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THE CASE OF EBOLA IN WEST AFRICA

- SWEDISH HEALTHCARE WORKERS' EXPERIENCES OF NAVIGATING GLOBAL HEALTH INTERVENTIONS

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SIMV10, Master's thesis, 30 credits
Spring semester, 2015
Supervisor: Kjell Nilsson

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Abstract

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In this time of global health interventions, preventing borderless diseases, such as Ebola, is a question of implementing global health policies in different cultural contexts. Although these interventions are mediated by international organs, the healthcare workers on the ground are actually those who implement policies. From this starting point, this thesis investigates the extent to which Swedish healthcare workers, when combating the Ebola virus disease in West Africa, take into consideration the local context in their application of global health preventive measures. It does so by exploring healthcare workers' experiences of navigating global health interventions, while negotiating culture. Qualitative semi-structured interviews were conducted with participants in the Swedish Civil Contingencies Agency's medical mission, which aimed to combat Ebola in Liberia and Sierra Leone. To understand their experiences, Michael Lipsky's 'bottom-up' theory and conceptualization of the street-level bureaucrat inspired this study's theoretical foundation. Three themes were prevalent in the interview material: *Navigating the field and establishing trust, Consolidating objectives* and *Negotiating culture*. This thesis argues that constant flexibility and adjustment to the pre-existing challenges in the field are vital in the adaptation of health policies. Moreover, flexibility is dependent on the information transferred from the field. Without rapid information transferal, bureaucracies and their employees have false perceptions of the field, on which they articulate their objectives for partaking in the health interventions. It is further argued that these actors continuously have an internal negotiation of 'Self' in relation to 'Other' and the bureaucracy that they work for, while trying to navigate health interventions in a foreign context. In conclusion, the 'one size fits all' approach does not work and this mindset (re-)produces a dichotomy between 'us' and 'them' where a certain way of doing things is seen as predominant.

Keywords: Borderless diseases; Ebolavirus; Swedish healthcare workers; global health interventions; street-level bureaucrat; global health machinery

Table of content

1 Introduction

In the mid-1990s one single case of an ebolavirus was reported in Côte d'Ivoire; but, following that incident, nothing indicated the presence of the disease in the West African region (Feldmann 2014). Almost two decades later, news spread throughout the world about a terrifying virus with the capacity to become global. EBOLA had hit Guinea, Liberia and Sierra Leone. The outbreak exceeded the number of cases and deaths combined in the near forty year long history of the disease (WHO 2014e). Thousands of people died in these hardest-hit countries. This borderless disease was spreading like a plague, and the question on people's minds was: When would this terrifying virus come knocking on our door and how should we protect ourselves from it?

8 August 2014, the World Health Organization (hereinafter WHO) declares the situation to be a "public health emergency of international concern" (WHO 2014d). As a central figure in providing leadership in critical health situations, the WHO coordinated international teams in the mission to combat the disease and prevent a continued spread (WHO 2014b:34; WHO 2014i:20). Humanitarian aid was sent to the three hardest-hit countries; however, as situation deteriorated and the actors present in the region were incapable of combating the disease alone. At this stage, the WHO requested Sweden to partake in the mission to combat Ebola. The Swedish Civil Contingencies Agency took on this task on behalf of the Swedish government on 20 October 2014. The initial idea was that the agency together with the Liberian Ministry of Health, operate and staff an Ebola treatment unit in Monrovia. Thus, the vast process of recruiting Swedish healthcare workers and other non-medical personnel began. However, the local needs were continuously changing as the number of cases fluctuated up and down. This required flexibility of the agency and its staff in their application of global preventive measures against the disease (MSB 2015).

In our age of global health interventions, combating borderless diseases, such as Ebola, is a question of mediating health policies in autonomous states. Although these health policies are mediated by international organs, such as the WHO, the healthcare workers working in the field are those who are actually implementing the policies. Thus, in this process of 'bottom-up' implementation of health policies, healthcare worker's experiences are important to consider as these can contribute to assessing the obstacles of disease prevention (Moore and Williamson 2003:617-8). It becomes even more relevant to illuminate these experiences when the healthcare workers move across territorial borders and enter culturally different contexts, as in the case of the medical staff working for the Swedish Civil Contingencies Agency. Each geographic area has its own pre-requisites with regards to resources, culture and so on, which influence the possibility for adaptation. Consequently, to transfer health policies on preventive measures should involve a

consideration of these local circumstances. Thus, how culture is negotiated in the implementation of global health policies impacts the transferability of policy to the unique circumstances of the context (cf. Hewlett & Hewlett 2005:292; Holmes, Greene & Stonington 2014:477; Abraham 2007; Hanefeld 2010:100). With this starting point this thesis pursues the subsequent objective:

1.1 Purpose and research questions

The purpose of this thesis is to investigate the extent to which Swedish healthcare workers, when combating the Ebola virus disease in West Africa, take into consideration the local context in their application of global health preventive measures. In doing so, the following questions will be explored:

- What are Swedish healthcare workers' experiences of navigating global health interventions towards Ebola in the current "hot zone" of West Africa?
- How do these healthcare workers negotiate their role in this culturally different context?

1.2 Limitations

This thesis does not evaluate policy implementation *per se*; rather, it portrays the experiences of implementation from a 'bottom-up' perspective. Exploring healthcare workers' experiences of navigating health interventions and negotiating culture is highly relevant as research concerning this is limited. To pursue this purpose, semi-structured interviews are conducted to grasp these experiences. As these experiences portray a snapshot of subjective understandings of a particular event, this thesis does not claim generalizability. Moreover, this study mainly focuses on healthcare workers that are public employees in Sweden, who work in direct contact with the citizens. All interviewees have been deployed in Liberia or Sierra Leone and have participated in the Swedish Civil Contingencies Agency/*Myndigheten för samhällsskydd och beredskap* (hereinafter MSB) mission in these countries. Thus, this study is further limited to these countries. Additionally, to depict a nuanced picture of the context other participants apart from healthcare staff in MSB's mission have also been interviewed, such as logistic advisors, who have not focused on the purely medicinal aspects of the Ebola preventive measures. From a medical perspective, they lack direct contact with citizens. Nonetheless, their close collaboration with the healthcare personnel make their voices a valuable addition in grappling the work conducted on the ground in West Africa.

1.3 Terminology

Before embarking on the background, I would like to present a few notes on terminology. *Ebola* is used to refer to the ebolavirus or the Ebola virus disease (hereinafter EVD). *West Africa* refers to the three countries hardest-hit by the ebolavirus, that is, Guinea, Sierra Leone and Liberia. However, Liberia and Sierra Leone are central for this thesis, as the interviewees were solely stationed there. *Health workers* and *healthcare workers* are used interchangeably and refer to individuals that provide health care in a systematic way to others, such as nurses and doctors.

The definition of *health* adopted is that of the World Health Organization (hereafter called the WHO), which states that: "[h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1948). This definition has been criticized for its generality, because it includes both social well-being and physical health. It is this generality, which creates a blurring of lines, where social problems, such as war and crimes, could be defined as health problems (Callahan 2012:63-65). Nonetheless, this understanding of health lies at the core of the organizations work (see WHO 1948), which includes infection prevention and control guidance for Ebola. Thus, this definition is used because of its influence on the EVD preventive measures implemented in West Africa by MSB[1].

Global health involves the universal enhancement and equity in health for all people. The *global* aspect is emphasized, as issues affecting health that transcend national boundaries are in focus. These issues become global as several countries are affected, which is the case during epidemic infectious diseases (e.g. HIV, SARS or Ebola). Health is also affected by transnational factors, such as climate change and urbanization (Koplan *et al* 2009). Global health has been the underlying motive for the current Ebola intervention (WHO 2014d). Such *global health interventions* are understood as the mediation of disease preventive measures by third parties in autonomous states.

Finally, the use of acronyms is limited; however, besides the WHO and EVD, the most frequently used acronyms are MSB for *the Swedish Civil Contingencies Agency*, HIV for *Human Immunodeficiency Virus*, AIDS for *Acquired Immunodeficiency Syndrome* and SARS for *Severe Acute Respiratory Syndrome*. The medical terms used are limited to the most relevant, which are explained when used in the text.

[1] As explained in *2.1 What is Ebola?* WHO has a leading role in health emergencies, such as the current EVD outbreak. MSB, as a Swedish governmental organization, functions under this leadership in their Ebola mission in West Africa. It is therefore assumed that WHO's notion of health impacts the WHO preventive measures implemented by MSB.

1.4 Disposition

This introductory chapter has presented the studied case, the research aim and questions. Moreover, it provides the limitations of this study and put forth a terminology section with an overview of the most frequently used terms and abbreviations. Thereafter, the second chapter presents *previous research* and situates this study within the presented academic field. The subsequent chapter called *The case of Ebola in West Africa* provides the reader with some background information regarding the disease, its trajectory in the region and the prevention challenges it presents for these countries. The fourth chapter presents the *theoretical framework*, which is based on Michael Lipsky's (1980:3) notion of the street-level bureaucrat. It depicts this actor as described by Lipsky and goes on to argue that the street-level bureaucrat becomes a global actor, who moves across national borders and is embedded in a so-called global health machinery. It moreover presents the limitations of Lipsky's theory. Thereafter, the *Methodology* chapter provides an overview of the material collection process. It is influenced by constructivist epistemic relativism[2], as it argues that the voices in this thesis are a snapshot of a particular time and place of subjective understandings of an experienced reality. The sixth and subsequent chapter combines the presentation of the empirical material with a theoretical analysis. It presents three main themes found in the interview material; *Navigating the field and establishing trust, Consolidating objectives* and *Negotiating culture*; and discusses these through a theoretical lens. The last chapter provides a concluding discussion, which summarizes and discusses the main findings.

[2] Constructivist epistemic relativism refers to the idea that individuals' knowledge of their reality is subjectively constructed and relative to themselves and the context wherein this knowledge is created (cf. Kukla 2000:4).

2 Previous research

This chapter provides an overview of previous research on borderless diseases in the West African context. Two borderless diseases are mainly discussed; the Ebola virus disease and HIV. These diseases are borderless in nature because their infectious character creates a potential for global spread and a difficulty to hinder this mobility (Ritzer 2011:232). As this thesis focuses on Ebola in West Africa, research on this topic is primarily discussed. However, there are a limited number of studies within social sciences on this topic. Consequently, while navigating the academic field research on HIV/AIDS is also depicted to give an understanding of what has previously been emphasized with regards to the prevention of borderless diseases. Moreover, by highlighting HIV/AIDS research there is also an attempt to illuminate some aspects of the local context that other studies argue could impact the application of health policies. Furthermore, as this thesis focuses on health workers' experiences of combating borderless diseases it is relevant to portray research in this area. The final paragraph of this chapter situates this thesis within the presented academic field.

2.1 The academic field

Since the first Ebola outbreak 1976 in the Democratic Republic of the Congo (DRC formerly Zaire) multiple medical journals have published reports on the subject. However, these reports have increased as of last year, which is presumably due to the vast death rate and the regional and possible global spread of Ebola. Medical journals, such as *The New England Journal of Medicine*, have presented several discussion articles on the topic that range from the panic and paranoia associated with the disease (cf. Gonsalves & Staley 2014) to the global discrepancies in resources (cf. Fauci 2014). However, as of yet, a limited number of studies on Ebola have been anchored within social sciences and little to nothing has utilized a sociological perspective.

In academia, the research on Ebola has been relatively limited to the field of medicine. The epidemiological aspects of Ebola, such as contamination strategies (cf. Pandey *et al* 2014); clinical documentation inside Ebola centers (cf. Bühler *et al* 2014) and transmission dynamics (Nishiura & Chowell 2014) have been some of the focal points. Despite the predominantly epidemiological research focus in this field, some articles also highlight the socio-cultural aspects of Ebola. In for example Nishiura's and Chowell's (2014) study on the contamination and transmission dynamics of Ebola virus disease (EVD) economic and socio-cultural factors are identified to be hampering the prevention of EVD. They argue that African regions with insufficient resources not only lack a sufficient amount of healthcare workers and other personnel; but, they also lack adequate infrastructure and essential medical equipment. Nevertheless, these factors are not the sole contributors to an increased spread of EVD. Socio-cultural aspects, such as burials and funeral

practices, also intensify the spread and obscure the implementation of preventive measures (Ibid.).

The challenge of disease prevention due to cultural practices has also been emphasized in other studies (cf. Pandey *et al* 2014; Bah et al 2015; Boulton 2014); yet, few studies give attention to how local beliefs and practices can contribute to the control measures (Hewlett & Amola 2003:1246). Hewlett and Amola (2003:1247-8) argue that:

> The urgent context of these outbreaks often leads to the neglect of local people's feelings and knowledge. The general impression is that, without Western interventions, the epidemic would kill hundreds and spread to all parts of the world; local practices and beliefs are perceived only as amplifying the outbreaks.

The significance of understanding local beliefs and practices for disease prevention has been emphasized within HIV/AIDS research. In for example Hess and McKinney (2007:113) study it is argued that behavior could potentially be encouraged or discouraged to decrease HIV transmission if peoples' behavioral patterns, beliefs and attitudes are identified. Similarly, Moore, Kalanzi and Amey (2008) stress the importance of grasping local attitudes. Their study indicates that social stigma and discrimination associated with HIV/AIDS impacts HIV-positive individuals' patterns of disclosure. By knowing the attitudes that guide these behavioral patterns health policies and the provision of health services could improve (Ibid.:361). However, Green's (1992:121) study emphasizes that it is not only vital to recognize local beliefs and practices, but it is essential to incorporate traditional healers for preventing HIV transmission, as people in many African societies' seek traditional rather than biomedical treatment for sexually transmittable disease.

The importance of contextualizing or adopting health programs to local situations has been underscored in several studies that have argued that an 'one size fits all' approach does not work (cf. Hewlett & Hewlett 2005:292; Holmes, Greene & Stonington 2014:477; Abraham 2007; Hanefeld 2010:100). Besides the lack of attention in research towards the relationship between indigenous cultural practices and disease control efforts, there is also a gap in regards to health workers' experiences of working with disease prevention (cf. Hewlett & Amola 2003:1246; Prince & Otieno 2014:929-930). This involves a lack of knowledge with regards to understanding how healthcare workers' experience the process "of navigating global health interventions" (Prince & Otieno 2014:929). As health workers' interact, first-hand, with patients, their experiences can contribute to assessing the obstacles of disease prevention (Moore & Williamson 2003:617-8). In

a similar vein, Richter *et al* (2013) emphasize the importance of illuminating healthcare workers perspectives. They argue that "[f]rontline nurses are well situated to identify policy gaps during the implementation of HIV and AIDS policies and can suggest remedial steps, which can contribute to a bottom-up policy approach" (Ibid.:56). The bottom-up policy approach is significant to improving the treatment of HIV-positive individuals, as healthcare workers deliver healthcare within the policy framework and are affected by these policies in their daily interaction and provision of care to patients (Ibid.:53). Clearly, these perspectives are important to study, as health workers can both identify policy gaps and can contribute to assessing obstacles of disease prevention, and several researchers, such as Turale (2014:443) and Prince and Otieno (2014:929), concur.

