Mediating Uncertainty, Consolidating Knowledge

An Ethnographic Study of Pandemic Management in Norway

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Abbreviations

CBRNE Nasjonal behandlingstjeneste for CBRNE medisin (Center for emergency medical preparedness for unwanted events of: Chemical, Biological, Radioactive, Nuclear and high yield Explosives)

CC- Meetings Crisis Committee meeting (Krise Utvalg møte, KU-19)

CDC Centers for Disease Control and Prevention

CEPI	Coalition for Epidemic Preparedness Innovations
COVAX	COVID-19 Vaccines Global Access
ECDC	European Centre for Disease Prevention and Control
GAVI	Global Alliance for Vaccines and Immunisation
MHCS	The Ministry of Health and Care Services (the Ministry) Helse og Omsorgsdepartementet (HOD)-
ICT	Infection Control Team at the Norwegian Directorate of Health- Smittevern teamet
NDH	The Norwegian Directorate of Health - Helsedirektoratet
NIPH	The Norwegian Institute of Public Health- Folkehelseinstituttet
NMA	The Norwegian Medicines Agency- Legemiddelverket
TITQ	Test, Isolate, Trace, Quarantine- TISK; Test, Isoler, Smittespore, Karantene
VoC	Variant of Concern- category used in the assessment of new virus variant
VoI	Variant of Interest- first step in assessing a new virus variant
WHO	World Health Organisation

Introduction

With the development of the Covid-19 pandemic in the world and Norway, on March 12, 2020, the Norwegian government imposed the strictest regulations on the population ever done in peacetime. The country was on lockdown, and life as one knew it stopped. Nevertheless, the level of compliance and trust in the government shown by the population has been high. During the first months of the pandemic outbreak, the government told the population not to wear facemasks, and they did not. Norwegians were told not to hoard toilet paper and essentials, and they did not. The government called for a "dugnad" (voluntary work done with other people) to keep fellow citizens safe, and most of the population participated. Igniting and keeping the Norwegian "dugnadsånd" translatable to "the spirit of will to work together for a better community" has been salient in making people actively follow infection protection measures and advice put forward by the government and health authorities. The general population of Norway have, throughout the pandemic, shown an unprecedented level of trust in the decisions made by the government and shown very little- to no resistance to the imposed corona measures, which stands in stark contrast to other countries, where protests began almost immediately, both in Western countries and at a larger global scale (Alderfer, 2020).

Both global and national health actors rapidly established that the only way out of the pandemic was by reaching herd immunity in the population or developing a vaccine. Most Western countries opted for the vaccine strategy, and a race to develop one began. A population survey conducted on behalf of a Norwegian newspaper portrayed a preliminary low Covid-19 vaccine uptake amongst the general population, with concerns about vaccine safety. That stood in stark contrast to the high level of participation in the Children Immunisation Programme. By the end of 2020 came the first reports of a vaccine qualified for distribution, and Norway received their first batch of vaccines the last week of 2020 and instantly began the rollout. With the gradual rollout of vaccines during the first half of 2021, no significant vaccine scepticism was visible in Norway that could influence the success of the immunisation programme. During the latter half of 2021, small groups of unvaccinated people became visible in the statistics from the vaccine

registry (SYSVAK), and the Norwegian Public Health Institute made an additional effort to reach these groups to provide information and to try to identify any potential logistical bottlenecks that could affect vaccine uptake.

My initial research interest lay in the projected discrepancy between the general population's trust in government and health authorities, and the prediction of an initial low vaccine uptake. However, with the progression of the vaccine rollout and the development of the pandemic, my interest of inquiry was turned towards the actors in pandemic management, more precisely the Norwegian Directorate of Health and the Norwegian Institute of Public Health. The pandemic was characterised by a high level of uncertainty, where the actors in pandemic management continuously had to relate to nonknowledge in decision making. When there were no right or wrong answers but a constant weigh-in of the level of regulations and restrictions needed in specific situations, knowledge and diverging situational understanding created friction in the layers of pandemic management.

In this thesis, I explore how the health authorities utilised public trust in pandemic management, and to what extent trust played a role in providing order to uncertainties and the complexities of the crisis. I also consider how a lack of confidence in assessments and knowledge created tension in, and amongst the two organisations. The concept of knowledge as a field of inquiry emanated from its significance and place in pandemic management, and as a point of departure for exploring the beliefs, morals and sensemaking of actors in pandemic management.

Pandemic management was a process of defining and categorising through the progression of the pandemic, considering vulnerable groups, virus mutations and vaccine protection, where different kinds of knowledge shaped government and public perception of trust and risk in times of a crisis. Risk perception played a significant part in pandemic management, as it created future possibilities and produced present realities.

Thesis structure

I have divided this thesis into two sections; Part I- Pandemic Management. This section is mainly based on fieldwork conducted at the Norwegian Directorate of Health (NDH) and accounts from media. Chapter 1, introduction. In Chapter 2 I attempt conceptualise the notion of trust, and situate it within the context of pandemic management. I consider the government and health authorities' use of the concept of 'dugnad' as means to have people follow infection protection advice. Chapter 3 presents the concept of knowledge, and knowledge production in pandemic management. It also makes account of the role of risk perception in pandemic management, and how that shapes the situational awareness amongst actors in pandemic management. In Chapter 4, I present pandemic management as performance, where I draw on the works of Goffman (1959, 1967), and his theories of performance and teams.

Part II-Vaccines, is mainly based on fieldwork conducted at the Norwegian Institute of Public Health (NIPH). Chapter 5 provides an introduction to the NIPH, with a short outline of their role in pandemic management. Then I introduce my field, the Department of communication, before I give a brief introduction to the history of vaccines in general and in Norway. In Chapter 6 I give an account of the Covid-19 immunisation programme in Norway, as well as analysing the varying sentiments that a vaccine carries. I also make an account of the communication team's effort into reaching unvaccinated groups.

Theory and Methodology

This thesis explores how the state project of emergency preparedness gets enacted through bureaucratic practice, and what contradictions arise at the intersection between bureaucracy and uncertainty in crisis management. It further explores how these contradictions were navigated by actors in pandemic management, as they had to mediate uncertainty at the convergence of regulations and research, and how these actors attempted to obtain coherence as advisory organs.
The project further explores how actors' notions of hope, beliefs and morals get entangled with the rationale and logics of pandemic management. Through conducting seven months of

ethnographic fieldwork at the Norwegian Directorate of Health, from May to November, 2021, and six weeks of fieldwork at the Norwegian Institute of Public Health, from October to November, 2021, I located my study at the heart of national emergency preparedness and knowledge production in pandemic management.

Some of the key concepts I will approach in this thesis is the concept of trust, knowledge and risk perception. Heyman (2004) states that "rapid organisational analysis requires a variety of analytical approaches for diverse contexts and issues, but always with the power question in mind." The theoretical framework of power will be discussed in relation to the concept of knowledge, following the theories of Foucault (1975; 1978; 1980; 1991). Attention to power yielded important in pandemic management, as it is was made explicitly visible through the Norwegian state exercise of power through regulations and legislations during the pandemic, as well as through the designated roles and mandates of the Norwegian Directorate of Health and the Norwegian Institute of Public Health, founded in the Infection Protection Act (Smittevernloven, 1994, § 7-1-7-12). Eric Wolf distinguishes between four types of power: power as a personal attribute; power as the ability of one person to impose their will on another; tactical or organisational power, which allows some to limit the actions of others; and the last, structural power, which is a type of power that regulates the political economy (1982:586-587). Structural power is, according to Wolf, what "shapes the field of action so as to render some kinds of behaviour possible, while making others less possible or impossible" (Wolf, 1982:587, in Eriksen, Schober, 2017, p. 11). Wolf's distinction of structural power as connected to the concept of knowledge, together with Foucault theories of knowledge and power (1975; 1978; 1980; 1991) has been an analytical tool to consider power relations in this thesis.

Max Weber describes three types of legitimate authority, the traditional, rational-legal, and the charismatic. Weber linked formal authority to bureaucracies, which he considered as highly structured, formalised, and impersonal organisations. A bureaucracy, according to Weber had the characteristics such as labour specialisation, formal rules and regulations, with a well-defined hierarchy within the organisation, and impersonality in the application of rules (Gerth and Mills 1946:196-244). According to Weber, the legitimation process of power is exerted through formal rules and regulations. This rationalisation process is what gives bureaucrats and politicians their power, because it seems legitimate (Gerth and Mills 1946:196-244). How power

is legitimised outside of the rational/legal paradigm has been the concern of several scholars (Scott, 2001; Weber, 1968). Weber also discussed the role of competence, or expertise, as a source of bureaucratic authority. He distinguishes between disciplinary competence and the experience based competence, which is gained through service (Mangset, M. 2019). All the characteristics of a Weberian "ideal" bureaucracy highlights a bureaucracy as a democratic, predictable and efficient organisation, through practices of transparency, filing and recording. I consider these characteristics of bureaucratic practice and expertise as a valuable reference point in exploring the bureaucratic process of pandemic management.

Methodology

My fieldwork took place in Oslo, Norway, between the months of May to November, 2021. The Covid-19 pandemic was both the inquiry of my study, as well as it influenced the development of my fieldwork. Majority of my fieldwork consisted of observing meetings, which was either conducted online, or by physical attendance at the organisations. I collected the majority of my data through meeting observations, conversations with employees outside of meetings, as well as through informal interviews conducted online. I followed several regular meetings on a weekly basis nearly consistently over the months I conducted fieldwork at the Norwegian Directorate of Health (NDH). At the end of my fieldwork at the NDH, I conducted overlapping fieldwork at the Norwegian Institute of Public Health (NIPH), where it was arranged for physical and digital meeting attendance. During the initial phase of my fieldwork at NDH, I used the meetings as a point of entrance to locate a "case" to follow, yet, I soon realised that identifying, nonetheless follow a specific "case" was practically impossible, both from a point of access and due to the rapid caseworking process in pandemic management. I continued to observe meetings and spend time at the organisation, and gradually the dynamics of pandemic management became an inquiry of interest. Together with the data collection at the organisations, I also draw on articles from the media about pandemic matters, as they fill in 'gaps' in my data collection at the organisations.

Access

I had been in contact with the assistant department manager at the Emergency Preparedness department during the fall of 2020, and she invited me to the NDH to have a talk and discuss the

possibility of doing research related to the ongoing pandemic. At the time being, my research interest in pandemic management was triggered by the preliminary low interest amongst the general population in taking a vaccine against Covid-19, and how that would manifest in pandemic management. As the vaccine roll out had not yet begun at the time of our meeting, I was not completely comfortable with basing my whole research project on one population survey, and I was happy to meet with people who were in the midst of pandemic management.
I was then given permission by the top management to conduct fieldwork at the NDH, and with the Emergency Preparedness department, which I from here on will refer to as the Preparedness department, where I began my fieldwork at the end of May 2021. At the time I began my fieldwork there were regulations on physically attending work, and the majority of employees at the NDH were restricted to working from home. The Preparedness department had only a few people present at the organisation. My contact person thought it would be a bit challenging to invite me in on a daily basis, as the rest of her department was not allowed to. Although my presence at the organisation was approved by top management, there was no need to bring too much attention to my presence at the organisation. Therefore, my access to the department was arranged on a day to day basis, depending on meeting activity deemed relevant to my project, or people at the organisation.

As I had no prior knowledge of emergency preparedness, crisis management or the inner workings of a bureaucratic organisation like the NDH when embarking on my fieldwork, it was a steep learning curve trying to orient myself in the field of pandemic management. Moreover, studying pandemic management is studying political elites (Scott, 2008), which comes with their own challenges (Shore, 2010). By "studying up" (Nader, 1975), I consider the obstacle of access as addressed by Nader (*ibid)*. I did not expect to get access to the kinds of meetings I was allowed to observe, and although my presence may have been questioned, I was never asked to leave a meeting. Multiple meetings I attended at the NDH were very formal and directed, and their content was of such character that I occasionally felt like I should not be there. I have allowed myself to hold on to that feeling of discomfort throughout my fieldwork and writing process, as it has guided me through the process of writing this thesis. I had a somewhat different experience of gaining access to the Norwegian Institute of Public Health, which I go into further details about in chapter 5.

My fieldwork consists of multi-sited ethnography (Marcus, 1995), recognised by its inclination to "following" (objects, persons, events) as a tool for organising fieldwork (Van Dujin, 2020). Van Dujin identifies the hurdle of multi-sited ethnography and the "following" strategy as something that can "lead a fieldworker to be both everywhere and nowhere at once"(*ibid*). I can fully relate to the sensation of "being everywhere and nowhere" at once. When studying issues across organisational boundaries, Van Dujin identifies the challenges of multi-sited ethnography as the "continuous need to negotiate access, the inevitable pressure it puts on a researcher to "unfollow" their field(s), and it's perplexing ability to highlight the lack of a whole, unveiling instead a plethora of perspectives across sites which may or may not align" (*ibid.).* It has been shown hesitancy towards the analytical approach of multi-sited ethnography, as it holds the possibility of the ethnographer losing contextual information and explanations of the causation of various occurrences (Fangen, 2010). Still, the very way pandemic management was organised, and with people working in separate camps, was the issue of losing contextual information, a continuous part of the field I was studying.

The Doors of Bureaucracy

The location of NDH was in a tall rise office building they shared with other communal service offices and companies. Inside of the entrance was a reception where one had to register on arrival. The reception area was divided from the rest of the building by glass gates that would only be opened either by the receptionist or with an access card. I had to register at the reception every time I arrived at the NDH, and wait for someone from the preparedness department to come and pick me up. After a short elevator ride up to the floor of the department was another security door in place. A high security portal which works to prevent any unauthorised access. It is a round, cylindrical compartment with two interlocking automatic sliding doors. Integrated sensors will confirm if the person entering is alone, and if so, the second door opens. Once inside, the office space consists of a big shared area that contains a small kitchen area and a few small meeting rooms. Most of the time I spent at the NDH was behind yet another security door, leading into the 'only authorised personnel' section of the office space. Extra safety in the way of a heavy duty door separated the secluded section from the rest of the offices. You needed an extra security clearance to have access to the area, and if any were not authorised personnel, one had to write entry logs every time one came and left the area, signing your name, affiliation and

time and date. Meetings relating to the Covi-19 pandemic were held in the secluded section, as the CC- meeting, morning meeting with the Ministry, and the Covid-19 strategy meeting.

Not having an access card imposed limits to my ability to move freely around the organisation, as I was pretty much confined to the area I was placed. If I was to move between areas of security, or floors or departments, I had to be walked by someone. Which I avoided as much as possible. Under normal circumstances, the inability to meet people would have been a disadvantage, however, due to corona restrictions it was generally an empty office space for a substantial amount of my time at the organisation. During fall of 2021, the restrictions were easing and people started showing up at the office again. I was at this time spending time at the communication department at NDH, and sat in on various meetings with new people I had never met. I was once introduced by my contact person as the "student with no access card but access to the corona meetings".

Ethical considerations

As previously mentioned, taking the role as an observing participant into my field brought about feelings of discomfort of my own presence during certain aspects of conducting fieldwork. I have valued that feeling, as it has guided me through the process of writing this thesis, and to be conscious of people's work life and professional world (Hume, Mulcock, 2004).

I have been conscious of not collecting or disclosing information that have been defined as 'exempt from public', disclosing information in breach of confidentiality agreements. Although I have based my study around the practices of pandemic management, not peoples 'entire culture and social life' (Hannerz, 2003:208), I have made several considerations into how to best ensure correct representations as I fully acknowledge that data collected for this thesis has come about through a collaborative procedure between me and my objects of research (Bernard, et .al. 1986), as ethnographic description is a multistage process, from data collection through the finished analysis presented as an ethnographic account (Bernard, et. al 1986). When it comes to the category of anonymity, I have provided people with varying degrees of anonymity. When I refer to people who have had a leading public figure in pandemic management, or when their job position is 'common knowledge', e.g. Health Director or Deputy General of NIPH, I have chosen to use full names. When I have found it preferable to provide some degree of anonymity, I will only refer to their job position, expert background, department affiliation or organisational

affiliation. I consider it only to be 'some degree' of anonymity, albeit the pandemic management involved many people. Because the environment of pandemic management was considerably small, it was hard to remove any identity marker without leaving out significant parts of the stories. In some ethnographic accounts I have given people fictitious names as a narrating technique.

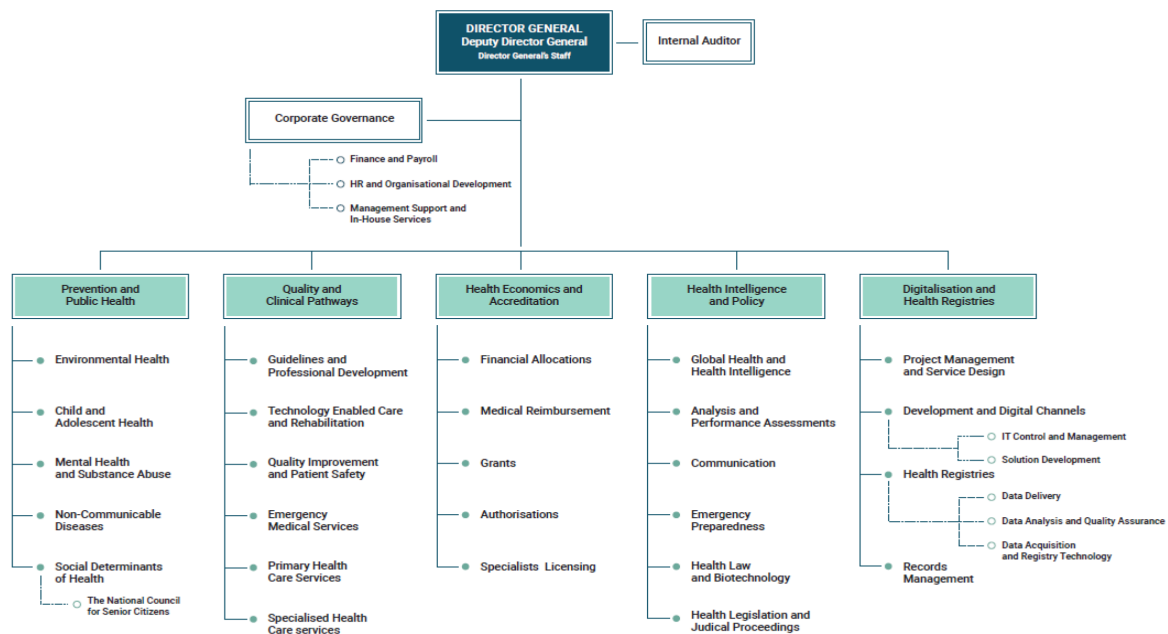
Pandemic Management Actor: The Norwegian Directorate of Health

The Norwegian Directorate of Health (NDH) was established in 2008, and is an executive agency and professional authority under the Ministry of Health and Care Services. The NDH is located in Oslo, except for the department of Health Registers which is located in Trondheim, and the organisation has approximately seven hundred employees. The public mandate of the agency is to improve the health of citizens and the society as a whole through targeted activities across services, sectors and administrative levels, which entails The Directorate will do so as an executive agency, a regulatory authority, and an implementing authority in health policy areas (Regjeringen, 2023). In addition, the Directorate of Health has the overall responsibility for the national health emergency in Norway (Helsedirektoratet, 2022). The government defines the responsibilities of the NDH to be: "following up on and giving advice on conditions that affect the health of the population and the development of the health and care service, preparing national norms in selected areas, being an expert body for authorities, service apparatus, interest organisations and professional communities, having specialist expertise in Norwegian health legislation and develop a comprehensive national health preparedness" (Regjeringen, 2023).

