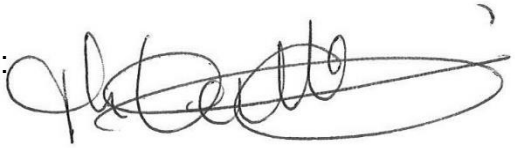
Discreet Power through Reputation

Bureaucratic Empowerment and Disease Control in the EU

Submitted by Thibaud Deruelle to the University of Exeter as a thesis for the degree of Doctor of Philosophy in European Politics in September 2020.

Signature: 

Abstract

The European Centre for Disease Prevention and Control (ECDC) is the agency in charge of detecting and assessing communicable diseases in the European Union (EU). Over its fifteen years of existence, the “Centre” has not only assessed risks but also occasionally advised on how to manage them. Assuming an advising role on the management of risks is usually how agencies contribute to policymaking in the EU, but the ECDC is particularly constrained by the limits imposed on its mandate by EU treaties. Public health is only a coordinating competence in the EU and the ECDC is, in principle, barred from giving explicit advice on how to manage public health risks. The goal of this thesis is to explain how the ECDC is empowered beyond its mandated activities. It addresses the puzzle of the Centre’s empowerment by investigating the role of reputation and by proposing an original causal mechanism of empowerment through reputation. I probed this mechanism through a narrative analysis of four areas of empowerment of the ECDC: the creation of the Centre, HIV/AIDS, antimicrobial resistance (AMR) and the 2009 H1N1 crisis as well as an area with a negative outcome: non-communicable diseases (NCDs). My research shows that over the 15 years of the ECDC’s existence, the role of reputation in the Centre’s empowerment has been to assist actors in engaging in inferential processes that set a course of action towards the ECDC’s empowerment. These findings are important for the literature on bureaucratic reputation: reputation ought to be further used in public policy to understand how and why agents put their trusts in others to produce change. On European agencies, this thesis also demonstrates that a power approach is relevant and, ironically the best way to not eschew the least powerful European agencies from scientific scrutiny.

Acknowledgements

Thank you, Professor Claudio Radaelli for showing me the tricks of the trade.

Thank you, Dr Eva Thomann for helping me to lay out the foundations of this manuscript.

Thank you, Dr Angela Cassidy for showing me that drawbacks in the field are just one other type of data, albeit a painful one.

Thank you, Professor Isabelle Engeli for your dedication, your support and teaching me so much in so little time. You are a role model.

Thank you, Sophie.

Thank you, Lena and Claude, Jonathan, Georges, and Iggy.

And thank you to all those who helped in any way over the last five years, if you happen to read those pages, please be assured that I consider it a privilege.

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Abbreviations: A-EN

AIDS: Acquired ImmunoDeficiency syndrome

AMR: AntiMicrobial Resistance

ARHAI: Antimicrobial Resistance and Healthcare Associated Infection Programme (ECDC)

BSE: Bovine Spongiform Encephalopathy

BSN: Basic Surveillance Network

CDC: Centers for Disease Control and Prevention (US)

CDSC: Communicable Disease Surveillance Centre (UK)

COVID-19: CoronaVirus Disease of 2019.

DG SANCO/DG SANTÉ: Directorate-General for Health and Food Safety

DIPNET/EDSN: European Diphtheria Surveillance Network

DIVINE: European Network for the Prevention of emerging (food-borne) enteric viral infections

DSN: Disease Specific Network

EAAD: European Antibiotics Awareness Day

EARS/EARSS: European Working Group for Legionella Infections

ECDC: European Centre for Disease Prevention and Control

ECID: European Centre for Infectious Diseases

EEA: European Environment Agency

EFSA: European Food Safety Authority

EIGE: European Institute for Gender Equality

EISS: European Influenza Surveillance Scheme

EMA: European Medicines Agency

EMCDDA: European Monitoring Centre for Drugs and Drug Addiction

ENISA: European Network and Information Security Agency

ENIVD: European Network for Imported Viral Disease

Abbreviations: EN-L

Enter-net/FWD-Net: European Food- and Waterborne Diseases and Zoonoses Network

EPHA: European Public Health Association

EPIET: European Programme for Intervention Epidemiology Training

ESAC: European Surveillance of Antimicrobial Consumption

ESSTI: European Surveillance of Sexually Transmitted Infections

EU: European Union

EUCAST: European Committee on Antimicrobial Susceptibility Testing

EU-IBIS: European Union Invasive Bacterial Infections Surveillance

EUMC: European Monitoring Centre on racism and xenophobia

EU-OSHA: European Agency for Health and Safety at Work

EuroCJD: European Creutzfeldt-Jakob Disease Surveillance Network

EuroHIV: European Centre for the Epidemiological Monitoring of HIV/AIDS

EuroTB: European Surveillance of Tuberculosis

EUVAC.NET: European surveillance network for selected vaccine-preventable disease

EWGLINET: European Working Group for Legionella Infections

EWRS: Early Warning and Response System

FDA: Food and Drug Administration

HEOF: Health Emergency Operations Facility

HIV: Human Immunodeficiency Viruses

HPA: Health Protection Agency (UK)

HSC: Health Security Committee

IHR: International Health Regulation

IPSE/HAInet: Healthcare-Associated Infections Surveillance Network

JIACRA: Joint Interagency Antimicrobial Consumption and Resistance Analysis

LGBT: Lesbian Gay Bi Transsexual

Abbreviations: M-Z

MEP: Member of the European Parliament

MSM: Men who have Sex with Men

OCS: Office of the Chief Scientist (ECDC)

PHC: Public Health Capacity and Communication unit (ECDC)

PHEIC: Public Health Emergency of International Concern

QUANGOS: Quasi-Autonomous Non-Governmental Organisation

RIVM: Rijksinstituut voor Volksgezondheid en Milieuhygiene

RONAFA: Joint Scientific Opinion on measures to reduce the need to use antimicrobial agents in animal husbandry in the European Union

SARS: Severe acute respiratory syndrome

STI: Sexually Transmittable Infections

TATFAR: Transatlantic Taskforce on Antimicrobial Resistance

WHO: World Health Organization

Chapter 1. Introduction

Viruses do not know borders, nor do they travel alone. They thrive on people; they thrive on goods and travel fast in our globalized economy. The epidemic crises that have occurred over the last 20 years demonstrate the relevance of studying the transnational governance of communicable diseases. The 2002 severe acute respiratory syndrome (SARS), the 2000s “avian flu” (H5N1) outbreaks and the 2009 “swine flu” (H1N1) have shown that risks of epidemics are an intricate and globalized issue. Health crises are not new, but we are only rediscovering the important impact they can have on societies. Most recently, the SARS-CoV-2, commonly referred to as COVID-19, led most of the world to restrict freedom of movement and social contacts, impacting lives and economies worldwide. The COVID-19 crisis highlights the inherent epidemiological risks to globalization and freedom of movements; just as previous pandemics have demonstrated those risks beforehand, albeit in a less disruptive way. Communicable diseases are inherently, a transboundary issue.

This observation is even more relevant in the European Union (EU), where freedom of movement - a cornerstone of EU integration - has led to a significant expansion of the circulation of goods and persons between European countries, thus increasing the potential impact of communicable diseases. While Member States are mutually dependent in facing health threats, public health is still predominantly the responsibility of national authorities. Nevertheless, the field of public health in the EU is not a blank slate. In 2004, the EU established an agency, the European Centre for Disease Prevention and Control (hereinafter referred as ECDC or the Centre, consistently with the shorthand used in official documents

and by research participants). Hence, how to explain that there is an EU agency for disease control since public health remains the preserve of Member States?

Structures of cooperation in the area of epidemic surveillance are not new to the EU and other organizational features, have preceded the Centre. Until 2004, those were mostly connecting national authorities in disease specific networks and existed independently from one another. Upon its creation, the ECDC was tasked with helming those networks and providing information and expertise relevant to communicable disease control in the EU (see Regulation No 851/2004 establishing the Centre, European Union 2004). Despite these organizational features, public health remains far from being integrated: the EU only has a supporting competence in public health. This means that the EU can only intervene to support, coordinate and complement Member States' activities (Article 168 of the Treaty on the Functioning of the EU). The only exception to this limited capacity to act is epidemiological surveillance (the identification of infections for a given pathogen). Indeed, the EU has the competence to harmonize scientific practices and methods for the purpose of generating consistent data across the EU (see Decision No 2119/98/EC on communicable disease surveillance, European Union 1998). The bulk of communicable diseases control nevertheless rests on coordination and soft governance (Trubek, Cottrell, and Nance 2005) which limits capacity for action. This system of governance is relatively modest, which raises questions on the actual *control* that is exercised on communicable diseases by EU institutions.

The objective of this system of disease control is, ultimately, to coordinate the regulation of health risks - the governmental interference to control potential adverse consequences to health (Hood, Rothstein, and Baldwin 2001, 3; see also,

Weimer and Ruijter 2017). This objective is, however, not reached through a classic command-and-control approach to regulation (Baldwin, Cave, and Lodge 2013; Drahos and Krygier 2017; Koop and Lodge 2015; Levi-Faur 2011a). The control of communicable disease in the EU does not set out conditions and restrictions of behaviour (Lowi 1972); nor is it based on the notion of "regulatory state" (Majone 1994; Peters 2016) in which regulation corrects market failures. The control of communicable diseases in the EU is, in effect, a form of regulation that does not involve the bureaucratic legalization of prescriptive rules. This phenomenon highlights the need for an alternative understanding of regulation: voluntary, cooperative, network-based (Coen and Thatcher 2007; Levi-Faur 2011b) or unintended (Gunningham and Grabosky 1998; Levi-Faur 2011a). In the case of the regulation of risks of communicable diseases in the EU, most of the competence is in the hands of Member States who meet at ministry level in the Health Security Committee (HSC), a group formalized in the aftermath of the 2009 H1N1 crisis with the purpose to coordinate measures of disease control (de Ruijter 2019). This can be compared to a form of self-regulation (Baldwin, Cave, and Lodge 2013; Gunningham and Grabosky 1998; Thomann 2017): Member States are here both subject to and in control of the mechanism holding their behaviour accountable regarding health security, with no internal mechanism of coercion. Coordination relies first and foremost on the good-will of Member States. Hence, this regime sets-up clear practical limits to the production of a coordinated response which have far reaching consequences on the day-to-day handling of disease control in the EU, in particular for the ECDC.

While the role of the European Commission is restricted to *supporting* Member States' coordination, the role of the ECDC is even more limited. These limits are

embodied in the sharp division between risk assessment and risk management that characterizes the control of communicable diseases at EU level (Reintjes 2012). Risk assessment is the identification of risks through the evaluation of the magnitude, mechanisms and gravity of threats to public health (Greer, Mätzke, and Linz 2012). These technical and scientific tasks related to surveillance are the purview of the ECDC. In practice, the Centre gathers epidemiological intelligence from Member States' health agencies across the EU as well as neighbouring third countries (Norway, Iceland and Lichtenstein). However, the ECDC is formally excluded from encroaching on matters of management: treatments such as vaccination and restrictions such as confinement have remained the prerogative of national authorities, as defined in the Centre's Founding regulation (European Union 2004).

This distinction is not unique to the ECDC (Hood, Rothstein, and Baldwin 2001; Weimer 2017; Weimer and Ruijter 2017), for instance, this limit is also imposed on the European Food Safety Authority (EFSA) (Ansell, Vogel, and Vogel 2006; Borrás, Koutalakis, and Wendler 2007; Rimkutė 2018). However, in the case of the ECDC, it is particularly rigidly enforced because unlike EFSA, the ECDC operates in a system wherein the EU only has coordinating competences and therefore cannot produce binding rules. This is vastly different from the landscape of communicable diseases in Member States. At national level, assessment and management are two sides of the same coin: For instance, during the COVID-19 crisis, the French health agency *Santé Publique France* was expected to publicly advise the French government regarding containment. However, unlike at national level, independent experts in the ECDC cannot demonstrate a form of entrepreneurship nor emerge as the catalyst for a coordinated answer. In sum, the

mandate of the ECDC seems to be reduced to a trickle, to the point of being compared to a “hollow core” in the literature (Greer 2012; Greer and Mätzke 2012).

With this severe restriction on the scope and capacity for action of the ECDC, it raises the question: What is the purpose of a scientific agency with such a limited purview on its area of competence? It is, indeed, puzzling to contemplate an organization made of experts involved in serious and time-sensitive risk-regulation that ultimately does not wield *a* form of power over disease control.

Section 1 situates the research puzzle by analysing the role of the ECDC through a power-based approach. A power-based approach is relevant, because the ECDC appears powerless in the first place. Political science is somewhat ill-equipped to discuss forms of power that are discreet and distinct from rulemaking. Yet it is highly relevant, especially in the midst of the COVID-19 pandemic. Discussing the power of the ECDC is important to appraise normatively the functioning of disease control in the EU. The argument I defend in this thesis is that the ECDC is not a powerless organization, but rather that the Centre wields a form of power over disease control that is discreet and distinct from rulemaking: a conceptual power (Carpenter 2010) - *i.e.* the power of shaping cognition and defining the terms of problems and debates. Because the ECDC’s power is purely *conceptual,* the Centre has been able to wield this power over some aspects of risk management. My research on the ECDC’s *empowerment* shows that the Centre has extended its conceptual power through shaping cognition and defining the terms of problems and debates beyond its purview. Section 2 outline how a reputational approach to empowerment generates the necessary leverage to explain the empowerment of the ECDC. I build on the claim that there is a cause-

and-effect relationship between bureaucratic reputation and power (Carpenter 2001, 2002, 2010; Carpenter and Krause 2011; Maor, Hebrew, and Ben-Nun 2013). This research thus seeks answers to the following research question: *What is the role of reputation in empowering the ECDC beyond its mandate?* I adopt an interpretive approach to explore this causal link between empowerment and reputation, which I detail in Section 3. I then give an overview of my research objectives and findings in Section 4. and present the structure of the thesis in Section 5.

1. The Role of the ECDC: a Power-Based Approach

The 2004 Founding Regulation of the ECDC (European Union 2004) provided the Centre with the mandate to cover surveillance, detection, and risk assessment of threats to human health from communicable diseases and outbreaks from unknown origins. In practice, the ECDC's role in risk assessment has been to centralize epidemic intelligence that is produced by national public health agencies (de Ruijter 2019). There are two channels through which this intelligence is compiled. The first one is indicator-based intelligence, based on the continuous monitoring of reported cases on disease such as HIV, smallpox. The second one is event-based intelligence, based on computer-based early warning system (EWRS) which detects emerging threats, such as COVID-19 or H1N1. Figure 1. below illustrates the role of the ECDC in risk assessment depending on the type of intelligence.

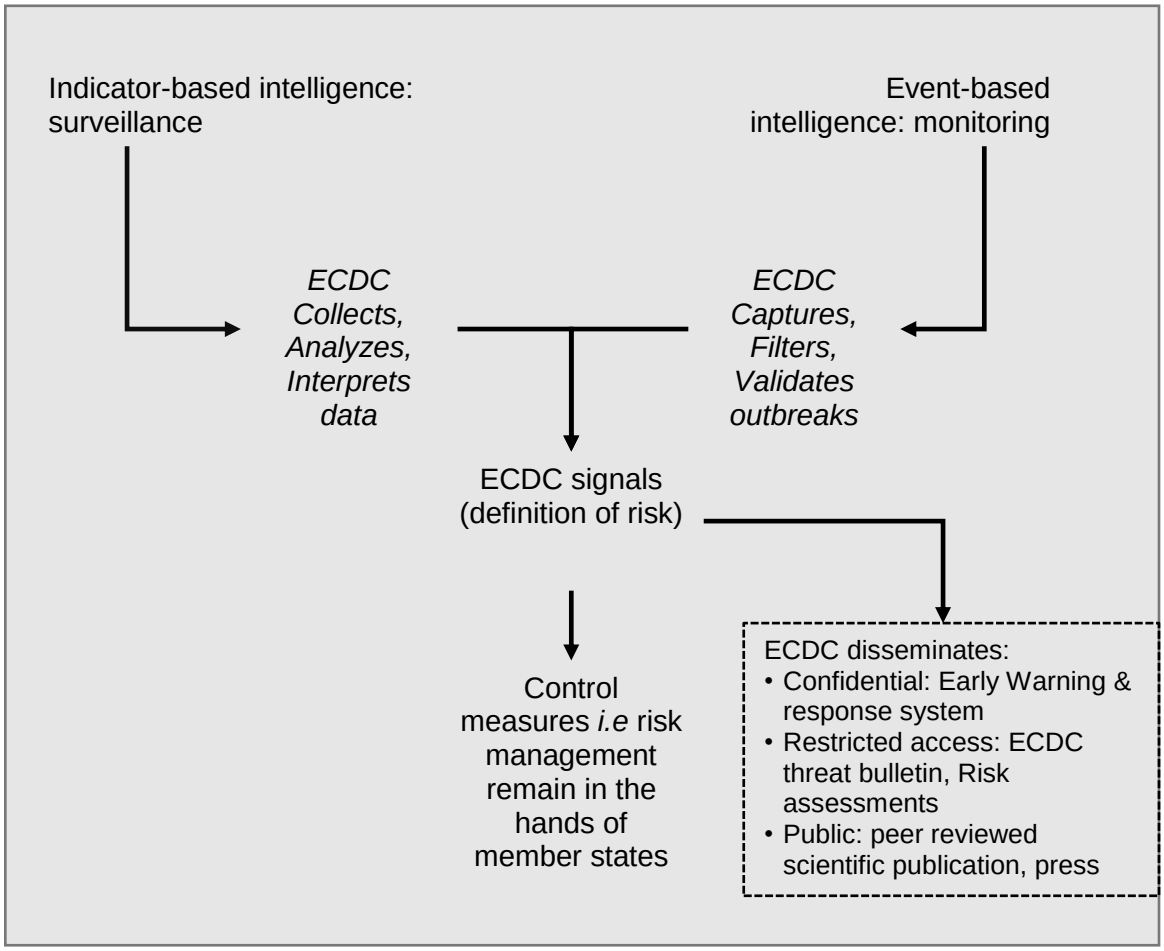

Figure 1. The ECDC's role in risk assessment in the context of communicable disease control in the EU adapted from the ECDC first work programme (European Commission 2005)

The Founding Regulation purposefully omits one of its key aspects: risk management and specifically states that the "Regulation does not confer any regulatory powers on the Centre" (European Union 2004). Due to the nature of EU integration, regulation and regulatory powers have specific meanings in EU institutions: *Regulation* usually mean legal binding texts co-decided by the European Parliament and the Council of Ministers, used to harmonize legislation across the EU. Without capitalization, *regulation* is the policy-making mode for the adoption legally binding Decisions by the European Commission, for instance on

specific cases regarding competition. In both cases, meanings of the word *regulation* are tied to rulemaking. On the term *regulation,* the literature on communicable disease control in the EU underlines the importance of the sharp division between risk assessment and risk management (Greer, Mätzke, and Linz 2012; Deruelle and Engeli 2020). As per legal texts, the formal prohibition to exercise regulatory powers means that the ECDC is bounded to identify risks but cannot produce unequivocal guidelines on how risks ought to be managed (Adolph, Greer, and Massard da Fonseca 2012; Bergeron 2010; Elliott, Jones, and Greer 2012; Greer 2012; Liverani and Coker 2012), as outlined in table 1. below.

Governance of communicable disease	**Indicator-based: continuous monitoring of reported cases on disease such as HIV, smallpox.**	**Event-based: report of outbreaks for diseases such as H1N1 influenza, COVID-19**
Risk monitoring: ECDC has the mandate to harmonize surveillance	Reporting scientific networks (helmed by the ECDC)	Computer-based early warning system (EWRS) (helmed by the ECDC)
Risk assessment	ECDC produces scientific/technical documents based on risk monitoring for the Commission and Member States	
Risk management: prevention, preparedness: vaccines, funding ect.	Supporting/coordinating competence: European Commission facilitates coordination between Member States and ECDC is formally prohibited to be prescriptive	

Table 1. Task allocation in the prevention and control of communicable diseases in the EU

The role of the ECDC thus appears limited, due to a narrow legal basis for competences and the baroque legal and organizational features that characterizes communicable disease control in the EU. I argue that the ECDC is not powerless, but that its power is subtle and discreet. Indeed, organizations such as the ECDC are often examined as structures of cooperation but rarely as structures of power (Moe 2005). Disease control in the EU is based on coordination and relies on the production of scientific knowledge and epidemic intelligence to foster coordination. Considering that neither the Commission, nor the HSC dispose of the scientific capacities that the ECDC possesses, the ECDC actually has the resources and the potential to hold a *form* of power over the control of communicable diseases: the Centre can frame epidemiological knowledge as different level of risks. This form of power is distinct from classic command-and-control understanding of regulatory power and cannot be conflated with rulemaking, hence, how to conceptualize this form of power?

In his seminal article on “The New European Agencies”, Majone (1997) argues that credible information produced by the European agencies can play a constitutive role in shifting other actors’ preferences (see also: Zito 2009). Daniel Carpenter in his book on the US Food and Drugs Administration (2010) makes a similar claim: agencies have a conceptual power. This power is concerned with shaping cognition and defining the terms of problems and debates, through the formal and informal definitions of concepts, vocabularies, measurements. Carpenter identifies that regulatory organizations can display three faces of power: directive, gatekeeping, and conceptual power. The first two faces of power are concerned with command-and-control mechanisms: directive power consists of *directing* the behaviour of regulatees through legally binding rules; gatekeeping

power is concerned with *allowing* products on the market. The third face is described as subtle and often neglected: it is conceptual power (Carpenter 2010, p. 64). Power is thus not only about the compliance to prescriptive rules: “A may exercise power over B by getting him to do what he does not want to do, but he also exercises power over him by influencing, shaping or determining his very wants” (Lukes 1974, 27) [1]. Power can thus also be *conceptual,* in the sense that one influences and shapes what others want.

With a clear mandate to set standards and scientific criteria for epidemiological intelligence, the ECDC displays attributes of conceptual power, as it defines concepts, vocabularies, measurements and can raise attention on epidemic problems. Per legal terms, this conceptual power should be limited to risk assessment activities, while the management of risks strictly remains the preserve of Member States. However, the very nature of conceptual power calls into question the distinction between exercising a conceptual power in risk assessment and exercising a conceptual power in risk management.

The nature of conceptual power - based on shaping cognition and defining the terms of problems and debates, through the formal and informal definitions of concepts, vocabularies, measurements - challenges a conceptualization of power that would be enacted and restricted by the law only. Conceptual power does not

[1] This distinction between different faces of power relates to seminal debates on the analysis of power (Bachrach and Baratz 1962; Dahl 1957; Lukes 1974). A simple, intuitive formulation of power can be found in Dahl’s concept of “A has power over B to the extent that he can get B to do something that B would not otherwise do” (Dahl 1957). Bachrach and Baratz (1962) bring in the notion of non-decision to complement Dahl’s conceptualization. Yet both concepts rely on the notion of conflict as a condition for power to be exercised and draw on Weber’s concept of domination which he defines "as the probability that certain specific commands (or all commands) will be obeyed by a given group of persons" (Weber 1922, p.212). Lukes (1974) suggests a departure from the conflict-centric view of power: “A may exercise power over B by getting him to do what he does not want to do, but he also exercises power over him by influencing, shaping or determining his very wants” (1974, 27). Lukes’ approach - adding a third, more subtle dimension - is akin to Carpenter’s conceptual power (2010, 64).

necessarily require any formal arrangements to be exercised. Taking cues from Majone (1997), this form of power is dependent on the credibility of the information produced by the ECDC rather than legal terms. The claim defended here is that in spite of legal limitations, the ECDC has been able to wield a conceptual power over some aspect of risk management. This claim relies on the fact that assessment fundamentally informs management (Hilgartner 2000; Jasanoff 1998) Moreover, institutions produce classifications (Douglas 1986) and classifications promote particular solutions (Entman 2003, 5). Rather than just passing-on information to the European Commission and Member States, the ECDC can frame epidemiological knowledge as different level of risks. As it defines risks, the ECDC plays a primordial role in eliciting the way Member States' respond to and manage health threats.

Hence this research is concerned with the *empowerment* of the ECDC - understood as the process through which the Centre extends its conceptual power through shaping cognition and defining the terms of problems and debates beyond its remit. As an inquiry in empowerment, this research endeavour is not based on the hunch that the Centre is a behind-the-scenes regulator. The phenomenon under scrutiny is not that the ECDC has developed directive or gatekeeping powers - this would not make sense in the EU system of disease control that is based on coordination. The ECDC's empowerment is primarily concerned with the Centre's conceptual power in risk assessment spilling-over risk management. Unlike for directive and gatekeeping powers, conceptual power can develop informally without empowering the Centre to create rules.

Indeed, evidence shows that over 15 years of existence, the scope of the conceptual power of the ECDC has not been strictly restricted to risk assessment.

There is evidence of the ECDC's empowerment in HIV/AIDS (Steffen 2004; 2012; Smith 2016) wherein the ECDC took on an increased role in prevention in specific Member States at the end of the 2000s. In more recent years, I observed another empowerment wherein the ECDC has developed a role in helping Member States to develop their national plans to fight antimicrobial resistance (AMR). Amid the 2009 H1N1 pandemic, the ECDC developed an advisory role on vaccines for the ECDC amid the crisis. This thesis brings evidence of the Centre's empowerment in four cases: the creation of the ECDC, HIV/AIDS, the 2009 H1N1 pandemic and AMR. Drawing on a hisrotical comparative analysis, these cases show that over time the conceptual power of the ECDC has developed, and that the Centre's advisory prerogatives have increased. This advisory role constitutes a form of conceptual empowerment in and of itself: despite legal limitations, the ECDC has not only shaped risk assessment, but also the terms of the debate on the type of measures of management that would be applied. The ECDC's empowerment is differentiated: the ECDC is not empowered on all public health topics that are part of its mandate of surveillance. Rather, empowerment occurs *in silos,* on specific health topics, such as the management of specific known diseases, for instance, smallpox or HIV, or in reaction to the discovery of new salient diseases such as the 2009 H1N1 pandemic.

Raising the question of the empowerment of the ECDC, especially vis-à-vis a discreet power is more relevant than ever. Most recently, on COVID-19 the ECDC has been proactive on the front of management by providing advice on when to rely on, and when to exit, confinement. Nevertheless, due to the timeframe of the fieldwork of this research, this thesis does not analyse COVID-19 as a case of empowerment. Early observations of the COVID-19 crisis indicate that public

health, while still a prerogative of experts is nowadays more scrutinized, contested and politicized than in the recent past (Clemens and Brand 2020; Greer and de Ruijter 2020; Reeves 2020). Yet, the allocation of authority in the field of health and specifically communicable diseases remains opaque to the public (Adolph, Greer, and Massard da Fonseca 2012; Renda and Castro 2020; de Ruijter 2019). Clarity of roles and competences is of paramount importance to manage citizens' expectations and attention (Berger 2011). And one of the goals of this research is, through the case of the ECDC, to offer some insights on the ongoing conversation on the role of knowledge in public health, which sparked amid the COVID-19 crisis (Comfort et al. 2020; Huang 2020; Pacces and Weimer 2020; Qi et al. 2020; Van Dooren and Noordegraaf 2020).

In sum, this thesis contends that the ECDC is not a powerless organization, but rather holds a conceptual power in risk assessment. The goal of this research is to explain how this empowerment occurs in spite of the severe limitations imposed on the Centre's scope and capacity for action. Research findings show that the Centre has occasionally extended this conceptual power through shaping cognition and defining the terms of problems and debates in management. This empowerment is possible because it operates at a purely conceptual level, which does not require formal arrangements to be exercised. In Section 2. I discuss propositions of the literature on European agencies, to find only limited explanatory leverage for the development of a conceptual power. I thus turn to the literature on bureaucratic reputation which offers an explanation of empowerment better suited to the case of the ECDC as a conceptual power.

2. Explaining Bureaucratic *Empowerment*

Empowerment - defined here as the process through which an agency extends its power over its area of expertise - is a concept that ought to be clarified vis-a-vis the literature on European Agencies. Empowerment, in earlier literature (Coen and Thatcher 2007; Dehousse 2008; Keefer and Stasavage 2003; Pollack 1997) is defined as the process that occurs at the creation of the agency. The form that this empowerment takes is explained by the logics of delegation (Franchino 2002; Majone 2001) followed by the principal. In this sense, empowerment is a product of the limited delegation of tasks that is characteristic of the EU (Majone 2002). Such characterization endures in the more recent scholarship on *De Novo* bodies, which promotes the claim that European agencies are intergovernmental bodies (Bickerton, Hodson, and Puetter 2015; Hodson 2015). The implications for empowerment is that it should remain narrow and arguably static (Bickerton, Hodson, and Puetter 2015).

Yet, this disposition towards a static view of empowerment is challenged by the legal and public administration scholarships (Keefer and Stasavage 2003; Chiti 2004; Hauray and Urfalino 2009; Wonka and Rittberger 2010; Egeberg and Trondal 2011a; Chiti 2012; Busuioc 2013; Ruffing 2015). As I will develop more in detail in the second chapter, a host of European agencies are able to exercise quasi-regulatory powers, despite a delegation of tasks that is initially more limited (Busuioc 2013; Chiti 2012; Wonka and Rittberger 2010). As for explaining empowerment, the scholarship has favoured the study of these agencies' autonomy vis-à-vis principals (Busuioc 2009; Egeberg, Trondal, and Vestlund 2014; Groenleer, Kaeding, and Versluis 2010; Versluis and Tarr 2012; Guidi 2015)

and does not discuss empowerment *stricto sensu*. This emphasis on autonomy is a testimony of the influence of Majone's (1997) foundational claim that European agencies' ability to perform regulatory tasks depends on a reputation of credibility and that credibility is guaranteed by regulatory insulation (Busuioc and Rimkutė 2019; Ossege 2015)

The *autonomy* approach to European agencies also draws on the scholarship on independence and control of regulatory agencies (Bach and Ruffing 2013; Ennser-Jedenastik 2015; Gilardi 2005; Guidi 2015; Maggetti 2007, 2012; Maggetti and Verhoest 2014), which underlines the role of *de facto* independence as a determinant of regulatory agencies' influence (Maggetti 2012 74–99, 101–140). Independence is a seminal concept to grasp to what extent the power of regulatory agencies can deviate from statutory prescriptions and emancipate them from the influence of principals (Maggetti and Papadopoulos 2018). It sheds light on agencies' independence and autonomy as the guarantee for agencies to hold a central place in rulemaking (Busuioc 2009; Maggetti 2012). This is not a form of empowerment that is possible in the control of communicable diseases in the EU, as it is a system of governance based on supporting competences and coordination. Hence, the independence and autonomy approaches are inherently limited to understand the empowerment of the ECDC: more independence or autonomy would hardly mean more discretion to exercise a conceptual power. And these approaches do not generate sufficient leverage to explain the conceptual empowerment of the ECDC beyond its mandate.

As a case of empowerment, the ECDC is thus an deviant case (Gerring 2006, 2008; Gerring and Cojocaru 2015; Lijphart 1971; Przeworski and Teune 1970). Deviant case analyses are studies of single cases that are known to deviate from

established generalizations (Lijphart 1971, 692). Indeed, the literature shows that European Agencies' empowerment is usually the result of an increase in their autonomy and independence from their principal and regulates alike. In the case of the ECDC, empowerment occurs without an increase in autonomy or independence. As deviant case of European agencies' empowerment, the case of the ECDC is useful to uncover the empowerment of the Centre as a theoretical anomaly (Gerring and Cojocaru 2015, 655) that uncovers a deviant path for the empowerment of European agencies and probes for new explanations rather than refute the propositions made by the literature on independence and autonomy. In this vein this research falls within an institutionalist scholarship interested in "who and what institution gains or is given the responsibility for 'doing something' about the issue" (Gusfield 1984, 5). A more robust understanding of the mechanisms that grant organizational power is essential to understand the capacity for collective action instantiated in public institutions. Ultimately, the puzzle of the ECDC demands an answer to the seminal question: *how do non-majoritarian institutions become powerful?* Albeit regarding a dimension of empowerment that is not concerned with the independence and autonomy of agencies regarding rulemaking.

I thus turn to the literature on bureaucratic reputation (Carpenter 2000; 2001; 2010; Maor 2010; Carpenter and Krause 2011; Maor et al. 2013; Busuioc and Lodge 2015; Capelos et al. 2016; Maor 2016; Maor and Sulitzeanu-Kenan 2016; Lee and Ryzin 2019; Boon, Salomonsen, and Verhoest 2019; Overman, Busuioc, and Wood 2020) to examine propositions on empowerment that are not primarily concerned with the independence to *de facto* make rules. The reputational literature on European Agencies, in the right path of Majone's foundational claim

on credibility (1997), emphasizes that a reputation of credibility is a desirable asset to maintain their power (Busuioc and Lodge 2017; Busuioc and Rimkutė 2019; Rimkutė 2020) and avoid reputational risks (Busuioc 2016; Rimkutė 2018). In his seminal book on reputation and power, Carpenter (2010) developed more explicitly the causal link between power and bureaucratic reputation, in a detailed study of the development of the US Food and Drugs Administration (FDA). This is based on the claim that there is a cause-and-effect relationship between bureaucratic reputation and power (Carpenter 2001, 2002, 2010; Carpenter and Krause 2011; Maor, Hebrew, and Ben-Nun 2013). Through an analysis of the agency's history, Carpenter accounts for the development and maintenance of the FDA's reputation and its empowerment. His book brings evidence to the claim that reputation, rather than regulatory arrangements explain why he found, over time, an increase in the FDA's power.

Reputation depends on the agency's functions and actions being widely acknowledged by its audiences - "any individual or collective that observes a regulatory organization and can judge it" (Carpenter 2010, 33) - on the basis of its distinct performances (Carpenter 2010; Carpenter and Krause 2011). For agencies, audiences can be regulatees, principals and may be referred to as stakeholders. The meaning made of the role of an agency can empower the organization: "Reputation can, by assigning expertise and status to government agencies, allow them to define basic terms of debate, essential concepts of thought, learning and activity. […] Reputations can expand or deflate the legal authority about an organization – its capacities, intentions, history, mission – and these images are embedded in multiple audiences" (Carpenter 2010, 33). Audiences have beliefs regarding the tasks an agency can (not) or should (not)

perform (Carpenter 2001; 2010; Carpenter and Krause 2011). These beliefs can thus build the directive, gate-keeping or conceptual power of the agency (Carpenter 2010, 10). Unlike approaches of empowerment only concerned with rulemaking, Carpenter's approach studies the three "faces" of the FDA's power and thus produces leverage for an empowerment concerned with the conceptual power of agencies.

In effect, bureaucratic reputation is a theory of empowerment: it explains how power is dependent on reputation. Bureaucratic reputation is thus another analytical lens that informs us on the discrepancies between *de jure* and *de facto* tasks of an agency. But the reputational scholarship does not exclusively tie empowerment to rulemaking. By exploring the link between the ECDC's empowerment and the Centre's reputation, I generate the necessary leverage for a clear causal mechanism of the ECDC's empowerment as a deviant case of European agencies' empowerment.

In sum, bureaucratic reputation is a suitable approach for unveiling the discreet empowerment of the ECDC as a conceptual power, and the central research question of this thesis is: *What is the role of reputation in empowering the ECDC beyond its mandate?* This inquiry is based on the argument that the ECDC holds a form of conceptual power beyond the strict limits of its purview and that conceptual empowerment can be completely informal. Bureaucratic reputation is a suitable approach because it does not necessarily tie empowerment to agencies' influence on rulemaking.

3. An Interpretive Approach for Investigating the Causal Link between Empowerment and Reputation

Bureaucratic reputation is a set of beliefs about an organization's capacities, intentions, history, and tasks that are embedded in a network of multiple audiences (Carpenter 2010). Studying reputation requires consideration of the interactional contexts or webs of relationships in which it is ensnared and embedded; and one can only investigate this by appraising the interactions between actors of the prevention and control of communicable diseases. This approach to research resonates with the methodological position of symbolic interactionism (Blumer 1998) and is firmly grounded in an interpretive approach to research.

Interpretivism seeks to analyse the meaning of concepts in their specific context and to understand actors' explanations for what they do or believe (Bevir and Rhodes 2006; Finlayson 2004; Lin 1998; Lukka 2014; Schwartz-Shea and Yanow 2011; Soss 2006; Yanow 2007; Yanow and Schwartz-Shea 2006). The study of "meaning-making" is the central characteristic of this research tradition. This research orientation implies that meaning is understood as constructed, dynamic and contextual. Organizational reputation is best suited to the interpretive approach as it revolves around the meaning given to institutions and organizations. Organizations, as *material entities* need meaning and beliefs to be attached to them, to become relevant for policy. This meaning in turn constitutes their reputation. Interpretive approaches magnify beliefs and meaning as core empirical elements and thus have a different epistemology than studies that measure relationships of control, accountability, or independence.

The goal of this thesis is neither to determine if “reputation” is necessary or sufficient to agenda-setting; nor to embrace all causal explanations of the ECDC’s empowerment. The aim is to understand the causal mechanisms of reputation on the outcome of interest. Causality is a contentious concept in interpretive social science. It has been the subject of considerable debates within interpretive communities and, to this day, no consensus has been reached (Schwartz-Shea and Yanow 2011, chap. 3). The selected methodology in this research relies on an understanding of causality developed for interpretive research: constitutive causality (Lebow 2009; McCann 1996; Ylikoski 2013). Constitutive causality is the relationship between (1) actors’ meaning making of a specific context and (2) a course of action. Ontologically it means that constitutive causality focuses on “knowledgeable” agents and how their meaning-making affects the surroundings where they operate.

For instance, to the question: “why is the ECDC proposing advice on the management of health threats?”, a constitutive-causal answer could be: “actors involved in the management of health threats think that the ECDC either can or should advise on this specific issue because it is the only or most competent organization to do so”. This perspective on causality means that the reason-explanation is a causal explanation: in this example, the ECDC is empowered *because* the knowledge and beliefs of other actors made possible a course of action which empowered the ECDC. But this causal relationship is almost tautological if too little attention is given to details and context. The interpretive approach invites researchers to look for contextual elements, or ‘what constitutes the world’. To complete the picture of the causal relationship, one must ask: what

makes the causal relationship between reputation and a course of action towards empowerment possible?

This relationship can be understood as a form of symbolic interactionism which Blumer (1998) distilled in three core principles: that people act toward things, including each other, on the basis of the meanings they have for them (1); that these meanings are derived through social interaction with others (2); and that these meanings are managed and transformed through an interpretive process that people use to make sense of and handle the objects that constitute their social world (3) (Blumer 1969, 2). In effect it means that reputation echoes through different audiences until a context propitious to change occurs and some of these audiences either let happen or foster this change. The expected mechanism thus underpins considerable complexity. A constitutive-causal explanation of these phenomena allows for a fine and precise exploration of such mechanisms in the field. It also eschews nuances while analysing the processes and actors through which reputation contributes to setting a course of action towards empowerment.

4. Research Objectives

This research explores the case of the ECDC as a deviant case of empowerment and answers the question of determining the role of reputation in this empowerment. This study is based on the argument that the ECDC is not a powerless organization but exercises a conceptual power. The hunch that elicits the research question is that the ECDC's conceptual power is not limited to the Centre's mandated activities on risk assessment but occasionally spills over

management. This form of empowerment is *deviant* in the sense that it does not rely on the Centre's ability to influence a rulemaking process, and is better apprehended through bureaucratic reputation, than the classic approaches on agencies' autonomy.

I propose an original mechanism for empowerment through reputation. This mechanism offers a clear articulation for the role of reputation the empowerment of the ECDC and is grounded in constitutive causality. I probe this mechanism through a narrative analysis of four areas of empowerment of the ECDC. The case of the creation of the Centre shows that reputation precedes the agency and thus, reputation is already determinant at the time of the ECDC's creation. The case of HIV/AIDS and the case of the 2009 H1N1 pandemic discuss empowerment during the implementation of the Centre. While HIV/AIDS case investigates the formation of reputation and empowerment in the medium term, the 2009 H1N1 pandemic is a case for empowerment amid crisis. The case of AMR brings evidence on the formation of reputation of the ECDC's reputation amid cooperation with two other agencies and what it means for empowerment along the way. Finally, the last case, the extension of the Centre's mandate to non-communicable diseases shows one area where in spite of expectations, empowerment does not occur: non-communicable diseases.

I generate original evidence: previous studies primarily focused on disease prevention and control (Greer 2012), the issue of the diversity of types of surveillance in Europe (Reintjes 2012), or the punctual role of the ECDC during the H1N1 crisis rather than the ECDC itself (Versluis, Asselt, and Kim 2019). Data for the narrative analysis was generated through in depth interviews and textual analysis. Epistemological goals were three-fold: to generate data on reputation

about the Centre and the way it developed over time (1), to analyse the relationship between participants to the process of empowerment and the Centre's reputation (2), and to discern the role of reputation in participants setting a course of action towards the ECDC's empowerment (3).

My research leads to three main findings: Reputation alone does not empower, it needs the intercession of agents who infer, from reputation that empowerment is appropriate in the eyes of audiences. These agents include the ECDC itself in the case of HIV/AIDS and the European Commission in the case of the creation of the ECDC, H1N1 and AMR (1). Measurements of reputation do not have an explanatory power on why empowerment occurs, however they are useful to identify the appropriate scope of empowerment in the eyes of audiences. There is no *magic formula*, no perfect reputation that can be measured to assert that it leads to empowerment. Reputation cannot be separated from contextual elements and specifically from a problem to which the ECDC's empowerment is the answer. In all cases, the problem is not only the cause of empowerment, but problem framing indicates the area of disease control wherein empowerment occurs (2). The ECDC manages a discreet reputation and has integrated that it is in the interest of the good functioning of disease control that the Centre does not appear powerful or power-hungry. The negative case is particularly eloquent regarding this finding: in spite of research expectations regarding the extension the mandate to NCDs, the Centre's discretion is determinant in hindering the process of empowerment (3).

These findings are important for the literature on reputation, as well as the literature on European agencies, and the scholarship interested in the power of non-majoritarian institutions. Reputation is not only relevant to the study of

reputation management but can be operationalized more systematically. Reputation ought to be further used in public policy to understand how and why agents put their trusts in other agents to produce change. On European agencies, this thesis demonstrates that a power approach is relevant and, ironically, the best way to not eschew the least powerful European agencies from scientific scrutiny. Finally, on non-majoritarian institutions it shows that scientific institutions' power ultimately depends on their audiences and that formal barriers to organizational change are not as impervious as they may appear in legal texts.

Like any other studies, this thesis has limitations. The goal of this research is concerned with theory generation. My aim is contextual specificity, rather than generalization (Rhodes 2017, 199): I analyse one case in depth. Generalization of findings is thus limited, even though my theoretical claims have applications beyond the ECDC, as developed in the conclusions. The selection of cases also has limitations, which are inherited from the narrow empirical field. Moreover, the circumstances under which this thesis was written are unusual. COVID-19, the most salient problem vis-à-vis the ECDC and its empowerment appeared within the last 6 months of my PhD. While integrating COVID-19 in the research design was not feasible, the existing empirical material builds up chronologically to the year 2020, therefore I discuss COVID-19 in the conclusion. The foremost limitation relates to barriers in access to key informants: the ECDC staff. I detail this issue further in Chapter 3., as well as the strategy I resorted to counteract this limitation.

5. Structure of the Thesis

Chapter 2. discusses propositions from literature regarding the empowerment of European agencies as well as on the explanatory leverage of reputational approaches. While my approach is based on Carpenter's (2010), I present an original contribution to the literature on reputation by proposing a causal mechanism of empowerment through reputation. The key contribution is that reputation is not a cause for empowerment but rather that it informs knowledgeable agents who set a course of action towards empowerment.

Turning to methodological aspects Chapter 3. details my ontological position - social ontology; as well as the analytical approach I use - narrative analysis. The handling of data necessitates to uncover the meaning that participants put on events, actions and situation, and thus the chosen methodological approach is narrative analysis. In this chapter, I reflect on data generation, as well as limitations which characterizes this study at the yardstick of interpretive research standards. Finally, I outline the rationale for case selection.

Empirically, this thesis discusses the empowerment of the ECDC from the origins of the Centre - before its creation in 2004 - to 2019.

Chapter 4 discusses the creation of the ECDC, in the aftermath of the SARS crisis, it sets the scene for the development of the Centre's reputation and power. This case assists in understanding the initial expectations regarding the role of the Centre and generate useful knowledge vis-à-vis the development of its reputation. The ECDC was created as the consolidation and repackaging of different organizational elements set up by epidemiological surveillance organizations across Member States. The context of SARS is of paramount importance in

explaining the creation of the ECDC - and thus its initial empowerment - but so are its future audiences' expectations.

Chapter 5 paints the picture of the early years of the Centre. In its infancy, the ECDC was bringing under its roof pre-existing scientific European networks. The HIV network (EuroHIV) was amongst the networks that were incrementally absorbed by the ECDC. Chapter 5 explains the role of reputation in the development of the ECDC's advisory role in HIV/AIDS. The ECDC shed light on the surge in HIV case in a select group of countries in Eastern, Central and Southern Europe wherein the Centre took on an advisory role.

Chapter 6 discusses the role of reputation amid the 2009 H1N1 pandemic. This event is seminal for disease control: it was salient and triggered fear in the public; audiences have considered it a test for the ECDC (Liverani and Coker 2012). This chapter starts with the early days of the Centre, discusses the crisis and shows change in the ECDC's reputation after the crisis. The context of crisis is defined by contingency and uncertainty on how to tackle the crisis, but as uncertainty decreases the ECDC takes on an advisory role for Member States on the question of vaccination in the fight against the pandemic.

Chapter 7 shifts the focus on antimicrobial resistance (AMR), a public health problem which gained traction in public health policy networks in the 2000s. The European Commission was instrumental in recognition of this as a *One Health* problem, meaning that the problem is not only relevant to human health but also to animal and plant health, as well as wider environmental issues. In a sense, it is an approach that underlines the interdependence of living organisms and reflects upon public health by borrowing from environmental approaches. The ECDC is

thus not alone in this endeavour and works in close cooperation with two European agencies, the European Food Safety Authority and the European Medicine Agency. The formation of social information about the ECDC is thus more layered than in the other cases, as social inferences about the ECDC are both drawn from its unique role and its collective endeavour with sister agencies.

Chapter 8 compares the cases outlined in chapter 4 to 7 and adopts a comparative approach to probe the causal mechanism. This chapter also discusses a negative case of empowerment: the extension of the ECDC's mandate to non-communicable disease, which rationale for selection is discussed in Chapter 3, along with the other cases. The last chapter discusses conclusions: I develop the three findings highlighted earlier in Section 4. I appraise an alternative claim on the link between power and reputation. I discuss the limitations of this thesis, the contribution of this study to the literature and conclude on future research avenues.

Chapter 2. Towards a Reputational Mechanism of Empowerment

Chapter 2 lays out the theoretical foundations for a mechanism of empowerment of the ECDC and formulates research expectations on the role of reputation in this mechanism. The mechanism of empowerment of the ECDC offers a within-case, token level contribution in defining the relationship between reputation and empowerment. As the study of a deviant case of a European agency's empowerment, an account of the ECDC generates exploratory theoretical explanations compared with typical cases such as EMA which gained over time the autonomy to wield *de facto* substantial rulemaking powers (Chiti 2004). Ultimately, it explores avenues of enquiry on European agencies and the scholarship on bureaucratic reputation, which have been - so far - overlooked.

Empowerment refers to the process through which the Centre extends the power it wields over its area of expertise: disease control. The literature on European agencies develops claims that are useful to understand the empowerment of the ECDC. The European Union (EU) has legal limitations inherent to an integrated polity with 27 sovereign states: European agencies are empowered, short of delegation of powers, and the most powerful type regulate *de facto* (Majone 2001; Franchino 2002; Gilardi 2002; Keefer and Stasavage 2003; Chiti 2004; Hauray and Urfalino 2009; Wonka and Rittberger 2010; Egeberg and Trondal 2011a; Chiti 2012; Busuioc 2013; Ruffing 2015). Similarly, discussing the empowerment of the ECDC entails comparing restrictions to the Centre's power, as defined in its mandate, to power exercised *de facto*.

The ECDC has been expressly precluded from claiming regulatory powers over disease prevention and control, a rather unique and puzzling limitation, as

discussed in the first chapter. As a case of European agency, Chiti (2004) discards the ECDC from having any semblance of rulemaking powers. Busuioc (2013) assigns the ECDC to the category of "least powerful agencies": the ECDC is an information provider, barred to wield *de facto* rulemaking power. This limitation is not imposed on the most powerful agencies, endowed with decision-making and/or quasi regulatory powers, this is the case of the European Medicine Agency (EMA), for instance. The literature on European agencies has been mostly concerned with the empowerment of agencies endowed with decision-making and/or quasi regulatory powers (Busuioc, Curtin, and Groenleer 2011; Bach and Ruffing 2013; Tom Christensen and Lægreid 2007; Groenleer 2014; Groenleer 2009). Their empowerment amounts to developing their *de facto* autonomy over rulemaking at EU level. However, the ECDC cannot weigh in on rulemaking since the EU is not competent in formulating rules in the area of disease prevention and control (Vos 2016; de Ruijter 2019), its empowerment is limited to its conceptual power. A study of the ECDC's empowerment thus calls for specifications vis-à-vis the general model of causal relations between European agencies and their empowerment. As a deviant case, the empowerment of the ECDC is useful to probe for unspecified explanations vis-à-vis the empowerment of European agencies, which are not concerned with the autonomy to create rules, and focus on conceptual empowerment.

Building on this episteme, in Section 1, I discuss the literature on European agencies empowerment as a form of regulation in practice and generate contrasting research expectations on the ECDC's empowerment. I shed light on the Centre's conceptual power - *i.e.* shaping cognition, defining the terms of problems and debate - as defined in the ECDC's mandate and the conceptual

power the Centre is expected to wield beyond its mandate. With clear expectations regarding the empowerment of the ECDC, I turns to the literature on bureaucratic reputation in Section 2 (Carpenter 2001; 2010; 2002; Carpenter and Krause 2011; Maor 2010; Maor et al. 2013; Maor 2016; Carpenter 2020; 2020). Claims that reputation and power are causally linked are fleshed out in Daniel Carpenter's book: *Reputation and Power* (2010). Carpenter's approach, while seminal to the claim defended in this thesis, presents epistemological challenges for an account of the empowerment of the ECDC. Carpenter's causal explanation revolves around the ability to cultivate a reputation of "fear and respect", suitable for organizations that are already powerful, which stands at odds with the ECDC's limited mandate. Once the state of the art on reputation is presented, I review possible approaches to refine the ontology and the epistemology of reputation. Section 2 proposes a rejuvenated ontology: "reputation as social information", through which reputation can be conceptualized beyond a strategic resource for the Centre itself

This approach generates enough leverage to articulate the mechanism of empowerment through reputation in Section 3 of this chapter. The mechanism includes the parallel processes of "reputation-making" and empowerment and underlines how these processes feed from one another. Research expectations regarding the mechanism conclude this chapter in the last section.

1. European Agencies: Empowerment, Short of Delegation

Section 1 reviews the literature on agencification in the EU (Levi-Faur 2011; Majone 1994). The goal of this review is to establish research expectations regarding the empowerment of the ECDC, as a deviant case of European agency, deprived of means to influence rulemaking. European Agencies hold a singular place in the phenomenon of agencification (Majone 1994, 2001, 2002): while regulatory agencies usually emerge as the result of a delegation of powers to a public organization by a principal, the EU legal order prevents the formal delegation of powers to agencies. Yet, an important number of European agencies do contribute to regulatory activities (Busuioc 2013; Chiti 2012; Vos 2016): they regulate *de facto* rather than *de jure*. As such, the empowerment of European agencies beyond their legal mandates is the norm rather than exception (Wonka and Rittberger 2010). Through different single cases, as well as comparative studies, the literature shows that the empowerment of European agencies rests on their independence and autonomy vis-à-vis political pressure. However, this is only meaningful in areas where the EU has the competence to legislate or regulate. The ECDC operates in an area where the EU does not have such competences. Considering this caveat, in the third subsection, I articulate research expectations regarding the empowerment of the ECDC.

1.1. The Thorny Issue of Delegation in the EU

Agencification, understood as a shift towards a regulatory mode of governance, is a phenomenon present in most developed economies (Pollit et al. 2001; Skowronek 1982; Keller and Keller 1990; McCraw 2009). The widespread delegation of regulatory competences to non-majoritarian agencies, which are

neither directly responsible to voters nor elected officials, has become a defining characteristic of the regulatory state (Majone 1990, 1994), or regulatory capitalism, more broadly (Levi-Faur 2005; Levi-Faur and Gilad 2004). This classic approach developed in the American context offers a functionalist explanation as to why agencies are endowed with regulatory powers (Everson 1995): delegation is the response to targeted (economic) problems. It involves non-majoritarian institutions regulating the behaviour of specific actors which in turn may engage in regulatory *capture* (Dal Bó 2006; Laffont and Tirole 1991; Levine and Forrence 1990). However, in the EU, the delegation of regulatory powers to independent agencies is prohibited. This singular perspective on delegation revolves around the legal interpretation that delegating regulatory powers to agencies other than the institutions threatens the EU's institutional balance; this is the basis of the Meroni doctrine, developed by the European Court of Justice in the case Meroni v High Authority (1958)[2]. Indeed, the EU is already based on the principle of delegation from Member States to European institutions. In the words of Majone: "the delegation of regulatory powers to bodies other than the three policy-making institutions established by the Treaty would violate fundamental, and presumably immutable, principles of the communitarian system" (2002, 321). By way of contrast, separation-of-powers does not prevent the US Congress from delegating extensive rule-making powers to independent agencies which has led to the creation of powerful regulators such as the FDA, as evoked in the introduction. Yet, Majone (2002) argues that the growing complexity of EU policymaking ought

[2] The Meroni doctrine has been debated, especially with regards to the EU's growing competences (Hatzopoulos 2012, 325). The creation of the European Securities and Markets Authority in 2015 and the subsequent judgement of the European Court of Justice regarding the form of discretion the agency enjoys has since *mellowed* the Meroni doctrine (Nicolaides and Preziosi 2014), but does not apply retroactively.

to promote the recognition of an autonomous *regulatory estate*, especially in the case of market regulation (Egan 1998; Egeberg and Trondal 2009, 2016; Trondal 2007, 2010; Trondal and Peters 2013).

This functionalist interpretation is thus limited when it comes to understanding the empowerment of European agencies, since the mechanism of formal delegation is absent in the EU context (Coen and Thatcher 2007; Christensen and Nielsen 2010; Thatcher 2011).. Majone (2001) contends that the empowerment of European agencies reflects a logic that is distinct from functional considerations. In his view, the creation of agencies is not just a matter of making the decision-making process efficient, but first and foremost, it signals that credible commitments have been taken to address a specific policy (Majone 2002). His claim is seminal for the scholarship on European agencies: it proffers that, absent of formal delegation, the empowerment of these agencies' rests on the legitimacy of expertise, which acts as a safeguard against factionalism in decision-making (Majone 1997). *In fine*, Majone (2002) refutes the argument of the Meroni doctrine: while European agencies are not delegated regulatory power, their scientific credibility is enough to grant them a form of authority over regulatory matters. This claim is supported by a host of contributions (Busuioc 2013; Chiti 2004, 2012; Egeberg and Trondal 2011; Hauray and Urfalino 2009; Ruffing 2015; Wonka and Rittberger 2010) and shows that, ultimately, it is crucial in the EU context to consider the empowerment of agencies as a process that is largely informal.

1.2. EU agencies: Regulation in Practice

What are the propositions put forward by the literature as for how this informal empowerment occurs? The literature on European agencies demonstrates that despite the Meroni doctrine, agencies in the EU may be empowered beyond their formal mandate (Chiti 2004, 2012; Wonka and Rittberger 2010). The case of EMA is particularly insightful as developed by Hauray and Urfalino (2009) (see also Keleman 2002; Kelemen 2014; Vos 2016) . Hauray and Urfalino posit that in medicine licensing, decision-making is conflated with scientific evaluation, making the process "autonomous" from political pressure. They argue that the authorization procedure of pharmaceuticals has *de facto* replaced the decision-making phase in the policy cycle. Therefore, while the authorisation of medicines in the EU is, *de jure,* a decision of the Commission, all actors involved transparently admit that the decision is taken by EMA. Independence is, here the normative crux of the decision-making process because it is assumed to guarantee a fair process. The case of EMA illustrates the foundational claim of the literature on European agencies: the European Commission acts as a relay for European agencies' authority which in turn depends on their independence and autonomy from the pressure of the Commission, Member states and stakeholders (Busuioc 2009; Egeberg, Trondal, and Vestlund 2014; Groenleer, Kaeding, and Versluis 2010; Versluis and Tarr 2012; Vos 2016).

This claim is supported by the literature on regulatory agencies which draws a causal link between the independence of agencies and their ability to regulate, with an emphasis on *de facto* autonomy (Gilardi 2005a, 2005b). The work of Maggetti (2007, 2011) was particularly influential in demonstrating that formal independence is neither a necessary nor a sufficient condition for explaining variations in *de facto* independence (Bach and Ruffing 2013; Maggetti and

Verhoest 2014; Ennser-Jedenastik 2015; Guidi 2015). Building on those findings, Groenleer (2014) uses a comparative approach between the European Food Safety Authority (EFSA) and EMA to probe this argument with European agencies. EFSA has on paper more autonomy than EMA, but EMA has *de facto* developed more autonomy. Groenleer explains that EFSA is perceived by the European Commission as well as NGOs as a conflictive partner, unlike EMA, which has strained relationship of accountability between EFSA and stakeholders. In the same vein, Busuioc, Curtin, and Groenleer (2011), study the functioning of the European Police Office (Europol). Their methods focus on hard and soft law elements as well as an investigation of the actual practices. They find that contested autonomy stifles the development of European agencies. In his book, Groenleer (2009) compares variations in six European agencies – EMA, EFSA, the European Environment Agency (EEA), the European Monitoring Centre on racism and xenophobia (EUMC), the European Union Agency for Law Enforcement Cooperation (*Europol*) and the EU's Judicial Cooperation Unit (Eurojust). His conclusions stress that European agencies develop autonomy by generating the support of actors in their environment. Reaching similar conclusions, Martens (2010) analyses how the European Environment Agency (EEA) behaves autonomously in practice. He underlines the importance of trust and being a loyal partner. But in both Groenleer and Martens' work, the specifics of how support, trust and loyalty translate into more autonomy and, ultimately, more power are not discussed in depth. Indeed, this scholarship is more prone to appraise variation in autonomy than to explain the mechanism that links autonomisation and empowerment (Busuioc, Curtin, and Groenleer 2011; Bach

and Ruffing 2013; Tom Christensen and Lægreid 2007; Groenleer 2014; Groenleer 2009).

The *autonomy approach* has predominantly focused on the most powerful agencies, as highlighted in the first chapter. Indeed, this scholarship has been instrumental in identifying agencies who hold a central role in the production of regulation in the EU, through their important influence on the rule-making process For instance Busuioc (2012b) investigated the European Financial Supervisory Authorities and their quasi regulatory powers. Chiti (2004) identifies two forms of rulemaking processes for autonomous agencies: 1) participation in the adoption of binding implementing rules and 2) regulation by soft law, but Chiti excludes "information agencies" from the scope of his study. In the same vein, the studies described in the previous paragraph (Groenleer 2009; Martens 2010) discuss the autonomy of EMA, EFSA and other agencies, which through scientific expertise can weigh in more or less successfully on the production of rules. In this approach, the study of autonomy and regulatory independence is already a way to study European agencies empowerment: variation in *de facto* autonomy means variation in the regulatory powers European agencies are *de facto,* able to wield. In sum, autonomy is linked to agencies' empowerment in areas where the EU either has exclusive competences (such as monetary affairs, with the European Central Bank) or shared competences with Member States (such as medicine licensing, with EMA).

The least powerful agencies, in areas of competence with no rulemaking - such as the ECDC - are often discarded from this approach. This is not an empirical gap: the autonomy approach generates limited leverage on the case of agencies with no rulemaking powers. However, the ECDC operates in an area where the EU

does not have substantial competences: in the matter of public health, the EU shall complement national policies, encourage cooperation between Member States and if necessary lend support to their action, as laid down in Article 168 of the Treaty on the Functioning of the EU (ex-article 152 in the consolidated version of the treaties at the creation of the ECDC). The ECDC thus cannot weigh in on rulemaking since the EU is not competent in formulating rules (as per treaty limitations, see also Vos (2016); de Ruijter (2019)). The empowerment-through-autonomisation relationship thus appears too limited for the case of the ECDC: less accountability would not necessarily mean more discretion for the Centre in the limited system of communicable disease control in the EU. The counterexample would be EFSA: EFSA's mandate, like the ECDC's is limited to the assessment of risk. But EFSA's mandate includes the promotion of coherence between risk assessment, risk management, and can weigh in on the regulation of food safety at EU level (Borrás, Koutalakis, and Wendler 2007; Groenleer, Kaeding, and Versluis 2010), while there are no rulemaking processes on which the ECDC can weigh in. I therefore turn to the case of the ECDC and the expected forms of empowerment the Centre is subject to.

1.3. Empowerment of the ECDC Beyond its Mandate: Research Expectations

The Founding Regulation (European Union 2004) imposes strict limits on what the Centre can do, and restricts the power of the ECDC to a conceptual power risk assessment - *i.e.* the ability to shape cognition and define problems regarding epidemiological conditions (Carpenter 2010). The main argument of my thesis is that the ECDC is likely to have exercised a form of conceptual power not only in

terms of assessment but also in risk management. The ECDC's empowerment is the difference between the conceptual power of the Centre as defined in its mandate, and the conceptual power the Centre is eventually able to exercise, despite formal limitations. The study of the ECDC empowerment is inherently comparative: it incites research into the variation of power between two points in time, rather than between the Centre and another agency. This subsection turns to the public administration and public policy literature to appraise the conceptual power of the ECDC within the limits of its mandate. I conclude by generating research expectations on the forms of empowerment that may logically occur for the ECDC.

