Securitization of a humanitarian crisis:

Norway's international response to Ebola

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Abstract

The Ebola epidemic of 2014-2015 was the largest Ebola outbreak ever, killing over 11,000 people. In this thesis, I explore the Norwegian response to this crisis, focusing particularly on two projects conducted by the government: a field hospital in Sierra Leone and a vaccination trial in Guinea. Adopting a theoretical approach from International Relations, social constructivism, I unpack the government's agendas, values and motivations underlying its Ebola response, and relate them to debates structuring Norwegian foreign and global health policies.

I found that the Norwegian government had a dual ambition: helping those affected (humanitarian) and protecting the Norwegian population from the virus (biosecurity). I argue that the biosecurity objective became predominant after the repatriation of an infected health worker to Oslo in October 2014, leading to a partial securitization of the response. This security framing opened a window of opportunity for the government to mobilize exceptional financial resources and implement innovative projects to tackle the crisis. Finally, I argue that Norway's Ebola response is representative of the Norwegian global health priorities: an approach privileging vertical, technology-based interventions, promoting multilateralism, and mixing *idealpolitik* and *realpolitik*.

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<div align="right">Antoine de Bengy Puyvallée, 15.05.2017</div>

Table of contents

VI

List of figures

List of tables

List of abbreviations and acronyms

BMFG: Bill and Melinda Gates Foundation

CDC: The Center for Disease Control and Prevention (US)

CEPI: Coalition for Epidemic Preparedness Innovation

DFID: Department for International Development (UK)

DSB: Civil Protection Agency / Directorate for Civil Protection (Norway)

ERID: Emerging and Reemerging Infectious Diseases

ETC: Ebola Treatment Center

GAVI: Global Alliance for Vaccines and Immunization

GLOBVAC: Global Health- and Vaccination Research Program (Norwegian Research Council)

GOARN: Global Outbreak Alert and Response Network

HIV/AIDS: Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome

IHP: International Health Partnership

IHR: International Health Regulations (WHO)

INGO: International non-governmental organization

MdM: Médecins du Monde/Medicos del Mundo/Doctors of the World

MFA: Ministry of Foreign Affairs (Norway)

MSF: Médecins sans Frontières/Doctors without Borders

MoH: Ministry of Health and Health Care Services (Norway)

MoU: Memorandum of Understanding

NIPH: Norwegian Institute of Public Health

NORAD: Norwegian Agency for Development Cooperation

NOK: Norwegian Kroner

PHEIC: Public Health Emergency of International Concern

UK: United Kingdom

UN: United Nations

UNDP: the United Nations Development Program

UNICEF: the United Nations Children's Fund

UNMEER: the United Nations Mission for the Ebola Emergency Response

UNOCHA: the United Nations Office for the Coordination of Humanitarian Affairs

UNSC: the United Nations Security Council

US: United States

USDTRA: Defense Threat Reduction Agency (US)

USSR: Union of Soviet Socialists Republics

WHO: World Health Organization

Introduction

Background: The Ebola Outbreak, 2013-2016

Between 2013 and 2016, Ebola killed over 11,000 people and is estimated to have contaminated more than 28,000 (WHO, 2016a). 99.9% of the cases occurred in three West African countries: Sierra Leone, Liberia, and Guinea. To get an idea of the exceptional scale of this outbreak, the largest Ebola epidemic recorded prior to this occurred in 2000 in Sudan, and led to 425 cases, including 224 deaths (WHO, 2014a).

Ebola is a frightening illness, one of the deadliest infectious diseases on Earth (see for instance how it was portrayed by Garrett, 1994; Preston, 1994). Its mortality rate is extremely high – 71% in December 2014, at the peak of the epidemic, before falling to a 40% average for the overall outbreak (WHO, 2014c, p. 1). The symptoms usually start with fever and extreme fatigue, similar to other common diseases in the region such as malaria. After a few days, these symptoms are complemented with vomiting and diarrhea. The second week after contracting the disease, either a 'shock' occurs leading to organ failure, decreased consciousness, coma and eventually death, or the symptoms slowly disappear and the patient gets better (London-School-of-Hygiene-and-Tropical-Medicine, 2015). Ebola is a disease transmitted person-to-person, in case of direct contact with infected blood, secretions and other bodily fluids – in other words, by touching a contagious patient, an infected body, or materials contaminated with these fluids (bedding, clothing, etc.) (WHO, 2016c). A patient becomes contagious only when symptoms have started to manifest themselves – so after the incubation period, usually lasting between fourteen and twenty-one days (London-School-of-Hygiene-and-Tropical-Medicine, 2015). It should be noted that five strains of the Ebola virus exist, three having led to large outbreaks in Africa: Bundibugyo, Zaire and Sudan. The 2013-2016 epidemic was caused by the Zaire strain.

In a retrospective study, the World Health Organization (WHO) found that the epidemic started in a remote Guinean village, located in a forest area close to the border to Liberia and Sierra Leone. The "patient zero" was a two-year old boy that felt sick on December 26th 2013 and died two days later. Following his deaths, his three year-old sister, his grandmother, his mother and a family friend from Sierra Leone died mid-

January 2014 (WHO, 2014d). Clusters of transmissions occurred but remained unidentified until March, 23rd 2014, when WHO officially acknowledged the Ebola Zaire epidemic (*Ibid*). The Ebola diagnosis came as a surprise, as the virus had never been identified previously in this part of Africa. By July 2014, the virus had reached the biggest cities and the transmission rate accelerated dramatically, particularly throughout the autumn 2014 (see Figure 1). The WHO declared Ebola a *Public Health Emergency of International Concern* on August 8th, recommending travel restrictions and starting to mobilize the global community for a response (WHO, 2014f). This procedure was heavily criticized for coming too late, as the outbreak was already the largest in history with 1,711 contaminations and 932 deaths (Moon et al., 2015, p. 2206; WHO, 2015b, p. 8). The epidemic finally came under control in the spring 2015 when the transmission rate decreased, but sporadic outbreaks continued until February 2016.
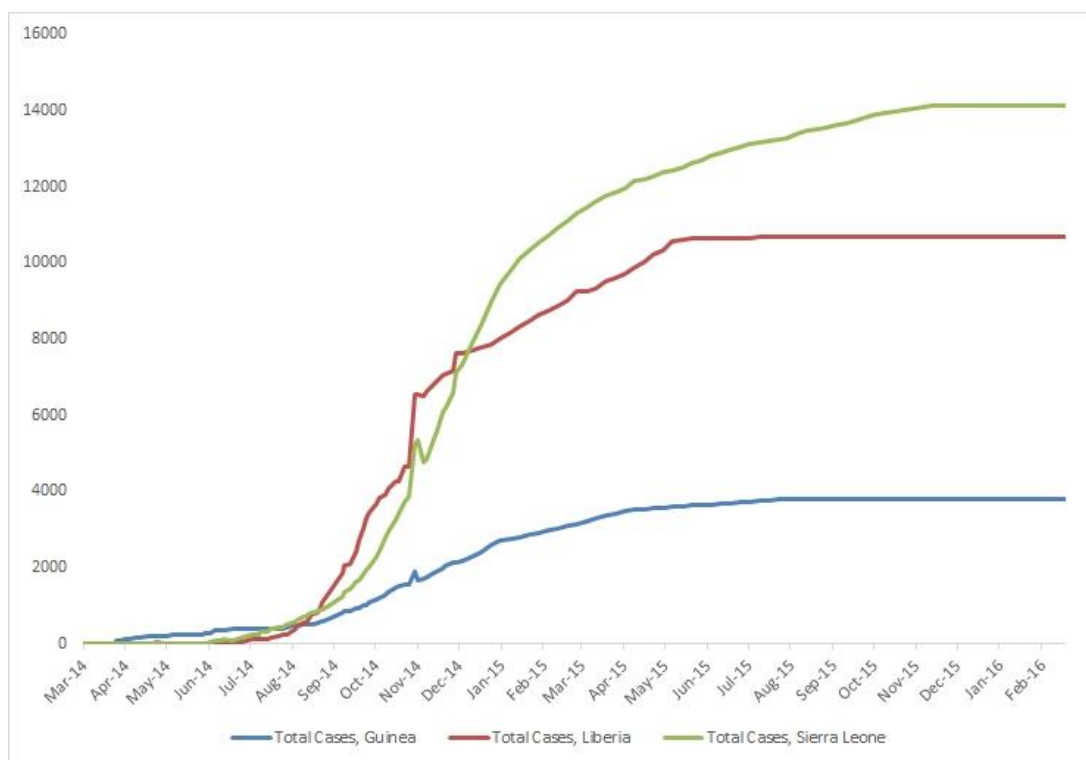
Figure 1: "Total suspected, probable, and confirmed cases of Ebola virus disease in Guinea, Liberia, and Sierra Leone, March 25, 2014 – February 14, 2016, by date of WHO Situation Report, n=28603"
Source: US Center for Disease control (CDC, 2016)

Ebola has drawn considerable attention, leading to a tremendous political and scholarly interest in global health security. Several commissions and panels were set-up to review the crisis and assess what went wrong (Moon et al., 2015; UN-High-Level-

Panel, 2016; US-Academy-of-Medicine, 2015; WHO, 2015b), themselves reviewed by academic scholars (Gostin et al., 2016; T. Ottersen, Hoffman, & Groux, 2016). In this research project, I will focus specifically on Norway's international response to the Ebola crisis – an angle, to my knowledge, never adopted before. Before presenting my research questions, rationale and methodology, I will first proceed to a review of the literature and introduce my theoretical approach.

Literature review and theoretical approach

The concept of global health security has been extensively discussed, but as Aldis noted, there is no agreed upon definition of what it means (Aldis, 2008). Before reviewing the different interpretations of global health security, I will first present the backdrop against which the concept prospered: the reconceptualization of security since the 1990s. Finally, I will introduce my theoretical approach and my research questions.

The reconceptualization of security since the 1990s

The end of the Cold War led to dramatic changes in the conceptualization of security by scholars of International Relations – the concept being very much neglected until the 1990s (Baldwin, 1997, p. 9). Security has traditionally been conceptualized at the level of the nation state and defined in politico-military terms: an issue becomes a security threat to the state when military attention is required. On the other hand, health, social welfare development and humanitarian action are often referred to as 'low politics', having less relevance for International Relations (Baldwin, 1997, p. 9). The concept of security still includes this military dimension, but has been considerably broadened to encompass issues such as globalization, economics, humanitarian emergencies, human rights, health, etc. (Baldwin, 1997, p. 5; Davies, 2010a, p. 2). The UN report "The Responsibility to Protect" states that sovereignty not only gives states the right to "control" its affairs, it also conferred on the state's primary "responsibility" for protecting the people within its borders (UN, 2001). It proposed that when a state fails to protect its people – either through lack of ability or willingness – the responsibility shifts to the broader international community. The report places thus the individual as the main referent for security, instead of the nation state.

I will briefly present the scholarly debates from 1990 onwards that have been concerned with reconceptualizing security: *securitization theory* and *critical security theory*. The aim is not to provide an extensive discussion of these theories and debates, but to lay out their grounding principles in order to properly review the scholarly literature on global health security (Coupland, 2007).

Securitization theory

Ole Wæver, Barry Buzan and Jaap de Wilde, referred to as the Copenhagen School, suggested a new approach to security with their securitization theory (Buzan, Wilde, & Wæver, 1998). Deriving from constructivism and its premise famously laid out by Nicholas Onuf that "the social world is of our making" (Onuf, 1989), securitization theory envisages security as a socially constructed phenomenon – and not an objective condition (Kittelsen, 2013, p. 33). To them, security is intersubjectively negotiated between a *securitizing actor* defining an issue as an existential threat (via a *speech act*) and an *audience* accepting this claim. The acceptance of the security discourse allows the securitizing actor to implement measures going beyond the ordinary procedures (exceptional policies) (Balzacq, 2005; 2011, pp. 1-2; Kittelsen, 2013, p. 33; McDonald, 2008, p. 567). To that extent, "the claim of security made through a speech act is therefore not just descriptive but performative – it changes reality by changing the way in which issues are seen" (McInnes & Rushton, 2011, p. 119). For example, on December 21st, 2002, when President Bush rolled up his sleeve in full publicity to be immunized against small pox, it was simultaneously a public health measure to protect the US population and a way to prepare the nation to go to war. Within this conceptual framework, this act constitutes a "visual securitization" (Hansen, 2011), complemented by *speech acts*, that allowed the government to implement extraordinary procedures (Allen 2007 in Roalkvam & Sandberg, 2010). It is also important to note that the Copenhagen School's agenda was normative: 'de-securitize' policies to avoid these exceptional measures (Balzacq & Guzzini, 2015, p. 97; Kamradt-Scott & McInnes, 2012; McInnes & Rushton, 2011, p. 119).

Securitization theory is highly complex, particularly in regards to the nature of the speech acts (Balzacq, 2005, 2011). Without going into too much details, I would like to highlight a debate, a divide even, between two generations of scholars within this conceptual frame. The first, inscribed in the poststructuralist tradition, focuses primarily

on the speech act itself. To these scholars, talking of an issue with a security vocabulary can be enough to make it a security threat. In other words, they believe "in a 'social magic' power of language, a magic in which the conditions of possibility of threat are internal to the act of saying 'security'" (Balzacq, 2011, p. 1). The second generation, referred to as "sociological", analyzes the negotiation process between actors through which an issue is defined and accepted as a threat. For these scholars, securitization is analyzed "in terms of practices, context, and power relations that characterize the construction of threat images" (Balzacq, 2011, p. 1). In this sociological understanding of securitization theory, the context (events in the material world) play an important role by substantiating (or disproving) ideological claims, ensuring (or failing to ensure) their success, because "language does not construct reality; at best, it shapes our perception of it" (Balzacq, 2005, p. 181). McInnes and Rushton even argue that if speech acts shape our understanding of events in the empirical world, they have to resonate with their immediate context to ensure a sustained securitization (McInnes & Rushton, 2011, p. 118).

Critical security theory

Critical security theory, unlike securitization theory, aims at re-conceptualizing security by changing the referent: it advocates for the individual to be at the center of the analysis, instead of the nation state. The philosophical roots of critical security theory derive from classical liberalism and its emphasis on the individual. Critical security theory was mainly developed within the Welsh School, and most thoroughly explained in the classical book written by Booth, *Theory of World Security* (Booth, 2007). The core question of critical security theory is to uncover what makes individual humans insecure and how this can be tackled. Within critical security thinking the state can both provide security and constitute a threat to an individual. Finally, with equality as its foundation, critical security theory has a strong normative premise (Booth, 2007, p. 38), not present in securitization theory and the realist understanding of security (Booth, 2007, p. 348). The human security concept, famously developed by the United Nations Development Program (UNDP) in its 1994 *Human Development Report* (UNDP, 1994), derive from this understanding of security. It is based on a people-centered, multidimensional definition of security, wherein individuals should be "*free from fear and free from want*" (UNDP, 1994, p. 24).

Global health security: review of the literature

Global health security is not a new concern. As noted by many, health security was one of the main driver of the international sanitary conventions and of colonial medicine in the nineteenth century (Fidler, 2005a; Harrison, 2006; Hoffman, 2010; King, 2002). Global health security re-emerged strongly in the 1990s out of the reconceptualization of security, particularly in the United States (Weir, 2014), with the US Institute of Medicine 1992 report forging the concept of *Emerging and Reemerging Infectious Diseases* (ERID) (Lederberg, Shope, & Oaks, 1992). The dark picture of global health described in this report was strongly opposed to the dominant view in the 1980s claiming victory in the war against the microbe, following the success of the smallpox campaign and progress in technology (Davies, 2008, p. 298; Lakoff, 2010, p. 68). The focus on *Reemerging Infectious Diseases* led to a new narrative concerning the state's vulnerability to infectious diseases, particularly propagated to the American public by the influential best sellers including Laurie Garrett's *The Coming Plague* (Garrett, 1994) and *The return of Infectious Diseases* (Garrett, 1996), as well as Richard Preston's *The Hot Zone* (Preston, 1994). It gained eventually international attention and led to the revision of the International Health Regulations (IHR) undertaken by the WHO from 1995 and the set-up of surveillance mechanisms, such as the Global Outbreak Alert and Response Network (GOARN) in 1997. Global health security was also embraced by scholars and developed as an analytic concept within a burgeoning literature starting out with Fidler and Price Smith in 1991 (Fidler, 1999; Price-Smith, 1999).

Over a period of twenty years, numerous scholars and policy makers adopted and used the concept of *global health security*. However, as noted by William Aldis, there is absolutely no consensus on a theoretical definition, nor on a common methodology to manipulate the concept (Aldis, 2008, p. 370). One could argue that it became a *buzzword*, hiding competing understandings and interests. The concept's main issue is perhaps its lack of clarity in regards to the referent taken for security (*security for whom?*) (Rushton, 2011). Davies usefully divides the literature in two strains, based on the referent they take: the *statist perspective* places the nation state and national interest at the center of its analysis, whereas the *globalist perspective* takes the individual as a starting point, and places notions of equality, vulnerability and development at the core of its analysis (Davies, 2010b).

In what is to follow I will provide an overview on the different conceptualizations of global health security. I will review the literature based on the referent for security chosen, either the state or the individual, which will allow me to present my conceptual approach in a final sub-section.

Global Health Security from a statist perspective

The literature and policy initiatives on global health security has largely been dominated by an approach privileging the state as the main referent of security (Caballero-Anthony & Gayle, 2014, p. 36). The predominance of the statist perspective can be explained by the tendency of International Relations scholars to place the state at the center of their analyses. It may as well draw from the very nature of health security and its roots in public health. Feldbaum and Lee usefully recall the difference between clinical medicine, concerned with the health of individuals, and public health, "the collective action taken by society to protect and promote the health of entire populations" (Harley Feldbaum & Lee, 2004, p. 19). Thus, "the focus of global health security (more commonly known as public health security) is populations or human communities" (Harley Feldbaum & Lee, 2004, p. 20). As public health is generally managed at state level, it is logical that the state is the main referent for security.

Scholars adopting a 'statist perspective' have highlighted three main connections between health and security:

(1) bioterrorism and the risk of biological attacks;
(2) the risk that an epidemic leads to instability at state or regional level because of its political, social, economic or military consequences;
(3) the risks related to globalization and the travel of diseases, and the increased vulnerability of every state, including the most developed (Davies, Kamradt-Scott, & Rushton, 2015, pp. 20-21; Elbe, 2010, pp. 8-9; Fidler, 2004, p. 252; McInnes, 2014, p. 9; McInnes & Lee, 2006; Rushton, 2011, pp. 782-783).

I will now briefly review the literature exploring each of these understandings of global health security.

Bioterrorism

The literature analyzing the threats carried by bioterrorism is abundant (see for instance Bhalla & Warheit, 2004; Enemark, 2014; Koblentz, 2014; Vogel, 2012), but of little relevance for the analysis of the Ebola crisis, as the epidemic occurred naturally. I will simply recall what is meant by bioterrorism to provide a comprehensive definition of the concept and recall that this aspect is an important component of global health security – even if actors from the humanitarian field often disregard this facet.

Biological warfare has always existed, from the contamination of water supplies by Greeks and Romans, to the catapulting of plague-infected corpses by Mongols and the distribution of smallpox-infected blankets during the conquest of America (Koblentz, 2014, p. 121). Two major international treaties were signed in the 20th century to prevent biological attacks: the 1925 Geneva Protocol and the 1972 Biological Weapons Convention, ratified by 160 countries (Koblentz, 2014, p. 122). Although no biological attack has been led by a state since then, it several states developed offensive biological weapons, such as the USSR and Iraq (Vogel, 2012).

The concept of bioterrorism, meaning biological attack by an individual or terrorist group, emerged in the 1990s, and was reinforced by two major events: the Aum Shinrikyo sect plan to conduct a biological attack in the Tokyo subway (which failed, but was replaced by a chemical attack with Sarin gas); and the anthrax letter attacks in the USA right after 9/11 (Koblentz, 2014, pp. 126-127). The latter attack resulted in five deaths and was led by a microbiologist from the US army. It revealed a vulnerability to bioterrorist attacks, but also the risks engendered by the development of large biosecurity defense programs and the growing number of trained personnel who could potentially misuse their knowledge (Enemark, 2014). In reaction to the anthrax letter attack, the US government convened an influential working group on global health security, *the Global Health Initiative*, explicitly framed as a response to bioterrorism. Including Western countries and Mexico, the initiative's agenda was expanded to infectious diseases, broadening the meaning of global health security (Rushton, 2011).

Health crisis and its consequences on state stability

A narrative highlighting the potentially disastrous effects of a health crisis on national security and state security emerged in the 1990s (Fidler, 1999; Price-Smith,

1999). It was first developed in literature labelled "positivist" (Kittelsen, 2013, p. 11), seeking to predict the potential impacts - economic, social, political or military (Davies, 2010b, p. 1176) – of a health crisis on state stability. These studies focus almost exclusively on infectious diseases displaying at least one of these features: high lethality, easy transmission, causing important economic damage or raising a lot of fears (Enemark, 2009, p. 191; Price-Smith, 2009, p. 3). Most of this work focused on the potential consequences of the HIV/AIDS epidemic, particularly in weak states (Altman, 2003; Ostergard, 2002, 2006; Price-Smith, 2001; Singer, 2002). These scholars argued that diseases with the potential to cause massive human loss could render the state incapable of functioning (politically and/or economically), and eventually lead to its failure (Price-Smith, 2001, p. 9). Concerns were expressed, for instance, on the consequences of the HIV/AIDS epidemic for the most affected states' military forces and their capacity to ensure security – military personnel being particularly exposed to HIV/AIDS and sexually transmitted diseases in general (Elbe, 2006; McInnes & Lee, 2006). A failing state would also have an impact on regional (and even global) security, with a massive flux of displaced populations, closing borders, and security dilemmas for neighboring countries (Price-Smith, 2001, p. 15). This narrative on global health security was clearly adopted by the United Nations Security Council with its resolution 1308 on HIV/AIDS associating the epidemic with a threat to global security, particularly because of its impact on security forces (UNSC, 2000).

A second strain of literature, rooted in securitization theory, was critical of the assumption that an epidemic could lead to state failure (Elbe, 2006; Fourie, 2007, 2014; McInnes & Rushton, 2010). To these scholars, these claims are exaggerated and are more ideological and normative than empirically grounded. They argue that decades of HIV/AIDS in weak sub-Saharan countries did not lead to state failure, despite the incredible toll on human life. These authors are more interested in assessing the consequences of securitizing epidemics and analyzing the securitization process itself than discussing the potential effects of an epidemic on state security (see 2.1.3.).

More consensual than this debate on state failure is the argument that epidemics represent a serious challenge to the state and society as a whole. Firstly, they can have disastrous economic consequences for the affected countries in particular and the global economy in general, as demonstrated by pandemics such as SARS (2003), Influenza H5N1 (2005) and Influenza H1N1 (2009) (Heymann & West, 2014; Huang, 2009;

Osterholm, 2005). The fear that an epidemic could lead to massive economic losses has been central to the emergence of international cooperation on infectious diseases in the 19th century: merchants lobbied strongly to set-up efficient control systems minimizing trade disruption (Harrison, 2006; King, 2002). Secondly, epidemics represent a threat to society and to state's legitimacy.

Medical historian Charles Rosenberg defines epidemics as a social phenomenon "illuminating fundamental patterns of social value and institutional practice" (Rosenberg, 1989, p. 2). He concluded that "a particular society constructs its characteristic response to an epidemic" (Rosenberg, 1989, p. 2). Epidemics thus constitute a test for a society, highlighting underlying values and exacerbating social predispositions, such as defiance against the state or inter-group conflict. They constitute an even a bigger challenge to the state by holding it accountable for crisis management. As recalled by Roalkvam and Jani, "states gain legitimacy through performance – the support, protection, and public services they provide to their people" (Roalkvam & Jani, 2013, p. 115) and this is absolutely crucial in regards to security provision (Goldstein, 2010). In the context of an epidemic, adopting an appropriate response, providing basic services and containing the outbreak might become a difficult task for the state, which will be held accountable both by its national citizens and the international community (Roalkvam & Jani, 2013, p. 117). The most catastrophic scenario for a state would be the failure to protect its population and contain the outbreak. However, overreacting might also create tension and raise criticism. In the 1976 Swine Flu outbreak, the US government was heavily criticized internally for spending $135 million on a massive vaccination campaign that ended up doing more harm (through side effects) than the outbreak itself (Lakoff & Collier, 2008, pp. 40-42). In the 2009 H1N1 pandemic, the Egyptian government implemented a massive cull of pigs. Domestically, this measure targeting primarily the Christian minority was popular and interpreted as the expression of a government on top of the situation. However, the international community criticized it heavily for being inefficient and unfair (Davies et al., 2015, p. 105; Roalkvam & Jani, 2013, p. 126). Responding to an epidemic is thus a particularly challenging task for a state and may put its legitimacy at stake.

Globalization and the movement of pathogens

The last decade has seen the emergence of a literature led by a few key authors, which attempts to apply securitization theory to analyze the context and consequences of the narrative linking globalization with an increased vulnerability to infectious diseases (Davies, 2008, 2010a, 2010b; Davies et al., 2015; Elbe, 2006, 2010, 2014; Kamradt-Scott & McInnes, 2012; McInnes, 2016; McInnes & Lee, 2006, 2012; McInnes & Rushton, 2011; Nunes, 2014; Weir, 2014; Youde, 2012, 2015). The basic assumption of these authors is that a security approach to global health should not be taken for granted or deemed self-evident. On the contrary, scholars should explore how global health came to be connected with security (Nunes, 2015, pp. 60-61). Indeed, "pathogens are brute 'material facts', but how we respond to disease outbreaks […] is a product of ideas about the nature and scale of the threat posed by pathogens, what we should collectively do to address that threat, and how those measures should be ranked in relation to other priorities we have as societies" (Davies et al., 2015, pp. 10-11). To cut a long story short, defining a health threat shapes an understanding of the world, and reflects different interests and values that should be unpacked (McInnes & Lee, 2012, pp. 4-5). Medical anthropologist Charles Rosenberg holds a similar argument when he argues that epidemics reflect "a particular configuration of institutional forms and cultural assumptions" and concludes "a particular society constructs its characteristic response to an epidemic" (Rosenberg, 1989, p. 2). Furthermore, as agents and structures are "mutually constitutive", narratives shape the way we see the material context, but material events also influence the success or failure of a narrative (Davies et al., 2015, p. 11). For instance, Davies and colleagues convincingly argue that the revision of the International Health Regulations (IHR) from 1995 to 2005 was made possible by the development of a narrative on the vulnerability to infectious diseases linked to globalization, but also recurrent outbreaks reinforcing this narrative such as Plague in India (1994), Ebola in Zaire (1995), West Nile Virus next to New York City, USA (1999), SARS (2003), and H5N1 (2005) (Davies et al., 2015).

By questioning the underlying values, interests and power-dynamics of the securitization of health, this literature raises important questions about the main beneficiaries from this trend *(security for whom?).*To find an answer, one has to analyze the nature of the threats identified (*security from what?*) (Rushton, 2011). As mentioned, these threats are primarily bioterrorism and infectious diseases with

pandemic potential – both being crucial security concerns of Western countries. Developing countries mention other diseases as their top health priorities – those already having disastrous effects on the health of their populations. The prioritization of these diseases thus leads to a reallocation of funds from public health interventions to preparedness, mostly in the interest of the West (Aldis, 2008, p. 373; G. W. Brown & Stovea, 2014, p. 305; Horton, 2017; Lakoff, 2010, p. 59; Rushton, 2011, p. 780).

Securitizing global health has further consequences highlighted by these scholars. Firstly, it leads to the creation of an inside/outside dichotomy: the disease is presented as an external threat to the national community - "a foreign enemy that much be vanquished or contained" (Davies, 2010b, p. 1176). And indeed, most of the infectious diseases with pandemic potential emerge from the developing world, not the West, reinforcing the narrative defining them as external threats (Lakoff, 2010, p. 59). Secondly, the issue of global health gains prominence thanks to the use of security vocabulary, and many believe this will translate into increased focus and resources in the field (Davies, 2010a, p. 19; Enemark, 2007, p. 20; David Heymann quoted in Horton, 2017; Lakoff & Collier, 2008, p. 18; McInnes, 2014). Thirdly, as identified by the Copenhagen school, securitization "is the move that takes politics beyond the established rules of the fame and frames the issue either as a special kind of politics or as above politics" (Buzan et al., 1998, p. 23). In other words, it is a way of depoliticizing the debate by raising an issue above normal politics. As a result, securitization can lead to legitimizing exceptional measures, such as the militarization of an intervention and attacks on human rights – for instance the measures taken by the US to avoid the immigration of HIV-positive migrants (Elbe, 2006; Rushton, 2012). Finally, securitization affects the values and motivations behind policies. Indeed, action to counter a global health threat "could quickly become mired in self-interest" as "assistance should be provided to developing states to help 'fix' their health infrastructure because it protects the West and states that are currently 'secure' from these pathogens in the long run" (Davies, 2010b, p. 1177). Securitization at national level thus leads to action based on foreign policy principles, rooted in the national interest (Thieren, 2007, p. 219). In Singer's words, securitizing HIV/AIDS was "not just a matter of altruism, but simple cold self-interest" (Singer, 2002, p. 158).