Health preparedness comprises preparedness in the health and care services, follow-up of victims and those affected by incidents and crises, CBRNE (environmental medicine, infection control, nuclear preparedness and explosives), security of supply for medicines and materials and food and drinking water safety. Health preparedness has been extensively developed in Norway over the past two decades, with, amongst other things, the government's establishment of a crisis committee and a national health emergency plan.

The top management consists of the Director of Health; Bjørn Guldvog, and two Assistant Directors of Health, Olav Slåttebrekk and Espen Nakstad. The NDH is divided into five divisions; Prevention and Public Health; Quality and Clinical Pathways; Health Economics and Accreditation; Health Intelligence and Policy; Digitalisation and Health Registries, each with a division director. Within each division there are between four and six departments, who each has a department manager.

Organisational chart:



Retrieved from Helsedirektoratet (2019).

Forerunners of the Norwegian Directorate of Health

The Directorate of Health (Helsedirektoratet), established after World War II in 1945, was the professional body in the Norwegian central health administration up until 1993. The directorate was a leader in the development of the health system in the post-war period under the directors of health Karl Evang and Torbjørn Mork. Karl Evang was a pioneer within health enlightenment in Norway, and he had a large influence on the development of the Norwegian health care system (Nordy, 2022). In 1972, his predecessor Torbjørn Mork stepped into the role as the Health

Director, until his death in 1992. For two decades, he led Norway's work in the World Health Organization (WHO), where he won great recognition (Alvik, 2023).

The Directorate of Health has gone through several restructurings and reorganisations, one in 2002, where it was named Social and Health Directorate (SHdir), placed under The Ministry of Health and Care Services and the Ministry of Labor and Inclusion. In 2008, (SHdir) went to another reorganisation, and the Norwegian Directorate of Health was established. First under the direction of Bjørn Inge Larsen, 2008-2012. In 2021, Bjørn Guldvog stepped into the role as the Director of Health (Helsedirektoratet, 2022).

The Norwegian Directorate of Healths' role in Pandemic Management

The role of the NDH in pandemic management has been substantial due to its role and mandates as an authoritative body and as responsible actor of health preparedness. NDH emergency staff on January 1, 2020 to follow the development of the virus. January 31, the Ministry of Health delegated to the NDH to coordinate the efforts of the health and care sector in collaboration with the NIPH and other affected actors. That same day is the coronavirus (Sars-cov-2) defined as an communicable disease which endangers public health, and a notifiable disease. The Ministry of Health and Care's authority was delegated to the NDH in accordance with the authorization provisions in the Health Preparedness Act on February 6 (Regjeringen.no).

The Emergency Preparedness Department

The Emergency Preparedness department is placed under the division of Health Intelligence and Policy, with approximately 30 employees. The office space was placed on opposite sides of the department floor, with open office spaces belonging to employees of other departments were located. At the other side of the floor you had the closed off section of the Preparedness Department, which only authorised personnel were given access.

Chapter 2: '*Dugnad'*- Doing Good in Times of a Crisis

Conceptualising Trust

The concept of trust was an essential part of classical sociological theories (Smith, 1759; Simmel,(2004 [1900]:177-178); Weber, 1947; 1951 [1915]; Durkheim; 1964 [1893]), where they all discussed the significance trust have in social interaction and cohesion.In contemporary social theories, trust is described as the glue that holds society together, and the workings of and the existence of society as we know it would not exist without it (Fukuyama, 1995; Glanville, Paxton 2007; Habermas, 1984; Misztal, 1996; Putnam, 1995). For some scholars, trust is closely linked to modernity, where trust is viewed as a social mechanism for reducing complexity and as a strategy against uncertainty (Giddens, 1990. Luhmann, 1979; Beck, 1992). Giddens classifies trust into two categories; trust in a person and trust in abstract systems (1990:34); Eriksen, following Giddens, distinguishes between two primary forms of trust, the "trusting a "who" or trusting a *what.* Trusting who is when you have confidence in and rely on people in your society but not your government. Trusting what is when one considers the government reliable, but one's fellow citizens do not (Eriksen, 2022).

Hardin (2001, 2002, 2006) proposed a theory of trust as an "encapsulated interest", explaining that our perception of the benefit of the relationship or outcome regulates the incentives to trust. Misztal finds trust to extend further than beliefs, considering that trust is to believe despite uncertainty, and thus always entails an element of risk since one cannot have complete knowledge and can not keep others' behaviour under observation (1996, p. 18), which shares similarities to the widely used definition by Rousseau et al. (1998), who defines trust as to be "the willingness to accept vulnerability based upon positive expectations about another's behaviour", implying that trusting entails risk, as one can never have full knowledge about another person's behaviour. Parsons (1969a: 142, referenced in Misztal, 1996, p. 67) views trust as "the attitudinal ground- in effectively motivated loyalty- for the acceptance of solidarity relationships". Here trust functions as a belief that others will put the interest of the collective before an individual's self-interest, relating trust to solidarity and cooperation. Misztal states that the obligations inherent in social relations are mainly responsible for the production of trust (Misztal, 1996, p.21). Although this highlights the degree to which there is not a consensus on

the definition of trust and that the school of thought varies, it is a common view that trust is and has been the precondition or cause of what is good and valuable in one's personal lives and society at large. Trust is linked to the notion of 'civil society', solidarity, cooperation and economic prosperity, yet measuring trust has proved challenging, as the concept holds different meanings and has different implications.

Uslaner (2002) considers institutional trust, in contrast to generalised trust, to be strategic and based on calculations of trustworthiness. In contemporary societies with a high level of institutionalisation, a more depersonalised trust is considered, that being trust in the institution's ability to perform its functions and to maintain order, differing from the type of trust described to create and maintain personal relationships, which is in line with what (Eriksen, 2022) considers trusting a *what*, still, institutionalised and generalised trust are considered to be related. According to Luhmann (1979), a political system in complex societies is legitimised through procedural rules and institutional performances that secure acceptance of the system, and where trust in a system is based on performance, not shared norms or values, following Goffman (1959) and his concept of *presentations*. This trust in systems stems from the standpoint that "everything appears to be ok" and "everything seems normal". The idea that people want to keep the facade and not lose face applies not only at an individual level but also at a systemic level. When institutions appear to function correctly, this legitimises and induces trust in the system (Mangset, M. 2021. Misztal 1996, p. 249).

The Nordic countries are characterised by a high level of general/social trust, figuring in the top percentile in quantitative studies about trust. Trust is a cherished value in society, and its significance got renewed attention during the pandemic. In the Corona Commission Report, Norway's high level of trust in each other and the authorities was highlighted as contributing to the population's compliance with regulations and recommendations, and the high level of participation in the Covid-19 vaccination program (NOU 2021:6; NOU 2022:5). In Christensen, T. and Lœgreid, P. 's research on Norwegian trust in government, they found that people's trust in government is general, where a high level of trust in one institution tends to extend to other institutions (Christensen, T. and Lœgreid, P, 2005). The Corona commission highlighted the high level of trust, the stable economy, highly functioning welfare politics and well-organised work life, together with a well-developed health care system and a highly competent public sector, to

be "structurally, economic and cultural aspects of Norwegian society that laid the foundation of a successful management of the pandemic". The structural, economic and cultural aspects put forward by the commission show that Norway's high level of social capital has contributed to creating and maintaining social and institutional trust. Eriksen (2020) suggests *Janteloven*, the Law of Jante, as an explanation for Norway's high level of general and institutional trust. Authored by the Danish-Norwegian novelist Aksel Sandemose in 1933, the ten commands of Jante denote a code of conduct, a social attitude towards expressions of personal success or individuality, often comprised to: "You are not to think you are anything special, or that you are better than us." The Law of Jante is by Scandinavians often considered to be quintessentially Scandinavian. Although it is considered to carry negative connotations of conformity, suspicion and envy by some, it is considered to be an explanation for the egalitarian nature of Nordic countries, promoting collective interest over pursuing individual gains.

Conceptualising 'Dugnad'

During the early months of the pandemic outbreak, the government called for a national 'dugnad', translatable to *voluntary work done together with other people for the common good*, to limit the spread of the Covid-19 virus. The word 'dugnad' derives from Old Norse, meaning 'help or good deed'. In 2004, 'dugnad' was awarded Norway's national word and is commonly considered 'typical Norwegian' (Lorentzen, 2011). 'Dugnadsånd' is translatable to *the spirit of the will to work together for a better community* and is considered an essential part of Norwegian culture. The word 'dugnad' is not easily translatable to other languages, so I will continue to use the Norwegian word 'dugnad' throughout my writing. *Dugnad* is not a typical Norwegian concept, as several countries have their classification of 'collective effort' or 'collective voluntary work effort', where Germans will speak of *Gemeinschaftsarbeit*. In France, it is called *travail du groupe.*

In *Dugnad*, Dr Juris Kristian Østberg writes about the historical accounts of the concept of 'dugnad' in Norway, dating back to the 16th century. A dugnad occurred when a smallholder or a farmer had neighbours come to help with a task without payment. Further, he writes that the day of *dugnad* also is a gild day of celebration, and when work was completed, a feast was held(1925, p, 1). Max Weber speaks of a similar concept in "*Economy and Society*", where '*Bittarbeit'* is described as "free labour for the asking", typically in the form of neighbours

helping out a household in urgent need, mainly followed by compensation in the form of a feast. (1978, p. 361-362). Some core elements of 'dugnad' are voluntariness, obligation, reciprocity, unpaid labour, time-restricted, and with some social gatherings before or after.
Although ‘dugnad’ mainly involves maintenance, repair or garden work in one's local community, the concept has, with time, altered from local to regional or even national through its growing use in political discourse in Norway. 'Dugnad' carries connotations deeply embedded in Norwegian society, with established standards and rules of conduct that are difficult to change or oppose (Penner, 2021), making it a fertile concept for political means in creating social cohesion.

‘Dugnad’ in Pandemic Management

Igniting and maintaining the Norwegian 'dugnadsånd' through targeted communication has been beneficial in making people actively follow hygiene and behaviour advice introduced by the government. Having a 'dugnad' against an infectious disease entails coming together, figuratively speaking, to do a collective action, preferably while keeping a social distance. In *Code Red*, Nakstad accounts for when the concept of 'dugnad' was introduced to pandemic management. He writes that he suggested using the word 'dugnad' to appeal to people's efforts in containing infection during an Emergency Committee meeting at the NDH (2021:107). Further, he writes that the Director of Health was favourable to the idea, and together they developed infection protection advice to communicate to the population of Norway throughout the pandemic. The advice went as follows:

1. Stay home if you are sick
2. Keep your distance from others
3. Cough in your elbow
4. Wash your hands

According to Nakstad, this established the individual's responsibility to contribute to containing infection, and the order they were presented was not coincidental." If you stay at home, you will not infect anyone in the public space" (2021:107).

At the start of 2022, I arranged a conversation through Skype with the assistant director at NDH, Espen Nakstad. Behind us were two years of pandemic life, where he had been one of the most prominent figures in management. He gained massive popularity due to his ability to communicate complex information tangibly, making him a well-sought-after persona both by the

media and the public. At the NDH, he was by some just referred to as ‘the star’ due to his communication skills, expert competence and contribution to pandemic management. I called him on Skype at the agreed time but got no answer. I then received an email where he asked if we could move the interview to one hour, stating he was busy at the moment since he had to finish some work-related matters. While waiting for the hour, I scrolled through Norwegian news sites and found a newly published article informing me that Espen Nakstad had tested positive for Covid-19. It was now getting somewhat late in the evening, yet he appeared on Skype as we had agreed. After making sure he was up for an interview, he talked about how it has been for him to lead health preparedness during this crisis. He explained that it, first and foremost, has been a tremendous amount of work but, at the same time, very meaningful work. He believed that their effort had positively affected people's lives by contributing to fewer people being infected, fewer deaths and fewer consequences for the whole of society compared to other countries.

In *Code Red* (2021), Nakstad writes that he was the one who brought the concept of ‘dugnad’ to pandemic management. Therefore, I asked him about his thoughts on the concept and why he found it useful to implement it during this crisis.: "It became evident very early that most people wanted to contribute to the best outcome of this situation in Norway, and if you are to give people a chance to contribute, you need to tell them how to contribute. To appeal to a feeling of 'dugnad' when people are devoted to contributing is very effective", he stated, as he elaborated further: "It is a concept with positive connotations that most people connect to 'chipping in', even if they maybe do not really want to. The concept was used for almost a year before we concluded that we should communicate a little differently because it became apparent that the general population started to be a little tired of the dugnad".

The government's choice of 'dugnad' as rhetorical means to combat contagion in the population was effective, yet it was critiqued for diluting the meaning of the concept of 'dugnad' and masking the implication the restrictions had on people. The restrictions and regulations implemented by the government generally had a low level of voluntariness during the first stages of the pandemic, and they continued over a prolonged time frame. Thus it was not consistent with the general *idea* of the concept, and the government and health authorities use of 'dugnad' was firmly critiqued in public media (See: Alstadheim 2021; Moe, 2021; Revheim-Rafaelsen,

2021; Øverenget, 2020). The relationship between the general public and the public and the state can be considered to be of a reciprocal nature. By participating in the 'dugnad', following regulations and recommendations, generous economic incentives were put in place to ease the financial constraints on people. Marcel Mauss' famed book *The Gift* Mauss identified the place of gift-giving as an organising principle of social cohesion in archaic civilisations, where exchanges and contracts took place in the form of presents. Mauss viewed gift exchange as a 'total social phenomena', evinced in all institutions of society, such as family, religion, laws, politics and economy ([1925]2002:3-4). According to Mauss, the collective activity of giving, receiving and reciprocating appears as an act of voluntariness. In reality, they are mutually obligatory acts, and to exclude oneself from the norms of gift-giving could threaten established alliances or group relationships ([1925]2002:17).

Mary Douglas's (1990, p.x) notion that there is no such thing as a free gift and that *The Gift ([1925] 2002)* actually is about 'politics' and human solidarity. The Norwegian concept *of dugnad*, described as *voluntary work done together with other people for the common good,* comprises the aspect of both gift-giving and solidarity. The Norwegian health authorities and governments' rhetorical use of the concept 'awakening the Norwegian ‘dugnadsånd', translatable to *the spirit of will to work together for a better community,* pertains to the ethos of the Norwegian 'dugnad' culture, where in this context, reciprocity forms its own order of interaction between the general population and the state. The corona 'dugnad' induced imaginations in the population in the form of the intimate action of saving the lives of the fellow citizens who were vulnerable to suffering severe illness or death by Covid-19.

The shared responsibility and solidarity that ‘dugnad’ brought forward, together with the voluntariness and care enacted by the general population by following the government's recommendations, was reciprocated with generous economic incentives by the government. However, the fairness of the incentives has been heavily debated. With the government's continuous communication of the importance of ‘dugnad’ to keep the numbers of infected low, citizens of Oslo received several official SMS, asking the public to follow the restrictions with wordings like: "We can do this together. Do it for Oslo". ‘Dugnad’, one could argue, accompanies the social democratic cooperation ideology already established in Norwegian welfare policy discourse (Askheim, 2017), which brought forward a sense of community on a

national scale. By actively using the term 'dugnad' in communicating with the public, health authorities arguably appealed to a national identity, creating a shared sense of belonging and a belief in a common identity and purpose (Anderson, 2016), with following expectations and responsibilities.

The combination of voluntariness, reciprocity and obligation provides a duality that can give rise to tension (Lorentzen. Dugstad, 2011), where different forms of participation can create both moral winners and losers (Sørhaug, 1989). 'Dugnad', as a symbol of social cohesion, enclosed similarities and marked off elements which differed (Cohen, 1985, p. 14). Whereas uneven participation could cause tension and annoyance among the populace, adopting the role of an 'outsider' (Cohen, 1985) frequently resulted in frustration revealed through harsh opinions exchanges. Deviation from expected behaviour in mask use, distancing, social gatherings, travelling, and especially stances on vaccines would be the target of public critique.

As our conversation continued, we discussed how 'dugnad' had manifested in society through the pandemic. While it originally was intended to promote *good behaviour* in public by following advice given by health authorities to stop the spread of the virus, it later converted into a concept used in the vaccine debate. By the fall of 2021, the number of infected was increasing nationally, and globally there were strong indications that the vaccine effect was declining with time, pushing forward the debate about a third vaccine dose. Simultaneously the Covid-19 vaccination programme had reached the entire population eligible for a vaccine, making it possible to grasp how many had turned down the vaccine offers, which contributed to a great deal of public tension with heated debates in public media. Some claimed the whole of society was being held hostage by unvaccinated people due to corona restrictions, and a great deal of the general public, health professionals and health authorities considered participating in the Covid-19 vaccination program as a prolonged part of the national ‘dugnad’.

A recent experiment (2021) conducted by the University of Bergen (UiB) showed that the incentives for taking the vaccine were affected by how its benefits are described. They found that people were more inclined to take the vaccine if it is presented as a collective responsibility. They stated that: "The message that as many people in society as possible should get the vaccine motivates more than the message that it is good for you to get the vaccine". They further wrote:

"It can be useful to draw attention to a sense of community and to remind yourself of others' expectations of us, and our expectations of others" (Sætrevik et al., 2021).

Some people were eager to show their contribution by posting pictures of themselves on social media wearing face masks or from the 'office', which temporarily took the form of a cabin or summer house with a stunning view. These lunch breaks entailed a walk in nature in solitude or a selfie from a vaccination centre, predominantly of a shoulder with a cotton ball taped to it. The former prime minister of Norway, Erna Solberg, posted a picture of herself receiving a vaccine on Instagram, as did several other public personas.

In *The Gift* (1990), Marcel Mauss gives an account of this when he explains that "gifts are to be given, taken and reciprocated, and if a gift is kept too long, the reputation of the recipient is at stake". Adloff and Mau highlight the importance of gifts, reciprocity and trust for the cooperation of actors and to the establishment of social order (2006:109), pointing to the argument that: "Reciprocity of both rules and expectations must always be established and assumed" (Wenzel, 2001:330, as cited in Lyon et al., 2014), placing trust as the central mechanism for social relations to come into existence. Arguably, the concept of 'dugnad' does not only trigger a notion of 'doing good for others'*; it* is embedded with a sense of reciprocal duty and morality.

The general population showed high trust in the government and the experts and participated largely in the 'dugnad' initiated by the health authorities. The pandemic highlighted the relationship between the individual and the community and between rights and duties, where 'dugnad' invoked cooperation, group solidarity and social cohesion. Utilising the concept of 'dugnad' during the crisis proved effective as means of uniting a population around a common strategy and end goal. The health authorities and the government quickly established "expectation for action within a collectivity" (Portes & Sensenbrenner, 1993, p.1323) through cultural norms associated with 'dugnad'. Having strong cultural norms that support collectivity over individuality has been beneficial as an aid in managing the pandemic. One can argue that the reciprocal connotations that come with the concept of 'dugnad' was met by generous financial aid packages from the government aimed to help people and businesses through economic hardship following a crisis of this magnitude. It is argued that social capital builds trust (Cook, 2004; Fukuyama, 1996; Putnam, 1993), and financial aid packages allow people to worry less

about finances, eliminating economic incentives not to follow the health authorities' and governments' regulations and recommendations.

