

When local gets a global focus:
Ebola outbreak narratives in Toronto
Star in 2014 – 2015

Master's Thesis

**Development and International Cooperation
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Abstract

In my Master's Thesis '*When local gets a global focus: Ebola outbreak narratives in 2014 – 2015 in Toronto Star*' I research Ebola outbreak narratives of the most recent Ebola outbreak. Toronto Star is Canada's biggest daily newspaper which is being published in Toronto, Ontario. As my theoretical background, I use Melissa Leach's (2008) categorization on thematic narratives related to haemorrhagic fevers (for example Ebola and Marburg virus). Her categorization includes: (1) A global threat: tackling the emerging plague out-of-Africa, (2) Deadly local disease events: the building of universal rapid response, (3) Culture and context: building positively on local knowledge, (4) Mysteries and mobility: taking long-term ecological and social dynamics seriously. Building on these, my research questions in this thesis are (1) What kinds of outbreak narratives on Ebola were presented by Toronto Star during 2014 – 2015? (2) Who were presented as the main actors during the 2014 – 2015 Ebola outbreak by Toronto Star? and (3) What kinds of roles did the main actors receive over the outbreak period by Toronto Star? As a theoretical background for analysis of actors and different roles, I use Propp's (1968) and Seale's (2002) idea that a good story includes heroes, helpers and villains. At the end of a story, villains lose and heroes win. In health-related stories, disease and death are portrayed as a villain, whereas doctors and nurses are seen as heroes because they are trying to tackle disease and overcome death. I also use theories by Katz, Kornblat, Arnold, Lief and Fischer (2011) as well as by Brown, Mackey, Shapiro, Kolker, Novotny (2014) which introduce global health diplomacy actors. These theories help me to identify the main Ebola actors being presented in the research data.

My research data consists of 97 relevant articles related to the Ebola outbreak published in Toronto Star in 2014 – 2015, collected through the database ProQuest Central. The results of my analysis indicate that Toronto Star represented the following main narratives: (1) Ebola as a global security threat, (2) Deadly local disease events and slow universal response, (3) Culture and context: more attention should have been given on how to include locals into the outbreak response and (4) The 2014 – 2015 Ebola outbreak as an outcome of long-lasting poverty and lacking health care systems in West Africa. Further, the analysis showed how the ministries of health in Guinea, Sierra Leone and Liberia as well as the presidents of the three mentioned countries are considered as the core global health diplomacy actors. Instead, the relevant actors of the United Nations (UN) as well as the Canadian government, Canada's Minister of Foreign Affairs, the U.S. Government and the U.S. President are considered as multi-stakeholder global health diplomacy actors. Médecins Sans Frontières, International Federation of Red Cross and Red Crescent Societies, the Public Health Agency of Canada, Centers for Disease Control and Prevention (CDC), health care workers, social mobilization authorities, burial team members, local chiefs, quarantine officers, public health experts, officials, scientists, shipping companies, airline companies, pharmaceutical companies and private donors are considered as informal global health diplomacy actors. In the Ebola narrative, the roles for different actors vary from victims to heroes as well as from aiders to opposers.

Key words: Ebola outbreak, narrative, Toronto Star

Tiivistelmä suomeksi

Gradussani *'Kun paikallinen saa globaalin fokuksen: Ebolan leviämisen narratiivit vuosina 2014 – 2015 Toronto Star -lehdessä'* tutkin otsikon mukaisesti Ebolan leviämisen narratiiveja viimeisimmän Ebola-epidemian ajalta. Toronto Star on Kanadan suurin päivittäin ilmestyvä sanomalehti, jonka julkaisupaikka on Torontossa Ontarion provinssissa. Teoreettisena viitekehystenä käytän Melissa Leachin vuonna 2008 kehittämiä temaattisten narratiivien kategorisointia verenvuotokuumeista (esimerkiksi Ebola ja Marburgin virus). Hänen kategorisointi sisältää seuraavat narratiivit: (1) Globaali uhka: Afrikasta nousevaa ruttoa vastaan taisteleminen, (2) Tappavat paikalliset sairaustapaukset: globaali nopea reagointi paikallisiin tapahtumiin, (3) Kulttuuri ja konteksti: paikallisen tiedon ja osaamisen hyödyntäminen, (4) Mysteerit ja kuolleisuus: ekologisen ja sosiaalisen dynamiikan huomioiminen. Näiden pohjalta graduni tutkimuskysymykset ovat vastaavasti (1) Millaiset leviämisen narratiivit Toronto Star esitteli vuosina 2014 – 2015? (2) Ketkä Toronto Star esitteli päätoimijoina Ebola-epidemian aikana vuosina 2014 – 2015? (3) Millaiset roolit päätoimijat saivat Ebola-epidemian aikana Toronto Star – lehden mukaan? Teoreettisena viitekehystenä toimijoille käytän sekä Proppin (1968) että Sealen (2002) ajatusta siitä, että hyvä tarina sisältää niin sankareita, auttajia kuin vastustajia. Tarinan lopussa vastustajat häviävät ja sankarit voittavat. Terveysteen liittyvissä tarinoissa sairaus ja kuolema esitetään vastustajana. Sitä vastoin lääkärit ja hoitajat nähdään sankareina, sillä he yrittävät taltuttaa sairauden ja voittaa kuoleman. Tutkimuksessani käytän myös sekä Katzin, Kornbletin, Arnoldin, Liefin ja Fischerin (2011) että Brownin, Mackeyn, Shapiron, Kolkerin ja Novotнын (2014) teorioita, jotka esittelevät toimijoita globaalin terveysdiplomatian kentällä. Kyseiset teoriat auttavat Ebola-alueen toimijoiden löytämisessä Toronto Starin artikkeleista.

Aineistoni koostuu 97 relevantista Ebola-artikkelista, jotka on julkaistu Toronto Star lehdessä vuosina 2014 – 2015 ja kerätty ProQuest Central -palvelun avulla. Analyysini tulokset osoittavat, että Toronto Star esitteli seuraavat päänarratiivit: (1) Ebola globaalina turvallisuusuhkana, (2) Tappavat paikalliset sairaustapaukset ja hidat globaali reagointi tapahtumiin, (3) Kulttuuri ja konteksti: enemmän olisi pitänyt kiinnittää huomiota paikallisten osallistamiseen, (4) Ebolan vuosina 2014 – 2015 leviämisen taustalla pitkään jatkunut köyhyys ja vaillinaiset terveydenhoitojärjestelmät Länsi-Afrikassa. Tämän lisäksi Guinean, Sierra Leonen ja Liberian terveysministeriöt ja maiden presidentit nähdään globaalin terveysdiplomatian ydintoimijoina. Sen sijaan YK-järjestelmän olennaiset toimijat, Kanadan hallitus, Kanadan ulkoministeri, Yhdysvaltain hallitus ja Yhdysvaltain presidentti nähdään monisidosryhmäisen globaalin terveysdiplomatian toimijoina. Lääkärit ilman rajoja, Punaisen Ristin ja Punaisen Puolikuun yhdistysten kansainvälinen liitto, PHAC, CDC, terveydenhuollon työntekijät, sosiaalisen liikkuvuuden auktoriteetit, hautausiin jäsenet, paikalliset kyläpäälliköt, karanteeniviranomaiset, kansanterveyden asiantuntijat, viranomaiset, tutkijat, laivayhtiöt, lentoyhtiöt, lääkeyhtiöt ja yksityiset lahjoittajat nähdään epävirallisen globaalin terveysdiplomatian toimijoina. Ebola-tarinassa roolit eri toimijoille vaihtelevat uhreista sankareihin ja avunantajista avun vastustajiin.

Avainsanat: Ebola-epidemia, narratiivi, Toronto Star

Abbreviations

EVD = Ebola virus disease

CDC = Centers for Disease Control and Prevention

GOARN = Global Alert and Response Network

IHR = International Health Regulations

MSF = Médecins Sans Frontières (Doctors Without Borders)

NGO = Non-governmental organization

PHAC = the Public Health Agency of Canada

PHEIC = Public Health Emergency of International Concern

PPE = Personal Protective Equipment

UN = The United Nations

UNICEF = The United Nations Children's Emergency Fund

UNMEER = United Nations Mission for Ebola Emergency Response

WHO = The World Health Organization

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1 INTRODUCTION

In this Master's Thesis, I am focusing on the most recent Ebola outbreak which took place mostly in West Africa between March 2014 and June 2016. I am interested in how Ebola was dealt with in the articles of Toronto Star from a narrative point of view. I conduct my analysis of Ebola outbreak narratives by using Melissa Leach's categorization of thematic narratives related to haemorrhagic fevers (2008). I am curious to see whether the narratives in Toronto Star align with her categorization. By researching Ebola outbreak narratives of the newspaper articles of Toronto Star, I am aiming to get an overview of an Ebola outbreak in West Africa in 2014 – 2015 through the story being described in one particular Western newspaper. I argue that stories covering global health emergencies can be told from different angles depending on the news source and where the news is being published. In this thesis, I want to concentrate on a Western, North American perspective: how the Ebola story is being told for readers of Toronto Star. This highly respected Canadian newspaper aims at delivering factual and truthful information. Thus, it is not a tabloid for instance. In its own website it highlights its mission:

“Toronto Star's core mission is to focus public attention on injustices of all kinds and on reforms designed to correct them”.

(Toronto Star, About the Toronto Star, 2016)

I argue that the most recent Ebola epidemic is an example of what globalization might cause. We live in a globalized world today where local epidemics might become global events which do not recognize borders because of international trade and travel. At the same time, many challenges countries face are trying to be solved not only on a national level but also on an international level. The international community feels a duty to help those who are suffering. It also bears the burden, if not successful in its mission. It is remarkable that global events are being reported at such fast speed because we live in the era of 24/7 news cycle. Information concerning global events taking place in West Africa is easily within reach of those who are living in North America, i.e. on the other side of the world.

I find the 2014 – 2015 Ebola epidemic fascinating from a Social and Public Policy and a Development Studies point of view. I consider my study to deal with globalization, security,

Global South, health and educational policies. I argue that the 2014 – 2015 Ebola epidemic is a consequence of long-lasting poverty, a lacking health care system and a lack of education in West Africa. It is obvious that West African countries have not been able to afford functioning health care systems or proper schooling in the past decades. Thus, social and public policy is not functioning properly in Sierra Leone, Liberia or Guinea. Health and education policies are at the core of social and public policy and that's why Ebola epidemic can be also seen as an issue of Social and Public Policy in the academic field. It is obvious that the West African nations needed international assistance and help during the Ebola epidemic because they were not able to stop the epidemic with their own resources. In addition to these, the most recent Ebola outbreak is an outcome of neglect by Western nations towards West African countries because the epidemic was not stopped quickly and effectively enough. Thus, the 2014 – 2015 Ebola epidemic is also an issue of Development Studies.

The most recent Ebola epidemic is being discussed in both medical and social science related academic publications. For example, one of the leading development studies journals, *Third World Quarterly* devoted a thematic issue (vol 37, no, 3, year 2016) to the Ebola outbreak. The publication highlights different aspects of the outbreak including the role of international relations in terms tackling the outbreak, the role of pharmaceuticals in the battle against the disease as well as the framing of Ebola under crisis narratives. In this Thesis, I will take an advantage of these articles but I use Melissa Leach's (2008) categorization on haemorrhagic fevers as my main theoretical background. Her categorization gives a reason for why Ebola outbreaks should be tackled. It also gives a reason for why Ebola outbreaks have arisen over and over again in the African continent.

The aim of this thesis is to see what kinds of outbreak narratives on Ebola were presented by Toronto Star during 2014 – 2015 and if they were in line with Melissa Leach's (2008) categorization. I also want to find out who were presented as the main actors during the 2014 – 2015 Ebola outbreak in the articles of Toronto Star, and what kinds of roles they received over the outbreak period. I am aiming to perceive the 2014 – 2015 Ebola outbreak from the perspective of one particular western newspaper which has not been discovered earlier in the research literature.

My research questions are the following:

- 1. What kinds of outbreak narratives on Ebola were presented by Toronto Star during 2014 – 2015?**
- 2. Who were presented as the main actors during the 2014 – 2015 Ebola outbreak by Toronto Star?**
- 3. What kinds of roles did the main actors receive over the outbreak period by Toronto Star?**

I aim to answer these research questions by analyzing my research material which consists of articles of Toronto Star being published between March 2014 and December 2015. I am using Toronto Star because its articles received my attention during the journalistic internship I did for Kanadan Sanomat between 13th of Aug, 2014 - 13th of Feb, 2015 in Toronto, Canada. Toronto Star is the largest Canadian daily newspaper published seven times a week in the Greater Toronto Area, Canada. The newspaper is owned by Toronto Star Newspapers Limited.

This Master's Thesis consists of six Chapters. After this Introduction Chapter, I will move into the 2nd Chapter which briefly discusses Ebola as a disease and the most recent Ebola outbreak in light of the literature. I have divided the 2nd Chapter into smaller sections: Ebola as a medical phenomenon (2.1.), Ebola and cultural practices (2.2.), History of Ebola outbreaks (2.3.), Ebola as international health emergency (2.4.), Reasons for Ebola's quick and wide spread during the 2014 – 2015 outbreak (2.5.), Ebola response by international actors (2.6.) and Main Ebola actors in the light of health diplomacy (2.7.).

The 3rd Chapter presents theoretical perspectives on news and outbreak narratives. From events to news (3.1.), focuses Galtung and Holmboe Ruge's theory (1965) as well as Seale's (2002) notions about health related stories. It also represents Leach's thematic categorization (3.2.) which functions as my main theoretical background for this Thesis, as mentioned earlier.

In the 4th Chapter, I will introduce my Methodology, Narrative Theory and how I will apply it in this Thesis (4.1.). I will also present my Collection and selection of the research material (4.2.), Methods of analysis (4.3.), Thematic analysis of the articles (4.4.), Categorization of the seven main phases of the 2014 – 2015 Ebola outbreak (4.5.) and the Pyramid of Global Health Diplomacy: Actors in the 2014 – 2015 Ebola outbreak (4.6.).

I consider my 5th Chapter as my main Chapter because I present the analysis of Ebola outbreak narratives in Toronto Star there. The fifth Chapter is divided into the following sections: Ebola as a global security threat (5.1.), Deadly local disease events and slow universal response (5.2.), Culture and context: more attention should have been given to how to include locals into the outbreak response (5.3.) and The 2014 – 2015 Ebola outbreak as an outcome of long-lasting poverty and lacking health care systems in West Africa (5.4.). I also present the pyramid of Global Health Diplomacy Actors in the 2014 – 2015 Ebola outbreak in the narratives of Toronto Star (5.5.) and the different roles actors received over the outbreak period (5.6.) at the end of the 5th Chapter.

The 6th Chapter is the last chapter which concludes the ideas provided in this Thesis as well as reflects my thoughts during the thesis writing process. The 6th Chapter is divided into two sections: Conclusions (6.1.) and Reflections (6.2.).

2 EBOLA AS A DISEASE

2.1. Ebola as a medical phenomenon

In this Chapter, I am going to explain the basic facts of Ebola virus disease. According to research literature, Ebola virus disease (EVD) or Ebola haemorrhagic fever is a serious, in many cases fatal, illness in humans. EVD belongs to a family of filoviruses, and is a zoonosis which transmits from wild animals to people. It is thought that EVD's natural host is bats in forest environments. However, there is no certainty about this, nor about precise viral transmission mechanisms. The discussion around the topic is ongoing. However, four different strains of Ebola have been found: Zaire, Sudan, Reston and Ivory Coast. The EVD case fatality ranges from 50% to 90% depending on a source of origin as well as the strain of EVD transmitted. The Zaire strain of Ebola was responsible for the 2014 – 2015 outbreak. It is the most virulent form of the disease and can kill up to 80-90% of the transmitted. Normally, it arises in tropical forest areas. (WHO, Ebola virus disease 2016; WHO Ebola Response Team, 2014; Leach, 2008; Hewlett and Hewlett 2008).

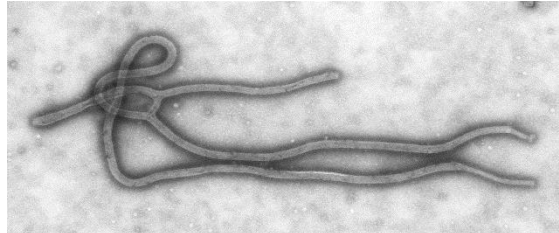


Photo 1: Electron Micrograph of the Ebola Virus (Reston virus strain). Photo credit: Cynthia Goldsmith / Centers for Disease Control and Prevention.

It is known that EVD spreads in the human population through human-to-human transmission, through contact with body fluids of symptomatic patients, and an individual must be sick to be contagious. An EVD patient usually gets the following symptoms: high fever, shivering and aches, gastric problems, rashes, throat lesions, spontaneous bleeding, renal failure, extreme lethargy and hallucinations. Ebola often kills its victims within two weeks. Transmissions can be stopped by a combination of early diagnosis, patient isolation and care, contact tracing, infection control, and safe burials. The incubation period is a maximum of 21 days. Before the 2014 – 2015 Ebola outbreak, there was no available vaccine

or antiviral treatment which could address symptoms. However, it is known that before the most recent Ebola outbreak at least the US government as well as the Canadian government had tried to develop a vaccine against EVD because it can be seen as a potential biological weapon. (WHO, Ebola virus disease, 2016; WHO Ebola Response Team, 2014; Leach, 2008).

2.2. Ebola and cultural practices

There are well recognized anthropologic factors involved in Ebola outbreaks. According to Roca, Afolabi, Saidu and Kampmann (2015) these factors are part of the picture why EVD spreads extensively during outbreaks. First, it is known that wildlife animals (e.g. bats) might carry zoonosis, and in Sub-Saharan Africa they are hunted, because of poverty and food insecurity. Most Ebola outbreaks in the past can be traced to a single index case who had contact with carcasses of nonhuman primates or bats in poor and remote African villages with lack of food. Secondly, according to Roca et al., virus outbreaks are often intensified by a bunch of cultural beliefs and practices of locals. During the outbreaks, stricken communities impute the disease to sorcery, witchcraft, or evil spirits. These views lead people to seek care from spiritual or traditional healers instead of health officials. Traditional healers often propagate the virus unintentionally due to a lack of knowledge and treatment methods. Thirdly, Roca et al. state that mistrust of governments and foreign aid workers has been identified as an anthropologic cause for EVD spread. For example, containment teams have been blamed for initiating the disease. Misconceptions have caused situations where aid workers have been unable to reach certain villages. Misconceptions have also led to the destruction of treatment units and physical attacks on containment teams, and in extreme cases to murdering of staff. Intense disease transmission in hospitals has added mistrust towards international aid workers and authorities due to erroneous beliefs that hospitals actually kill more than they cure. That's why locals do not always want to bring their relatives who have gotten ill into the hospitals. The problem in these situations is that infected people enhance the disease propagation in their communities. (Roca, Afolabi, Saidu and Kampmann, 2015)

Regardless of the earlier mentioned factors, Roca et al. see that the major anthropologic factor affecting to the Ebola spread is burial practices and beliefs around the topic. In Sub-Saharan Africa, some communities hold a view about life after death in which *'the goal of life*

is to become an ancestor in the spirit world or to join the creator in heaven.' In order to receive the goal it requires a "proper burial". If the "proper burial" is not followed, *'the person might be subjected to severe torture, rejected by the ancestors, or transformed into wandering ghosts or totems.'* (Roca, Afolabi, Saidu and Kampmann, 2015.) According to Roca et al., the so called "proper burial" includes many different religious rites; keeping a corpse for three days before a burial and a communal hand washing in the water which was used while bathing the corpse. It is important to remember that both a mourning ceremony and a burial gather hundreds of people in close contacts with an EVD infected corpse. They also point out that many have avoided seeking health-care during an Ebola outbreak because of a fear of being buried in a plastic bag somewhere far away from relatives and in the absence of them. Families have also refused to notify authorities of possible Ebola-related deaths. WHO has developed recommendations on safe burial practices so that transmissions during funerals would decrease. (Roca, Afolabi, Saidu and Kampmann, 2015). WHO sees that community engagement is the key to control the outbreak (WHO, Ebola fact sheet, 2015.) This is in line with Hewlett and Hewlett (2008) and Médecins Sans Frontières (2015). Both highlight the importance of understanding the culture and traditions of local communities and suggest that it is easier to organize Ebola-related activities on the ground if international aid workers are aware of the local culture and traditions.

2.3. History of Ebola outbreaks

The first known Ebola outbreak appeared in Zaire (i.e. the Democratic Republic of Congo) in 1976 (Hewlett and Hewlett, 2008.) Until December 2013, Ebola had emerged only as a localized disease and only a few people had contracted the virus (Paul & Sherill, 2015) Thus before the most recent Ebola outbreak, Ebola epidemics were limited both in size and geographical spread. The largest outbreak before 2014 occurred in Uganda between 2000 and 2001. During a time period of three months 425 cases occurred. This outbreak was controlled by application of interventions to minimize further transmission. The control was delivered through the local health care system with support from international partners (WHO Ebola Response Team, 2014.)

According to WHO, the most recent Ebola outbreak in West Africa was the largest and most complex Ebola outbreak since its discovery in 1976. During the outbreak, there were more

cases and deaths than in all previous outbreaks combined. Before 27 March 2016, 28 646 Ebola cases and 11 323 Ebola deaths were reported (WHO, Ebola Situation Reports, 2016.) It is known that not all of the cases were reported; some of the symptomatic people evaded diagnosis and treatment, there were also laboratory diagnoses that were not included in national databases and suspected Ebola victims were being buried without a diagnosis. Thus the numbers of EVD cases and EVD deaths are not accurate. (WHO, Ebola virus disease, 2016; WHO Ebola Response Team, 2014, WHO)

On the next page, you can see Table 1 that depicts the affected countries, Ebola cases and Ebola deaths in terms of numbers during the 2014 – 2016 Ebola outbreak. The table is taken from WHO's Ebola Situation Reports – website, and highlights the vast numbers of Ebola cases and deaths in Guinea, Liberia and Sierra Leone compared to other countries where only single cases appeared. I am going to use the table in the findings chapter.

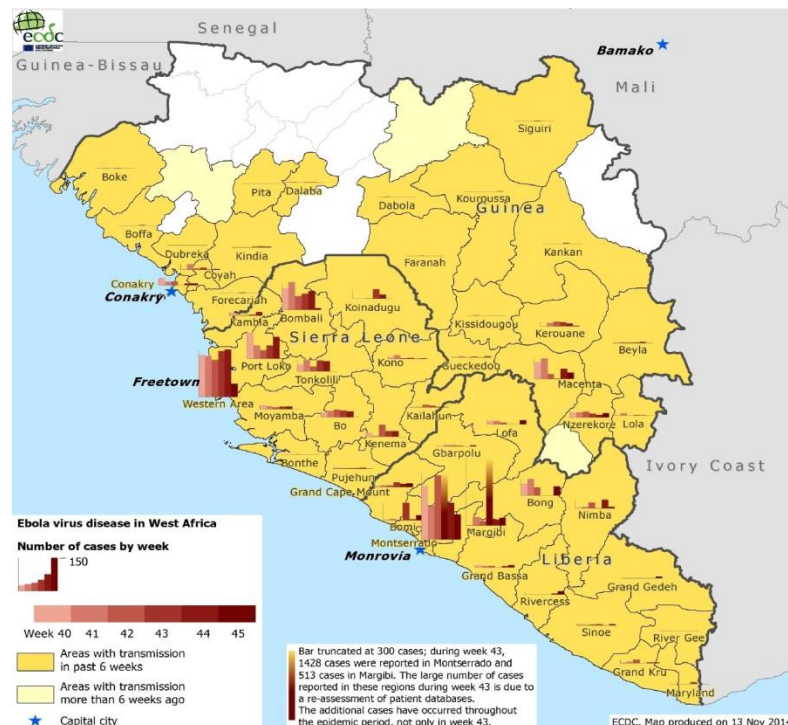
Affected countries	Ebola cases	Ebola deaths
Guinea	3811	2543
Liberia	10675	4809
Sierra Leone	14124	3956
Italy	1	0
Mali	8	6
Nigeria	20	8
Senegal	1	0
Spain	1	0
United Kingdom	1	0
United States of America	4	1
Total	28646	11323

Table 1. Ebola cases and deaths before 27 March 2016. Source: WHO, Ebola Situation Reports, 2016.

