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Activating *Dugnad* under COVID-19 and the Imagination of Equality in the Norwegian Welfare State

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See table of contents

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Article abstract

In Norway, the institution of the welfare state and trust in the government defined the country's approach to tackling the pandemic. In particular, the government's strategy to activate the cultural concept of *dugnad* (voluntary, reciprocal communal work), which relies on an equal standing of all participants, plays into the national imaginary of an egalitarian and just society. However, like in other countries, COVID-19 has put the spotlight on inequalities in access to healthcare, information, adequate housing, and more. Investigating infection measures and their indirect consequences can clarify which values and people are given priority in a crisis and who is seen as belonging to Norwegian society.

This article points to the pandemic as a magnifying glass revealing the lack of enough emergency care nurses, physicians, equipment, hospital and psychiatry beds, adequate health literacy efforts and more. Moreover, it magnifies heteronormative and Eurocentric ideas of who makes up a family, compounded by nationalistic notions of who is Norwegian enough to belong.

By activating *dugnad*, politicians transferred their responsibilities as elected leaders to individual citizens, leading to the growth of socioeconomic inequalities and health disparities during the pandemic while also resulting in the poor communication of the long-term and indirect costs of pandemic measures.

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“Not a Major or Complicated Task”

Activating *Dugnad* under COVID-19 and the Imagination of Equality in the Norwegian Welfare State

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Abstract: In Norway, the institution of the welfare state and trust in the government defined the country’s approach to tackling the pandemic. In particular, the government’s strategy to activate the cultural concept of *dugnad* (voluntary, reciprocal communal work), which relies on an equal standing of all participants, plays into the national imaginary of an egalitarian and just society. However, like in other countries, COVID-19 has put the spotlight on inequalities in access to healthcare, information, adequate housing, and more. Investigating infection measures and their indirect consequences can clarify which values and people are given priority in a crisis and who is seen as belonging to Norwegian society.

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By activating *dugnad*, politicians transferred their responsibilities as elected leaders to individual citizens, leading to the growth of socioeconomic inequalities and health disparities during the pandemic while also resulting in the poor communication of the long-term and indirect costs of pandemic measures.

Keywords: Norway; pandemic; equality; dugnad; COVID-19; inequality; healthcare; welfare state

Résumé : En Norvège, l'institution de l'État-providence et la confiance envers le gouvernement ont défini l'approche du pays face à la pandémie. La stratégie du gouvernement visant, en particulier, à activer le concept culturel de *dugnad* (travail communautaire volontaire et réciproque) qui repose sur l'égalité de tous les participants, s'inscrit dans l'imaginaire national d'une société égalitaire et juste. Cependant, comme dans d'autres pays, la pandémie de COVID-19 a mis en lumière les inégalités en matière d'accès aux soins, à l'information, à un logement adéquat, etc. L'étude des mesures de lutte contre l'infection et de leurs conséquences indirectes peut clarifier quelles valeurs et quelles personnes sont prioritaires en cas de crise, et qui est considéré comme appartenant à la société norvégienne.

Cet article considère la pandémie comme une loupe qui révèle le manque d'infirmières dans les services d'urgence, de médecins, d'équipements, de lits d'hôpitaux et de psychiatrie, d'efforts adéquats en matière d'éducation à la santé, et bien d'autres choses encore. Par ailleurs, la pandémie amplifie les idées hétéronormatives et eurocentriques des membres d'une famille, auxquelles s'ajoutent des notions nationalistes sur les Norvégiens qui ont le droit d'appartenir à une famille.

En mobilisant le *dugnad*, les politiciens ont transféré leurs responsabilités de dirigeants élus aux citoyens individuels, ce qui a conduit à l'augmentation des inégalités socio-économiques et des disparités en matière de santé pendant la pandémie, tout en entraînant une mauvaise communication des coûts indirects et à long terme des mesures de lutte contre la pandémie.

Mots-clés : Norvège ; pandémie ; égalité ; dugnad ; COVID-19 ; inégalité ; soins de santé ; état providence

Introduction

Like a magnifier, COVID-19[1] forefront societies' weaknesses and strengths, along with their ways of leadership. In Norway, the institution of the welfare state,[2] high levels of trust in the government,[3] and cultural concepts of solidarity, openness, and equality have defined both the national crisis response and international perceptions of the country. Upon its onset in the early months of 2020, Norway's pandemic measures included, among others, restricting border crossings, national and local lockdowns, school and daycare closures, information campaigns, and different contact-limiting or hygiene-promoting approaches now widely acknowledged as successful. However, like in other countries, COVID-19 also exposed inequalities in access to healthcare, information, education, and adequate housing, as well as unveiling, and at

times normalizing, ableism, heteronormativity, xenophobia, and exclusive nationalism that proliferates Norwegian mainstream society, including its government.

When I started writing this article, Norway had just gone into its first lockdown, and I, like supposedly most people, was scared. However, how the pandemic and necessary restrictions were communicated was also fascinating. During the government's very first press conference, one word in particular captivated my attention: *Dugnad*. *Dugnad* is a core concept in Norwegian society, which can be translated as "voluntary communal work." As I will discuss further below, the concept of *dugnad* is closely related to Norwegian ideas of egalitarianism, solidarity, and unity. It assumes that people come together *on equal terms* to resolve a shared burden or work towards a common goal.