Chapter 3: Knowledge in the Times of the Pandemic

"I think that all the uncertainty has made it difficult, because even though one knows a lot, many of the answers we have provided have been impacted by great uncertainty, and we are not used to that. Health services are built upon solid knowledge developed over time, and then suddenly you are providing a ton of answers that affect the whole of society when you don't even know what is right, what is reasonable, and what is the right level of risk and what is not. And I think that is very challenging, to give that many answers into an uncertain environment."

-Employee at the Norwegian Directorate of Health

In the early months of 2020, the scientific community was facing uncertainty, contradicting reports and a general lack of knowledge of the potency of the novel virus. The alert was high in scientific environments, and amongst some medical professionals in Norway it was an ongoing "quest for knowledge" (Nakstad, 2021:59-64). During a conversation I had with a leading figure in pandemic management, he stated that: "Probably the most significant problem one has throughout the pandemic is the insufficient knowledge base, and that one does not work enough to gather that knowledge or to generate it if it does not already exist." He continued: "To make good assessments of judicial proportionality proves challenging when you have to base it on insufficient knowledge, and because of the challenging nature of the situation it is important to ask those critical questions to the accepted truths." A recurrent impediment to pandemic management was the lack of scientific knowledge about the virus and its mutations, the long term effects after being sick, the effect the varying restrictions and regulation had on society at large, and the vaccine effect. Consequently, inquiries into the scientific legitimacy to claims of knowledge were addressed numerous times by people within both NDH and NIPH, by independent scientific environments, and by the media and the general population. The prevailing knowledge gaps required experts to sometimes give advice based on what some considered to be subjective belief or unsupported speculation. As one leading figure in pandemic management put it: "Just because there is an absence of studies on it, does not mean it is not so.

You use your logical sense and past experiences." In *The Problem of Secret Intelligence* (2021) the Norwegian intelligence officer Kjetil A. Hatlebrekke describes it like this: "Would it be possible to understand the colour green if you never have seen the colour, and if there never existed a word for green? The answer is yes. As long as blue and yellow exist, one can explain that a colour can appear through the combination of blue and yellow. Thinking like this is what makes research and intelligence possible." (Hatlebrekke, 2021, cited in Bentzrød, 2021).

Conflicting knowledge, claims of what was "scientific knowledge" and what was termed "unscientific" created tension in pandemic management, and disagreements between organisations, within organisations, between experts and between state and the public. A discernible gap between expert knowledge and the experienced based knowledge can result in the decision-making process scrutinised, where it may be questioned or deemed illegitimate by people affected (Eriksen and Schober, 2017: 12-13).

"The most dangerous form of ignorance is to not know what you do not know, the unknown unknowns." The statement is taken from the recently published book *Code Red*, written by the assistant director of the NDH, Espen Nakstad (2021, p. 85). The concept of 'unknown unknowns' dates back to 1955 and was created by two American psychologists in their development of the 'Johari Window', a framework for understanding conscious and unconscious bias (Luft, Ingham, 1955). The phrase was made famous by the former United States Secretary of Defence, Donald Rumsfeld, when he in 2002 were asked for evidence that Saddam Hussein attempted to supply terrorist groups with weapons of mass destructions:
"...There are known knowns; there are things we know we know. We also know there are known unknowns; that is to say we know there are some things we do not know. But there are also unknown unknowns- the ones we do not know we do not know."

In *Code Red* (2021), the assistant director of the NDH further writes that: "there also is 'unknown knowns;' that is knowledge we do not know that we possess." (2021, p. 85-86). I would like to add one more to their list, which is what I would call the 'unknowing knowns', also referred to as agnotology, which is the study of ignorance, specifically the formation of ignorance. Agnotology refers to the deliberate or unintentional dissemination of disinformation, selective presentation of facts, and the development of uncertainty or doubt in order to alter

public perception, policy, or decision-making (Proctor, 2008). Ignorance can for instance be produced through censorship, distortion of facts, propaganda and misinformation, limited access to education, and by cultural norms and values (Proctor, 2008). In the perspective of pandemic management, misinformation was a major conundrum for health authorities and governments, which altered public perception in various situations. It is vital, however, to distinguish between dismissal and suppression of knowledge, since they are not synonymous with the manufacture of falsity as non-knowledges, such as fraud, hoaxes, or propaganda, which are intentional distortions of knowns (Bernstein 2009*a-b*, in Croissant, 2014).

Kourany and Carrier suggest that the quest for knowledge, especially scientific knowledge operates like a searchlight, where there is an intentional need to leave something out while illuminating others. They consider this selective ignorance as not something to criticise, rather they are unavoidable (2019, p. 12). Though, according to David Michaels, the notion of agnotology has a variety of meanings, where some are even favourable. There is not all knowledge that would benefit a society if it was disclosed. Examples would be bomb- making or how to alter viruses to become more deadly. Michaels, however, focuses on agnotology as an "deliberately anti-epistemic strategy" where "some kinds of scientific interaction are epistemically damaging and hurt the production of knowledge."(2008, p.61).

Expert Knowledge and Scientific Legitimacy

For knowledge to be considered scientific it is required to be based on validated scientific methods organised by general principles. There is a prevalent view that scientific objectivity is the kind of feature that gives us permission to trust scientific knowledge claims. Research on the consequences of smoking sponsored by Tobacco companies or climate-change studies endorsed by big Oil companies are generally well known examples of knowledge claims lacking scientific objectivity. According to Heather Douglas, by asserting that a scientific claim of knowledge is objective, we are affirming its reliability and indicating that the claim can be trusted by yourself and by others (2009:17).

Medicine and health were central subjects in his work of Michel Foucault, and used to illustrate his broader theories of the interconnectedness of knowledge and power (1975;1980; 1991), as well as his theories on governmentality and biopolitics originating from his analysis of

quarantine enforcements during the plague and the emergence of public health measures in the eighteenth century theories on governmentality and biopolitics, (1978; 1979a; 1980; 1991). Foucault argued that real power lies in institutions governing the human experience, like the system of education and the medical profession. These institutions, according to Foucault, govern the social reality of our existence, hence, power and knowledge can not be separated (1980). By abandoning the idea of power as merely a suppressive force preventing knowledge, as Foucault saw it, it was knowledge that produced power (1980:59). In order to speak about knowledge, he argued, one must investigate the process of its construction. The ability to define or construct a discourse in which a subject can be discussed and establish premises for what is thinkable and inconceivable is, according to Foucault, as important as the ability to use coercive force (1980:61). According to Foucault, when something is deemed as knowledge, power is inherently involved in the process (1980:119), where claims to specialised knowledge should be viewed as claims of power, as knowledge produced under the label of science deemed knowledge legitimate or valid (Lewellen, p. 192).

Nadasdy has stated that the label "science" is the "marker of validity" and therefore a powerful label that has legitimising potency. He suggests that the usage of the term "unscientific" demonstrates this internal power struggle over the term "scientific" within scientific communities. If knowledge is labelled "unscientific", its legitimacy is removed, and with it the power inherent in the knowledge (Nadasdy, 2003:138). Nadasdy has stated that the label "science" is the "marker of validity" and therefore a powerful label that has legitimising potency. He suggests that the usage of the term "unscientific" demonstrates this internal power struggle over the term "scientific" within scientific communities. If knowledge is labelled "unscientific", its legitimacy is removed, and with it the power inherent in the knowledge (Nadasdy, 2003:138).

Eric Wolf conceptualisation of power demonstrates its inseparable relationship to knowledge. Wolf distinguishes between four different modes of power: individual power, or an individual's potency. Second is social power, denoting the ability of one person to impose their will on others. The third type of power is what Wolf refers to as tactical or organisational power, or the ability to control the settings in which people interact. The last and final type of power is what Wolfe refers to as structural power, which is the ability to define the social field and our understanding of the world (Wolf, 1990,[1989] p. 586-587).

Max Weber (1946) discusses the bureaucratisation of scientific knowledge, where a particular type of knowledge forms the basis of a bureaucracy. The bureaucratisation process helps rationalise and objectify knowledge, removing the subject from the knowledge, thus making it appear objective. As long as bureaucratic rules are employed, anyone can function as a bureaucrat, and bureaucracy helps objectify knowledge (1946:8). Considering Weber's account through the lens of pandemic management, the bureaucratisation of scientific knowledge could refer to the incorporation of scientific knowledge into bureaucratic structures, like government agencies and public health organisations. This process led to the rationalisation and objectification of the knowledge, which can make it appear more objective and legitimate.

Fast Science and Cherry Picking

During the pandemic, the continuing quest for knowledge in order to manage the crisis more effectively opened up for the concept of *fast science,* that is knowledge presented as science without the standard validity markers- like peer review, gained mainstream acceptance as scientific knowledge, used to assess and potentially base strategy upon. Nakstad states that there was a clash of knowledge in the scientific environment already from the early onset of the pandemic (Nakstad. 2021:308-309), where the disagreement between experts on how to handle a growing pandemic was disputed. The new concept of *fast science,* and the following acceptance of it as validated science throughout the pandemic stands in contrast to the traditional view that the validation of research depends on whether it has been peer reviewed. As a means in the fight against the virus, access to fast science has been a valuable resource, for instance when questions of future strategies have been raised. In the epidemiological environment, outbreak scientists have extensively been posting draft papers with the intent to make new research accessible faster, before its peer-reviewed, where the sharing of unvalidated research has contributed to the understanding and containment of previous disease outbreaks (Kucharski, A. 2020: 237-238).

The other side of this is “that it requires people with the competence to assess the quality of the study for it to have any value to the pandemic management and implemented strategies. *How* one reads scientific knowledge is of significance”, I was once told by an employee at the NDH. Coming from a background in scientific research, he said that he often spent time reading up on scientific research on his own time, using his expertise to filter through the studies deemed

useful. He was of the perception that many studies were not adapted to fit the problem one actually was looking at, and therefore rendered useless as a knowledge base in pandemic management.

During my time with the NDH, I observed on several occasions commentaries or discussions pertaining the validity of studies, and the use of, or the failure to acknowledge certain studies.
Due to the nature of the pandemic, 'what is true today is not necessarily true tomorrow' nearly became a mantra at the time. When both the behaviour of the virus and the behaviour of people could impact the course and magnitude of the pandemic, certain 'accepted truths' in Norway altered throughout the pandemic without much contestation. It was not uncommon or strange for health authorities to regularly question what was deemed 'scientific knowledge', by exploring its usefulness, quality and legitimacy, as it provided weight to the assessments. Yet, when the two organisations really could not see head to head about a topic, the exchanges of opinions could get somewhat sharp.

During a CC-meeting, a leader at the NDH, brought up the new attention amongst some scientific environments in Norway to the concept of 'long-covid', which at the time was not given significant attention by the NIPH. He tells everyone participating in the meeting about something he recently heard on the radio. The story was about the developing understanding of potential long-term effects from the virus, where a lady, who after being ill with covid got an altered sense of smell which really affected the quality of her daily life. The leader then addressed a leader with the NIPH, and asked her if the NIPH had any thoughts or worries on the subject, which she slightly disdainfully rejected. The leader from NDH, seemingly annoyed by the nonchalant response, bursted out: "Well, it is not exactly joyful if your partner of many years all of a sudden smells like shit!". The room became awkwardly silent, before the meeting continued with the next topic on the agenda list.

The acknowledgement of 'long-covid' as a real implication of Covid-19 developed slowly over time, so did the acknowledgement that Covid-19 can spread via airborne transmission.
However, the most contested matter throughout the pandemic was the role of children in the spread of infection. The many 'accepted truths' of children's role in contracting or spreading the virus, or to which extent the virus, or the infection protection measures posed a threat to

children's health, led to debates amongst health authorities. The diverging opinions appear to arise from varying perceptions of risk.

Risk and Risk Perception

Risk is considered a fundamental constituent of life, as it is felt and experienced by all people. Although unwanted outcomes of situations, like the loss of material assets, status, health or one's life always have been a part of the human experience, the transition from accepting it as faith or destiny, to conceptualise it as risk occupies several contemporary theories about modern or postmodern societies, where risk is argued to be a consequence of modernity (Beck 1992, Giddens 1990, Renn, 2017). Here, risk is a tool in dealing with uncertainty and the complexities of contemporary societies. According to Renn, contemporary philosophical thinking and social scientific research have been influenced by questions related to the nature of risk, the social construction of risk issues, and cultural differences in conceptualising and interpreting risk (2017, p. xiv). Within the realm of risk research, there are two conceptualisations of risk that are seemingly contradictional. One is where risk is thought to be decided by facts, known as 'objective' risk. The other regards risk as a social construct that is unrelated to physical facts (Hansson, 2010).

Aven and Renn define risk into two categories; expressed by means of probabilities and expected values, and expressed through events/consequences and uncertainties (Aven, Renn, 2010). Further, they conceptualise risk as to "refer to uncertainty about and severity of the consequences (or outcomes) of an activity with respect to something that humans value" , where their definition opposes the idea that risk is a state of the world that exists independently of its assessors. According to them, risk requires 'a mental construction of the uncertainty (knowledge) dimension' (2010, p. 8-10). This approach to the concept of risk finds risk as a phenomena that originates in the human mind, as a tool in assessing and dealing with uncertainty and probabilities. Renn considers risk to be "paramount to our understanding of human agency, presupposing that human beings are capable of acting in a strategic fashion by linking decisions with outcomes." (Renn 2017, xiii). German sociologist Niklas Luhmann has postulated that human behaviour can only be understood if we know and explore what options (or, in the words of Luhmann, what contingencies) the actors considered before making their choice (Luhmann,

1990). In simple terms, risk is the possibility of something (bad) happening as an outcome of a situation, and is usually characterised by reference to potential events and consequences or a combination of these. The understanding of risk, the methods of assessment and management and even the definition of risk vary in different practice areas.

Within the scope of research on risk perception, there are two main schools of thought; the 'Psychometric Paradigm' (Slovic 1987), utilised to understand how types of risks are understood differently at an individual level. This approach posits that people's perceptions of risk are influenced by two main factors; the characteristics of the risk itself and the individual's subjective judgements and evaluations of those characteristics. Slovics' framework suggests that risk perception is not simply a matter of objective analysis, but is also shaped by subjective factors that vary across individuals and context.

The other is 'Cultural Theory', developed by Mary Douglas and Aaron Wildavsky (1982), where the perspective on the individual is positioned in a societal perspective. Deriving from Douglas grid/group theories developed in the 1970's, by categorising *culture* as sets of beliefs, values and behaviours, Douglas and Wildavsky' framework proposes that people's perception and responses to risk are determined by their cultural biases and values. As different cultures have different attitudes towards risk, the theory posits that it is these attitudes that shape how individuals and societies understand and respond to risk. According to Douglas and Wildavsky (1982), there are four cultural biases, or worldviews that shape how individuals and societies perceive and respond to risk: a hierarchical worldview that values rule-bound institutions, strong regulations and stability,individualistic worldviews is usually associated with liberal democracies because it values individual freedom and autonomy, egalitarian worldview is generally associated with socialist and progressive nations,in the fatalistic worldview, fatalism, destiny and resignation are valued, which is commonly associated with fatalistic or religious society. Cultural theory has been critiqued, where questions regarding its usefulness in estimating risk perception have been questioned. As a theory that describes tendencies, dispositions and worldviews, it is argued that cultural theory has its limitations as a framework to predict risk perception in specific situations (Boholm, 1996; Oltedal et. al. 2004).

Assessing risk played a substantial role in pandemic management by monitoring both national and international numbers of infected, hospitalizations and deaths. Categories like vulnerable groups, infection rate, herd immunity, virus mutations, geographical proximity, similarity or dissimilarity in strategy, or a population's vaccine status and effects were monitored in close relation to the pandemic development in Norway. Analyses based on the collected data made up foundations of the risk assessments produced by the NDH and the NIPH. If considering (health) risk as naturally occurring, as falling ill or dying from a disease caused by an epidemic or a pandemic has been part of human civilization from early accounts. Covid-19 carried a serious risk of illness and death for many people, simultaneously did the pandemic show that risk, through the process of risk perception was constructed, negotiated and contested.

Situational Awareness

"We early established cooperation through these assignment meetings. I established that during the summer of 2020. The reason was all the allocated assignments we were given, and it was important to have a discussion around them. It was practical, and it developed spheres for cooperation between caseworkers from NDH and NIPH, where they could bounce ideas off each other. It has developed to work better with time, but there are still a number of professional disagreements and differences due to different roles and different working methods, yes, different roles and different perspectives, which of course have been useful to discuss. And that type of discussion is very fruitful because it often corrects people's understanding of the situation and very many difficult issues get a better solution if you discuss it thoroughly and don't just pretend to agree."

The collaboration between the NDH and NIPH was to consolidate different types of knowledge, so as to obtain solid scientific and judicial recommendations as foundations for the government's pandemic regulations. It was important to ensure proportionality between the current situation and the recommendations presented by the organisations to the Ministry. On several occasions during in house meetings, the term 'situational awareness' was brought up during discussion. As I will discuss further, 'situational awareness' varied amongst actors in pandemic management, where it created friction within and between organisations. When faced with uncertainty, ascribing something as knowledge was often a conflict laden process, where management's focus of ensuring proportionality between the assessed situation and the recommendations depended

on a unified situational awareness. During an interview on decision making, psychologist Gerd Gigerenzer insists on distinguishing between the notion of 'uncertainty' and the notion of 'risk', as they often are interchangeably used. He explains the distinctions as: "a situation with risk, you basically have all the information. More precisely, you know everything that can happen in the future. You know the consequences and you know the probabilities." About uncertainties he explains: " Uncertainty, on the other hand, means that all future possible events aren't known, nor are their probabilities or their consequences. Gigerenzer further explains that dealing with risk requires a different approach than dealing with uncertainty: " With risk, all you need is calculation. With uncertainty, calculation may help you to some degree, but there is no way to calculate the optimal situation." To address uncertainty, he argues, humans resort to: "heuristics, intuition, finding people to trust, and adopting narratives to sustain you"(Edmonds, D. 2022).

The phrase *situational awareness* can in simple terms be understood as to understand what is going on around you. During meetings at NDH, I often heard mentions like: 'we have diverging situational awareness', which would occur either between employees at the NDH, or between the NDH and NIPH. The further into my fieldwork I got, the more I realised how many of the discussions were deemed to be caused by diverging situational awareness. An employee with the NDH explained it like this:

> ”Your situational awareness is your own perception of what is happening around you, and what it means. For instance, how serious the situation is, what consequences you think it can have and when you think these consequences can occur. In other words; your perception of what has happened or what is about to happen. Experience from real crises and exercises shows that people with the same background of experience who are fed the same information do not necessarily see the same danger potential in the situation or assess its consequences in the same way. In order for a crisis team to agree on a common goal for crisis management, it is therefore necessary that they have a reasonably agreed understanding of the situation. It usually requires that everyone involved tell each other what they actually base their own understanding of the situation on. Then

you usually achieve that many of them correct their own perception and it gradually becomes easier to read the situation equally."

Situational awareness is tightly connected to risk perception. Risk is commonly perceived as something that can result in undesired outcomes, where risk perception refers to the process by which individuals evaluate and assess the potential harm (or benefit) associated with a particular course of action or situation, and is a fundamental aspect of decision-making- particularly in circumstances where there is uncertainty or ambiguity of the consequences.

Children as Subjects of Pandemic Management

Foucault's description of discursive power presents discourse as a system of knowledge that has the ability to "determine the limit of thinking, perceiving, speaking or acting. The discourse contains the rules for designating a statement true or false." (Lewellen 2003:228) These guidelines, or rules, are often based on established criteria, such as empirical evidence or logical reasoning, and they shape the understanding of what counts as knowledge or information within a particular discourse. Thus, the rules or guidelines within a discourse shape how we evaluate knowledge claims and ultimately contribute to the formation of our beliefs and understanding of the world around us.

