-CoV-2 pandemic crisis in protecting the elderly?* This research study chose a conceptual framework to contribute to the construction of a theoretical body for the analysis of the character of the political leadership response and the instruments and measures that were used in crisis management.

THE CONCEPTUAL FRAMEWORK

For a description of Norwegian policy responses, researchers in this study were inspired by and used one part of the Framework for Evaluating COVID-19 Responses according to the OECD Recommendation of the Council on the Governance of Critical Risks (2014). There are three main policy responses that correspond to the major phases of the risk management cycle: (i) pandemic preparedness, (ii) crisis management and (iii) response and recovery (Figure 1.)

Before declaring SARS-CoV-2 a pandemic, many countries were assessed via the Global Health Security Index (GHSI) for their preparedness for pandemics (Bell & Nuzzo, 2021). According to a WHO report (2020), the United States of America (US) and the United Kingdom (UK) were identified as the most prepared countries in terms of *pandemic preparedness*. Prior assessments of countries such as Norway (16th on the GHS Index) are inconsistent with the actual performance during this pandemic. *Crisis management* is the next major phase in the framework for evaluating; this involves the policies and actions that governments deployed to deal with the crisis once it materialised. Crisis management entails responding appropriately, at the right time and in a coordinated manner across the government. Crisis management also requires clear communication with the public and transparency in decision-

Fig. 1: Framework for evaluating COVID-19 responses according to OECD (2022)



Source: OECD (2022). *First lessons from government evaluations of COVID-19 responses: A synthesis*, p. 5.

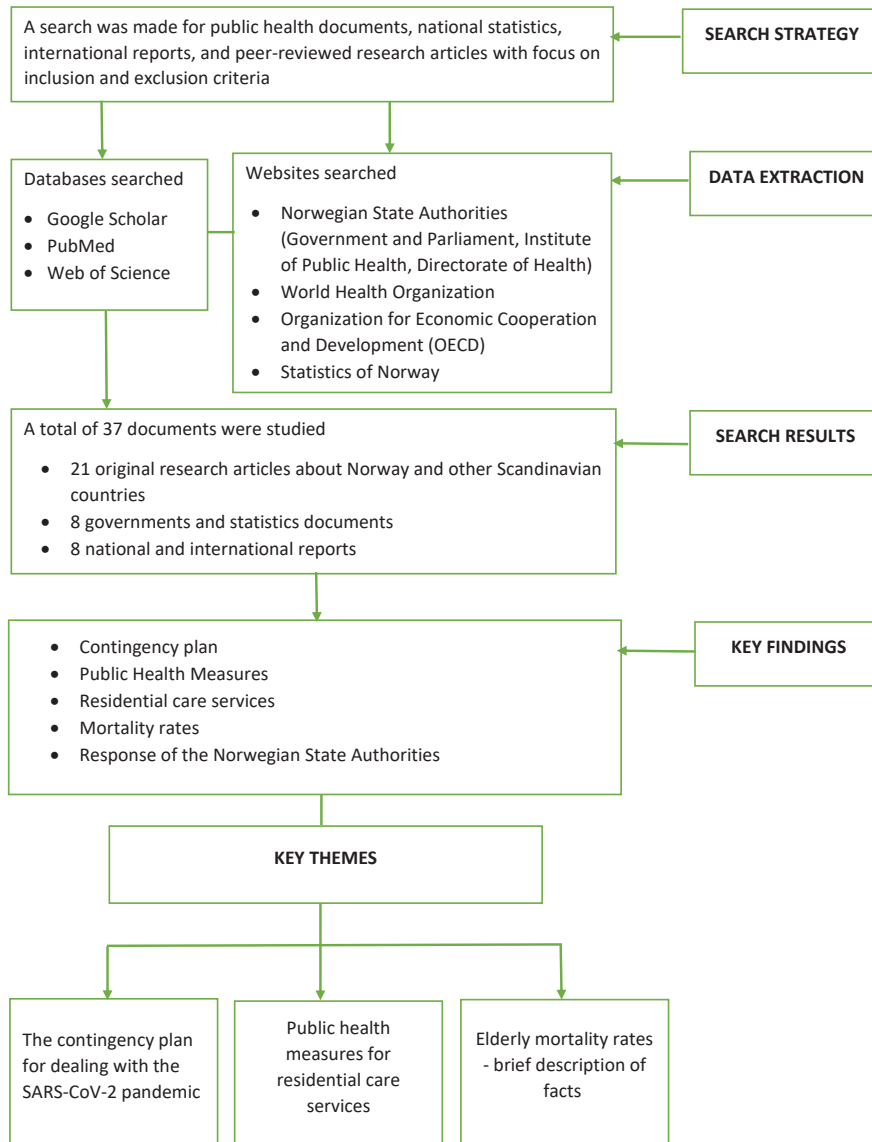
making, particularly as large-scale crises can critically impact people's trust in government (OECD, 2022). Finally, *response and recovery* policies are aimed at mitigating the impacts of the pandemic and economic crisis on citizens and businesses, additionally supporting economic recovery and reducing welfare losses. These policies include lockdowns and restrictions, e.g., general measures taken in order to limit the spread of the virus, economic and financial support to households, businesses and markets to lessen the impact of the economic downturn, health measures aimed at protecting and treating the population, and social policies aimed at protecting the most vulnerable populations (OECD, 2022). As an example of the differences in health measures instigated to protect citizens during the pandemic crisis, it is useful to point out the mixed messages that arose regarding face coverings; while many countries urged people to use coverings or respirators, the Norwegian Institute of Public Health (NIPH, 2020) did not recommend doing so. This split messaging led to uncertainty and sparked fears regarding which precautions should be implemented.