Upon announcing the first restrictions in March 2020, then-prime minister Erna Solberg drew on the concept of *dugnad* twice in her speech:

> We are facing a difficult time for Norway and for the world. Norway is being severely tested, not only as a society but also, each of us as individuals. In these times, everyday life will be different for all. We hope that the radical measures we are implementing will stop the virus [...] It is therefore **absolutely vital that every citizen participates in a *dugnad*** to slow down the virus [...] This demands a lot from all of us [...] **In Norway we stand together when called upon to do so. We mobilize *dugnad* and collaboration** in both small and large communities. (NTB 2020)[4]

This speech set the tone for all subsequent communications of measures, and in the coming weeks and months, *dugnad* was everywhere. Surprisingly, it also remained without critique in public discourse for a long time, and I found myself troubled with the way a collective "us" was activated to fight the pandemic.

To dissect this, I have explored academic work on the welfare state, *dugnad,* and egalitarianism/equality in a Nordic/Norwegian context. Here, Marianne Gullestad's conceptual work on Norwegian nationalism and society proves crucial. Ultimately, based on fieldwork conducted during the 1990s, her work highlights that COVID-19 merely magnified what has always been: *Some Norwegians are more equal than others.* Additionally, this exploration builds on and adds to the growing body of literature addressing *dugnad*, the welfare state, and Norwegian national identity in relation to the pandemic (for examples, see

De Lauri and Telle 2021; Gjerde 2021; Moss and Sandbakken 2021; Myhre 2020; Nilsen and Skarpenes 2022; Sandvik 2020).

In parallel to the pandemic, debate on Norwegian society's handling of the terror attack on 22 July 2011 surfaced as the tenth commemoration day for the victims approached. Foremost, this debate pertained to how the narrative that "all of Norway was attacked" concealed the political objective behind the attack, which specifically targeted members of the Labour Party and the values they stand for. The gradual normalization of hate speech over the past decade, and the growing acceptance of public statements anchored in right-wing extremist ideology, were also amplified. Like the pandemic, this crisis—a right-wing terror attack directed at the then-ruling Labour Party (Arbeiderpartiet) and its youth organization AUF (Arbeidernes Ungdomsfylking), where an extremist brutally killed 77 people and left many more injured and traumatized—was handled by conjuring an imagined national community, collectively hit, and standing together in unity.

This debate surrounding the aftermath of 22 July illustrates how usually positive social ideas like collectivity and solidarity can hide inequalities, political agendas, and motives, veiling the labelling of victims. In the aftershock of 22 July, narratives surrounding the victims, by opposition politicians, media, and on social media, depicted an erosion of which utterances were publicly accepted in Norwegian society.

The ways in which 22 July and the COVID-19 pandemic were handled, despite all their differences, are strikingly similar: The collective imagination that Norwegian society is made up of equal parts, with the same room for action, and equally affected by anything happening to Norway as a whole.

In this article, I argue that while the narrative of *dugnad* was used as a tool to conjure community and actions of solidarity, it also undermined the awareness of inequalities, injustices, and differences in suffering, and consequently led to an imbalance of the burden of measures, disproportionately impacting marginalized members of society. I further argue that *dugnad*, therefore, not only has a unifying effect, but also leads to othering, exclusion, or to the masking of socio-economic inequalities. To do so, I ask who or what was left behind when conjuring a national *dugnad,* but also question the government's use of the term. Does their activation of this key cultural concept fulfill the criteria for being a *dugnad*? To answer these questions, I will first discuss the cultural, social and linguistic meaning of *dugnad*. I will then turn to my

empirical material on the following two topics: access to mental healthcare and addiction treatment and the construction of belonging and how it impacted people of immigrant background and/or transnational family constellations during the first 18 months of the pandemic. As I will discuss further below, the reasons for selecting these areas of focus are closely interlinked with my positionality and location.

Being a Researcher in a Pandemic

COVID-19 arrived in Oslo via middle and upper-class ski tourists, mostly residing in the wealthy western quarters of the city. As it spread rapidly, news coverage "on the frontlines" depicted people in quarantine or self-isolating. They were shown working from home, with children occupied in the background, doing schoolwork each on their modern electronic devices, jumping on trampolines in huge back gardens, or building dens in spacious living rooms. Sacrifices seemed minimal and the message was clear: They stayed home out of solidarity and as part of a national *dugnad*. And, as the then Norwegian minister of health, Bernt Høie, claimed on the eve of the first national lockdown: partaking in this *dugnad* was not a "big or complicated task" (2020). Then, a day later, he used the term again: "The measures being taken will be experienced as burdensome for many, with major consequences to Norwegian society. But this is *dugnad* that we must do, as a community and on behalf of the community" (Statsministerens kontor 2020). Yet, Høie's claims of this *dugnad* being easy, as well as the media depictions of quarantine, failed to align with the realities I was both witnessing and experiencing.

My neighbourhood in Eastern Oslo, Tøyen, known for, among other things, having one of Norway's highest rates of children living under the poverty line, was especially hard hit. Both by infection rates and the consequences of pandemic measures. Most inhabitants lived in tight quarters, with no large living rooms and back gardens, as those depicted in the media. Particularly in the many public housing complexes, social distancing was all but impossible.

