

Nordic responses to covid-19 from a health promotion perspective

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Summary

On 30 January 2020, the disease covid-19 was declared by the World Health Organization to be an international threat to human health and on 11 March 2020, the outbreak was declared a pandemic.

The aim of this study was to analyse policy strategies developed by the five Nordic countries during the first 3 months of the pandemic from a health promotion perspective in order to identify Nordic responses to the crisis. Although the Nordic countries have a long tradition of co-operation as well as similar social welfare policies and legislation, each country developed their own strategies towards the crisis. The strategies identified were analysed from a health promotion perspective emanating from five principles: intersectorality, sustainability, equity, empowerment and a lifecourse perspective.

Denmark, Finland and Norway had lockdowns to varying degrees, whereas Sweden and Iceland had no lockdowns. Iceland implemented a test and tracking strategy from the very beginning. All countries based their recommendations and restrictions on appeals to solidarity and trust in institutions and fellow citizens. The analysis showed that the strategies in all countries could be related to health promotion principles with some differences between the countries especially regarding equity and sustainability. The Nordic governments took responsibility for protecting their citizens by developing policy strategies based on restrictions and recommendations congruent with the principles of health promotion. The findings also identified issues that will pose challenges for future pandemic strategies.

Key words: health promotion, Nordic countries, covid-19, policy strategies

INTRODUCTION

On 30 January 2020, the disease covid-19 was declared by the World Health Organization (World Health Organization 1986, 2016) to be an international threat to human health, and on 11 March, the outbreak of the SARS-CoV-2 virus was declared a pandemic (<https://www.euro.who.int>).

Decades ago, the American historian Charles Rosenberg proposed an analytical perspective to epidemics. We argue that the analysis he proposed also encompasses pandemics and can explain the responses to covid-19 we observed. Rosenberg depicts how epidemics can be understood as events that take a ‘dramaturgic form’ and follow a specific plot line which reveals ‘fundamental patterns of social value and institutional practice’ [(Rosenberg, 1989), p. 2]. An epidemic as a social event can be understood as happening in three acts. Act 1 entails a progressive revelation, characterized by subtle concerns and disparate warnings from researchers, governmental hesitation and a general indifference among the population. Act II, called ‘managing randomness’ by Rosenberg [(Rosenberg 1989), p. 4], is characterized by increased concern for management and public order built on a specific rationale. Finally, Act III, which he called ‘negotiating public response’ [(Rosenberg, 1989), p. 7], asks civil society to adopt the restrictions implemented by the state. In this article, we focus on Act II, i.e. the national concerns for management and public order regarding the pandemic.

In the search for ‘managing randomness’, the Nordic countries each developed policy strategies in order to develop a public response to the contemporary health crisis of covid-19. These strategies included measures like restrictions, recommendations and guidelines to be followed collectively and individually. As researchers embedded in Health Promotion research, we observed the different Nordic countries’ immediate responses to the pandemic crisis and developed a curiosity about specifically two questions: Which strategies did the Nordic countries develop in order to manage the health crisis, and based on what rationales and values? Which elements of guiding principles of health promotion were included?

The aim of the study was thus to describe the policy strategies developed by the five Nordic countries during the first 3 months of the pandemic and to analyse these responses from a health promotion perspective.

THE ROLE OF HEALTH PROMOTION IN A PANDEMIC CRISIS

International scholars argue that health promotion plays an essential role when dealing with covid-19. Saboga-

Nunes *et al.* emphasize that ‘(..) this crisis underscores the need for strong public systems, as well as the critical role of health literacy in promoting population health, and the need for effective communication and community mobilization efforts to enhance protective and self-care behaviours and measures at a societal, community and individual level’ [(Saboga-Nunes *et al.*, 2020), p. 3].

Similar advice is given in an editorial focusing on the role of health promotion in a pandemic crisis in Health Promotion International (Van den Broucke, 2020). In fact, the health promotion principles of intersectorability, sustainability, equity, empowerment and the life-course perspective have never been more relevant for promoting health in the current pandemic crisis (Saboga-Nunes *et al.*, 2020). This pandemic has put an extraordinary strain on public order and social cohesion and is a severe challenge for all nations and their governments, as well as for individual citizens. As Gulis (Gulis, 2020) highlights, the pandemic crisis re-actualized the relevance of health promotion as it was once defined in the Ottawa Charter (WHO, 1987) with the goal of enabling people to gain control over their health. Intersectorality, and by this community action and action across sectors, has proven to be of high importance in national responses to the pandemic (Saboga-Nunes *et al.*, 2020). Civic engagement seemed more important than ever, which once again emphasized the importance of not only clear communication and information but also structures that facilitate empowerment. The principles of a lifecourse perspective and equity were also important principles in the risk management of the pandemic.

THE NORDIC WELFARE CONTEXT

The Nordic countries (Denmark, Finland, Iceland, Norway, Sweden and the autonomous regions Faroe Islands, Greenland and the self-governing province of the Åland islands) have a long tradition of co-operation. The countries share historical events that are seen as constituting a ‘Nordic culture’, the countries have (at least originally) similar social welfare policies and legislation, a common labour market and Nordic residents can move freely across the borders. Each country has its specific language but (for the most part) share a common linguistic heritage, which gives Nordic citizens the possibility of communicating across borders.