METHODS

This study characterises as a descriptive qualitative research design with the aim of communicating and producing organised information concerning the subject investigated. The methods employed here involved bibliographic survey, analysis of public health policy documents, national statistics, international reports and documents from government agencies in Norway. Public health policy documents are defined in this research as written online documents that contain strategies and priorities, define goals and objectives, and are issued by the part of the public administration responsible for the protection of public health against the SARS-CoV-2 pandemic, with a focus on the elderly population. Although several public health documents are aimed at the general population, these health measures were also analysed because they included the elderly population.

According to Bowen (2009), document analysis is a systematic research technique which uses both printed and electronic materials as the source, analysing them in-depth to extract information and indications relative to the study objective. It is important to note that document analysis is a process involving skimming (superficial examination), reading (thorough examination), and

Fig. 2: Description of the search strategy, data extraction and search results



Source: Authors.

interpretation of the content to provide answers to research questions. The data obtained (e.g., excerpts, quotations or passages) were organised into major themes through thematic analysis to develop empirical knowledge (Green & Thorogood, 2018). Data gathering and analysis were conceptually driven and based on the framework illustrated in Figure 2.

Data collection

Taking into consideration that the main aim is to describe how the responses of the Norwegian political leadership to the SARS-CoV-2 pandemic crisis contributed to the protection of the elderly, the authors chose to analyse the health measures that were implemented to avoid increasing mortality rates in the populations discussed. This way, the focus was specifically on Norwegian State Authorities, including the Norwegian government and Norwegian Parliament websites, and publicly available documents focussing

on the pandemic period. Furthermore, information from the Norwegian Institute of Public Health and Norwegian Directorate of Health and Social Affairs was examined. The international reports published by the World Health Organisation (WHO, 2020) and the Organisation for Economic Cooperation and Development (OECD, 2021–2022) were analysed as a parameter. This type of analysis provided validity to the data obtained.

Other key websites were additionally searched, including the various government agencies in Norway's regional health authorities, as well as online databases, Google Scholar, PubMed, and Web of Science. Only current articles and reports that were available in their entirety were selected for review. In total, 44 documents were initially identified, of which seven were excluded from the further review – four documents were listed as rescinded and three documents were only summaries of original guidelines. The remaining 37 articles, reports, sets of statistical information and public policy documents were then reviewed regarding their recommendations and consideration of the health of the elderly population. Data were collected from March 2022 to June 2022. All the information concerning the methodology is summarised in Figure 2, which describes the search strategy, data extraction and search results. A structured review of Norwegian government documents was carried out relating to the statistics and measures appertaining to the elderly during the SARS-CoV-2 pandemic, specifically identifying within each document:

- Any specific measures to protect elderly citizens
- Any programmes and policies mentioned which reduce mortality rates in the elderly
- The response of the Norwegian State Authorities
- Any overviews of the national mortality statistics of the elderly

The search documents relating to these topics were noted and selected. Search records with document identification were kept, and relevant information was electronically saved, printed, allocated an identification code and sequentially organised into files.

To conduct the search, the following key search terms were used:

- 'healthcare services', 'residential care home', 'institutional care', 'nursing home*', 'health care services', 'nursing facilities', 'health services', 'social care', 'social services' and 'formal care'
- 'age*', 'older', 'elder*', 'old people', 'geriatric' and 'senior'
- Covid-19' 'coronavirus', '2019-ncov', 'SARS-CoV-2', 'cov-19', 'pandemic', '2019 novel coronavirus', 'coronavirus disease' and 'measure*'
- 'government policy', 'public policy', 'government legislation', 'national statistic*', 'public health', 'policy docum*' and 'Norway'

The inclusion criteria were that all the documents yielded had to be the full text (not a summary) and available online between 2020 and 2022. The exclusion criteria were books, chapters, conferences, poster abstracts and any material published before 2020.

Data analysis

We developed a structured data-abstraction instrument to enable us to perform a systematic content analysis of public policy documents. Firstly, all the documents were read completely to familiarise ourselves with the data. Secondly, instrument classification categories representing the different items and subitems that characterise policy format and content were derived inductively through repeated readings of the documents. The formulation and representation of the classification categories were discussed regularly at team meetings. Thirdly, using the data-abstraction instrument, the data analysis was continued to ensure the rigidity and consistency of the coding process; the entire process followed the guidance and requirements set out in Neuendorf's (2017) code book. To enhance the internal validity of the data analysis undertaken, we used the cross-coder assessment method during the coding phase of the content analysis. Cross-coder assessment refers to using more than one coder to code the same content independently before establishing inter-coder reliability for the adoption of the coded units of analysis (Neuendorf, 2017). Three researchers independently coded the presence or absence of each category in a random sample of 16 governmental and statistics documents; one researcher had a social-scientific background (MT), another researcher had a psychological one (VNF), the third had a medical background (MMN) and the fourth had a nursing science education (AS). Categories with coding difficulties between the three researchers were simplified and redefined, and the 16 government agencies' documents were re-coded. The theme and codes examples are as follows:

Theme 1. *Contingency Plan*

Norwegian primary healthcare system

Power distribution on various levels

The government's goals when dealing with the pandemic crisis

Assessment of disease burden and risk

The final data-abstraction instrument contained the following main topics: contingency plan, public health measures for the elderly, institutional care services for the elderly, mortality rates concerning the elderly population and the response of the Norwegian State Authorities.