Within the limits of its mandate the ECDC already wields a conceptual power. As an information provider (Busuioc 2013), the ECDC's activities revolve around identifying, assessing and communicating threats to human health from communicable diseases (see Article 3 of the Centre's Founding Regulation, European Union 2004). Majone (1997) posits that information and knowledge are the primordial attributes and resources of European agencies (see also: Radaelli 1999; Moe 2005; Zito 2009; Spendzharova and Ossege 2016). Information providers such as the ECDC, by the mere fact they embody the cognitive dimension of politics and public policy (Radaelli 1999; Zito 2009), hold a vantage point over their field. In this sense Majone was drawing an implicit link between information and European agencies' ability to shape the content, the structure of human cognition and the terms of the debate (Bergeron 2010; Radaelli and Dunlop 2013; Ruffing 2015; Schout 2009) amounting to conceptual power (Carpenter 2010). But conceptual power can lead to more than shaping cognition and the term of the debate. Indeed building on Majone, Zito (2009) claims that the power of

European agencies lies in producing information that shifts other actors' preferences, which is the form of empowerment that the case of the ECDC is concerned with.

I outline below two broad functions in the mandate of the ECDC which can be identified as conceptual power. The ECDC shapes cognition and scientific practices through the harmonization of surveillance across the EU, training programmes, and the development of good practices **(1)**. The ECDC shapes the terms of the debate on health risks through its vantage point in epidemiological surveillance, and through the assessment of threats it monitors **(2)**. From those expectations about conceptual power as per the ECDC mandate, and building on the literature on knowledge utilization, I formulate research expectations on the extension of its conceptual power beyond its mandate **(3)**, thus identifying the expected form of empowerment, the Centre is subject to.

(1)Shaping cognition and scientific practices. The scarce literature on the ECDC underlines the importance of networks in the governance of communicable diseases in Europe (Elliott, Jones, and Greer 2012; Jacobson 2012; Martin and Conseil 2012; Reintjes 2012; Steffen 2012). The ECDC was built on scientific networks, a common feature of European agencies (Dehousse 1997; Maggetti and Gilardi 2014; 2011) and has been compared to a scientific "hub" (Greer 2012). Levi-Faur (2011) emphasizes that the phenomenon of Agencification in the EU is characterized by the creation of agencies that either replace or control the networks. This phenomenon has also been likened to an "Integrated European Regulatory Space" (Levi-Faur 2011; Thatcher and Coen 2008) as well as a

“European Administrative Order” (Trondal and Peters 2013), a unique form of networked governance (Maggetti 2013b, 2013a) with important differences in the form of control that European agencies have over networks, and vice-versa. Alam (2007) for instance gives an account of the BSE crisis underlining top-down, bottom-up, as well as, circular drivers of change in the policy space under scrutiny. The way the ECDC helms scientific networks of data collection (Elliott, Jones, and Greer 2012; Jacobson 2012; Martin and Conseil 2012; Reintjes 2012; Steffen 2012) is a fundamental aspect of its conceptual power. It includes the harmonisation of scientific practices for surveillance, albeit the literature considers this harmonization limited in the first decade of the ECDC’s existence (Martin and Conseil 2012). Crucially, networks operate along an “information-based networking logic” (Eberlein and Newman 2008, 29) which “represent a soft, informal and gradual mode for the international dissemination of ideas and policy paradigms” (Stone 2004, 560) and thus networks are a crucial technology in shaping and structuring the debate on communicable diseases: “the availability and dissemination of credible information that meets professional technical criteria proves to be the most effective instrument for soft control” (Eberlein and Grande 2005, 100).

(2)Shaping the terms of the debate on risks. The role of the ECDC, as delimited by its mandate is to identify and assess risks, a role that can be likened to a fire-alarm, in the sense that its function is to alert decision-makers when epidemiological conditions present risks for public health (Damonte, Dunlop, and Radaelli 2014; McCubbins and Schwartz 1984). Information is central to risk regulation. But while risk assessment rests on scientific bases, information might

be interpreted and used by different actors of different professional, institutional, and cultural backgrounds (Hood, Rothstein, and Baldwin 2001, 24). When the ECDC communicates on risks, the Centre does so with implicit and explicit frames. In the words of Douglas (1986) institutions make classifications for us, they promote specific interpretive frames which carry over into the types of solutions that are selected to respond to policy problems. Framing, whereas risks or more generally “problems”, is a powerful instrument in public policy. Framing consists of selecting and highlighting specific aspects of a given issue, often in order to promote a particular solution (Entman 2003). The concept of framing finds its most comprehensive conceptualization in Schön and Rein’s work (1995) (see also: Baumgartner and Jones 1993; Stone 1989; Kingdon 2003) which demonstrates that frames are necessary to perceiving and making sense of social reality. Information-rich situations require an operation of selectivity and organization, which is what framing means. The role of framing has become seminal in policy analysis (Daviter 2007; Guaschino 2019; Knaggård 2015; Mintrom and Luetjens 2017) where the meaning produced by actors influences the understanding of a given issue. In sum, “framing is a process in and through which policy-relevant actors intersubjectively construct the meanings of the policy-relevant situations with which they are involved, whether directly or as onlookers and stakeholders” (van Hulst and Yanow 2016, 97).

(3) Research expectations on the ECDC’s conceptual power beyond its mandate. As per its mandate, I expect the ECDC to exercise a conceptual power in risk assessment through scientific practices, and through framing public health conditions as a problem. Both functions are based on information, the primordial

attribute and resource of the Centre (Majone 1997; Gilardi 2002; Bergeron 2010; Ruffing 2015). I thus expect that the conceptual power of the ECDC beyond its mandate rests on the use of this primordial attribute and resource in shifting other actors' preferences on the matter of risk management.

Propositions from the literature on knowledge utilization (Haas, 2004; Rich, 1991; Sabatier, 1998; Weiss 1979) in which power and knowledge perform complementary functions (Radaelli 1995) can assist in contrasting the ECDC's conceptual power within and beyong its mandate. This scholarship presents different models of knowledge utilization (Daviter 2015, Dunlop 2014, Huckfeldt 2001, Weiss 1979), among which the 'enlightenment model' (Greene 1998, Weiss 1979, Jordan and Russel 2014) resonates the strongest with conceptual power. The enlightenment model describes knowledge utilization as research findings shaping the way people think about issues (Weiss 1979, 429). However, knowledge can also be used instrumentally to inform decision making and improve policy action; knowledge use can be symbolic, to support pre-existing preferences; finally, it can be imposed by a higher level of decision-making (Patton 2003, Owens et al. 2006, Dunlop 2014, Radaelli and Dunlop 2013). Dunlop and Radaelli (2013), contrast these models on the account of the causal mechanisms they underpin regarding policy learning. In the enlightenment model, knowledge use is open-ended and there is uncertainty about the issue and who should learn from it. While this is a good conceptual fit for the conceptual power the ECDC is intended to wield, it is not satisfying with regard to the Centre's empowerment.

Indeed, the crux of the ECDC empowerment lies in steering the terms of the debate in terms of risk management - a logical extension of its conceptual power in risk assessment. This echoes an instrumental model, wherein knowledge is

used to inform decision-making and which can result in expert involvement in preference formation (Dunlop 2014). This model includes that specialized epistemic communities with high level of certification assume the role of teachers to decision-makers (Dunlop 2014). The ECDC is in and of itself an epistemic community in the sense that it is embedded in a transnational network of professionals sharing beliefs based on practice, a common notion of validity and engaging in a common policy enterprise (Haas 1992, 3); albeit one with a very high level of certification, since it is an institutionalized scientific organization intended to take part in the governance of disease prevention and control through the production of knowledge. I thus posit that the empowerment of the ECDC beyond its mandate is possible through an instrumental logic of knowledge utilization (which adds-up to, rather than supersedes, the 'enlightenment' logic). Through the production of scientific knowledge, framing, the ECDC may shift Member States preferences and ultimately the response to public health problems. In terms of knowledge utilization, it means looking at conceptual power not only as a form of 'enlightenment', but as a form of instrumental use of knowledge. **I thus expect to observe the ECDC's empowerment as a development of its advisory role in the management of communicable diseases in Member States.**

As seen in the previous section, the ECDC cannot weigh in on the production of European rules in management, since the EU can only complement and coordinate Member States' policies. But it still leaves the possibility for the ECDC to exercise a conceptual power - based on an instrumental use of knowledge - over management, such as vaccination, treatment and containment but also the prevention and communication to the public of those risks (Mätzke, and Linz 2012,

890). This form of empowerment can be likened to a deepening of the role of the ECDC in areas of public health in which the ECDC already holds a role in terms of surveillance. Having established research expectations on the outcome of interest, empowerment, I now turn to the literature on bureaucratic reputation (Section 2), in order to analyse the theoretical foundations of the causal relationship between reputation and empowerment. I thus turn to the seminal work of Carpenter on the FDA (2010) which links reputation and power causally.

2. Bureaucratic Reputation: State of the Art

"Bureaucratic reputation" has developed in a fruitful scholarship over the last 20 years (Carpenter 2000; 2001; 2010; Maor 2010; Carpenter and Krause 2011; Maor et al. 2013; Busuioc and Lodge 2015; Capelos et al. 2016; Maor 2016; Maor and Sulitzeanu-Kenan 2016; Lee and Ryzin 2019; Boon, Salomonsen, and Verhoest 2019; Overman, Busuioc, and Wood 2020). The interest in studying reputation is most evident in Daniel Carpenter's work, on explaining state building in the US context (Carpenter 2000). This approach is particularly insightful in the US context due to the relative independence of "governmental agencies" compared to the development of the "State" in Europe (Carpenter 2000; Levi-Faur and Gilad 2004; Majone 1990; Skowronek 1982). Carpenter's work is not without kinship with Majone's work: bureaucratic reputation fits with the idea that agencies' ability to perform regulatory tasks depends on a credible and unique reputation (Majone 1997). Carpenter thus suggests going beyond the functional explanation of "delegation" as the source of an agency's power. He postulates that reputation is

the primary source of power for an agency. In his book , Carpenter (2010) presented a detailed study of the FDA. Through an analysis of the narratives that surround the agency throughout its history, Carpenter gives an account of the development and maintenance of the FDA's power. His book brings evidence to the claim that reputation, rather than regulatory arrangements explain the extent of the regulatory tasks of the agency. Ultimately, the reputation of the FDA is claimed to be the reason why regulatees observe rules and decisions made by the agency, even though the causal mechanism between reputation and power is not particularly detailed in Carpenter's work.

This section analyses how Carpenter's claim can inform my inquiry in the empowerment of the ECDC. First the causal link between change in reputation and change in power is explored: Carpenter's claim sheds light on reputation formation and reputation management, more than it does so on the causal relationship. This presents an epistemological challenge for this study, which I explain in a second subsection. I then present a rejuvenated ontology of reputation to overcome the epistemological challenge.

2.1. Bureaucratic Reputation as the Cause of Power?

Bureaucratic reputation is understood as "a set of beliefs about the unique and separable capacities, roles, and obligations of [an agency], where these beliefs are embedded in audience networks" (Carpenter 2010, 45). Bureaucratic reputation is considered a key ingredient to agencies' power: institutional autonomy, resources, and ultimately survival depend on an agency's reputation among its own audiences. The reputation of an agency is defined by the beliefs

that audiences - “any individual or collective that observes a regulatory organization and can judge it” (Carpenter 2010, 33) - have on the tasks an agency can (not) or should (not) perform. Audiences assign organizations’ status and expertise and allow them ‘to define basic terms of debate’ (Carpenter 2010, 33; Carpenter and Krause 2011). Audiences “can grant conceptual power to the regulator by accepting the agency’s definitions of technical terms and concepts” (Carpenter 2010, 33, see also Boon, Salomonsen, and Verhoest (2019)). These beliefs in return enable or prevent the agency from performing those tasks.

While measurements of reputation have been subsequently developed, using large *n*, (Lee and Ryzin 2019; Overman, Busuioc, and Wood 2020), Carpenter does not rely on numerical measurements of reputation. His understanding of the notion is that it is inherently studied within one case and he warns researchers that quantitative and qualitative comparisons across different cases of agencies may be non- sensical (Carpenter 2020). In his approach, variations can be observed across audiences - regulatees and principals are both audiences but might have radically different images of the agency - as well as over time. An increase in the reputability - the state of having a good reputation - is perceived comparatively to the image audiences previously had of the agency. An account of an agency’s reputation without prior contextual knowledge, does not produce the necessary leverage to understand empowerment: two agencies with a high reputability across all of their respective audiences, might not benefit from similar effects of empowerment due to differences between their regulatory environments, their expected roles and the contingency of events.

Thus, in Carpenter’s approach variations in reputation are identified along four dimensions, based on the type of judgement formulated by audiences. The

performative dimension represents audiences judging the quality of competence in terms of efficiency and effectiveness. For the ECDC that would relate to its ability to gather epidemic intelligence for instance. The *technical dimension* relates to the credibility of the information that is produced, in the case of the Centre that would be risks assessments. The *moral dimension* is the ethical aspects of agency behaviour, especially regarding its audiences, for the ECDC that would be the way the Centre deals with its partners in scientific networks. Finally, the *procedural dimension* reflects the respect and attachment for rules and procedures[3].

Dimensions of reputations offer a measurement of reputation but does not measure the causal effects of reputation. Carpenter posits that the four dimensions cannot be at their highest point at the same time, as each dimension is a facet of reputation that takes away from another one. The argument proffered by Carpenter is that agency and context specific *formula* of those four dimensions can increase the agency's power. For instance, reputability in the procedural dimension of an agency shows professionalism and might not incite empowerment, especially if audiences had a low opinion of the agency's scientific credibility. In that case, enhancing the reputability of the agency along the procedural dimension would have been more effective. Another example: in a dense organizational environment, the technical dimension is of paramount importance to deal with a complex, networked set of audiences, but it might be at the expense of the performative dimension which revolves around effectiveness and efficiency. In sum, change in reputation is likely to occur along those four dimensions. Yet "dimensions of reputation" do not generate any leverage on how

[3] The four dimensions of reputation and the way they have been subsequently defined are reviewed are clarified by Boon, Salomonsen, and Verhoest (2019)

change in reputation translates to change in power, but only on how a loss in reputability may be detrimental to the agency (Boon, Salomonsen, and Verhoest 2019; Busuioc and Lodge 2017; Busuioc and Rimkutė 2019).

2.2. Epistemological Challenges of "Empowerment through Reputation"

In his study of the FDA (2010), Carpenter underlines that the most important factor at play in the relationship between reputation and power is the strategy of the FDA itself. Carpenter shows that the FDA built a reputation that allowed it to position itself as a protector of the public good and acquire a legitimate role in the policy process. The US legislator had initially charged the FDA with the responsibility to guarantee drug safety. Over time, the FDA engaged in a form of mission creep, adding efficacy requirements to their decisions. These additional requirements were eventually incorporated into legislation as it had become too difficult for legislators to challenge the authority of the FDA (Maggetti and Papadopoulos 2018, 178–79). The causal link suggested by Carpenter is insightful as long as the case studied is that of a powerful agency looking for establishing or extending its authority. For the FDA, reputation is a powerful resource setting the agency on a path of empowerment: reputation reinforces the role of the FDA among regulatees, grants *de facto* regulatory powers and makes it politically unsustainable to not formally delegate further tasks - all because the FDA used a reputation of credibility to strategically extend its prerogatives. The causal link is thus highly dependent on the micro-foundations of the agency's behaviour: the FDA as portrayed by Carpenter is a power-hungry organization.

This is not surprising; Carpenter's study of the FDA is the culmination of a research agenda focused on agency behaviour (Carpenter 2000; 2001; Carpenter and Krause 2011). The reputation-based approach embeds insights from foundational texts on public administration (Kaufman 1981; Simon, Smithburg, and Thompson 1950). Among them, the seminal book by Wilson, *Bureaucracy: What Government Agencies Do and How They Do It* discusses the role of reputation as a form of incentive or even risks for agencies on many occasions. For instance, claiming that "Reputation - for influence, style and access - is a key part of the relationship between executive and constituencies" (1989, 205). Carpenter's work on the FDA defends the claim that reputation may not only have an instrumental value but also an intrinsic one. Agencies may have internalised the norm that reputation is a positive value and a source of pride – in other words that it is normatively appropriate to have a high personal or bureaucratic reputation, according to the 'logic of appropriateness" (Maggetti and Papadopoulos 2018, 180). Building on Carpenter's work, recent reputational accounts have focus on the various strategies that agencies adopt to maintain, enhance or even correct a given reputation (Boon, Salomonsen, and Verhoest 2019; Busuioc and Rimkutė 2019; Maor, Hebrew, and Ben-Nun 2013; Maor and Sulitzeanu-Kenan 2016). I will present propositions from this literature in the third section of this chapter.

Ultimately, Carpenter's epistemology is more articulate regarding the formation of reputation and its effects on agency behaviour, than it is regarding its effects on power. By focusing on "reputation" as a behavioural incentive, reputational accounts present an important epistemological challenge for a study of the ECDC's empowerment. If the Centre is the driver of change and the outcome is empowerment, one must logically assume that the ECDC is power-hungry. In

order to achieve its mandate, the FDA needed to establish its authority: the FDA rules - among other things - over market-entry and must therefore ensure that its rules are respected by regulatees. In order to *be* powerful, the FDA must *project* a powerful image. As seen in the first section of this chapter, the ECDC is embedded in a system of soft governance wherein competences are scarce and the role of the ECDC constrained by organizational arrangements. In these conditions, the ECDC would hardly be incentivized to groom a reputation of “fear and respect” as Carpenter found in the case of the FDA.

Reputation is routinely seen as a strategic resource for agencies (Maor, Hebrew, and Ben-Nun 2013; Busuioc 2016; Busuioc and Lodge 2016; Christensen and Lodge 2016; Capelos et al. 2016; Busuioc and Rimkutė 2019; Rimkutė 2020), but this ontological position limits the study of reputation to reputation management. As such, empowerment is the result of agencies managing their reputation. However, is empowerment through reputation necessarily the result of the agency explicitly grooming a reputation for the purpose of empowerment? The ontology of reputation must be reconsidered in order to overcome the challenge posed by Carpenter’s approach. Before developing more precisely the causal mechanism of empowerment, I suggest opening the grand angle of reputation and turning to alternative ontological propositions, beyond reputation as agencies’ strategic resource.

2.3. A Rejuvenated Ontology: Bureaucratic Reputation as Social Information

Carpenter's claims, on the intricate link between power and reputation, are a seminal contribution for the literature as it posits that reputation conditions both power and agencies' behaviour. Yet, it is because reputation management and power are conflated that the epistemology of reputation presents important challenges. Ontologically, this approach assumes reputation as a strategic resource for the Centre and follows in the footsteps of Bourdieu (1984): "reputation as a form of social distinction" with a focus on reputability as a desirable end to reach. A similar understanding is found in the concept of honour (Post 1986) as well as in the work of Axelrod (1985) who finds that good reputation is desirable in collective endeavours, as it promotes the reciprocity of cooperative behaviours. Indeed, reputational accounts of European agencies reflect this ontology of reputation as a strategic asset. Christensen and Lodge (2016) propose that reputation is the micro-foundation of agencies' choices in giving an account of their activities. Busuioc and Lodge (2015) suggest that reputation structures accountability relationships. Busuioc and Rimkutė (2019) see reputation as a way to achieve a more nuanced understanding of how and why European agencies strive for legitimacy. The literature on Bureaucratic reputation has thus preferred an ontology of reputation that revolves around the properties of reputation as a strategic resource for agencies themselves.

This ontology is somewhat narrow. To overcome the challenge posed by Carpenter's approach, I suggest examining other ontological assumptions regarding reputation. The goal of this rejuvenated ontology is thus to go beyond the assumption that engaging strategically with reputation is the prerogative of agencies themselves, and to conceptualize reputation independently to the actor engaging with this information. Adam Smith in his Theory of Moral Sentiments

(Smith 1761) sees reputation as a type of information readily available to agents who need to make-up a judgement. For Smith a “good reputation” signals potential business partners that one is trustworthy. While this conceptual approach assists in understanding specific strategic behaviours, it offers more ontological depth: reputation is a form of evaluated information that surmise the many judgements and interpretations emitted about a specific economic actor. In Gloria Origgi’s book, *Reputation. What it is and why it matters* (2012), the notion of reputation is given a crisp and comprehensive definition, independently of how actors relate to it : “Reputation is a special kind of social information about the value of people, systems and processes that release information” (Origgi 2012, 401). This is the preferred definition for this research as it eliminates the bias in favour of the study of reputation management but does not eschew the desirability of a “good reputation” for agencies. This conceptualization, while not discussing specifically agencies or empowerment presents the concept of reputation under a new light, underlining the nature of reputation as a form of information. Building on this new episteme, useful assumptions can be inferred on how this relates to the contribution of audiences to this social information.

Audiences are the “animating concept” of bureaucratic reputation (Carpenter 2010; Maor 2016) as they interpret the role of the Centre and evaluate its actions. I build on this claim to advance our understanding of the micro-foundations of reputation and advance an original concept in bureaucratic reputation: audiences’ social inferences. Social inferences result from the process of attribution in which audiences engage. Attribution - a concept fleshed-out by Heider (1958), developed by Jones and Davis (1965) as well as Weiner (1974) - is concerned with the cognitive process individuals go through as they witness events and the role

played by protagonists. It posits that individuals process information in an intuitive manner and draw inferences about actors and their social environments (Ross and Anderson 1982). Social inferences are the result of the evaluative process wherein audiences attribute the ECDC with tasks it can (not) or should (not) perform. Social inferences thus do not amount to mere beliefs but to audiences' expectations about what the Centre ought to do.

Social inferences are an ontology in itself: audiences continuously engage in a process of attribution. "The observer of an episode forms inferences about the attributes or properties of the situations" (Ross and Anderson 1982, 130). Social information about an agency is thus a constant aggregation of social inferences rather than fixed assessments. In this macro-cognitive perspective (Ravasi et al. 2018), reputation is a continuous and collective process of social construction which highlights the dynamic nature of this social information. In sum, reputation is the continuous aggregation of audiences' social inferences, which include their expectations of what the Centre ought to do.

Opening the grand angle of ontological assumptions, reputation can thus be conceptualized beyond a strategic resource for the Centre itself. The reputation of the ECDC is a form of dynamic social information amounting to audiences' social inferences. As information rather than strategic resource for agencies, the concept of bureaucratic reputation can travel beyond the intricacies of reputation management, to explore how any agents engage with reputation, without necessarily being driven by reputation management. The challenge is to articulate a causal mechanism of empowerment through reputation which accounts for the participation of these knowledgeable agents.

3. A “Reputational” Mechanism of Empowerment

The “reputation management” mechanism drawn from Carpenter (2010) is based on precise micro-foundational assumptions: the agency wants to establish its authority, the agency thus cultivates an authoritative reputation amongst its audiences, if successful the agency is empowered. In this section, I distance the expected mechanism from two fundamental assumptions of this causal explanation.

(1) Engaging with reputation is the prerogative of Agencies. To generate enough explanatory leverage, the mechanism must leave room for agents engaging with the agency’s reputation, for another purpose than reputation management.

(2) Engaging with reputation is curating reputation. If agents engage with reputation, without being driven by reputation management, the cause of empowerment is not micro foundational (the agency wants to establish its authority). Therefore, another cause, external to the agency must be identified. I identify a context-dependent cause: the recognition of a transnational public health problem.

This section first discusses how actors are expected to incite a course of action towards the ECDC’s empowerment by linking problems to the Centre. I then lay out the causal mechanism of empowerment, I discuss the role of the ECDC and audiences in this mechanism and I detail the making of reputation and empowerment as two parallel processes that feed off each other.

3.1. Inciting a Course of Action: Reputational Inference and Problem Recognition

Building on the assumptions of the garbage can model (M. Cohen, March, and Olsen 1972), I posit that the mechanism of empowerment through reputation takes place in an environment of *organized anarchy*, and that purposeful agents operate in a context of ambiguity. Ambiguity is best defined as "the presence of multiple, conflicting, and irreconcilable interpretations public events, situations and processes" (Zahariadis 2003; see also: Mahoney and Thelen 2009; Ackrill, Kay, and Zahariadis 2013; Zahariadis 2016; Cairney, Oliver, and Wellstead 2016). The notion of ambiguity relates both to the meaning given to a specific issue by different organizations and to the meaning given to each organization in the process. It results in capricious processes which make organizational choices hard to predict but offers rich and complex ex-post explanations. Ambiguity of roles is a characteristic of the system prevention and control of communicable diseases in the EU is best described as soft governance. The system of disease control in the EU is characterized by a sharp division between risk assessment and risk management. However, this distinction is hard to pinpoint with precision (Jasanoff 1998). And national authorities, while they remain in charge of management, may interpret roles and events differently. The context of ambiguity is thus inherent to the system of governance and leads to various interpretations of the ECDC's role.

In a context of ambiguity, the role of an agent is to "create meaning " (Zahariadis 2008, 16). Agents engage with social information about the ECDC for the purpose of assigning a role to the Centre. This process is inherently inferential: from social information, the agent infers that it is appropriate for the Centre to take on a role beyond its mandate. The agent is referred to as a *purposeful agent* that infers from

social information what is appropriate, in the eyes of audiences, for the ECDC to take on a new role. Purposeful agents thus engage in *reputational inferences,* meaning inferring from the reputation of an agency what it ought to do, formulating a judgement regarding what course of action is appropriate, based on reputation.

Reputational inference is the process of drawing a line in social information. Purposeful agents promote *an* interpretation of the role of the ECDC that they infer from the various social inferences that populate social information about the Centre. As *knowledgeable agents*, their meaning-making affects the surroundings where they operate. Purposeful agents thus assign a new role to the ECDC which seems appropriate, considering social information about the Centre. But what compels purposeful agents engage in those inferences?

Reputational inferences occur in a specific context, in which purposeful agents look for solutions and rely on the ECDC. Taking cues from the public policy literature, the recognition of a problem, can be propitious to the search for solutions (Ackrill, Kay, and Zahariadis 2013; Kingdon 2003; Zahariadis 2008). The recognition of problems is particularly important in risk regulation, wherein accidents and natural disasters act as focusing events (Birkland 1998, 2004). The purposeful agent is thus the one who, in the face of a public health problem, forms inferences about the role that the ECDC ought to take on. This focus on problems is also relevant due to the *fire alarm* role of the ECDC. A key aspect of the role of the ECDC is to detect epidemiological threats. As the ECDC is the organization meant to raise attention to problems, purposeful agents may see the ECDC as the appropriate organization to tackle them. In sum, following the recognition of a transnational public health problem, the purposeful agent forms the following

inference: *despite limitations in the ECDC's mandate, the appropriate solution is for the Centre to tackle the problem*.

The foundational claim of the mechanism of empowerment through reputation is that a specific process occurs for reputation to have an effect on power: the purposeful agent relies on reputation to draw inferences on what the agency ought to do about a specific problem. I identified this process as *reputational inferences*, meaning the inferences by which reputation is a useful type of information about an institution to link a problem to a solution (the ECDC). I thus do not expect that change in reputation can, on its own, change the nature or the extent of the powers an agency is endowed with. For the causal mechanism to be set in motion, the agent draws conclusions regarding what can be made of an agency in a specific context and incites a course of action that empowers the ECDC. Yet, this is only a part of the mechanism: it follows logically that the ECDC makes-sense of its own role, and that audiences also contribute to the mechanism. I articulate the mechanism of empowerment below.

3.2. Reputational Mechanism of Empowerment

Reputation, conceptualized as social information, brings nuance to research expectations regarding the causal mechanism: I suggest that, reputational change is not part of the causal sequence of the mechanism of empowerment, but rather that reputation, as social information informs the different agents that take part in the mechanism of empowerment. Therefore, the goal of mechanism is not to explain reputational change, but to understand ways, actors engage with social information. As such, reputation as social information is treated as a dynamic

process which is parallel to empowerment rather than conflated in one mechanistic sequence. In sum, the suggested mechanism of empowerment includes two distinct processes. On the one hand, reputation is a continuous process of social inferences which, considered as a whole, forms reputation (social information about the agency). On the other hand, the process of empowerment is the causal chain linking the recognition of a transnational public health problem with the outcome of empowerment. The causal mechanism is outlined in diagram 2.1. below.

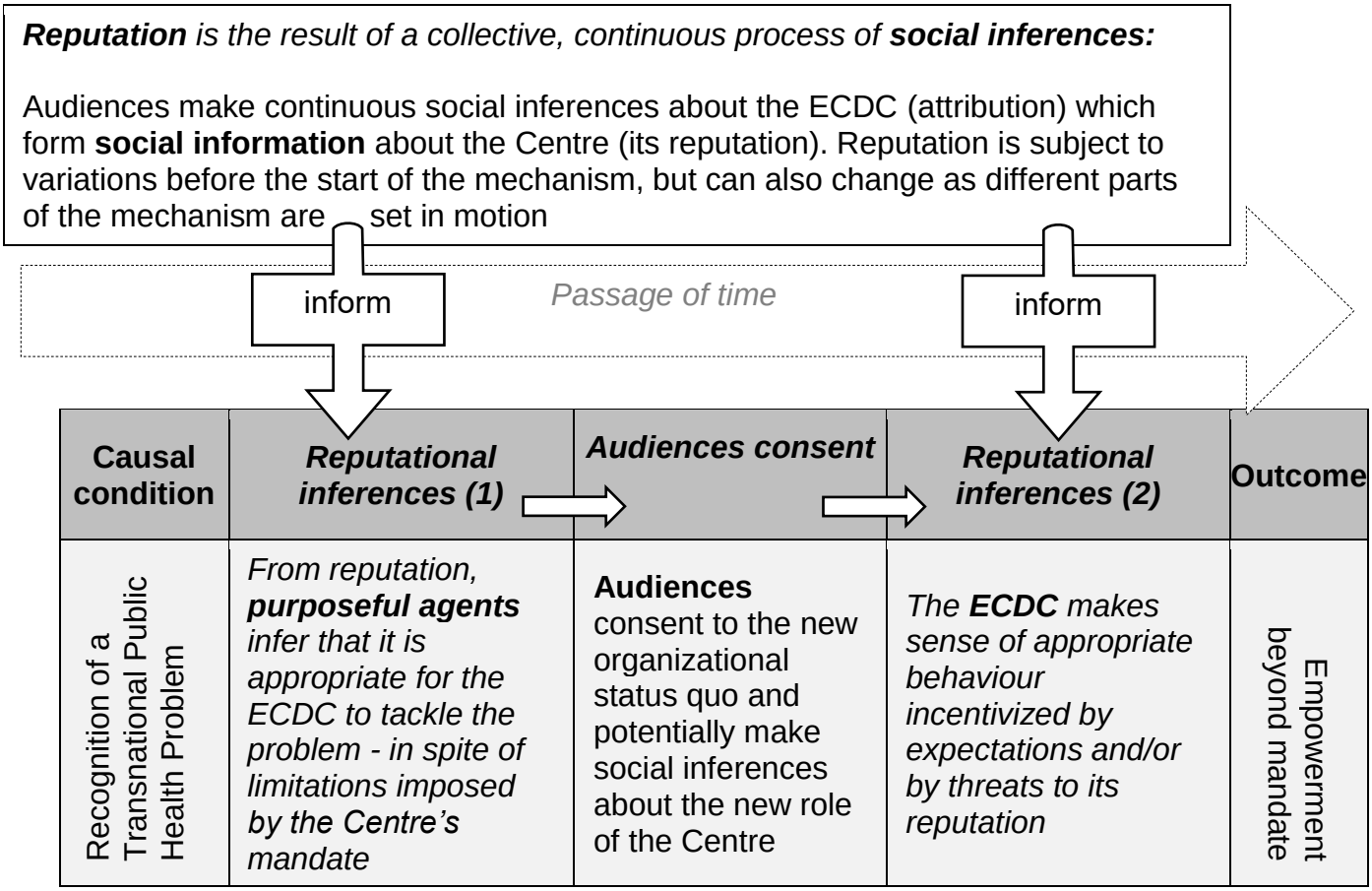

Diagram 2.1. Expected Mechanism of Empowerment through Reputation

The cause is - as discussed in the previous subsection - the recognition of a transnational public health problem. The first part of the mechanism is the intervention of a purposeful agent who infers from reputation, that it is appropriate for the ECDC to tackle the problem, despite limitations in the Centre's mandate **(1)**. The second part relates to audiences consenting that the ECDC takes on this new role **(2)**. The third part is the ECDC's efforts in making sense of this new role by relying on social information **(3)**. Each part presents the intercession of knowledgeable agents engaged in activities that transmit causal forces from the recognition of a transnational problem to the empowerment of the ECDC. The subsection concludes on the mutually transformative relationship between reputation as a dynamic process and the different parts of the process of empowerment.

(1) A purposeful agent who infers from reputation, that it is appropriate for the ECDC to tackle the problem, despite limitations in the Centre's mandate. The purposeful agent is the inciting element of the mechanism who sets a course of action towards empowerment. The previous subsection already underlines the rationale of the inferential process in which the purposeful agent engages. The purposeful agent engages strategically with reputation, *for the purpose of securing audiences' consent*. As a result of reputational inferences, the purposeful agent links the ECDC with a problem.

But which agent, particularly from an institutional point of view may emerge as a purposeful agent? Due to the distinction established in this chapter between reputation as a form of incentive on agencies behaviour and reputation as social information, it may seem logical that the purposeful agent is an agent outside the ECDC. But the goal of operating this ontological shift was - in effect - to extend the

realm of possibilities as to who would be engaging with reputation. I thus posit that any audience, including agents within the ECDC can be purposeful agents, as long as they infer from reputation that it is appropriate for the ECDC to tackle the problem. Amongst ECDC audiences, a specific audience is however expected to emerge as purposeful agents: Commission officials from DG SANTÉ. The European Commission has been known for attempting to control European agencies (Franchino 2002; Krapohl 2004), even though its status as unique "principal" has been contested (Dehousse 2008) underlines due to the multi-level networked character of EU governance.

Nevertheless, Commission officials from DG SANTÉ are the best placed agents to draw inferences on what the agency ought to do about a specific problem. They hold a central role in the functioning of the system of prevention and control of disease: the Commission is the key institution that can be proactive in the coordination of risk management and directly deals with both member States and the ECDC. Therefore, officials from DG SANTÉ are likely candidates to engage in reputational inferences and incite a course of action towards the ECDC empowerment.

(2) Audiences consent. Audiences are the "animating concept" of bureaucratic reputation (Carpenter 2010; Maor 2016): they interpret the role of the Centre and evaluate its actions. Audiences are thus key in producing social information about the agency. But in the context of disease prevention and control, audiences hold more power than in the case of the FDA in the US or even the EMA in the EU. An important part of the FDA's audience are regulatees. The concept of regulatees needs *at minima* to be specified for the ECDC. Regulatees - entities whose behaviours are steered by regulators - usually recognise (even to

contest) the authority of regulators. In the case of the ECDC those “regulatees” would be national governments and national public health institutes. However, the ECDC is barred from giving them prescriptive advice. Relationships of accountability are quite singular in the case of disease prevention and control. Audiences hold the ECDC accountable and are expected to be wary that the Centre encroaches on risk management. Audiences’ consent is thus crucial to the mechanism unfolding. Their consent is necessary in order for the ECDC to take on a role that leads to empowerment.

(3) The ECDC makes sense of appropriate behaviour, taking cues from social information. Once a purposeful agent has inferred a new role for the Centre, it follows logically that the ECDC itself makes sense of the appropriate behaviour taking cues from social information. The process in which the ECDC engages is - like for the purposeful agent - a form of reputational inference, in the sense that the ECDC infers from reputation. In this part of the mechanism, focused exclusively on the ECDC itself, propositions from the literature on reputation management are integrated to the mechanism. As discussed in the second section of this chapter, the literature on bureaucratic reputation is prolix on how reputation informs agencies’ behaviour, with notable case studies of European agencies. Building on the literature on reputation, I identify which incentives the ECDC takes cues from as it makes sense of its role in tackling the problem.

Let us return to the micro foundations of social information about the agency: audiences continuously engage in social inferences. As noted in the previous section, audiences draw inferences in terms of the expectations they hold about the agency. For instance, if an agency carries out its duties below expectations, it might damage its reputation. In the literature these are the reputational incentives

discussed in the second section of this chapter, which explain agencies' strategies to maintain, enhance or even correct a given reputation (Boon, Salomonsen, and Verhoest 2019; Busuioc and Rimkutė 2019; Maor, Hebrew, and Ben-Nun 2013; Maor and Sulitzeanu-Kenan 2016). In the context of the causal mechanism, audiences' expectations are expected to be important incentives in assisting the ECDC to make sense of the appropriate behaviour to adopt, as it takes on a new role.

But audiences' expectations are not the only behavioural incentives pinpointed by the literature on reputation. A fundamental reputational incentive is "uniqueness" (Carpenter 2001), a concept emphasizing the distinctive characteristics of an agency that establish the exclusive character and unique activities of an agency. Building on this core idea, "threats to uniqueness" have been found to be the cause for jurisdiction claiming (Maor 2010; Maor and Sulitzeanu-Kenan 2016; Rimkutė 2018). I thus expect that in making sense of its own role, the ECDC will be attentive to avoid duplicating the tasks performed by other organizations such as the World Health organization, other European public health agencies (such as EMA and EFSA), or even national public health agencies.

I thus expect that the ECDC makes sense of appropriate behaviour taking cues from audiences' expectations and/or incentivized to maintain a unique character in disease prevention and control.

Diagram 2.1. above presents the two distinct processes at play. The relationship between these processes is based on the idea that reputation is social information, and therefore is a form of dynamic information which knowledgeable agents "tap in" in order to make-sense of a specific context, defined by the recognition of a

transnational public health problem. Reputation “informs” purposeful agents in *Reputational inferences (1)*. The purposeful agent engages strategically with reputation, *for the purpose of securing audiences’ consent*. Audiences’ consent is crucial to the mechanism: their consent is necessary for the ECDC to take on a role that leads to empowerment. Audiences’ consent depends on their expectations, which make up reputation in the first place. Audiences are thus the tipping point wherein both processes are entirely intertwined. Eventually empowerment does occur without the ECDC taking-on a new role. Just like purposeful agents, descending arrows show that reputation “informs” the ECDC in *Reputational inferences (2)*. Hence both the first and the last parts of the mechanism are a form or “reputational inference”, part 1 is reputational inference to link a problem and the ECDC, part 2 is reputational inference to make sense of the role the ECDC ought to take on.

The primary role of reputation in this mechanism is thus to inform knowledgeable agents who engage in activities that transmit causal forces from cause to outcome. Yet, what it the role of empowerment in explaining reputational change? Reputation as a dynamic social information may be independently subject to change before the cause occurs (for reasons separate from the problem). Epistemologically, this is a crucial element of the mechanism: reputational change is highly contextual and the origin of change in social information must be clearly identified to draw a clear picture of empowerment. Yet, empowerment may initiate reputational change as a result of the outcome, audiences form new social inference about the new organizational *status quo* and the way ECDC makes sense of its own role. This underlines the importance time in the epistemology of

reputation and indicates that processes of empowerment may have effects on the following ones.

In sum, reputation and empowerment both depend on each other, albeit in different ways and at different times in the sequence of the mechanism. Reputation contributes to empowerment through the intercessions of a purposeful agent, audiences and the ECDC and, as their *meaning-making* affects the surroundings where they operate. Reputation changes as a result of these agents' intercessions.

4. Conclusion: Research Expectations

This chapter introduced a mechanism of empowerment through reputation for the ECDC. The mechanism is based on inferential processes. A first process, *social inferences* is the micro foundational basis of reputation, audiences engage constantly in this inferential process which underlines the dynamic nature of reputation as a form of social information. The second process, *reputational inferences* builds on social information to set a course of action towards empowerment. Social information assists agents in forming inferences regarding what is appropriate from the point of view of audiences

In the first two parts of the mechanism, agents try to fix a problem and on the other hand the ECDC makes sense of its own role. This mechanism is built on a specific understanding of causality: constitutive causality. Indeed, the mechanism is built on the relationship between actors' meaning making of a specific context (both organizational and situational) and a course of action.

This mechanism fills a gap in the literature on European agencies, which has been so far ill-equipped to discuss the power of least powerful agencies (Busuioc 2013).

Yet, it builds on - rather than embraces - the assumptions of the bureaucratic reputation scholarship. When applied to the ECDC, the approach developed by Carpenter has epistemological limits, which were overcome through a rejuvenated ontology of reputation: reputation as social information. Before turning to the next chapter wherein I explain how I intend to probe this mechanism with empirics, let us turn to four fundamental research expectations and how they relate to the conventional wisdom in the literature.

Reputation alone does not empower (1). Carpenter's causal explanation is focused on how the FDA curated a specific reputation, this project is based on the assumption that reputation, as social information is probably less *malleable* than expected. Agents may not hold a great deal of control over reputation. Therefore, the mechanism does not "predict" reputational change: change may occur either before the causal mechanism or as the result of the behaviour of the ECDC in the causal mechanism, but *reputational management is not necessary for empowerment (2).*

Problem recognition and framing are cause for change (3). Building on the public policy literature, context, problems and ambiguity are at the forefront of the mechanism because they incite purposeful agents to look for solutions. In that respect, *the European Commission is a key protagonist … but so is the ECDC who ultimately makes sense of its own role (4).* Ultimately, this study participates to the debate on "who controls European agencies?" albeit with an argument that relates to the fate of European agencies rather than their everyday participation to rulemaking.

Chapter 3. Interpreting Reputation and Empowerment: Research Design

The design of this research is grounded in the interpretivist paradigm of the social sciences. Interpretive approaches offer interpretations of interpretations: they make sense of how participants interpret the social world (Bevir and Rhodes 2006; Finlayson 2004; Lin 1998; Lukka 2014; Schwartz-Shea and Yanow 2011; Soss 2006; Yanow 2007; Yanow and Schwartz-Shea 2006). The research goal I seek a methodology for, is to explain the role of these interpretations in setting a course of action towards the outcome: empowerment. This goal comes with a specific ontology: reputation is not "out there" but constructed through intersubjective meaning-making. Reality is multi-layered and complex, and a single phenomenon can have multiple interpretations which are meaningful properties of social reality (Bevir and Rhodes 2015; Wilkinson 2011). Reality is thus intersubjective and socially constructed between various world-views (Schwartz-Shea and Yanow 2011). As such, this research concentrates on meanings and beliefs, rather than laws and rules, correlations between social categories, or deductive models. In sum, ontologically, reputation is not an objective element of reality, and is not accounted for as a variable: reputation is a form of dynamic social information wherein research participants draw subjective inferences.

Interpretive research does not abide by positivist standards of reliability and falsifiability and is only concerned with some aspects of validity. Rather, interpretive research is concerned with proofs of coherence, systematicity and trustworthiness regarding the fulfilment of research goals. These are not mere epistemological specifications: these standards also assist the conduct of research

in a preceptial way. I will for now outline one over-arching precept of interpretivism, which is a pledge for coherence between the page and the field (Yanow 2000). In effect, this means recognizing explicitly that the field is not at the service of the argumentation, and that engaging with the field might challenge research explanations. In sum, the goal of this chapter is to demonstrate my own ability to answer the question concerning whether I take sufficient precautions in my characterization of the role of reputation in the empowerment of the ECDC.

With the aim of embracing social reality in its complexity and diversity, interpretive research follows a specific logic of inquiry that is defined by the iterative character of research in the field: abductive reasoning (Yanow 2000). Abduction underlines that the research process is not guided by research expectations (as in induction), nor by the expectation to situate the focus of research in existing models (deduction). Rather, the primordial logic of inquiry is the process of making of a perplexing observation, the central puzzle and possible explanations in the field. “In abductive reasoning, the researcher’s thinking is led, or, more actively, directed, in an inferential process, from the surprise toward its possible explanation(s)” (Schwartz-Shea and Yanow 2011, 28). The logic is thus one of making-sense, “puzzling-out” (Geertz 1973; Yanow 2000) and ultimately presenting to the reader a trustworthy representation of a complex social reality. Research expectations must thus be confronted to the reality of the field, by relying on rigorous and systematic methods.

Therefore, I must explain what should be expected of research expectations. The causal mechanism (presented in chapter 2) is not a deductive model: the goal is to *probe* research expectations, not to *test* them. The question is to grasp if, when and how reputation has played a role in informing actors as they set a course of

action toward the empowerment of the ECDC. My methodological ambition is threefold. First, I want to generate data on the formation of social information about the Centre. Second, I want to analyse how social information informs different actors as they engage in inferential processes of meaning-making. Third I must shed light on how this inferential process sets a course of action towards the ECDC's empowerment. As such, the handling of data necessitates to uncover the meaning that participants put on events, actions and situation, and thus the chosen methodological approach is narrative analysis (Béland 2019; van Eeten 2006; Hinchman and Hinchman 1997; Roe 1994; Stone 1989). Narratives are "stories" that embody the subjective point of view of their narrators and - more importantly - narratives describe experiences and perceptions through time, which is epistemologically sound for "reputation as dynamic social information" and a mechanism based on "actors setting a course of events". Narratives are reconstructed from textual sources and in-depth interview. The coherence between ontology of epistemology (Hall 2003) ensures that this research explores the empowerment of the ECDC as a social ontology.

This chapter outlines the abductive reasoning that has characterized my approach to research. An abductive inquiry is articulated around the back and forth iterative steps that the researcher takes from deskwork to fieldwork and vice-versa (Yanow 2000). The first methodological move is to situate my ontological and epistemological position (in section 1) and detail a systematic approach to narrative analysis (in section 2). I then move on to the field. This first exposure to data was instrumental in making sense of how to apply my methodological approach. In section 3, I outline a map of the ECDC audiences and lay out how this mapping has informed my approach to textual sources; I discuss methods of

interviews and limitations related to access in the field. I then return to deskwork. In section 5, I discuss interpretive standards of research, the strategies I use to adhere to them, and their limitations. In section 6, I explain my approach to the field: I discuss the selection of cases, and the inherent limits of this research towards generalization.

1. Interpretive Approach and Social Ontology

The primary ambition of interpretive research is to understand actors' explanations for what they do or believe (Bevir and Rhodes 2006; Yanow 2000). Interpretivism has been described as "a type of social science that is only remotely empirical and concerned primarily with problems of meaning or hermeneutics" (Ragin 2014, 3). This only partially true: interpretivism is both eminently empirical *and* concerned with problems of meaning. As such, interpretivism seeks to analyse the meaning of concepts in their specific context. Concepts in interpretive research are developed *in situ* - meaning that concepts used throughout the analysis must adhere to the language of participants in the field (Ellis 2016; Fujii 2010). Epistemologically, interpretivism thus privileges situated knowledge and situated knowledgeable agents for the generation of evidence. As such, the study of *meaning-making* with respect to context informs the logic of inquiry in this research (Soss 2006).

This orientation for contextuality implies that meaning is constructed, dynamic and contextual (Geertz 1973; Lin 1998). This inclination towards meaning *in situ* underpins a specific ontological position. Interpretivism is grounded in a social

ontology[4] informed by post-positivist social theories which attend to matters of representation through language, text and symbol in the constitution of social life. In a social ontology, reality is not only grounded in raw facts but in the various world-views of participants and witnesses of social processes (Schwartz-Shea and Yanow 2011). This meaning-making is not only the result of different interpretations of events and roles but also depends on a variety of systems of meaning that are either subjective (specific to the actor making meaning) or intersubjective (socially constructed between actors) (Rhodes 2017).

A social ontology underlines particularly the intersubjective nature of reality (Smith 1974; Sandberg and Alvesson 2011). Przeworski (1990) for instance claims that social relations endow individuals with objectives and possibilities of action which can *only* be set in motion through interactions with other individuals. A social ontology means that social reality is, in effect, a whole of interactional contexts and relationships. From this perspective, a social ontology is inherently marked by a tension between subjective point of views and how they aggregate to form an intersubjective reality (Katznelson 2003; Pettit 1996). This claim is particularly important to underline what this means for research concerned with organizations. In a social ontology, organizations are considered to be wilful actors on their own (Haas and Haas 2002), but they are not unitary actors (Peters 2015). Organizations embody this tension between the subjective and the intersubjective. They have an organization, subjective point of view, which is inherently produced by the aggregation of individual, interdependent, subjective point of views. This

[4] This ontological position may be referred to interpretive or constructivist ontology (Smith 1974; Schwartz-Shea and Yanow 2011). I privilege the term “social” for it represents better the changing, intersubjective nature of reality.

underlines the complexity of objectively drawing a picture of organizations' point of view.

This is not to say that this position consists of negating that there is an objective reality. Interpretivism postulates, for instance, that organizational arrangements *do* exist *objectively* but are only relevant for the meaning actors attach to it (M. D. Jones and Radaelli 2015). Interpretivism is concerned with thick descriptions, ambiguity, details (Gerring 2012; Yanow 2000). Therefore, it challenges the reductionism of objective understandings of reality, for it eschews the nuances that one hopes to grasp thanks to this approach. This ontological position takes its source in Plato's cavern metaphor and Descartes' wax argument: human cognition is limited, and such limits have an incidence on how social reality ought to be approached as an object of study. *In fine,* there is a tension between one the one side, objectivity as a core principle of intellectual honesty and on the other side the pretention to aim for a form of manageable exhaustivity (thick description). It is this tension that the researcher must make sense of. In Howard Becker's words (1998, 210), the goal is "to refine the portrait of the whole—in order to offer, in the end, a convincing representation of its complexity and diversity". I thus turn to the analytical approach, narrative analysis, to present the methods which assist my own sense-making social reality.

2. Narrative Analysis

The goal of interpretive research is to paint a picture of the ambiguities and the intersubjectivity of singular phenomena of the social world (van Hulst and Yanow

2016; Yanow 2000). Following a social ontology, narrative analysis is a suitable approach for it analyses subjective interpretations that participants make of events and relationships. Narrative analysis has a been extensively used in public policy, with common applications to case-studies (Béland 2019; van Eeten 2006; Garvin and Eyles 1997; McBeth et al. 2007; Roe 1989, 1994; Schlaufer 2018).

The “narrative paradigm” was invigorated by Fisher (1985) who portrayed research participants as *Homo narrans*, positing that humans are inherently story tellers. Informants are prone to give testimonies, meaning that they to convey information into story lines. The researcher can thus analyse these testimonies to determine how trustworthy they are compared to already acquired knowledge (Fisher 1985). Narrative analysis eschew *a priori* concept definition and measurement (Bold 2011; van Eeten 2006; Roe 1994), in order to focus on the ambiguities, nuances, and complexities of participants’ interpretations. It thus includes epistemological properties that are coherent with the study of reputation as social information. Two distinct approaches are commonly accepted in narrative analysis: “In the first type, analysis of narratives, researchers collect stories as data and analyse them with paradigmatic processes. The paradigmatic analysis results in descriptions of themes that hold across the stories or in taxonomies of types of stories, characters, or settings. In the second type, narrative analysis, researchers collect descriptions of events and happenings and synthesize or configure them by means of a plot into a story or stories” (Polkinghorne 1995, 12). The first approach, characterized by a quasi-ethnographic perspective on research, is concerned with the collection of stories as data, and results in descriptions of themes across the stories. The second approach collects descriptions of events and happenings and synthesize them by means of a plot. In the context of this research, it means articulating the

analysis in function of sources (as in treating each interview as a narrative), and then reconstructing narratives in functions of the events and the causal explanation they offer.

The analysis of evidence must attain three goals: achieving a description of social information about the ECDC, and grasping how social information informs actors, and how this sets a course of action towards the ECDC's empowerment. I have thus selected the second approach, reconstructing narratives and synthesizing them by means of a plot, which is favoured by case-studies shedding light on subjective interpretations of a situation (Garvin and Eyles 1997; Roe 1989, 1992, 1994).

Two reasons motivated that choice: first it allows for a description of the multiple interpretations of how actors set a course of action towards empowerment. Second, by tying-in the subjective point of view of audiences, the analysis is more efficient in comparing and assessing the formation of social information about the ECDC (Bedsworth, Lowenthal, and Kastenberg 2004; Roe 1989, 1994). Through this method, I thus contrast the form of inferences (whereas social or reputational inferences) in which actors engage. I define more precisely what constitutes a narrative below (subsection 2.1), before presenting the systematic approach for the selection and analysis of narratives, withing cases (subsection 2.2).

2.1. Reconstructing Narratives

The use of narratives in social sciences has had a growing interest since the 1990s (Riessman 1993). This has considerably increased the possible definitions of what

constitutes a narrative (Elliott 2005). Narratives have been defined as a type of discourse (Hinchman and Hinchman 1997) with a clear sequential order that connects events in a meaningful way and for a definite audience and thus offers insights about the world and/or people's experience of it. Narratives are thus sequences of events, actions, with a plot tying together participants/observers' interpretations and events (Riessman 1993, 2007). Clandinin and Connelly (2004) established a simple yet robust structuralist model of narratives as a set of three elements: temporality (1), causation (2) and human interest (3)

(1)**Temporality** is the delimitation of a sequence of events in time. It presents a clear beginning and end to the plot. It imbues a specific context to narratives. For the sake of coherence, narratives should not exclude relevant events occurring within the defined temporality.

(2)**Causation** is the logical sequence in which the storyteller or narrator describes one event causing another. Narratives relevant to policymaking usually have the form of causal stories (Stone 1989). Causation is a crucial explanatory element of narrative analysis in public policy (van Eeten 2006; Garvin and Eyles 1997; Majone 1989; Polkinghorne 1995; Roe 1989, 1994) in which narratives are about often about assigning blame and responsibility. Narratives in themselves are not a cause but explain a specific course of action by identifying the purposes or motives of a person or an organization as the cause (Stone 1989). This is in line with constitutive causality and research expectations (chapter 2) which underline the importance of purposeful agents in setting a course of events towards empowerment. In this research, causation is thus mostly concerned with the way

actors set a course of action towards the ECDC's empowerment through reputational inferences.

(3)**Human interest** illustrates the narrator's version of the action that includes, excludes, emphasizes and ultimately provides an interpretation or a commentary and reflects a particular understanding of the events described (Feldman 2004). It presents a subjective understanding of context. Narrative analysis thus brings to light the narrator's interpretive frames, which is crucial to understanding the formation of social inferences by audiences. Audiences, as seen in subsection 2.1 are inherently organizational. Organizations produce "frames", they create a coherent social reality and members of an organization are subject to the influence of dominant interpretations and worldview in the organization (Mumby and Clair 1997, 181). As informants are *de facto* sharing their experience as members of a more general substrate of audiences, or even set of audiences, and since the mapping of sources is inherently organizational, I operate a shift from subjective **"human interest",** to subjective **"organizational interest".**

The method outlined here is based on reconstructing narratives and synthesizing them by means of a plot. As such and in order to preserve coherence and clarity, I reconstructed narratives according to one systematic principle: narrators and protagonists are conflated[5]. For instance, if the narrators are officials from DG SANTÉ in the Commission, the narrative is about them doing something, or experiencing particular events. It follows logically that the narrative identified in the

[5] The Narrative Policy Framework (NPF) (Jones and Radaelli 2015; McBeth et al. 2010; McMorris, Zanocco, and Jones 2018) differs from most understandings of narrative analysis for - among other things - the importance it gives to protagonists, such as heroes and villains. This focus on protagonists was inspiring, even though I distance methods from the rigid categorization of *types* of protagonists for the purpose of epistemological coherence.

analysis are inherently about a narrator explaining, in a self-reflecting way their own purpose and motives vis-à-vis a course of action. It does not mean that narrators only “talk” about themselves, but rather that the protagonist’s actions are situated in its own interpretive frames. This is crucial to uncover inherently inferential processes, as per research expectations (chapter 2). Following this clarification on narratives, I develop a systematic approach of narrative analysis for studying role of reputation on the ECDC’s empowerment.

2.2. A Systematic Approach to Narrative Analysis

Narratives are contained units of analysis: they are not cases (case selection are discussed in the fifth section) but stories about cases The goal of this systematic approach is to identify and synthesize narratives about the organization of disease prevention and control in the EU. This method offers guaranties that social information about the ECDC is comprehensively described and contextualized; that the role of social information in informing actors’ inferences is accounted for; and that the course of action towards empowerment is clearly identified. Narratives are not preconceived units but emerge following exposure to the field. When approaching data, patterns, explanations arise, and plots start to emerge. At that point of fieldwork, “proto” narratives emerge. They are ill defined stories which need to be reconstructed with care and systematicity[6]. This is supported by a

[6] Narratives (N=16) are compiled in a table in Appendix B. according to the elements to establish a narrative highlighted above.

rigorous, approach to the field, breaking down the reconstruction of narratives with five distinct steps:

#1 **identify the temporality**. Narratives are within-case units of analysis. *Prima facie,* one could assume that narratives thus abide by two temporal delimitations: the recognition of a transnational problem and the outcome of empowerment. Yet, this only generates evidence over the time frame of the expected course of action towards empowerment. Narratives starting before the recognition of a problem and/or ending after empowerment has occurred must be considered for two reasons. First, this approach is a guaranty of the trustworthiness of the research process: I am engaging with a large temporal range of data in order to allow for competing explanations than the expected problem-dependent mechanism to emerge from the analysis. Second, social information exists and may change independently of the process of empowerment. For instance, narratives that precede the recognition of a problem are relevant to discuss the formation of social information about the agency, setting the context and ultimately explain problem recognition. In the same vein, empowerment may have an incidence on social information about reputation and thus narratives post-empowerment is relevant.

#2 **identify narrators.** Narrator and protagonists are conflated, narrators are thus the central actor, who sets a course of action and whose purpose and motives are explained in the narrative. The narrators not systematically the "source" that produced the largest sheer amount of evidence regarding the narrative. Rather the narrators are the central actors, whose inferential process is described in the narrative, according to their own subjectivity. Narrators may be the ECDC or be one of its audiences (I will present audiences in Section 3. See

also table 3.1). Audiences' subjective point of view is first and foremost relevant for they are originating from specific organizational positions. In the field, informants would rarely share personal opinions on record and their testimonies would be framed with regard to the *conventional interpretation* from the point of view of the organizations they belong to. Narrators are therefore identified as a collective of individuals belong to one or more organizations. As discussed earlier, the assumption here is not that organizations are unitary actors (Haas and Haas 2002; Peters 2015) but that organizations are individuals sharing certain values, and experiencing the social world from a similar organizational point of view. When identifying narrators, it is thus fundamental to identify the lowest organizational level and best to mention the individuals who are part of the collective of narrators/protagonists. For instance, while sometimes resorting to "the Commission" as a synecdoche in the narrative, the narrators will have been first identified as a officials in DG SANTÉ in the Commission.

#3 **identify narrators' organizational interest.** Building on the criteria that narrators/protagonists are inherently collective and organizational, the narrator's "organizational" interest is the identification of a specific point of view, as well as interpretive frames that characterize the collective identified as narrators. It is an account of the *stakes* that the narrators/protagonists are facing. This element of narratives is particularly informative on the formation of reputation, as it unveils why audiences form specific social inferences about the Centre. For instance, explaining why a set of audience expect the ECDC to take on a specific role.

#4 **identify causation.** Causation is the linkage between the purposes or motives of the protagonist and a course of action. Narrators/protagonists are agents either setting or participating in setting a course of event towards

empowerment and explain why in the form of a story. Causation is inherently about a narrator explaining, in a self-reflecting way, their own purpose and motives vis-à-vis a course of action. Since narrators and protagonist are conflated, narrators/protagonists are *always* explaining their own purpose and motives, causation and human interest are two sides of the same coin. Considering research expectations, this methodological approach is particularly fruitful regarding purposeful agents and why they attribute to the ECDC the role to tackle a specific problem.

#5 **Triangulate findings across different data sources.** Triangulating data is a key technique to enhance the trustworthiness of the analysis. Triangulation is defined here as the mix of data sources, with the purpose to cast light on diverse viewpoints upon a phenomenon (Denzin 1989, 2017). In the case of this research it is designed to enhance the trustworthiness of factual finding (Fusch, Fusch, and Ness 2018), while other applications such theory triangulation, or investigator triangulation - more popular in mixed qualitative-quantitative methods (Hussein 2015; Jick 1979) were discarded because they were ill-adapted to the logic of inquiry and the conditions of this research. Denzin (1978) suggests to think about data in terms of properties, for instance sources describing an event will contain information about people, time, and space. These three data points are inter-related, but not all sources may contain the same type of data point (Fusch, Fusch, and Ness 2018) Take two sources discussing the same event, one could discuss people and time, while the other one could discuss people and place. A third source could then confirm the data points from the two previous ones.

However, not all sources may present the same data point. Triangulation is thus seminal to flag elements of the fieldwork that would need further clarification. This is of primary importance here because in my approach, narrator and protagonist are conflated, my approach runs the risk of accounting for partial evidence of the process under scrutiny. Ultimately, the goal of triangulation is to evaluate the coherence between the testimonies of narrators/protagonists and with other informants. To demonstrate the robustness of my findings, I outline the sources used from triangulation in each narrative, following the template in table 2.4. below. I reconstructed narrative both from interviews and textual sources. Triangulation thus includes multiple methods of access as well as multiple sources.

Narrative descriptors: • **Protagonist** • **Plot** • **Temporality**	**Mapping sources**			
	Narrator/ Protagonists (interviews)	*Narrator/Protagonists (textual sources)*	*Interview sources used for triangulation*	*Textual sources used for triangulation*
Narrative 1				
Narrative 2				

Table 3.1. Template for mapping sources according to narratives

After defining my position regarding research traditions (interpretivism), ontological assumptions (social ontology) and the chosen methodological approach (narrative analysis), I turn to the field to identify sources and detail methods of data generation

3. Identification of Sources and Data Generation

The goal of data generation in this research is threefold: first, it must address social information and audiences' social inferences, second, it must unveil the experience of research participants, in order to generate evidence that is audience specific . These inferences can be fixed in written forms but can also (re-)constructed a *posteriori* through oral testimonies the two methods of data generation are thus textual sources and interviews. Textual sources and interviews were primarily expected to provide different data points: textual sources were the primary sources for objective information, such as dates description of events, while interviews were more important regarding the meaning participants would attach to events. This is not to establish an impervious distinction between the two types of sources. Both methods would eventually unveil meaning *and* objective information, but I primarily relied on them for their respective strengths. Nevertheless, the first methodological move in the field was to map audiences of interest (as outlined in first subsection). This allowed me to maximize my exposure to textual sources, as outlined in the second subsection. The third subsection details how I identified informants and underlines limitations regarding my lack of access to potential informants. The final subsection details interview techniques I used in the field.

