

# **From Outbreak to Pandemic Narrative: Reading Newspaper Coverage of the 2014 Ebola Epidemic**

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**ABSTRACT** *Using framing analysis, this article explores how the English language press organized coverage of the 2014 Ebola epidemic in West Africa. The coverage began with a standard “outbreak” narrative that defined the problem in terms of “primitive” lifeways and inadequate humanitarian aid. However, after the World Health Organization declared an international emergency and after Ebola carriers began to appear in the West, the framing changed toward a “pandemic” narrative that shifted attention away from medical solutions, humanitarian aid, and national safety toward government and military action, biosecurity, and the global species network. This change in the press narrative makes sense to populations in the West because they increasingly live within a “pandemic culture” that has become characteristic of globalized societies.*

**KEYWORDS** *Press coverage; Ebola; Pandemic narrative*

**RÉSUMÉ** *Cet article a recours à une analyse des cadres pour explorer comment la presse de langue anglaise a couvert l'épidémie d'Ébola en Afrique de l'Ouest. Cette couverture a commencé par une narration conventionnelle sur les origines de la maladie qui a mis l'accent sur les modes de vie « primitives » et l'aide humanitaire inadéquate. Cependant, suivant l'état d'urgence déclaré par l'Organisation mondiale de la santé et l'arrivée de personnes atteintes d'Ébola en Occident, le cadre narratif a changé, soulignant l'idée d'une « pandémie » tout en attirant l'attention du public sur les interventions gouvernementales et militaires, la biosécurité et le réseau mondial d'espèces plutôt que sur les solutions médicales, l'aide humanitaire et la sécurité nationale. Ce changement narratif paraît normal pour les populations occidentales parce que celles-ci vivent de plus en plus dans une « culture de la pandémie » typique des sociétés mondialisées.*

**MOTS CLÉS** *Couverture médiatique; Ébola; Narration pandémique*

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*Canadian Journal of Communication* Vol 41 (2016) 611-630  
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## Introduction

Since the appearance of HIV/AIDs in the 1980s, people around the world have experienced an increasing number of news stories about emerging diseases that may pose a threat to populations in the global North. These include, in the last decade alone, Avian Flu, SARS, H<sub>1</sub>N<sub>1</sub> and its variants, and Ebola. Analysts have noted that news coverage of disease outbreaks has developed into a standard story format that involves three general stages: sounding the alarm, mixed messages, and crisis and containment (Holland & Blood, 2010; Nerlich & Halliday, 2007; Ungar, 2008; Vasterman & Ruigrok, 2013). This framework tells a story about a growing threat to a community, uncertainty about what it means and how to effectively respond, and ultimately the triumph of medical expertise and health authorities.

With the 2014 Ebola outbreak in West Africa, the press once again mobilized this standard story framework. Beginning in late March, when reports of the outbreak began to surface in the West, journalists cited health authorities and medical personnel from humanitarian organizations, who began to call for international aid, drawing attention to this deadly disease. The outbreak likely began in Guinea in late December 2013, eventually spreading primarily to Sierra Leone and Liberia. Over the next several months, over 28,000 people were infected and over 11,000 died.

The virulence, lethality, and extreme symptoms of the disease marked it out as a much more dramatic news event than other recent outbreaks. As concern mounted about the potential for international spread, it soon became apparent that the World Health Organization (WHO) was in no position to lead an international response. National governments began to reinforce their biosecurity<sup>1</sup> systems to reassure their populations that there was no cause for alarm. Journalistic accounts, however, provided mixed messages about the efficacy of these systems, while continuing to publish apocalyptic stories describing conditions in West Africa and the inadequacy of Northern aid being sent to the affected region. When an Ebola carrier travelled to the United States from Liberia and infected two nurses on September 24, 2014, the press coverage entered into a crisis and containment stage of reporting—the “developed” world was under direct threat.

At this stage of the reporting, however, the nature of the story changed away from the standard disease narrative. The crisis and containment stage did not work out the way it was supposed to—a story about impermeable national border security combined with containment of the disease in Africa through financial aid and medical science. Instead, as the disease continued to spread, the United States, France, and Britain responded by sending large-scale military missions and billions of dollars to the affected countries to build clinics, oversee the transportation of supplies, train local people to work in the clinics, coordinate the work of other agencies, and provide security, beginning the process of building a biosecurity system in West Africa. Although this response was reported as a containment of the outbreak, it actually marked a shift in the standard disease story. It incorporated an element of the “pandemic narrative” (Gerlach & Hamilton, 2014) to make sense of the failure of containment, to address high levels of anxiety in Northern populations, and to map out responsibility for managing biosecurity.

This article explores the characteristics of the standard disease narrative in English language newspaper coverage of the 2014 Ebola outbreak, and, using a framing analysis, outlines the ways in which the press organized the story. Asserting that two events were instrumental in shifting the story toward a pandemic narrative, the article defines the concept of the pandemic narrative and shows how it applied to the press coverage. Finally, it argues that the pandemic narrative is a discursive resource that emerges from a broader “pandemic culture” that is increasingly characteristic of globalized societies. From this perspective, the press coverage of the 2014 Ebola outbreak contributes to our understanding of what it means, and what it feels like, to live within pandemic culture.