The studies conducted on healthcare workers' experiences in Ebola inflicted areas are limited. In Bühler *et al*'s (2014) study on the lack of clinical documentation in Ebola wards, healthcare workers were interviewed to understand and problematize the absence of standardized documentation methods. Also conducting interviews, Hewlett and Hewlett (2005) focused on local healthcare workers' general views and experiences of nursing during the Ebola outbreaks in Central Africa. The interviewed nurses highlighted three main themes, which describe their overall experience of working during an Ebola outbreak: 1) lack of medical equipment, 2) stigmatization by community, co-workers and family and 3) commitment to nursing despite hazardous working conditions. The two former themes are also reflected in other studies on the topic and have been identified as hurdles that impede the Ebola control efforts in Africa (cf. Nishiura & Chowell; Pandey *et al* 2014; Kinsman 2012).

As previously mentioned, there is a shortage of literature on healthcare workers' "experiences of navigating global health interventions" (Prince & Otieno 2014:929). However, one of few studies that illuminate this perspective is the ethnographic study by Prince and Otieno (2014) in Kenya. It focuses on healthcare workers perspectives on navigating the juxtaposition of donor funded health interventions towards high-profile diseases like HIV/AIDS with public health services. The study highlights the uneven work situation that exists between healthcare workers in HIV care and health workers in under-resourced public health services. Prince and Otieno (2014) emphasize the importance of recognizing the impact global health priorities may have on the local healthcare systems and healthcare professionals. By prioritizing and directing funds towards high-profile diseases local medicinal issue might be neglected. Consequently, 'local' medicine comes to be less attractive as professional ambitions are difficult to attain and stress leads to a decreased commitment to the work. Although, this thesis does not aim to explore this

particular juxtaposition it is important to recognize that global health priorities can impact the pre-existing health system and its healthcare professionals.

Nonetheless, there is some research in the area of global health interventions and policy transfer, which focuses on caregivers' perceptions of HIV/AIDS prevention. Moore and Williamson (2003) conducted an interview-based study on this issue in Lomé, Togo, which investigated the effect socio-economic, cultural and institutional factors have in HIV/AIDS prevention. Based on the perceptions of healthcare workers they concluded that disease preventive interventions ought to include an awareness of these structural factors, which are contributing components in the spread of HIV/AIDS. In a similar vein, Kevany *et al* (2012) and Ngoasong (2011) stress the importance of modifying global health interventions to the needs of the recipient community. Kevany *et al* (2012) point to the improved efficiency of HIV-related interventions when these become adapted to the local setting and socio-cultural environment. Evidently, these researchers stress the importance of applying a 'bottom-up' approach while implementing health policies in different cultural contexts.

Seemingly, the incorporation of socio-cultural factors in disease prevention is essential; however, for disease prevention in West Africa the security aspect is important to consider (cf. Rodrick 2006; Ahonsi 2010). Since the late 1980s the region has been engulfed by a security crisis, which has not only impacted HIV/AIDS prevention, but disease prevention in generally. As pointed out by Rodrick (2006:53-54), this crisis, caused by violent conflict, has exacerbated the risk factors associated with potential HIV/AIDS transmission, such as a deteriorated health infrastructure, population movements, sexual exploitation and a reduction in scope and quality of HIV/AIDS control strategies. As the healthcare system breaks down, the spread of infectious diseases (e.g. tuberculosis) increase, while treatable diseases (e.g. malaria) are untreated (Ibid.:59). Thus, the regions instable political situation seems to have affected the countries' capabilities to adopt preventive measures against HIV/AIDS. From another perspective, it can be argued that:

> […] emerging and re-emerging infectious diseases remain significant obstacles to political stability and economic development; if only because in a realist, Hobbesian sense, they kill more than conflict (Ibid.:53).

Nonetheless, in contrary to Southern and Eastern Africa, the countries along the Mano River Basin, i.e. Liberia, Sierra Leone and Guinea, face the additional challenge of coordinating HIV/AIDS health policies that adhere to the regions ethnic and linguistic mixture (Ibid.). However, in many African countries, such as Ghana, mass media has had a critical role in

transferring knowledge and awareness of HIV/AIDS. Although, Benefo and Takyi (2002:93-94) point to a biased knowledge distribution via mass media, as most individuals only adopt one protection method, mass media has had the capacity to reach larger parts of the Ghanaian population than interpersonal interventions. A conclusion that can be drawn from this study is that the role of mass media in disease prevention is important to consider due to its power in influencing peoples' behavior and perception of borderless diseases. As mass media can be used by stakeholders to transform individuals' minds there is an inherent political and power aspect of this process that has to be considered. It is a question of power and politics in the sense that certain health norms and values transferred via media could become hegemonic or dominant. However, based on mass media reports one cannot assess individuals' internalization of the information transferred via media (cf. Benefo & Takyi 2002:78). Although, it would be interesting to explore the West African peoples' internalization of the disease information transferred by mass media, this objective would not have been feasible within the frame of this thesis due to the study's current aim, the flight restrictions in the Ebola 'hot zone' and high infection risks.

The previous research on HIV/AIDS prevention presented in this chapter clearly stresses the impact local culture and historical events (violent conflicts) have on the prospects of adopting preventive measures in the West African region. Additionally, the regions ethnic and linguistic mixture illuminates the fluidity of the geographical borders between the countries in the region. It can be argued that the fluid borders create a situation where health policies have to recognize the hybridity in culture within the West African context to be efficiently implemented (cf. Hewlett & Hewlett 2005:292; Holmes, Greene & Stonington 2014:477; Abraham 2007; Hanefeld 2010:100; Rodrick 2006). Subsequently, it is questionable if a top-down formulation of policy can be mediated without a bottom-up approach, as an 'one size fits' all approach for preventing borderless diseases will presumably lack awareness of the cultural constellations existing within different areas.

The reviewed literature illuminates the absence of research on health workers' experiences of navigating global health interventions. It further shows an overall lack of attention to health workers' experiences from Ebola inflicted areas. The aforementioned research review also portrays the importance of adjusting global health interventions to the local and cultural circumstances of recipient communities. With these factors in mind, it seems relevant to portray health workers' experiences of navigating global health interventions towards Ebola. With first-hand experiences of adopting preventive measures in the current Ebola 'hot zone' they could contribute to an understanding of the local prerequisites for implementation and illuminate the policy gaps. These experiences could give a 'bottom-up' portrayal of the situation, which is

currently lacking. This kind of understanding is not only important for the EVD, but also for other diseases and global health interventions to maximize efforts and results. Moreover, an intervention is inherently a mediation of heath ideals in different cultural contexts. Thus, as pointed out by several researchers, the 'one size fits all' approach does not work when implementing global health interventions. This is perhaps especially relevant to consider when health interventions are implemented by external actors, as they may not be familiar with the context at hand. Thus, it also seems significant to recognize the potential negotiation of different cultural understandings of the disease and the implementation of the EVD preventive measures. In light of the knowledge gap within the academic field, the importance of health workers' experiences of navigating global health interventions in culturally different contexts cannot be overemphasized. Because of this, this thesis aims to investigate the extent to which Swedish healthcare workers, when combating the Ebola virus disease in West Africa, take into consideration the local context in their application of global health preventive measures.

3 The case of Ebola in West Africa

In this chapter of the thesis some background information is presented. It aims at outlining the context wherein the EVD preventive measures are adopted. The initial sub-section focuses on explaining Ebola as a virus and its implications on humans. The World Health Organization's role in preventing the Ebola epidemic is also presented here. The following sub-section gives a brief overview of the disease trajectory in West Africa. Finally, some of the challenges that impede disease prevention are presented. These challenges are divided into three sub-levels – macro, meso and micro – to facilitate an overview of the societal factors impacting disease prevention.

3.1 What is Ebola?

The West African population daily faces several deadly, but preventable, disease outbreaks, such as Malaria, HIV/AIDS and tuberculosis (cf. WHO 2014a). What distinguishes the Ebola virus disease from these is its mysterious and highly fatal character. As of September 2014, the natural reservoir, or the original source of infection, is undetermined; but, fruit bats are thought to be carriers of the virus. The mortality rate is estimated to be between 50-90 percent (Boulton 2014). By comparison, the SARS outbreak in 2003 had a death rate of approximately 9.6 percent (WHO 2004). At present, there is no vaccine or treatment for Ebola. Healthcare workers can therefore only treat the effects of the disease, such as high fever, diarrhea and pain (Boulton 2014; Hewlett & Hewlett 2008:3).

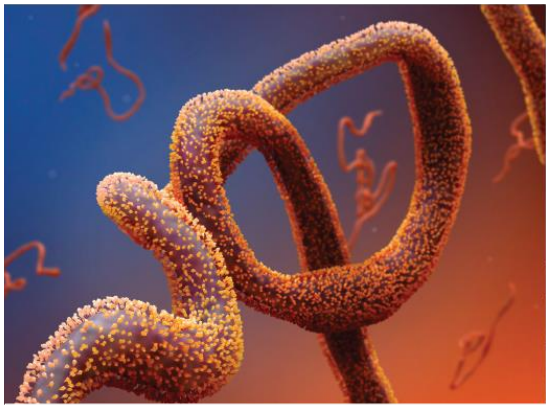

Figure 1.1: *Ebola virus seen under microscope*
Source: Boulton 2014:989

The first Ebola[3] cases were discovered near tropical regions in the Democratic Republic of Congo (DRC formerly Zaire) in 1976 (Peters & LeDuc 1999; Burke, Declerq & Ghysebrechts 1978:273). During the subsequent years new species of EVD were discovered and identified based on geographic origin (Boulton 2014:988). Of these, three Ebola species are transmittable to humans; Zaire Ebola virus, Bundibugyo Ebola virus (detected in Uganda) and Sudan Ebola virus (Gostin, Lucey & Phelan 2014). Ebola is a filovirus, so called because of its thread-like structure (see Figure 1.1) (Boulton 2014:988).

The virus is zoonotic, i.e. it is transferable between humans and animals, which is particularly relevant because 'bush meat' is a source of nourishment in some rural areas. In for

[3] The virus was named after the river Ebola in DRC (formerly Zaire).

example Congo this is thought to have been the origin of the latest Ebola outbreak. Handling infected animals or eating undercooked meat becomes a source of transmission. Moreover, the traditional burial practices also become an issue since transferal is still possible via dead tissue (Boulton 2014; Gostin, Lucey & Phelan 2014:1096).

If infected by Ebola, a person is incubated[4] between two to twenty-one days. During this period the virus destroys the white blood cells that are vital for combating infections in the body (Hewlett & Hewlett 2008:3-4). The initial symptoms (e.g. high fever, pain and diarrhea) are similar to other common tropical diseases, such as malaria and cholera. Due to this similarity, it is difficult to diagnose the disease at its early stages (Boulton 2014; WHO 2014a).

Once an outbreak of Ebola has been confirmed, the following WHO strategies of containment are applied (1) resource mobilization and coordination of control and preventive actions, (2) establishing surveillance systems for tracing infection cases, (3) adopting behavioral intervention programs aimed at reducing social practices that enhance transmission, and (4) establishing isolation units adopting nursing precautions. As a central figure in combating Ebola the "WHO must coordinate international teams (MSF, Red Cross, GOARN, US CDC, UNICEF, etc.) and serve as a focal point for national and international teams" (WHO 2014b:34). This is in line with the organizations core functions to provide leadership in critical health situations and engage in collaboration with regards to this when needed (WHO 2014i:20)

3.2 The disease trajectory

In the current West African Ebola outbreak the most lethal Ebola species, i.e. the Zaire Ebola virus, is sweeping across the region, with an epicenter consisting of Sierra Leone, Liberia and Guinea (see Figure 1.2) (CDC 2015; WHO 2014a). Prior to December 2013 no Ebola related deaths had been recorded in the region (Gostin, Lucey & Phelan 2014). On 23 March 2014, the WHO made a public notification about a Guinean EVD outbreak on its website (WHO 2014c). In the months that would follow, the disease spread from Guinea, to

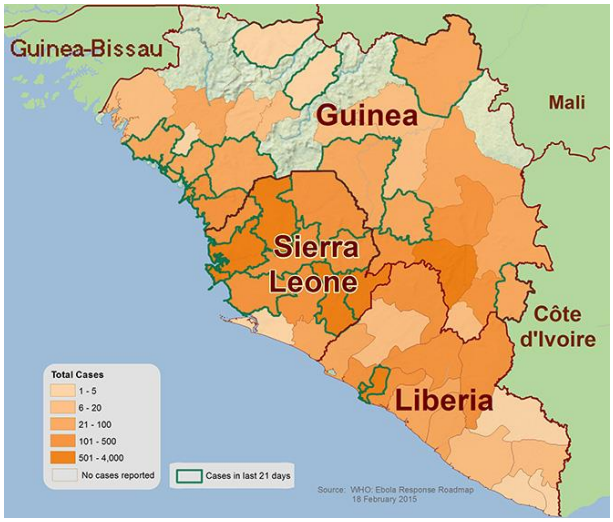

Figure 1.2: *Ebola outbreak Distribution Map - the "hot zone"* Source: CDC 2015

[4] Incubation period is the time from the moment one is exposed to an infection until one is first showing symptoms of it.

Liberia and Sierra Leone. The epidemic continued to gain geographic amplitude in West Africa and neighboring regions. Consequently, the WHO declared on 8 August 2014 that the situation was a "public health emergency of international concern" (WHO 2014d).

After six months, the Ebola epidemic had exceeded the number of cases and deaths of all past outbreaks combined; thereby, becoming the longest and most severe Ebola epidemic in the near forty year long history of the disease (WHO 2014e). In contrast to previous outbreaks the current outbreak has not been concentrated to rural areas. All capital cities – Conakry, Guinea; Monrovia, Liberia and Freetown, Sierra Leone – of the countries at the epicenter of the outbreak have experienced vast epidemics. The rapid spread of the virus has shown the inadequacy of health responses (Gostin, Lucey & Phelan 2014; WHO 2014e).