3.1. Mapping audiences for exposure and intersubjectivity

Mapping audiences is a fundamental aspect of any reputational account, as audiences are the "animating concept" of bureaucratic reputation (Carpenter 2010;

Maor 2016). The ECDC is, as discussed in the previous chapter, a discreet agency. Arguably, the ECDC has a narrower set of audiences than regulatory giants such as the US Food and Drug Administration (Carpenter 2010), for instance the ECDC does not regulate economic actors. Up to the COVID-19 crisis, the ECDC had a minimalistic media presence and was very little known by the public. The fewer the audiences, the less complex it is to map the field for relevant audiences. The relatively narrow set of audiences is an empirical aspect of this research that ensures that exposure and inter-textuality were reasonable goals to achieve in the field.

The concept of exposure (Fujii 2010) rests on the notion that the inquiry must remain opened to the wide variety of meanings made by research-relevant participants of their experiences. This particularly relevant in a multilevel system such as the EU where individual actors are often part of an organization itself situated in a larger organizational order (Saurugger 2013). Exposure is thus important to draw a comprehensive picture of social information about the ECDC. “The differences of interpretation and meaning that can emerge from exposure of this sort provide, depending on the research question, are precisely the type of material that is of interest to interpretive researchers” (Schwartz-Shea and Yanow 2011, 85). In researching reputation exposure is a useful strategy to approach a variety of audiences. The efforts to maximize exposure point the researcher to different sources and forms of evidence which underlines the intersubjectivity of the evidence generated (Yanow 2000) and the attention given the intersubjectivity of audiences (Fujii 2010), in line with the social ontology developed in this chapter’s first section. This particularly relevant for the study of reputation, which as a form of social information is inherently intersubjective and shaped by an entire

network of actors. “The differences of interpretation and meaning that can emerge from exposure of this sort provide, depending on the research question, precisely the type of material that is of interest to interpretive researchers” (Schwartz-Shea and Yanow 2011, 85).

I categorized audience in three groups (see Diagram 2.1): (1) audiences representing EU Member States, (2) audiences representing the scientific community, (3) and audiences in European institutions.

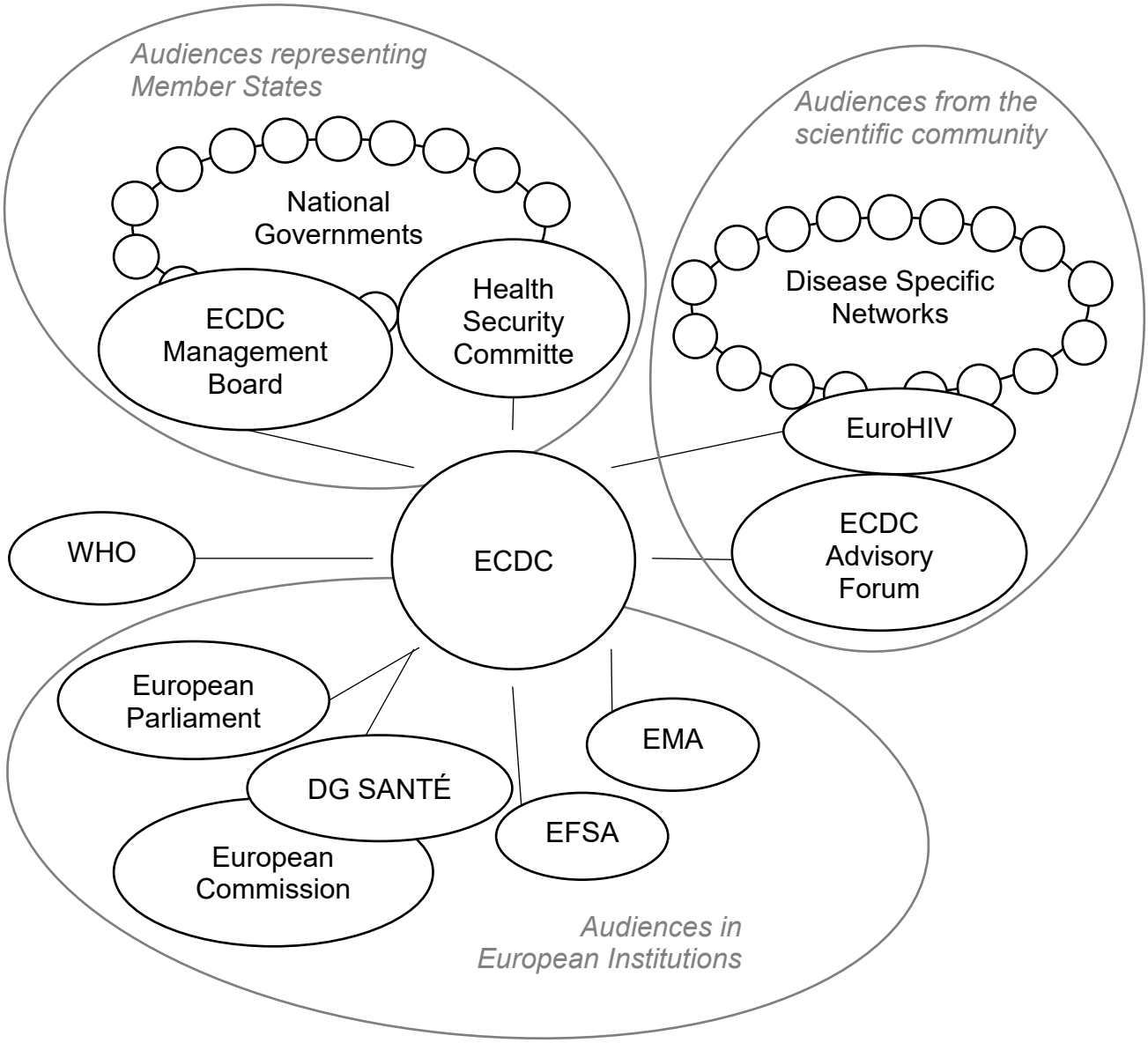

Diagram 3.1. Mapping Sets of Audiences

Diagram 3.1. visualises the different types of audiences of interest, across the five cases described above. The whole population of audiences - “any individual or collective that observes a regulatory organization and can judge it” (Carpenter 2010, 33) - is not expected to be relevant in each case, rather audiences become relevant because of the problem. For instance, it is unsurprising the find that in the 2009 H1N1 pandemic, national governments were highly relevant audiences, while the European Food Safety Authority (EFSA) would not be a relevant audience. Audiences are grouped in three sets, depending on the type of organization their members belong to:

(1) **Audiences representing EU Member States**. This includes **National Governments,** especially in times of crisis. The **Health Security Committee** (HSC) was presented in the first chapter, the HSC is a forum that facilitates the coordination of risk management between Member States. The **ECDC Management Board** is one of the governing bodies of the ECDC where Member States are represented and on which I will elaborate below.

(2) **Audiences representing the scientific community.** This category of audiences includes the scientific community at large in **Disease Specific Networks** (DSNs) which are pan European scientific networks which are now under the stewardship of the ECDC, such as **EuroHIV**. They include microbiologists, epidemiologists, public health experts**.** The **Advisory Forum** - the second ECDC governing body - is a more specific set of audience, it includes scientific experts selected by Member States

(3) **Audiences in European Institutions.** This includes the **European Commission** and more specifically **DG SANTÉ**, the Directorate General for Health and Food Safety, which until 2014 known as the Directorate-General for Health and Consumer hence, I will use the former acronym **DG SANCO** while referring to the Directorate pre 2014. It includes the **European Parliament** as well as two other European agencies dealing with public health issues, the **European Medicine Agency (EMA)** as well as the **European Food Safety Authority (EFSA)**

The **World Health Organization** (WHO) shares characteristics of audiences representing the scientific community and of the next category, in the sense that the WHO is an international organization based on global networks of public health. Hence why the WHO was omitted from this category

This categorization of audiences underlines the three-dimensional nature of the ECDC. The ECDC includes in its internal organization, two governing bodies: the Advisory Forum and the Management Board. Yet those governing bodies are external audiences of the ECDC rather than internal ones. The crucial difference between the two is that the Management Board - among other things - approves and monitors the implementation of ECDC's work programme and budget, it adopts its annual report and accounts. The Advisory Forum is concerned with scientific matters and as such holds the ECDC accountable regarding the credibility of its scientific input. Members of the Management Board and the Advisory forum both include senior representatives of national public health institutes and agencies, nominated by the Member States. Members of the Advisory forum are nominated based on their scientific competence while

members of the Management Board represent national authorities. Members of the governing bodies are all part of the relatively small scientific public health community. Depending on the organizational context in Member States (Elliott, Jones, and Greer 2012) members of the Advisory Forum and the Management Board are likely to be working in the same organization or in a close relationship at national level. Moreover, both bodies also include representatives of the European Commission and the European Parliament. These representatives differ from national representatives: the European Commission representative acts usually as the *guardian of the treaties* to the governing bodies, recalling rules, limits of the mandate and updating members on the latest advancements on the Commission's side. The representative of the European Parliament are usually more focused on budgetary issues, since budgetary lines are decided by the European Parliament (Lord 2011). The Advisory Forum and the Management are thus particularly interesting *fora* where interpretations of the context, of the role of the ECDC are actually discussed and debated. They both form a microcosm of the ECDC's audiences, and in a sense are fora for the formation, exchange, and diffusion of social information about the Centre.

3.2. First Access to Data: Textual Sources

Textual sources were instrumental in setting-up basic knowledge and contextualizing my understanding of the field. They constitute my first exposure to data as "artifacts" - written traces in the field (Yanow 2000). They have three different relationships with meaning-making: they are created with a specific meaning; meaning is projected on them; meaning is read from them (Yanow 2007,

114). As developed in the literature concerned with textual analysis, policy relevant texts are forms of action that also provide representations (Fairclough and Fairclough 2015). Texts used are thus artifacts of the interpretations that shaped organizational arrangements after the recognition of a public health problem. Unlike the testimonies I will access through interviews, texts are embedded in their specific time-period and thus convey a form of meaning that is produce both *in situ* and *in tempo* and thus is useful data in making sense of social information about the agency in the specific timeframe.

The mapping of audiences gives useful indications on how to navigate textual sources: textual sources are embedded in specific organizational contexts, the search for textual sources thus starts with the identification of relevant organizational actors. Organizations produce a host of documents which embody subjective organization of views. A specific type of document, minutes of meetings is instrumental: in those textual sources transcribe dialogues in which individual confront different interpretations. The fundamental textual sources were the minutes of the ECDC's Management Board and Advisory Forum meetings - the governing bodies of the Centre. The minutes of the ECDC's the Management Board and the Advisory transcribe dialogues between ECDC staff and members of the governing bodies. In those texts, the ECDC staff develops argumentatively their position vis-à-vis audience expectation. In the same vein, minutes from meetings of EFSA's and EMA's respective governing bodies were also rich in interpretations on the role of the ECDC.

Beyond the minutes of its Management Board and its Advisory Forum, the ECDC publishes a host of scientific publications: *Rapid Risk Assessments, Policy Briefings, Scientific Advice, Technical Report, Surveillance Report and Guidance.,*

as well as peer-reviewed articles in *Eurosurveillance* (the scientific publication managed by the ECDC). These textual sources are instrumental in situating in time the ECDC's actions, as well as sometimes, the rationale for those actions. Regarding national governments most national sources remain out of reach because of linguistic limitations. Minutes of the HSC, textual sources from the Council of Ministers, the European Parliament, and the European Commission were accessed from their respective websites.

Finally, regarding the scientific community, the public health literature was an important part of my textual sources, including *Nature, The Lancet,* and the *European Journal of Public Health*. Textual source from those publications were treated as data that carried interpretations specific to the scientific community.

Each chapter includes a table modelled after table 3.1. which lists sources at the beginning of each narrative. Table 3.2. below reviews the sample of texts used for evidence throughout the empirical analysis, according to their institutional source.

Source	Type of documents	Number of documents	Total
ECDC	Annual work programme	3	67
	Strategy and guidelines	5	
	Risk assessment	6	
	Mission reports	5	
	Directors' Annual report	4	
	Minutes of the Advisory Forum	24	
	Minutes of the Management Board	16	
	Memoranda and reports on the role of the Centre	2	
	Information web pages	2	

European Commission	Preparedness and guidelines	5	20
	Programmes and progress reports	5	
	Legislative texts: proposals, opinions and decisions	6	
	Communications on health threats	2	
	Press releases	2	
European Parliament	Reports on legislation	3	3
Council of the European Union	Minutes / proceedings	5	7
	Conclusions	2	
EU legislation (excluding Commission Decisions)	Regulations	2	7
	Directive	1	
	Decisions	4	
Other EU agencies and joint reports of the ECDC with other agencies	Joint reports with EMA and EFSA	5	9
	EMA	2	
	EFSA	2	
External auditors	External Evaluations	3	3
Academic literature in public health	Publications from: Eurosurveillance, The Lancet, Nature, European Journal of Public Health, BMC Public Health, *et al.*	37	37
CDC	Progress Report	1	1
WHO	Report	3	3
TOTAL			127

Table 3.2. Textual sources

3.3. Identifying Informants and Access Limitations

While analysing textual sources, particularly minutes of the governing bodies, I was able to identify a first round of potential informants to interview about ECDC. I contacted 85 potential informants, all of them either formerly or currently working

for organizations described in Diagram 2.1. Mapping Sets of Audiences. I received 16 positive answers that eventually led to an actual interview. In an abductive fashion, the sample of informants evolved throughout fieldwork. Previous informants' recommendations were particularly helpful in contacting members of the Management Board of the ECDC. Seven additional informants were contacted through snowball sampling (Cohen and Arieli 2011). This method of sampling has limitations, specifically because it removes part of my control over the sampling method and relies on previous informants, which may impart a bias in selection. However, in this case, sampling only assisted in developing the sample, which might have otherwise been as important. But the goal is exposure, not representativity. Some informants are for instance retired and not easily contacted or even identified. Snowball sapling was thus of great help in building the sample, with only sparse limitations.

Additionally, one informant contacted me spontaneously (interview 24)[7]. In the first year of my PhD (2016) I authored a peer-reviewed article on the creation of the ECDC (Deruelle 2016) which raised the attention of this informant who had participated in the processes I described. However, this article served as a form of *visit card* in the field, with informants confirming the accuracy of my descriptions and conclusions, which after the difficulties in access were both reassuring and useful to develop trust with informants. Table 3. below gives an overview of the 24 informants I interviewed and how they were identified.

[7] This interview brought confirmatory evidence on the aspect of creation of the ECDC and was thus instrumental in triangulating data

NUMBER	SURNAME, FIRST NAME	CURRENT AND/OR PAST POSITION	INTERVIEW DATE	CONTACT IDENTIFIED IN …
1	Yannakoudakis, Marina	Former Member of the European Parliament	30-Jan-19	textual sources
2	*Anonymized*	DG SANTÉ Official	06-Feb-19	textual sources
3	Roux, Philippe	DG SANTÉ Official	06-Feb-19	textual sources
4	*Fully anonymized*		07-Feb-19	textual sources
5	Guglielmetti, Paolo	DG SANTÉ Official	07-Feb-19	textual sources
6	Popovici, Florin	President of the Romanian National Institute of Public Health - member of the Advisory Forum	08-Feb-19	textual sources
7	*Anonymized*	Member of the Advisory Forum	08-Feb-19	textual sources
8	*Anonymized*	WHO	14-Feb-19	textual sources
9	*Anonymized*	WHO and former ECDC staff	14-Feb-19	suggested by informant 8
10	*Anonymized*	EFSA staff - former DG SANTÉ staff	04-Mar-19	textual sources
11	*Anonymized*	Former ECDC staff	08-Mar-19	suggested by informant 1
12	John Watson	Member of the Advisory Forum	26-Mar-19	textual sources
13	*Fully anonymized*		27-Mar-19	textual sources
14	*Anonymized*	Member of the Advisory Forum	01-Apr-19	textual sources
15	Tegnell, Anders	State Epidemiologist, Sweden - member of the Advisory Forum	12-Apr-19	textual sources
16	*Anonymized*	French National Agency for Public Health staff	11-Jul-19	textual sources
17	*Anonymized*	EMA staff	26-Jul-19	suggested by unavailable source
18	Sauer, Fernand	Former Director of Public Health - DG SANTÉ	26-Jul-19	textual sources
19	Viso, Anne-Catherine	French National Agency for Public Health staff - member of the Management Board	02-Aug-19	suggested by informant 16
20	Kunsagi, Zoltan	EMA Staff	02-Aug-19	suggested by unavailable source

21	De Raedt, Lieven	Federal Public Service Health, Belgium - member of the Management Board	05-Aug-19	textual sources
22	Piha, Tapani	Former DG SANTÉ Staff	19-Aug-19	suggested by informant 18
23	Scheres, Jacques	Former European Parliament delegate to the Management Board	16-Oct-19	suggested by informant 19
24	Weinberg, Julius	Former epidemiologist, Public Health Laboratory Service Headquarters, London, UK	25-Mar-20	at the informant's initiative

Table 3.3. List of interviews

Fieldwork started on 11 January 2019 (following from the approval of the University of Exeter ethics committee - see Appendix A)[8]. In-depth interviews allow the researcher to record a verbatim transcript, making it easier to abide by the precept that concepts are defined in situated knowledge claims. Interviews we all recorded (expect for informant 4 who refused to be recorded) interviews were then transcribed by myself, most of the time right after the interview took place. Three informants (11, 18 and 24) also completed their interviews with email exchanges, either to correct the accuracy of their interview. Evidence from those exchanges were included in the analysis.

A crucial aspect of fieldwork was the "confrontation" between the previous knowledge I had of the field and the use of concepts *in situ* (Yanow 2000). The difficulties I initially encountered in the field were issues of *tacit information* about the organization of disease communication and control. Tacit information is a type

[8] Informants were free whether or not to disclose their identity. **Digital recordings were deleted**, consent forms and transcripts are kept on my professional OneDrive in a password protected file in accordance to the European General Data Protection Regulation (GDPR). No special category of personal data (as defined in the GDPR) were collected (racial or ethnic origin; political opinions; religious or philosophical beliefs; trade union-membership; data concerning health; sex life and sexual orientation; genetic data; biometric data).

of information that “encode complex meanings that are not obvious to the professional stranger” (Rhodes 2017, 55). I entered the field with a project informed from the literature on regulatory agencies, using the word *regulation* somewhat liberally, which proved to be somewhat contentious. My hunch about the ECDC was not that of a behind-the-scenes regulator, directing Member States on questions of risk management. Nevertheless, the wording of the project I sent to informants, did leave room for this interpretation, which led to difficulties in access and prevented me from interviewing any current staff member of the ECDC.

The focus on *regulation* and *regulatory powers* which was initially at the forefront of this project thus shifted towards the distinction between risk assessment and risk management, as developed in the first chapter. As Howard Becker emphasizes (1998, 151), language used by informants is an entry point into the specific ways informants conceptualize the social world. Such conceptions and the way they collided with my own, eventually are the pivot point of this research. According to some informants, who insisted to stay off record, this partially explained some of the difficulties I encountered in terms of access. Indeed, after contacting 30 ECDC staff members, the Director of the ECDC, Andrea Ammon, requested a list of the staff members I had contacted; I honoured that request on 17 January 2019. I received a letter sent as email attachment on 24 January 2019, the Director had decided to bar me from interviewing current ECDC staff (as allowed by code of conduct for European institutions staff). The same informants suggested - still off-record - that I could attempt to still access ECDC by exclusively contacting the Director.

Rhodes (1988) notes - on interviewing elites, that the researcher must show perseverance. Elite interviews end-up sometimes as negotiations and Rhodes underlines that elites engage in a mental projection of ways in which the researcher might use the information, which is something I experienced first-hand. On 16 October 2019 I sent an email to the Director, stating that “My project has gone through major changes since I have been in the field doing interviews. I understand that the wording of my project has raised some eyebrows, specifically because of my liberal use of the word regulation. I would like to underline that I use the word regulation as a concept of political science and in a sense that is synonym of influence rather than “command and control” or explicit and directive regulation. Some of my interviewees have asked if my goal was to advocate for a specific role of the ECDC regarding this aspect. I would like to reassure you: this is not the case” (email sent on 16 October 2019). The Director answered to me 15 days later, to notify her acceptance to provide written answers to a questionnaire, citing the change of scope in my work and the fact that I would only interview her as positive development. Since written questions are inherently different than the method of in-depth interviews, I engaged with textual sources *ad fontes* in order to be as exhaustive as possible in my questions. I sent a set of seven written questions on 20 December 2019. On 20 March 2020, the Director’s office contacted me to know if I still needed the answers to these questions, I answered affirmatively. I sent a last reminder on 3 July 2020, but I never received answered to these questions. The sudden consequences of the COVID-19 crisis undoubtedly did not help in making the Director available to answer.

This non-access comes with limitations on the conclusion I can draw regarding the behaviour of the ECDC. Claims of trustworthiness cannot be expected to be as

reliable when ECDC staff are the identified narrators/protagonists in a narrative. These problems of access were circumvented, to a certain extent, by the extensive use of textual sources as well as the reliance on two interviews with a former ECDC staff member (interview 9, 11). The minutes of the ECDC's the Management Board and the Advisory offer relevant insights. In those texts, the ECDC staff develops argumentatively their position vis-à-vis audience expectations, yet minutes of those meetings are not expected to be exhaustive. The Director's decision did not extend to members of the Advisory Forum or the Management Board who work in close contact with ECDC staff members. Former DG SANCO officials who were also involved closely with the functioning of the ECDC were also a great help to circumvent difficulties of access and provided explanations on the point of view of the ECDC. Yet these circumventions have their own set of limitations: the subjective point of view of ECDC staff was not sufficiently accessed through interviews. My own sense-making of how the ECDC infers its own role is thus dependent on truncated data from minutes and partial data from interviews.

Yet, these difficulties were already data about reputation in and of itself: the control of their reputation is obviously an apparent concern of the ECDC's top management. *In fine,* with a focus on reputation, interviews from informants outside the ECDC are more important in drawing evidence about reputation and reputation as social information takes its source in the social inferences that audiences engage in about the ECDC.

3.4. Technique of Data Generation: In-Depth Interviews

Regarding the generation of data from interviews, my goal was two-fold: I wanted to know what social information participants inferred about the ECDC and I wanted informants to outline why they would see particular courses of action as permissible, reasonable, and right. The difficulty lies in the ontology of reputation: social information is an object of analysis that cannot be fully understood attending only qualities presumed to be intrinsic to them. Audiences' social inferences may be unconscious or simply never shared whether orally or in script, the generation of data thus requires that interviewees put words on their interpretations and beliefs on the role of the ECDC. These goals required that questions of meaning be placed at the forefront, rather than being pushed to the side on the basis of assumptions I had carried into my fieldwork

I used in-depth interviews, which are conversational exchanges pursued for the purpose of generating information rather than questionnaires. *In-depth* refers to the discursive and conversational nature of interviews. (Bevir and Rhodes 2015; Schwartz-Shea and Yanow 2011; Soss 2006; Yanow 2007; Yanow and Schwartz-Shea 2006). In-depth interviews allow for meaning making to be spoken. The crucial role of the researcher is to engage the interviewee in formulating beliefs and opinions. In depth-interviews offer a way to learn how individuals knit together their own conceptions and put them to use and thus offers an excellent way to map the conceptual world of participants

Through in-depth interview I got to know interviewees and their individual stories. Interviews lasted between 30mn and an hour. Interviews were unstructured: I kept my interview agenda flexible, to seize the opportunity to generate data and press

for clarifications, and elaborations. Soss (2006, 136) defines in depth interview as “a dynamic method – one that offers flexibility in the interview itself and shifting standpoints over time. It is centred on discursive and dialectical conversations with interviewees”. This approach provides the interviewee with the occasion to use particular words of interest and underline issues that they consider to be salient (Soss 2006).

I particularly relied on *judgement questions* (Soss 2006), which require the interviewee to express opinions that reveal implicit standards and interpretations. Such questions invite responses with evaluative and comparative language. For instance, regarding advice: *In context X,* w*as the advice formulated by ECDC given more credit than WHO advice?* is a judgement question, which invites informants to evaluate the role of ECDC in relationship with the role of WHO, on a precise issue. In a simpler form, the question could be: *Was the ECDC’s advice on X important for management?* or *What were your expectations regarding the ECDC on X?* This approach to interview was particularly efficient in the field: I asked interviewees to *narrate* their experience of working with or alongside the ECDC, and pressed for judgements on the ECDC’s role, their own behaviour as well as other actors’ behaviours. These judgements were often the most sensitive part of the interview and some informants sometimes only agreed to having these conversations “off the record”. Other times, informants would share opinions but frame them as the *conventional interpretation* from the point of view of the organizations they belong to, rather than individual opinions. These testimonies were the most valuable. This would - in most cases - automatically discard questions relative to one or more cases. I would then concisely present my prior knowledge of the case, as well as the “hunches” I had at the time of the interview.

This would ensure that informants react or even correct my assertions. Interviews would also offer information that I might have missed from the textual sources, especially by indicating archived documents I would be unaware of (this was particularly important for the earliest textual sources). Informant 18 was for instance keen on sharing some Commission documents about the implementation of the ECDC that had slipped through my own searched.

Overall, the generation of data was focused on thick descriptions, ambiguity, details (Gerring 2012; Yanow 2000) and concerned with maximizing exposure, in order to assist the re-construction of narratives as indicated in subsection 2.2. this came with some limitations, especially in terms of access as described in subsection 3.3. But other limitations must be examined at the yardstick of interpretive standards.

4. Research Design: Coherence and Limitations

Let us turn to interpretive research standards and assess how the selected methods and strategies to uphold to them whether in the field or on the page. Five criteria can be identified in the literature (Schwartz-Shea and Yanow 2011), transparency (1), procedural systematicity (2), trustworthiness (3), reflexivity (4), positionality (5). As seen previously, due to the abductive logic of inquiry and the absence of variables and hypotheses, interpretive research standards do not abide by positivist standards. Interpretive criteria for analysis are checks and practices are concerned with proofs of coherence and logic laid out in the argumentation. Concerns about the coherence and the logic of the argumentation

show some parallels with the criteria of falsifiability and reliability; however, both falsifiability and reliability presumes that research is conducted with respect to a model's hypotheses that can be tested to evaluate the model's posited causal relationships. Both coherence and logic of argumentation mean recognizing explicitly that field and logics are not at the service of the argumentation, but rather that researchers engage with the field and the logic of inquiry in a way that might challenge their explanations. Some aspects of validity internal, construct and external validity[9], are however relevant to interpretive research and are discussed as part of the standard of trustworthiness (internal and external validity) and systematicity (construct validity). I present how my research design measures at the yardstick of the five criteria mentioned above, including limitations inherent to the approach I articulated above.

(1) Transparency relates to coherence and ethics. It assists the relationship of accountability which I seek to establish with the readers. It thus underlines my own process of sense-making (Schwartz-Shea and Yanow 2011, 87). Transparency's purpose is to give the reader a demonstration of my reasoning and ultimately enables them to criticize and challenge choices made throughout the inquiry as well as knowledge claims I formulate in conclusion. "It is a key to the legitimacy of interpretive sense-making: rather than making the connection between process and conclusions appear seamless, reflexivity reveals and, where possible, *analyses* the consequences of a reliance on a *human* research instrument" (Schwartz-Shea and Yanow 2011, 103). In this section I demonstrate

[9] Regarding validity, see Drost's (2011) four types of validities. Her typology also includes statistical conclusion validity (which asses the validity of the relationship between two variables). It is here discarded because it is at odds with an interpretive epistemology and the methodological choices made in this thesis

the goodness of fit of my methodology and thus I already compel myself to enact transparency in the presentation of the research design. This is a form of self-audit as much as an effort in experience-sharing, which I abided to in this chapter's previous section regarding my entry in the field and my difficulties in access. Part of the efforts in transparency are also to bridge positivists and interpretive standards and avoid limiting the audience of this research. This is what I strive for in the next two point about trustworthiness and systematicity.

(2) Trustworthiness refers to "ways to suspend judgment or to avoid a 'rush to diagnosis', that is, to prevent from settling too quickly on a pattern, answer or interpretation" (Yanow and Schwartz-Shea 2006, 105). Strategies to enhance trustworthiness offers guaranties to the readers regarding the internal validity of findings. It also helps to counterbalance the important limitations which this study has vis-à-vis external validity (generalizability).

Internal validity is concerned with trustworthy cause-and-effect relationships between treatments and outcomes (Drost 2011). In effect, strategies for trustworthiness increase the internal validity of research. In the present case, I relay on two: triangulation and member-checking. Triangulation of sources was discussed in subsection 2.2. of this chapter. Member-checking is a gold standard for trustworthiness. It consists of having research-relevant participants check the analysis. Member-checking was particularly relevant to understand the cognitive processes in which actors engaged. Member-checking is a strong element to support the trustworthiness of my interpretation. I secured member-checking for chapter 4 (SARS) (interview 10, 18, 24) and chapter 7 (AMR) (interview 20), the feedback I received from the four informants cited above was confirmatory and

only highlighted additional evidence which I had not been able to access. I was not able to rely on this approach as much as expected. In some cases, ideally, ECDC staff members would have been the best choice for member-checking. Wherein member-checking could not be secured, guaranties of the trustworthiness of my interpretations are not as convincing. Yet, member-checking is complementary to triangulation, which is the proper crux of trustworthiness in the analysis.

As I address the trustworthiness of my own interpretations, I must reflect on the trustworthiness of the data. Sources are dependent on what organization accept to give access to the public. For instance, I have noted a clear difference between minutes of the ECDC's Advisory Forum in the early years of the ECDC's existence and in more recent years. Early minutes are meaning-making rich, opposed opinions are highlighted, often with the names of the speaker. With time, the minutes became more succinct and less imbued with the form of meaning-making relevant to this research. Moreover, it is impossible to conclude that the organization is strategically reducing the amount of information. In the case of this study, it was not a problem, due to triangulation. In effect, my lack of access to informants has been detrimental to my inquiry in the early years of the ECDC. But it is also the period of time wherein textual sources are rich in interpretations. In the latter period under scrutiny, textual sources were less rich in interpretations but access to informants was not problematic. Both limitations are thus addressed with data triangulation. Nevertheless, this research is highly dependent on participants to lift the curtain on their own activities.

Eventually, to what extent does trustworthiness inform generalizability? External validity implies generalizing to other contexts, settings, and times (Cook

and Campbell 1979). Epistemologically, this approach can be replicated to cases of European agencies which, like the ECDC, are nothing but a conceptual power and yet demonstrate a form of empowerment. This is generalization that is only applicable to a precisely targeted population, but with the limits to delegation to European agencies, similar cases are identified in the current population (I will discuss those in Chapter 9. Conclusions). This research is however not generalizable across populations of regulatory agencies or even European agencies. As Geertz (1973) points out, in interpretive science, the researcher assembles thick descriptions of participants' conceptual worlds so that she can compel them to speak to social scientific concepts. The ECDC is an deviant case, as discussed in the first chapter. It shows a form of empowerment that is somewhat anomalous, since it is not concerned with the ECDC's ability to *de facto* make rules. And thus, this monograph is concerned with thick description and data rich evidence: it focuses on the internal validity of the case rather than is external validity.

(3) Procedural systematicity refers to the systematicity of my approach to data analysis (Schwartz-Shea and Yanow 2011, 17). Procedural systematicity ensured a careful implementation of techniques used for generating and analysing data, as well as a rigorous approach to evidence. It bears some similarities to construct validity as both are concerned with the adequacy of analytical approach and field. This chapter's second section already makes the case for using narrative analysis and outlines five steps for the analysis (sub- section 2.2.). A crucial point is to preserve the most accurately possible the subjectivity of data since this subjectivity informs the analysis.

The chosen approach to conflate narrator and protagonists is concerned with magnifying audiences' point of view as embedded in organizational positions. This choice is thus motivated to draw a picture of inter-subjective experiences of the process narratives describe. Two other choices were on the table. The first alternative was to focus on narrators, without systematically identifying protagonists. For instance, DG SANTÉ would be the narrator of the ECDC's *story* (since the Centre would be the protagonist). This approach is still relevant to inter-subjectivity, but it raises questions in terms of causation. If a narrator is not the protagonist, the narrator is not just subjective but partial: as a simple observer of the action of the protagonist, the narrator only has limited information to interpret the protagonist's behaviour. The second alternative was to focus on a protagonist, probably the ECDC and bring in as many points of views, hence many narrators. It resembles what is done in metanarratives (Garvin and Eyles 1997; Roe 1989), but metanarratives focus on a specific problem rather than a specific protagonists. I argue that protagonists' actions are better situated and interpreted when they are presented in their own interpretive frames. I would also argue that choosing a protagonist would reduce the empirical scope of the analysis. Focusing on *what the ECDC has done*, only tells a partial story. Other protagonists (and, therefore narrators) are necessary to understand the field of communicable diseases which provides a host of evidence on contextual elements in which reputation has a role in the empowerment of the ECDC.

(4) Reflexivity is an exercise in self-criticism about the conduct of the research. It engages the researcher to self-challenge and proffer healthy doubts throughout the research process: "the general idea is that the researcher

consciously searches for evidence that will force a self-challenging re-examination of initial impressions, pet theories or favoured explanations" (Schwartz-Shea and Yanow 2011, 105). Reflexivity incites to scrutinize the way knowledge claims have been affected by field context and by the researcher's own way to make sense of data. This was the rationale behind explaining my entry in the field in section 1 of this chapter. Reflexivity also includes making sense on my own understanding of as well as my own learning process about the ECDC empowerment. It comes at the end of the abductive, iterative process of research, to make apparent which elements of the research process have shaped knowledge claims and choices (Schwartz-Shea and Yanow 2011, 102–4)**.** This involves the self-conscious testing of emerging explanations, apparent reflections on what seems clear and what seems ambiguous and questioning whether I have been wrong in my characterization of the world (Schwartz-Shea and Yanow 2011, 108).

Data analysis was thus conducted consistently with the precept that evidence must not been discarded to accommodate the logic of argumentation: research expectations alone cannot fully produce the *denouement* of entangled interpretations. The puzzle is not made sense of without addressing alternative characterization of the phenomenon. My research expectations are that the causal mechanism presented in chapter 2 offers the necessary explanatory leverage to answer question of the role of reputation on the ECDC's empowerment. I resort to a reflexive technique: "negative case analysis". Negative case analysis does not refer to a strategy of sampling but is a logic designed to sharpen the argumentation (Becker 1998, 192–94). It bears some resemblance to counterfactual analysis (prevalent in the study of international relations and historical research) and

tackles the following question: “How does the reader know that you didn’t look only for confirmatory evidence?” (Yanow and Schwartz-Shea 2006, 107).

This research probes the causal mechanism detailed in chapter 2. This mechanism is an original proposition, based on some of the scientific gaps, but it also marks a departure from the literature. Classic explanations of reputational empowerment involve to study dimensions of reputation, which my own theoretical framework does not. In order to probe alternative explanations, I will, along my own analysis, include dimensions of reputation as an additional theoretical lens. Dimensions of reputation are thus included as a negative-case analysis, in the sense that this explanation is not what I expect from research but may as well uncover aspects of the mechanism empowerment, that I could not foresee. The robustness of this explanation will be analysed in the conclusions (chapter 9).

(5) **Positionality** refers to my own subjectivity in the process of sense-making. As reality is intersubjective, my own research participates in developing the web of interpretations about communicable disease in the EU. This aspect is particularly relevant when the focus of study is a relatively unknown institution which recently peaked interest. I have a responsibility as a researcher to discuss the power relationships that contributed to this process of sense-making. My difficulties of access for instance are power-imbued: I was powerless in front of this refusal, but the interpretations of informants also underline concerns vis-à-vis power dynamics, and if this project were seen as detrimental it would be most likely because so few studies exist in the first place.

Positionality is also relevant regarding my own background and the reasons that led me to study the ECDC. My interest in health policy stems from my interest

in the ECDC as a case of European agency, rather than the contrary. I could only picture myself doing a PhD that related to EU public administration. Before undertaking this PhD, I worked at the European Parliament and the European Commission. This gave me somewhat of an insider's perspective regarding EU institutions, but I had never worked on health-related topic. And yet, I have nourished an interest for public health, since my experience as an observer of the 2009 H1N1 crisis management has left on me a strong impression. Members of the medical profession have been always somewhat important in my life and discussing the role of health experts is also for me an exercise in scepticism, towards a world I always saw as somewhat powerful.

5. Selection of Cases

Case selection was cemented after a first access to the field through official documents. To provide a clear reputational account of the ECDC over time, cases had to cover the 15 years of existence of the Centre. In this section I address first the rationale to identify the population of relevant cases. Cases are selected on the outcome variable, empowerment which, as detailed below is coherent with the ECDC as a deviant case of empowerment. Once the population of cases was identified, I outline my strategy for selecting cases and why some options were discarded before describing the cases.

5.1. Rationale for Relevant Cases and Strategy for Case Selection

The empowerment of the ECDC is a deviant case of European agencies empowerment (Gerring 2006, 2008; Gerring and Cojocaru 2015; Lijphart 1971; Przeworski and Teune 1970): while most approaches are usually concerned with empowerment over rulemaking (Busuioc 2009; Egeberg, Trondal, and Vestlund 2014; Groenleer, Kaeding, and Versluis 2010; Maggetti 2012; Maggetti and Verhoest 2014; Ennser-Jedenastik 2015), empowerment is limited to the conceptual face of power. The empowerment of the ECDC is relevant to the study of European agencies because we understand little about it (Gerring 2008; Lijphart 1971). The goal of this research is not to study the effects of reputation. Rather, it is to study a phenomenon – the ECDC's empowerment through reputation - that the literature is ill-equipped to explain.

The ECDC's empowerment is an *anomalous* outcome with regard to other cases, empowerment does not occur through a well identified path relative to the general model of causal relations (Gerring and Cojocaru 2015). As a deviant case study, the purpose of this research is to reveal why the case is deviant (Lijphart 1971) and thus to identify the causal path that leads to this anomalous outcome. Case selection is thus concerned with probing the role of reputation in the empowerment of the ECDC and the rationale for relevant cases is to select on the outcome variable, *i.e.* "the practice of restricting one's set of observations to cases in which some phenomenon of interest has been observed and excluding from the set cases in which the phenomenon was not observed" (Collier and Mahoney 1996).

Selecting on the outcome is controversial (Dion 1998; Geddes 1990). King, Keohane and Verba (1994) in their seminal book on social inquiry argue that

“something can be said about the causes of the dependent variable; but the inferences are likely to be biased since, if the explanatory variables do not take into account the selection rule, *any selection rule correlated with the dependent variable attenuates estimates of causal effects on average”* (author’s emphasis) (King, Keohane and Verba 1994, 130). The goal of this research is not to appraise causal effects, but to understand the mechanism that links reputation and empowerment. Selection biases (Geddes 1990) are thus not a problem since the question is not *why* but *how*, and since generalization is not the purpose of this thesis. This research is thus concerned with cases where there is an observable empowerment of the ECDC. This is in line with constitutive causality: I want to understand what constitutes the causal path for the outcome wherein I seek to identify the role of social information.

Relevant cases of empowerment were identified through exposure to the field (Schwartz-Shea and Yanow 2011, 88). The population of cases is limited. The initial empowerment is the ECDC’s creation in the aftermaths of the SARS crisis. There is evidence of the ECDC’s empowerment in HIV/AIDS (Steffen 2004; 2012; Smith 2016) wherein the ECDC took on an increased role in prevention in specific Member States. I observed a similar form of empowerment regarding Tuberculosis. I observed another empowerment in which the ECDC has developed a public role in promoting advice as well as in the field of antimicrobial resistance. I also observed a limited form of empowerment the 2009 H1N1 pandemic and the development of an advisory role on vaccines for the ECDC amid crisis. While other recent health scares such as the E.Coli outbreak in 2013 in Europe, the Ebola outbreak of 2014 in Africa and the Zika outbreak in 2015 in South-America were also considered, but eventually discarded as they were not a

direct threat in the EU. The rationale for selecting among this population of cases is two-fold: I acknowledge the necessity to give a clear picture of reputation over time, and to generate enough leverage for a comparative analysis. Table 3.4. sums up case selection.

Cases	Selected	Non-selected	Rationale
Creation of the ECDC	X		Initial empowerment
HIV/AIDS	X		Two similar cases. HIV was selected because of its relative salience.
Tuberculosis		X	
2009 H1N1 crisis	X		Seminal case of health crisis
E. Coli		X	Low relevance for the governance of health threats in the EU
Ebola		X	
Antimicrobial resistance	X		Recent case

Table 3.4. Population of cases and selection

The independence of cases is usually a seminal criterion in case selection (Gerring and Cojocaru 2015). If cases affect each other, they are not providing independent evidence of the causal proposition. If the question of interest is a causal one, this problem may be understood as one of interference (Gerring and Cojocaru 2015). However this opinion is not unanimous. Maggetti, Gilardi, and Radaelli (2013) explain that "qualitative approaches to interdependence […] have specific strengths that can yield unique insights into the nature of interdependence, especially when cross-case comparisons are combined with within-case analysis and, possibly, counterfactual reasoning". Here again, the logic of inquiry - based on an interpretive approach and focused on within case analysis - is the reason why the interdependence of cases is not a trap I will try avoiding. Rather, I embrace the independence of cases. Two arguments motivate that choice. First, there is no

possibility to find entirely independent cases when studying one agency. Second, as a monograph, one of the goals of this research is to give a representative image of the ECDC and its reputation throughout it 15 years of existence. This inclination for a historical account of the ECDC highlight interdependence as a strength of the analysis rather than a case for bias. Reputation is not a snapshot; it is dynamic social information that changes and builds over time. Interdependence is thus acknowledged, and the time dimension will be discussed in the conclusions (Chapter 9.).

The ultimate goal is to compare these cases and highlight different conditions (Przeworski and Teune 1970) in which reputation has a role in empowerment. Here I strive for difference in the way this process of empowerment unfolds. Since I select cases on the outcome, the method of agreement (most-different method) is the most appropriate (DeFelice 1986; Gerring 2006, 2008; Gerring and Cojocaru 2015; Lijphart 1971; Przeworski and Teune 1970). Most-different cases vary widely in background factors while sharing a common outcome. This method of case selection thus serves accurately the purpose of this research.

In order to, generate the method of agreement selection, I generated a truth table (Table 3.5. below) along two dimensions.

Ambiguity of the ECDC's role when empowerment occurs	***Type of intelligence used for monitoring risk in communicable disease prevention and control***	
	Event-based monitoring	Indicator-based surveillance
High ambiguity	2009 H1N1pandemic	HIV
Low ambiguity	Creation of the ECDC	Antimicrobral resistance

Table 3.5. Truth table

The first dimension - ***Type of intelligence used for monitoring risk in communicable disease prevention and control -*** differentiates conditions wherein communicable disease are recognized as public health problems. As presented in the first chapter (see Figure 1.), the recognition of a transnational problem in the control of communicable disease may occur because of indicator-based surveillance (such as for diseases like HIV/AIDS) or event-based monitoring (such as for outbreaks like H1N1). In effect, this dimension differentiates cases according to the salience of the problem. In event-based monitoring, risks are inherently framed as *salient*: this is the type of intelligence that signals outbreaks. Time is of the essence: both cases selected in Event-based monitoring are public health events that were framed as crises. The context crisis situations reduce choice opportunities and induces urgency. These characteristics are absent from indicator-based surveillance: data is regularly updated; surveillance is done on the medium and long term, therefore threats are not sudden and disruptive like in event-based monitoring. In sum, epidemic intelligence differentiates cases of empowerment according to the salience and the urgency of the problem.

The second dimension - ***Ambiguity of the ECDC's role when empowerment occurs -*** is concerned with the ambiguity of the role of the ECDC in the area of disease control wherein empowerment is observed. Ambiguity is expected to have an effect on the way the purposeful agent infers a new role for the ECDC. A high ambiguity means that social information about the agency is ambiguous: audiences may have conflicting or vague expectations about the Centre. However, in a context of low ambiguity, social information is clear, and audiences share similar interpretations about the ECDC. Ambiguity thus affects reputational inferences. A purposeful agent engaging in reputational inference in a context of

high ambiguity may enjoy some discretion vis-à-vis the role they infer for the Centre but may also face considerable difficulties in grasping what audiences want. As shown in table 3.5., HIV/AIDS and H1N1 are the two cases categorised with a high ambiguity; they occur within the first five years of the Centre's existence, as the ECDC is still in a phase of implementation. A context of low ambiguity however indicates that audiences agree about the role of the Centre and thus, it is easier for the purposeful agent to secure audiences' consent.

There is a third dimension that highlights the difference between cases: informal empowerment vs. formal empowerment. HIV/AIDS, H1N1, AMR are all cases of empowerment wherein the ECDC is *de jure* competent for risk assessment, the empowerment of the ECDC is thus informal. On the other hand, the case of the creation of the Centre shows the initial formal empowerment of the ECDC. This dimension, unlike the first two does not generate leverage for a proper comparison between the four cases: there is no case of formal empowerment to which the creation of the ECDC could be compared to. Nevertheless, through fieldwork, I identified a *negative case* of formal empowerment: the extension of the Centre's mandate to non-communicable diseases (NCDs). NCDs are a negative case because it lacks the outcome of interest, empowerment: in spite of audience supporting an extension of the mandate and discussions on this topic in the Centre's governing bodies, the mandate of the ECDC is not extended to NCDs; there is no empowerment. Table 3.6. below classifies cases according to the formal vs. informal dimension

Cases	**Informal Empowerment** [in an area wherein the ECDC is *de jure* competent for risk assessment]	**Formal Empowerment** [extension of the scope of the ECDC's mandate]
Creation of the ECDC		X
HIV/AIDS	X	
2009 H1N1 crisis	X	
Antimicrobial resistance	X	
Non-Communicable diseases		X

Table 3.6. Cases according to types of empowerment

The case is relevant because it adheres to the possibility principle (Mahoney and Goertz 2004). In the case of NCDs, empowerment is *possible*: there is a problem that has been discussed in more recent years as numerous audiences infer that this should be part of the agency's mandate especially in recent years. In sum, NCDs case thus assist in generating comparative leverage for the case of the creation of the ECDC. As a negative case, it highlights which missing elements of the mechanism explain the absence of empowerment.

In fine, the selection of these five cases responds to three epistemological goals: cases cover the *history* of the ECDC, from its creation to recent years with NCDs; cases are *most-different,* in order to probe the mechanism in various conditions and its includes a negative case to probe the mechanism further*;* finally, the selection of cases generates enough leverage for comparisons.

5.2. Description and Treatment of Cases

This project ought to offer in depth insights on the empowerment of the ECDC, the role of reputation in this empowerment, as well as to bring information to those seeking a better understanding of the organization of disease prevention and control in the EU. Evidence is drawn from textual sources (N=127) as well as interviews (N=24) and analysed through a systematic approach to narrative analysis. These methods were selected because of their descriptive property regarding the course of action towards empowerment and their analytical properties regarding intersubjectivity, social ontology. The next five chapters present and reflect upon empirical evidence of the reputational source of the ECDC's empowerment. Chapters 4, 5, 6 and 7 are case-specific and chapters were arranged in order to guide the reader through a chronological order of the story of the ECDC as well the different contexts of disease prevention and control inherent to each case

Case 1 (Chapter 4.). The initial empowerment is the creation of the ECDC. This case was included to anchor the historical perspective: there is a low ambiguity - at the time of creation of the Centre - as most audiences agree that the ECDC's role should be limited to advice. It is in the event-based category because the creation of the ECDC is routinely linked to the 2002 SARS crisis (Greer 2006; Greer and Löblová 2016; Liverani and Coker 2012). This is the first case chronologically.

Case 2 (Chapter 5.). Following closely in the timeline is the case empowerment in HIV/AIDS (Steffen 2004; 2012; Smith 2016) wherein the ECDC took on an increased role in HIV prevention in specific Member States, from the early years

of the ECDC to the turn of the 2010s. This is a case of indicator-based surveillance wherein ambiguity is high: this is the infancy of the agency, the ECDC is in a phase of implementation of its Founding Regulation (European Union 2004). As such, the Centre is mostly preoccupied with finding the added value it can bring to disease control. Another case was considered: tuberculosis, but it was discarded due to strong similarities with HIV, while being less data rich.

Case 3 (Chapter 6.) Chronologically, the third case is the 2009 H1N1 pandemic. It is the first and only major health crisis that the ECDC had to deal with before COVID-19. Ambiguity is high, there are contradictory interpretations of what the ECDC ought to do in the face of a large-scale event of the sort.

Case 4 (chapter 7.) The fourth case chronologically is antimicrobial resistance: in the 2010, the ECDC took on an increased role in the surveillance and the management of antimicrobial resistance, which is indicator-based. Nevertheless, unlike in other cases. Ambiguity is low when empowerment occurs: the ECDC's role is clearly defined vis-à-vis the other agencies it cooperates with on AMR.

Chapter 8. analyses similarities across the population of positive cases and outlines how the negative case supports the findings drawn from the comparison of positive cases. The prevention of NCDs is a long-standing public health issue in the EU. This case - the possibility to extend the mandate of the ECDC to NCDs. The third evaluation (2019) shows support across ECDC audiences for an extension of the mandate to NCDs. The case informs on recent social inferences about the ECDC.

In the conclusions (chapter 9), I build on the research design elements presented in this chapter to discuss the role of reputation in empowerment, the probing of

alternative explanations and reflect upon the significance of findings for the study of reputation, European agencies' power and the empowerment of non-majoritarian institutions

Chapter 4. A Conceptual Power in the Making

On 21 April 2004, the *Founding Regulation* of the ECDC (European Union 2004) entered into force, effectively creating the Centre, and limiting its mandate to the harmonization of surveillance and risk assessment. These legal provisions were the result of an unusually prompt decision-making process between the three European institutions. The European Commission put forward its proposal on 2 August 2003, which only went through one reading of the European Parliament and the Council of Ministers, a relatively uncommon practice in the lengthy legislative bargaining that characterizes the EU (Kokki and Haigh 2004). This swift process is often explained as a quick and functional response to the severe acute respiratory syndrome (SARS) crisis that occurred between November 2002 and July 2003 (McKee, Atun, and Coker 2008; Greer and Mätzke 2012; Greer and Löblová 2016). This idea that time has come for an agency to be created is a recurring theme in the official narratives of agency creation as well as in the literature on the emergence of European agencies (Maggetti 2013). For instance, the Bovine spongiform encephalopathy or "mad cow" disease is cited as a seminal cause in the creation of the European Food Safety Agency (EFSA) (see: Alam 2008, Gehring and Krapohl 2007). In this perspective, the ECDC looks like a mundane case of agency creation: a crisis triggered a response; this response was a new agency which signalled that credible commitments had been taken (Majone 1997).

At first glance, the crisis-followed-by-agency-creation relationship appears plausible. However, in the field of disease prevention and control in Europe, some features preceded the crisis; notably scientific, disease-specific networks (DSNs),

initially supported financially by the European Commission (Altenstetter 1994; Guigner 2004; Steffen 2004, 2012), which then became an integral part of the Centre. The creation of the ECDC is thus not an organizational big bang but the evolution of pre-existing organizational arrangements. The crisis-followed-by-agency-creation explanation only partially sheds light on the creation of the Centre. The creation of a European agency dedicated to disease control has been disputed among experts and has been a topic of disagreement between European institutions since the late 1990s. The SARS crisis while important to understand the temporality of the creation of the ECDC, only partially explains the emergence of the Centre. Crucially it does not offer leverage as for why the ECDC emerged with its specific limitations. At a minimum, the creation of an agency has to be contextualized within the frame of the different interpretations aired at the time of its inception. As shown by Moe (2005), institutional emergence is a political process through which power is created, distributed, and crucially embedded in organizational features. To answer questions about the creation of the ECDC, it is necessary to go beyond the crisis as a single explanation and open the *grand angle* of narratives on the emergence of EU cooperation in disease prevention and control.

Four narratives are important to understand this process. The first narrative highlights how technical and scientific cooperation emerges in the early 1990s, under the auspices of epidemiologists cooperating throughout Europe. The second narrative shows how the question of sustaining scientific cooperation becomes salient from the mid-1990s and runs through the implementation of the ECDC. The third narrative revolves around health threats, including SARS, explains why decision-makers eventually support the creation of the ECDC. The

last narrative offers some explanatory leverage on the design of the Centre and the role of DG SANCO officials as purposeful agents. These narrators/protagonists are all future audiences of the ECDC, who draw inferences about what a potential agency would be able to bring as opposed to the existing networked organizational arrangements. Figure 4.1. below sums up audiences of interest for the creation of the ECDC.

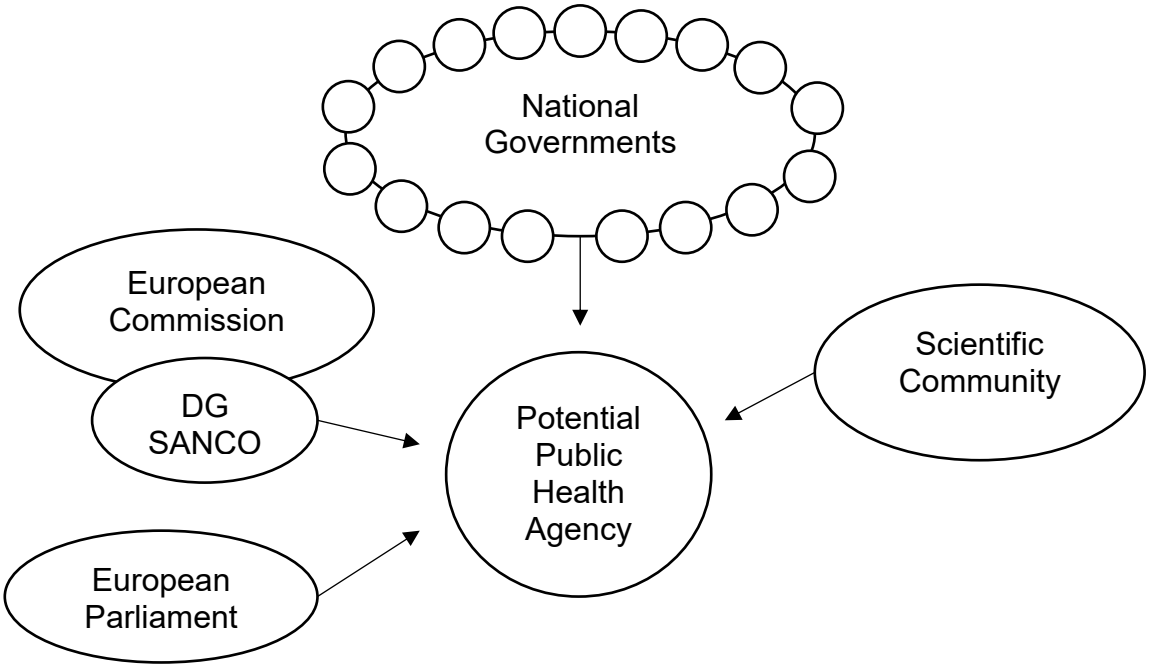

Figure 4.1. Relevant audiences for the creation of the ECDC

This chapter refutes the functional narrative of crisis as the sole explanation of agency creation. I argue that the creation of the ECDC is the result of a medium-term process during which organizational arrangements emerged, changed and eventually were repurposed amid a focusing event: the SARS crisis. The central claim of this chapter is that this process is *already* the result of a mechanism of empowerment through reputation. Knowledgeable agents in the Commission's DG Santé made purposeful choices regarding the design the Centre. Those choices were based on social information about a potential agency. Reputation thus

precedes the Centre: before its creation, audiences draw inferences about what a potential agency would be able to do as opposed to the existing networked forms of cooperation. Struggles over the meaning of existing organizational needs and solutions are, before the Centre even exists, the first elements of the reputation of an agency. Social inferences (*i.e.* audiences' expectations) shape social information about what the Centre ought to be even before its existence.

Five sections structure this chapter. Section 1. presents a short discussion on the role of focusing events and the temporality over which the expected causal mechanism unfolds. In Section 2., the three narratives are outlined and analysed. In Section 3., the role of purposeful agents in the Commission in inferring an appropriate design for the ECDC is discussed. The fourth section focuses on the tail-end of the causal mechanism and analyses how a new-born ECDC infers its own role. The last section discusses how research expectations hold-up to the analysis.

1. Agency Creation as Reputational Inference

Let us go back to the claim that "reputation precedes the ECDC" and sum-up research expectations regarding the creation of the ECDC. As an account of agency creation, this chapter echoes the approach that disease control networks that precede European agencies have a structuring role regarding their design (see Neal 2009, Ekelund 2013, Pierre and Peters 2009). Indeed, the creation of ECDC did not mark the beginning of scientific cooperation in the field of disease prevention and control. Different disease-specific scientific networks, such as

EuroHIV (which will be more prominently described in the next chapter) shape-up from the late 1980s onwards. Evidently, these scientific networks address a relatively narrow audience of experts, yet they form the earliest form of social inferences made about what will eventually become the ECDC. Audiences form social inferences about those nascent forms of cooperation, their level of success and what they ought to do, and thus reputation precedes the Centre.

But change can only occur as purposeful agents infer a course of action from reputation, a process in which reputational inferences are incited by the recognition of a transnational public health problem. The literature on agenda-setting provides valuable insights on the matter; specifically, because the conventional wisdom on the ECDC underlines a causal relationship between the SARS crisis and the existence of the Centre. Crises are not objective causes of changes but rather the product of "meaning-making" which takes the form of public policy narratives (Radaelli, 2000). Crises are events which are framed as an acute and pressing problem (Demortain 2006, Alam 2007, Knaggård 2015). As a problem is defined, the process begins with a search for clues about appropriate solutions (Zahariadis 2003, 73).

Going back to purposeful agents and their role in agency creation, I argue that during this search for clues, the reputation of existing organizational arrangements influences the solution they champion. Purposeful agents engage in reputational inferences about existing organizations to judge how appropriate it would be for these arrangements to be superseded by a new structure. The rationale that guides these purposeful agents revolves around the idea that audiences see the Centre as better suited than existing organizational arrangements. These expectations about a new agency revolve around the performative dimension of

reputation: the added value of an agency is that it will “do the job” in a manner that is more efficient and competent than existing organizational arrangements. Whereas creating an agency sustains, develops or completely replaces former organizations, purposeful agents reach these conclusions by means of reputational inferences. In other terms, reputation as a form of social information guides purposeful agents’ understanding of appropriateness in the ambiguous context that usually characterizes agenda-setting in times of crisis. Reputation, while not explaining the whole process of agenda-setting, does inform the appropriate choices for organizational change. As such, reputation is seminal in understanding the design of the Centre, and the breadth and depth of its powers.

But the reputational story of agency creation does not end with the entry into force of the Founding Regulation of the ECDC. Reputational inferences carry beyond the creation of the Centre. Over the process of decision-making, the meaning made of organizational needs and choices is discussed and contested. The politics of agency creation are expected to have an effect on how the Centre infers its own role. An agency highly contested during its creation may for instance inherit an aggravated reputation as audiences already opposed the existence of the ECDC and may hold resentment over the process. The decision-making process may also rally around the project of agency and thus positively change how the newly created agency is perceived by audiences. The newly born agency inherits a reputation which is neither quite the social information that pre-existed its creation nor newly formed social inferences. However, it is updated social information that has profound effects on the implementation of the Centre. As expected in the causal mechanism under scrutiny here, in the implementation phase, the Centre

engages in reputation inference to define and understand its appropriate role and purpose.

In sum, reputation, as a form of social information is an important basis for inference throughout the process of creation of an agency and underpins two research expectations. First, I expect that reputation guides purposeful agents in defining a strategy for the creation of the ECDC and securing audiences' consent. Second, At the tail-end of the process, I expect that social information, inherited from the process of creation, guides the Centre in understanding its role during the implementation phase. A clear continuity can be established between reputation of pre-existing organizational arrangements and reputation of the ECDC. It is thus seminal to explore the formation of social information prior to the creation of the Centre. Section 2. and 3. below present four narratives on the organization of disease prevention and control. The first three narratives offer evidence on how social information about pre-existing arrangements evolved over the span of 10 years, specifically as the nature of the problem changed in the eyes of audiences. The fourth narrative highlights the role of DG SANCO officials as purposeful agents. Sources I used to reconstruct narratives are compiled in table 4.1. below.