### **Telling disease stories**

Despite the large sample size analyzed in this research project, a framing analysis is useful for examining in more depth the narrative elements of the news stories. Frames are “a central and organizing idea or story line that provides meaning to an unfolding strip of events” (Gamson & Modigliani, 1987, p. 143). They organize, embed, classify, and interpret for the reader the large amount of information in public circulation (Entman, 1993; Gamson, 1989; Tuchman, 1978). Through a process of “selection and salience,” (Entman, 1993, p. 52) frames privilege particular understandings of reality. They teach the receiver how to make sense of facts and how to contextualize problems, information, and characters. When used repeatedly, frames configure and delimit the range of interpretations available to the public. They also indicate how specific centres of power can shape the ways in which meanings are ascribed to events (Entman, 1993). As is common in newspaper disease reporting, the sources cited in the Ebola coverage included the typical set of institutional actors who are usually consulted and quoted to frame the issues, the top four of which included the WHO, government health officials, the U.S. Centers for Disease Control and Prevention (CDC), and Médecins Sans Frontières (MSF).<sup>2</sup> Interestingly, the tone of the coverage of these organizations tended to become more negative as the crisis developed, with the exception of MSF which, for much of the time, was the only major international organization providing medical services in the affected regions.

A number of analysts have noted that there is a set of journalistic frames that offer conventions and forms for telling the disease story. The frames will vary to some extent depending on whether or not the disease has broken out in the global North or South, but generally, are organized into a three-part narrative structure. The first part is the “sounding the alarm” stage in which the disease is first reported with a focus on the speed of its spread, calls for humanitarian aid, human interest stories from the affected areas, and statements from medical experts and health officials on the risk it poses to the global North. The second stage is the “mixed messages” stage in which stories of the disease spread continue along with speculations on potential impacts on other regions. These reports are combined with stories about national preparedness plans, border security precautions already in place, and aid sent to diseased areas. The third stage is the “crisis and containment” stage, which relates stories of infections that have reached the audience’s home country, but also provides reassurances that the medical system can control the disease spread and remove the threat from the community (da Silva Medeiros & Massarani 2010; Ungar, 2008; Vasterman & Ruigrok, 2013).

Sheldon Ungar (1998) goes further with this analysis by defining the conditions in which a perceived crisis can become a “hot crisis.” He defines hot crises as those that “entail dread-inspiring events that are developing in *unpredictable* ways and are seen as having the potential to pose an imminent personal threat to specific populations” (p. 37). Examining the Zaire Ebola outbreak of 1995, Ungar (1998) argues that the press employed a “mutation-contagion package” of discursive tools that characterized the outbreak frames including: “microbes are on a rampage,” “microbes are cleverer than us,” “engineering microbial traffic,” “microbes know no boundaries,” and “waiting for the next plague” (pp. 43–44). The result of this framing was a hot crisis because contextual factors like the recent publication of widely discussed books such as Richard Preston’s *The Hot Zone* (1994) and Laurie Garrett’s *The Coming Plague* (1995) as well as the popular film *Outbreak* (Henderson, Kopelson, & Petersen, 1995), had just set an apocalyptic context that could be attached to the real events of the Ebola outbreak. However, if a hot crisis occurs, primary definers in the media work to contain it and reduce fear by “othering” (pp. 49–50) the crisis—emphasizing its location in a remote, underdeveloped part of the world—and by highlighting the strengths of Western medical regimes. This “containment package” (p. 52) was mobilized very quickly in the Zaire Ebola coverage of 1995 and was quite successful in allaying public fear.

Priscilla Wald (2008) argues that journalistic narrative framing, such as the Zaire Ebola coverage analyzed by Ungar (1998), participates in a deeper “meta-frame” that she refers to as the “outbreak narrative.” Reading across works of journalism, fiction, film, popular science, and government policy, Wald (2008) states:

The outbreak narrative—in its scientific, journalistic, and fictional incarnations—follows a formulaic plot that begins with the identification of an emerging infection, includes discussion of the global networks throughout which it travels, and chronicles the epidemiological work that ends with its containment. As epidemiologists trace the routes of the microbes, they catalog the spaces of global modernity. Microbes, spaces, and interactions blend together as they animate the landscape and motivate the plot of the outbreak narrative: a contradictory but compelling story of the perils of human interdependence and the triumph of human connection and cooperation, scientific authority and the evolutionary advantages of the microbe, ecological balance, and impending disaster. (p. 2)

According to Wald, accompanying this narrative structure is a set of characters that includes heroic medical personnel; threatening military authorities; valorous disease detectives; patients zero; hapless carriers; populations that continue to practice “primitive” lifeways; and a vicious, anthropomorphized virus. In the end, the outbreak narrative reaffirms the authority of science and the security of national boundaries. Journalistic disease stories draw upon the outbreak narrative format, culminating in two types of containment. The disease is contained through the efforts of medical practitioners and health authorities, who retain a heroic status in the narrative (Everts, 2013). Public anxiety is contained through the repetition of the familiar narrative structure and frames, with their reassurances of the security of the national community (Davis, Stephenson, & Flowers, 2011).