By 10 May 2015 approximately 11 080 EVD deaths had been reported in Guinea, Sierra Leone and Liberia. Although there is a decrease and stabilization of EVD cases in total, flare-ups remain a risk (WHO 2015). Thus, "[j]ust when the outbreak looks like it is coming under control, sudden and unexpected flare-ups occur, again giving the virus a new breath of life" (WHO 2014e).

In retrospect, the early reactions from the international community towards the epidemic were slow. According to Seth Berkley, chief executive of the Global Alliance for Vaccines and Immunization, the increased attention on Ebola was mainly due to the realization that it may not stay isolated there. As he puts it: "[i]t's more about fear of the disease taking hold in the west than it is about the disease in the south" (cited in Brooks 2014:32).

3.3 Disease prevention challenges

On a macro-level, three challenges can be identified; *competing health priorities*, *poor public health infrastructure* and *post-conflict statehood*. Firstly, the populations' health status is weak, as diseases such as malaria, HIV/AIDS and tuberculosis are some of the leading causes of mortality (cf. WHO 2014a). Thus, these competing health priorities strain already weak healthcare systems. Moreover, insufficient healthcare facilities become virus amplifier sites due to the lack of strict infection control, protective gear and trained personnel, among other things. These factors place healthcare workers at greater risk for infection, which ultimately leads to a shortage of human resources (Gostin, Lucey & Phelan 2014). In the three hardest-hit countries the response capacity diminishes extensively due to the pre-epidemic ratio of 1-2 physicians to 100 000 people (WHO 2014e). Finally, the countries at the epicenter of the outbreak are emerging from civil conflict, which destroyed healthcare systems among other things (WHO 2014a). As a result of the Ebola epidemic these fragile economies face greater economic hardships, such as rising prices of goods

and services, increased poverty and decreased national revenues (WHO 2014e; World Bank Group 2014).

Three challenges can also be identified on a meso-level; *porous borders*, *communal mistrust* and *traditional medicine*. Due to poverty, the populations move across the borders of Guinea, Liberia and Sierra Leone to find opportunities elsewhere. Moreover, communities and families live along the borders, which increase the movement across. The porosity of the borders creates a situation where diseases can be transferred within the region, which makes it more difficult to control the spread (WHO 2014a; WHO 2014f).

Despite the efforts of communicating the risks involved in cultural practices, such as traditional burials, there are barriers to controlling these sources of transmission (Gostin, Lucey & Phelan 2014:1096). The communal mistrust existing within the West African society towards community 'outsiders', such as the government, has entailed certain resistance in the adoption of the recommended health countermeasures. This has resulted in cases of home-treatment of EVD patients, hiding of sick and traditional burials and so on (WHO 2014f). The mistrust in public health becomes a barrier to epidemic outbreak control, as trust enables a change in attitudes and behavior (WHO 2005:27). This third challenge can be seen as tied to trust. Traditional medicine constitutes a source of healthcare for approximately 80% of the population in the developing world (WHO 2014g:212). Consequently, traditional healers and medical practices play an important role in the contamination of the disease. In the strategy against Ebola it has been recommended that such communal figures be included in risk communication because of the trust given to them by the communities (WHO 2014h).

On a micro-level, *entrenched poverty*, *limited access to modern health care* and *social stigma and fear* seem to be challenges impeding the control of the outbreak. The region suffers from entrenched poverty, which entails that people are unable to meet their basic needs (WHO 2014a). Consequently, there is an economic and structural challenge of accessing healthcare due to poverty and weak health systems. Moreover, the stigma associated with the disease may exacerbate the spread, as uninformed individuals hide sick people so that they are not excluded by their communities (Nishiura & Chowell 2014).

4 Theoretical framework

The theoretical framework portrayed below is constructed around Michael Lipsky's (1980:3) notion of the *street-level bureaucrat*, that is, an actor that provides public services in direct interaction with citizens and has relative autonomy in the execution of this work. Usually, street-level bureaucrats are public employees, such as health workers, that give access to government programs. This framework seems suitable in this study as Lipsky's conceptualization of the street-level bureaucrat coincides with this thesis focus on health workers and their experiences of implementing health policies from a 'bottom-up' perspective. Moreover, Lipsky's understanding of the street-level bureaucrat is, in this thesis, framed within a global context, as the services provided by the bureaucrats are not confined to national borders. These so-called global public services are mitigated within a web of organizations, which connects institutions at national, sub-national and transnational levels. Consequently, the global street-level bureaucrat is acting within a global network when providing global public services in direct interaction with the citizens they encounter around the globe. In the following sections, the transformation towards a more global role of the street-level bureaucrat is discussed in depth, in the light of 'the borderless diseases'. The first section provides a portrayal of the street-level bureaucrat, as depicted by Lipsky. The second section focuses on the interaction between non-governmental and governmental actors within the paradigm of global health governance. The third section discusses the role of this bureaucrat on a global arena and the final section discusses the limitations of Lipsky's theory.

4.1 Lipsky's street-level bureaucrat in action

> ...the reality of the work of street-level bureaucrats could hardly be farther from the bureaucratic ideal of impersonal detachment in decision making. On the contrary, in street-level bureaucracies the objects of critical decisions - *people* - actually change as a result of the decisions (Lipsky 1980:9).

The Weberian modern bureaucracy, characterized by impersonal detachment to ensure equality (Weber 1968:956-958), has perhaps faded away from the work conducted on the streets. The bureaucrats functioning on the ground have a critical role in citizen's lives because they impact their entitlements to public health. Through the direct or indirect provision of public benefits via health services, the street-level bureaucrats determine individuals' eligibility for government benefits and sanctions. The policies delivered by bureaucrats are often immediate and personal, as decisions are based on individual determinants and made on the spot (Lipsky 1980:3-8). In this

process, the street-level bureaucrat is a policymaker based on two related facets of their work: "*relatively high degree of discretion*" and *"relative autonomy from organizational authority"* (Ibid:13). The bureaucrat has freedom of choice (*discretion*) in the decisions made about citizens in the interaction with them. It is expected that professionals, such as doctors, exercise discretionary judgements in their field of expertise. For instance, a doctor can determine if a patient is eligible for a particular treatment. Consequently, the bureaucrat is quite independent from authority when executing discretionary judgement (Ibid.13-25).

Lipsky (1980:23) argues that:

> Street-level bureaucrats enjoy considerable discretion in part because society does not want computerized public service and rigid application of standards at the expense of responsiveness to the individual situation.

Lipsky's statement emphasizes the dual role of the bureaucrat that potentially has conflictual implications for them. On the one hand, it is expected that the street-level bureaucrat adheres to routines and procedures of the bureaucracy, which are assumed to ensure equal treatment of all. On the other hand, the bureaucrat should be responsive to unique, individual circumstances. The adherence to both increased efficiency and individual circumstances do at times collide. To improve efficiency, the bureaucracy reduces people into 'cases', which are framed as categorized 'clients'. Based on qualifying and disqualifying characteristics the bureaucrat determines if a person is eligible for bureaucratic intervention. However, many who work in the world of public services value the human aspect of the street-level work and hope to improve the lives of the clients they serve. In other words, "[t]hey derive satisfaction from making a difference for some clients and resist efforts to reduce the discretion that permits them to have this influence" (Ibid.105). Hence, the street-level bureaucrat aspires to provide an ideal level of service; yet, obligatory procedural requirements and constrained resources (fiscal and personnel) of the agency limit them from attaining this ideal (Ibid.40, 105-106). Consequently, "[t]o deliver street-level policy through bureaucracy is to embrace a contradiction" (Ibid.71).

It is usually expected of the bureaucrat to act as an advocate, that is, to utilize their position, skills and know-how to secure the best service for the client. However, advocacy is not always compatible with the organization or the work environment this agency constitutes. A large caseload and mass influx of clients makes it difficult to free enough time to devote to the client. Moreover, advocacy is incompatible with the street-level bureaucrat's job of determining whether a client is credible and eligible for the service being offered. For example, is the patient that is

asking for medicine truthful in their description of symptoms? Finally, the agency may in itself hinder advocacy. The advocate seeks resource dispersal to clients, while the agency hoards and tightly controls the resources. The advocate seeks to secure special treatment for individuals and utilizes discretion to gain benefits for clients, while the agency seeks equal treatment of all clients so that claims of special treatment do not occur (Ibid.72-74).

Sometimes street-level bureaucrats feel alienated in their work. Alienation involves the workers relationship to their work. For example, a job can be alienating if the worker lacks control of the production process of their work, is asked to dehumanize others or has no decision-making power over their work (Ibid.75). For the street-level bureaucrat, alienation concerns the relationship with the client and becomes evident in at least three instances. Firstly, to achieve efficiency and optimal use of resources the bureaucrat does not work with the client as a whole. The client is categorized and the bureaucrat is specialized in certain parts of the process, which leads to alienation, as the client is not followed throughout the process (Ibid-77-78). In the words of Lipsky (1980:78): "[s]treet-level bureaucracies that are oriented towards transforming clients are revolving doors because the solutions they offer people are not adequate. […] [The bureaucrats] are alienated to the extent they experience this discrepancy as loss of control over situations they are supposed to control". Secondly, the bureaucrat cannot control the 'reality' outside the agency that contributes to the client's need of services. Finally, there is an uncertainty regarding the number of clients in need of service and the amount of time required per client. Thus, the street-level workers have a difficulty controlling the pace of their decision-making (Ibid.). Consequently, "[a]lienated work leads to dissatisfaction with the job. Job dissatisfaction affects commitment to clients and to the agencies for which they work" (Ibid:79). Hence, as the rigid bureaucratic structure alienates the bureaucrat, the bureaucrat comes to be an unsatisfied employee, which affects their capability of providing services to the citizens.

As previously mentioned, the duality of the street-level bureaucrat's role is contradictory. In order to deal with these contradictions, inadequate resources and the influx of cases they develop coping mechanisms to deal with the responsibilities at hand (Ibid.18, 71). There can be a tension between the bureaucrat's capabilities and their own and/or the agencies objectives. This tension is at times dealt with by physically (quitting) or psychologically withdrawing from the work. However, it is also possible that the bureaucrat closes this psychological gap by modifying their objectives to better fit personal goals and capacities. Although, specialization can be alienating, it is a coping mechanism used to tackle the stressful strains of seeing the client as a whole. By compartmentalizing the client and focusing on a specialized area, the bureaucrat perhaps feels less stressed and more capable of providing satisfactory services. Moreover, in situations with a

heavy workload the bureaucrat may privately restrict the scope of their authority by for example strictly adhering to rules in order to deny discretion (Ibid.142-149). Finally, instead of restricting discretion the street-level bureaucrat may opt to increase it "in order to salvage a semblance of proper client treatment as they define it" and escape the bureaucratic structures of work that may limit this (Ibid.150).

4.2 'Borderless diseases' in an era of global health governance

Public health services provided by street-level bureaucrats transcend national borders in the wake of globalization, here seen as:

> …the set of processes involving increasing *liquidity* and the growing multi-directional *flows* of people, objects, places and information as well as the structures they encounter and create that are *barriers* to, or *expedite*, those flows (Ritzer 2011:2).

Rather than performing in a web of bureaucratic networks within the state territory, the global bureaucrat acts across these borders, as borderless diseases have come to threaten public health on a global level. These diseases are borderless due to their infectious nature, which creates a greater potential for global spread and a difficulty to impede this mobility (Ritzer 2011:232). National governments are no longer able to secure the health of their citizens, as health has become a global issue. Thus, the public health services offered to the world's citizens come to function within a paradigm of global health governance.

This paradigmatic shift denotes the transformation of public health decision-making in the light of globalization. Public health decision-making is enacted within the framework of global governance, where the concept of governance encapsulates an idea of decision-making resting on looser non-hierarchical networks of actors participating in policymaking and implementation (John 2001:9). Thus, governance refers to "the processes and institutions, both formal and informal, that guide and restrain the collective activities of a group" (Keohane and Nye 2000:202), which transcend the nation. Borderless diseases are not bound to nations and this requires collaboration across geographical borders. Public decision-making regarding these issues is therefore no longer confined to national borders, as global flows increasingly penetrate these structures. Thus, in the context of global health, governance comes to involve the mechanisms and means utilized by governmental and non-governmental actors, such as the WHO, National Health Ministries and Doctors Without Borders/*Médecins Sans Frontières* (MSF), to regulate, control or improve the borderless diseases (Kay and Williams 2009:1-2).

Just like the process of public health decision-making changes with globalization, so does the street-level bureaucracy. It is no longer confined to national territory; rather, it becomes one of many cogs in the global health machinery. This machinery, consisting of formal and informal actors, collectively becomes the policymakers and implementers of global health initiatives towards borderless diseases. And so, these street-level bureaucracies use the means and tools established through governance to guide and restrain actions against these diseases. Ergo, the bureaucracy is no longer solely influenced by its national government in its provision of health programs, as global health policies or guiding principles for health are reflected in their health programs (Kay and Williams 2009:11; Lipsky 1980:3). In other words: "[t]hese influences establish the major dimensions of street-level policy [levels of benefits, categories of eligibility, nature of rules, regulation and services] and account for the degree of standardization that exists in public programs from place to place […]"(Lipsky 1980:14). Thus, so-called 'glocalization' take place as the merge between the global and the local distinctively differs for diverse geographic areas (Ritzer 2011:159).

The relationship between the global health machinery, the street-level bureaucracy and the street-level bureaucrat can be understood as a continuous system of relations, where actors are a part of the social context this network creates. As the sociologist Granovetter (1985:487) puts it:

> Actors do not behave or decide as atoms outside a social context, nor do they adhere slavishly to a script written for them by the particular intersection of social categories that they happen to occupy. Their attempts at purposive actions are instead embedded in concrete ongoing systems of social relations.

Granovetter emphasizes the interconnectedness that exists between social actors. As embedded units in this system, they act in relation to the context it constitutes. Being a system of social relations, the global health machinery can be understood as a transaction domain. The concept of transaction domain encapsulates an idea of a defined sphere or domain, wherein social exchange is collectively agreed upon by the actors interacting in this system. Each domain has a particular consensual logic of action (Frödin 2013:72-73). In this light, the global health machinery, consisting of actors at transnational, subnational and national levels, becomes a transaction domain because this particular social context is collectively defined by the interacting agents. By mutually agreeing on definitions of this as a particular situation, specific roles and logics of interaction are invoked. Within every transaction domain, each role, such as the street-level bureaucracy contra the bureaucrat, is associated with particular deontic powers, that is,

obligations, rights and empowerments. When there is domain consensus regarding a particular transaction domain, such as the global health machinery, the actors in interaction share an understanding of the logics of interaction, specific roles and the deontic power associated with these roles (Frödin 2008:69-70; 2013:72-73). It can be argued that the 'global' street-level bureaucrat departs from this transaction domain, that is, the global health machinery, when entering or interacting with other domains to perform their work. For instance, the healthcare worker's logic of action, which functions within their usual transaction domain, is perhaps not similar to the logics of action valid or legitimate within the entered new healthcare setting or with the logic of action held by the patient one is interacting with. Ultimately, this may lead to a collision between different logics of action.