Narrative descriptors: • Protagonist • Plot • Temporality	Mapping sources			
	Narrator/ Protagonists (interviews)	*Narrator/Protagonists (textual sources)*	*Interview sources used for triangulation*	*Textual sources used for triangulation*
• **The Charter Group** • **The genesis of communicable disease control in the EU** • **1993-2002**	*Members of the Charter Group* interview 24	*Scientific journals* Bartlett, Chris. 1998. '"Eurosurveillance": Monitoring Disease in the European Union'. *'Eurosurveillance': Monitoring Disease in the European Union*, October. http://depts.washington.edu/eminf/1998/Eurosurv/euro1.htm. Giesecke, Johan, and Julius Weinberg. 1998. 'A European Centre for Infectious Disease?' *Lancet* 352 (9136): 1308. MacLehose, L, M McKee, and J Weinberg. 2002. 'Responding to the Challenge of Communicable Disease in Europe'. *Science (New York, N.Y.).* 295 (5562): 2047–50. Lancet, The. 1998. 'Editorial. Not Another European Institution'. *The Lancet* 352 (9136): 1237. Newton, Lisa, Olivier Grimaud, and Julius Weinberg. 1999. 'Establishing Priorities for European Collaboration in Communicable Disease Surveillance'. *European Journal of Public Health* 9 (3) Krause, Gérard. 2008. 'How Can Infectious Diseases Be Prioritized in Public Health?' *EMBO Reports* 9	*Public health professionals in the 1990s* interviews 4, 10, 12, 14, 18, 23	*Scientific journals* Butler, Declan. 1998. 'Call for Europe-Wide Public Health Agency'. *Nature* 395 (6698): 106–106. Dove, Alan. 1998. '"European CDC" Lobbies for Support'. *Nature Medicine* 4 (11): 1214–15. Tibayrenc, Michel. 1998. 'Coordinating European Public Health'. *Nature* 396 (6707): 108–108. Tibayrenc, Michel. 1999. 'European Centre for Infectious Disease'. *The Lancet* 353 (9149): 329. Tibayrenc, Michel, Marc J Struelens, Santiago Mas-Coma, and Jean-Claude Piffaretti. 2002. 'The European Centre for Infectious Diseases: An Adequate Response to the Challenges of Bioterrorism and Major Natural Infectious Threats'. *Infection Genetics and Evolution* 1 (3): 179–81.
• **DG SANCO** • **Opposing the creation of a new agency** • **1998-2002**	*Current and former Commission staff:* interviews 2, 3, 4, 5, 18, 22	*European Commission documents* European Commission. 2002. 'Press Release - David BYRNE European Commissioner for Health and Consumer Protection Future Priorities in EU Health Policies European Health Forum on "Common Challenges for Health and Care" Gastein, 26 September 2002'. European Commission, Decision No 2119/98/EC of the European Parliament and of the Council of 24 September 1998 Setting up a Network for the Epidemiological Surveillance and Control of Communicable Diseases in the Community. 1998.	*Public health professionals in the 1990s* interviews 10, 12, 14, 23	No textual source

• **Member States** • **The constructio n of health threats** • **2001-2002**	*Former MEP:* interview 1 *Former representative of the European Parliament in ECDC's Management Board* interview 23	European Parliament. 1997. 'Recommendation for Second Reading on the Common Position Adopted by the Council with a View to Adopting a European Parliament and Council Decision Setting up a Network for the Epidemiological Surveillance and Control of Communicable Diseases in the Europe'. European Parliament. 2004. 'Report on the Proposal for a European Parliament and Council Regulation Establishing a European Centre for Disease Prevention and Control - A5-0038/2004'. Council of the EU. 1996. 'DRAFT MINUTES of the 1924th Council Meeting (Health)'. ——— 1997. 'OUTCOME OF PROCEEDINGS, Working Party on Health'. ——— 1998. 'DRAFT MINUTES of the 2131st Meeting of the Council (HEALTH)'. Decision No 2119/98/EC of the European Parliament and of the Council of 24 September 1998 Setting up a Network for the Epidemiological Surveillance and Control of Communicable Diseases in the Community. 1998	*Current and former Commission staff:* interviews 2, 3, 4, 5, 18 *Public health professionals in the 1990s* interviews 10, 12, 14	European Commission. 1998. 'Opinion on the European Parliament's Amendments to the Council's Common Position Regarding the Proposal for a Decision Creating a Network for the Epidemiological Surveillance and Control of Communicable Diseases in the European Communities'. ———. 2003. 'PRESS RELEASES - Press Release - Extraordinary Council Meeting EMPLOYMENT, SOCIAL POLICY, HEALTH AND CONSUMER AFFAIRS Brussels, 6 May 2003'. 6 May 2003. ———. 2003. Proposal for a Regulation of the European Parliament and of the Council Establishing a European Centre [for Disease Prevention and Control /COM/2003/0441 Final - COD 2003/0174. 2003.
• **DG SANCO** • **Creating the ECDC** • **2002-2004**	*Current and former Commission staff:* interviews 2, 3, 4, 5, 18, 22	*European Commission documents* European Commission. 1998. Decision No 2119/98/EC of the European Parliament and of the Council of 24 September 1998 Setting up a Network for the Epidemiological Surveillance and Control of Communicable Diseases in the Community... ———. 2003. Proposal for a Regulation of the European Parliament and of the Council Establishing a European Centre [for Disease Prevention and Control] /COM/2003/0441 Final - COD 2003/0174. 2003.	*Public health professionals in the 1990s* interviews 10, 12, 14, 23	Council of the EU. 2004. 'Interinstitutional File Proposal for a Regulation of the European Parliament and of the Council Establishing a European Centre [for Disease Prevention and Control] – Outcome of the European Parliament's First Reading'.

Table 4.1. Mapping sources according to narratives of the ECDC creation

2. Narrating the Organization of Disease Prevention and Control

Four distinct narratives were generated from the analysis. Three narratives are analysed in this section, while the fourth narrative is detailed in Section 3. The first three narratives describe the formation of social inferences regarding organizational arrangements that precede the ECDC and the construction of health threats as a transnational public health problem. In terms of temporality, narratives span from the early 1990s to the implementation of the ECDC. The narratives describe how protagonists/narrators eventually all soften up to the creation of the ECDC. Narratives are reconstructed and triangulated with different informants and different official sources, detailed in table 4.1. above and at the beginning of each narrative below.

2.1. "*Not Another European Institution*": The Charter Group Narrative

The Charter Group narrative accounts for the genesis of disease prevention and control in the EU between 1993 and 2002. The narrators/protagonists are members of the Charter Group, an informal group of epidemiologists working on bringing together the different European networks for disease prevention and control in the EU in the 1990s. As proposals for a centre for disease control emerge, evidence shows that the Charter Group wanted to preserve their own networked organization of communicable disease, which characterizes its organizational interest. Therefore, the Charter Group initially opposed the creation of an agency dedicated to communicable disease control, which characterizes causation in this narrative. Evidence was generated mostly from publications from members the Charter Group, which include publications from four

journals of practitioners: ‘Nature’, ‘The Lancet’, ‘Science’ and ‘Infection Genetics and Evolution’. In the late 90s, in a series of letters, articles and editorials, these publications were the theatre of a debate that opposed different public health experts. Data is also generated from an interview with a former member of the Charter Group (interview 24). Data was triangulated with six interviews with public health experts who were active during the temporality under scrutiny (interviews 4, 10, 12, 14, 18, 23) as well as publications from experts outside of the Charter Group.

The organization of disease prevention and control started with the creation of disease specific networks. EuroHIV was the first disease-specific network (DSN) to emerge, supported financially by the European Commission (Altenstetter 1994; Guigner 2004; Steffen 2004, 2012). This approach was emulated for the surveillance of other diseases and new networks sprung up over the years, which I will discuss in Chapter 5. However, the first holistic, disease control organization was the “Charter Group”. As a network of public health experts, it was the first in Europe not to be disease specific. It has been mentioned by Greer (2006, 2012), on the political science side and in public health publications by Krause (2008), MacLehose, McKee, and Weinberg (2002) and by Newton, Grimaud, and Weinberg (1999), some of them, members of this “Charter Group.” The most precise source on the origins of the Charter Group is a 1998 lecture given in Washington by Chris Bartlett, the then-Director of the British Communicable Disease Surveillance Centre (CDSC) who shared paternity of the Charter Group with Gijs Elzinga from the *Rijksinstituut voor Volksgezondheid en Milieuhygiene* (RIVM), the Dutch National Surveillance Centre. They convened experts from each of the then 12 EU Member States, as well as the heads of institutions, with responsibility for national surveillance, to meet in London in December 1993. The goal was to draw on national resources to achieve common

surveillance in Europe (interview 24), and to flesh-out the coordination of epidemiological surveillance by creating a network out of the different disease-specific networks in Europe. In the mid-1990s, the Charter Group had been developing jointly agreed standards for disease surveillance via the prioritization of infectious diseases (Newton, Grimaud, and Weinberg 1999); and, as soon as September 1995 they were publishing a monthly peer-reviewed scientific journal of epidemiologic surveillance "Eurosurveillance" and developed the European Programme for Intervention Epidemic Training (EPIET), training public health doctors and epidemiologists to the same methods, standards and ethos (Bartlett 1998). The Commission granted funds to the Charter Group to draw up an inventory of all the international surveillance and training collaborations that were currently taking place in the EU (Bartlett 1998). The Charter Group also passed on *expert advice* to the Commission the results of their efforts to prioritize communicable diseases (Newton, Grimaud, and Weinberg 1999).

The Charter Group's network approach was politically endorsed in September 1998 with the creation of *A Network for the Epidemiological Surveillance and Control of Communicable Diseases in the Community* established by a Decision of the European Parliament and the Council of the European Union (European Union 1998). However, Decisions are nonbinding instruments, used here in order to facilitate the work of the Charter Group and provide limited funding rather than to create a new organization. The Decision lists epidemiological surveillance and prevention, (two elements of the self-defined mission of the Charter Group) and formalizes the Basic Surveillance Network (BSN), a network supposed to centralize epidemic intelligence from DSNs such as EuroHIV. This was rapidly followed by a Commission Decision (22 December 1998) to set-up an Early Warning and Response System for the control of communicable diseases (EWRS). This IT system brought into permanent

communication the Commission and national organizations in charge with collecting information relating to the epidemiological surveillance of communicable diseases. The year 1998 thus marks a first milestone in the organization of disease control and prevention in Europe and highlight formal organizational arrangements that audiences deemed appropriate in 1998 (interviews 12, 14, 18, 23, 24).

Another proposal emerged: in September 1998, the International Board of Scientific Advisors (a group mainly comprised of micro-biologists and researchers) met in Paris and manifested their support for a European Centre for Infectious Disease (ECID) (Butler 1998). The group had the financial support of the French *Institut de Recherche pour le Development,* which supports the development of scientific programmes at national and international levels. The idea was also supported by "several scientific organizations, including the European Society of Clinical Microbiology and Infectious Diseases" (Butler 1998). The proposal was championed by Michel Tibayrenc, Director of the *Centres d'Etudes sur le Polymorphisme des Mico-organismes* in Montpellier, France and suggested the creation of a "scientific board" based on the existing US Center for Disease Control (CDC), with "health policy remaining under the sovereignty of each nation and the ECID providing complementary overall coordination" (Tibayrenc 1998). Rather than a network for disease surveillance based on cooperation, the ECID would be more ambitious, modelled after the US CDC, and focused on research on site, an area in which the Charter Group had demonstrated no ambition. The proposal for a European agency triggered important debates among the members of the epidemiologic community and received thorough criticism from supporters and members of the Charter Group. The journal for medical practitioners *The Lancet* featured an unsigned editorial titled "Not another European Institution" (Lancet 1998). The Editorial recalled the accomplishments of the Charter Group, in terms of trainings

and surveillance. It was followed by a stream of back and forth open letters and articles dedicated to support one form of cooperation over the other, in different public health journals (see: Butler 1998; Dove 1998; Giesecke and Weinberg 1998; MacLehose, McKee, and Weinberg 2002; Newton, Grimaud, and Weinberg 1999; Reichhardt 1998; Tibayrenc 1998, 1998; Tibayrenc et al. 2002).

The subjective, organizational interest that transpires from these sources shows that members of the Charter Group were quite protective of their project, an interpretation corroborated by some informants (interview 4, 10, 12, 14). The tone of the debate was rather rough and imbued with political undertones: this was a clash between the creation of a European-wide institution and the reluctance of national experts to cede (national) control over their project. The Charter Group, an established structure of cooperation had a good reputation across the disease surveillance community and the proposal for an ECID seemed an attempt to bypass the step by step approach that the Charter Group had followed for close to 5 years. As early as 1998 The Charter Group had been accepted as the vehicle for organizational arrangements that would be incremental and *ad hoc*. The creation of a structure that would supersede it was at best, incongruous and at worst, threatening.

This debate pits two dramatically different rationales for the advancement of disease prevention in Europe. Was there ground to institutionalize cooperation further than it had just been with the 1998 decision? Proponents of the Charter Group insisted there was no need for “bricks and mortar” (Giesecke and Weinberg 1998) for a credible and effective cooperation. Proponents of the ECID were on the other side insisting that a fully fleshed agency would bring credibility to the whole enterprise. The debate did not create an observable shift in the preferences of practitioners and the idea of an ECID, mirroring the US CDC faded away. The *Institut de Recherche pour le Development*

did not finance a new meeting and the proposal championed by Michel Tibayrenc, facing pressures from the rest of the policy community never got off the starting blocks[10].

This narrative shows that up to 2002, the Charter Group opposed the creation of a centre for disease control. Their organizational interest was to preserve *their* network of networks. And despite dissonant voices, most social inferences in which the scientific community around communicable disease control engaged show that the "brick and mortar" solution is not favoured.

2.2. Not a New SANCO agency! The European Commission Narrative

The "European Commission" narrative accounts for the promotion, within the European Commission, of the creation of an agency dedicated to communicable disease control, between 1998 and 2002. The narrators/protagonists are officials from DG SANCO. After the institutionalization of the Basic Surveillance Network (BSN) in 1998 (European Union 1998), expectations in the Commission were that networked, financially frugal arrangements were sufficient. However, within DG SANCO, officials are promoting the creation of a centre for disease control, which characterizes their organizational interest. Therefore, the European Commission while initially opposed to the creation of an agency dedicated to communicable disease control, eventually softens-up to the idea of a centre for disease control which characterizes causation in this narrative. Evidence was re-constructed from six interviews with current Commission officials and three former Commission officials who all witnessed or

[10] Interestingly, Michel Tibayrenc reiterated his plea for an ambitious centre in the press amid the Covid-19 crisis (Tibayrenc 2020)

participated to the creation of the ECDC (interview 2, 3, 4, 18, 22). Additional evidence was drawn from official documents of the Commission. Data was triangulated with interviews from public health experts outside of DG SANCO (10, 12, 14, 23).

Within the European Commission, specifically in DG SANCO (now known as DG SANTÉ), the opportunity to reinforce scientific cooperation on the matter of communicable disease control was, for the first time, within arm's reach (interview 2, 3, 4, 18, 22). Following the 1992 Maastricht Treaty, for the first time, legal competences were attributed to the European Commission to complement national policies, within the limits of disease prevention, health information, and education (art. 129). This support culminated in 1998 with the previously mentioned proposal for a Decision creating a Basic Surveillance Network (BSN) for the epidemiological surveillance and control of communicable diseases (European Union 1998). But subsequently the European Commission appears to not favour further developments in communicable diseases control. As one informant puts it, it demonstrates within DG SANCO a certain lack of ambition at the time, as well as a lack of resources: the Commission had just inherited new competences but some officials were resistant in the face of the structural limitations (interview 18).

Nevertheless, several DG SANCO officials actually championed the creation of agencies in the sector of health (interview 2, 3, 4, 18, 22). An important protagonist in that respect was Fernand Sauer who joined DG SANCO in 2000 as Director for Public Health, after having set-up the European Medicine Agency. He reckons that agreeing that the struggled with convincing official from DG SANCO and the Secretary General and the Legal Service that concept of the ECDC was relevant (interview 18). A key problem was the issue of financing this project. In December 2000, DG SANCO was in the midst of discussions regarding the first EU health programme which would

run from 2003 to 2007 (interview 2), however, the Commission services had not granted DG SANCO to request additional resources. The Health Commissioner's attention was actually absorbed by the recent bovine spongiform encephalopathy or "mad cow" disease and the creation of the European Food Safety Agency (interview 18). Quite understandably, opponents within the Commission decried the dispersal of efforts, while some within DG SANCO also wanted to keep a form of control over newly acquired competences of the Commission (interview 4 and 18). The key point argued by Fernand Sauer (interview 18) was that *ad hoc* cooperation with experts of the Charter Group could not make up for the lack of expertise and resources within the Commission. For instance, the different disease-specific European networks that existed then had not harmonized their methods for collecting data (interview 18). Furthermore, the financing model for these scientific networks was not sustainable on the long term: the European Commission cannot renew *ad eternam* the same projects. Crucially, scientific networks had to compete with many other projects to obtain funding.

In 2002, these efforts eventually rallied the Commission services behind the idea of an ECDC. In September of that year, Commissioner David Byrne mentioned in a public speech the ambition to set-up an agency, "we have committed ourselves to creating a European Centre for Disease Control by 2005. This will bring together the expertise in Member States and will act as a reference and co-ordination point both in routine and in crisis situations" (European Commission 2002). As discussed earlier, the literature on the ECDC underlines the role of the SARS crisis in the Commission coming to terms with the idea of an agency (Greer 2012; Greer and Löblová 2016). However, the dates do not exactly add-up. The SARS crisis began in November 2002 with an outbreak in southern China, while Commissioner Byrne mentioned the ECDC two

months before. The fact that the SARS crisis is so important in the conventional wisdom about the ECDC tends to eschew the efforts that were carried within the Commission, a nuance that was welcome by some informants, when I discussed my findings with them (interviews 10, 15, 18).

This narrative shows how social inferences regarding the network-based organizational arrangements changed throughout the period of 1998 to 2002 within the Commission, thus giving way to purposeful agents to champion the creation of the ECDC. However, two elements are crucial for purposeful agents to enact change: a transnational public health problem must be recognized, and the appropriate response must be inferred from social information about existing organizational arrangements. Both the recognition of a problem and social inferences on the network-based organizational arrangements are developed in the following narrative, while the role of DG SANCO officials as purposeful agents will be analysed in Section 3.

2.3. The Construction of Health Threats as a Transnational public health Problem:

The narrative below accounts for the construction of health threats as a transnational public health problem, between 2001 and 2002. The narrators/protagonists are the co-legislating European Institutions: the Council of Ministers and the European Parliament. After 11 September 2001, the threat of attacks via the chemical agent anthrax incited national governments to address the transnational dimension of health threats, which characterizes Member State's organizational interest. Therefore, national governments came to term with the need for better coordination, which characterizes causation in this narrative. Evidence was generated from documents of

the Council of Minister as well as documents from the European Parliament. While most data come from textual sources, they were supplemented by an interview with a former Member of the European Parliament (MEP) (interview 1) and a former representative from the European Parliament to the ECDC's Management Board (interview 23). Data sources from the narrators/protagonists are relatively scarce but evidence was triangulated with interviews with Commission officials and public health experts (interview 2, 3, 4, 5, 10, 12, 14, 18 - which were already used as sources in the previous narratives) and documents from the European Commission.

This narrative presents how, the problem that the creation ECDC responds to, was progressively constructed over the temporality under scrutiny in this chapter. Two collective protagonists, with their subjective appraisal of the problem are the focus of this narrative: the European Parliament and the Council of Ministers. At a different pace, both institutions came to terms with the idea that the limitations of diseases prevention in the EU can be somewhat overcome by the creation of an agency. This narrative thus sheds light on how their interpretation of the problem varies over time but also on the social inferences they make of the Charter Group and disease specific networks as a solution.

The problem of disease prevention and control in Europe in the 1990s was defined in the larger context of the timid development of a health policy in the EU (interview 10, 12, 18). The development of a health policy in the EU has been described as an incremental development likened to a spill-over dynamic (Greer 2006). Since borders are now opened and microbes know no borders, transnational cooperation is needed to tackle potential transnational health problems. But health threats were not yet perceived as a salient problem (interview 2, 3, 4, 5, 10, 12, 14, 18). European institutions were rather concerned by capacity-building. While the European

Parliament describes the problem of disease prevention and control as a matter of "shortcomings in structure" (European Parliament 1997), the Commission and the Council were more restrained and, respectively, underline "growing" (Council of the EU 1998) and "increasing" (European Commission 1998) needs.

The institutional bargaining that occurred during the decision-making process on the *Decision No 2119/98/EC* 1998 setting up the Network for epidemiological surveillance or Basic Surveillance Network, (BSN) offers precise insights to map the inferences institutions made regarding the organization of disease prevention and control. The European Parliament championed early on the creation of a European Centre (interview 1, 23). This was out of character in a context of growing hostility towards agencification where new agencies were seen as an "irresponsible" development of the European Executive that endangers the balance of power between elected bodies and technocratic institutions (Lord 2011, 912). Nevertheless, the European Parliament demonstrated no suspicion toward the creation of an agency dedicated to surveillance (European Parliament 2004). What explains the role of the European Parliament in championing the *agency approach* rather than the *network approach*? Competences regarding disease prevention and health information only *complement* national policies (interview 1, 23). The European Parliament's defiance towards agencification only holds when the creation of agencies weakens parliamentary oversight and accentuates deparliamentarization (Lord 2011, 913). In the case of the ECDC, the evolution of network-based organizational arrangement into a proper European agency would actually increase the opportunity of the European Parliament to exercise an oversight, specifically through the budgetary procedure (interview 1). As soon as 1997, the European Parliament thus champions the creation of the Centre. The amendments of the European Parliament demonstrate that the creation of an agency

is the favoured way to build capacity: “Having regard to the current shortcomings in the structures for the epidemiological surveillance of communicable diseases in the Member States and, therefore, the need to establish a permanent structure at Community level”; and suggests “collecting information relating to epidemiological surveillance and coordinating control measures in order then to forward them to a central body: the European Centre for the Surveillance of Communicable Diseases” (European Parliament 1997).

In 1998, this approach was systematically countered by the Council. The Council of Ministers was indeed favouring the network approach, with three prominent advocates: Spain, Sweden, and the UK showing clear concerns over the financing of the system, and clear preferences to leave the operational costs of the network to be financed by Member States themselves (Council of the EU 1996, 1997, 1998; European Commission 1998). This position was interpreted within the policy community as the reluctance of the EU’s Member States to cede sovereignty over public health policy (interview 10, 12, 14, 18, see also: Butler 1998). Moreover, the Decision to set up a network bore no additional budgetary costs and was an appropriate response to a non-salient problem.

Problem perception changed radically in the 2000s due to the persistence of health crises, inherited from the 1990s, such as food-borne diseases (“Mad Cow” disease). But particularly, the question of bioterrorism (the post 9/11 anthrax contamination) shifted the issue from a functional problem to the recognition of threats (European Commission 2003b); European Commission 2003). The organization of the Council itself changed to reflect the recognition of this problem. At the end of 2001, the Health Security Committee (HSC) an informal group gathering national agencies in charge of risk management was created under the chairmanship of the Commission (interview

18). With a stronger focus on health threats in the organization of the Council, the question of the creation of an agency able to identify and advise on such matters became more appropriate. As early as June 2001, the possibility of a “European Centre” was mentioned in the conclusions of the European Council at Gothenburg (European Commission 2003a), where concerns about bioterrorism were specifically underlined.

In November 2002, the SARS crisis shocked national capitals (interview 4). It was a focusing event, as Birkland (1998) puts it: it was sudden, rare, and potentially harmful (interview 2, 5, 12, 14, 18). Nevertheless, the impact of SARS on the European continent was limited. According to the WHO (2015) in the month preceding the Commission’s proposal (July 2003), 33 cases had been reported on the European continent—excluding Russia (31 in the EU). At the end of 2003 the WHO concluded that 25 cases were confirmed in the EU, 27 in total for the continent (excluding Russia), with one case resulting in the death of the patient. All cases were imported; there was no domestic spread of the epidemic, no local transmission. However, while at the European level SARS had been limited, at the global level, 8096 cases were confirmed. The crisis seemed a matter of global scale rather than a continental one. But it shed light on the weaknesses of the continent’s preparedness, as highlighted in the Commission’s proposal for the creation of the ECDC: “Communicable disease outbreaks can pose a significant threat to the health and well-being of the European Union’s citizens, as shown during the recent spread of the SARS virus” (European Commission 2003b). The risk of a similar outbreak was thus the problem. The event was a shock which convinced many that there was a need for a better coordination (interview 2, 3, 4, 5, 10, 12, 14, 18).

The construction of health threats as a transnational problem explain how the creation of an agency eventually became an appropriate answer. This narrative shows that the cause of the creation of the ECDC is more complex than the conventional wisdom would let one think. But, crucially, it also demonstrates that the construction of a transnational public health problem - health threats - has an impact on the social inferences made of network-based organizational arrangements. As the recognition that the EU was leaving itself opened to health threats became more prominent in the Council, national governments made the logical inference that the network-based organizational arrangements were insufficient. The following section describes how officials within DG SANCO infer from this social information about networks that audiences are now ripe to the idea that an agency will be more apt to tackle the problem of health threats.

3. DG SANCO Officials as a Purposeful Agents

This narrative accounts for the role purposeful agents, in DG SANCO, inciting a course of action that leads to the creation of the ECDC, between 2002 and 2004. The narrators/protagonists are officials in DG SANCO who championed the creation of an agency dedicated to communicable disease control, which characterizes organizational interest. Therefore, DG SANCO officials engage in reputational inferences to infer the design of the ECDC from audiences' expectations, which characterizes causation in this narrative. Evidence was re-constructed from six interviews with current Commission officials and three former Commission officials who all witnessed or participated to the creation of the ECDC (interview 2, 3, 4, 5, 18, 22). Additional evidence was drawn from official documents of the Commission. Data

was triangulated with interviews from public health experts outside of DG SANCO (10, 12, 14, 23).

As purposeful agents, officials of DG SANCO inferred, from social information what expectations audiences have regarding the future ECDC. They engage strategically with reputation, *for the purpose of securing audiences' consent*. But, unlike the reputation of an up and running agency, social inferences are in this case drawn from the pre-existing organizational arrangements. The challenge they face is thus to search for clues: what appropriate proposal can be made regarding a future ECDC? How to secure future audiences' consent? While this social information will imbue the proposal they put forward, a first challenge is actually to gather this social information in an ambiguous organizational context, before formulating an appropriate proposal (European Commission 2003b). The narratives described earlier show that resistance towards change have come from two audiences: the scientific community and national governments, while the European Parliament generally supports the creation of an agency. Purposeful agents in the Commission, led by Fernand Sauer (interview 18) thus reached out to these audiences in order to infer the appropriate design of the future Centre. These efforts to approach relevant audiences were made in the larger context of preparing the EU's first health program. Beyond Fernand Sauer who did the more political heavy lifting, two SANCO officials were instrumental in formulating the initial ECDC proposal: Maarit Kokki, now an advisor to the ECDC director, and her head of unit for "communicable diseases", Ron Haigh (as mentioned by informants in interviews 5, 18).

3.1. “Taking the Temperature” with National Governments

On the case of Member States, a key issue was to actually be able to discuss the matter. Council formations usually discuss legislation at the agenda. The council in its Employment, Social Policy, Health and Consumer Affairs configuration was too limited to be this forum. Officials in the Commission thus were particularly adamant in taking advantage of the newly formed HSC for strategic discussions (interview 18). The HSC with a specific focus on health security gathered national officials in charge of public health risk management (interview 2, 3, 4). As such, the HSC provided the ultimate avenue for discussing the creation of an agency that would complement, through the assessment of risk, the work done by the members of the HSC in their respective countries.

The key proposals for the ECDC were to provide independent scientific advice, technical support, while the Commission would retain the mandate of ruling on case definition (European Commission 2003b). This balance between capacity building in risk assessment and avoiding to encroach on risk management was crucial in the formulation of the European Commission’s proposal (interview 2, 3, 4, 5, 18, 22). The Founding Regulation thus clearly included a formal prohibition of regulatory powers. It made clear to Member States that there will be no attempt to introduce regulatory powers from the backdoor, which echoed the concerns raised by two Member States: the UK and Germany (Council of the EU 2004). Such bureaucratic drift was anyway prohibited the Treaty and the *Meroni* doctrine which forbids the formal delegation of regulatory authorities to European agencies (interview 18). But it ensured that the organizational design of the Centre would be appropriate and in line with the expectations of Member States (interview 5, 10, 12, 18, 23).

3.2. Building on the Work of the Scientific Community

At a more technical level, DG SANCO officials were also able to consult the members of the different networks (EuroTB, EuroHIV), as well members of the Charter Group. These were national experts, in charge of criteria for notification of diseases, or for the supervision of the public health program (interview 18). The European Parliament was instrumental in channelling this dialogue and constituted a useful ally to the DG SANCO purposeful agents. During a seminar held by MEP Antonios Trakatellis (a biochemist by trade) on 6 November 2002, Fernand Sauer presented the main features of the future ECDC. His goal was to reach out to national institutes: the goal was not to take over the current activities but rather to improve cooperation. A week later, an article in Eurosurveillance the publication created by the Charter Group shows that the scientific community had rallied behind the idea of a small but strong European Centre that would crucially build on existing networks. The rationale reported in the article was that increasing harmonisation was needed in order to maintain scientific credibility (Handysides 2002). Two informants (interview 12, 15) underline that at that time, members of the Charter Group had come to realize the limitations that they would face as a network, especially as financing would not be renewed (interview 18).

Eventually, there was low ambiguity on the role the ECDC ought to take: most audiences were in agreement that a *brick and mortar* Centre was appropriate, but it should not be such a qualitative leap compared to previous arrangements. The Commissions' proposal for the creation of the Centre mentions the importance of transitioning from the current organizational structure to the ECDC. The Communicable Disease Network created in 1999 is presented as foundational: "The basic formula for cooperation amongst Member States and the Commission in the

framework of Decision 2119/98/EC is not being questioned" (European Commission 2003a). The agency is a core concept superimposed on the existing network. Nevertheless, key features of the suggested ECID such as financing, and hosting research labs are not retained. The ECDC is not a European "CDC" based on the US model but a "hub" (Greer and Matzke 2012), a centre that coordinates networks, composed of different authorities in charge of epidemiological surveillance in the EU. It keeps all the existing features (including, for instance, the publication of Eurosurveillance) and is still based on the coordination and "synergies between the existing national centres for disease control" (European Commission 2003a). It brings similar public health professionals than the Committee that had been set-up by the 1998 Decision "Setting up a Network for the Epidemiological Surveillance and Control of Communicable Diseases in the Community" (interviews 10 and 15). National information and expertise are still the corner stones of the ECDC.

3.3. Reputational Inferences and their Explanatory Limits

DG SANCO officials, as purposeful agents, engaged - as expected - in reputational inferences that revolve around the performative dimension of reputation: they inferred that the network-based approach was in the eyes of its audiences, ill-equipped in the face of adverse events. Yet, the process of designing the proposal was inclusive vis-à-vis the scientific community involved in surveillance across Europe, an audience whom activities were directly impacted by the creation of the ECDC. This inclusive approach certainly had a positive effect on the swiftness of the legislative process a source of pride among DG SANCO officials (interview 18). Indeed, informants

underline the inspiration from the scientific community which helped to define the core functions to be incorporated in the ECDC (interview 5, 18).

It is worth noting that the attention given to future audiences of the ECDC is reflected in the design of the governing bodies of the Centre, namely the Management Board and the Advisory Forum. The Management Board is composed of one member designated by each Member State, two members designated by the European Parliament and three members representing and appointed by the Commission. The Advisory Forum is composed of members chosen from senior scientific personnel from the national competent bodies, but also of 6 representatives of civil society: (European doctors, European pharmacists, the European Public Health Association (EPHA) and the European Patient Forum as well as two scientific associations (presently, the European Society for Clinical micro biology and the European Federation for airway diseases) (interview 18). The ECDC is thus designed to offer channels of communications between the Centre and national experts and to maximize the attention given to future audiences.

However, this organizational feature of the ECDC cannot be explain by reputational inferences alone. In the early 2000s, the number of European agencies was rapidly increasing, specifically around DG SANCO. Fernand Sauer was involved in the preparation of the Commission's White Paper on European Governance, namely the section on 'Better application of EU rules through regulatory agencies' which offered two ways: an agency of completely independent experts and an agency that included Member States. As the former director of EMA, Fernand Sauer was keen on the benefits of including Member States *within* the Centre (interview 18) which prevents more conflictual relationships such as what has been observed with EFSA (Ansell, Vogel, and Vogel 2006)

As demonstrated, the choice made by DG SANCO official was informed by the reputational inferences they were able to construe. But their experience with creating other agencies should not be undermined. Reputational inferences are thus necessary albeit not sufficient to understand the design of the Centre, and the breadth and depth of its powers. The network-based organizational arrangements were not deemed enough to tackle the looming threat of large pandemics and bioterrorism. But due to their positive reputation and the turf sensibilities of national experts, these networks could not be wiped out by an organizational big bang. To be appropriate, the creation of the ECDC required a balanced proposal that would not create a powerful agency, seen as detrimental to the national experts in charge of risk management. And the design of the Centre was influenced by lessons learned from the creation of EMA and EFSA. Hence an agency compared to a “hub” (Greer 2012), formally barred from exercising regulatory power and that included Member States in its governing bodies and scientific work. Following the creation of the ECDC the voices given to audiences within the Centre are of paramount importance. The governing bodies serve as fora for reflexive discussions in which participants muddle through the role of the Centre and make sense of its audiences’ expectations.

4. Making Sense of the Scope of the Centre’s Mandate

This section analyses how the ECDC engaged in reputation inferences in the early days of its existence. This is not a narrative, there is no *causation*. Rather this section sets-up stakes that the ECDC is facing regarding its empowerment and reputational stakes that will have repercussion over the next cases. The creation of the Centre is its first empowerment, wherein the conceptual power of the ECDC over management

is fixed. But, the early days of the ECDC from the entry into force of the regulation to the end of 2005 were the first opportunities for the Centre to infer its own role. Evidence shows that following is creation, a nascent ECDC engaged in reputational inferences. Evidence is generated from official documents that elaborate on the implementation of the ECDC. Minutes of the ECDC Management Board, minutes from the ECDC Advisory Forum, documents published by the ECDC as well as communications from the director are analysed. Following such a swift process, internal documents of the ECDC show that a lot remained to be defined. Numerous discussions revolved around the definition and the clarification of what is expected of the Centre.

The swiftness of the creation of the ECDC came with the promise that the Centre would be rapidly operational, which was effective as of 20 May 2005. DG SANCO officials were once again at the forefront. A Health Threats Unit was created within DG SANCO in Luxembourg with George Gouvras and Stephan Schreck respectively as head and deputy. Other officials, Tapani Piha, Stef Bronzwaer, Franz Karcher, Frank Van Loock, Solvejg Wallyn, Germain Thinus and Helmut Walerius as well as seconded experts from Member States (Paolo Guglielmetti, Johanes Hendriks, Bruno Lustig, Albrecht and Guido Werner) did the technical ground work and in some cases joined the ECDC or DG SANCO later on. Their tasks included finding the provisional site of the Centre (Solna, north of Stockholm), managing the initial funds, organising the Management Board and kicking-off the first round of recruitments. The first governing body to be up and running was the Management Board which convened on 28 September 2004 and discussed a lot of the groundwork to be done in preparation of the commencement of official operations 8 months later. The first director of the ECDC Zsuzsanna Jakab was elected by the Management Board in March 2005. She had

previously worked for WHO Europe as well as the Hungarian Ministry of Health. Finally, the Advisory Forum convened for the first time on 28 April 2005.

The question of increasing surveillance capacity in the EU was a primary expectation of Member States and the only area in which the ECDC has the mandate to harmonize (which will be analysed in Chapter 5.). In the early days of the Centre, members of the Management Board muddle through the exact contribution that the ECDC is expected to input. The question of balance with the Member States remains a top priority for DG SANCO officials who participate in these early meetings: “the projects the centre will start are about the coordination on surveillance, not the surveillance itself. Data collection will still be a responsibility of the Member States” (ECDC Management Board 2005a, 8). This central question is also linked to the EWRS, the computerized system for event-based monitoring. The EWRS is meant to be overtaken by the ECDC once the Centre has sufficient IT capacity available. However, there is some ambiguity on how the EWRS should be handled. The Founding Regulation only mentions that information must be passed on to the ECDC (European Unionn 2004). Nevertheless, as early as autumn 2004, new interpretations in European capitals and in the Advisory Forum suggest that the ECDC will be more involved: “The exact relationship between ECDC and the Commission in the EWRS operations needs to be defined. The Commission nominates the persons, based on MS [Member States] nominations, who are entitled for distribution and reception of the EWRS messages. Several MSs stated that the management of EWRS, including the principles and practice of nominating MS delegates, should be critically reviewed in the context of developing communications in the new set-up with functioning ECDC” (ECDC Advisory Forum 2004, 4). As expected, the coordination of surveillance tasks formerly handled by the Network are entirely taken over: “The Centre, through the operation of the dedicated

surveillance networks and the provision of technical and scientific expertise, shall support the networking activities of the competent authorities recognized by the Member States." (Article 5(1)). A gradual process is envisaged for taking over these responsibilities. For each disease, the Centre will either receive and analyse the surveillance data directly forwarded to it by national contact points" (ECDC 2005, 8). The ECDC also takes over cooperation with the publication Eurosurveillance, created by the Charter Group (ECDC 2005a).

More controversially, the fine line between assessment and management is an important topic of discussion as governing bodies make sense of the role of the Centre. The form that ECDC's advice should take is the object of controversies, the term *guidelines* for instance is considered too coercive and the term *guidance* should be preferred (interview 11). "*Guidelines* should be used for responses that require a political commitment, while non-binding g*uidance* amounted to mere recommendations" (ECDC Advisory Forum 2005a, 8). These reflections revolved around the purpose of the Centre and the first year of the existence of the ECDC is clearly an exercise in muddling-through audiences' expectations rather than engaging in a clear process of reputation inference. These questions are mostly raised by the members of the Advisory Forum, a number of which were active in the networks of epidemiological surveillance.

The crucial role of scientific input was best defined by ECDC Director Zsuzsanna Jakab: "The Director had emphasized the separate roles of the MB (governing body with supervising and administrative, sometimes political role) and the AF (technical and advisory role of the Director), and that discussions in the event of a public health crisis would be with the AF not with the MB. They asked to further clarify the role of the ECDC in a public health crisis and set up procedures for collaboration between the

Commission, the Member States and ECDC" (ECDC Advisory Forum 2005a, 3). The limits of the role of the ECDC in health crises are summarised in 2005 Executive Summary of the ECDC's Directors Annual Report "The role of the ECDC in the event of a European public-health crisis has been defined for risk monitoring (leading role), risk assessment (leading role), risk management (support role) and risk communication (coordination role)" (Jakab 2006). The ECDC thus have a role much more important in framing conditions as a crisis than being hands on the management of the crisis. While the literature has shown that this can be a powerful tool (Damonte, Dunlop, and Radaelli 2014), it signals that the ECDC's role in times of crisis is limited to assessment, an aspect of the role of the ECDC that will be further explored in chapter 6 on the H1N1 pandemic. Finally, the issue of bioterrorism, while crucial to convince Member States to support the creation of the Centre was not crucial in the process of making sense of the role of the ECDC. In the temporality under scrutiny, the issue is only mentioned twice: first in the Annual Work Programme for 2005-2006 (ECDC 2005a) and second during a meeting of the Advisory Forum in which the issue is clearly established as outside of the scope of the ECDC's activities: "The Centre can only be involved in the phase of outbreak investigation when a release of chemical agents has occurred, but not any further as soon as an act of bioterrorism is confirmed. […] The Director clarified that, as long as a case is of unknown origin, ECDC can investigate on its own responsibility, but as soon as the origin is determined, a decision must be taken on continuation of responsibilities. When a biochemical incident has been established, the Centre must stay out" (ECDC Advisory Forum 2006d, 9).

The contestation over the breadth and depth of the power of the ECDC was a recurring theme of the narratives accounted for in this chapter. Arguably, building on audience

expectations was instrumental in rallying support over the creation of the Centre. However, it shows that in the early days of its existence, the ECDC is left with the task of conciliating and making sense of this new role. As the response to the salient problem of health threats without holding the reins of risk management, the ECDC is not an oddity, but its role certainly is to define, as demonstrated by the questions raised in the governing bodies of the Centre. In these efforts of sense-making of its own role, the ECDC can draw on social inferences which constitute the embryo of its reputation, but in the infancy of the Centre, the exercise seems limited to the inferences channelled by DG SANCO.

5. Discussion: The Role of Reputation in Explaining the ECDC's Initial Conceptual Power

Reputation precedes the Centre. This approach to agency creation may seem counter-intuitive but is nevertheless meaningful in an organizational context in which the ECDC is the result of incremental organizational arrangements that eventually crystallize amid a crisis. The reputation of the Charter Group and more precisely the consensus regarding its shortcomings mirrors of the expectation's audiences hold of the future Centre. These expectations are eminently *performative,* but they are limited. This explains the limited ECDC mandate. This first case probes the mechanism of empowerment through reputation and explains the limits of the power distributed and embedded in the structure of the ECDC. The relationship between empowerment and reputation is summarized in table 4.2. below.

Social information		***Cause***		***Purposeful agent***	***Audiences granting consent***	***Outcome***
When does change in social information occur?	*The* Making *of reputation*	*Transnational Public Health Problem*	*Problem-brokering and framing*			*Empowerment over the Management of Disease Control*
Prior to the recognition of the problem	Audiences expectations at the creation of the ECDC	Focusing event - SARS	2002: Global crisis – collective framing	European Commission - DG SANCO	National governments	Mandate/Harmonization of surveillance

Table 4.2. Relationship between Empowerment and Reputation

DG SANCO officials are clearly identified as the purposeful agents that acted with the intention to create a new agency. Their behaviour is partially explained by the process of reputational inference. As the problem of health threats is recognized among audiences, purposeful agents infer that the Centre is an appropriate answer, better suited than the pre-existing networks to the challenges ahead. But the Centre must not be created at the expense of the organizational arrangements formed by the scientific community, which explains why the ECDC inherits the task to centralize and develop the organizational arrangements that preceded it. The ECDC came to be in a context of anxiety vis-à-vis health crises but must not overlap the prerogatives of national structures. In this arduous task, the ECDC does not dispose of a comprehensive understanding of the expectations of its audiences and members of the governing bodies lean on the DG SANCO to infer what is expected of the new ECDC. This probes the first research expectation regarding this case: reputation guides purposeful agents in defining a strategy for the creation of the Centre.

This chapter shows that the process of agency creation is already the product of a causal mechanism based on social inferences. The role of purposeful agents, here officials of DG SANCO is important at all stages of reputational inference. They infer

that the Centre is the appropriate response to the looming threat of epidemics and bioterrorism. Once audiences' consent is formally secured through legislation, the ECDC is created, DG SANCO officials participate in the limited reputational inferences that the ECDC engages in about its own role. The fact that governing bodies are initially chaired by DG SANCO officials and that the Commission has 3 seats in the Management Board definitely reinforces the important presence of DG SANCO in the early days of the Centre. Yet, reputational inferences do not explain everything about the choices made by the purposeful agents. Their recent experiences with EMA, EFSA and the phenomenon of agencification in the EU also contribute to the attention given to audiences.

Evidence also confirms the second research expectation - social information, inherited from the process of creation, guides the Centre in understanding its role during the implementation phase. The discussions taking place within the governing bodies of the agencies in its early days showed the crucial role given to scientific input (surveillance) for the purpose of risk assessment while clearly delimiting that risk management is outside of the ECDC's turf. Expectations regarding the newly formed ECDC clearly restrict the power of the Centre to its conceptual form. The ECDC muddles through its role from social information inherited from the process of creation: the qualitative leap of a *brick and mortar* Centre, while modest, demonstrates the importance of the performative dimension in social information.

As for conceptual power, through the coordination of surveillance, the ECDC is meant to be able to shape fundamental patterns of research, communication, as well as the vocabularies, measurements, and standards used by national surveillance organizations. While a form of coordination was already in place since the Decision of 1998, it was fundamentally changed by the existence of an ECDC which became

the engine of the harmonization of surveillance. But this conceptual power is “discreet”. The ECDC is expected to define the level of a risk but must avoid encroaching on risk management. The appropriateness of the ECDC’s input will be discussed further in Chapter 6. This intricate division of tasks leaves room for some interpretation of the role of the ECDC during a health crisis. This is an important aspect of the role of the Centre which will pave the way for future reflections on the ECDC’s role following the H1N1 pandemic.

This case asserts the role of reputation, as social information in explaining the power of the Centre at its creation. Social information is however on the brink of change: governing bodies ask many questions and are still learning how to make sense of the role of the Centre. Audiences are thus prone to “wait-and-see” what this new player will offer before forming new social inferences. This is particularly relevant in a crowded organizational space in which the ECDC cohabits with national surveillance systems.

Chapter 5. Surveillance and its Strategic Use: the Case of HIV/AIDS

HIV/AIDS prevention is a seminal feature of the early days of disease control cooperation in Europe. When the ECDC was created in 2005, the fight against AIDS/HIV was already a somewhat fleshed-out, coherent EU policy, despite the lack of specific legal provisions or formal competences. In 1984, the *Institut de Veille Sanitaire,* now *Santé Publique France* convened experts working on HIV from other national public health agencies in order to move towards coordinated surveillance practices (Hanvoravongchai, Coker, and Liverani 2013). Special meetings of health ministers occurred as early as 1986 and two specific financing programmes were dedicated to HIV/AIDS over the course of the 1990s (Altenstetter 1994; Hervey and McHale 2004; Steffen 2004). The programme *Europe against AIDS* set up in 1991 ran until 1995 and relied heavily on the EuroHIV network to respond to immediate uncertainty. This programme tested different tools, fostered data harmonization for EuroHIV and supported the exchange of good practices in terms of prevention. The second program, *AIDS against Europe* (1996 – 2000), was more substantial and directly aimed to control the epidemic. The overall goal was to contain the spread of HIV/AIDS.

EuroHIV was the first disease-specific network (DSN) to emerge, supported financially by the European Commission (Altenstetter 1994; Guigner 2004; Steffen 2004, 2012). This approach was emulated for the surveillance of other diseases and new networks sprung over the years, hosted by different national public health agencies, such as EWGLI (legionella infections) in 1986 or ENS-CARE influenza in 1992. The institutionalization of a *Network for the Epidemiological Surveillance and Control of Communicable Diseases in the Community* in 1998, as seen in the previous chapter

increased the interconnectivity between these DSNs. By 2006, the EuroHIV network included fifty-three countries, thus covering the entire WHO-Europe region. Apart from producing epidemiological statistics (incidence, prevalence, mortality, transmission routes), EuroHIV also provided analyses of the epidemic's evolution as well as annual surveillance reports. In 2004, the purported aim of creating ECDC was to bring DSNs under the same roof. This process is in large part what the implementation of the Centre consisted of. However, DSNs did not completely disappear. They subsisted as means to generate data but with the ECDC administrating them and producing risk assessments, prompting the comparison of the Centre with a hub of networks (Greer 2012). As of January 2008, the EuroHIV data-system was the fourth network formally transferred to the ECDC, at the same time as the Tuberculosis network, EuroTB.

The case of HIV/AIDS presents useful insights regarding the *modus operandi* of the Centre in an area of indicator-based surveillance. Crucially, it offers key insights on the implementation of the Centre in a period wherein DSNs were absorbed by ECDC. EuroHIV and the other DSNs are networks which did not "resist" the trend of agencification (Levi-Faur 2011). The emergence of European agencies from transnational networks is a well-documented cause of agency creation (Blauberger and Rittberger 2015; Carpenter 2001; Coen and Thatcher 2007; Levi-Faur 2011). The literature on regulatory networks highlights the complex, multi-level character of transnational networks as an important condition of their resilience (Coen and Thatcher 2007; Eberlein and Grande 2005) but little is known on the power struggles that occur when networks are integrated into an agency. Before the ECDC, DSNs were helmed by different national public health agencies which *de facto* lost ownership of the network they established in the first place. Indeed, regulatory networks enjoy an

important degree of freedom characterized by open and collegial modes of governance (Levi-Faur 2011).

The ECDC's mandate to harmonize surveillance and take over networks process of surveillance harmonization gives a first picture of the conceptual power exercised by the ECDC over surveillance arrangements. The Centre is harmonizing scientific practices, disease definitions, in sum, in the area of surveillance, the ECDC is shaping cognition through the formal and informal definitions of concepts, vocabularies, measurements, *i.e.* exercising a conceptual power. Turning to HIV/AIDS, and the EuroHIV network, this conceptual power does not seem to be strictly limited to surveillance and risk assessment. Evidence show that in the case of HIV, limited interventions of the ECDC have steered national prevention in six Member States with subpart surveillance and prevention systems for HIV. Hence, I argue that the ECDC has exercised a conceptual power over HIV prevention albeit in a limited number of Member States. This chapter discusses how this process is the result of the ECDC engaging in reputational inferences with regards to the problem of HIV/AIDS in Europe.

This chapter presents a case of reputational empowerment with the ECDC as the purposeful agent inferring that it is appropriate for the Centre to steer national policies of HIV/AIDS prevention. Evidence show that empowerment occurred after the ECDC built a strong reputation in HIV/AIDS through the process of harmonizing surveillance. The claim defended in this chapter is that, nevertheless, empowerment is not the result of the ECDC's efforts in managing reputation. Rather, reputation-making and reputational inferences are two separate processes in which the ECDC engaged at different times and for different reasons. Four distinct narratives shed light on this process. The first narrative highlights the ECDC's strategy to take over the networks.

The second narrative, from the perspective of DSNs discusses some of the apprehensions regarding the new organizational arrangements. The third narrative shifts the focus back on the ECDC taking over the Euro HIV network and taking stock of expectations. The fourth narrative illustrates how the ECDC took on an advisory role in prevention of HIV/AIDS, following an upsurge of cases in Europe. In terms of audiences, this case focuses on a limited set of audiences. All audiences include scientific experts who are involved in the HIV prevention, which is a modest epistemic community. Figure 5.1. below sums up audiences of interest on HIV/AIDS.

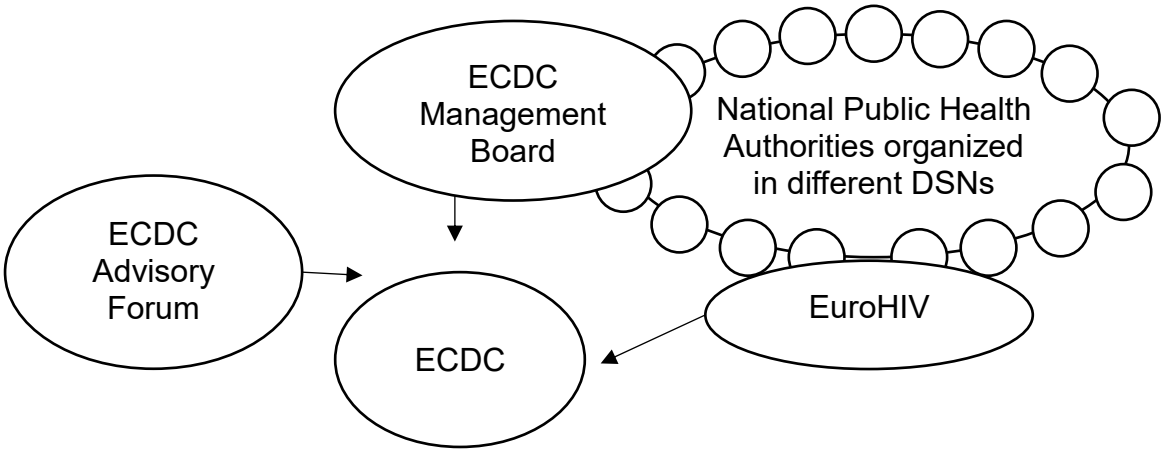

Figure 5.1. Relevant ECDC audiences on HIV/AIDS

This chapter is organized in five sections. First, a short discussion on research expectations is outlined. Second, the first two narratives, with their *grand angle* on DSNs are analysed. The first two narratives paint the picture of the larger context of the ECDC taking over DSNs: the first one encapsulates the organizational interest of the ECDC, the second one reflects the organizational interest from the position of DSNs. The third section discusses the surveillance of HIV and the way the ECDC answers to some of the expectations that audience held vis-vis HIV//AIDS in a third narrative. The fourth section discusses the causal mechanism: I show evidence of the ECDC taking on the role of a purposeful agent and exercising a conceptual power over

the prevention of HIV/AIDS in targeted EU members. The last section draws lessons on the causal mechanism from the case of HIV/AIDS.

1. Reputation-making in the implementation phase

In the case of the Centre's empowerment in HIV/AIDS, I identify the ECDC itself as the purposeful agent. The ECDC took on an advisory role in the prevention of HIV, after taking over EuroHIV, from 2009 onwards. At that point in time, the ECDC had identified an upsurge in HIV/AIDS cases in six Member States. I thus expect that the ECDC inferred an appropriate course of action to tackle the upsurge in HIV infection, taking cues from social inferences from members of the EuroHIV network and securing their consent. Yet, this is only the tail-end of the story of reputational empowerment. Between the creation of the ECDC and 2009, evidence show that the Centre built a strong reputation in HIV/AIDS through the development of surveillance. *Prima facie,* the ECDC's empowerment in HIV/AIDS thus looks like a case of empowerment through the management of a good reputation amongst audiences (Carpenter 2010; Maor 2010; Carpenter and Krause 2011; Busuioc and Lodge 2015; Capelos et al. 2016; Maor 2016; Busuioc and Lodge 2017; Busuioc and Rimkutė 2019; Rimkutė 2020). Indeed, the case of HIV/AIDS shows a process of empowerment in which the ECDC enjoys a great deal of discretion: the ECDC is the problem-broker and the purposeful agent inferring a new role for itself.

Yet, I argue that while there is seemingly a continuity between reputation-making and empowerment, the ECDC did not engage in reputation-making for the purpose of empowerment; and thus reputation-building and empowerment are two separate

processes. The context of implementation offers additional explanatory leverage on the formation of social information on the ECDC regarding HIV/AIDS. The mandate of the ECDC during this phase of implementation was to take over and harmonize surveillance. Within DSNs, these new organizational arrangements created losers and winners. However, public health officials who were members of these DSNs also were crucial audiences for the ECDC: they worked for national public health authorities and in some cases, were also members of the Advisory Forum or the Management Board of the ECDC. Taking over DSNs thus entails clear reputational stakes: as members of EuroHIV witness and cope with organizational changes caused by the creation of the ECDC, they also form social inferences about the Centre.

The argument I defend in this chapter is that the ECDC, as a newly established agency, was aware of those reputational stakes. Therefore, the Centre engaged in reputation-building for the purpose of harmonizing surveillance, which endowed the ECDC with a strong reputation in HIV/AIDS, long before the recognition of a problem. Hence, the ECDC was not engaging in reputation-making for the purpose of empowerment. Yet, and unintendedly, the reputational gains which the ECDC enjoyed had an impact on social information, which in turn informed reputational inference. In sum, reputation-making in the implementation and empowerment are two separate processes in which the ECDC engaged for different reasons. This underpins two research expectations. First, the ECDC engaged in reputation-making for the purpose of achieving its mandate to harmonize surveillance. Second, the ECDC engaged in reputational inferences because a problem was recognized along the way.

Ultimately, the case of HIV/AIDS requires to examine both processes in order to probe these research expectations. Section 2., 3. and 4. below present four narratives on ECDC and HIV/AIDS. The first three narratives discuss the implementation of the

ECDC, the harmonization of surveillance and specifically EuroHIV. They show the building of the ECDC's reputation among DSNs with a focus on EuroHIV. The fourth narrative highlights the causal mechanism, with the ECDC as a purposeful agent looking for solutions to an upsurge in HIV/AIDS cases. Sources I used to reconstruct narratives are compiled in table 5.1. below[11].

[11] The case of HIV/AIDS is the case that suffered the most from my lack of access to sources. This is reinforced by the fact that this case includes very few audiences and that three out of four narrators/protagonists are from the ECDC. Table 5.1. underlines techniques of triangulation that I relied on here. I discuss this more in details in Chapter 9

Narrative descriptors: • Protagonist • Plot • Temporality	Mapping sources			
	Narrator/ Protagonists (interviews)	*Narrator/Protagonists (textual sources)*	*Interview sources used for triangulation*	*Textual sources used for triangulation*
• **ECDC - Surveillance and Communication Unit** • **The added value of harmonized surveillance** • **2005-2008**	*Former ECDC staff:* interview 11 See Chapter 3 for details on problems of access	*ECDC Documents* ECDC. 2005. 'Framework for a Strategy for Infectious Disease Surveillance in Europe (2006–2008)'. ECDC Management Board. ———. 2007. 'Annual Report of the Director 2006'. European Centre for Disease Prevention and Control. 1 January 2007. ———. 2008. 'Memorandum by the European Centre for Disease Prevention and Control'. House of Lords - Intergovernmental Organisations Committee. ———. 2009. Annual Report of the Director - 2008'. Minutes - 2nd, 12th, 13th and 14th ECDC Advisory Forum Meeting	*Public health professionals* interview 2, 5, 6, 12, 14, 15, 16, 18	*European Commission documents* European Commission. 2005. 'Programme of Work for 2005-2006'. ECDC Management Board. *Scientific journals* Ternhag, A., A. Tegnell, B. Lesko, K. Skaerlund, and K. Skärlund. 2004. 'Basic Surveillance Network, a European Database for Surveillance Data on Infectious Diseases'. *Eurosurveillance* 9 (7): 1–2.
• **DSNs** • **Coping with organizational change** • **2005-2008**	*Members of the Advisory Forum and members of DSNs* interview 6, 10, 12, 14, 15, 16, 19, 23	*ECDC Documents* Minutes - 3rd, 4th, 7th, 10th, 11th, 13th and 14th ECDC Advisory Forum Meeting	*Current and former Commission staff:* interview 2, 4, 5, 18 *Former ECDC staff:* interview 11	No textual sources for triangulation, however minutes of the Advisory Forum encompass the point views of all participants to the meetings

• **ECDC - Surveillance and Communication Unit** • **Expectations vis-à-vis EuroHIV** • **2005-2009**	*Former ECDC staff:* interview 11 See Chapter 3 for details on problems of access	*ECDC Documents* ECDC. 2005. 'Framework for a Strategy for Infectious Disease Surveillance in Europe (2006–2008)'. ECDC Management Board. ———. 2009 'Mapping of HIV/STI Behavioural Surveillance in Europe'. Technical report. Minutes - 7th, 11th, 12th and 13th ECDC Advisory Forum Meeting	*Members of the Advisory Forum and members of DSNs* interview 10, 12, 14, 15, 16, 19, 23	No textual sources for triangulation, however minutes of the Advisory Forum encompass the point views of all participants to the meetings
• **ECDC - Surveillance and Communication Unit** • **Steering HIV/AIDS prevention in target countries** • **2009-2016**	*Former ECDC staff:* interview 11 See Chapter 3 for details on problems of access	*ECDC Documents* ECDC. 2009. *Mapping of HIV/STI Behavioural Surveillance in Europe*. Technical report. ———. 2012. 'Country Mission Romania: HIV, Sexually Transmitted Infections, and Hepatitis B and C'. ———. 2013. 'Joint Technical Mission: HIV in Greece'. *European Centre for Disease Prevention and Control*. ———. 2015a. 'HIV and Hepatitis B and C in Latvia'. ———. 2015b. 'Technical Mission: HIV in Cyprus, 15–17 October'. *European Centre for Disease Prevention and Control*. Minutes - 7th, 11th, 22nd, 23rd and 24th ECDC Advisory Forum Meeting	*Members of the Advisory Forum and members of DSNs* interview 6, 14, 15, 16, 19, 23	*Scientific journals* Altman, Dennis, and Kent Buse. 2012. 'Thinking Politically about HIV: Political Analysis and Action in Response to AIDS'. *Contemporary Politics* 18(2): 127–40. Burton, Dennis R. 2019. 'Advancing an HIV Vaccine; Advancing Vaccinology'. *Nature Reviews Immunology* 19(2): 77–78. Garrofé, Beatriz Cebolla, and Arne Björnberg. 2013. *The Euro HIV Index 2009*. Saarbrücken: LAP LAMBERT Academic Publishing. Greer, Scott L. 2006. 'Uninvited Europeanization: Neofunctionalism and the EU in Health Policy'. *Journal of European Public Policy* 13(1): 134–52. Poku, Nana K., Alan Whiteside, and Bjorg Sandkjaer. 2007. *AIDS and Governance (*1st ed. Ashgate Publishing Limited. Steffen, Monika. 2004. 'AIDS and Health-Policy Responses in European Welfare States'. *Journal of European Social Policy* 14(2): 165–81.

Table 5.1. Mapping sources according to narratives of HIV/AIDS prevention in the EU

2. Narrating Organizational Change in Disease Surveillance

Section 2. contrasts the organizational interests of two groups of narrators/protagonists on the same events. This section presents useful insights in the formation of the ECDC's reputation. Two distinct narratives on organizational change in surveillance describe the absorption of DSNs in the ECDC and the protagonists' expectations vis-a-vis new organizational arrangements. In terms of temporality, the narratives span from the creation of the ECDC in 2005 to January 2008, when EuroHIV was integrated to the ECDC. The two narratives have distinct narrators/protagonists: the first narrative presents the development of the ECDC's strategy to take over DSNs. The second narrative follows the same process but with the goal to account for the subjectivity of national public health officials who were passing on the reins of the DSNs.

2.1. The Added-Value of Harmonized Surveillance: the ECDC Narrative

The narrative below accounts for the implementation of the ECDC, between 2005 and 2008. The collective narrators are staff members from the ECDC's Surveillance and Communication Unit, the unit in charge of harmonizing indicator-based surveillance. In this phase of implementation, a top priority was to fulfil the mandate given to the ECDC on harmonization and demonstrate the added value of the Centre, which characterizes organizational interest. Therefore, the Surveillance and Communication Unit started a process of evaluation of DSNs and develop new processes for the

purpose of harmonization, which characterizes causation in this narrative. Evidence is drawn from publications of the ECDC and minutes from the Advisory Forum's meeting. Due to difficulties in access there is only one interview source from the ECDC (interview 11). However, data triangulation is rather strong with eight interviews (interview 2, 5, 6, 12, 14, 15, 16, 18) including three interviews with DG SANCO officials and six interviews of public health experts who were involved in DSNs at the time.

During the implementation phase of the ECDC, the harmonization of surveillance was the most important mandate (interview 2, 5, 6, 11, 12, 14, 15, 16, 18). "From the very start (even before it had been proposed by the Commission) it had always been envisaged that ECDC would work, coordinate and support the DSNs" (interview 11). As an agency in the making, the ECDC was under the pressure to prove the "added value" that the Centre was bringing to the organization of surveillance in Europe through the process of surveillance harmonization (ECDC Advisory Forum 2005a). The process of taking over DSNs was helmed by Andrea Ammon, head of Surveillance and Communication unit and future Director of the ECDC. The ECDC had a clear mandate for the integration of the DSNs within its own structure, but national institutes would still collect data. "One of the key responsibilities of the ECDC is surveillance: partly to consolidate European surveillance activities of the past years and integrate the relevant parts into the ECDC and partly to take further the European vision of surveillance" (ECDC 2005b, 7). The endeavour was two-fold: on the one-hand it meant centralizing the management of DSNs at the ECDC, and on the other hand it meant harmonizing surveillance practices through the standardization of operating procedures (interview 6, 11, 14, 15, 16, 18). Indeed, the existing DSNs had no

harmonized methods for collecting data and running information technology tools necessary to dissemination (interview 18).