The Nordic countries rank high in international evaluations, such as the Health Development Index, which measures quality of life through factors like social cohesion and social inequalities (<http://hdr.undp.org/en/data> last accessed 03 January 2022). They all have well-

functioning universal healthcare services, and also have public health policies in place that embrace health promotion principles (Fosse and Helgesen, 2019). Raphael and Bryant state that the Nordic countries ‘provide leadership in implementing policies and practices consistent with WHO principles of health promotion at the national, regional and municipal levels’ [(Raphael and Bryant, 2020), p. 373]. They also emphasize that there are good outcomes of the Nordic welfare model (Raphael and Bryant, 2020). In addition, the WHO commission on the social determinants of health has pointed to the Nordic states as being good at addressing these health determinants (Commission on Social Determinants of Health, 2008).

The Nordic countries have long traditions of social welfare policies, and are known to have lower levels of income inequality than most countries (Esping-Andersen, 1990) and high levels of equality materially, educationally, and in terms of health and well-being. The social welfare policies are characterized as belonging to a social-democratic welfare regime based on principles of solidarity, universalism and a de commodification of rights. As Esping-Andersen notes, the different Nordic countries blend in different elements of socialism and liberalism when providing social welfare (Esping-Andersen, 1990). This model still has a high legitimacy among the citizens in these countries, and the level of trust (which is said to be a necessary ingredient for a functioning welfare system) between the population and the authorities is generally high (Holmberg and Rothstein, 2017). Studies have demonstrated a strong correlation between trust and equity in the Nordic countries (Reiersen and Torp, 2020).

Based on the characteristics mentioned above, it could be expected that the Nordic countries would manage well in a pandemic. By ‘manage well’, we mean that governments would take responsibility for protecting their citizens, that the populations would adhere to guidelines and recommendations to prevent the spreading of the virus, and that the healthcare systems would be able to cope and to protect vulnerable groups of citizens.

The administration of health in the five Nordic countries

A trait shared by all five countries is the split responsibility between different levels of government for the administration and governance of health. Health is administrated and promoted on national, regional and municipal levels and is thus provided from a whole-of-government approach.

A key actor in the administration of health is each country’s ministry of health, which has the overall responsibility

for regulating and supervising the health and care services. The health ministries in all the Nordic countries are supported by national institutes or agencies, which provide research-based information on matters of public health. An important difference between the Nordic countries, however, is the level of interdependency between expertise and governments. According to the Swedish Constitution [Svensk författningssamling (SFS), 1974:152] the government is not allowed to intervene in the authorities’ decisions. The idea of the authorities as independent, professional specialist authorities weighs heavily in Swedish administrative and political tradition. As highlighted, in the discussion of this article, this can perhaps explain the Swedish difference compared with the other Nordic countries’ search for ‘managing randomness’.

Regarding the administration of primary healthcare and the promotion of health, local governments in Finland and Norway, regions in Denmark and Sweden, are made responsible. In Iceland, the state is primarily responsible for all healthcare including health promotion. Local authorities (municipalities) in the four countries where the administration of primary healthcare and the promotion of health are governed on a local or regional level have a high degree of autonomy and thus responsibility for the local conditions and health policy. Health promotion is in general in focus on a national policy level. A common trait in the national health policies in Finland, Norway, Iceland and Sweden is emphasis on the health-promoting principle of creating societal conditions for good and equal health. The Danish health policy sets its focus on an effective healthcare system as well as on reducing social inequality in health. All five governments adhere to the aim of better health for all through a whole-of-society approach to the promotion of health.

AIM

Our aim was to identify the policy-level strategies the five Nordic countries took to address the pandemic from a health promotion perspective in the first three months after the first cases were confirmed in late February 2020. To this end, we conducted a comparative study focusing on the design of policies in each country. The study was framed according to the following research questions: What were the different policy strategies in the Nordic countries? What/who were the main institutions/actors involved in the strategies? What were the aims of these strategies? Were these strategies coherent with the principles of health promotion? The first step was to identify the national policy strategies to get a picture of the similarities and differences among the Nordic

countries. The second step was to analyse these strategies from the perspective of health promotion.

MATERIALS

The scope of the study included analysis of policy documents, such as regulations, recommendations and guidelines. Official speeches by various spokespersons and press releases were also included.

The qualitative research methods of document analysis (Yin, 1989; Flick, 2009) uses documents as data source. Documents analysed in this study include policy documents outlining the policy strategies developed with the aim of controlling the spread of the virus and protecting vulnerable citizens. There are two different types of comparative studies of such documents, one with a focus on institutional design, and the other on policy instruments applied for implementing the policy design (Vining and Weimer, 1998). Because the interest of this study was in *what* policy strategies were developed in order to ‘manage randomness’ [(Rosenberg, 1989), p. 2] and how or whether these cohere with principles of health promotion, the study primarily focused on the content of the policies. This analytical focus resulted in a content analysis (Hsieh and Shannon, 2005) of the different policy strategies presented nationally in the specific time period of the three first months of the pandemic, i.e. from approximately 11 March to 31 May 2020.