During a conversation I had with one of the most prominent figures of pandemic management, I brought up the role of children, wondering if he would like to share his thoughts on the subject with me?: "Eh, you know, this is a challenging subject, because to understand a pandemic you need to understand the meaning of exponential growth. And then you understand that to not have infection protection measures directed at children and youth, eh, can result in that the burden of infection protection measures becoming greater later." In epidemiology, terms like 'exponential growth' and 'reproduction number (R)' are used when talking about and understanding virus transmission, and were heavily used during the Covid-19 pandemic.[1] He continued: "We have managed to keep the schools open a lot more compared to many other countries in the world.

[1] The R-number shows how fast a disease is spreading, as it represents the average number of people infected by one person. The number of transmissions remains more or less constant when the value of R = 1. This means that 1 person with coronavirus only infects 1 other person. If the value of R is greater than 1, the number of people getting infected is increasing. If R = 2, the number of people affected doubles with each 'generation' of transmission, beginning with 1 person infecting 2 others. These 2 infect 4 others. And these 4 people infect 8 others. When something increases or decreases by a certain percentage over several periods, you have what is termed exponential growth.

They have actually only been closed on a national scale once in March/April of 2020. In other countries, schools have been closed for six months, even up to a year. Those who one-sidedly critique infection control measures against children, they never highlight this.”

The closing of schools and kindergartens in Norway was, according to the Deputy General at NIPH, the only infection protection measure they did not agree with, when the country closed down in March 2020. In the days leading up to lockdown, people publicly raised concerns of having their children in school, where some parents did take their children out of school. In the Corona Commission Report, it was concluded that closing schools on a national scale was the

right thing to do at the time (NOU 2021:6). Children's right and duty to education stands heavily in Norway, and the closing of schools provided children with a school of lower quality. He continued:” And in this debate, one never discusses long-covid, and one never discusses the trauma it might be for a child to inflict disease and death to their grandparents. In Sweden there are probably more than a thousand children feeling guilty because they transmitted disease that ended in the death of their grandparents. Those kinds of perspectives are not being raised at all.”

He was not the only one who raised a similar concern. The Norwegian jurist, lawyer and associate professor of jurisprudence at the Faculty of Law at the University of Oslo, Anne Kjersti Befring, raised a similar question during a presentation she held during a lunch seminar at NDH, where she addressed nuances of children's experience in the pandemic. Children exist in a context of family and risk groups. This is in line with the argument made by Arendt, who stated that we should not insist on “separating children from the adult community as though they were not living in the same world and as though childhood were an autonomous human state, capable of living by its own laws” (Arendt, quoted in Malkki 2015:102). According to Elshtain, who builds on Arendt's ideas (cited in Malkki, 2015), the protection of childhood from public and political matters is crucial. Elshtain's view is that childhood is not a political condition that requires liberation, but rather a crucial phase in human development that demands safeguarding. “Childhood is a fragile and vulnerable period in which individuals are preparing for the future, and it is necessary to provide a safe and secure environment for them during this time. If we fail to do so, we are failing to fulfil our responsibilities towards children and betraying them” (Elshtain 1994:7-13, in Malkki, 2015:102).

As we continue our conversation he states that: “the unwillingness of accepting children's role in spreading the virus had great consequences for pandemic management. It could have resulted in vaccination of schoolchildren before the new school year, like they did in Denmark. That could potentially have given us a much smaller wave of infection leading to less need of infection protection measures. We had a significantly big wave of infections this fall, together with many cases of RS virus, and the school absence for children in Norway during this pandemic has never been higher than it was these last six months, after we got vaccines.” He laughs a little: “ One can discuss if this has been good handling, but eh, it is what it is.”

Prior to the pandemic, epidemiological research done on social contacts amongst people in numerous countries showed that children have the most contacts (Kucharski 2019: 80). A study on social contacts and infection during the 2009 flu pandemic in Hong Kong found that it was the number of social contacts amongst children that drove the pandemic (2019:90). After experiencing what we had just experienced with an explosion of infected, mainly children and youth of school age, I raise the question of children's role in spreading of disease, and ask why epidemiological knowledge of children and contagion has, to the best of my knowledge, not been publicly discussed? He replied: “Hmm, yes, not only have they steered clear, they have, they have not wanted to, not wanted…” He paused a little: “It is still the official position of the NIPH that children get little sick and infect to a small extent, and that viruses are not airborne, transmission is just through droplet spread and close contact. Both cases are well documented for a year and a half that it is not the case. But it is difficult based on the roles one has, and it is difficult to penetrate it more than we have done.”

During a research conference in the fall of 2021, immunologist Anne Spurkland made a commentary on the role of children in pandemic management, where she stated: “Children don’t have clothes on”, referencing the well known Danish fairytale "The emperor's new clothes"[2], by

[2] The Emperor's New Clothes is a fairytale from 1837 written by the Danish author H.C. Andersen. In the fairy tale, we hear of an emperor who is tricked into thinking he is walking around in clothes of the most beautiful fabrics, when in reality he is walking around in only his underwear. It is not until a little boy mentions that he is without clothes that the rest of the people openly acknowledge that the king is in fact naked.

H. C. Andersen. The fairytale has become an expression of reluctance to point out problems and following the collective thought in avoidance of standing out or losing their own facade. Her objective was that children should get vaccinated, as it would have had a lot less cases of infection amongst the younger population. Children under the age of 5 were never offered a vaccine against Covid-19 in Norway, and children between the age of 5-11 could, on the request of their parents receive one. From the age of 12 was one offered a vaccine in Norway.

The different representations of children and what role they were given in the pandemic, as victims of politics, or as risk carriers, largely impacted pandemic management. Ideas pertaining to what the 'best for children' implied, was defined through a process of validating knowledge claims as 'objective truths', while disregarding others. According to Ortwin Renn "The many hypothetical futures that were not selected are often more important for understanding social responses to specific phenomena than the actual response to any particular phenomenon." (2017: xiii)

Actors in pandemic management were all trying to do what was best for the children, yet, the diverging beliefs of what that entailed made children a disputed subject. The varying assumptions of children's role in contracting and spreading the virus, as well as the concern over the consequences to children's wellbeing after being subjected to infection protection measures that interfered with their daily lives, was in a way two different approaches to risk that one can presume came from 'objective' as well as 'subjective' risk perception. As the 'objective' risk perception , the one that deals with numbers and statistical data to calculate probabilities, from past to present, the 'subjective' risk perception is formed through people's past experiences, which in a much bigger extent relates to uncertainties and an imagined future of consequences. Classifying risk as 'objective' or 'subjective' is argued to be a simplification of a complex issue, as risk is both fact-laden and value- laden (Hansson, 20101), however, by making a distinction between risk and uncertainty (Gigerenzer 2014; Edmonds, 2022) and employing the traits of risk, as measurable and factual, while employing the traits of uncertainty to subjective risk perception, or contingencies, demonstrates how subjective risk in the case of concern for children's well being exist in the imagined future of possibilities, which may be influenced by an experts background, values and moral stance (Douglas 1987).

Chapter 4: Pandemic Management as Performance

In Erving Goffman's work “Performance of Self in Everyday Life”, he posits that social interactions are like theatrical performances, in which individuals present themselves to others through a carefully managed and constructed performance (1959). Goffman pays particular attention to what he calls “frontstage” and “backstage” behaviour as communicative custom. Where frontstage behaviour reflects internalised norms and expectations for behaviour shaped partly by one's physical appearance, the setting, and particular role one plays in it. Backstage behaviour refers to one's behaviour when no one is looking (although there might always be somebody looking). When people are backstage, they often prepare for upcoming front stage performances by rehearsing certain behaviours or interactions, which are tightly connected to one's status and role, as it defines others' expectations of oneself (1959). In the works of Erwin Goffman, the focus on the performance between individuals in social interactions is useful in understanding how actors perform roles in an effort to create order (1959, 1967). Crisis management is to an extent a social performance, in the sense that political leaders, health officials and experts are constantly managing their roles in order to maintain public trust and credibility.

Goffman defines a team as an arrangement of individuals for interactional purposes that, through close cooperation, manage to uphold a certain definition of the situation, separate from social structures or social organisation (1959:108). Further, Goffman (1959:74) states that teamwork relies on trust which creates a bond of mutual dependency between team members. This mutual dependency is argued by Goffman to create cohesion across socially and structurally dividing lines. Team performances would, according to Goffman, weld it together again. Managing the pandemic was a team effort between people from different organisations, professional backgrounds and with different levels of authority and status. It was important to uphold a sense of togetherness in the organisation and between organisations, and only working digital made that more difficult. It demanded management to pay closer attention to any disunity or dissatisfaction to avoid any cracks in the team. As Goffman states, any team member can easily disrupt the outward image of the team by not acting in accordance with the team performance,

and the awareness of this by fellow team members is what brings team trust into being (1959:88) Breuer et al., (2016) have found that team trust matters more in virtual teams than teams who meet in-person, due to the added uncertainties and risks that follow under conditions of digital communication.

The Sibling Fight

"The relationship between the Directorate of Health and the Norwegian Institute of Public Health resembles that of a brother and a sister arguing. And then the mom and dad need to mediate the situation."

One early morning at the NDH, I took a spot in the office and began talking with one of the employees. We are the only two people in the room, which makes it a preferable time to engage in a conversation. After a little while the Corona Commission report, published in April, 2021 became the centre of our conversation. There were some nerves and apprehensiveness prior to the publication of the report. It was the first official assessment of the Norwegian government and health authorities' management of the first part of the Pandemic, where every decision was scrutinised and assessed. We discussed the report, which concluded that the overall management of the pandemic was good, yet there were some issues it highlighted. In the report, critique was directed at Norway's lack of preparedness in managing a crisis of this magnitude, that the decision to implement "the most invasive measures in Norway in Peacetime" was done seemingly quickly and with little documentation of the process. The commission further pointed out that the decision to close down the country should have been made by the government, and not the NDH, who were allocated the authority through the Infection Protection Act. Although several concerns were raised publicly as to if human and constitutional rights were overseen in the process, the commission did not find it to be unconstitutional (NOU 2021:6, chapter 2.2). I asked his opinion on the critique given to the health authorities, which he said he found justifiable, and that they were right about a lot of things. A topic addressed in the commission report was the cooperation between the NDH and NIPH, so I asked him what he thought about the relationship between the NDH and the NIPH so far during the pandemic, and it looked like a thousand thoughts were running through his head before he replied: "The relationship between the Directorate of Health and the Norwegian Institute of Public Health resembles that of a brother and a sister arguing. And then the mom and dad need to mediate the situation. The

Ministry being the mom and dad". The analogy he presented between a sibling fight and that of the relationship between the two organisations during this crisis was both humorous and striking. It was not a well kept secret at the house that it occasionally had been 'pretty heated' between employees at the NDH and employees from NIPH. Yet, by ascribing it to such infantile traits put a humorous twist to it. He added: *"What does a mom and dad do when a sister and brother are fighting? They're not allowed to sit in their separate rooms and be mad at each other. Now they have to talk it out in the living room, right!"*

The relationship between the NDH and NIPH was frequently portrayed by the media as a collaboration characterised by disagreement and tension. At the NDH, staff said it was influenced by the newly established case working process established by the Ministry, where assignments were given on sometimes unreasonably short deadlines. Due to time restraints, recommendations had to be made quickly and usually based on thin knowledge and uncertainty, which nourished prevailing disagreement between experts of what is the best or right recommendations to present the government with. Another aspect put forward as a reason for the many disagreements was the question of role understanding. The term 'role- understanding' was frequently mentioned throughout my fieldwork, and it was a concept of significance for people from the NDH as well as the NIPH. The described bickering and disagreement stemmed from the varying conceptualization of the role ascribed to each organisation, in regards to 'who can say or have an opinion about what', I was told.

In a letter sent from the General Director of Chief of Staff at NIPH to the Corona commission titled "Examples of blurred role understanding, diverging advice and duplication of work, The Norwegian Institute of Public Health versus The Norwegian Directorate of Health" (Aftenposten, 2021), several examples of what they consider to be unclear roles, wrong infection control advice and double work is presented. The recount of the days up to and the time after March 12, 2020 has been described by many people involved in pandemic management as confusing and chaotic, with a high level of uncertainty. The letter from the General Directors Chief of Staff depicts a time where the management of the pandemic was influenced by unclear roles, diverging advice and double work:

> "The examples below illustrate, in our opinion, the inconsistencies and duplication of the work between the NDH and us, and is what we consider contrary to the Infection Protection Act (Smittevernloven) and the Health Preparedness Act (Helseberedskapsloven) [...] The matters of concern are both surveillance and advisory. For advisory, divergent advice contributes to confusement and additional work in the sense that we need to work to correct the mistakes done by the NDH, but also the issue that the NDH are using resources on work already done /being done that they don't have sufficient knowledge about. We would be pleased to have resources from the NDH to compile advice. It is important that surveillance systems are connected and supplemental to each other."

Content from the letter has been published in separate Norwegian newspapers since it was made publicly attainable, and news stories about it have been created. The focus in media discourse has been on the bickering between the organisations about 'who is supposed to do what' while the country finds itself in a major crisis (Johansen, Dommerud, 2021).In one of the articles written about the letter, a journalist interviewed a researcher in Child Health and Development at NIPH about the accusations and critique made by NIPH against the NDH. The journalist stated: "You are supposed to be a supplier of knowledge. But is it your function to control the discussion or the flow of information at the NDH?" The researcher from NIPH replied: "No, it is not. This is about something else. In times of a crisis we can't have a continuous debate between us that pertains to our basis of knowledge". The assistant director at the NDH is interviewed in the same article, but he has a different opinion. He thinks that during a crisis it is important to have a continuous discussion amongst experts related to the knowledge that the restrictions and regulations are founded on: "It is important that not a single researcher or case worker put restraints on such a discussion", he stated in the article (Stensland, 2021).

A few months after our initial talk about the relationship between the NDH and NIPH, we sat down again for a conversation. This time we met through the digital platform Teams, but it did not stop the conversation from developing freely. I would describe him as a bureaucrat veteran, with a solid amount of insight and understanding of public administration following a long and extensive background in the organisation. He has a sharp and quick mind, never short of an answer or a humorous remark. I had not managed to shake the sibling analogy, which I think I

pictured too vividly in my mind, and I had been wanting to ask some more followup questions to the matter:

> “So, if I’m gonna be a little serious now at the beginning”, our conversation started off with, as he went to explain the changes in the public health administration dating back to 2002. He informed me that back in 2002 the Directorate of Health re-emerged, the Institute of Public Health existed, but was also slightly different, and with that big change to the organisations the topic of roles was addressed: “Back then there was a big discussion about roles, to be clear about who has which roles”, he explained. “Few are concerned about that in day-to-day life, but there are important differences embedded in these roles. But when it comes to infection control, particularly, I believe it has always been a typical area of conflict”, he said. He continued by explaining that he believes that the conflicts that emerged between different experts probably would have emerged in many areas of expertise if you had the same intense interplay: “As soon as you start talking about public health and the prevention field, the researchers come sneaking with their stuff and it very quickly develops into this ‘you are meddling in our role and they are meddling in yours’. And when it comes to infection control in this pandemic I think it is very difficult to keep the roles separate, since the role of the NIPH is to have knowledge about the field, have an overview of current research and to give infection control advice. But they are constantly worrying about how the advice affects the society as a whole. And that is not their job. Does that mean that they absolutely should not do it? No, that is probably not the wisest, as they can frame their situational awareness in a holistic societal understanding. But then they can’t come to us and say that we are interfering too much into their domain”.

He paused, and said slightly apologetic that this was a long answer on his behalf, before he continued to elaborate:

> “But it is challenging to keep roles separate when you have this interconnected value chain beginning with the infection control advice and

then all the way to the government's decision making on how to implement all restrictions or recommendations in all sectors holistically." "But I think," he continued: "the role aspect is tricky, and there are a lot of strong experts in these sectors. So I think I want to add something that I often say: 'Strong people'… When someone says that about someone, you should follow up with the question: Ok, so do you mean strong? Or difficult? Because very many of them are very self-assertive and confident in their expertise, but maybe not as good at collaborating across different sectors." "But he does not want to point a finger at just one organisation, because everyone has ownership in this", he explains. He further thinks it could have been sorted out by the use of other management instruments than what has been used through this crisis.

I asked if he could give an example?:

"I think it has to do with the essence of a crisis, because just recently I know we delivered assignment 630 or 640, we get bombarded, right. Last Thursday we delivered on ten big assignments before the big press conference the following Saturday with this kind of 'Now we are opening up society' thing. It is a massive workload, but that is how it is. The Ministry sends out the assignments with a copy to us and the NIPH. Then we get advice on the infection control that we implement in our considerations, we conclude and deliver our final recommendations to the Ministry. And even though we have been doing this for two years now, the NIPH can not abstain from writing in every single assignment that they ask that their answer is attached to the document that the NDH delivers to the Ministry. I mean, if I had worked in a structure where I had people who behaved in that manner I would have called for a meeting immediately and said: How childish can you be? You have PhD's, you are professors, and now you are sitting here writing for the six hundredth time stating that we shall add your documents to the final deliverance. This is something we all agreed to is a routine. It is pointless guardianship and childish behaviour!"

> He paused a bit: "The management instruments would have been: Now we are going to sit together and work these things out. Because you are going to like each other, whatever it takes. Otherwise you can do other tasks. And that is the thing I feel, that you need to put down strong management guidelines to facilitate a process where one can make different people work well together. And to do that you have to meet, and that has been the challenge here, that these meetings become very digital [...] Research has shown that the threshold is lower in a digital channel than in real life. It is easier to address the more difficult things, it creates a distance to the matter. It is a little more distant and flat, it's two dimensional". But my main point is that one could implement management instruments that are commonly used in organisations to make people work together. Everywhere there are people, you will find disagreement, words that tangent conflict for instance. It has become very much like that a disagreement is a conflict, instead of saying that disagreement is a different view of something where there is no absolute knowledge.
> And maybe you should have had NIPH with you, now it is divided into two separate camps."

His last remark was of significance. The NDH and NIPH had for the majority of the pandemic been divided into two separate camps, where practically all interaction between them was digital. This was different from the Swine Flu pandemic of 2009, where I had been told that physical meetings occurred much more frequently.

In the days before the implementation of lockdown in Norway, a former assistant director at NDH had been summoned back from a trip to Spain following the progression of the pandemic situation in Norway. Due to his position, he was exempted from quarantine regulations, but unfortunately he had contracted corona. As a result, approximately forty people, majority employees at NDH, were placed in a fourteen day quarantine, including the Director of Health at

NDH, the General Director of NIPH and the former Secretary General to the Ministry of Health (Dommerud, 2020).