Global Health Security from a globalist and a cosmopolitan perspective

Global health security has not only been envisaged as a way to ensure the security of states. Stemming from critical security studies, a literature emerged to broaden the agenda to secure individuals against health threats. This approach never really succeeded in challenging the mainstream literature where state is the principle referent. However, some practitioners and scholars have adopted a more traditional security vocabulary to promote development goals and cosmopolitan values, blurring the statist and globalist perspectives and contributing to a confusion on the meaning of global health security.

Global health security understood as human security

The UNDP Human Development Report mentions health security as one of the key components to human security (UNDP, 1994, p. 3). In its proposal for a "world social charter", it develops its position on health, advocating a world where "no human being is denied primary health care or safe drinking water and all willing couples are able to determine the size of their own families" (UNDP, 1994, p. 6). Literature on global health security from critical security studies relies on two key normative principles (G. W. Brown & Stovea, 2014, p. 311; Caballero-Anthony & Gayle, 2014; Davies, 2010b, pp. 1180-1184; McInnes, 2014). The first is that the individual should be at the center of the analysis. The second is that all human beings should have an equal status. As a result, the approach is rooted in cosmopolitan ideas of development, global justice and solidarity (Adams, Novotny, & Leslie, 2008, p. 317). It privileges an "ethos of care" over an "ethos of security" (G. W. Brown & Stovea, 2014, p. 304). Scholars draw a clear relation between health and poverty, focusing on the determinants of health (O. P. Ottersen et al., 2014) and their impact on individual health and security (G. W. Brown & Stovea, 2014; Chen & Narasimhan, 2003; Chiu et al., 2009). Health is seen as a key feature of human security but also as an instrument to address other insecurities for the individual (Elbe, 2010, p. 108).

Much of the literature with a human security perspective on global health security focuses on the consequences of the HIV/AIDS epidemic for individual human lives. They analyze the social impact of the disease, the stigma associated with it, and

take as a dependent variable the individual's position in the society (its gender for instance) (Fourie & Schönteich, 2001; Kristoffersson, 2000; Tiessen, Parpart, & Grant, 2010). Other scholars who draw from securitization theory analyze the effect of 'securitizing HIV/AIDS' on human lives, including the implementation of population control policies that can sometimes lead to human rights violation (Elbe, 2006).

A cosmopolitan perspective on global health security

The challenge of changing the established referent for security, the nation state, has led to the development of a narrative in which the security vocabulary from the statist approach is being used to promote the cosmopolitan values of the globalist perspective. Much of this literature uses the economic concept of global public goods – a good everyone can enjoy, allowing for win-win partnerships between developing and developed countries (Kickbusch, 2013; 2016, pp. 15-16; Ng & Ruger, 2011, p. 9). Security shall then be provided for all individuals on this planet (Davies, 2010b, p. 1187), because after all, "there is nothing unjust about the aim of limiting the international spread of infectious diseases" (Davies et al., 2015). These authors and policy makers strategically use security vocabulary to benefit from an increased availability of resources to address security threats. In Davies' words: "Some who espouse globalist ambitions us[e] the language of securitization promoted by the statist perspective to call for more resources to be devoted to the world's health" (Davies, 2010b, p. 1189). Many scholars tried to assess the effect of the securitizing global health for the situation of the most vulnerable (DeLaet, 2014; Elbe, 2006; McInnes & Rushton, 2010; Rushton, 2011). WHO has been particularly instrumental in trying to mix the statist and globalist perspective, insisting that the problems of the most vulnerable might become a threat to everyone (Davies, 2010a, p. 145). Another attempt to reconcile these two perspectives was made with the Oslo Ministerial Declaration (Ministers-of-Foreign-Affairs et al., 2007), suggesting that improvement of health in one region has positive consequences everywhere (Davies, 2010b, p. 1187). It addresses concerns from the statist perspective (infectious diseases with pandemic potential), as well as issues from the globalist perspective (such as environmental challenges, development issues and trade policies) (Rushton, 2011, p. 792).

Theoretical approach; rationale and research questions

My literature review of global health security highlighted competing interpretations of the concept, supported by different theoretical approaches to international relations. In my research, I wanted to avoid projecting a pre-defined understanding of global health security on the Norwegian Ebola response. I decided thus to proceed inductively – giving priority to observing, listening, and understanding the actors' perspectives before relating what happened to a specific theory. I adopted a *social constructivist theoretical framework* – the main conceptual approach of IR scholars studying global health (Davies, 2008, 2010a; Davies et al., 2015; Lakoff & Collier, 2008; McInnes, 2016; McInnes & Lee, 2012, 2015; Nunes, 2015; Roemer-Mahler & Rushton, 2016). This approach led me to unpack the competing "political and normative frameworks" (Lakoff & Collier, 2008, p. 12) or the "assemblage of perceptions, meanings and practices" (Nunes, 2015, p. 64) at play within the Norwegian bureaucracy during the Ebola crisis (and reflected in the government's policies). Following McInnes and Lee, my aim was to "look at the agendas (goal pursued), resources deployed, values declared and their links to global health governance" (McInnes & Lee, 2012, pp. 4-5). In other words, I took as independent variable the Ebola crisis and as dependent variables the different values, interpretations and policy prescriptions competing for the framing and operationalization of the Norwegian political response to Ebola. What's more, I adopted a 'sociological' approach to social constructivism and securitization theory (Balzacq, 2005, p. 181): not only did I analyze the competing "political and normative frameworks" (Lakoff & Collier, 2008, p. 12), I also explored their links and relations to contextual events and empirical developments. I support indeed the premise that frames, perceptions and meanings have to resonate with empirical developments to be adopted (Davies et al., 2015; McInnes & Rushton, 2011, p. 118).

This research constitutes an original approach that should bring new light on Norwegian global health policy and more generally, provide an interesting case within a burgeoning literature on global health security. It will also provide insights on the translation of a contested global concept into the Norwegian context and allow me to elaborate on a Norwegian understanding of global health security, as expressed during the Ebola crisis. To my knowledge, this has never been realized yet.

Concretely, I have translated this conceptual approach into four research questions, exploring the agendas, values, resources and connections to global governance of Norway's political response to Ebola (McInnes & Lee, 2012, pp. 4-5):

Q1. What did Norway do in reaction to the Ebola crisis? (Resources deployed)

Q2. How was the policy problem (The Ebola crisis) understood and defined? And why was such response decided upon (Agenda and goals pursued)?

Q3. How was the response legitimized (What values and motivations were put forward)?

Q4. What are the Norwegian Ebola response's roots in the Norwegian foreign policy and global health governance?

Methodology

A social constructivist, qualitative International Relation project opened to interdisciplinarity

In this thesis, I adopted a classical methodology employed in International Relations (IR). As explained above, I developed my research questions based on a research agenda deriving from social constructivist theory. I chose to realize my study with qualitative methods, usually considered as being the best way to realize an in-depth analysis of a topic, an event or a policy (Lamont, 2015, p. 79). I conducted eighteen semi-structured interviews, a review of the literature and an in-depth analysis of official documents (I provide more details of this work below). I triangulated the data collected from each method to cross-check my hypotheses and make sure my arguments were supported by different sources (Lamont, 2015, p. 79).

Interdisciplinarity is the mantra for the Centre for Development and the Environment and is the cornerstone of its master program in which this thesis is written. Interdisciplinary research does not mean "replacing disciplines", but "building on them" argued Desmond McNeill, underlying that "it is important to be open to a variety of perspectives and methods, and to have a critical attitude to one's original

discipline"(McNeill, 2012, p. 23). It is exactly what I attempted to do in this thesis, dealing with a field, global health, considered to be in nature interdisciplinary:

> "Global health is an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care" (Koplan et al., 2009, p. 1999)

Concretely, I proceeded to a review of scholarly work emanating from different disciplines to obtain a better and more complete understanding of the Ebola crisis: epidemiology and public health, medical history, anthropology, political science, economy, international law, etc.

I will describe hereafter my collection of data through interviews, official document analysis and academic literature.

Interviews

Interviews are an excellent tool for qualitative analysis, allowing researchers "to gain factual data about a particular phenomenon, event or object, to elicit the opinion or perspectives of an interview participant, or to learn more about their behavior" (Lamont, 2015, p. 83). In this section, I will first describe and justify my interview sample and then present and discuss some of the practical aspects of my approach.

Altogether, I led eighteen semi-structured interviews lasting between thirty minutes and one hour. I audio-recorded sixteen of them, and took notes by hand for two. I interviewed primarily those who were directly involved in the set-up of the Ebola response - bureaucrats from the Ministries and Directorates (13) and doctors from the Bergen Health Trust (2). I targeted mostly bureaucrats for two reasons: they play a key role in the policy making process and are often more accessible than politicians – an accessibility that was confirmed by the high level of response I received. On the contrary, I was planning to interview some of the Members of Parliament who debated the Ebola response, but did not manage to get access to them. Finally, I interviewed some experts of Norwegian global health and development policies (3) to better situate

the Ebola response in the Norwegian context. Following Mosley's methodology, I make available in Annex 1 a list detailing my interviewees' institutional attachment, the way they were contacted as well as the duration and context of the interviews. I have also included in this list those who were contacted but from whom an interview was not possible (Mosley, 2013, p. 99).

Of course, I could have done more interviews. It should be noted however that it is extremely time consuming to obtain one, prepare for it, realize it and then transcribe it and analyze it. Provided the time frame available to complete this research project, I did not have the capacity to do more and thus had to make some choices. To ensure my sample's reliability and validity, my strategy consisted in interviewing at least two persons from the same institution to compare their experiences and views. I managed to do this for most of the institutions involved, except for the Ministry of Foreign Affairs - diplomats being difficult to gain access to (among other things, because they are appointed on the other side of the globe). I find my sample large enough and representative enough to draw reliable and valid results from it – particularly when contrasting them with the results from my document and literature analysis (triangulation) (Lamont, 2015, p. 79).

I conducted these eighteen interviews from April 2016 to December 2016, in two rounds. I started with a first series of three interviews in spring 2016; preliminary work that provided me with valuable factual insights and helped me finding relevant policy documents. After exploring the academic literature throughout summer 2016 and refining my factual understanding of Norway's response to the Ebola crisis, I could then formulate a questionnaire that I used for a second round of interviews, led between mid-September and mid-December 2016. I contacted potential sources by email and met several of them in person during conferences (the global health community is relatively small in Norway) – a direct contact that proved to be highly successful in securing interviews. I also benefitted from a so-called "snow-ball effect" (Bertaux, 1981, p. 37), retrieving from informants the name and contact details of other persons involved in the policy process. I secured several interviews thanks to the recommendations and mediation of some of my sources.

I decided to lead semi-structured interviews because this format allows some flexibility in the discussion whilst maintaining a basic structure, making it possible to

cross-reference interviews and find common patterns (Lamont, 2015, p. 84). Proceeding with this non-standardized format with elites also give them a chance to elaborate on some aspects I might have ignored, thus opening some new ways of thinking about the topic (Dexter, 2006). After each interview, I transcribed the audio-recording with the software HyperTranscribe™. I obtained almost two hundred pages of interview transcript that I coded in NVivo11™. I proceeded then to an in-depth analysis of the data retrieved and found some patterns thanks to coding; I also cross-checked facts with official documents (see next section).

Finally, interviewing people requires strict ethical guidelines, particularly for a project like this. The Ebola response is a sensitive topic, given that it was dealt with by a relatively small community of actors. I followed the guidelines from the Norwegian Center for Research Data (NSD) that authorized this project (reference 49682). I ensured that every interviewee understood what my research was about, the aims of the interview and how I would use the data. They all gave me their informed consent, in an oral or written form. I did my best to anonymize the data presented in this work to protect my informants. I would also like to stress that the audio recordings, transcripts and contact information were stored with all due precautions, following NSD's requirements.

Official Documents Analysis

Norway was ranked last year as the sbest democracy in the world by *The Economist*'s Intelligence Unit's Democracy Index (Economist, 2017). The quality of the Norwegian democracy has concrete consequences for social science research: the transparency of the political institutions allows great access to official documents, made available to everyone on an internet database. I could thus easily find a wide range of official documents relating to the set-up of the Norwegian Ebola response: evaluation reports, press releases, policy statements, speech transcripts, budget documents (Lamont, 2015, p. 80). It should be noted that most of these documents (except for a majority of press releases) were published in Norwegian. I translated the extracts I quote in this work myself (they are marked with a *). I used official documents for two main purposes: to gain factual knowledge and check the information provided by my informants and to analyze the framing of the response, the government's agenda and its

underlying values. I will briefly present hereafter the different documents I worked with.

The first step of my research consisted of getting an overview of the Norwegian government's reaction to the Ebola crisis. In the absence of a document providing a detailed overview, I collected all the press releases from the Ministry of Foreign Affairs on the topic. I found eight of them, published between April 2014 and March 2015 (MFA, 2014a, 2014b, 2014c, 2014d, 2014e, 2014f, 2014g, 2015a). They were built around a similar structure: their purpose was to announce and explain an action from the Norwegian government and justify it by providing a brief contextual update about the crisis. The MFA's press releases were not only useful to 'map' the Norwegian response, but also to get a snapshot of the government's understanding of the situation throughout the crisis. They were however incomplete, providing only limited information about the financial details of the response. I decided to combine them with two other sources for more accuracy: the report from the WHO detailing the ear-marked contributions made for the Ebola response (WHO, 2016b) and the data base run by the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), the Financial Tracking Service, recording transactions made in response to humanitarian emergencies (UNOCHA, 2017). The aggregation of these sources allowed me to find the allocation of NOK 439.5 million of the total NOK 500 million response (88%), a level of detail satisfactory to draw reliable conclusions.

With this overview complete, the second step of my research consisted of getting a detailed account of the two projects operationalized with public resources: the set-up of a field hospital and its base camp in Moyamba, Sierra Leone, and of the vaccination trial led in Guinea. I found numerous documents on the project in Sierra Leone:

- Two evaluation reports: one from the Directorate of Health reviewed by the Ministry of Health (Health-Directorate, 2015a) and one from the Bergen Health Trust containing a lot of working documents useful to understand the policy-making process (HelseBergen, 2015).

- One long press release from the Directorate of Health presenting the project with several interviews from volunteers (Health-Directorate, 2015b)

- The project outline from by the coordinator of the response, the British
  Department for International Development (DFID), detailing the measures taken
  in Sierra Leone by the UK and its coalition (DFID, 2014). This document also
  referred to the guidelines set by the WHO in its Ebola Response Roadmap
  (WHO, 2014b).

Moreover, the vaccination trial led in Guinea was coordinated by the Norwegian
Institute of Public Health that did not make many public documents available on its
website. I found most of the information I needed in the WHO's documents, particularly
the minutes from the coordination meetings (WHO, 2014e, 2015c) and its
communication around the project (WHO, 2015a, 2015d). Scientific explanations on the
trial were published in the article detailing the trial's result (Henao-Restrepo et al.,
2015).

Finally, for the third step, I conducted an in-depth analysis of the Norwegian
government's framing of the response, trying to uncover, by following a social
constructivist theoretical approach, the values and goals supporting this policy. Based
on the preliminary results transpiring from my interviews, I coded all the official
documents I found originating from Norwegian institutions. In the absence of
interviews with political actors, I relied heavily on the transcript of the parliamentary
debate on Ebola, during which the Ministers of Health and the Minister of Foreign
Affairs introduced the Norwegian response. These introductory speeches were followed
by the views on the response expressed by one delegate from each of the seven political
parties represented in Parliament (Stortinget, 2014). Similarly, I extensively used the
volunteers' interviews published in the Directorate of Health press release as I did not
have the opportunity to interview many of them (Health-Directorate, 2015b). I would
like to stress that due to the scope of this research project, I could not do an extensive
media analysis to study the framing of the response. I consider however that the number
of official documents on the issue is large enough to draw reliable and valid conclusions
on the government's strategy, particularly when compared with interview results.

Academic Literature

I extensively used the academic literature on the Ebola crisis and on global
health security to make sense of the Norwegian response to Ebola – I provided an

extensive literature review earlier in this introduction. I developed a particular interest for the social constructivist approach, developed by many scholars of international relations studying global health security and Ebola (Davies, 2008, 2010a; Davies et al., 2015; Lakoff & Collier, 2008; McInnes, 2016; McInnes & Lee, 2012, 2015; Nunes, 2015; Roemer-Mahler & Rushton, 2016). I tried to apply their research agenda to the case of the Norwegian response to Ebola (see theoretical approach)

It should be noted that only a few academic works focused specifically on the Norwegian global health policy, and none, to my knowledge has analyzed Norway's position towards global health security. I was thus extremely careful not to apply generalized conclusions deriving from the global health security literature to Norway. I made a systematic effort to align them with the results of my fieldwork (interviews, official documents analysis), as well as the interesting, but limited, literature on the Norwegian foreign policy in global health and development (Borchgrevink, 2004; De Carvalho & Neumann, 2015; Kloster, 2012; Leira, 2007; Lodgaard, 2002; Sandberg & Andresen, 2010; Stokke, 1989; Tvedt, 2007).

Thesis Outline

In Chapter 1, I provide an overview of the Norwegian international response to Ebola. I discuss the allocation of the NOK 500 million response and present in detail the two projects led directly with public resources: the Ebola Treatment Center and its base camp in Moyamba, Sierra Leone, and the vaccination trial in Guinea. This preliminary work constitutes a necessary empirical base in the analysis I develop in the following chapters.

In Chapter 2, I explore the Norwegian government's understanding of the Ebola crisis. I show that it interpreted the situation both as a humanitarian crisis, having a severe impact on the lives and livelihoods of the people living in West Africa, and as a biosecurity threat that could potentially hit Norway if it was to spread. I suggest also that few – if any – in Norway adopted the narrative present on the global stage (particularly in the UN Resolution on Ebola) drawing a causal link between epidemic and state fragility.

I work in Chapter 3 to uncover the government's intentions and values underlying its decision to set-up a strong response to Ebola. I demonstrate that the Norwegian authorities framed their contribution as a humanitarian project, putting forward values of altruism and solidarity that echoed important dimensions of the Norwegian national identity. However, I also explain that the government had other goals in mind, including containing the outbreak in West Africa to protect the Norwegian population and to avoid panic by appearing in control of the situation. I conclude that the response was partly securitized after the repatriation of a health worker infected by Ebola – a process that led to some conflictual situations, particularly between the governmental administration and doctors from the Bergen Health Trust.

Having established that the government's intentions partly shifted from humanitarian concerns to ensure Norway's biosecurity, I show in Chapter 4 that this securitization process had important consequences in the operationalization of the response. The repatriation of the volunteer infected by Ebola opened a window of opportunity to mobilize exceptional financial resources and implement innovative, *adhoc* projects. The result is a highly-professionalized response designed with uncommon security features - a costly, heavy-handed intervention.

Finally, in Chapter 5, I link the Norwegian response to Ebola to broader issues and debates of global governance. I suggest that the emergency modality of intervention dominating the Ebola response fits well with Norway's recent global health policy based on a vertical, technological approach. I suggest also that the extensive use of multilateralism in the Norwegian Ebola response echoes a foreign policy privileging pragmatism, a quest towards moral authority (from which derives status) and the promotion of a collaborative world-order, in the interest of small states like Norway. Lastly, I conclude that global health security constitutes a promising field that can realize a foreign policy objective of better combining *idealpolitik* and *realpolitik*.

1. Responding to Ebola, the Norwegian Contribution

Nine months after Ebola took its first victim in West Africa, the World Health Organization (WHO) declared on August 8th, 2014 the epidemic a *Public Health Emergency of International Concern* (PHEIC). By the time WHO raised the alarm, it is estimated that 1711 people had been infected in three countries (Sierra Leone, Liberia, Guinea), leading to 932 deaths (WHO, 2014f). The epidemic was on the verge of being out of control, spreading fast in countries with extremely weak health systems unable to cope with the challenge - a situation that led *a posteriori* to strong criticisms against the WHO for reacting too late (Moon et al., 2015, p. 2206; WHO, 2015b, p. 8). The global community scaled up its response rapidly from August 2014 and throughout the autumn 2014. The WHO took the role of global coordinator of the crisis' health aspects, defining guidelines to fight the disease and avoid transmission (WHO, 2014b). In addition, an *adhoc* UN Mission for Ebola Emergency Response (UNMEER) was set-up on September 19th, on request of the UN Security Council, to coordinate the cross-sectoral response and address the larger consequences of the outbreak, such as "*food security, protection, water, sanitation and hygiene, primary and secondary health care, and education, as well as the longer-term recovery effort that will be needed*" (WHO, 2014b, p. 6). UNMEER was active until July 31st, 2015, indicating that it took almost a year for the global response to take control over the epidemic.

What did Norway do in this global response? In this chapter, I will present how the Norwegian government spent NOK 500 million to contribute to the international efforts against Ebola. Figure 2 provides a detailed overview of the allocation of the Norwegian financial contribution. I find that the Norwegian response followed two logics. The first is rather typical of Norwegian humanitarian policy: the government supported international-non-governmental organizations (INGOs) and did so relatively early, from the spring 2014. Norwegian authorities also responded positively to the multilateral organizations' requests for funding, formulated when the global response kicked off in the autumn 2014. The second logic of the response revealed a more interventionist approach. Norwegian policy-makers concluded that the resources and expertise of traditional humanitarian actors were too limited and were concerned that

the situation would become completely out of control. Therefore, the Norwegian government decided to fund and run two projects directly with public human resources. Norway contributed then to set-up, staff and run a field hospital and base camp in Moyamba, Sierra Leone and led the study steering group of a vaccination trial in Guinea organized under the sponsorship of the WHO.

ALLOCATION OF THE NORWEGIAN RESPONSE TO EBOLA IN MILLION NOK, TOTAL NOK500 MILLION

Category	Value
Field hospital, Sierra Leone	110
WHO	106
World Bank	70
Vaccination trial in Guinea	33
World Food Programme	31
African Union	17,5
UNICEF	17
MSF Norway	16
UN Multi-Partner Trust Fund	15
Red Cross	14
Norwegian Refugee Council	11
Non specified	59,5
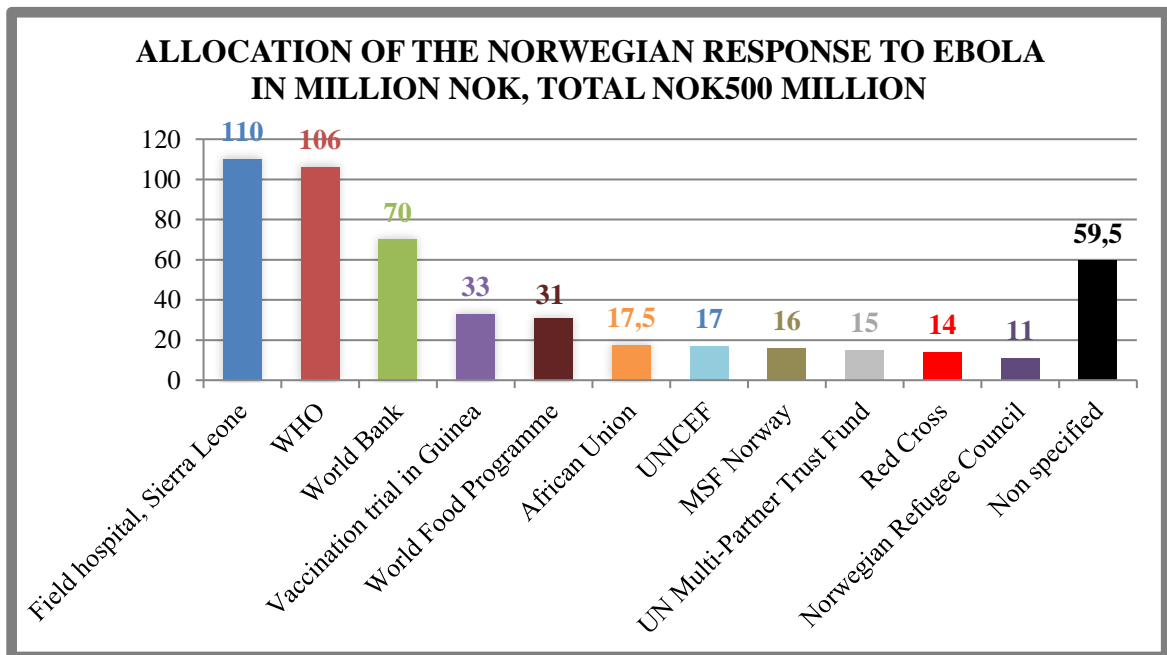
Figure 2: Overview of the Norwegian financial contribution to the global response to Ebola

Source: Data aggregated by the author. Information retrieved from the Norwegian Ministry of Foreign Affairs (MFA, 2014a, 2014b, 2014c, 2014d, 2014e, 2014f, 2014g, 2015a), the WHO (WHO, 2016b), the Financial Tracking Services from the United Nation Office for the Coordination of Humanitarian Affairs (UNOCHA, 2017)

1.1 The contribution to INGOs and multilateral organizations

The Norwegian government started responding to the Ebola crisis by supporting INGOs, that were the first actors to raise the alarm on the global scene (MFA, 2014a). When the global response was scaled up in the autumn 2014, Norway answered to the appeals of several multilateral organizations launching initiatives to tackle the outbreak and its indirect consequences. Altogether, the Norwegian authorities dedicated more than half of the response's budget to the multilateral system, and approximately 8% to

NGOs[1] (see Figure 3). I will discuss and detail this finding in the following sub-sections.

AGGREGATED DISTRIBUTION OF NORWAY'S CONTRIBUTION TO EBOLA

Non-specified
12 %

NGOs
8 %

State-led projects
29 %

Multilateral
Organizations
51 %
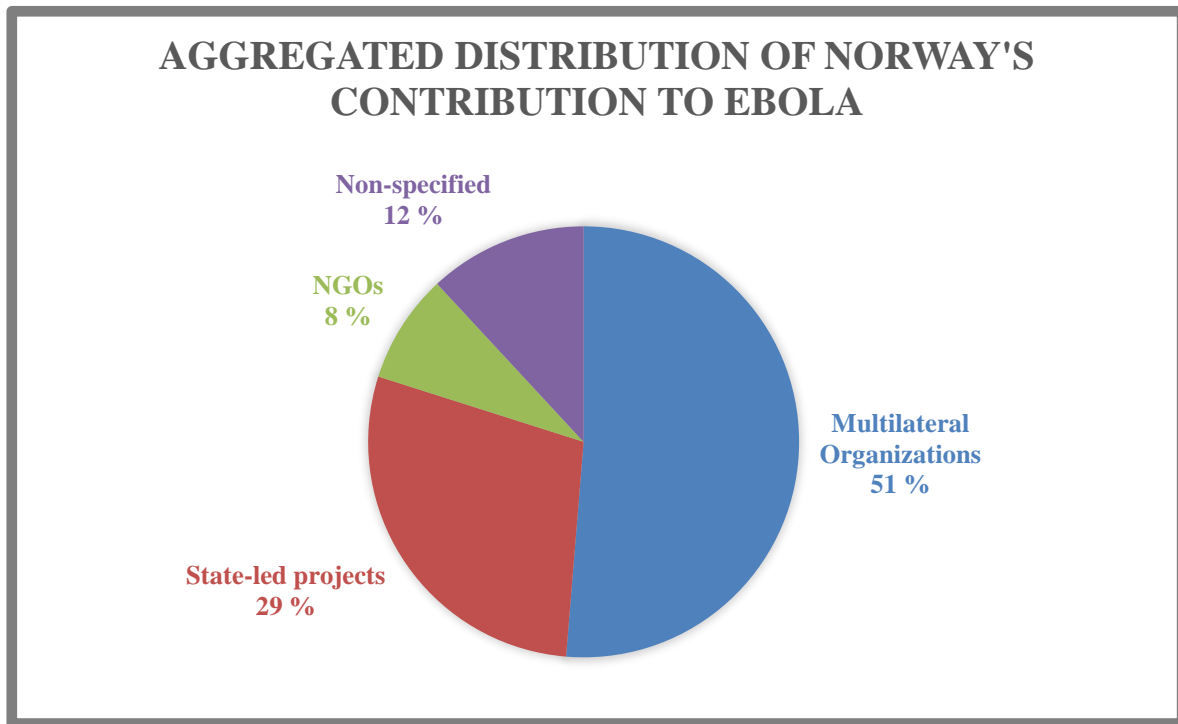
Figure 3: Aggregated distribution of Norway's financial contribution to the global Ebola response
Source: see figure 1

1.1.1 NGOs

Traditionally, the Norwegian government works closely with NGOs to implement its humanitarian and development policies. According to Tvedt, between 1990 and 2005, half of the development aid budget allocated bilaterally by Norway was channeled by over 200 different NGOs (Tvedt, 2007, p. 616). An informant confirmed this observation by telling me that *"the usual way Norway usually respond in times of crises, is actually through the NGO system"* (Interview n°14). The response to the Ebola outbreak in West-Africa shows that the Norwegian government first tried to follow this standard procedure, but upon realizing the NGOs' maximal capacities had been reached, decided to implement state-led projects. Providing the exceptional size of the contribution to the fight against Ebola, this led the share of the budget allocated to NGOs to fall to a relatively small amount (8%).

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[1] Providing that I could not find the allocation of NOK 59,5 million, this share might be slightly higher.