Andrea Ammon and the rest of the Surveillance unit were facing a Dantean task: there were 17 DSNs to incorporate in the ECDC. The process properly started with the evaluation of each network (European Commission 2005b). The process was very much in the hands of the ECDC (interview 2, 5, 6, 11, 12, 14, 15, 16, 18). In 2005, the ECDC produced the “Framework for the evaluation and assessment of EU-wise surveillance networks in 2006-2008” which spilled out a comprehensive method of assessment. Evaluation teams made of externally recruited experts were responsible for the evaluation. Three criteria were central to evaluation: usefulness of the network, technical performance and the fulfilment of their contract objectives (as DSNs financed by the European Commission). Most of the evaluation occurred between the second half of 2006 and the first semester of 2007. It started with a preparatory workshop for the first evaluation teams in September 2006 at the ECDC followed by other workshops and visits to the DSNs’ coordinating centres (ECDC Work Programme 2008). DSNs were integrated in the ECDC as their operating procedures met the standards established by the ECDC (interview 15). All networks were preserved but one, the DIVINE network. Table 5.2. below offers a chronology of the integration of these networks.

Acronym	Date of integration in the ECDC	Full name
BSN	Jan-07	Basic Surveillance Network (former Charter Group network)
EU-IBIS	Oct-07	European Union Invasive Bacterial Infections Surveillance
Enter-net/FWD-Net	Oct-07	European Food- and Waterborne Diseases and Zoonoses Network
EuroTB	Jan-08	European Surveillance of Tuberculosis
EuroHIV	**Jan-08**	**European Centre for the Epidemiological Monitoring of HIV/AIDS**
IPSE/HAInet	Jul-08	Healthcare-Associated Infections Surveillance Network
EISS	Sep-08	European Influenza Surveillance Scheme
ESSTI	Jan-09	European Surveillance of Sexually Transmitted Infections
DIPNET/EDSN	Jan-10	European Diphtheria Surveillance Network
EARSS	Jan-10	European Antimicrobial Resistance Surveillance Network
EWGLINET	Apr-10	European Working Group for Legionella Infections
ESAC	Jul-10	European Surveillance of Antimicrobial Consumption
EUVAC.NET	Sep-11	European surveillance network for selected vaccine-preventable diseases
ENIVD	Sep-11	European Network for Imported Viral Diseases
EUCAST	Sep-11	European Committee on Antimicrobial Susceptibility Testing
EuroCJD	Dec-11	European Creutzfeldt-Jakob Disease Surveillance Network
DIVINE	Discontinued	Prevention of emerging (food-borne) enteric viral infections

Table 5.2. List of networks sorted by date of integration to the ECDC (data collated from the ECDC website)

Harmonizing DSNs was first and foremost an exercise in rationalization of surveillance in Europe (ECDC 2005b). The first network to be integrated, the Basic Surveillance Network (BSN) was a product of the Charter Group and the 1998 Decision referred to in chapter 4 (European Union 1998). The goal of the BSN had been to provide “an easy one-step access to simple descriptive data on numbers and incidences” (Ternhag et al. 2004). The BSN covered the 40 diseases listed in the decision, some of which were also covered by other DSNs. However, the BSN only covered Member States pre-2004 wave of accession to the EU, while a DSN such as EuroHIV was covering the whole WHO region. There were important discrepancies between DSNs

mandate (interview 2, 5, 6, 11,12, 14, 15, 16, 18), with reliable data for HIV and Tuberculosis but patchy data for diseases such as viral hepatitis (ECDC 2008b). In addition, each DSN had its own website, database and scientific publications. The ECDC was adamant that harmonization would more economically efficient and would avoid duplication of work. This was an important self-publicized added value of the ECDC (ECDC 2005b). The fragmented system of DSNs meant that considerable input was needed from national agencies which had to fill in manually questionnaires sent out by DSN at a regular basis mandate (interview 12, 14, 15, 16; see also: Ternhag et al. 2004).

A crucial aspect of the process of harmonization was the creation of an electronic tool that would centralize all data and offer an unprecedented access to surveillance across the EU (interview 2, 11, 12, 15, 16). The key rationale was that the ECDC would become a “one-stop-shop” for surveillance. “The main operational reason for the centralisation was IT systems. With the DSNs there were 15 different databases, 15 different sets of software and 15 different IT teams supporting the system. Going to 1 database and 1 IT team was definitely more efficient” (interview 11). The aim was to “develop databases and systems that could host both basic disease variables, as presently collected by the Basic Surveillance Network, and the more disease-specific data, as collected in the surveillance networks will be a priority in the next couple of years. A unified database that provides all the evidence needed for public health action will have to be developed to provide politicians and public health leaders with the information required” (ECDC 2005, 9). The electronic system, named European Surveillance System (TESSy) entered its pilot phase in autumn 2007 (Annual Report of the Director - 2008 2009). TESSy was publicized as an important element of the added value that the ECDC was bringing to surveillance: “The Director remarked that

TESSy should be linked to a decision-making process, and that doing so would represent a significant added value by ECDC" (ECDC Advisory Forum 2008b, 5). This argument of added value resonated quite well with DG SANCO: "The EC representative congratulated ECDC for the remarkable work and the quality of TESSy, as it is in line with the legal requirements and provides added value" (ECDC Advisory Forum 2008b, 5). However, the implementation of TESSy was met with more circumspection in national public health agencies, as I will account for in the next narrative.

An additional obstacle to harmonization were discrepancies in terms of case definition used for the surveillance of diseases mandate (interview 2, 5, 6, 18). Despite a list of case definition consolidated in 1998 (European Union 1998) and amended in 2002 (European Union 2002), DSNs were not automatically using these definitions, which made the comparability of data virtually impossible (interview 5). The issue of case definition ruling became an important point to solve to move forward with the harmonization of surveillance. Here again, the argument of bringing added value is key to the strategy of the ECDC: "On the issue of European added value, it must be made clear how a uniform data collection will actually improve surveillance and outbreak detection in MS: having the data in one place is convenient and can be interesting, but that alone is not enough (ECDC Advisory Forum 2007d). Some representatives of the Advisory Forum had even previously pointed out that "case-definitions are practical tools for surveillance, and could therefore be managed by the ECDC, without the requirement of community legislation" (ECDC Advisory Forum 2005a, 7). As per the ECDC Founding Regulation (European union 2004), case definition remains in the hands of the Commission. Nevertheless, DG SANCO had signalled that in the implementation phase of the ECDC, changes in the list of diseases

were possible (ECDC Advisory Forum 2005a). During the year 2006, the ECDC led an extensive work in revising case definitions (ECDC 2007a). The key was not to just update case definitions but to have case definition that could be translated and used by national agencies in charge of surveillance (interview 2, 5, 6, 18). In September 2006, the ECDC presented a proposal for a revision of case definitions. The new case definitions were accepted in December 2007 (European Union 2008), which was saluted by the Director of the ECDC as a major step forward improving data comparability at EU level (ECDC Advisory Forum 2008a).

The implementation of the ECDC strategy for harmonizing surveillance shows that the organizational interest of the Centre lied in the demonstration of its added value. These efforts in building reputation are one of the strategic tools at the disposal of the ECDC to achieve its mandate of taking over DSNs. The whole process of harmonization is thus guided by one principle: only the combination of data from several European countries would result in 'EU added value'. This process led to the evaluation of DSNs, the creation of the database TESSy and the harmonization of case definition over the course of 2 years. The role of the ECDC must be noted as a form of conceptual power: case definition frames the debate by defining which risks ought to be monitored. This narrative sets the scene to understand the social inferences that public health official in national agencies form vis-à-vis the ECDC.

2.2. Coping with Organizational Change: National Public Heath Agencies' Narrative

Like the previous narrative, this narrative accounts for the implementation of the ECDC, between 2005 and 2008. However, the narrators/protagonists are national

public health officials who are members of DSNs. These narrators/protagonists were coping with organizational change. As DSNs were absorbed by the ECDC, national public health officials were concerned that some of their ongoing projects would not survive the harmonization process, which characterizes their organizational interest. Therefore, they contest the harmonization process, which characterizes causation in this narrative. Evidence was generated from 8 interviews of informants who were active DSN members and witnessed the process of harmonization of surveillance (interview 6, 10, 12, 14, 15, 16, 19, 23) as well as minutes from the Advisory forum meetings. The quasi totality of Advisory Forum members are also national public health officials. The Advisory Forum minutes are thus prolix on the organizational interest that national public health agencies hold regarding the harmonization of surveillance. This narrative is triangulated with three interviews (interview 2, 4, 5, 18).

The continuation of the work carried out by DSNs was a crucial issue for national public health officials (interview 6, 10, 12, 14, 15, 16). Networks were in most cases initially financed by the national agency that were hosting them. In effect, funding from the European Commission became necessary to running these networks over the 1990s. As a former ECDC official put it: “DSNs gradually lost most of their funding. ECDC then re-organised and re-branded the networks. There were good operational reasons for all this, but it was not universally appreciated by colleagues who used to run the hubs” (interview 11).

The 1998 Decision (European Union 1998) also led to the creation of new DSNs: the Basic Surveillance Network as well as ESSTI (surveillance of sexually transmittable infections). The first health programme (2003-2007) had replaced the different smaller-scale programmes that had financed these networks over the years, but the second health programme, planned for 2008-2013 did not guarantee access to EU financing

anymore (interview 18). EuroHIV for instance would have had to compete in the new financial cycle facing a much broader competition than before. This was confirmed by informants (interview 11, 15, 18) who underlined that DSNs were financially tied. As a result, DSNs had reduced leverage on the ECDC's strategy to harmonize surveillance, as their integration in the Centre was in a "change or die" situation. Some informants underline that the loss of ownership over DSNs triggered important concerns: notably because of the loss of control over the data (interview 2, 11, 12, 14, 16). "Some of the colleagues that ran the old DSNs though it might be done in a much more decentralised way than eventually happened. Some of them thought the DSN hubs would continue to operate pretty much as before, but with their annual grants being processed by ECDC rather than DG SANTÉ. What in fact happened is that a team led by Dr Andrea Ammon conducted an evaluation of the DSNs, validated the useful work they were doing, but proposed a new model" (interview 11).

Members of the Advisory Forum were adamant to obtain guarantees that the ECDC surveillance would be built on what has been achieved in the DSNs and contribute to on national capacity rather than replace it (ECDC Advisory Forum 2005b). From 2005, the Advisory Forum harbours these apprehensions: "G Brucker expressed his concern on the question of continuity in general and in particular how the Centre would be in a position to take over at an early stage very important work as the one done by (*sic*) e.g. the French national institute on HIV/AIDS" (ECDC Advisory Forum 2005a, 9). As seen in the previous narrative, national public health institute were still in charge of producing data and remained a key component of the organization of surveillance.

The ECDC, especially in its early days was a modest structure with limited human resources. The Centre was always meant to build on national public health agencies and DSNs (interview 2, 4, 5, 11, 12, 18). A number of participants in the Advisory

Forum were also members of a DSN (ECDC Advisory Forum 2005c) this included Jean-Claude Desenclos from the French *Institut de Veille Sanitaire* (now *Santé Publique France*), who was Head of EuroHIV at the time. The key issue was to find an organizational solution which would perpetuate the involvement of national public health institutes, albeit through a new organizational nexus: the ECDC. A first avenue was Working Groups in Advisory Forum which started as soon as 2005. Jean-Claude Desenclos became the chair of the Surveillance Working Group. These practices helped to exchange good practices and the point of view of DSNs. Regarding surveillance *per se*, it also meant that in Member States, public health institutes had to organize themselves to abide by procedures to facilitate consultation and data transmission. Each Member State, had to designate one Coordinating Competent Body, which depended on each Member States' organization of surveillance (ECDC Advisory Forum 2007c). Each Coordinating Competent Body had one National Coordinator, acting as the main entry point for interactions between the country and ECDC. The National Coordinator was then in charge of identifying experts for National Focal Points on specific diseases. In Member States, the harmonization of surveillance under the auspices of the ECDC meant that new roles and responsibilities had to be created to cope with organizational changes (interview 6, 10, 12, 14, 15, 16).

While organizational changes were important, informants underlined that the harmonization of surveillance practices, specifically through the new TESSy database was the most difficult process to cope with (interview 6, 12, 16). In the early discussions regarding TESSy, the Advisory Forum relays concerns: "The AF agreed with the methodology and plan in general but asked for some flexibility on the timeframe to allow for the necessary mobilization of resources at the national level. […] Some members sought more clarity on the high-level purpose of the database.

The Director reminded members that the development of this database must be seen in the context of the Europe-wide surveillance strategy which was developed and presented to the AF last year. There is a clear mandate for this in the Founding Regulation and needs to be put in place now in order to take over from the DSNs next year" (ECDC Advisory Forum 2006c, 7). Minutes of the Advisory Forum even underline "the feeling that ECDC may have under-estimated the difficulties of the transition" (ECDC Advisory Forum 2007b). There was a clear concern that networks would cease to be fora of cooperation and exchange of good practices and that their contribution would be limited to the transmission of data (interview 6, 10, 12, 14, 15, 16).

National Public Health Officials perceived TESSy as "perhaps too technology-driven" (ECDC Advisory Forum 2007b). The shift to TESSy included the generation of highly specific datasets that national public health agencies were not able to produce which raised concerns especially among new Member States (interview 6). This was the case for instance for surveillance practices such as molecular typing: "If molecular typing of micro-organisms should become a standard procedure, many countries would be hard pressed to comply with such regulatory requirements" (ECDC Advisory Forum 2008b). This prompted some members in the Advisory Forum to advocate a more lenient approach: "Several members expressed their doubts about a coercive approach in the reporting implementation and asked for a more pragmatic one as well as some flexibility from the Commission. Each country should be authorized to send some data that is not necessarily strictly compliant due to their specific surveillance system limitations" (ECDC Advisory Forum 2008a).

This narrative underlines the expectations that national public health agencies had about the ECDC in its implementation phase. Social inferences are formed along the moral dimension of the Centre's reputation: there were expectations among audiences

that the Centre would attend to national public health agencies' needs. The harmonization of surveillance included obligations for Member States, which was met with some apprehensions. However, these obligations also came with the promise of added value. Turning to the specific case of EuroHIV, evidence shows that while the ECDC is set on advancing the harmonization of surveillance, it is actually wary and mindful of audiences' expectations.

3. EuroHIV's Expectations

This narrative account for the absorption of the EuroHIV network between 2005-2009. The narrators/protagonists are staff members from the Surveillance and Communication Unit in the ECDC, the unit in charge of harmonizing indicator-based surveillance. Their organizational interest remains unchanged: in this phase of implementation, a top priority was to fulfil the mandate given to the ECDC on harmonization and demonstrate the added value of the Centre. However, evidence shows that the ECDC was wary of EuroHIV members' expectations to preserve some features of the network as it took over, which characterizes causation in this narrative. Evidence was generated from publications of the ECDC and minutes from the Advisory Forum's meeting. Due to difficulties in access there is only one interview sources from the ECDC (interview 11). However, data triangulation is rather strong with seven interviews (interview 10, 12, 14, 15, 16, 19, 23) of public health experts who were both part of DSNs and the Advisory Forum at the time.

While an adaptation of standard operating procedures was necessary to comply with TESSy, the harmonization of HIV/AIDS surveillance had – at first – a less profound

impact on surveillance practices than for other network: substantial coordination of practices had already been achieved by EuroHIV (interview 14, 15, 16). As seen in the previous section, collaborators of EuroHIV kept on being involved in the surveillance of the disease albeit in renewed arrangements and different capacities. Nevertheless, the process of harmonization led to important organizational changes: EuroHIV was eventually fused with the ESSTI (Sexually Transmitted Infections). Members of the Advisory Forum interpreted the new grouping of diseases as the marker of a loss of commitment and skills from experts in specific diseases: “Some concerns were raised regarding the disease groupings. It was feared that this could lead to a loss of commitment and skills from experts in a specific disease”. (ECDC Advisory Forum 2007c, 5). Informants corroborate this interpretation and also underline that the loss of the “brand” EuroHIV was considered an important drawback at the time (interview 10, 12, 14, 16, 19).

Moreover, the geographical scope of surveillance was contentious (interview 14, 16, 19). EuroHIV had over the years developed as a pan-European network that would not only cover EU countries but all countries of WHO Europe which included all former Soviet Union countries (this was also the case for EuroTB, both networks were piloted from France). The key issue did not lie in the reporting of data, but in the development of a common strategy for surveillance. From the perspective of members of EuroHIV, a strategy limited to EU Member States was unproductive (interview 14, 16, 19). Discussions took place on the matter until a few months before the integration of EuroHIV to the structure of the ECDC, in January 2008: “Regarding non-EU countries who contribute to some of the DSNs, it was explained that ECDC would like to keep them included, but that they are not able to fund it. […] EuroHIV met the previous week and agreed that all 53 countries would remain in the network after its transfer to ECDC”

(ECDC Advisory Forum 2007c, 13). WHO would support the coordination of non-EU members with the ECDC based EuroHIV (ECDC Advisory Forum 2008a).

In spite of some flexibility, members of EuroHIV fathomed the costs of integrating the DSN to the ECDC: members of EuroHIV apprehended that more strategic aspects of surveillance would be undermined (interview 10, 12, 14, 16, 19). In EuroHIV, national public health agencies made no distinction between surveillance, risks assessment and measures of prevention, sharing and diffusing good practices that related to all relevant areas (interview 11). This is also shown by evidence from minutes of the meetings of the Advisory Forum: “There was disagreement as to ECDC’s role as regards prevention work. Some members welcomed any actions that ECDC takes on this matter and hoped it would take on a strong role. Others were more cautious and warned against ECDC getting into what are political issues at national level” (ECDC Advisory Forum 2006c, 6). In sum, members of the DSN expected that ECDC’s activities will not be limited to surveillance activities.

The Centre was receptive to these expectations (interview 11). One official of surveillance unit stands out, Marita Van de Laar, Head of Disease Programme who was instrumental in developing the HIV/AIDS strategy (ECDC Advisory Forum 2006c, 2007b, 2007d, 2008a). In 2007, the Surveillance Unit of the ECDC developed the 2008 work plan on HIV/AIDS, STIs and blood-borne infections (ECDC Advisory Forum 2007d). Along with considerations on the development of epidemiological surveillance, the question of standardised behavioural surveillance in relation to HIV is promoted by Marita van de Laar in her presentation of the work plan to members of the Advisory Forum. Behavioural surveillance differs from epidemiological surveillance and is concerned with behavioural data that explain the transmission of the disease from one patient to another. Behavioural surveillance usually monitors two types of indicators:

demographic indicators (age sex, sexual orientation) and types of behaviours adopted (types of sexual intercourses, injecting drug use) (McGarrigle et al. 2002). Behavioural surveillance is thus primarily concerned with the identification of groups at risk. In 2009, the ECDC produced a technical report "Mapping of HIV/STI behavioural surveillance in Europe" (ECDC 2009d) which reviewed the current state of behavioural surveillance programmes related to HIV and other sexually transmissible diseases. The goal of the report was to support Member States in the implementation of a key set of behavioural indicators related to HIV and STI in Europe" (ECDC 2009, 1). Looking more closely at the behavioural indicators, the first suggested indicator was actually "Knowledge about HIV infection and protection". With behavioural surveillance came the opportunity to better approach populations at risk: men who have sex with men, injecting drug users, migrants from high prevalence countries and sex workers. Finally, one population was also of primary interest: people living with HIV/AIDS. Yet, the 2009 report was bound to suggestions on surveillance of behaviours and does not venture into prevention.

More explicit recommendations were formulated in the general framework on strategies for disease specific programmes (ECDC 2010b). On HIV/AIDS, the document developed guidance on behavioural surveillance related to STI and HIV. It included a toolkit with technical guidance, assessment on populations and methods, assistance for implementation of behavioural surveillance through pilot projects, and workshops, all for the purpose of reaching out to groups at risk. Groups at risks were specifically discussed in the document. The ambitious strategy echoed expectations that ECDC would not simply turn EuroHIV into a database of surveillance, but that it would also steer surveillance strategically and bring added value to the previous organizational arrangements. The development of the framework was particularly

welcome in the Advisory Forum: “Several representatives complimented the first-rate quality of the report delivered by ECDC on behavioural surveillance related to HIV and STI. It was considered to be excellent, with feasible and sound conclusions” (ECDC Advisory Forum 2007d).

Throughout the period under scrutiny, the ECDC was receptive to audiences’ expectations and thus was engaging in reputation-building. Yet, the purpose of reputation-building is not empowerment. Rather the ECDC, as a new agency was aware of those reputational stakes and demonstrating its added value, in order to incite the cooperation of EuroHIV members in building cutting-edge surveillance. Surveillance in HIV/AIDS was an area in which the implementation of the mandate to harmonize surveillance was the smoothest: EuroHIV was one of the most integrated networks and progress regarding harmonization proved more rewarding than for other disease networks (interview 10, 14, 16, 19, 23).

Indeed, the behaviour of the ECDC in shaping a strategy on HIV/AIDS shows that engaging in reputation-building bears some importance on the ECDC, and the way it infers its own role. The importance of demonstrating the added value of the Centre has been a constant in the micro-foundation of the behaviour of the ECDC: “Surveillance is information for action […] It is important that the output data from the surveillance systems meet the expectations and needs of those engaged in public health in Europe in order to be useful information for decision-makers in the public health field” (ECDC 2005b, 10). With HIV/AIDS, the ECDC demonstrates this added value through the technical dimension of reputation: the ECDC supports the development of innovative practices in data collection in Member States. But at the same time, it also answers audiences’ expectations which confine to the moral dimension of reputation: the voluntary approach of EuroHIV had to be preserved.

This narrative analysed the formation of social inferences regarding HIV/AIDS, and how this incentivized the ECDC to respond to these expectations However, narratives focused on the formation of reputation. The last narrative analyses the causal mechanism of empowerment. In a context of surveillance harmonization, and with a clear understanding of the stakes of harmonizing surveillance in HIV/AIDS, what causal condition has empowered the ECDC to steer prevention? The following section builds on the narratives outlined so far and brings new evidence to answer this question.

4. From Surveillance to Prevention in the Fight against HIV/AIDS

The narrative below accounts for the ECDC taking on an advisory role in behavioural prevention in HIV between 2009 and 2016. The collective narrators are staff members from the Surveillance and Communication Unit in the ECDC, the unit in charge of harmonizing indicator-based surveillance. After developing surveillance, the ECDC detected an upsurge in HIV cases in some Member States. The ECDC follows a logic of problem-solving which characterizes its organizational interest. The Centre is incentivized by audiences' expectations to intervene. Therefore, the ECDC, acting as a purposeful agent infers that it ought to take on an advisory role, for a select number of Member States, in HIV/AIDS prevention, which characterizes causation in this narrative. Evidence was generated from publications of the ECDC and minutes from the Advisory Forum's meeting. Due to difficulties in access there is only one interview sources from the ECDC (interview 11). This narrative is triangulated with six interviews (interview 10, 12, 14, 15, 16, 19, 23) as well as political science papers on HIV in

Europe. Ultimately, this narrative shows the unfolding of the mechanism and evidences of the ECDC's conceptual power over prevention. Therefore, it explains how the ECDC took on a steering role on HIV/AIDS prevention in six Member States.

Problem-framing is of special importance. Indeed, the epidemic is no novelty. The recognition of a problem is possible because the ECDC has developed surveillance in the first place. With increasingly harmonized surveillance practices and the development of reliable behavioural data, the ECDC had a unique vantage point on epidemiological conditions (interview 14, 16, 23). The 2009 ECDC technical report "Mapping of HIV/STI behavioural surveillance in Europe" (ECDC 2009d) had underlined disparities in terms of geographical spread: several countries in Eastern and Southern Europe were going through an upsurge of cases.

Eastern Europe had been protected from the disease until the 90s: only a small number of cases had been reported despite massive HIV testing in these countries (Altman and Buse 2012; Poku, Whiteside, and Sandkjaer 2007). Nevertheless, the breakdown of communist statehood left already underfinanced health care systems and public health institutions without resources (Greer 2006). In Estonia the annual number of new infections amounted to nearly 1,500 in 2001 vs 34 in 1993 (Steffen 2004) similar progressions were observed in Poland, Romania, and Latvia which were unable at that time to deal with a major epidemic. EuroHIV had a positive role on the reduction of the epidemic, importing risk-reduction strategies from EU countries. Yet, when the ECDC took over EuroHIV in 2007, disparities were still important (Garrofé and Björnberg 2013) and national public health agencies had expectations that ECDC would build on the progress made so far (interview 14, 15, 16, 19, 23).

Historically, HIV/AIDS has been framed as a societal problem: the mode of transmission of the disease and its prevalence among men who have sex with men and drug injectors has led to important stigma for groups at risk. With the development of behavioural surveillance, sexual transmissions were identified as only one of the determinants of this upsurge: "In response to a suggestion to prioritise MSM, she [Marita van de Laar] agreed that this is an important group that requires attention but added that in Eastern Europe the situation might be different since the data is scarce" (ECDC Advisory Forum 2010a, 7). This upsurge was linked to the drug epidemic, which included the use of risky products through injections. The question of transmission via drug injection in several countries of the EU became a central topic in HIV/AIDS (ECDC Advisory Forum 2010a, 2010b, 2010c).

The ECDC emerged as the purposeful agent engaging in reputational inferences about what course of action is appropriate. The causal condition is the new framing of the problem through behavioural surveillance. The ECDC had the consent of audiences. Audiences' expectations had been high regarding HIV/AIDS, from the launch of the Centre. Among EuroHIV members, there were hopes within the Advisory Forum that the ECDC would take on a greater role in terms of prevention (ECDC Advisory Forum 2006c, 6) and some countries were seeking further advice than in the strict field of surveillance. In that respect, some informants underline that there was a clear East-West division within the Advisory Forum, with new Member States welcoming as much input as possible from the ECDC (interview 6, 14, 16).

As the problem-broker and with the vantage point conferred by the centralization of surveillance data, the ECDC inferred that it was appropriate to assist these countries in aspects of prevention (interview 11, 15, 16, 19, 23) and offered to proceeds with country visits to offer more tailored input. The ECDC conducted 5 country visits in

which the prevalence of infection through drug injection was high: Romania (11-13 May 2011), Latvia (26-30 September 2011 and 2-4 September 2014) Greece (28-29 May 2012), Cyprus (15-17October 2014), and Bulgaria (19-21 September and 14-15 November 2016). All of these country visits were done by the invitation of the Member States. Following these visits, the ECDC formulates recommendations which are non-binding. (ECDC Advisory Forum 2010a, 2010b, 2010c).

But the line between assessment and management of risks is more questionable than for most diseases. Ambiguity is high amongst audiences: on top of still learning about the limits of the Centre's remit, HIV/AIDS blurs the line that differentiates where the ECDC is competent and where it is not. Indeed HIV/AIDS is a distinct epidemiological problem: the HIV virus is prone to rapid mutations which to this day makes the development of vaccines very difficult (Burton 2019). Management relies substantially on public information campaigns and outreach to the public and in particular groups at risk. The ECDC's recommendations would vary greatly in terms of the type of advice. Some recommendations targeted the question of further development of behavioural surveillance, this was particularly the case for Latvia (ECDC 2015a) and Romania (ECDC 2012a). Other recommendations had a much broader public health approach and recommended change in prevention, hence management. Due to the stigma carried by HIV/AIDS and the behavioural surveillance data at hand, the ECDC's recommendations were specifically concerned with the protection of groups at risk.

On men who have sex with men, recommendations address "issues of stigma and discrimination experienced by MSM and the LGBT community in Cyprus" and the consequences it bares on prevention groups at risk (ECDC 2015b). Similar recommendations were formulated for Bulgaria, while in Greece, the lack of access to treatment for sex workers and migrants with HIV was subject to recommendations as

well. Solutions proposed by the ECDC went beyond surveillance issues and offered hands-on approaches to practical problems. Recommendations formulated in the case of Greece suggested the development of syringe distribution programmes, the scaling-up of opioid substitutes available and the reminder that: “Testing should not be mandatory or coercive, and everyone involved in providing medical services and care should fully respect fundamental rights with due regard to EU and national legal provisions concerning data protection” (ECDC 2013, 19). The power exercised over the national prevention policies remained purely conceptual: recommendations were not binding, and the ECDC only came after being invited.

5. Discussion: Added Value in the Implementation Phase

The case of HIV/AIDS shows that the causal relationship between reputation-building and empowerment can be layered and requires nuance to analyse the role of reputation in the empowerment of the ECDC. The ECDC engaged in reputation-building for the purpose of developing and harmonizing HIV/AIDS surveillance. The progress made by the ECDC created a vantage point for the Centre on epidemiological conditions in the EU and allowed the ECDC to identify an upsurge in HIV/AIDS. Yet, the purpose of reputation building was not empowerment. In sum, reputation-making in the implementation and empowerment are two separate processes in which the ECDC engaged for different reasons. This confirms the two research expectations developed in this chapter’ first section. The ECDC has engaged in reputation-making for the purpose of achieving its mandate to harmonize surveillance. But only took on an advisory role because a problem was recognized along the way. The relationship between empowerment and reputation is summarized in table 5.3. below.

Social information		***Cause***		***Purposeful agent***	***Audiences granting consent***	***Outcome***
When does change in social information occur?	*The* Making *of reputation*	*Transnational Public Health Problem*	*Problem-brokering and framing*			*Empowerment over the Management of Disease Control*
Prior to new framing of the problem	Strategic use of reputation: added value & HIV network expectations	Upsurge of HIV cases in select group of Member States	2009: ECDC proposes new framing on determinants of HIV	ECDC staff - Disease Programme - Surveillance Unit	Select National agencies and surveillance network inviting ECDC for country visits	Advisory role in behavioural surveillance and prevention

Table 5.3. Relationship between Empowerment and Reputation

The case of HIV/AIDS is also particularly insightful about the implementation of the ECDC. EuroHIV as one of the historic DSNs had to be defined in the larger context of the ECDC harmonizing surveillance. Yet, EuroHIV has its specificities. Two elements single out the case of HIV/AIDS compared to other DSNs. First, the relative advancement of harmonization of surveillance in EuroHIV made coping with changes in operating procedures less controversial than in other DSNs. Second, EuroHIV network members had clear expectations on the future of HIV//AIDS surveillance in the ECDC since the creation of the Centre. Social inferences are not the preserve of the causal mechanism under scrutiny, but are an ontology in themselves: audiences continuously engage in reputational inferences. As two distinct processes of meaning-making, they have a transformative effect on organizational arrangements, but without a clear causal condition, they do not provide a coherent mechanism to explain the outcome of interest. Indeed, as expected, reputation as a form of social information is only relevant in the mechanism as the purposeful agent links problem and social information.

In the case of HIV/AIDS, the ECDC acted as a purposeful agent. But, the ECDC also acted as problem broker. New information about the situation with HIV would not have been produced, if it were not for harmonization of surveillance which shaped the reputation of the ECDC in the first place. The causal mechanism is thus complex with different sequences which fed off and affected each other. A way to observe this relationship is in the dimensions of reputation that were identified: during the process of surveillance harmonization, audiences drew social inferences following the moral dimension of reputation. They expected ECDC to show flexibility and to be attentive to their needs. The ECDC did not respond by trying to curate a reputation of flexibility. Rather the Centre was focused on added value which resonated more with the technical dimension of reputation. As demonstrated, this had a positive impact on the audiences.

When a clear upsurge in HIV/AIDS was identified, audiences consented that the ECDC offered more on the matter of prevention, where it was needed. Exercising power over the management of risks is thus not as simple as pleasing audiences and directly answering their expectations. The ECDC brought added value which in the medium term was crucial for audiences to consent to an increased involvement of the ECDC in national prevention plans. The ECDC is thus quite successful in addressing HIV/AIDS and its behaviour was ultimately well received by public health experts working at national level; the fact that the ECDC had the upper hand in terms of surveillance practices is also important in this respect. This strategy is however more difficult to implement when the ECDC engages more directly with national risk management systems in times of crisis, as explored in the next chapter on the H1N1 pandemic.

Chapter 6. Empowerment amid crisis? Preparedness and the 2009 H1N1 Crisis

The 2009 H1N1 influenza, also known as *swine flu* H1N1 crisis, was a global pandemic, the initial outbreak was reported in Mexico on 4 April 2009. The first European case of H1N1 infections were reported on 27 April 2009 in Spain (ECDC 2009a). It was the first global pandemic since the 1968 Hong Kong Flu (SARS geographical scope was more limited), thus signalling the large scale of the threat and reinforcing its framing as a crisis (Figuié 2014). However, the months of May and June 2009 mark a turning point: mounting evidence showed that the crisis was not as bad as predicted (Nicoll and McKee 2010) and public authorities came to terms with the fact that the pandemic was not as salient as expected. The official end of the pandemic as defined by the World Health Organization (WHO) was 10 August 2010. But even before the summer of 2009, conditions could hardly be qualified as crisis-like (ECDC 2009b).

Yet, and in spite of its deceiving seriousness, the H1N1 pandemic was a driver of change in the coordination against cross-border health threats. Following that event, preparedness, defined as the state of readiness to respond to threats in the EU was entirely revamped. The 2013 Decision of the Commission on health threats (European Union 2013) institutionalized the Health Security Committee (HSC). The HSC was in the wake of the H1N1 pandemic, an informal group made up of national Health Ministries' representatives with authority on questions of risk management in their respective Member States (de Ruijter 2019). Following the 2013 Decision, the HSC gained the ability to decide quickly on the coordination of national responses, without having to be endorsed by the Council of the European Union. The Decision also

establishes a mechanism for the joint procurement of medical countermeasures (Wukich 2019, Baekkeskov 2017; de Ruijter 2019). However, regarding the ECDC, the Decision merely formalised what was already part of practices in terms of surveillance and risk assessment (Greer 2012; Greer, Mätzke, and Linz 2012). Indeed, the ECDC had already taken over the day-to-day running on the Early Warning Response System (EWRS), as discussed in Chapter 4, a practice that the Decision legally sanctioned. Organizational change post-crisis is thus not concerned with the ECDC's empowerment.

However, evidence shows that during the crisis, after an initial period of extensive work in assessing risks, the ECDC participated in developing advice on vaccines, despite the fact that it is not part of the mandate of the Centre, nor that it was part of initial preparedness plans (Versluis, Asselt, and Kim 2019). A requirement of the mandate of the ECDC is to be wary to not overstep the fine line between assessment and management of risks. In other terms it means that the ECDC's guidance regarding preparedness ought to avoid prescriptive input on how to manage the crisis. This organizational distinction entails that the only area in which the ECDC would be exercising a conceptual power would be in framing the problem and defining risks. The puzzle of this chapter is thus, to understand how the ECDC took on an increased role on risk management in vaccines *amid* crisis.

The case of the 2009 H1N1 pandemic sheds light on the mechanism of reputational empowerment in which the causal condition, the recognition of a transnational public health problem is characterized by uncertainty. Crises are characterized by uncertainty vis-à-vis the problem, in the sense that they are sudden and unexpected events (Birkland 1998). Health crises are unpredictable and the nature of the problem in the case of the H1N1 pandemic was characterized by uncertainty (Versluis, Asselt, and

Kim 2019). In the case of novel strain of virus, uncertainty is commonplace: data to establish the extent of risks to human health trickles down gradually and the severity of the disease cannot be determined right away. Once uncertainty about the seriousness of the pandemic was cleared, response measures shifted towards the common purchase of vaccines. As a result, the ECDC saw its role change with an increased participation in advising on vaccine use. The central claim of this chapter is that reputational inferences occurred amid crisis, as part of a shift in preparedness plans. Because conditions change amid crisis, the European Commission acts as a purposeful agent to course-correct, amid crisis, preparedness plans that had been developed before H1N1.

In effect, within the public health community, the 2009 H1N1 pandemic was considered a test for the ECDC (Liverani and Coker 2012): it was the first time that the ECDC would be dealing with a salient health threat identified through event-based monitoring. For the first time as well, Member States' governments would be a primary audience, through meetings between the ECDC and the HSC. Figure 6.1. below maps out the different audiences. The ECDC is embedded in a sophisticated system of monitoring response to health crises which includes a dense network of organizations that constitute the ECDC's audiences. DG SANCO and the Advisory Forum are both audiences of interest. The European Medicine Agency (EMA) as well as the World Health Organization (WHO) are also audiences which role will be more precisely outlined in narratives. National Governments, which are determinant regarding audiences' consent, are represented in two bodies: the management Board and the HSC which frequently meets and interact with the ECDC amid crisis.

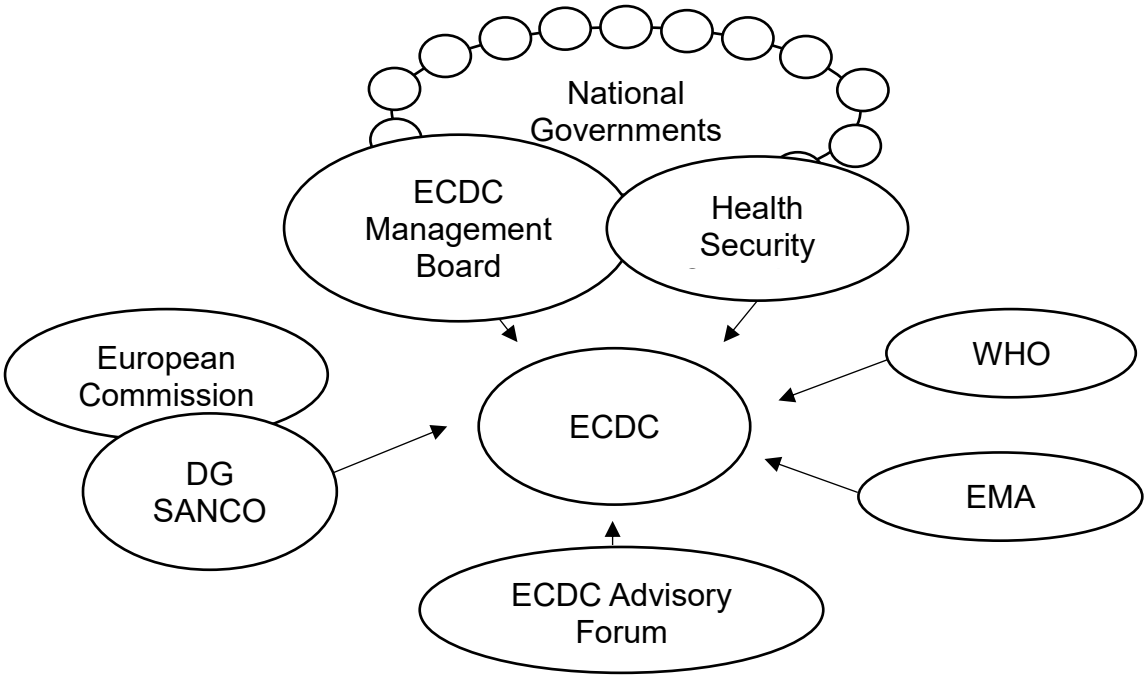

Figure 6.1. Relevant ECDC audiences on H1N1

Five sections structure this chapter. In Section 1., a short discussion on reputational inferences in a context of crisis is outlined. Section 2. paints the picture of the larger context of preparedness between 2005 and 2009. Section 3. includes two narratives which span from 2005, to July 2009, the date of the turning point once the salience of the crisis is reframed. Both narratives reflect the organizational interest of the ECDC and highlight the ambiguity of its role. One narrative details the ECDC making sense of its own remit in surveillance, especially vis-à-vis WHO. The other narrative details the ECDC muddling through the fine line between risk assessment and risk management, up to the heart of the crisis. Section 4. discusses reputational inferences amid crisis and contrasts the role of the ECDC as defined before the pandemic as opposed to its role inferred during the pandemic. This narrative discusses the role of uncertainty in the way the causal mechanism unfolds and analyses how the Commission ultimately inferred a new role for the ECDC. This section concludes on

how, post H1N1 pandemic, social information about the ECDC has been updated. The last part draws lessons on the role of uncertainty in the articulation of the causal mechanism: problem framing is of primary importance in eliciting reputational inferences. But due to the fast-paced nature of the crisis, sense-making of the problem, reputational inferences and audiences' consent are contiguous processes.

1. Reputational Inferences in a Context of Crisis

Among the exogenous factors likely to foster policy change, crises are often considered as a golden opportunity for pushing new solutions upon the agenda (Birkland 1998; Boin et al. 2009, 2013). Crises are widely perceived as a driver for a critical juncture, a breakdown point or a tipping point, that leads to institutional change (Capoccia 2016; Collier and Collier 1991; Pierson 2000, 2004; Mahoney 2000; Thelen and Conran 2016). Crises are choice opportunities, *i.e.*: "occasions when an organization is enabled and thus expected, to produce behaviour that can be called a decision" (M. Cohen, March, and Olsen 1972, 2). However these opportunities might be hindered or facilitated (Gerlak and Heikkila 2011; Smith and Elliott 2007). Borrowing from the literature on policy learning, I posit that intra-crisis (*i.e.* amid crisis see: Deverell 2009), information-processing is complex and choice opportunities are limited (Kamkhaji and Radaelli 2016). The mechanism of reputational empowerment is based on inferential processes, hence the question: what are the effects of crisis conditions on reputational inferences?

Health crisis are usually characterized by uncertainty (Avery and Kim 2009; Kenis et al. 2019; Santos-O'Connor et al. 2014), especially in the case of novel diseases such

as H1N1 (A. C. Keller et al. 2012; Versluis, Asselt, and Kim 2019). Research highlights the challenge of dealing with uncertainty in policymaking (Koppenjan, Koppenjan, and Klijn 2004). Crucially it distinguishes between two forms of uncertainty: epistemic uncertainty which stems from imperfect knowledge (and can be reduced with information that is available), and ontological uncertainty which relates to unpredictability (with no available information to reduce it) (Brugnach et al. 2008; Isendahl et al. 2009; Walker, Haasnoot, and Kwakkel 2013). In the case of H1N1, uncertainty is characterized by a lack of available information. However, this changes after a few weeks, as new information emerges on the seriousness of the pandemic.

Evidence shows that intra-crisis, the European Commission operated a shift in its preparedness plans. This was the result of a course-correction. Indeed, following SARS, the European Commission had developed preparedness plans which were designed for salient health crises. When the H1N1 crisis started in April 2009, uncertainty was high, but it decreased as soon as May 2009: the pandemic was not as serious as anticipated. The context of crisis is thus important to understand how reputational inferences intra-crisis may differ from the process of task allocation pre-crisis. I expect that, intra-crisis the European Commission, acting as a purposeful agent infers a new role for the ECDC as new information is available about the problem.

This underpins a first research expectation: the European Commission engaged in reputational inferences intra-crisis because of a decrease in uncertainty about the nature of the pandemic. The European Commission assigned a new role to the ECDC, with the consent of audiences, as part of a larger shift in preparedness plans. The case of 2009 H1N1 crisis thus accounts for the role of problem uncertainty in the way the causal mechanism unfolds. Sense-making of the problem, reputational inferences

and audiences' consent are thus contiguous processes which, as they unfold, set a course of action towards change intra crisis.

Moving away from the effect of crisis conditions on reputational inferences, what to expect of the effect of the crisis on reputation? In the previous two cases, the *making* of reputation had been an important part of the *story* of empowerment. However, with H1N1, only four years have passed since the creation of the ECDC and the Centre is still in its implementation phase. Unlike with indicator-based surveillance, whereas the ECDC can demonstrate its added value, event-based monitoring *de facto* is a short-term, sudden event. I thus do not expect that change in social information, pre-crisis is particularly insightful, neither do I expect to take stock of reputational change intra-crisis, due to the fast paced nature of change and the fact that the ECDC is only one of many actors involved in the response to the pandemic. However, the public health literature (Nicoll and McKee 2010; Nachtnebel et al. 2012; Whelan et al. 2012; Crosier, McVey, and French 2015) is prone to discuss lessons learned from the crisis. My second research expectation is that change in social information, with the formation of new social inferences is expected to occur post H1N1 crisis.

To sum-up, I expect that crisis conditions have an effect on both the mechanism and the formation of social information. I expect that change in uncertainty about the problem is the cause for empowerment and that post-crisis, social information about the Centre will be updated in the light of the ECDC's role. These expectations are probed in four narratives. The first narrative discusses the European Commission's preparedness plans post SARS. The second and third, both from the point of view of the ECDC present evidence of the Centre making sense of its own role from its early days to the turning point of the crisis. The two narratives bring evidence on this process regarding surveillance and vis-à-vis the question of risk management, respectively.

The fourth narrative highlights the European Commission's course correction amid crisis and details the causal mechanism of empowerment at play for the ECDC. Sources I used to reconstruct narratives are compiled in table 5.1. below.

Narrative descriptors: • Protagonist • Plot • Temporality	**Mapping sources**			
	Narrator/ Protagonists (interviews)	*Narrator/Protagonists (textual sources)*	*Interview sources used for triangulation*	*Textual sources used for triangulation*
• **DG SANCO** • **Preparedness inter-crisis** • **2005-2009**	*Current and former Commission staff:* interviews 2, 4, 18, 22	*European Commission publications* European Commission. 2005. *Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions on Pandemic Influenza Preparedness and Response Planning in the European Community*. European Commission DG SANCO. 2008. *EXERCISE AEOLUS FINAL REPORT*. European Commission. 2006. *Health Emergency Operations Facility*.	*Former ECDC staff:* interview 11	ECDC. 2007. Pandemic Influenza Preparedness in the EU - Status Report as of Autumn 2006 ECDC. 2012. European Pandemic Preparedness Timeline, 2000-2012. ECDC Minutes - 3rd and 9th Advisory Forum Meeting. WHO. 2005. International Health Regulations WHO, and European Commission. 2005. 'Pandemic Influenza Preparedness Planning : Report on a Joint WHO/European Commission Workshop, Luxembourg, 2-3 March 2005'. Minutes - 3rd and 9th ECDC Advisory Forum Meeting Elachola, Habidah, Jaffar A. Al-Tawfiq, Abdulhafiz Turkestani, and Ziad A. Memish. 2016. 'Public Health Emergency Operations Center - A Critical Component of Mass Gatherings Management Infrastructure'. *Journal of Infection in Developing Countries* 10(8): 785–90. Florenz, Karl-Heinz. 2005. *"Strategy against an Influenza Pandemic."* Oral question with debate O-0089/2005. European Parliament. Scoones, Ian, and Paul Forster. 2008. 'The International Response to Highly Pathogenic Avian Influenza: Science, Policy and Politics'.

• **ECDC - Unit for Preparedness and Response** • **Making sense of own role for the ECDC: monitoring** • **2005-2009**	*Former ECDC staff:* interview 9, 11	*ECDC publications* ECDC. 2005. *ECDC's Annual Work* ECDC. 2005. *ECDC's Annual Work Programme 2005-2006*. ECDC. Annual Work Programme. ———. 2006a. *Avian Influenza A/H5N1: Collected Risk Assessments, Technical Guidance to Public Health Authorities and Advice to the General Public*. ———. 2006b. *Risk Assessment: The Public Health Risk from Highly Pathogenic Avian Influenza Viruses Emerging in Europe with Specific Reference to Type A/H5N1 Version June 1st 2006*. ———. 2009. *ECDC Risk Assessment: 2009 Influenza A(H1N1) Pandemic (Update 30 April 2009)*. Minutes - 1st, 3rd, 6th, 8th, 12th and 18th ECDC Advisory Forum Meeting Minutes - 6th, 11th and 12th ECDC Management Board Meeting."	*Participants to ECDC governing bodies:* interview 14, 16, 23 *Current WHO staff:* interview 8-9 *Current Commission staff:* interview 2, 5, 18, 22	Amato-Gauci, A. et al. 2011. 'Surveillance Trends of the 2009 Influenza A(H1N1) Pandemic in Europe'. *Eurosurveillance* 16(26): 19903 Cox, A., P. Guglielmetti, and D. Coulombier. 2009. 'Assessing the Impact of the 2009 H1N1 Influenza Pandemic on Reporting of Other Threats through the Early Warning and Response System'. *Eurosurveillance* 14(45): 19397. Danzon, M. 2004. 'ECDC and WHO: A Common Mission for Better Health in Europe'. *Eurosurveillance* 9(12): 1–2. European Commission. 2009. 110 OJ L (COM) *2009/363/EC: Commission Decision of 30 April 2009 Amending Decision 2002/253/EC Laying down Case Definitions for Reporting Communicable Diseases to the Community Network under Decision No 2119/98/EC of the European Parliament and of the Council* European Commission, DG SANCO. 2010. *Assessment Report on the EU-Wide Response to Pandemic (H1N1) 2009 Covering the Period 24 April 2009 – 31 August 2009*. European Commission.
• **ECDC - Unit for Preparedness and Response** • **Making sense of own role for the ECDC: risk management** • **2005-2009**	*Former ECDC staff:* interview 9, 11	*ECDC publications* ECDC. 2005. *ECDC's Annual Work Programme 2005-2006*. ECDC. Minutes - 2nd, 4th, 6th, 8th, and 11th and 12th ECDC Advisory Forum Meeting Minutes - 3rd, 10th and 1st Extraordinary ECDC Management Board Meeting. ECORYS Nederland. 2008. *First External Evaluation of ECDC*.	*Participants to ECDC governing bodies:* interview 14, 15, 23 *Current Commission staff:* interview 2, 5, 18, 22	European Commission. 2009. *Health Security in the European Union and Internationally.* European Commission. Commission Staff Working Document. European Commission, DG SANCO. 2005. *Communicable Diseases Handover of Files*. Luxembourg: European Commission.

• **ECDC - Unit for Preparedness and Response** • **Increase in certainty and new reputational inferences** • **April 2009 - end of 2009**	*Former ECDC staff:* interview 9, 11	*ECDC publications* ECDC. 2010a. *Annual Report of the Director: 2009*. ———. 2010b. *The 2009 A(H1N1) Pandemic in Europe. A Review of the Experience*. ECDC. Special Report. ———. 2010c. *Timeline on the Pandemic (H1N1) 2009*. EMA, and ECDC. 2009. 'European Strategy for Influenza A/H1N1 Vaccine Benefit-Risk Monitoring'. Minutes - 14th, 18th, 23rd ECDC Advisory Forum Meeting Minutes - 11th and 12th ECDC Management Board Meeting Economisti Associati, et al. 2014. "External Evaluation of ECDC 2014." Greco, Donato, Eric Stern, and Géraldine Marks. 2011. *ECDC CORPORATE REPORT Review of ECDC's Response to the Influenza Pandemic 2009–2010*. ECDC.	*Participants to ECDC governing bodies:* interview 6, 14, 15, 22 *Current and former Commission Staff:* interview 2, 3, 4, 5, 18	Council of the EU. 2009. *DRAFT MINUTES of Extraordinary Council Meeting (Health)*. ———. 2010. *Conclusions on Lessons Learned from the A/H1N1 Pandemic – Health Security in the European Union*. 3032nd GENERAL AFFAIRS Council meeting. *European Commission* European Commission. 2009. *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions - Pandemic (H1N1) 2009*. ———. 2010. *Lessons Learned from the H1N1 Pandemic and on Health Security in the European Union*. European Commission. Commission Staff Working Document. European Commission, DG SANCO. 2010. *Assessment Report on the EU-Wide Response to Pandemic (H1N1) 2009 Covering the Period 24 April 2009 – 31 August 2009*. European Commission. *Scientific Publications* Nicoll, Angus, and Martin McKee. 2010. *"Moderate Pandemic, Not Many Dead—Learning the Right Lessons in Europe from the 2009 Pandemic."* European Journal of Public Health 20 (5): 486–88. Baekkeskov, Erik. 2016. 'Same Threat, Different Responses: Experts Steering Politicians and Stakeholders in 2009 H1n1 Vaccination Policy-Making'. *Public Administration* 94(2): 299–315.

Table 6.1. Mapping sources according to narratives of H1N1 preparedness and management in the EU

2. Preparedness for Crisis Management: The European Commission inter-crisis Narrative

The narrative below accounts for preparedness for health crises between 2005 and 2009. The narrators/protagonists are DG SANCO officials. This temporality is characterized by a context of anxiety following the SARS crisis and periodical health scares linked to the H5N1 “avian flu”, which characterizes the organizational experience of the narrators/protagonists. Therefore, DG SANCO cooperated with WHO and eventually ECDC to prepare for the next crisis, which characterizes causation in this narrative. Evidence was generated from four interviews (interviews 2, 5, 18, 22) with DG SANCO Staff and official documents from the Commission. Data was triangulated using one interview with a former staff member of the ECDC (interview 11), documents from the ECDC, from the European Parliament and from WHO as well as academic publications.

In the 2005-2009 temporality, informants (interviews 2, 5, 18, 22) describe a period of anxiety during which public health actors are animated by the question of preparedness for the *next* crisis. Before the ECDC has even been implemented, a new threat emerges: the H5N1 influenza or so-called “Avian Flu”. The disease was not a novelty. The first outbreak of H5N1 was reported in Hong Kong in 1997, but up to 2005, Europe had been particularly shielded from the disease. On 24 July 2005, outbreaks of Avian Influenza were reported by Russia via WHO Europe. Confirmation that the outbreaks were caused by the H5N1 highly pathogenic virus was made available by WHO on 5 August 2005. In early August, outbreaks of the disease were also reported by Mongolia and Kazakhstan. On 7 October 2005, the Romanian government reported suspicions of Avian Influenza in poultry. On Sunday 9 October,

the Commission's services were notified of an outbreak of avian influenza in a Turkish turkey farm. While the 2005 outbreak only affected birds in the EU, the risk of transmission to humans was possible: in Indonesia, several human cases have been associated with avian influenza. Throughout the period under scrutiny the threat of Avian Influenza remained important. On 11 June 2008, another outbreak of highly pathogenic avian influenza (H5N1) was reported in Hong Kong – the site of the first reported human deaths from this virus in 1997. Media reports portrayed the possibility of a major catastrophe (Scoones and Forster 2008). However, during the period under scrutiny, no human casualties are reported on the European continent. Asia was the continent the most affected. Two informants underlined how these events influenced plans or preparedness: the attention of DG SANCO officials was geared towards potential threats coming from Asia (interview 2, 22).

In 2005, DG SANCO had not yet passed the baton to the ECDC especially on event-based public health threats. The ECDC was still in a phase of implementation, staff recruitment was still ongoing (interviews 2, 5, 11, 18, 22) and the Commission cannot yet fully rely on the input of the Centre. DG SANCO was then newly equipped with a "Health Threat" Unit in its Luxembourg office which took the lead regarding preparedness (European Commission 2006). In 2005 DG SANCO organized a common Pandemic Preparedness Planning Workshop, with the WHO held in Luxembourg March 2005 (WHO and Commission 2005). The Workshop produced a Communication on pandemic influenza preparedness and response planning in the European Community along with a generic preparedness communication (European Commission 2005), which included enhanced preparedness and response, the establishment of standard operating procedures for outbreak response and the completion of pandemic influenza preparedness assessments. The language used in

this communication makes specific references to H5N1 and focuses preparedness efforts on threats that would mirror H5N1 *i.e.* spread from Asia.

This pro-active behaviour mirrored the keenness of the WHO and other organizations involved in preparedness. By 2005, the 196 WHO Member States had signed the International Health Regulation (IHR), a legally binding agreement for WHO members to act in accordance with an international legal framework in managing serious public health risks and emergencies (WHO 2005). The IHR had a direct incidence on preparedness at EU level. Key points of the IHR include the definition of a Public Health Emergency of International Concern (PHEIC) as "an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response", as well as a requirement for countries to report such PHEIC, which will be discussed in the next narrative. But the IHR also championed the formation of Public Health Emergency Operation Centres, which would build capacity to respond promptly and effectively to public health emergencies (Elachola et al. 2016).

The European Commission had a good record of working with the WHO (interview 2, 8, 9, 18, 22) and DG SANCO was already actively working at the creation of a centre of the sort. From 2003, DG SANCO develops Health Emergency Operations Facility (HEOF), fitted with a crisis room installed in Luxembourg for the management of alerts and emergencies notified by Member States (European Commission 2006). The HEOF was under the responsibility of the newly created "Health Threat" Unit in DG SANCO in Luxembourg (European Commission 2006). Due to the geographical location of the Health Threats unit, it was deemed necessary to develop an "information Centre" in Brussels to coordinate Directorate Generals within the

Commission to work on a potential crisis (interview 18, 22). DG SANCO also championed the creation of a crisis operation room in the ECDC and convinced the European Parliament to allocate one million euros to build an operation centre for the ECDC in the 2006 Budget (interview 11). As underlined by informants, the looming threat of H5N1 influenza was a catalyst to build emergency response capacity (interview 2, 5, 11, 18, 22). As soon as 2006, the Commission started to increasingly rely on the ECDC. Table 6.2. below summarizes the main events and publications that structure preparedness in the inter-crisis period.

2005	**March**	European Commission and WHO European Region. First European Pandemic Preparedness Planning Workshop, Luxembourg
	May	World Health Assembly adopts the new International Health Regulations which start to apply in June 2007
	Autumn	Detection of A**(**H5N1) infected birds outside. Some decision-makers fear that an H5N1 pandemic is imminent.
	November	European Commission publishes a Communication on pandemic influenza preparedness and response planning in the European Community along with a generic preparedness communication
2006	**January to May**	Human outbreak of A**(**H5N1) in Turkey and Azerbaijan and appearance of infected wild birds in about half of the WHO European Region countries with some infected poultry but no human cases.
	September to November	At request of Health Commissioner ECDC undertakes a survey of pandemic preparedness and holds three workshops with EU Member States to discuss the findings and prepare a progress report
2007	**January**	ECDC publishes its first review of pandemic preparedness in the EU
	June	2005 International Health Regulations come into force
2008	**October**	Aeolus Simulation Exercise

Table 6.2. Events and Publications related to preparedness (ECDC 2012b)

As a former official from DG Santé explains “the influence the commission exercises in the ECDC comes through the ability to guide EU policies at a broader level, which might actually be - putting myself in the shoes of the Commission - naturally more efficient for the ECDC” (interview 22). At the request of the European Commissioner for Health Markos Kyprianou the ECDC undertook a survey of pandemic preparedness, visiting 12 countries (ECDC Advisory Forum 2007a) and held three workshops with EU Member States to discuss the findings and prepare a progress report (ECDC 2012b). The ECDC conducted 12 country visits (ECDC Advisory Forum 2007a) which resulted in the publication of its first review of pandemic preparedness in the EU (ECDC 2007b) as of Autumn 2006, highlighting important disparities across Member States. The ECDC was also invited, along with national agencies to take part in simulation exercises organized by the European Commission as soon as November 2005 (ECDC Advisory Forum 2005b, 7). The series of culminated with the Aeolus simulation exercise, which took place in October 2008 and received some media attention (European Commission 2008). In a video archive of the event passed on by an informant (interview 22), the HEOF, the health threat unit staff and the Commissioner for Health are all shown in a simulation of a sudden and contagious outbreak.

In the post-SARS period, plans for preparedness are thus structured around two events: the 2005 H5N1 “avian flu” scare and the 2005 WHO International Health Regulation. This is characterized by the recent health scares and the realisation that Member States need assistance to prepare for the *next* health crisis. The next narratives outline more precisely, the role attributed to the ECDC in preparedness, up to the beginning of the crisis.

3. The ECDC Making Sense of its Own Role in Health Crises

The two narratives outlined in this section both reflect the organizational interest of the ECDC from 2005 to April 2009 and highlight the ambiguity of its role. The first narrative details the ECDC making sense of its own remit in surveillance, especially vis-à-vis WHO. The second narrative details the ECDC muddling through the fine line between risk assessment and risk management. In both narratives, causation unfolds at the beginning of the crisis. The organizational interest of the ECDC is to make sense of its own role. When the crisis kicks-off, this process pays-off: the ECDC's behaviour in the early days of the crisis is a product of this process of sense-making

3.1. Making Sense of a Narrow Remit in Event-Based Monitoring

This narrative accounts for the ECDC making sense of its own role in surveillance from 2005 up to the heart of the crisis in June 2009. The narrators/protagonists are staff members from the Surveillance and Communication Unit in the ECDC. Evidence show that since its creation, the ECDC has been making sense of its own role in a crowded monitoring system, which characterizes some of its organizational interest before and amid the H1N1 crisis. Early in the temporality, the ECDC cooperated with the WHO on a common reporting system, but when the crisis kicked-in, surveillance overlaps were yet to be completely resolved, which characterizes causation in this narrative. Evidence was generated from two interviews with former ECDC staff members (interview 9, 11) and documents of the ECDC. Data was triangulated using three interviews with members of the ECDC governing bodies (interview 14, 16, 23), two interviews with DG SANCO officials (interview 2, 5, 18, 22) and two interviews with

WHO officials (interview 8, 9), as well as academic publications and documents from the European Commission.

As discussed in the previous chapter, an important leitmotif of the implementation of the ECDC was to demonstrate the added value of the Centre. In the case of indicator-based surveillance systems, this entailed a form of harmonization of surveillance systems for disease-specific networks which was presented in chapter 5. However, in the case of event-based monitoring, organizational questions are radically different: the tool for coordinated surveillance predates the creation of the ECDC: indeed, the Network for the Epidemiological Surveillance and Control of Communicable Diseases in the Community (European Union 1998) was created in 1998. The Network was made up of two components: the first one, ESCON (Epidemiological Surveillance Component of the Network) which linked the Member States national agencies responsible for the collection of epidemiological surveillance information. The second component, the Early Warning and Response System (EWRS), connected the authorities of Member States responsible for taking measures for the control of communicable diseases (ECDC 2005a). Since its creation, the purposed of the EWRS has been the rapid exchange of information on emerging outbreaks (ECDC 2005a, 10)

The role of the ECDC vis-à-vis the EWRS is mentioned in the Founding Regulation of the Centre: “The Centre shall support and assist the Commission by operating the early warning and response system and by ensuring with the Member States the capacity to respond in a coordinated manner” (European Union 2004, article 8(1)). “The Centre shall analyse the content of messages received by it via the early warning and response system. The Centre shall provide information, expertise, advice and risk assessment” (European Union 2004, article 8(2)). However, in the early days of

implementation of the Centre, members of the Advisory Forum press clarifications: “The exact relationship between ECDC and the Commission in the EWRS operations needs to be defined. The Commission nominates the persons, based on MS [Member States] nominations, who are entitled for distribution and reception of the EWRS messages. Several MSs stated that the management of EWRS, including the principles and practise of nominating MS delegates, should be critically reviewed in the context of developing communications in the new set-up with functioning ECDC” (ECDC Advisory Forum 2004, 4). Within the ECDC, the question of consolidating a hold on the functioning of the EWRS is crucial to the director of the ECDC, Zsuzsanna Jakab (interview 2, 4, 11, 14, 16, 18, 22), as highlighted in the first programme of work of the Centre: “Another prime objective for the Centre is to participate and assist in the operational aspects of the Early Warning and Response component of the Community network. In 2006, the Centre should become the focal point for all relevant information on communicable diseases across Europe” (ECDC 2005 p.3).