In the following section the role of the street-level bureaucrat as a global actor is discussed. Focus is on the collision of transaction domains that can occur when the street-level bureaucrat moves beyond national borders, and enters and interacts with other domains.

4.3 The global street-level bureaucrat

The street-level bureaucrats of relevance for this thesis have been stationed in West Africa. They have moved across national borders and come to interact with clients that exist in another context. The street-level bureaucrat has become a global actor. It can be argued that the bureaucrat has entered a different transaction domain where the preexisting relationship between domestic bureaucrats and clients is not based on the similar premises as the ones they are used to. Due to the history of civil war in the region, the governments lack legitimacy, which has impacted the communal trust towards outsiders and government officials, such as bureaucrats (see *2.4 Disease prevention challenges*). Moreover, the weak statehood of the West African countries has also resulted in poor health infrastructure. Thus, when entering the context of West Africa, these factors become some of the premises for interaction that the 'global' street-level bureaucrat encounters.

This thesis argues that to move across transaction domains implies the movement across cultures. Culture is a fluent and elusive idea; yet, it is argued that culture is communally shared understandings of reality, projected by individuals through their beliefs and practices. People draw upon the meaning that culture constitutes to make sense of their reality (Tomlinson 1999:18-20). In the case of street-level work, cultural influences can be seen as reflected in the practices of the bureaucrat. This is illuminated by the sociologist Julius Roth (cited in Lipsky 1980:85), who argues:

> There is no evidence that professional training succeeds in creating a universalistic moral neutrality... On the contrary, we are on much safer ground to assume that those engaged in dispensing professional services (or any other services) will apply the evaluations of social worth common to their culture and will modify their services with respect to those evaluations…

Hence, each transaction domain is influenced by the particular culture of the context wherein it exists, which is reflected in the logics of action in this sphere. Thus, as the bureaucrat moves across domains, and into a new context, it becomes a movement across cultures. This means that the previous modifications of services applied in one context, may not fit those of a different context. Understanding the culture may therefore enable an understanding of the premises embedded in the logic of action that exists in the new domain. Culture comes to constitute the logic of action and is reproduced in the particular domain, as it is projected through the actions and practices of the individuals in the transaction domain. By collectively agreeing upon definitions of this particular situation (the transaction domain) specific roles are assigned with deontic power. This mutual agreement is based on consensus regarding the logic of action within the domain, that is, there is a shared understanding of the set of rules that govern the domain. However, through this process of constructing a domain, and assigning roles with deontic power, borders of inclusion and exclusion are drawn for this sphere. Not acknowledging the logic of action (domain consensus) and lacking knowledge of it, may disable interaction, which excludes the actor from this sphere (cf. Frödin 2013:72-73).

Subsequently, the 'global' street-level bureaucrats' movement across domains seems to depend on both their internal negotiation with, and understanding of, the cultural context they enter. To be able to intervene successfully in an unfamiliar context, the 'global' street-level workers' actions find legitimacy through adopting the locally pre-existing logics of action. By coming into contact with other transaction domains, the bureaucrat has to internally negotiate the local logics of action with their own inherent logics of action. Through this process, a consolidation could occur so that consensus is reached. However, this consolidation would perhaps be impossible without knowledge of the culture wherein these logics of action are constituted.

Because the 'global' street-level bureaucrat provides services to the citizens in a different transaction domain, the legitimacy of the services provided are dependent on the social trust the citizens have for the transaction domain that the bureaucrat acts within. As Kenneth Arrow (1974:23) puts it: "[t]rust is an important lubricant of a social system," and so without trust, the

system, or in this case the bureaucrat acting within it, is unable to provide services without encountering hurdles in the provision of services. Hence, if the transaction domain, wherein the bureaucrat acts, is not trusted, then the bureaucrat representing this domain is seen as untrustworthy, and vice versa (Gran 2002:420; Farris, Senner and Butterfield 1973:145). Thus, in interaction with the citizen the role of the bureaucrat and their provision of services come into question.

4.4 Limitations of Lipsky's theoretical framework

> An action that is well adapted to one occasion may be illogical and dangerous in another. To appreciate the logic of actions and the rationality that defines them, the action must be viewed as a *strategy* rather than a response; the decision/action environment must be viewed as *multifarious* rather than dualistic; the quandary of the street-level bureaucrat must be viewed as emanating from the need strategically to *assimilate* or to *balance* multifarious competing pressures rather than simply involving a need to maximize utilities (Moore 1987: 82).

This quote summarizes one of the main critiques towards Lipsky's theory. In Lipsky's attempt to construct a general framework to portray the processes within the street-level bureaucracy and the actors involved in this domain of public policy, the theory disregards the particularities within public service. Consequently, the theory does not differentiate between different street-level contexts, such as healthcare, policing, social work and so on, and the different elements of decision making processes that are enacted within each of these contexts (Moore 1987:83-84).

Furthermore, the theory overlooks the need to balance or to combine various competing pressures experienced by the bureaucrats in their work (Ibid.:80-81). Lipsky (1980:72-79;105-106) argues that the bureaucrats' ration energy, time and resources to maximize services for the clients. Through this decision process stress caused by work overload is reduced. Hence, within the theory the decision process emphasizes the benefits of the procedures to maximize services, rather than the procedures required to undertaking the job. Moore (1987:84-86, 91) points out that the ambiguities that arise while determining the procedures required for preforming tasks, are affected by the street-level bureaucrats' different, but coexisting, frames of reference. By defining street-level bureaucrats in more general terms, Lipsky overlooks individual and occupational frames of reference that are guiding in decision making processes (Ibid.:84-86,91).

An additional critique towards Lipsky's theoretical framework is the lack of attention given to professionalism and professional status in public organizations. The bureaucrats' professional

status affects their personal motives and commitments to job, but it also influences the degree of discretion that the actor is able to exercise. In the words of Evans (2011:371): "[p]rofessional status has an influence on the extent of freedom that an occupational group exercises and entails a commitment to values that should inform the use of that discretion". Evans further argues that Lipsky's theory dismisses the managers as a homogeneous group, whom are dedicated to policy implementation. In doing so, the theory does not critically engage in an analysis of their role and influence on the provision of public services. Consequently, establishing a problematic dichotomy between "policy servants" (the managers) and "policy distorters" (the street-level bureaucrats), as the multifaceted role of the managers is overseen (Ibid.:372-373).

It seems clear that the overall critique towards Lipsky's theoretical framework concerns its generality, as it draws dichotomous lines between managers and workers and disregards the particularities within different street-level contexts. In an attempt to tackle this limitation of Lipsky's theory the concepts of culture, transaction domain and domain consensus have been integrated in this thesis theoretical framework to emphasize the particularities of different street-level contexts and to stress that individuals' have different frames of references. Moreover, to take a step away from generality is in line with this thesis objective to not generalize healthcare workers subjective understandings of a particular context. Rather the focus of this study is to illuminate experienced particularities of a specific street-level context.

5 Methodology

This thesis is a single case study that focuses on one particular phenomenon, that is, street-level bureaucrats' experiences of employing preventive measures against Ebola to combat the disease in West Africa (cf. Yin 1984:13-26; Flyvbjerg 2004). All interviewees were deployed by the same organization for this Ebola mission, and worked in Liberia and/or Sierra Leone. This study centers on this particular Ebola mission and the street-level bureaucrats' experiences from it. Overall, this study aims at gaining contextual understanding of the experiences of street-level bureaucrats in relation to the Ebola epidemic, and does not wish to generate generalizable results (cf. Flyvbjerg 2004). It is therefore stressed that the experiences portrayed of the situation in West Africa only illuminate fractions of a multifaceted context of the disease. In other words, the voices in this thesis are a snapshot of a particular time and place of subjective understandings of an experienced reality (cf. Kukla 2000:4). In the subsequent sections, the process of navigating the field, interviewing and ethical considerations are discussed and explained. These three parts are followed by a discussion concerning the research encounter. The final section outlines the coding and analysis process.

5.1 Navigating the field

A 'net' was cast in search for potential interviewees with experiences of combating Ebola in West Africa. The initial objective was to interview Swedish health workers representing different organizations that had intervened in one of the three countries in the Ebola 'hot zone'. Hence, the aim was to portray the more general experiences of adopting preventive measures in the region. Three organizations – Doctors without borders (MSF), Red Cross and Swedish Civil Contingencies Agency (MSB) – with Ebola missions in West Africa, were contacted in the turn of the month January/February 2015. All had deployed Swedish health workers to the region. Each agency was contacted via phone, and contact details to human resources managers were attained. Ideally, these managers would act as a link between me and potential interviewees. However, a setback was faced when the contacted personnel from the Red Cross did not respond to any emails or calls and MSF declined involvement in the study. Subsequently, the initial objective had to change, which perhaps was for the best. The study came to focus on one agency's mission to fight Ebola in West Africa. Hence, the street-level bureaucrats' experiences would be contextually and organizationally framed in a similar situation enabling a more in-depth and thick description of the case (cf. Merriam 1994:24-28).

Through acquaintances, I came into contact with one of the MSB project managers for the Ebola mission in Liberia. The MSB project manager forwarded my request, to come in contact

with health workers, to a selected group of MSB delegates. These included both medical and non-medical staff that had been deployed to Liberia. The manager created a link between the potential interviewees and I. Consequently, this person came to be the gatekeeper to the studied field by granting access to a selected group of people. This process could be problematic because the gatekeeper is then "indirectly in a position to decide what data are collected" (Eklund 2010:130). Although, the gatekeeper may lack access to other doors that grant access to additional parts of the field. More importantly, without this gatekeeper the field may have not been accessed at all. Nonetheless, the encountered interviewees voluntarily suggested other potential interviewees, which limited the influence of the gatekeeper's bias on this study.

5.2 The interview process

The interviewees of interest were healthcare workers, identified in this thesis as street-level bureaucrats within public health, working with Ebola prevention in West Africa. The specification of this target-oriented selection was sent out with the interview request (cf. Chein 1981:440 cited in Merriam 1994:61). All interviewees had participated in MSB's mission against Ebola sometime between September/October 2014 and February/March 2015. They had been recruited by MSB for the mission based on their occupational expertise; for the healthcare workers this concerned their medical competency.

Seven out of nine MSB responding delegates chose to partake in the study. Two out of the seven were non-medical staff. Although, these did not 'fit' the targeted criteria of being healthcare workers or street-level bureaucrats[5], it seemed relevant to include their experiences due to three main reasons. Firstly, these experiences could provide a nuanced and more in-depth picture of the context, as the preventive measures do not solely focus on medical aspects. Secondly, their close collaboration with the healthcare personnel, make their voices a valuable addition in grappling the work conducted on the ground. Finally, there were a limited number of health workers (5) that volunteered to the study, despite efforts in contacting additional interviewees using contact information passed on by participating interviewees. Thus, to gain a deeper understanding of the context their collective (medical and non-medical) experiences are seen to create a narrative that describes the situation in the region in the light of Ebola.

The same interview guide was used (see *Appendix II*) for all interviews. It was schematized into four blocks; background, context, culture and implementation; to keep focus on the thesis topic and objective. To enable a storytelling situation, the questions asked were formulated as open as possible with introductory words like *how* and *what*, and asked for their personal

[5] In direct contact with the citizens the street-level bureaucrat provides public services (Lipsky 1980:3)

experiences. The interviewees were initially asked to present themselves and the reasoning and motives behind their involvement in the Ebola mission. The following questions concerned their negotiation of culture and experiences of the context, wherein their work was situated. The final questions involved their experiences of implementing preventive measures towards Ebola. During the course of each interview, follow-up questions were asked that focused on further elaboration and/or explanation of experiences, opinions and thoughts (cf. Kvale 1996). The guide was adjusted and not followed rigorously to enable a conversation-like situation; thereby, attaining the criteria for semi-structured interviews (cf. Bryman 2011:412-16).

I asked the interviewees to choose the site for the interview so that they would feel comfortable during the research encounter. All but three interviews were conducted at the offices of the interviewees. The remaining interviews were conducted at the home of an interviewee, at a café and via Skype. A phone interview (Skype) is perhaps not always optimal as the interviewee's facial expressions and body language cannot be read; however, this was the most feasible option since the interviewee was in Africa (cf. Ibid.433). All interviews were conducted in Swedish, which is the native language for the majority of the interviewees. Thus, language barriers could be minimized and the conversations could flow more easily. With the permission of the interviewees, the interviews were recorded and transcribed in Swedish. Only the quotes used in the analysis have been translated into English. The shortest interview was 35 minutes, and the rest took approximately 60 minutes. Much of the discursive themes provided resurfaced in the different interviews.

5.2.1 Ethical considerations

The topic at hand may not seem particularly sensitive; however, in revealing ones experiences; opinions, feelings and viewpoints about EVD prevention and the Ebola mission are put on display. To be critical or skeptical towards an organization and its objectives in an Ebola intervention can be a sensitive matter because it could result in certain sanctions, such as exclusion, for the participating individuals. It was therefore particularly important to keep in mind the ethics of interviewing. In doing so, this study adheres to The Swedish Research Council's (2011) guidelines for *good research practice*.

Before each interview the interviewee was once again informed of the research aim, utilization of the interview material and voluntariness of participation. Furthermore, each individual was given the opportunity to ask questions. Thereafter, the option of anonymity was presented, and only one interviewee opted for this. As previously mentioned, all interviewees allowed for the interview to be tape-recoded. For the interview rendered anonymous, the

transcription of the recorded material required careful exclusion of details, which could reveal the interviewee's identity or in any way be traced back to the person. Moreover, the criterion of confidentiality has been adhered to, as emphasized by the 2013 *World Medical Association Declaration of Helsinki*, article 24: "Every precaution must be taken to protect the privacy of research subjects and the confidentiality of their personal information". Hence, to protect the integrity of all interviewees the recoded material was deleted after transcription, and transcripts and additional personal information have been re-coded and stored safely on an external hard drive.