The first trace of the Norwegian government's reaction to the Ebola crisis is a press release announcing a small pledge (NOK4 million) to the NGO *Médecins sans Frontières* (MSF) (MFA, 2014a). This communication, published in April 2014, is paradoxical. On the one hand, it indicates an early involvement in the crisis, at a time when the international community had not yet reacted. On the other hand, the amount pledged is extremely modest, and reflects more a good relationship and cooperation with the INGO than a real concern for the situation. A second wave of funding was announced much later, on July 31st 2014, allocating an additional NOK5 million to MSF. Interestingly, the following press releases do not indicate the exact allocation of money to INGOs – only in the last press release summarizes the government's support of MSF, the Red Cross and the Norwegian Refugee Council (MFA, 2015a). I found, thanks to the Financial Tracking Service from UNOCHA, that all these pledges were made between August and October 2014, so relatively early in the response set-up (UNOCHA, 2017). Based on the elements I have, it seems the Norwegian government did not provide any contribution to INGOs after the end of October 2014, indicating a shift in priorities.

In the case of a humanitarian emergency, the starting point of any political response formulated by Norwegian authorities is to establish possible support for NGOs (Interview n°14). These independent humanitarian actors are seen as important collaborators and are respected for their expertise, their experience and efficiency, their ability to get aid operational in a few days (sometimes a few hours), and their connections on the ground. Outsourcing to INGOs is considered to be the most cost-effective way of operating, as recalled by an informant: "*in lots of cases, it's a lot cheaper to use another partner [talking about INGOs]; who has experience, knowledge, on the ground, and an entire system. They have a system set-up for doing this all the time!*" (Interview n°1). In addition, the moral authority of INGOs enables them to lead effective communication strategies to raise the media and public awareness about the situation on the ground. Having a dialogue with the INGOs is thus the first step of the Norwegian government in the face of a humanitarian crisis – a strategy that I also found in the case of the Ebola crisis. However, my informants' recurrent use of the word "*usual*" or "*usually*" to refer to the traditional collaboration between the MFA and INGOs highlights a contrast between "normal" humanitarian emergencies and the "exceptionality" of this specific crisis (Fassin & Pandolfi, 2010, p. 45). The scale,

nature and immediacy of the problem made it 'abnormal' and demonstrated the insufficiency and inadequacy of the NGO-led responses – something that the NGOs acknowledged themselves according to a source recalling that they told him rapidly, "*we've passed our limits, we can't take anything more!*" (Interview n°1). The government focused then on other ways to cope with the crisis.

1.1.2 Multilateral organizations

In its response to the Ebola crisis, Norway gave priority to the multilateral system, channeling more than half of its total financial contribution through multilateral organizations (Figure 3) – even if the country would not derive much visibility from these donations. This policy is in line with the strategy Norway traditionally adopts in humanitarian aid and development: Leira and colleagues recall that the Ministry of Foreign Affairs has an objective to channel fifty percent of the total aid budget via multilateral organizations (Leira, 2007, p. 22), an ambition that Stokke found already in official documents from 1969 (Stokke, 1989, p. 188).

The Norwegian government decided to support six international organizations with earmarked contributions of a value superior or equal to NOK 15 million. This money, in addition to the yearly funding, was specifically allocated to emergency plans in West Africa. The main beneficiary was by far the WHO, recording NOK 106 million from Norway (WHO, 2016b). It is also interesting to note that this donation was the 8th biggest to the WHO, placing Norway at a similar level to heavy weights like the UK and Germany (see figure 4). The massive support of Norway to the WHO is not surprising for at least two reasons. The first is that the WHO played a critical role in the global response set-up, despite the concurrence of the *adhoc* UN platform set-up to manage the crisis, the United Nations Mission for the Ebola Emergency Response (UNMEER). Its slow reaction was often criticized by the people I talked to (Interview n°1, Interview n°7; Interview n°14), but at the same time, its expertise and leadership were clearly recognized: *"everything we did was in line with the needs as they were seen by the WHO and by the European Union"* (Interview n°15). The second reason for Norway's strong commitment to the WHO is its historic proximity with the international organization. One of my interviewees highlighted this particular relationship to WHO when stating *"we are very close to the WHO historically, and also*

emotionally [...] There are some connections there, also for why we use so much resources [to support the WHO]" (Interview n°14). This quote recalls that Norway has always given a strong priority to the WHO, a policy illustrated by the role Norway played in its establishment in 1948 or the appointment as Secretary General from 1998 to 2003 of Gro Harlem Brundtland, former Norwegian Prime Minister (Sanne, 2011, p. 205). Norway's substantial support to the WHO during the Ebola crisis, despite some criticisms about its management of the situation, is thus inscribed in a long tradition of cooperation with the organization.

Top donors to the WHO Ebola response, as of 22 April 2016

	USA - Total*	World Bank	African Dev. Bank**	UNDP	Japan	Canada	UK	Norway	Germany	Wellcome Trust	BMGF ***
USD	109,21	67,21	48,12	34,83	23,62	21,12	14,76	14,18	13,00	12,23	11,67
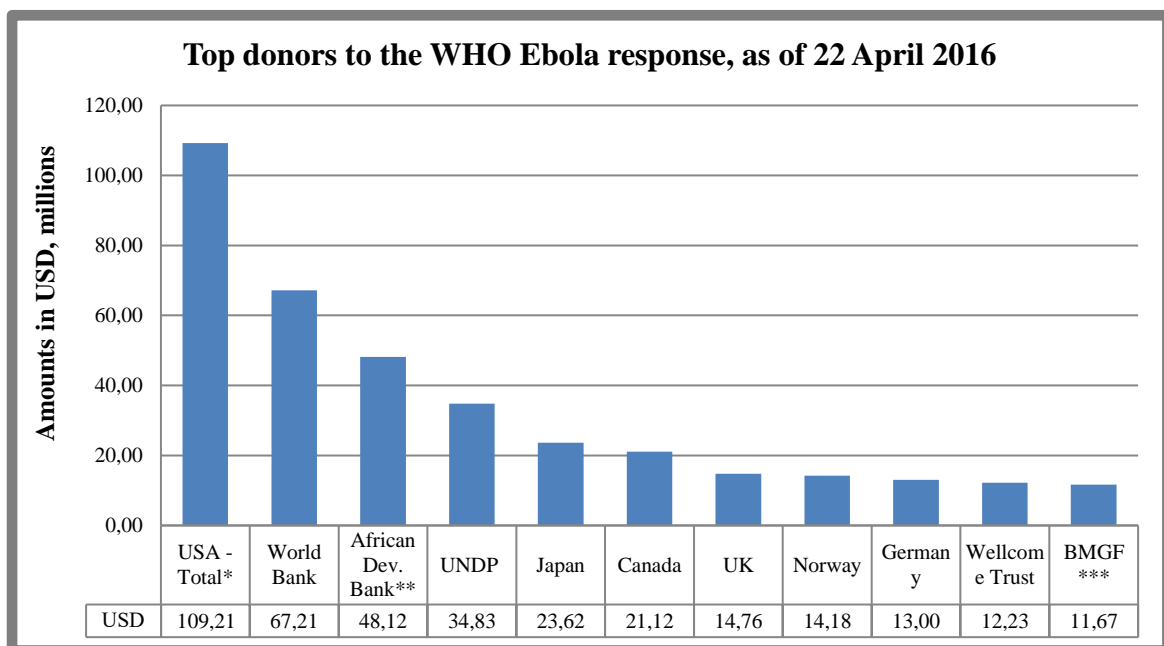
Figure 4: Top donors to the WHO Ebola response, as of 22 April 2016

Source: data aggregated by the author from WHO (2016)

* Overall contribution from the USA, including from the USAID, the CDC and DTRA
** African Development Bank Group
*** Bill and Melinda Gates Foundation

The Norwegian government also made a large donation of NOK 70 million to the World Bank fund to fight Ebola – a contribution that aimed at stimulating the impacted countries' economy and consolidate urgently their health system (MFA, 2014d). The donation of NOK 17.5 million to the African Union targeted similar objectives. Finally, Norway gave NOK 33 million to the World Food Program, NOK 17 million to United Nations Children's Fund (UNICEF) and NOK 15 million to the UN multi-partner trust fund to tackle the indirect consequences of the epidemic, such as access to food and water, or children's education (UNOCHA, 2017).

To sum up, between half and two-thirds[2] of Norway's financial contribution to the global response to Ebola was channeled via INGOs and international organizations. This indicates on the one hand that the set-up of the Ebola response was rather representative of the Norwegian way of handling humanitarian crises and development funding. On the other hand, Norway's response to Ebola is rather original when considering support for INGOs that was relatively small in comparison to other emergencies. This can be explained by the decision taken to set-up two projects led with public resources, accounting for almost a third of the total contribution. This direct involvement of the state is rather unusual, which explains why I will spend disproportionate analytical attention to them in this thesis. I will now, in the following two sections, provide a detailed overview of these projects – a work that will lay a necessary base for my analysis in the following chapters.

1.2 The Ebola Treatment Center in Moyamba, Sierra Leone

1.2.1 The British-led response in Sierra Leone

On August 28th, 2014, the WHO defined priority actions to stop the Ebola outbreak in its *Ebola Response Roadmap* (WHO, 2014b). The UK took the responsibility of coordinating the health-related aspect of the global response in Sierra Leone, on request and on behalf of the WHO and on the invitation of the local government (Health-Directorate, 2015a, p. 30). The UK is a former colonial power of Sierra Leone and has kept a close relationship with the country – a context that made it the response's "*natural*" leading partner (Interview n°1). The British authorities' main goal was to "*control the spread of Ebola in Sierra Leone and the region, leaving a legacy of stronger health systems*" (DFID, 2014, p. 5). To do so, they set-up a response divided in eleven different projects, ranging from setting up medical facilities and laboratories, ensuring safe burials, educating the population on the transmission mechanisms, and supporting the global and regional preparedness systems (DFID, 2014, p. 1; HelseBergen, 2015, p. 9). Overall, the UK dedicated the colossal amount of NOK 4.3 billion to finance their response in Sierra Leone (DFID, 2014).

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[2] Depending on the allocation of the NOK 59.5 million I could not find.

The core aspect of the British action plan – accounting for more than half of the total budget (DFID, 2014, pp. 17-19) - was to open *adhoc* medical facilities to diagnose, isolate and treat patients, all around the country. These facilities were of different natures and sizes: one main facility was located next to the capital city, six comprehensive Ebola treatment centers (ETC) were built with a capacity of approximately one hundred beds, and dozens of smaller and more competences-limited facilities were set-up, such as Ebola care units (ECU), community care centers (CCC) or Ebola holding centers (EHC). As the main task of the UK government was to coordinate global efforts, it invited INGOs and partner countries to join its response by providing additional funding, human resources and in-kind donations such as laboratories, base camps, etc. (DFID, 2014, pp. 18-19). It resulted in the constitution of heteroclite alliances set-up facility by facility, under the leadership of DFID (UNMEER, 2015). Norway decided to join one of these coalitions by contributing to the set-up of an Ebola Treatment Center.

1.2.2 The Ebola Treatment Center in Moyamba

The Norwegian government decided to participate with the British-led response in Sierra Leone by contributing to the set-up of an Ebola Treatment Center (ETC), composed of a field hospital with a capacity of a hundred beds and of a base camp where the personnel lived (Health-Directorate, 2015a, p. 31; HelseBergen, 2015, p. 9). The DFID asked Norway to take care of the facility built in Moyamba, a rural district of 300,000 inhabitants (Statistics-Sierra-Leone, 2015) located in the Southern area of Sierra Leone (see map figure 5). Based on the information I collected from my interviews, Norway was allocated this very center because of the features of the Norwegian base camp tool kit, allowing it to be self-sufficient (particularly in terms of water supply) and thus fitting well the conditions imposed by the local geography (Interview n°8; Interview n°12). Moyamba was not one of the most affected districts by the epidemic, but its location at a crossroad of the North-South and East-West traffic in Sierra Leone led the British authorities to conclude the need of a large treatment facility there (Interview n°8). The Norwegian government gave its green light to join the UK response on October 9th 2014 (Health-Directorate, 2015a, p. 5). To regulate the cooperation, a Memorandum of Understand (MoU) was signed on October 31th 2014, and was further developed with annexes – an *adhoc* process particularly difficult and

time-consuming which had to be done in a few weeks (Health-Directorate, 2015a, pp. 30-31; 33). The ETC was functional for four and half months, opening on December 18th, 2014 and closing in on March 31st, 2015 (Health-Directorate, 2015a, p. 5). Altogether, the Norwegian government invested NOK 109 million in the Moyamba ETC, making this project the most expensive component of its Ebola response (Health-Directorate, 2015a, p. 50). I will now present the highly complex organization set-up of the project, and then briefly discuss its results.
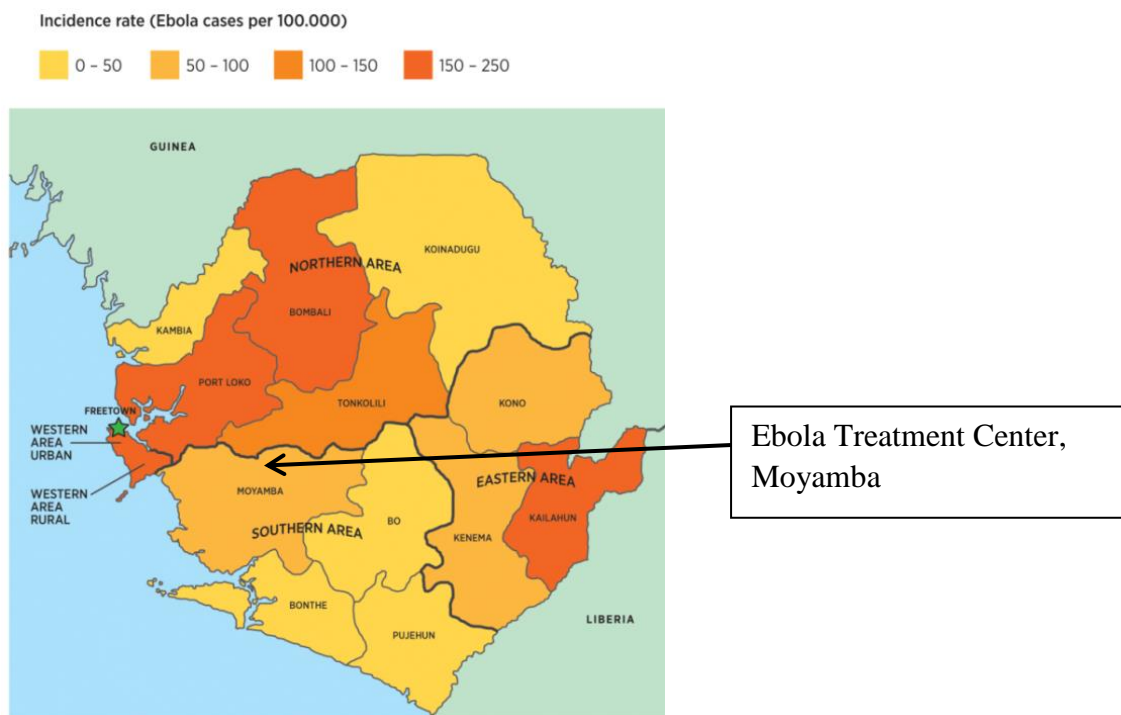
Figure 5: Incidence rate of Ebola in Sierra Leone per district, and location of the Moyamba ETC
Source: (Brolin Ribacke et al., 2016) (©creative commons)

Organization of the Moyamba Ebola Treatment Center

The Ebola Treatment Center encompasses two distinct sub-projects, involving different actors: the medical center, and the base camp where the staff were living. The ETC's organizational set-up ended being extremely complex, involving many different actors. I will try to describe briefly each actors' role. For more clarity, I also drew up a 'map' of the actors that I presented in a poster at the GLOBVAC conference 2017 and that I make available in Annex 2 (de Bengy Puyvallee, 2017).

DFID was the leading actor in both sub-projects and took the responsibility – on top of the overall response coordination – to rent the area where the facilities were built, to pay for the levelling work, to train the health personnel, and to handle the contacts with the local authorities (Interview n°1). The treatment facility was built and run by an INGO, the Spanish branch of *Doctors of the World (Medicos del Mundo)*. It was also supported by the French INGO *Solidarités International*, responsible for decontamination and hygiene (WASH protocol). Norway provided the medical staff – altogether three teams composed of fifteen persons each: two doctors, one or two ambulance men, and eleven to twelve nurses (HelseBergen, 2015, p. 13). In addition, USAID and the US Center for Disease Control (CDC) financed the set-up of a laboratory run by the US Defense Threat Reduction Agency (US DTRA), which started running one month after the facility's opening (USAID, 2015, p. 2).

The base camp was assembled by the Norwegian Civil Protection Agency (DSB) that sent some personnel on the ground from November 2014. The camp was built with the standard elements (the 'tool kit') DSB has available and uses regularly to support UN missions: tents, kitchen and cooking equipment, accommodation and beds, showers, toilets, water purification system, telecommunication equipment, etc. (everything needed to build temporary accommodation in a short amount of time). DSB led this project via the International Humanitarian Partnership (IHP), a network of seven governmental civil protection agencies. This cooperation mechanism allowed for the provision of ten personnel from Sweden, Finland, and Estonia (Interview n°12), out of the forty-two persons who were sent to Moyamba to build and run the facility (Health-Directorate, 2015a, p. 39). The base camp comprised accommodation for all the personnel working at the treatment facility, and comprised, in addition to basic features (beds, bathrooms, kitchen) a training center, high speed internet, a cinema, a relaxation space, air condition, etc. (Interview n°12; internet blog from Norwegian personnel working in the base camp (Collective, 2015) – see pictures in Annex 3). The facility was quite comfortable, justified by my informants by the fact that it was a "*closed camp*". The camp was indeed surrounded by fences and security personnel hired from a local private security company (Interview n°12). The employees were not allowed to go out, justifying the necessity for comfort on site (Interview n°8, Interview n°12, Interview n°14).

After the mission finished, the ETC was dismantled. Some elements of the base camps were donated to Sierra Leone or DFID, whilst the most expensive components (communication and satellite systems, self-disinfecting toilets, parts of the cooking equipment) were brought back to Norway (Interview n°12).

Project's outcomes

The ETC in Moyamba ran with Norwegian health personnel from the December 18th, 2014 to March 31st, 2015, with a capacity of one hundred beds. In four and half months, ninety-two patients were admitted, including thirty-three Ebola cases of which eighteen died (Health-Directorate, 2015a, p. 33). The mortality rate was 58%, slightly lower than the other ETCs opened by DFID (HelseBergen, 2015, p. 18). However, despite the care provided to the patients, the mortality rate remained high, the average without treatment being 71% in December 2014 (WHO, 2014c, p. 1).

In hindsight, it appears that the treatment capacity of the Moyamba ETC was clearly overestimated. Of course, at the time of its set-up, only limited epidemiological data was available and it was not possible to predict the transmission patterns of the virus, as noted by almost all my informants who worked on this project (Interview n°7; Interview n°8; Interview n°12; Interview n°14; Interview n°15; Interview n°16). It is also important to keep in mind that this contribution was part of the larger response from DFID, WHO and UNMEER, which had a more significant overall impact (Health-Directorate, 2015a, p. 50). However, as stated in conclusion of the report from the Health Directorate: "*The input turned out to be extremely expensive when compared to the amount of patients taken care of*" (Health-Directorate, 2015a, p. 50 *)[3]. My analysis in the following chapters will offer some explanations for why this project was so expensive, and yet still seen as legitimate by my informants. I will suggest, among other things, that this cost is inherent to the reactive nature of the response and the lack of functioning health system, making it heavy handed. The INGO Save the Children recalled that the funds pledged to fight Ebola correspond with the cost needed to provide annual health coverage in these three countries for at least three years (Save-the-Children, 2015).

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[3] This * after a source indicates that the quote was originally in Norwegian and translated to English by the author

1.2.3 The actors and institutions involved in Norway

As the Norwegian contribution to the Moyamba ETC was substantial and original, it required the participation of a lot of different governmental institutions. I will provide hereafter a brief description of the roles and responsibilities taken by the different Norwegian actors. Annex 4 provides a visual representation of this.

The cross-sectorial nature of the project resulted in the involvement of numerous governmental institutions: four ministries, three governmental agencies, and one regional health trust. The project was set-up in only a couple of months, necessitating a lot of coordination between all these actors in stressful conditions (Interview n°1; Interview n°6, Interview n°7). At the Ministry level, the leading and coordinating role was attributed to the Ministry of Health (Health-Directorate, 2015a, p. 30). The Ministry of Foreign Affairs was the general coordinator of the Ebola crisis, but did not dedicate many personnel to this specific project. It should be noted that unlike the UK Ministry of Foreign Affairs, which delegated the project to the DFID, the Norwegian MFA kept this project at a high level and did not delegate the responsibility to NORAD. The Ministry of Defense was in charge of transporting material and equipment with one military transport aircraft Hercules C-130, leading twenty-four missions altogether (MFA, 2015a). Finally, the Ministry of Justice, under the authority of which the Directorate for Civil Protection lies, was involved with the civil protection side of the project.

As suggested above, the base camp was mostly handled by the Directorate for Civil Protection (DSB). It was set-up based on two resources developed and used in several other emergencies: the Norwegian support teams, in charge of deploying camps and facilities to "*help the helpers*" (Health-Directorate, 2016, p. 19) and the Norwegian teams dedicated to the United Nations Disaster Assessment and Coordination (UNDAC), providing information and communication technologies material in case of an emergency (*Ibid*, Interview n°12). DSB followed a relatively standard procedure to set-up this base camp – the only difference being a closer follow-up from the Ministry of Justice providing the project's considerable size (Interview n°12).

The health aspects of the Moyamba ETC project was however something completely new for the Norwegian government, necessitating an *adhoc* system. The

Ministry of Health was leading the overall project, and played a crucial coordinating role (Health-Directorate, 2015a, p. 45). It was described by one of my informants as the "*strategic arm*" of the project (Interview n°7), chairing weekly coordination meetings that proved to be essential for the completion of the project according to the "*learning points*" from the Directorate of Health's report (Health-Directorate, 2015a, p. 46). The Directorate of Health, placed under its authority, was delegated the "*operative*" side of the project (Interview n°7) – and played a central role from the very beginning. This role included, among other things, the development of the Memorandum of Understanding with the DFID and contacts with partners (Health-Directorate, 2015a, p. 33). In parallel, the Bergen Health Trust was delegated the responsibility of recruiting qualified volunteers for the project and organizing practicalities on the ground. Finally, the Institute of Public Health provided advice on medical protocols and helped on communicating information (Health-Directorate, 2015a, p. 47). The set-up of the treatment facility included a wide range of Norwegian institutions in an *adhoc* organizational structure. This led naturally to uncertainties and disputes over the roles and responsibilities of each, for instance between the Health Directorate and the Bergen Health Trust both in charge of some elements of the project's operationalization (Health-Directorate, 2016, p. 32; HelseBergen, 2015, p. 22). In reaction to this "*learning point*", the Health Directorate was asked to develop a more efficient organization model that it presented in a follow-up report published recently (Health-Directorate, 2016).

Setting-up the Moyamba Ebola Treatment Center was thus extremely complex, involving different networks of actors and institutions: several international partners (DFID, IHP, MdM, Solidarités International, US DTRA, Sierra Leone government), and a wide range of Norwegian institutions (four ministries, three agencies, one health trust), indicating a project well anchored in the Norwegian system. However, the gap between the resources deployed, the highly complex organization structure and the modest results obtained is troublesome. Why all these efforts to respond to a humanitarian crisis? I will show in the following chapters that the perception of Ebola as a biosecurity threat played a critical role in mobilizing all these resources.

1.3 The vaccination trial project, Guinea

The final component of Norway's response to the Ebola crisis was the contribution to a WHO-sponsored vaccination trial project in Guinea with an upstart in March 23rd 2015. This project drew considerable national and international attention when it was announced in *The Lancet* on July 31st 2015. Preliminary results showed 100% efficacy of the vaccine against the Ebola Virus Disease (EVD) (Henao-Restrepo et al., 2015). Norway contributed to the project with a grant of NOK 33 million (MFA, 2015a). As in the previous section, I will attempt here to describe the project's organizational set-up, the institutions involved, and its main results. This work will lay the necessary empirical base for my analysis in the following chapters.

1.3.1 *Ebola, ça suffit!* An innovative vaccination project.

In the autumn 2014, when the Ebola epidemic in West Africa seemed to be out of control, many actors came to look for a vaccine that could help prevent the spread of the virus. The WHO convened a scientific meeting in September 2014. The objective was to prepare for a High-Level meeting on October 23rd, 2014 convened to evaluate the different vaccine candidates. In partnership with the pharmaceutical industry, representatives discussed the advancement of vaccine candidates in the clinical trial process and more importantly, on the feasibility to set-up vaccination trials in the affected countries in West Africa (WHO, 2014e). Shortly after this meeting, observing that trials were planned unilaterally by the USA in Sierra Leone and Liberia, some actors (including Norway) decided to set-up an open collaboration to lead two clinical phase III vaccination trials in Guinea, sponsored by the WHO. One of these trials called "*Ebola, ça suffit!*" ("Ebola, that is enough!") targeted the general population in Guinea with a sample of 4000 volunteers vaccinated (WHO, 2015d). The other parallel trial aimed at vaccinating front-line workers, 1200 altogether (WHO, 2015a, pp. 2-3).

The trial *Ebola, ça suffit!* aimed at testing the VSV-EBOV vaccine with an innovative clinical trial design. It was adopted a "ring vaccination method", a strategy deriving from the smallpox eradication campaign in the 1970s, but that had never been used as a research design before (Interview n°3; University-of-Oslo, 2015). The ring vaccination method involved vaccinating "a cluster of individuals at high risk of

infection, owing to their social or geographical connection to a confirmed index case" (Henao-Restrepo et al., 2015, p. 858). In other words, it is a reactive approach: when a patient is diagnosed with Ebola, all persons that have been in contact with him/her will be vaccinated to create a protective ring, supposed to stop the outbreak from developing further (WHO, 2015d). This study-design is original and innovative because it does not correspond to the scientific 'gold standard' of vaccination trials - the randomized double blind placebo control study. It implies indeed that all participants will receive the vaccine tested (no placebo is administered), half of them being injected immediately, the other half twenty-one days later (Henao-Restrepo et al., 2015, p. 859). The efficiency of the vaccine is then measured by comparing the number of cases found in the two groups – instead of being compared to a group that received a placebo. This is not the project in which to discuss the scientific quality of this vaccination trial study design. It should be noted however that it raised some debates among medical doctors, and that no consensus on its scientific robustness has yet be found (Interview n°3; Burton & Hackman, 2017; Krause, 2015). The results are however extremely encouraging (100%), showing also that this trial design is "logistically feasible, even in resource-poor settings and in a crisis situation […] [and] successful when the incidence of Ebola virus disease is low in the general population and new cases are concentrated in family and community contacts" (Henao-Restrepo et al., 2015, p. 865). The Ebola outbreak was taken as a window of opportunity for the WHO and its partners to develop an innovative approach to vaccination trial in times of crisis. It was the strong political will amongst the main actors that pushed this trial forward, as expressed in a WHO High Level meeting on January 8th 2015: "*crisis must be catalyst for change*" (WHO, 2015c, p. 5), and later called "*a generational opportunity*" the timing to develop a vaccine against Ebola (*Ibid*, p7).

1.3.2 A WHO-sponsored vaccination trial in times of emergency: an innovative organizational set-up

The Ebola, ça suffit! trial has been designed as a collaborative trial, open to everyone, and placed under the regulatory sponsorship of the WHO. As mentioned above, the WHO was instrumental in mobilizing the international community and relevant stakeholders to set-up vaccination trials, especially with a High-Level meeting on October 23rd 2014. In this meeting's minutes, the WHO summarizes the situation and

the way it sees its role: "*The rush of urgent activities demands strong leadership from WHO in its coordinating and convening roles*" (WHO, 2014e, p. 14). To fulfill this task, it was pointed to the "*need for find[ing] innovative ways of securing the accelerated and coordinated engagement of multiple partners that have a role to play in bringing safe and effective vaccines to those in greatest need*" (WHO, 2014e, p. 13). This vaccination trial is the translation of this strategy into actions. The WHO provided the arena and the infrastructure (particularly in regards to teleconferences) to bring together different actors of different natures. The consortium created was composed of the WHO, the Ministry of Health of Guinea, Médecins sans Frontières/Epicentre, and the Norwegian Institute of Public Health (NIPH) (Research-Council, 2015). In addition to coordinating and being the regulatory sponsor of the study, the WHO supervised, together with the Ministry of Health of Guinea, the implementation of the ring vaccine trial on the ground. MSF was in charge of implementing the front-line workers trial. Finally, the Norwegian Institute of Public Health played a critical role in the project by leading the study steering group, and was also the secretariat for the scientific advisory group (University-of-Oslo, 2015). Among others, the University of Bern, the University of Maryland, the London School of Hygiene and Tropical Medicine and the University of Oslo assisted in providing scientific advice. (NIPH, 2016, p. 30). The trial received funding from the WHO, MSF, the Wellcome Trust, the government of Canada through different institutions, and the Norwegian Ministry of Foreign Affairs through a NOK 33 million grant from the GLOBVAC program (MFA, 2015a).