However, a challenge of handing-over the management of the EWRS to the ECDC was the question of compatibility of surveillance with WHO IHR standards (interview 2, 4, 8, 9, 11, 14, 16, 18, 22, 23). As mentioned in the previous narrative, one of the requirements of the IHR is countries’ obligation to rapidly report PHEIC. According to informants from the WHO (interview 8, 9), the ECDC was perceived as a complementary structure that would reinforce cooperation between members of the EU and that would specifically support the development of surveillance and response in new Member States. An informant from the European Commission however underlines that “WHO Euro colleagues in Copenhagen were nervous since we seemed to pursue similar objectives in our respective programmes” (interview 18). The fact that the ECDC had been supported and then staffed with frequent WHO

collaborators was also an asset in avoiding turf-sensitive issues between the two institutions (interview 11, 14, 16, 18, 22, 23). This interpretation is supported by a publication by Marc Danzon, then WHO Regional Director for Europe: “The recent nomination of Mrs Zsuzsanna Jakab as Director of the ECDC will no doubt enhance this collaboration. Mrs Jakab has worked at WHO as director of several of its divisions” (Danzon 2004).

ECDC staff members were constructive vis-à-vis WHO requirement (interview 2, 5, 8, 9, 11, 14, 16, 18, 22, 23). It is best described in 2005 by Johan Giesecke the Chief Scientist of the ECDC as he presents’ the Centre’s proposals for an implementation of the IHR in Europe: “A key goal of these proposals is to make the systems for Member States new reporting obligations under the IHR (*sic.)* compatible with the existing systems for reporting outbreaks to the EU. For example, making EWRS a platform for reporting to WHO as well as the EU” (ECDC Advisory Forum 2005b, 10). Indeed, there is a host of evidence that the ECDC governing bodies championed a symbiotic functioning of reporting tools at EU and WHO level. “There was universal support for the principle of using the EWRS also as the reporting tool for IHR since cases requiring notification under IHR must also be notified under EWRS” (ECDC Advisory Forum 2006b, 4). “The question was therefore not one of taking over WHO’s functions in Europe, but rather to explore how ECDC could best support the process” (ECDC Management Board 2006, 11). Discussion eventually led to the consensus that: “EWRS should be used for notification under IHR […]and that Member States should report surveillance data to ECDC for further transmission to WHO” (ECDC Management Board 2006, 12)**.**

Nevertheless, on the eve of the H1N1 pandemic, the EWRS and the WHO reporting tool are still completely distinct and national agencies still have to report twice. “One

problem, highlighted in the 2009 survey of the ECDC, was the duplication of notifications and alerts to WHO and to the EU. National authorities became upset with the growing demand, especially when criteria and formats were different. We tried step by step to harmonize the format and timing of notifications" (interview 18). The hand-over of the EWRS proved lengthier than anticipated. While this process was supposed to be completed by April 2007 (ECDC Advisory Forum 2006d, 13), it was eventually completed by 17 November 2007 (ECDC Advisory Forum 2007d). Evidence shows that the handover process between DG SANCO and the ECDC is similarly to TESSy, difficult on a technical level: "Concerning EWRS, the European Commission noted some technical and security issues. It acknowledged that the handover from the European Commission to ECDC took more time than foreseen."(ECDC Management Board 2007b, 4). These technical difficulties consisted mostly of errors in reporting, which affected ambitions to make the EWRS consistent with the WHO reporting tool, as pointed out during a meeting of the Management Board: "there were several legal and political issues which could not be answered at the present time, and which would require discussion in other fora, including the Health Council […] From a technical point of view, it was pointed out that the IHR covered a broader scope of notifications than the EWRS, including biological and nuclear threats. Using the EWRS as the reporting tool might therefore not always work" (ECDC Management Board 2006, 11–12).

On 4 April 2009, an outbreak of influenza-like illness was identified in Veracruz, Mexico, with the first severe cases reported in Mexico City, on 15 April 2009. Despite containment efforts by the Mexican authorities, the virus started to spread beyond national borders and a week later the first cases were reported in the United States. On 21 April 2009, the US Center for Disease Control concluded that the virus was

spreading from human to human and showed a unique combination of influenza genes similar to swine borne H1N1 influenza (European Commission, DG SANCO 2010; ECDC 2009c). That evening, and as per its mandate in monitoring threats to human health, the ECDC became proactive on the issue as. On 24 April the ECDC published a Rapid Risk Assessment, a procedure that the ECDC had so far only used only twice for outbreaks of avian influenza in 2006 (ECDC 2006a, 2006b). The characteristics of the H1N1 outbreak and its subsequent development into a global pandemic was largely unexpected. At the time, the probability of an influenza-type pandemic coming from Asia was considered to be much more important than from the Americas and an America-borne pandemic took everyone by surprise (interview 2, 5, 8, 9, 11, 22).

As discussed in chapter 5, the EU legislation on communicable disease (European Union 2002) includes a list of disease definition which had been recently updated through the work of the ECDC in harmonizing surveillance. The H1N1 strain of influenza was at the time absent from the legislation. Following the operating procedures set-up in the pandemic preparedness plan and rehearsed during simulation exercise, the Health Threat unit in Luxembourg convened a teleconference with the HSC who rapidly agreed that a common definition was needed in order to harmonize surveillance activities (interview 5). Case definition is part of risk assessment but needs to be updated in legislation. The Commission required the ECDC to put in place a draft case definition to be proposed for a fast-tracked agreement by the Member States in the HSC (interview 2, 5, 8, 9, 11, 22). The ECDC called experts internally and externally to work out a valid, robust case definition (ECDC 2009c). The Commission Decision is adopted on 30 April 2009 (European Commission 2009a) with voting consent of the HSC during a meeting over the phone. The input of the ECDC was decisive in case definition (interview 2, 5, 11, 22) and the

Decision mirrored exactly the technical document that had been produced by the ECDC (ECDC 2009c). The process of coming up with the definition was quite swift but was also a novelty that could only be achieved through intense cooperation between DG SANCO, the HSC and the ECDC (interview 2, 5, 9, 11, 22). This was a success for the ECDC as the question of swiftly developing case definition needed improvement following preparedness exercises (ECDC Management Board 2008b, 13). It was also important as the basis for surveillance throughout the crisis.

The EWRS had never been exposed to such a surge in reporting (Cox, Guglielmetti, and Coulombier 2009). In order to enhance the reactivity of the reporting system, the ECDC created an ad-hoc basis in the EWRS regarding H1N1. On 5 May 2009, European countries started to contribute with epidemic intelligence reports on cases detected on their territories (Amato-Gauci et al. 2011). The question of communicating epidemic intelligence raised concerns in Member States. The main point of contention was the duplication of efforts between reporting to the WHO (within the framework of the IHR) and the ECDC (EWRS). In a crisis wherein epidemic intelligence is crucial, this is not trivial. Informants (interview 5, 14, 16, 18) were prompt to underline the burden that is represented to Member States, as illustrated by the minutes of the May 2009 meeting of the Advisory Forum: “One remarked that it would be easier having to report only to WHO instead of reporting to both WHO and EWRS. The EWRS is a subset of the WHO questionnaire, so filling out both questionnaires almost amounts to a duplication of the workload. [..] Paolo Guglielmetti, European Commission, said that efforts were underway in regard to the reporting to WHO and EWRS. He was optimistic that — after some minor changes in the schematics — WHO would agree to accept the reporting system used by EWRS” (ECDC Advisory Forum 2009a, 6). After some discussions on how to preserve the link between WHO and its members,

it was agreed that WHO should have access to the EWRS and would then be directly notified of cases through the same channel as used within the EU.

This narrative shows that the Centre was still very much in a phase of implementation of surveillance at the time the pandemic kicked-off. Turf-sensitive issues must be underlined here between WHO and ECDC, even though evidence shows that this created procedural difficulties rather than conflict between the two organizations. Ultimately, the ECDC maintained its own surveillance procedures and thus exercise the conceptual power that one can expect, as per the Centre's mandate. Nevertheless, across the same temporality, the possibility of the Centre exercising conceptual power over risk management amid crisis raises concerns among audiences.

3.2. Walking the Fine Line Between Risk Assessment and Risk Management,

This narrative accounts for the ECDC making sense of its own role in the event of a health threat from 2005 up to the heart of the crisis in June 2009. The collective narrators are staff members from the Surveillance and Communication Unit in the ECDC. Evidence show that since its creation, the ECDC has been making sense of the fine line between assessment and management, but that ambiguity remains on the eve of the crisis, which characterizes its organizational interest. As the crisis starts, the ECDC takes on a proactive role on advice, eliciting criticism from Member States, which characterizes causation in this narrative. Evidence was generated from two interviews with former ECDC staff members (interview 9, 11) and documents of the ECDC. Data was triangulated using three interviews with members of the ECDC

governing bodies (interview 14, 15, 23), and two interviews with DG SANCO staff (interview 2, 5, 18, 22), as well as documents from the European Commission.

The question of separating risk assessment and risk management was a seminal question of the implementation of the ECDC, as already touched upon in Chapter 4. Task allocation between the ECDC and DG SANCO was established early, with the communication of “handover files” to the ECDC staff (European Commission, DG SANCO 2005) as well as in the first Programme of Work of the ECDC (European Commission 2005b), both authored by the European Commission. Once an outbreak or an event matching the reporting criteria is notified through the EWRS, the Commission then asks ECDC to prepare a rapid risk assessment on the situation (Santos-O’Connor et al. 2014). The ECDC has the role of providing the required scientific advice in this process and the scientific legitimacy to do so (European Commission, DG SANCO 2005). However, the Commission remains responsible for the supervision and for the adoption of technical and procedural requirements and thus for its risk management tasks. The ECDC assists the Commission in that task especially by providing a rapid risk assessment. In the case of an unknown outbreak, the Centre is therefore able to assess all available scientific information (ECDC 2005, 10).

During the period under scrutiny, the clear separation of roles between the ECDC, the European Commission and the HSC is somewhat contentious (interview 5, 11, 14, 15, 18, 22). The issue is frequently mentioned during the discussion with the Advisory Forum. In effect, the Head of the Preparedness and Response Unit, Denis Coulombier and the different representatives of the Commission (most of the time Stefan Schreck, DG SANCO) engage throughout the period of scrutiny in a form of pedagogy vis-à-vis the Advisory Forum. Yet, the fine line between risk assessment and risk management

was in practice more difficult to pinpoint than the black and white distinction outlined in the Founding Regulation (interview 5, 14, 15, 23); as illustrated by those comments from a DG SANCO official:: “in a crisis, the distinction tended to become blurred” (ECDC Management Board 2005b, 5).

Nevertheless, the ambiguity of this issue did not seem to be perceived as a potential hindrance to the implementation of organizational arrangements, as discussed in July 2005 in the Advisory Forum: “Mr Schreck stressed that in the area of public health it could be misleading to talk about risk assessment and risk management as separate entities. ECDC should do surveillance, but also identify areas where the MS need to be more harmonised. Suggestions from ECDC could then be imposed on the MS by EC decisions, after the Commission has proposed them as binding measures to the Network Committee” (ECDC Advisory Forum 2005a, 7). Stefan Schreck, the representative of the Commission delimits the competences of the ECDC. However, his intervention in the Advisory Forum leaves open to interpretation that through a proactive behaviour, the ECDC would be able to push for harmonization of public health response beyond surveillance. A year later, the Head of the Unit of Preparedness and Response, Denis Coulombier, once again discusses the tasks of risk assessment and risk management: “The tasks were separate but complimentary and under the regulations were respectively for the ECDC (with State Epidemiologists) and the EC (with Ministries of Health). The AF was in universal agreement that the spirit of the Regulations should be respected” (ECDC Advisory Forum 2006b, 6).

However, evidence shows that this fine line between risk assessment and risk management was harder to navigate than anticipated, and that boundaries to the role of the ECDC should be more clear-cut. In later meetings of the Advisory Forum, the representative of the Commission becomes more assertive. “Stefan Schreck clarified

several aspects of the roles of Member States, Commission and ECDC based on the legal framework. He explained that Member States are responsible for the risk management. The Commission is only a facilitator for this process, but he accepted that perhaps this should be explained more clearly" (ECDC Advisory Forum 2006d, 14). These reminders continue as members of the Advisory Forum suggest a more hands-on role for the ECDC on the matter of advice in case of pandemics "The European Commission reiterated that there is a clear separation between the roles of ECDC and the Health Security Committee (HSC). ECDC advises, especially in the area of risk assessment, whereas the HSC was convened to share views on policy. The Director added that ECDC does attend HSC meetings as an observer, and that there is still some discussion to be had on the split between science and policy" (ECDC Advisory Forum 2007c, 5). This underlines the ambiguity on the role that the ECDC ought to take in the case of a public health crisis.

Indeed, some ambiguity persists over the distinction until the eve of the H1N1 pandemic (interview 2, 5, 9, 11, 14, 15, 18, 22, 23) including in the Management Board: "He [The Head of the Preparedness and Response Unit, Denis Coulombier] agreed that there is a rather artificial separation between risk assessment and risk management in the event of an outbreak" (ECDC Management Board 2007a, 12). According to three informants who participated in meetings of the ECDC governing bodies (interview 14, 15, 23), this period of muddling through the role of the ECDC is actually due to the nature of risk regulation as practised at national level, where the confinement of assessment and management is not as rigid as in the European framework. In the informants' opinion, this did not stem from a strategy of power creeping. Rather, this is a complex learning process, trying to make sense of the

ambiguity on the appropriate ECDC contribution to this new multilevel system of disease control.

This ambiguity was resting on the notion of advice: if the ECDC collects epidemiological data through the EWRS, it also has the potential to formulate coordinated solutions to offer the HSC. Yet, the form that this advice would take is of paramount importance in order to not encroach on risk management (interview 2, 5, 9, 11, 14, 15, 18, 22, 23). A former staff member of the ECDC recalls how this sensitive issue came down to naming types of documents (interview 11). The word "*guidelines"* was considered too strong and debated in the Advisory Forum: "Professor Johan Giesecke presented the issue of producing guidelines to promote a uniform response. He proposed some prioritisation criteria for topics and also some candidate topics that had been suggested by the Advisory Forum. He also outlined the procedure for monitoring diffusion and use. The terminology: Guidance, Guidelines needed to be looked at" (ECDC Advisory Forum 2005c, 3). Eventually the term *guidance* was adopted because it was considered less binding than *guidelines* (interview 9, 23): "It was stressed that use of the word 'recommendations' should be avoided; likewise 'guidance' was a preferred term to 'guidelines', as ECDC's documents shall always clarify that they are dealing with scientific advice and risk assessment and that mandatory rules or guidelines are in the competence of the Member States" (ECDC Management Board 2008b, 8). As a former official from DG SANCO explains: "The reluctance of the Management Board of the ECDC is very understandable. It is the board of people who own the communicable disease control in their countries" (interview 22). But another former official from DG SANCO underlines the advantages of this approach: "guidance is a text, that is non-binding by nature, but that reflects best practice as generally agreed between practitioners. If anybody in the network or

outside comes up with a much better idea, it creates an opportunity to review and then validate the better approach" (interview 18).

Nevertheless, on the eve of the crisis, the purpose of the ECDC is still ambiguous. The first external evaluation of the Centre conducted in 2008 highlights this fact: "From the external evaluation it became clear that the distinction between risk assessment and risk management is not always clear to everyone. Although to all those closely associated with ECDC, i.e. the Management Board, the Advisory Forum and the Centre, it was clear that ECDC's role is risk assessment. Upon request of the Member States, the Commission and other Community agencies, the ECDC may have an advisory role in risk management, but this latter remained a prerogative of the Member States, supported by the coordination of the Commission" (ECDC Management Board 2008a, 5). After the first evaluation, in 2009, the ECDC director, Zsuzsanna Jakab, asked two insiders Pat Troop and Fernand Sauer (interview 1) to reflect on the first evaluation. Reflecting on this Fernand Sauer (interview 18) explains regarding these elements: "the most important one being the clarity of purpose. When as an organizer you manage a number of highly specialized experts, they tend to lose sight of the overall public health purpose: strategic public health issues as opposed to pet projects destined for scientific publication" (interview 18).

Effectively, the scope of the mandate was discussed in two conclusions of the report conclusion 3: "The distinction between risk assessment and risk management is not always clear" (ECORYS Nederland 2008, 101). The Management Board was rather unambiguous on this issue: "The question of risk assessment versus risk management was however an important issue which merited careful attention. To all those closely associated with ECDC, i.e. both the Management Board, the Advisory Forum and the Centre, it was clear that ECDC's role was risk assessment. Upon request of the

Member States, the Commission and other Community agencies, the ECDC may have an advisory role in risk management, but this latter remained a prerogative of the Member States, supported by the coordination of the Commission" (ECDC Management Board 2008a, 10).

When the H1N1 crisis started in March 2009, some ambiguity remained on the appropriate input expected from the ECDC. But demand for scientific input was important: in 2009 the Centre received 22 requests for scientific advice from the Commission, 12 requests from Member states, 2 from international agencies, 1 from a non-EU country as well as 6 from the general public (Economisti Associati et al. 2014)**.** Compared to the 8 requests received in 2008, the number is exceptionally high. During the year 2009, the ECDC produces 15 risk assessments all exclusively related to H1N1, which the Centre discusses with the HSC. Another key publication developed for the pandemic was the "Daily Update", which included factual information on the number of case and was published daily from 25 April 2009 till 19 January 2010 (ECDC Advisory Forum 2009a).

The information produced by the ECDC was discussed on a daily basis during joint audio-meetings with national agencies contributing to EWRS representatives and the HSC. Four informants underlines that early on, Member states also showed some reluctance to receive *guidance* from the European Commission and the ECDC. An official working on the dossier at DG SANCO at the time reports that Member States would become irritated to be told what to do (interview 5, 11, 18, 22). He reports in the early days of the crisis, interactions between the ECDC and the HSC proved sometimes difficult: the ECDC tends to discuss in its meetings with the HSC containment measures, which resembled advice on the management of risk and was met with circumspection by Member states.

In the early days of the crisis, the blurred limes between risk assessment and risk management has important consequences for the ECDC. The role taken-on by the Centre is not aligned with social inferences among national governments. This relates to the procedural dimension of reputation: key audiences have a rather negative opinion of the approach taken by the ECDC. Yet, and due to the fast-paced nature of the crisis, this has no severe consequence on the reputation of the ECDC. Indeed, new information drives out old, and as the threat of H1N1 rapidly appeared more benign than expected, the European Commission operated a shift in preparedness. The outcome for the ECDC was surprising: it entailed the Centre taking on an advising role. The next narrative outlines this process and analyses how this empowerment is the result of reputational inferences.

4. *"You can't do Public Health without having to talk about vaccines!"* the Commission intra-crisis narrative

The narrative below accounts for the role taken-on by the ECDC as uncertainty about the crisis decreased in June 2009, up to December 2009. The narrators/protagonists are ofrficials from DG SANCO. Evidence shows that once uncertainty decreases and the H1N1 epidemic is reframed as less serious than expected, DG SANCO looks for shifting preparedness plans, which characterizes its organizational interest. DG SANCO, acting as a purposeful agent, inferred a new role for the ECDC: advising on vaccines, which characterizes causation in this narrative. Evidence is generated from two interviews (interviews 9, 11) with ECDC Staff and official documents from the Centre. Data was triangulated using six interviews with current and former DG SANCO officials (interview 2, 3, 4, 5, 18, 22), three interviews with members of the Advisory

Forum (interview 6, 14, 15), academic publications on the H1N1 pandemic, and documents from the European Institutions.

The temporality of this narrative picks-up as uncertainty about the problem. Indeed, from the early days of the crisis, appeared that the pandemic was not as severe as previously feared (interview 2, 3, 4, 5, 6, 11, 14, 15, 18, 22, see also: Nicoll and McKee 2010). As one former official of the ECDC recalls: “Early on there was a signal that this is not [the Spanish flu of] 1918, but it was difficult to communicate that. We were cautious about being over optimistic because these viruses can make a comeback” (interview 9, 11). This new framing of the pandemic changed the belief among national governments that severe measures such as confinement or border control might be needed to contain the virus. This is corroborated in the ECDC report on the pandemic: “A major issue that emerged early on was that after the initial uncertainty of the first two months, it quickly became apparent that this was not the major pandemic that countries had prepared for; it was neither H5N1 nor a 1918–2019 pandemic-like virus. This posed some difficulty because the pandemic preparedness plans that were already activated by this time had been prepared to respond to a more severe—or worse case (sic.) scenario—and it took a lot of effort from the EU/EEA countries’ advisors to modify their relatively inflexible plans, while dealing with the day-to-day issues brought up by the pandemic”(ECDC 2010c, 31). As an official who was working in DG SANCO at the time recalls, the HEOF in Luxembourg worked at RED level form 29 April 2009, but it stopped working at that level shortly after on 26 May 2009. The activities of the “information centre” in Brussels were discontinued at an early stage of the crisis (interview 22). In the case of a highly pathogenic pandemic, measures of risk management may lead to a temporary halt on free movement, which creates a domino effect on many aspects of the Single Market. The HEOF in Luxembourg was meant to

facilitate coordination between Member States on measures of risk management. Eventually it appeared quite early in the crisis that such measures were not needed (interview 22) and that the pandemic was not the crisis that the EU had prepared for (interview 2, 3, 4, 5, 6, 11, 14, 15, 18 22).

According to a former staff member of the ECDC, Member States were not interested in coordinating health measures efforts, which was particularly clear once the crisis appeared less serious than expected (interview 9, 11). Nevertheless, there was an aspect of risk management that brought consensus among Member States: the question of vaccines. The development and deployment of a new vaccines had been discussed as soon as the first H1N1 related Council of the European Union on 30 April (Council of the EU 2009). From May 2009, the Commission's plans for preparedness took a sharp turn. As pointed out during a meeting of the Advisory Forum: "By October/November 2009, a vaccine would be available, but it might take a total of two years before the 2.5 billion doses became available that are needed for adequate protection" (ECDC Advisory Forum 2009a, 7). Member States wanted guidance on "priority groups", i.e. which categories of the population that should be vaccinated in priority, since the availability of vaccine doses was limited (interview 11, 22). The Commission needed scientific input for its guidance to Member States. It thus formed an *ad hoc EU* Pandemic Vaccine Task Force on 4 May 2009 (ECDC 2010d; Greco, Stern, and Marks 2011).

The European Commission thus engaged in reputational inferences intra-crisis because of a decrease in uncertainty about the nature of the pandemic. The European Commission assigned a new role to the ECDC, with the consent of audiences, as part of a larger shift in preparedness plans. The *ad hoc EU* Pandemic Vaccine Task Force involved the European Medicine Agency (EMA) and the ECDC (ECDC 2010d; Greco,

Stern, and Marks 2011). While the inclusion of EMA was self-evident, the role of the ECDC was more controversial. Before the crisis evidence shows that there was the ambition within the ECDC to work on vaccines, but this enthusiasm had been met with reservation both by the Commission and by national agencies representatives in the governing bodies: “the European Commission reaffirmed that the policy agenda of the vaccination policy should stay in the hands of the MS. If a policy agenda was to be discussed, it could be split between the MS and the European Commission. The European Commission also called for a meeting to discuss the pertinence of setting up the committee on vaccines” (ECDC Management Board 2007b, 4); “One AF member said they were surprised by the advice published by ECDC on this issue, as their country did not need to be reminded of vaccination” (ECDC Advisory Forum 2008b, 10). Prior to the H1N1 crisis, Member States were thus averse to the ECDC getting involved in vaccines.

How to explain audiences’ consent? There was no change in social information about the Centre: reputational inferences were contingent of the new framing of the pandemic as a less serious transnational public health problem. What used to be inappropriate before and in the early days of the crisis period had then become self-evident, since vaccines were deemed the only way forward (interview 11). Moreover, the fact the ECDC would advise Member States on a precise topic was indeed more acceptable than letting the ECDC decide of its own agenda in matters of advice. In sum, a new framing of the problem created the conditions for audiences’ consent, in spite of social information remaining the same.

The taskforce developed a communication and impact assessment package for Member States’ consideration in September 2009: “The main objective of this Communication is the protection of public health […]To this end, and in response to

requests by the Council of Health Ministers, the Commission is also making available in parallel to the present text, five separate Commission staff working documents on vaccine development, vaccination strategies, joint procurement, communication to the public and support for third countries." (European Commission 2009b). The ECDC's input on vaccination strategy and priority groups was decisive (interview 2, 3, 4, 5, 11, 18, 22).

The work of the ECDC on vaccines did not stop there. Its collaboration with EMA was continued over advice on vaccines, protocols for safety and effectiveness of studies and published materials. The two agencies published with British Health Protection Agency (HPA) the "European Strategy on Influenza A/H1N1 Vaccines Safety Monitoring" in October 2009 (EMA and ECDC 2009). Informants also underline the difficulties in collaborating on guidance, with the EMA being critical of the ECDC's approach to advice on vaccinations for people at risk (interview 6, 9, 11, 14, 15, 18, 22) a key issue was that the ECDC would be vocal about how to use the vaccine before EMA had been able to complete its authorisation procedure for the vaccine. This cleavage in terms of approach is corroborated by discussions in the Advisory Forum: "EMA's more restricted view with its focus on individual medicines with ECDC's broader epidemiological and public-health view was beneficial" (ECDC Advisory Forum 2010b, 4). But as a former ECDC staff member expressed: "This is public health. You can't do public health without talking about vaccines from time to time" (interview 11).

Hence, the ECDC exercised a limited conceptual power by producing the advice that steered Member States strategies on vaccines, even though informants (interview 14, 15) have underlined the limited impact of this advice considering the lack of coordination between Member States in managing the pandemic. Indeed, the ECDC

shaped the EU's position but evidence is scarce when it comes to appraising impact in Member States. Coordination between Member states remained weak throughout the crisis (Baekkeskov 2016). Indeed, sharing epidemic intelligence created precious resources, but the coordination of management is difficult and lengthy. Therefore, knowledge was the same in every member state, but decisions were different (interview 2, 3, 4, 5). At the same time, the ECDC was still active on the front of surveillance harmonization: the Centre was able to disseminate the key practices to national institutions in October 2009 with the specific aim to improve coordination between Member States in an emergency situation (ECDC 2010c, 2010a). The ECDC's work on vaccines was an extra task.

Moreover, as the H1N1 pandemic was not seen as a salient threat anymore, efforts were geared towards improving preparedness for the next health crisis rather than the management of the current one. A host of official publications discuss "lessons learnt" during the crisis and ways to enhance preparedness (Council of the EU 2010; European Commission 2010). As part of efforts to understand lessons learned about the crisis, DG SANCO conducted a survey with the British Health Protection Agency (HPA) in September 2009 (European Commission, DG SANCO 2010). The aim was to gather Member States' evaluation of the crisis response at EU level over the period between 24 April and 21 August 2009. The ECDC was praised for its the scientific input. The Centre's risk assessments were noted as "excellent and reliable" and the ECDC was pointed to as "the entity that provided the most information and in a timely manner" (European Commission, DG SANCO 2010, 40). The ECDC staff was also praised for its scientific capacity and dedication during the crisis (ECDC 2010a, ix). Overall, all countries participating in the survey – in total 22 – were satisfied with ECDC's scientific support and information on the pandemic (European Commission,

DG SANCO 2010). This survey however does not discuss the appropriateness of the ECDC's input. The view that the ECDC's risk assessments were encroaching on risk management in the early days of the crisis are absent from the survey. However, the report was prolix on inferences based on the technical and performative dimensions of the ECDC's reputation. Likewise, within the Advisory Forum, the role of the ECDC is praised: "One member characterised the role of ECDC during the pandemic as crucial" (ECDC Advisory Forum 2010b, 4). It shows that post-crisis, social inferences have been updated: ECDC was before the crisis a more discreet agency and its contribution to the crisis brought visibility to its work. Nevertheless, while evidence shows that social inference about the ECDC have changed, this does not lead to substantial change when 2013 Decision on Health Threats.

5. Discussion: Uncertainty and Reputational Inferences

In April 2009, as the crisis is about to begin, ambiguity of the ECDC's role and uncertainty regarding the problem where both high. As per my first research expectation, the role of uncertainty was of primary importance: with added ambiguity on the role of the ECDC, it explains the difficulties for the ECDC to makes sense of its own role, up to the gaining of the crisis. Once uncertainty decreased, it incited the European Commission to operate a shift in terms of preparedness. Indeed, pre-crisis, the European Commission, with the WHO had prepared as much as possible for the next crisis. However, preparedness in public health is a complex task: it is a matter of preparing for a salient problem with an unpredictable form. It is thus not surprising that the European Commission relied on reputational inferences amid crisis as managing

health crises is usually a matter of adjusting response as the crisis goes on. This reasserts the importance of problem framing in initiating the mechanism. The relationship between empowerment and reputation is summarized in table 6.3. below.

Cause		***Purposeful agent***	***Audiences granting consent***	***Social information***		***Outcome***
Transnational Public Health Problem	*Problem-brokering and framing*			*When does change in social information occur?*	*The* Making *of reputation*	*Empowerment over the Management of Disease Control*
Focusing event - new framing once uncertainty decreases	2009: Global crisis – WHO and ECDC instrumental in framing salience	European Commission - DG SANCO	National governments	After empowerment	National governments' expectations inherited from creation process	Advisory role in the question of vaccines and target population

Table 6.3. Relationship between Empowerment and Reputation

The matter of fact however is, the more salient a transnational public health is and the more actors are involved in disease control in the EU. The ECDC is thus only one of many pieces of the response system. This bears some importance on the causal mechanism: sense-making of the problem, reputational inferences and audiences' consent are contiguous processes. Ultimately because of the salience of the crisis, Member States keep a close eye on what the ECDC ought to do. Reputational inferences are thus, in a similar way than in the case of the creation of the ECDC, a matter of deciphering what audiences would likely consent to. The fundamental and yet simple lesson regarding reputation is that reputational stakes depend on the audience which observe the work of the ECDC.

As per my second research expectation, change in the social information about the Centre is not observed intra-crisis but as a result of lessons learned about the crisis. These new social inferences are based on the technical and performative dimension

with this social information being shared once the crisis is over and lessons are learned. This underlines how the causal mechanism may bring change to the reputation of the Centre, but it does not answer the question of the role of reputation on the ECDC. Reputational inferences intra crisis are not due to change in social information, but due to decreased uncertainty and a purposeful agent having to remodel plans for preparedness intra crisis, with limited choice opportunity.

Overall, evidence showed that the ECDC was able to foster surveillance harmonization, albeit with difficulties. In the same vein, the conceptual power of the ECDC over management was limited. The case of the 2009 H1N1 pandemic, like the case of HIV/AIDS, paints the picture of the implementation of the Centre, albeit in an area which was yet to explore in this research: event-based monitoring. When compared to the case of HIV/AIDS, it shows that in this area, the ECDC is more constrained. Between 2004 and 2009, there is a tension between, on the one side, a strategy of demonstrating its added value in indicator-based surveillance and on the other side a much more restrained approach to the event-based risks. The opportunity to exercise a form of conceptual power on the management side of public health is less complicated when targeting specific Member States on a non-salient issue. Unlike with indicator-based surveillance in which the ECDC could advise Member States individually, the role of the ECDC is more constrained by the role played by HSC: in the event of a health threat, the ECDC addresses ministers as a group, rather than individual public health agencies as in the previous case. As evidence shows, the ability for the ECDC to advise on vaccine use had been disputed in the past. An avenue for future research would be to analyse how the H1N1 reputational gains have enabled the ECDC to further be involved in advice on vaccination in the 2010s.

Chapter 7. Seizing the Rewards of Inter-Agency Cooperation in the Fight against Antimicrobial Resistance

Antimicrobial resistance (AMR) is a singular public health problem. AMR occurs when bacteria, viruses, fungi, and parasites resist the effects of medications, making common infections harder to treat and increasing the risk of disease spread. This is due to the general over-consumption of antimicrobial drugs, which causes a variety of infections to resist treatments. Unlike HIV/AIDS or the H1N1 virus, AMR is not a communicable disease. Rather than an external threat such as a pandemic with a geographical progression, the causes of AMR rest on the practices and the choices made by medical professionals. In terms of risk management, solutions to reduce AMR do not solely rely on reducing the number of affected patients but on the cautious use of drugs. AMR is at the frontier of public health and environmental concerns: interventions are systemic rather than targeted on a specific group or event. This logic is reflected in the AMR policy developed by the European Commission. The EU is considered a precursor in the fight against AMR, even preceding the WHO in publicizing the problem. In recent years, AMR has become a flagship of the EU's health policy under the "One Health" approach. The concept of "One Health" emerged in the early 2000s, as a strategy to expand interdisciplinarity between all aspects of healthcare for humans and animals (Cassidy 2016).

Following this holistic approach, the European Commission has developed an integrated strategy that involves the ECDC as well as the European Food Safety Authority (EFSA) and the European Medicines Agency (EMA). From 2009 onwards, the Commission mandated theses three "health agencies" to cooperate closely in building up an integrated *One Health* surveillance system of AMR. The risk

assessment of AMR is done through indicator-based surveillance, like in the case of HIV/AIDS. The ECDC has the mandate to harmonize surveillance and take over the two scientific networks dedicated to AMR the European Antimicrobial Resistance Surveillance Network (EARSS, and then EARS-Net) and the European Surveillance of Antimicrobial Consumption Network (ESAC-Net). But unlike HIV/AIDS, and the EuroHIV network, the challenge for the ECDC is not only to absorb the network, it is also to cooperate with its sister agencies. Hence, the conceptual power of the ECDC (shaping cognition, defining terms of the debate) is here shared and constrained because of cooperation: surveillance harmonization is not exclusively the preserve of the ECDC, the Centre shares these prerogatives with EFSA and EMA.

However, while the development of surveillance is the product of inter-agency cooperation, evidence shows that the ECDC has exercised a conceptual power over preparedness and prevention in Member States on its own. In 2016, the Centre was tasked by the European Commission to monitor the development and implementation of national plans to fight AMR. Hence the ECDC took on an advisory role in the management of AMR. However, empowerment only occurred once inter-agency cooperation was well into place and had produced seminal scientific outputs. Specifically, once the ECDC had developed standards and best practices for Member States, which inter-agency cooperation made possible.

The claim defended in this chapter is that the empowerment of the ECDC in the fight against AMR was possible because of inter-agency cooperation. The three agencies built-up surveillance together, but each of them with their *specialty*, as such, the ECDC emerged as the agency dealing with human health data while EFSA and EMA focused on animal health. Interagency thus built-up the reputation of the ECDC in AMR in

human health. Once surveillance was more routinized, from 2015 onward, the European Commission was able to take stock of the problem: Member States were relatively ill-equipped to tackle AMR. The European Commission acting as a purposeful agent inferred a new role for the ECDC: to review national plans to fight AMR in Member States. Audiences' consent was secure because the Centre's reputation had built-up over time, through inter-agency cooperation.

This chapter offers novel insights on the making of reputation. Inter-agency cooperation did not only enhance the credibility of the ECDC, it created incentives for the Centre to bring a unique contribution vis-à-vis EMA and EFSA. The case of AMR is thus particularly insightful on *uniqueness* as a fundamental incentive in reputation-making: the ECDC makes sense of its role, collectively with is sister agencies. Reputational gains are then put to use by the European Commission who acts as the purposeful agent, trying to solve the problem of patchy preparedness in Member States. Three narratives shed light on this process. The first narrative highlights the ECDC's organizational experience in its implementation phase: before inter-agency cooperation the Centre already develops its own turf in AMR. The second narrative discusses the development of inter-agency cooperation. The third narrative shifts the focus back on the ECDC, as the Centre is tasked by the European Commission to monitor national AMR plans. In terms of audiences, this case focuses on the other agencies, EFSA and EMA, in order to generate enough leverage to understand reputation-making. Member States represented in the Management Board of the Centre are relevant to the question of audiences' consent. Figure 7.1. below sums up audiences of interest in AMR.

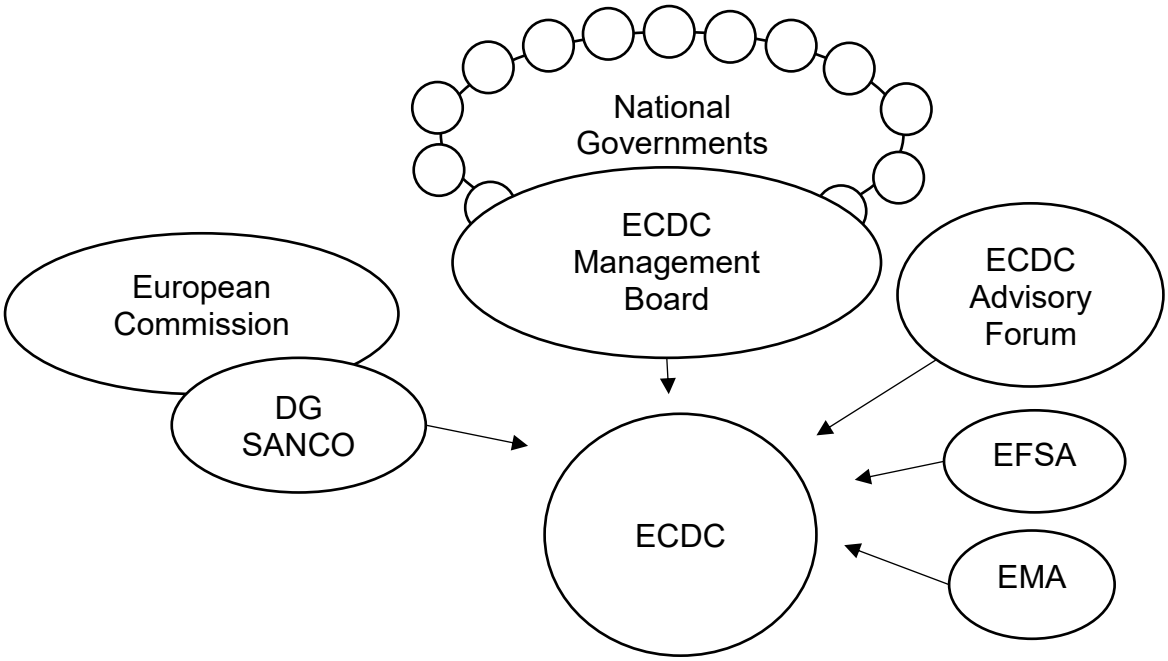

Figure 7.1. Relevant audiences on AMR

Four sections structure this chapter. First, theoretical expectations are discussed. I outline how uniqueness is a useful concept to understand ECDC rationales in making sense of its role. Second, the first two narratives, with their focus on inter-agency cooperation are analysed. The third section shifts the focus back on the ECDC and how updated social inferences allow the Centre to increase its role in the preparedness of Member States. The last section draws lessons on the interplay between reputational incentives and the mechanism of empowerment.

1. "Uniqueness" and Reputational Incentives

A key aspect of the case of AMR is that inter-agency cooperation leads to specific forms of incentives for the ECDC. In previous chapters, audiences' expectations were

a central element of how the ECDC inferred its own role, whereas before the process empowerment (as in Chapter 5., when the ECDC was harmonizing surveillance networks), during (as in Chapter 6., when the ECDC was making sense of its own role amid crisis), or after (as in Chapter 4., when the ECDC was muddling through own role following the creation of Centre). In the case of inter-agency cooperation, I expect that new forms of incentives will be centre stage, namely threats to the Centre's uniqueness. *Uniqueness* emphasises the distinctive characteristics of an agency that differentiates it from similar organizations. The exclusive character of an agency depends on its functions and actions being widely acknowledged on the basis of its distinct performance (Carpenter 2010; Carpenter and Krause 2011) as well as the capability of the Centre to deliver outputs that cannot be provided by another organization (Carpenter 2001; Maor and Sulitzeanu-Kenan 2016). It thus logically follows that an agency cannot thrive or survive in an environment in which conditions prevent the sustainability of a reputation of uniqueness. As Wilson notes "an organisation is like a fish in a coral reef: To survive, it needs to find a supportive ecological niche" (Wilson 1991, 188). In the unusual settings that is the cooperation of the ECDC with EFSA and EMA, uniqueness is a relevant issue. One that at face value indicates that agencies are incentivized to mark their difference and thrive for clarity vis-à-vis their own specific turfs (Busuioc 2016).

Turf is understood as an agency's distinctive "jurisdiction/mission" (Wilson 1991, 189) or "regulatory dominion" (Maor 2010, 136). This delimited "turf" and the need for an agency to protect it leads to specific bureaucratic behaviour already pinpointed by Wilson (1989, 189–90), as the efforts "to seek out tasks that are not performed by others", "to fight organisations that try to perform your tasks", and relatedly, therefore, "to be wary of joint or cooperative ventures". The concept of turf thus underlines that

cooperation can be deemed risky, lead to rivalry and ultimately put at risk the Centre's uniqueness. The concept of turf applied to a reputational approach is not new in the study of European agencies (Busuioc 2016), with a notable application to modes of cooperation that involved European agencies and its national counterparts. In this multi-level setting, evidence shows that threats to reputational uniqueness trigger turf protecting tendencies which in turn undermined proper cooperation. Turf protecting behaviours are thus ultimately deemed to create situations referred to as "cooperation" in name only. However, in the case of the ECDC's cooperation with EFSA and EMA conditions are different. Agencies do not compete for the ability to regulate in a multi-level system, rather they engage in a joint, consensual venture with different areas of scientific competence and a common goal.

My research expectation is that in in the case of AMR, turf protecting behaviours do not lead to a stalemate. Rather, turf protective behaviours are expected to set off a process in which the ECDC, in concert with EFSA and EMA reflect, make sense, and eventually clarify and define their respective roles. This offers some explanatory leverage as for the micro foundations of the ECDC's behaviour. Following the Commission's mandate to cooperate, the ECDC makes sense of its turf and gauges reputational incentives and threats. Then, to borrow Wilson's analogy of the ecological niche, rather than engaging in turf "wars" with EFSA and EMA, the three agencies eventually develop an ecological equilibrium in which turf is now clearly delimited and understood: roles are assigned, and each unique expertise is reinforced. The Centre's turf-sensitive behaviour is thus the primary dynamic of reputation-making in the case of AMR.

Turning to the causal mechanism of empowerment, reputational gains explain audiences' expectations and ultimately, their consent. Social information about the

ECDC changes through inter-agency cooperation, especially regarding the technical dimension of reputation. When the problem of national plans is formally recognised by the European Commission, social information informs the European Commission regarding what the ECDC ought to appropriately do to tackle the problem. Ultimately, this chapter presents insights on the making of the ECDC's reputation on the topic of AMR, and the way it informed the European Commission as a purposeful agent. Section 2., 3. and 4. below present three narratives on ECDC and AMR which happen successively. The first narrative precedes inter-agency cooperation and focuses on the experience of the ECDC in the years that led to the Commission's mandate to cooperate, the second one details inter-agency cooperation and scientific synergy between agencies. The third one illustrates the process of empowerment. Sources I used to reconstruct narratives are compiled in table 5.1. below.

For EFSA and EMA, like in the case of the ECDC, most of the textual data was generated from minutes of the governing bodies of the agencies. This included only a Management Board respectively for EMA and EFSA.

Narrative descriptors: • **Protagonist** • **Causation** • **Temporality**	***Mapping sources***			
	Narrator/ Protagonists (interviews)	*Narrator/Protagonists (textual sources)*	*Interview sources used for triangulation*	*Textual sources used for triangulation*
• **ECDC - Management** • **Demonstrating Commitment on AMR** • **2005-2009**	*Former ECDC staff:* interview 9, 11	Eurosurveillance editorial team. 'Note from the Editors: 10th European Antibiotic Awareness Day (EAAD) – Raising Awareness about Prudent Use of Antimicrobials to Help Curb Antimicrobial Resistance'. *Eurosurveillance* 22, no. 46 (16 November 2017): 171116–2. Monnet, D. L., and K. G. Kristinsson. 'Turning the Tide of Antimicrobial Resistance: Europe Shows the Way'. *Eurosurveillance* 13, no. 46 (13 November 2008): 19039. Minutes - 3rd, 4th, 5th, 14th, 18th ECDC Advisory Forum Meeting	*Public health experts involved in AMR:* interview 2, 8, 12, 13, 14, 15, 17, 20, 21, 23	No textual sources for triangulation
• **ECDC, EFSA, EMA** • **Making sense of respective turfs in surveillance** • **2009-2015**	*Former ECDC staff:* interview 9, 11 *EMA staff:* interview 10, 17 *EFSA staff:* 1interview 13, 20	ECDC, EMA .2009. *The Bacterial Challenge: Time to React*. Joint Technical Report. EMA, EFSA, ECDC. 2009. 'Scientific Opinion on the Substantiation of Health Claims Related to Boron' ECDC/EFSA/EMA. 2015. *First Joint Report on the Integrated Analysis of the Consumption of Antimicrobial Agents and Occurrence of Antimicrobial Resistance in Bacteria from Humans and Food-Producing Animals (JIACRA I)*. ———. 2017. *Second Joint Report on the Integrated Analysis of the Consumption of Antimicrobial Agents and Occurrence of Antimicrobial Resistance in Bacteria from Humans and Food-Producing Animals (JIACRA II)*.	*Public health experts involved in AMR:* interview 3, 8, 9	CDC. 2014. *First TATFAR Progress Report*. CDC. European Commission. 2011. *Action Plan against the Rising Threats from Antimicrobial Resistance*. Communication from the Commission to the European Parliament and the Council. ———. 2013a. 303 OJ L *2013/652/EU: Commission Implementing Decision of 12 November 2013 on the Monitoring and Reporting of Antimicrobial Resistance in Zoonotic and Commensal Bacteria* ———. 2013b. 303 OJ L *2013/653/EU: Commission Implementing Decision of 12 November 2013 as Regards a*

		Minutes - 16th, 19th ECDC Advisory Forum Meeting Minutes - 3rd, 12th, 20th, ECDC Management Board Meeting Minutes - 76th, EMA Management Board Meeting Minutes - 56th, 60th EFSA Management Board Meeting		*Union Financial Aid towards a Coordinated Control Plan for Antimicrobial Resistance Monitoring in Zoonotic Agents in 2014* ———. 2018. *Progress Report New AMR Action Plan*. European Commission.
• **ECDC - ARHAI Programme, Office of the Chief Scientist** • **Responding to expectations as the reference for human health** • **2016-2019**	*Former ECDC staff:* interview 9, 11	ECDC. 2017. *Proposal for EU Guidelines on the Prudent Use of Antimicrobials in Humans*. ———. 2018. *Country Visits Reports*. Minutes - 46th, 48th ECDC Advisory Forum Meeting Watier, Laurence, Philippe Cavalié, Bruno Coignard, and Christian Brun-Buisson. 2017. 'Comparing Antibiotic Consumption between Two European Countries: Are Packages an Adequate Surrogate for Prescriptions?' *Eurosurveillance* 22(46): 17–00352	*Public health experts involved in AMR:* interview 5, 4, 12, 15, 17, 20, 21	Council of the EU. 2016. *Council Conclusions on the next Steps under a One Health Approach to Combat Antimicrobial Resistance*. Castro-Sánchez, Enrique et al. 2018. 'Articulating Citizen Participation in National Antimicrobral Resistance Plans: A Comparison of European Countries'. *European Journal of Public Health* 28(5): 928–34.

Table 7.1. Mapping sources according to narratives of the fight against AMR

2. Developing a Unique Turf: The ECDC Narrative

The narrative below accounts for the ECDC efforts and pro-active approach towards AMR from 2005 to 2009. The narrators/protagonists are ECDC management officials. Evidence show that in this temporality, the ECDC is incentivized to develop a turf in AMR, which characterizes its organizational interest. In doing so, the Centre demonstrates its commitment to AMR and builds its reputation, which characterizes causation in this narrative. Evidence was generated from two interviews with former ECDC staff members (interview 9, 11), minutes of the ECDC's advisory Forum and two publications from editorial team of Eurosurveillance, the ECDC's journal. Data triangulation is rather strong with ten interviews (interview 2, 8, 12, 13, 14, 15, 17, 20, 21, 23).

In 2001, the European Commission launched an EU strategy to combat AMR which covered a range of actions such as data collection, surveillance, research and awareness-raising. Around that time, the Commission was set on the fact that AMR relates to the animal sector (interview 8, 9, 21). EFSA was instrumental in the implementation of the legislation on prudent use of antimicrobial agents (interview 2, 13, 17, 20) with specific attention to zoonoses (disease transmitted from animals to humans) and specifically the ban in use of antibiotics used for growth promotion in animal feed, effective from January 2006 (European Union 2003).

When the ECDC was created in 2004, the EU is mostly active on the animal health side of AMR. Yet, early on, the ECDC demonstrated ambitions to be involved in the fight against AMR (interview 12, 14, 15). As soon as 2005, ECDC Director, Szuzanna Jakab

proposed an ambitious plan on AMR: coordinating relevant surveillance activities, the creation of a dedicated website, information to the public, country visits and developing a self-assessment tool for countries to apply to their AMR. However, the project was postponed and eventually, only the scientific panel came to fruition (ECDC Advisory Forum 2005c). In 2005, members of the Advisory Forum of the ECDC were still set on AMR as a problem out of the scope of the Centre's mandate : "While all AF members agreed that AMR is an important public health issue some thought the project might be too ambitious in view of ECDC's limited means"(ECDC Management Board 2005b, 10). As seen in previous cases, during this phase of implementation, public health experts are still muddling through the role of the Centre, and a year later, the tide had changed. In February 2006 the members of Advisory Forum were discussing an assessment tool for country visits on the topic of AMR and were adamant that the ECDC should advise Member States on their national programmes: "The importance of this work for Member States was noted by all who commented and there was even a suggestion to eventually extend monitoring also to the veterinary (breeding and treatment) sector. There was also agreement that in many Member States good programmes exist, but compliance was not always of same order, although some of the actions taken in some countries show the progress that can be made. […] Nevertheless the importance and urgency of the issue was such that ECDC was urged to initiate country visits and assessments as soon as possible" (ECDC Advisory Forum 2006a, 47). Some of these proposals go far beyond the scope of the ECDC's remit, especially surveillance in the veterinary sector. Nevertheless, this prompts the ECDC Director to advance the idea of inter-agency cooperation: "EFSA has agreed to have joint interpretation of data. The ECDC scientific panel needs to be

coordinated with the EFSA scientific panel. Further discussions will take place with EFSA" (ECDC Management Board 2005b, 10)

This U-turn vis-à-vis AMR was interpreted by an informant as the result of "politics" within the Centre (interview 23).Some actors within the ECDC were willing to take on a more proactive role on preparedness, while some were more hesitant, likely as a matter of carefulness vis-à-vis the ECDC's original mandate (interview 9, 11, 23). Indeed, informants (interview 11, 15, 23) underline the importance of the internal lobbying of the European Antimicrobial Resistance Surveillance Network (EARSS) within the Centre. The same informants attribute members of EARSS with the responsibility for the Centre to take on the organization of the European Antibiotic Awareness Day (EAAD).

Since 2007, the ECDC has organized the European Antibiotic Awareness Day (EAAD), a yearly event to promote awareness vis-à-vis AMR which first took place on 18 November 2008. At the time, this new task was welcomed with enthusiasm among public health experts (ECDC Advisory Forum 2008b) also demonstrated by the editorial "Turning the tide of antimicrobial resistance" (Monnet and Kristinsson 2008). The yearly EAAD is an important marker of the role taken by the ECDC not only in the bear some effec of this narrative but up to present day (Eurosurveillance editorial team 2017). This outreach role is described as one of the fundamental roles of the ECDC (interview 2) even though the field of AMR is actually where this role was really pioneered (interview 15). Evidence shows that the Advisory Forum of the ECDC talked in great length about the adequacy of the message,: "the Centre decided not only to disseminate key messages and slogans to the general public, but also to address concerns and raise awareness regarding primary care prescribers per se. A series of key messages have been developed based on facts

and references from published studies. […] some European doctors in Brussels discussed the tone of ECDC's messages and opined they are too prescriptive and that it would be better if primary care prescribers get the message across to patients" (ECDC Advisory Forum 2009a, 16-17). Nevertheless, the scope of the ECDC's outreach remains limited, especially compared to similar campaigns at national level (interview 15).

Beyond the role of EARSS in promoting the outreach role of the Centre, informants underline that Zsuzsanna Jakab, the first Director of the ECDC was keen on developing a media profile (interview 11, 12) and to build a media profile for the Centre. A second rationale put forward from an informant from the Commission (interview 2) underlines that the role of the ECDC is coherent with it mandate. The ECDC is the only agency with a mandate on public health communication, albeit usually limited to communicating risk assessment. When prompted on the importance of EMA in regulating antimicrobial consumption compared to ECDC, the same source evoked the interpretation that as quasi-regulator, EMA would actually be ill-fitted for campaigning against the use of products it allows on the market in the first place.

This narrative shows that prior to the Commission mandating the three agencies to cooperate, the ECDC already takes on a distinct unique role on AMR by engaging with the public and the practitioners who take care of their health. It informs on the early process in which the ECDC makes sense of its own role in the fight against AMR. The next narrative picks-up the story of inter-agency cooperation, as ECDC, EFSA and EMA engage in frequent collaboration. This narrative sets-up the scene for the process of collective reputation-making which characterizes inter-agency cooperation in AMR.

3. Reputation-Making through Scientific Synergy: The Trio of Agency's Narrative

This narrative accounts for the cooperation between EFSA, EMA and ECDC, from 2009 to 2015. It runs from the first request of the European Commission for agencies to cooperate and describes the technical work in which the three agencies engage collectively. The narrators/protagonists are officials, working on AMR in the three agencies. Evidence shows that the trio of agencies is committed to the development of an integrated surveillance system for AMR, which characterizes their common organizational interest. The three agencies engage in turf-sensitive behaviour, in order to make sense of their respective roles and develop a common message through reliable data., which characterizes causation in this narrative. Evidence was generated from two interviews with ECDC staff members (interview 9, 11), two interviews with EMA staff (interview 10, 17), two interviews with EFSA staff (interview 13, 20), minutes from the agencies' governing bodies as well as joint reports by the three agencies. Data was triangulated with two interviews (interview 3, 6) and documents from the European Commission.

The role of the Commission in fostering inter-agency cooperation is of paramount importance. Some of the informants recount how, in the 2000s, the problem of AMR and who should act on it was unclear and difficult to tackle (interview 13, 20). This uncertainty stimulated a blame game between professionals of the animal sector and human health sector. An informant (interview 3) underlines that in this temporality some of the questions asked by the Commission to agencies were often addressed differently to one agency

from another, which led to disagreements not only regarding their “turf” but also regarding the positionality of their expert input. The end of the blame game faded at the turn of 2007-8 which marks the European Commission embracing the One Health approach (interview 10, 13, 17, 20).

Inter-agency cooperation is formally launched with a request from the European Commission (interview 10, 13, 17, 20). for a “common short report on antimicrobial resistance (AMR) focused on zoonotic infections based on the information currently available” (ECDC Advisory Forum 2009b, 14). This report (EMA, EFSA, ECDC 2009) becomes the first joint scientific opinion and provides the scientific input that is used to develop the Commission’s first action plan against AMR (European Commission 2011). An additional avenue of cooperation is established between ECDC and EMA with the publication, in September 2009, of a joint report “The Bacterial Challenge: Time to React” (ECDC, EMA 2009). It is then followed by a joint scientific opinion focused on zoonotic infections. In the early days of the temporality under scrutiny, ECDC and EFSA collaborate more closely together than with EMA, the yearly “EU summary report on antimicrobial resistance” done by ECDC and EFSA is of crucial important in the surveillance (EFSA Management Board 2013, 2014) but only focuses on resistance indicators. The formalisation of Inter-agency cooperation is gradually formalised via bilateral memoranda of understanding (except in the case of the ECDC- EMA one that is a working arrangement). The temporality of these formal agreements mirrors the development of cooperation accounted for in this narrative: EFSA – ECDC in 2008, EMA – ECDC in 2010, EFSA – EMA in 2012. All texts mention AMR but do not define any specific distribution of roles or tasks, which is noted by the representative of the European Commission in the Management Board of the ECDC (ECDC Management Board 2008b)

who calls for more details on prioritisation and operationalisation of the strategy between agencies. As a purposeful agent, the Commission is eager to set the three agencies on the path of cooperation, which is the signal of credible commitments to tackle issue. At the same time, the Commission appears mindful of the "organic" aspect of the process of sharing tasks and defining roles.

Inter-agency cooperation was also a way for agencies to define their respective roles in the larger picture of health governance (interview 10, 13, 17, 20). This process of muddling through task allocation kicked off as soon as the ECDC discussed cooperating with EFSA on zoonoses: "[ECDC] should (a) encourage collaboration starting with one area, (b) consider asking DG SANCO [the Commission] to invigorate the collaboration with the veterinary sector (ideally to establish a standing collaboration committee), and (c) work on the clarification of mandates of ECDC and EFSA regarding any potential overlap in the zoonoses paper" (ECDC Advisory Forum 2008c, 6). Further evidence shows that the process of setting up inter-agency cooperation was imbued with turf sensitive behaviours (interview 13, 17, 20). Textual sources offer candid comments from the ECDC on the relationship between ECDC and EMA which proves to be more complicated. While complementarity between the agencies is underlined: "the combination of EMA's more restricted view with its focus on individual medicines with ECDC's broader epidemiological and public-health view was beneficial" (ECDC Management Board 2010, 17). Questions arose on potential overlaps between the ECDC and EMA: "And how do ECDC and EMA differ in their approaches as advisers to the Member States; how can we distinguish their different roles and responsibilities?" (ECDC Management Board 2010, 9). Indeed, their respective turfs are not as clearly delimited one could assume. EFSA's turf is limited to livestock and other animals while the ECDC's

and EMA's respective mandates revolve around public health. Still, while EFSA has a clearly defined quasi-regulatory role to take-on animal health, EMA's and ECDC's respective turfs are less obvious despite a stark difference in the breadth of power they respectively exercise over rule-making.

In fine task allocation was correlated to the type of surveillance data that each agency was able to access. Indeed, a key mandate for the three agencies was to establish a link between consumption of antimicrobial agents and resistance. All the data at the disposal of the agencies actually come from the Member States. A first step in scientific cooperation is thus to progressively coordinate the way data is retrieved in Member States. The efforts to harmonise data varied vastly from one agency to another (interview 10, 13, 17, 20). EFSA had already done considerable work in this sense through the Scientific Network for Zoonosis Monitoring Data, due to the importance of those indicators for the food market and the 2003 regulation on zoonosis. The ECDC took over EARSS (now EARS-Net) in 2010 (ECDC Management Board 2005b, 10) as well as the European Surveillance of Antimicrobial Consumption Network (ESAC-Net). Finally, the Commission mandated EMA to create the European Surveillance for Veterinary Antimicrobial Consumption network (ESVAC), with the project starting in April 2010. In terms of data each agency produces a different output: ECDC harbours data on human consumption of antimicrobials and antimicrobial resistance in bacteria, EMA monitors animal consumption of antimicrobials, and EFSA monitors antimicrobial resistance in bacteria found in food-producing animals. The ECDC thus is the sole agency in charge of human data, defining a clear turf for the Centre, while EFSA and EMA share the animal health turf according to their regulatory dominions. The Centre's specific resources in terms of data means that while the output is inherently collective, each agency brings to the table

a unique and irreplaceable contribution. However, this unique contribution is not *only* the result of agencies making sense of their turf in reaction to reputational incentives. Rather, turf is inherited by the agencies through the surveillance networks they take charge of.

The tasks of data collection and harmonisation were a complex and Dantean process. The surveillance systems were not ready from the get-go to produce sustained data (interview 8, 9, 13, 17, 20). Member states' data were sometimes inexistent or inferred from completely different methodologies (interview 20). In this respect, a core achievement was the 2013 Decision on harmonised monitoring of AMR (European Commission 2013a). The Decision led to the implementation of a harmonised monitoring system which fostered comparability between Member States. The first output of this operation was the publication of the 2015 joint inter-agency antimicrobial consumption and resistance analysis (JIACRA) report (ECDC/EFSA/EMA 2015) by the trio of agencies which underlined that the use of certain antimicrobials in animals and humans is associated with the occurrence of resistance to these antimicrobials. The first JIACRA report was very much anticipated by the scientific community (interview 20). According to informants, it contributed to promote the topic as a top priority of the Juncker Commission in the area of public health (interview 20).

The cooperation between agencies on this report was described as complex and time consuming (interview 10, 13, 17, 20). Each agency mandated a committee working on the document. All committees work together but each committee must also report to their own agency (interview 20). Following the first JIACRA report cooperation has become increasingly smoother according to the experts interviewed (interview 13, 10). Ten years later and with a third JIACRA report published in 2020 (European Commission 2018),

cooperation is now more natural, with agencies working together without requests from the Commission. JIACRA reports are now recognised as a crucial contribution of the agencies to public health, with important value (interview 8, 17, 20). The second JIACRA report 2017 (ECDC/EFSA/EMA 2017) establishes a clear correlation was found between the level of manufacturing standards and the quality of the treatment via medicated feed, which gave sufficient grounds for the Commission to propose the latest regulation (European Union 2019) on veterinary feeds (interview 10). The legislation also includes the obligation for EU Member States to collect data on the sale and use of antimicrobials in animals (Anderson et al. 2019), which will have a positive effect on the quality of data in future surveillance reports. With the cooperation between EFSA, EMA and ECDC is reaching maturity in terms of surveillance, the fight against AMR is gaining in credibility in Europe and beyond (interview 20, 17). The three agencies have been part of the US-led Transatlantic Taskforce on Antimicrobial Resistance (TATFAR) which started to publish progress reports and share good practices in 2014 (CDC 2014). This move was particularly supported by EMA: “The need for a strengthened global action is emerging, along with nationally strengthened surveillance and prudent use of antibiotics, as well as the implementation of the One Health approach” (EMA Management Board 2012, 7). This global dimension is also reflected in the relationship between the three agencies and the World Health Organization (WHO), notably to pool scientific resources within the WHO (interview 8, 9).