I shared some of the characteristics of my neighbourhood, as a queer person without Norwegian citizenship, and as a single parent living in a small apartment. However, being white, holding an EU passport, having a permanent residency permit, and having no underlying health conditions with increased risk for severe illness in the event of a COVID-19 infection, distinguished me and my child from many of my neighbours.

The precarity of not holding a Norwegian passport, and having my relatives far away impacted me, like many others, significantly. With increasingly stringent border restrictions, as well as ongoing illness in my family, it felt as though I would never see my loved ones again. I felt alienated by how politicians and media depicted immigrants, and the indifference shown by much of the Norwegian population with no family abroad. Seemingly, Norway, having been my home for almost two decades, suddenly became a country with neither compassion nor place for those of us without proof of Norwegian citizenship and ancestry. Moreover, the consequences of the isolation inherent to social distancing concerned me deeply, as did the closing down of society, including many of its vital social services.

Without this positionality, these aspects of the pandemic might have remained out of reach, and out of conversation. Interviewing people, immersing myself in news items, and documenting my experience became a way of coping with the pandemic, and of recovering from depression in the aftermath. As the pandemic remains ongoing, we continue to be both observers and participants, all while our memories begin to fade as life withdraws from a state of emergency, morphing into this (new) normal.

Methods

Already in the first days of the first lockdown, as a means of coping, I began interviewing people working with marginalized groups, as well as friends and acquaintances who belonged to these groups. By November 2021, I had interviewed or had conversations with thirty-one participants.[5] Most lived and/or worked in the Eastern parts of Oslo, and some in other parts of Norway. Some were interviewed twice. All participants were informed that I had no established plan for the collected material, and that this research was not connected to any formal project. Almost all belonged to my neighbourhood, and while I had no academic affiliation at that time, interlocutors knew me from my child's school, through my engagements in various civil society activities, by being my neighbour, or through my previous academic work.

Most interviews were narrative, except those with healthcare or social service providers, which remained more targeted and structured. All interviews were conducted in Norwegian, many over the phone. All translations presented here, of both interviews and news articles, were translated by me unless otherwise indicated.

Remaining fluid in my approach to who or how many I talked with was intentional, as I wanted to capture something ongoing that I did not yet have words for. I was interested in the discrepancy between what I saw around me and the imagined audience that lived normative Norwegian middle-class lives seemingly addressed in press conferences. My questions changed over time and shifted as new restrictions were announced. Most questions remained open, such as: "Can you describe the first day of lockdown? What was it like for you?"; "You work as a XXX, can you describe if/how your work has been impacted by the pandemic?"; or "The government just announced the following restrictions. Can you describe what that means for you?"

In addition to a diary with "fieldnotes," I also composed a small media archive, collecting news and debate articles[6] relating to one or more of the following topics, in relation to the pandemic: belonging/othering, psychosocial effects, class and race perspectives, and, after noticing its ubiquitous presence, *dugnad*. Although I initially also collected screenshots of online debates relating to these topics, this was gradually abandoned as the often-racist tone in the comment sections began negatively impacting my mental health.

The Norwegian Concept of *Dugnad*

In revisiting my fieldnotes, my obsession with the term *dugnad* and its application is apparent. And with good reason: *Dugnad* was one of the most used words of that period (see also Moss and Sandbakken 2021). During the first weeks of lockdown, many leading politicians conjured *dugnadsånd* (a condition where people willingly participate in *dugnad*) in almost every public speech. Most media articles also named *dugnad* in one way or another when reporting on prevention measures. Consequently, the sign for *dugnad* was added to Statped's[7] overview as one of the twelve most important signs related to COVID-19, and as the only culture-specific concept listed along with terms like virus, corona, pandemic, quarantine, etcetera.

The History of Dugnad

The term *dugnad* has ancient roots, embedded in the Norse word *dugnaðr*, meaning help, support. The word *dugnaðamarðr* defined a person that was **inherently** helpful. Thus, the double-meaning is incorporated: *dugnad* is both something one does, and a moral judgement about a person's character as they participate in *dugnad*. This moral aspect is further constituted in the verb connected to the noun, *duga*, meaning, besides helping, being useful and proving one's worth (Baetke 2005 [1965], 94).

In Norway, legal concepts of neighbourhoods originate in the tenth century (Haff 1929). Upon their conception, neighbourhoods consisted of several small farms situated near one another and dependent on reciprocal relations to survive. Helping others in larger projects such as haymaking, roofing, or construction and upkeep of roads and bridges was called *dugnad*. Illustrating the temporality of *dugnad*, these activities commonly lasted a whole day or longer, and smaller exchanges of labour were not included under the concept. Who held duties to collaborate in these undertakings was regulated by customary law and customary organization of these neighbourhoods. Importantly, *dugnad* was only exchanged between equals, horizontally rather than vertically. More prosperous owners of larger farms could consequently not request that smaller neighbouring farms participate in *dugnad*.

Beyond being defined by its specific temporality, its reciprocity, and its framework of exchanging unpaid labour for the common good, *dugnad* was also regulated by ideas of belonging and societal organization (Haff 1929). Thus, it holds inherently egalitarian qualities, as a tool for both community building and social control (Lorentzen and Dugstad 2011; Nilsen and Skarpenes 2022). As its etymology shows, *dugnad* is also deeply entangled with morality and agency. Over time, *dugnad* became less defined by specific tasks, simultaneously growing, both in its application and its attached value. Specifically, it came to encompass a nationalistic component.