To increase the objectivity and reliability of the assessment, three researchers independently coded all the documents using the data-abstraction instrument. The three coders initially agreed on 87%, 89% and 91% of the codings for the research objective, thereby establishing an acceptable level of inter-coder reliability. For coding in which discrepancies arose, discussions were held until a consensus was reached and all coding was approved. In cases in which the three researchers could not agree on coding the documents, or had difficulties in interpreting data, a fourth researcher (AS) was invited to review these documents. Coding disagreements were discussed and resolved until a consensus was reached.

ETHICS

All data analysed in this report are publicly available; therefore, no ethical approval was required.

RESULTS

This section presents the contingency plan for dealing with the SARS-CoV-2 pandemic. Furthermore, the represented public health measures for residential care services and brief descriptions of the facts about mortality rates in the country concerning the elderly population are reported. It is important to highlight that the structure of the health system is directly connected with the Norwegian public health response to the SARS-CoV-2 pandemic, since the unified public health system contributes to the better emplacement of public health policies in an equitable way. This phenomenon is clearly demonstrated by the epidemiological data concerning the mortality rates of the elderly population.

The contingency plan for dealing with the SARS-CoV-2 pandemic

The Norwegian health system is a decentralised universal health system with a free-of-choice provider financed by taxes, with a predominantly public production of services covering the population in Norway. Physicians are publicly salaried employees. The state is responsible for the provision of specialised care through four regional health authorities, which further control the provision of specialised health services by 27 health enterprises (Martinussen, 2022). The municipal level organises and finances primary healthcare services according to local demand. The central government has overall managerial and financial responsibility for the hospital sector.

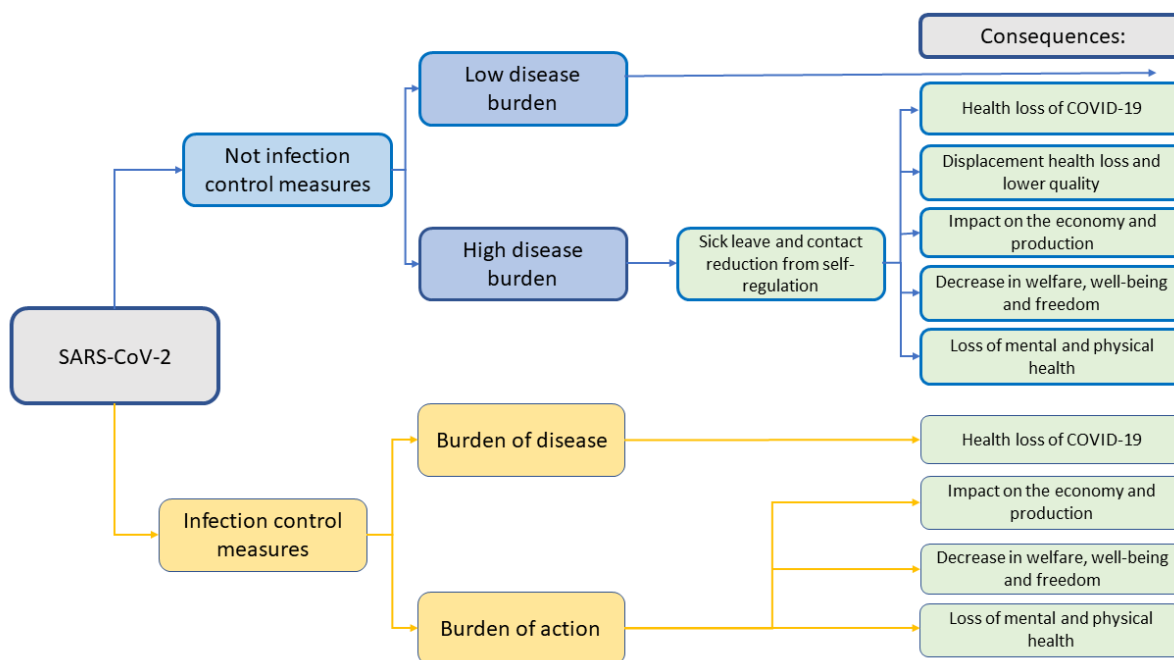
The power distribution of these organisations is divided into two levels: a central one and a local and regional one. The central level, or centralised system level, is composed of a government body, represented by the Ministry of Health and Care. This level directs the Norwegian healthcare services through comprehensive legislation, annual budgetary allocations and various governmental institutions such as the Norwegian Directorate of Health and the Norwegian Institute of Public Health. The regional and local level (or the decentralised system level) is represented by the regional and local authorities in the municipalities across the country. This level has the responsibility for primary care in terms of nursing facilities, residential care homes, home care, ambulatory care and general practitioners. In addition, the regional level takes control over the implementation of the national health policies, including the setup, planning, organisation, governance and coordination of all subordinated local health trusts (hospitals) in their region. This

way, all the levels are interconnected and work in an interdependent way, and all have the freedom to emplace more specific measures considering the epidemiological, sociocultural and special needs of each region (Øyri & Wiig, 2022).