With the 2014 Ebola outbreak, however, the standard press outbreak narrative, with its usual frames, did not work. As in other cultural sites, that narrative is fraying around its edges. Popular culture in particular has explored unsuccessfully contained disease threats through literature (Atwood, 2004; Simmons, 2010; Whitehead, 2012), films such as *Contagion* (Shamberg, Sher, Jacobs, & Soderbergh, 2011), *World War Z* (Bryce, Gardner, Kleiner, Pitt, & Forster, 2013), and *Dawn of the Planet of the Apes* (Chernin, Clark, Jaffa, Silver, & Reeves, 2014), television programs such as *The Walking Dead* (Darabont, 2010), *The Last Ship* (Kane & Steinberg, 2014), and *The Strain* (del Toro & Hogan, 2014), and games such as *Pandemic* (Z-Man Games, 2007), *Plague Inc.* (Ndemic Creations, 2012), and *Pandemic 2.5* (Dark Realm Studios, 2012). These and many other examples no longer work on the assumption that standard biosecurity procedures can protect us from emerging diseases within our globalized society. This same logic is entering into press coverage as well.

### **Framing Ebola**

Examination of the Ebola press coverage elicited a number of questions. How were the Ebola stories being told? What elements were present to produce a particular set of meanings? How were the stories being classified and contextualized by the press? What range of interpretations was opened up by the configuration of the stories?

To answer these questions, a Factiva database search of newspaper articles for the period from January 1 to December 31, 2014, was conducted. Preliminary research showed that this time period would include the earliest references to the Ebola outbreak in the international press—starting on March 22 when Guinean officials confirmed that a spreading infection was Ebola—to the point at which the story began to drop out of the press coverage as a major international story in mid-December.<sup>3</sup> Search terms included: Ebola, Ebola outbreak, Ebola epidemic, Ebola pandemic, Ebola outbreak in West Africa, and Ebola virus in West Africa. The search turned up 115,512 newspaper articles from around the world.

The search was further limited by focusing on English-language newspapers in the global North. Reviewing these sources revealed that the newspapers with the most stories and with the most in-depth reporting included the *Washington Post*, the *New York Times*, and the *Wall Street Journal* from the United States; the *Guardian* and the *Telegraph* from the United Kingdom; and the *Globe and Mail*, *National Post*, and *Toronto Star* from Canada. Inputting these parameters produced a list of over 2,000 articles, and after reviewing these articles, any sources that appeared to be duplicate reports, were under 500 words in length, were primarily focused on international finance, or were only short references embedded within stories that were about other issues were eliminated. This left a final sample of 485 articles.<sup>4</sup>

The first step in the coding process involved identifying the main story elements that characterized the Ebola coverage, followed by analyzing how these elements combined together to produce frames. Story elements are distinct from frames in that they are largely factual and descriptive in nature. Frames produce meaning and interpretations, allowing for evaluation of events in terms of our hopes and fears about the events. They provide a basis for advocating a way forward and enable us to identify

protagonists and antagonists, evaluate strengths and weaknesses, contextualize and judge the actions of actors and agencies involved in the event.

A preliminary examination identified seven dominant story elements that organized the Ebola narrative: local customs are hampering disease control efforts, the global North is not doing enough to help, the disease is spreading out of control, a potential vaccine is under development, Northerners are contracting the disease, Ebola is a global health emergency, a U.S. military response will be mobilized. This list shows that some story elements may also be frames. For example, elements relating to local customs and the inactivity of the global North were also frames for explaining why the disease occurred, and why it was spreading. Other story elements appeared to be more descriptive, but when combined together, they produced frames for evaluating what was happening and prescribing what needed to be done.

Coding and organizing the articles a second and third time and evaluating the implicit concerns and evocative register of each piece, how those concerns were being contextualized, and the nature of the problems they posed, concretized the frames that were structuring the Ebola story. These included local African lifeways are contributing to the spread of Ebola, the global North is not providing enough aid, the global health system is very fragile, and national health security systems are inadequate. The first two frames appeared early in the coverage during the “sounding the alarm” stage, while the third frame appeared in the “mixed messages” stage, and the fourth during the “crisis and containment” stage. Given the nature of the disease narrative usually found in the press coverage, one can anticipate what the frames might be. However, the Ebola story defied those expectations in a number of interesting ways.