2.4. Ebola as international health emergency

According to WHO Ebola response team, the outbreak got its beginning in December 2013, when the first cases occurred in districts of Macenta and Guéckédou in Guinea. During March 2014, the number of cases arose suddenly in the area and new cases were also found in the Guinean capital, Conakry. At the same time, the epidemic spread to Lofa and other districts in Liberia. In May, the epidemic expanded from Guinea to the Sierra Leonean districts of Kenema and Kailahun. The second increase in case incidence happened in Guéckédou, Macenta and Conakry between May and June. Further cases were also reported in Lofa. (WHO Ebola Response Team, 2014). It is essential to point out that the districts of Macenta, Guéckédou, Lofa, Kenema and Kailahun are border areas of the three countries. They also remained the focus of transmission. From July 2014 onward, there were sharp

increases in case numbers at the epicenter of all three countries, at other sites away from the epicenter, and in the capital cities of Conakry, Freetown and Monrovia. (WHO Ebola Response Team, 2014). An interesting fact is that the very first EVD outbreaks occurred in remote villages in Central Africa, near tropical rainforests, but the recent outbreak in West Africa involved both urban and rural areas. (WHO, Ebola virus disease, 2016). However, although EVD spread to many parts in Guinea, Liberia and Sierra Leone, it was not reported in all districts in the countries: among the total of 67 districts in the three mentioned countries, only 43 reported one or more confirmed, probable, or suspected cases, and more than 90 % of cases were reported from just 14 districts. (WHO Ebola Response Team, 2014). Over the outbreak period, the most affected countries by the virus were the three mentioned countries, even though single cases also occurred in Nigeria, Senegal, Mali, Spain, Italy, the United Kingdom and the United States as the table on page 9 shows. At the epicenter of the crisis, Sierra Leone, Liberia and Guinea faced vast challenges in implementing control measures at the scale required to stop transmissions and to provide medical care for all persons with the infectious disease. (WHO Ebola Response Team, 2014; WHO Ebola Situation Reports, 2016)



Map 1. Location of the outbreak. Credit: Center of Travel medicine, 2014.

During the summer of 2014, the outbreak got out of control and on August 8, 2014, the WHO Director General, Dr. Margaret Chan gave a PHEIC.

”Ebola is a public health emergency of international concern.”
(WHO, Ebola virus disease, 2015; WHO Ebola Response Team, 2014)

Guidelines for how, when and whose responsibility it is to respond to international health emergencies is defined in the international health regulations (the IHR) which were adopted by the Health Assembly in 1969. Current international health regulations were recreated in 2005 and were adopted by the Fifty-eight World Health Assembly on 23 May 2005. The IHR (2005) entered into force on 15 June 2007. It includes 66 articles which are organized into ten parts. (International Health Regulations 2005 (2nd Edition), WHO, 2008.)

”The purpose and scope of the IHR (2005) are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.”
(Article 2 in the IHR (2005))

The IHR (2005) require states parties to notify WHO of ‘all events within their territories that may constitute a public health emergency of international concern’ (Article 6.) What kinds of events are to be reported then? According to Article 1.1., these include ‘extraordinary events which constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response’. So called “decision instrument”, i.e. WHO, is being used to guide states parties in determining whether a disease event may constitute a public health emergency of international concern, PHEIC (Article 12.). Thus, the newest international health regulations demand that a state, where haemorrhagic fever cases are appearing, would notify WHO if the situation can be seen as an international threat (Leach, 2008.) According to the regulations, it is WHO Director General's duty to decide in which occasions it is necessary to announce the statement, and when the event falls into the category. It is also his/her duty to convey the IHR Emergency Committee (WHO, Alert, response, and capacity building under the International Health Regulations (IHR), 2016.)

As shown by McInnes (2016), this was the third time ever, WHO gave a PHEIC. The first time was in 2000 on HIV/AIDS, and the second time was on polio, only a few weeks before PHEIC was given on Ebola. As McInnes points out, it is interesting why Ebola received so much more media attention than polio, malaria or a diarrhoeal disease even though it did not kill as many people as the other mentioned diseases did in 2014 – 2015. He states that Ebola received lots of media attention because there was an assumption of an emerging global health crisis made by international actors. However, he sees that the term 'crisis' does not come from a traditional understanding; rather it finds its ground from social constructivism. (McInnes, 2016). According to Sellnow & Seeger (2013), the traditional point of view sees 'crisis' as a threat to life which creates anxiety and stress. Secondly, a crisis is an event that has uncertainty and would need an immediate response by agencies and groups to limit and contain the harm. Thirdly, a crisis is unpredictable by key stakeholders. A crisis might also reach across regional, cultural, economic and political boundaries. Historically, the worst crises have been infectious disease pandemics and earthquakes. The 1918-1919 influenza (Spanish flu) probably infected across the globe 500 million people and caused probably more than 20 million deaths (Sellnow & Seeger, 2013.) McInnes uses ideas from Onuf (1989) while talking about social constructivism.

“The social world does not exist independent of observation, but rather is what we choose to make it, and that the ideas we use in observing and understanding the social world also shape that world.”

(McInnes, 2016; Onuf, 1989, 383)

Thus McInnes sees that understanding of the social world guides the actions for establishment of socially legitimate pathways of response. He suggests that the West African Ebola outbreak and the response to it could be understood as a crisis through a global health narrative consisting of three elements: globalization, securitization and politicization.

2.5. Reasons for Ebola's quick and wide spread during the 2014 – 2015 outbreak

In the academic literature, three reasons have been stated, as to why Ebola spread so quickly and widely. First of all, Guinea, Sierra Leone and Liberia were not ready to face the outbreak,

because they were not fully recovered from civil wars which took place between the end of 1980s and the end of 1990s. These wars originated from authoritarian rule, corruption and the loss of Western foreign aid (Sherrill & Somerville, 2015.) Still today, Guinea, Sierra Leone and Liberia have weak healthcare systems and are lacking human and infrastructural resources (WHO, Ebola virus disease, 2015.) They also score poorly on the Human Development Index (HDI). In 2013, Sierra Leone was placed on the 183rd out of 187 countries, whereas Guinea ranked 179th place and Liberia ranked 175th place (Human Development Reports, 2013.) The second reason behind the wide spread of Ebola was seen as incomplete governance of global bodies (e.g. WHO) and their slow response to the outbreak (SciDevNet, 2015.)

”Although international response eventually occurred, it only arose when the epidemic was already out of control and had been considered an international public health threat. An additional trigger for the international response was the appearance of cases in the United States and Europe. Suddenly, it became obvious that Ebola poses an urgent threat not only to West Africa but also to the international community at large.”
(Roca, Afolabi, Saidu and Kampmann, 2015)

The third reason for why Ebola spread so dramatically has been stated as a lack of inducements for EVD drug research and development (SciDevNet, 2015.) Still, there is neither licensed treatment proven to neutralize the virus nor there is an Ebola vaccine. However, a range of blood, immunological and drug therapies are under development as well as potential Ebola vaccines are undergoing evaluation (WHO, Ebola virus disease, 2016.) There are also some medical reasons related to the disease itself, for example the human body's race to contain unfamiliar or virulent pathogens (SciDevNet, 2015.) In this thesis, I am focusing mainly on the explanations dealing with social sciences.

As told earlier, according to WHO Ebola Response Team, the scale of the epidemic in 2014 – 2015 was extreme, because of the attributes of the affected populations and lacking control efforts. In addition to this, WHO Ebola Response Team (2014) suggests that because Guinea, Sierra Leone and Liberia are extremely interconnected, the virus had a chance to spread geographically. There is lots of cross-border traffic at the epicenter and the connections by road are relatively easy between rural towns and villages as well as between the densely populated capitals of the three countries. The large intermixing population disseminated the

infection easily. However, a large EVD epidemic was not foreseeable. (WHO Ebola Response Team, 2014)

I find it important to research the Ebola outbreak through different phases. I believe that by looking at the outbreak in smaller sections, explanations for why the epidemic got out of control can be found. The same thing applies, while looking at how the outbreak got under control again. For me, it is important not to look at EVD outbreak from a medical point of view but from a social science point of view because there are social factors affecting the spread of the epidemic. Paul and Sherrill (2015) argue that Political Science & Politics can situate the outbreak in a comparative perspective as well as bring clarity to the situation. They show how the outbreak can be decoded through diverse lenses, such as international organizations, public opinion, public health, international law, human rights, security, political behavior, migration, ethnic politics, intersectional analysis, identity, and the politics of care. Paul and Sherrill suggest that in order to combat EVD outbreaks intergovernmental coordination, intervention of international organizations (including intl. NGOs), market actors (e.g. pharmaceutical companies and commercial airlines), and synchronization of state efforts with subnational response frameworks are needed. (Paul and Sherrill, 2015)

2.6. Ebola response by international actors

It can be stated that the 2014 – 2015 Ebola outbreak was an occurrence that fulfilled the IHR 2005's requirements for a public health risk in West Africa and even elsewhere. Thus, the international law gave the premise for Ebola response by international actors, and it was not based on charity or a certain country's willingness to help Ebola stricken countries. In this thesis, I am interested in the actions taken by international organizations. While analyzing the data, I am looking at the main actors of the epidemic as well as actions taken by them. It can be said that through certain actions taken by certain organizations, the outbreak was brought under control during the winter of 2014 – 2015. Next I am going to briefly introduce the main international actors in global virus outbreaks: World Health Organization (WHO), Global Alert and Response Network (GOARN) and Médecins Sans Frontières (MSF). According to its constitution, The World Health Organization (WHO)

”is to act as the directing and co-ordinating authority on international health work; to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate.”

(WHO, 2006, 2)

WHO is part of the United Nations organization and the leading organization in global health. It acts under International Health Regulations. The organization was founded in 1948. During the 2014 – 2015 Ebola outbreak, the Director General of the organization was Margaret Chan. Thus, it was her duty to give a PHEIC in August 2014. WHO's headquarters are located in Geneva, Switzerland but the organization has six regional organizations all over the world. (WHO, About WHO, 2016). WHO's regional office for Africa is located in Congo. Over the Ebola outbreak period, WHO received lots of critique from other health-related actors concerning its actions and inactions. Most critique focused on what was perceived as a slow international response to the Ebola outbreak in 2014 – 2015. In the literature, the slow response is seen as a consequence of budget cuts to WHO's annual budgets between 2008 – 2012 and staff reductions in the same time period (Busby and Grépin, 2015; Youde, 2015.) The other reason for WHO's slow response is found within WHO's structure. I.e. the relationship between the central office and regional organizations is seen as too complex.

”WHO is so decentralized that it is essentially seven different organizations awkwardly held together. WHO has no control over or input in how the regional organizations operate or who their leaders are. This fragmentation undermines WHO's ability to act as an unitary actor and faithful agent for its mandate”.

(Youde 2015, 12)

I will come back to the slow universal response and WHO's role in the Ebola outbreak response in the Findings Chapter. Instead, Global Alert and Response Network (GOARN) is WHO's and its partners' common network that responds to outbreaks of international concern. The network was established in 2000. Since then, it has coordinated over 130 international public health emergencies. WHO coordinates GOARN by using resources of the network. GOARN consists of over 200 institutions and networks which have human and technical resources for rapid identification of, confirmation of, and response to public health emergencies on a global scale. It has also over 600 partners (e.g. national public health

institutions and hospitals, ministries of health, academic and research institutions, technical institutions and networks, UN and international organizations as well as NGOs). In short, GOARN's purpose is to deploy technical teams to health crisis areas to assist with needed activities. Teams usually consist of experts from different fields of study: anthropology, coordination, clinical management, epidemiology, logistics, infection control, social mobilization, and risk communications. (WHO, Global Alert and Response Network (GOARN), 2016)

Médecins Sans Frontières (MSF) was founded in 1971 by French doctors who had worked in the Nigerian civil war. As an outcome, they wanted to find a way to work both rapidly and effectively in public health emergencies without political, economic or religious obligations (Toronto Star, 3 Nov 2014.) Today MSF is an international, independent, medical humanitarian organization whose aim is to deliver emergency aid for those affected by natural disasters, epidemics, armed conflicts and healthcare exclusion. MSF international binds 24 associations, and is based in Geneva, Switzerland from where it provides coordination, information and support to the MSF Movement. It also implements international projects and initiatives (Médecins Sans Frontières, 2016.) In 2014, MSF worked in more than 70 countries all over the world (Toronto Star, 3 Nov 2014.) The organization's work is carried out by thousands of health professionals, logistical and administrative staff. The majority of MSF's workers come from those countries where it is operating by providing medical assistance (Médecins Sans Frontières, 2016.) MSF Canada was founded in 1991 and it has two offices in the country; the headquarters are located in Toronto and another office is located in Montréal. MSF still works with the same principles as back in 1971 without political, economic and religious commitments. The organization is driven only by medical need (Toronto Star, 3 Nov 2014.)

2.7. Main Ebola actors in the light of global health diplomacy

I see actors on the Ebola field to deal with health diplomacy, and that's why I find it important to look at a theory which covers the topic. Katz, Kornblet, Arnold, Lief and Fischer (2011) have introduced a health diplomacy theory which has three different forms: core diplomacy, multi-stakeholder diplomacy and informal diplomacy. The theory focuses on U.S. health policies and actions, but I find it relevant while talking about the 2014 – 2015 Ebola

outbreak. The theory helps me to identify the main Ebola actors being presented in the articles of Toronto Star.

The first form, i.e. core diplomacy, consists of formal, high-level negotiations both among nations and between nations. For example, bilateral treaties and agreements take place between national representatives. Whereas, multilateral treaties and agreements involve international negotiations with multilateral institutions, such as the World Health Organization (WHO) and the World Health Assembly (WHA). Usually, the aim of these negotiations is to get a signed agreement between different parties. (Katz, Kornblet, Arnold, Lief and Fischer, 2011)

The second form of health diplomacy is called as multi-stakeholder diplomacy where negotiations are conducted among various state, non-state and multilateral actors. The aim is to achieve common goals. These negotiations take place in partnerships between government agencies (e.g. CDC) as well as global initiatives (the Global Alliance for Vaccines and Immunization) and international organizations. In practice, the multi-stakeholder diplomacy is conducted by technical experts in different national agencies. It is to be emphasized that these agreements only outline obligations but they are not legally binding on sovereign states or in international law. (Katz, Kornblet, Arnold, Lief and Fischer, 2011)

The third form of health diplomacy, informal health diplomacy, takes place between public health actors working all over the globe and their counterparts in the field. This includes host country officials (e.g. government employees), private sector organizations (the Bill and Melinda Gates Foundation), the public, as well as representatives of multilateral and nongovernmental organizations. It also includes international research collaborations. According to Katz et al., informal global health diplomacy is being used in the situations of crisis when humanitarian assistance and disaster response is needed. In 2005, major relief organizations and UN system decided that in order to improve the effectiveness of humanitarian responses, i.e. the co-operation between local, national and international actors, both multistakeholder negotiations and informal global health diplomacy is necessary. By then it was decided that WHO would take the main responsibility in coordinating task division. (Katz, Kornblet, Arnold, Lief and Fischer, 2011)

Brown, M., Mackey, T., Shapiro, C., Kolker, J. and Novotny, T. (2014) have created a

diagram based on health diplomacy theory by Katz et al. According to Brown et al. the main point of the pyramid is to both illustrate and emphasize different aspects of global health diplomacy practice. The pyramid consists of three different levels. Core global health diplomacy is located at the top of the pyramid because the number of practitioners is fewer there than on the lower levels. On the top of the pyramid, interactions and negotiations among state actors and governments take place. Thus, Brown et al. locates health attachés and diplomats there. Whereas, in the middle, multi-stakeholder global health diplomacy takes place, and interactions as well as negotiations among state and multilateral actors are being conducted. Thus, Brown et al. locates multilateral institutional representatives and government agency representatives in the middle of the pyramid. At the lowest level of the pyramid, informal global health diplomacy takes place, and interactions among public health actors and their counterparts in the field are conducted. Thus, Brown et al. locates host country officials, NGOs, universities, the public and private businesses at the lowest level of the pyramid. Brown et al. highlights the fact that on the lower levels of the pyramid, there are more practitioners who are less specific compared to the top of the pyramid. (Brown, M., Mackey, T., Shapiro, C., Kolker, J., Novotny, T., 2014)

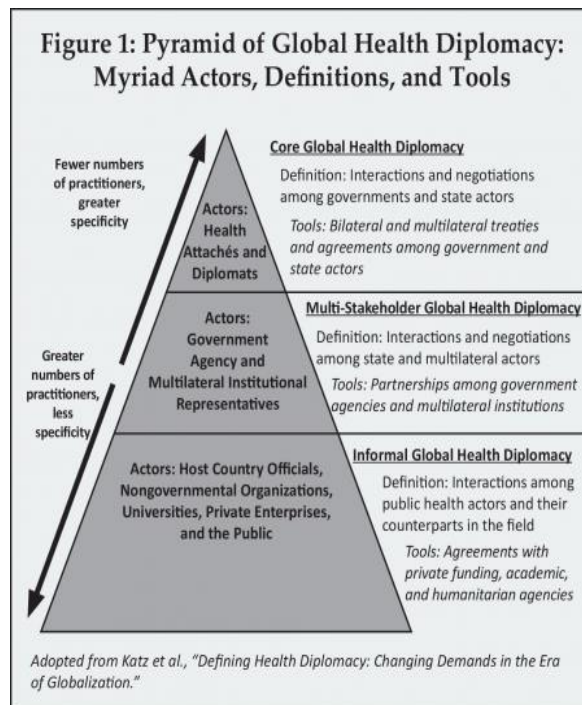


Figure 1. Pyramid of Global Health Diplomacy: Myriad Actors, Definitions and Tools. Source: Brown, M., Mackey, T., Shapiro, C., Kolker, J. and Novotny, T., 2014.

I am going to use the theoretical division of health diplomacy as well as the pyramid of global health diplomacy later on in this thesis, first in the Methodology – Chapter and then in the Findings – Chapter while talking about actors on the Ebola field. In this study, in general, I understand a narrative as an overall 'Ebola story' which consists of small stories being told in the articles of Toronto Star. The overall narrative consists of different phases of the Ebola outbreak. It also includes different actors taking different roles on the Ebola ground. As a conclusion of the 'Ebola as a disease' – Chapter, I find it both interesting and relevant to research the most recent Ebola outbreak. I find it useful to look at the 2014 – 2015 Ebola epidemic through narrative theory, health diplomacy and Leach's categorization. Next, I will move into my theoretical concepts: news and outbreak narratives. The main focus of the next Chapter is to open up a concept of "Ebola outbreaks".

3. THE THEORETICAL CONCEPTS: NEWS AND OUTBREAK NARRATIVES

I will begin this chapter with a definition of news because in my investigation of Ebola narratives, I draw from previous discussion about the nature of news and their narrative character. Later on in this chapter, I will describe the concept of “outbreak narratives” that informs my analysis of the research material.

3.1. From events to news

On a very theoretical level, Galtung and Holmboe Ruge (1965) focus on a question ”How do 'events' become 'news' ?” by introducing the chain of news communication which focuses on how news is to be selected from everything what happens around us and how we form an image concerning what is happening around us. Galtung and Holmboe Ruge's chain:

Media perception → Selection / Distortion → **Media image** → Selection / Distortion → **Personal image**

Thus, media gets a certain perception of an event, and it interprets it into a media image. Then, for example a reader of a newspaper reads a story and gets a personal image of an event that has occurred. In between different phases of a chain, there is the selection/distortion process. This means that only a few events happening all over the world are to be reported in the main media channels. Also the images they represent are to be selected carefully. Galtung and Holmboe Ruge's model focuses not only on the chain but what strikes our attention. (Galtung and Holmboe Ruge, 1965)

According to them, an event can be called news if it happens with the same frequency as the news medium. After that, if the event happens with the same frequency as the news medium, it has to be a newsworthy event. A certain event is fascinating if it is interpreted with a clear interpretation from which many and inconsistent implications can be made. I see that many times the media simplifies issues and makes them black and white in order to provoke discussion. I argue that during the 2014 – 2015 Ebola outbreak, the western media provoked a narrative for western readers that there was a real threat of Ebola spreading in Europe and North America even though only a few Ebola cases altogether appeared in the USA, Spain and the UK (see Table 1). (Galtung and Holmboe Ruge, 1965)

Galtung and Holmboe Ruge also remark that we usually pay attention only to those events which are familiar to us and do not notice those events which are culturally distant. Thus, the culturally distant news is left unnoticed. Galtung and Holmboe Ruge highlight that a culturally remote country may hit the news mainly if it is related to someone's own country. Later on in this thesis, we will see that the timing when Ebola hit the Canadian news sphere is related to the fear of global Ebola spread. Thus, culturally distant news came close to home. (Galtung and Holmboe Ruge, 1965)

They also highlight the fact that news is many times 'olds' because the certain event is expected or hoped for. However, Galtung and Holmboe Ruge remind that events have to be rather unexpected and rare to become 'good' news like the Ebola story was. However, when news has reached the headlines, it will continue to be defined as news for some time because of inertia in the system as well as because the unexpected has become familiar. The overall story of the most recent Ebola outbreak was kept in news for over two years. (Galtung and Holmboe Ruge, 1965)

Seale (2002) refers to Galtung and Holmboe Ruge (1965) by adding that a story will make the news if it is recent, negative, compatible with dominant stereotypes, superlative (the biggest, most destructive, most dangerous), relevant to an audience's daily life experience, personalized, involving important people or sources, and contains so called hard facts such as numbers, names or places. (Seale, 2002)

According to Seale, who is referring to Galtung and Ruge (1965), 'news' is 'olds' meaning that today's car crashes, muggings and suicide bombings are actually similar events which have happened in the past over and over again. News is also reported in the same familiar format as in the past. As Seale points out, the most recent news usually becomes 'old' unless a really big event happens, such as the World Trade Center incident. In short, newspaper readers know in advance what to expect while reading stories considering health news because they are familiar with the common story structure. (Seale, 2002: Galtung and Ruge, 1965). Seale takes an example of AIDS epidemic in the 1980s.

”AIDS was implacably negative, threatening a wide-spread epidemic that brought almost certain death. It was happening 'now', and some analysts say (Check, 1987; Klaidman, 1991) that it was only when it came close to 'home' (threatening the heterosexual community) that coverage intensified. Dominant stereotypes about homosexuals, drug users and prostitutes figured large and 'unexpected' communities, such as haemophiliacs, became involved, so that searching for the next risk group (mothers and babies, as it turned out) was for a time the newshound's task. Scary 'discoveries' involving transmission through spittle and toilet seats could be trumpeted (and then condemned as irresponsible 'scares'). The potential size of the eventual 'epidemic' could be hyped and here numbers and authoritative sources played a major part, as well as a metaphoric connection with the plague. Stories of people affected by the disease made for a plentiful supply of personalised 'human interest' material, made even more exciting if that person was already a celebrity.”