From the central level perspective, the government's goals for dealing with the pandemic were to safeguard life and health while keeping society open and allowing the economy to function as normally as possible. Moreover, the government and the public health agencies focussed on maintaining the population's immunity, keeping the disease burden low, protecting vulnerable groups and prioritising children and young people. These measures were to prepare society in case the situation deteriorated, and in order to maintain this level of preparedness, the government and public health agencies only utilised information and data that are knowledge-based and open in a targeted and coordinated manner. In addition to these internal actions, one of the priority goals going forward is that Norway should further cooperate with global efforts to mitigate the consequences of the pandemic (HOD, 2022). The Norwegian government has also prepared itself for any future pandemic waves until 2023. The government is prepared to decide on the precise steps to be taken based on an overall assessment at the necessary time and when the development of a situation indicates a need for national measures. Decisions must take into consideration the positive and negative societal effects of the pandemic's development in addition to infection control measures, including health, economic and welfare consequences. As far as possible, affected parties will be given the opportunity to comment on the measures. The assessments behind the decisions are to be published. The plan includes a course of action in the case of a serious new virus variant, which would necessitate prioritising the reduction of infection numbers. In the case of a less serious virus variant, health considerations may indicate extensive infection control measures, while other societal considerations could indicate that very burdensome infection control measures need not be implemented.

According to the documents analysed when assessing measures, the duration of any course of action needs to be considered. The Ministry of Health and Care Services has produced a flow chart for mapping the effects of two alternative strategies in the face of a SARS-CoV-2 pandemic – one strategy using infection control measures to control or kill the infection and the other letting the infection spread through the population. If the costs of infection control measures are greater than the gain, the avoided loss of health by fewer people would deem it economically unprofitable to introduce measures. The most important benefits of introducing the measures are first and foremost the costs avoided, including the societal cost. The flow chart is presented in Figure 3.

Fig. 3: Map effects of the two alternative Norwegian strategies when facing a SARS-CoV-2 pandemic



Source: The Norwegian Directorate of Health (2022, pp. 15–16).

Assessment of disease burden constitutes a baseline in the assessment of risk as a starting point as to whether measures should be implemented. At this point, the local and regional levels have more freedom to access the data and implement measures recommended by the central level, based on epidemiological criteria. For the assessment of disease burden, there is a need for an overview of the national and local situation, as the assessment must include treatment capacity in both the specialist health service and the municipalities. The capacity of the municipalities can be overwhelmed before the capacity of the specialist health service. Municipalities are responsible for primary care and public health, including general practitioners (GPs), immunisation centres, and long-term care and social services. The vulnerable population evaluated in this article – elderly people – live in their own homes or in nursing facilities and residential care homes throughout the various municipalities. Prevention measures for these citizens, according to the ‘Strategy and Contingency Plan for Handling the COVID-19 Pandemic’ (HOD, 2021), use the following specific management indicators as a basis for assessing risk and the need, if necessary, to implement measures:

- The number of new hospital admissions and number of concurrently admitted patients (total occupancy)
- The occupancy rate in intensive care units
- The age distribution of the inpatients
- The processing capacity in the municipalities (HOD, 2021, p. 19)

The assessment of risk must also be seen in connection with other burdens on the services, such as influenza and other respiratory infections. It must be based on a comprehensive assessment of the total burden on the health service at that time and the development of the epidemic.

Public health measures for residential care services

The Norwegian Directorate of Health, along with the Norwegian Institute of Public Health, was responsible for publishing guidelines for residential care services during the pandemic. The first SARS-CoV-2-related guidelines for nursing homes were published on 29th February 2020. The advice was to treat infected residents on-site to avoid hospitalisations, as far as possible. A ban on nursing home visits applied from 12th March to 27th May 2020. Additionally, some nursing homes instituted bans on their staff working in multiple sites to reduce the risk of contagion. In February 2021, restrictions on nursing home visits were relaxed since most nursing home residents had been fully vaccinated. While exact figures are not available, an estimated half of all SARS-CoV-2-related deaths in 2020 were in nursing homes. Overall, 3% of all nursing home residents were infected in 2020 and 1% died (NIPH, 2021).

Another document was released on 3rd April 2020 in the form of a video with advice on dealing with SARS-CoV-2 in long-term care (LTC) facilities. Relevant information we extracted from the content analysis showed that care services were notified that special efforts were being taken to ensure sufficient access to personal protective equipment (PPE) in the municipalities, including the LTC facilities. This was ensured through the national distribution of PPE among the hospitals and municipalities, which was based on the reported stock (Saunes et al., 2022). In Norway, the municipalities are responsible for providing reasonable, high-quality primary healthcare, LTC and social services to everyone in need. All health and care institutions are required to have an infection control programme that gives written guidelines for general infection control measures and for the examination, treatment and care of patients (Kirkevold et al. 2020). In each residential care home, there must also be a system for monitoring infections at institutions and guidelines for detecting and restricting outbreaks of infection. The system must be designed to ensure that infections can be quickly discovered and identified, and it must be clear who has the medical and organisational responsibility for the infection control measures.