The first decades after the Second World War are often described as a monumental national d*ugnad*, where Norwegians built the welfare state under strong social democratic political leadership (Gullestad 2002, 53; Nilsen and Skarpenes 2022). Therefore, participating in *dugnad* and being a socially responsible citizen became closely connected, and reinforced by Nordic welfare ideas: that working towards a common good is also working towards one's own good (Nilsen and Skarpenes 2022). Contemporarily, *dugnad* relies on the idea that everyone in Norway is equal, and therefore capable of participating and imparting with their time and labour for "the common good."

The Social Meaning of Dugnad

Newcomers to Norway are often introduced to *dugnad* through social interaction, when asked to participate in tending to the neighbourhood, cleaning the backyard, painting a fence, or some similar task at a given time. While social interactions are otherwise rather restricted and comparatively formal in Norwegian culture, neighbours chat freely during their participation in *dugnad*, introducing themselves and often sharing food and drinks.

While painted as a voluntary social engagement, *dugnad* is accompanied by high social expectations of participation. For example, the board of an apartment co-op might convey that while participating in *dugnad* is voluntary, tenants who excuse themselves can instead offer a certain sum of money to the housing association. In children's sport clubs, parents might be obligated to engage in *dugnad* by selling toilet paper or baking cakes for certain events.

No visible social sanctions for not participating exist; however, indirect comments and social pressure to contribute in the future are common. Non-participation will, over time, lead to a silent exclusion from the imagined community of neighbours, parents, or other groups. This poses pressures on those who have financial, health, and/or other capacity restraints hindering their participation. Also, *dugnad* has been employed in differentiating the "us" from "them"; for example, seeing immigrants who arrived in the seventies as not having participated in "building the nation" (Gullestad 2002, 53).

Dugnad—a Norwegian Specialty?

Today's social institution of *dugnad* in Norway is less defined; however, some characteristics must be upheld in order for an act to be considered *dugnad*. Defining aspects are that the effort takes time, includes more than one person, has been requested, and contributes to the collective good or to the well-being of a group of people. It must be an unpaid effort, publicly acknowledged as valuable. Often following a rather formalized, almost ritualistic frame, *dugnad* has three stages: the request (in a co-op newsletter, a poster in a foyer, an official's or institution's appeal); the collective effort (varying in scale, timeframe, and number of people participating); and, lastly, the reward (shared foods and drinks, official praise, collective confirmations of achievements and belonging).

Being familiar with several different countries, I struggled for a long time to grasp what was so special about *dugnad,* or why it is so deeply intertwined with Norwegian identity. Through conversations with other immigrants, I learned that they too found the deep meanings of *dugnad* intriguing, especially as none of us were strangers to voluntary communal work in our respective other home countries. "It's just expected," a friend from Eastern Europe shared. "How do you think we made it through communism? Of course, we help each other, there's no need to name it,[8] everyone does it," she laughed, "it's typical Norwegian that helping each other needs to be praised and is seen as something extraordinary, as typically Norwegian."

Her amusement about Norwegians seeing reciprocal help as something special, needing explicit mention, captured something central: It is its meaning, rather than the activities, that makes *dugnad* specifically Norwegian.

Staying home and following the guidelines from governmental and health authorities happened worldwide during those days. However, in Norway it was framed as a collective and patriotic act of solidarity; a national *dugnad* to protect the elderly and the sick, and to relieve hospitals. And it was successful. According to research from the Department of Health, 90 to 95 percent of the population closely heeded the government's guidelines (Sølhusvik 2021, 190).

The High Costs of *Dugnad*

So, what or who goes unprioritized when *dugnad* and stopping the spread of the virus is prioritized above all else? In the following sections, I will explore some aspects of this.

When officials understood that COVID-19 had reached Norway, a hectic reorganization of resources began. All "non-essential" healthcare facilities were closed to prevent contagion or were turned into emergency facilities. Healthcare workers were reassigned to increase emergency capacity at hospitals or told to free their schedules and remain on standby. Scheduled operations were postponed, patients were released from rehabilitation centres, inpatient addiction treatment and open psychiatric wards almost without warning, and harm-reduction measurements were shut down. Within the discourse of Corona-*dugnad* was the implicit communication that physical healthcare was uniquely prioritized, and that mental health issues were less of a societal threat than the virus. More explicitly, participating in the national *dugnad* meant refraining from asking for help unless it was a matter of life or death.

Addiction Treatment and Harm-Reduction Measures

In Oslo, the only safe injection site was closed. Existing problems with poor ventilation, along with limited space, made maintaining distance within the facility impossible. Additionally, as bodily fluids/blood could contaminate surfaces, risks of infection were high. However, all these issues and risks preceded the pandemic (interview with Stefan, 7 April 2020). Just as with the deficit of intensive care nurses, the lack of intensive care units, and poor communication technologies at the public psychiatric hospitals (see below), the shortcomings of the safe injection site were preventable and structural. The pandemic merely functioned as a magnifier of deficits.