(Seale, 39)

As will be pointed out later, it seems that the most recent Ebola outbreak was 'olds' because Ebola was included among the others like AIDS, SARS and Swine flu.

The media also uses lots of metaphors while creating rhetorical effects. Seale points out that, for example, cancer can be seen as a battle (Sontag, 1991; Seale, 2002) or a race (Seale, 2001a; Seale, 2002). Instead, descriptions of new drugs can be seen as 'magic bullets' or 'breakthroughs'. According to Seale, numbers are also important tools for creating contrasts. Generally, they are used to exaggerate effects either very small or very large and at the same time very important, so that news value is automatically improved. (Seale, 2002). While going through the research data, I paid attention to both metaphors and numbers being presented in the data as a way of exaggerating the epidemic.

As previously mentioned, I found that Ebola hit the news in Canada because there was a threat of global Ebola spread even though it seemed unusual that a haemorrhagic fever of West African origin would cross the North America. The Ebola story was kept in news in one way or another for at least two years, and many different types of micro stories were written under one big Ebola story. So, I consider that in the case of the most recent Ebola outbreak in West Africa, all of the aspects mentioned earlier were also mentioned in the research data. This will be shown in the Findings chapter.

3.2. Ebola outbreak narratives: Leach's thematic categorization

There are many authors who have written fictional stories about emerging infectious diseases. Probably the most famous authors are Laurie Garrett who focused on the discoveries of Lassa fever and Ebola in *The Coming Plague* (1994) and Richard Preston who focused only on Ebola in *Hot Zone* (1994). (Leach, M., 2008). In my analysis, I will draw from the work of an academic researcher Melissa Leach (2008).

As reported by Leach (2008), haemorrhagic fevers (e.g. Ebola, Marburg and Lassa fever) have captured both popular and media imagination as deadly diseases which come 'out of Africa'. They are a big concern as 'emerging infectious diseases' and a threat of global spread. There is also a possibility that haemorrhagic fever outbreaks might need quick international policy responses and control measures. According to Leach, there is a large variety of ways of framing haemorrhagic fevers but she uses the term 'outbreak narrative' while talking about narratives around Ebola, Marburg and Lassa fever. Leach's thematic narratives give a reason why haemorrhagic fevers should be tackled. They also give different explanations for why haemorrhagic fevers have emerged over and over again. According to Leach, her paper, *Haemorrhagic fevers in Africa: Narratives, Politics and Pathways of Disease and Response* (2008), makes a comparison between global outbreak narratives and deadly local disease events in terms of culture and context, as well as long-term social and environmental dynamics. The paper aims to integrate different views of disease response so that haemorrhagic fever outbreaks could be tackled more responsibly, effectively and sustainably in the future. It emphasizes that different actors and institutions (e.g. people and health care personnel living in the outbreak area), media channels, international organizations, scientific and disciplinary institutions) respond differently to Ebola, Marburg and Lassa fever outbreaks. At the same time, different actors articulate their views in the form of storylines or narratives. Narratives are important because they describe the problem from an other perspective, they describe relevant factors involved as well as what to do about the problem. According to Leach, above all, Ebola outbreak narratives serve to justify institutional as well as policy pathways for disease response which have material effects. Leach's paper is based on web-based sources, literature and interviews conducted with the World Health Organization. In her paper, the role of the World Health Organization is highlighted through examples which are provided by the representatives of the organization. Leach reminds that her paper "offers only a preliminary mapping of narratives" (Leach, 2008, 3) and

differentiates her outbreak narratives according to their themes. The four distinct themes are as follows:

- “1. A global threat: tackling the emerging plague out-of-Africa*
 - 2. Deadly local disease events: the building of universal rapid response*
 - 3. Culture and context: building positively on local knowledge*
 - 4. Mysteries and mobility: taking long-term ecological and social dynamics seriously”*
- (Leach, 2008, 2)*

As reported by Leach, the presented haemorrhagic fever narratives overlap, and so do actors and networks associated with them. This theory argues that some of the narratives dominate while others are neither so coherent nor clear, and they get less attention and resources. Leach emphasizes that all of the narratives involve social, virological, epidemiological, ecological and technological processes which are interlinked. However, these are prioritized differently in different narratives. There is also a shared goal which is to minimize suffering from Ebola, Marburg and Lassa fever. Different narratives emphasize suffering differently, e.g. on the axis of global suffering vs. local suffering. As shown below, Leach's paper concentrates on a story where at one end exists the fear of global Ebola spread, and at the other end exists local response in African settings. As an outcome, a response which integrates local people and knowledge is hoped for. A main reason for Ebola outbreak response can be found from endeavors towards more stable and resilient societies. (Leach, 2008)

“A key overall story running through this paper concerns the shift from global scare stories to focused local responses in African settings, and then, to responses that integrate local people's own system framings, Sustainability goals and knowledge – becoming more effective, stable and resilient as a result.”

(Leach, 2008, 3)

I am using Leach's categorization in my Master's Thesis in order to get an understanding of the 2014 – 2015 Ebola outbreak in West Africa and elsewhere. For me, it provides a framework to figure out what happened on the ground, who was involved in the battle against Ebola and how Toronto Star reported the outbreak.

3.2.1. A global threat: tackling the emerging plague out-of-Africa

Leach has adopted the term 'outbreak narrative' from Priscilla Wald (2008), who describes what she sees as 'a paradigmatic story about newly emerging infections'. The definition emerged during the aftermath of HIV discovery in the 1980s. It has many applications, but a following story structure can be found in stories concerning newly emerging infections. (Leach, 2008)

”(this) 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 catalogue the spaces and interactions 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”

(Wald, 2008, 2; Leach, 2008, 6)

Thus, the first policy narrative is being put into a frame of an overall story; an emergence, a spreading, a turning point in the number of cases, a fading and the end. Accordingly, in the Findings Chapter, I am going to present different phases of the outbreak based on the research material. I argue that the Ebola outbreak story got its beginning when the first Ebola case arose. The story came to a turning point when the number of Ebola cases started to decline remarkably and systematically, and the story ended when the last Ebola stricken country was declared to be Ebola-free.

According to Leach, approximately 60 newspaper articles were written about Ebola in more or less sensationalized terms in the United Kingdom during the 1995/6 Ebola outbreak in Kikwit, Zaire. The newspaper articles portrayed EVD as an emerging and horrifying disease which comes 'out of Africa' and threatens Europe and North America. At the time, the articles asserted that Northern populations need to be protected. Thus, the narrative had a global focus back in 1995/6. In the Findings chapter, I will show the relationship between the global and local focus in the newspaper articles of Toronto Star. Leach reminds us that the politics of fear and the threat around Ebola shaped international policy responses. Also, the outbreak in

Kikwit, Zaire turned out to be an occurrence that led to a creation of a revised set of International Health Regulations (IHR) in 2005. I will also look at the concepts of fear and threat in the Findings chapter. (Leach, 2008; Heymann et al., 1999)

3.2.2. Deadly local disease events: the building of universal rapid response

The second policy narrative emphasizes that Ebola outbreaks should be tackled because Ebola is deadly among the local populations. Thus, the narrative gets a local focus in opposition to the first narrative. Even though the effect is on local populations, outbreaks need to be tackled with the help of international actors. However, the second narrative overlaps with the first one because international response is needed. The aim of the response is to limit disease mortality and control the progression of the disease at a local scale over a short period of time. In this narrative, the use of GOARN can be seen as a strategy for resilience, but Leach reminds us by referring to the interviews given by the staff members of WHO, that international organizations are usually only able to respond to short-term outbreaks and leave the area when the outbreak is over. Thus, it is necessary to build national capacity for epidemic preparedness and response. (Leach, 2008)

The second policy narrative includes means for tackling the virus when outbreaks are due arise. According to Leach, institutional arrangements should be available and rapidly mobilized when outbreaks arise which can be seen as a strategy for resilience. Means for tackling the virus include isolation techniques in isolation wards, instructions for contact tracing, providing of health education for local populations (concerning symptoms and means of transmission) as well as limitation of 'dangerous' local behaviours e.g. the washing and burial of corpses. This is in line with Hewlett and Hewlett (2008) and MSF's (2015) report. (Leach, 2008)

Leach's paper highlights vaccinations as a way of reducing Ebola cases during the outbreaks. However, it is thought that pharmaceutical companies did not show any interest in funding vaccines for poor African populations before the latest Ebola outbreak. This is because it was not seen as profitable. Neither global philanthropists nor public-private partnerships had funded vaccines against Ebola in the past. This might be because mortality rates in Ebola had been low in the past compared to other diseases, such as malaria, HIV and TB, which are

common in West Africa. In contrast to this, the paper mentions that there has been some vaccine development for haemorrhagic fevers in military contexts which has been driven by the fear of bioweapons. (Leach, 2008). In the Findings Chapter, I will describe different means of tackling the virus which were used in 2014 – 2015 Ebola outbreak and presented by Toronto Star.

According to Leach's paper, the first two narratives are co-constructed with notions of scientific authority. Disease response and control is based on epidemiological and virological facts as well as practices of clinical medicine. Health care personnel carry an important role in disease response and control. In contrast to this, local populations are often presented as ignorant in the second policy narrative. Epidemic control is seen in the following way:

“Epidemic control is not rocket science; it involves the simple principle of breaking the cycle of transmission.”

(Leach, 2008: WHO's representative in an interview in Geneva on July 8 2008)

Responding to an Ebola outbreak is not an easy task for any organization. In the past, international organizations have had problems with their Ebola emergency responses. Hewlett and Hewlett (2008) points out specific aspects which might cause anxiety in the local populations during the Ebola responses implemented by international actors. Among others, there are some examples where locals have been denied permission to bury Ebola victims. In these cases, some suspicions such as “a dead person's body parts are stolen” have arisen. This has caused worries among locals which has caused distrust towards international aid workers. Thus, careful attention has to be given to burial practices and how they are being carried out. (Hewlett and Hewlett, 2008.) Ignorance by the local population is another factor which needs to be taken into account while battling on the Ebola ground. Kunii et al., reports that during the Ebola outbreaks in Gabon between 1994 and 1997, in one village, only two thirds of the population could name Ebola as a ravaging disease in the area and could explain it in scientific terms. For one third of the population, Ebola seemed to be sorcery and evil spirits. (Kunii et al., 2001.) In the Findings Chapter, I will also look at locals' beliefs reported by Toronto Star and how they were affected during the most recent Ebola outbreak.

3.2.3. Culture and context: building positively on local knowledge

The third policy narrative is being formed on the basis of the realizations from the mid-1990s when researchers realized that culture matters while tackling Ebola virus outbreaks. First of all, haemorrhagic fevers are seen as long-present amongst local populations because they have developed culturally-embedded ways to live and deal with Ebola, Marburg and Lassa fever. The third narrative suggests, based on Hewlett and Hewlett's (2008) notions, that the way locals perceive haemorrhagic fevers should be added to Ebola outbreak responses. For example, whether they see haemorrhagic fevers as epidemic or endemic. Secondly, it was considered that western-style responses were many times culturally inappropriate and the response provoked both fear and anxiety among local populations. According to interviews of WHO staff members, responders on the ground noticed that Ebola outbreaks could not be tackled if the locals were not taken into account. It seemed that so called top-down western response was denying people's basic human rights. That's why it is important to include local knowledge and culture in response strategies of international responders. It is clear that local populations have knowledge which international aid workers do not have because they come from outside of the region. Thus, locals can inform international responders amidst an Ebola outbreak. At the same time, they can make the responses context-specific, acceptable by local communities and more appropriate in terms of culture. (Leach, 2008)

The third outbreak narrative emphasizes the inputs of anthropologists and anthropological knowledge as well as tools for response strategies. Barry Hewlett's pioneering 'outbreak anthropology' (Hewlett and Hewlett 2008) has been pivotal in developing this narrative by suggesting that anthropologists should be included in integrated Ebola response teams, because anthropologists are experts of cultural knowledge. Since 2001, WHO has included anthropologists into its own outbreak responses. (Leach, 2008)

“We have anthropologists at the frontline of our teams now”; that “we would be fearful to go to the field without an anthropologist”, and that “anthropological integration is now a key pillar of our response strategy – as important as isolation”. He notes that “this was not the case ten years ago”.

*(WHO's the Director of Outbreak Alert and Response Operations
in an interview in Geneva on 8 July 2008)*

The third policy narrative reminds us that context matters. Thus practices and technologies suited to limit contagion in one location (region, village etc.) may not work in another location. I agree with Leach that there is an overlap between the second and third narrative which can be later seen in the Findings Chapter.

3.2.4. Mysteries and mobility: taking long-term ecological and social dynamics seriously

Leach points out that the first three outbreak narratives focus on short term responses whereas the fourth outbreak narrative focuses on long-term response to haemorrhagic fevers. There is evidence that Ebola outbreaks are increasing both in frequency and severity. That's why Leach considers that long-term ecological and social dynamics should be taken seriously. Also, underlying causes behind re-occurring Ebola outbreaks should be defined.

According to Kuiken et al. (2003), more attention needs to be given to the identification of the underlying causes for the emergence of infectious diseases, which are related to anthropogenic social and environmental changes. This might help decrease the rate of emergence of infectious diseases as well as allow the transition to a more sustainable society. While talking about social dynamics, the focus is on structural violence and health systems, i.e. poverty, inequality and 'structural violence' (Farmer 2003). It is understandable that outbreaks get out of control in countries with long-term and widespread poverty and conflict, where health systems are declining. Urbanization causes its own challenges as well. For example, viruses multiply easily in overcrowded hospitals and populous urban slums of developing countries. Thus Leach suggests that while battling against haemorrhagic fevers, it is necessary to decrease poverty and conflicts, which are part of the leading causes for re-appearing haemorrhagic fevers. It can be seen that pathways of disease response involve moving from 'reactive to sustainable control'. This includes the training and funding of frontline health workers as well as building of existing health systems which requires resources from international actors. In the Findings Chapter, I will present how Toronto Star dealt with social dynamics in relation to 2014 – 2015 Ebola outbreak. (Leach, 2008)

Leach looks at ecological dynamics, e.g. ecosystem dynamics and climate change while looking for reasons why Ebola outbreaks are emerging more frequently and why the epidemics are more difficult to tackle than before. It is probable that infectious diseases will

increase in the future due to climate variations and extreme weather events through accelerating deforestation, and on the other hand through distribution, reproduction and survival rates of pathogens and vectors (Leach, 2008: Patz et al 2005.)

In order to answer my research questions, I will use Leach's thematic categorization of outbreak narratives. I will read my research material from the four different points of views presented in this Chapter. Her categorization gives me the tools to dig deep into my research material and categorize it accordingly.

4 METHODOLOGY: NARRATIVE ANALYSIS OF EBOLA OUTBREAK

As continuation of the previous one, in this Chapter I will present the methodological approach of my study and the methods used. First, I will briefly explain a narrative approach to newspaper articles and after that explain how I will apply it in my study.

4.1. Narrative approach to newspaper articles

What is a narrative? In literature, there are plenty of different definitions for a narrative. According to Abbott, narrative is a combination of a story and a discourse which defines its two components in a following way:

“Story is an event or sequence of events (the action), and narrative discourse is those events as represented”
(Abbott, 2002, 16)

In practice, “narrative is somebody telling somebody else, on some occasion, and for some purposes, that something happened to someone or something”
(Herman, Phelan, Rabinowitz, Richardson and Warhol, 2012, 3)

Thus, narrative is an ongoing process of creating, using and arranging symbols that organize human experience in sequential and consequential ways, as units of discourse but also as ways of seeing, behaving, and being (Fisher, 1987, 63; Sunwolf and Frey, 2001, 121). According to Herman et al. (2005), narrative is so called multidimensional purposive communication from a teller to an audience. While looking at a narrative, we pay attention to a narrative's characters, setting and plot structure in order to get a big picture of the narrative.

According to Propp (1968), most of the folk tales can be reduced to a few stock characters and functions. The characters are interchangeable depending on the purpose which they serve. For example, an evil force can be represented by a witch or a dragon; a ruler by a chief or a king; a loved one by either a daughter or a wife. Many stories include heroes, helpers and villains. Usually, heroes and villains meet in the midst of a struggle. At the end, heroes win and villains lose. (Seale, 2002, 28; Propp 1968). According to Seale, in health coverage the overall story being told is life of the body and its struggle against evil, i.e. death. At the end

of health stories, people become either heroes or victims, for example Seale refers to cancer patients who become cancer heroes or cancer victims depending on whether or not they won the battle against the disease. Doctors and research scientists are often represented as helper-heroes because they bear magical cures whereas nurses behave like angels. Instead, villains take the form of disease. (Seale, 2002). Seale highlights the fact that many of the elements included in narratives are also included in health representations by the media.

In this thesis, I define the narrative as an overall ‘Ebola story’ being presented in the articles of Toronto Star in 2014 – 2015. The overall ‘Ebola story’ consists of smaller stories which I call micro-stories. These micro-stories are presented in individual newspaper articles which form the overall ‘Ebola story’.

4.2. Collection and selection of the research material

Let me start this section by explaining why I ended up choosing articles of Toronto Star as my research data. First of all, when I considered my topic, I also considered the data collection and ended up using newspaper data because it seemed to fit into my research plan as a whole. It was also practical because I could not travel to West Africa and research the topic there. After I had decided that I want to use newspapers as my source of data, I also had to decide whether I want to look at only one newspaper or compare different newspapers. I also had to decide whether I want to look at a West African newspaper or a Western newspaper. Finally, I chose Toronto Star because it seemed to cover the topic well. The newspaper had also received my attention earlier while I was living in Toronto and doing my journalistic internship at a Finnish Canadian newspaper. The news reporting of Toronto Star represents a western perspective towards the West African Ebola outbreak in 2014 – 2015. I considered it only as one example of Ebola news reporting. I could have also taken another Western newspaper or a West African newspaper alongside of Toronto Star and compare two different newspapers and different ways of reporting the same issue.

I collected my data in three parts, partly during the spring of 2015, in the fall of 2015 and during the spring of 2016. By doing the data collection in parts, I was able to cover all of the published articles related to the issue in the years of 2014 and 2015. I conducted the data collection through NELLI by searching Toronto Star's articles. In ProQuest Central, I searched articles with keywords of Ebola and 2014 (/ 2015). By using the chosen keywords, I

noticed that some of the articles only mentioned Ebola and a year, but did not focus on the Ebola outbreak. Thus, I divided my articles into two categories: relevant (97) and irrelevant (30), and excluded irrelevant (30) articles from the research material.

Thus, my data consists of 97 articles which I took a careful look at. I felt that 97 articles were not too many for a Master's Thesis because news articles are often short in length.

Below, you can see a table of release months of relevant Ebola articles. The table shows how many Ebola related articles were being published per month in Toronto Star in 2014 – 2015.

Month	Number of articles (Year of 2014)	Number of articles (Year of 2015)
January	0	6
February	0	1
March	1	6
April	2	3
May	0	1
June	1	0
July	1	0
August	17	5
September	11	0
October	24	2
November	10	0
December	5	1
Total	72	25

Table 2. Toronto Star's articles concerning Ebola outbreak in 2014-2015 in numbers divided by months.

As Table 2 shows, Toronto Star covered a higher number of relevant Ebola articles in the year of 2014 compared to the year of 2015. Approximately 75 % of all the Ebola related articles were published in 2014, and only 25 % in 2015. Toronto Star published the highest number of Ebola articles per month in August 2014 and in October 2014. However, the newspaper covered approximately three relevant news items per week also in September 2014. In 2015,

the most relevant Ebola news was published in January and in March. In January, the newspaper looked back at the year 2014 whereas March was a one-year milestone in the Ebola fight.

My research material consists of only text and there are no photo images in my research data. This is because when I printed the articles from ProQuest Central, there were no photo images available. Thus my analysis is a text analysis.

4.3. Methods of analysis

I started my analysis by printing out the articles I was going to analyze. After that, I read through the research material. While reading it through one article at a time, I took some notes concerning the content of the article. I also underlined the facts which seemed the most important and the most fascinating concerning the entire Ebola outbreak period. Thus, while reading the research material through the second time, I was able to focus on the underlined sentences and the issues which seemed to interest me the most. I tried to look for reasons and consequences for different occurrences, especially for the PHEIC. I also tried to get the timings right; what happened and when.

4.3.1. Thematic analysis of the articles

After reading through my research material and finding out the occurrences, facts and actors which interested me the most, I cut my printed articles into smaller pieces based on the context of the sentences. After that, I put the small pieces of articles into separate piles and categorized them under the following titles: narratives of spreading disease, unsafe burial practices, slow global response, lacking resources, travel bans and travel restrictions, harmful misconceptions and misunderstandings by local communities, anxiety and fear, means of battling the virus, the impact of the epidemic, Ebola heroes and Ebola victims. I figured the titles out easily from the data. After that, I tried to go through the piles one by one. However, I noticed that it was not very easy to handle the tiny pieces of paper because they were all over and some of them even got lost. So, I printed the used articles again, underlined the facts I was interested in and handled the articles one article at a time by using the 10 themes mentioned earlier. These themes helped me to place the articles under Leach's (2008)

categorization (I-IV) as follows:

- Spreading disease (I)
- Unsafe burial practices (III)
- Slow global response (II)
- Lacking resources (IV)
- Travel bans and travel restrictions (I & II)
- Harmful misconceptions and misunderstandings by local communities (III)
- Anxiety and fear (III)
- Means of battling the virus (II)
- The impact of the epidemic (IV)
- Ebola heroes and Ebola victims (I-IV)

Thus, I used a thematic analysis of the articles while analyzing my data. Also, some other themes came up but I considered that these were not necessary while thinking of my research questions and Leach's categorization. Among the other themes, Toronto Star wrote about suspected Ebola cases in Canada but these cases did not turn out to be Ebola.

4.3.2. Categorization of the seven main phases of the 2014 – 2015 Ebola outbreak

As the guideline for my analysis, I created a categorization of seven main phases of the 2014 – 2015 Ebola outbreak based on my 2nd Chapter as well as my research data. I figured the different phases out while reading through my research material. While conducting my analysis, I followed the categorization most of the time. The categorization helped me to keep focused and not get sidetracked, because I could not concentrate on every single event of the 2014 – 2015 Ebola outbreak. Instead, I tried to see the outbreak as a whole. It also helped me to place different events into different phases.

The seven main phases of the 2014 – 2015 Ebola outbreak are the following:

1. The beginning of the 2014 – 2015 Ebola outbreak
2. The spread of the 2014 – 2015 Ebola outbreak inside of West Africa
3. Ebola as an international public health emergency

4. The spread of the 2014 – 2015 Ebola outbreak outside of West Africa
5. A turning point in the 2014 – 2015 Ebola outbreak
6. The fading of the 2014 – 2015 Ebola outbreak
7. The end of the 2014 – 2015 Ebola outbreak

I will use the categorization in the Findings Chapter while responding to my first research question. My aim is to present outbreak narratives brought up by Toronto Star one by one according to the categorization.