According to Ursin et al. (2020), the elderly and those with compromised immune systems or with long-term conditions were particularly affected by the regulations. Norway’s Infection Control Act authorises the government to make binding decisions and implement quarantine, travel bans and other tough measures in the case of a health crisis, and many such restrictions were implemented. However, for many of the families of these groups, the fact that they were unable to visit, or finding that those they loved died alone, was a significant source of anxiety and further grief. To address this issue and relieve social stress, the government announced on 27th May 2020 that visits by family members to residential facilities would be allowed (Ursin et al., 2020).

Elderly mortality rates – a brief description of the facts

According to the Norwegian Institute of Public Health's daily report (2022), SARS-CoV-2-associated deaths were defined as deaths where SARS-CoV-2 is indicated as an underlying or contributing cause of death (NIPH, 2022). Data concerning deaths were extracted on 5th July 2022. Whereas only deaths with a positive sample were previously included in the Message System for Infectious Diseases (MSIS in Norwegian), deaths without a positive test are now also included in MSIS. For each death in the Cause of Death Register, only one underlying cause of death is selected. The National Institute of Public Health follows rules formulated by the WHO for selecting this underlying cause of death. It is not possible to say that the underlying cause of death is the most important factor leading to the actual death without being able to say how much any other maladies may have contributed. If multiple causes of death are applied to the death notification, the disease or diseases that are not registered as the underlying cause of death will be registered as contributing causes of death. Whether SARS-CoV-2 becomes the underlying or contributing cause of death depends on where the doctor applies the diagnosis codes on the death notice. This decision is up to the individual medical doctor.

Until 31st December 2020, there were 31,981 nursing home patients in Norway (SSB, 2021). In 2020, the average age of a deceased person was 81 years old; the median age was 84 years and 241 (52%) were men. One hundred and seventy (37%) deaths in hospitals, 270 (59%) in other health institutions and 10 (2%) in the person's own home were reported to the National Institute of Public Health. The place of death is not stated for 11 (2%) deaths (FHI, 2020). On 15th June 2020, the Norwegian Institute of Public Health's daily report on COVID-19 presented an overview of SARS-CoV-2-related deaths according to the place of death (Saunes et al., 2022). Of the 242 registered COVID deaths up to that date, 93 deaths (38%) occurred in hospitals, 143 deaths (59%) in other healthcare institutions (including LTC) and 1 death occurred at a patient's home. Danielsen et al. (2022) confirmed that in the first year of the pandemic, 0.69% of all nursing home residents became infected by SARS-CoV-2 and 1.3% of all deaths in nursing homes were related to COVID-19.

DISCUSSION

The public health professionals and their mutual collaboration with political leaders play an important role in policy development and provide knowledge of health systems, including making recommendations when change is warranted and developing plans to address various societal situations in connection with public health protection. During a pandemic crisis, trust contributes to adherence to health guidelines, such as social distancing and wearing face masks, additionally reducing the spread of misinformation, fostering support for and adherence to the lockdown-encouraged vaccination, and facilitating a greater sense of community (Sibley et al., 2020; Cairney & Wellstead, 2021; Lalot et al., 2022). The main aim of each country's political leadership during the outbreak of the SARS-CoV-2 pandemic was to bring the pandemic under control as effectively as possible with as little as possible impact on its citizens.

Public health measures for residential care services, the level of restrictions in long-term care and the composition of personnel, professional training and personal protective equipment in different countries at the start of the pandemic all varied; this is also true of the times at which the restrictions were eased and their duration. Norway's relative success in handling the pandemic during the first year has been attributed to factors such as rapidly implemented containment measures, geographical location, low population density, high levels of trust in government and generous social welfare arrangements (OECD, 2021). Healthcare personnel are mentioned as crucial participants in the containment of the virus. Their willingness to follow and put into effect the necessary measures is crucial to encouraging individuals to implement and adopt the necessary restrictions. In Norway, researchers confirmed that having a permanent, stable staff who do not work in other locations is perhaps the most important improvement that can be made to control infection, and this could reduce mortality (Kirkevold et al. 2020).

Gautun (2022) continues that Norway and Denmark had a slower spread of infection and fewer deaths in elderly care in relation to COVID-19 than other European countries. Both these countries implemented a national lockdown quickly, which may have had some bearing on these results. This early lockdown was critical at the start of the pandemic when residential care services in many countries, such as nursing homes, lacked infection control equipment and test equipment. Askim & Bergström (2022) drew attention to the fact that Norway's response was more influenced by gerontology-related science compared to Sweden's response, which was more influenced from a public health perspective. The central government response in Norway included swifter and more

decisive moves to restrict outsider access to elderly care institutions and a far higher presence of doctors and trained nurses in elderly care (Kvinnslund et al. 2021, p. 345).