Community-level infections "on the street" were of major concern for health authorities. As staying home or distancing oneself was impossible for many people with addiction problems, they were considered among those most risk-exposed. In response, Oslo municipality provided emergency housing facilities and a clinic for COVID-19-infected people appertaining to this group. Healthcare staff working at this clinic volunteered to be posted at the facility, which meant that all workers here were experienced with this patient group (interview with Astrid, 21 April 2020). Despite their efforts, it was not enough. While COVID-19 infection rates stayed relatively low amongst drug users, 2020 saw the highest rate of overdose-related deaths. This was explained by the Norwegian Institute for Public Health as likely being caused by a highly potent opioid circulating that year, as well as pandemic restrictions that consequentially impeded both prevention and harm-reduction services (FHI 2021).

Mental Health Treatment

Although official statements remained that mental health was important and that those struggling with mental health issues should be treated, this contrasted starkly with lived experiences. On 15 March, officials announced that psychologists, in line with physiotherapists, chiropractors, opticians, and others, had to close their offices to prevent the spread. The public psychiatric hospitals (Distriktspsykiatrisk senter/DPS) and the public children's and youth psychiatric hospitals (Barne- og Ungdomspsykiatrisk Poliklinikk/BUP)[9] closed for outpatient treatment. This was communicated via an automated text message to all patients, stating their treatment would be postponed until further notice.

A week into the lockdown, NRK, the Norwegian government-owned public broadcasting company, communicated the principles of prioritization that health authorities would apply as a means of avoiding a full collapse of the health system: Pediatric and youth patients, along with those with complex addiction problems or severe mental illnesses, were to be prioritized (Veli, Svaar, Ravndal, and Zondag 2020). However, these were the same people that were disproportionately affected by restrictions and/or lacked the resources to access help. Also, evaluations of who was at risk were, naturally, difficult and not always correct:

> A user was discharged on the day [of the first lock-down] **with a real risk of suicide**, and the hospital ward did not inform the DPS responsible for her day-to-day treatment that she had been discharged. She was only taken care of because she, that is, the user herself, called

> [XXX], who is her assigned municipal public health nurse, and asked, "What do I do now?" And she only called because they had a standing alliance, because she trusted her. A user in this situation has to reach out themselves. **And she was in acute danger**. [XXX] had to rearrange everything to assist her, but it **was sheer luck** that she called**. Otherwise, it could have ended badly**." (Emil, 7 May 2020; my emphasis)

In an interview, Emil, a specialist mental health consultant who worked in one of Oslo's Eastern districts, shared with me his concerns over the poor communication between specialized health services and patients after the COVID-19 outbreak. Emil emphasized how communication inadequacies were not new, yet they had been amplified by the pandemic, so many users experienced these deficits simultaneously:

> And about the flow of information, these users who received treatment at the DPS or were hospitalized, and who were notified on the day that they would be discharged immediately or that they would no longer receive follow-up, they have often experienced poor communication before, many information problems already existed before, and these are users that the municipality **MUST prioritize. If you were so unwell the day before that you had to be hospitalized, then you are not suddenly healthy**. (Emil, 7 May 2020; my emphasis)

In many cases, only "red-listed"[10] patients were called in person;[11] and only a few were offered continued treatment sessions by phone, under the condition that these might also be cancelled without notice, should the therapist be needed for "more urgent" work. For emergencies, patients were advised to call helplines or present at the ER if necessary. Group sessions, spaces for peer support, along with all social spaces, were closed.

The patients were not alone in struggling with the situation. A psychiatric nurse working at a DPS told me how helpless she felt during the first week of the lockdown, not knowing how her patients were doing, worrying deeply about them, yet having no options to reach out. She had no access to their contact information, nor a work cellphone to call them. As she had medical training, she was on standby, in case the somatic hospitals needed her labour. Therefore, she was restricted from booking appointments for her patients (Sanna, 31 March 2020).

Accessing Care

When the government shifted its position, allowing psychologists to treat patients if they could ensure that infection prevention procedures were met,

the harm was already done. According to the Norwegian Association of Psychologists' (Psykologforeningen) president, Håkon Skard, many had already manifested the perception that it was impossible to get psychological help during the pandemic (Møller 2020).

Additionally, unless digital treatment sessions were offered, psychologists could only receive patients if waiting rooms did not need to be shared. This excluded many of the public secondary mental healthcare services. Besides the large numbers of patients belonging to one DPS or BUP, privacy regulations and cyber security requirements, in addition to often outdated electronic devices, rendered it practically impossible to follow up with patients in any other way than by phone. And even this was not always possible. The parent of a child receiving treatment at BUP described their experience with specialist health services during those first weeks:

> We were informed in early March, prior to the lockdown, that they would follow up with my daughter over the phone from then on [...]. But then, on Monday after the announcement of the national lockdown, my daughter's therapist called to say that she could not talk to us over the phone, and that there would be no treatment at all for unforeseen time. There was no prior notification, no other offer ... if we were worried, we could call the front desk, but when we tried that a few days later, we couldn't get through. When we finally succeeded, we were told by the receptionist that the psychologist was out of office due to the restrictions, and could not contact us from home as she had no access to patient files nor had she taken a work phone with her when she went home at the start of the lockdown. Not until we had complained several times to both the front desk and her colleagues did she contact us again. No, the specialist health service had no system for that [staying in contact with patients during lockdown] and showed little willingness to make it work. (Carlos, 7 May 2020)

Dugnad – Good for Everyone?