4.3.3. Pyramid of Global Health Diplomacy: Actors in the 2014 – 2015 Ebola outbreak

In addition to the analyzing tools on pages 41 and 42, I used a pyramid of Global Health Diplomacy created by Brown et al., pictured on page 25. Thus, while conducting my analysis, I located different actors mentioned in the research data into different levels of the pyramid. My aim was to find and differentiate core global health diplomacy actors, multi-stakeholder global health diplomacy actors and informal global health diplomacy actors mentioned in the research data.

Next, I will proceed to the Findings Chapter, where I will present the results of my analysis on Ebola narratives in Toronto Star.

5 FINDINGS: EBOLA OUTBREAK NARRATIVES IN TORONTO STAR

Because we live in a globalized world today, different media channels choose which stories they want to cover themselves and which stories can be produced based on findings of others. Global media channels put some of their resources into covering Ebola stories on their own during the most recent Ebola outbreak. Toronto Star was among them. In August 2014, the newspaper sent their global health reporter, Jennifer Yang, to Sierra Leone to report on everyday life in an Ebola-stricken country. Yang wrote an article about her experiences on the ground. She described her feelings and thought processes before travelling to Sierra Leone, on her way there and while reporting on the ground.

“...My editors and I agreed this was a major story, one we had a role in telling. And we believed the risks were manageable. I'm not sure what I was expecting here but I was surprised to see life unfolding somewhat normally – people are shopping, socializing, mingling. Of course, there is worry and fear in the air (everyone is washing their hands and the word “Ebola” is on everyone's lips), but there is no panic or chaos.”

(Toronto Star, 14 Aug 2014)

During Yang's trip, there were a few things she paid especial attention to. First, she was surprised that people would travel to Sierra Leone amidst an Ebola outbreak.

“On my flight, I was surprised to see people still coming to Sierra Leone for business or maybe even pleasure; one Chinese couple looked like they might have been tourists. One Frenchman said he was flying to Sierra Leone to start a new finance job in Freetown; when I asked him whether he was worried about Ebola, he just shrugged.”

(Toronto Star, 14 Aug 2014)

Secondly, she was surprised by the welcoming reaction of a young boy.

“An hour after arriving in Sierra Leone, I witnessed something that was simultaneously adorable and ominous... As we passed through a strip of ramshackle shops and homes, a group of children started running towards us, waving and smiling. One giggling little boy, who couldn't have been older than 7, ran up to the bus and shouted: “EBOLA IS HERE!”

Yes, it certainly is, I thought. And now I am here, too.”

(Toronto Star, 14 Aug 2014)

Thirdly, she noticed how much attention she was paying to her own body as well as other people's bodies:

“Another fellow I met at the hotel was also nonplussed but made an interesting remark. “You know,” he said, as we sat in the hotel restaurant, “that waiter who is the only one working and his forehead is just covered with beads of sweat. I'm not so sure I would have noticed that if not for the Ebola outbreak.” To me, this articulates what it is likely to be in a country stricken with Ebola – your awareness is constantly heightened and you are always noticing other people's bodies, as well as your own. I paid attention to every tickle in my throat, every sharp pain, every sore muscle. I took my temperature every day.”

(Toronto Star, 14 Aug 2014)

I consider Toronto Star a reliable source of Ebola related news because they wanted to send Jennifer Yang into the Ebola affected area, and did not only report information collected by news agencies such as Reuters or The Associated Press (AP). This probably led Toronto Star to provide unique insights into the outbreak. Yang's article reminded the readers of Toronto Star that life unfolded quite normally in the Ebola stricken countries even though only a few media sources did report on it. However, Toronto Star's focus is a global focus, and thus the locals' perspective into the Ebola outbreak is only reported partially. It is clear that the newspaper represented a western approach towards the issue. This may both be because Toronto Star's readers are mainly Canadian and interested in a Western perspective, and because the newspaper had limitations in data collection; Yang was able to stay on the Ebola ground only for a short period of time.

In this chapter, I will present the results of my analysis of the Ebola outbreak narratives as well as the actors and their roles presented in narratives in Toronto Star. This chapter is divided into different phases of the 2014 – 2015 Ebola outbreak which I will present chronologically. I will begin the presentation of my results by describing how the 2014 – 2015 Ebola epidemic first appeared in the narratives of Toronto Star. After that, I will move into the second phase of the outbreak; the Ebola spread inside of West Africa. Then, I will look at Ebola as an international public health emergency and how it was narrated by Toronto Star which again will lead me to the fourth phase; the spread of Ebola outside of West Africa.

Later on in this chapter, I will highlight the fact that the spread of Ebola was reported differently when it happened inside of West Africa versus when it reached Europe and North America. At the end of 'Ebola as a global security threat' -section, I will address the fading of the 2014 – 2015 Ebola outbreak as well as how Toronto Star saw the outbreak at the end of 2015.

5.1. Ebola as a global security threat

Leach summarized the first type of Ebola outbreak narratives as 'A global threat: tackling the emerging plague out-of-Africa'. However, I prefer to call it 'Ebola as a global security threat' because the aspect of threat was strongly emphasized in the fall of 2014. I argue that this certain aspect guided the Ebola response in West Africa, especially after a few Ebola cases appeared in the United States and one case in Spain. The first narrative provides insights into the spread of Ebola as well as into the fear it caused globally.

5.1.1. The beginning of the 2014 – 2015 Ebola outbreak

According to Toronto Star, how did the Ebola story begin? The newspaper notified its readers of an emerging Ebola outbreak for the first time on 25 March 2014:

"Africa's biggest Ebola outbreak in seven years threatens to spread from Guinea to neighbouring Sierra Leone and Liberia, the United Nations says."

(Toronto Star, 25 March 2014)

As stated in the newspaper article, the outbreak began in Guinea, and started to spread already before the first news was being published in Canada. The news was based on the fact that suspected cases were found in southeast border areas of Guinea where people move and do business between all three countries. On 23 March 2014 WHO had posted a quick note on its website:

"The Ministry of Health of Guinea has notified WHO of a rapidly evolving outbreak of Ebola virus disease."

It was said in the announcement that there had been 49 reported cases and 29 reported deaths.

The Ministry of Health of Guinea acted under Article 6 of the IHR (2005) by notifying WHO of a possible public health emergency of international concern. WHO again reported it forward according to the regulations. As stated by Toronto Star, the announcement did not get much attention, but it was the first announcement given by WHO concerning the outbreak (Toronto Star, 23 March 2015, Médecins Sans Frontières, 2015.) At the same time, it was the first time the media noted it in Western countries.

Toronto Star reported about certain events only when they happened for the first time, which is typical for news reporting. When the same event happens for subsequent times, it is not considered to be as important and fascinating as it is during the first time. Thus, in this analysis, I pay especial attention to the “firsts”.

When it comes to Canada's actions in terms of Ebola response, the “first” happened on 19 April 2014. On that day, Toronto Star reported on Canada's actions in terms of tackling the outbreak. The newspaper reported that the Canadian government would give 1.2 million dollars in order to help fight the virus. It seems that the government saw the emerging outbreak as a threat for security already by then, and wanted to act accordingly.

“Biological threats such as the current Ebola outbreak do not recognize borders.”

(Minister of Foreign Affairs, John Baird, Toronto Star, 19 Apr 2014)

Based on the article, Canada's Minister of Foreign Affairs legitimized Canada's support in the Ebola affected region. For readers of the newspaper, this gave an idea as to why Canada was donating a fairly big sum of money into the battle against the outbreak: the Canadian government wanted to take part in the battle before it would spread any further. At the same time, the Canadian government announced its advice not to travel to Guinea because of security concerns. This was also the first time when travel restrictions were mentioned in the data. In contrast to this, WHO saw the epidemic from a different point of view. It did not recommend countries to impose travel or trade restrictions, because it expected Ebola to appear only as a local virus. MSF described the outbreak as “unprecedented”. Therefore, it can be noted that the beginning of the epidemic was seen from very different point of views by different actors. (Toronto Star, 19 Apr 2014)

In the first phase of the 2014 – 2015 Ebola outbreak, the story took place in Guinea as well as on the border areas of Liberia and Sierra Leone. The main actors in the first phase were The Ministry of Health of Guinea, WHO, MSF, the Canadian government and Canada's Minister of Foreign Affairs. Here I see the actors mainly as informants who provide information about concerning what is happening in West Africa. Instead, I find Canada acting as a sponsor in the battle against EVD.

5.1.2. The spread of the 2014 – 2015 Ebola outbreak inside of West Africa

Toronto Star did not publish any news articles concerning the outbreak in May 2014. However, on 21 June, the newspaper reported that the outbreak had surpassed previous records with 528 cases and 337 deaths. At the same time, it reported that the epidemic had spread from Guinea to Sierra Leone and Liberia, and was getting “out of control”. (Toronto Star, 21 June 2014)

”In Liberia, nurses are abandoning their posts. In Sierra Leone, a hospital is overwhelmed.” ... “And in Guinea, health workers are struggling to track people who have been potentially exposed to Ebola, the virus behind an outbreak that has grown ”out of control””

(Dr. Bart Janssens, MSF's director of operations, Toronto Star, 21 June 2014)

“This is the first time an Ebola outbreak has spread across borders to three countries in that part of Africa, (giving) it the largest geographical spread”

(WHO's spokesperson Fadela Chaib, Toronto Star, 21 June 2014)

“We've seen a resurgence of an epidemic which is really worrying” ... “The epidemic is continuing to spread in different sites in at least three countries” ... “If we don't see something moving toward a better-controlled epidemic, it will continue” ... “There's no guarantee it will not spread further for weeks and weeks to come – and yes, into neighbouring countries.”

(Dr. Bart Janssens, MSF's director of operations, Toronto Star, 21 June 2014)

These examples show that there was some sort of panic in the air in West Africa in June 2014 and the public health experts were helpless at the time. They were not sure what to do in

order to get the epidemic under control. At this point of the Ebola story, Canada sent in its own experts; the Public Health Agency of Canada (PHAC) replied to WHO's request for help to come and work in the Ebola region. After the request, a team of scientists and a mobile lab were sent to Guinea. (Toronto Star, 21 June 2014)

At the end of July 2014, Toronto Star reported a new “first”: Sierra Leone's top virologist had passed away because of Ebola. Dr. Sheik Humarr Khan was the first expert who had taken care of Ebola patients, contracted the virus and died because of it. Humarr Khan's death had a strong influence on the country's Ebola outbreak response, because only few days later, Sierra Leone's President Ernest Bai Koroma declared a public health emergency in the country. Thus, Sierra Leone was the first country to declare the public health emergency during the 2014 – 2015 Ebola outbreak. (Toronto Star, 29 Aug 2015.) Liberia declared the state of emergency straight after Sierra Leone did, also at the end of July whereas Guinea was the last country to announce the declaration in mid-August 2014. (Toronto Star, 1 Aug 2015.)

July marked another “first” when airport screenings took place for the first time in West Africa at the end of July 2014. This was a consequence of Patrick Sawyer's death in Lagos, Nigeria. According to the research data, Sawyer had brought EVD with him from Monrovia, Liberia to Lagos, Nigeria by an airline company called Asky Airlines. After the occurrence, Asky Airlines suspended its flights to Freetown, Sierra Leone and Monrovia, Liberia. (Toronto Star, 30 July 2014.)

It is interesting that Toronto Star wrote only five articles concerning the Ebola outbreak between March 2014 and July 2014. Only the most important news concerning the issue was reported. To a reader, it seems that during the given time period, there was a news gap, and the outbreak got out of control slowly but surely. This raises questions: Why did Toronto Star not follow the Ebola story intensively during the spring and summer of 2014? Kamradt-Scott (2016) states that one reason why Ebola got out of control unnoticed is that the countries most affected by the virus did not act responsibly in the matter by giving too little weight to the emerging outbreak at its beginning. He suggests that the governments of Guinea, Liberia and Sierra Leone should have asked for international assistance earlier (Kamradt-Scott, 2016.) Thus, I suppose that maybe West African governments did not share enough information outside and international media channels could not get information concerning what was happening in West Africa.

By 4 Aug, there were altogether 1,711 cases and 932 deaths (Toronto Star, 8 Aug 2014.) Based on the narratives of Toronto Star, I argue that the spread of Ebola inside of West Africa happened between the end of March 2014 and 8 August 2014 even though EVD continued to spread even further after the Ebola outbreak became an international public health emergency. I suggest that the aggressive spread of Ebola in West Africa led to WHO's decision concerning Ebola outbreak as an international public health emergency. In the second phase of the 2014 – 2015 Ebola outbreak, the story took place in Guinea, Liberia and Sierra Leone.

According to research data, the main actors in the second phase were UN, WHO, public health experts, the Public Health Agency of Canada (PHAC), scientists and Sierra Leone's President Ernest Bai Koroma. I claim that the main duty of international actors was information sharing in addition to medically related activities during the second phase of the outbreak. Also, local nurses and health workers were mentioned in the data.

5.1.3. Ebola outbreak as an international public health emergency

Timing for the third phase of the most recent Ebola outbreak is easy to find in the research data: on 8 August 2014, WHO declared the Ebola outbreak as an international public health emergency by stating that the collective health security is dependent on immediate support for the affected countries. The declaration was given by WHO Director-General, Dr. Margaret Chan in Geneva, and was based on the recommendation given by Emergency Committee of International Experts on the current Ebola outbreak in Guinea, Liberia, and Sierra Leone. (Toronto Star, 8 Aug 2014)

“This is the largest, most severe, most complex outbreak in the nearly four decades history of this disease”

(Margaret Chan, Toronto Star, 8 Aug 2014)

On 23 March 2015, Toronto Star published an article where it looked back at the first year of the outbreak. The article suggests that WHO's own staffers had asked for help at early stages of the health crisis. They had also proposed that the global emergency should be declared two months before the organization actually did so (Toronto Star, 23 March 2015.) This was the

third time ever that WHO declared a PHEIC under the 2005 revisions to the International Health Regulations. The first time WHO declared a PHEIC was in 2009 with Swine flu, and the second time WHO declared PHEIC (on polio) was only few weeks before it declared Ebola as PHEIC (Kamradt-Scott, 2016.)

After the PHEIC was given, Ebola spread even further in the African continent. By 23 September 2014, Ebola had reached five West African countries including Senegal. Before this date, there had been altogether at least 6,574 Ebola cases. The highest number of reported cases were in Liberia (3,458) followed by Sierra Leone (2,021) and Guinea (1,074) (Centers for Disease Control and Prevention, 2014.) This meant that EVD had exceeded previous records in terms of case numbers and numbers of deaths. At the same time, it had also reached big, populous cities and the geographical spread was wider than ever before.

In mid-September 2014, for the first time in its history, UN Security Council convened an emergency meeting on a public health issue while discussing the ongoing Ebola outbreak. Before, the Council had discussed HIV/AIDS in 2000. After a 15-0 vote, the Council gave an emergency resolution which was based on the speed of transmissions. At the time, Ebola cases were believed to be doubling every three weeks. (Toronto Star, 19 Sep 2014)

”Ebola is a threat to international peace and security”

(Toronto Star, 19 Sep 2014)

At the Council meeting, David Nabarro, a leader of the United Nations' Ebola fight, spoke about his concern:

”The outbreak is accelerating away from the control effort,” (he warns). And the longer it does that, the harder it is to get it under control.”

(Toronto Star, 19 Sep 2014)

It seems that the UN Security Council meeting was a starting point for increasing support towards West African countries suffering from Ebola. According to the data, the emergency resolution got support from 130 co-sponsors, and UN Secretary General Ban Ki-moon established United Nations Mission for Ebola Emergency Response (UNMEER). The establishment of UNMEER was seen as an “unprecedented step” taken by the UN. (Toronto

Star, 19 Sep 2014)

In the third phase of the 2014 – 2015 Ebola outbreak, the story took place in Geneva, Switzerland as well as at the UN's headquarters in New York, the United States of America. Even though the exact timing for the third phase is 8 August 2014, I still wanted to include the establishment of UNMEER under the same headline because it was a remarkable UN decision. There was also a clear causation between the declaration of the PHEIC and the establishment of UNMEER. The third phase of the outbreak focuses on international decision making. As seen in the narratives of Toronto Star, the main actors in the third phase were WHO; Emergency Committee of International Experts on the Ebola outbreak in Guinea, Liberia, and Sierra Leone; WHO Director-General Dr. Margaret Chan; UN Security Council; David Nabarro – a leader of the United Nations' Ebola fight; and UN Secretary General Ban Ki-moon.

5.1.4. The spread of the 2014 – 2015 Ebola outbreak outside of West Africa: Fear, travel bans and transmission mechanisms in the focus of discussion

As mentioned in the Methodology chapter, the 1995/6 Ebola outbreak in Kikwit, Zaire received a global focus. This time, the focus of the Ebola related articles changed from local to global, the latest in October 2014. If the UN Security Council meeting did not change the focus of the outbreak from local to global, the spread of Ebola from West Africa to Spain and the United States did.

“This virus, believed to originate in bats, has now crossed continents for the first time, with infections in Spain and the United States sowing fear and distrust.”

(Toronto Star, 18 Oct 2014)

First, the newspaper reported an Ebola case in the United States. According to the article, the viral disease was brought into the country by a traveler from Monrovia, Liberia. Thomas Eric Duncan was visiting his relatives in the United States when his Ebola symptoms arose. Before he had travelled to North America, he had helped his landlord's ill, pregnant daughter to get to a hospital in Liberia. Apparently, the woman was infected with Ebola, and Duncan had caught it from her. Four days after Duncan's arrival to Dallas, he had become ill and sought treatment at Texas Health Presbyterian hospital. Though, it was recorded that he had

recently come from Liberia, he was just given antibiotics and turned away. Two days later, he was brought back to the hospital where he died on 8 Oct (Toronto Star, 3 Oct 2014; Toronto Star, 15 Oct 2014.) Two Ebola transmissions followed Duncan's case. The contracted were nurses who had taken care of him. In the Ebola narrative, Thomas Eric Duncan was seen both as an Ebola victim and as a villain because he brought EVD to the United States of America. The micro-story about his fate caused fear among the general public. Duncan was accused of irresponsible behaviour. In the second case, Toronto Star reported on the first western patient who caught EVD outside West Africa. The patient was a Spanish nursing assistant, Maria Teresa Ramos who had helped a Spanish missionary after returning back from Sierra Leone. Ramos contracted Ebola from him, but survived. Her dog was euthanized for being a possible source of Ebola (Toronto Star, 10 Oct 2014.)

In general, transmissions outside of West Africa received a lot of media attention. I find the explanation for this in the principles of news reporting as described in the third chapter; it is meaningful to share stories of those who are close to us and who we can relate to. Also, Canada is a melting pot and many Canadians have relatives and friends all over the world. That's why people travel back and forth between their countries of origin and Canada. Many people also travel for business and pleasure. Thus, it is possible that somebody could bring a ravaging infectious disease to Canada while returning abroad, as the SARS epidemic in 2002 – 2003 showed. After Duncan's case appeared, discussions around the possibility of Canadians catching the virus started. Ebola was not an "African" problem anymore; it had reached the neighborhood of Canadians. I consider that the anxiety was justified but I find it contradictory that on one hand Toronto Star provoked the unnecessary fear of Ebola and on the other hand it tried to calm down the scared Canadians.

"Ebola is the nightmare disease. It is messy, virtually incurable and usually fatal. It is also, in all probability, less likely to kill Canadians than the common flu. Still, the scare is on. When Ebola was confined to West Africa, it was viewed as one of those exotic illnesses that people there contract. But it was seen as largely irrelevant to us. No more. Now that it has reached the United States and Europe, it is front-page news."

(Toronto Star, 15 Oct 2014)

"I have never seen a health event strike such fear and terror, well beyond the affected boundaries"

(WHO's director general Dr. Margaret Chan, Toronto Star 15 Oct 2014)

“Fear of an Ebola outbreak may be widespread because of the severity of the virus, McGeer says. The images that have been shared from West Africa don't calm the anxiety, either. There's an element of horror to the hemorrhaging,” she says. But with no direct flights between Canada and West Africa, and a small number of Canadian health workers in the area, McGeer says the fear in Canada is “not reality.”

(Toronto Star, 8 Aug 2014)

I argue that EVD received lots of attention in the Western world because of the nature of the disease, high mortality rate and also because of the way how media portrayed it. As I mentioned in the Methodology Chapter, I did not have any photos covering the outbreak in my research data. However, I consider that the photo images would have actually had even a stronger influence on people's reactions concerning the outbreak than the mere text because they would have made the outbreak more concrete. It is obvious that fear of Ebola spread more than the actual disease during the 2014 – 2015 Ebola outbreak (see Table 1). I argue that the fear of Ebola was portrayed in the Western media the same way as back in 1995/6 in the British newspapers; fear caused stigmatization of the African population which was seen in the precautionary measures taking place in the West at the time.

“The real reason to fear Ebola is what it says about us. We are now catch up in a fear narrative that is producing irrational behaviour with negative impact on the entire African continent that will hurt for decades to come. Calls for closing borders to people coming from Africa is overreaction at its worse. Africa is a magnificent continent of 56 countries of which three, all in one part of West Africa, are suffering from the Ebola virus. The three affected states are far closer to Europe than to the unaffected African countries on the other side of the continent. We are effectively stigmatizing an entire continent of millions of people. ”

(Toronto Star, 17 Oct 2014)

In October 2014, in order to calm down the general public, Toronto Star wrote an article: *“In Canada fears are real – but overblown”*. The main point of the article was to calm readers down and tell them not to worry. The article also highlighted the importance of the Ebola fight. It convinced the readers that fear takes some of the focus away from West Africa, and makes things more complicated on the Ebola ground, e.g. travel restrictions are seen as

problematic if personnel is unable to get in and out of West Africa and if relief equipment does not reach its destination.

Toronto Star provided lots of information concerning transmissions (mainly in numbers) in West Africa, transmission mechanisms, how the contracted were taken care of and whether or not they survived. This applies to the entire Ebola outbreak time period. I consider that the main reason for this was to remind the readers that it is not easy to catch an EVD in North America. In October, amidst fears of Ebola, the newspaper wanted to highlight the issue by showing that health-care workers were at the highest risk on Canadian soil.

“...the general public in North America has no reason for fear... The evidence so far available about Ebola shows that risk in the United States and Canada is confined mainly to health-care professionals. That's understandable. The Ebola virus isn't easy to contract. It requires direct contact with contaminated vomit, diarrhea, blood or other body fluid. Brave doctors, nurses, paramedics another health-care providers are far more likely to encounter such material than a person on the street.”

(Toronto Star, 27 Oct 2014)

The newspaper also informed its readers about practical measures which would take place if Ebola cases would arise on Canadian soil. I see this as a precautionary measure which aimed to calm down those who were worried about possible Ebola cases. On 17 October, the newspaper informed its readers that The Public Health Agency of Canada has an Ebola response team in the country which can be deployed within hours of a newly confirmed case (Toronto Star, 17 Oct 2014.) Again, on 18 October, the newspaper published an article covering different actions taking place at the hospitals in the province of Ontario. Amongst other measures, 10 hospitals were named as referral hospitals for potential Ebola cases, Ontario's public health laboratory was prepared for Ebola tests and extra personal protective equipment was sent to health-care facilities in the province. According to the article, also 75% of all staff members who needed to undergo an Ebola training had completed it (Toronto Star, 18 Oct 2014.) I argue that because there was some fear in the air that Ebola might reach Canada, the PHAC had to take some responsibility in order to be prepared if Ebola cases would appear in the country. The research data actually pointed out a few suspected Ebola cases being tested in Ontario but none of those turned out to be Ebola.