### **Frame 1: “Primitive” African practices are contributing to the spread of the disease**

When the Ebola story first began to appear in the English language press in late March 2014, it was framed in a predictable way as a moral judgment of how certain cultural practices of people in Guinea, Sierra Leone, and Liberia were facilitating the spread of the disease. Ten percent of the articles in the sample employed this frame, concentrated in the period between late March and early August. Reporters emphasized the lack of basic infrastructure in the affected region. For example, one American virologist described Freetown, the capital of Sierra Leone, as “three million people; very high population density, not much running water [and] common latrines. ... If the virus is able to get to Freetown, you could see hundreds or thousands of Ebola cases there. It would be a total disaster” (Yang, 2014a; see also Diallo & DiLorenzo, 2014; Roy-Macauley, 2014; York, 2014). Exacerbating these conditions was a local lack of trust in scientific medical procedures and facilities. Many people in the area were reported as blaming medical workers for the disease: “often all people see at the clinic is a doctor sticking a needle in someone for a blood test and then them dying shortly afterwards. ... That becomes a conspiracy theory that we are actually injecting them with something that kills them” Freeman, 2014a, para. 15; see also Freeman & Sanchez, 2014; McKay, 2014a; Phillip, 2014b).

According to the press, it was not only distrust of Western science that motivated “premodern” behaviours among West Africans but also religious beliefs. Doctors work-

ing in the region were frequently reported as saying that witchcraft belief was widespread in the rural regions of Sierra Leone, Guinea, and Liberia, “There is a section of the population here who simply don’t believe Ebola is real, they think it is witchcraft and so they don’t come to the treatment centres” (Akkoc, 2014, para. 19; see also Nossiter, 2014b; Phillip, 2014a; Wintercross, 2014). Practices around funeral rites were also repeatedly reported as signifying the primitive, “The final farewell can be a hands-on, affectionate ritual in which the body is washed and dressed, and in some villages carried through the community, where friends and relatives will share a favorite beverage by putting the cup to the lips of the deceased before taking a drink” (Sun, Dennis, Berkstein, Lenny, & Achenbach, 2014, para. 16; see also Douglas, 2014; McNeil, 2014; Roy-MacAulay & Paye-Layleh, 2014).

Combined with poor living conditions and “primitive” beliefs, West Africans were reported as compounding “their” problems by hunting for “bushmeat,” a term that refers to any kind of animal that can be found in the forest. Media attention focused on one type of prey in particular:

The virus is believed to be linked to certain species of forest-dwelling fruit bats, which are considered a delicacy in some parts of West and Central Africa. The bats could be spreading the virus directly to humans who consume them. Moreover, the fruit infected by these bats can drop to the ground and be consumed by chimpanzees, gorillas and other primates, which can then spread the virus to humans through the bush-meat trade. if no page number. York, 2014, para. 11; see also Hesman-Saey, 2014; Nossiter, 2014a; Wallace, 2014)

The accumulation of these stories and the emphasis on traditional practices and superstitions served to reinforce pre-existing Western frames about Africa and Africans as diseased. Sierra Leone, Guinea, and Liberia were cast as primitive, premodern places that export disease and are inhabited by irresponsible global health citizens. Their lifestyles became associated with cultural difference from more “advanced” nations and they became a threat to those nations. Generally lacking from the news coverage was an exploration of many of the everyday practices of people in the region as expressions of extreme poverty, produced in part through the practices of global capitalism rather than primitivism, and the lack of cultural awareness and sensitivity of the Western aid-based health apparatus.

### **Frame 2: The global North is not providing enough aid**

From the beginning of March 2014 and continuing until mid-October, 34 percent of the articles in the sample were organized around the amount of aid the global North and international non-governmental organizations (NGOs) were sending to the affected region. Regular calls for more aid by organizations such as MSF and the WHO were a constant feature of the coverage. Despite the call, NGO personnel were frequently reported as complaining about a lackluster response from the international community: “Globally, the response of the international community is almost zero . . . . Leaders in the west are talking about their own safety and doing things like closing airlines—not helping anyone else” (O’Carroll, 2014, para. 2; see also Sengupta, 2014a; Siddons, 2014; Smith, 2014).

The frame of “the global North is not doing enough” was constructed largely through two types of stories. First, there were growing calls, particularly from MSF, prompting the WHO to take the lead on the outbreak and come up with a plan. However, the WHO management did not call a meeting of regional health officials until three months into the outbreak and it took another month and a half (August 8, 2014) before it declared the epidemic an international public health emergency. In the meantime, doctors, health officials, and editorialists sharply criticized the WHO for its inaction, stating that it had “snoozed on the sidelines” for five months and been “shamefully slow” in helping to organize a response (New York Times Editorial Board, 2014, para. 3; see also Cheng, 2014; Kitamura, 2014; Martin, 2014).