To sum-up, this vaccination trial was made possible via the collaboration of a broad range of actors: an International organization (the WHO), states (Guinea, Canada, Norway), an NGO (MSF/Epicentre), universities and research centers (several of them for the scientific committee), a philanthropic organization (Wellcome trust), and indirectly, the pharmaceutical industry providing the vaccine. A major pharmaceutical company, Merck, owns indeed the license rights from the vaccine tested, after having bought them for US$50 million to NewLink Genetics, a smaller pharmaceutical company who obtained the license in the first place from the Canadian Public Health Agency for $205'000. Merck did not contribute financially to funding the trial, but was indirectly involved as it was responsible for acquiring the authorizations of the regulatory authorities to commercialize it afterwards (Dumiak, 2015; Pierson, 2014).

1.3.3 The actors and institutions involved in Norway

Norway has played an important role in this vaccination trial, both in its conception, its operationalization and its funding. Two bureaucrats seem to have taken critical initiatives for this project to happen: John Arne Røttingen, leader of the study steering group, and Tore Godal, an experienced and influential Norwegian diplomat. Their names appear in every participant list from the WHO's High Level meetings and teleconferences relating to the project (see for instance WHO, 2014e, 2015c) and they have been systematically mentioned as a key actors by my informants (Interview n°2, Interview n°3, Interview n°5, Interview n°10, Interview n°11). Tore Godal's involvement is rather unsurprising. His approach to global health has been very much oriented towards the development of vaccines, as illustrated by the critical role he played in the creation of Gavi, the Vaccine Alliance and the set-up of the GLOBVAC program to support vaccination research in Norway. He was even called the "*founding father of Gavi*" in a laudatory tribute from NORAD for his 75th birthday (NORAD, 2014), and he holds an observer seat in the board of the GLOBVAC program since its creation in 2006 (Research-Council, 2012; Svennerholm, 2006).

The roles among the Norwegian actors were clearly defined: the Ministry of Foreign Affairs asked the GLOBVAC program from the Norwegian Research Council to fund the project. In exchange, the GLOBVAC board could assess the scientific credibility of the project and provide advice based on its long experience with vaccines. The Institute of Public Health was the operational actor of the project, leading the study steering group, hosting the secretariat of the scientific advisory group and providing scientific expertise. The vaccination trial involved less participants on the Norwegian side than the Ebola Treatment Center, making it dependent on a few key individuals.

To conclude, I tried in this chapter to provide an overview of the Norwegian response to Ebola. I showed that the Norwegian government sought first to support INGOs, as it traditionally does. When the global response kicked-off, it provided extensive support to some international organizations, channeling half of the response's budget through the multilateral system – a strategy in line with what Norway usually does in response to humanitarian crises. The originality of the Norwegian response to

Ebola lies in the decision to directly lead some projects with public resources: the Ebola Treatment Center in Moyamba and the vaccination trial in Guinea. Why take this decision? How were the projects framed? What was the government's agenda with these projects? Those are some of the questions I will try to answer in the following chapters.

2　Norway's dual understanding of the Ebola crisis

In the precedent chapter, I attempted to answer my first research question - what did Norway do in reaction to the Ebola crisis? I presented the resources deployed by the Norwegian government and suggested that the response's magnitude and complexity raised some questions relating to the definition of the problem and motives to address it. In this second chapter, I go back to the roots of the Norwegian response by looking at the governmental recognition of the Ebola outbreak as a policy problem and its framing as a 'crisis'.

Defining an event as a crisis is a social and discursive construction, a subjective process by which a problem comes to be seen as urgent and can no longer be ignored (Warner, 2013, p. 78). Thus, different situations with comparable outcomes might be treated differently depending on the social context, the power dynamics and the social forces at play. In Hilhorst's words, "societies selectively choose risks for attention and this choice reflects about values, social institutions, nature and moral behavior […] There are in the end no objective criteria by which to measure a crisis" (Hilhorst, 2013, p. 3). To Hilhorst it is crucial to understand *how* a situation becomes an emergency, and *who* has the power to do so. Medical anthropologist Charles Rosenberg holds a similar argument in his analysis of epidemics. He argues that epidemic outbreaks induce a political response built around a dramaturgy whose first step is a "progressive revelation" (Rosenberg, 1989, pp. 3-4). He notes that the definition of a problem generally starts with a period of denial, before communities finally acknowledge the gravity of the situation and can envisage taking action.

In this chapter, I will first show that the realization of the outbreak's consequences was slow and suddenly accelerated in the early autumn 2014 when the Norwegian government defined the situation as a "crisis". This will allow me to analyze the negotiation process underlying this definitional work: on what base was Ebola seen an emergency, and who was influential in this process? The key argument of this chapter is that the Ebola outbreak came to be recognized as a problem of multiple reasons that can be formulated in three different discursive narratives. The first

emphasizes the vulnerability of the people in West Africa and the humanitarian crisis resulting from the epidemic. The second highlights the biosecurity risks to Norway (and the world) by associating globalization with increased national vulnerability due to the travel of pathogens. Finally, the third narrative points out the destabilizing potential of an uncontrolled and growing health crisis for regional and global security. This multidimensional definition of the Ebola crisis, I will argue in the next chapter, had consequences for the framing and the objectives of the response.

2.1 A threat to human security: the vulnerability of the people and societies in West-Africa

The first discursive narrative framing the Norwegian definition of the Ebola crisis described the outbreak in terms of human suffering and number of deaths. It also highlighted the crisis's economic and social consequences of people living in the impacted countries.

The government's press releases (Health-Directorate, 2015b; MFA, 2014a, 2014c, 2014e, 2014g, 2015a; MoH, 2015) constantly mentioned the health impacts of Ebola in West Africa by presenting, often in detail, updates on the number of infected people, number of deaths in the affected countries, etc. In the forty-five minute parliamentary debate on Ebola, the estimated amount of deaths caused by the virus was repeated no less than four times and seven out of the nine interventions explicitly referred to the epidemic's health impacts in West Africa to stress the significance of the crisis (Stortinget, 2014, p. 368; 372; 373). To the question *why was it important to intervene in West Africa?* most of the bureaucrats I talked to answered by invoking the epidemiological curves, the toll on human lives or human suffering. "*It was very horrible seeing this people dying in the streets and not getting any help at all*" answered one of my informants (Interview n°14), whilst another stressed that "*our main concern was to take care of the people to reduce the damage for the health and the lives of the people*" (Interview n°6). Most interviewees – particularly those working in relation to the treatment center in Sierra Leone - defined the Ebola crisis as a "*humanitarian situation*", a "*humanitarian crisis*" and identified important "*humanitarian needs*" (Interview n°1; Interview n°7; Interview n°9; Interview n°10; Interview n°12; Interview n°13; Interview n°14; Interview n°15).

This narrative was often complemented by a discourse on the social and economic consequences of the epidemic, highlighting the vulnerability of these societies. My informants told me for instance that they

> "*saw that the Ebola crisis was damaging much more than the health of some people locally at that time [...] It was in fact threatening development of the society as such, being isolate from the world economy, not having contact with travel, etc.*" (Interview n°11)

They also recalled that they "*know that [...] infections from epidemics create a lot of secondary negative impacts on the whole system, the whole economy*" (Interview n°3) or that Ebola "*threatens traditional development aid [...] You risk to ruin everything you invested over ten years with one outbreak!*" (Interview n°7). This argument was also adopted by Børge Brende, Minister of Foreign Affairs, when he warned that "*the impact of the Ebola outbreak in the affected countries goes far beyond the health sector. Agricultural production is falling dramatically, and the economic consequences will be serious*" (MFA, 2014f). The concerns expressed here stress the vulnerability of the people and societies in West Africa, not only because of the health impact of the outbreak, but also because of its broader socio-economic consequences. This narrative was well summarized by an informant from the Ministry of Foreign Affairs who told me that when the government started looking into the issue, "*it was already clear that this was a devastating outbreak: socially, economically, and health-wise for these countries*" (Interview n°10).

Theoretically, this narrative presenting the Ebola outbreak as a complex humanitarian issue corresponds to what Sara Davies called the "globalist" perspective of global health security (Davies, 2010b). Its focus on how Ebola affects the livelihoods of the people in West Africa can be seen as analysis of the outbreak's consequences on the various aspects of human security, including of course health (directly affected by the virus) but also broader determinants such as access to food, the economic situation, the changed social environment, etc. (indirectly affected by the epidemic). It defines the Ebola crisis mostly in terms of West African people's and societies' vulnerabilities, invoking values such as cosmopolitism and solidarity (Adams et al., 2008, p. 317). Interestingly, this narrative was present across virtually all governmental institutions and political parties. Rather consensual, it can be interpreted as an uncontested aspect of the Norwegian definition of the Ebola crisis.

2.2 A biosecurity risk to Norway (and the world): globalization and the travel of pathogens

A second narrative defined the Ebola crisis as a biosecurity threat to Norway – and more generally, the world. A central element of this narrative is the argument that globalization connects countries in an unprecedented way, facilitating the travel pathogens in what has become "*a global village*" (Interview n°9). As mentioned in the introduction's theoretical framework, the adoption of this narrative on the global scene has been extensively studied by scholars applying securitization theory (Davies, 2008; Davies et al., 2015; Elbe, 2010; McInnes, 2016; Nunes, 2014; Weir, 2014; Youde, 2012). I will now try to discuss how this narrative was widely adopted in Norway during the Ebola crisis, and how it greatly influenced the Norwegian government's understanding of the situation.

The Ebola outbreak was defined in the early autumn 2014 as a major biosecurity threat by several epidemiological predictions. A study from the CDC, published at the end of September 2014 (CDC, 2014), seemed to have been particularly authoritative, as no less than three informants mentioned it (Interview n°1; Interview n°10; Interview n°15). This study predicted that the amount of Ebola cases would rise exponentially in the following four months, ranging between 550,000 and 1,4 million cases by January 20th, 2015, depending on the amount of under-reported cases. The uncertainty about the epidemiology of the outbreak (the lack of reliable data) and the risk that it might become a pandemic was a major concern for Norwegian politicians, for instance the Minister of Foreign Affairs who declared that "*we cannot say with certainty how many have been infected or died from Ebola. The numbers are incomplete and uncertain. It is likely that there is high level of underreporting, because many are reluctant to seek health care*" (Børge Brende in Stortinget, 2014, p. 368 *). Despite a public discourse aimed at reassuring the population (see next chapter, 3.2.2), the government was, according to my informants, extremely concerned by what it considered as a major biosecurity threat – particularly after the repatriation of the infected health worker. This event gave credibility to the threat and in many ways, good reasons for the government to fear a possible escalation. The bureaucrats I talked to reported that the government saw Ebola as "*a health threat*" (Interview n°6) or "*a health security issue*" (Interview n°3). Other interviewees recalled the context in these terms: "*we saw the growth in the*

epidemic […] and the possibility that it would spread in other parts of the world, and even to Norway" (Interview n°12); "*I personally was quite concerned that this was going to develop into something like a pandemic […], far beyond the West Africa countries*" (Interview n°10)? Another recalled the context of the previous epidemic for which the government's management had been heavily criticized (Roalkvam & Jani, 2013):

> "*We had the last pandemic close on us, the H1N1, it was not a long time ago! It hit Norway at some point rather hard. We know that we'll get something serious at some time. I think a lot of us were thinking: 'is this what's starting now?' So I think we were very anxious at some point, early on that autumn. I had some weeks I was rather anxious and really busy trying to get the whole system up at the national level*" (Interview n°14).

Many of my sources used words from the lexical field of fear to describe the context during which Ebola became a major political issue: "*in the beginning, it was a lot of fear!*" (Interview n°1), "*the fear that everyone had against Ebola, its deadliness, and everything*" (Interview n°12), "*I personally was quite concerned*" (Interview n°10), "*we were very anxious*" (Interview n°14), "*we really feared an escalation of the outbreak*" (Interview n°7). This fear clearly illustrates that the Ebola crisis was not only understood in terms of its impact in West Africa (narrative 1), but also seen as a major political problem with potential consequences for Norwegian biosecurity.

Why was the perception that the Ebola epidemic was a serious biosecurity threat for Norway so widely adopted? I argue that the endorsement of this definition was facilitated by the adoption of a narrative linking globalization with increased vulnerability to infectious diseases. As recalled in the theoretical framework, this narrative re-emerged in the 1990s, first in the USA (Weir, 2014), before being exported successfully to the global scene (Davies, 2008; Davies et al., 2015; Elbe, 2010; McInnes, 2016; Nunes, 2014; Youde, 2012). It led to important policy changes, for instance the revision of the International Health Regulations in 2005 and their progressive implementation since then (Davies et al., 2015). When talking to the Norwegian bureaucrats working on the Ebola response, I was struck by the constant repetition of this narrative (almost in the same words): "*we think that this is a fact that in a globalized world, with population movements, with climate change, the world is shrinking rapidly, and therefore a disease in a part of the world, may become a disease*

problem at home." (Interview n°10), "*Infections do not see borders*" (Interview n°3), "*Epidemics spread over borders […] you don't know when it can come to Norway*" (Interview n°5), "*After all, a disease, sees no borders. If it has a way to be transferred from one place to other, it will!*" (Interview n°7); "*I mean, the world is smaller, the communications are better, things are spreading faster. Yes, everybody agrees to that!*" (Interview n°9). Norway's increased vulnerability to epidemics and biosecurity threats was also clearly expressed in the parliamentary debate by two members of Parliament: "*if we believe scientists, it is only a question of time before the next pandemic becomes reality*" (Gry-Annette Amundsen in Stortinget, 2014, p. 373 *); "*this won't be the last time we will experience an epidemic in the world. Norway was hit by a pandemic no more than four years ago*" (Kjersti Toppe in Stortinget, 2014, p. 374 *). The large adoption of this narrative was instrumental in defining the Ebola outbreak as a biosecurity threat to Norway – a view fitting the "statist" perspective of global health security (Davies, 2008). However, as recalled by securitization theory, one should keep in mind that defining the Ebola outbreak as a biosecurity threat should not be taken for granted (Buzan et al., 1998, p. 28; McInnes & Rushton, 2010, p. 245; Nunes, 2014, p. 939). A source from the Ministry of Health with a background in public health refuted the fact that the Ebola virus could have had a large impact in Norway, as an influenza pandemic could have for instance (Interview n°9). Similarly, a Member of Parliament recalled that

> "*it takes a lot to be infected by Ebola. Therefore, the risk that the disease spreads in countries with well-functioning health systems is relatively low. There, the patients would be isolated and handled rapidly, stopping the virus's spread*" (Marit Nybakk in Stortinget, 2014, p. 371*)

The definition of Ebola as a biosecurity threat for Norway was thus facilitated by the adoption of the narrative linking globalization with increased vulnerability and a particular context combining worrisome epidemiological prediction and the importation of the disease in Norway with the repatriation of an infected volunteer.

2.3 A threat for regional and global security

Finally, a third narrative developed an understanding of the Ebola outbreak as being a threat to regional and global security. It was mostly developed by the UN

Security Council and the United States, and although it appears in the Norwegian government's assessment of the situation, it does not seem to have been widely adopted in Norway.

The UN Security Council stated in its resolution 2177, adopted on September 18th 2014,"*that the outbreak is undermining the stability of the most affected countries concerned and, unless contained, may lead to further instances of civil unrest, social tensions, and a deterioration of the political and security climate*" (UNSC, 2014, p. 1). It concluded that "*the unprecedented extent of the Ebola outbreak in Africa constitutes a threat to international peace and security*" (UNSC, 2014, p. 1). The United States through their president Barack Obama, held a similar position, presenting Ebola as "*a potential threat to global security if these countries break down*" (Obama, 2014). The argument that an epidemic might lead a state to fail is well known and has been developed by the global health security literature labelled earlier "positivist" that sought to evaluate the impact of epidemics (particularly HIV/AIDS) on state stability (Altman, 2003; Fidler, 1999; Ostergard, 2002, 2006; Price-Smith, 1999, 2001; Singer, 2002). A clear parallel with the debate on the HIV/AIDS epidemic can be established. For instance, the Security Council resolution 2177 on Ebola is only the second resolution on a global health security issue, after the resolution 1308 on HIV/AIDS. Both highlight the same concerns that the epidemic might affect "stability" and "security" of the most affected regions and the world (UNSC, 2000, 2014).

I did not find much evidence suggesting that this narrative was widely adopted by the Norwegian government. My analysis shows that only one press release from the Ministry of Foreign Affairs develops a similar argument: "*The Ebola outbreak in West Africa is the worst the world has ever seen, and is a serious threat to health, security and development both in the region and globally*" (MFA, 2014g). The definition of the outbreak as a threat to "*health*" and "*development*" corresponds to the first narrative presenting it as a humanitarian crisis. What is interesting here is the inclusion in the situation assessment that Ebola should be considered as a threat to "*security*", both in the region and globally. Only one of my informants, working at the Directorate for Civil Protection, highlighted the potential risks for regional security, particularly because of displaced populations:

> *"if you look at a food-related crisis, people starving in one region, they will move into another region and things might get destabilized. If water gets scarce in one area, people will move to another area, and then you will have a destabilized situation that will impact a third area. So in that way, the Ebola outbreak, or another disease outbreak, is nothing different"* (Interview n°15)

The same line of argument was developed in the "positivist" literature by Andrew Price-Smith, who argued that population displacements during an outbreak would lead neighboring countries to close their borders and experience security dilemmas that might affect regional and global stability (Price-Smith, 2001, p. 15).

It does not seem that many in Norway believed the Ebola outbreak would lead to state failure and be a major destabilizing factor for global security. The argument was only put forward officially by the Ministry of Foreign Affairs (and expressed together with humanitarian concerns), and brought up by one of my informants who work closely with security issues deriving from emergency situations. When I mentioned this narrative, one of my interviewees was provoked, qualifying the connection made between epidemics and state failure "*a very simplistic way to think about it [health security]*", recalling from his experience during the HIV/AIDS response that this argument was "*very small*". "*I don't think anybody seriously thought about this destabilization thing*" he concluded, "*researchers like to say that*" (Interview n°4). This narrative might have been brought up by the Ministry of Foreign affairs more as a way to echo the international call for attention, rather than with the aim to influence the Norwegian understanding of the crisis. A resolution from the UN Security Council bears indeed a considerable symbolic impact and can be instrumental in drawing attention to an issue, as the organ is considered as the main authority in matters of international security and peace keeping (Williams & Bellamy, 2014, p. 415). This authority is particularly important for Norway; a country that has shown throughout history a strong commitment to support and sustain the UN peace keeping system (De Carvalho & Neumann, 2015, p. 58). A press release from the Ministry of Foreign Affairs issued the day before the adoption of the resolution 2177 (September 17th) supports this interpretation, aiming to show that Norway was paying attention to the crisis and was willing to be part of an international response (MFA, 2014f).

The Norwegian understanding of the crisis was not influenced by the narrative that developed a link between epidemic and state failure, and more generally presented epidemics as a *"threat to international peace and security"*. It seems instead that this "positivist" interpretation of global health security was taken more as a way to mobilize resources and be part of the international response created by the UN Security Council resolution – an argument that I will further develop in the last chapter of this thesis when exploring the inclusion of the Norwegian response to Ebola in the country's foreign policy.

2.4 Conclusion: Norway's dual understanding of the Ebola crisis

This chapter aimed at analyzing Norway's understanding of the Ebola crisis. I recalled that the Norwegian government, as with the international community in general, was relatively slow to acknowledge the outbreak as a 'crisis'. Ebola was placed on top of the agenda in Norway during the early autumn 2014, after the virus traveled to national territory through a returnee infected health worker, and in parallel to the international mobilization orchestrated by the UN system (WHO, UN Security Council, and later UNMEER). I argued that the Norwegian understanding of the crisis relied mostly on two narratives highlighting different aspects of the situation. One put forward the humanitarian consequences of the outbreak in West Africa, health-wise, socially and economically. It insisted on affected people's vulnerability, a focus that can be categorized as part of the 'globalist' perspective of global health security (Davies, 2008). The second defined the Ebola crisis as a biosecurity threat to Norway (and the world), by relying on the adoption of an older narrative linking globalization and an increased vulnerability to infectious diseases. It corresponds more to what Sara Davies called the "statist" perspective of global health security, taking national territory as main referent (Davies, 2008). The Norwegian government defined Ebola both as an humanitarian crisis *and* a biosecurity threat, a dual understanding that, I will suggest in the next chapter, had consequences for the government's intentions, objectives and legitimation of its Ebola response. Finally, the narrative highlighting the regional and global security consequences of states failing due to the epidemic seems to have been less influential in the Norwegian definition of the crisis. Rooted in the HIV/AIDS

context, this narrative has been developed by a 'positivist' literature based on a traditional understanding of security in national-military terms. I suggest that its power lays more in its adoption by the UN Security Council and the considerable attention it drew, including in Norway, on the situation in West Africa, rather than on its capacity to influence the Norwegian framing of the crisis.

3 Setting-up the Norwegian response: conflicting intentions and legitimation strategies

After describing the Norwegian response to Ebola in chapter 1, I argued in chapter 2 that the Norwegian government had a dual understanding of the Ebola crisis. It saw it both as a humanitarian crisis with a terrible impact in West Africa and as a biosecurity crisis that could threaten Norway. In this third chapter, I will explore the influence of this dual understanding of the situation on the government's motivations and legitimation strategies for setting-up a response. In other words, I delve into the question: *what values and motives were put forward to justify a governmental intervention in the crisis?*

"The motivations for the Norwegian contribution were thus both humanitarian and selfish" concluded the Health Directorate in its evaluation of the Ebola treatment center project in Moyamba, Sierra Leone (Health-Directorate, 2015a, p. 50 *)[4]. Departing from this conclusion, I will first seek to understand why values such as solidarity, altruism and volunteering were mentioned to describe the government's intentions. I will argue that these concepts echoed ideals from the Norwegian identity and provided a powerful communication framework. Secondly, I will analyze what the Directorate of Health called the *"selfish"* motivations of the government. I suggest that these self-interested intentions fall into two categories: (1) to protect the national interests and ensure Norway's biosecurity by containing the disease in West Africa and (2) to ensure the government's legitimacy by managing the Norwegian public opinion in a difficult context. Finally, I will show that two sets of intentions and legitimation strategies were more contradictory than complementary, which eventually led to conflicts between the actors involved in the Moyamba ETC project.

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[4] The original word in Norwegian is "egennyttig", that can be translated by "selfish" or "self-interested"

3.1 Altruism, solidarity and Norwegian identity

I indicated in chapter 2 that the Norwegian government was particularly concerned with the humanitarian impact of the Ebola crisis (see Chapter 2, section 2.2). Reflecting this understanding of the situation, the government framed its response as a humanitarian contribution to support affected countries. The Minister of Health invoked a moral obligation to help: "*Norway and other resourceful countries **must** contribute to scaling up assistance*" (emphasis added, Børge Brende in Stortinget, 2014, p. 370 *). Humanitarianism is often depicted as a core aspect of the Norwegian (and Nordic) identity, both in the self-representation of the country's foreign policy and in the country's reputation abroad (Leira, 2007, p. 10). As recalled by J.K. Schaffer (Schaffer, 2017), many scholars identified this element in the Nordic identity, describing Nordic countries as "moral superpowers" (Dahl, 2005, p. 895) "global good Samaritans" (Brysk, 2009, p. 1), or a "good power" (De Carvalho & Sande Lie, 2015, p. 56). I will begin this section by showing that the government framed its contribution to echo this aspect of the Norwegian identity, putting forward values such as *solidarity, altruism* and *volunteering*. I will then demonstrate that this framing was instrumental in mobilizing bureaucrats and volunteers, and provided the response with a solid legitimacy.

3.1.1 Norwegian identity and the government's humanitarian intentions

In Norway, humanitarian aid has traditionally been justified on moral grounds and ethics, encompassing thus "ideas about proper and improper, right and wrong, and good and evil" (Jeffries, 2014, p. 6). It became eventually powerfully connected to the Norwegian identity. Stokke recalls that in Norway, "aid has primarily been justified by altruistic arguments" (Stokke, 1989, p. 172) and that aid's "main thrust" is nothing else than a "moral obligation" (Stokke, 1989, p. 169). He demonstrated that core values and norms of the Norwegian society were mobilized to frame aid as an altruistic policy, including the welfare state ideology (presupposing a large, powerful and interventionist state), the Christian philosophy of universal brotherhood (leading to a moral obligation to be part of international solidarity), and a strong support for human-rights arguments. It is not to say that no other motives were intertwined, but that this frame was clearly the dominant one (Stokke, 1989, p. 172). Further studies confirmed this analysis,

including those from Tvedt who coined Norwegian aid policy as the result of a "regime of goodness" or a "good doer regime". To quote him, the Norwegian humanitarian policy is "organized around and sought legitimacy from the founding dictum – it is morally correct for people who are well-off to give something of their wealth to people who have very little" (Tvedt, 2007, p. 621). In a study on the Norwegians self-image on their country's foreign policy, Leira and colleagues also argued that humanitarian aid is consensually seen in Norway as a "direct expression for moral virtue" (Leira, 2007, p. 16), associated with values such as internationalism, solidarity and economic and social equalities (Leira, 2007, p. 10). It should be noted that this general trait is likely to be reinforced in a crisis context, as altruistic motives are often the core driver of a response to an emergency setting (Fassin & Pandolfi, 2010, p. 16). Helping in an emergency derives from a moral obligation, based on our common humanity, to care for others – "to do good" (Thieren, 2007, p. 219). It includes an ideal of purity, wherein the altruistic intention of the gesture (its 'goodness') can be seen as more important than the content of the action itself (Calhoun, 2013, p. 52).

In the material collected from my fieldwork, I find that the government and bureaucrats often framed the response to Ebola as a moral obligation to help and connected it with the Norwegian identity. Asked why Norway decided to help West African countries, someone from the Health Directorate told me "*I think it's quite deep in our souls that we should try to contribute. Not to get anything back, but as a rich country, we see it as part of our culture to contribute with what we can do*" (Interview n°8). Another informant underlined the traditional involvement of Norway in humanitarian crises: "*it was considered as a humanitarian need, and we've been big on humanitarian aid for many years*" (Interview n°7). This legitimation of the response based on tradition and national identity was not surprising to a close observer of Norway's humanitarian policy: *"We [Norwegians] have this image of ourselves as being the saviors in a way - the good-doers. That's very much a narrative when it comes to Norwegian interventions abroad, especially if it's financed by aid budget"* (Interview n°13). Interestingly, to another informant from the Ministry of Health, the intention to be morally good acted both on the bureaucrats' way of thinking and as a pressure to act emanating from public opinion. He first argued that "*We [Norwegians] are in a way, either you can call it idealistic, or you could call it naive – or probably a combination*" which leads to a *"naive thinking that this could help at a sort of high level, making the*

globe better place. I think it's a way many people would think also in government institutions" (Interview n°9). However, he also noted that "*there was no political 'no' option*" for the government, that had to set up a response because "*the public in Norway and the media would demand that Norway was doing something*" (Interview n°9). The government was then fulfilling a moral duty to help on behalf of the Norwegian people by its involvement in the fight against Ebola.

Following the understanding of the situation in West Africa as a humanitarian crisis, humanitarian intentions (although not alone) played a significant role in the Norwegian government's decision to set-up an intervention. Following the conclusions from many scholars (Leira, 2007; Stokke, 1989; Tvedt, 2007), I find that ethical arguments, typically formulating a moral obligation for Norway to help, powerfully resonated with the Nordic identity and the Norwegian culture. I will show in the next part (3.1.2.) that this framing was central in the government's communication strategy that powerfully framed their messages by referring to values such as altruism and solidarity. This framing, I will demonstrate in the last part (3.1.3), was particularly successful in mobilizing volunteers, who massively adhered to the response and legitimized it as a humanitarian intervention.

3.1.2 Altruism and generosity, a powerful communication frame

In the coming paragraphs, I will analyze the government's communication around the Norwegian response's main component: the set-up of a treatment center in Moyamba, Sierra Leone, run with Norwegian health personnel. Due to the scope of this research project, I could not conduct an extensive media analysis. I focus instead on the government's press releases, reports and my interviews – a sample of material that I consider significant enough to draw reliable conclusions. I will show that the communication put forward values such as altruism and selflessness, as suggested by the title of the main press release on the project in Sierra Leone: "*Help everyone, save many*" (Health-Directorate, 2015b *). These values resonating with the Norwegian identity gave the project a strong legitimacy, particularly to some volunteers who were disappointed when they found the government had other motives for setting-up this response (see section 3.3.)