Here, we identified and analysed similarities and differences among the countries regarding their strategies and measures. Specifically, what triggered our curiosity was the immediate development of particular national responses to the pandemic crisis. We define ‘policy strategy’ in this study as an overall objective decided by the authorities in response to the actual health crisis, and ‘measures’ as the content in the course of action decided by the authorities in order to achieve that overall objective, whether in the long- or short-term.

Using policy documents as sources of data for a comparative analysis presents two obvious limitations: one that the documents only represent political intentions. Secondly, that the documents are contextualized in different countries, representing different strategies, and thus making the comparison difficult. Moreover, the documents reflect government ideology, or specific rationales as identified by Rosenberg (Rosenberg, 1989). However, these documents are highly relevant to further an understanding of the immediate response to the pandemic crisis and how health and Nordic welfare ‘values’ were politically promoted. The aim of this study is not to discuss potential effects of the policy strategies but

rather to describe how these strategies are in alignment with the normative principles of health promotion. The analysis also allows an opportunity to identify challenges of the pandemic crisis that could be addressed from a health promotion perspective. The discussion and conclusion of this paper should therefore only be regarded as a tentative observation of lessons learned from the first 3 months.

Rosenberg’s thoughts on how national responses to epidemic crisis reflect social values and institutional practices served as a theoretical frame for a first descriptive analysis of the national responses in the five Nordic countries. To analyse the different responses to the pandemic crisis from a health promotion perspective, we used Saboga-Nunes *et al.* (Saboga-Nunes *et al.*, 2020)’s description of the five principles of health promotion in times of crisis: intersectorality, sustainability, empowerment and public health engagement, equity and a life-course perspective.

Researchers from the five different Nordic countries, each embedded in health promotion research and the Nordic Health Promotion Research Network (<https://nhprn.com> last accessed 03 January 2022, Ringsberg 2015), conducted this empirical study. Monthly virtual working meetings were held to facilitate the collaborative work of this project.

FINDINGS

All levels—national, regional and local—were activated during the covid-19 pandemic. National strategies were politically decided based primarily on advice from the national expert agencies, except for some measures that were taken as precautions decided by the governments. Daily press conferences were held in all countries where representatives of both national governments and national expert agencies were central spokespersons.

The findings point to essential differences in the national responses to the pandemic. To some extent, however, the policy strategies were found to be similar. The countries had differences in restrictions on the everyday and social lives of their citizens, in appeals to individual responsibility, and in the roles of governments as public health authorities.

The national policy strategies

The five Nordic countries all developed specific and independent national responses to the pandemic crisis, with the national responses of Sweden and Iceland deviating more than the other three (Table 1).

Table 1: Strategies, institutions, policy arguments and restrictions in the covid-19 responses of the Nordic countries

Country (population)	What strategies?	Which institutions (decision-making and implementation)?	Main arguments for the policy strategy	What restrictions?
Iceland (0.36 million)	To ensure that the necessary infrastructure of the country, particularly the health-care system, can handle the workload that inevitably results by preventing/limiting/slowing down spread of the virus by testing, tracking and isolation of possible/positive cases	National Government supported by: <ul style="list-style-type: none"> • Directorate of Health/Chief of Epidemiology • Department of Civil Protection and Emergency Management • Landspítali—University hospital • Municipalities • Health services both public and private • deCode, (private company) 	<ul style="list-style-type: none"> • Prevent or delay the outbreak • Prevent overload of healthcare service • Protect vulnerable groups 	Restrictions from 29 January and after: <ul style="list-style-type: none"> • Tracking and isolation • Travellers from certain countries, and later from all countries • Two-week quarantine • Abstain from travelling • Attendance at school, kinder-gardens, and university limited to 100 and later 20 persons • Admittance controls at health and care institutions
Norway (5.4 million)	A ‘knock down’ strategy by implementing restrictions and partial lockdown: <ul style="list-style-type: none"> • Recommendations regarding hygiene and social distancing 	The National Government supported by: <ul style="list-style-type: none"> • Directorate of Health • Norwegian Institute of Public Health • County governors • Municipalities 	<p>To:</p> <ul style="list-style-type: none"> • Limit the spread of the virus for the sake of vulnerable citizens • Safeguard the functioning of the healthcare system 	Restrictions from March 12 and after: <ul style="list-style-type: none"> • Partial lockdown of public and private institutions, cultural institutions, shopping centres, restaurants, cafés and night clubs • Closing of the borders • Two-week quarantine for travellers from abroad • Admittance controls in health and care institutions • Domestic tourist travels in the early stage <ul style="list-style-type: none"> • Social gatherings
Denmark (5.8 million)	A mitigation strategy by: <ul style="list-style-type: none"> • Implementing recommendations, restrictions and lockdown 	The National Government supported by: <ul style="list-style-type: none"> • Danish Health Authority • National Institute of Epidemiology and Research • Federal Police • Regions • Municipalities 	<p>To:</p> <ul style="list-style-type: none"> • Limit the spread of the virus for the sake of vulnerable citizens • Safeguard the functioning of the healthcare system 	Restrictions starting 13 March and after: <ul style="list-style-type: none"> • Total lockdown of public and private institutions, culture institutions, shopping centres, restaurants, cafés and nightclubs <ul style="list-style-type: none"> • Closed borders • No travelling abroad • No public/private arrangements with more than 10 participants except funerals • Restrictions on professions like hairdressers, tattoo artists • No visits to care homes or hospitals