The infection protection measures enforced on society necessitated different sectors to rapidly adapt to digital platforms, the NDH included. The rapid digitalisation of the organisation enabled the ability to speed up work processes that previously was not attainable. The impact of the rapid technological shift on the organisation was also discussed by the head of the Preparedness and Emergency Medical Department at NDH. He did not want to leave out the positive aspects of working mainly digitally, like the ability to connect to people quickly, and how it engendered a fast pace to case working processes. Nevertheless, he found the transition demanding, especially when it came to building relationships between people. Without the ability of meeting physically, he found it strenuous trying to build relationships, as he thought it could affect a person's sense of belonging to, understanding, and trust in the organisation. When I asked if he thought it affected pandemic management, he said he was certain that it had: “Some misunderstandings could have been solved, certain issues could have been solved faster and better if we could have met physically, and not just met through a screen”. The restraints placed on meeting physically variably affected pandemic management, as it both sped up work and impeded on working relationships. To counter any divergence of viewpoints between the two organisations, he said he was responsible for gathering management for a weekly meeting, “to address the difficult stuff”. He told me that by having a regular dialogue, the relationship between the two organisations improved in time. I asked when they started having these meetings, and he told me they started before summer 2020, before he quickly checked his meeting log, and provided me with the exact date. Further, he told me that they started out meeting physically, but now it is just digitally. “It was important that we started this sitting around a table together, but now it is okay that we meet digitally. Me and Gunn Peggy (Deputy Director General at NIPH) are sharing liquorice when we are to physically meet”, he said, and laughed softly.

It has been stated that the most essential period for organisational participants to create trust is at the start of their relationship (McKnight et. al. 1998, Rosen, et. al. 2007). Studies on organisational trust highlight the importance of face-to-face meetings, at least introductory, which will help team members to see others as knowledgeable and trustworthy individuals (Cheng et. al. 2016). The importance of trust between team members can not be understated, as

Ashforth and Lee argues, team members who don't trust each other are likely to spend additional time and effort monitoring one another, duplicating each other's work, and documenting problems (1990, p. 262).

It is stated that something seemingly ordinary as a handshake has significance in building a trusting relationship, as the handshake is a social ritual that is imbued with symbolic meaning. It has been suggested that a handshake is perceived as a sign of cooperation, increasing people's cooperative conduct and impacting deal-making outcomes (Schroeder et. al. 2019). Yet, it has become apparent that handshakes differ in purpose and significance depending on social context, circumstance, and scale (Oxlund, 2020). The new work mode challenged the leaders to be attentive to any divergence or difficulty amongst its employees, where disagreement may have protracted as it proved harder to build cooperating relationships.

Meetings as an arena for performance, R.Sandler and Thedvall (2017) argues the importance of meetings as an ethnographic inquiry in that "meetings are where power is produced and enacted, dynamics of identity and hierarchy are negotiated, and organisation is produced, determined and challenged." (2017, p.1). The influential work of Schwartsman (1989) on ethnography of meetings has opened up to meetings as an inquiry of research in anthropology. Her definition of meetings as events where people "assemble for the purpose ostensibly related to the functioning of an organisation or a group" (1989:7) has brought ethnographic attention to meetings as a point of inquiry into organisational life. Ervin Goffman defined meetings "as social encounters with a central situational focus" (1963:80, cited in Sandler and Thedvall, 2017: 4). Abram, influenced by Schwartzman, states that "meetings are the apotheosis of contemporary bureaucratic life, containing dilemmas and contradictions that are at the heart of modernity", as it renders order to formal institutions (2017:27). Meetings in the context of modern government are deemed as institutionalised gatherings, consisting of "ritual performances" in which rules are enacted, ritual correctness is met with manipulative political game-playing, and formal transparency is intertwined with relational and information secrecy", where "meetings are what generates and maintains the organisation" (2017:27). Breuer et al., (2016) have found that team trust matters more in virtual teams than teams who meet in-person, due to the added uncertainties and risks that follow under conditions of digital communication.

Meetings had a significant role in organising and designing pandemic management, and therefore became an important aspect of my fieldwork. From the very onset, meetings served as my point of entrance to the organisations, to people and to topics. This is addressed by Garsten and Sörblom, where they state that ethnographic fieldwork in organisations frequently requires meetings to function as the primary point of access to the ethnographer (2017:128).

As accounted for in the methodology chapter, my access to the field had to be negotiated on a day-to-day basis, and was repeatedly centred around meetings. My introduction to pandemic management was through meeting observation, and it quickly became apparent that meetings held a key position in pandemic management. Garsten and Sörblom suggest recognizing a singular meeting as part of a continuous process of meetings, unfolding over time and space, by not viewing it as a fixed entity, rather as a contingent and socially constructed area (2017:131). Brown, Reed, Yarrow (2017:10) states that meetings are "central to the life of formal institutions", and as I observed during my time at the NDH, pandemic management was a meeting intensive process, and organisational life was centred around meetings as a place to order relations, understandings, and to share and consolidate knowledge (Abram, 2017).

I mainly observed the weekly regular meetings in connection to the pandemic, but occasionally I sat in on meetings not directly related to the Covid- 19 pandemic, such as departmental meetings or meetings related to preparedness in general. The schedule of the regular meetings I was given access to observe during a typical week at the NDH would consist of:

Assignment meetings; which ran Monday through Friday at 10.00 to 10.30, but were later scaled down to Mondays, Wednesdays and Fridays. The set agenda for these meetings was to introduce new assignments, give a status report on ongoing assignments and give a summary of completed assignments. The meeting was led by either a division director, department manager or one from the preparedness department, depending on who was available. The main actors were generally division directors, employees from the NDH and NIPH working with allocated assignments from the Ministry, and one from the preparedness department, who had the technical responsibility of the meeting. An updated list of assignments was distributed by mail beforehand, where meeting participants had to give a status report on their respective assignments. It was several times pointed out that his meeting was not an 'arena for caseworking', making it neutral to any expert discussions.

Meeting with the ministry and **Covid-19 Strategic Discussion** was every Tuesday at 08.00 to 08.30 and 08.30- 09.30. The Ministry led the first part of the meeting and would then sign off, where the meeting continued as an 'Covid-19 strategy meeting'. The main actors were the ministry, the NIPH and the NDH. The meeting would start off with a presentation of the infection situation in Norway by the director or assistant director at NIPH. Then occurring matters would be discussed.

The **County Governor meeting** was every Wednesday at 14.00-15.30. This was organised by the NDH, with participants from NIPH, the Directorate for Civil Protection and Emergency and county governors.

The **Crisis Committee meeting** was every Thursday at 08.00-10.00, and was organised by the NDH. Participants from NIPH would present the epidemiological development while the NDH would present the weekly status report. Then the meeting would progress with the meeting agenda, which was set and distributed through email before the meeting. Any issues that had been reported, and status on previous matters were brought up for discussion.

Meetings Kill Work Hours

Despite being a central actor in pandemic management, the organisation followed the same restrictions and regulations as imposed on society at large, and with periods where few people were present on a daily basis at the organisation, the pre-pandemic way of organising bureaucratic life was replaced by home office, email communication and digital meetings. Although digital meetings made it possible to summon people without having to worry about infection prevention or the spatial and temporal limitations that come with organising physical meetings, it came with limitations. Organising crisis management through online meetings was described to me as challenging, it was even considered as a reason for recurring disagreements between the NDH and NIPH.

Room 100 was a big meeting room located in the high-security area of the Preparedness department that served as the location for several regular meetings, like the Tuesday meeting with the Ministry of Health and Care Services, the weekly Crisis Committee meeting and the

weekly meeting with the Country Governors. The room has a blurred glass wall that one could vaguely get a sight of people through while passing along the corridor. The exterior sun shades were always lowered during meetings, blocking the view straight into an office building across the street. Inside of Room 100 was a long wooden table that stretched lengthwise across the room, seating around 15 people. Extra chairs were placed along the walls, adding distance between people and providing additional seating. Both table and connected chairs had a modern feel, where the table top was in a light hue and the chairs were in metal and black with low backs. The director at NDH had his seat at the end of the table, where a bigger comfortable looking office chair was placed, cushioned and with a high back. The wall behind his chair was covered with draped maroon coloured curtains in a heavy weave. Across the table were four big screens covering the end wall, with a camera pointing directly at the maroon wall. The seat next to the Directors, on the right, was often held by one of the assistant directors, the other seats were commonly held by directors of varying divisions or departments. Some participated more or less consistently from Room 100, others appeared occasionally depending on the agenda set for the meeting. The second assistant director generally participated online, but occasionally he participated from Room 100, sitting at a small desk situated at the back corner of the room.

During a Covid-19 strategy meeting, a conversation about meeting culture occurred amongst participants. There was a long discussion about overtime at the NDH, and how the structuring of work made it impossible to avoid. One of the leaders at NDH stated: “This is the responsibility of the leaders at the Ministry, here and with the NIPH. We need to take the consequences of that as leaders, that we have not really made it work. Have I done enough to make it work? I have talked about this many times. It is the Ministry that does not grasp the magnitude of the workload they present us with, we are completely backed up. There are too many things, plain and simple.” A meeting participant followed by saying: “We attend meetings all day long, then consequently we have to work in the evening.” “There are meetings constantly,” was stated by another. “I support her work description”, was uttered across the table, then the conversation ended by one of the leaders stating: “Meetings kill work hours.”

It is a common viewpoint that meetings have a tendency to seize disproportionally amounts of time in contemporary worklife, in addition to the role meetings held in pandemic management as a place to order relations and to consolidate knowledge and understandings, made it even more

pervading in organisational life.During a CC meeting at a time where the infection rate again was going up, the discussion around the table was centred on the current situational awareness. Towards the end of the meeting, the collaboration between the NDH and NIPH was again brought up. One meeting participant stated that "it is the cooperation with NIPH we don't have any control over,", she then elaborated: " NIPH provides us with a document with inputs, and then they hand us the final document one hour before the deadline with numerous changes." Tied by the legal mandates of the Norwegian Infection Protection Act, the NDH were required to base their advice in cooperation with expert knowledge provided by the NIPH. Not complying with the set deadline, or making big changes to a document right before the deadline required NDH to subsequently adjust the document, which created tension between team members, which could manifest as a lack of confidence in each other.

If team members acted in opposition to the established work agreement, the deviating conduct of a team member disrupted the work process between the organisation. As pandemic management was arranged in a strict hierarchical order, deviance from the established norms created tension in the layers, and occasionally led to uncertainty about the standpoint of NIPH about matters relevant to the assignments that were to be solved. (Goffman, 1959:88).

Overtime was a recurring problem to all of the actors in pandemic management and at all levels in the organisations. By the end of 2021, employees at the NDH and NIPH had worked thousands of hours overtime, many of which they never got compensated for.[3] While spending time with some of the staff at the preparedness department, an interview with the Director of

Health is brought up: "That interview was so great, where Bjørn said: '*Well, the most difficult thing during the pandemic has been to separate job from work*". He laughed a little, then added: "It is so descriptive of how it has been!".

[3] "Statsansatte jobber gratis i mange tusen timer under pandemien". https://frifagbevegelse.no/ntlmagasinet/statsansatte-jobber-gratis-i-mange-tusen-timer-under-pandemien-6.158.839603.291601947d

Performing Expertise

Mary Douglas (1987) use of the terms *professional thought world* and *thought styles*, that is indicating the set of "professional traditions, values, ethical norms and views on knowledge" that are mobilised when experts undertake professional matters (Douglas cited in Kleven, in *ed*. 2003). How an expert approaches a certain issue, their perceptions and assertions, is argued by Douglas (1987) to stem from "ideologies deeply rooted in how their particular education and training have taught them to perceive, define and solve problems" (Douglas, 1987, cited in Kleven, in *ed*. 2003).

The ICT, the infection control team, and the team responsible for the TITQ strategy at the NDH, mainly consisted of people with a medical background. Medicine practises strong codes of ethics that emphasises the protection of human health: '*a doctor shall base his practice with respect for fundamental human rights, and on truth and justice in relation with patients and to society*'[4]. Inhabiting a professional background in medicine gave legitimacy to the team members' assertion of knowledge and expert advice, yet, there were incidents where the experts were told by management to leave their '*professional thought styles'* when assessing the current situation and define proper advice to the government. Kleven states that experts' professional *thought styles* will be influenced "by the agency's primary functions, professional dominance and institutional characteristics developed over time" (*in ed*. 2003). Experts' perception of an issue have influenced the definitions of threats and risk during the pandemic, and case workers '*professional thought world'* (Douglas, 1987) have influenced the assertion of knowledge and their strategies for solutions. Many meeting hours went to consolidate the situational understanding within the organisation, between management and caseworkers, and from caseworkers to management. The director at NDH asked on several occasions to be updated on 'where the organisation stands" on certain matters, and employees would, by expressing new knowledge, introduce additional information of consideration.

At the end of my fieldwork, Norway was experiencing a situation with a new virus variant, Omicron, and a high number of infected. The discussion between the NDH and NIPH was

[4] Code of Ethics for Doctors §1
https://www.legeforeningen.no/om-oss/etikk/etiske-regler-koder-deklarasjoner-og-lignende/code-of-ethics-for-doctors-/

centred around if "it is better to act now or wait a little." Some voices at the NDH were questioning if the level of infection control measures was sufficient at the time being. The director at NIPH said she thought it was a difficult discussion, "but we are open to changing our position on infection control measures as the situation develops. It is not like we are totally against implementing measures."

During a CC meeting a few days later, a member with the ICT asked if they should initiate an assignment (to the ministry), with the reason that they wanted to be "a little ahead of the situation". "There are a few of us who are a little worried for these children", referring to numbers provided by the NIPH that showed an increase in children being hospitalised from Covid-19. "We want to know what direction the Crisis Committee thinks we should take?" The director at NDH replied in a rebuking manner that he wanted them to understand that the NDH has an advisory role, not a governing role: "our role is to describe effects of the measures and the level of risk resulting from different options. I do not like that we practically are forcing the government to make a decision." He continued: "The way this sounds is like how a doctor talks when treating patients. We include the medical profession in the assessment. It is important that we give options for action." His concern was that the role understanding of the NDH would be scrutinised and critiqued. "It is important that it is a democratic process," he said as a finishing note to his response.

"We must, indeed, all hang together, or most assuredly, we shall all hang separately."

-Benjamin Franklin

The recurring friction between the NDH and NIPH was at times addressed in the media. It occurred on a few occasions that some actors in pandemic management publicly stated opinions that were not in line with their organisations advice or guidelines communicated to the public. On one occasion, Professor Aavitsland, Director of Division for Infection Control and Environmental Health at NDH tweetet: "That was that pandemic"[5], early June of 2021. The statement was scrutinised by the media and the public. In media discourse, representatives from

[5] Preben Aavitsland, "That was that pandemic" (2021, June 6.).
https://twitter.com/Prebens/status/1401465455269888001

each organisation would explain the diverging opinions as something that would give quality and assurance to the knowledge base which they would build their advice and recommendations on. Although diverging views were publicly portrayed as a feature of a good and robust case working process by health authorities, it regularly resulted in varying messages to the general population through the media, and managers found the need to state the importance of a unified health management in discussions during meetings.

I took a seat at the main desk in the Emergency room at the Preparedness department together with Are, who served as the Chief of Staff for the day. It was a little before 08.00 o'clock in the morning, but he had probably been to work for a couple of hours already. Room100 is located in a closed-off section of the Preparedness department, and was where the central Covid-19 meetings were held, like the Crisis Committee meeting I was about to sit in on. It is located just around the corner from the Emergency room, and I can hear fast footsteps, distant talking and cheerful greetings. A couple meeting participants run to the coffee machine placed in the tiny kitchen section situated on the doorstep of the Emergency room. The coffee maker is noisy, to the point that people nearly make an assessment of when is a good time to make a coffee so that you don't grind coffee beans during an important phone call. Maybe it is a calculated purchase, since it allows you to keep a private conversation while making a coffee, in an area so quiet that whispering is the only other option, besides stepping into a soundproof room. Are had already brewed fresh pots of coffee, and made sure that cups, water and glasses were at hand on the table in Room100. A task that I was told became the responsibility of the Preparedness department during the pandemic handling. Occasionally, I was given access to sit in on the meeting in the physical meeting room, but today the room was full of employees and had only a limited amount of seats. Are connected us to the meeting room digitally, and Room100 appeared on giant screens that almost covered the entire wall. My seat was only about two metres from the screen wall, and if you sit there long enough you can feel the heat coming off the monitors. If the screens were on long enough it made the room noticeably warmer and the air quality dry and dense, which gave the room the resemblance of a modern day bunker.

The clock turned 08.00 sharp, and the Director of NDH had taken his designated seat at the end of the long table, formally dressed in a white shirt and tie. He opened the meeting by welcoming participants by name and department or organisational belonging, which served as a way to take attendance since the majority participated digitally, and several were not from the NDH. The

Director of NDH said a few introductory words, followed up by a walkthrough of the Covid-19 situation report and status reports from state administrators. The Director addresses an employer with the NDH whose responsibility for the past year and a half had been the state administrator's reports to the NDH. He thanked him for his service and commitment to the subject. “Thank you for your trust”, he replied.

The meeting continued with a review of two ongoing assignments, and the participants at the meeting were informed that in the assignments to the Ministry of Health, the NDH recommends to postpone fully reopening the society until they reach the 90% mark of the population being vaccinated. At this time, Norway was registering growing numbers of infected, mainly driven by the younger population in schools. Part of the pandemic strategy which was decided on before summer was built on the predictions presented by NIPH dating back to March. Their calculations predicted an insignificant level of people infected sometime between August and mid September, and that the NIPH was convinced that the capacity in intensive care units would not be overloaded. The strategy was to open schools on level green in the fall, meaning no state regulated infection control measurements in schools or kindergartens against Covid-19. A viewpoint amongst many government and social actors was that children had suffered unnecessarily through the pandemic, due to variable strict measures like closed schools; cancelled sports and activities; kohorts; and number restrictions of social contacts. At this point, many voices argued that it was an absence of proportionality between restrictions affecting children and youth, and the seriousness of the coronavirus. One dominant idea was that Covid-19 did not pose danger to children; most children did not get infected; or infected others. The other view was shaped by the fear of potentially underestimating the consequences an infection with Covid-19 could have on children, and on their ability to catch and spread the virus in the population. The government decided on opening schools ‘on green’, which implied low infection protection measures. The ‘Traffic light model’, was a categorisation model of infection protection measures divided in three levels, to be used in schools and kindergartens. The levels were green, yellow and red, where green implied low infection protection measures, and red implied a high level of infection protection measures.

The CC meeting followed its regular order, with a prepared agenda that listed topics and cases to be presented and discussed. The formality was consistent, with a strict order of when to speak,

and it was not appreciated to 'take the floor' without it being your turn. This kept a formal order of the meeting, where the agenda and timeframe was orderly kept. Simultaneously, the punctilious organising of the meeting occasionally contributed to discussions where the timeliness of the participants' comments varied. During a conversation I had with an employee at NDH, he commented on the meeting culture during the pandemic. He was critical to what he described as this "unwritten law" that if you have a meeting, you bring out all the reflections by people raising their hands and speaking in turn. "Meetings", he said, "that are opinions you take in turn. I have never seen any research that supports that that is an effective way to get good reflections."

A younger male employee from the Infection Control Team (ICT) at NDH held a presentation about the potential risk of a virus variant with a reduced vaccine effect, termed a VoC.[6] He presented three scenarios, from worst to best, and pointed to the total numbers of transmission globally, and vaccinated people with high transmissibility. "This is described as highly real scenarios by experts", he stated. "We can be in the starting pit, we have seen many developments in just one year", referring to the different mutations and variants of the Covid-19 virus that has emerged over time. "Has the virus taken out its full potential?" He rhetorically asked, and added that many experts view the middle scenario as a very likely one. The ICT therefore recommends one to two years of continued increased preparedness in the society: "Because in assignment 513/514 it says 'we are on our way out of the pandemic' ", he concluded. The Director of NDH asked him if they were in consensus with the NIPH. The former department director at NIPH answered that she had to get back to them on this, while the acting assistant director at NDH commented that: "It is very good from a TITQ perspective if one could be united in a perspective like that. It is very reasonable."