The second kind of story within this frame was a press critique of Northern governments, which were accused of having slashed the WHO’s funding, for example, “Over the past two years, the organization has seen its budget decrease by 12 percent and cut more than 300 jobs. The current budget saw cuts to WHO’s outbreak and crisis response of more than 50 percent from the previous budget” (Youde, 2014, para. 5; see also Boseley, 2014b; Burman, 2014; Fink, 2014). This raised the question of who should be leading and coordinating the response to international health crises:

according to one infectious disease expert, ‘there is no one to implement command, control and communications. No one.’ Multiple, uncoordinated organizations are attempting to confront a disease that is out of control. ‘They are quibbling over 25 to 30 bed units,’ the expert vents. (Gerson, 2014, para. 3; see also Freeman, 2014b; Hinshaw & McKay, 2014; Landler & Sengupta, 2014a)

The image that emerges from the coverage is of cost-cutting, uncaring governments that were investing their resources in strengthening their own national biosecurity at the expense of global healthcare and humanitarianism. Meanwhile, a number of African leaders, NGO spokespersons, and even U.S. officials close to the president stated that Ebola must be treated as a threat to humanity. Newspaper editorials began to call for a more global perspective: “We may prevent an epidemic on U.S. soil, but ... our ability to prevent an epidemic here doesn’t reduce our obligations abroad. Even if the epidemic remains only in West Africa, the continued spread of Ebola infections could eventually rank as one of the cruelest natural catastrophes of recent times” (Gottlieb & Troy, 2014, para 2; see also Associated Press, 2014; Eilperin & Sun, 2014; P. Wilson, 2014. Despite the news media’s developing sense of a rudderless response and increasingly desperate calls for more aid, governments continued to provide less than what was required. However, the response and the corresponding coverage began to change as a result of two main news events in August and September of 2014.

### **Frame 3: The global health system is too fragile**

On August 8, 2014, the WHO finally declared the West African Ebola outbreak an international public health emergency, setting off a news wave that lasted for the next two months. Declaring the epidemic a global emergency had a number of implications, primarily for Guinea, Sierra Leone, and Liberia. It meant that they should immediately activate emergency management plans, mobilize community leaders to help fight the

outbreak, establish a pipeline of necessary supplies, provide safety measures for health-care workers, establish treatment centres near the sites of the outbreaks, conduct exit screening at airports and prevent travel by infected cases and contacts, isolate cases and contacts, and regulate funeral practices. At the same time, the WHO called for a coordinated international response with itself as the coordinating organization.

With this event, the press reporting entered the mixed messages stage of the disease narrative. Up to this point, news stories were careful to “other” the Ebola epidemic, locating it squarely in West Africa with little chance of crossing to the global North. However, after August 8, 2014, the frame about West African lifeways diminished significantly and was replaced by a new frame that centred on the fragility of the global health system, present in 39 percent of the total sample. By early August, it had become clear to a number of commentators that contrary to expectations, the WHO was unable to lead the fight against Ebola. The organization was assumed to be the cornerstone of a global health system, but with the declaration of an emergency on August 8 and the lack of an accompanying plan, realization dawned that there was no global health system in place—despite government and United Nations promises to produce one after the SARS and H1N1 outbreaks in the early 2000s. News reports reflected that realization with an increasingly panicky tone: “We are about to witness a human catastrophe that could destroy large portions of a continent and pose a global threat. And the response of the world ... is feeble, irresponsible and disrespectful of nature’s perils” (Gerson, 2014, para. 1; see also Kennedy & Boseley, 2014; McGregor, 2014; Strange, 2014).

#### **Frame 4: National biosecurity systems are inadequate**

After the global health system frame emerged in August, newspaper audiences received mixed messages about the risk posed by Ebola. On the one hand, it appeared as though Ebola was running out of control in Africa and was a threat to other parts of the world, while on the other hand, readers were reassured that national biosecurity systems in the global North were up to the task of holding the virus and its carriers at bay. For example, the *New York Times* followed the quarantine officer at the Newark Liberty International Airport to detail her job and emphasize the security protocols in place to protect Americans from the Ebola virus (Hartocollis, 2014). The *Washington Post* ran a story on a U.S. based online tool called “HealthMap” that searches social media sites, local news, government Web sites, doctors’ social networks, and other sources to identify disease outbreaks around the world (Ngowi, 2014). There were numerous stories about the extraordinary precautions taken by hospitals in preparation for an outbreak (McKay, 2014; see also Grant, 2014; Huntsberry, 2014; Lipkin, 2014). A large number of stories focused on promising vaccine research, the results of which had already been used on Americans who had contracted Ebola in Africa (e.g., Bernstein & Dennis, 2014; Boseley, 2014a; Yi Dionne, 2014).<sup>5</sup>

Unfortunately, on September 29, 2014, Thomas Eric Duncan, a Liberian man visiting relatives in Dallas, Texas, was diagnosed with Ebola. Duncan had visited a Dallas hospital five days earlier complaining of flu-like symptoms, but was given antibiotics and sent home. No one checked on his background. Sadly, he later died of the disease, but in the meantime, two American nurses were infected. News coverage focused on

the number of people he could have infected, the errors made by the hospital staff, and the fact that one of the infected nurses subsequently took a flight to Cleveland to visit family after suffering from a fever (Allen, 2014; see also Grant, 2014; Pengelly & Siddique, 2014; Swaine, 2014). Concerns about this story were reinforced when a Spanish nurse was diagnosed with Ebola on October 6, 2014, after treating two priests who had contracted the disease in Liberia and Sierra Leone.