(continued)

Table 1: (Continued)

Country (population)	What strategies?	Which institutions (decision-making and implementation)?	Main arguments for the policy strategy	What restrictions?
Finland (5.5 million)	<p>To limit/slow down the spread of the virus by:</p> <ul style="list-style-type: none"> • Involving the citizens in responsibility to follow • Implementing restrictions and partial lockdown • Guiding principle: life first 	<p>The National Government supported by:</p> <ul style="list-style-type: none"> • Ministry of Health and Social Affairs • The Finnish Institute for Health and Welfare • Other ministries • Parliament • The municipalities • The police and border control 	<ul style="list-style-type: none"> • Save lives and protect the population • Protect vulnerable groups such as persons aged 70+ • Safeguard the functioning of the healthcare system, society, and the economy 	<p>State of emergency/The Emergency Powers Act implemented March 16 and restrictions from March 17 and after. Partial lockdown of:</p> <ul style="list-style-type: none"> • Schools, except Grades 1–3 • Public premises like cultural and sports facilities <ul style="list-style-type: none"> • Restaurants, cafés and night clubs • Closing of the borders • Isolating the Uusimaa region temporarily • No visits to care homes and hospitals • Public meetings restricted to 10 persons • Two-week quarantine for citizens returning to Finland
Sweden (10.3 million)	<p>To ‘flatten the curve’ to support the health-care:</p> <ul style="list-style-type: none"> • Emphasis on protecting those groups at greatest risk, mainly 70+ • Shared responsibility between society and citizens • Individual responsibility following evidence-based advice and restrictions from expert agencies • Sustainability of response strategies 	<p>The National Government supported by:</p> <ul style="list-style-type: none"> • Public Health Agency • National Board of Health and Welfare • Agency for civil Protection and Emergency Planning • Co-operation agreement with the Swedish Association of Local Authorities and Regions 	<ul style="list-style-type: none"> • Minimize the spread of infection to protect human life and health • Secure healthcare capacity and resources for health and medical care 	<p>Restrictions from 12 March and after on:</p> <ul style="list-style-type: none"> • Meetings of more than 500 persons, later 50 • Distance working for high schools and universities • Visits to elderly with in-home care forbidden

From total lockdown to no lockdown

The overall objectives of all national responses were the same: namely, to limit the spread of the virus. The arguments for limiting the spread of the virus were the same in all five countries: viral spread should be minimized for the sake of the vulnerable and the safeguarding and functioning of the healthcare system. What further seems to characterize the five Nordic countries is the

specific form of measures implemented for achieving these national goals. Denmark and Norway implemented total and partial lockdowns, closed their borders, and implemented restrictions on social gatherings and visits to care homes and hospitals. Finland implemented a targeted lockdown, but also closed its national borders (it was the only Nordic country to temporarily close a regional border) and made the same restrictions

on visits and social gatherings. Iceland had no lockdown, but had a clear and early strategy of testing, tracking, quarantine and isolation and implemented restrictions on social gatherings and visits to care homes and hospitals, which became key measures to manage the situation. Sweden had no lockdown and adopted a different strategy with the objective of keeping society as open as possible, with reference to a holistic view on health and how social factors affect health. This response was based on a rationale of sustainability over time, following the advice and restrictions established by its Public Health Agency.

Responsibility—both a collective and individual matter

In addition to restrictions, other measures were developed and stressed for limiting viral spread during the first 3 months. These measures, developed in close collaboration with scientific experts, were general recommendations about how citizens should act in this crisis. Experts in epidemiology played a central role for all national responses to the pandemic and more specifically in recommendations given to citizens. These recommendations put a strong emphasis on each citizen's individual responsibility in limiting the spread of the virus. In Denmark, Finland and Norway, solidarity-invoking terms were used to stress the importance of each individual's behaviour (see Empowerment and public health engagement section). The Finnish president highlighted this appeal to solidarity by stressing that saving lives was the first and most important political priority, and political priority was also manifested in Iceland's response to the pandemic through the catchphrase 'We are all civil protection'. Sweden put a strong emphasis on the responsibility of citizens in this pandemic through the recommendation to 'keep distance', and by highlighting the need to see this crisis as a shared responsibility between society and citizens. Sweden also strongly emphasized the responsibility of the elderly and citizens at risk by recommending self-isolation.