While the cooperation between ECDC and EFSA in terms of publication remains more important than with EMA, an informant underlined that this is due to their joint mandate regarding the yearly “EU summary report on antimicrobial resistance”. The same informant (interview 20) cited for instance the sheer volume of weekly meetings between

experts of the three agencies. Moreover, technical collaboration between EFSA and EMA increased, notably because of their common mandate on the animal side of surveillance. Together, they produced a seminal report: the 2017 Joint Scientific Opinion on measures to reduce the need to use antimicrobial agents in animal husbandry in the European Union, and the resulting impacts on food safety (RONAFA) (EMA and EFSA 2017). This report, while not receiving direct publicity at political level was described by informants as a “bible” for antimicrobial use in the food industry (interview 13, 21). It formulated seminal guidance notably on prophylactic and metaphylactic use in animals, which paved the way for the 2018 Regulation (European Union 2019).

In sum, this narrative shows that each agency brings a unique contribution to surveillance: task-sharing is the result of making-sense of turfs, which was strongly correlated to already established relationships with their respective audiences. Crucially, it shows that inter-agency cooperation resulted in cutting-edge scientific outputs which changed the way audiences perceived the three agencies. At the end of this temporality, the ECDC has new scientific resources, an enjoys a good reputation regarding the Centre’s unique role in human health. The ECDC’s reputability, particularly regarding the technical dimension of reputation has increased within the Public Health community, in the EU and beyond. The next section outlines how the status that the ECDC acquired through inter-agency cooperation in AMR informs the European Commission’s inference as it takes on the role of purposeful agent.

4. Seizing the Rewards of Technical Cooperation: Problem shaping and audiences' consent

This narrative accounts for the ECDC taking on an advisory role on AMR national plans, from 2016 to 2019. The narrators/protagonists are ECDC management officials. The delimitation of turfs discussed in the previous narratives is here of paramount importance: within the trio of agencies, the ECDC has become the reference for human health and responds to audiences' expectations in Member States, which characterizes its organizational interest. Evidence show that the ECDC takes on an advisory role on AMR national plans after the European Commission inferred that the Centre should take on this role, which characterizes causation in this narrative. Evidence comes from two interviews with former ECDC staff members (interview 9, 11), minutes of the ECDC's Advisory Forum, reports by the ECDC as well as a publication from Eurosurveillance. Data was triangulated with seven interviews (interview 5, 4, 12, 15, 17, 20, 21), Conclusions of the Council of the EU and an academic publication from the public health literature.

The first JIACRA report marks a shift in the fight against AMR (interview 9, 11, 17, 21). Indeed the report highlighted important geographical variation across the continent and European countries are at very different stages of development of national plans for AMR (60% completed, 25% in process, 9% with no plan) (Castro-Sánchez et al. 2018). Moreover, these plans are structured around very different strategies. A central issue stemmed from huge variations in the collection of data on AMR (interview 9, 11, 17, 20). As seen in previous chapters, risk management cannot be achieved without proper surveillance data. The Juncker Commission had made AMR a top priority for DG SANTÉ,

which some informants interpret as the effects of the first JIACRA report (interview 17, 20). Indeed, following the first JIACRA report, the European Commission in its second action plan on AMR (European Commission 2017a) highlights the necessity that Member States make progress on their respective national plans to fight AMR. Crucially it also meant that DG SANTÉ expected that the ECDC would ensure visibility and impact of coordinated efforts to fight AMR (interview 5, 9). Indeed, the Action Plan (European Commission 2017a) describes the respective roles of agencies with more details and underline that the ECDC's role is to assess national action plans. The European Commission is here the purposeful agent inferring that the ECDC, with a prime reputation on AMR and human health, should tackle the problem of patchy preparedness in Member States.

Evidence shows that audiences' expectations are high regarding the involvement of the ECDC in national plans on AMR. Indeed, in 2016, the ECDC proposed to strengthen the surveillance of resistance by initiating an integrated reporting system which would compile quasi-automatically national data, thus automating the data collection for the JIACRA reports. This was met with circumspection by members of the Advisory Forum (ECDC Advisory Forum 2016). Members from Austria, Spain, Finland and Denmark underlined that they had no dedicated national surveillance systems for AMR. Therefore, they advocated that it would be better for ECDC to help Member States to improve their national surveillance rather than creating an integrated system. Once national surveillance was improved data could be collected in a timelier matter (ECDC Advisory Forum 2016). Members of the Advisory Forum clearly indicated their expectations that the ECDC ought to engage directly in the field. However, the scientific community's reiterated expectations are not the only marker that the ECDC has enjoyed reputational

gains from inter-agency cooperation. Expectations that more operational efforts can be deployed to support actions plans are also underlined by the Council of Minister of the EU (Council of the EU 2016) albeit in a way that does not make the ECDC a central piece of the project. In the 2016 conclusions of the Health Council on AMR, minister propose to “set up a voluntary country-to-country peer review system in which representatives from one or several Member States evaluate each other's national action plan, reflect about policy options and provide recommendations to support Member States to improve measures taken” (Council of the EU 2016). Overall, at the time of reputational inferences, ambiguity about the role of the ECDC is low: audiences agree that the ECDC is the most competent organization to assist preparedness in Member States (interview 9, 11, 12, 15, 21). Indeed, as the ECDC framed the problem regarding the lack of preparedness in human health, through its surveillance input in the JIACRA report, the Centre has created the condition for audiences to consent that it ought to take on an increased role in shaping the management of risks of AMR at national level.

Therefore, the ECDC took on an advisory role on risk management regarding AMR. In February 2017, the Centre made a proposal for EU guidelines on the prudent use of antimicrobials in humans (ECDC 2017). At that point, the consumption and resistance data from the second JIACRA report (ECDC/EFSA/EMA 2017) was available to the ECDC (interview 9, 11). The accumulation of reliable and comparable data is a useful tool in benchmarking and assessing the situation in specific countries, as underlined by the public health literature (Watier et al. 2017). The document was particularly welcome by DG SANTÉ. “The Commission was grateful for ECDC’s guidance on prudent use of antimicrobials which would be published in the Official Journal” (ECDC Advisory Forum 2017a, 10). In June 2017, the document was published with only cosmetic changes by

the European Commission under the name “EU guidelines on the prudent use of antimicrobials in humans in June” (European Commission 2017b). The guidelines included measures to be considered by Member States when developing and implementing national strategies to promote the prudent use of antimicrobials and elements of good practice to be followed by healthcare professionals. They also identify activities that may be taken by international organisations and agencies in support of national strategy development and implementation. The wording used in the recommendations (e.g. ‘establish’, ‘ensure’, ‘consider’, ‘explore’) reflects the expected benefits, the level of evidence and the applicability in diverse settings. Throughout this document, specific policies, interventions, indicators, medical conditions, and antimicrobials are mentioned as examples to support the design and implementation of the guidelines.

But the role of the ECDC went beyond the production guidelines: the ECDC visited Member States to assess and evaluate their national plans. Visits were always initiated by Member States’ invitation. Between 2016 and 2019[12], the ECDC visited a total of 9 countries: Spain (15-19 February 2016), Italy (9-13 January 2017), Romania (6-10 March 2017), Luxembourg (29 May - 2 June 2017), Malta (3 to 7 July 2017), Belgium (20-24 November 2017), Norway (12–16 March 2018), Bulgaria (15 to 19 October 2018), Estonia (25 to 29 March 2019) (ECDC ‘Country Visits Reports’ 2019). The output of the visits included observation based and evidence-based assessments of the threat that AMR poses to the country, a comparative review of consumptions in hospitals and assistance

[12] A visit to Malta occurs in 2009, but is only referenced in the follow-up visit report in 2017 (ECDC ‘Country Visits Reports’ 2018). A visit to Latvia is conducted from 26–30 September 2011 which focused on reviewing legislation (ECDC ‘Country Visits Reports’ 2018)

in the implementation of national strategies, and recommendations on how to improve in each area. The Centre assessed national plans according to six areas of appraisal: the development of an intersectoral coordinating mechanism (between animal and human health) (1), advocacy targeting practitioners at local level (2), laboratory capacity (3), surveillance of AMR, surveillance of usage (5) and guidance on antibiotic utilisation (6). All criteria are referenced in country visit reports (ECDC 'Country Visits Reports' 2018). At least two of these criteria are characteristic of the ECDC's exercise of conceptual power over risk management: advocating practitioners and guidance on antibiotic utilisation. Moreover, on the exercise of conceptual power, informants (interview 12, 15, 21) highlighted that since visits were always done through Member States' invitation, national agencies were even more receptive to the evaluations made by the ECDC and the recommendations had a profound impact on national action plans.

In sum, the role of the ECDC in risk management was consented by audiences due to the technical and reputational gains that the Centre had benefited from inter-agency cooperation. At the turn of 2015 the ECDC's reputation and specifically its technical dimension has gone through important change dues to inter-agency cooperation and the ECDC has emerged as the reference organization for human health among the scientific community, including in national health authorities. The European Commission, acting as a purposeful agent was looking for enhancing preparedness in Member States and inferred a role for the ECDC that was appropriate. At the end of the temporality under scrutiny, the Centre's conceptual power has thus drastically increased: from sharing conceptual power in risk assessment and surveillance, to the exercise of a conceptual power on risk management in AMR.

5. Discussion: Pooling Resources, Curating a Unique Reputation

Through field work, the metaphor of an eco-system wherein agencies adjust to each other mirrored informants using a medical metaphor with the term “physiological” (interview 17, 20). Following my research expectation, inter-agency cooperation did not translate in adverse consequences for AMR. Indeed, turf-sensitive behaviours and perceived threats to uniqueness could have had more profound externalities, but instead it guided agencies in making-sense of their own roles. The first narrative presented the field of AMR before inter-agency cooperation. As the ECDC was *muddling through* what could be its role, evidence shows that the organization took the lead on the matter of outreach and engagement. In this specific temporality, the ECDC emerged with a unique contribution by talking a front-stage role in raising awareness about AMR. The relationship between empowerment and reputation is summarized in table 7.2. below.

In the second narrative, the role of the turf protecting behaviours was important in attributing tasks between agencies. As a form of reputational incentives, threats to uniqueness are particularly probing regarding the ECDC’s behaviour: the ECDC, as the youngest agency defined its own role in contrast with its sister agencies. And yet, the Centre was less concerned with defending its turf than with the opportunity to define it, which had a positive impact on inter-agency cooperation, including reputation gains. But task-sharing between human and animal sides was also the result of the relationship between agencies and their designated scientific networks. In sum, as inter-agency cooperation became increasingly sophisticated and routinized, the ECDC made sense of its own role but also developed technical capacity on human health, which had a positive

effect on its reputation. As a dynamic process of social inference, the reputability of the ECDC on AMR was positively affected by inter-agency cooperation, which secured audience's consent regarding the Centre's empowerment.

The last narrative brought new evidence on reputation-making and its interplay with the mechanism of empowerment. When the problem of national plans was formally recognised through the JIACRA report, social information informed the European Commission on what the ECDC ought to appropriately do to tackle the problem. But ultimately, the interest of this case rests on the making of the ECDC's reputation on the topic of AMR: reputational gains and audiences' updated expectations are logical elements to explain why the Commission inferred that role. The ECDC has acquired a new status, as the sole agency of the trio that tackles human health. Due to its unequalled status vis-à-vis human health, audiences logically agreed that the ECDC ought to take an increased role in also shaping "preparedness" as well as the problem of AMR. The relationship between empowerment and reputation is summarized in table 7.2. below.

Social information		***Cause***		***Purposeful agent***	***Audiences granting consent***	***Outcome***
When does change in social information occur?	*The* Making *of reputation*	*Transnational Public Health Problem*	*Problem-brokering and framing*			*Empowerment over the Management of Disease Control*
Prior to the recognition of the problem	Turf-sensitive considerations & national governments' expectations	Patchy Preparedness in Member States	2015: First JIACRA report by ECDC, EFSA and EMA identifies problem	European Commission - DG SANCO	National governments inviting ECDC for evaluation	Advisory role in the evaluation of national plans

Table 7.2. Relationship between Empowerment and Reputation

The case of AMR also paints a topical picture of inter-agency cooperation in health. There are numerous European agencies dealing with health: as discussed in Chapter 4., the ECDC was created amid a trend towards agencification in the EU, specifically in the area of health. Fifteen years later agencies now have more defined organizational roles and have been increasingly more prone to join forces. Looking ahead, this inclusive approach to governance has the potential to spill-over in all aspects of health policy. As an overarching approach, the principles of One Health could be applied to other areas in which the trio of agencies could have a relevance. As inter-agency cooperation was a vehicle for reputational gains and ultimately empowerment, it is crucial to consider that this form of joint mandates may be of relevance in future cases of the ECDC's empowerment.

Chapter 8. Comparing the Mechanism of Empowerment through Reputation across Cases.

This chapter builds on Chapters 4., 5, 6., and 7 to provide a comparative approach of the cases of empowerment. The first goal of this chapter is to analyse similarities and differences across the population of positive cases. This approach is methodologically coherent with the strategy for case selection, the method of agreement (or most-different method). Through comparison, I analyse the different iterations of the causal mechanism analysed so far. The point of comparing similarities is to probe research expectations about the mechanism, as developed in Chapter 2. Two expectations are verified: *problem recognition and framing are the cause of mechanism* and *reputation does not empower without the intercession of purposeful agents.* The comparison confirms the pertinence of the mechanism of empowerment through reputation articulated in Chapter 2. Yet, the four positive cases have differences which are defined along two dimensions (see Chapter 3. for case selection): *ambiguity of the role of the ECDC at the time of empowerment* and *type of intelligence used for monitoring risk in communicable disease prevention and control.* I compare how these conditions affect the causal mechanism. Both *ambiguity* and *type of intelligence* bear some effects on the way the mechanism unfolds. They may respectively, hinder reputational inferences or induce contingency. However, this only affects the unfolding of the mechanism in a limited way.

Chapters 5, 6., and 7. show that the Centre has extended its conceptual power through shaping cognition and defining the terms of problems and debates beyond its purview, which corroborates the initial claim developed in Chapter 1. about the Centre's empowerment. However, this empowerment takes place *in silos*: the empowerment of the

Centre occurs in specific areas, defined by diseases. Moreover, after the initial empowerment which created the Centre with competences limited to assessing risks, empowerment has remained discreet. In terms of empowerment, outcomes include advisory roles in behavioural prevention regarding HIV/AIDS (Chapter 5.), on vaccines amid the 2009 H1N1 crisis (Chapter 6.) and on the evaluation of national plans to fight AMR (Chapter 7.).

Chapter 5. 6. And 7. present cases of informal empowerment wherein the ECDC already has a mandate regarding risk assessment. In those cases, the empowerment of the ECDC operates at the level of a conceptual power: the ECDC's scientific input and opinions has spilled-over risk management - but only with the consent of audiences. Yet, this only one of the two possible forms of empowerment. In Chapter 4., I showed that the mechanism of empowerment through reputation does explain the initial formal empowerment of the ECDC, which conferred the Centre with a conceptual power in assessment as well as important limits regarding risk management. This chapter presents a *negative* case of formal empowerment: the extension of the Centre's mandate to non-communicable diseases (NCDs). NCDs are a negative case because the case lacks the outcome of interest, empowerment: in spite of audiences supporting an extension of the mandate and discussions on this topic in the Centre's governing bodies, the mandate of the ECDC was not extended to NCDs. The claim defended here is that all elements of the mechanism were present, except for the ECDC's willingness to make sense of this role: evidence shows that the ECDC's management is opposed to an extension of the mandate. The negative case highlights the importance of the ECDC's discretion in the mechanism of empowerment. The second goal of this chapter is thus to use the leverage

of a negative case both to further probe the pertinence of the mechanism and to offer a point of comparison for the initial case of formal empowerment.

In sum, in this chapter I compare the mechanism of empowerment through reputation through the five case. Through a comparative approach, I generate confirmatory leverage on my research expectations regarding the mechanism. Section 1. reconstructs an overview of the role of reputation over fifteen year of discreet empowerment of the ECDC. For each positive case, I account for the making of reputation and the unfolding of the mechanism. In the same section, I articulate my comparative approach around similarities and differences between cases. While all positive cases confirm the causal mechanism, they also showcase specific iterations of the relationship between power and reputation, as expected from case selection. In the second section, I present the narrative on the extension of the mandate to NCDs. I probe the case of NCDs as a negative case of empowerment for the ECDC. In the third section, I analyse the negative case comparatively with the other cases, and specifically the creation of the Centre and I reflect more in detail on the ECDC in inferring its own role. Eventually, I summarize lessons learned about the mechanism in Section 4.

1. The Mechanism of Empowerment through Reputation across Cases

In this section, I compare the mechanism across the positive cases. In all four cases, the cause is the recognition of a transnational public health problem. Three elements link the cause to the outcome of interest: a purposeful engaging in reputational inferences, audiences' consent and the ECDC making sense of its own role. However, reputation is

crucial to make sense of these three elements, as it informs participants engaging in those processes. For each case, I summarize below, the cause, the elements of the mechanism, the outcome of interest and reputational change. Table 8.1 below compiles the mechanism of empowerment and reputational change for each case.

The creation of the ECDC followed the SARS crisis. When SARS occurred, DG SANCO officials, acting as purposeful agents, pushed forward a proposal for the creation of the ECDC. The proposal limited the power of the ECDC to risk assessment. Indeed, such limits were a *sine qua non* condition for audiences to grant their consent. DG SANCO officials had successfully engaged in reputational inference: they had identified the appropriate form that the ECDC should take. Indeed, reputation preceded the Centre: in the midst of SARS, audiences agreed regarding shortcomings that previous networked arrangements had, comparatively to an agency of *brick and mortar.*

The case of HIV/AIDS demonstrated that the ECDC, in its implementation phase, engaged in reputation-building for the purpose of developing and harmonizing HIV/AIDS surveillance. The progress made by the ECDC created a vantage point for the Centre on epidemiological conditions in the EU and allowed the ECDC to identify a problem: an upsurge in HIV/AIDS cases. The Centre acted as a purposeful agent as a matter of problem solving rather than reputation building. However, the purpose of reputation building was not empowerment, and yet, it is because of reputation building that audiences granted their consent.

The case of the 2009 H1N1 pandemic showed the mechanism of empowerment through reputation unfolding amid crisis. A few weeks in the crisis, as uncertainty decreased, a new framing of the problem emerged, which prompted the Europe Commission to act as

a purposeful agent and infer a new role for the ECDC on vaccines. Reputational inferences and audiences' consent are here contingent processes due to the fast-paced nature of the crisis. Crucially, this case of empowerment showcases reputational change as a consequence of the outcome.

Eventually, the case of AMR accounted for the cooperation between the ECDC, EFSA and EMA. Inter-agency cooperation was instrumental in building up surveillance and the reputation of the ECDC as the reference on human health and AMR. But it also framed the problem. The publication of the first major surveillance output by ECDC, EFSA and EMA demonstrated that preparedness in member States was patchy. This prompted the Commission to act as a purposeful agent and infer that the Centre should take on an advising role on national preparedness. The reputation of the ECDC on AMR was positively affected by inter-agency cooperation, which secured audience's consent regarding the Centre's empowerment.

Change in reputation and change in power are thus parallel processes which do not necessarily happen at the same time. These processes feed into each other rather than depend on each other. This is because the relationship between empowerment and reputation does not hold-up to the yardstick of causal chains based on a form of path dependence. Rather, it is based on a specific understanding of causality: change happens because of strategic interactions between participants to the process. The Commission, the ECDC (who both can act as purposeful agents) produce meaning, inferred from social information, which set a course towards empowerment. Considering change in social information as a cause of empowerment would be a fundamental error: causality requires *a minima* that causes occur before effects.

Case	Cause		Reputational inferences	Audiences granting consent	Social information		Outcome
	Transnational Public Health Problem	*Problem-brokering and framing*	*Purposeful agent*		*When does change in social information occur?*	*The* Making *of reputation*	*Empowerment over the Management of Disease Control*
Creation of the ECDC	Focusing event - SARS	2002: Global crisis – collective framing	European Commission - DG SANCO	National governments	Prior to the recognition of the problem	Audiences expectations at the creation of the ECDC	Mandate/ Harmonization of surveillance
HIV	Upsurge of HIV cases in select group of Member States	2009: ECDC proposes new framing on determinants of HIV	ECDC staff - Disease Programme - Surveillance Unit	Select National agencies and surveillance network inviting ECDC for country visits	Prior to new framing of the problem	Strategic use of reputation: added value & HIV network expectations	Advisory role in behavioural surveillance and prevention
H1N1	Focusing event - new framing once uncertainty decreases	2009: Global crisis – WHO and ECDC instrumental in framing saliency	European Commission - DG SANCO	National governments	After empowerment	National governments' expectations inherited from creation process	Advisory role in the question of vaccines and target population
AMR	Patchy Preparedness in Member States	2015: First JIACRA report by ECDC, EFSA and EMA identifies problem	European Commission - DG SANCO	National governments inviting ECDC for evaluation	Prior to the recognition of the problem	Turf-sensitive considerations & national governments' expectations	Advisory role in the evaluation of national plans

Table 8.1. Cross-case comparison of causal mechanism of empowerment

1.1. Comparing Similarities across Cases

Building on table 8.1., I discuss two lessons from this comparison: the recognition of a transnational public health problem is the cause in the sense of having temporal precedence and appealing to the operation of the mechanism (1); purposeful agents link social information and problems to a course of action that leads to empowerment (2).

(1) Transnational public health problems are causes for empowerment: the recognition of a transnational public health problem has temporal precedence over all other elements of the mechanism of empowerment: problems are an appeal for purposeful agents to engage in reputational inferences. But as illustrated in the table 8.1. above, change in social information, which is its own process, sometimes precedes the recognition of the problem: it was the case with SARS as well as with HIV/AIDS and AMR. The “story” of empowerment thus may start with how and why audiences think the Centre ought to do something before a specific problem is identified. Yet the mechanism is in all cases kicked-off by the recognition of a transnational public health problem.

Problem-framing is important to understand the area of public health wherein the ECDC exercises power over disease control as an outcome of the causal mechanism. In the case of the creation of the ECDC, the lack of robust organizational arrangements in times of crisis is the problem. In the case of HIV/AIDS, the ECDC is the problem-broker framing the upsurge in HIV cases as a drug-injection related issue, as part of its move towards behavioural surveillance. The empowerment of the ECDC on a behavioural approach to risk management is thus a logical step in

the eyes of audiences. In the case of H1N1, once uncertainty has decreased, the problem is framed as a collective action problem regarding vaccines and can be thus identified as a prelude to the increased role of the ECDC in advising on vaccines. In the case of AMR, the problem identified by the trio of agencies was the lack of preparedness. Here again problem framing explains the role that the ECDC takes on as a result of the mechanism of empowerment. The recognition of a transnational public health problem is thus the cause of the mechanism due its temporal importance and the way it influences the outcome of empowerment.

(2) Purposeful agents link social information to a course of action that leads to empowerment: the mechanism of empowerment is based on a specific understanding of causal relationship, constitutive causality. Constitutive causality is the relationship between actors' meaning making of a specific context and a course of action. Constitutive causality focuses on "knowledgeable" agents and how their meaning-making affects the surroundings where they operate. A crucial element of the mechanism of reputational empowerment is that knowledgeable agents infer from social knowledge a specific course of action for the ECDC, in a context largely defined by the way conditions are framed as a problem. I identified such a knowledgeable agent as a purposeful agent since their inferential process revolves around giving the Centre a new purpose. Change in social information is not necessary for the purposeful agent to engage in reputational inferences: purposeful agents use social information as a basis to form inferences on what is possible and appropriate, in search for solutions to a problem.

It is important to note that purposeful agents do not infer a new role for the Centre *because* social information is *ripe* for empowerment. Purposeful agents engage in reputational inferences to find solutions to problems. The four cases show that purposeful agents foster a course of action based on a specific problem, with the purpose of securing audiences' consent. In all positive cases, audiences and the target population of the ECDC's conceptual power are consistently the same groups. Consent as an element of the mechanism is thus determinant: it explains how those who produced social information about the Centre are seminal participants of the mechanism of empowerment.

1.2. Comparing Differences across Cases

Below I compare the four cases and highlights their specificities via-a-vis the causal mechanism. My aim in using comparison is contextual specificity, rather than generalization (Rhodes 2017, 199). Case selection was based on the method of agreement: cases are most different. Two dimensions differentiates cases (see Chapter 3. for case selection): *ambiguity of the role of the ECDC at the time of empowerment* and *type of intelligence used for monitoring risk in communicable disease prevention and control.* I compare how these conditions affect the causal mechanism. And discuss another difference between these cases: the organization emerging as the purposeful agent.

The first dimension - ***Ambiguity of the ECDC's role when empowerment occurs*** - is concerned with the ambiguity of the role of the ECDC in the area of disease control wherein empowerment is observed. Ambiguity is both low in the case of the

creation of the ECDC and in the AMR case. At the time of creation of the Centre, most audiences were in agreement that a brick and mortar Centre was appropriate, but that nevertheless the ECDC's power should be limited to risk assessment. In the case of AMR, audiences agree that the ECDC is the most competent organization to assist preparedness in Member States. In the case of HIV/AIDS, ambiguity is high amongst audiences: on top of still learning about the limits of the Centre's remit, the specificity of measures of management in HIV/AIDS blurs the line between risk assessment and risk management. In the case of H1N1, the ECDC has been making sense of the fine line between assessment and management, and ambiguity remained up to the heart of the crisis. Logically, both cases with a high ambiguity unfold amid the implementation of the Centre: audiences still making sense of the role of the ECDC and prone to forming new social inferences about the Centre.

There is evidence that ambiguity affects how participants to the process of empowerment make sense of social information. Indeed, amid the H1N1 crisis the ECDC has difficulties in deciphering what role it is expected to take amid crisis. Nevertheless, ambiguity may both give the purposeful agent more discretion, as in the case of HIV/AIDS, or constrain it, as in the case of H1N1. However, I interpret this difference as the result of the respective set of audiences with which the purposeful agent secures consent, rather than *ambiguity*. Indeed, in the H1N1 case, audiences are mostly scientists delegated by national health agencies. These audiences are most likely less politically wary than national governments who are the audiences granting consent in the case of H1N1.

Overall, the ambiguity of the role of the ECDC does not produces significant effects on the way the mechanism unfolds. Reputational inference is - in any case - the

process of drawing a line in social information. Purposeful agents promote *an* interpretation of the role of the ECDC that they infer from the various social inferences that make up social information about the Centre. This process may be more difficult in conditions of high ambiguity but not significantly. Regarding social information, high ambiguity cases are data rich regarding social information about the Centre. But low ambiguity cases provide fresh and interesting takes on the making of reputation: *reputation precedes the agency* in the case of the creation of the ECDC and *threats to uniqueness* in the case of AMR.

The second dimension - ***Type of intelligence used for monitoring risk in communicable disease prevention and control*** - the recognition of a transnational problem from indicator-based surveillance (endemic diseases like HIV/AIDS and AMR) or event-based monitoring (outbreaks of diseases like H1N1 and SARS). In effect, this dimension differentiates cases according to the salience of the problem: both SARS and H1N1 are framed as crises and both cases are characterized by contingency and urgency. Crises accelerates the temporality over which the mechanism unfolds: reputational inferences take place at a fast pace, intra-crisis. In the case of the 2009 H1N1 pandemic (Chapter 6.), this led the Commission to engage in reputational inference as uncertainty decreased, all the while a lot of unknowns remained about H1N1. In the same vein, both the case of the creation of the ECDC and the case of H1N1 show that the purposeful agent, the consent of audiences and the ECDC making sense of its own role occur less clearly as a sequence in cases of crises. Salience induces contingency to the mechanism of empowerment through reputation. These characteristics are absent from indicator-

based surveillance: in the case of HIV/AIDS and AMR, the mechanism unfolds sequentially.

Looking at the cases of HIV/AIDS, H1N1 and AMR, the difference between event-based monitoring and indicator-based surveillance shows that the impervious line between risk assessment and risk management was likely meant for the ECDC in times of crisis rather than regarding endemic diseases wherein there are low stakes. Indeed, amid crisis the management of risk may include social distancing, quarantines which affects Member States way beyond the competences devoted to public health in the treaties. With problems identified through indicator-based surveillance, Member States have less at stake: securing consent is thus less complex.

Turning to the ECDC, the four cases show that the ECDC's discretion and control over the process may vary greatly from on case to the other. When the ECDC is not the purposeful agent as in the case of HIV/IDS (Chapter 5.), its contribution to the causal mechanism is relatively limited: it may be a problem-broker (as in the case of AMR), but most of its contribution to the mechanism intervenes after audiences' consent. In the case of HIV/AIDS, however, the ECDC enjoys a great deal of discretion: the Centre is both the problem-broker and the purposeful agent. When those two roles are taken on by the same organization, the purposeful agent enjoys unequalled control over the process of empowerment. Regarding HIV/AIDS, while the ECDC did not curate a reputation for the purpose of empowerment, the Centre embraced a role that would *de facto* spill-over the management of risks. The discretion of the ECDC is thus a crucial element of the mechanism of empowerment.

The next section analyses the negative case of empowerment: NCDs. While most elements are lined for this formal empowerment to occur, the discretion of the ECDC is the element undermining this process. The following section discusses the ECDC's discretion as, well as how the case of NCDs compares to the case of the creation of the ECDC, as two cases concerned with formal empowerment.

2. Narrating the ECDC's Aborted Empowerment in Non-Communicable Diseases

The case of the extension of the Centre's mandate to NCDs lacks the outcome of interest: empowerment. Despite key audiences, in the ECDC Management Board supporting an extension of the Centre's mandate, there is no empowerment. The claim defended in this case is that, while seminal conditions are reunited for empowerment, the management of the Centre is opposed to the extension of the mandate. The case is relevant because it adheres to the possibility principle (Mahoney and Goertz 2004): empowerment is *possible*, audiences expectations are coherent with empowerment, there is a problem that has been discussed in more recent years, there are purposeful agents attempting to set a course of action towards empowerment, and yet not empowerment. The point of the negative case is thus to highlight the importance of the ECDC's discretion in the mechanism of empowerment. One narrative sheds light on this process. This narrative accounts for social information about the ECDC's mandate in the Management Board since the creation of the ECDC and follows from the year 2014 onward, the work of purposeful agents who are unsuccessful in bringing change about.

Member states represented in the Management Board are the main audience of interest. Representatives of the Commission also sit in the Management but usually do not participate in writing recommendations. Finally, members of the Advisory Forum they provide evidence of the inferences made about the ECDC as scientific representatives. Figure 8.1. below maps the different audiences.

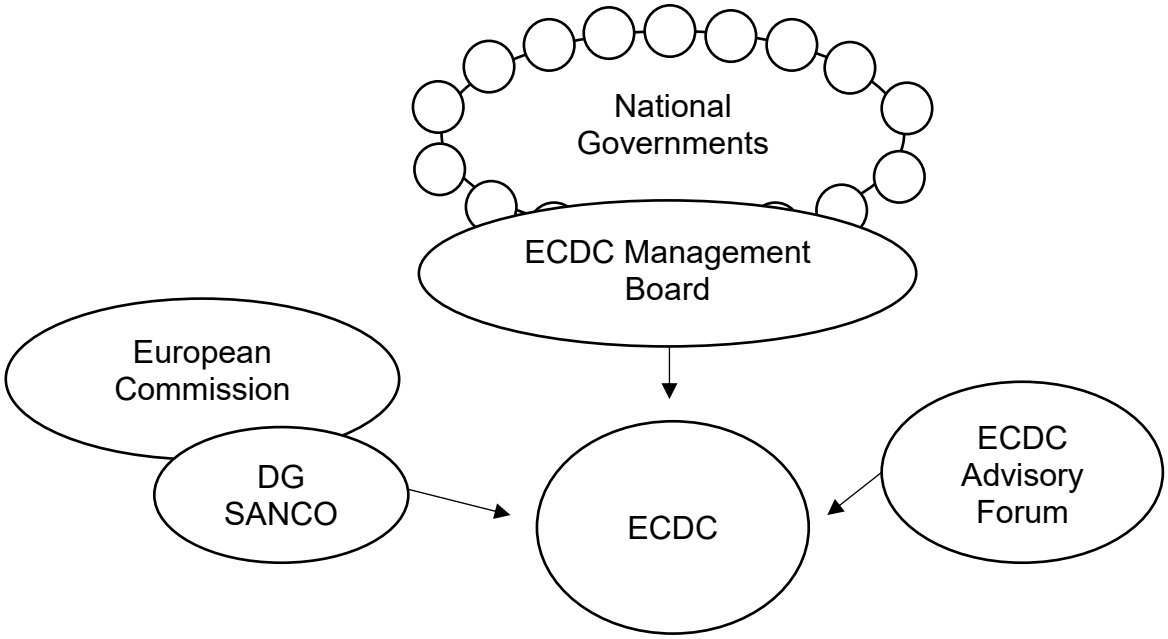

Figure 8.1. Audiences engaging in social inferences about the ECDC's mandate

This narrative account for members of the Management Board's interpretations of the future of the Centre, as they discussed the possibility of extending the mandate amid three external evaluation processes. External evaluations harboured social inferences that the ECDC audiences formulate about what the Centre ought to become, at three different points in time (2008, 2014 and 2019). The narrators/protagonists are members of the Management Board of the ECDC in favour of an extension of the mandate to NCDs: this group of national representatives emerged amid the second evaluation in 2014. Overtime, most

Management Board members rallied around the idea of extending the scope of the ECDC's remit to NCDs, which characterizes their organizational interest. Amid the third evaluation, they were unsuccessful in promoting an extension of the mandate, due to the resistance of the ECDC and DG SANTÉ, which characterizes causation.

Evidence is based on four interviews of the members of the Management Board (interview 14, 19, 21, 23) as well as minutes of the meetings of Management Board. Additional evidence was generated for the purpose of triangulation, including four interviews with DG SANTÉ officials (interview 14, 19, 21, 23), three interviews with members of the Advisory Forum (10, 15, 16), minutes of meetings of the Advisory Forum and the three reports on external evaluations. Sources were equally used in both narratives and are detailed in table 8.2. below.

Narrative descriptors: • Protagonist • Causation • Temporality	**Mapping of sources**			
	Narrator/ Protagonists (interview sources)	Textual sources from the Protagonists	Interview sources used for triangulation	• Textual sources used for triangulation
• **ECDC Management Board** • **Promoting an extension of the Centre's mandate** • **2004 to 2019**	*Members of the Management Board* interview 14, 19, 21, 23	Minutes - 13th, 28th, 29th, 30th, 31st, 32nd, 33rd, 34th, 35th, 36th, 37th, 38th, 40th, 41st, 42nd, 43rd, 44th, 45th, 46th & 1st Extraordinary, ECDC Management Board Meeting	*Current and former Commission staff:* interviews 2, 3, 4, 18 *Members of the Advisory Forum:* interview 10, 15, 16	*External Evaluations:* ECORYS Nederland. 2008. 'First External Evaluation of ECDC', Economisti Associati. 2014. 'Second External Evaluation of ECDC', PWC. 2019. 'Third External Evaluation of ECDC', Minutes - 2nd, 50th, 52nd, 54th, 58th ECDC Advisory Forum

Table 8.2. Mapping sources for the narrative on the scope of the ECDC's mandate

2.1. The Rationale for Formal Empowerment

The ECDC's Founding Regulation includes a provision to "extend the scope of the Centre's mission to other relevant Community-level activities in public health, in particular to health monitoring" (European Union 2004), specifically mentioning that "the Commission may submit any proposals for amendments to this Regulation which it deems necessary" (European Union 2004), which was also underlined by informants (interview 10, 18, 19). In the early days of the ECDC, the process of external evaluation is considered seminal for the future of the Centre. Evidence points out that within DG SANCO the process ought to be used to change the Founding Regulation: "Under Article 152, the Commission could propose changes in the regulations *(sic.)* of ECDC, and also propose legislative changes under Decision 2119/98" (ECDC Advisory Forum 2005a, 6-7). This specific provision regarding external evaluation is thus crucial for empowerment: it is based on the assumption that options to change the scope of the mandate of the Centre must be left opened for periodical review.

Fernand Sauer former Director for Public Health in DG SANCO and key protagonist of the creation of the ECDC confirms this analysis: "Regular reviews are a standard clause in many EU texts. In our ECDC proposal it was definitively linked to a possible extension of tasks. First, when we chose the name of ECDC, we did not mention communicable disease in the title. We foresaw the possibility of later extension to major health threats spreading to all Member States, like obesity for example" (interview 18). As analysed in chapter 4, the process of creation of the ECDC was a "crystallisation" of existing arrangements within a structure of "brick and mortar": the

external evaluation was leaving room for adjustments in the legal text. An informant from the Advisory Forum (interview 10) highlights for instance that the scope of the mandate of the Centre was - during the process of its creation - the centre of debates, specifically regarding the possibility to extend the mandate to non-communicable diseases (such as diabetes or cancer for instance).

In practice, the evaluation is two-fold. The first process is an *ex post* evaluation of the work of the ECDC by an external contractor. The different evaluators have adopted similar strategies for data generation with surveys and/or questionnaires for key stakeholders including members of the Management Board and the Advisory Forum. The evaluators periodically present their findings throughout the process with a steering committee, appointed by and made-up of members of the Management Board. Following the conclusion of the external evaluation, a drafting group (often including members of the steering committee) is formed to reflect on the evaluation conclusions, the prospect of an extension of the ECDC mandate and to formulate recommendations (interview 19). This collaborative and participatory approach to evaluation (Lemire, Peck, and Porowski 2020) emphasizes stakeholders involvement in all aspects of the evaluation (inception, implementation and formulation of conclusions).

Following the first evaluation in 2008, minutes of the Extraordinary Management Board meeting show that the question of scope was particularly important: “While the first four sets of recommendations were uncontroversial, the expansion of the mandate was intensively debated.” (ECDC Management Board 2008c, 8). Different views of the scope the ECDC’s activities were shared by the Management Board members: “One member advocated the enlargement of ECDC’s geographical scope

to include all neighbouring countries but left it open whether ECDC should cover diseases outside the area of communicable diseases" (ECDC Management Board 2008c, 9), while another member expressed that "ECDC might be young as an institution, he added, but not as far as the experience of its people was concerned. With this expertise, ECDC could easily forge ahead" (ECDC Management Board 2008c, 9). But this view is not shared by everyone: "One member pointed out that ECDC's duty was to be consistent and remain within its current scope" (ECDC Management Board 2008c, 9), a view which seems prevalent in the Management Board at the time: "The Chair then asked all members for a brief statement on a potential extension of ECDC's remit. The consensus expressed by all members was that ECDC should concentrate on its core tasks" (ECDC Management Board 2008c, 10).

The Management Board's conclusion on the scope of the ECDC's tasks was thus to consolidate: "the Management Board endorsed the conclusion that the ECDC should focus on the consolidation of current tasks" (ECDC Management Board 2008a, 6).The first evaluation did not translate into change in the scope of the ECDC's activities or mandate, as highlighted in the Centre's Annual Work Programme for 2009: "The conclusions of the evaluation report and the Board's comments have been positive on the work accomplished to date, seeing ECDC as an independent centre of scientific excellence that already made a significant contribution in the fight against communicable diseases in Europe. It also stated that ECDC should focus on the consolidation of its current tasks in the coming years and deepen its activities" (ECDC 2008a, 5).

Fernand Sauer (interview 18), formerly Director of Public Health at DG SANCO key protagonist in the creation of the ECDC participated as an external observer to follow-up discussions. As he described: “there were conflicting priorities in Member States expectations. More advanced countries wanted the ECDC to work on very specific priorities. Small Member States had priorities all over the place and cried out for help”. He also underlines that “There might have been a certain degree of rivalry between the best experts from Member States, recently recruited by the ECDC and those left at home.” (interview 18). This interpretation was corroborated by another informant (interview 16)

2.2. Rallying behind Non-Communicable Diseases

The first evaluation was conducted in the context of implementation of the ECDC. The context of the second evaluation is vastly different: while the Centre had then finished integrating surveillance networks (as discussed in chapter 5), two crises were influential regarding the future of the Centre. First, the 2009 H1N1 crisis was a first test for the ECDC. Second, the 2008 financial crisis made access to additional budgetary resources more difficult. References to extending the scope are thus muted: an extended scope would mean that more financial resources are needed, as highlighted by an informant (interview 11). Another informant (interview 19) underlines that this evaluation was geared toward optimization and stabilization and that overall, the quality of the second evaluation is held in better regards than the first one.

The second evaluation was conducted by Economisti Associati between September 2013 and August 2014 (ECDC Management Board 2013, 14). The steering committee and then the drafting group were both chaired by Daniel Reynders (representative for Belgium in the Management Board). The conclusions reached by the evaluation were considered to be of “high quality” (ECDC Management Board 2014b) and the report did not steer-up debate (ECDC Management Board 2014a) which explains the relatively scarce textual evidence in the minutes of the Management Board’s meetings.

Paradoxically, one of the reasons for this lack of controversy is that national representatives felt that the diversity of national interpretations were accurately represented. As highlighted by Daniel Reynders, chair of the Drafting group: “It was difficult to find common recommendations as one of the conclusions of the external evaluation is that all the Member States have divergent views and ideas. Nevertheless, it was concluded that the evaluation was successful, and the report was good” (ECDC Management Board 2015, 5). The evaluation report indeed transcribed this plurality of interpretations: “There is much more uncertainty on whether the mission and tasks of the ECDC as currently designed are still in line with future stakeholders’ needs, or should be changed” (Economisti Associati et al. 2014, 168). However the report also mentions that “the majority of interviews were against the idea of expanding ECDC mandate towards the surveillance of noncommunicable diseases, variously pointing to the need to avoid another ‘public health elephant’ or to leave time to ECDC to consolidate its activities without further major disruptions” (Economisti Associati et al. 2014, 168).

Unlike with the first evaluation, the Management Board's recommendations were not reproduced in minutes. However, on the question of extending the scope of the ECDC's activities, the evaluation highlights three groups of countries:

- a "conservative" camp: "respondents from the UK, Belgium and some new MS appear persuaded (*sic.)* overall that ECDC mission should remain as it is, because broadly in line with needs" (Economisti Associati et al. 2014, 168).
- a "new management" camp: "in some Nordic countries (SE, DK) where the majority of respondents see a clear need at least for a partial change in ECDC mission […] the Nordic Countries respondents would like to see stronger provisions to have less duplications of work and build stronger synergies with WHO and national bodies alike to cope with budgetary constraints" (Economisti Associati et al. 2014, 168–69). "Nordic Countries" are also pushing for "a substantial strengthening of the vaccine effectiveness assessment component and a much clearer ECDC mandate in this field" (Economisti Associati et al. 2014, 169).
- a "progressist" camp in favour of a clear extension: "in the Mediterranean and in France prevail the requests for a stronger mandatory harmonisation of surveillance systems to increase their comparability and for expanding the mandate of ECDC to noncommunicable diseases" (Economisti Associati et al. 2014, 169).

An informant from the Management Board (interview 23) who presented himself as long-time advocate of broadening the scope of the ECDC mandate beyond non-communicable diseases, underlined that the debate on NCDs had been enduring.

Comparing the ECDC to a *tool*, this source underlined that it is easier to adapt the tool to new challenges than to create a completely new one. Non-communicable diseases would be a “logical step” for the ECDC, citing the probable benefits of an agency like the ECDC to tackle cancer, for instance. This view was also supported – at least in principle – by an informant from another health agency (interview 10) citing obesity as a major issue in DG SANTÉ, with no agency to support this work.

2.3. Facing the Lack of the ECDC’s Appetence for an Extension of its Mandate

With the third evaluation, the question of NDCs came back with force. The problem was defined in simple terms by a former DG SANTÉ official: “If the need for European capacity in public health becomes more pressing, for example, then the question is that should we create a new agency? Or should we expand an existing agency?” (interview 22). The controversial nature of the topic is something I observed first-hand during fieldwork. I met most informants before the external evaluation was finished. The timing of fieldwork proved somewhat complicated as I would interview members of Management Board who were not allowed to discuss the evaluation publicly. Nevertheless, most informants were able to share their views on the appropriate scope of the ECDC and the issue of extending the mandate of the ECDC was thoroughly discussed by informants who were then active whether as: members of the Management Board (interview 14, 19, 21), members of the Advisory Forum (interview 15, 16), or DG SANTÉ officials (interview 3, 4).

The third evaluation was conducted by PWC Luxembourg between June 2018 and September 2019 (PWC 2019). The steering committee and then, the drafting group

were both chaired by Anne-Catherine Viso, representative for France - a country at the forefront of the "progressist camp" - in the Management Board (ECDC Management Board 2019a). The third evaluation (PWC 2019) is not as exhaustive as the second one on Member States' preferences regarding the future of the Centre. Moreover, Management Board's recommendations were not publicly available at the time of writing. Nevertheless, minutes of the Management Board meeting account for conclusions on the mandate: "According to the evaluation results, the majority of the consulted stakeholders consider that there is a need for the Centre to have a clarified and potentially extended mandate in the area of cross-border threats to health from other sources than communicable diseases. […] Nevertheless, the analysis does not give a clear indication for a recommendation on the ECDC mandate" (ECDC Management Board 2019b, 7). Rather the evaluation contained a recommendation to do an impact assessment on such an extension (PWC 2019).

And yet, evidence from interview with informants from the Advisory Forum and the Management Board shows that opposing the extension has become the exception. Members of the Advisory Forum appear overwhelmingly in favour of an extension of the mandate of the ECDC, with minutes of their meetings exclusively reporting oral interventions from proponent of an extension of the mandate. "Mika Salminen, AF Member, Finland, said that the AF should engage in a thorough discussion on the extension of the Centre's mandate, everything from health promotion to non-communicable diseases […] Frode Forland, AF Member, Norway, pointed out that the distinction between contagious and other diseases had become somewhat old-fashioned and inaccurate, especially if one looked at certain forms of cancers and

chronic forms of communicable diseases.[…] Silvia Declich, AF Member, Italy, also said that the AF should reflect on the mandate. The one-health perspective, which includes animal health, could lead to a readjustment of ECDC's mandate to include new aspects such as non-communicable diseases"(ECDC Advisory Forum 2017c, 4). One member of the Advisory Forum who participated in the steering group also came in favour of a possible extension: "Kevin Kelleher, AF Member, Ireland, suggested that it would be more appropriate for ECDC to take an all-hazards approach when debating options for the future" (ECDC Advisory Forum 2017b, 5), a view he confirmed during our interview two years later (interview 7). Two informants from the Management Board (interview 21, 23) were supportive of the extension of the mandate, while Anne-Catherine Viso, French representative and chair of the steering committee and drafting group (interview 19) had to maintain a neutral stance. Only one dissonant voice from Germany, who is also a member of the Management Board (interview 14) emitted reservations and underlined that communicable diseases surveillance is not properly harmonized. Evidence thus corroborates the evaluation's finding that Member States support the ECDC's mandate to be extended to NCDs, while this view was also championed by other stakeholders.

Catherine Viso (interview 19) underlined that NCDs have been at the forefront of the EU's Third Health Programme (2014-2020) which "promote health, prevent disease and foster healthy lifestyles through 'health in all policies" (European Commission 2016). The creation of the ECDC was used as a way to continue financing the harmonization of surveillance (as seen in Chapter 4.), quite logically the same agency could harbour projects which were no longer financed through the health

programme, such as diseases based on “lifestyle”. Then, what does explain that instead of a recommendation to change the scope of the ECDC’s mandate, PWC suggested, in effect, that a second evaluation, in the form of an impact assessment should be conducted?

Evidence from interviews shows that the extension of the mandate to NCDs does not have a lot of traction within DG SANTÉ. While Commission officials are known for avoiding to be prolix on political issues, two informants from DG SANTÉ (interview 3, 4) underlined the difficulties in achieving this extension of the mandate to NCDs: “I have no strong views about it, I mean any structure could work for NCDs, it could be a different agency, it could be the same. But I would say the political and the financial context is so that there is little margin for such an extension because that would mean if not doubling but at least a reasonably important increased in staff and means which countries are not ready to invest” (interview 3). Fernand Sauer, formerly Director of Public Health at DG SANCO (interview 18) and key protagonist in the creation of the ECDC explains that the current context is not auspicious to entrepreneurship: “To be honest, in my time, in the eighties and nineties, it was much easier to come up with new ideas and to test them. Of course, if you got it wrong in Council and Parliament, it was terrible for your credibility. I guess that nowadays it may be more difficult to take initiatives, especially with so many countries with divergent needs”. As for who could emerge as this successful entrepreneur, he underlined that: “it has to come also from a more strategic vision at the top of DG Santé” (interview 18).

Turning to the ECDC, evidence shows that the Director of the ECDC, Andrea Ammon is not particularly supportive of an extension of the mandate: “Andrea

Ammon, ECDC Director. With regard to the contribution to EU health security beyond infectious diseases, this topic had been under discussion ever since the inception of ECDC. The last two external evaluations had examined and rejected the idea of extending the Centre's remit, and therefore ECDC would continue to concentrate on infectious diseases" (ECDC Advisory Forum 2017b, 11). Amid the evaluation process, Andrea Amon appears to use a strategy of postponement: "Andrea Ammon pointed out that the comments received on the written procedure had been somewhat contradictory as, on one hand, it was suggested to deprioritise some activities and, on the other hand, ECDC was asked to do additional tasks. For this reason, and in order to have a more informed discussion, ECDC had suggested to postpone this item until the ECDC long-term strategy has been developed and the results from the External Evaluation were available" (ECDC Management Board 2018, 17). The management of the ECDC thus appear to be reluctant to take on this role.

This narrative demonstrated that Member States' social inferences, regarding the scope of the ECDC have progressively changed to the point that a consensus emerged regarding the future of the Centre and NCDs. Yet, an extension of the mandate is unlikely to happen as a result of the third external evaluation: a new evaluation, in the form of a European Commission impact assessment is most likely a strategy of postponement. This narrative thus highlights an important lesson: *the ECDC is a key protagonist of the causal mechanism who can ultimately oppose its resistance to empowerment.*

3. Interpreting the Negative Case: The ECDC's Discretion Regarding Empowerment

The narrative analysis on external evaluation shows that the director of the ECDC is not receptive to Member States' social inferences. Social information about the Centre is, in the case of the external evaluation, at odds with the image that the Director of the ECDC wants to project. The extension of the mandate is a missed opportunity to empower the ECDC and shows that the Centre engages in reputation management for other purposes than empowerment. And in recent years important cleavages have become apparent among ECDC staff on the topic of NCDs (interview 2, 3, 15, 16, 11), which I will reflect upon in the next chapter.

The change of mandate initially supported by the "progressist camp" did not translate into change. Four informants underlined that internal dissensions within the staff of the Centre had plagued the evaluation process, with ECDC staff having different views on how the Centre should be taken forward (interview 12, 15, 16, 11). Dissensions were also briefly touched upon during an interview with informants from DG SANTÉ in the first case (interview 2), the informant commented the concerns the Director of the ECDC had vis-à-vis ECDC participating to this study, in the second case (interview 3), the informant suggested that part of the ECDC staff were also in favour of the Centre covering NCDs. These dissensions would explain why the ECDC's management is not keen on taking on new tasks. More prosaically, the issue of funding this extension of the ECDC's remit must also play a part in the cautious position that the Director has adopted through the evaluation process, as mentioned

by members of the Management Board (interview 14, 19, 21, 23) and Commission staff (interview 3, 4).

The existence of different rationalities is problematic from the point of the ECDC, as highlighted by a DG SANTÉ official: “I guess what the Director of the ECDC was concerned about is also the fact that there might be different voices coming from different members of staff which may not be in line with what her views are. So, that's always a danger if the members of staff convey a different message than she would like conveyed. […] And you can undermine the reputation of the Centre if ten people say ten different things” (interview 2). The narrative analysis on external evaluation shows that the director of the ECDC is not receptive to Member States’ social inferences. Social information about the Centre is, in the case of the external evaluation, at odds with the image that the Director of the ECDC wants to project. The extension of the mandate is a missed opportunity to empower the ECDC and shows that the Centre engages in reputation management for other purposes than empowerment.

A possible extension of the mandate to NCDs would expose an important cleavage within the Centre, opposing this time those who see the Centre as an instrument for public health, and those who see the Centre as a centre for scientific research. This cleavage relates more to the purpose of the Centre and offers some explanation as for the diverging views within the Centre itself (interview 12, 15, 16, 11).

The negative case assists in generating comparative leverage for the case of the creation of the ECDC. Table 8.3. below compares the case of the creation of the ECDC and the case of NCDs.

Case	***Cause***	***Reputational inferences***	***Audiences granting consent***	***Social information***		***Outcome***
	Problem-brokering and framing	*Purposeful agent*		*When does change in social information occur?*	*The* Making *of reputation*	*Empowerment over the Management of Disease Control*
Creation	2002: Global crisis – collective framing	European Commission - DG SANCO	National governments	Prior to the recognition of the problem	Audiences expectations at the creation of the ECDC	Harmonization of surveillance
NCDs	Problem brokering and framing are ambiguous	Progressist camp in the Management Board	National governments	After the recognition of the problem	Audiences expectations at the creation of the ECDC	Extension of mandate to NCDs

Table 8.3. Comparison of causal mechanism of empowerment between cases of formal empowerment

Cases of formal empowerment differ from cases of informal empowerment because they require a legislative change. However, the case of NCDs and the case of the creation of the ECDC, while both concerned with formal empowerment present differences in most aspects of the mechanism: where SARS was a salient issue, NCDs are not. Problem brokering, and framing are ambiguous regarding NCDs: there is no event, as with SARS, to focus the ECDC's or the Commission's attention, there is no striking report which members of the Management Board can evoke to underline the importance of the problem. Moreover, as underlined by a DG SANTÉ informant (interview 4) current scientific networks in NCDs are not as developed as

(communicable) disease-specific networks were in the early 2000s, specifically regarding surveillance. The extension to NCDs would thus not benefit from the same head-start than the ECDC had on communicable diseases in 2004, which makes the *leap* much harder to take.

Without scientific networks to base its work on, on NCDs, the ECDC would probably be, at least in part, similar to the Centre's early approach to AMR. a broad "public health" approach, based on outreach. As seen in chapter 7 on AMR, before surveillance was developed with EMA and EFSA, the ECDC organized the European Antibiotic Awareness Day (EAAD), the yearly event promoting awareness vis-à-vis AMR. This outreach role was described as one of the fundamental roles of the ECDC (interview 2) even though the field of AMR is where this role was really pioneered (interview 15). Yet, there is no precise indication on the breadth nor the depth of the prerogatives the Centre would take on. Ultimately, this induces ambiguity about the form this extension of the mandate would actually take.

In the case of the creation of the Centre, there were purposeful agents in DG SANCO championing the creation. In the case of NCDs, resistance to change is found within the most typical purposeful agents: DG SANTÉ officials and the ECDC management. Representatives of Member States, who are usually key audiences regarding formal empowerment are here, ironically, unable to bring change about. Even though evaluations were design for empowerment, and a majority of audiences eventually supported change, the likelihood of empowerment remains low, especially as with COVID-19, the health agenda has fundamentally changed.

4. Lessons Learned on the Mechanism

This chapter compared the mechanism of empowerment through reputation through five cases: four positive cases, and one negative case. Through this approach, I generated confirmatory leverage on research expectations regarding the mechanism and drew four lessons on the mechanism of empowerment through reputation.

(1) Transnational public health problems are "causes" for empowerment. Without a problem, purposeful agents are not incited to engage in reputational inferences.

(2) Purposeful agents link social information to a course of action that leads to empowerment. Purposeful agents use social information as a basis to form inferences on what is possible and appropriate, in search for solutions to a problem.

(3) Conditions such as **ambiguity and salience have a limited effect on the way the mechanism unfolds in positive cases** however both **high ambiguity and low salience,** arguably, **have contributed to the negative outcome** in the case of NCDs

(4) The ECDC's discretion is a crucial element of the mechanism. Not because the Centre is power hungry, but rather because empowerment may conflict with strategic views on the purpose of the ECDC.

Chapter 9. Conclusions: The Role of Reputation in the ECDC's Empowerment

Throughout its 15 years of existence, the ECDC has enjoyed limited forms of empowerment in risk management.. The argument defended in this thesis is that the ECDC has exercised a conceptual power that is not limited to the Centre's mandated activities on risk assessment but occasionally spills over risk management. I investigated this phenomenon as a deviant case of empowerment: unlike most cases of European agencies analysed in the literature, the ECDC's empowerment does not amount to *de facto* rulemaking. The goal of this research was to explain the mechanism underpinning this empowerment. Considering the explanatory power of reputational accounts on power (Carpenter 2010), I addressed this puzzle by investigating the role of reputation in the Centre's empowerment.

I followed an interpretive logic of inquiry that relied on making-sense and sorting-out the role of reputation in the mechanism leading to the outcome of empowerment. The goal of research was not a "quest for causes" (McCann 1996), but to explain the outcome through the role of reputation. I proposed an original mechanism for empowerment through reputation in Chapter 2. I probed this mechanism through a narrative analysis of four areas of empowerment of the ECDC: the creation of the Centre, HIV/AIDS, the 2009 H1N1 crisis and antimicrobial resistance (AMR) as well as an area with a negative outcome: non-communicable diseases (NCDs). My research shows that over the 15 years of the ECDC's existence, the role of reputation in the Centre's empowerment has been to assist actors in engaging in inferential processes that set a course of action towards the ECDC's empowerment. These

conclusions are thus the premise for an original claim: **Reputation, as form of dynamic social knowledge, is a useful resource to purposeful agents in inferring what the Centre ought to appropriately do, in spite of the limitations inherent to its mandate**. This claim is based on a robust set of corroborating evidence: I analysed data qualitatively in 16 narratives which included thick descriptions of both processes of empowerment and reputation-making and demonstrated the trustworthiness of my interpretation of the relationship between reputation and empowerment.

I articulate this claim through three key findings:

Finding 1. Reputation alone does not empower, it needs the intercession of agents who infer, from reputation that empowerment is appropriate in the eyes of audiences. Empowerment is dependent on contextual elements: problems and the way they are framed have a stronger explanatory power than reputational change on the phenomenon of empowerment.

Finding 2. Measurements of reputation do not have an explanatory power on why empowerment occurs, however they are useful to identify the appropriate scope of empowerment in the eyes of audiences.

Finding 3. The ECDC's discretion in the process must not be undermined: the ECDC manages a discreet reputation and has integrated that it is in the interest of the good functioning of disease control that the Centre does not appear powerful or power-hungry.

I address these findings in Section 1. First, I discuss how interdependence between cases is useful in reconstructing the story of the ECDC's empowerment over time:

this reconstruction highlights that change in reputation and empowerment are parallel processes which feed-off each other and are intertwined under the stewardship of purposeful agents. I thus develop and discuss Finding 1.: reputation does not empower on its own. I then address alternative explanations in order to probe the trustworthiness of the mechanism and I develop Finding 2.: measurements of reputation do not have an explanatory power on why empowerment occurs. I assert the prevalence of my claim on the role of reputation in empowerment through comparison with an analysis based on dimensions of reputation. Finally, I reflect on the role of the ECDC in this process and discuss Finding 3.: The Centre has cultivated a discreet reputation.

In Section 2. I discuss the trustworthiness of my analysis: I reflect upon data triangulation, specifically in relation to my difficulties in accessing informants (as seen in Chapter 3.), as well as the limitations regarding case selection. Considerations regarding case limitations are particularly relevant in the light of recent developments in the midst of the COVID-19 pandemic.

In Section 3. I discuss the scope and the generalizability of this research regarding European agencies, as well as the concept of conceptual power and what it brings to our understanding of the power of non-majoritarian institutions. Finally I discuss the contribution of these findings to the scholarship on reputation.

Finally, in Section 4. I suggest avenues for future potential research, including a comparative approach to reputational empowerment, avenues for future research that relate to the epistemology of reputation and finally, future research on the ECDC empowerment and COVID-19.

1. A Reputational Account of the ECDC's Empowerment

My research provides evidence to the claim that that the role of reputation in empowerment is characterized by the constitutive-causal link between three elements: a problem, reputation and a course of action towards empowerment with, at its core, the purposeful agent engaging in reputational inferences. Problems and the way they are framed, set-up the basis for the precise field of public health wherein empowerment may occur. Reputation, as dynamic social information harbours meaning which defines the appropriate scope of empowerment and determines the consent of audiences, without which empowerment is not possible. Therefore, social information about the ECDC is the yardstick of what the Centre can appropriately do; and from which purposeful agents take cues to infer that it is appropriate for the ECDC to take on a role beyond its mandate.

Purposeful agents' inferential role embodies constitutive causality in itself. Constitutive causality is the relationship between actors' meaning making of a specific context and a course of action. The purposeful agent is the actor making meaning out of a specific context. In the mechanism of reputational empowerment, the context is defined by the recognition of a problem; the meaning made is that the ECDC should tackle the problem; the episteme used to infer if that is appropriate, is reputation. If the purposeful agent is right in their inference of the ECDC's reputation, it sets a course of action towards empowerment. This causal link has far reaching consequences for the study of reputation. As a form of dynamic social knowledge,

reputation changes over time but grasping this change via measurements does not appear relevant.

1.1. The Constitution of the ECDC's Reputation over Time

The *story* of the ECDC's empowerment is inherently tied to its reputation. Reputation is not a cause in itself but explains how and why knowledgeable agents, inferring from social information, have occasionally fostered the empowerment of the ECDC. Across the 16 narratives that I reconstructed for the analysis (see Appendix B.), social inferences formed by the Centre's audiences shed light on how interpretations of the role of the agency inform courses of action towards the ECDC's empowerment. Acknowledging the interdependence of cases over time shows that, over 15 years, hazardous episodes of disease control, framed as problem are the cause for empowerment. Audiences, as witnesses of these events have continuously engaged in social inferences and thus empowerment has led to reputational change. Across cases, purposeful agents intercede between reputation and a course of action towards empowerment and as a result, the ECDC's reputation has built up over time. Reflecting upon this first finding, the relationship between reputation and empowerment is one of intertwined processes which feed of each other: reputational inferences are the basis for empowerment, but the process of empowerment does change reputation.