Agatha, a manager at NDH joins in, supporting the view of ICT and the acting assistant Director. She points to Denmark who at that point had a very open society, yet still had a few parishes on lock-down. "The communes need clear communication about preparedness", she added. The Director of NDH smiles, it appears as if something threw him a little off the Covid-19 track.

[6] Variant of Concern " (VoC), a category used in the assessment of new virus variants. The category of Variant of Interest (VoI) is the first step in assessing a new variant. This terminology has been extensively used by several international health organisations in assessment of virus variants in the work with Covid-19. For a virus variant to exceed from a VoI to a VoC, several criterias need to to be met, where the top ones are: transmissibility; morbidity; mortality.

“Parishes”, he said, “I wonder if they still use parishes in Denmark?”. The mood in the meeting changed, some people asked follow-up questions a bit jokingly, and the room started buzzing with laughter and smiles.

All while this goes on, the people observing the meeting from the emergency room discuss that the NIPH had not mentioned these scenarios in their assignment deliverance, and that it became a matter that was brought up at a higher level, implying the Ministry. The meeting continued with a discussion around the communication strategy when moving forward, and puts an emphasis on the importance of guiding the communes through difficulties they may face with the new strategy and the increasing numbers of infected. During this time, there was a growing discontent within several communes with what they experienced was deficient crisis management from the government. The TITQ strategy had been downgraded, Norway lacked Covid-19 self tests, and the new strategy was based around more testing.

A member of ICT gets the opportunity to speak, and he highlights “the spillover effect from children to elderly and unvaccinated people”, where he urges to take the necessary and sufficient measures: “As TITQ is the greatest tool we have”. He sees it as inevitable for communes to go to level yellow, “And if that is not enough” he continued: “Then vaccinate everyone over the age of 11”. The former department director from NIPH comments, and says as a follow-up to what was just stated that maybe this will get more people to get the vaccine. She simultaneously used the opportunity to question statements uttered in the media that the health authorities don’t have control. “What does that even mean?” she asked, in a tone of voice disclosing her annoyment with the media coverage. “ We now have a much better overview of the pandemic, if you look at it from an overall perspective.” At the time, it was quite a media focus on the failed predictions and mathematical models the NIPH had provided, questioning their usefulness in the pandemic handling.

In a conversation I had with an employee at NDH, he spoke of mathematical models: ” But you know, when it comes to mathematical modelings, if you multiply eight uncertain factors with each other it will not provide a more certain answer. It is ‘shit in-shit out’, like one says in statistics. And it does not appear that one takes that into account, and that is why one repeatedly gets it wrong with those kinds of modelings. There is nothing wrong with the models, but when

you add all those factors of uncertainty while not correcting for the effect of infection protection measures, then you miss." NIPH modelling and predictions were often, during meetings, referred to as 'weather forecasts'. Adam Kucharsky considers the paradox of forecasting outbreaks: "although a pessimistic weather forecast won't affect the size of a storm, outbreak predictions can affect the final number of cases," as outbreak predictions can influence the final number of cases, due to responses from health agencies (2020, p. 142).

The Director of NDH takes the word, and says: "We must be reunited in our message. We can not get stuck out there and appear unsecure". "Salute to Line and Camilla for going out in the media and saying that they didn't quite get it right", Agatha quickly voiced from the sideline, referring to NIPH's failed prediction of expected numbers of infected. "Every single person in Norway cares about this", she continued, while she pulls up a map of Denmark on the shared screen, which shows parishes who are under lock down. The Director of NDH smiles a little embarrassed: "Yes, hmm, eh, anyone here who wants to comment on this?" A participant makes a little side comment, and then the Director states: "If we don't hang together, they will hang us separately", reciting the famous Benjamin Franklin quote that he supposedly said after he signed the Declaration of Independence in 1776. By having a unified front, Benjamin Franklin hoped to avoid a tormenting public execution at the hands of the British government. At this time, the Norwegian health authorities were under public scrutiny due to the adverse coincidence of a downplayed prevention strategy and quickly increasing numbers of infected.

Although the Director of NDH recited the quote in a seemingly light-hearted way, the underlying seriousness was not to be mistaken. From the early onset of the pandemic, opposing views had arisen amongst health authorities on how to best handle the pandemic. I was told on different occasions that the Director of NDH showed patience and kept a unifying approach during meetings with the other health management actors, while the opposing views between the organisations made already demanding work more challenging. By reciting Benjamin Franklin, the Director at NDH was ,yet again, seeking to reunite the situational awareness of the actors in the meeting, and to keep a unified view during a demanding time characterised by uncertainty.
As a unified front always stands stronger together.

Some Concluding matters

According to Goffman, the object of a performer is to sustain a particular definition of the situation (1959:90) Perceivable disagreement creates what Goffman refers to as a 'false note' (1959, p.92), and in the event of a 'false note', what matters is to sustain the definition of the situation.

The strategy of actors in pandemic management was not always to try to conceal disagreement between the NDH and the NIPH, rather, it was highlighted to give robustness to advice, claimed to be part of a good case solving process, and the upholding of a democratic process in managing the pandemic. When the facade of a unified expertise fissured and the backstage friction seeped through the cracks, publicly addressing the disputes, one can consider, was an endeavour of impression management (Goffman, 1959:60). It was stated by actors in pandemic management that speaking openly about disagreeing views contributed to upholding trust towards health authorities amongst the general population. Goffman argues that one can consider that in the case of an interorganisational team, generally, public disagreement not only incapacitates them for cooperation, but also embarrasses the reality that is sponsored by the team (1959:91). The two organisations were by law forced to cooperate and act as a team, and one can consider that organisational disputes can occur as a result of the tension between the experience of being directed while striving for its desired autonomy.

As a final remark, the meetings as an arena where no real debate took place, although concerns were raised and questions were asked, may have contributed to a higher level of uncertainty with employees of the organisation and a prolonged inter-organisational conflict. This is not meant as a critique of the organisations use of digital platforms to conduct meetings, but as debates over the distinction of 'real' life vs. the virtual or digital (Miller, Horst, 2012; Boellerstorff, 2008, 2012), meetings conducted over digital platforms holds many similarities to in-person meetings, although it appear to entail a different set of 'rules of conduct', I therefore deem it relevant for mentioning.

Part II Vaccines

Chapter 5: "Better Health for All"

From the early onset of the pandemic, experts and governments pointed to vaccines as the key solution to bring the pandemic under control and to save lives. During the Covid-19 pandemic, vaccines were developed, approved and distributed at a rate unlike anything seen before, and population groups were vaccinated in an unprecedented short time. Mass vaccination of the population was by experts and governments considered essential to reach the goal of ending the pandemic. To reach this goal, you need a vaccine, and a population that is willing to take it.

Vaccines have from its early discovery been a contested subject. From the development of the first vaccine, from variolation to the inoculation of cowpox virus from kettle to human, vaccines have saved lives, caused public protests, and it has practically eradicated diseases in populations. Preliminary surveys conducted during fall 2020, on the general population's willingness to take a vaccine against Covid-19 was surprisingly low, one out of four would not, compared to the high participation in the 'Childhood Vaccination Programme', with a participation rate in the 95 percentile for most of the vaccines.

After the approval and distribution of the first vaccine batch (Pfizer), Norway began distributing its first vaccines in the late of December of 2020. By early September of 2021, 75% of the general population above 18 years of age was deemed fully vaccinated after having received two doses of a Covid-19 vaccine. The immunisation programme was considered a great success, and Norway was headed towards a full re-opening of society as the month progressed. Simultaneously, a change in the government was about to take place. The Conservative Party who had governed the population of Norway through roughly eighteen months of pandemic life was now counting its last days in office, shortly to be succeeded by a coalition consisting of the social-democratic Labour Party and the agrarian Center Party, after they won the Parliamentary elections held on 13 September 2021. At the end of serving nearly half of their time in office

managing the pandemic, the political will to fully re-open the society was strong, despite increasing numbers of infected in the population. In the 'National Reopening Plan[7], a strategy

put forward by the former government, the development of the infection situation and burden of the disease, the capacity of health service and progress in vaccination was listed as decisive for implementing steps of the reopening plan (Regjeringen 2021). During the fall months of 2021, the general population between the ages of 18 to 85+ had been offered both one, two, or even three doses of a vaccine against Covid-19, and the amount of people who had not yet made use of the offer was now visible in the statistics. In this chapter I aim to explore the idea of a national immunisation programme, and vaccine hesitancy, from the perspective of the *providers* (here through the organisations operating as an extension of the state), and how these ideas translate into the general population. To accomplish this, I conducted fieldwork with the communication department at the Norwegian Institute of Public Health and analysed documents and public media discourse regarding Covid-19 vaccines.

An Introduction to the Norwegian Institute of Public Health- "Better Health for All"

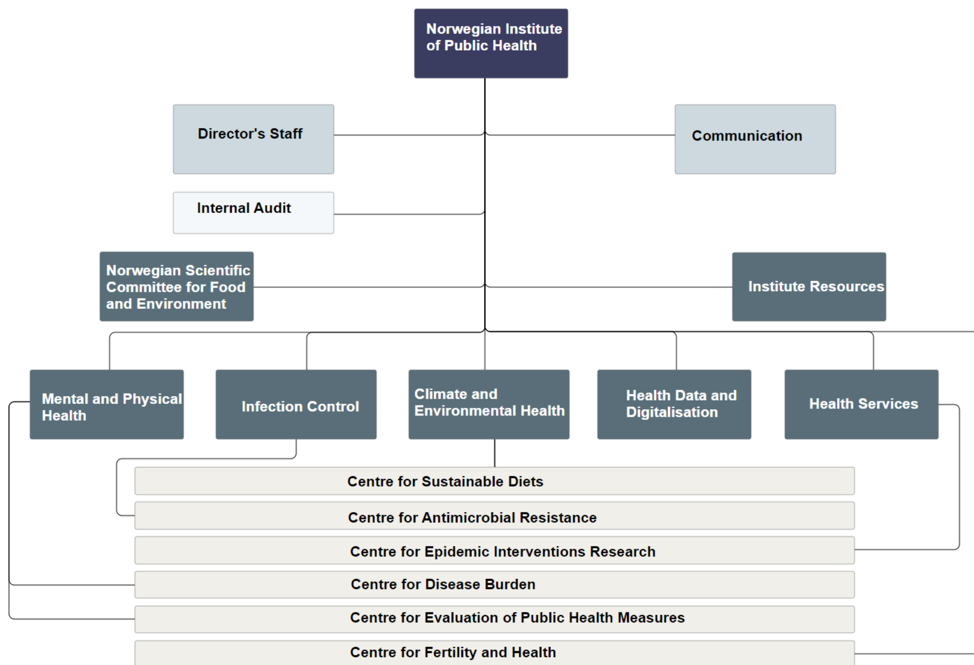
The Norwegian Institute of Public Health, (NIPH), is a national competence institution placed directly under the Ministry of Health and Care Services, with offices in Oslo and Bergen. The NIPH monitors developments in public health and healthcare services, works to improve general health by focusing on health promotion and disease prevention in the population, provides education in relevant subject areas, and disseminates knowledge to government, national and local authorities, health services, politicians, media and the general public. The NIPH has a central role in global health preparedness by providing knowledge to the health system, and serves as the national infection control institute, with associated functions and responsibilities. The NIPH is also responsible for immunisation programmes in Norway, which includes the responsibility for the purchase, storage, distribution and follow-up of vaccines in the immunisation programmes.

[7] A four step plan for the reopening of society, presented by the government in April 2021. Execution of the different stages was dependable on infection rate, capacity in health services and vaccination rate. Regjeringen (2021).

The NIPH describes its social mission as to: "Produce, summarise and disseminate knowledge to support good public health efforts and healthcare services. In this way contributing to better health, both in Norway and worldwide" (FHI 2022). Further, it defines its social mission into three core tasks: "Knowledge; more, better and faster knowledge for health and sustainable services. Preparedness; new solutions to protect life and health. Infrastructure; health data, laboratories and services for the future." (FHI 2022, Social mission of the Norwegian Institute of Public Health).

The organisation is divided into five divisions, with underlying departments. The top management group includes the Director General, two Deputy Director-Generals, Executive Directors, Preparedness Leader, the Director of Institute Resources, the Chief of Staff and the Communications Director. In the years prior to the Covid-19 pandemic, the NIPH had about 900 employees, which increased to approximately 1100 during the Covid-19 pandemic.

Organisational chart:



Organisational chart of NIPH, with an overview of management, divisions and underlying departments. Retrieved from: https://www.fhi.no/en/about/this-is-the-norwegian-institute-of-public-health/organisation-/

A brief history of the Norwegian Institute of Public Health (NIPH)

The Norwegian Health Institute was established in 1929 after a generous donation to the Norwegian government of 1 million NOK from the Rockefeller Foundation to build a new institute. The founding of a public health institute was a continuation of the previous notion of governmental responsibility for public preventive measures and the idea of a public institute addressing population health issues. At the outset, the institute was responsible for performing chemical analyses of food and water and providing sera and vaccines to the population. Public health policy underwent a significant reorientation due to establishment of the Norwegian welfare state after 1945 under the direction of the social democratic labour party. The medical-political vision of Karl Evang, the Health Director until he retired in 1972, was influenced by the left-wing social medicine of the 1930s and the public health practices he had encountered in Britain and the United States while living in exile during World War II. In Evang's vision of the welfare state, public health was a crucial component. Egalitarian and universal, it was to offer all Norwegians good disease protection and state-funded, high-quality medical care for illnesses and injuries, regardless of their income or area of residence. Achieving these goals required an expansion of preventive healthcare, carried out by district medical officers (distrikstleger), assisted by specially trained public health nurses, and supervised by county medical officers.

Norway's many small local hospitals merged into a network of large central hospitals with particular care institutions (Hubbard, 2006). For decades, the extent of the NIPH was limited to infectious disease control. However, in the 1970s, with the establishment of a toxicology and epidemiology department, the institute's scope grew, with an increasing focus on preventing non-contagious diseases. Several public preventive measures were introduced to the population between the years 1940 to 1990; this included disease registries, screening programs for infectious diseases, and mandatory vaccinations. In 1956, NIPH introduced a national free-of-charge children's vaccination programme, and in 1975 the Norwegian Notification System for Infectious Diseases (MSIS) was established at the NIPH. This registry made it possible to monitor the prevalence of infectious diseases in Norway continuously and to identify

outbreaks at an early stage. The system soon became, and still is, an indispensable part of the national surveillance system of infectious diseases (FHI 2017).

As a result of the decentralisation of microbial services that took place in the 1970s and 1980s, where microbial laboratories became part of most hospitals, a reorganisation and name change of the institution took place, where the new name was 'Public Health' (Folkehelsa), with the establishment of new departments of environmental medicine and community medicine. Implementing the Communicable Disease Control Act in 1995 gave the NIPH significant responsibilities and tasks in national infectious disease control. In 2002 and 2003, a new public health institute emerged after a comprehensive reorganisation of the central health administration in Norway. After merging with several other institutes, the responsibility for all health-related population registries, except the Cancer Registry of Norway, lay with the NIPH. It would also coordinate all public collections of epidemiological data in the country. In 2014, the NIPH took over the Norwegian Cause of Death Registry operation from Statistics Norway. In 2017, the Division of Health Services was established, and the Knowledge Center became a part of the division, focusing on knowledge production for and to health services (FHI 2017).

The Role of the NIPH in managing the Covid-19 pandemic

The NIPH is essential in pandemic preparedness as the national infection control institute and is responsible for national immunisation programmes. By serving as the national knowledge provider for the entire health sector, NIPH kept surveillance on the national and international epidemiological situation, performed health analyses and conducted research on the areas of infection control during the pandemic. The surveillance of infectious diseases is performed through several different reporting systems, lab analyses, and registries, and accordingly through the reporting system for infectious diseases (MSIS) and the outbreak warning system Vesuv, and the national vaccine preparedness and the national vaccine registry (SYSVAK).

Holding the role of secretariat for the Pandemic and epidemic committee, the NIPH is to provide expert advice to the NDH in matters of emergency preparedness and crisis. On request by the Ministry of Health, NIPH would, together with the NDH, provide the government with knowledge and recommendations for pandemic management. NIPH provided knowledge and infection prevention advice to the health sector, communes, and the general population. Most of

the information provided by the NIPH to the general population was through public media, the online health service information platform helsenorge.no, NIPH’s own website and social media channels.

The Department of Communication

During fall of 2021, I was able to establish contact with the communication department at the NIPH. I was then invited to follow the institute's communication department for a couple of months, where I spent the majority of the time with one team responsible for the Covid-19 related information in press and on social media platforms (SoMe), I will refer to them as the SoMe- team, and one responsible for communication related specifically to the Covid-19 immunisation programme, which I will refer to as the vaccine-team.

I was invited to come to the office one day a week to observe during the weekly departmental meeting, in addition to a weekly morning meeting held on Teams. Invitations to spend time with the team responsible for the immunisation programme commonly came with a short notice, and had to be negotiated throughout my entire time at the organisation. Due to my limited access to the NIPH, meeting employees proved challenging, nonetheless interrupting them during their busy workdays. At the end of my agreed time with the organisation, my connection with people at the NIPH faded as I experienced members of the communication team and experts with the Covid-19 immunisation programme either stopped responding to my emails, or just did not show up for scheduled interviews. This chapter is therefore based on meeting observations, and informal conversations while manoeuvring between meeting rooms, walking through hallways, or over lunch, together with accounts from fieldwork at NDH, and Norwegian media sources.

Before I was given access to the organisation I had to sign several disclosure documents, and I experienced a strong sense of protectiveness of their work, making it hard to get a deep insight into their field. On several occasions I experienced having communicated to me clear boundaries and limitations to what I could use in my thesis, mostly in relation to the specific task that was currently undertaken by the teams. Some of my questions would be answered with phrases like:” You can see, but not use it in your thesis” or “everything we do here is research”, implying that it was off limits for me to use. The slightly reservedness towards my presence must also be seen in

the light of the organisation being a public health research institute, and its strict policy regarding the disclosure of sensitive data. Although I was invited to attend meetings by team leaders, my presence may have been seen as an inconvenience in certain situations.

As I began my fieldwork at the communication department at NIPH, the society was declared re-opened, the immunisation programme was considered a great success, and the vaccination rate in Norway was higher than preliminary predictions would suggest. Nonetheless, the communication teams at the NIPH were still providing updated infection protection advice to the public through various channels, and working to reach unvaccinated groups of the population with information about the Covid-19 immunisation programme. With increasing infection rates in the population, and groups of unvaccinated people, the vaccine-team focused on finding ways to reach population groups they prior had been unsuccessful to reach.

A Brief History of Vaccines

With the medical and scientific development that generated in the 19th and 20th centuries, a better understanding of diseases and disease prevention grew, ultimately leading to what is suggested to be one of the greatest inventions of humanity, namely vaccines. Vaccines have greatly reduced the prevalence of diseases globally, preventing outbreaks, epidemics and globally saving millions of lives. The WHO suggests that vaccinations today prevent 2-3 million deaths each year (WHO 2022). In the centuries before the development of the first vaccine, epidemics were contained by the use of quarantines. In the 17th and 18th centuries, smallpox was one of the leading causes of death in Europe. Accounts of smallpox in Europe date back to the 6th century, but it is assumed it originated in Asia where the disease is considered as old as humanity itself.