Travel restrictions and travel bans into and from the most affected countries came into the picture at the same time when fears in the West appeared, i.e. after Duncan's and Ramos' cases became public, even though both Canadian and CDC officials had asked the public to avoid non-necessary travel to West Africa already at the beginning of August 2014. Toronto Star provided many articles covering travel restrictions, and they were seen from a few different perspectives. At one end, they were seen as a precaution in order to avoid the spread from West Africa to elsewhere whereas at the other end they were seen as a restriction to aid reaching its destination. The research data provided exact information how, where and when the screening procedures would take place.

“Hours after Duncan's death, U.S. Officials announced they were increasing screening procedures at five airports that receive 94 per cent of travellers coming from the three Ebola-affected countries. Starting Saturday, the first of the five airports – John F. Kennedy International Airport in New York – will start implementing the new measures, which include taking the temperatures of all passengers arriving from Sierra Leone, Guinea and Liberia. On Wednesday, Canada also announced new measures at six airports, including Pearson International, where quarantine officers from the Public Health Agency will now be stationed to perform “targeted temperature” screening on passengers who look ill or declare recent contact with a sick person. In the United Kingdom, new screening measures are also now being implemented for travellers from countries affected by the epidemic.”

(Toronto Star, 10 Oct 2014)

The screening procedures divided experts' opinions on whether or not they were useful.

“One issue is whether airport screenings of prospective travellers from West Africa can reliably detect those who might have Ebola. A person could pass body temperature checks performed at the airports by, for instance, taking ibuprofen or any common analgesic. Secondly, CDC officials say that asymptomatic patients cannot spread Ebola. Yet diagnosing a symptom can depend on subjective understandings of what constitutes a symptom, and some may not be easily recognizable. Is a person mildly fatigued because of short sleep the night before a flight – or because of the early onset of disease? Moreover, said some public health specialists, there is no proof that a person infected – but who lacks symptoms – could not spread the virus to others. “It's really unclear,” said Michael Osterholm, a public health scientist at the University of Minnesota who recently served on the U.S. Government's

National Science Advisory Board for Biosecurity. "None of us know." Finally, some also question the official assertion that Ebola cannot be transmitted through the air. "We know for a fact that the virus occurs in sputum and no one has ever done a study (disproving that) coughing or sneezing is a viable means of transmitting," said virus researcher Charles L. Bailey. Unqualified assurances that Ebola is not spread through the air, Bailey said, are "misleading.""

(Toronto Star, 11 Oct 2014)

As an outcome, the previous example shows that there is not enough evidence to confirm whether or not Ebola can spread on a plane. Thus, screenings at the airports may not prevent Ebola to spread from one country to another. They might be only waste of money and time. For Canadian officials, airport screenings did not provide enough security. Thus, Canada started to halt visa applications from West African countries at the beginning of November 2014 which was seen as a precaution in order to avoid the emergence of Ebola cases. Many actors considered halting of visa applications as an overreaction (Toronto Star, 1 Nov 2014.) Steven J. Hoffman, an Assistant Professor of Law and the Director of the Global Strategy Lab at the University of Ottawa and a Visiting Assistant Professor of Global Health at Harvard University, did not see halting of visa applications reasonable, and gave a counterargument in the following way:

"... denying visas to people who have visited Guinea, Liberia and Sierra Leone in the last three months is not science. My own research has shown that travel restrictions under these circumstances don't work. There is also no evidence that West Africans pose a risk to Canadians' health (especially if they're currently living outside of their countries). Consensus among public health officials is that pushing international travel underground and into illegal channels causes more harm than good. Finally, WHO has not recommended these restrictions – it strongly advocates against them – and slammed Australia when that country implemented restrictions just before Canada."

(Toronto Star, 4 Nov 2014)

The spreading phase of the 2014 – 2015 Ebola outbreak outside of West Africa, led to discussions whether Ebola precautionary measures were based on scientific facts or not. In some areas, fear took over scientific facts, and led to precautionary measures which were not necessary because Ebola cases remain very rare outside of West Africa. Of course, on the

other hand, no one knows how many Ebola cases and deaths there would have been, if no travel bans or airport screenings had taken place in the fall of 2014.

In a nutshell, between October 2014 and November 2014, as the discussion has shown, Toronto Star covered opinions and stories related to fears of the Canadians caused by the uncontrollable Ebola outbreak in West Africa. It also introduced travel restrictions and airport screenings and different precaution measures that were taking place at different hospitals in the province of Ontario. It seems that the United States acted as a big brother by showing the way for Canada in precautionary measures. The global focus of the outbreak was strongly highlighted in the fall of 2014, and the focus of the newspaper articles was on Canadian soil. It has to be mentioned that in October 2014, Toronto Star published the highest number of Ebola articles per month compared to the other months during the 2014 – 2015 Ebola outbreak. I argue that this was due to the fact that Ebola was not only ravaging somewhere far away in “Africa”, rather it had been brought close to home by the media. In reality, the outbreak was still affecting West African countries, not North America. It is interesting how only one Ebola death, a few confirmed cases and a few suspected cases close to home made things look worse than they were in reality, and how a vast number of deaths looked very distant because they happened somewhere far away from home. I argue that this is due to how different cases were reported: West African Ebola cases were mainly mentioned only through numbers whereas cases appeared in North America and Europe were reported in detail.

Based on the research data, I see the main actors in the spreading phase of the 2014 – 2015 Ebola outbreak outside of West Africa to be The Public Health Agency of Canada (PHAC), quarantine officers at the main North American and British airports taking temperatures of travelers coming from West Africa, CDC officials and public health specialists. It seems that this phase was led by local North American authorities. I also consider Thomas Eric Duncan as an Ebola actor in the Ebola narrative because he brought EVD from Liberia to North America, but he was not an actor in the battle against the disease.

5.1.5. A turning point in the 2014 – 2015 Ebola outbreak

In January 2015, after five months WHO declared the health emergency of international

concern, Toronto Star reported that the outbreak had reached the so-called turning point; Ebola cases had started to decline in the most affected countries of Guinea, Sierra Leone and Liberia. At this time, Sierra Leone was the most worrying hot spot. The news was based on WHO's predictions (Toronto Star, 29 Aug 2015.)

5.1.6. Fading of the 2014 – 2015 Ebola outbreak

Toronto Star did not describe in detail the fading phase of the 2014 – 2015 Ebola outbreak, but it emphasized that the 2014 – 2015 Ebola outbreak was full of ups and downs in terms of new case numbers and fatalities. To me, it seemed that it was difficult for the newspaper to report on the fading phase because it was not clear whether the epidemic was really fading or not.

On 23 March 2015, a year after the Ebola outbreak was officially announced, the newspaper reported that the virus had disappeared from the daily news even though it had not disappeared in West Africa; it was still spreading in some parts of Guinea and Sierra Leone. There were also cases which could not be traced to any known point of contact meaning that the virus was not under control. (Toronto Star, 23 March 2015)

After January, the newspaper published less than 20 Ebola outbreak-related articles in the year 2015. I believe reporters of Toronto Star did not find it important to focus on Ebola outbreak anymore - maybe they felt that the issue was covered well enough from different angles, and the readers would like to focus on other topics. Probably, there were also more important topics to report in foreign news.

On 29 Aug 2015, Toronto Star reported that the last known Ebola patient was released from hospital in Sierra Leone, and the countdown for the country to be Ebola-free had started (Toronto Star, 29 Aug 2015.) Instead, on 30 Dec 2015, the newspaper reported that Guinea, the first West African country ravaged by the virus, was declared to be Ebola-free (Toronto Star, 30 Dec 2015.) The research data does not tell whether or not Liberia was able to become Ebola free by the end of 2015. The data mentions that despite the declining cases of EVD at the end of 2015, WHO saw it important to stay in the area affected by Ebola in order to prevent a re-emergence of the virus.

“The coming months will be absolutely critical,” said Dr. Bruce Aylward, a key member of WHO's Ebola response team. The organization's outbreak response crews will remain in Guinea, Liberia and Sierra Leone through 2016, he said. “to prevent, detect and respond to any new cases.”

(Toronto Star, 30 Dec 2015)

5.1.7. The end of the 2014 – 2015 Ebola outbreak

Even though my research data ends at the end of 2015, I wanted to find out when the 2014 – 2015 Ebola outbreak was declared to be finally over. According to WHO, Sierra Leone was declared to be Ebola-free on 17 March 2016, Guinea on 1 June 2016 and Liberia on 9 June 2016. (WHO, Media centre, 2016.) Thus, Ebola re-emerged in Sierra Leone and Guinea in 2016.

Academic literature has questioned the 2014 – 2015 Ebola outbreak as a global security threat. Colin McInnes (2016) wonders why the PHEIC was given during the Ebola outbreak. He shows that many more people died because of malaria, a diarrhoeal disease or HIV in 2014. At the same time he wonders why Ebola received so much more attention after the PHEIC than Polio did. His suggestion is that the answer can be found from social constructivism and from the concept of 'crisis' which guided the Ebola response. According to McInnes, the 2014 – 2015 Ebola outbreak was tied into the impact of globalization on health, through ideas of shared risk and a globally accepted pathway of response which when it failed, enhanced the sense of crisis. This again provided a reason for a large number of Ebola related headlines as well as preoccupied decision makers while other diseases did not get as much attention and were even ignored (McInnes, 2016.) Toronto Star also used the concept of crisis many times during the outbreak period. Thus, McInnes' theory gives tools to look at the first narrative from a fresh point of view and reminds me to not take newspapers' narratives as the entire truth. I have to note that while I was going through the research material, I found an understanding that the Ebola outbreak was so dire and difficult to stop that it needed a better international response, and giving a PHEIC was a necessary thing to do. Of course, the material got me thinking about why the outbreak got so much more media attention in the fall of 2014 compared to previous months since the beginning of the outbreak. I see it simply that

Ebola was “an African problem” at the beginning of the outbreak (during the spring and summer of 2014), and the focus of the outbreak changed in October 2014 after Duncan's and Ramos' cases were made public. At that time, EVD became a global problem and received lots of media attention. Towards the end of the year of 2014, when the threat of a global spread was over, Ebola became “an African problem” again and the West lost interest. My view is supported by the example below:

“The next big story concerned Ebola. The outbreak actually began in late 2013 but for as long as it was confined to West Africa it was simply the veil of another familiar story (true or not) of that region's hopelessness. But after the death that occurred in Nigeria in July, and the prospect of jet travel bringing the virus to North America – as happened in September – the Ebola news spread exponentially on the back of the most robust factor contributing to the spread of stories, which is fear. But verifiability, the seeming proof of things that distinguishes truth (whatever that may be) from rumour, worked against the Ebola story. Nobody in Canada died. The sickness was controlled – here, anyway – so that by October, the story returned to being one of African hopelessness rather than the threat it briefly seemed to be to North America and Europe. The story lost propinquity and did not stoke fear anymore.”
(Toronto Star, 2 Jan 2015)

5.2. Deadly local disease events and slow universal response

“The warnings began days after the first Ebola case was confirmed in West Africa. As more bodies piled up, the alarms grew louder, clearer and more urgent. March 31: “We are facing an epidemic of a magnitude never before seen ...” Two weeks later: “(Our) teams are facing an unprecedented phenomenon ...” Another month passed. “The epidemic is out of control.” This last warning came in late June, when Ebola had already infected more than 600 people in three of the world's poorest countries. It was hard to imagine the situation getting worse, but this week Ebola's infection toll surpassed 9,000... How did we get here? Joanne Liu, international president of the aid organization Medecins Sans Frontieres, shakes her head in frustration. For months, her people have repeated the above warnings – both through the media and in meetings with the World Health Organization, which took five months to declare an international health emergency.”
(Toronto Star, 18 Oct 2014)

As Leach has argued, outbreaks should be tackled quickly after their appearance before they have time to spread widely (Leach, 2008.) Leach calls the second outbreak narrative 'Deadly local disease events and the building of universal rapid response'. However, I call the second Ebola outbreak narrative 'Deadly local disease events and slow universal response'. As stated both in the academic literature (Kamradt-Scott, 2016) and as stated by Joanne Liu in the previous example, the universal response was too slow in the 2014 – 2015 Ebola outbreak. Thus, EVD had too much time to spread among the local populations of Guinea, Sierra Leone and Liberia causing probably more deaths than necessary. As said earlier, the international emergency response eventually happened, but it required some EVD cases to arise outside of West Africa, e.g. in Spain and in the United States (see Table 1). Based on the research material and research literature, the expected Ebola response was led by the officials of big international organizations. This was due to a lack of resources in West African countries which could not battle against the epidemic by themselves. It appears that the Ministries of Health in Guinea, Sierra Leone and Liberia also delayed their Ebola response because they did not ask for help early enough.

I argue that the most important aspect of responding to an Ebola outbreak is cooperation; a duty of local governments of affected countries, international governments and international organizations based on solidarity and the threat of global spread. Thus while looking at the second policy narrative, I focused mostly on actions as well as inactions of the international community and the Liberian, Sierra Leonean, Guinean and Canadian governments. While I went through my data, I found out that more than 200 organizations were working in the field during the most recent Ebola outbreak (Toronto Star, 30 December 2015.) However, it seemed that only a few organizations, Médecins Sans Frontières, International Federation of Red Cross and Red Crescent Societies, WHO, UNICEF and PHAC operated on the Ebola ground over the outbreak period. For some reason, Toronto Star highlighted the actions of Médecins Sans Frontières above the others. It might be that they really worked harder on the Ebola field than any other organization or it might be that the NGO has a stronger influence in Canada than other health related NGOs. For example, the International President of Médecins Sans Frontières, Dr. Joanne Liu, is a Canadian.

I agree with Leach (2008), and I consider the second policy narrative to be a continuation of the first policy narrative. The main focus here is on the actors and not so much on specific

timings as I framed the first policy narrative. Thus, the headlines of different chapters are slightly different than in the first narrative.

5.2.1. The beginning of the 2014 – 2015 Ebola outbreak

According to MSF's internal report, the NGO was involved with the outbreak response from early on, even before it received media attention. On 14 March 2014, the medical aid organization had got a warning from the Ministry of Health in Guinea of a 'mysterious disease' going on in the country. As a response to the message, the organization sent three teams straight away with supplies to Guinea. The first MSF team arrived in Guéckédou on 18 March and started to take care of the sick in Guéckédou hospital, to train local health staff and to raise awareness of the virus among the locals. The team also conducted safe burials and ran ambulances. On 22 March, the Guinean Ministry of Health declared the Ebola outbreak. Staffers of MSF were part of a team who identified the spreading disease to be Ebola. (Médecins Sans Frontières, 2015)

”Within the first two weeks, more than 60 MSF international staff were deployed to Guinea and had set up three Ebola management centres in Guéckédou, Macenta and Conakry, whilst tracing alerts and trying to carry out all the other 'normal' priority activities in an Ebola outbreak.”

(Médecins Sans Frontières, 2015, 6)

Unfortunately, the research data does not provide a very clear picture concerning MSF's or WHO's actions after the first Ebola case was confirmed. Instead, Kamradt-Scott (2016) summarizes well WHO's actions from 22 March 2014 onwards. He explains that only a few hours after the emerging disease was found out to be EVD, the WHO secretariat in Geneva mobilised a response team via GOARN. The team was deployed to Guinea in order to assist local health authorities. In addition to this, the secretariat alerted both Sierra Leonean and Liberian health officials to initiate Ebola surveillance. The GOARN team arrived in Guinea on 28 March 2014 and started an assessment of local conditions immediately. The findings of the assessment were presented at a press conference in Geneva on 8 April. Kamradt-Scott emphasizes that at the briefing WHO officials noted the ongoing outbreak in Guinea to be one of the most challenging Ebola outbreaks ever faced. (Kamradt-Scott, 2016)

5.2.2. In the aftermaths of Ebola outbreak as an international public health emergency – declaration

Toronto Star does not provide information concerning who was responding to the outbreak in the spring or in the summer of 2014. Instead, in the fall, it put Médecins Sans Frontières on a pedestal but blamed the international community in general for being too slow in its Ebola emergency response during the first six months of the outbreak (Toronto Star, 11 Sep 2014.) The biggest blame was swarmed over WHO because it holds the highest mandate in global health issues. While going through the data, I got an understanding that MSF's voice was the loudest criticizing WHO's inadequate response (Toronto Star, 17 Sep 2014.) It also seemed that MSF was working harder in terms of taking care of patients and raising Ebola awareness in the Ebola affected area compared to WHO. MSF also gave many suggestions for WHO to increase its participation, but WHO did not seem to listen to MSF.

“Five months have passed since the Ebola virus was first confirmed in West Africa – but, according to a top aid official, the emergency response is still leaderless and suffering from a kind of “Ebola psychosis” that has made the global community reluctant to join the front-line fight...The ministries of health and governments of each country have a responsibility, but the other thing is that somehow the WHO needs to step up. They keep telling me (MSF's representative, Dr. Joanne Liu), 'We're not an emergency response organization.' I'm sorry but you're the World Health Organization. You need to step up to that role because you have the legitimacy and the authority to do that.”

(Toronto Star, 21 Aug 2014)

“The grim reality on the ground is that patient care and efforts to prevent the spread of the outbreak rests on the shoulders of the few. A dwindling population of brave, local health-care providers and the extraordinary Médecins Sans Frontières (Doctors Without Borders) are providing these life-saving services. International calls to find health workers and urgently needed medical supplies, such as personal protective equipment and diagnostics, have met with tepid results. This is an appalling response to an international medical emergency.”

(Toronto Star, 11 Sep 2014)

“This is a biological threat, and I find it completely unacceptable and ridiculous that the

know-how is in the hands of a private international NGO,” Liu said... Canada should be doing more, according to Liu. She questions, for example, why the Canadian government managed to deploy its disaster assistance response team (DART) within 24 hours of the 2010 earthquake in Haiti but six months after the Ebola outbreak began in Guinea, no Canadian teams have been mobilized for West Africa.”

(Toronto Star, 17 Sep 2014)

Kamradt-Scott (2016) points out that Médecins Sans Frontières blamed the WHO's secretariat for doing nothing to combat the EVD during the first months of the outbreak, but notes that it would be erroneous to say that, and shows how the organization had continued to mobilize technical support and resources to assist the affected countries in April 2014. He mentions that by 7 May 2014 some 113 technical experts had been deployed to assist the health authorities in Guinea (88), Liberia (23), Sierra Leone (1) and the WHO African regional office. According to Kamradt-Scott, the expertise was drawn from partner organizations and recruited via the WHO's surge capacity mechanisms. That's why he does not accept MSF's blame. He also reminds that the 2014 – 2015 Ebola outbreak began like any other Ebola outbreak in terms of case numbers and mortality numbers. Thus, he does not see why WHO should have been doing more during the first months of the outbreak. (Kamradt-Scott, 2016)

Based on my data, it is difficult to find the truth about whether or not WHO's actions were adequate during the first six months of the outbreak. I rather argue that in general the international community was too slow in its response. I think that it is not necessary to point fingers only at WHO.

“We know what needs to be done but the global response to support the work has so far been inadequate. Instead of fear and closed borders we need to take the fight to Guinea, Liberia and Sierra Leone and get them the human, technical, and financial resources they need to protect their population and get out in front of this disease's spread. We know what to do and we can do it. We need a massive assistance scale-up as quickly as possible. Our government responded quickly and has made a great start by sending equipment and supplies to help establish temporary medical facilities and by financing the purchase of protective gear. But more, much more, is still needed.”

(Rosemary McCarney, President and CEO of Plan Canada, Toronto Star, 17 Oct 2015)

“... the most urgent need is for “people who will roll up their sleeves and do some legwork in the field” - everyone from doctors and nurses to “social mobilization” teams who can help spread education and awareness. ” People need to go and walk around and talk to the elders, talk to the villagers, and explain to them what's going on,” she said. “If we don't act rapidly ... fear will be changed into panic and then irrational behaviour. We need to stop that vicious cycle.”

(MSF's international president, Dr. Joanne Liu, Toronto Star, 21 Aug 2014)

5.2.3. Obstacles in the Ebola fight: fear and travel bans

Why were only a few international organizations willing to help? I think that the fear of catching the Ebola virus while helping on the ground was a barrier for many not to go to the Ebola field. In an interview MSF's international president Dr. Joanne Liu, looks at the issue from a slightly different point of view. She brings up an opinion that maybe the way in which media portrayed the outbreak, caused an absence of humanitarian organizations in the area affected by Ebola.

“People think the only way to make a difference in an Ebola crisis is to come with a cosmonaut outfit and work in an isolation centre.”

(Toronto Star, 21 Aug 2014)

“While you're in Monrovia, you're just laughing at it... (The U.S.) has one or two cases and you see that amount of panic – but you've seen a hundred cases that day and there is a lot less panic on the streets of Monrovia.”

(Toronto Star, 1 Nov 2014)

However, it is a matter of fact that even the health personnel became patients and victims of the Ebola outbreak. This is even though the international organizations tried their best to protect their workers and volunteers. According to WHO, health workers had a chance to catch an EVD between 21 and 32 times more likely than ordinary population during the most recent Ebola outbreak. (WHO, Ebola health worker infections, 2016)

Sometimes international aid agencies had to pull their operations on the ground if something

unexpected happened due to a precaution. At the end of August 2014, a Senegalese epidemiologist who worked for WHO in Sierra Leone tested positive for Ebola. In the aftermath of the occurrence, the United Nations agency pulled its people from eastern Sierra Leone, including a Canadian (MSF) team who was in charge of a mobile laboratory. The incident meant a shutdown of a mobile laboratory which again meant that blood samples had to be sent to Kenema government hospital which caused delays in diagnoses. (Toronto Star, 28 Aug 2014)

“Without a lab, everything is slower, ” said MSF spokesperson Karin Ekholm, speaking from the capital, Freetown. “It makes the whole process smoother when can discharge or confirm cases more regularly ... and not keep people awaiting for the test results.”

(Toronto Star, 28 Aug 2014)

These types of incidents led to an even bigger lack of personnel on the Ebola ground. As mentioned earlier, the tightening travel restrictions also prevented aid and personnel from reaching the Ebola region. According to data, at the end of August 2014, there were only two carriers which served Sierra Leone, even some shipping companies did not land in the country. (Toronto Star, 26 Aug 2014)

“There's this stigma and it's starting to seriously impact not only the economy ... but also the ability of humanitarian and emergency responders to move personnel and supplies in and out... At the moment, the medical agencies here on the ground probably have enough supplies of personal protective equipment to last for another week or so ... (we need to) continue the resupply.”

(Sierra Leone's UN representative, David McLachlan-Karr, Toronto Star, 26 Aug 2014)

Travel restrictions had also an influence of Canada's actions. Toronto Star reported that the aid package Canada offered for the Ebola region got stuck in North America for about a month.

“In September, Canada offered 2,5 million dollars worth of medical supplies such as rubber gloves. But it took almost a month to free up a military plane capable of flying some of that equipment to West Africa. Other supplies were sent by the much slower sea route.”

(Toronto Star, 15 Oct 2014)

Thus, some of the aid being sent to help the ravaged West African countries did not arrive on time and made the battle even more difficult on the ground. In practice, this meant that the EVD had more time to spread.

5.2.4. Canadians on the Ebola ground

Despite the slow universal response at the beginning of the outbreak, an international emergency outbreak response did eventually happen.