Public service announcements also reinforced the understanding that help was unavailable and/or that asking for help would be self-centred. For example, as stated on a website for COVID-19 information and municipal mental health services in Fredrikstad, a town in Southeastern Norway: "The whole country is participating in a *dugnad* to slow down the spread of the coronavirus. This means that several mental health and addiction treatments and services are limited or postponed" (Fredrikstad Kommune 2020).

Connecting *dugnad* so closely to the unavailability of life-saving services is misplaced, as three psychologists also clearly formulate in an opinion piece:

Dugnad is supposed to be for the good of everyone. Therefore, it must also embrace those who struggle most at this time. So far, it seems some of those most in need have fallen through. These holes in the safety net must be closed as quickly as possible (Lauveng, Lind, and Jansson 2020).

Services that remained open and accessible were underused (Møller 2020). Plausibly, the cause was twofold: Firstly due to a lack of adequate communication on their availability during lockdown, their lack of visibility, and the difficulty in accessing them during the pandemic. Second, the government, media, and population maintained an extreme focus on *dugnad.* It was a national *dugnad* to free the health services from every unnecessary burden; it was a national *dugnad* to stay home; and it was a national *dugnad* to comply with the infection prevention measures.

This illustrates the dark side of the *dugnad*-narrative: Calculations of the indirect consequences of infection-reducing measures were all but absent (Sandvik 2020, 307), with little focus on whom the *dugnad* was for, and at whose cost participation was demanded. Some groups were expected to sacrifice more than others, and this with minimal return. The corona-*dugnad*, therefore, lost the original *dugnad* characteristics of reciprocity and egalitarianism. Instead, *dugnad* had become a "political disclaimer of responsibility" (Hungnes 2016) towards certain members of society.

Here, the cultural narrative of equality as sameness contributed to the down-prioritization, relying on assumptions that everyone has the same privileges and necessities to participate in *dugnad* on equal terms. Criminologist Kristina Bergtora Sandvik coined the term *dobbeltdugnad,* illustrating how children and youth have carried both the burdens of the general *dugnad* (staying home), along with the additional burdens that emerged as consequences of the general *dugnad* (that is, exposure to domestic violence, while being isolated from public services) (2020, 305). She accents that mobilizing the cultural concept of *dugnad* has enabled both interventions and omissions that should cause some discomfort (2020, 304). While she refers to children as the most vulnerable group, I would argue that there are other groups in Norway that are explicitly *made* marginal, and thus suffer cumulative vulnerabilities.[12]

Dugnad: Conjuring Sameness by Othering

"Innvandrer-smitte" – Immigrant Contagion

An elderly neighbour often sits outside on the main square of our district. He usually spends his days there, either on a bench or inside the local library. Almost everyone in the neighbourhood knows him, and he has full oversight, knowing which children belong to which adults, who was moving away, along with general goings-on, without ever being intrusive. Originally from Northern Africa, he had come to Norway in his forties for work, but was now on social benefits as his health had declined, preventing him from doing manual labour. His apparent absence in the public space worried me, and I suddenly noticed that both his name and his address were foreign to me, even though we had chatted almost every day over the past six years. I knew that he lived alone and belonged to the high-risk group for severe infection, due to several medical conditions in addition to his age. When I met him again and told him I had been worried, tears came to his eyes. He shared how terrified he had been and that he had exclusively stayed home over the last couple of weeks. "I did not want to get up anymore," he told me. "I've been so alone, it wasn't good for me, I couldn't do it anymore." However, he feared going outside even though he suffered deeply in his loneliness. Luckily, a Somali nursing student from the neighbourhood had checked in on him. He explained all the guidelines from the health authorities, carefully in Arabic. But maybe most importantly, he encouraged him to go outside for a while every day (fieldnote excerpt, June 2020).

When the contagion in the eastern districts of Oslo was no longer containable, and these neighbourhoods became the national epicentre of the epidemic, the national discourse changed. Concerned physicians described illiterate immigrants, deficient in Norwegian, and therefore incapable of following the guidelines. They also acknowledged the government's shortcomings in providing adequate information tailored for this minority population. A new *dugnad* started, where health professionals and prominent members of society with immigrant backgrounds appeared in the media, reading out guidelines in their respective (other) mother tongue (Fransson 2020). Unofficially, however, this *dugnad* was already ongoing, as members of different language communities and (immigrant) civil society organizations had voluntarily translated announcements, restrictions, and guidelines. Some had also, as the Somali nursing student mentioned above, gone from door to door in diverse neighbourhoods, sharing information and checking in on the elderly.

However, xenophobic voices swiftly surfaced, especially in the comments sections of social media and online media, but also in opinion pieces printed in major newspapers. Broadly, these portrayed "immigrants" as incapable of understanding the concept of *dugnad*, compounding discourses that depicted immigrants[13] as a public health threat. Rather than pin-pointing the conditions many of them lived under as problematic, it was their "culture" that was considered the issue.

In mid-April 2020, Norwegian-Somali Amira Ibrahim criticized the lack of focus on class perspectives and socioeconomic factors in public debates on high infection rates in Eastern Oslo, especially amongst the Norwegian-Somali population. Her opinion piece was in response to a report from the Norwegian Institute for Public Health (FHI) in early April 2020, which spotlighted those with Somali background as having the highest infection rates. The report changed the discourse about infection rates: COVID-19 altered its appearance, becoming Somali.