In Norway, the mortality rates in the first and second waves of the pandemic were among the lowest in the world. The first wave of SARS-CoV-2 cases was curbed through a national lockdown introduced in mid-March 2020, and Norway was one of the first countries to start gradually reopening society in April, with no new rise in cases observed until late summer. The second wave saw less restrictive containment measures, although a rise in cases in March 2021 demanded national restrictions. In contrast to most EU countries, death rates were lower through the second wave than through the first. The SARS-CoV-2 death rates in 2020 were nearly nine times lower than the EU average, and no excess mortality was observed (OECD, 2021). By investigating the national statistics and the government communication of pandemic measures to its citizens, and especially to the nursing homes and residential care services, the analysis shows that the initial use of regulatory instruments was sufficient in the first wave. Despite the lack of preparedness in some aspects, Norway has arguably performed well in handling the pandemic quickly and effectively compared to other countries. One explanation is that the government succeeded in making the objective of crisis management ‘United We Stand’, and therefore had a successful collaboration in decision-making with health experts (Christensen & Lægheid, 2020). The Norwegian public, as is the case in other Scandinavian countries, expresses a high degree of confidence in the government, and this confidence was largely maintained during the pandemic (Christensen & Lægheid, 2020; Petrov et al. 2020; Laage-Thomsen & Frandsen, 2022). The Norwegian government actively appealed to its population to launch a collective action in the fight against the pandemic, and today we can, based on data analysis, conclude that the Norwegian government succeeded in its aim.

Saunes et al. (2022) emphasised that extensive reliance on giving recommendations, rather than forcing through legislation, led to fewer formal restrictions in the first phase of the pandemic in Nordic countries compared with much of the EU/EEA. In general, restrictions on internal mobility were very limited in time and area. Bans on visits to nursing homes and hospitals were only enforced strongly for a few months. Additionally, many political leaders supported the restrictions, regardless of their political standing, which helped the heads of the government remain steadfast. According to Christensen & Lægheid (2020), in March 2020, Norway invoked the National Preparedness Act, which accredited the government with the power to establish countrywide decisions on various restrictions. According to Aasland & Braut (2022), the Norwegian role of county governor has specified responsibilities during an emergency situation, including being the chairperson of the County Emergency Council (CEC). The main factor in the successful coordination of the public health response is the governors’ ability to support the municipalities and the local communities, balancing the need for independence against the need for state control. Karlsen et al. (2022) highlighted that municipal public health coordinators (PHCs) are an important ‘tool’ for providing local intersectoral public health work. The founders of the social services facilities are the municipalities, and thus, the ability of the governors to coordinate work on measures against the spreading of the pandemic had a direct impact on the protection of those placed in these facilities. Norway’s leadership communicated the importance of responsibility, nationhood, patriotism and the sense of valuing communication in the community (Christensen & Lægheid, 2020). Communication should cultivate a sense of belonging; in the case of Norway, talking about the love of their country and nationalism inspired many individuals to respond positively to the government’s requirements.

There are several limitations and strengths to this study that should be noted. The results strengthen knowledge transfer by relating the results and experiences of a country which had low death rates as a result of the SARS-CoV-2 pandemic. Our methodology is feasible and can be reliably replicated in future updated reviews, or similar comparative research in EU countries could be carried out. Norway, a European country, managed to competently take care of and protect vulnerable groups, including the elderly, and thus this country has become a good example of how to manage a pandemic or other crises. Several limitations should be considered when interpreting these results. Due to the ongoing nature of the SARS-CoV-2 pandemic, our data collection was deliberately restricted to public health websites and national statistics reports. The list of policy documents identified for this analysis is not exhaustive, and more recent documents might have been published during the submission process of this article. Other public health or government documents might also not have been identified during the research stage. A wider range of documents (e.g., research articles or annual reports) may provide additional insight as to the range of consequences of the SARS-CoV-2 pandemic. A further limitation of this study is that we relied on the cause of death from the registries for COVID-19-associated mortality, which is dependent on the registration of COVID-19 among those who died.

CONCLUSIONS

The public health measures enacted by the Norwegian political leadership to protect the elderly in response to the SARS-CoV-2 pandemic crisis necessitated collaboration with public health professionals when they focussed on reducing the elderly mortality rates through contingency plans for dealing with the SARS-CoV-2 pandemic. This collaboration contributed to the success in containing the crisis as it unfolded and was beneficial in drawing up the recovery policy aimed at mitigating the impacts of the pandemic situation. The results of the authorities' actions provide decision-makers from public health policy with insights to draw upon for political discussion to further improve on the Norwegian government's responses to crises. Further research is required to examine the experiences of the leaders of residential care services in connection with how they reflected on measures impacting the social and healthcare services and mortality rates of the elderly during the SARS-CoV-2 pandemic; such research could be performed through in-depth interviews. Furthermore, the Norwegian policy responses, such as public health measures, restrictions, the social consequences for vulnerable groups such as the elderly, and cross-government and cross-community cooperation, will all need further analysis.

Despite posing new challenges, Norwegian leadership has deployed significant efforts to respond to the SARS-CoV-2 pandemic crisis. The impact of their public health measures in protecting the elderly during the SARS-CoV-2 pandemic crisis can be a good practice example for other countries. The collaboration of the political leaders, mutual communication and the level of citizens' trust in political leaders are fundamental preconditions for successfully preventing the spread of a contagion during a pandemic or potential pandemic. The findings of this study contribute to a better understanding of the connection between the political responses and public health measures, as well as a way to disseminate information and the impact of implemented public health measures provided by residential care services towards the elderly.