5.3 The intersubjective research encounter

In the intersubjective situation that an interview conversation constitutes, the researcher does affect the outcome of the interview through the interaction with the interviewee. As Holstein and Gubrium (1995:2) point out:

> …all interviews are interactional events. Their narratives may be as truncated as forced-choice survey answers or as elaborated as life histories, but, in any case, they are constructed in situ, a product of the talk between interview participants.

Consequently, this interaction process constructs knowledge of a phenomenon in collaboration with the interviewer (Ibid:3).

With a point of departure in this idea of the interview encounter, one has to have a critical approach towards the information derived through this process, as the researcher's background and preconception of the situation influence the questions asked and the understandings of these. Subsequently, with a different background or preconception, the same information would perhaps not be accessed. It would therefore not be possible to generate empirical generalizations; however, as previously mentioned, this is not the purpose of this thesis. Nonetheless, commonality of discourse or similar experiences of a particular situation (e.g. the Ebola mission) could imply that the knowledge constructed of a phenomenon during one research encounter does not always differ from another encounter. In other words, when the knowledge construction of a phenomenon/situation is similar in different interview encounters perhaps this implies that the interviewees share a particular understanding of the 'reality' of a phenomenon. This shared understanding of a phenomenon is perhaps not influenced by the researcher's preconceptions, but rather that the researchers' biases may impact how much of this reality the interviewee choses to reveal (cf. Holstein and Gubrium 1995:2-3; Crang and Cook 2007:15).

In the process of mitigating my own position in relation to the interviewee certain aspects had to be considered. Being an outsider trying to enter the field can be difficult, as 1) *suspicion of the studies motives could arise amongst the interviewees*, 2) *language differs between the interacting parties* and 3) *backgrounds (ethnicity, gender and age) collide*. All interviewees had been recruited or volunteered to partake in MSB's Ebola mission. For this thesis I did not in any way represent or collaborate with MSB. I believe that the interviewees therefore were not suspicious of the study's motives and because of this they perhaps felt freer to express their opinions. Secondly, without knowledge of the interviewees background it would have been difficult to ask relevant questions and understand the language used during the encounter. It was therefore relevant to acquire information of the biomedical understanding of EVD, including some knowledge of MSB and its Ebola mission, before the research encounter. Nonetheless, this did not entail an all-encompassing knowledge of each interviewee's background; rather, it facilitated the encounter. Finally, my background, mainly my African roots, was of interest for some of the interviewees. It became a conversation starter and as such it established a more relaxed research encounters. Subconsciously, it was perhaps a topic that unified both parties, as both parties had experiences of the African continent, which may have made the interviewees more inclined to share these experiences.

5.4 Coding the material

Initially, the interviews were transcribed in their entirety and notes of interesting themes were taken on a separate sheet. During a later stage of the coding, these were revisited to achieve a clearer synthesis of the empirics. Certain colloquial language was corrected to increase the readability. Only the quotes portrayed in the analysis have been translated into English. In the proceeding stage, the transcribed material was printed out and thoroughly read several times in relation to the study's aim and research questions in order to find main themes and patterns. By looking for sub-themes, these overarching patterns became refined. The following themes were emphasized in the material:

1. *Navigating the field and establishing trust*
2. *Consolidating objectives: personal and organizational goals*
3. *Negotiating culture: local and organizational culture*

In coding the material for this thesis there was a continuous negotiation between theory and empirics. After the transcription of the empirics, the theoretical section was adjusted so that the

theoretical framework would coincide with the empirics. It mostly involved conceptual adjustments, which would fill the gap between what had been stated in the interviews and the explanatory terms in the theory. Throughout the analysis, the theoretical framework is used as a lens to analyze the empirics. Thus, each presented theme is intertwined with an analysis based on this framework.

6 Analysis

The analysis is divided into three main sections; *Navigating the field and establishing trust, Consolidating objectives* and *Negotiating culture*. The first section is more descriptive as it emphasizes the MSB delegates' experiences of the field and the process of establishing trust within this context. In the subsequent section, the clash and/or consolidation between different objectives, mainly those of MSB, the delegates and the local co-workers, are discussed and analyzed. The final section focuses on the negotiation of culture that occurred when these actors moved across national borders. Using the theoretical lens these experiences are discussed and analyzed to explore *Swedish healthcare workers' experiences of navigating global health interventions towards Ebola* and *how these healthcare workers negotiate their role in this culturally different context*. All interviewees are presented by using fictional names to maintain confidentiality and occupational titles are used to differentiate between interviewees with or without a background in healthcare. 'MSB delegates' refer to all interviewees, regardless of occupational title.

6.1 Navigating the field and establishing trust

Entering the field, many of the interviewees experienced that everyday life in Liberia seemed to continue as usual with a few exceptions, which were already visible on the flight to Monrovia. There was a scarcity of passengers on the airplane and the majority of the passengers worked with Ebola in one way or another. As a result of a decreasing influx of tourists to Liberia, economic consequences where observable, as Dr. August (14 April 2015) states: …*there has been some tourism there earlier, and that has totally disappeared and they are suffering from it; restaurants and all businesses*. The interviewee goes on to vividly describe the apparent changes in everyday life:

> *What struck me right away were all of these external things; when you landed and in town, everywhere, there were large posters and placards and [information was] painted on walls and houses; how Ebola is transmitted, how to protect oneself and the need to call an ambulance if you have symptoms. It was very intense. Ebola, Ebola, Ebola everywhere […]. It was as constant reminders; it was otherwise not visible in the city [Monrovia]. Besides that, it looked just like any West African city. And then, there was also this thing of not shaking hands, and that was also a bit strange. When you meet somebody, it's so natural that you hold out your hand; it's no touch that applies, and you got used to that after a while. And walking in town there where a lot of people, but all kind of went around and made sure that they didn't touch each other. That was very strange. Otherwise, externally, you could not see that much.*

Dr. August clearly highlights observable changes in culturally normal practices in West African societies. The usual way of greeting each other had transformed in the light of the disease. For these societies, culture, as communally shared understandings of reality, became different, which came to be evident in peoples' practices (Tomlinson 1999:18-20). In a similar vein, Gustav (27 March 2015), a security advisor for humanitarian emergency response, stresses the lack of close contact amongst people and further states: *I would actually say that what I saw was the absence of things rather than the presence of Ebola.* These observations of the situation in the capital of Liberia, Monrovia, did not differ much from the other interviewees' perceptions of the field in Greenville, Liberia and Freetown, Sierra Leone. For many of the interviewees it was perhaps not surprising that close human interaction had become absent in lieu of the increased risk awareness induced by these governments' information spread for disease prevention. What came to be evident for some interviewees was the absence of death and horror on the streets, which had been portrayed by international media in the early stages of the Ebola outbreak. As Fredrik (7 April 2015), the team leader for logistics puts it:

> *I was surprised that life was much more normal than I had thought. The preconception or information you had, made you believe that there was much more disease then there actually was. […] a horror picture had been painted that wasn't the reality.*

This quote highlights the lack of consolidation between the 'reality' perceived on the ground and the portrayal of this 'reality' projected beyond the confines of the Ebola hot zone. In projecting information about 'reality' on the ground to the rest of the world, perhaps the lack of consolidation between these representations is due to the liquidity of information leaking through the barriers of the national confines. In other words, the barriers of the nations, wherein Ebola is a reality, may be so impermeable that information slipping through is not liquid enough for it to come through in its entirety. Applying the concept of globalization, it is possible to argue that all information does not easily *flow* across barriers, as information has different levels of *liquidity* and the barriers it encounters are similarly non-porous (cf. Ritzer 2011). The projected images of Ebola in the country context, in which the MSB delegates were deployed, became a basis for their preconceptions and expectations of the field. In this light, it is presumable that this projected depiction of the field also came to be the basis for why some of the delegates chose to partake in MSB's mission. In other words, some of the interviewees volunteered to the mission because the situation seemed so serious and the Ebola outbreak could potentially spread worldwide. As the preconception of the field did not coincide with 'reality' on the ground, they questioned their

individual motives and reasoning for participating in the mission. On another note, it is worth to point out that fear and risk awareness associated with borderless diseases, such as Ebola, created a hype concerning a potential global spread, which may be a reason that could explain why this perception of horror lingered on.

Although, life seemed fairly normal on the surface, fear and risk awareness had become entrenched parts of the Liberian and Sierra Leonean societies. This was something expressed by all interviewees. Nurse Karin (26 March 2015) describes an encounter with communal fear towards the disease and its association with the 'imperial whites' in the following way:

> *[…] stories were circulating, and it did that in both countries, [saying] Ebola doesn't exist; we [the white] have come to harvest and sell organs, for example. One man, a survivor told [us] that his wife had died from Ebola, so he had become sick and then thought he would go to MoD1 [Ebola treatment unit in Monrovia]. Then his neighbors said 'you cannot go there, they will kill you there. You will get two yellow pills, and so you will die and they will take all your organs, and we will never see you again. That is what happens there.' […] There where several of these prejudices.*

Remembering the challenges presented in the background (see *2.3. Disease prevention challenges*) it can be argued that fear impedes the possibility of implementing preventive measures against Ebola in the region. People may not seek healthcare due to rumors that propagate fear and this increases the spread of the disease, which was something expressed by all interviewees. Hence, going to these Ebola centers to seek help was nothing short of an act of bravery.

> *If you're in because of tonsillitis or something else […] and you are in because of that and not Ebola, there is a great risk of you contracting Ebola because you're moving in that environment.*
>
> - Dr. Max, 30 March 2015

> *I thought that it was incredibly courageous [that people] sought care. Everybody was terrified of this center, and everyone knew that people with Ebola were lying there […].*
>
> - Dr. August, 14 April 2015

Not only are surviving patients exposed to the risk of actually contracting the disease at the center, those who are lucky enough to survive, face the risk of stigmatization (WHO 2014a). People feared that survivors would bring the disease back to the community. And so, some

survivors, but also local healthcare workers, were excluded from their communities, evicted from their apartments and even fired from their jobs. For many of the interviewees this behavior was based on a lack of knowledge of the disease. The governments of Liberia and Sierra Leone had spread information about the disease in the capital areas; however, communication with the rural regions seemed to be weaker. News of the Ebola epidemic seemed not to travel fast, as rural areas lacked preparedness and awareness of the disease, which two interviewees highlight:

> *I would say that there was a lack of reporting of what was happening in the counties or in the different regions. You didn't know that much. There were some counties that were really good at reporting, and then there were some with a large number of unrecorded cases […] Later when they came out to the villages on the countryside, large populations had been infected by Ebola, and a lot had died from Ebola. But they [the villagers] didn't even know that the country had Ebola, and at this time the epidemic had been going on for almost 9 months. So communication with the countryside was very difficult.*
>
> - Gustav, 27 March 2015

> *It is so far away from Monrovia, so no one controls it…you can say that they have their own rules. […] I got a perception of that it was Greenville, and they had to solve their own things down there.*
>
> - Nurse Jacob, 18 March 2015

The two abovementioned quotes indicate the authorities' inability to reach the distant regions in these countries, as communication is insufficient, roads are poor and rule of law does not apply everywhere (WHO 2014a). Some peripheral regions seem to have become isolated units functioning on their own. This peripheral autonomy sheds light on the government's incapability of penetrating the communities on the countryside. The relative distance between Monrovia and the rest of the country is so great that it becomes questionable if the government is able to assert and fortify its power, as an authority, in these regions. The relationship between these parties also weakens as the population perceives the government as corrupt and untrustworthy. Thus, although people actually sought care at these Ebola treatment units (hereinafter ETU), the topic of trust was still underlined during all research encounters. The interviewees felt that people were skeptical towards authorities and distrusted them mainly due to the ongoing corruption in these countries.

Absolutely zero trust and a constant complain about corruption.[…] People were very talkative, and they might have been that anywhere if you knew the language, but because we knew English we could hear all of this. [People also said] 'We know that a lot has come to this country [Liberia], but it doesn't go to those it should'

- Dr. Ingrid, 12 April 2015

These three countries; Sierra Leone, Guinea and Liberia; have a very disordered past with great distrust to authorities…great distrust. And you didn't trust at all. Liberia was perhaps the best in the context. It was perhaps better in Liberia than in the other two countries that still have a lot of [Ebola] cases. You questioned, and didn't dare to trust. They knew how corrupt everything was.

- Dr. Max, 30 March 2015

Despite the general distrust towards authorities people were still willing to seek healthcare. Perhaps the information regarding Ebola prevention had reached the population or perhaps trust for the ETU's was established. Several of the interviewees maintained that the Liberian and Sierra Leonean communities had internalized the information concerning the virus since safety precautions, such as 'no-touch' and basic sanitarian measures (e.g. frequent washing of hands), were applied. Furthermore, to increase the legitimacy of the information transferred to the people the governments of these countries utilized well-known communal figures, such as heads of tribes and football stars, to inform the people. Overall, fellow countrymen seemed to be more trustworthy than foreigners. If these countrymen were recognized by the communities, their word held greater strength than governmental authorities, which Dr. Max (30 March 2015) underlines: *It is not possible to come as a white westerner and tell them how to live to not contract it [Ebola]; rather, that is something they have to do themselves.* Since the well-known communal figures shared the local people's understanding of reality and thus also their practices and beliefs, it is presumable that they trusted them more than outsiders. It can be argued that their actions and beliefs found legitimacy in the communally shared understanding of reality (cf. Tomlinson 1999:18-29).

To further gain legitimacy for the Ebola prevention endeavor and encourage people to seek treatment, patients who were declared cured were given certificates legitimizing this status. According to some of the interviewees, the main argument was that transparency leads to trust. Thus, if it could be verified that 1) everyone who enters an ETU does not die, 2) relatives can securely visit these units and 3) and if bodies of dead relatives were released; then perhaps individuals potentially carrying the disease would seek treatment.

Nonetheless, as indirectly pinpointed in Dr. Max's previous statement, there seemed to be both suspicion against 'the white man' and an identifiable dichotomy between African/Western, black/white, local/external and familiar/foreign. The dichotomy between 'us' and 'them' creates a cultural border, where the foreign aid workers come to belong to another transaction domain with a different logic of action. This is further illustrated by the circulating rumors questioning the 'actual' objectives and endeavors of foreign aid workers. These rumors project an idea of reality, which is fortified by the peoples' beliefs. Consequently, as people believe these rumors, they act upon them to tackle and respond to the reality they create (cf. Tomlinson 1999:18-20; Frödin 2013:72-73).