A striking feature of the communication concerned with the treatment center in Sierra Leone was the focus on personal stories from volunteers, used as a vehicle to project values of altruism and humanitarianism. The main press release on the project (Health-Directorate, 2015b) begins by describing the tasks undertaken by the Norwegian health personnel. It continues with the interviews of nine volunteers and a picture of each, providing a human face for the project to be identified with. Volunteers described their motivations to go to Sierra Leone mostly by stressing the importance to provide assistance, presented as a moral obligation to help: "*In Norway, we have a lot of resources, and I think that we have an obligation to help*" (Juni E. Dalen in Health-Directorate, 2015b *); "*I felt like the world society was not doing enough to stop the Ebola epidemic. That is the reason why it was an easy decision to make when I got the opportunity to help*" (Gavin S. Williams in Health-Directorate, 2015b *); "*Norway has so much resources and competences that we ought to help*" (Håkon A. Bolkan in Health-Directorate, 2015b *) or "*I am grateful I was given the opportunity to help*" (Inger L. Godager in Health-Directorate, 2015b *). The volunteers also described their experience in the field by detailing the patients' suffering, explaining the care they provided and recalling the lives saved. Some mentioned deaths, many talked about the safety protocols illustrated by several pictures of the volunteers at work wearing full protective equipment. This press release's strategic focus was thus mainly on the humanitarian aspects of the project, expressed through the volunteers' values of selflessness and sacrifice – echoing ideals from the Norwegian identity. It presented the volunteers as heroes, taking risks to help others in an altruistic action, whilst at the same time suggesting that these risks were mitigated by strict biosafety measures. The word "heroes" was actually used by one of my informants to describe the volunteers: "*Our thinking was that they [the volunteers] were kind of heroes, risking their lives*" (Interview n°14). The same idea transpires also from an interview from the Minister of Health: "*This work hasn't been without risk, and I'm impressed by all those who have shown such willingness to help fellow human beings in a difficult situation*" (MFA, 2015a).

Interestingly, the press release does not mention the project's organization, the partners involved, the budget allocated to it, or concrete numbers of patients admitted – it is only mentioned that "*many survive*" (Health-Directorate, 2015b *). As the center admitted 33 Ebola patients over three and half months, of which 18 died (58%) (Health-

Directorate, 2015a, p. 33), one can conclude is that the press release was "*politically written*", as confessed by a source at the Health Directorate (Interview n°8). The communication seems to have been closely monitored by the project's leadership. This transpires clearly in the Bergen Health Trust's strategic plan (available in its evaluation report), where it is stated there that they will "*media train those who shall express themselves*" and "*work on ethical guidelines and media policy for the personnel traveling, in collaboration with the Directorate of Health and the Directorate for Civil Protection*" (HelseBergen, 2015, p. 65). A volunteer confirmed that the Health Directorate was keen to control communication "*they were quite clear on how they wanted us to do thing, particularly on media-communication. They sent their own people to handle the media*" (Interview n°0). A source at the Health Directorate confirmed that the communication was highly sensitive and illustrated this by the creation of a common inter-institutional communication platform, responsible for monitoring official statements on Ebola (Interview n°1). In a discussion with a source who had an observer status on this policy, he concluded that a "*narrative*" was created to "*present development and humanitarian efforts as Norwegians being the good doers*". He argued that "*this is a story that is easy to sell! Just look at the media coverage at the time; look at all the stories about the Norwegian heroes fighting Ebola in Western Africa. That is a much easier story when it comes to engaging the public!*" The reason for this is that "*of course, these Norwegians out there, with all these protections, trying to help locals hit by Ebola, it is a spectacular story!*" (Interview n°13). The frame adopted by the Norwegian government was also adopted by the media because it was simple, spectacular and echoed the moral obligation to help – an important part of Norwegian national identity. These conclusions were supported by two informants working for the Ministry of Health: "*obviously, a personal story is much more appealing to the media than a strategic view of the Minister!*" (Interview n°7), whilst another stressed that "*having the feeling that you are contributing - I think it is important. That's what the media sold - and that's fair enough!*" (Interview n°9).

The communication around the Moyamba ETC project framed the Norwegian volunteers as "*heroes*" (Interview n°14) personifying altruism and purity in humanitarian work, as identified by Calhoun (Calhoun, 2013, p. 52). Through this framing, the project was mostly legitimized by its altruistic dimension - the state fulfilling Norway's moral duty to help. In the debate on the Ebola response, a Member

of Parliament insisted on this selfless aspect of the Norwegian humanitarian policy, qualifying it as "*the political prioritization to provide assistance based on what is actually needed in the field, without pursuing other agenda*" (Sylvi Graham in Stortinget, 2014, p. 372 *). Theoretically, I suggest that a parallel can be drawn between this framing and these intentions and those from the "globalist" interpretation of global health security, emphasizing solidarity and an ethos of care over an ethos of security (Adams et al., 2008, p. 317; G. W. Brown & Stovea, 2014, p. 304).

3.1.3 Solidarity, an attractive driver for action for volunteers

The framing of the response to the Ebola outbreak as a humanitarian intervention echoed not only a desire from many Norwegians to show solidarity towards the victims, but also *to be* part of a solidarity project. Solidarity is "a form of interaction and of intergroup relations", or more precisely "the ability to engage in cooperative activity to strive for common goals, and a sense of unity and bonding" (Jeffries, 2014, p. 6). Volunteering, providing assistance, "*having the opportunity to help*" (Inger L. Godager in Health-Directorate, 2015b *) was an important driver for action for most of the actors sent on the ground in the Moyamba ETC project. This resonates of course with the national identity, as recalled by an informant: "*I think that deeply in Norway, you will see that volunteers and volunteer actions are (...) it's valued very high*" (Interview n°8). Not only was the desire to be part of a solidarity project explicit in the personal stories examined above, but it also manifested itself by the successful recruitment of volunteers. The Minister of Health highlighted for instance in his address to Stortinget that "*The Norwegian health personnel has responded very positively to the health authorities' invitation to volunteer: more than 300 persons have manifested interest so far, many of them having extremely relevant competences*" (Børge Brende in Stortinget, 2014, p. 370 *). This enthusiasm was also underlined in the Health Trust's report, stressing the desire of many Norwegians to be actively engaged in the crisis response (HelseBergen, 2015, p. 13).

The desire to be part of a solidarity project was strongly advocated at institutional level by the Bergen Health Trust. The organization, in charge of recruiting and managing the personnel to be sent to Sierra Leone, placed "*international solidarity*" in the opportunity section of its SWOT analysis (HelseBergen, 2015, p. 62). Similarly,

the opening of its project report is very revealing of this state of mind, with the quote of two lines from a famous Norwegian poem by Arnulf Øverland "Du må ikke sove" ("Dare not to sleep"), published in 1937, and calling for action against the exactions committed by the Nazis and Fascists (HelseBergen, 2015, p. 3). Here is the verse from which the two lines are extracted, in Norwegian and in an English translation:

English (Toralfs, 2005)	Norwegian original
"You oughn't abide, sitting calm in your home	*«Du må ikke sitte trygt i ditt hjem*
Saying: Dismal it is, poor they are, and alone	*og si: Det er sørgelig, stakkars dem!*
You cannot permit it! You dare not, at all.	*Du må ikke tåle så inderlig vel*
Accepting that outrage on all else may fall!	*den urett som ikke rammer dig selv!*
I cry with the final gasps of my breath:	*Jeg roper med siste pust av min stemme:*
You dare not repose, nor stand and forget"	*Du har ikke lov til å gå der og glemme!»*

The Bergen Health Trust was thus strongly motivated to "*deliver the assistance we can, also for those situations happening far from our domestic borders*" (HelseBergen, 2015, p. 3) – something confirmed by a source working in this organization:

> "*Norway wanted to assist internationally to help a very, very critical situation in the Western African countries. So I think the project in itself, how it was explained, and how it was presented by the Norwegian Prime Minister and the Health Minister, it was excellent! I think everything was as it should be. And we're very proud of being in the project for that manner!*" (Interview n°16)

I conclude that the main component of Norway's response to Ebola – the Moyamba ETC project - was framed largely as a humanitarian project in the government's communication, resonating with the Norwegian identity and the moral obligation to help those in need. The government could show itself as fulfilling the country's moral duty; instrumental in mobilizing volunteers and providing legitimacy to the response. However, as I will now demonstrate, the government also aimed at containing the outbreak in West Africa and to ensure Norway's biosecurity (3.2). I will show in the last part that the gap between the multiplicity of motives and the communication's framing as an humanitarian project ended up creating misunderstandings and conflicts between the actors involved (3.3).

3.2 Self-interests: national biosecurity and managing public opinion

With its response, the government intended to fulfill a moral duty to help the victims from Ebola and built large parts of its communication around values of altruism and humanitarianism. This was instrumental in mobilizing volunteers and legitimized the response by appealing to the national identity. However, the government also had clear self-interests in setting-up a response. In this section, I will suggest that, after a long period of what medical anthropologist Charles Rosenberg calls "denial" (Rosenberg, 1989, p. 9), a contextual element – the repatriation of an infected health worker – led to the "recognition" of the problem and the set-up of a response (*Ibid*, p.5). The Norwegian government intended to prevent the epidemic from spreading to national territory and managed the fear of the population by appearing in control of the situation.

3.2.1 Defining Ebola as a crisis: "a progressive revelation"

The Norwegian government first defined the Ebola outbreak as a "*crisis*" in a press release from the Ministry of Foreign Affairs (MFA) published on October 10th 2014 (MFA, 2014d). The analysis of the relevant press releases of the MFA reveals that this recognition was "progressive" (Rosenberg, 1989, p. 3), before suddenly accelerating. First neutral and descriptive of the humanitarian work of MFS on the ground in April 2014 (MFA, 2014a), after which the MFA's assessment of the problem was gradually revised to describe a worsening situation. On July 31st 2014, what was happening in West Africa was seen as being of "*great concern*", but the communication was meant to be reassuring, insisting that "*the number of cases reported in Guinea is dropping*" (MFA, 2014c). In the early autumn 2014, the evaluation of the outbreak changed rapidly: on September 17th, the MFA stated "*the situation is dramatic*" (MFA, 2014f); on October 6th, the situation became "*critical*" (MFA, 2014b), and finally it concluded on October 10th that there was a "*crisis*" going on (MFA, 2014d).

After a long period of what Rosenberg calls "denial" (Rosenberg, 1989, p. 9), the early autumn 2014 constituted a turning point. The "revelation" of the crisis (Rosenberg, 1989, p. 3) was relatively late in Norway, delaying the set-up of a response.

Alarms bells were rung by the local section of the INGO Doctors without Borders (MSF) as early as April 2014 (MFA, 2014a), and the WHO declared the outbreak a "public health emergency of international concern" in August 2014 (WHO, 2014f) – two months before the Norwegian MFA used the term "crisis". What seems to have triggered Norway's "revelation" of the crisis is the announcement of an Ebola infected Norwegian citizen, on October 5th, 2014 and her spectacular repatriation to Norway on October 8th, 2014. This event coincides exactly with the beginning of a massive communication campaign by the MFA, that released three press releases in a little more than a week, on October 6th, October 10th and October 14th (MFA, 2014b, 2014d, 2014g). The term "*crisis*" was used to qualify the situation for the first time on October 10th, two days after the volunteer was admitted to Oslo's main hospital. I suggest that the return of this volunteer "imported" the Ebola crisis to Norway, making it no longer possible to ignore the ongoing crisis in West Africa. To that extent – and I will further develop this argument in section 3.3.2 – the images of the health worker's return constituted a visual securitization of the crisis (Hansen, 2011), precipitating the end of what Rosenberg called the period of "denial" and accelerating suddenly the process of a "progressive" revelation (Rosenberg, 1989, p. 3).

Norway was not the only actor to acknowledge the gravity of the crisis relatively late. One of the main lessons highlighted by the many commissions reviewing the Ebola crisis was the general slowness of the global community's response (Moon et al., 2015, p. 2206; US-Academy-of-Medicine, 2015, p. 1; WHO, 2015b, p. 7). This lesson was also shared by the Norwegian Directorate of Health, acknowledging in its report that "*the international response came too late*" (Health-Directorate, 2015a, p. 4).

3.2.2 Ensuring Norway's biosecurity: pro-active or reactive, that is the question

"*The Ministry of health and health care services has the overall responsibility for the society's security and preparedness in regards to health and health care sectors*" (Health-Directorate, 2016, p. 18). In other words, the Ministry of Health and the institutions placed under its authority – the Health Directorate and the Institute of Public Health – are responsible for ensuring Norway's biosecurity. As the Ebola outbreak came to be perceived as a biosecurity threat for Norway (see Chapter 2, 2.3), it became

the responsibility of the government (and particularly the Ministry of Health) to do something to protect Norway. This responsibility was recalled for instance by a source at the Ministry of Health "*our ministry has the key responsibility to provide for the safety health-wise, of our population*" and further insisted on the Ministry's "*obligation to work for the good health of Norwegians*" (Interview n°7).

This responsibility, of course, influenced greatly the government's motives for engaging with the crisis. Its intentions were not only altruistic and humanitarian, but also self-interested with the protection of Norway from the virus. This was clearly confirmed in many of my interviews:

> "*I think we started with the idea to try helping people affected in West Africa. But of course, there was the possibility for this to become an enormous situation, very difficult to handle. The possibility that it would spread to Europe and to the United States, of course, that did something with the government's willingness to do something. I'm sure about that!*" (Interview n°12)

Another source drew a clear parallel between the response set-up and the return of the infected doctor to Norway, highlighting the security motives behind the response:

> "*I think that if you ask people that have been involved, [...] they would have in principle a broad view, but a lot of the logic and the action is also very much to protect Norway - and even more when this [Ebola] became a risk - because when we had this sick health workers coming back, you know, it was a big thing!*" (Interview n°4)

The dual objective of helping West African people and ensuring the national biosecurity transpires clearly in a few governmental documents, for instance the first press release from the MFA: "*Norway donated NOK 4 million to Médecins Sans Frontières for treatment of Ebola victims **and** efforts to contain the disease in West Africa*" (emphasis added; MFA, 2014a *). The Health Directorate concluded in its report evaluating the Moyamba ETC project that "*the motivations for the Norwegian contribution were thus **both** humanitarian **and** selfish*" (emphasis added; Health-Directorate, 2015a, p. 50 *).

Responsible for ensuring national biosecurity, the government had two possible political choices: being *proactive* by participating in the containment of the virus in West Africa or being *reactive* by reinforcing preparedness measures in Norway. In the words of one of my informants: "*you have responsibility to protect your own civilian*

population, and in doing so, should one be proactive or reactive? You know, it's pretty standard!" (Interview n°1). The Norwegian government decided to do both, by intervening in West Africa and preparing the Norwegian health system for a potential pandemic (Health-Directorate, 2015a). However, taking action at international level was perceived as the best option by my informants. They often argued so connecting globalization with an increased vulnerability:

> "*We have for a long time argued for the need to also to look at the international dimension - because after all, a disease sees no borders [...] Actions taken in the region, in the World Health Organization, in the UN, will have implications for what actions are necessary to do at national level. That's the starting point for our thinking in such an emergency*" (Interview n°7)

> "*We just tried to stop an outbreak. Then you go down where the source is, and you work with it. This is what the CDC does all the time! [...] You have to stop it at the source, and that's what we did.*" (Interview n°15)

> "*Infections do not see borders, and I think it's a clear responsibility for national public health institutes to work internationally when it comes to infection control*" (Interview n°3).

This way of envisaging the response is far from being original worldwide. In the UK for instance, taking proactive measures abroad to ensure national biosecurity is even part of the general response plan to infectious diseases: "*The government's 'Health is global' plan states that the Government will "protect the health of the UK proactively by tackling health challenges that begin outside our borders*" (UK_Department_of_Health, 2016, p. 13).

I argue that, with its response, the Norwegian government intended to ensure national biosecurity by adopting a proactive policy and joining efforts to contain the outbreak at its source. This is a clear self-interested, foreign policy objective that did not appear in the humanitarian framing of the response.

3.2.3 Managing public opinion: everything is under control

Another self-interested objective from the government with this response was to demonstrate to the Norwegian public that it was on top of the situation and was taking the necessary measures to protect national biosecurity (including by being proactive).

As mentioned in the theoretical framework, epidemics constitute a serious challenge for the society as a whole and more particularly to state's (and the government's) legitimacy (Roalkvam & Jani, 2013, p. 115; Rosenberg, 1989, p. 2). An issue particularly difficult for the government was to manage public opinion: it needed to convince the population that the measures taken were necessary and appropriate (and thus make sure that the threat was perceived as serious) but also to avoid creating panic that would damage its credibility to manage the situation properly. In addition, it should be noted that actions at international level can back-fire to the domestic scene, for instance if a health worker sent by the government would get infected. The example of the Norwegian experience of the 2009 H1N1 pandemic constitutes a good example of how difficult it is to manage such situation. The Ministry of Health launched a massive vaccination campaign, criticized for being excessive and irrelevant. Despite intense communication, Norwegians were not convinced of the seriousness of the threat and only a few were vaccinated. However, the publication of a picture of a seriously ill teenager in a respirator led to what Hansen calls a visual securitization of the pandemic (Hansen, 2011). As a consequence, "overnight attitudes shifted from indifference to panic" (Roalkvam & Jani, 2013, p. 124). The panic created an enormous pressure on the vaccination program that became suddenly undersized. In the case of Ebola, the image of the sick doctor being repatriated in a quarantine airplane, treated by health care personnel in protective equipment made the headlines of Norwegian newspapers for several days (see Figure 6). The Health Directorate noted "*an enormous interest from the media*" and "*a colossal interest in the population*" for this case (Health-Directorate, 2015a, p. 16 *). I would argue that these images of the sick health worker's repatriation carried the same symbolic potential than the intubated teenager infected by the H1N1 flu had: it led to a visual securitization of the crisis (Hansen, 2011).

Figure 6: Repatriation of the Norwegian volunteer infected by Ebola, entering here Oslo's main hospital, 07.10.2014

The government had to carefully manage its communication in the days following the announcement of the infection of a Norwegian citizen (October 5th, 2014). It had to demonstrate that it could handle the situation of this sick worker, avoid the further spread of the virus on Norwegian soil, and reassure the population on the unlikelihood of an Ebola epidemic in Norway. This was underlined by one of my informants: "*you remember, when the MSF doctor got sick? It was critical that that doctor became well again. If she had gone really ill, or died, then I think it's really, you know, it's counterfactual history - but what would have happened if she'd died?*" (Interview n°1), but also appeared in the Health Directorate's report: "*a critical task was to lower the fear in the Norwegian public space*" (Health-Directorate, 2015a, p. 16 *). These motivations explain the Ministry of Foreign Affairs' heavy communication plan following the announcement of a volunteer's infection, including the publication of three press releases within a week (MFA, 2014b, 2014d, 2014g), and the rise of the Norwegian contribution to the international response from NOK 80 million to NOK 320 million (see also Chapter 1, 1.1). The Ministry of Health's decision to provide health personnel to a DFID-led treatment center in Sierra Leone matches this period, with the green light for the project given on October 9th, 2014 - the day following the volunteer's

repatriation (Health-Directorate, 2015a, p. 5). It seems that the government, with this hyperactive policy, did manage to avoid panic. This self-interested objective was duly noted by a critical informant from the Ministry of Health, who saw this project as being highly political and aimed at reassuring the public:

> "*All politicians would need to be seen as doing something. 'Handlekraft', it's called in Norway. [...] This was perceived as a huge threat at the time in Western Africa - and what could we not do? We couldn't sit here doing nothing, so we had to do something, and what could we do? We send out people to do something! I don't think the result even mattered. I've made the same comment as you have, and it's not a popular comment!*" (Interview n°9)

What's more, it was critical for the government to convince the population that the health workers would be safe, to justify the need to send Norwegians overseas – otherwise, the response would not have been perceived as legitimate. To highlight this point, a source took the counter-example of Sweden, where

> "*they had huge issues with fear in the population. Health personal would come home and their kids wouldn't be invited to birthday parties anymore, the teachers didn't want them in school. All these kinds of things happened, which didn't happen here. So the whole communication and the relationship you have with the population, it's very important!*" (Interview n°1).

This explains why, in the communication on the project in Sierra Leone, much focus was placed on the security measures ensuring the "*heroes*'" biosecurity (including many photos of volunteers wearing full protection equipment) (see 3.1.2.). In his address to Parliament, the Minister of Health also insisted twice on this point to justify the intervention. He first insisted on the government's efforts to ensure the volunteers' safety: "*we prepare ourselves so that the Norwegian volunteers can contribute in the safest and most secure conditions possible*", and then clearly expressed that this was critical for the project's legitimacy: "*A basic precondition for sending Norwegian health personnel as part of the response against Ebola is our ability to provide them with a safe environment and that they would have good and proper treatment if they came to be infected*" (Bent Høie in Stortinget, 2014, p. 370 *).

I argue that, with this response, the government intended to reassure its public opinion after the repatriation of the sick health worker and demonstrate that it had control over the situation – in other words, legitimize itself. To do so, it had to appear

active internationally and guarantee that this project would not expose Norway to increased biosecurity risks by another importation of the virus through an infected health worker.

I close this section with the conclusion that the Norwegian government had a dual self-interest in setting-up a response. On the one hand, it aimed at fulfilling its responsibility to ensure the biosecurity of the nation. It did so by adopting a proactive policy internationally and joining efforts to contain the outbreak in West Africa. On the other hand, it saw the biosecurity threat, especially after the repatriation of the infected health worker, as an extremely sensitive topic regarding the management of its public opinion. It had both to avoid panic and appear to be in control of the situation. These self-interested intentions, as I will demonstrate in the next section, did not match the altruistic framing of the response, which ultimately created conflict between the governmental administration and the volunteers.

3.3 Conflicting intentions and the securitization of the response

The government had several motivations and objectives for setting-up a response to the Ebola crisis. The project was meant to both provide a humanitarian contribution by participating with the international emergency response and to contain the outbreak in Sierra Leone to protect Norway. However, the ethos behind these intentions is contradictory (Thieren, 2007): one is rooted in altruism and the provision of care for those suffering; the other is rooted in self-interest and security (G. W. Brown & Stovea, 2014, p. 304; Davies, 2008). I will show in this last section that, to some stakeholders, despite the response's initial altruistic framing, the biosecurity motivations became predominant in the project's objectives. This perception created a conflict over the Moyamba treatment center's ending between the Health Directorate and the Bergen Health Trust. I will conclude by arguing that the irruption of biosecurity objectives in the conceptualization of the response would suggest at least a partial securitization of the policy.

3.3.1 Humanitarian or biosecurity response? Conflict around the response's motives

The project to set-up and run a field hospital in Sierra Leone was highly complex and involved a large number of actors and institutions (see Chapter 1, 1.4.). In this difficult context, some tensions arose between stakeholders, particularly between the Health Directorate (working on behalf of the Ministry of Health) and the Bergen Health Trust (working in close cooperation with the volunteers). Much of the dispute related to information sharing and the division of tasks and responsibilities between the two organizations. The conflict took quite large proportions, as it was exposed by the press (Bleidvin, 2016), was the object of a written question in Parliament (Grung, 2016) and was extensively discussed in the report from the Bergen Health Trust (HelseBergen, 2015, p. 6). I will not enter into too much details on this issue of task repartition, but instead expose another conflictual point relating to the ending of the project. I will show that it illustrates different intentions for engaging with the project and divergent understandings of the project's nature and objectives.

The Health Directorate and the Bergen Health Trust had diverging views on the timing of the project's ending. Whilst the government decided to terminate the Norwegian contribution in Moyamba on March 31st, 2015 (three and half months after its start), the Health Trust wanted to continue the project in a different format, but with a long-term perspective. The organization's position was detailed in its report

> "*The Bergen Health Trust alerted the Health Directorate early on that it was necessary to pursue the Norwegian contribution in Moyamba for a minimum of a year or two. This recommendation was based on solid scientific evidence, nonetheless that the infection rate could have increased again. The Health Directorate decided instead to recommend the Ministry of Health to terminate the Norwegian contribution as soon as possible, latest on March 31st, 2015. The Bergen Health Trust considers that the project should have continued for at least one to two more years, but in a much lighter format*" (HelseBergen, 2015, p. 21 *).

Earlier in its report, the Bergen Health Trust brought up other arguments to advocate the need to continue the project, including the disastrous state of the health system and the many deaths among the Sierra Leone health personnel due to the

epidemic (HelseBergen, 2015, p. 6). This position was understood by informants from the Ministry of Health and the Health Directorate as:

"They wish they could have done more, I believe. That was the issue" (Interview n°6);

"They had another purpose with the mission. They wanted to stay longer. They wanted to build a long-term relationship to the government, down there. That wasn't our mission! [...] We had two different goals: our goal was to be in and out, very quickly. And the goal of Helse Bergen was to stay there longer" (Interview n°8).

I interpret this conflict as the result of conflicting intentions and motivations for this project – or, as put by my informant, the two organizations had different purposes. On the one hand, the government aimed at both providing emergency aid and containing the outbreak in order to ensure Norway's biosecurity. It considered both these objectives fulfilled by March 2015, as the epidemic in the region - although not over at that time - appeared to be under control. The project's colossal cost, particularly because of the presence of government employees, was no longer seen as justified by the government: *"Sending out professional health care workers from the government in Norway, it's very costly, per capita – and using so much resources longer than necessary would tie up the budget in the Ministry of Foreign Affairs, making them unable to support other good projects"* (Interview n°8). On the other hand, the Bergen Health Trust, working closely with the volunteers, seemed to have been much more motivated by the humanitarian aspect of the project than its biosecurity objectives. Its desire to establish a long-term relationship on the ground and to help the health system recover from the epidemic's side effects are all signs of these altruistic intentions (HelseBergen, 2015, p. 6). To that extent, the government's refusal to prolong the project was interpreted as a betrayal of the project's altruistic objectives and created resentment. This was expressed in clear terms by an informant at the Bergen Health Trust:

"The Directorate of Health, they advised the Ministry to stop the project as fast as possible - when the threat to Norwegian citizens, for the Western part of Europe and so forth, when the threat was over, they just stopped the project immediately! I was very disappointed about that!" (Interview n°16)

Later in the interview, he expressed again his disappointment using strong words: *"When we realized how this project finished, I felt kind of shameful that the*

perspective of international solidarity and altruism was taken away from us - and I'm very disappointed about that!" (Interview n°16).

The conflict between these two different views, "*in and out*" versus "*long term relationship*" originates, I conclude, in different understandings of the project's nature and objectives. The gap between the project's framing (mostly humanitarian, altruistic) and its multiple objectives (humanitarian, biosecurity, political) seems to have confused some stakeholders and created misunderstandings, particularly as the project evolved. I will argue in the next section that this conflict illustrates more generally a securitization of the response prioritizing national self-interests.

3.3.2 The securitization of the Norwegian response

I argued throughout this chapter that the Norwegian government intended, by setting-up a response to the Ebola crisis, to both provide humanitarian assistance and to ensure the country's biosecurity – or in the words of an informant, "*it was the combination which you will see in many situations at the moment: you have an element of humanitarian aid, which is very important, but balanced with civil protection issues*" (Interview n°14). I will suggest in this last part that the "balance" between these different objectives seems to have shifted in favor of the self-interested side of the response, indicating at least a "partial securitization" of the response (McInnes & Rushton, 2011, p. 127). It should be noted that by securitization, I mean the process that led the prioritization of national biosecurity objectives. I argue that the response's securitization is mainly the result of a context - the repatriation of the infected health worker – that confirmed the seriousness of the threat (Balzacq, 2005, p. 181; 2011, p. 1; Davies et al., 2015, p. 11; McInnes & Rushton, 2011, p. 118)

I demonstrated that the Norwegian government had placed the Ebola crisis on the political agenda since the early autumn, demonstrated by a press release from September 17th qualifying the humanitarian situation as being "*dramatic*" (MFA, 2014f). The government asked the administration from the late summer 2014 to explore different options to participate with the international response and provide emergency assistance – leading to the establishment of close contacts with INGOs and the UN system (see Chapter 1). At first, the response was primarily humanitarian, aiming at helping those affected by the virus. This echoed important values deriving from the

national identity, including solidarity, global justice and a moral obligation to help those in need (Leira, 2007; Stokke, 1989; Tvedt, 2007) and corresponds to a globalist understanding of this global health security crisis (Adams et al., 2008; G. W. Brown & Stovea, 2014; Caballero-Anthony & Gayle, 2014; Davies, 2008, 2010b). However, I also argued that the narrative linking globalization with increased vulnerability to infectious diseases was widely adopted by my informants and the government – a process observed in many other countries and on the global stage over the last decade (Davies, 2008; Davies et al., 2015; Elbe, 2010; McInnes, 2014, 2016; Rushton, 2011; Weir, 2014). Following this narrative, Ebola was seen as a threat to Norway's and the world's biosecurity. To that extent, the spectacular repatriation of the infected health worker the second week of October 2014, combined with worrisome epidemiological predictions, constituted symbolic *speech acts* providing a *context* reinforcing the *credibility of the threat* and thus triggered the response's securitization (Balzacq, 2005, p. 181; 2011, p. 1; Davies et al., 2015, p. 11; McInnes & Rushton, 2011, p. 118). The *audience*, the Norwegian population, was then more likely to accept the seriousness of the threat. It is in this context, mid-October 2014 that the response began to be securitized with the priority to contain the outbreak in West Africa. The response's securitization had, I will show in Chapter 4, concrete consequences on the implementation of the response, including the mobilization of exceptional resources and the set-up of unusual measures. Paradoxically, the *securitizing actor*, the government, had to be extremely cautious in its communication and framing of the situation in order to avoid panic - something that would explain why much of the response's framing was centered around its humanitarian aspects.