The Duncan story brought into question the preparedness of nations in the global North, and the United States in particular. From that point onward, the dominant press story was about the adequacy of national biosecurity systems, present in 40 percent of the total sample. An enhanced tone of insecurity entered into the reporting:

“Oh my gosh, it’s getting worse and worse. Who’s in charge here?” said Ashish Jha, a professor of health policy at Harvard School of Public Health. “Just because hospitals should be ready doesn’t mean they are. That’s why the [government] messaging has changed. But for the general public, there’s an increased feeling no one knows what’s going on.” (Armour, 2014)

Experts voiced their fears about the mutation of the disease:

The longer the Ebola outbreak goes on, the greater the chance that the disease could mutate, too. Scott Gottlieb, who served as a top FDA official under President George W. Bush, has warned that there’s even a chance that Ebola could go airborne. ... The World Health Organization also warned that given the scale of the outbreak, there’s a possibility that Ebola will go from epidemic to “endemic” in West Africa. (Kollipara, 2014)

Airport screening, the main tool in detecting Ebola carriers, was suddenly soundly criticized in the press:

Professor Mike Jackson, an expert in airport security at Birmingham City University, explains why infected passengers will not necessarily be found using screening measures. “There is quite a lag between the time that you catch Ebola and when you show the symptoms,” he said. “Consequently you could come straight from close contact with an Ebola victim get on a plane and fly to the UK. Although you might have caught Ebola the checks would not show this because at this point you would have no symptoms.” (Dawood, 2014)

Criticisms of the U.S. government’s handling of biosecurity became a feature of the new reporting:

On Thursday night, in televised remarks, Mr. Obama sought to reassure the public about the dangers from Ebola. But the sense of crisis that emanated from the White House was in sharp contrast to Sept. 30, when Thomas Eric Duncan ... tested positive for Ebola. (Shear & Landler, 2014, para. 12)

Along with this sense of crisis came calls for flight bans to the United States from West Africa, primarily from Republican senators and from the Governor of New York State (e.g., Kollipara, 2014).

From focusing on West African social and cultural practices and the inadequate humanitarian aid sent from the North, the Ebola news narrative changed direction to

emphasize the fragility of the global health system and the inadequacy of national biosecurity. The problem became one of the “diseaseability” of the North—the sense of being surrounded by a diseased world and being vulnerable to it in a way that was previously not the case. While moving into this “crisis and containment” stage in the context of an emerging “hot crisis,” newspaper coverage wrestled with the problem of how to resolve the crisis. The usual containment package of othering the disease, emphasizing the expert medical aid sent to the affected region, and focusing on the strength of the Western health establishment would no longer work to cool the growing sense of crisis. The answer that eventually emerged was substantially different than in past news media disease narratives and shifted the story from an outbreak narrative to a pandemic narrative.

### **The pandemic narrative**

The pandemic narrative finds its roots in fictional representations of large-scale disease outbreaks, but has seeped into other media and genres (Gerlach & Hamilton, 2014). Typically, within the fictional pandemic narrative, a virulent virus appears, mutates, and spreads at a rate that prevents any meaningful response by health authorities before it is already global. National governments fail in their duty to protect borders and domestic public health systems are immediately irrelevant, overwhelmed not only by the magnitude of the disease but by their outmoded knowledge, logic, and practices that are anchored in the notion of viable boundaries, misplaced faith in science, and planning that is based on the last outbreak. Millions or even billions of people die, often represented through a common biodisaster aesthetic of ruined world cities such as New York, London, Paris, and Tokyo. Civil interaction is abandoned in favour of instrumental, survivalist behaviour. Hopes for a solution shift to international health organizations, such as the WHO, which also fail. In addition to the increasingly futile search for a cure, regulatory responses must include militarized containment of the diseased, but quarantine strategies are overwhelmed by the scale of the diseased population and as a result, the ragged remnants of governmental organizations retreat to remote locations (underground, the Arctic, the sea, etc.). The story becomes that of the experiences of small groups of survivors struggling to preserve both their lives and their humanity while learning to live *with* the disease as a part of everyday life, rather than curing or containing it.

This increasingly common pandemic narrative is different from the usual journalistic disease story format in several respects. The central characters are no longer medical researchers, but government decision-makers and military personnel who step out of their secondary roles and become primary responders. Science does not necessarily manage to control and eradicate the problem. Its role is to provide biosecurity techniques rather than a cure. The scale of devastation is at a much higher level than we are used to seeing over the past century. In the typical outbreak story, dozens and maybe hundreds are infected, but in the pandemic narrative, infection is global and involves hundreds of thousands and even millions—possibly even threatening the survival of the species.<sup>6</sup> Consequently, humanitarian aid is no longer an adequate means of addressing the problem. In the outbreak stories, risks tend to come from outside the borders of the global North while in the pandemic narrative distinctions

between the local and the global are more problematic. Everything is part of the networked global society. The distinction between inside and outside is still present, but more ambiguous. As a result, the imagined community can no longer be simply the nation state, but rather the global species network.