During the MSB mission in Liberia and Sierra Leone, several interviewees elicited that suspicion regarding the objectives of their mission was directed towards them by Liberian and Sierra Leonean co-workers. The role of the MSB delegates was not always obvious for their local co-workers, which Nurse Karin (26 March 2015) explains in relation to her encounters in Sierra Leone:

> *When they understood that we firstly were not British and secondly that we actually would work and not just walk around with some protocol checking what they were doing, then everything opened.*

Dr. Ingrid (12 April 2015) portrays a similar encounter in Greenville:

> *We often had to explain. I don't believe that they thought it was obvious that we were there to combat Ebola, because I believe, that they rightly thought that they had already been doing this themselves. They almost got angry when we said: 'we are here to combat Ebola'. They said: 'it would have been better if you fixed the generator…it would be better if you made this place into what it was before…look there, the lampposts are still there but we don't have electricity anymore'*

Running into the local population, Nurse Jacob (18 March 2015) says:

> *It was actually a really small town [Greenville] and we thought that everyone should know why we were there.*

The quotes indicate that these Swedish healthcare workers were outsiders. Although not uttered, skepticism from local co-workers seemed to put the role of the MSB delegates into question and

ultimately their individual justification for being there. Thereby, it also seemed as if the legitimacy of their intended actions were being questioned. Some of the interviewees brought forth this issue by arguing that they had to assert their role and the objectives of their work to their local co-workers. Hence, if the motives of the MSB delegates were deemed untrustworthy because of their abstract work roles and tasks, their provision of services is challenged. It becomes difficult to provide services within the local health system if the motives behind these services are deemed invalid (cf. Gran 2002; Farris, Senner and Butterfield 1973). In the words of Nurse Jacob (18 March 2015):

> *[…] they [the hospital staff] said: 'What are you actually doing here, because you're supposed to support us, but how?' […] It became really hard for us to work at that point. 'We cannot give you anything, and we have come to support you'. It's quite vague and it became kind of made-up. They wanted concrete things and not being able to give anything concrete made it much harder to work.*

Evidently, the issue of trust was not isolated to the relationship between the citizens, local authorities' and healthcare workers. It also encompassed the relationship between the local co-workers and the foreign aid workers. If the motives of the MSB delegates are deemed illegitimate thus leading to untrustworthiness, it impacts the local co-workers' understanding of MSB as an organization. Eventually, it also affects the social system wherein the organization is included. In a similar vein, the perception of the social system can be seen as impacting the idea individuals may have of the organizations constituting it (cf. Gran 2002; Farris, Senner and Butterfield 1973). Thus, if people distrust the governments of these countries, and if they also are skeptical towards the motives of foreign aid workers, then distrust may trickle down to other entities they are associated with, such as MSB. Consequently, the MSB delegates entered an arena where they had to assert themselves and establish trust in lieu of the distrusted social system of both internal (Ministry of Health, the local government) and external (WHO, foreign aid workers etc.) actors they were associated with. This task proved difficult because of the perceived abstractness of the motives behind their task. Nevertheless, as outsiders, the MSB delegates could become trusted if they were regarded as insiders of the local health system. Thereby, their practices and perhaps even motives could find legitimacy in a communally shared understanding of this systems reality, i.e. the culture governing the local health system (cf. Tomlinson 1999:18-29).

In sum, embarking on a global health intervention is entering a field of complexities where many obstacles lay in the way of such a mission, which was quite clearly depicted through these

interview encounters. The obstacles encountered by the MSB delegates did not differ much from those previously mentioned (see 2.3 *Disease prevention challenges*); however, two aspects were mainly stressed; trust and the relative normality of everyday life. It becomes clear that these aspects are interlinked with issues of risk, fear and corruption. Additionally, the aspect of information and its transferal both within and outside the region has a clear impact on both the external and internal perception of the situation. Certain reasoning is drawn from projected information that becomes the basis for preconceptions with regards to risk, fear and so on related to the Ebola 'hot zone'. As portrayals of the situation come to be rumors or notions of 'truths' they spread throughout communities and have the power to establish distrust against certain actors. Distrust may become fortified if these actors' affiliates are also distrusted, and so, just like an infection it spreads and occupies one cell at a time. For many of the MSB delegates this entailed a process of establishing trust by legitimizing the motives of their mission. At its core, this involved concretizing these motives and objectives so that they became visible actions. Through this process it was possible for the delegates to establish trust. By doing so, the preconception of their motives came to be falsified. Nonetheless, one interviewee stresses the importance of building trust by establishing a relationship over a longer period of time:

> *I had been there for 3 months and they started calling me veteran, I had been there the longest. You should never go out on a mission to such a place if you cannot be there for at least 6 months up to 1 year because it takes such a long time to get the hang of it; it takes time to learn, find the right roads, get the right contacts, establish collaboration and trust amongst each other. This is built up during a longer period of time.*
>
> - Fredrik, 7 April 2015

Based on this, it is questionable if trust is possible to establish when the rotation of foreign aid workers seems so frequent. Although, some of the interviewees felt that they had successfully established trust by concretizing their motives through actions. Thus, perhaps the best practice for short-term missions is to avoid abstractness of objectives.

Nevertheless, having one's motives constantly questioned by others may lead to a questioning of 'Self'. Perhaps even more so when one's perceptions of the context become falsified and one's individual motives thereby come into question. Thus, obstacles encountered on the ground do not only limit the possibility of a health intervention, but they also impact the foreign aid workers understanding of 'Self' in their role. In the following section this is discussed

more in-depth in relation to the consolidation of objectives that occurs within the MSB delegates as well as in the organization they belong to.

6.2 Consolidating objectives

Initially, MSB had three main tasks, Gustav (27 March 2015) clarifies these as follows:

> *[…] help build parts of the Ebola treatment units that were placed all around Monrovia. […] support other foreign medical teams that came and would work in these Ebola treatment units […]. And as a third component in our mission […] to have medical service on standby for relief workers*

However, the circumstances in the Liberia were continuously changing with the fluctuation of detected Ebola cases. As the number of cases seemed to decrease in Liberia the question was if MSB's initial medical mission should still focus on the WHO assigned tasks. Dr. Max (30 March 2015), who was involved in the planning of MSB's mission and conducted the first assessment in Liberia, shares his thoughts concerning this:

> *Then we went home and […] the number of Ebola cases decreased tangibly rapid in Liberia. It was already noticeable when we were there. The decrease had begun, and it was a question of what this would entail. Despite this the UN, WHO requested that Swedish MSB contribute with a foreign medical team to run their own and support another Ebola treatment unit in Monrovia. Long before the request came, you could anticipate; 'will this actually be needed?' But that coordination is not held by MSB, rather you basically do as you are told or you say 'we can do this, and we are prepared to take on this.'*
>
> …
>
> *[Returning to Monrovia] We realized that we could not continue to recruit and to motivate [the need for] the huge amount of personnel that were requested for this task. We immediately realized, and offered to right away find other possibilities to work with, before people came down.*

These thoughts do not only highlight the flexibility required by MSB in this mission, they also illuminate the social system in which the organization comes to belong in as it embarks on this mission (cf. Granovetter 1985:487). As the WHO requests MSB's involvement, MSB falls under the umbrella of the WHO. Subsequently, MSB becomes a cog in the WHO coordinated global health machinery, which is trying to prevent the global spread of Ebola. Dr. Max (30 March

2015) seems to concur with this argument, as he states: *[…] you have to take a step back and see yourself as a cog in a giant machinery*. In applying the notions of transaction domain and domain consensus to this relationship (cf. Frödin 2008:69-70), it is presumable that MSB finds certain consensus with the WHO and their agenda regarding Ebola; otherwise they would not have taken on their request. By doing so, MSB comes to adjust the logic of action within their transaction domain to that of the machinery. Thus, the interacting actors share an understanding of which roles they have within this domain, i.e. which cog they are within this giant machinery. However, seeing oneself as a small entity of a greater whole could lead to alienation, as each actor is specialized in a certain part of the process and will therefore not be able to follow the process to the finishing line (cf. Lipsky 1980:77-78).

In light of the transformative nature of the outbreak MSB's mission in Liberia firstly expanded from Monrovia to the town of Greenville in Sione County, Liberia. In late December 2014 it extended to Freetown, the capital of Sierra Leone (MSB 2015). As personnel arrived to Monrovia the assigned tasks were not as expected. When volunteering for MSB's mission against Ebola, all interviewees asserted that this mission primarily focused on medical aspects, i.e. healthcare, medical knowledge, medical staff and so on. The mission had been declared to be primarily medical in nature; however, for many, the medical emphasis of the mission had in reality become over-shadowed by logistics. According to Dr. Ingrid (12 April 2015) it: *felt like a building project with medical advisors and it should have been a medical project with non-medical helpers, advisors.* Since the medical objectives of the mission were not experienced as the primary focus tension arose between the healthcare workers personal goals and the agencies objectives. MSB seemed to have retreated from their initial medical emphasis and perhaps this was due to the continuously transforming nature of the situation in Liberia. With a stance in Lipsky's (1980:144-145) theoretical framework, it can be argued that the bureaucracy experienced difficulties in achieving its objectives and choose to adjust these to better fit their capabilities in a tumultuous context. And so, its shifted objectives came to be reflected in the tasks assigned to the health workers, as some of them felt that their medical skills were not utilized. Before entering the field their assignments lacked clarity in beforehand and did not require the competency they had.

> *We were a bit redundant, and so we got to do chores that were not necessary, but were improving the situation. […] We [the medical group] didn't really have any roles, so we had to make them up. […] I'm a specialist with a double competency, and a doctor with double competency, we screwed together cabinets, which didn't have anything to do with Ebola. So, it became a lot of these tasks that you don't need high competency for.*

- Nurse Jacob, 18 March 2015

> *When I came in January and asked what I would do, I got the question: 'Hasn't anyone in Sweden recruited you and told you what you would do?' I said: 'No, they just told me that I would find out when I came'*
>
> - Dr. Ingrid, 12 April 2015

Although the tasks at hand seemed unclear the healthcare workers believed that their competency would be utilized. Being recruited as medical personnel several of the interviewees experienced confusion in their actual work role or position in Liberia. While in Sierra Leone the situation was different, as Dr. August puts it: *It felt so frustrating when we were there in Liberia and didn't have any patients and the few patients that were there were taken care of by Cuban doctors and nurses. But here [in Sierra Leone] we got proper tasks.* Hence, the perception these health workers had regarding the tasks they would embark on did not coincide with the actuality of the situation in Liberia. The medical mission was by some not experienced as an actual medical mission. For those who had been motivated by the mission's medical focus, volunteered due to this and recruited on the basis of their medical competencies, the work in the field was not as anticipated. Dr. August stresses this clearly by pointing out that *proper tasks* involve taking care of patients and not doing these anticipated tasks led to frustration.

Taking care of patients and providing health services to citizens is something these healthcare workers do in their everyday life in Sweden. Using Lipsky's (1980:13-25) terminology, all but one of the interviewed health workers directly interact with patients in Sweden; therefore, they impact these lives through exercising discretionary judgments that determine their eligibility for health services. They are street-level bureaucrats that have the power to make policy as they are relatively independent from organizational authority and can quite freely make decisions in their provision of services. Thus, as these individuals choose to partake in MSB's medical mission; recruited and employed as medical staff; they believed that their provision of health services, i.e. taking care of patients, would be the same in the field. This proved not to be the case.

In contrast to the healthcare personnel deployed in Sierra Leone, those in Liberia felt a discrepancy between their role as street-level bureaucrats at home and the loss of this 'Self' in the field. Some feelings of frustration could be sensed during some of the interviews as these health workers competencies were not utilized. While some of the interviewees coped with this by making up tasks that would grant satisfaction, stories were told about co-workers who were not

able to adjust to the flexibility the situation required of them. It can be argued that these found it difficult to consolidate both their own motives for volunteering and perceptions of the objectives of their individual tasks with the work they had to perform in the field (cf. Lipsky 1980:144-145). For all the interviewees the main motive for participating in MSB's mission stemmed from feelings of compassion and helpfulness. In general, it was believed that they could contribute with their competencies to ease the situation:

> *I have been to West Africa before and thought that they needed help. I know the area and I can help.*
>
> - Nurse Jacob, 18 March 2015

> *I am used to working with no-touch policy, and this is something that would fit me.*
>
> - Dr. Ingrid, 12 April 2015

> *If we in the West don't do anything, who is then going to do anything? We have the resources, and can send both people and equipment. So this was one of the reasons for why I signed up.*
>
> - Nurse Karin, 26 March 2015

Despite the fact that some interviewees felt that the assigned tasks did not require medical skills, job satisfaction could still be found. Presumably these other assignments were still in line with the individual motives that had pushed these actors to participate in the mission. Interpreting Lipsky (1980:144-145, 148), it can be argued that job satisfaction was found as the personal goals came to be modified to the situation and its required capacities. It is also imaginable that as some goals are competing with each other, the professional ideology, which in this case can be seen as taking care of patients, outweighed and guided goal orientation. Thus, the incompatibility of tasks with this ideology leads to job dissatisfaction. Nurse Jacob (198 March 2015) describes this internal tension between objectives and the search for motivation as follows:

> *There were a lot of us that strongly considered resigning and going home because we were supposed to do one thing and now we just walked around there. […] You have to find something else, and there are often a lot of useful things you can do that are not as 'fine'. It's 'fine' to take care of a bunch of patients and its 'fine' to do an achievement you can put your name on, but there are a lot of things that have to function around this. […] I find it quite easy to do these things instead […]. It has to be done. So this made it possible for me to stay: 'Yes, I'm still doing something,*

I'm not just sitting here and getting a paid vacation in Liberia'. […] So, it was to find something that made the day meaningful.

- Nurse Jacob, 18 March 2015

According to Lipsky (1980:142-149) it is at this crossroad the employee implements coping mechanisms to deal with the situation. As the quote illustrates, two possible coping mechanisms were considered when the objectives of the mission were not as anticipated; quitting or finding other tasks that would grant job satisfaction. Hence, contrary to the dissatisfaction and frustration experienced by some deployed in Liberia, the healthcare workers in Sierra Leone did not have to consolidate their objectives to find meaningfulness in their tasks. They had been assigned clear positions and tasks that required their medical skills. As they provided health services to citizens, had a high degree of discretion in decision-making and independence from authority in this work, they were so-called street-level bureaucrats in the field. Nevertheless, for those in Liberia who were not capable of consolidating objectives to find meaningfulness in their work, quitting perhaps seemed like the only option. They had anticipated that their role as street-level bureaucrats would continue but in a different setting. Instead they lost the high degree of discretion and independence from authority they were used to, and perhaps expected in this context. As Dr. Ingrid (12 April 2015) puts it: …*you get there and have to be extremely flexible and then I think you should have also trusted me to make my own decisions.* Not being able to have decision-making power over one's own work may lead to feelings of alienation, as highlighted by Lipsky (1980:75-79). The feeling of alienation is perhaps one reason for why some of the Swedish healthcare workers stationed in Liberia choose to return home ahead of time. In becoming alienated they would not have been satisfied with their work, which impacted their commitment to both the patients and the agency they work for.