The role of authorities

All five countries regarded communication from authorities to the population (presenting the overall strategies as well as the specific recommendations) as highly important. In Sweden and Iceland, the national strategy was presented at joint press conferences by experts representing the Public Health Agency, the National Board of Health and Welfare and the Agency for Civil Protection and Emergency Planning in Sweden and the Directorate of Health and department of Civil Protection in Iceland. Governments in the other

countries were presented as key actors (often represented by the prime minister), along with different national expert agencies through daily press conferences. The rationales behind the measures were explained by referring to mainly scientific as well as ethical reasons. Journalists as representatives of a civic society often had the opportunity to ask questions about the political decisions behind these measures during these press conferences.

National policy strategies from a health promotion perspective

The identified policy strategies were analysed from the five health promotion principles proposed by Saboga-Nunes *et al.* (Saboga-Nunes *et al.*, 2020), who argue that these principles are highly relevant in the current pandemic situation. As outlined in the following findings (Table 2), differences among the countries in policies are identified concerning preparedness for urgent situations, test capacities, priorities in re-opening society and the focus on marginalized people.

Intersectorality

The principle of intersectorality sets focus on the ability of mobilizing collaborative actions that include both a whole-of-society, as well as a whole-of-government perspective [(Saboga-Nunes, 2020), p. 4]. The principle was applied from the very beginning in all five countries.

The total lockdown in Denmark (11 March) and the partial lockdowns in Finland (16 March) and Norway (12 March) demanded in general a collaboration between the different sectors of the government. Corresponding collaborations also took place in Iceland and Sweden, although there were no lockdowns. An intense intersectoral collaboration was established between the different sectors of the national governments and its ministries around the development and implementation of restrictions and recommendations, and management of the pandemic became a shared objective in all policies at a governmental level. However, other stakeholders at national, regional and local levels were also involved in managing the pandemic.

The Nordic countries were not equipped to respond urgently to national crises (with the exception of Finland, which had an Emergency Power Act that could be applied in such situations), which pertained also to the healthcare systems. As demonstrated in Table 1, one of the main arguments behind the national responses to covid-19 was to reinforce the national healthcare systems, and each country made intensive efforts to strengthen its healthcare capacity in intensive care,

Table 2: Health promotion principles as elements in the covid-19 strategies of Nordic countries

Intersectoral	Sustainability	Empowerment and public health engagement	Equity	Life course perspective
<p>All national responses were based on</p> <ul style="list-style-type: none"> • Vertical and horizontal collaboration between ministries, health authorities and other authorities at the state level, including expert institutions • Collaborations between national, regional and local government levels • Differences appeared regarding preparedness for an urgent health crisis • Finland made use of its Emergency Power Act and Iceland used a combination of two legislations (the Civil Protection Act and Act on Health Security and Communicable Diseases) 	<p>All national responses were based on</p> <ul style="list-style-type: none"> • Increased reinforcement of and resources to healthcare • Financial support to small and larger enterprises and to individuals through the social insurance system • Increased testing in Denmark, Finland and Norway • Differences appeared in the strategies of re-opening society in Denmark, Finland, Norway based on different arguments regarding sustainability • Sweden referred to the concept of sustainability in the decision to not implement a lockdown • Iceland referred to the concept of sustainability regarding the development of a test and tracing strategy 	<p>All national responses were based on</p> <ul style="list-style-type: none"> • An emphasis on solidarity, the idea of ‘us together’ • Civic and individual responsibility through information and recommendations • An emphasis on information through frequent press conferences given by government/authorities to enable and ensure public engagement 	<p>All national responses were based on</p> <ul style="list-style-type: none"> • Identifying vulnerable citizens • Communicating to different groups of citizens • Sweden differed in its approach to equity through its decision of not closing primary and secondary schools 	<p>All national responses were based on</p> <ul style="list-style-type: none"> • Different recommendations and restrictions for different age groups • Aiming to protect the social situation for children and young people • Special recommendations for the elderly

general care and treatment and care for the elderly. All countries lacked equipment, ranging from technical devices for intensive care to simple personal protective equipment. Finland has national emergency stockpiles which were opened up at the end of March 2020, but these supplies were soon shown to be insufficient with regard to personal protective equipment. In all countries, strong efforts were made for improvement, involving actors from the public and private sectors as well as volunteer organizations.

Sustainability

Sustainability is shortly understood as actions promoting a resilient public health, environment, culture and society [(Saboga-Nunes *et al.*, 2020), pp. 4–5]. Different

aspects of this principle were considered in the national responses.

The sustainability of the healthcare system was an important focus of the national strategies in all five countries. The national governments set focus on the capacity of the national healthcare system by enforcing a re-prioritization and ensuring a healthcare system that could provide care and treatment to covid-19 patients. People were asked to stay home if they had only some flu-like symptoms and to follow the recommendations in order to avoid overloading the hospitals and other healthcare systems.

The principle of sustainability was also taken into consideration regarding the many consequences of the general and partly lockdowns or restrictions. Financial

arrangements were settled in all countries in order to minimize the negative social and economic consequences of the lockdowns for small and larger companies, organizations, regions and municipalities as well as the sports and cultural sectors. Individual citizens were also given financial support through the social insurance system, e.g. unemployment benefits.