The pandemic narrative finds its ultimate roots in “pandemic culture” (Gerlach & Hamilton, 2014). Pandemic culture is an outcome of being regularly informed that people of the global North are constantly vulnerable to disease due to global interconnectedness. Since the emergence of HIV/AIDS in the 1980s, there have been a series of “pandemic scares” that have been productive of disease anxiety (Aaltola, 2012). The ongoing nature of these threats has produced an affective condition of threatening uncertainty, an “anticipatory anxiety” (Ironstone-Catterall, 2011) within a fragile global situation that is constantly generating threats (Massumi, 2007). Because disease threats are linked to the body and the social practices of everyday life, anxiety becomes a part of the environment in which we all live rather than a response to tangible disease threats (Massumi, 1993).

This emergent pandemic culture no longer relies on the logic of prevention that has characterized risk societies in recent times, but rather on *pre-emption* (Massumi, 2007). Whereas prevention assumes a causal world that is knowable through expert research, pre-emption is a response to unpredictability and indeterminacy. It is offensive rather than defensive, requiring constant action to ensure that diseases and other problems do not spread out of control. Consequently, medical science is not necessarily the answer to disease outbreaks. Vaccine research takes too long and diseases can proliferate in the meantime. Militarized action is more efficient in producing results in the near term and states will resort to it more readily than in the past.

The movement toward the pandemic narrative provides a lens through which to understand the nature of the critiques of government action or inaction levelled by NGO health officials, who were among the primary definers in the Ebola press reports. Earlier in 2014 when news stories first began to appear and employed the journalistic outbreak narrative, calls for more aid from Western countries assumed the nation state as the imagined community. The governments of Sierra Leone, Guinea, and Liberia would use the aid, in coordination with international aid agencies and the WHO, to deal with the problem. Local lifeways were a complication, but were a regional problem that would have to be dealt with by national authorities. Meanwhile, the press reported on steps taken in Western nations to reinforce their biosecurity systems to detect disease carriers at airports, set up hospital isolation wards, train hospital staff, and conduct vaccine research in conjunction with pharmaceutical companies. Government and medical science were working hand-in-hand to prevent the spread of the disease. The main complaint in the news was quantitative, not qualitative—governments were not donating enough.

With the shift in frames late in the summer, the logic of the press discourse began to change. When the WHO declared Ebola an international public health emergency, the nation state was no longer an adequate form of imagined community. The emerging disease worldview that is common in press coverage, combined with calls from aid agencies and the WHO to view the West African outbreak as a threat to the world,

produced a shift in the imagined community from nation state to global network. This perspective was reinforced when Thomas Eric Duncan entered the United States and infected hospital staff there. The indeterminate potentiality of disease became manifest and the anticipatory anxiety in the background throughout the outbreak became an open anxiety that was expressed in press reports through criticisms of government biosecurity practices, fears about the mutation potentials of the Ebola virus, and calls for flight bans. Experts and citizens quoted in the press no longer considered strategies of prevention sufficient. The conditions were right for a shift from a preventive strategy to a pre-emptive strategy more consistent with pandemic culture.

That pre-emptive strategy was announced on September 16, 2014, when President Obama outlined a plan to send 3,000 American military personnel to Liberia along with a further \$600 million in spending, over and above the \$175 million already committed. The military personnel would construct 17 new 100-bed clinics in Liberia, train local health workers, and oversee the transportation of supplies and personnel to needed areas. On September 18, 2014, French President François Hollande announced the establishment of a military hospital in Guinea along with military air support, and on October 9, 2014, U.K. Prime Minister David Cameron announced that 750 British troops would be sent to Sierra Leone along with three helicopters and a medical support ship to construct a hospital and an Ebola training academy. Two months later, the U.S. Congress approved a budget that included an unprecedented total of \$5.4 billion for combating Ebola. In late September, while troop deployments were being announced, President Obama also hosted a meeting of delegates from 44 countries to discuss how to develop an effective global disease detection and monitoring system along with a system of regional bioresearch and containment facilities. These developments and their consistent characterization in press coverage as appropriate, and in fact, long overdue, marked the full transition to a global pandemic-based response away from a national outbreak model. From that point onward, nations of the global North would be on the offensive to pre-empt Ebola by establishing a biosecurity regime in West Africa.