“Recent days have seen a significant increase in the world's lagging response to the Ebola crisis in West Africa: China and Cuba are sending doctors, the World Bank approved a 105-million US grant, and the United States pledged 3,000 troops, 1,700 new Ebola beds and training for hundreds of health-care workers”

(Toronto Star, 17 Sep 2014)

In the fall of 2014, the focus changed slowly but surely to means of battling the outbreak from blaming the international community for not helping effectively enough. This happened after UN had requested help in order to get the international community involved in the battle against Ebola. According to Toronto Star, the United States was one of the first countries responding to the outbreak and was seen as an example for other countries. It offered military help, put up some hospitals for Western aid workers who fell sick while helping on the Ebola ground, trained hundreds of health care workers on the ground, and distributed hundreds of thousands of so called home health care kits (Toronto Star, 17 Sep 2014.) According to research data, the government of Canada did not only follow what its ‘big brother’ was doing for the Ebola fight but also sent its own citizens into the field. According to research data, Canadians worked and volunteered in the West Africa region through the Public Health Agency of Canada, Médecins Sans Frontières and the International Federation of Red Cross and Red Crescent Societies.

As said earlier, Toronto Star did not only follow the efforts of the United States, but also its own citizens' efforts in the Ebola fight. It published a few articles concerning working conditions, motivations and emotions of Canadian workers and volunteers helping in the

Ebola affected region. I find that Toronto Star interviewed Canadians partly because it was easy to get a hold of a Canadian aid worker through Canadian-related NGOs, and because it helped readers of the newspaper to identify themselves with a Canadian aiding in West Africa. Thus, these interviews brought the faraway African issue close to home. At the same time, Toronto Star explained the practical ways that the government and Canadian-related NGOs are providing aid in the Ebola region. This included where taxpayers' money is going and how individual donations to charities are being spent. This also meant that Canadian related NGOs got some public coverage which might have had an effect on financing of the NGOs by getting new private donors.

“Canada has drawn considerable global attention for its donation of hundreds of doses of experimental vaccine. But over the past two months, Canadian scientists have also been making quieter contribution – living and working in the Ebola hot zone.”

(Toronto Star, 16 Aug 2014)

The article published on 16 Aug 2014 provides an insight into the way of life of Winnipeg lab scientists at the frontline.

“Canadian scientist Heidi Wood found herself inside a tent in a remote region of Sierra Leone last week, staring at a line on her computer screen and willing it to stay straight...” To be honest, lab work is lab work,” Wood says. “It’s a little different here; you need to think about generators and where your electricity is coming from. But as long as you have a level table, and the equipment you need, it’s really not that hard to do.”

(Toronto Star 16 Aug 2014)

“For the last month, Wood and her colleagues have lived in a Kailahun hotel, where they have grown accustomed to the cold-water showers and occasional scorpions found outside their dining hall. There are small comforts brought from home; Wood packed peanut butter in her luggage and Deschambault brought maple syrup, which inspired him to attempt pancakes in the hotel kitchen, which is really just a charcoal grill. They leave the hotel every day 9 a.m. and take the bumpy 15-minute drive to the MSF treatment centre, where they will spend all day working with a virus that at this centre has killed between 60 and 65 per cent of its victims. ”

(Toronto Star 16 Aug 2014)

Additionally, on 1 Nov 2014, Toronto Star published an article related to Canadian aid workers' motivation for travelling to West Africa and helping on the ground. It also highlighted the challenges aid workers face when leaving to West Africa, working on the ground and after arrival back to Canada. Before travelling to West Africa, Canadian aid workers felt that they could not miss the opportunity to help in the Ebola field regardless of the risks.

"I think your motivations (for going) can be hidden even from yourself," she says. "The epidemic is interesting, there's a certain adventurism – but I realized while I was there how really valuable what I was doing was and that became the motivation ... I really had something to offer."

(Toronto Star, 1 Nov 2014)

"I remember thinking: 'I have to do this. If I don't do this, I don't know if I can look at my face in the mirror,'" Graham says. "For me, awareness is a responsibility," Ngan says. "I have the skills and training and the needs are so high on the ground."

(Toronto Star, 1 Nov 2014)

Canadian aid workers were also afraid of prejudices. They were afraid of their close ones rejecting them for the incubation period of EVD after their return from West Africa to Canada.

"I'm worried about being ostracized; I am worried about suddenly things changing (and there) is a legal locked quarantine; I am worried about the communities of people that I know avoiding me. I think that would be very upsetting. Very upsetting."

(Toronto Star, 1 Nov 2014)

It is interesting that similar feelings and fears were described by both Canadian interviewees and their West African colleagues which will be shown later in this chapter.

5.2.5. Means of battling the outbreak

As stated earlier, past outbreaks were local outbreaks which faded over a short period of time. This meant there had been no need for different means to battle against EVD outbreaks. Conversely, this outbreak behaved in a very different way by spreading quickly from one country to another, because of the Kissi tribe's behaviour. At the same time, the global response was too slow. So it became necessary to look more deeply into the virus itself and to figure out different means for battling against it. Thus, while looking at the second Ebola outbreak narrative, I also took a look at different means for tackling the outbreak.

Toronto Star presented a variety of means from awareness spreading to vaccine development. Its descriptions of different actions taken by the international health care personnel on the Ebola ground were well-illustrated. I found them very educative and informative. The following example provides lots of information on what was to be done to EVD sampling tubes; how the EVD samples were being collected, how the virus in the sample tubes was being deactivated and how the samples were being tested. The example also shows the importance of carefulness in lab workers' actions while dealing with the disease. For readers of the newspaper, the following example shows that the health workers on the ground knew what they were doing, and their actions were based on scientific methods, not on random actions. At the same time, the example might have decreased readers' fears concerning the outbreak. This is due to shared and available knowledge.

“Every morning, someone suits up in protective personal equipment – a face mask, suit and gloves- and walks to the edge of the treatment centre's “low-risk” zone, where they are handed the blood samples collected from suspected and confirmed Ebola patients. Each tube is bagged and individually sprayed with disinfecting chlorine, which destroys the virus, and then placed inside a larger bag, which is also sprayed down. The blood samples are then placed inside a “glove box.” It resembles a small clear plastic tent that you might put over your picnic food to keep out the flies – and it is what they have here in lieu of the multimillion-dollar lab they work inside back home. Once zipped up, the tent is hermeneutically sealed, with battery-powered filters to regulate the air pressure inside. Jones handles the most dangerous part of the work: deactivating the virus. Wearing a protective suit, mask and face shield, he slips his hands into gloves built into the side of the box and carefully pipettes blood from the tubes, squirting some into a smaller tube that contains a substance that kills the virus. Another sample of blood is collected for storage and then the collection tubes and the blood they contain are dumped in a bucket -a brownish-red slurry of

blood, tubes and extra-strength bleach. Ebola is transmitted by bodily fluids, especially blood, so Jones works slowly and carefully. He reads out each patient's name, age, sex for Deschambault to jot down in a record book. As of last week, the book already had 657 entries... After the samples are purified by Deschambault, Wood performs the final step. Essentially, she places the samples in a mixture that contains a "probe" that can emit a fluorescent light – undetectable by the human eye but picked up by the "Nano," a white, 17,000 dollar machine about the size of a rice cooker, in less than hour. The more (viral) DNA that's in there, the more light that you will see," Deschambault explains. "That will mean the more positive the sample is."

(Toronto Star, 16 Aug 2014)

While looking at the different means to tackle the outbreak, I mostly concentrated on vaccine development because drug and vaccine development against EVD was an ongoing process by many pharmaceutical companies and state laboratories. In Canada, PHAC took part in the process which was followed by the newspaper. PHAC's vaccine development work against Ebola formed its own micro-story with many twists in the newspaper articles. I have to admit that for me, it was difficult to follow the vaccine development story because the newspaper reported only bits and pieces of a large topic. On the other hand, I think that a reader has to have a certain kind of understanding how vaccine development processes (including legal procedures) take place in order to understand how pre-developed drugs and vaccines are tested during epidemics.

In a nutshell, the Public Health Agency of Canada had pre-developed a vaccine against EVD in its Microbiology lab in Winnipeg before the year of 2010 and in 2010 the Canadian government had licensed the vaccine (dubbed VSV-ZEBOV) to NewLink Genetics located in the USA. Between the years of 2010 and 2014, NewLink Genetics had not proceed further with vaccine development, and thus in 2014, the pre-developed product was sold to Merck which was about to develop it further. (Toronto Star, 1 Aug 2015)

In November 2014, Toronto Star announced that Canada had sent VSV-ZEBOV vaccinations to Switzerland in order to let the WHO start a Phase 1 clinical trial. The aim was to test the safety of the vaccine. Later on, in March 2015, the newspaper reported that Phase III clinical trials had begun in Guinea where volunteers were getting shots through the "ring vaccination"– technique. Later on that year, *The Lancet* published an article saying "the

vaccine has been 100 per cent protective for people who received an injection”, and WHO official Dr. Marie-Paule Kieny said that this Canadian developed vaccine “could be a game changer” in the fight against Ebola. According to Toronto Star, VSV-ZEBOV was long considered one of the two leading candidates in the Ebola vaccine development. The other one was a product being developed by GlaxoSmithKline. (Toronto Star, 1 Aug 2015; The Lancet, 2015)

The newspaper provided general information concerning complexities of vaccine and drug testing, and emphasized the importance of safety in the testing processes. The main message was clear: actors in the public as well as private sectors should develop Ebola vaccines and drugs, preferably as soon as possible.

”Intense development work on experimental drugs and vaccines is underway, but it is not simple to create a new treatment, put it through clinical trials and manufacture it. Although the need is urgent, rigorous testing for safety and efficacy cannot be short-circuited. But the government, researchers and the private sector must make the quest for therapeutics and vaccines a high priority in case the worst-case scenarios come true.”

(Toronto Star, 27 Sep 2014)

Roemer-Mahler and Elbe (2016) question why drugs and vaccines received lots of attention in the 2014 – 2015 Ebola outbreak. They argue that it was not likely that the pharmaceuticals being tested during the most recent EVD outbreak would be ready to use in the given time period, i.e. the epidemic would fade off before the pharmaceuticals would be tested and ready to give to Ebola patients and general public. Roemer-Mahler and Elbe (2016) argue that the international response to EVD was an issue of securitization and pharmaceuticalisation. They think that intervening in the underlying causes of an emerging outbreak is better than simply providing drugs as a quick-fix solution. However, drugs are something concrete which can get political support more easily. The article tells that especially governments in Europe and in the USA, WHO and many NGOs emphasized the importance of medicine and vaccine development in order to contain the current epidemic and prevent future epidemics. According to Roemer-Mahler and Elbe, after the PHEIC was given, many hundreds of millions US dollars were being put into the pharmaceutical development. Because there was political support by different actors, it was possible to plan and run vaccine trials within months instead of years. I.e. the different stages of drug development were run in parallel.

Roemer-Mahler and Elbe point out that the vaccine development was made possible by existing experimental drugs and vaccines against EVD. These had been under development since the beginning of the 21st century and led by the fear of bio-weapons. Also already existing institutions dealing with vaccinations and drugs made it easy to pursue pharmaceuticals against EVD. (Roemer-Mahler and Elbe, 2016)

I believe that Toronto Star followed the vaccine development process and narrative very carefully because Canada was highly involved. In my mind, the reporting on Canada's participation in the vaccine development unfortunately took some of the focus away from events happening in West Africa in the spring of 2015.

5.2.6. Fading of the 2014 – 2015 Ebola outbreak

It can be seen that the support towards West African countries arose dramatically after UNMEER was established in September 2014, and in December 2014, there was more help on the Ebola ground than before it.

"Two months into the United Nation's Ebola mission, glimmers of hope are emerging in West Africa: the international response has scaled up, burial teams have more than doubled, and Liberia and Guinea have met aggressive targets, according to a top official with the World Health Organization."

(Toronto Star, 2 Dec 2014)

Because international assistance increased dramatically at the end of 2014, the most recent Ebola outbreak was able to enter a fading phase at the beginning of 2015 as mentioned earlier. The only thing WHO was concerned at this time was complacency. WHO wanted to highlight the importance of battling the entire Ebola fight and not leaving it halfway.

"...We are not good until we're at zero," said Tustin, 35. "We can never be complacent and think, 'Oh, it's going down, it's getting better.' Until we're at zero, that's the only time that we can breathe."

(Toronto Star, 21 Jan 2015)

"As the WHO's Dr. Bruce Aylward once said, there is no such thing as having "a little bit less Ebola," just as there is no such thing as being "a little bit pregnant." "This is a horrible, unforgiving disease," he told reporters in October. "You've got to get to zero."

(Toronto Star, 21 Jan 2015)

"As human beings with compassion and as countries with great resources, we need to put more efforts into the response," she said. "We can't become complacent just because it is not in our backyard. One Ebola case is one too many. "

(Toronto Star, 21 Jan 2015)

"We often talk about how steep the drop in cases has been... The only thing that has dropped more quickly and more steeply is the new contributions in financing"

(WHO assistant director general Bruce Aylward, Toronto Star, 16 March 2015)

At the beginning of 2015, the number of active Ebola cases started to decline dramatically. The fading of active Ebola cases happened with the help of international actors. Toronto Star highlighted on 23 March that this was due to successful contact tracing, epidemiological surveillance and public outreach, which were built on collaborative coordination, community acceptance and foundations built on trust. However, the newspaper article reminded readers that it was too early to declare victory over the Ebola outbreak. The remaining hot spots needed to be identified and cleared so that the outbreak would not burst into flames again (Toronto Star, 23 March 2015.)

"It's true that we have seen a number of impressive successes in recent months. International assistance helped turn the tide against a disease that has already killed close to 10,000 people, and there has been a dramatic decline in the numbers of active Ebola cases. But these gains are the result of sustained and concentrated efforts, built upon a series of essential tasks: contact tracing, epidemiological surveillance, public outreach and more. These are not simple things to do. They require community acceptance, collaborative coordination and foundations built on trust. But they have also been shown to work – which makes it all the more worrisome that this hard-earned knowledge is not necessarily being implemented in order to finish the job."

(Toronto Star, 23 March 2015)

Instead, at the end of 2015, Toronto star highlighted WHO's better response to the outbreak compared to the time period when EVD emerged. The article represents the key ways to battle against the Ebola outbreak, and at the same time, it forms a tiny story concerning the battling methods against Ebola. The micro-story fits well under Leach's second policy narrative.

“That commitment marks a welcome shift from WHO's unsatisfactory response in the early stages of this epidemic, signalling that much has been learned from past failures. In addition to vigilant monitoring, lessons include: Resources must be mobilized as soon as a case is detected. WHO initially failed to grasp the immense danger posed by the outbreak. It declared a “public health emergency of international concern” eight months after the first known Ebola fatality, and after almost 1,000 people had died. That lethargy allowed the epidemic to spread to critical levels. Teamwork is essential. Ebola was finally defeated through the combined efforts of more than 200 government agencies, aid organizations, hospitals and academic institutions from around the world. They were able to supply hard-hit areas with badly needed doctors, nurses, infection control experts, logisticians, lab workers, public health professionals, emergency specialists and “social mobilization” authorities. Bold scientific innovation is vital. WHO backed deployment of experimental drugs in a desperate effort to stem Ebola's deadly tide, and it appeared to work. In particular, a new vaccine pioneered in Canada was described as a “game changer” in the battle against the outbreak. Dubbed VSV-EBOV, the new compound was developed by scientists at the Public Health Agency of Canada's national Microbiology Laboratory in Winnipeg. Smarter work is needed at the grassroots level. An important strategy in ultimately defeating the virus was simply having volunteers go house-to-house in an affected area to explain the risks posed by Ebola. Finding ways to safely dispose of infected bodies was key. And researchers had a great deal of success using a “ring vaccination” approach, going out in the field to immunize everyone they could find who had been in recent contact with a known Ebola patient. Humanity will never be free of the menace posed by stubborn pathogens such as Ebola, but it can do better to limit their deadly toll. Lessons learned over the past two years must not be forgotten. With any luck, these insights could spare the world from having to endure another disaster caused by this horrific virus.”

(Toronto Star, 30 Dec 2015)

5.3. Culture and context: more attention should have been given to how to include locals into the outbreak response

Leach ended up calling the third outbreak narrative 'Culture and context: building positively on local knowledge'. However, I ended up calling the third Ebola outbreak narrative 'Culture and context: more attention should have been given on how to include locals into the outbreak response'. As stated both in the academic literature (Weiss, 2015) and the research data, locals were not included into the outbreak response in the manner they should have, instead the response was again top-down. Weiss (2015) wrote the following:

“the response to Ebola thus far has been substantially top-down-that is, organized by the medical and public health communities rather than a mass movement led by those most at risk for infection. That direction likely relates to the nature of the affected communities. The minimal requirements for purposive social mobilization include an identifiable, ideally directly affected, and cohesive “we” that takes collective action; a claim or demand and a target; and available resources, space for engagement, and access to policy makers' help.

Framing Ebola-as-cause poses daunting challenges.”

(Weiss, 2015, 5)

I argue that because locals were not taken into account in a proper manner, the Ebola response was not as effective as it could have been. Another factor which made the response difficult was lacking anthropological knowledge of responders on the ground. Even though the Ebola response was led by the international aid workers, there were also locals working on the Ebola ground as I will point out in this section. Also the co-operation between locals and the international aid workers increased over the outbreak period.

The third narrative is not as strongly emphasized in the research data compared to the other narratives. I have divided the third narrative by themes and not by different phases of the outbreak because I considered it function better here.

5.3.1. Locals' misconceptions

It seems that during the 2014 – 2015 Ebola outbreak, locals had many misconceptions concerning the disease. For some reason, it was difficult for the local population to

understand what Ebola is and how it can be cured. It was also difficult for them to trust the international aid workers' actions. For the first time, Toronto Star brought the issue up on 9 April 2014. The article was written after a treatment centre in Guinea was attacked by locals who blamed international aid workers for bringing EVD into the country. In the aftermaths of the occurrence, MSF had to suspend its activities at the clinic, and patients continued to be treated by local doctors (Toronto Star, 9 Apr 2014.)

“There are lots of rumours going around in Guinea, including that Ebola can be cured with coffee and raw onions and that this is a foreign plot to bring down the government,” ... “The belief was that MSF brought Ebola into Guinea and the reaction was pretty strong.”

(MSF spokesman Sam Taylor, Toronto Star, 9 Apr 2014)

“Villagers often blame sorcery when large numbers of people suddenly start to die... It is always the same thing with every epidemic.”

(Medical anthropologist, Dr. Alain Epelboin, 9 Apr 2014)

“...You go in there and you say,” Alright, everybody. Here's what you need to do to not get sick and get through this outbreak.” And they say, “You brought this here!” and they throw stones at you.”

(Toronto Star, 11 Apr 2015)

The problem of trust-building was not only an issue at the beginning of the outbreak, but throughout the outbreak period. It was also considered that in order to stop the outbreak, it was necessary to get the locals involved in the battle against EVD.

“A team of health workers and journalists were found dead in Guinea on Thursday, according to several media reports. The team – which included local administrators, two medical officers, a preacher and three journalists, according to Reuters – went missing after visiting a village in Nzerekore, the same region where false rumours about medics infecting villagers recently caused riots to break out. The eight were pelted with rocks and then “killed in cold blood,” according to a government spokesperson; their bodies were recovered from a septic tank and three had their throats slit.”

(Toronto Star, 19 Sep 2014)

“During the critical early stages of the outbreak last year, for instance, villagers sometimes attacked health workers out of misunderstanding about how Ebola is spread. This lack of public trust and awareness set efforts to stem the epidemic back significantly, and was identified as a crucial gap early on – and yet even now, misinformation remains widespread, and health workers still find themselves assaulted in some areas. Overcoming this challenge will require trust between responders and the remaining Ebola-affected communities, where people have seen their lives and societies turned upside down by the disease. Getting to zero cases depends on it.”

(Toronto Star, 23 March 2015)

As Leach argued earlier and as the previous examples show, locals felt threatened when Ebola hit the ground; fears arose and several misunderstandings were being formed. Similar behaviour by the locals was seen this time than what had been seen during the previous Ebola outbreaks. This raises questions: Why did the same problems appear again? Why were lessons from the previous outbreaks not learned? Were there anthropologists involved with the 2014 – 2015 Ebola outbreak? Unfortunately, my data does not provide answers to these questions.

5.3.2. Lacking anthropological knowledge of responders

I argue that responders to Ebola in 2014 – 2015 lacked anthropological knowledge because Ebola spread out unexpectedly in an unprepared region where sick and their caregivers moved on a vast scale from one village to another (Medecins Sans Frontieres, 2015.) According to Joseph Fair, WHO was classifying Ebola by country which was a mistake.

“This thing was happening at the nexus of three countries that do not see any difference between themselves. I don't think the world was taking that into account,” said Fair, who has lived and worked in Sierra Leone for much of the past decade. “We were classifying it by country; we were saying the outbreak was in Guinea. So you had skeleton teams in Sierra Leone and Liberia.”

(Toronto Star, 18 Oct 2014)

MSF highlighted the same issue in its report (2015):

”The problem initially was not so much the number of cases, but that the hotspots were spread out in so many locations,” says Dr Armand Sprecher, MSF public health specialist. ”In the past, Ebola stood still for us and we could quickly set up operations in the same area to contain it. This time, people moved around much more and Ebola travelled with them. So we had to replicate activities and move around our handful of experienced staff like chess pieces, trying to gauge where they'd be best placed to act fast.”

(Medecins Sans Frontieres, 2015, 6)

It also seems that some of the actions taken by the West African governments were also lacking anthropological knowledge. In September 2014 while the Ebola situation was at its worst in West Africa, the Sierra Leonean government organized a few ”National Stay At Home” –days in order to get the situation under control. This required citizens to stay at home while health workers went door-to-door searching for possible missing Ebola cases. MSF saw the action as ineffective because there was a possibility that lockdowns drove patients underground. This would spread the disease even further. (Toronto Star, 12 Sep 2014)

Shortcomings in burial practices may be attributed to a lack of anthropological knowledge in the emergency teams as well as a lack of knowledge in the local populations. Thus, international aid workers should have paid more attention to funeral and burial practices by consulting local communities more effectively on how to bury the Ebola victims. As mentioned in the second chapter, African tribes have habits of touching and embracing the bodies of the dead which should not be allowed in the funerals of those who have passed away because of Ebola.

”Ebola is relentlessness. Even after it dispatches its victim, the virus will shed from the corpse, making funerals super-spreading events. Mourners often wash, touch or even embrace the bodies of their dead. Two or three weeks ago, two unsafe burials were performed in a nearby village and then more than 30 to 35 people got infected.”

(MSF's Anja Wolz, Toronto Star, 13 Aug 2014)

According to the articles of Toronto Star, MSF was the main organization bringing up obstacles which it faced while working on the Ebola ground. In a newspaper article published

on 23 March 2015, the organization looked back on the first year of the Ebola outbreak and named a few obstacles related to anthropological knowledge. According to the article, on 10 May 2014, Guinean media had brought up the president's opinion about the aid organization's actions: "MSF is spreading panic in order to raise funds". According to MSF, this occurrence complicated the Ebola response in Guinea. Also, in Sierra Leone, at one point, the country's ministry of health and partners at a government hospital had refused to share lists of potentially exposed contacts. Both of these occurrences made it difficult for MSF to operate on the ground. (Toronto Star, 23 March 2015)

5.3.3. Local aid workers

While going through the research material, I made a remark that the actions of western aid workers were described more carefully than the actions of local aid workers. Thus there are more examples and micro-stories available of international aid workers handling the Ebola outbreak on the field compared to locals. However, the research data provides also some examples of locals working in the region affected by Ebola. To me, it seemed that the locals took care of the dirtiest jobs. They buried the Ebola victims and disposed of waste of the Ebola patients. They were working as hygienists and burial team members. There were also some local nurses, doctors and epidemiologists working in the field. The following example provides a glimpse into the life of Ahmed Lengor (46), a local hygienist.