Considerations about how to re-open society to meet the objectives of social sustainability and ensuring resilience were a focus in Denmark, Finland, Iceland and Norway. In the sixth week of the pandemic (mid-April), the Danish government announced that the pressure had lowered. Similar announcements were made in early May in Finland, Iceland and Norway, where it was declared to be reasonable to adjust some of the restrictions. Different priorities were made in the Nordic countries. In Denmark and Norway, day-care institutions, school and after-school programmes had been opened for only children whose parents had critical jobs, so the re-opening began by allowing small children to go back to their day-cares and primary schools again. The national arguments for allowing small children to resume normal daily life were based on the consideration that re-opening these institutions would provide parents the possibility to work again and increase the children's well-being. In Finland, the libraries were a first priority, and allowed to open at once for borrowing books and other materials. The primary schools reopened in the middle of May as did outdoor recreational facilities, subject to the restrictions on the numbers of people who could gather that still were in place. At that time, it was also stated that it was time to loosen up the restrictions for people over 70 years old. The importance of functional capacity, physical and mental wellbeing and social contacts was emphasized.

With this controlled re-opening of society, the national governments emphasized hygiene and intensified communication with citizens, and test capacities were also strengthened. Citizens with mild symptoms could now be tested and a strong emphasis was placed on how to continue strengthening the national test capacities. With the exception of Iceland, who from the beginning of the pandemic had a clear test strategy and a high test capacity, the other Nordic countries continued developing their test strategies.

In Sweden, where there had been no lockdown, after three months society still had few restrictions. The principle of sustainability seems to have played an essential role for the Swedish strategy of not closing down society. Instead, a strong appeal was made by the Government for its citizens to follow recommendations and restrictions given by the Public Health Agency and

the Government. Sweden emphasized that measures should be based on advice from scientific experts, and be both evidence-based and sustainable over time. Deficiencies in special accommodations for the elderly were accentuated during this period, and additional staff training was done (capacity building) as a measure related to sustainability.

Empowerment and public health engagement

Empowerment should be approached as actions that advocate for individual and community empowerment in the sense where people and communities are given tools to act and gain control over their health [(Saboga-Nunes *et al.*, 2020), p. 5].

In all five countries, it was argued that each citizen should demonstrate a sense of solidarity with the most vulnerable in society. In other words, a shared but also individual responsibility was stressed in the communication directed to citizens through different terms: *samfundssind* (Danish, social mindedness), *dugnad* (Norwegian, joint work done voluntarily for the common good), *håll avstånd* (Swedish, keep physical distance), *me yhdessä/vi tillsammans* (Finnish/Swedish in Finland, we together) and *við erum öll almannavarnir* (Icelandic, we are all civil protection). This shared responsibility was also manifested through the different recommendations and restrictions communicated to the citizens. A strong emphasis was placed on communication to increase people's knowledge about and understanding of the given recommendations, and thus help ensure public engagement. The communication strategy focused on accessible information and recommendations with the main target of creating security. From the start of the pandemic, various guidelines, educational materials and other types of communication were offered and used to help people adopt daily practices that would limit the spread of the virus. Communications moved from simple and informative (for instance, about how to properly wash hands) to more advanced and nuanced ethical pleas for solidarity and collective efforts to comply with the given regulations, obligations and guidelines in order to promote collective good (here understood as reduced risk of infection). Non-governmental organizations (NGOs) targeted various age groups and worked to involve people in joint efforts by using positive approaches and concrete suggestions about how to follow the protective measures.

In all countries, the recommendations were targeting everyday life and how to cope with the new situation with a specific emphasis (at least during the first period

of the pandemic) on healthcare professions, the elderly and other vulnerable citizens. Denmark in particular developed a targeted communication strategy with a focus on guidelines for vulnerable citizens and families with children and vulnerable relatives on how to cope with the pandemic. Specific attention was also given to young citizens and personal well-being and mental health.

Equity

This guiding principle of the analysis is about the rights of the citizens to health, leaving no one behind [(Saboga-Nunes *et al.*, 2020), p. 7].

The strategies in all countries as well as the decisions to have lockdowns in three of the countries were argued as important for the sake of healthcare capacities, but also for the sake of vulnerable citizens. In all countries, vulnerable citizens were mainly defined as the elderly (70 or older) and the chronically ill. Denmark also targeted youngsters and citizens with mental vulnerabilities, citizens who felt lonely because of the pandemic, and homeless people. In mid-April, pregnant women were also categorized as vulnerable in Denmark.

Considerations were made concerning how communication could target these different groups of citizens. In Finland and Denmark, every household received instructions sent out by the national authorities concerning the coronavirus and covid-19 by postal mail (Finland) or by digital post (Denmark) in spring 2020. Instructions were also made available in other languages, both online and in various places where citizens with other ethnic origins lived and worked. The city of Helsinki used mobile technology to send an SMS in three languages with information about the coronavirus and contact details in case of suspected infection to all its citizens who had a mobile phone. In Denmark, a large number of hotlines were created by the national police and other interest organizations giving citizens the chance to ask for information or practical advice, and also professional help regarding for instance issues like mental health. In Finland, similar hotlines were opened up by municipalities and NGOs, and social media influencers were defined by the government as critical operators during the crisis, and these received support for sharing information about the pandemic.