I would not go as far as to argue that "*international solidarity and altruism was taken away*" from the project (Interview n°16), but suggest that this side of the project lost prominence throughout the project set-up – a shift that would indicate at least a "partial securitization" of the response (McInnes & Rushton, 2011, p. 127). This shift, noted by this source from the Bergen Health Trust, was also confirmed by other informants. A senior bureaucrat from the Health Directorate told me for instance:

> "*At least my ambition and my motivations were on the humanitarian and health response part of this. Of course, when you take the broader picture, you can see it as a civil protection response as well. But I can remember, when I went to the UK the second time I think, and someone there actually*

*said that this was basically something they did to protect the English people from getting the Ebola epidemic, I was quite shocked! I wasn't thinking - that was not my thinking when I was working with this**, at least when we started the whole operation**.*" (emphasis added, Interview n°14)

A staff member from the Directorate for Civil Protection supported this view when saying:

"*I think **we started** with the idea to try helping people affected in West Africa. But of course [...] the possibility that it would spread to Europe and to the United States, that did something with the government's willingness to do something. I'm sure about that!*" (emphasis added, Interview n°12)

The humanitarian motivations were thus downplayed by biosecurity concerns for the national territory that introduced a self-interested dimension to the response's *raison d'être*. This process was resisted by some, for instance the Bergen Health Trust that expressed clearly its disappointment.

To conclude this chapter, I suggest that the government response intended to pursue several objectives at the same time: providing humanitarian aid; ensuring Norway's biosecurity and protecting the Norwegian population; and appearing in control of the situation. However, these multiple objectives did not match the response's framing, mostly presenting the Norwegian contribution as a humanitarian, altruistic response. This created disappointment and resentment from some volunteers from the Bergen Health Trust, who felt that the altruistic dimension of the project disappeared in its implementation. I suggested that the government's intentions seemed to have been at least partially securitized due to the reinforcement of biosecurity concerns – both through worrisome epidemiological prediction and the repatriation of a sick volunteer. This securitization of the government's intentions, I will show in Chapter 4, had concrete consequences, including the availability of exceptional resources, the possibility to take extraordinary measures (such as experimenting with *adhoc* projects) and an unusual focus on security issues on the ground.

4   Implementation of a securitized humanitarian response

I suggested in the last chapter that the Norwegian response to Ebola was at least partially securitized when biosecurity concerns were introduced to the project's rationale. This, I argued, modified the values behind the government's involvement by justifying the pursuit of national self-interests: containing the outbreak to protect Norway (Davies, 2010b, p. 1177; McInnes, 2016, p. 391; Rushton, 2011, p. 779; Singer, 2002, p. 158). This securitization of the government's intentions had consequences on the response's implementation, the issue being elevated "beyond the established rules" and "above politics" (Buzan et al., 1998, p. 23). Scholars have pointed out that securitization can lead to the legitimation of measures never taken before, therefore extraordinary (outside the ordinary procedures) (Fourie, 2014, p. 110; Nunes, 2015, p. 60), a process that can lead to the militarization of the issue (Elbe, 2006). Many also observed an increased availability of resources for securitized issues (Davies, 2010a, p. 19; Enemark, 2007, p. 20; Fourie, 2014, p. 111; Heymann quoted in Horton, 2017; Lakoff & Collier, 2008, p. 18; McInnes, 2014). I will explore throughout this fourth chapter the implementation of the Norwegian response to Ebola and show that it presented unusual characteristics in comparison to other emergency responses. I argue that these exceptional features were made possible by the securitization of this policy.

4.1 Implementation in urgency: the availability of resources

The first striking feature in the Norwegian government's response to Ebola is its magnitude in financial terms. Altogether, Norway dedicated over NOK 500 million to finance the fight against Ebola (MFA, 2015a), a remarkable amount compared to its other contributions to other significant humanitarian crises. Over the last decade, Norway's most significant emergency responses seem to have been to Nepal (2015) and Haiti (2010), in reaction to the disastrous earthquakes that hit these countries. The Ministry of Foreign Affairs donated NOK 230 million to Nepal (MFA, 2015b) and NOK 200 million to Haiti (NORAD, 2010, p. 3). Both these contributions represent less than half of the amount pledged for the Ebola crisis. I will show in the first part of this

chapter that a lot of money was made available in a context of urgency, a securitization context that provided political arguments to legitimize the mobilization of large resources. Table 1 below presents a summary of the financial contribution announced by the Norwegian Ministry of Foreign Affairs throughout the crisis in the eight press releases published on Ebola.

Table 1: Financial contribution to fight Ebola announced by the MFA in its press releases

	3. April 2014	31. July 2014	17. September 2014	6. October 2014	10. October 2014	14. October 2014	5. December 2014	26. March 2015
Additional contribution announced (million NOK)	4	15	58.7	106.3	70	75	*	*
Total amount pledged (million NOK)	**4**	**19**	**77.7**	**184**	**254**	**329**	**334**	**500**

* The press release from December 5th details the plans for the vaccination trial project. The last press release of March 2015 summarizes broadly the main financial contributions made to fight Ebola.

4.1.1 A temporality of urgency – "crisis mode"

Before analyzing the allocation of the response's budget, I would like to first recall the context in which the decision to set-up a response was made. This context was characterized by a temporality of urgency at the political level; a "crisis mode" that affected the operationalization of the response by the administration.

I showed in chapter 3 that the Norwegian government partially securitized its motivations for responding to the Ebola crisis when a volunteer was infected and repatriated to Norway. Following this event, the government led an intensive communication campaign, publishing three press releases in a week (MFA, 2014b, 2014d, 2014g) – as much as was published in the seven months preceding the volunteer's infection (see table 1). This urgent communication corresponds with the time in which more than half of the total response's funding was allocated. The Norwegian pledges to the international response raised from NOK 80 million to NOK

320 million, an increase of NOK 250 million in a week (see table 1). In addition, the government mentioned several times the urgency to operationalize the Norwegian response. The opening of the Minister of Health's address to Parliament, quoting the infected volunteer's first words after her discharge, is striking: "*The clock is ticking; the amount of deaths is rising. We have to act now*". (Bent Høie in Stortinget, 2014, p. 370 *). Similarly, the Minister of Foreign Affairs recalled "*we have no time to lose*" for launching the vaccination trial project, qualified in the same press release as being a "*fast-track trial*" (MFA, 2014e).

Quite naturally, this urgency affected the climate in which the bureaucrats were working to set-up the response. When asked about their experience during the set-up of the response, they constantly referred to it as a stressful period with a lot of pressure. Many of my informants qualified the set-up of the response as "*a question of urgency*" (Interview n°11), recalling that "*there was an urgency among funders, including here, in Norway*" (Interview n°3) or that "*clearly, the experience of an emergency situation was very much dominating here*" (Interview n°7). This context had consequences on their work, as it was described "*a race against time*" (Interview n°10), leading to "*a lot of pressure*" as "*people are under a lot of stress*" (Interview n°2). Talking about the complexity of the Moyamba ETC project and the many coordination meetings necessary to achieve rapid results, a senior bureaucrat from the Ministry of Health concluded that it was "*quite some pressure*" (Interview n°6). And indeed, it is important to recall that the administration had only a few weeks to operationalize the two projects that the Norwegian government was going to implement – the vaccination trial and the field hospital in Sierra Leone – two unprecedented projects with a highly complex organizational structure. A source at the Public Health Institute recalled that the vaccination project was financed and set-up in less than five months, when "*usually, you plan this for two years in advance!*" (Interview n°2).

The context in which the Ebola response was operationalized was thus dominated by a temporality of urgency. I interpret this as a sign of the securitization of this policy, as the response's set-up corresponds with the repatriation of the sick health worker and the importation of the virus on national territory. As I will now try to demonstrate, this urgency to implement projects as fast as possible led to a highly political and flexible allocation of resources.

4.1.2 An exceptional availability of resources

A striking feature of the Norwegian response to Ebola is its exceptional size, as it was more than two times bigger than the two largest humanitarian emergency operations from the last decade, after the earthquakes in Haiti (2010) and in Nepal (2015) (MFA, 2015b; NORAD, 2010, p. 3). A source at the Directorate for Civil Protection – the institution managing Norway's contribution to humanitarian emergencies – confirmed the exceptional nature of this response: "*I think that the Ebola operation was of course much more expensive than any other operation that we have ever been a part in*" (Interview n°12). This exceptional financial effort indicates, I argue, a securitization of the humanitarian response. It was noted by many scholars that securitizing an issue leads to an increased availability of resources (Davies, 2010a, p. 19; Enemark, 2007, p. 20; Fourie, 2014, p. 111; Heymann quoted in Horton, 2017; Lakoff & Collier, 2008, p. 18; McInnes, 2014). Several of my informants acknowledged, directly or indirectly, that presenting the Ebola crisis as a biosecurity threat was a tactical argument in order to mobilize more resources than for a regular emergency response. A source at the Ministry of Health was very direct in this regard: "*preparedness and defense, it's easy to get money for, because people fear that something might happen if you don't spend money on it*". To him, the advantage of using the fear raised by the context of the repatriation of the health worker is very clear, as "*you get more money, you get more attention, and you get political support*". He concluded, "*if you can scare people and say that you'll get Ebola if you're not giving me 100 million kroner to develop a vaccine - of course you get 100 million kroner!*" (Interview n°9). He was not the only person I talked to that mentioned the potential of security arguments to mobilize more resources:

> "*This thing of 'my security' has a lot to do with getting a public opinion that is ready to act, you know. Because it is much harder to say 'we, in Norway, have a good health system, but we need to be in solidarity with them, because that's good for all, and it's part of right to health'. Yes that's true, but how do we do it, you know? It's much easier to say 'Ebola, we need to act! Here is the need to do this, and we need to protect ourselves!' So, it is a sort of a political argument.*" (Interview n°4).

Talking more generally, another source declared "*I see health security as a potential additional political leverage to get more support: more financial support, more*

technical support, more collaborative efforts on global health" (Interview n°3), whereas an observer from the Norwegian development policy noted that this way of using security arguments to get more support has been used as a political strategy by the current government: "*since the blue-blue government came in power [in 2013], it [security] became much more a way of branding aid initiatives*". To him, the use of such an argument in the context of Ebola was not surprising: "*it was such an urgency; and often, when you have this huge urgency, then money is available, they take action*" (Interview n°13). Interestingly, to these informants, the humanitarian character of the response was not altered by this framing, interpreted as only a strategic argument to mobilize the population: *"I think the humanitarian argument, the development assistance thinking, the Christian humanitarian approach has been much more important - that's my personal view - than a global health security agenda from a Norwegian perspective"* (Interview n°9). The securitization of the response was then thought more as a tactical move to increase the scope of the response than a real change of nature to many of my informants. Nevertheless, it is striking to note how the insertion of national interests in the response's objectives was instrumental in legitimizing an exceptionally expensive response.

4.1.3 An allocation of resources politically driven

The Norwegian response to Ebola, amounting to a total of NOK 500 million, was channeled through many different organizations, particularly the WHO (25% of the total amount), and the World Bank (14%) (see Chapter 1). I showed in the introduction the government supported many INGOs and other agencies of the UN system, for instance the World Food Program and UNOCHA. However, I also mentioned that the allocation of a substantial part of the total funding (approximately ¼) was not detailed by the Ministry of Foreign Affairs. Based on the information I have, it seems that the government decided to support many different projects and organizations. Such a dispersal of the funding available can be understood, I suggest, when contextualized in the temporality of urgency during which the response was operationalized. I showed indeed that most of the pledges to the international response were made in a few weeks, leaving virtually no time for the administration to identify the best projects and realize cost-benefit analyses. The context of urgency and the securitization of the response led the government to make political decisions to support the project, as suggested by an

informant: "*I mean, funding defense, it's very difficult to do cost-benefit analysis of that! [...] It's just political! You decide: this is the thing to do, and you do it!*" (Interview n°9). Another consequence of this context is that the government chose to support initiatives fitting its historically strong commitment to address health issues and emergencies through the multilateral UN system, via public-private partnerships and among other things, vaccines (De Carvalho & Neumann, 2015; Storeng, 2014). This appears very clearly with the large donations to the WHO, the World Bank, the World Food Program and UNOCHA, as well as the decision to test a vaccine in an organizational form close to a public-private initiative (see also Chapter 5). Highlighting the bricolage made from these traditional policies, an informant told me, when asked why the government supported the WHO so strongly even though it was heavily criticized, "*we are very close to the WHO historically, and also emotionally [...] There are some connections there, also for why we use so much resources [to support the WHO]*" (Interview n°14). Moreover, given the massive amount of resources made available, the Ministry of Foreign Affairs benefited from a certain liberty in the allocation of the resources, as illustrated by the large amount of money allocated without being publicly detailed. The securitization of the response allowed for a certain flexibility in the allocation of resources.

The vaccine trial project in Guinea is illustrative in many ways of this flexibility offered by the securitization of the response. The project was seen as "*an exceptional case*" by an informant at the Research Council (Interview n°11). He explained that the approval by the GLOBVAC program's board was made in a rather unusual way: "*it was not a normal procedure, it was more a dialogue with the Ministry of Foreign Affairs*" (Interview n°11), which allowed the project to obtain funding "*in a flexible way*" (Interview n°5). Normally, the GLOBVAC program issues a funding announcement, to which everyone affiliated to a Norwegian institution can apply to and compete for in an transparent process (Research-Council, 2017). In the case of the Ebola vaccine, given the fact that the trial had to happen extremely fast (before the epidemic was over), no open call for proposal was issued: the project led by John Arne Røttingen and the Institute of Public Health was presented spontaneously, without competition. According to my informants, this unusual procedure was accepted by the Research Council on two conditions: first that the Ministry of Foreign Affairs would officially send earmarks to finance this project; second, that the GLOBVAC's board could assess the scientific

credibility of the project before approving it (Interview n ° 5; Interview n ° 11). This way of proceeding created a clear unease among my informants who struggled to legitimize it. A source at the Research Council reminded me in theory, "*the Research Council is an agency under the Ministry of Education and Research - and it's only the Ministry of Education and Research which can give instructions to our board*". However, in practice, "*other Ministries can say to us: 'you get this money, and you should use them to meet these objectives' […] [with] many strings attached to it*", as it happened in the case of the Ebola vaccine. In this case, the Research Council's position was experienced as quite uncomfortable: "*we can always say: 'no, we won't do that'. But we know that if we do that, then the money will take the same way without our help, and then we know that this will be of poor quality*" (Interview n°11). In the words of another informant, "*it's likely to think that this project would have been eventually funded anyway*" (Interview n°5). The GLOBVAC board could thus only give a yes or no answer to a project "*considered as high risk*" (Interview n°5), based on its scientific credibility, and taking into account the "*pressure*" from the Ministry of Foreign Affairs (Interview n°10).

I suggest that this flexibility from the Research Council was made possible by a combination of three factors. The first is what seems to be a structural weakness of the Research Council vis-à-vis the Ministry of Foreign Affairs that has a certain degree of control over the Council's funding – despite its formal independence. The second factor is the securitization context of the response that allowed for the mobilization of exceptional resources in an urgent way: "*We of course wanted to be part of a solution to a very urgent problem*" (Interview n°11) said one of my informants, whilst another recalled that the situation "*was quite unique*" (Interview n°5). It should also be noted that from a biosecurity point of view, if successful, this project would provide a tool (a vaccine) to ensure Norway's biosecurity against the epidemic. Finally, the third factor was the influence of a central actor of this project, Tore Godal. I demonstrated in the first chapter (see section 1.3.3) that he played a central role in the set-up of the project. His exceptional influence in the Norwegian global health policy, illustrated by a laudatory tribute from NORAD for his 75th birthday, published only a few months before this project (NORAD, 2014), certainly played a critical role in ensuring the Ministry of Foreign Affairs' strong commitment to this project. This support translated with the earmarks sent to the Research Council asking it to finance this project in an

unusual way. Personal connections in a rather small epistemic community also contributed to create links between institutions – a network instrumental in mobilizing funding and support from different organizations. Tore Godal, advisor at the Ministry of Foreign Affairs, was described as being "*good friend [of] Peter Smith*" (Interview n°10), the current chair of the GLOBVAC board and former governor of the Wellcome Trust – two important funders of the vaccination trial.

The example of the vaccination trial project's funding illustrates a political and flexible funding of the Ebola response. The securitization of the issue provided the government clear flexibility in the allocation of resources. This flexibility could be seized as a window of opportunity by some influential bureaucrats to lead projects without the full weight of normal bureaucratic constraints. It also shows that the administration operationalized its response largely based on what Norway traditionally does in global health: the support of the UN system and the development of vaccines via public-private partnerships (see also Chapter 5).

4.2 Extraordinary measures: a humanitarian response securitized

In this second part of this chapter, I will show that in many ways, the measures taken in the context of Norway's response to Ebola fell outside normal politics, or, to quote the Copenhagen School, went "beyond the established rules" (Buzan et al., 1998, p. 23). The government's choice to lead projects never realized before as well as the professionalization of the response and the resulting focus on strict security protocols are all signs, I argue, of the response's securitization. I will also discuss the gap between the Moyamba project's costs and its results and finally, conclude by an analysis of the role of the military in the Norwegian response.

4.2.1 Securitization and *adhoc*, innovative projects

I argued in the first part of this chapter that the securitization of the response and the resulting focus on national interests opened a window of opportunity for the government to mobilize exceptional financial resources to address the crisis. Another effect of this securitization was the possibility to take extraordinary measures, by

setting-up *adhoc* and innovative projects (Fourie, 2014, p. 110; Kamradt-Scott & McInnes, 2012, p. 95; Nunes, 2015, p. 60). I will hereafter show that the two projects directly led by the Norwegian bureaucracy were original, *adhoc* projects envisaged as tests to develop new response models for epidemics.

First, it should be said that both the vaccination trial in Guinea and the field hospital in Moyamba included innovative features. The originality of the treatment center project is particularly striking, as it is the first time that the Ministry of Health sent health personnel from the public sector abroad to fight an epidemic – a deployment that required volunteers to take a special course in England beforehand to learn biosafety protocols (Health-Directorate, 2015a, p. 32). The Institute of Public Health regularly had experts on the ground, but their mission was not to provide health care as was the case in the treatment center (Interview n°14). This lack of precedent had concrete consequences on the implementation of the project. For instance, the organizational setting resulted from a circumstantial coalition between Norway, the UK and several NGOs (see chapter 1), everything had to be negotiated from scratch with the British authorities and agreed upon in a Memorandum of Understanding - a process that took a lot of time and resources (Health-Directorate, 2015a, pp. 30-31). Furthermore, the project was located in a part of the world Norway did not have close ties with, as illustrated by these statistics from the aid budget: in 2013, Norway did not provide any development assistance to Guinea and only NOK 14.4 million to Sierra Leone (NORAD, 2017). A source at the Health Directorate summarized the uniqueness of the response as such:

> "*you had a contagious disease, you had West-African countries we didn't know well, we were thinking of sending health personnel, equipment, all these kinds of things and working with another country. It's not something that states do – not normally!*" (Interview n°1).

Also symptomatic of the project's exceptionality, an informant from the Civil Protection Agency pointed out the unusual decision making process that led to validate Norway's involvement in Sierra Leone:

> "*It was the first time we had the decision taken at the highest level in Norway. Normally, when we have a request from the UN, I decide on my level, or my deputy director - that's the level where it's decided whether we are going to do the support or not. But in this special - in the Ebola situation,*

we took it to the top, to the Ministry of Justice, just to be sure that they knew the threat, they knew what could be the consequences, what do we need if we should do this in a secure way" (Interview n°12)

The vaccination trial led in Guinea was also remarkable in at least two of its features: the research design and the organizational set-up. The study was built around an innovative methodology, 'the ring vaccination', consisting in vaccinating clusters of people who had been in contact with an infected patient and without the use a placebo control group (Henao-Restrepo et al., 2015). This way of vaccinating was used in the smallpox eradication campaign, but never as a research study design. In addition, the project was built around an *adhoc* coalition under the sponsorship of WHO; a public-private partnership involving governments, an international organization, a philanthropic organization, an INGO, research institutes and universities.

"*I think that sort of urgency was present also in many other countries, in the sense that authorities also wanted to contribute by finding adhoc ways and doing things more quickly*" (Interview n°3) said an informant working on the vaccination project. I suggest that the securitization of the response, a result of biosecurity concerns and a sense of urgency, provided a window of opportunity for authorities to implement innovative projects and exceptional measures. Scholars, following securitization theory's argument (Balzacq, 2005, p. 181; Balzacq & Guzzini, 2015, p. 100; Buzan et al., 1998, p. 23; Vuori, 2008, p. 88), have documented similar patterns in other securitized health issues, for instance in the case of pandemic influenza (Abraham, 2011, p. 800; Kamradt-Scott & McInnes, 2012; Kittelsen, 2013, p. 252) or the HIV/AIDS pandemic (Elbe, 2006; Fourie, 2014; Ingram, 2013, p. 100; McInnes & Rushton, 2010, p. 244; 2011). A source at the Institute of Public Health told me that with the vaccination trial, they "*wanted to do more of an effectiveness study, more pragmatic study, trying to demonstrate how you would use a vaccine in the case of an outbreak, and test the effectiveness of that in a response*" (Interview n°3). Roemer-Mahler and Elbe argued in their analysis of the Ebola crisis that securitization "creates an exceptional political space in which pharmaceutical development can be freed from constraints" (Roemer-Mahler & Elbe, 2016, p. 376) – a political space that seems to have been used in Norway as a window of opportunity to test novel approaches to handle global health security crises. This was also confirmed by an informant working on the project in Sierra Leone, who told me:

"it was a project with a very high political profile: it was a major goal to see if this way of organizing international aid by recruiting health care personnel [from] the public health services [...], if that could improve the quality of the aid provided" (Interview n°16)

Both projects illustrate Norway's search for *adhoc*, innovative solutions to cope with a crisis perceived and framed as having the potential to impact the country's biosecurity.

4.2.2 The professionalization of the response

At the peak of the response's securitization in the beginning of October 2014, the Norwegian government realized that the response through the NGOs would not be enough, even if *"the usual way Norway usually respond in times of crises, is actually through the NGO system"* (Interview n°14). It had the potential to become problematic, as illustrated by the infection of a health worker from MSF that "imported" the biosecurity threat to Norway. In order to contain the outbreak in West Africa safely, the response had to be professionalized and scaled up, and this could only be achieved by the mobilization of resources from the public sector with strict security regulations. This assessment was declared by the Ministry of Health, who said that "*so far, organizations like MSF and the Red Cross have done a great job, but it is not enough*" (Bent Høie in Stortinget, 2014, p. 370 *), furthered when he recalled several times the importance of ensuring volunteers' safety in Sierra Leone (see Chapter 3, 3.2.). In the operationalization of the response, the mobilization of health workers from the public sector via the Bergen Health Trust can be interpreted as a sign of the professionalization of the response – some INGOs seen as lacking competences in epidemic management (HelseBergen, 2015, p. 24). A practical consequence of the state's direct involvement and the resulting professionalization of the response is an unusual focus on security measures of the ground: "*security is always the key, especially if you send someone from the national government*" recalled one of my informants (Interview n°15). Security measures concerned both biosafety protocols to prevent the spread of Ebola or other diseases as well as the physical security of the volunteers on the ground, in a context in which some health workers had been attacked (HelseBergen, 2015, p. 18)

Biosafety measures were taken both within the treatment center's red zone, but also to isolate the base camp from the surrounding environment. "*We did a lot of adjustments to the camp to be able to handle the biological threat if we can call it that,*

*Ebol*a" explained a source at the Civil Protection Agency (Interview n°12). "*To avoid getting Ebola into the camp, we wanted to have quite strict preventers: it was inside and outside - clean and infected zone*" uttered an informant from the Health Directorate (Interview n°8). Concretely, these measures translated in the interdiction for the volunteers to get out of the base camp or the ETC. "*In fact, they were locked in the camp for 6 weeks, it's like prison almost!*" said an informant (Interview n°12). Whilst "*normally, when you go out for a mission, you work very closely with the locals*", this time, "*we didn't want to work too close with the locals*" (Interview n°8). The reason was biosafety protocols: "*because of the Ebola situation, we didn't want to have locals working and living in our camp, because they will move back and forth to their families in the weekend and that kind of things*" (Interview n°12). All the personnel needed to run the base camp had thus to be sent from Norway or partner countries via the International Humanitarian Partnership, which of course considerably increased the project's budget. Also, some equipment had to be purchased specifically for this project to deal with the biosecurity threat, including toilets with ultra violet light that "*will clean all the room because of the intensity of the radiations*" and that "*were bought from the military and [...] were very expensive!*" (Interview n°12).

Quite rapidly, biosafety became the central issue of a conflict between the Bergen Health Trust and one of the partner INGOs, Medicos del Mundo (MdM), in charge of the treatment center. The INGO was considered by the Norwegian Health Trust as "*lacking competences*" and being understaffed, which could have put everyone in danger (HelseBergen, 2015, p. 24). The situation became critical a couple of weeks before the opening of the treatment center, as the Health Trust threatened to demobilize the volunteers and cancel the whole project in a letter addressed to the Directorate of Health (HelseBergen, 2015, pp. 23; 97-98). An emergency meeting was convened in Madrid in late November 2014. It resulted in an increased amount of responsibilities for the Norwegians, described by the Health Trust in its report: "*Norwegian health personnel got the responsibility to take care of the Ebola patients in the red zone inside the ETC. This was not a responsibility that was agreed upon in the MoU, but this arrangement was the best for the ETC Moyamba, both professional-wise and for organizational aspects*" (HelseBergen, 2015, p. 5). The NGO's competence and professionalism were severely assessed by an informant from the Bergen Health Trust: "*I do not want to make problems for the NGOs, but in very many situations, they are*

given tasks that they are totally incompetent of fulfilling" (Interview n°16). This contrast between the NGOs and the highly professionalized public health care response is, I suggest, symptomatic of the response's securitization.

Additionally, some military measures were taken to ensure the Norwegians' and international volunteers' security. Asked what was the main difference between the base camp in Moyamba with what is usually put in place, an informant listed: "*the security measures, the fences, the guards, the isolation units*" (Interview n°12). The camp was qualified by the same source as being "*like [a] prison*" and was being watched by "*all-day-round guards*" as reported by the Health Trust (HelseBergen, 2015, p. 19). Curious about the presence of these guards, I learnt in a follow up question that they "*were locally hired*", from "*a local security company*" (Interview n°12). Similarly, security was a crucial concern in the vaccination trial project, as it is well known that such biomedical measures can create a lot of resistance, particularly in a society in crisis (Roalkvam, McNeill, & Blume, 2013, p. 5). An informant from the Norwegian Institute of Public Health depicted the situation as such:

> "*Early 2015, there were a lot of resistances in the Guinean society. Some aid workers and some health care workers were attacked. I think some health care workers' cars were set fire to. So it was extremely volatile, and we were very afraid that this would make the trial impossible to carry out.*" (Interview n°2)

He continued by describing the measures taken to address these security risks:

> "*we worked very closely with social anthropologists, and set-up a very thorough community engagement plan which was followed very thoroughly. We recruited and trained only local staff, several hundred Guineans, not to bring in any white faces. We didn't want any white faces on the ground. We didn't want white aid workers because we thought this could put the trail in peril possibly*" (Interview n°2)

The Norwegian state placed a strong focus on security for the two projects it was directly involved in. These measures, whether aiming to ensure the volunteers' biosafety or their security, are the sign of the professionalization of the response. The Ebola crisis was perceived as being both too large and too dangerous to let the INGOs deal with it alone. I argue that this perception and the resulting professionalization is one of the signs of the response's securitization. This focus on the security measures on

the ground have had, as I will now show, a significant impact on the costs needed to finance the Moyamba ETC project.

4.2.3 Project's cost versus results for the treatment center in Moyamba

"*The Health Directorate considers that it was not much room of maneuver to lower the costs while, at the same time, guarantee the personnel's safety and fulfill its obligations as employer*" concluded the Directorate of Health in its evaluation of the Moyamba ETC project, costing altogether NOK109 million (Health-Directorate, 2015a, p. 50 *). Indeed, providing all the security measures described in the precedent section and the professionalization of the response with health workers from the public sector, it does not seem like this project could have been much cheaper. The state had to pay the volunteers' basic salary, which was significantly higher than that for INGO personnel – MSF Norway offering 'only' NOK 10 604 per month to its field workers (MSF, 2017). In addition, the Ministry of Health agreed to grant significant financial compensation of NOK 3000 per day to health care workers for the risks taken (HelseBergen, 2015, p. 15). As mentioned above, Norway also had to send more agents than usual to run the base camp to keep it isolated from the surroundings. In addition, the security measures – both in terms of biosafety and in terms of security – were extremely costly. The securitization of this project resulted in making it exceptionally costly in comparison to other interventions, because of the unusual costs of the human resources deployed and the security measures – seen as uncompressible. "*I think the government accepts that, sometimes, it gets expensive*" concluded an informant highlighting the necessity of the additional costs (Interview n°12), whilst another source criticized the project for being "*heavy handed*" (Interview n°9).

In comparing these costs with the results obtained over three and half months – the admission of 92 patients, of which 33 were diagnosed with Ebola and 18 died (Health-Directorate, 2015a, p. 33) – the words of the the Directorate of Health are significant, the "*project was extremely expensive, if measured per treated patients*" (Health-Directorate, 2015a, p. 50). The Directorate's attempt to legitimize this is however more disputable: "*since the number of patients was unpredictable, it makes more sense to interpret the Norwegian efforts as a contribution to a cost-effective*

establishment and running of treatment capacity". It is unquestionable that the government could not predict the epidemiological situation and that in order to ensure the highest levels of security for its personnel, options were extremely limited. However, a source at the Ministry of Health concluded that a governmental response would always be too "*heavy handed*":

> "*The main strategic problem was that, as seen after these teams were built up and the infrastructure was made, it was a too heavy-handed strategy. Mobile teams would have been of course much better. But then, for security reasons on the individuals, it was not possible to have official Norwegian mobile teams – it would have cost a fortune! You can only use NGOs I think, that are really in the field, with people willing to take larger personal risks and be much more flexible. All the official requirement for security, water, hygiene, food, this and that, of course, it's like sending a big battle ship alone into the ocean: you need the small cruisers and destroyers to run around and do the main job!*" (Interview n°9).