Variolation is a disease prevention technique that is traced back to the sixteenth century China, although older accounts of it are traced back to either India or China. Variolation consisted of inoculating healthy people to the dried scabs or pus of smallpox from smallpox patients, which would provide immunity against the disease. The procedure was not risk free, around 2 percent of variolations resulted in death, but was yet smaller than the 30 percent chance of death that smallpox usually came with (Kucharsky, 2019. p. 166), and it is estimated that in the 18th- and

19th century as many as 45 million people died from the virus in Europe. Variolation became popular in eighteenth century England, and was introduced by the writer and poet Lady Mary Montagu. As the wife of the British ambassador to Turkey, she had witnessed a successful variolation in Constantinople in 1771, and after experiencing death in her family from the disease, she let her young son have the procedure, which he survived. A couple years later, back in London, she had her daughter go through the procedure, and she too survived. After this experience, she became an advocate for the procedure, she even wrote a letter to the English monarchy as part of her campaign to implement variolation in England. But it was not always agreed upon if the risk was worth it. The procedure quickly spread, and caught popularity when the French Queen at the time, Marie Antoinette successfully went through the procedure (Aastorp, H. 2004).

The french writer Voltaire observed that other Europeans thought that englishmen were fools and madmen to use the method. *"Fools because they give their children smallpox to prevent them catching it; and madmen because they wantonly communicate a certain and dreadful disease to their children, merely to prevent an uncertain evil*". He noted that the criticism went the other way too: "*The English, on the other hand, call the rest of the Europeans cowardly and unnatural. Cowardly because they are afraid of putting their children through a little pain; unnatural, because they expose them to die one time or another of the small-pox"* (Kucharsky, 2019, p.166-167)

Regardless of the contested safety and risk of variolation it eventually led to the invention of a successful vaccine against smallpox, by Edward Jenner (1749-1823) in 1796. Leading to it being eradicated in 1980. It had been observed that humans who contracted cowpox, which were non harmful for humans, did not contract smallpox. Jenner began to vaccinate people with material from infected animals. The word vaccine originates from the latin word "vacca", which means "cow". Chemist and microbiologist Louis Pasteur (1822-1895), known as the progenitor of modern immunology further developed the science of vaccines, contributing to vaccines against anthrax, chicken cholera, and rabies. Over the past two centuries, Pasteur's discoveries have contributed to the development of vaccines against some of the world's deadliest diseases, and today there are vaccines against more than 25 infectious diseases.

With the outbreak of Sars-Cov-2 in 2019, vaccines and vaccine development became a focus of global health agencies and governments, which spurred a race against the virus resulting in the unprecedented scientific achievement of developing a vaccine against Sars-Cov-2 in just six months. Although the impact of the Covid-19 pandemic and its vaccination programme has been affected by global inequality, by misinformation, politics and policy mistakes, a study conducted by the WHO and ECDC estimated that by November 2021, 470'000 lives had been saved among those aged 60 years and older since the start of the vaccine roll-out in 33 countries across the WHO European region (ECDC 2021).

A brief history of vaccines in Norway

Smallpox was the third most common cause of epidemic outbreaks in Norway and the rest of Europe in the 18th century. Edward Jenner's development of a vaccine using fluid from cowpox rather than smallpox vesicles contributed to a safer, and more efficient method to immunise a population. The method was first implemented in Great Britain, and later followed by numerous European countries. In Norway, which at this time was under Danish rule, vaccination occurred sporadically from 1800, and was then made mandatory by law in 1810. The vaccination programme was carried out with considerable efficiency, however, the vaccine was not completely unsafe, where postvaccinal encephalitis was a feared vaccine complication which occasionally caused death. Within two generations this first national programme of disease prevention had virtually eliminated the disease from Norwegian society. The vaccine against tuberculosis was a mandatory vaccine up until 1995, before it became voluntary.

In 1952 was the 'Childhood Immunisation Program' introduced in Norway, with its aim to prevent serious diseases or death amongst children and adolescents. Children in Norway are offered vaccines against 12 different diseases from infant to adolescence. The program is administered by the NIPH, and all vaccinations are registered in the National Vaccine Register, (SYSVAK). Vaccines are provided at health stations and in schools, administered by Public Health nurses. All vaccination is free of charge and it is non-compulsory to participate in the program. Norway has a very high level of participation in the 'Childhood Immunisation Program', as high as 97 percent for some of the vaccines (FHI 2017). Historically Norway has both produced and imported vaccines. By the end of 1970's it was considered that the vaccine production at the NIPH no longer was sufficient, and in 1983 parts of the production was

cancelled in wait for better production facilities. The government decided to close down government run vaccine production in Norway in 2011 and all the vaccine production equipment was given to commercial health agencies in 2016. After the outbreak ov Covid-19, there have been raised questions as to whether Norway should produce vaccines, but its ability to sustain the population with vaccines is considered unlikely (NOU 2022:5:284)

Chapter 6 Vaccines and its sentiments

My research interest in the general population's participation in the Covid-19 immunisation programme, and the government's response to this, was sparked by a population survey presented in Norwegian media during the fall of 2020. It depicted as many as ‘4 out of 10 would not take a vaccine if offered now’ (Andresen, 2020; Ipsos, 2020). The seemingly low number of people willing to take a vaccine against Covid-19 stood in contrast to the high level of participation in the Childhood Immunisation Programme, where participation is amongst the highest in the world, reaching the 95 percentile. Previous research on vaccine coverage has shown that there generally is a higher participation in childhood immunisation programmes than in adult vaccination (Larson, 2020, p. 118), nevertheless, Norway needed more than a fifty percent vaccination rate to combat the pandemic. From the first dose given in December of 2020, to April of 2022, 4 237 099 people over the age of 18 have received two doses of a vaccine against Covid-19, considered being fully vaccinated. Being a country of only 5,5 million people, the immunisation programme has received a high uptake.

Choosing a strategy

The Norwegian Ministry of Health and Care Services commissioned the NIPH to organise the national Coronavirus immunisation programme. An external ethics advisory group was formed to set objectives and priorities for the coronavirus immunisation programme. The ethics advisory group established three categories for prioritisation in the first phase of the immunisation programme; risk factors for severe illness and death, the infectious situation, and occupation. The prioritisation categories were based on the defined core values of equal respect, welfare, equity, trust, and legitimacy, where the goals of the priorities of the coronavirus immunisation programme were to reduce the risk of death, reduce the risk of severe illness, maintain essential

services and critical infrastructure, protect employment and the economy, and lastly, re-open society ranked in the order of their importance. In the first phase of the immunisation programme, the recommended groups were risk groups and health personnel, where order of prioritisation depended on infection situation, and thirdly critical societal functions (Feiring et al. 2020:4).

Risk groups were early defined as elderly and people with underlying illnesses making them predisposed to become severely ill from the virus. Shielding the elderly from the coronavirus had been a significant goal of the earlier phases of pandemic management strategy, considerably based on social solidarity, where the needs and wants of the more robust part of the population had to succumb to the protection of the elderly and weak. Norway would eventually be able to provide vaccines to its entire population, and prioritisation followed in order of necessity, from the oldest to the younger part of the population. When uncertainty of the vaccine's effect surfaced, booster doses were offered to those deemed to benefit from the, where people have received up to 4 doses throughout the pandemic. No vaccines got approved for use on children under the age of 5 in Norway. Geographical variations were not initially taken into consideration, but throughout the summer of 2021, the government decided to re-distribute vaccines to communes with higher infection rates, leaving some communes with less vaccines. After guidance from the ethic advisory group, voluntariness of the immunisation programme was critical, as it should be based on trust, which is not to be taken, but to be earned (FHI 2022).

Vaccines *are* Trust

The high vaccine uptake, and practically no public upheaval around the Covid-19 immunisation programme in Norway, was by many people involved in pandemic management explained by the preexisting high level of trust in the Norwegian society. If compared to the US or Germany, vaccine hesitancy and resistance has been outspokenly stronger amongst its populations. Vaccines can produce political friction, religious or moral pressures, and a wide range of emotions, from anxiety and fear to hope and protection (Larson, 2020), as shown in numerous anthropological research on vaccines (Streetfland, et. al. 1999; Fairhead, Leach, 2012; Larsson, 2020; Kasstan, 2021). Vaccines are considered as a classical example of the prevention paradox, where successful disease prevention makes us forget the vaccine exists, as it is no longer visible. Thus, any negative effects of the means used become dominant in people's perception of the

problem (Nøkleby, Bergsaker, 2006). Vaccine hesitancy, or reluctance to take a vaccine, has been closely linked to the lack of trust or mistrust in the vaccine's safety or the government (Larson, 2020). Through open communication and a visible presence in media, social media and information hotlines, the communication department at NIPH continuously worked to build awareness around the immunisation programme in Norway.

I had arranged to meet my contact person at the bottom of their office building on a Wednesday morning in October. The building can not be entered without a keycard, and inside there are security glass gates which I can not enter without an access card. It is my first time at the office at Myrens, and I am there to meet my contact person and the rest of the staff. I have been invited to the office on Wednesdays for some weeks, a day they hold their weekly staff meeting, and most people are there. Some are still alternating working from home. The communication team responsible for the immunisation programme tends to be more at the office located at Lindern, closer to those responsible for the Covid-19 immunisation programme. He reached out his hand for a handshake, and I reached out mine, "Yes, now it is legal again", he said with a smile. After an elevator ride up to the office and a quick view of the layout, I made a small tour around the office to present myself to the staff. I told them about my research interest and my purpose for being at the office. An employee with the communication department at the NDH once stated to me while I was there that she thought that the only ones who had managed to cooperate during this crisis properly had been the two organisation's communication departments. With that in mind, I openly share that prior to coming to them, I had spent time at the NDH, and I noticed a little shift in the room. One lady turned to me and said in a little less friendly tone: "Oh yeah, and who do you think did a better job?" A little startled by the question, I smiled and replied in a friendly manner that I was not here to compare the organisations.

After finishing the introduction round at the office, I got a cup of coffee before sitting in the main meeting room with my contact person. The meeting room was about five stories up, with big windows running along the exterior wall, providing a beautiful sky view of Aker River (Akerselva) and the surrounding area. A long table extends through the room. It is a tight space with little room to walk around the sides of the table, but the big windows create a spacious feel. A giant projector screen is mounted on one short-end wall. It is easy to connect people on teams from here.

We had corresponded through emails before my arrival, but this was an excellent opportunity to have a more extended conversation about his thoughts and experiences with the communication department's role in pandemic management. He talked me through his tasks during the pandemic and told me that he was working at the NIPH during the 2009 swine flu pandemic. Wise from experience, they organised the communication teams differently this time around. He explained that they only operated with one communication team during the swine flu pandemic, which left people burnt out. So this time, they organised an A and a B team to maintain their staff better.

Further, he told me about his involvement with the 'Infection Stopp App' (Smittestopp appen). He was involved in the app's development and thought it initially worked well if only enough people had downloaded it. Approximately 1 million people downloaded the app in Norway. The NIPH created the app to trace infection in the population, thereby reducing the virus's spread. The app gained little traction within the general population, raising questions about privacy protection, and was discontinued in August 2022. Our conversation proceeded, and the topic changed to the Covid-19 immunisation programme: "We were very wary of the results in the initial population surveys showing low vaccine uptake in the general population, as presented in media, fall 2020", he said, referring to the previously mentioned population survey on vaccine uptake that presented lower uptake than desired. It triggered a focus to maintain and continue to build trust around the immunisation programme whilst maintaining awareness for any deviations in the population.

I asked what he thought had contributed to maintaining trust during the pandemic.: "Factors that have contributed to building trust have been openness and to provide information as soon as questions arise- do not hold anything back," he replied. "We did not need AstraZeneca or Janssen; we had enough vaccines." We continued our conversation around the topic of vaccines and trust. He remembered a conversation between him and representatives from the NIPH during Arendalsuka, the most prominent political gathering in Norway held annually. One of the people there stated: "A population's willingness to get vaccinated might be the greatest sign of trust". He found it to be an intriguing concept to view vaccines as trust. In the rapid creation, approval and distribution of Covid-19 vaccines, unlike anything seen before, people's willingness to inject their bodies with a substance one is yet to know the long-term effect from and how one's body

will respond might be just that, the greatest sign of trust. Our conversation was coming to an end; he had to go and finish up some tasks before the department meeting that was about to take place soon. Since our conversation had ended on the topic of vaccines as trust, I sat in the empty meeting room thinking about a conversation that had taken place the previous day between employees from the communication team responsible for the immunisation programme. They were working on a communication strategy to reach groups they had been unsuccessful in reaching with vaccine information. They were deciding on questions in the population survey, designed to pick up on any potential vaccine hesitancy. One meeting participant read out a survey question: "To what extent do you conceive the health authorities to be open about the information they have regarding the corona vaccine?" The survey showed that 75% of the participants found that to be largely accurate: "That is a good argument for keeping the question, if anything supposedly was to happen. For instance the AstraZeneca incident, then the level of trust went up." Measuring the level of trust in the population was done every other week throughout the pandemic, indicating the general population's satisfaction with the health authorities or the government. It was an important indicator to monitor that gave health authorities valuable feedback on the general population's perception of pandemic management. Petersen et al. (2021) argue that the long-term benefits of sustaining trust through transparent communication of negative vaccine information outweigh the short-term negative impact negative information may have on vaccine uptake. They state that transparency is key in sustaining trust, a critical resource for handling future health emergencies and the ongoing pandemic. It is difficult to determine if such 'radical transparency' (Dalio, 2017) (Petersen et al., 2021) decreased vaccine uptake in the general population. However, the health authorities registered that the ‘trust barometer’ spiked when AstraZeneca got pulled from the immunisation programme, indicating that it increased trust in health authorities, which can positively affect people's willingness to follow recommendations in the long run. Striving for openness and transparency around the vaccines helped reinforce the relationship between the general population and the state by strengthening the sense that the state puts the safety of its citizens first.

In the first Corona Commission Report, published in April, 2021, criticism was given to the authorities for not providing sufficient information to the population as a whole. By providing corona information in various languages, information campaigns in social media and through

door to door information campaigns in immigrant dense areas, the reach of corona information broadened. It became a priority for health authorities in cooperation with volunteer organisations to better reach priority groups in the population (NOU 2021:6:180-182).

When a Vaccine causes harm

During early spring 2021, Denmark put the AstraZeneca vaccine on hold after reports of severe cases of low platelets, blood clots and bleeding after vaccination. Soon after, Norway reported similar cases. Norwegian health authorities followed Denmark's lead and put AstraZeneca on hold. The vaccine was mainly offered to healthcare workers, a group prioritised for vaccination due to their profession and importance whilst managing the pandemic. In March 2021, three people were hospitalised with severe symptoms in Norway, and one death caused by similar symptoms was reported. Doctors and scientists were unsure what caused these people to fall severely ill, but they all thought it was linked to the AstraZeneca vaccine. A team of Norwegian doctors and researchers worked intensely to find a treatment for and the cause of the condition, later identified as VITT-Vaccine-induced Immune Thrombotic Thrombocytopenia. At this stage, Norwegian health authorities urged vaccinated healthcare workers to report any cases of thrombosis if occurred. One week after the vaccine was put on hold, Oslo University Hospital and the team of doctors and scientists who had worked on the case suddenly announced a press conference about their findings. They reported a causal link between the vaccine and the patient's condition just hours before the previously announced press conference to be held by EMA (European Medicines Agency), regarding the safety of the AstraZeneca vaccine. The experts at EMA concluded that the vaccine is safe and that the need of the vaccine for protecting people against Covid-19 is more significant than the potential risk of adverse side effects. At the time of the news, around 23 countries had suspended the use of AstraZeneca; eight countries, including Norway, decided to discontinue the use permanently, while the remaining countries decided to reintroduce the vaccine. The remaining doses of the AstraZeneca Vaccine were either distributed directly to a receiving country or donated to Gavi/Covax- the international vaccine cooperation alliance.

In Vaxxers (2021), Professor Sarah Gilbert and Dr Catherine Green give the inside story of the development of the Oxford AstraZeneca Vaccine and provide a short description of this incident in their book. In a chapter written by Sarah Gilbert, she gives an account of Monday, 22 of March 2021, which was "the day of the long-awaited interim results that found the vaccine to be well tolerated with no safety concerns*". The * was explained to mean: "*Well tolerated is the term used by clinicians, researchers and regulators to indicate that there have been no significant side effects that would prevent us using a vaccine- in everyday language, it is safe*". She further writes that the suspension of the use of the vaccine in some European countries due to the concerns about: "some rare health issues that may or may not have been caused by the vaccine", was described by her as: "*the clouds on the other blue sky the promise of the vaccine pertained* "(2021:26).

Why Norway chose to weigh risks related to the AstraZeneca, and later Janssen vaccine, more heavily than its benefit may be explained by the current infection rate and the low death toll in the population, the vaccines storage and expected deliveries of other vaccines. Nonetheless, one can consider the influence of experts and health authorities' morals and beliefs when so strongly advising against it. The Director General at NIPH, Camilla Stoltenberg, was summoned to a meeting by the former Minister of Health, Bent Høie after NIPH recommended discontinuing AstraZeneca from the immunisation programme. She described the meeting as 'special', and that it differed from previous meetings. According to her book, she was met with a dislike of the NIPH's conclusion to discontinue AstraZeneca and that it would have been preferred if the matter was left open for the politicians to decide on (Sølhusvik, 2021). She describes it as surprising that the question of vaccines, formerly considered only a concern of experts, suddenly became a highly political matter (Sølhusvik, 2021).

I was not conducting fieldwork at the time of the decision to pull AstraZeneca from the immunisation programme. However, I was at the NDH while the Janssen case was ongoing. The Janssen vaccine, from the company Johnson & Johnson, got put on pause by its distributor after reports of severe cases of thrombosis in vaccinated Americans. EMA investigated reports of plausible side effects from the vaccine. During a press conference, Norway's prime minister, Erna Solberg, stated that stopping the Janssen vaccine could lead to a 12-week delay in the immunisation programme. The Janssen vaccine, also a virus vector vaccine, was shown to have a

higher risk of severe side effects and was never used in the immunisation programme in Norway. After deciding to pull the Janssen vaccine from the immunisation programme, the government decided to keep the Janssen vaccine as an emergency vaccine despite the recommendations from the NMA (Norwegian Medicine Agency) and the NIPH to stop the use entirely. After some deliberation, it was decided to offer the vaccine outside of the immunisation programme, where it was referred to as an 'optional vaccine'. The NIPH did not recommend making the vaccine available to the population because of fear of injuries and, in the worst case, deaths caused by the vaccine. Offering Janssen as an 'optional vaccine' meant that individuals could ask for the Janssen vaccine at their primary care doctor, at their own risk, but still covered by the Norwegian Patient Injury Compensation (NPE).

While spending time at the Preparedness department at NDH, I got an insight into the various assignments that were ongoing through the assignment meetings held several times weekly. During my first week at the NDH, I picked up on a meeting that was about to take place about 'Volunteer vaccination' with an employee at the communication department. I quickly emailed the woman who was listed as the person responsible for the assignment to ask her if there was a chance I could sit in on the meeting. She was okay with me joining her, and I was invited to the communication department one floor up. Again, I needed an escort, as I needed an access card to move freely around the offices or the different floors. Ingrid was friendly, sharp-witted, and clever. I had noticed her and her quick remarks during a previous meeting, which stood out a little fresh and funny amongst a more serious group of people. When I was around, it seemed like she was constantly on her way to go somewhere, or do something, always with a fast-paced walk and an above-average speed of talking. It was hard to decipher whether it was her characteristics or from months of an immense workload.