"Ahmed Lengor... has walked 20 minutes from his home to the treatment centre where he is paid a daily rate of 42,000 leones, about 10 dollars. His days are filled with vomit, stool, blood and bodies – which he must clean then dispose of. "
(13 Aug 2014)

Additionally, burial team members on duty are described in the following way:

"These boys are in their late teens and early 20s, dressed in soccer jerseys and dirty flip flops. They are the burial team and theirs is one of the most dangerous jobs in any Ebola outbreak. These boys labour in the heat in full PPEs. Sweat pours out of their boots and glasses when they take them off. The slightest mistake – a slip of the glove, a snag on a nail – could cost their life. Their days are spent with corpses, some found in pools of blood.

Sometimes, rigor mortis has seized the bodies and they have to wrestle with stiff limbs to fit them in the body bags.”

(13 Aug 2014)

Also, Alpha Sesay gives a face to a contact tracers in the Ebola narrative:

“Alpha Sesay is a volunteer contact tracer with the Red Cross. He is 20, polite and wears a seemingly permanent smile and a T-shirt that says “Spread the word and not the disease.

Kick Ebola out of Sierra Leone.””

(13 Aug 2014)

The research data shows that Ebola survivors as well as family members of Ebola patients, victims and survivors were sometimes being shut out of the communities they were living in because they were being seen as a threat by other community members. In extreme cases, they were being asked to leave their communities without any real reason. As a solution to this problem, in the spring of 2015, WHO started to educate approximately 2,000 Ebola survivors to become health-care workers in Sierra Leone. This was due to two reasons. Firstly, it was believed that Ebola survivors can treat Ebola patients because they are immune to the strain of EVD which was present. Secondly, stigmatized Ebola survivors who treat Ebola patients could get an opportunity to contribute to their own societies and regain self-respect. (Toronto Star, 9 March 2015)

5.3.4. Co-operation between locals and international aid workers

Even though the research material does not provide exact examples of locals providing anthropological information for international aid workers, it provides examples of co-operation between locals and the international aid community. It seems that the co-operation between locals and the international community increased over the outbreak period.

”These daily meetings are attended every day by some 50 people – NGO workers, government officials, local chiefs – who gather to discuss the latest numbers and problems: villages that initially refused chlorine are now complaining they have none; another patient

who has gone into hiding; a new rumour spreading from Nigeria that saltwater washes will ward off Ebola.”

(Toronto Star, 13 Aug 2014)

The article shows that daily meetings in villages with local representatives and international aid workers were seen as a good way to increase the knowledge of the locals in terms of Ebola awareness. At the same time, local representatives and aid workers were able to discuss ongoing issues. The meetings were also seen as a way to help to build trust between local representatives and international aid workers.

5.4. The 2014 – 2015 Ebola outbreak as an outcome of long-lasting poverty and lacking health care systems in West Africa

Leach called the fourth type of Ebola outbreak narratives as 'Mysteries and mobility: taking long-term ecological and social dynamics seriously'. However, I found it better to call it 'The 2014 – 2015 Ebola outbreak as an outcome of long-lasting poverty and lacking health care systems in West Africa' because the aspect of poverty and lacking health care systems in the area were strongly emphasized over the outbreak period. These two underlying causes were strongly represented in the research data. Leach's theory focuses also on ecological dynamics but in my research data, there is only one article which talks about climate change. Thus, I am not giving much attention to ecological dynamics here. However, Leach's framing is suitable also for the fourth Ebola outbreak narrative.

According to research data, many actors have argued that the epidemic could not have happened outside of West Africa region, and the crisis could have been avoided if more attention would have been given into building health care systems in Sierra Leone, Liberia and Guinea. Thus, the long-lasting outbreak was seen as a consequence of negligence. This means that western countries had not paid enough attention to capacity building in health issues in the region during the last decade neither were they willing to pay enough attention at the beginning of the outbreak. Over the outbreak period, it became clear that different actors wanted to put more resources into the development of health care systems in West African countries in the near future.

Next, I am going to look at Leach's fourth policy narrative and the discussion held in different

phases of the outbreak.

5.4.1. The spread of the 2014 – 2015 Ebola outbreak inside of West Africa: major problem – lacking resources

During the 2014 – 2015 Ebola outbreak, it became clear that Ebola is a disease without mysteries. Thus, there are means to battle against EVD outbreaks and to get an ongoing outbreak under control. My understanding is that the major problem during the most recent Ebola outbreak was lacking material and human resources, especially at the early stages of the outbreak response. Proper resources would have been the key in order to stop the outbreak at its early stages. Then, the numbers of victims and rate of transmission would have remained much lower. Among the other lacking items, there was a lack of ambulances, chlorine, health care personnel and burial team members. In the research data, the issue was highlighted especially in August 2014.

“When it comes to Ebola, there is no mystery as to what needs to be done, Fukuda said. The only challenge that remains is rallying the resources required to do it. “This is a disease that we have worked on and fought against for decades,” he said. “We understand how it's transmitted, how it goes from person to person, and when you understand that you have the keys for success.”

(Toronto Star, 23 Aug 2014)

“With Ebola, you need to be a step ahead”, she (Anja Wolz) says. “In Sierra Leone, they have been two steps behind, four steps behind. It is frustrating. I'm really frustrated,” she (Anja Wolz) says. “We know what to do but we don't have the capacity to do it.”

(Toronto Star, 13 Aug 2014)

“This is the reality of fighting this Ebola outbreak. Too many patients, too many bodies, and not nearly enough money, people, chlorine or even ambulances to stop the dying...Only four ambulances serve this district of roughly 465,000 and one pulls up with five people crammed inside – three are confirmed to have Ebola. If the other two were not already infected, and did not have protection, chances are they probably have the virus now.”

(Toronto Star, 13 Aug 2014)

“(Jimmy) will not be buried today because there are already nine bodies in the morgue – one has been rotting for four days.”

(Toronto Star, 13 Aug 2014)

”One time during a meeting, I wrote down in my notebook, 'Everything is about fuel.' It was a recurring issue,” Tustin recalls. ”If you have people in the field but they don't have the tools to do their job... then Ebola will not go down to zero.”

(Toronto Star, 21 Jan 2015)

I argue that the biggest problem concerning the 2014 – 2015 Ebola outbreak emergency response can be summarized not only by a lack of resources, but also by a lack of skills among those who treated Ebola patients. A micro-story about the Kenema government hospital in Sierra Leone is an extreme example of the issue. According to data, the situation at the hospital was “everyone's nightmare”. Between 25 May 2014 and 13 Aug 2014, 20 hospital workers died there because of Ebola. Among them was Dr. Sheik Humarr Khan, the country's top expert on viral haemorrhagic fevers. One of the MSF's logisticians (Chenard) who specializes in water and sanitation visited the hospital and gave the following notions afterwards:

”It's the worst place I've seen as an Ebola treatment centre”... ”Take everything that you want to avoid in a treatment centre – and you are in Kenema. There was blood on the walls, starving patients and hygienists using water that was ”brown like mud.” Health workers moved from high-risk to low-risk areas without changing clothes; ”you never knew who was next to you,” Chenard says. ”It could be a patient, suspected or confirmed ... it could be hospital personnel...They don't have the means to work properly,” he says. ”It's not like they do not try. They really try their best. But there are not enough numbers and there are not enough skills.”

(Toronto Star, 13 Aug 2014)

According to data, third sector organizations were lacking resources on the Ebola ground. For example, MSF's staff was lacking of staff members as well as hospital beds and ended up in a situation where they had to turn some Ebola patients away from the hospital in Sierra Leone in the fall of 2014.

”At the treatment centre, the biggest ever built by MSF, they have reached maximum capacity...what was to be a 50-bed centre. There are now 80 beds.”

(Toronto Star, 13 Aug 2014)

”MSF is refusing to expand. Without additional staff and resources, patients and staff will be put at risk, says Anja Wolz, who has been running MSF's emergency response in Kailahun. She already served Ebola missions in Guinea and Liberia when MSF asked her to come to Sierra Leone. A few days ago, she finally went home for a much-deserved break but says she expects to spend Christmas in West Africa.”

(Toronto Star, 13 Aug 2014)

As the previous comments show, the outbreak was quicker to spread than the local and international communities were able to tackle it, and it was simply due to lacking resources.

5.4.2. Ebola outbreak as an international public health emergency: in the core of negligence

“This couldn't happen anywhere else in the world”

*(Dr. Richard Schabas, Ontario's former chief medical officer of health,
Toronto Star, 15 Oct 2014)*

It is obvious that long-term social dynamics were not under discussion before the 2014 – 2015 Ebola outbreak was declared as an international public health emergency. Before this, Toronto Star focused on reporting other Ebola-related issues. According to the research data, the newspaper published its first article concerning long-term social dynamics on 13 Aug when Allison Thompson (Assistant Professor at the Leslie Dan Faculty of Pharmacy, Dalla Lana School of Public Health & Joint Centre for Bioethics, University of Toronto) wrote an article dealing with Ebola drug development and international co-operation. As the headline *“Drugs aren't the only solution for Ebola”* shows, she did not see the lack of an Ebola vaccine as the only problem. Instead, she called for structural solutions for Ebola crisis. (13 Aug 2014)

“It gets complicated when diseases such as Ebola germinate in impoverished countries where basic public health infrastructure is a luxury, where public health education is lacking and

where communication about the spread of the disease instills more fear about the people trying to help than about the disease itself. The result is many infected people will avoid treatment, spreading the disease and hindering our ability to contain it... And the most important question will remain unasked and unanswered: why do we not help poor countries create the most basic conditions for their people to be healthy? Until we can answer this question, no amount of drugs will stop the rise of preventable disease.”

(Toronto Star, 13 Aug 2014)

As the following examples will show, the negligence towards West African nations was considered an underlying cause for the long and ravaging outbreak. The newspaper underlined that many western governments had cut budgets for development aid some years before the epidemic began, and the worsening outbreak was seen as an outcome of these budget cuts.

“The Ebola outbreak has been an entirely “avoidable” crisis that can be largely traced to the impact of budget cuts. It was made possible by a series of brutal reductions – supported by the world's industrialized countries, including Canada – to the UN's main health organization, effectively preventing it from responding to the outbreak earlier. In addition, several countries (including Canada) cut budgets to national health institutes, which have delayed research for a vaccine.”

(Toronto Star, 18 Oct 2014)

“If we had paid attention to the current crisis six months ago, there is good reason to believe that this disease would have spread more slowly. If we in the West had spent the last decade working with West African and international health partners to build capacity into health systems through public health training, medical education and infrastructure improvements, then the virus may never have wreaked such havoc.”

(Toronto Star, 23 Oct 2014)

Nunes (2016) supports the idea of negligence. According to him, Ebola should be seen as a 'neglected' issue in global health. The negligence is addressed through the themes of responsibility, Western interests, security concerns and global inequalities. He states that all of these frame Ebola as an 'African problem' leading to short-term, crisis-management responses rather than to long-term structural solutions. (Nunes, 2016)

5.4.3. Turning point and fading of the 2014 – 2015 Ebola outbreak: looking into the future

After the outbreak had hit its turning point in the winter of 2014 – 2015 and was fading in the spring of 2015, the international community started to look both back with its response and into the future so that future epidemics could be contained more quickly. The research data shows two different ways to get prepared for the future outbreaks: to bolster local health services in West Africa as well as to spur the international community to respond faster.

“There's a need too, to bolster local health services and to ensure they are better-equipped to cope in the future. Countries must have the systems in place to identify and report outbreaks quickly so that they can be contained. The international community, too, needs to respond faster. The WHO, which drew flak for being slow to declare a health emergency in this outbreak, has just set up an expert panel to draw the appropriate lessons.”

(Toronto Star, 16 March 2015)

In December 2014, Dr. Keith Martin (a previous Member of Parliament in Canada and an executive director of the Consortium of Universities for Global Health) wrote an article: *An extraordinary opportunity to improve health in W. Africa*. His article points out how Ebola outbreak should be seen above else as an opportunity to improve health in Sierra Leone, Liberia and Guinea.

“The emergency response infrastructure being built to stop the virus's progression should be converted into the permanent public health, primary care and surgical infrastructure these countries have never had. This will also serve as the early warning system to identify and stop the spread of the next outbreak. Canada, the U.S. and a few other nations have deployed a civil-military response to stop the virus's spread. Other nations with these capabilities in Europe, Africa and Asia need to follow suit. This is the right approach. Competent militaries have the heavy lift, personnel, materiel and organizational capability to create and protect health-care services in a time of crisis. They can rapidly build the infrastructure and safely deploy and protect health workers and materiel where they are needed in an emergency. Civilians can be used to augment this effort by providing the broad range of medical and non-medical skills needed to staff these structures. Public health, primary and surgical care

capabilities are vital to identify, quarantine and treat those infected with Ebola, identify their contacts and monitor them. It is also the structure to provide the prevention, treatment and care for those affected by non-Ebola illnesses. The opportunity is to convert these emergency structures into permanent structures. By working closely with and being guided by local governments, ministries of health, finance and social services in Liberia, Sierra Leone and Guinea, UN agencies like the World Health Organization, academia, NGOs, the private sector and others can be mobilized to train and retain the domestic human infrastructure needed to run a health system. Universities can be engaged to train workers across skill sets. Long-term partnerships can be fostered between academic institutions outside the region and with governments and universities in West Africa. This can be used not only to train workers and educators in medicine, nursing and public health but also in law, finance, management, engineering, veterinary sciences. These are the broad range of professional skills a competent, non-corrupt public service needs to improve health outcomes for their citizens. This will also help to address poor governance, which is endemic in developing countries and yet chronically neglected by development agencies. Failing to address this will cripple the ability of these nations to improve health outcomes and will neutralize the effectiveness of any development initiatives.”

(Toronto Star, 9 Dec 2014)

The other aspect which is highlighted in Leach's fourth narrative is ecosystem dynamics and climate change. As stated by Leach, Ebola outbreaks are emerging more frequently and the epidemics are more difficult to tackle than before due to the ecological dynamics (Leach, M., 2008.) When I went through the research data, there was only one article focusing on the issue as I mentioned earlier. This might be because the events on the ground comprised the largest portion of the Ebola-related news in Toronto Star. It might be also that the issue was considered more carefully in 2016, after the outbreak had ended. On 20 October 2014, the newspaper published an article: *“Did environmental decline help the spread of Ebola?”* The article asks whether there is a link between deforestation and the West African Ebola outbreak, and concludes that more research is needed around the topic.

“It would be premature to conclude that deforestation or other causes of ecosystem change were the factors behind this outbreak, but they remain part of the equation for Ebola, other emerging illnesses and even established diseases like malaria... Indeed, scientists started linking infectious diseases with environmental alteration decades ago. Today, climate change

complicates the issue: predictions suggest the changing climate will allow for the spread of invasive species, degrade ecosystems' resiliency and ultimately broaden the reach of some diseases. Undoubtedly, part of the solution to this growing threat is to build the necessary prevention and response infrastructure to deal with outbreaks of exotic diseases. The World Health Organization is an obvious necessity in our globalized world and yet it remains chronically underfunded. It's time for its member nations to step up and give the body the funds and authority it needs to do its essential job. But equally important to our long-term health outlook is the health of our ecosystems. These are inextricably linked. Part of preventing the spread of exotic diseases in the decades to come must involve an approach to global health that acknowledges and explores that connection and works to reduce deforestation, climate change and other major drivers of disease emergence.”

(Toronto Star, 20 Oct 2014)

5.5. Global Health Diplomacy Actors in the 2014 - 2015 Ebola outbreak in the narratives of Toronto Star

As said earlier, the division of Global Health Diplomacy Actors helped me answer the second of my three research questions. I modified a pyramid about Global Health Diplomacy Actors which was created as a visual aid by Katz et al. (see Figure 2). I argue that the 2014 – 2015 Ebola outbreak dealt with all three levels, but the lowest two levels were highlighted more than the top of the pyramid. This is in line with Katz et al. who argue that multi-stakeholder negotiations and informal global health diplomacy are needed as a part of a disaster response or humanitarian assistance.

I placed the state actors of the West African countries at the top of the pyramid because according to the IHR (2005), they were the ones to declare public health emergencies in their own countries. However, the research data does not really talk about them, nor their actions. Instead, it focuses on actions and comments given by representatives of UN bodies as well as Canadian and U.S. authorities who I have placed in the middle of the pyramid. Also, informal global health diplomacy actors which are at the bottom of the pyramid, are highlighted in the research data. The pyramid highlights big institutions and organizations but also individual actors.

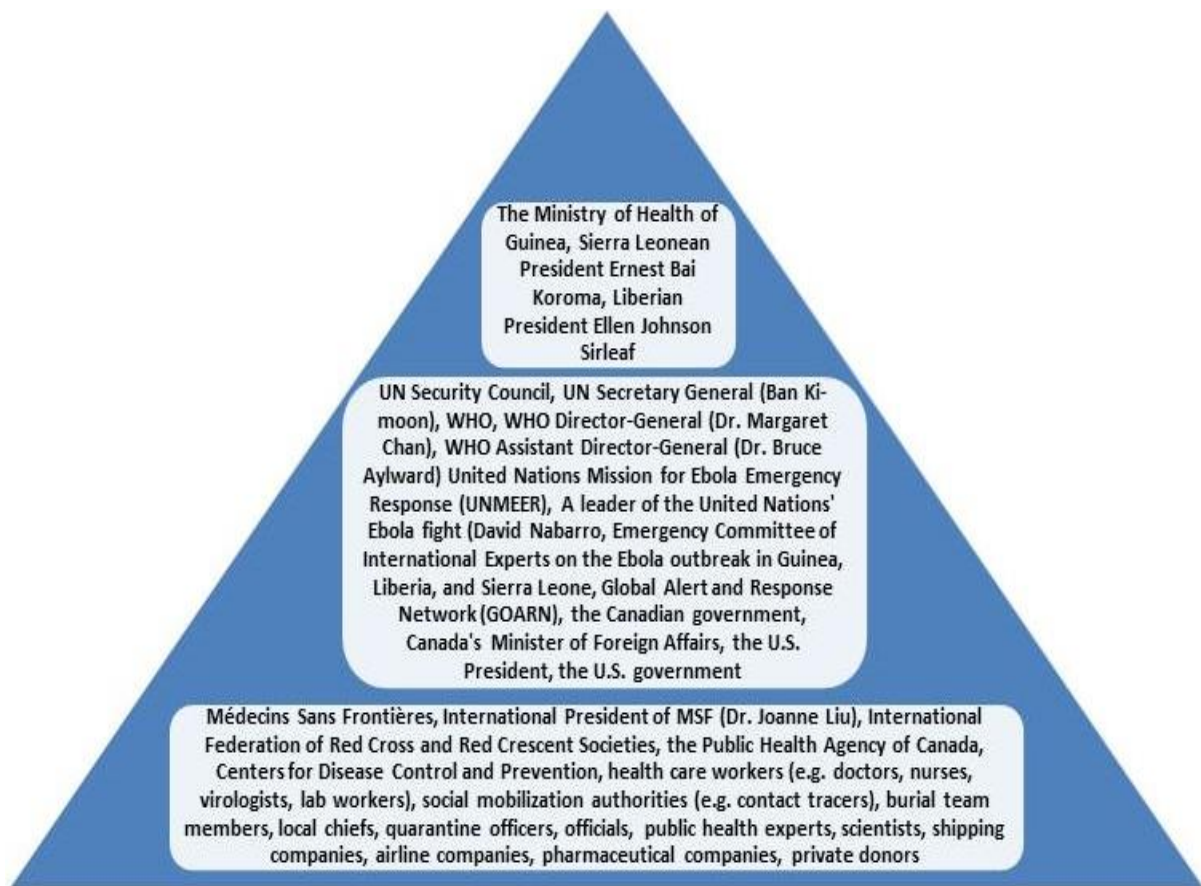


Figure 2: Pyramid of Global Health Diplomacy Actors in 2014 – 2015 Ebola outbreak in Toronto Star. On the top level: core global health diplomacy actors, in the middle: multi-stakeholder global health diplomacy actors, at the bottom: informal global health diplomacy actors.

My research data confirms the theory by Katz et al. At the top, there are less actors than at the bottom of the pyramid, and they are more homogeneous. In contrast, at the bottom, the actors are more diverse, including local and international aid workers who co-operate both in West Africa and in the Western countries. I find that the pyramid highlights the co-operation between different actors even though it does not show what the specific relationship of one actor to another is. The pyramid functions as a simplification of the actors in the 2014 – 2015 Ebola outbreak. I find that some of the actors, e.g. representatives of WHO, could have been placed in two different levels: in middle of the pyramid as well as at the lowest level of the pyramid because they also had actors operating on the ground.

5.6. From Actors to roles

Here I defined an 'actor' from two different points of view. On one hand, I defined it as a party who tries to tackle the outbreak, as I showed by using the theory covering global health diplomacy actors. On the other hand, I defined an 'actor' as a subject in the Ebola story. In that sense, I used ideas of Propp (1968) and Seale (2002) in my analysis.

In the Ebola narrative, those killed by Ebola were seen as victims whereas aid workers and Ebola survivors were often seen as Ebola heroes. Here is an example of the first baby to survive, who was seen as an Ebola hero:

“Isata, a 22-month-old girl...became the youngest patient to be discharged from the centre. Staffers stayed late and came in on their day off to watch her leave. After she was doused in chlorine, she tottered out of the isolation ward and into the open arms of the joyful nurse. Everyone cheered.”

(Toronto Star, 13 Aug 2014)

Sometimes the same person was seen both as an Ebola-hero and an Ebola victim. Doctor Sheik Humarr Khan was given both of the roles.

“He's a hero... He fought like an animal. He fought for people's lives. And now his own time has come.”

(Assata Khan, Dr. Sheik Humarr Khan's sister, Toronto Star, 30 July 2014)

Thomas Eric Duncan, a Liberian man who brought EVD from Liberia to the United States of America, was seen above all else as a villain because of his actions. His behaviour was seen irresponsible.

There is not much to say about the Guinean, Liberian and Sierra Leonean state actors. However, using the categories of heroes and villains, they come across more as villains. According to the data, they were too slow to ask for help from the international community. The international community was seen from two different angles in the research data. From one angle, they were seen as helpers and from the other, they were seen as villains because they were too slow and not effective enough in their actions on the ground.

6 CONCLUSIONS AND REFLECTIONS

6.1. Conclusions

I started this Thesis with three main research questions:

- (1) What kinds of outbreak narratives on Ebola were presented by Toronto Star during 2014 – 2015?
- (2) Who were presented as the main actors during the 2014 – 2015 Ebola outbreak by Toronto Star?
- (3) What kinds of roles did the main actors receive over the outbreak period by Toronto Star?

As a result of my analysis, I identified four different outbreak narratives in Toronto Star. These narratives were built on Melissa Leach's (2008) categorization but have been modified according to the contents of my research material. The outbreak narratives identified were:

- 1) Ebola as a global security threat
- 2) Deadly local disease events and slow universal response
- 3) Culture and context: more attention should have been given on how to include locals into the outbreak response
- 4) The 2014 – 2015 Ebola outbreak as an outcome of long-lasting poverty and lacking health care systems in West Africa

As a conclusion, the 2014 – 2015 West African Ebola outbreak got its beginning quietly in Guinea and spread unnoticed to Sierra Leone and Liberia in the spring of 2014. The disease spread easily from one country to another. It received Canadian media attention because there was a supposed threat that EVD might spread to North America through international travel. The aspect of fear and securitization guided the international response.