To conclude, I argue that the securitization of the response led to a professionalization of Norway's projects through the direct involvement of the state. This led to a considerable increase in the security requirements, and in the case of the Moyamba treatment center, the implementation of a "*heavy handed*" project (Interview n°9). It certainly contributed to ensuring the volunteers' safety, as none were infected with Ebola, but it also diminished the effectiveness of the response, simultaneously exploding its cost. I conclude that a securitized state-led intervention is likely to always be very costly, as it is politically impossible for a government to lower the safety standards and risk having personnel in the field infected.

4.2.4 The military's involvement: a humanitarian intervention securitized

To finish this chapter exploring the implementation of the response, I will discuss the role of the military in the Norwegian response. I will show that the army was requested to contribute to the project in Sierra Leone by providing extensive indirect support. It did not however have any leadership responsibility. This means, I suggest, that the humanitarian response was partially securitized, but did not become a security/military operation.

The Norwegian military was asked to support the project in Sierra Leone by providing solutions for medical evacuation and the transport of material. A military aircraft transported more than ninety tons of material from the Civil Protection Agency to set-up the base camp. The UK also used it, and did twenty-two trips to Sierra Leone to transport British material (Health-Directorate, 2015a, p. 6; 39). Furthermore, the Norwegian contribution was inscribed in the project coordinated by DFID, which used extensive military resources for the logistics. "*All the logistical infrastructure was taken care of by the UK military, on DFID diem basically. DFID paid for it*" summarized an informant (Interview n°1). The British armed forces were also used to help coordinate the public health response in Sierra Leone and to train the health workers in the UK before they were sent to the field (HelseBergen, 2015, p. 16). The same informant considered that the military structure was a great asset in such a setting: *the army is very good at doing this kind of things, like "we have 3 people sick here", "we have a body here", that organizational skill, I mean, they are very good at doing that. That was really helpful!"* (Interview n°1). Another of my informants added that the large presence of the UK military in the country made the whole operation more secure:

> "*They [the UK] have a strong military relationship, so they know what's going on in Sierra Leone. [...] It also made it more secure for us, because then we have the network, and also the security from the British armed forces - because they were quite heavily involved in Sierra Leone*" (Interview n°8)

The international text of reference when it comes to the use of the military in an emergency setting is the UN Office for the Coordination of Humanitarian Affairs (UNOCHA) *Oslo Guidelines*, developed in 1994 and revised in 2007. This document aims at regulating the conditions in which the military forces can be used in an emergency context, particularly for the multilateral response organized under the UN umbrella. Below are three extracts from the *Oslo Guidelines'* standards regulating the use of military (UNOCHA, 2007, p. 14):

> (1) "*Military and Civil Defense Assets should be employed by UN humanitarian agencies as a last resort, i.e. only in the absence of any other available civilian alternative to support urgent humanitarian needs in the time required*"
> (2) "*A UN humanitarian operation using military assets must retain its civilian nature and character.*"

(3) *"Insofar as military organizations have a role to play in supporting humanitarian work, it should, to the extent possible, not encompass direct assistance"*

The description of the involvement of the Norwegian and British military seems to fit at least the second and third elements. DFID for the UK and the Directorate of Health for Norway were indeed leading the humanitarian response and the support provided by the military was very much indirect, to the extent that it did not provide aid directly to the population but rather took care of the logistics. The point stating that the use of the military should come as "*last resort*" is however more questionable in the case of the Ebola crisis. This is the object of heated debate, too vast to go into details for the scope of this thesis (see for instance: Barry & Jefferys, 2002; S. Brown & Grävingholt, 2015; Fassin & Pandolfi, 2010; Gourlay, 2000; Winslow, 2002). I will simply argue that in order to consider the situation as a "last resort", the securitized understanding of the crisis legitimizing these extraordinary measures must be acknowledged. The securitization provided a certain flexibility for the Norwegian administration to use military assets, room to maneuver that was used for practical purposes: "*in principle, the military is always last resort, but there are a lot of good reasons to use them anyway*" said an informant from the Civil Protection Agency (Interview n°15).

It should be noted however that many of my informants were clear on the fact that the military should not have been in charge of the response, as was the case with the American response. The US deployed indeed up to 2800 soldiers in Liberia to contribute to the efforts to contain the outbreak (Giahyue, 2015). Such a direct mixing of the humanitarian response with military personnel was troublesome for the bureaucrats I talked to, and many argued that this played a crucial role in the government's decision to cooperate with the UK rather than the US: "*our tradition fits better with the UK than the US. They are more military-based operations. So it's easier for us to connect to the UK*" an informant from the Directorate of Health explained (Interview n°8), whilst someone from the Ministry of Health recalled that working with the US is not simple because "*their system approach is different*" (Interview n°7). The same argument concerning this feeling of unease towards the US militaristic approach was developed more extensively by another interviewee who highlighted the ethical issues:

"My personal view is that it would have been much, much harder to do this together with the Americans. Not that we couldn't, but that the practical issues of it would have been more complex. [...] Remember the military factor of the American response, which is always complicated when you deal with health personal. Mixing health personal and military is complicated! [...] Working with army functionality is difficult for ethics, and policies, and all these kinds of things" (Interview n°1)

The use of the military as the main component of the Norwegian response to Ebola is quite unusual in an emergency context, and was made possible by the securitization of the response. It should however be noted that it was considered crucial; that the use of military assets should remain limited to the provision of indirect support, following the *Oslo Guidelines*. The American response to Ebola appeared much more like a security operation and was seen as incompatible with the Norwegian way of dealing with emergencies, and highlights the fact that the Norwegian response was not fully securitized, but remained in nature a humanitarian operation.

This chapter explored the implementation of the Norwegian response to Ebola and demonstrated that an exceptional amount of resources was dedicated to the response and that unusual measures were taken. I argued that these developments were made possible by the securitization of the response which provided the government with more flexibility to implement the response. The same process, I recalled, has been found by scholars in other securitized contexts (Davies, 2010a, p. 19; Enemark, 2007, p. 20; Kamradt-Scott & McInnes, 2012; Lakoff & Collier, 2008, p. 18; McInnes, 2014; McInnes & Rushton, 2010, 2011). Furthermore, the insertion of biosecurity concerns in the government's narrative surrounding the response had concrete consequences which were documented in this chapter.

5 Situating the Ebola response in the Norwegian global health and foreign policy

After outlining the Norwegian response to Ebola at international level (chapter 1), I highlighted the government's dual understanding of the crisis, as being both a humanitarian emergency and a biosecurity threat (chapter 2). I also showed that the repatriation of an infected health worker constituted a powerful visual narrative that led to a partial securitization of the response by the Norwegian government (chapter 3). This security moment opened a window of opportunity for the authorities to mobilize exceptional resources and implement innovative, *adhoc* projects (chapter 4). In this last chapter, I aim to situate this response in the context of global health governance and of Norwegian diplomacy. I suggest that in many ways, this response echoes the objectives of Norwegian foreign policy (and global health policy) from the last decade: a strong focus on vertical, technology-based interventions, designed to be collaborative and multilateral, and thought to be a mix between *idealpolitik* and *realpolitik* – advocating ideals *and* promoting national interests. I conclude that the shared philosophy between Norway's recent global health policy and the Ebola response is likely to lead to an overall securitization of Norwegian global health policy in the coming years.

5.1 Securitization leads to vertical, technology-based interventions

5.1.1 Horizontal versus vertical approach to global health

Global health has historically been structured around a debate between two sets of policies referred to as "horizontal" and "vertical" (Cueto, 2004; Mills, 2005). The horizontal approach is often described as systemic because of its focus on strengthening health systems and its objective to tackle the broader determinants of health (Ng & Ruger, 2011, p. 10). It is considered to have formed its apex with the Alma-Ata Declaration of 1978, inviting the international community to ensure "Health for All" (Cueto, 2004, p. 1868). The premise underlying horizontal policies is that "diseases in

less-developed countries were socially and economically sustained and needed a political response" (Cueto, 2004, p. 1872). On the other hand, the vertical approach consists of targeted initiatives, often disease-specific, such as the campaigns to eradicate smallpox and polio, or those addressing TB and malaria (Mills, 2005, p. 315). Vertical programs are conceived to have measurable outcomes that can be displayed in statistics and interpreted through cost-benefit analyses, justifying and legitimizing the investment of resources (Ng & Ruger, 2011, p. 10; Storeng, 2014, p. 868). They perceive and define health problems as natural phenomena that should be addressed with technological solutions (Cueto, 2004, p. 11). Vertical initiatives are usually perceived as value-neutral and thus applicable everywhere by reproducing the same protocols tested successfully in clinical medicine and evidence-based studies (McInnes, 2016, p. 385; McInnes & Lee, 2012, p. 18).

Vertical programs and their promotion of technology have historically been favored by the US government (King, 2002, p. 771; Ng & Ruger, 2011, p. 10) and since 2000 are strongly advocated by billionaire Bill Gates through his philanthropic foundation, the Bill and Melinda Gates Foundation (BMGF) (Birn, 2005; Storeng, 2014). The vertical approach in global health policy has also been adopted by several other donors worldwide, including Norway. Since the 2000s, the Norwegian government has been a strong supporter of immunization, framing vaccines as low-cost solutions to global health problems (Kloster, 2012, pp. 78-88). It also strongly supported the set-up of coalitions such as Gavi and the Global Fund, built around the idea that technological solutions should be available to most (Sandberg & Andresen, 2010). This shift towards a vertical approach to global health policy was confirmed in one of my interviews by an experienced bureaucrat from the Ministry of Health:

> "*There has been a long discussion internationally, and also in Norway, whether this kind of primary health care approach from Alma-Alta - which is really basically system building, is the strategy to follow. Or whether you should follow kind of the quick fixes line, with supporting GAVI, and the Global Fund, and all these initiatives that inject vaccines and lead to quick results. And partly based on frustration with WHO, and also based on success of GAVI, and Global Fund, and so on - I think the Norwegian support has been shifting in the direction of the Fund and GAVI*" (Interview n°9).

5.1.2 Responses to emergencies: standardized and technology-based

The policies aiming to respond to emergency situations and catastrophes have considerably evolved since the 1980s with large INGOs taking responsibility in crisis management. Emergency aid has become standardized, professionalized, and more and more technology-based. Aid is thought to be delivered everywhere and function independently from the context in which the crisis is occurring. Peter Redfield, describing the standardization of emergency aid using the example of the emergence of the humanitarian kit in MSF in the 1980s, concluded that the kit represents a

> "self-consciously global system, mobile and adaptable to 'limited-resource environment' worldwide. While parts of it may be flexible in application, the result is not at all fluid in the sense of flowing around community involvement. Indeed, the kit system is the exact opposite of local knowledge […] it represents a mobile, transitional variety of limited intervention, modifying and partially reconstructing a local environment around specific artifacts and a set script" (Redfield, 2008, pp. 160-161).

I showed earlier in this thesis that the Moyamba ETC project followed the logic of the 'humanitarian kit' - particularly the base camp provided by Norway. It was assembled from the standard elements owned by the Directorate for Civil Protection (tents, beds, kitchen, telecommunication devices, etc.), with a few additional elements to adapt to the situation (such as ultra-violet toilets) and was built to be self-sufficient and isolated from the local environment (Chapter 1, section 1.4.2).

Collier and Lakoff drew up convincing parallels between preparedness measures from the WHO, the humanitarian kit of NGOs (for instance MSF) and the promotion of technological, low-cost interventions by philanthropies (such as the Gates Foundation). To them, all these measures reflect an "emergency modality of intervention" that they define as:

> "The emergency modality does not involve long-term intervention into the social and economic determinants of disease. Rather, it emphasizes practices such as surveillance and reporting systems, or simple technological fixes" (Collier & Lakoff, 2008, p. 17).

The humanitarian tool kit and standardized, technology based responses to catastrophes share similar features and objectives with vertical programs in global health. These

interventions are targeted, often short-term, relying on technological solutions, and are designed to have measurable outcomes and 'cost-effectiveness'. They can be deployed without taking the local context into account, and do not target the broader determinants of the crisis.

5.1.3 The Ebola response: a vertical intervention

The securitization of the Norwegian response to Ebola created a context of urgency, instrumental in the mobilization of exceptional resources (see Chapter 4, 4.1.1). I suggest that the securitization process led eventually to set-up a response dominated by an "emergency modality of intervention", sharing similar features with a vertical approach to global health. When looking at the Norwegian response to Ebola, particularly the two projects directly managed by state administration, this conclusion is striking: the projects were designed to be transposable everywhere - the treatment center was meant to be self-sufficient and the vaccine trial was conceived with a flexible clinical research design to adapt to a difficult environment. They both relied heavily on technology - a vaccine, personal protective equipment, ultra-violet toilets, etc. – and did not attempt to incorporate the local knowledge and culture, although they proved to be critical to stop the epidemic (Richards, 2016). Finally, they both targeted the immediate problem - treating the patients, avoiding further spread of the virus - without addressing the broader socio-economic determinants that allowed the outbreak to become so large in the first place.

Interestingly, Roemer-Mahler and Elbe drew a similar conclusion from their analysis of the global response to the Ebola crisis (Roemer-Mahler & Elbe, 2016, p. 488). They concluded

> "The process of securitization promotes the perception of an immediate, potentially irreversible danger that creates a perceived need for rapid response. In a situation perceived as an emergency, alternative policy options, such as long-term engagement with complex socioeconomic issues and political negotiations, for instance, appear less suitable. Demand increases for a quick fix to aver the imminent danger" (Roemer-Mahler & Elbe, 2016, p. 492).

The need for short-term and rapid intervention induced by the securitization of an issue leads to a vertical approach, prioritizing technology-based solutions in the conceptualization of the response:

> "Technological solutions become particularly attractive in this context not only because they are hoped to work rapidly, but because they may appear politically more neutral, minimizing the risk of difficult political confrontation" (Roemer-Mahler & Elbe, 2016, p. 493)

This focus on technological solutions to solve biosecurity crises reinforces what Elbe calls the "pharmaceuticalization" of global health security, meaning a growing interest from governments to acquire medical countermeasures to ensure the biosecurity of their population (Elbe, 2010, 2014; Elbe, Roemer-Mahler, & Long, 2014, p. 265; Roemer-Mahler & Elbe, 2016). Roemer-Mahler and Elbe noted that the combination of the *securitization* and the *pharmaceuticalization* of the Ebola response opened a window of opportunity to lead accelerated clinical trials and test drugs and vaccines whose efficacy and potentially harmful side-effects had not been fully evaluated. In a crisis situation, the risk assessment is indeed much changed from a 'normal' context, as "in a situation of perceived 'emergency' and 'threat to security', it seems easier to justify risks as acceptable" (Roemer-Mahler & Elbe, 2016, p. 496). The vaccine trial project led in Guinea that the Norwegian Ministry of Foreign Affairs qualified as a "*fast-track trial*" (MFA, 2014e) is a good illustration of this argument. As recalled by an informant comparing the trial project to other US-led vaccination trials, "*we were taking most risks with the vaccine that was likely to have side-effects. And we took the risk in terms of the country where it was most probably difficult to carry it out*" (Interview n°9)

The securitization of this health crisis and its temporality of urgency at play, resulted in privileging vertical, technological responses, or an "emergency modality of intervention" (Collier & Lakoff, 2008, p. 17). Norway seems to have followed this policy with its Ebola response; a strategy very much in line with its approach to global health since the 2000s.

5.2 Norway's advocacy for a collaborative, multilateral response

The Norwegian response to the Ebola crisis reflects a strong support for a multilateral system and multilateralism. Half of the response's budget was dedicated to directly support international organizations and, as I will show hereafter, the two projects led by the state were multilateral and were considered a way to promote collaborative efforts. This conclusion is anything but surprising. Many scholars using social constructivist theory have analyzed the commitment of small states (particularly from Scandinavia) to multilateralism (Björkdahl, 2007; De Carvalho & Neumann, 2015; Ingebritsen, 2002; Neumann & Gstöhl, 2004). They traditionally put forward two arguments. The first is that small powers have an interest in having a system based on sovereign equality to increase their status and influence whilst minimizing the costs of their foreign policy (Björkdahl, 2007, p. 541; De Carvalho & Sande Lie, 2015; Nagelhus & Sending, 2015; Neumann & Gstöhl, 2004, p. 12). The second argument is that multilateralism increases the capacity of these countries to promote norms and shape multilateral organizations' agendas (Björkdahl, 2007, p. 541; Ingebritsen, 2002; Long, 2016, p. 14). I will in this section show that Norway's decision to set-up its Ebola response based on a multi-actor collaboration was pragmatic, but also a way to advocate the need for a more efficient multilateral system to respond to epidemic outbreaks.

5.2.1 Norway, small power and multilateralism

Since its independence, Norway has shown a strong commitment to strengthen the multilateral system, a support that eventually became an important aspect of the Norwegians' self-representation of their country's foreign policy. This is illustrated in the pride Norwegians take in having provided the UN its very first Secretary-General, Trygve Lie, or when former Minister of Foreign Affairs Jonas Gahr Større described Norway as the "UN's best friend" (Leira, 2007, p. 20). Neumann and de Carvalho argued that in order to seek status on the global arena, a small state will try to increase its power by seeking moral authority and be perceived as a "good power" (De Carvalho & Neumann, 2015, pp. 12-13). Through their commitment to strengthening the multilateral system, small states gain recognition from both the great powers (for helping them institutionalize a system shaped in their best interests) and from other

middle and small powers (for helping bind the great power's behavior by institutionalizing decision making) (Nagelhus & Sending, 2015, p. 75). Norway's prioritization of humanitarian aid, development and international peace negotiations (De Carvalho & Sande Lie, 2015, p. 57) provides the country with moral authority and the reputation of being a "good Samaritan". Norway is then recognized on the global stage as "a helper, a team player, one to rely on to help fund and support initiatives taken by others" (Nagelhus & Sending, 2015, pp. 85-86).

By supporting multilateralism and engaging with fields from which the country can derive moral authority, Norway can gain status, the reputation of being a good power and a seat at the decision table. This position provides it with the opportunity to weigh on the agenda and promote norms that can further reinforce its status and multilateralism (Björkdahl, 2007, p. 541; Ingebritsen, 2002; Long, 2016, p. 14). Furthermore, investing in multilateral projects can be perceived as a pragmatic way to adapt to the limited resources available. Multilateralism is then a way for small states to achieve more whilst minimizing the costs of foreign policy (Björkdahl, 2007, p. 541). Finally, it was also argued that status not only affects the country's reputation abroad, but also national public opinion by creating "spillover effects on the domestic arena in the form of support to the sitting government" (De Carvalho & Sande Lie, 2015, p. 63). I observed the same phenomenon, detailed in chapter 3 where I described the values echoing the national identity and the traditional self-representation of Norwegian foreign policy (humanitarianism, altruism, being a "good doer") as being instrumental in mobilizing support for the project led in Sierra Leone.

5.2.2 Multilateralism, the pragmatic way against Ebola

For small powers, joining a multilateral initiative is often seen as a pragmatic move: minimizing costs and achieving more results by pooling resources (financial, expertise, human resources) (Björkdahl, 2007, p. 541; Long, 2016, p. 14). In the case of the Ebola response, pragmatism was very much put forward by my informants to justify the decision to join the UK-coalition to fight the epidemic in Sierra Leone. They constantly recalled that Norway was "*a small country*" or a "*little country*" (Interview n°1; Interview n°6, Interview n°7; Interview n°8; Interview n°13; Interview n°15), a way for them to recall the fact that Norway did not have the resources to set-up a field

hospital on its own. "*Norway, small country, northern end of the world, we don't have a governmental system for sending health personal anywhere [...] So we had to find a partner!*" one of my informants told me (Interview n°1), whilst others stated "*quite early concluded: this is probably the best way of using limited Norwegian resources by pooling them into a bigger set-up, where we don't have to be responsible for everything*" (Interview n°7) and that "*logistically, we cannot do it on our own. It is better to be under a British umbrella, because they know how to run the show - and we can fit in one part of it*" (Interview n°9). A source from the Civil Protection Agency concluded that "*to be able to punch a bit above our weight, we need to cooperate with other countries*" (Interview n°15).

Joining the UK-led coalition was perceived as a way to contribute in an efficient and rapid way to the international Ebola response, or, as the Health Directorate puts it in its evaluation report, participate in a broader "*cost-effective establishment of treatment capacity*" (Health-Directorate, 2015a, p. 50 *). According to several of my informants, Norway sought first to support a UN response, but decided to join the UK project, once it was clear that the UN, for multiple reasons, had trouble with implementing the response: "*one of the reasons why we connected with the UK was the lack of good structures at UN-level that we could fit in directly*" an informant at the Ministry of Health explained (Interview n°7). Interestingly, another source believed that working together with the UK was in fact supporting the UN system:

> "*that was our way of trying to work with the WHO and the UN, because we saw that as the fast track. We explored both the Nordic initiative, but actually Norway was a bit ahead of the others ones [...] then we got information [...] that the UK was far ahead in trying to get something done*" (Interview n°14)

The donations made to INGOs and multilateral organizations – constituting around two thirds of the total budget dedicated by Norway to the fight against Ebola – also illustrate Norway's choice to pool resources for more efficiency. As noted by an observer of Norwegian development policy, this is quite common among Nordic countries:

> "*that's very common to think like that, otherwise, they would have to start from scratch [...] and here, they had to act fast. It's not uncommon that Nordic countries are working this way. The Danish budget for instance, they have reduced the number of priority countries, but even then, in some of*

these countries, they have other donors handling their money! Even Luxembourg is handling Danish money in a priority country for Danish aid! The thinking is that it lowers the transaction costs" (Interview n°13).

The result of this strategy, in addition to increase efficiency, is also an extreme complexity of the project's organizational structure – as made explicit in the maps of actors available in Annex 2 and Annex 4.

5.2.3 Multilateralism as a way to promote norms: the global governance of outbreaks

As noted by some scholars (Björkdahl, 2007, p. 541; Ingebritsen, 2002; Long, 2016, p. 14), multilateralism is often used by Nordic countries to promote norms. In the case of the Ebola crisis, the outbreak constituted a serious test for the revised International Health Regulations and the international regime of health crises governance. The securitization of a crisis can lead to the exacerbation of national interests (Hooker, Mayes, Degeling, Gilbert, & Kerridge, 2014) and increase the likelihood of some states acting unilaterally and breaking the current regime in place was high. As noted by some of the international commission reviewing the crisis, this eventually happened, with several actors putting in place restrictions on trade and travel, which, in addition to harming the region even more, fueled mistrust from the affected countries towards the regime of pandemic governance and, as a result, could have resulted in discouraging countries from reporting cases in future outbreaks (Moon et al., 2015, p. 2207; US-Academy-of-Medicine, 2015, p. 6). Norway and other small countries, because of their limited resources, are dependent on this international regime to ensure their biosecurity. It was in Norway's interest to promote a collaborative approach to pandemic response – a goal appearing explicitly in the vaccination trial project in Guinea.

It was argued that the dual process of securitization and pharmaceuticalization shaping the international response to Ebola eventually led to a "race for Ebola drugs", particularly vaccines (Roemer-Mahler & Elbe, 2016). This race for vaccine allowed Norway to promote a multilateral approach to vaccine trials in times of crises, in contrast to the unilateral initiatives privileged by great powers, particularly the US. An informant recalled,

> *"it was also a lot of tensions indicating dissatisfaction from many actors - including the head of research in the DG research from the European Union. He was very strong in his statements against the US approach of just making bilateral agreements with institutions in the two countries and not really discussing it openly with others - more or less independently from WHO"* (Interview n°3)

In reaction to this unilateral approach, a small, *adhoc* group consisting of a dozen people met informally and decided to form a working group open to everyone under the sponsorship of WHO. As an aside, it is interesting to note the similarity of this approach to Sweden's promotion of norms relating to international peacekeeping in the UN, as described by Annika Björkdahl: "*Swedish representatives attempted to build coalitions in support of the idea of conflict prevention, using informal meetings for interpersonal and argumentative persuasion*" (Björkdahl, 2007, p. 544). In the case of the vaccination trial, Norway wanted to promote the norm of an open, transparent, multi-stakeholders trial placed under the control of the referent International Organization, the WHO. The initiative taken by the Norwegian delegates and the rapid promise of funding made by the Norwegian Ministry of Foreign Affairs played a key role in getting the trial on track. In order to win what was described as "*a political competition*" (Interview n°3), this trial had to be innovative in its design and risks had to be taken in regards to the location and the safety of the vaccine – an approach justified by the crisis situation (Roemer-Mahler & Elbe, 2016, p. 496). The circumstances were summarized as such by one of my informants:

> *"In contrast to USAID that had plans for a big randomized trial, 30'000 people in Liberia - which they had completely designed it in the US - we sort of played David: we were taking most risks, with the vaccine that was most likely to have side-effects, and with the country where it was probably the most difficult to carry it out*" (Interview n°10).

In the end, the consortium led by Norway and the WHO was the first in the world to announce the creation of a vaccine 100% efficient against Ebola. The entrepreneurs who wanted to demonstrate that a multilateral approach was more efficient won their gamble against the unilateral US approach: "*We were more risk-taking and much smaller and it happened that we succeeded; and they, they sort of failed*" concluded one of my informants (Interview n°10).

The success from this collaborative vaccination trial provides Norway with a political capital critical in the promotion of a global approach to pharmaceutical research during epidemic outbreaks. As exposed elsewhere (de Bengy Puyvallee & Storeng, Forthcoming), Norway used this political capital by playing a critical role in the creation of the Coalition for Epidemic Preparedness Innovation (CEPI). This new partnership aims to finance research and development of vaccines against diseases with epidemic potential and develop new ways of testing vaccines in emergency settings (CEPI, 2016), a process that corresponds to what Roemer-Mahler and Elbe called "institutionalizing pharmaceutical responses to health security threats" (Roemer-Mahler & Elbe, 2016, p. 496). By capitalizing on the success of the vaccination trial in Guinea, Norway manages to promote a collaborative approach to vaccine research and development; a norm from which the country can derive moral authority, status and enhanced biosecurity.

5.2.4 Multilateralism as a way to increase the country's status

Multilateralism is also a way for small states to increase their status on the global scene, by being perceived as a "good power" (De Carvalho & Neumann, 2015, pp. 12-13) or a "helper, a team player, one to rely on to help fund and support initiatives taken by others" (Nagelhus & Sending, 2015, pp. 85-86). The attitude adopted by Norway within international organizations during the Ebola crisis is quite revealing of this role of "helper". By taking initiative under the leadership of the WHO, pledging funds rapidly to get the project started and answering the call from Guinea – a country "*left alone*" from vaccination trials projects (Interview n°2) – Norway played the role of a team player. Norwegians appeared as reliable partners with good intentions, a reputation from which the country can derive moral authority. What is more, the Norwegian government was the first to support the multi-donor fund from the World Bank dedicated to the fight against Ebola (MFA, 2014d). This rapid contribution provided legitimacy to the initiative; a legitimacy particularly important to the extent that the World Bank was not necessarily expected to intervene in a health crisis, as its focus is now on infrastructures and long term development as opposed to its initial focus on rehabilitation (Marshall, 2014, p. 570). Norway's willingness to contribute to a multilateral fund from which there is little political credit is illustrative of its reputation

as a "team player", which enhances its status and provides access to the negotiation table.

Norway also played the role of a helper in the UK-led response in Sierra Leone. Since its independence, Norway has had a close relationship with Great Britain, following the UK in most major diplomatic decisions, such as those relating to European integration (Haugevik, 2015). This close cooperation is particularly important in the field of global health: "*the UK is rather close to Norway, especially on the health side, with years and years of close cooperation*" recalled a source, before concluding that "*the UK is, or has been, a kind of inspiration for Norway, looking on the health side*" (Interview n°14). During the Ebola crisis, the UK took leadership in the coordination of the response in Sierra Leone. As the former colonial power, "*it was natural for the UK*" to take this role (Interview n°1), but it also contained some risks, including accusations of neocolonialism, which the British government was well aware of. According to an informant,

> "*For the Brits, the whole colonial thing was very difficult, because they were always worried about 'now we show-up again'. And they were very strict with the whole colonial history, being worried about being perceived as telling people what to do, and how to do it*" (Interview n°1)

By joining the project led by DFID, Norway provided multilateral caution and legitimized the British intervention – something that the Norwegians working on the project were well aware of: "*politically, it's easier to sell when you have other countries say 'yes, we're willing to go in this, with you'*" (Interview n°1). It should also be noted that Norway was the first country to negotiate a way to be part of the British intervention. According to an informant, this Norway-UK cooperation was instrumental in reinforcing the response's multilateral character by integrating other countries within the coalition:

> "*What the Brits did after we developed the MoU [Memorandum of Understanding], is that they presented it to Denmark, to South Korea I think. So they basically took the agreement we developed and said to other countries that wanted to, or were looking to maybe supporting their Ebola-response: 'here is the general framework we have with Norway. Can we use it with you guys too?' So the whole development that we did with them, it also helped them so that they can pull in other partners too!*" (Interview n°1).

