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# Can a COVID-19-related curfew be justified on medical grounds?

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## OPINIONS

LINDA MADSEN

E-mail: linda.madsen@usn.no

Linda Madsen, associate professor in social science at the Centre for Care Research South and the Department of Nursing and Health Sciences at the University of South-Eastern Norway. She has long experience of research on infection control, biosecurity, civil protection and crisis management.

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## **It's high time to examine how medical expertise is being used to change the legal basis for political interventions.**

The Norwegian government seeks to add a curfew to its COVID-19 control toolbox by putting in place legal authority for this measure ahead of a potential situation with escalating infection rates. A draft bill was recently circulated for comments [\(1\)](#). The Minister of Justice, Monica Mæland, wants to be able to 'act quickly, if necessary' [\(2\)](#), but how can a curfew possibly be an appropriate 'tool'? Would it add anything other than a false sense of security? The authorities are clinging to the belief that a curfew is a last resort – despite clear warnings from both the Norwegian Institute of Public Health and the Norwegian Directorate of Health that the benefits with regard to infection prevention and control will be minor at the most [\(3, 4\)](#). Section 1–5 of the Act relating to the Control of Communicable Diseases stipulates that *infection prevention measures must be based on clear medical grounds, be necessary on account of infection prevention and appear appropriate following an overall assessment*. So how does the government justify the need for a curfew from a medical point of view?

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## The inadequacy of other measures

The authorities want to have this 'tool' at hand in the event of a sharp increase in infection rates. Several submissions to the consultative process call for clear criteria in relation to when the authorities deem a curfew to be necessary. The joint consultation memo of the Ministry of Justice and Public Security and the Ministry of Health and Care Services mentions various indicators, such as the infection situation, test-, contact tracing- and treatment capacity, availability of personal protection equipment as well as the risk entailed in failing to introduce new or reinforced measures [\(1\)](#). In Germany, the national authorities have set a limit for the number of confirmed cases per 100 000 inhabitants and intensive care units' occupancy rate as the guiding criteria for introducing regional or local curfews (*Ausgangssperre*) [\(5\)](#). The problem is that such criteria only say something about the infection situation – and nothing at all about either the anticipated added benefits or the negative side-effects of a curfew. Infection rates and intensive care units' occupancy rates appear (despite their known weaknesses) to be clear indications that infection control measures have hitherto been inadequate.

*«In other words, it is the inadequacy of other measures – and not the appropriateness of a curfew – that justifies a curfew»*

And it is precisely the inadequacy of other measures that constitutes the self-evident reason for the Norwegian authorities advocating a curfew as a disease control measure. In other words, it is the inadequacy of other measures – and not the appropriateness of a curfew – that justifies a curfew. However, even when carefully scrutinising the ministries' consultation memo, studying other official documents and examining the health authorities' language usage in the public debate, it remains unclear *how* a curfew can be proposed as a suitable measure for controlling COVID-19.

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## Intrusive measures can only be justified by expected added benefits

Curfews are frequently claimed to have proven effective in reducing infection rates in countries where they have been used. Nevertheless, a review of international literature in favour of curfew-type measures mainly identifies quantitative studies that give readers little insight into what the terms *curfew*, *stay at home orders*, *strict lock down* and *home isolation* actually mean in practice [\(6–9\)](#). Similar terms may have very different content. For example, *home isolation*, as used in one of the articles [\(8\)](#), seems to correspond to a kind of general curfew. This can hardly be compared with home isolation as used in the Norwegian context, where the term is associated with individuals required to self-isolate at home following a positive SARS-CoV-2 test result. In addition, when assessments have been made of specific cases of a curfew where the

general public are forbidden to be in public areas during certain hours or at any time day or night, the curfew has always been combined with the intensification of other infection control measures. Therefore, it is impossible to tell whether stagnation or decline in infection is a result of the curfew or of other measures. In the above-mentioned literature, little or no information is provided about contextual factors of importance for infection transmission and infection control, such as demography, geography, sociocultural and socioeconomic factors, or local variations within the country. This also applies to the countries from which the Norwegian authorities have obtained information via its embassies [\(1\)](#).

*«The Norwegian Medical Association refutes the assertion that a curfew is an appropriate measure»*

What 'medical', or for that matter 'infection-control-related' grounds make curfews 'appear appropriate' as a supplement to already existing measures 'following an overall assessment' (see the Communicable Diseases Control Act)?

According to the authorities, the use of a curfew as a measure to control the pandemic is justified by medical knowledge that the virus is transmitted via human hosts in close proximity in time and space. A curfew thus aligns with the apparently endless list of infection control measures provided for in the Norwegian Communicable Diseases Control Act, aiming at preventing infection transmission by ensuring distance between potential carriers of the virus and new hosts – until the latter group have gained immunity through vaccination. However, in its consultation submission, the Norwegian Medical Association points out that it is primarily physical contact among humans that paves the way for infection, not simply being outdoors [\(10\)](#). Hence, the Norwegian Medical Association refutes the assertion that a curfew is an appropriate measure. The same conclusion is emphasised by several consultative bodies such as the Faculty of Law at UiT The Arctic University, Fredrikstad Municipality, Oslo Municipality, the Legal Policy Association, and the University of South-Eastern Norway [\(1\)](#). If relevant, medical advice advocating the use of a curfew must focus on the anticipated added benefits of this measure in comparison with less intrusive measures – and weigh these against negative side effects. High infection rates, and the fact that other measures are regarded as inadequate, are based on medical knowledge, but knowledge of the infection situation provides no professional, empirical, or scientific evidence that can justify the introduction of curfews.

In its consultation submission, the Norwegian Medical Association emphasises that both the introduction of legal authority for curfews and the implementation of curfews will serve to undermine the trust of the population – a fragile value that must be tended wisely [\(10\)](#). Likewise, the authorities must demonstrate prudence and intelligence in their utilization of medical knowledge when selecting and paving the way for *appropriate* infection control measures.

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