With these developments, the Ebola story entered the “containment” portion of the crisis and containment stage. Press reports were overwhelmingly positive about these developments, providing as they did a set of concrete steps for combating Ebola. Shortly before the U.S. plan was announced, MSF was still sounding the alarm in the press about Western inaction and a leaderless emergency response (Yang, 2014b). However, after the shift to pandemic culture logic, the language changed dramatically:

The key is for countries to put in place specific infrastructure for disease detection and prevention, including systems to improve their laboratory network for tracking disease, epidemiological staff to respond and emergency operations centers that can activate within 120 minutes, according to CDC Director Tom Frieden. None of that exists in Guinea, Sierra Leone and Liberia, Frieden said. If that kind of infrastructure was in place, the Ebola outbreak “wouldn’t have happened,” he said. Putting those systems in place in countries “costs money,” he said. “It’s not cheap to do something like this.” (Eilperin & Sun, 2014, para. 17; see also Farmer, 2014; Whitfield Bellows, 2014; S. Wilson, 2014.

The issue was no longer about increasing aid. Some criticisms were still levelled in the press. For example, United Nations representatives complained that the new, large treatment centres under construction in the fall of 2014 were not going to adequately address the crisis because they were not mobile and could not travel to the changing locations of Ebola outbreaks (e.g., Sengupta, 2014b). This criticism, however, fell flat in the press and demonstrated the extent to which the UN and other agencies were still working within an aid-based crisis and containment logic and did not understand the transition to pandemic logic. Western governments were no longer interested in simply combating Ebola in West Africa. They were busy establishing a lasting biosecurity infrastructure to secure West Africa as an unstable and threat-generating locus within the global network.

## Conclusion

This quick shift to a pandemic narrative format in the press is increasingly sensible to Northern audiences because of our participation in a “pandemic culture.” Pandemic culture is a product of life within an interconnected global society perceived as highly fragile and subject to unpredictable disruptions. The imagined community is no longer simply the nation as an immunological unit, but rather the global society. Although disruptions may be local in origin, our interconnectedness means that they can quickly amplify into global problems. Consequently, people in the global North are culturally primed with an anticipatory anxiety about disease spread and other risks. While the outbreak narrative accepts that emerging diseases will appear but can be studied and understood to prevent their spread, the pandemic narrative assumes unpredictability and indeterminacy. Scientists and governments can no longer be sure that they can control the spread of disease within the interconnected global context, therefore, they must pre-empt it by attempting to eliminate the conditions that could give rise to contagion.

It is the logic of pre-emption and the anxiety over diseaseability that made the resolution of the press narrative of Ebola in 2014 sensible and acceptable. The news frames of primitive West African lifeways, non-existent global healthcare, and flawed national biosecurity set the problem in such a way that direct intervention by the United States, France, and the United Kingdom seemed to be the proper solution. The military nature of that intervention and the importation of massive resources to build a biosecurity system in West Africa made sense within the pre-emptive logic of pandemic culture. It is likely that the pandemic narrative will be an increasingly enduring element of how we tell disease stories in news coverage and elsewhere for the foreseeable future.

## Notes

1. Biosecurity is the process of monitoring and regulating the movement of life forms in order to ensure that biological order is maintained within a particular community. This form of security is distinct from, but works in conjunction with, national security in which health management is part of a response to the broader range of threats of globalization (see Everts, 2013).
2. Quoted sources in the sample broke down as follows in terms of proportion of cited experts:

World Health Organization	20.7 percent
Government Spokespersons	19.7 percent
U.S. Centers for Disease Control and Prevention	12.5 percent

Médecins Sans Frontières	10.1 percent
Disease Experts	8.7 percent
Doctors and Nurses	5.8 percent
Others	22.5 percent

3. In the final sample of 485 articles, the proportion of articles in each month broke down as follows:

March	3 (0.61 percent)
April	4 (0.82 percent)
May	2 (0.41 percent)
June	3 (0.61 percent)
July	11 (2.3 percent)
August	64 (13.1 percent)
September	55 (11.3 percent)
October	213 (44 percent)
November	78 (16 percent)
December	52 (10.7 percent)

4. This data shows the extent to which the outbreak was not a major concern in the English-language press until the WHO categorized it as a global public health threat in early August. In October, the large spike in stories is largely due to the appearance of Ebola in the United States.

The proportions of articles from the news sources broke down as follows:

<i>Washington Post</i>	121 (25 percent)
<i>New York Times</i>	84 (17.3 percent)
<i>Wall Street Journal</i>	72 (14.8 percent)
<i>Telegraph</i>	79 (16.3 percent)
<i>Guardian</i>	23 (4.7 percent)
<i>Toronto Star</i>	72 (14.8 percent)
<i>Globe and Mail</i>	17 (3.5 percent)
<i>National Post</i>	17 (3.5 percent)

American news sources accounted for 57 percent of the sample, British sources 21 percent, and Canadian sources 22 percent.

5. Stories about vaccine research were very common in the Ebola coverage and arguably constituted another news wave starting in early August. The primary debate in the press was about the ethics of using an untested vaccine on the populations of West Africa. On August 13, 2014, the WHO announced that experimental drugs could ethically be used in this case. The ethics of research laboratory testing were to be superseded by the ethics of disaster zone treatment.

6. At the height of the Ebola outbreak in 2014, panicky predictions of 1.4 million infections were common in press reports.

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