In the public sphere, this was blamed primarily on ignorance among immigrants, lack of integration, and cultural differences (see for example Hagen 2021; Jensen and Helgheim 2020; Krasnik et al. 2020, 4). Crowded housing in many eastern districts, few public parks in the neighbourhoods, and intergenerational households were named as further concerns (Rashidi 2021). Both discourses, one on deprivation and the other on misbehaviour, shared commonalities: both disregarded the fact that the eastern Oslo districts shared something else besides crowded houses and a multilingual and multicultural population—they constituted historical working-class neighbourhoods. Cleaners, taxi drivers, shop assistants, nurses, sanitation workers, and many other professions defined as critical for the functioning of society. More importantly, many of these were not restricted as a result of the lockdown. When working from home was an impossibility, and with workplaces in high-risk environments, these workers daily risked their own health, and that of their family, to keep society moving.

As discussed above, participating in *dugnad* and being a socially responsible citizen are closely interlinked with public imaginaries and assumptions of equality. Failing to participate therefore can be conflated with failing to be a good citizen or a "proper" Norwegian. Instead, one can come to be labelled as abusing Norwegian society's ideals of equality and solidarity. Ironically, the high costs of participating in *dugnad* for those made marginal in society are

extinguished by ideas of an equal society. This equality, however, is entirely contingent on the capability to contribute.

Closing the Borders

In early 2021, the Norwegian government effectively closed the border for almost all non-citizens and non-permanent residents (Huse 2021). Exceptions were made for necessary travel; however, the definition of necessary varied broadly and excluded, among others, residents without permanent residence permits. Several journalists positioned themselves at Oslo airport to ask people why they were travelling, despite restrictions. People leaving then were commonly perceived as not participating in *dugnad*. However, here too, the public directed their judgement at those with an immigrant background. A comment in one of Norway's leading newspapers, *Aftenposten*, read:

> Simultaneously, thousands of Norwegian citizens have planned trips abroad for Easter. More specifically: Thousands of immigrants have planned an Easter holiday abroad. [...] others think it's perfectly natural to take a trip to Punjab now that you have time off. [...] Some have a place in Greece they'd like to visit. Others have a cabin in Sweden. But they don't. For those who do not join the *dugnad*, the only answer is a resounding "no" to travel. Don't go abroad if you absolutely don't have to (Sollien 2021).

Holiday homes in Greece and cabins in Sweden are typically places white majority Norwegians would own and visit, but, as the commentator says: "They don't." This excerpt makes it obvious who is blamed for the rising infection rates: immigrants, specifically those with a Pakistani background. A prominent member of parliament and Oslo politics from the party Fremskrittspartiet (FrP), Christian Tybring-Gjedde, uttered that "Norwegians are staying in Norway now—so should immigrants. It's about showing solidarity with society as a whole" to the Norwegian newspaper *Dagbladet* (Gilbrant 2021). And they were not alone in specifically blaming the Norwegian-Pakistani community (Olsen and Andreassen 2021). The virus' appearance had mutated again, becoming Pakistani.

Both the Prime Minister and Minister of Health praised the opportunity to spend quality time with one's nuclear family (understood as the household one lived in) during Easter. Media also reported on cabin owners, promoting summer holidays within Norway, instead of travels to "Syden"—the south. Yet, for the many without Norwegian citizenship, or with partners and families living abroad, the situation was starkly different.

Unmarried couples had to prove that they had lived together to get their non-Norwegian partners into the country. This explicitly excluded queer couples where one partner was located in a country where queer relationships were forbidden and punishable. Additionally, couples who were from a non-Western country had no possibility of reuniting. Grandparents, siblings, and other family members that were not married or had children in Norway were defined as having no close family (Byggenæringens Landsforening 2021). The quarantine rules, where people renting instead of owning apartments or entering from specific countries had to stay in quarantine hotels, made visitation practically impossible for many parents who lived abroad, separated from their children (Bugge 2021). In early summer 2021, the Norwegian state funded quarantine hotels for Norwegian students studying abroad; however, international students studying in Norway who had visited their families were not exempt from the costs.

Meanwhile, there were still daily reports on *importsmitte*, infections that could be traced to people entering from abroad (Holtekjølen and Furuly 2021; Larsen 2021; Strand 2021). The numbers were especially high among migrant workers from Eastern Europe. Many employers broke the quarantine regulations or forced workers to go through them under extremely poor conditions, sometimes without pay. The Polish immigrant community experienced especially high rates of infections (Diaz et al. 2020, 5, Holtekjølen and Furuly 2021). I heard from several Polish friends that they worried about using Polish in public. Some even stopped speaking it entirely outside their homes, in response to the hostility they experienced. The appearance of Corona had transformed again: This time, it became Polish. Ultimately, the restrictions appeared more driven by money and prestige than by infection prevention, and people, occupations, and activities were divided into useful/non-useful, worthy/unworthy, belonging/foreign. More granularly, decisions regarding who could enter and who could not reflect values that deeply clash with ideals of egalitarianism, inclusiveness, and equality.