It was known that West African countries cannot cope on their own because they were lacking resources and skilled personnel. The international community was slow in its initial

Ebola response but took stronger action after the WHO declared the international health emergency and founded UNMEER in the fall of 2014. The response was led by the international community and locals were not taken into account in a proper manner. The same misconceptions came up that were seen in earlier haemorrhagic outbreaks. For example, in some cases, locals used services provided by traditional healers which spread the disease further. Their funeral practices involved touching and embracing the dead bodies which caused new Ebola cases. Also some of the aid workers got attacked by the locals who accused the international community of bringing Ebola into West Africa.

Ebola also got its victims from local and international health workers. Altogether over 500 health workers passed away because of EVD over the outbreak period. However, aid organizations tried to keep their volunteers and workers as safe as possible. The way media portrayed the epidemic was seen as preventing aid workers from coming and working in the Ebola treatment centres and villages ravaged by the disease.

In the fall of 2014, travel restrictions and travel bans slowed down aid from reaching its destination in West Africa, which let the disease ravage the area even more. At the same time in Western countries, travel restrictions were seen in many cases as a way to stop the spread of the disease. However, opposite opinions were being heard. There was also little scientific evidence to support travel restrictions.

This localized disease outbreak received global attention the latest in October 2014 after a Liberian man brought EVD to North America. In October and November 2014, the focus of the news reporting changed from a West African disease to the Canadian fear of it. The main question at the time was how Canada was to be prepared if a single Ebola case were to arise. Increased airport screenings, visa bans and precautionary measures at the hospitals in Ontario were seen as the answer.

The numbers of active Ebola cases in West Africa started to decline dramatically at the beginning of 2015. The fading of the active Ebola outbreak happened with the help of international actors. Contact tracing, epidemiological surveillance and public outreach started to show results slowly but surely. However, it was highlighted that it was too early to declare victory over the Ebola outbreak, because the disease was still spreading in Sierra Leone and Guinea. Before the Ebola epidemic ended in the summer of 2016, the case numbers

fluctuated at least a few times. Thus, it was hard to see the actual end of the epidemic, and there was lots of discussion whether the Ebola epidemic will stay endemic in the area.

During the 2014 – 2015 Ebola epidemic, different means of tackling the outbreak were being introduced. The focus was on vaccine development because it was seen as a good way to reduce Ebola cases if not this time, maybe when a new epidemic arises. PHAC took part in the development process of the VSV-ZEBOV vaccine, a product now owned by the pharmaceutical giant Merck. The vaccine is considered to be one of the leading candidates as a future vaccine against Ebola.

The aspects of poverty and lacking health care systems in Sierra Leone, Liberia and Guinea were strongly emphasized over the outbreak period and were seen as underlying causes for the long lasting outbreak. Many actors argued that the epidemic could not have happened anywhere else in the world. Especially at the beginning of the outbreak, the outbreak response was lacking material resources, personnel and skills. The issue of negligence was also brought into discussion. It was seen that the 2014 – 2015 Ebola outbreak was partly due to Western countries not paying enough attention to weak health care systems in the region at the beginning of the outbreak, nor during the last decade. However, over the outbreak period, Western actors did put more resources into West Africa and showed their interest in developing health care systems in the region in the near-future.

I divided the actors in the Ebola affected area into core global health diplomacy actors, multi-stakeholder global health diplomacy actors, as well as informal global health diplomacy actors. I categorized the Ministries of Health as well as the Presidents of Guinea, Sierra Leone and Liberia as the core global health diplomacy actors. As the multi-stakeholder global health diplomacy actors, I categorized the following: the UN system including UN Security Council, UN Secretary General (Ban Ki-moon), WHO, WHO Director-General (Dr. Margaret Chan), WHO Assistant Director-General (Dr. Bruce Aylward), A leader of the United Nations' Ebola fight (David Nabarro), United Nations Mission for Ebola Emergency Response (UNMEER), Emergency Committee of International Experts on the Ebola outbreak in Guinea, Liberia, and Sierra Leone, Global Alert and Response Network (GOARN) as well as the Canadian government, Canada's Minister of Foreign Affairs, the U.S. Government and the U.S. President. Finally, under the category of informal global health diplomacy actors, I placed the following: Médecins Sans Frontières, International President of MSF (Dr. Joanne

Liu), International Federation of Red Cross and Red Crescent Societies, the Public Health Agency of Canada, Centers for Disease Control and Prevention (CDC), health care workers (e.g. doctors, nurses, virologists, lab workers), social mobilization authorities (e.g. contact tracers), burial team members, local chiefs, quarantine officers, public health experts, officials, scientists, shipping companies, airline companies, pharmaceutical companies, private donors (e.g. Bill and Melissa Gates Foundation).

According to my findings, those who died of Ebola were seen as victims whereas aid workers and Ebola survivors were often seen as “Ebola heroes” in the overall Ebola story. Sometimes the same person was seen both as an Ebola-hero and an Ebola victim. The international community was also seen from two different perspectives. On one hand, they were seen as helpers and on the other hand, they were seen as villains because they were too slow and not effective enough in their actions on the ground. Guinean, Liberian and Sierra Leonean state actors were seen more as villains than heroes. This is because they were too slow to ask for help from the international community.

6.2. Reflections

I can honestly say that my knowledge concerning Ebola outbreaks and news reporting increased remarkably during the writing of this Master's Thesis. I started the process with the notion that there is a severe Ebola outbreak going on in West Africa and it would be nice to know more about the epidemic and its sociological aspects. Slowly but surely, I did learn more about the topic. Toronto Star was a natural choice as a news source, as I explained in the introduction section. I felt that it was an advantage for me that I had applied to a Medical School three times during my Social Science Degree without getting into the school. Thus, I was partly familiar with the terminology of natural sciences (e.g. virus, zoonosis, transmission mechanisms, and epidemic vs endemic) which helped me to understand the disease itself even though it was not the focus of the study.

When I started to conduct my analysis, I first tried to look for so called Ebola crisis narratives but for some reason “crisis narrative” did not sound right as my main concept. Rather than just focusing on the concept of crisis, I thought that my data gave a broader perspective into the West African Ebola outbreak of 2014 – 2015. Additionally, I decided against simply using

the concept of crisis narrative because I was not sure if the Ebola outbreak would fulfill the definition for a crisis (see Introduction Chapter, page 19). When I found Leach's (2008) categorization, I was happy because her theory seemed to fit into my data by providing a large framework to research the data from four different points of view. It also solved my terminology problem, as did Katz et al. (2011) and Brown et al. (2014) with their theoretical models concerning actors in the field of global health diplomacy.

Based on this Master's Thesis, I find Melissa Leach's categorization (2008) relevant while looking at haemorrhagic outbreaks and outbreak narratives. I believe that my findings are in line with her categorization. However, her categorization was too broad for my purposes and did not define my study enough. As an outcome of this, I ended up writing smaller amounts on many different topics. If I had chance in the future, I would like to focus my study on one narrative and use different newspapers, both Western as well as West African, and compare them. In the future, I could also interview aid workers who were operating in the countries affected by Ebola in order to get a deeper level of understanding about what happened in practice on the ground. I argue that using data from newspapers for one's research is very challenging in terms of getting a deep understanding of the core issues. Because newspapers try to cover a certain topic from different angles, in this case an Ebola outbreak, they cannot focus deeply on one aspect. This is just part of the way news reporting is done in general.

I also found it difficult to look for different actors in the 2014 - 2015 Ebola outbreak in my research data because I was aware that there were about 200 different actors operating in the Ebola affected region but my research data was mainly talking about a few major ones. Of course, this is also related to the way news reporting is conducted. It would not make sense to mention all of the operating actors, only those which are remarkable in the Canadian context. However, I think that I got a clear understanding of the different global health actors.

I argue that my study falls under Social and Public Policy as well as Development Studies because it highlights the old problem of inequality between Western countries and West African countries. It also emphasizes the traditional North-South divide, i.e. Western actors' duty of coming to help poor Africans who cannot cope on their own. I hope that more resources are being put in order to develop the West African health care systems in the near future, so that they could cope better if/when a new outbreak emerges.

I realized that writing a Master's Thesis is a process which requires time to reflect on your thoughts. The knowledge builds from tiny pieces when you add recently gained knowledge to previous knowledge. During the process, you have to go back and forth between introduction, methodology and analysis -chapters. Another thing that the Master's Degree Programme in Development and International Co-operation taught me was the idea that conducting research means going back and forth between “library, living room and laboratory”. In practice, research literature is needed in order to reflect on the ideas which arise from the research material. My research literature gave me the tools to make a more in depth analysis of the research data. Because I had no direct contact with West African Ebola outbreak region, I have no first person perspective on the issue.

During the process of writing the Master's Thesis, I realized the true value of co-operation between different actors in the case of emerging Ebola outbreaks, but also more broadly in the case of emerging health crises. No one can do anything alone. Ebola outbreaks cannot be tackled with only the knowledge of international doctors and nurses working on the ground, but rather interdisciplinary teams consisting of technical assistants, epidemiologists and anthropologists. This co-operation is highlighted in the International Health Regulations and emphasized by WHO. I am hoping to use my understanding of interdisciplinary team work in the future while working in the field of international co-operation.

While writing the thesis during the spring of 2016, I realized that many of the issues related to an Ebola outbreak can be considered the same way while looking at the emergence of the Zika virus. Namely, the Zika virus also poses a threat of global spread because of international travel. Many countries have proposed some recommendations for pregnant women not to travel to areas where Zika cases are emerging, e.g. to Brazil. Because the Zika virus poses a threat of global spread, WHO has its own role to play again. In the coming months, it would be interesting to see whether or not the organization acts earlier on with this outbreak compared to the Ebola outbreak. Finally, I believe that in the future I can use the knowledge gained during the writing of this Master's Thesis by finding similarities and differences between outbreaks and how they are reported when new emerging viruses appear.

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<http://www.who.int/features/ebola/health-care-worker/en/>

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APPENDIX 1

Headlines of Toronto Star related to the 2014 – 2015 Ebola outbreak

(* the chosen articles in the research data)

Year of 2014

March

* Officials rush to contain Ebola virus in Guinea (25 Mar 2014)

April

* Ebola rumours pose own threat: Misinformation about virus can undermine physicians' efforts, say anthropologists (9 Apr 2014)

* Ottawa gives 1.2 M dollars to help fight deadly Ebola virus (19 Apr 2014)

June

* Ebola outbreak in West Africa 'out of control': Doctors Without Borders says more help is needed (21 June 2014)

July

* Ebola claims life of MD who fought it: Sierra Leone doctor lauded for assuming task 'few others' were willing to take on (30 July 2014)

August

* Ebola spurs emergency measures: Hundreds of health workers deployed as deadly virus worsens in West Africa (1 Aug 2014)

Ebola outbreak is no TV fantasy: Disease spreads in Lagos, Aug. 5 (6 Aug 2014)

* West Africa flights halted amid Ebola crisis: Health agency says Canadians at low risk as British Airways cuts service to two countries (6 Aug 2014)

* Systems in place to battle outbreak should it land here: 'We shouldn't be afraid,' local physician says, adding chance virus will spread unlikely (8 Aug 2014)

* Brampton hospital takes disease precautions (9 Aug 2014)

* Patient with Ebola-like symptoms improving: Health minister, doctors say concerns over threat should be 'put to rest very soon' (10 Aug 2014)

* Brampton patient cleared from having Ebola virus (11 Aug 2014)

* Drugs aren't the only solution for Ebola (13 Aug 2014)

* The grim view from ebola ground ZERO: Despite glimmers of hope like the survival of 22-month-old Isata, the death toll is still steadily climbing in West African outbreak (13 Aug 2014)

* Standing at Ebola ground zero: Star Reporter plunges into outbreak zone – discovering fears amid normalcy as disease sweeps West Africa (14 Aug 2014)

* U of T prof on ethics panel that OK'd drugs: Offering unproven Ebola meds moral duty, WHO says (14 Aug 2014)

* CANADA'S EBOLA WARRIORS: Winnipeg lab's scientists adapt to disease's hot zone (16 Aug 2014)

* Top aid official slams 'vacuum' in leadership over Ebola crisis: World Health Organization 'needs to step up' in response to epidemic, Canadian doctor says (21 Aug 2014)

Canada must stop Ebola at the borders: U.S. Couple reunites in isolation, Aug. 19 (22 Aug 2014)

* UN to boost efforts in Ebola fight: Outbreak could continue another six to nine months (23 Aug 2014)

Second Quebecer cleared of Ebola: Man who visited Guinea tests negative after being placed in isolation at Montreal hospital (24 Aug 2014)

* Travel restrictions hinder fight against Ebola: Emergency responders infected as epidemic worsens in isolated African countries (26 Aug 2014)

* News of health care worker's infection recalls tense journey to heart of outbreak (28 Aug 2014)

* Canadian scientists to be placed in isolation: Ebola team's evacuation from Sierra Leone sparks concerns about delays in blood tests (28 Aug 2014)

* DNA unlocks disease's lineage: international researchers risk their lives to reveal origins evolution of deadly illness (29 Aug 2014)

September

* Medicine and military alone will not save us from Ebola (2 Sep 2014)

* An ominous Ebola forecast (6 Sep 2014)

* Slow global response to Ebola costing lives (11 Sep 2014)

* Crisis not getting better in Liberia, Sierra Leone (12 Sep 2014)

Taking Ebola more seriously: Scientists predict rapidly worsening outbreak (14 Sep 2014)

* Response to Ebola outbreak 'absolutely not enough': Many more workers needed to halt crisis, says medical expert (17 Sep 2014)

* Ebola, not terrorism, is Canada's greatest threat (18 Sep 2014)

* UN declares virus a threat to peace, security (19 Sep 2014)

Taking Ebola more seriously: Scientists predict rapidly worsening outbreak, Sept. 14 (21 Sep 2014)

* UN must wrestle with global tsunami of crises (24 Sep 2014)

* UN struggles to cope with rampant outbreak: 'Humanitarian catastrophe' could affect up to 20,000 people by early November (26 Sep 2014)

* Canada ramps up monetary aid to fight deadly virus: 30 M dollars in funding will support treatment, prevention and 'broader humanitarian' needs (26 Sep 2014)

* Ebola's worst-case scenarios (27 Sep 2014)

October

Death of common sense a bad omen: Sweating it out in war against Ebola, Sept. 28 (1 Oct 2014)

* Ebola finds its way to North America: Liberian man who aided ill pregnant woman in Africa is now hospitalized in Dallas (3 Oct 2014)

Patient being tested for Ebola in Toronto hospital (3 Oct 2014)

* The man who accidentally discovered Ebola – and lived (4 Oct 2014)

* We are safe, but think of others (4 Oct 2014)

* Our response to Ebola inadequate: Dallas hospital initially sent man with Ebola virus home, Oct. 2 (6 Oct 2014)

* U.S. weighing extra level of screening for Ebola virus (7 Oct 2014)

* Ebola fears now starting to take hold in the West: Millions of dollars more needed to battle virus (10 Oct 2014)

Fighting Ebola trumps politics (11 Oct 2014)

* EXPLAINER: CAN EBOLA SPREAD ON A PLANE? (11 Oct 2014)

how did nurse get ebola? (14 Oct 2014)

* Canadian-made vaccine starts clinical trials: Only 100-per-cent effective in animals so far, first results expected by December (14 Oct 2014)

* In Canada, Ebola fears are real- but overblown (15 Oct 2014)

Potential cure for U.S. nurse battling virus (15 Oct 2014)

* Narrative of fear around Ebola is the real problem (17 Oct 2014)

* Are we ready for an Ebola outbreak? : Risk in West is low, but fear is spreading and virus has found cracks in health system (17 Oct 2014)

* Ontario boosts precautions against possible spread: Ten referral hospitals have control systems already in place (18 Oct 2014)

* Time to put Ebola into perspective: How the West made a small problem worse (18 Oct 2014)

* Ebola alarm puts focus on citizen needs: The epidemic reminds us governments have critical role in potential mass crisis (18 Oct 2014)

* What did the world did wrong about Ebola: everything: Despite warnings, WHO failed to treat crisis seriously or adjust to how virus was spreading (18 Oct 2014)

* Lessons from the Ebola outbreak: WHO pegs Ebola death rate at 70%, Oct. 15 (18 Oct 2014)

Memorial service held for first U.S. Victim of Ebola (19 Oct 2014)

* Did environmental decline help the spread of Ebola? (20 Oct 2014)

* New study warns of Ebola-infected travellers: Airport screening more likely to catch passangers at departure, research suggests (21 Oct 2014)

* What Canada can do about Ebola (23 Oct 2014)

* Ebola's terrible toll (25 Oct 2014)

* Experimental vaccines 'not the magic bullet': Serums in testing expected to be available in 2015, but success is not guaranteed (25 Oct 2014)

* Relax, don't panic (27 Oct 2014)

* Ebola outbreak exposes flawed Canadian aid policy (27 Oct 2014)

Be compassionate to people who fear illness: Hypochondria is rare, but with the Ebola outbreak, many still need guidance from their family doctor (28 Oct 2014)

* Don't worry about Ebola readiness: Relax, don't panic, Editorial Oct. 27 (31 Oct 2014)

November

* Behind the choice to fight Ebola: Canadian health workers share motivations, challenges impacting decision to help (1 Nov 2014)

* Canada halts visas as virus precaution: Application ban for several West African countries are rare move, according to experts (1 Nov 2014)

Gripped by fear, America goes to the polls: The balance of power in the Senate is at stake, but Ebola and Islamic State may doom Obama's Democrats (1 Nov 2014)

* With Ebola, Canada forgets its Ethiopian miracle: Thirty years ago when famine struck, Canada led the way (1 Nov 2014)

* Help save lives beyond the borders of your country: Medecins Sans Frontieres 'guided only by medical need' (3 Nov 2014)

After Ebola scare, nurse gets beloved pet back: Nina Pham finally sees her dog Bentley as his 21-day isolation ends (3 Nov 2014)

* Ottawa's Ebola visa ban puts all at risk in long run (4 Nov 2014)

* Poll finds support for quarantine to stop spread of Ebola: Most Ontarians don't believe outbreak is likely here, but still back isolation period (5 Nov 2014)

* Tory visa ban will worsen Ebola risk: Canada halts visas as virus precaution, Nov. 1 (7 Nov 2014)

Pop stars band together to battle Ebola (11 Nov 2014)

* University of Toronto startup searching for Ebola cure: Software analyzes effectiveness of existing and hypothetical drugs (14 Nov 2014)

When fear hits too close to home: A frightened electorate is deemed helpful to the Conservatives, but hope is also a powerful political weapon (15 Nov 2014)

* Fighting Ebola on Facebook (15 Nov 2014)

Critics obviously don't know it's Christmas (22 Nov 2014)

* Strange Ebola vaccine case needs shot of clarity (26 Nov 2014)

December

* Socialized risks and privatized profits: Strange Ebola vaccine case needs shot of clarity, Nov. 26 (1 Dec 2014)

* Caution urged despite gains made in war against Ebola: WHO official warns against complacency, says goal is to 'get to zero' cases (2 Dec 2014)

* An extraordinary opportunity to improve health in W. Africa (9 Dec 2014)

* Ebola threatens malaria fight, WHO says: Millions still have no access to diagnosis and treatment, new report suggests (10 Dec 2014)

* Ebola's deadly toll shows need to boost health care: 'No contry is stable' without resilient systems, resources, WHO's director general says (12 Dec 2014)

Pick a charity and get out of the way (16 Dec 2014)

'I'll be home for Chistmas, you can plan on me' - 'I'll Be Home for Christmas,' 1943 (20 Dec 2014)

...and nine more people (27 Dec 2014)

Year of 2015

January

* Doctor who fought SARS now battles Ebola in Liberia: Mount Sinai's Allison McGeer is inspired by colleagues who helped her in 2003 (2 Jan 2015)

World actually became safer in 2014: Horrors such as Syria are outliers on a planet where mass violence, death are ebbing (2 Jan 2015)

* Looking back on the year in storytelling: The events of 2014 that made us care and the news that fell through the cracks (2 Jan 2015)

* American survivors of Ebola have their lives changed forever. Wrenched from obscurity by often-fatal disease, those who are recovering feel sense of duty to help fight virus 'in the biggest way' (4 Jan 2015)

Ohio bridal shop linked to Ebola survivor forced to close (9 Jan 2015)

* Ebola slowdown offers little comfort: Ryerson epidemiologist says complacency is newest threat in the race to zero cases (21 Jan 2015)

* Threat to global health isn't over, UN warns: WHO flags 'complacency' as biggest risk and says more funding needed to stem virus (22 Jan 2015)

* Signs of hope appearing at ground zero? (22 Jan 2015)

Ebola's forgotten victims (31 Jan 2015)

February

Hoskins shaking up health ministry (1 Feb 2015)

* Proving her mettle in throes of Ebola: Dr. Matshidiso Moeti didn't know what awaited her in WHO's most challenging role (3 Feb 2015)

March

Local pastor missing in North Korea: City councillor fears reverend has been detained by regime (2 March 2015)

* Toronto doctor returns from front lines of Ebola fight (9 March 2015)

* Measles could kill more than Ebola, paper says: Vaccinations recommended to prevent another epidemic in vulnerable West Africa (13 March 2015)

* Getting to zero (16 March 2015)

Digest (19 March 2015)

* Too early to declare victory in fight against Ebola (23 March 2015)

* A year of living dangerously for those on Ebola front lines (23 March 2015)

* Fear, confusion loosening grip on Liberia (23 March 2015)

SickKids researcher receives 100,000 US dollars Gairdner award: Doctor cited for work on embryo development (26 March 2015)

April

* Medical experts race against time in quest to develop Ebola vaccine (6 April 2015)

* Suspected case tests negative in Toronto (6 Apr 2015)

* How Ebola was like the movie Jaws (11 Apr 2015)

May

But should we even be fighting ISIS?: How afraid should we be of Islamic State? May 9 (14 May 2015)

* Peer support Peer support needed for local Ebola workers (25 May 2015)

June

July

August

* Ebola vaccine timeline (1 Aug 2015)

* Ebola vaccine seems effective: Canadian creation could stop outbreak, prevent disasters, but still needs approval (1 Aug 2015)

* Weapon against Ebola (5 Aug 2015)

Mediterranean Desperation: Saving lives at the world's most dangerous border: Doctors Without Borders is the only major humanitarian organization actively rescuing refugees in the Mediterranean. It has saved more than 10,000 people so far. But in the world's biggest crisis region, timing is everything. (22 Aug 2015)

* How the Ebola outbreak unfolded in West Africa (29 Aug 2015)

* Milestone in Ebola fight (29 Aug 2015)

September

Cherry, MacLean, Buble join Walk of Fame (30 Sep 2015)

October

* Ebola resurfaces among the 'cured': 93 Sierra Leoneans tested at different stages of recovery; half had virus in their sperm (16 Oct 2015)

* Experimental vaccines 'not the magic bullet': Serums in testing expected to be available in 2015, but success is not guaranteed (25 Oct 2015)

November

December

From deep inside earth to the far side of Pluto, other science advances of 2015 (20 Dec 2015)

* Don't forget vital lessons (30 Dec 2015)