REFERENCES

- Aasland, T., & Braut, G. S. (2022). Independence, trust, and loyalty. The county governor's coordination of public and voluntary resources in crises in Norway. *Journal of Contingencies and Crisis Management*, 1–11.
- Aldrich, A. S., & Lotito, N. J. (2020). Pandemic Performance: Women Leaders in the COVID-19 Crisis. *Politics & Gender*, 16(4), 960–967.
- Askim, J., & Bergström, T. (2022). Between lockdown and calm down. Comparing the COVID-19 responses of Norway and Sweden. *Local Government Studies*, 48 (2), 291–311.
- Bell, J. A., & Nuzzo, J. B. (2021). Global Health Security Index: Advancing Collective Action and Accountability Amid Global Crisis, 2021. Available https://www.ghsindex.org/wp-content/uploads/2021/12/2021_GHSIndexFullReport_Final.pdf (August 2022).
- Boin, A., Kuipers, S., & Overdijk, W. (2013). Leadership in Times of Crisis: A Framework for Assessment. *International Review of Public Administration*, 18 (1), 79–91.
- Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative research journal*, 9, 27–40.
- Bruce, R., Cavgias, A., Meloni, L., & Remigio, M. (2022). Under pressure: Women's leadership during the COVID-19 crisis. *Journal of development economics*, 154, 1–10.
- Cairney, P., & Wellstead, A. (2021). COVID-19: effective policymaking depends on trust in experts, politicians, and the public. *Policy Design and Practice*, 4(1), 1–14.
- Christensen, T., & Laegreid, P. (2020). Balancing Governance Capacity and Legitimacy: How the Norwegian Government Handled the COVID-19 Crisis as a High Performer. *Public Administration Review*, 80(5), 774–779.
- Danielsen, A. S., Cyr, P.-R., Berg, T. C., Jønsberg, E., Eriksen-Volle, H.-M., & Kacelnik, O. (2022). Register-based surveillance of COVID-19 in nursing homes. *Tidsskr Nor Lægeforen*, 1–8.
- D'Cruz, M., & Banerjee, D. (2020). 'An invisible human rights crisis': The marginalization of older adults during the COVID-19 pandemic - An advocacy review. *Psychiatry Res*, 292, 1–9.
- Gautun, H. (2022). Elderly care during the pandemic: Norway and Denmark stand out. Available <https://www.oslomet.no/en/research/featured-research/elderly-care-during-pandemic-norway-denmark-stand-out> (November 2022).
- Green, J. & Thorogood, N. (2018). Qualitative methods for health research. SAGE, 2018.
- Haslam, S. A., Steffens, N. K., Reicher, S. D., & Bentley, S. V. (2021). Identity Leadership in a Crisis: A 5R Framework for Learning from Responses to COVID-19. *Social issues and policy review*, 15(1), 35–83.