Narratives of "us" vs. "the others" - Equality Understood as Sameness

Racialized immigrants had again—as described above—become the "other," this time because of their assumed non-participation in the national *dugnad*. Gullestad argues that "there are close relations among egalitarian cultural themes, majority nationalism, and racism" (2002: 45). She closely links the concept of equality to Norwegian identity, and therefore to the idea that

people must feel that they are the same to be of equal value. The image of the egalitarian Norwegian state is not just an emic part of Norwegian identity, it is also a carefully and constantly reproduced "national myth" (Abram 2018, 88). The most common Norwegian translation for equality is "*likhet*," meaning more accurately "sameness" while also encompassing egalitarianism and equality (Vike et al. 2001).

To achieve equality, differences are consequently down-played, while commonalities are emphasized, resulting in what Gullestad calls "imagined sameness", a key concept for analysing Norwegian society. However, Norway's population has never been homogenous. Minorities like the Indigenous Sámi peoples, Tater, Roma, Kven, Jews, and immigrants have always been a part of the nation's fabric, even when excluded from the collective imagination of the majority society. As Marianne Lien illustrates in her work on Båtsfjord in Finnmark, a north-south divide also exists when it comes to understanding equality as sameness in Norway, which Gullestad had not given the attention it might deserve (Vike et al. 2001, 86–108). However, even if equality is practiced differently regionally (Abram 2018, 100), common imaginaries proliferate throughout the country. It is the specifics of who is considered the "same" and who is labelled "the other" that vary, not the need for sameness to feel equal that differs. Since March 2020, this has become increasingly visible through border restrictions, access to different health services, and discourse around quarantine and infection rates. Instead of focusing on health and socioeconomic inequalities inside Norway and their causes, population groups that endangered the imagination of equality in the country were made into "the other"—constituted by an imagined collective Norwegian identity.

Conclusion

Creating collective accountability for fighting the pandemic by appealing to the Norwegian tradition of *dugnad* was ultimately a political strategy. Focusing on *dugnad*, and implying the sameness of all people living in Norway, shows how socioeconomic differences were muted to implement measures that ultimately came with a greater cost for specific social groups already made marginal. So far, this strategy has been considered highly successful in keeping COVID-19-related deaths at bay. However, the long-term and indirect costs have barely been considered. The moral economy surrounding COVID-19 strictly divided the people participating in the *dugnad* from "the others" who did not. It also divided those belonging to the country from those who did not, and who were

therefore inherently less deserving of entry. The "us" were healthy, middle- and upper-class, white Norwegians without family members abroad, especially not in non-European countries or non-heterosexual relationships; a social group with resources to participate in this *dugnad* and for whom that "was not a major or complicated task."

By activating *dugnad*, politicians transferred their responsibility as elected leaders to individual citizens. Socioeconomic inequalities and health disparities have expanded during the pandemic. While the growing queues at food pantries render this all the more visible, the rhetoric of collectivity and *dugnad* works toward keeping it hidden. The legality of several measures remains under investigation, especially those relating to entry restrictions.

The pandemic has served as a magnifying glass, clearly showing the lack of enough emergency care nurses, physicians, equipment, hospital and psychiatry beds, and adequate health literacy efforts. Moreover, it magnifies heteronormative and Eurocentric ideas of who makes a family, compounded by nationalistic notions of who is Norwegian enough to belong. All these are not phenomena that suddenly appeared with the pandemic. They have merely become more visible.

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Notes

1 The coronavirus disease, 2019 outbreak.

2 The Nordic welfare model is characterized by the existence of a large public sector, high taxes, free health care and education, and other inclusive welfare structures.

3 In the first month, nine out of ten supported the government's infection prevention measures, and three out of four trusted government-provided information (Moss and Sandbakken 2021, 882).

4 Excerpt from Prime Minister Erna Solberg's speech on 12 March 2020, translated by the author. Emphasis added.

5 The length of these ranges from around 15 minutes for the follow-ups to about an hour for the first interviews/conversations.

6 I only had a subscription to Aftenposten at the time, so other than that I only had access to articles without a paywall. The news sites I checked daily were NRK, Dagsavisen, and Aftenposten, but I also followed VG, Dagbladet, opinion pieces in local newspapers, and media sites directed towards a more academic audience, like Khrono, Agenda Magasinet and similar.

7 A national public service for special needs education.

8 However, I was told during a presentation of this paper at the research seminar series of the social anthropology department at Uit - The Arctic University of Norway that there is indeed a name for a similar concept in Russian, which would translate to "Saturday-work."

9 Both DPS and BUP are specialized health care services delivered after a referral from a primary care provider. There are long waiting lists and patients must have severe health issues that cannot be treated in primary care to get accepted.

10 Three practitioners working at different psychiatric outpatient clinics shared that they had to label patients from green to red, following a risk assessment, and were only allowed to follow up with the most severe cases.

11 This might differ throughout the country, but I have heard similar accounts from nine interlocutors (working as psychologists/psychiatric nurses/psychiatrists and from patients or their next of kin), from various areas in Norway.

12 While beyond the scope here, the situation for people with physical disabilities, victims of domestic violence, Roma, and people living in poverty, warrant further attention.

13 A Norwegian euphemism for citizens with an African, Middle Eastern, or Asian background, usually limited to people of colour and Muslims.

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