These health workers were in a sense also deprived of the advocacy position that follows with the role as a street-level bureaucrat. In other words, how can you be an advocate if you are not interacting with those you are advocating for? How will you know what services are the most suitable for your clients if you have not even met them? Working with assignments that do not require specialization, such as screwing together cabinets, means that this work position cannot be used to secure services for clients. Advocacy becomes less possible if this position does not even involve direct provision and interaction with these clients. However, as stressed by Lipsky (1980:72-74), advocacy is also dependent on the organization wherein this is enacted. The bureaucracy may impede measures for advocacy by tightly controlling or hoarding resources,

while the advocate seeks to disperse these. One interviewee describes an experience regarding this:

> *The absolute greatest challenge was to formulate oneself in such a way that what you were doing could be seen from an Ebola perspective. […] It was a big issue that we could not gain hearing for simpler things, rather it was more 'we are going to build a bench here were we are going to sit to take the temperature of people suspected for Ebola.' So it was a great challenge to see the needs and know that the resources were there and you were just allowed to do things that were [directly] related to Ebola. But we were good at reformulating so that we still succeed. […] It was such a slow and stiff decision path; instead of saying 'now we have combated Ebola and we have people and resources in place, can we not take 5 million to do something that is not directly Ebola related, but indirectly'; a discussion regarding that was not even possible to have. […] and I thought that it was an absolute waste of resources that we were sitting there.*
>
> - Dr. Ingrid, 12 April 2015

This statement clearly highlights the measures taken to control the organizations resources, both in regards to human and fiscal capital. It also shows how the interviewee tries to frame resource dispersal within the so-called Ebola perspective held by the agency. Thus, advocacy is gained through portraying resource dispersal as something of interest for the organization, which seems to be done through modifying the goals for spending resources based on the goals of the agency. Dr. Ingrid's account also indicates the resistance that exists to efforts that reduce discrepancy, such as constrains in resources (cf. Lipsky 1980:72-74). As seen in the personal motives that guided some of the interviewees to partake in MSB's mission, the human aspect of street-level work and the hope to improve the lives of others was central, and is according to Lipsky (1980:105) the basis for job satisfaction for street-level bureaucrats. To attain this personal motive entails resisting resource constrains that may limit discretion, which permits these healthcare workers to have this influence (cf. Ibid: 105-106).

Something that was not only pinpointed in this previous quote, but also by other interviewees was the stiff and slow character of the agency and the global health machinery it was a part of. As portrayed by some of the interviewees, it could be understood as an ideal Weberian bureaucracy that is strictly following routines, standards and protocols (Weber 1968:956-958). It could be argued that this can be understood as an obstacle not only when exercising advocacy but also in responding to local circumstances. Mandatory procedures reduce the possibilities for discretion as the healthcare worker's freedom in decision-making becomes restrained by the

rigidity of bureaucratic structure. These structures limit the healthcare worker in such a way that s/he becomes unable to adhere to the interests of the patient; thereby, transforming this patient into a bureaucratic case number (cf. Lipsky 1980:40, 105-106). However, everyone did not get the opportunity to act as street-level bureaucrats out in the field. As touched upon, the rigid bureaucratic nature of the global health machinery encompassing MSB, required continuous adherence to bureaucratic structures, which Dr. Ingrid (12 April 2015) argues resulted in a slow information flow internally in the organization:

> *[…] everything [of the situation in the Liberia] is supposed to be reported in quite a stiff way. […] If you would have had a direct report then you wouldn't have come there as a doctor and become surprised that there were no Ebola patients to take care of and you did other things instead. […] I would say that the reporting lead to a slow information transfer.*

Consequently, the slow information transfer within the organization lead to the spread of a false image of the capacities that the situation required. Thus, as these healthcare workers entered the field they lacked purpose as their intentions for embarking on this mission did not coincide with the situation's requirements. The bureaucratic structures that were intended to facilitate the organizational information flow came to become barriers to these flows (cf. Ritzer 2011:2). Thus, the local circumstances were not adhered to as the bureaucracy was unable to see beyond these mandatory procedures. This inflexibility of the bureaucracy becomes particularly problematic as the bureaucracy moves across nations were these procedures and protocols do not always work. A constantly changing situation requires responsiveness and flexibility, which a stiff bureaucratic structure may be incapable of. Hence, to be tied up by mandatory procedures may lead to the incapability of adjusting to the local circumstances (cf. Lipsky 1980:105-106). Moreover, by adhering to routines and procedures the bureaucracy tries to be efficient; however, these same routines and procedures can lead to inefficiency. In the following section, the negotiation of culture that occurs when bureaucracies and bureaucrats move across borders is discussed more in-depth.

6.3 Negotiating culture

> *It is this country [Liberia] that is in lead and they are the ones accountable to its population and so on. So when the humanitarian circus comes it's a bit like a self-playing amusement park; we have our way of doing things and it's damn tough if the one we are helping says 'no, don't help me*

like that, help me like this instead'. So, even though we certainly want them to manage on their own, we want them to manage on their own in our way.

- Gustav, 27 March 2015

This quote emphasizes one of the main topics concerning culture that was brought up by the interviewees. Culture is an important aspect of humanitarian missions, such as the one embarked on by MSB in West Africa. As argued in this statement, these global health interventions involve a whole set of performances, just like a circus, that play their predetermined act in the field. Each actor has its own set of acts that are included in their performance. In other words, MSB and every other agency/actor have their particular role in combating Ebola. As an actor partaking in this grand performance, i.e. combating Ebola, MSB becomes a part of this 'circus', which has the WHO as its 'circus manager'. When these actors enter the field to conduct their particular act it can be difficult to step outside this performance. The show must go on although this perhaps results in a clash between the audience's preferences and the content of the performance. Likewise, the eagerness of wanting the receivers to internalize the circus' way of doing things also leads to a clash, as one way of performing is seen to be better than another; thus, creating a dichotomy between 'us' and 'them'. 'We' do it in one way, whilst 'they' do it in another way; yet, 'we' want them to do it in our way. However, to mediate the understanding that different logics of action are context dependent can be problematic (cf. Frödin 2013:72-73), which the following statement stresses:

The greatest challenge was perhaps introducing newly arrived Swedes to 'we are not here to take over and run anything.' […] It was a question of standing behind the Liberians without being noticed, so to speak. It's quite easy that you take over when you believe that you're an expert. In this context we weren't experts. For one thing, we're entering a medical system that is different to ours. This is about routines, both in regards to treatment, giving medication and different types of medication and you have other ways of documenting etc. We were not supposed to change these things; rather we were supposed to continue using them. We were not supposed to come in with our Swedish medical bag and go straight in and say: 'here we provide regular Swedish medicine', absolutely not! And I believe that some had a difficulty buying or comprehending that this was the case.

- Dr. Max, 30 March 2015

Conveying the idea that the MSB delegates were not there to 'take over' did not seem to get through. As mentioned in the previous section (see *5.2 Conveying objectives*) several of the healthcare personnel believed that their tasks would involve taking care of patients; however, as this quote indicates the main task was to support the Liberian personnel in their work. It seems as if this objective did not come across very clearly and as this information was re-conveyed in the field many seemed to not comprehend this. According to the aforementioned statement, some of the delegates thought that they were supposed to work as they usually did at home despite the fact that the context where the work would be performed had changed. Hence, as the context changes the manner in which work is performed also changes. In other words, the local health setting, as a particular transaction domain, had its own logic of action that differed from the context the Swedish healthcare workers were used to (cf. Frödin 2013:72-73). This was visible culturally, as there seemed to be a difference in the work routines employed by the local medical staff (cf. Tomlinson 1999:18-20). This created a situation where the Swedish healthcare workers had to adapt their work methods to those used within the new context that they were trying to work within. As Dr. Max previously emphasized, one cannot solely enter a new field and expect to be an expert in how things work there. Although, healthcare as a particular transaction domain may seem similar all over the globe in regards to roles invoked in this sphere, that is, a doctor is always a doctor regardless of where you are, the actual deontic power this role is associated with or the routines that govern this actors' behavior may differ depending on the context (cf. Frödin 2013:72-73). Thus, the way of performing healthcare becomes locally anchored. In short, health services become 'glocalized' and thereby adjusted to the context wherein it is performed (cf. Ritzer 2011:159). For the local health workers in Sierra Leone some of the prerequisites for healthcare were the shortage of resources in regards to medial staff and equipment. Subsequently, it was not possible to enter this new transaction domain of healthcare and assume that everything would be the same as in Sweden. Inventiveness and ingenuity seemed to be the catchword emphasized by some of the interviewees. Nurse Karin (26 March 2015) highlights this in the following way:

> *We worked with the Sierra Leonean team and there were nurses we simply had to teach [some had just passed their examination, others weren't fully trained]. Then there was a lack of things […]. We didn't have enough needles, pharmaceuticals and so you had to be very inventive. […] None of those things you take for granted here [in Sweden] were there. Rather it was kind of old fashioned; you measured heart rate with your fingers, you counted breaths and so on.*

To be able to adjust to the prerequisites of the situation by being inventive was required by these healthcare workers. However, to adjust to the new context and internalize the logic of action governing a healthcare setting requires an acknowledgement of these practices. By understanding this particular context as a transaction domain, it can be argued that to acknowledge its guiding logics of action, rules and routines of the domain become legitimate ways of interacting. As actors adjust to the culture existing within this domain their acknowledgement of its logics of action may become visible as they agree with the routines and practices employed in this sphere (cf. Frödin 2013:72-73). When these actors internalize this new culture, the shared understanding of its logic of action becomes portrayed in their beliefs and practices. It is through these logics of action that they come to make sense of the reality in this sphere (cf. Tomlinson 1999:18-20). However, this can be quite a difficult task in itself. Fredrik (7 April 2015), team leader logistics, brings forth this dilemma of consolidating different logics of action as he depicts the interaction between cultures in the work place:

> *You have a different work culture there and a different temperature to work in; it's a different environment to work in. They perhaps don't have same way of working that we might have wished for or are used to. But you can neither introduce our way of working or our culture; rather we had to adjust to them. But we still felt we wanted results and you had to push for that.*
>
> …
>
> *[…] we went in for it and did what we could to get good work performance and motivation of the staff. They got their equipment, they got their cloths and they got their means of assistance. But then it kind of was like they didn't use it in the way you had expected when they got it. And it was perhaps that they weren't used to it.*

Fredrik goes on to further say:

> *[…] in the way they are working here [in Liberia], everyone thought that everything was working perfectly. […] it was a total culture collision with how we work.*

As illustrated by this account, there seemed to be a negotiation between the MSB delegates' understanding of the logics of action within this new domain and the logics of action they bring with them to this context. Based on the presented statements, there appears to be a perception of a wrong versus a right way of performing work, in which the understanding conveyed about this dichotomy appears to be that the local co-workers wrongfully believe that their way of working is

perfect. Thus, it seems as if so-called 'good work performance' is defined differently by the local contra the foreign actors. Moreover, the means to instigate such performance amongst the staff also appear to differ. From the perspective of the interviewee, motivation and good work performance appear to be instigated by rewards, such as equipment and cloths, which are believed to push the worker to perform wanted results and objectives. Presumably, this perception is derived from a cultural idea based on a shared communal understanding that such rewards drive the worker to achieve 'good work performance' (cf. Tomlinson 1999:18-20). However, this shared communal understanding of practices within the workplace that may function as a logic of action in a Swedish context does not seem to work in this particular sphere. Thus, it can be argued that the logic of action in one context is not always transferable to another. Not acknowledging the logic of action in the local healthcare setting may make it difficult for the foreign healthcare workers to mediate Ebola prevention measures in this setting. They would lack understanding of the communal idea of reality that would explain practices and beliefs in this domain. Thus, a border is created between these different communal ideas of reality within the healthcare setting; thereby, creating a dichotomy between the local health domain and the foreign health domain. Ultimately, these foreign health workers would be excluded from the local health domain in which they are trying to mediate global health policies.

Nevertheless, by acknowledging the local healthcare settings logic of action and also adjusting to it is perhaps possible if the foreign healthcare worker merges or consolidates their own logic of action with the local logic of action ruling this setting. Through such an internal process, a hybrid or a fused transaction domain may emerge if local and foreign actors collectively agree and define this situation as a particular transaction domain with its specific roles and logic of action. Nevertheless, to impose a different logic of action in a transaction domain, which has not gained consensus by the actors embedded in this domain, would entail a difficulty in interaction. The idea is that if an actor engaging in a transaction domain is familiar with its governing logics of action, this individual will have the tools to navigate in this sphere. Moreover, the actor gains a certain role as a member of this domain, which inherently entails certain deontic power. Deontic power not only involves the obligations associated with this role it also comes with certain possibilities to exert power (cf. Frödin 2008:69-70; 2013:72-73). This is something Dr. Max (30 March 2015) previously pointed out when stating: *[…] It's quite easy that you take over when you believe that you're an expert. In this context we weren't experts.* Hence, having the role as an 'expert' in a particular domain gives certain deontic power, which may make it possible for an actor to 'take over' certain parts of the work. For the health worker, expertise involves the specialization in one area of the provision of health services to patients. By being specialized in

an area, healthcare workers' become more independent from organizational authority when making discretionary judgements. The organizational authorities lack the specialist knowledge these healthcare workers have and will therefore give these experts free hands in making decisions within their area of expertise (cf. Lipsky 1980:146-147).