In order to engage the public in the national strategies, various communication forms were used to reach as many groups as possible, i.e. leaving no one behind. Pictograms hung in public spaces and press conferences on national television or radio were followed up by experts' comments and recommendations. In Denmark, specific 'corona news' targeted youngsters, and videos

and songs about hygiene were developed. Coronavirus information sessions for children were organized in Norway and Finland, and in these, the Prime Minister, the Minister of Education and the Minister of Science and Culture answered questions posed by 7- to 12-year-old children in a videoconference about the coronavirus situation. Schools were allowed to use broadcasts for distance teaching. In Sweden, the Red Cross and Children's Rights in Society urged children to contact them if necessary. In Denmark, specific guidelines about social arrangements like children's playgroups were published for parents, focusing in the importance of reducing the number of social contacts.

The Swedish decision not to close primary and lower secondary schools was related to the principle of equity, i.e. the right of all children to go to school and pre-school, and the provision of opportunities for children from vulnerable environments to come to a safe environment during the daytime. The decision was also motivated by a desire to not affect children's futures by reducing their learning, corresponding to the principle of sustainability but also to the principle of the life course perspective.

The life course perspective

The principle of a lifecourse perspective promotes action that considers the effects of interventions in the long term of lives [Saboga-Nunes *et al.*, 2020), p. 8].

Authorities in all five countries paid attention to the different age groups by giving targeted recommendations and restrictions to different groups.

Specific attention was given to children and the consequences of the pandemic on their everyday lives. In order to limit the social consequences for children, Sweden and Iceland decided to keep all pre-schools and elementary schools open for all children, while distance learning or tele-education was stipulated for high-schools and universities, as in the other Nordic countries. In all countries, pre-school children were offered regular daycare; in Finland, Grades 1–3 were open as well, though the government advised parents who were able to arrange childcare at home to do so, and Denmark and Norway proposed the solution of home schooling. Much effort was put into the schools in order to support children.

Persons of working age were asked to work at home, if possible. Persons aged 70 and older and citizens who were chronically ill were protected by quarantine-like conditions and restrictions, and were urged to limit their contacts and stay at home as much as possible. They

were also recommended to exercise and spend time outdoors.

DISCUSSION

Each and every country developed its own strategy to ‘manage randomness’ in this global pandemic and health crisis. These different national concerns for management represent fundamental patterns of social value and institutional practices as highlighted by the historian Rosenberg and his analysis of epidemics (Rosenberg, 1989). Seen in this light, we would argue that the Nordic responses to the pandemic demonstrated social values and institutional practices that could be characterized as belonging to health promotion principles as well as ‘Nordic values’ of welfare states.

This discussion will emphasize, through the similarities and differences identified among the responses of the Nordic countries, the challenges identified from a health promotion perspective.

Differences in policy strategies and the Swedish exemption

The Swedish covid-19 strategy differed from the other Nordic countries in several respects and also received international attention. In the spring of 2020, there was a tacit agreement from all political parties with the Government’s initial strategy (Folketinget, 2021). Although Sweden continued having a strategy based on few restrictions and with focus on communicating recommendations on how to behave in the face of the infection (Folketinget, 2021), the national strategies in the other countries were continuously adjusted to current research and expertise. The fact that Sweden chose not to implement a lockdown as in the other Nordic countries or a national test strategy as in Iceland, has mainly been explained based on constitutional factors, the Swedish infection control legislation and the state administration organization [(Folketinget, 2021), para. 3.1]. In Denmark, Finland, Iceland and Norway, politicians also used several different expert councils and consultations among different authorities to facilitate consensus-based decisions, whereas in Sweden the decisions were based on information from the Swedish Public Health Agency (Sperre Saunes *et al.*, 2021).

In general, the national strategies were embedded in the welfare states’ focus on solidarity through the strong political appeal to demonstrate solidarity with vulnerable citizens. The countries had in common a general focus on collective and individual responsibility based on the value of civic solidarity, which could be

characterized as a Nordic welfare value. However, the countries differed in their approach to this value, in the sense that the balance between solidarity and equity seemed to be challenged by this crisis. Countries that are known internationally for a strong political focus on equity had a weaker emphasis on vulnerable citizens during the pandemic. As an immediate response to the crisis, elderly and vulnerable people were strongly recommended to self-isolate. This recommendation points to individual responsibility rather than to a collective responsibility. Some of the countries revised that recommendation by appealing more generally to every citizen’s responsibility for the sake of all and especially vulnerable citizens. A study of the Swedish response to covid-19 showed that solidarity was believed to be exercised through the ‘self-regulated’ individual (Nygren and Olofsson, 2020), and Sweden in particular seemed to have strong emphasis on individual responsibility in its national response to covid-19. This conclusion is corroborated by the fact that Sweden issued recommendations rather than impose restrictions.