(1) **Crystallising organizational arrangement under the roof of the ECDC (1990-2004):** In the years that preceded the creation of the ECDC (1993-2005), the

perspective of a centre for disease control was met with resistance by the Charter group; this informal group of epidemiologists wanted to preserve the networked organization of communicable disease control they had set up throughout the 1990s and therefore opposed the creation of a fully-fleshed, “brick and mortar” centre. In the same vein, after setting up the Network for epidemiological surveillance or Basic Surveillance Network (BSN) and the Early Warning Response System (EWRS) between 1998 and 1999, the European Commission was divided between proponents of financially frugal, networked solutions (EWRS and BSN), and entrepreneurs in DG SANCO championing the creation of an agency. The “blow” of the 2001 biological threats to anthrax marked a turning point: Member States softened-up to the idea that the control of health networked surveillance was not sufficient anymore. Eventually, the 2002 SARS crisis, reinforced these social inferences and precipitated the work of DG SANCO officials as purposeful agents. They inferred from social information the organizational features of the ECDC and created a Centre that would secure audiences’ consent. This first episode in the history of the ECDC demonstrates that the design of the Centre was the product of contested organizational arrangements, which explains the narrow remit of the ECDC in disease control, and specifically its exclusion from risk management.

In 2005, the freshly created Centre existed *de jure*, but its implementation was only starting. In this *infancy* phase of development, the ECDC’s director as well as the governing bodies were focused on making sense of organizational arrangements and specifically the remit of the ECDC. The Centre already had a reputation, inherited from the phase of creation. Nevertheless, social information was ambiguous and prone to rapid changes: some expectations that seemed crucial at

the turn of the millennium, such as bioterrorism, rapidly faded away, and audiences' expectations regarding the ECDC were increasingly focused on its mandate to harmonize surveillance. The Centre's reputation in 2005 sets the scene for reputation in the implementation phase of the ECDC (from 2005 onward and coming to term in the early 2010s). HIV/AIDS and the 2009 H1N1 crisis are the two cases giving an account of the implementation process, albeit regarding activities linked to two different types of intelligence, respectively indicator-based surveillance (known health risks) and event-based monitoring (emergent health risks).

(2)**The implementation of the ECDC in indicator base-surveillance (2004-2009):** The case of HIV/AIDS is particularly interesting regarding the process of harmonization of surveillance, which is part of the ECDC mandate. In its early years, a core motivation within the ECDC was to demonstrate the Centre's *added value*, therefore the ECDC surveillance unit went on to evaluate the existing surveillance networks and develop centralized information systems. This in line with expectations from the process of creation: the *raison d'être* of the Centre was to hold a vantage point on epidemic data and thus to centralize intelligence. However, amongst disease-specific networks, the ECDC's strategy was deemed not flexible enough, which caused some frustration. Zooming in on *EuroHIV*, the network collecting data on HIV/AIDS, I observed that expectations are most likely network specific. Members of EuroHIV have specific expectations regarding the geographical scope, and innovation in surveillance. The ECDC took stock of these expectations, with a predefined strategical approach to reputation building and bringing added value. As a result, the Centre developed behavioural surveillance on HIV/AIDS, which shed light on an upsurge in infections in the south-eastern part of the continent. The

ECDC, as the purposeful agent, engaged in reputational inferences. Audiences' expectations regarding the extent of the ECDC's involvement in responding to HIV/AIDS were not concerned with the division between assessment and management, rather, audiences were expecting that the Centre would further the work they had accomplished through network governance. In a young agency particularly interested in demonstrating its added value, these expectations ultimately strung a cord and granted the ECDC with audiences' consent on HIV/AIDS. The role of the ECDC regarding the upsurge in HIV infections subsequently went beyond simple risk assessment: the ECDC tailored advice on how to reach out to specific population at risks therefore shaping these Member States' responses to HIV between 2009 and 2016.

(3)**The implementation of the ECDC in event-based monitoring (2004-2009):** Turning to the case of H1N1 and event-based monitoring, the 2005-2009 temporality is equally marked by a context of implementation: the Centre was involved in assisting the implementation of the WHO's International Health Regulation. However, in this area, there was no process of network harmonization: the ECDC had *de facto* the charge of the Early Warning Response System, the unique communication tool for event-based monitoring. From 2005 to 2009, the context was imbued with anxiety following SARS and recurring health scares linked to the apparition of H5N1 outbreaks. At the time, the Commission, the WHO, and the nascent ECDC were all working in concert for the development of preparedness before the next big crisis. But, the ECDC was still making sense of its own role in this crowded organizational environment. In terms of surveillance, the ECDC's reporting system clashed with the WHO's. In term of risk management, the fine line

that separates this area from risk assessment was a blurry one. Contradicting expectations formed (but not apparent) around the time of the creation, with on the one side national governments (who refuse any creeping on management) and the other side the scientific community (unaccustomed to the strict separation between assessment and management), were seminal in maintaining ambiguity over the role of the ECDC.

When the pandemic became a salient problem in April 2009, these issues were yet to be resolved. On the side of surveillance, a compromise was eventually found regarding reporting between WHO and ECDC, but only after Member States voiced their frustration. In terms of management of the crisis, the ECDC's proactive behaviour in advising during the crisis was not aligned with National governments' interpretation that the Centre was only competent in assessing risk. This situation changed amid crisis in June 2009: the H1N1 pandemic was not as acute and dangerous as one would have expected: health systems were not overwhelmed; confinement would be unnecessary. Member States became increasingly interested in the only relevant measure, vaccines and nourished expectation that the EU would help them to coordinate on that issue. The Commission, acting as a purposeful agent, shifted preparedness plans and created a taskforce that included the ECDC as well as the European Medicine Agency, thus empowering the Centre to advise on management, albeit on a precisely defined issue. This what not due to a change in the reputation of the agency. Rather, the new framing of the pandemic led the Commission to draw reputational inferences, in the light of a new framing of the problem. A limited, punctual role for the ECDC in advising on vaccines was thus

appropriate but letting the Centre take initiatives on what to advise in management was not, which explains audiences' consent.

(4) **Diversification of public health activities (2009-2019):** Evidence shows that the ECDC enjoyed some reputational gains through its scientific advice during the crisis, but advice on vaccines was contentious, especially with regards to EMA who was also involved in advising Member State on vaccines. This had direct consequences on the fourth case: AMR in which the ECDC cooperates with EMA as well as EFSA. Between 2005-2009, the ECDC was developing a turf in AMR with the development of scientific networks and the European Antibiotic Awareness Day (EAAD). However, the European Commission was determined to bring together EMA, EFSA and the ECDC to develop surveillance in AMR. While turf problems characterize the relationship between agencies in the early days of their cooperation, among other things because of the contentious issues of vaccines during H1N1, the trio of agencies eventually makes sense of their respective turfs and develop a system of integrated surveillance for AMR in the EU. The growing reputation of the ECDC on technical surveillance of AMR defines the role the Centre eventually takes as audiences' consent for the Centre to evaluate national preparedness programmes, under the auspices of the European Commission as a purposeful agent.

Looking ahead, the 2020 COVID-19 pandemic will, most likely shake up, disease prevention and control in the EU. Reforming the role of the ECDC was clearly *in the pipes* as demonstrated by the discussion on NCDs that characterized the latter years of the period under scrutiny in this thesis. Before COVID-19, perspectives of

empowerment revolved around extending the Centre's scientific tasks to a new topic: NCDs.

The interdependence of cases produced a useful thread to reconstruct the *story* of the ECDC's reputation. Each case presents a form of reputational change that carries on with another case. Fundamental reputational stakes are set at the moment of creation, both the case of H1N1 and the case HIV are imbued with the question of bringing added value and thus building reputation in a crowded environment, which is directly linked to turf problems mentioned with regard to AMR. At the end of the period of scrutiny, reputation has *grown over time*. This is also demonstrated in the evolution of social information regarding the extension of the mandate to NCDs. A possible explanation of empowerment would be to underline that the building of the Centre's reputation is a driver for empowerment. This could be a satisfying explanation if the case of NCDs was not a negative case: purposeful agents in the ECDC's Management Board have failed to create a course of action that would lead to empowerment.

Rather than assuming that reputation builds up towards a critical mass that allows empowerment, it is more accurate to consider that reputation is a form of social information that does not have intrinsic properties *vis-a-vis* power. Empowerment occurs when purposeful agents appropriately infer that the ECDC should tackle a specific problem and secure audience's consent, not just because audiences share the normative view that the ECDC should be empowered beyond its mandate.

1.2. Appraising Alternative Explanation: Measuring Reputation

The constitution of reputation over time does not offer sufficient leverage on explaining why empowerment occurs. To the contrary, it highlights the hazardous process through which purposeful agents have linked a specific problem and social information about the ECDC. If the constitution of a reputation over time does not explain the phenomenon, do specific properties of reputation explain why empowerment occurs? In order to probe alternative explanations, throughout cases I appraised dimensions of reputation which were salient throughout the process of empowerment. There are four dimensions (Carpenter 2010). The *performative dimension* represents audiences judging the quality of competence in terms of efficiency and effectiveness. The *technical dimension* relates to the credibility of the information that is produced. The *moral dimension* is the ethical aspects of agency behaviour. Finally, the *procedural dimension* reflects the respect and attachment for rules and procedures. Table 9.1. below compiles dimensions of reputation relevant to each case of empowerment. Only 13 narratives are included below because these narratives present evidence on the making of reputation.

Cases	***Narrative title Temporality***	***Evidence on reputational stakes***	***Dimension(s) of reputation prevalent for empowerment***
Creation of the ECDC	*Not another European Institution 1993-2002*	*Centre solution is not favoured*	*Performative*
	Not a New SANCO Agency 1998-2002	*Centre solution is not favoured*	
	The Construction of Health Threats 2001-2002	*Current arrangements are not deemed sufficient (performative dimension)*	
	DG SANCO Officials as a Purposeful Agents 2002-2004	*Audiences form social inferences about new organizational arrangements*	
HIV/AIDS	*The added value of harmonized surveillance 2005-2008*	*Reputation building strategy based on added value (technical dimension)*	*Moral & technical*
	Coping with organizational change 2005-2008	*Harmonization seen as not flexible enough (decrease moral dimension)*	
	Inherited expectations in HIV/AIDS 2005-2009	*Expectations to further the work accomplished through network governance (technical) and flexibility (moral dimension)*	
H1N1	*Making sense of turf in surveillance 2005 - April 2009*	*Surveillance seen as redundant vis-à-vis WHO (decrease procedural dimension), threat to uniqueness*	*Technical & performative*
	Walking the fine line between risk assessment and risk management 2005 - April 2009	*Ambiguity on the line between assessment and management in scientific community - Role taken-on by ECDC is not aligned with social inferences in national governments (procedural dimension)*	
	You can't do public health without having to talk about vaccines July to December 2009	*Ultimately, reputational gains for the ECDC (performative and technical dimension)*	
AMR	*Developing a unique turf 2001-2009*	*Reputation building efforts (technical dimension)*	*Technical*
	Reputation-making through scientific synergy 2009-2015	*Reputational gains for the ECDC (technical dimension)*	
NCDs	*The thorny issue of NCDs 2004-2019*	*Expectations have changed through time but do not translate into empowerment*	*Performative*

Table 9.1 Dimensions of reputation as basis for empowerment according to narratives (see also Appendix B.)

The salience of specific dimensions of reputation is highly contextual. Dimensions offer an explanation of reputational stakes and dimensions, but no pattern emerges over time. Measurements of reputation do not have an explanatory power on why empowerment occurs. As social information, reputation is an intersubjective object which can only assist agents in producing meaning-making which sets a course of action towards empowerment.

However, in all cases, dimensions do indicate what is the appropriate scope of empowerment in the eyes of audiences. This is because social information about the Centre is the yardstick of what the ECDC can appropriately do. Reputation, as dynamic information harbours meaning which defines the scope of empowerment. In the case of the creation of the ECDC, the limits to the ECDC's scope are established in the Commission's proposal taking cues from social information based on performative considerations (Chapter 4.). In the case of HIV, social inferences were based on the technical dimension of the ECDC as well as the moral dimension; audiences supported that this "vantage point" was put to use (Chapter 5.). In the case of H1N1, social information changed once the crisis was over, and the ECDC was lauded by audiences for its technical input and the performative aspect of its work in conditions of crisis (Chapter 6.). In the case of AMR, the growing reputation of the ECDC in its technical dimension, through AMR surveillance defined the role the Centre eventually took as evaluator of preparedness programmes (chapter 7.).

Positive cases thus show that forms of empowerment respond to social information used as a basis for reputational inferences. However, in the case of NCDs, empowerment did not occur, not only because purposeful agents failed to link a problem to social information, but also because of competing rationalities, as well

as, the fact that the ECDC's management was not supporting empowerment in an area where the ECDC had no mandate to harmonize surveillance, nor could build on pre-existing scientific networks. The way the ECDC infers its own role, sometimes as a purposeful agent is crucial to the mechanism producing the outcome. An account of the ECDC's empowerment through reputation thus cannot avoid reflecting upon the Centre's organizational identity and its efforts to manage its reputation.

1.3. Managing Reputation for a Discreet Power

Analysing the empowerment of the ECDC through a reputational lens highlights that the purpose of the Centre is defined through a collective inferential process. Ultimately, empowerment is dependent on the ECDC's appetence for taking on a new role, as demonstrated by the negative case (Chapter 8.). Evidence (described below) shows that the management of the ECDC has internalised reputation as a value in itself (Maggetti and Papadopoulos 2018, 180).The ECDC has internalised that demonstrating its *added value* is indeed important to define its *turf* **(1).** The question, however, is what is the ECDC curating a reputation for? The ECDC is not curating a reputation for power over the prescription of rules, but rather for providing the most appropriate input to a system of governance based on cooperation **(2)**.

(1) **Added value and turf**: As per research expectations, the ECDC has largely inferred its own role from audiences 'expectations. This is constant across positive cases and a logical effect of empowerment through reputation. However, beyond

social information, the ECDC also interprets its own role according to self-reflecting logics. As seen in Chapter 5., the implementation of the ECDC was characterized by the importance given to the question of added value. In this period of implementation, the ECDC was the new element of a multi-level system articulated around the division between risk assessment and risk management. The Centre's challenge was to define its own role. In Chapter 6. (H1N1), evidence shows that the ECDC went through a self-reflective process regarding its role as a "fire alarm" that defines the magnitude of public health problems, and regarding the duplication of surveillance tasks performed by WHO. In Chapter 7 (AMR) demonstrating the ECDC's added value was important in the emerging governance of prevention against AMR. Moreover, in the negative case (NCDs), the incentives for the ECDC's lack of interest in pursuing actively an extension to NCDs were analysed as strategic considerations about the purpose of the Centre. Overall, the story of the ECDC is characterized by the fact that the ECDC is embedded in a fragmented and heterogenous landscape (Greer 2012); and that the Centre had to find its own "turf" *i.e.* the distinctive characteristics of an agency that differentiates it from similar organizations. The ECDC is thus curating a reputation, but this reputation remains far removed from the reputation of fear and respect that powerful regulators - such as the FDA – desire (Carpenter 2010).

(2) **Curating a discreet profile:** The ECDC's management has internalized that its role in disease control is inherently limited: there are many *don'ts* for the Centre. This is also fostered by DG SANTÉ: throughout the existence of the ECDC, DG SANTÉ has guided the ECDC on what is appropriate, whether as a purposeful agent or throughout meetings of the governing bodies of the agencies, as seen in Chapter

4. 5. and 6. in the minutes of the Centre's governing bodies. Important limitations are imposed *de jure* on the ECDC, because of the legal limits prescribed by the Treaty on the Functioning of the EU, as well as Member States' refusal to lose control over Public Health competence. From its inception the ECDC was conceived as a *palatable* solution for its audiences and specifically, national governments. Throughout its implementation, the ECDC appeared to walk on eggshells, as demonstrated by the discussions over the word guidelines vs guidance and the cold reception of the Centre's attempt to advise on management early on in the H1N1 crisis (Chapter 6.).

National governments are a key audience for the ECDC: they are in charge of risk management and they are the audience who are the wariest of encroachments of the limit between assessment and management. To not internalize this limit as an existential reputational stake would be a mistake. The ECDC must appear dedicated to Member States' needs, not as if promoting its own organizational interest. Otherwise, the ECDC would cause harm to the credibility of the information it produces for Member States and could damage any possibility to exercise a conceptual power in risk management, but also, crucially, in risk assessment. Disease control in the EU rests on Member States coordination: they may occasionally welcome advice on forms of coordination they have agreed upon (vaccines on H1N1, preparedness plans on AMR) but for the ECDC to come forward and try to foster this coordination would be a *faux-pas.* This explains why the ECDC does not appear *power-hungry*: the Centre cannot attempt power grabs without losing the trust of its audiences. Without this trust, the ECDC cannot effectively perform its tasks as an information-provider: in a system of disease control based

on coordination, this approach would jeopardize chances to actually foster coordination. In sum, it is crucial for the ECDC to curate a discreet profile in order to not upset the fragile system of disease control in the EU. The logic of appropriateness that the ECDC follows is thus one of a discreet agency, wary to give the impression that it encroaches on tasks and activities that are not part of its remit.

2. Trustworthiness and Limitations of this Study

This study used a narrative analysis to provide evidence based on thick descriptions. Methodologically, the trustworthiness of this analysis is based on a five-step approach to establish narratives (see Chapter 3. for the five steps and Appendix B for a full table of narratives) which demonstrates the procedural systematicity of the analysis and offers guarantees for construct validity. Moreover, in a reflexive move, I resorted to using a "negative case analysis", *i.e* a counter-factual analysis (Becker 1998, Schwartz-Shea 2006), wherein I probe an alternative explanation for the mechanism of empowerment, by examining reputational change according to Carpenter's four dimensions of reputation (Carpenter 2010). As described in Subsection 1.2., the negative case analysis probed the explanation that specific properties of reputation explain why empowerment occurs. I find that dimensions of reputation do not offer sufficient explanatory leverage on why there is empowerment, thus confirming that a reputational approach based on inferential processes - rather than measurements of reputation - has a stronger explanatory power.

The trustworthiness of the analysis and data selection is also strengthened by member-checking which consists of having research-relevant participants check the

analysis. I secured member-checking for chapter 4 (SARS) (interview 10, 18, 24) and chapter 7 (AMR) (interview 20), Ideally, ECDC staff would have been the best choice for member-checking, but difficulties in access prevented to reach ECDC current staff.

Empirically, the lack of access created various issues, depending on the narrative that was reconstructed. While narrators/protagonists are not systematically the "source" that produced the largest amount of evidence, additional interview data from ECDC staff members would have enhanced the trustworthiness of my own interpretations. Out of 16 narratives, six of them had staff members of the ECDC as narrators/protagonists. There were no narratives with ECDC staff members on the creation of the ECDC. Three out of four narratives on HIV/AIDS had staff members from the ECDC's Surveillance and Communication Unit as narrators. While minutes from the Advisory Forum especially were helpful in generating evidence, ECDC informants (interview 9, 11) were not involved directly in these processes which undermines the trustworthiness of my claims. Regarding the case of H1N1, two narratives are told from the point of view of the ECDC - Unit for Preparedness and Response, here ECDC informants were more certain of their claim: most ECDC staff members were directly concerned with this salient crisis. On AMR, two narratives were told exclusively from the point of view of the ECDC: however, informant 9, who used to work for ECDC was a key protagonist in building the ECDC's profile on AMR.

Access difficulties evidently affect causal claims. This is particularly the case for two narratives detailing the mechanism of empowerment through reputation: the narrative "From Surveillance to Prevention in the fight against HIV/AIDS" (Chapter 5. Section 4.) and the narrative "Seizing the Rewards of Cooperation" (Chapter 7.

Section 4.). Here, evidence of the inferential process of the ECDC was mostly based on textual sources. Trustworthiness is thus not as strong as in other cases where interviews could have brought additional evidence or at least confirm or infirm my own interpretations.

Overall, the two dimensions for case selection, ambiguity of the role of the ECDC and type of intelligence used for assessing health risks, did not produce the expected leverage. Other choices could have been made and should be considered in future studies, if the goal is to leverage comparison. Selecting cases of empowerment according to the type of purposeful agent could be a fruitful strategy, it would allow to contrast cases where the ECDC took on this role and cases where the Commission did. Audiences configuration could also be relevant. Indeed, does the relative importance of the scientific community vs policymakers among relevant audiences matter? The case of HIV/AIDS seems to indicate it is the case, but more comparative leverage is needed to properly draw conclusions.

This study also has limitations regarding the epistemology of power: while evidence was generated on empowerment, too little is known regarding what happens to this power over time. On HIV, for instance, it would be enlightening to analyse more closely what happened over the years that followed empowerment. This limitation is in part due to the fact that empowerment occurs in silos and thus, historical comparison was limited. This limitation would have been less important if time had permitted to include the case of COVID-19. Regarding the selection of cases based on *event-based monitoring*, COVID-19 would have been very useful to compare the 2009 H1N1 pandemic with a case wherein the ECDC is already an agency of *bricks and mortar.* This could have generated more points of comparative leverage

between those cases, and also would have generated useful contrast on social information with the most recent case in this study, the extension of the mandate to NCDs.

3. Generalizability and Contribution to the Literature

The methodological primary goal was to ensure internal validity. The role of this case-study was to highlight a deviant causal relationship *vis-a-vis* the general explanatory model of European agencies' empowerment (Gerring 2008; Lijphart 1971). Therefore, there is no aspiration in this study to claim strong generalizability. Nevertheless, findings highlight valuable lessons for the scholarship. In this section, I discuss generalizability through the prism of scope conditions. While the empirical scope of the study is modest, these findings have farther reaching implications for the conceptual scope and the causal scope of this study. The goal of contextualizing findings from a single case study is "to refine the portrait of the whole—in order to offer, in the end, a convincing representation of its complexity and diversity" (Becker 1998, 210). This discussion is divided in three parts, according to scope conditions (Emmenegger 2011; Goertz and Mahoney 2009; Tarrow 2010).

(1) **Empirical scope**, *i.e.* the empirical, temporal, spatial context wherein the mechanism of reputational empowerment is plausible. The ECDC's empowerment is anomalous with regard to other cases. It displays a surprising value (empowerment without de facto rulemaking) which, judged relative to the general model of causal relations that links empowerment and autonomy (Busuioc 2009;

Magetti 2012; Egeberg, Trondal, and Vestlund 2014; Groenleer, Kaeding, and Versluis 2010; Versluis and Tarr 2012; Guidi 2015), justifies the selection of a single case, according to Gerring (2008). The empowerment of the ECDC is relevant to the study of European agencies because there was much to understand about that case (Gerring 2008; Lijphart 1971). This thesis demonstrates that a power approach is relevant and, paradoxically that a power-based approach is the best way to not eschew from scientific scrutiny the least powerful European agencies including the European Agency for Health and Safety at Work (EU-OSHA), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the European Network and Information Security Agency (ENISA) or the European Institute for Gender Equality (EIGE).

(2) **Conceptual scope**, *i.e.* the core concepts that I operationalized, empowerment and reputation both bring relevant contributions to the literature The ECDC's empowerment is based on a peculiar *face* of power: conceptual power (Carpenter 2010), which relates to Lukes' third dimension of power (1974). Too little is known to date about how this form of power develops over time. As a future avenue for research, reputational empowerment is a robust framework to understand the mechanisms regarding how conceptual power is instantiated in multi-level and international settings, where the dispersion of power is important. in public institutions. Ultimately, studying conceptual power is relevant to understand further the role of experts in public policy (Rich 1991, Radaelli 1995, Dunlop and Radaelli 2013), albeit in roles where experts contribution is more nuanced and epistemologically more difficult to appraise than with directive or gate-keeping powers (Carpenter 2010). The unveiling of conceptual powers, is of paramount

importance to manage citizens' expectations and attention, and crucially, increase public accountability.

(3) **Causal scope.** The causal mechanism developed in this study was built on novel assumptions that relate to the literature on reputation (Carpenter 2000; 2001; 2010; Maor 2010; Carpenter and Krause 2011; Maor et al. 2013; Busuioc and Lodge 2015; Capelos et al. 2016; Maor 2016; Maor and Sulitzeanu-Kenan 2016; Lee and Ryzin 2019; Boon, Salomonsen, and Verhoest 2019; Overman, Busuioc, and Wood 2020). Ontologically, my approach privileged a thick description of reputation rather than reputation measured via dimensions. This choice was motivated by the ontological turn I operated: reputation is a form of dynamic social information, based on audiences' expectations. This approach has the advantage to qualify in context the reputation of the agency, rather than to rely on abstract measurements (dimensions of reputation) - an opinion that Carpenter has himself embraced recently regarding reputation (Carpenter 2020). Epistemologically, the causal mechanism of empowerment through reputation offers some advantage compared to approaches mostly concerned with reputation management: it invites scholars to appraise how reputation can be instrumentalized by other actors rather than agencies themselves, while still offering a useful episteme for agencies that would be power-hungry and curating a reputation for the purpose of power.

4. Future Potential Research

This is an exploratory study which, as a discussed in Section 3., has a limited scope. As a deviant case, this study uncovered a relevant mechanism for empowerment – one that was not considered previously (Gerring and Cojocaru 2015). The ECDC's empowerment is an anomalous outcome with regard to other cases of European agencies. Empowerment does not occur through the identified path of increased autonomy or independence but through the intercession of purposeful agents inferring from social information that an agency ought to do something about a problem. The goal of this last section is to suggest avenues for research that make use of the theoretical value of this finding. I suggest four avenues for future potential research. The first avenue is comparative and consists of testing the external validity of this theoretical proposition (Gerring and Cojocaru 2015) (1). Due to the exploratory nature of this study, the research design for reputational empowerment could be improved in future research, by systematising types of audiences as a contributing variable (2). This study also raises the question of the formation of reputation over time, notably in terms of aggregation (3). Finally, I conclude on the future of this study in the light of the COVID19 crisis (4).

(1) A comparative approach to reputational empowerment. The external validity of the proposition that social information that does not have intrinsic properties *vis-a-vis* power, but is put to use by purposeful agents to empower agencies ought to be assessed by further comparative analysis (Gerring and Cojocaru 2015, 64). This study explored a deviant case of European agencies

empowerment. To understand if this theoretical proposition can be applied beyond the case of the ECDC, a comparative analysis of European agencies' empowerment through reputation. Bureaucratic reputation does not need to be introduced to the study of European agencies, but the literature on European agencies and reputation has favoured the *accountability approach,* based on the claim that a reputation of credibility is a desirable asset (Majone 1997), which agencies should curate to manage accountability relationships (Busuioc and Rimkutė 2019; Ossege 2015). There is, however, an alternative route which can assist in understanding better the legitimization and empowerment of European agencies: one that acknowledges that an agency's reputation says as much about the agency as it does about its organizational environment. Overall, I propose to forge an avenue of research ahead of the notions of accountability and independence to bring in a power and reputation focused approach.

A comparative approach would allow for probing the causal mechanism with regard to different types of agencies, form the least to the most powerful in the EU (Busuioc 2013) and would be useful to look for the empowerment of European agencies beyond their autonomy to create rules. But future comparative research could also focus on comparisons between different contexts the EU's exceptionalism on matters of delegation. For instance, comparing in the same policy field, the ECDC and the US CDC. Additionally, a comparative reputational approach makes it possible to contrast the institutionalization of public policy actors in the decision-making process, particularly non-majority institutions and/or institutions that are offering scientific expertise.

(2) Refine the research design of reputational empowerment. Audiences are the "animating concept" of bureaucratic reputation (Carpenter 2010; Maor 2016). They interpret the role of the Centre and form social inferences about the Centre. Nevertheless, beyond treating audiences as the "producers" of social information, the research design of this study does not make an extensive use of audiences. Future research on empowerment through reputation, including the comparative approach suggested above, could make a more systematic use of audiences' status relative to each other. In the case of the ECDC, the configuration of audiences varied across cases, with a case such as HIV/AIDS with audience mostly made of experts and scientific institutions and the case of H1N1 mostly concerned with audiences made of decision-makers. More can be done in future research to categorise audiences and systematise their importance for empowerment. Such a research avenue would not only assert the field of empowerment in the reputational literature but would also open the black box of reputation as a vehicle for the power struggles that surround agencies.

(3) The aggregation of social inferences into reputation. Considering the ontological turn operated in this study – claiming that social information about the ECDC is the yardstick of what the Centre can appropriately do – the formation of reputation was treated in this study as a complex ad hoc process. More research can be done to systematise the aggregation of social inferences into a coherent reputation. Indeed, we must still expand our understanding of how audiences pass reputational judgments. If reputation is indeed a dynamic form of social information what are those dynamics? Audiences certainly pass judgements according to what they witness, as discussed earlier in this concluding chapter, each sequence of

empowerment leads also to reputational change. However, there are other mechanisms through which audiences pass judgements. Social inferences about an agency might be inherited from socialization with other audiences, hence raising questions on the diffusion of reputation. Audiences may embrace specific social inferences as the result of the agency's effort to curate a specific reputation, as demonstrated by Carpenter (2010). The reputation of an agency amongst citizen might have effects on how audiences of specialists view the agency (in the case of the ECDC, an agency of the EU Euroscepticism might paly a role in the way the public view or is even aware of the ECDC).

Building on the claim that social inferences as a form of attribution (Heider 1958, Jones and Davis 1965, Weiner, 1974, Ross and Anderson 1982), further research can be done on the micro-macro relationship in the process of reputation formation. In this research avenue, reputation scholars can emulate the recent "behavioural" shift in public administration, focusing on heuristics and cognitive biases. Heuristics and cognitive biases can assist in tracing the cognitive processes in which audiences engage when they pass on judgements and "mapping" the aggregation of social inferences into a coherent reputation.

(4) Future research on the ECDC empowerment and COVID-19. Turning back to the ECDC, more evidence is needed to appraise the mechanism of reputation empowerment amid the COVID-19 crisis. Early observations show that the case of COVID-19 has a strong potential as a positive case of empowerment. As a matter of fact, in recent months, the salience of COVID-19 has shifted the attention to increasing the role of ECDC in the *management* of health threats (Deruelle and

Engeli 2020). Indeed, before most European countries adopted measures of containment over the month of March 2020, the ECDC issued a risk assessment on 2nd March 2020 (ECDC 2020) which was structured around response measures, aligned with different scenarios of transmission progression. Containment was part of the advice that the ECDC suggested to follow as soon as clusters of human-to-human transmission would appear - a phenomenon that most Member States were experiencing at the time. Guidelines proposed by the ECDC were not unequivocal, five different scenarios were proposed and adapted to the variety of national contexts in the EU. Yet, the fact that a large number of Member States followed this advice constitutes a form of conceptual empowerment in and of itself: despite legal limitations, the ECDC has defined the terms of the debate on the type of measures of management that would be applied. This empowerment, while informal, is likely to be formalized, in a near future with a proposal from the European Commission to grant the ECDC with the capacity to recommend measures for controlling outbreaks, thus advising on risk management. While this was done in practice during the crisis, this measure would formally redefine the role of ECDC. However, as seen throughout the history of the ECDC, for change to actually translate into the real word, legal change must be followed by change in the logic of appropriateness - what audiences consider the ECDC ought to do - must change. Member States must consider that it is appropriate for the ECDC to engage in a form of entrepreneurship on the coordination of management. In sum, with COVID-19 as a clear transnational problem, the next empowerment of the ECDC on risk management depends crucially on what its audiences believe the Centre ought to do, *i.e.* its reputation.

Appendices

Appendix A: Ethics application

COLLEGE OF SOCIAL SCIENCES AND INTERNATIONAL STUDIES

All staff and students within SSIS should use this form; those in Egenis, the Institute for Arab and Islamic Studies, Law, Politics, the Strategy & Security Institute, and Sociology, Philosophy, Anthropology should return it to ssis-ethics@exeter.ac.uk. Staff and students in the **Graduate School of Education** should use ssis-gseethics@exeter.ac.uk.

Before completing this form please read the Guidance document

which can be found at http://intranet.exeter.ac.uk/socialsciences/ethics/

Applicant details	
Name	**Thibaud DERUELLE**
Department	**SSIS Politics**
UoE email address	**Td327@exeter.ac.uk**

Duration for which permission is required		
Please check the meeting dates and decision information online before completing this form; your start date should be at least one month after the Committee meeting date at which your application will be considered. You should request approval for the entire period of your research activity. Students should use the anticipated date of completion of their course as the end date of their work. Please note that retrospective ethical approval will never be given.		
Start date:04/03/2019	**End date:20/09/2020**	**Date submitted:**Click here to enter a date

Students only
All students must discuss (face to face or via email) their research intentions with their supervisor/tutor prior to submitting an application for ethical approval. **Your application must be approved by your first or second supervisor (or thesis supervisor/tutor) prior to submission and you MUST submit evidence of**

their approval with your application, e.g. a copy of an email stating their approval.	
Student number	**650051829**
Programme of study	**Doctor of Philosophy (PhD)** If you selected 'other' from the list above please name your programme here
Name of Supervisor(s) or Thesis Tutor	**Dr. Eva THOMANN**
Have you attended any ethics training that is available to students?	Yes, I have taken part in ethics training at the University of Exeter I audited the session on ethics in the POLM063 module last spring I have completed an online training "Research Integrity" on the learn upon platform under the supervision of Eva THOMANN Additionally, I have attended a one week course on Interpretivist research design at the ECPR summer school in Budapest (August 2017) with a one day session on ethics. Click here to enter a date.

Certification for all submissions

I hereby certify that I will abide by the details given in this application and that I undertake in my research to respect the dignity and privacy of those participating in this research. I confirm that if my research should change significantly I will seek advice, request approval of an amendment or complete a new ethics proposal. Any document translations used have been provided by a competent person with no significant changes to the original meaning.

Thibaud Deruelle

Double click this box to confirm certification ☒

Submission of this ethics proposal form confirms your acceptance of the above.

TITLE OF YOUR PROJECT

Unveiling a Discreet Power through Reputation: The (im)plausible regulator of disease prevention and control in Europe

ETHICAL REVIEW BY AN EXTERNAL COMMITTEE

No, my research is not funded by, or doesn't use data from, either the NHS or Ministry of Defence.

If you selected yes from the list above you should apply for ethics approval from the appropriate organisation (the NHS Health Research Authority or the Ministry of Defence Research Ethics Committee). You do not need to complete this form, but you must inform the Ethics Secretary of your project and your submission to an external committee.

MENTAL CAPACITY ACT 2005

No, my project does not involve participants aged 16 or over who are unable to give informed consent (e.g. people with learning disabilities

If you selected yes from the list above you should apply for ethics approval from the NHS Health Research Authority. You do not need to complete this form, but you must inform the Ethics Secretary of your project and your submission to an external committee.

SYNOPSIS OF THE RESEARCH PROJECT

Maximum of 750 words.

The aim of my thesis is to advance our understanding of the power of an agency of the European Union European Centre for Disease Prevention and Control (ECDC). Across the world, public health agencies are usually endowed with important regulatory powers. By contrast, the ECDC appears powerless—including a formal prohibition of regulatory power. This research project is at the intersection between the fields of regulation and public policy, which for the most part have neglected agencies and organizations with no authority to regulate. At the outset, my project draws on a seminal theoretical claim in the literature: that the source of power of an agency is its credibility rather than formal organizational arrangements. Studying the ECDC through the lens of reputational analysis unveils new dimensions of power, invisible to the conventional wisdom of regulatory studies. This claim is based on a causal argument: that there is a causal relationship between the reputation of the ECDC and variations in its power. Unveiling these causal mechanisms are expected to provide an answer to the central research question of this project: **how to explain, despite a formal prohibition of regulatory powers, that the ECDC still exercises some regulatory power?**

This question will be answered investigating four different regulatory processes: the creation of the agency, the prevention of HIV, the management of the H1N1 crisis and the policy against antimicrobial resistance.

My work belongs to the growing field of bureaucratic reputation that cultivates the claim that the credibility and power of a regulatory agency is in the eye of the beholder: the audiences. Audiences, for the ECDC refers to professionals who have been involved in the governance of disease prevention and can formulate subjective interpretations on the role and power of the ECDC. I will thus generate evidence through in-depth interviews. Reputation is not "out there" but constructed through the intersubjective meaning-making of the audiences. These interviews are the cornerstone of my empirical work. The role of interviews is not do uncover the truth but to create the conditions for interpretations to be spoken, understood and written. The generation of this tacit knowledge requires that interviewees put words on feelings and judgements about the ECDC while these impressions had been so far, perhaps, unconscious or simply never shared whether orally or in script. The crucial role of the researcher vis-à-vis the interviewees is to engage them in formulating beliefs and opinions.

I will be interviewing professionals of the control and prevention of diseases across Europe. That includes staff from regulatory agencies involved in health issues at EU level, staff from the WHO, staff from the European Commission, Members of the European Parliament and finally, national officials sent by their country of origin to advise on the activity of the ECDC in Stockholm. My interviews will thus lead me too five different destinations where I expect to interview elected as well as non-elected officials:

1. My first destination will be **Stockholm**, where the ECDC is based. My stay there should take up to 10 days as I hope to interview ECDC staff, hopefully the Director of the ECDC and/or staff close to her, as well as members of the Advisory Forum, a body within the ECDC, made of representatives of national regulatory bodies.

2. **Brussels**: I will then go on a long, intensive series of interviews at the European Commission, with Directorate General SANTE (health) staff, as well as Members of the European Parliament in Brussels. The former have been identified through the who's who of the European institutions, the latter have been selected because of the amendments they have presented during plenary sessions or because of their work as rapporteurs.

3. **Amsterdam**, **Paris**, **Parma**: additional interviews will take place in three additional locations: the World Health association Paris headquarters (WHO Europe), the European

Medicines Agency (EMA) in Amsterdam[13] and the European Food Safety Authority (EFSA) in Parma. Each of those 3 trips should not take more than half a week each, as my selection of potential interviewees is relatively smaller in those cases.

The data gathered during my field work will be used to achieve a better understandings of judgements, opinions and value that audiences have about the ECDC. Results are expected to provide an answer to the puzzle of how an agency without regulatory authority can nevertheless exercise power. By studying reputation in unusual organizational features, this research endeavour contributes to the ongoing debate on agencies and their regulatory powers in the EU.

INTERNATIONAL RESEARCH

It is intended that this research involves fata to face interviews with professionals located in Stockholm, Brussels, Amsterdam, Paris and Parma. All countries are EU Member States so I intend to abide by the RESPECT Code of Practice for Socio-Economic Research when carrying out these interviews. Sweden, the Netherlands, France and Italy are bound by European Directive 95/46/CE 'on the protection of individuals with regard to the processing of personal data and on the free movement of such data'. The Data Protection Act 1998 implemented this Directive in the law of England and Wales (and will still be into force at least for the Brexit transition period in the UK) and I will comply with its provisions.

Given these precautions and the fact that the participants are located in these countries but interviewed as professionals of an EU institutions or the WHO, I do not intend to make applications to Research Ethics Committees within Sweden, the Netherlands, Italy or France.

The following sections require an assessment of possible ethical consideration in your research project. If particular sections do not seem relevant to your project please indicate this and clarify why.

RESEARCH METHODS

The research will consist of in-depth interviews with experts and officials who participate to the governance of disease prevention and control in the EU. They either work in a full professional capacity or collaborate on an ad hoc basis to the

[13] Due to the British decision of leaving the UK, EMA is currently still in London. However, as of 30 March 2019, all staff will have settled in Amsterdam: https://www.ema.europa.eu/documents/other/ema-tracking-tool-relocation-amsterdam-main-milestones_en.pdf

activities of the ECDC, EFSA, EMA, WHO-Europe and public health related activities of the European institutions.

1. Designing data generation: in depth interviews

In-depth interview are designed in order to give enough flexibility to the process. The epistemology of this research is based on the assumption that knowledge is socially constructed rather than objectively determined. As I conduct interviews, I must enter the field with some prior insights while assuming that a fixed research design is inadequate due to the multiple, unpredictable and complex nature of reality. Indeed, an agency's reputation is not a visible "thing" but an image that embeds considerable uncertainty and ambiguity, evidence cannot be directly "collected" but rather requires access to the different audiences of the ECDC.

- In depth interviews are a dynamic method – one that offers flexibility in the interview itself and shifting standpoints over time. They are centred on discursive and dialectical conversations with interviewees and are particularly relevant for cases where behaviours and interests are better understood in the field than from theoretical inference.
- In depth interviews allow for an important degree of flexibility and allow to adopt different stances towards the interviewee, which are necessary when considering the power relations between interviewer and interviewee. In-depth interviews are generally open-ended, to provide the interviewee with the occasion to use particular words of interest. It is however structured to the extent that interviews will be on specific issues of disease prevention.
- Finally, in-depth interviews usually allow the researcher to record a verbatim transcript, making it easier to abide by the precept that concepts are defined in situated knowledge claims. Interviews offer a way to learn how individuals knit together their own conceptions and put them to use, and thus offer an excellent way to map the conceptual world of participants in ways that illuminate both coherence and inconsistency.

2. Sampling: identifying interviewees

I have designed the sampling of this research according to two principles: exposure and inter-textuality:

- The concept of exposure rests on the notion that the inquiry must remain opened to the wide variety of meanings made by research-relevant participants of their experiences. Interpretive research designs must anticipate that experiences and views will vary, especially in a multilevel system such as the EU where individual actors are often part of an organization itself situated in a larger organizational order.
- The efforts to maximise exposure point the researcher to different sources and forms of evidence which underlines the inter-subjectivity of the evidence generated. As a precept, this inter-subjectivity can be approached by the researcher as inter-textuality: evidence can be "read" for what they reveal about different interpretations of the object of study. This particularly relevant for the study of reputation in which opinions and judgements can be inter-subjective and shaped by an entire network of actors.

Potential interviewees, representative of the ECDC audiences have been identified, function of their involvement with specific organization of interests. These organizations are audiences of the ECDC as well as the ECDC itself. Due

to the discreet nature of the ECDC, the agency has fewer audiences that one could expect. It makes the case of the ECDC more approachable for a lone researcher with limited means. Participants are expected to provide two type of knowledge: subjective knowledge at the level of the organization they belong to (what were the dominant views within an organization) and subjective knowledge from their individual level. The goal of sampling in this research is thus to maximise exposure and intertextuality in order for me to interview different "storytellers". Participants are expected to illustrate their version of the action and ultimately provide an interpretation or a commentary and reflect a particular understanding of disease prevention and control (for more details on the participants, see box below).

3. Analytical procedure: policy narrative analysis

I will analyse the data from interview using a systematic approach to narrative and metanarrative analysis. Narratives are sequences of events, actions and sometimes lessons, with a plot tying together different parts into a meaningful whole. "Storytellers" illustrate their version of the action, through narratives that reflect a particular understanding of public policy making. This research analyses narratives about the organization of disease prevention and control. Narratives in themselves are not a cause, but harbour the different meanings given to the organization, its "reputation", which in turns has an effect on its ability to yield regulatory powers. Narrative analysis is thus a method to analyse how different actors have different representations about the reputation.

Following this first step, I will identify "dominant narratives" and counter-stories which are contrary to the dominant narrative. The goal of the method is to generate a metanarrative, derived from a comparison between the pluralities of voices. Metanarratives are policy narratives that embrace the major oppositions to an issue without in the process slighting any of that opposition. Within that large picture, a smaller picture will emerge from the analysis, one that explains the role of the ECDC.

Because conflicting meaning can be made of the organization's role and tasks, the causal mechanism of meaning making cannot be uniform. Rather it is expected to be largely contextual and contingent to representations of the organization amongst audiences. The metanarrative analysis offers the analytical leverage to contextualise the importance of these images and the relative effect of the meaning they carry.

The action points below follow the chronology of making sense of the data and suggest in a hermeneutic fashion to start by identifying narratives, then from narratives to construct a metanarrative and from this metanarrative to cast a new meaning on selected elements, thus making the narrative analysis an iterative process of sense-making.

a. Identify narratives: what "stories" do participants tell on disease prevention and control? Does it involve the ECDC?
b. Analyse narratives and understand their relative importance in the metanarrative
c. Run an analysis of the narratives: moving from stories to common element: images and representations that relate to the ECDC, its role and power
d. Make sense of the relative effect of the meaning made of the ECDC, whether it is embedded in the dominant narrative or conflicting narratives

4. Expected outputs

Results will be featured in their entirety in my PhD thesis. Nevertheless, I will also develop two additional papers which I would like to present at conferences such as PSA and ECPR, and hopefully submit for review in journals like Governance or Public Administration.

PARTICIPANTS

I will interview participants who are officials.

The first type of participants are staff of the organizations of interest. That includes ECDC staff, EFSA staff, EMA staff and WHO-Europe staff. All of them are either working on a permanent basis in their respective organizations or invited on an ad hoc basis to participate as experts. For each organization, I will contact around 10 people (a total of 40). In each case participants have been identified as members of staff in a managerial position who can discuss issues of governance. Names have been identified on the organizations' websites and in minutes of meetings.

The second type of participants includes officials who work in the "advisory forum" of the ECDC. These participants are actually national officials sent by their country of origin to advise on the activity of the ECDC in Stockholm, I plan on interviewing the official from France, Denmark, Germany due to their acute involvement in salient public health issues (3). Names have been identified in minutes of meetings.

Finally I will also interview officials from the European Commission and the European Parliament. In the case of the Commission I foresee 10 potential interviewees, identified on the website of the European Commission, in the case of the European Parliament, 6 MEPs have been identified thanks to the amendments they have tabled on the topic of interests (16 participants).

The total number of potential participants is rather large, bringing the number at 58. However, this is an "ideal" number of participants. My concern is that in the reality of the field, the number of participants will automatically shrink and that in some cases, interviews will be more useful to triangulate the knowledge already gathered rather than shed light on new elements. The large number is also a way to prevent that if an important number of them refusing to participate I still have enough participants to analyse data. My research is based on thick data rather than thin data, and therefore a few insightful interviews will always be more relevant than 58 superficial ones.

THE VOLUNTARY NATURE OF PARTICIPATION

I am likely to rely on emails to recruit experts and officials. Several email contacts have already been obtained from the websites of the organization I want to visit. As those organizations have a policy of transparency, obtaining identities and contacts has been a relatively easy task. I will use my university email address to establish a relationship of trust with my interviewees.

I will include an information sheet (see below) and will seek written consent (see below) from my participants in the early stages of our exchanges, both are based on the University's template. The consent form includes different levels of confidentiality that the participant can choose. When relevant, confidentiality will be preserved. Participation will also be voluntary. At the start of interviews I will ask participants whether they accept to be recorded and explain to them that they can stop the recording at any point during the session.

Participants will be able to withdraw from the research at any time. The information sheet emphasises that all participation is voluntary, consent can be withdrawn at any time and anonymity is granted by default. If data has already been fully anonymized, consistent with the data protection act/GDPR, personal identifiers have been removed, the identification key is destroyed and it is no longer possible to identify an individual's data and remove it.

SPECIAL ARRANGEMENTS

No special arrangement appear to be necessary at this stage. I plan on meeting people in their work environment and as long as oral communication is possible, the conduct of interviews should not face any specific difficulties.

THE INFORMED NATURE OF PARTICIPATION

The sample consent form I attached includes information about the nature of the project that I will give to participants. I will summarize key points at the start of each interview. Questions raised by participants at any stage of the process will be answered as promptly and as professionally as possible.

ASSESSMENT OF POSSIBLE HARM

All my interviews will be done with individuals answering in a professional capacity. Potential harm for the interviewees includes professional opinions that might damage their careers and/or professional interests. This is a hypothetical situation

with a low probability, nevertheless, I do address these unlikely scenarios by anonymizing by default the interviews.

My own safety is not peculiarly at risk. My travels will be limited to EU countries. Interviews will be conducted in the offices of agencies as well as other public bodies and I do not foresee potential physical harm nor an increase in exposure to accidents. The interactions I will have with my interviewees will be limited to the topic of health prevention, I therefore do not expect to be exposed to emotional or psychological harm, nor to be exposed to compromising situations.

I plan to be in daily contact with both of my supervisors, who will be able to locate my geographical position and with whom I will check before and after interviews, by email. If interviews are not possible on the informants' workplace, I will suggest a relocation in a public space (most likely a coffee place selected prior). I will not meet them in private locations (such as their own house).

DATA PROTECTION AND STORAGE

I will capture the identity as well as the job description (past or present dependent on the events discussed) of the participants. Interviews will be anonymous by default. Participants will be given the choice to disclose their identity on the consent form. Would they not choose to disclose their identity, I will not record any personal information about participants on my recording device at the beginning of the interview. Participants will also be given the choice to not be recorded, as clearly indicated on the consent form.

If informants opt-out of anonymity, any social identifier regarding the participants will exclusively include name and profession. No data will be stored regarding gender or political affiliation.

The consent form will also include how data will be stored. Whether or not the participants will accept to disclose their identity, I will follow a similar protocol to data storage:

- Consent forms will be scanned and stored in a password protected file on my University OneDrive. The original forms will be shredded.
- Digital recordings will be deleted as soon as I have an authoritative transcript of the interview. I will write the transcript myself.
- The transcripts will be kept in a password protected file separate from the consent forms on my professional OneDrive.
- All remaining data (forms and transcripts) will be destroyed as soon as my PhD is awarded

Data will be kept confidential and handled in accordance to the European General Data Protection Regulation 2016/679.

DECLARATION OF INTERESTS

My PhD is not funded. I assume the costs on my own personal funds. Nevertheless, I have recently applied for a scholarship awarded by UACES for PhD students trying to undertake fieldwork in EU contemporary studies.

The participants will be informed that no commercial or political interest is involved in the project. If UACES kindly accepts to award me a scholarship, participants will be made aware.

The results will only be used for academic purposes: they will be featured in their entirety in my PhD thesis. Nevertheless, I will also develop two additional papers which I would like to present at conferences such as PSA and ECPR, and hopefully submit for review in journals like *Governance* or *Public Administration.*

USER ENGAGEMENT AND FEEDBACK

I plan on relying on user feedback only if the content of interviews needs further exploration. Some aspects of this research involves discussing topics in which my expertise is limited (public health) and further clarification could be needed. As for use engagement, I plan on disseminating the results of my research to them as soon as it is published in peer-reviewed publications.

Participant Information Sheet

Title of Project: Unveiling a Discreet Power through Reputation: The (im)plausible regulator of disease prevention and control in Europe

Researcher name: Thibaud Deruelle

Invitation and brief summary:

Across the world, public health agencies are usually endowed with important regulatory powers, by contrast, the ECDC appears powerless—including a formal prohibition of regulatory powers. Based on interviews with professionals of the control and prevention of diseases across Europe, this research seeks to decipher how an agency without regulatory authority can nevertheless be the cornerstone of regulation. Participants will be interviewed with regards to their appraisal of four key moments in the existence of the ECDC: its creation, its role in the prevention of HIV, in the anti-microbial resistance policy, and in the management of the H1N1 crisis.

Please take the time to consider this information carefully and to discuss it with your management and/or colleagues.

Purpose of the research:

This project contributes to a better understanding of the governance of disease prevention and control and of the role information-based agencies like the ECDC hold in the organization of this policy.

Why have I been approached?

This research project is highly reliant on your experience vis-à-vis events that relate to your professional activities. You have been approached for this study because your professional experience as well as your expertise regarding the issue of disease prevention and control in Europe is highly valued. All participants are either experts or officials in the field of public health and the results will show faithful depictions of their testimonies.

What would taking part involve?

Taking part in the study involves one interview which is most likely to last for 30mn to an hour.

- I would like to record the interview with your permission, would you not allow it, you will be able to clearly indicate so on the consent form.
- You can stop the interview at any time and you will only have to answer questions you want to answer. All questions will be related to your professional activities.
- Sections of the transcript may be published as a way to illustrate my statements, in journal publications and in my thesis.

- Your name and your precise professional title will only be revealed with your express consent (see consent form attached).

What are the possible benefits of taking part?

This research aims to shed light on and give a faithful report on the nature of your activities in the prevention and control of diseases in Europe. Research like mine contribute to the field of EU policy in the EU and publicize activities that are largely unreported to an audience beyond your specific policy and scientific communities. One of the point of this research endeavour is to understand the governance of disease prevention and as such the results can contribute to the functioning of your professional field.

What are the possible disadvantages and risks of taking part?

I do not foresee important disadvantages or risks in taking part to the study. Nevertheless, if you consider that the content of your interview could lead to potential professional damage, you may at any stage of the process and before results are published, request for your interview to be anonymized or you may withdraw your participation.

How will my information be kept confidential?

You would participate to this project in a professional capacity and your identity will remain **anonymous** unless you give express consent in the form attached. **,** You **can** also **opt-out of being recorded**, in that case I will only take handwritten notes

Your data will be safe and secure and whether or not you choose to disclose your identity, I will follow a similar protocol to data storage:

- **Consent forms** which compile your data about you will be scanned and stored in a password protected file on my professional OneDrive. The original forms will be shredded.
- **Digital recordings will be deleted** as soon as I have an authoritative transcript of the interview. I will write the transcript myself, most likely within a week in order to be the most faithful to our discussion
- **The transcripts will be kept in a password protected file** separate from the consent forms on my professional OneDrive.
- **All remaining data (forms and transcripts) will be destroyed as soon as my PhD is awarded**.

Data will be kept in accordance to the European General Data Protection Regulation (GDPR). Personal data (name, profession) will be kept on Thibaud Deruelle's professional OneDrive in a password protected file and that, according to the GDPR, the data will not be transferred outside of the European Economic Area. No special category of personal data (as defined in the GDPR) will be collected (racial or ethnic origin; political opinions; religious or philosophical

beliefs; trade union-membership; data concerning health; sex life and sexual orientation; genetic data; biometric data).

What will happen if I don't want to carry on with the study?

You are free to stop taking part in the study at any time and without having to give a reason to withdraw. If an interview was already carried on, your data as well as any notes taken during our interview will also be promptly destroyed. Once data has been fully anonymized in a manner that is consistent with the data protection act/GDPR (personal identifiers have been removed, the identification key is destroyed), it is no longer possible to identify an individual's data and remove it. In order to exert your right to withdrawal, please note that data can only be withdrawn prior to full anonymization.

If you wish to withdraw, you can simply do it by contacting me by email td327@exeter.ac.uk

Will I receive any payment for taking part?

Your participation to my research project is highly valued, however your participation to the interview is not remunerated.

What will happen to the results of this study?

The results will only be used for academic purposes: they will be featured in their entirety in my PhD thesis. Nevertheless, I will also develop two additional papers which I would like to submit for review in journals like *Governance* or *Public Administration.* This research is not intended for publication in journals of public health. As soon as published results become available, I will communicate the outlet to you via email.

Who is organising and funding this study?

The research is entirely self-funded

Who has reviewed this study?

This project has been reviewed by the Research Ethics Committee at the University of Exeter (Reference Number….),

Further information and contact details

You can reach me:
Thibaud DERUELLE, td327@exter.ac.uk, by phone at +44 743 809 89 06 or directly at this address::
Department of Politics, University of Exeter
Amory Building, Rennes Drive, Exeter, EX4 4RJ UNITED KINGDOM

If you wish to address concerns to a third party, please contact my supervisor:
Dr Eva Thomann
E.Thomann@exeter.ac.uk
Department of Politics, University of Exeter

Amory Building, Rennes Drive, Exeter, EX4 4RJ UNITED KINGDOM

If you wish to know more about the ethical fitness of this project, please contact SSIS College ethics officer, Research Ethics and Governance Manager at the University of Exeter ssis-ethics@exeter.ac.uk+44 1392 726621

Thank you for your interest in this project

CONSENT FORM TEMPLATE THAT SIGNED BY PARTICIPANTS

Participant Identification Number:

CONSENT FORM

Title of Project: Unveiling a Discreet Power through Reputation: The (im)plausible regulator of disease prevention and control in Europe

Name of Researcher: Thibaud Deruelle

Please tick the appropriate boxes

1. I confirm that I have read the information sheet dated..... (version no.....) for the above project. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my legal rights being affected. ☐

3. I understand that taking part involves being interviewed and that this interview will be recorded and transcribed to be used for academic purposes only and that the transcript will be stored in a secure cloud base data storage until the completion of this project (up to 5 years). ☐

4. In the case I do not want to be recorded, I understand that the interviewer will take notes of the interview` ☐

5. I understand that recordings, transcript and notes of the interview are anonymized by default. Nevertheless and having considered the potential harm that it could cause professionally, I opt out of anonymity ☐

(In accordance to the data protection act/GDPR personal, full anonymity requires identifiers to be removed and identification keys to be destroyed. If you remain anonymous, once data is fully anonymized, it is no longer possible to identify your individual's data and remove it from the study. In order to exert your right to withdrawal, please note that data can only be withdrawn prior to full anonymization).

In the case I opted out of anonymity, I accept the following information to be indicated in future publications:

Name of the organization I currently or used to work for ☐

Current or past position ☐

Full name ☐

(Please check the boxes according to the level of confidentiality you are comfortable with. Would you like to change the level of anonymity you have agreed to after signing this form, please contact me at td327@exeter.ac.ukor by phone +447438098906)

6. I understand that the personal data shared with Thibaud Deruelle is protected by General Data Protection Regulation and that this data will be kept on Thibaud Deruelle's professional OneDrive in a password protected file and that, according to the GDPR, the data will not be transferred outside of the European Economic Area. ☐

7. I understand that relevant sections of the data collected during the study, may be looked at by Thibaud Deruelle's supervisors, Dr. Eva THOMANN and Dr. Angela CASSIDY. I give permission for these individuals to have access to my records. ☐

8. I understand that the data will be used for the purpose of academic publications in peer reviewed journals in the field of public policy and political science, as well as for the purpose of a PhD thesis. ☐

9. I agree to take part in the above project. ☐

_____ _____ _____

Name of Participant	Date	Signature
_____	_____	_____
Name of researcher taking consent	Date	Signature

When completed: 1 copy for participant; 1 copy for researcher/project file

Appendix B: Table for comparative narrative analysis according to narratives the elements

See next page

Case	Narrative title	Temporality	Narrators / Protagonists	Organizational interest specific point of view, interpretive frames of the narrators	Causation is the linkage between the purposes or motives of the protagonist and a course of action	Evidence on empowerment	Evidence on reputation as dynamic social information
1	*Not another European Institution*	*1993-2002*	*The Charter group*	*Preserving networked organization of communicable disease control*	*Opposing the "brick and mortar" solution*	*X*	*Centre solution is not favoured*
	Not a New SANCO Agency	*1998-2002*	*DG SANCO*	*Promoting the creation of a centre for disease control*	*Rallying the European Commission to the idea of a new agency*	*X*	*Centre solution progresses among future audiences*
	The Construction of Health Threats	*2001-2002*	*European Institutions*	*Recognising the transnational dimension of health threats*	*Coming to terms with the need for better coordination*	*X*	*Current arrangements are not deemed enough anymore (performative dimension)*
	DG SANCO Officials as a Purposeful Agents	*2002-2004*	*DG SANCO*	*Creating an agency that will respond to future audiences' expectations*	*Inferring, from social information, the design of the ECDC*	*Formal delegation of surveillance harmonization*	*Audiences form social inferences about new organizational arrangements*
2	*The added value of harmonized surveillance*	*2005-2008*	*ECDC - Surveillance and Communication Unit*	*Fulfilling its mandate and demonstrating the "added value" of the Centre*	*Evaluating DSNs, developing new processes, new information-exchange systems and common definitions*	*X*	*Reputation building strategy based on added value (technical dimension)*
	Coping with organizational change	*2005-2008*	*DSNs*	*Preserving DSNs features*	*Contesting harmonization process (organizational change and information-exchange system)*	*X*	*Harmonization seen as not flexible enough (decrease moral dimension)*
	EuroHIV's expectations	*2005-2009*	*ECDC - Surveillance and Communication Unit*	*Demonstrating the "added value" of the Centre*	*Taking stocks of expectations in building surveillance*	*X*	*Expectations to further the work accomplished through network governance (technical) and flexibility (moral dimension)*
	From Surveillance to Prevention in the Fight against HIV/AIDS	*2009-2016*	*ECDC - Surveillance and Communication Unit*	*Responding to expectations*	*Inferring need for guidance on behavioural prevention*	*Taking-on advisory role in behavioural prevention*	*X*

Case	Narrative title	Temporality	Narrators / Protagonists	Organizational interest specific point of view, interpretive frames of the narrators	Causation is the linkage between the purposes or motives of the protagonist and a course of action	Evidence on empowerment	Evidence on reputation as dynamic social information
3	*Preparedness for Crisis Management*	*2005-2009*	*DG SANCO*	*Responding to anxiety following SARS crisis and avian flu*	*Preparing for the next crisis with WHO*	*X*	*X*
	Making sense of turf in surveillance	*2005 - April 2009*	*ECDC - Unit for Preparedness and Response*	*Making sense of own role in a crowded monitoring system*	*Cooperating with WHO on building system of surveillance through IHR*	*X*	*Surveillance seen as redundant vis-à-vis WHO (decrease procedural dimension), threat to uniqueness*
	Walking the fine line between risk assessment and risk management	*2005 - April 2009*	*ECDC - Unit for Preparedness and Response*	*Making sense of the fine line between assessment and management*	*Inferring need for advice on management as crisis starts*	*X*	*Ambiguity on the distinction between assessment and management (procedural dimension)*
	You can't do public health without having to talk about vaccines	*July to December 2009*	*DG SANCO*	*Shifting preparedness plans following reduced uncertainty*	*Inferring a role for ECDC in the advising on vaccines*	*Taking-on advisory role on vaccines*	*Reputational gains for the ECDC (performative and technical dimension)*
4	*Developing a unique turf*	*2005-2009*	*ECDC - Management*	*Developing a turf in AMR*	*Demonstrating commitment of the Centre on AMR*	*X*	*Reputation building efforts (technical dimension)*
	Reputation-making through scientific synergy	*2009-2015*	*ECDC, EFSA, EMA*	*Committing to the development of integrated surveillance*	*Making sense of respective turfs in surveillance*	*X*	*Reputational gains for the ECDC (technical dimension)*
	Seizing the rewards of technical cooperation	*2016 - 2019*	*ECDC - Management*	*Responding to expectations as the reference for human health*	*Making sense of advisory role on AMR plans*	*Taking-on advisory role on AMR plans*	*X*
5	*The thorny issue of NCDs*	*2014-2019*	*Management Board of the ECDC*	*Rallying behind the idea of extending the scope of the ECDC's remit to NCDs*	*Facing the lack of the ECDC's appetence for an extension of its mandate*	*X*	*Expectations have changed through time but do not translate into empowerment*

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