Nonetheless, as previously indicated, in the context of Sierra Leone and Liberia these MSB delegates were not experts in the code of conduct for the transaction domain they entered. Thus, despite their occupational expertise, the medical system that they had entered differed in regards to its logic of action. As they were not part of this local system their occupational expertise, which had granted them certain empowerment at home, did not automatically grant them a similar status in the field until they would be acknowledged by this new system as experts. Dr. August (14 April 2015) depicts the experience of becoming included in this new system and gaining so-called deontic power through the role as a doctor:

> *[…] you could say that this doctor [in Sierra Leone] gave us free hands. […] the things we got to do felt really meaningful and we started organizing and initiated a medical record, medicine lists and also decided on some medication schedules and what types of medicine they would have during different phases of the disease and so on.*

As illuminated by this quote, the role assigned to Dr. August involved freedom to take discretionary judgements in certain areas of the work. Thus, this particular role came to be associated with specific deontic power. The interviewed Swedish healthcare worker had become a part of the local healthcare setting, i.e. the Sierra Leonean health domain. Moreover, it is interesting to note that for Dr. August to become a part of the local setting, this position was granted by the local doctor. In other words, Dr. August was forwarded trust and legitimacy by someone who was trusted and who had knowledge of the local context. Thus, through this position, access to the local healthcare setting was granted (cf. Frödin 2013:72-73; Gran 2002; Farris, Senner and Butterfield 1973).

As briefly argued in the previous section of this analysis (see *5.2 Consolidating objectives*) the interviewed healthcare workers that were in Sierra Leone had found that their role as street-level workers was similar in the field. Hence, they had moved across cultures while keeping this position, and so they had become 'global' street-level workers. Although the logic of action in this particular healthcare setting differed, the particular role they were assigned was associated with the similar deontic power as they were used to, which may have made it simpler to adjust to the unfamiliar context. Moreover, in this particular time and space the local healthcare was

working to combat Ebola and these external street-level bureaucrats had come to do the same. As these Swedish healthcare workers were assigned roles within the Sierra Leonean healthcare setting to do so, their personal goals with the mission came to be satisfied. Thus, it may have become easier to consolidate their inherent logic of action with the local domain's logic of action, as both the external and the local health workers shared the same objective; combating Ebola.

In the subsequent chapter, a concluding discussion is presented that provides a summary of the analysis and a final discussion concerning these findings. It briefly concludes the implication of these and suggests a path to further research.

7 Concluding discussion

While navigating the field the interviewed MSB delegates came across similar obstacles to those mentioned in the background chapter of this thesis. Nevertheless, two aspects were mainly emphasized; trust and the relative normality of everyday life. These aspects had clear links with how risk, fear and corruption were perceived both by the delegates themselves and by the people they came across in the field. Information transferred of the field, via international media, had limited liquidity since mainly the horror caused by the disease 'went viral'. The situation was portrayed selectively, as risk and fear formed barriers to the flow of information from the confines of the 'hot zone'. Based on this information transferal, the interviewed MSB delegates created a perception of how the EVD epidemic had impacted societal life in these countries, which did not coincide with the reality they experienced on the ground. Thus, some of the delegates were surprised that everyday life was relatively normal, although with one main exception. The Ebola virus prevention measures had forced societal changes, which resulted in the transformation of cultural practices. As the everyday reality of the local population had changed due to this deadly disease, it induced an altered collective understanding of this new reality. This came to be visible in peoples' beliefs and practices, such as the lack of close human contact (cf. Tomlinson 1999:18-20). Besides navigating in the field, the MSB delegates, as foreign actors, had to establish trust to facilitate the execution of their tasks. As pointed out by Arrow (1974:23) "[t]rust is an important lubricant of a social system" and so without trust, the system wherein you are trying to act, works against you. Specifically, for the MSB delegates this involved the local co-workers questioning their motives for being in the region. In general, rumors spread throughout these countries that questioned the motives for why the westerners were there. However, by legitimizing the motives of their mission the MSB delegates could establish trust. Basically, this involved the concretization of their motives and objectives so that the intentions of these became visible through actions.

Establishing trust involves a process of concretizing objectives by being transparent. However, being distrusted and continuously questioned by others may lead to a questioning of 'Self', as it may put into question ones motives for partaking in the mission. Perhaps even more so when the context does not fulfil the perceptions one had of it. For the healthcare workers in particular, the perceptions of MSB's medical mission did not concur with the tasks some of them were assigned. While the healthcare workers in Sierra Leone were taking care of patients; thereby, performing street-level work in direct interaction with citizens; some of the interviewed health workers in Liberia were assigned tasks or had to make up tasks that did not require their occupational expertise. In Sierra Leone job satisfaction was attained as personal goals; helping

others and being of use; were gratified. These actors had become 'global' street-level bureaucrats as they attained the status as heath workers and came to be embedded in the local health domain. In Liberia, dissatisfaction and frustration arose amongst the medical staff who had not been assigned street-level work and were unable to make up tasks. They lacked the deontic power, i.e. the high degree of discretion and autonomy in decision-making, which they were used to as street-level bureaucrats (cf. Frödin 2013:72-73; Lipsky 1980:13-25). Some came to be alienated due to the loss of decision-making power over their work (Lipsky 1980:75). Moreover, in this new field, these health workers lacked direction, as their work role lacked clarity. If they were not street-level workers on a medical mission, what role did they have? Those experiencing a loss of occupational 'Self' resorted to two different coping mechanisms; quitting or consolidating objectives. By making up tasks that corresponded to their personal motives, goals and perhaps even professional ideology (taking care of patients), some found meaningfulness and job satisfaction (cf. Lipsky 1980:148). Hence, as the situation changed they adjusted to it and bridged the discrepancy between the objectives of the tasks in the field and their personal goals.

Although it could be assumed that the domain of health is similar everywhere, the merge between global and local notions of health create glocalized health settings, i.e. geographically distinct health domains (cf. Ritzer 2011:159). For those healthcare workers who stayed in Liberia, it therefore became important to covey the idea that they were not there to 'take over'; rather they had to adjust to the logic of action within the local healthcare setting. They had to become a part of the local health domain, just as the Swedish healthcare workers in Sierra Leone. For the Swedish health workers with clear roles as street-level bureaucrats this seemed like a simpler task, as they became assigned roles within this pre-existing domain. However, for the healthcare workers who had to make up their own tasks this was a more difficult mission. As they were not assigned the position of street-level worker in this new field, these health workers had to establish a role that would fit in this domain. By making up tasks that fulfilled the objective of the domain, i.e. combating Ebola, a role in the local health system could be attained. However, this required knowledge of the logic of action within the local health domain to understand the specific roles assigned within it. In doing so, these health workers could find and fill a gap within this pre-existing system. To be able to act within this local domain they had to acknowledge the logic of action within that space, which could occur due to the shared objective to prevent the ebolavirus.

In conclusion, this study has aimed to investigate the extent to which Swedish healthcare workers, when combating the ebolavirus in West Africa, take into consideration the local context in their application of global health preventive measures. The MSB delegates' *experiences of navigating global health interventions towards Ebola in the current 'hot zone' of West Africa* illuminate the

complexities of embarking on such interventions. The local context continuously impacts the form of intervention that becomes possible. Not only does the situation require constant flexibility of the global health machinery and its employees, it also requires adjustment to the challenges, such as distrust, corruption and the lack of resources, which can impede the provision of healthcare. Basically, the Ebola prevention mission has to become glocalized. However, this is a problematic venture when the bureaucracy and its employees are a part of a giant machinery. As noted in the analysis, MSB fell under the umbrella of the global health machinery when working to combat Ebola. The agency became accountable to the machinery that it was embedded in and the objectives it set. To stray away from these objectives meant that the assigned task would not have been accomplished. However, due to the rapid decrease of cases in Liberia, MSB's mission came to focus less on medicine, which signified an attempt to adjust the mission to the changing needs of the local context. Then again, a total glocalization of the mission would perhaps entail an abandoning of the agency's assigned role within the global health machinery. Thus, the main issue of inflexibility seemed to derive from bureaucratic stiffness caused by a strict adherence to mandatory protocols and objectives. These bureaucratic structures also limited the information transferal within the global health machinery, as reports from the field slowly made its way through the organization. Consequently, the global health machinery could not rapidly, efficiently and flexibly adjust and respond to the continuous changes in the local circumstances. The machinery had lost connection between its cogs. As information became more solidified it slowly flowed through the barriers of the system, which resulted in false perceptions of the field, misleading information becoming the basis for potential objectives and slow adjustment to the transforming circumstances. Subsequently, this nexus of complication could have been avoided if information from the field had flown more freely.

Although the MSB delegates were a part of a larger system, their experiences indicate that they had a possibility to adjust their individual tasks to the local circumstances by making up assignments or by being inventive when resources were lacking. However, just as for the agency, this was only possible as long as these adjustments concurred with the main objectives of the mission. In those instances where the individual MSB delegate's personal goals collided with the objectives and tasks of the mission or when their inherent logic of action did not concur with local ones, the actors came to negotiate their role in this system. Particularly, for the healthcare workers this involved an internal *negotiation of their role in this culturally different context*. Their experiences revealed that these actors' had a continuous internal negotiation of 'Self' in relation to the 'Other' and the bureaucracy that they worked for, while trying to navigate health interventions in a foreign context. On the one hand, the 'Other' came to be the local culture

personified in co-workers and local communities, which had different medical practices. On the other hand, the 'Other' was the opposite of their occupational 'Self', i.e. the role of the non-street-level worker assigned to some of these healthcare workers. Subsequently, there was a conflict between whom the 'Self' was at home and who the 'Self' was in this new context. By negotiating 'Self' in relation to 'Other' these health workers either established a new role within the existing health domain or were included in it as street-level bureaucrats. Hence, by consolidating the discrepancy between 'Self' and 'Other' they found their role within this culturally different context.

The main implication of these findings seems to be the loss of the 'bottom-up' aspect in the application of global health policies, which occurs when the street-level bureaucrat's high degree of discretion and relative independence from organizational authorities is weakened or even lost. As this take place, the street-level workers ability to adjust their provision of services to the local circumstances is limited. Consequently, policy is no longer made on the ground; rather it trickles down from above. Thereby, the street-level bureaucrats become the alienated bureaucrats that are merely cogs within the global health machinery. Furthermore, considering the 'bottom-up' aspect of global health policy implementation, culture is an essential concept. Despite being an ambiguous and vague concept the negotiation of culture is an important component to policy implementing in different context. The 'one size fits all' approach and mindset (re-)produces a dichotomy between 'us' and 'them' where a certain way of doing things is seen as predominant. Although this issue has been touch in this thesis, to further engage in a discussion regarding this process of 'Othering', which creates dichotomizing borders between cultures, would have perhaps been an additional analytical aspect of interest. As this perspective perhaps could have revealed other mechanisms that enable and disable cultural negotiation and consolidation. Thus, on a final note, it would be interesting to engage in further research into what impact the 'Othering' process could have on the 'bottom-up' implementation of global health policies.

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Appendix I - List of interviewees

Nurse Jacob, 18 March 2015
Nurse Karin, 26 March 2015
Gustav, Security advisor for humanitarian emergency response, 27 March 2015
Dr. Max, 30 March 2015
Fredrik, team leader logistics, 7 April 2015
Dr. Ingrid, 12 April 2015
Dr. August, 14 April 2015

Appendix II – Interview guide

Bakgrund *– Background*

- Kan du berätta lite om dig själv?
  Can you please tell me a little bit more about yourself?

- Kan du berätta lite om det arbete du utför här hemma?
  Can you please tell me about the work you conduct here in Sweden?

- Varför bestämde du dig för att åka till Västafrika?
  Why did you decide to travel to West Africa?

- Hur kommer det sig att du valde att åka med MSB till Västafrika?
  Why did you choose to travel with MSB to West Africa?

- På vilket sätt förberedde du dig inför resan?
  In what way did you prepare for this trip?

Kontext *– Context*

- Vilket land(länder) i Västafrika arbetade du i?
  In what West African country(-ies) did you work in?

- När var du där senast och hur länge var du i regionen?
  When was the last time you were there, and for how long were you in the region?

- Kan du berätta om det arbete du utförde?
  Can you please tell me about the work you conducted?

- Kan du beskriva hur situationen såg ut i landet när du var där?
  Can you describe what the situation in the country was when you were there?

- Vad var dina upplevelser av din första kontakt med epidemin?
  What were your experiences of your fist contact with the epidemic?

- Hur kunde en dag ute på fältet se ut?
  How was a day out in the field?

Kultur och relationen med befolkningen *– Culture and relations with the population*

- Vad var din förståelse av den lokala kulturen innan du åkte? Stämde denna bild överrens med den verklighet du upplevde på plats?
  What was your understanding of the local culture before your trip? Did this picture concur with the reality you experienced on the ground?

- Hur såg din relation ut med den lokala befolkningen?
  What was your relationship with the local population?

- Hur upplevde du att den lokala befolkningen bemötte dig/er?
  How did you experience that the local populations treated you/You?

- Upplevde du att befolkningen hade förståelse för varför ni var där? På vilket sätt märktes/märktes inte detta?
  Did you experience that the local population understood why you were there? In what way was this noticeable/not noticeable?

- Vilken information om sjukdomen förmedlade ni/du till befolkningen? Hur upplevde du att sjukdomen förstods av befolkningen?
  What kind of information about the disease did you/You pass on to the population? How did you experience the populations understanding of the disease?

- På vilket sätt upplevde du att den lokala befolkningen tog åt sig den informationen om Ebola ni förmedlade?
  How did you experience that the local population internalized the information on Ebola that you passed on?

- Hur upplevde du befolkningens relation till det befintliga hälsosystemet och regeringen? Påverkade denna situation, befolkningens relation till er?
  How did you experience the populations' relationship to the existing health system and government? Did this situation impact the populations' relationship to you?

***Implementering** – Implementation*

- Vilka preventiva åtgärder arbetade du specifikt med?
  What preventive measures did you work with specifically?

- Vilka var de lokala förutsättningarna för att implementera åtgärderna?
  What were the local prerequisites for implementing these measures?

- Hade du möjlighet att anpassa åtgärderna utifrån de lokala förutsättningarna? (Skulle du kunna ge ett exempel på en situation där du anpassade åtgärder utifrån de lokala förutsättningarna och förklara varför du fattade detta beslut?)
  Did you have the opportunity to adjust these measures to these local prerequisites? (Could you give an example of a situation where you did this and explain why you made that decision?)

- Vilken form av inflytande hade MSB över sättet du implementerade de preventiva åtgärderna ute i fältet?
  What kind of influence did MSB have over the way you implemented the preventive measures out in the field?

- Upplevde du att det fanns svårigheter med att arbeta med och implementera de preventiva åtgärderna?
  Did you experience difficulties with working with and implementing the preventive measures?

Avslut *– Closing questions*

- Vad var det mest givande med arbetet?
  What was the most rewarding part of your work?

- Nu i efterhand, upplever du att något hade kunnat förbättras?
  Looking back, do you feel that something could have been improved?

- Har du något du vill tillägga?
  Do you have anything you would like to add?