Despite differences in their national responses, all five countries did cohere with the principles of health promotion described by Saboga-Nunes *et al.* (Saboga-Nunes *et al.*, 2020). The differences that emerged particularly clearly in our analysis were the approaches to the principles of sustainability and equity. All countries implemented severe restrictions on the everyday life of citizens, insofar as all citizens were encouraged to socially isolate through the lockdowns and other restrictions. Sweden deviated in this respect by having fewer and less severe restrictions, a strategy based on the principle of sustainability. The different countries had different approaches to sustainability, which influenced the national responses to covid-19.

The five countries also had different approaches to the principle of equity. On a large scale, the national responses were coherent with the objective of equity, although some parts of the population were more directly targeted in some of the national responses. Children and youngsters were targeted in all five countries, but with differences in communicative strategies. Denmark targeted parts of its population (those with mental vulnerabilities, those who felt lonely because of the pandemic, and the homeless) that were not targeted by other countries.

Challenges faced by the strategies

The findings presented here point to three main difficulties faced by the observed national responses to the pandemic from a health promotion perspective: (i) the

hardship of putting the responsibility of self-isolation on the elderly, (ii) the challenge presented by multi-ethnic populations and (iii) the consequences of social inequities among children. These challenges are identified because they conflict in general with the principle of equity in health promotion.

The national recommendations given to the elderly regarding their own responsibility for their health in the crisis, and the countries' more or less strong appeals for self-isolation, led in some cases to isolation and feelings of being discriminated against. The Finnish government paid attention to this issue and encouraged elderly to spend time outdoors, and Finnish restrictions care homes were also loosened. There was discussion in all countries that it was unfair that all persons 70 and older were recommended to isolate themselves, because this was not good for their mental health. The negative outcomes of this recommendation resulted in adjustments to the further recommendations in all countries except Sweden, which had recommended self-isolation as central strategy for halting the spread of the virus. This identified challenge reminds us to focus on the ethical dimension of healthy public policy, namely that health is not solely about adding years to life, but about adding life to years (Gulis, 2020).

The next challenge originates in the multi-ethnic populations of the Nordic countries. Recommendations, restrictions and information about the pandemic were translated into several languages in all five countries (although quite late according to some NGOs). At the start of the pandemic, not enough attention was paid to ethnic minority groups who did not necessarily understand the national language well, and it was difficult for these groups to obtain official information about covid-19 and follow the recommendations. Moreover, the employment of many people in these groups did not allow them to work remotely. There is reason to think that there needs to be more political awareness about the question of equity, because the pandemic had such differential effects on different social classes and ethnicities. Although civil servants and other white-collar workers were able to work from home, people in front-line employment were not able to do so. Bus and taxi drivers, shop assistants and people working in bars and restaurants are especially vulnerable because they are all more exposed to infection by meeting people in their work. Frontline healthcare workers are also a vulnerable group, and many of these, particularly in institutions for elderly, may have unsecure working conditions and time-limited contracts, which makes them extra vulnerable in a pandemic situation.

The focus on high incidence rates of covid-19 among people with non-Nordic ethnic origins fuelled social debates in Denmark, Norway, Sweden and Finland about the problem of stigmatization, and several experts highlighted the risk of taking a 'victim-blaming' approach in the communication strategies. The same experts pointed out that the incidence of covid-19 was related to social determinants and not ethnicity *per se* (Sodemann 2021).

Schools were closed in three of the countries and children were asked to follow classes from home via digital media, which put some children and families in an unequal situation, and some children were suddenly at risk of dropping out of school. Debates about the consequences of home school for children and families in the context of social inequities happened in all countries, and various initiatives aimed at solving the problem were developed. For example, some municipalities in Finland organized lunches for school-aged children so that they would all have the possibility to get a good lunch. What came to the fore in the societal discussions about home school were questions of children's well-being and learning possibilities, and how affects to those could affect their chances later in life.

CONCLUSION: LESSONS LEARNED FROM A NORDIC PERSPECTIVE

It is still too soon to determine how well the Nordic countries did in respect to the pandemic crisis, and the analysis proposed here is only a first observation of the immediate (i.e. within the first 3 months) responses to the pandemic. The governments demonstrated a shared responsibility for protecting their citizens in developing policy strategies based on restrictions and recommendations. The populations demonstrated to large extent individual responsibilities by following the restrictions and guidelines. The findings in this article, point to similarities and differences in the Nordic responses to the pandemic. All countries based their governmental recommendations on solidarity and a trust in institutions and populations. From a health promotion perspective, the principles of intersectorality, sustainability and empowerment were largely considered in all five countries although differently. Equity and a life course perspective were considered to some extent, but these should be emphasized more if there are future crises. Our findings also demonstrated challenges to the national strategies, and these allow insight about issues to be alert to in future crises.

SUPPLEMENTARY MATERIAL

Supplementary material is available at *Health Promotion International* online.

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