Norway's early and rapid contribution was critical in getting other actors on board, an outcome important for the UK to avoid being accused of interference in a former colony.

Finally, not only did Norway help the UK legitimize its intervention, it also strengthened the British response without getting much visibility on the international scene, nor much influence on the response design. My informants involved in the initiative were quite aware of Norway's position of weakness vis-à-vis the UK, showing deference to their British counterparts. A source recalled,

> "*You have to be a little bit responsible for the fact that when you come as a small country, and want to start engaging, why should they? Because they already have a huge operational environment! What difference would one small, tiny, little party do?*" (Interview n°1).

Asked about Norway's influence in the project, the same source thought it important to clarify that they were "*always, always aware that it was a British / UK led-response. It was never, we never got into a kind of position where we took up that space. It was their lead, they made the decisions*." (Interview n°1). Another informant concluded that "*at the end of the day, you have to align yourself with the leading body!*" (Interview n°15). This position of humbleness was also apparent on the sign at the entrance of the treatment center (Figure 7), where the Norwegian flag, representing the facility's largest contributor (by far), was barely visible in the lowest-right hand corner. Norway seems to have played the role of a helper and a good ally – a position that can be interpreted as an attempt to increase its reputation and status in the eyes of the British authorities.

Figure 7: Sign at the entrance of the treatment center in Moyamba

I conclude by arguing that Norway's support of the multilateralism during the Ebola crisis is the result of a combination of pragmatic policy (a way to achieve more results and minimize the costs for action), the defense of national interests (achieve a higher status on the global stage, getting a seat at the table and promoting norms in its favor) and an idea of the world order (that multilateralism is positive).

5.3 Ebola, global health security and Norwegian foreign policy: *idealpolitik* and/or *realpolitik*?

I argued in this chapter that Norway set-up a collaborative, vertical response to the Ebola crisis, resulting from both its current approach to global health and from the securitization context, playing a critical role in prioritizing an emergency modality of intervention. I would now like to conclude this chapter by suggesting that the securitization of the Ebola response is a consequence of the elevation of global health as a foreign policy issue – a process that Norway has been advocating for the last ten years. Because global health security promotes both ideals and national interests – echoing the official Norwegian foreign policy objectives since 2009 – I suggest that the topic is likely to gain prominence in the Norwegian global health agenda. This, in turn, might weaken the narrative representing Norway as a 'do-gooder' on the international scene.

5.3.1 Global health as a foreign policy issue

Over the last two decades, attempts have been made to elevate global health policy as a foreign policy issue; a trend that has drawn much scholarly attention (H. Feldbaum, Lee, & Michaud, 2010; Fidler, 2005b, 2006, 2011; McInnes & Lee, 2006, 2012; Møgedal & Alveberg, 2010; Thieren, 2007). Fidler recalls that global health was long considered a soft-power tool, falling in the category of "really low politics", because it was "considered as technical, humanitarian and non-political endeavors" (Fidler, 2005b, p. 180). This changed in the mid-1990s as the issue gained considerable attention. Global health came to be seen as having an impact on key aspects of foreign policy such as development, trade (economic interests), diplomacy (global governance of public goods), and security (bioterrorism, biosecurity vulnerability because of globalization, risk of state failure for weak states – see theoretical framework) (H.

Feldbaum et al., 2010; McInnes & Lee, 2012, pp. 49-77). The connections made between global health and the national interests led to an elevation of the field as "high politics" (Fidler, 2005b, p. 180; 2006, p. 54). This recognition appeared clearly with the interest of the UN Security Council with its resolutions on HIV/AIDS and Ebola (UNSC, 2000, 2014), or in the constitution of a multilateral coalition called the "Foreign Policy and Global Health Initiative" around the idea that "health is one of the most important […] foreign policy issues of our time" (Ministers-of-Foreign-Affairs et al., 2007, p. 1373). What is more, the prioritization of global health on the international agenda translated in a massive increase of funding: development assistance to health quadrupled between 1990 and 2007 (Fidler, 2011, p. 2).

The elevation of the issue from low to high politics is likely to create a tension between *idealpolitik* (pursuing ideals, normative goals) and *realpolitik* (defending the national interests). The aspects dominating global health as low politics are typically initiatives relating to development and humanitarian assistance – two sectors that tend to be highly normative (Eggen & Sending, 2012, p. 7). Calhoun recalls that humanitarianism contains an ideal of purity that would be denatured by the irruption of foreign policy objectives (Calhoun, 2013, p. 52). Thieren, considering the relationship between health and foreign policy in the case of humanitarian action concluded that "the altruistic, people-centered value of humanitarian action is in intrinsic opposition to foreign policy's interest-based, country-centric values" (Thieren, 2007, p. 219). He further insisted that "humanitarian arguments often guide foreign policy decisions, but they are often regarded as a mean to enhance reciprocity and national image. Humanitarian justifications are no longer altruistic then, but become interest-based and political" (*Ibid*). On the other hand, high politics aim at protecting (and eventually advancing) national interests, such as security and power capabilities (Fidler, 2005b, p. 180). This is the reason why many scholars have criticized global health security for being mostly the interests of western countries, instead of helping developing countries tackle their biggest health challenges (Aldis, 2008, p. 373; G. W. Brown & Stovea, 2014, p. 305; Horton, 2017; Lakoff, 2010, p. 59; Rushton, 2011, p. 780). The elevation of global health to the realm of high politics is a way of attracting more attention to the issue, but the consequence may be a stronger focus on national interests, even if they are disguised with global health's traditional normative goals.

5.3.2 Norway and global health as a foreign policy issue

Since 2006 Norway has, through the voice of its Minister of Foreign Affairs Jonas Gahr Støre, explicitly advocated for global health as an issue of foreign policy. Together with his French counterpart, Philippe Douste-Blazy, they took the initiative to create a multilateral coalition between Norway, France, Indonesia, Senegal, Brazil, South Africa and Thailand that developed the Oslo Ministerial Declaration of 2007 in which health is described as a top priority of foreign policy (Ministers-of-Foreign-Affairs et al., 2007, p. 1373; Møgedal & Alveberg, 2010). Jonas Gahr Støre also ordered a White Paper titled "Interests, Responsibilities and Opportunities. The main features of Norwegian Foreign Policy" that provoked a heated debate in public opinion. Indeed, whilst Norway has traditionally been reluctant to publicly define its foreign policy in terms of national interests, the Minister argued that the country should lead a foreign policy combining *idealpolitik* and *realpolitik*, by expanding its definition of its national interests: "*a considerable number of foreign policy areas that have until now been regarded as soft, or altruistic, must be upgraded to priority areas in order to safeguard Norwegian interests*" (MFA, 2009, pp. 22-23). Global health was regarded as one of the areas dominated by altruistic policies that should be considered part of the national interest (MFA, 2012), as illustrated by the transfer of the portfolio from the agency for international development, NORAD, to the Ministry of Foreign Affairs, (Kloster, 2012, p. 5).

In parallel to this, the Norwegian government decided to prioritize two topics within global health: vaccination and maternal and child health. It supported initiatives promoting vaccination programs, such as Gavi, and disease specific interventions such as the Global Fund, and decided to develop high level research on immunization on the national scene with the creation of the GLOBVAC program (Sandberg & Andresen, 2010). The prioritization of vaccines, described earlier as a shift towards a vertical approach to global health, was instrumental in setting-up new collaborative platforms (Gavi), an arena in which Norway is an important player due to the size of its contribution. This focus on collaborative, multilateral structures working through vertical programs was a way for Norway to use global health as a foreign policy issue: working with other to achieve ideals (saving lives; ensuring high level of immunization coverage) but also promoting Norwegian interests (mostly diplomatic). These coalitions

are typical examples of this mix between *idealpolitik* and *realpolitik* advocated by Jonas Gahr Støre – something that was clearly expressed in the White Paper n°15 from 2009, where it is stated in a section dedicated to global health: "*one of our key objectives must be to promote more effective forms of cooperation between formal multilateral actors and this wide range of new actors.*" (MFA, 2009, p. 89).

5.3.3 Ebola, Norwegian foreign policy and global health security

To conclude this chapter, I argue that the recent ambition to lead a foreign policy balanced between *idealpolitik* and *realpolitik* played a critical role in the way the government responded to the Ebola crisis. Furthermore, I suggest that the Ebola response, because of its scale and the momentum created by the crisis, is likely to deepen this approach in the future with the emergence of a pragmatic, Norwegian understanding of global health security.

As I demonstrated throughout this thesis, the Norwegian response to Ebola was motivated both by altruistic concerns for those affected in West Africa *and* preoccupation for national biosecurity. In other terms, this reflects a combination between *idealpolitik* (humanitarianism) and *realpolitik* (the defense of the country's biosecurity, diplomatic gains), following the objectives set by the 2009 White Paper. I showed also that the government started to react strongly to the Ebola crisis at the same time the issue was elevated to high politics by the UN Security Council. Despite not really adopting the narrative underlying the resolution's argument – that there is a causal factor between epidemics and state failure – the elevation of the issue led Norway to make its first substantial pledge to the international response. A few weeks later, the importation of the virus in Norway with the repatriation of a sick health worker constituted a proof that Ebola could threaten national biosecurity. The issue moved to the top of the foreign policy agenda, which gave more weight to the *realpolitik* motivations to set-up a response. The government, following the approach developed over the previous decade, promoted a collaborative, vertical response by supporting the British coalition in Sierra Leone and playing a leading role in the set-up of a vaccination trial in Guinea. The securitization of the Ebola crisis led to an increased availability of resources to operationalize a humanitarian response and achieve foreign policy objectives.

The rise of global health security on the global agenda after the momentum opened by the Ebola crisis is, I suggest, likely to reinforce Norway's approach to global health balanced between *idealpolitik* and *realpolitik*. It creates a window of opportunity for Norway to put forward diplomatic interests by playing a leading role in a reform of global health governance and also increase the country's biosecurity. In order to influence this process, Norway has to be part of the most powerful forum where this topic is discussed – the Global Health Security Agenda. This initiative, led by the US, is unsurprisingly dominated by a statist perspective following the traditional American understanding of health security (Weir, 2014). It aims at working on prevention, detection and response by helping partners respect their obligations under the WHO International Health Regulations and create *adhoc* projects, bringing different partners such as philanthropies and NGOs (Inglesby & Fischer, 2014). Norway joined the initiative at its launch, according to an informant a sign, "*we have now rejoined the health security now as it has emerged – we are much more similar to the US position*" (Interview n°4). This was not always the case according to this source, as Norway was working actively with Canada and Japan in the beginning of the 2000s to integrate the human security perspective in global health security (globalist perspective), before "*losing interest*" (Interview n°4). The move towards the US approach is the sign of an ideological shift, clearly visible with the adoption of the narrative linking globalization with increased vulnerability. I suggest that it is also a pragmatic, strategic move to align the country's position to the dominant understanding of the concept in the main forum discussing it. Norway does not seem to have fully lost interest in the globalist interpretation of the concept, as demonstrated by the framing of the Ebola response as a humanitarian intervention. Also, I did not find evidence of a narrative drawing a causal factor between epidemics and state failure. This results in a balanced interpretation of global health security, mixing a globalist and statist perspective in what I call a *cosmopolitan* perspective putting forward global health as a global public good, with shared vulnerabilities and shared responsibilities. However, as I argued, this position is not necessarily in majority on the global scene. This led one interviewee to conclude "*the whole concept [of global health security] is risky, and we need to know exactly what we do, [...] One shouldn't just be following the big brother in everything!*" (Interview n°4). It will be interesting to observe in the coming years if Norway will be able to influence the concept of global health security towards a more globalist

perspective – and not only bring a "humanitarian caution" to an initiative promoting, above all, western interests. In the meantime, this pragmatic position is likely to be successful in Norway, because it corresponds to the collaborative, vertical approaches to global health of the past decades:

> "*while we used to be broad, solidarity-based, process-oriented, try to build systems and capacity, we are now much more – the way I see it – based on initiatives, together with other key players, on innovation, that kind of things [...] This also means that health security, more than universal health coverage, will somehow get the response from Norwegian authorities, because that is much more related to initiatives, what you can do with others, vaccines, etc. The universal health coverage would be much more seen as wishful thinking.*" (Interview n°4)

Finally, this position and the move towards the US understanding of global health security can be interpreted as a betrayal of an *idealpolitik*, for instance the Bergen Health Trust. As recalled earlier, *idealpolitik* has shaped large parts of the Norwegian identity and self-representation of the country's foreign policy (Leira, 2007). This tradition and identity is now seriously challenged by the frequent irruption of *realpolitik*, an observation that led an informant to conclude:

> "*This whole narrative of presenting development and humanitarian efforts as Norwegians being the good doers, [...] I think that's a narrative that's about to fall apart in a way - because there is not really, it's not really a credible story anymore! Because these funds are increasingly linked up to Norwegian political interests, and that's also the official policy!*" (Interview n°13).

The framing of aid would then have to be re-adjusted to match this new reality – a process with uncertain outcomes in regards to domestic support for development aid, because it contradicts almost sixty years of idealistic, altruistic framing.

Conclusion: Institutionalization of an emergency modality of intervention

"The humanitarian emergency is an awkward symbol, simultaneously of moral purity and suffering, of altruistic global response, and of the utter failure of global institutions. The humanitarian of response suggests a world united by common humanity; the emergencies themselves reveal a world divided by deep material inequality, by violent conflicts, and by illicit, exploitative trade" (Calhoun, 2013, p. 29)

Throughout this thesis, I analyzed the Norwegian response to Ebola following four research questions (McInnes & Lee, 2012, pp. 4-5):

(1) What did Norway do in reaction to the Ebola crisis (Resources deployed)

(2) How was the policy problem (The Ebola crisis) understood and defined? And why was such response decided upon (Agenda and goals pursued)?

(3) How was the response legitimized (What values and motivations were put forward)?

(4) What are the Norwegian Ebola response's roots in the Norwegian foreign policy and global health governance?

To answer these questions, I adopted a well-established approach in International Relations: a theoretical framework deriving from social constructivism supported by a qualitative methodology. My aim here was not to challenge the theory, but rather use the conceptual tools it provides to analyze the material I collected from eighteen semi-structured interviews, an in-depth analysis of official documents and a review of the academic literature. I found this conceptual framework useful and relevant to grasp the complexity of Norway's Ebola response and analyze how the government's goals, values and motivations resonated with and were adapted to the context (Davies et al., 2015). Additionally, I tried to enrich my study by extending my literature review to publications from different disciplines (anthropology, economy, epidemiology and public health, medical history, international law, etc.), bringing thus an interdisciplinary dimension to my work. Finally, my analysis highlights three main conclusions that I will develop hereafter.

Firstly, the Norwegian response to Ebola was deeply rooted in the country's foreign and global health policies. As a small state, Norway has historically privileged the multilateral system in its diplomatic strategy. The Ebola response does not constitute an exception, with more than half of the budget channeled through multilateral organizations and important efforts made to set-up multi-actor coalitions. I argued that this policy is driven, among other things, by pragmatism (cost-effectiveness), a desire to promote norms (a global governance of health crises), and an ambition to act according to the country's moral authority and status (a do-gooder and a team player). Similarly, I demonstrated that the response format is illustrative of the Norwegian priorities in global health policy. This includes a vertical approach to global health, reflected in the emergency modality of intervention leading to a short-term, technology-based and donor-driven projects (Collier & Lakoff, 2008, p. 17). It also includes the ambition to elevate global health as a foreign policy issue by mixing *idealpolitik* and *realpolitik* – appearing here in the government's double ambition to *both* help in West Africa *and* contain the outbreak to ensure Norway's biosecurity.

Secondly, I unpacked two competing "political and normative frameworks" (Lakoff & Collier, 2008, p. 12) at play in the policy-making process: *humanitarianism* and *biosecurity*. On the one hand, the *humanitarian framework* emphasized the consequences of the epidemic on the people in West Africa, the suffering and deaths due to the virus itself, but also the larger consequences of the crisis, such as access to food and water, population displacement, education, etc. This framing resonated strongly with the Nordic humanitarian identity and the Norwegians' self-representation of their foreign policy – making it particularly successful in mobilizing volunteers and public support around values such as altruism and solidarity. On the other hand, the *biosecurity framework* stressed the potential risks for Norway if the virus was to spread outside of West Africa. This frame was supported by a narrative linking globalization with increased biosecurity vulnerability, largely embraced on the global scene (McInnes, 2016), and, I suggest, also widely adopted in Norway. I argued that these two frames co-existed, but were not equally influential throughout the entire policy-making process. I showed that the infected volunteer's repatriation to Oslo constituted a pivotal moment, leading to a securitization of the response. This event provided images with a powerful symbolic meaning, resonating with the news from West Africa dominating international actuality by bringing an acute immediacy and a troubling proximity to the

problem. The Norwegian government reacted strongly to this episode, launching a massive communication campaign, pledging unusually high amounts of money to the global response and deciding to get directly involved by setting-up projects led with public resources: a field hospital in Sierra Leone and a vaccination trial in Guinea. The response's securitization provided a window of opportunity for the Norwegian government to mobilize exceptional financial resources and set-up unusual projects that were both innovative and risky. It also created an extremely difficult situation to handle for the government, that had both to appear in control of the situation and make sure that its international action would not backfire (for instance if a public health worker was to get infected).

Thirdly, I suggest from the Ebola experience that Norway developed a specific understanding of global health security, mixing what Sara Davies calls a "globalist" and a "statist" interpretation of the concept with the coexistence of the humanitarian and the biosecurity frame (Davies, 2008, 2010a, 2010b). The result of this nuanced and mixed interpretation was what I call a *cosmopolitan* understanding of global health security, putting forward shared values and responsibilities. The goal is to promote the governance of health seen as a global public good (focusing on the *world's* biosecurity) and to tackle the elements threatening human security in developing countries. It should be noted that this dual objective for global health security was already present in the Oslo Ministerial Declaration (Davies, 2010b, p. 21)

These three conclusions help understand the Norwegian government's decision to institutionalize the measures taken during the Ebola crisis. Following the field hospital project in Sierra Leone, the Health Directorate has been working on the development of emergency medical teams to be deployed, in cooperation with the EU and the WHO in the event of health crises (Health-Directorate, 2016). As demonstrated elsewhere (de Bengy Puyvallee & Storeng, Forthcoming), the Norwegian Institute of Public Health and the Ministry of Foreign Affairs used the political capital gained from the successful vaccination trial in Guinea to play a critical role in the launch the Coalition for Epidemic Preparedness Innovation (CEPI), a new public-private partnership aiming at securing markets for pharmaceutical companies to develop vaccines against diseases with epidemic potential (CEPI, 2016).

Finally, I suggest that these two initiatives – CEPI and the emergency medical teams – reflect a paradox in the lessons the Norwegian government drew from the Ebola crisis. Norway widely acknowledged that the main cause of the Ebola epidemic was the weakness of the health systems in the region. "*The Ebola outbreak underlines the importance of good health systems*" said Borge Brende, Minister of Foreign Affairs (Stortinget, 2014, p. 369 *), whilst the report from the Health Directorate concluded that "*all the core capacities from the international health regulations shall be strengthen, so that member states will be better prepared for the next crisis*" (Health-Directorate, 2015a, p. 51 *). Yet, despite this assessment, Norway invests massively in developing response capacities such as pharmaceutical counter-measures (vaccines) and medical teams that can intervene rapidly, everywhere. The government pledged NOK 1 billion to CEPI for its first five years of existence (CEPI, 2017). Whilst these measures are essentially *reactive* to epidemic outbreaks, there is little focus on strengthening national health systems and being *preventive*. The Norwegian Institute of Public Health did set-up a four-year project (2015-2019) to help Ghana, Malawi and Moldova implement the International Health Regulations, but its budget is 'only' of NOK 19 million – less than 2% of the donation made to CEPI (UNOG, 2017, p. 4). Norway's decision to institutionalize an emergency modality of intervention is certainly pragmatic, as it transpires from the Health Directorate's report: "*unfortunately, it is easier to work internationally in adhoc crisis management than developing in the long-term health systems*" (Health-Directorate, 2015a, p. 51). These tools will certainly enhance the world's biosecurity (*realpolitik*), but they do not tackle the broader determinants of epidemics by improving human security in developing countries (*idealpolitik*). It is disappointing to the extent that a lot of money was available during and after the Ebola crisis. Save the Children recalls that the global Ebola response could have financed three years of universal health coverage in the impacted countries (Save-the-Children, 2015). It also questions Norway's ability to safeguard its cosmopolitan understanding of global health security in a global context largely dominated the US leadership (until now), traditionally putting forward the defense of national interests for justifying its engagement.

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Appendix

Interviewee	Contact	Date	Length	Type/place
Category 1: Bureaucrats (ministries, directorate, agency)				
Directorate of Health				
Interview n°1	Referred by supervisor 11.03.2016 Follow up 16.06.2016 & 31.08.2016: No Response	05.04.2016	56 mins	In person/Café
Interview n°8	Email: 20.09.2016 Follow up 13.01.2017	29.09.2016	34 mins	In person/Office
Interview n°14	Referred by informant 10.10.2016 Email 07.11.2016	10.11.2016	54 mins	In person/Café
Institute of Public Health				
Interview n°2	Email 30.03.2016	18.04.2016	40 mins	In person/Office
Interview n°3	In person 23.02.2016 In person 02.09.2016 Email 05.09.2016	13.09.2016	42 mins	In person/Office
Research Council				
Interview n°5	Email: 23.09.2016	28.09.2016	30 mins	Phone
Interview n°11	Email: 03.10.2016	17.10.2016	58 mins	In person/Office
Directorate for Civil Protection				
Interview n°12	Email 20.09.2016 – declined 22.09.2016 Referred by informant 13.10.2016	26.10.2016	50 mins	In person/Office
Interview n°15	Referred by informant 10.10.2016 & 26.11.2016	12.12.2016	47 mins	Phone
Ministry of Health				
Interview n°6	Email: 21.09.2016	28.09.2016	55 mins	In person/Office
Interview n°7				
Interview n°9	Referred by personal contact 16.09.2016	30.09.2016	48 mins	In person/Office

Ministry of Foreign Affairs				
Interview n°10	Referred by MFA-2 26.09.2016	30.09.2016	31 mins	In person/Office
MFA-1	Email: 21.09.2016 Declined: 26.09.2016	-	-	-
MFA-2	Referred by MFA-1 Not relevant	-	-	-
MFA-3	Email: 10.10.2016 Email: 28.11.2016 No response	-	-	-
NORAD				
NORAD-1	Email: 04.10.2016 Email 12.10.2016 Email 01.11.2016 No response	-	-	-
Category 2: Volunteers/Doctors from Bergen Health Trust				
Interview n°0	In person 23.02.2016	29.03.2016	Hand notes	Skype
Interview n°16	Email: 04.11.2016	22.12.2016	40 mins	Phone
HelseBergen-1	Email 04.11.2016 Email 21.11.2016 Email 05.12.2016 No response	-	-	-
Category 3: Experts Norwegian global health/development policy				
Interview n°4	In person 02.09.2016	15.09.2016	50 mins	In person/Office
Interview n°13	Email 31.10.2016	03.11.2016	59 mins	In person/Office
UiO-1	Email 01.11.2016	08.11.2016	Hand notes	In person/Office
NUPI-1	Email 06.09.2016 Declined 19.09.2016	-	-	-
NUPI-2	Email 01.12.2016 No response	-	-	-
PRIO-1	Email: 28.11.2016 No response	-	-	-
Category 4: Members of Parliament expressing views during the debate on Ebola (Stortinget, 2014)				
Marit Nybakk	Email: 10.10.2016 No response	-	-	-

Sylvi Graham	Email: 10.10.2016 No response	-	-	-
Knut Arild Hareide	Email: 10.10.2016 No response	-	-	-
Kjersti Toppe	Email: 12.10.2016 No response	-	-	-
Ketil Kjenseth	Email: 12.10.2016 No response	-	-	-

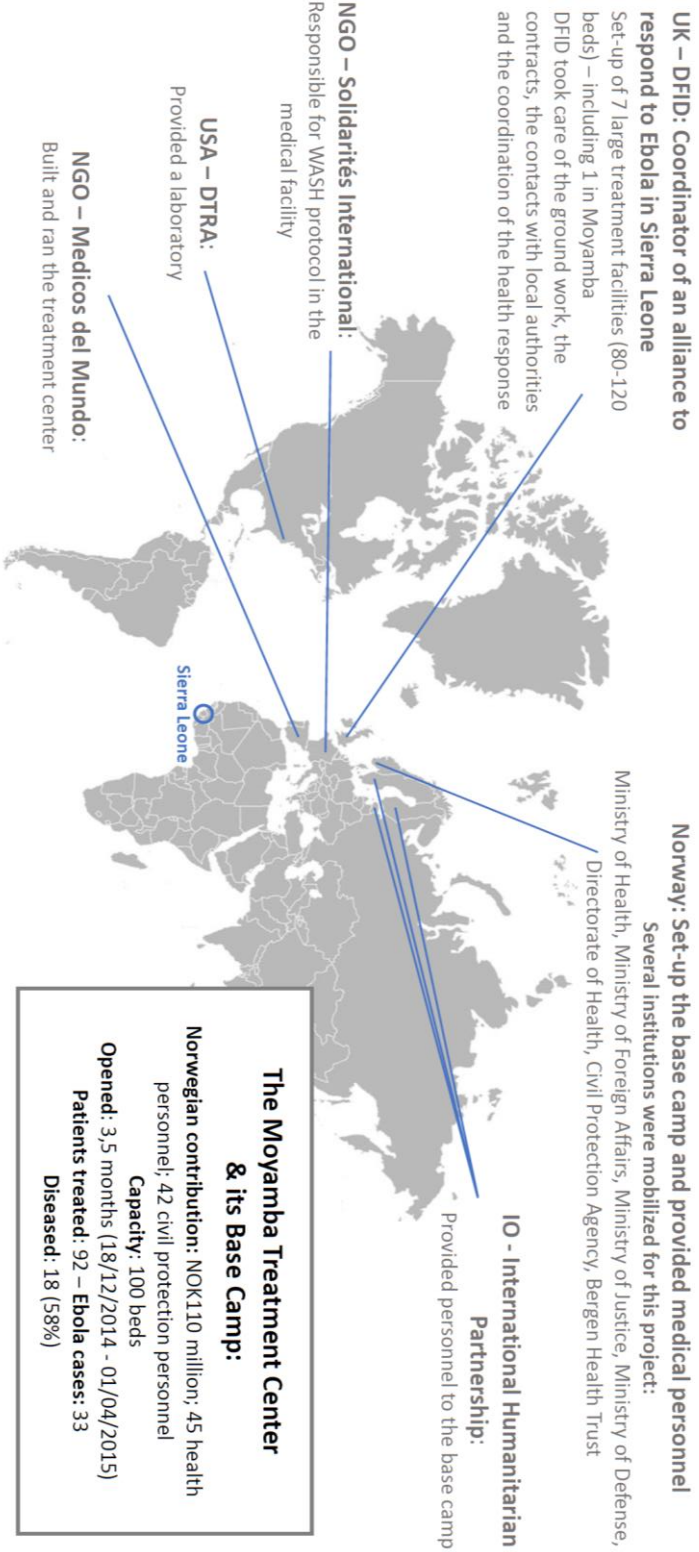**Annex 2: Organization set-up of the Moyamba Ebola Treatment center (de Bengy Puyvallee, 2017)**

The Base Camp

Credit: Helsedirektoratet

The Treatment Facility

Credit: Helsedirektoratet

UK – DFID: Coordinator of an alliance to respond to Ebola in Sierra Leone
Set-up of 7 large treatment facilities (80-120 beds) – including 1 in Moyamba
DFID took care of the ground work, the contracts, the contacts with local authorities and the coordination of the health response

NGO – Solidarités International:
Responsible for WASH protocol in the medical facility

USA – DTRA:
Provided a laboratory

NGO – Medicos del Mundo:
Built and ran the treatment center

Norway: Set-up the base camp and provided medical personnel
Several institutions were mobilized for this project:
Ministry of Health, Ministry of Foreign Affairs, Ministry of Justice, Ministry of Defense, Directorate of Health, Civil Protection Agency, Bergen Health Trust

IO - International Humanitarian Partnership:
Provided personnel to the base camp

The Moyamba Treatment Center & its Base Camp:
Norwegian contribution: NOK110 million; 42 civil protection personnel; 45 health personnel
Capacity: 100 beds
Opened: 3,5 months (18/12/2014 - 01/04/2015)
Patients treated: 92 – **Ebola cases:** 33
Diseased: 18 (58%)

Sierra Leone

<u>Annex 3</u>: Pictures of the Ebola Treatment Center and the base camp in Moyamba, Sierra Leone

Source: Blog from participants to the project "Camp Moyamba" (Collective, 2015)

The Ebola Treatment Center in Moyamba

Individual guest tents, equipped with air condition

The gym

The TV room

The UK military help transporting personnel to the base camp

Annex 4: Norwegian institutions involved in the Moyamba ETC project, adapted by the author from (Health-Directorate, 2016, p. 32)