- Helse- og Omsorgsdepartement HOD. (2021). The Norwegian Directorate of Health. Strategi og beredskapsplan for håndtering av covid-19-pandemien. Normal hverdag med økt beredskap (Translated to English: The Government's strategy and contingency plan for dealing with the covid-19 pandemic. 'Normal everyday life with increased preparedness'). https://www.regjeringen.no/contentassets/236099613f534684ba61b6b6c35ec55a/210927_strategi_beredskapsplan_c19.pdf (May 2022).
- Helse- og Omsorgsdepartement HOD. (2022). The Norwegian Directorate of Health. Regjeringens strategi og beredskapsplan for håndtering av covid-19-pandemien. (Translated to English: The Government's strategy and contingency plan for dealing with the covid-19 pandemic). https://www.regjeringen.no/contentassets/c774cd9f6c8a42e7ab264db24f0b5b8f/220405_regjeringens_strategi_beredskapsplan_c19.pdf (Juni 2022).
- Karlsen, T.-I., Kiland, C., Kvåle, G., & Torjesen, D. O. (2022). 'Health in All Policies' and the Urge for Coordination: The Work of Public Health Coordinators and Their Impact and Influence in Local Public Health Policies: A Cross-Sectional Study. *Societies*, 12(1), 11.
- Khan, S., Siddique, R., Shereen, M. A., Ali, A., Liu, J., Bai, Q., Bashir, N., & Xue, M. (2020). Emergence of a Novel Coronavirus, Severe Acute Respiratory Syndrome Coronavirus 2: Biology and Therapeutic Options. *Journal of clinical microbiology*, 58(5), e00187–20.
- Kirkevold, Ø, Eriksen, S., Lichtwarck, B., & Selbæk, G. (2020). Infection control at nursing homes during the COVID-19 pandemic. *Sykepleien Forskning*. 2020 (15), 1–19.
- Kvinnslund, S. et al. (2021). Myndighetenes Håndtering Av Koronapandemien. Rapport Fra Koronakommisjonen. (Translated to English: The authorities' handling of the corona pandemic. Report from the Corona Commission). Oslo: Prime Minister's Office. NOU 2021: 6.
- Laage-Thomsen, J., & Frandsen, S. L. (2022). Pandemic preparedness systems and diverging COVID-19 responses within similar public health regimes: a comparative study of expert perceptions of pandemic response in Denmark, Norway, and Sweden. *Global Health*, 18(3), 1–18.
- Lalot, F., Heering, M. S., Rullo, M., Travaglino, G. A., & Abrams, D. (2022). The dangers of distrustful complacency: Low concern and low political trust combine to undermine compliance with governmental restrictions in the emerging Covid-19 pandemic. *Group Processes & Intergroup Relations*, 25(1), 106–121.
- Martinussen, P. E. (2022). Let's stick together: The role of self-interest and ideological beliefs for supporting a 'solidaristic' health policy in Norway. *Health Policy*, 126(3), 262–268.
- Neuendorf, K. A. (2017). The Content Analysis Guidebook. 2nd Edition. SAGE.
- Nicola, M., Alsafi, Z., Sohrabi, C., Kerwan, A., Al-Jabir, A., Iosifidis, C., Agha, M., & Agha, R. (2020). The socio-economic implications of the coronavirus pandemic (COVID-19): A review. *International journal of surgery*, 78, 185–193.
- Norwegian Institute of Public Health (2020). Weekly report. [Internet] Norwegian institute of public health, Oslo (2020). Available from: <https://www.fhi.no/publ/2020/koronavirus-ukerapporter/> (November 2022).
- Norwegian Institute of Public Health (Folkehelseinstituttet). (2021, 2022). Infection control advice for the population. <https://www.fhi.no/en/op/novel-coronavirus-facts-advice/facts-and-general-advice/infection-control-advice-for-the-population/> (April 2022).
- OECD. (2022). The first lessons from government evaluations of COVID-19 responses: a synthesis. Available at <https://www.oecd.org/coronavirus/policy-responses/first-lessons-from-government-evaluations-of-covid-19-responses-a-synthesis-483507d6/#figure-d1e237> (October 2022).
- OECD - European Observatory on Health Systems and Policies (2021). Norway: Country Health Profile 2021, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels. <https://www.oecdilibrary.org/docserver/6871e6c4-en.pdf?expires=1658330373&id=id&accname=guest&checksum=9731DD954F-4093D9EAB96839B4D738DD> (May 2022).
- Petrov, A. N., Hinzman, L. D., Kullerud, L., Degai, T. S., Holmberg, L., Pope, A., & Yefimenko, A. (2020). Building resilient Arctic science amid the COVID-19 pandemic. *Nature Communications*, 11(1), 1–4.
- Saunes, I. S., Vrangbæk, K., Byrkjeflot, H., Jervelund, S. S., Birk, H. O., Tynkkynen, L. K., Keskimäki, I., Sigurgeirsdóttir, S., Janlöv, N., Ramsberg, J., Hernández-Quevedo, C., Merkur, S., Sagan, A., & Karanikolos, M. (2022). Nordic responses to Covid-19: Governance and policy measures in the early phases of the pandemic. *Health policy (Amsterdam, Netherlands)*, 126(5), 418–426.
- Sergent, K., & Stajkovic, A. D. (2020). Women's leadership is associated with fewer deaths during the COVID-19 crisis: Quantitative and qualitative analyses of United States governors. *Journal of Applied Psychology*, 105(8), 771–783.
- Sibley, C. G., Greaves, L. M., Satherley, N., Wilson, M. S., Overall, N. C., Lee, C., Milojev, P., Bulbulia, J., Osborne, D., Milfont, T. L., Houkamau, C. A., Duck, I. M., Vickers-Jones, R., & Barlow, F. K. (2020). Effects of the COVID-19 pandemic and nationwide lockdown on trust, attitudes toward government, and well-being. *The American psychologist*. 75(5), 618–630.
- Statistics Norway. (2021). Care services. <https://www.ssb.no/en/helse/helsetjenester/statistikk/sjukeheimar-heimetenester-og-andre-omsorgstenester> (February 2022).

Sturm R. E., Vera D., Crossan M. (2017). The entanglement of leader character and leader competence and its impact on performance. *The Leadership Quarterly*, 28(3), 349-366.

Ursin, G., Skjesol, I. & Tritter, J. (2020). The COVID-19 pandemic in Norway: The dominance of social implications in framing the policy response. *Health Policy and Technology*. 9(4), 663-672.

Williamson, C. Albone, R., Veitch, G., Juergens, F., Galvani, F., Duffield, J., Mihnovits, A., Stovell, J., Sleaf, B., & Timlin, A. (2021). *Bearing the brunt*. HelpAge International. London.

World Health Organisation. (2020). Coronavirus disease (COVID-19) India Situation Report - 26 [Internet] World Health Organ. (2020) Available from: https://www.who.int/docs/default-source/wrindia/situation-report/india-situation-report-26.pdf?sfvrsn=a292c9c5_2 (February 2022).

Øyri, F. S., & Wiig, S. (2022). Articulating Concepts Matters! Resilient Actions in the Norwegian Governmental Response to the COVID-19 Pandemic; Comment on 'Government Actions and Their Relation to Resilience in Healthcare During the COVID-19 Pandemic in New South Wales, Australia and Ontario, Canada'. *International Journal of Health Policy and Management*. 11(9), 1945-1948.