We sat in a small meeting room with a tall narrow table, a couple of tall chairs, and a big screen on the wall. I placed myself on one of the tall chairs in the back corner of the room, trying my best to stay out of the camera lens. "This can be an interesting meeting; we hate that we got this assignment from the Ministry ", she said while she tried to connect to the big screen on the wall, unsuccessfully. Ingrid signed on through her laptop and cleared with the other meeting participants that I could sit in on the meeting. In addition to Ingrid, the meeting participants were communication representatives from NIPH and the Norwegian Medicines Agency (NMA). The

meeting agenda was to organise a joint communication strategy for the Janssen vaccine. The three organisations have different roles and mandates when it comes to the matter of vaccines. The NMA is the national authority responsible for approving and following medicines on the Norwegian market. The NMA's role during corona vaccination is to monitor the safety of the vaccines in clinical use. The NMA also makes the necessary regulatory decisions in collaboration with the EMA and other European authorities, including everything from updating the vaccine side effects list to ultimately withdrawing the vaccine's approval. The NMA and the NIPH collaborate on collecting and handling vaccine side-effect reports and have access to national and international data on vaccine safety. The NIPH is responsible for purchasing, storing and distributing the vaccines, providing information about the vaccine and guidelines for use, and prioritising groups for vaccination. The NDH is responsible for purchasing and distributing vaccination material to municipalities. All three provide information to the national online platform for health information, *Helsenorge* (HealthNorway), which is a platform used to communicate Covid-19 related information to the general population during the pandemic.

"It is important to communicate that it is not a part of the immunisation programme and that they do not recommend it", the participant from the NIPH stated. "Who is it that does not recommend it?" Ingrid asked." Predominantly, we do not give recommendations, but it should not be approved as a medical drug in Norway", a representative from NMA replied. "But it is!" Ingrid quickly declared. They continued to discuss the increasing reports from the US of adverse side effects and expected that more would come with time. "Do not do it! That is the advice we should give the politicians. This is contrary to The Health Care Act; this is not health care!" one of the participants stated. "Yes, but it is decided", Ingrid replied, as she steered the conversation towards the practical implementations of the assignment. The task was to provide an information brochure about the Janssen vaccine. The meeting participants found it challenging to decide what it should contain and where it should be accessible to the general population. As the meeting ended, one of the participants stated:" This is extremely challenging and in no way a win-win." Ingrid quickly replied: "Professionally challenging, can we say?".

The case of the AstraZeneca and Janssen vaccines brought unexpected challenges to pandemic management. Advising against highly anticipated vaccines had known consequences; simultaneously, the potential consequences to life and health were not a risk health authorities

were willing to take. Several of the people I talked to about the subject, briefly or long, found it unsettling. "Vaccines are not supposed to do harm or kill", one person told me, "It was devastatingly tragic". I was once told about a discussion that took place during a meeting relating to the case of AstraZeneca. When discussing the five reported deaths, and strong indications of a higher perceptibility amongst women under the age of forty to develop adverse side effects from the AstraZeneca vaccine, one of the assistant directors at NDH had stated that by the continuing use of the AstraZeneca vaccine, one could risk another 20 or so deaths in the next few months amongst young women, and that would not be acceptable in terms of health policy.

Vaccines carry sentiments, unlike any other medical substances. To the Norwegian health authorities, assessing what poses a more considerable risk- the virus or the vaccine- was not straightforward. The issue of vaccine safety is embedded with moral and ethical connotations, and it took much consideration from people responsible for the immunisation programme in Norway. Globally, it was a contested matter, as the AstraZeneca and the Janssen vaccine presented health authorities and governments with real-life ethical questions or trolley dilemmas of their kind. In a classic trolley dilemma, a bystander sees a runaway trolley headed directly toward five people who will shortly be killed. The observer is located next to a switch that, if activated, would re-route the trolley, killing one person along the way but keeping the other five safe. In the second scenario, the observer standing on a footbridge, accompanied by a big man, sees the trolley heading for the five people. If he pushes the man off the bridge, the body will divert the trolley, saving the five people but killing the man. What should the bystander do? Most people presented with this dilemma believe he should pull the switch but not push the man. Why it is so has been debated by academics for decades. One common explanation is the distinction between the immorality of intentional harms and the acceptability of only predictable ones (Rosenbaum L., 2018). The trolley dilemma highlights the tension between utilitarianism- which holds that behaviour is justified if its outcomes benefit the common good. Our moral intuitions of right and wrong (Edmonds, D. 2014) are not unfamiliar notions regarding the ethical and moral considerations of vaccine trials or other medical ethics problems. Oftedal and Dahl (2019, 2020) assert that vaccine dilemmas are real moral dilemmas, arguing that they should not be parallelled with trolley dilemmas. They further argue for cautiousness if using trolley-based reasoning in discussions regarding vaccine trial ethics and possibly medical research ethics, pointing to the complexities of vaccine dilemmas (2020). Nevertheless, in the case of the AstraZeneca and the

Janssen vaccine, Regardless of the magnitude of the potential benefit of continuing with the vaccines, not all foreseen harms felt morally akin. To health authorities, continuing with the AstraZeneca and the Janssen vaccine in the immunisation programme was not morally justifiable.

Vaccine hesitancy as *intelligence*

Vaccine hesitancy, according to the 'SAGE Working Group on Vaccine Hesitancy', "refers to the delay in acceptance or refusal of vaccination despite the availability of vaccination services" (Noni, 2015) and was considered among the top global health threats (WHO, 2019). A reluctance amongst people towards vaccines is not a new phenomenon, and authorities have battled this phenomenon in various ways, from voluntary vaccination to vaccine mandates. In *Stuck* (2020), Heidi Larson looks at what influences attitudes towards vaccination and explores why and how vaccines provoke anxiety, perceptions of risk and rumours worldwide. Considering vaccines to be a relational subject, Larson states that vaccine acceptance depends on trust in scientists, industries that produce them, health professionals who deliver them and the institutions that govern them (p.xxxv). Vaccine sentiments vary from the more extreme views to people being hesitant but choosing to continue vaccinating.

During some free time between meetings at the NIPH offices at Lindern, I see an opportunity to ask about the preliminary indications of a slightly low vaccine acceptance amongst the general population, dating back one year. When asked how they felt about the issue, she looked at me and said:" We did discuss it. However, we considered it to be a sign of intelligence." "Intelligence?" I replied, trying to make sure that I heard correctly. "Yes, intelligence", she repeated. "At the house here, we saw it as a sign of intelligence." She explained that they did not find it odd that people hesitated to take a vaccine produced and distributed in such a short time when it usually takes years before it gets approved and distributed. The conversation abruptly ended as we had to move on, but she said we could find time to discuss this further. Unfortunately, she never found the time to have that conversation. I thought about what she had said several times throughout the rest of my fieldwork, curious about how considering vaccine hesitancy as intelligence influenced the communication campaign. If vaccine hesitancy had persisted amongst the general population, would it still be considered intelligence? In Cambridge

Dictionary, intelligence is "*the ability to learn, understand, and make judgments or have opinions that are based on reason."* Thorndike defined intelligence as *"the power of good responses from the point of view of truth or fact"* (1921, p. 124). By following Thorndike's definition of intelligence, viewing vaccine hesitancy as intelligence implies that health authorities placed trust, or confidence, in the general population to reach a solution that would benefit the actors, both as an individual and as a collective. This orientation towards the belief in autonomy and reason was present in much of the NIPHs' assessments and advisories provided throughout the pandemic, demonstrated through the reluctance towards, and occasional criticism of the government's tendency to favour regulations over recommendations. Emphasis was placed on that the immunisation programme was to be free of charge, voluntary to participate, and the NIPH held a strong stance against vaccine mandates.

Several countries implemented vaccine mandates to varying extents. Implementing a national corona-pass as an infection control measure was addressed by the government during the fall of 2021, after Denmark, a country Norway closely monitored during the pandemic, proposed corona-pass mandates for its citizens in an attempt to curb a third wave of infections. In Finland and Denmark, there were reports of spikes in vaccine uptake after the introduction of corona pass. Introducing a domestic corona pass was discussed several times during meetings at NIPH. Questions as to if "we are more susceptible to implement national measures over corona pass?" was rhetorically asked, as an employee continued: "We are probably very restrictive with the implementation of corona pass. We will not impose measures on unvaccinated people because they do not take the vaccine that we offer. It has to do with human rights", she stated. A few days later, the topic was again discussed during a meeting. The attitude towards it remained similar: "A corona pass is supposed to lessen restrictions; it can not be used to limit people," one meeting contestant stated. Low state-level interference in people's autonomy and freedom of movement was a strong sentiment with the NIPH, shown through the disinclination to implement national corona pass and vaccine mandates.

As I spent more time with the vaccine team, *how* they communicated the vaccine was intricate, and I experienced the team leader to be particularly attentive and mindful of their responsibility. "We can never state that a vaccine is safe. The state does, but we cannot", a team member responsible for the immunisation programme once responded to one of her colleagues during a

conversation about information material to use in a campaign they were about to launch. She turned to me, seemingly with a need to elaborate: "You see, we can not state that a vaccine is completely safe."

The NIPH received criticism from several accounts for the "wait and see" strategy they allegedly settled on at the onset of the pandemic, where the risk tolerance was higher than that of the NDH and the government. Regarding vaccines, NIPH showed a higher risk aversion than the Norwegian government, as with governments and health authorities in numerous countries worldwide. The NIPH's deliberate choice of not using statements of vaccine safety in their communication efforts was a different approach to that of EMA, who stated the AstraZeneca vaccine was safe, even after confirmed reports of adverse side effects and death. The complexity of and contextual contingency of vaccine hesitancy is recognised in research on the subject, yet, the fear of adverse side effects is a predominant driver of hesitancy towards vaccines (Betsch et al., 2018; Casiday, 2010; Karlsson et al., 2021; Larson et al., 2014; Larson, 2020; Neumann-Bohme et al., 2020). Knowing that vaccine avoidance is by many driven by the fear of adverse side effects, the communication strategy never specifically targeted vaccine safety; it targeted vaccine efficiency or vaccine benefits outweighing the risk. By treating vaccine hesitancy in the general population as merely a sign of intelligence, the communication strategy focused on providing people with good information to make well-informed decisions about vaccines. This became a quandary with the Janssen vaccine. Here the situation was the opposite. The government was favouring the vaccine; the experts were hesitant. There was a fear amongst many experts that people would choose the Janssen vaccine to get ahead in the vaccine queue. The pros of the vaccine were that you only needed one dose to be considered fully vaccinated, and it was a virus vector vaccine created by using old and known technology, which could matter to some people. Besides, Norway was to receive a significant number of doses, which would have sped up the vaccination coverage in the population. The cons were the reports of adverse side effects, and according to the NIPH, the risk of the vaccine outweighed the benefit in the current state of the pandemic. The NIPH solved this by communicating through their platform that they *do not* recommend the Janssen vaccine; instead, the public should choose an mRNA vaccine offered through the immunisation programme. By viewing vaccine hesitancy amongst a population as intelligence, health authorities met the population with understanding and respect, which laid some guidelines for communicating vaccines to groups less willing to receive one.

Disease and Stigma

With the global spread of Covid-19, stigma spread with it. Historically, when a disease has appeared under certain circumstances, stigmatisation and scapegoating have followed. Diseases have been racialised for centuries, nicknaming diseases after countries or ethnic groups (Kucharski, 2020; Snowden, 2020). The stigma connected to a specific disease also appears more country-specific and local (Bagcchi, 2020), highlighting specific societies' structures and vulnerabilities. Countless studies highlight the connection between infectious diseases and stigma and their effect on society. (See; Alonso and Reynolds, 1995 on HIV/AIDS; Siu, 2008 on SARS; Minor and Venables (2017) on Ebola; Abney (2018) on Tuberculosis). Covid-19 was no different, where racial stigma increased, assisted by former US President Donald Trump's Tweet on March 16, 2020, using the term "Chinese virus," which later has been linked to the rise of anti-asian hashtags on Twitter (Hswen et al., 2021) and a rise of anti-Asian sentiments (Huang, 2023), especially towards East- Asians. When new virus variants appeared during the beginning of the pandemic, virus mutations bore the name after places of discovery, where 'the Wuhan' signified the original virus, 'the British variant,' 'the Indian variant' or 'the South African variant' were virus mutations discovered in respective places. Eventually, the WHO announced a new naming system for variants of Covid-19, by naming them after Greek. According to the WHO, the new naming system avoided stigmatisation of countries and aided scientists when discussing virus variants.

According to Erving Goffman, *stigma* is a characteristic that sets a person apart from others in a social group and consigns them to a disreputable or impure position (Goffman, 1963, p. 3). The stigma associated with an infectious disease is highly contextual and contingent on the moral standards that govern behaviour in various social contexts (Goffman:42). The experience of changes in a person's identity or social status can be due to factors such as illness, disability, or other personal crisis. In Mary Douglas's "*Purity and Danger: An Analysis of Concepts of Pollution and Taboo" ([1966] 2002),* the concept of purity and impurity are signifiers of order and disorder. According to Douglas, purity is an important concept that governs social order and serves as a way to distinguish between what is acceptable and what is not. On the other hand, danger refers to things considered threatening to the established social order. Following the theory of Mary Douglas, stigma can be understood as a form of social labelling that separates

individuals or groups from the mainstream based on their perceived difference. This difference can be physical, cultural, or behavioural and may be stigmatised due to its association with danger or impurity (Douglas, 2002).

Reaching Unvaccinated Groups

The cornerstone of NIPH's social mission is to improve the health condition of the general population by providing equal health services to *all* of Norway's population. The egalitarian welfare paradigm that emerged post World War II in Norway is well ingrained in Norwegian society and played a significant part in pandemic management. For NIPH and the government, the immunisation programme needed to be equally available to the entire population to have a predominantly vaccinated population. Measures were implemented, such as making the vaccine free of charge and easily accessible. Under the section 'Toolbox for an equal vaccination offer' in the Vaccination Guide (FHI, 2023), created by NIPH for health personnel, a section dedicated to maintaining equality of the immunisation programme reads: "About facilitation and information measures that can enable groups with different conditions to make an informed choice about vaccination." (FHI, 2023, Vaksinasjonsveilederen). The 'Vaccination Guide' is mainly for the Covid-19 and influenza immunisation programs, with an emphasis on enabling people to make an informed choice of whether or not to get vaccinated. While acknowledging the existence of vaccine hesitancy amongst the general population, it advises minimising the exposure of vulnerable groups, which could lead to stigmatisation. Vulnerable groups are defined here as elderly people, people with varying disabilities, immigrants, homeless people, drug addicts and paperless immigrants, or minority groups, being religious groups or subcultures distanced from the greater society (FHI, 2023).

At the time I was given acceptance to the communication department at NIPH, the team responsible for the immunisation programme was working on campaigns towards groups in Norway with a lower vaccine uptake than the population at large. Campaign material consisted of information material in numerous languages, banner ads, an information film, advertised over different channels (FHI 2022, Informasjonsmateriell til befolkningen). These groups were people from Eastern Europe, especially the Polish population which is the largest immigrant group in Norway. There was at the time a considerable group of relatively young people of Polish descent hospitalised from Covid-19. The Ministry was attentive to the situation, and there was a sense of

pressure on NIPH to increase the vaccine uptake. The second group was the Sami population residing in the northern parts of Norway. As the infection rate and hospitalisation from Covid-19 were rapidly increasing in the northern county Troms & Finnmark it turned the attention of health authorities to increase the vaccine uptake in the county. The county had, up until this time, not had any significant outbreaks of the virus despite being in the second year of the pandemic. At the time of the meeting, there was a trend showing a low vaccine uptake in the statistics. The county is Norway's biggest by geographical extent, yet the area is the overall lowest populated, with approximately a quarter million people mainly concentrated around cities and towns along the coastline. Troms and Finnmark is also the geographical centre of Sami, the indigenous population of Norway.

The communication team leader responsible for the immunisation programme invited me to attend meetings with the team on the topic of "How to reach groups hard to reach" so I could observe how they approached their communication efforts to promote vaccine uptake. A campaign in Troms and Finnmark was to be launched that week to reach people between the age of 18-55 due to lower participation in the immunisation programme. During an online meeting between NIPH representatives and representatives from Troms and Finnmark the situation in the northern county is being discussed. "We in Finnmark are experiencing an outbreak of infection for the very first time", said a municipal chief medical officer from the county. She is concerned about the low vaccine uptake and the ongoing outbreak of infection in the area. She is worried about the development of the infection situation, and appears dissatisfied by the seemingly less attention people in that region are receiving from the health authorities. She explains that she experiences that trust in the government and state institutions, or agencies that appear to function as an extension of the state is low amongst parts of the population in her county. In addition to that, they had encountered issues with substitute doctors, questioning both the vaccine and the pandemic in general."This is a bigger issue that the health authorities need to address- it is a problem to public health", she stated.

The relationship between the Sami people and the Norwegian state has through history been complicated and conflicted. From the early seventeen hundreds and up until newer times, "Norwegianization " of the Sami and Kven people was part of an active assimilation policy led by the Norwegian state with the goal to integrate the Sami and Kven people into Norwegian

society. The assimilation of Sami people was mainly coerced, and most people lost their language, religion, and identity as a cultural minority. Due to the negative assertion of the Sami people in Norway, many held their Sami identity hidden from their descendants. King Harald, the reigning king of Norway, asked for forgiveness for the Norwegian state's assimilation policy when he opened the Sami Parliament in 1997.

The meeting participants from NIPH offered to contribute financially and with expert knowledge in the creation of info material for the Sami population. They continued to discuss various reasons for the low vaccine uptake and shared their knowledge on the subject. “This is an indigenous health issue”, one of the representatives from the county stated. One of the people from NIPH turned to me and said she finds it embarrassing that the NIPH does not have a department for indigenous health, and her discomfort appeared heartfelt and sincere.

The varying dispositions people have to vaccines, or to its providers, affects the vaccine uptake. Some vaccine hesitancy in the population was anticipated by the NIPH, but when the number of hospitalisations and deaths rose amongst groups with low vaccine uptake there was a need to act. Larson (2020) argues that dialog and understanding is needed to bridge the gap between vaccine providers and people hesitant to vaccines. The communication team put in a substantial effort to reach groups with a lower vaccine uptake, to improve their knowledge about the vaccine, while increasing their own understanding and knowledge on matters that required different approaches than previously done.

Some Concluding Remarks

The vaccination programme's focus on voluntariness, transparency and availability has helped to minimise stigmatisation between vaccinated and unvaccinated. This is not to say that stigmatisation, blame or discredit of people based on their stance on vaccines did not occur in public debates or on social media. As stated by Larson (2020), “there is something in vaccines that rouse political nerves, moral and religious nerves, and sparks emotions of hope and fear” (2020, p.xxiii). By avoiding the use of words such as *dugnad* in the communication of the immunisation programme, otherwise heavily used during pandemic management, there has been a communicative focus on the individual's freedom of choice when deciding on vaccination, and a ‘radical transparency’ (Dalio, 2017) around vaccine safety has been an effective way of

minimising the emergence of vaccine rumours, which is deep-rooted in the movement of vaccine scepticism (Larson, 2020). An immunisation programme based on social solidarity can have contributed to taking the sting out of the public vaccine debate in Norway, preventing it from becoming heavily politicised. I would consider that the transparency around vaccine safety strengthened the relationship between the health authorities and the public rather than triggering substantial public fears around the vaccines.

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