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The Art of Collective Response in Global Health Governance:

Competing Frames, the Public Sphere and Pandemic Crises

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Under the WHO six-phased classification scheme, both the 2003 SARS epidemic and the 2014 Ebola epidemic qualified as phase five and thereby should have triggered comparable immediate international containment efforts. The divergent outcomes—effective collective response in the case of SARS and crisis protraction with regards to Ebola—are therefore especially striking. Whereas SARS remained limited to around 700 deaths, Ebola had already killed more than 1,400 people by the time that the WHO first acknowledged the epidemic. The paper asserts that politicisation and framing can offer a valid explanation, and accordingly investigates how both affected the international responses to SARS and Ebola. The author argues that—even in the allegedly rational scientific field of health—policymakers engage in framing in order to cope with uncertainty of international crises through categorising epidemic outbreaks and prescribing a particular course of action. Tracing the evolution of both epidemics, the paper identifies five frames, namely 'securitisation of medicine,' 'medicalisation of insecurity,' economics, human rights and development. The author holds that they significantly impacted the sense-making phase of the evolving epidemics and thereby determined the extent or lack of collective response. In the face of uncertainty of pandemic crisis, the triangular relationship between policymakers, the public sphere and accountability can offer a more elaborate account of crisis management and collective action, as political frames become important as sense-making vehicles within broader global governance processes and can best explain policy responses.

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ABBREVIATIONS

EVD   Ebola Virus Disease

ERIDs   Emerging and Re-emerging Infectious Diseases

FAO   Food and Agricultural Organisation of the United Nations

GAR   Global Alert and Response

GOARN   Global Outbreak Alert and Response Network

GPGH   Global Public Goods for Health

IHR   International Health Regulations

SARS   Severe Acute Respiratory Syndrome

UNMEER   United Nations Mission for Ebola Emergency Response

UNSC   United Nations Security Council

WHA   World Health Assembly

WHO   World Health Organisation

1. Introduction

The world is rife with potential sources of insecurity. Nowhere is this more evident than in global politics where decisions and prioritisation affect millions. Over the past decades a number of epidemic outbreaks have especially occupied public and scholarly attention, and heightened anxiety about infectious diseases in a world of open borders. It does not necessarily have to be a killer virus bringing humanity to the brink of extinction, but the threats posed by disease are very real and highly unpredictable. Accordingly one would think the shadow of the future—scenarios of aggressive viruses, common invisible enemies—has a unifying impact on global health governance. When SARS broke out in China in February 2003 and quickly spread, it did indeed trigger an unprecedented collective response by the international community and was contained within 8 months by July of the same year (WHO 2003a; Mackenzie & Merianos 2013). It is striking by contrast that the Ebola outbreak in West Africa in March 2014 has not been halted to date. Although both outbreaks similarly qualified as pre-pandemic under the World Health Organisation's six-phased pandemic alert, the response to Ebola has been slow and inconsistent (WHO 2009; Farrar & Piot 2014). Whereas SARS remained limited to around 700 deaths, Ebola had already killed more than 1,400 people by the time that the WHO first acknowledged the epidemic (WHO 2014a,b). Presently the disease has been ravaging West Africa for over a year with a current death toll of 10,823 (WHO 2015a). Why is it that the international community reacted so rapidly and efficiently in one case but seemed ill-prepared, even unwilling, in the other one?

In this context much has been written about WHO deficiencies, particularly concerning lacking resources, political coordination and effective bureaucracy problems (Godlee 1994; Ruger & Yach 2008; Garrett & Pang 2012; Clift 2013). While these can effectively explain response vacuums, they cannot convincingly account for variation in WHO responsiveness.

There is, however, another factor that has been often overlooked, namely the impact of framing. Especially in light of uncertainty related to pandemic crises, the public sphere and its expectations become a point of reference in the sense-making phase of crisis management. The threat level of a local outbreak—whether it will turn into a full-fledged pandemic for instance—can hardly be predicted. Unfolding crises nonetheless demand action as the world turns to policymakers for guidance, and hence confront policymakers with the dilemma of the uncertainty paradox: the need for certainty where there is uncertainty. This paper argues that, in the absence of scientific consensus, it is precisely this uncertainty paradox that opens the floodgates to politicisation of pandemic crises, and renders decision-makers highly susceptible to public influence and social conventions (Boin 2005a; Paul & Sherrill 2015). In the first month of its outbreak Ebola was referred to as both an "unprecedented[...]epidemic" (MSF 2014a) and "relatively small still" (Samb 2014). Likewise SARS was played down by Chinese authorities at first, while the WHO declared it a global threat (WHO 2003b; Tai & Sun 2007).

This paper consequently sets out to investigate how politicisation and framing affected the international responses to SARS and Ebola. It especially looks at the triangular relationship between policymakers, the public sphere and accountability in the face of uncertainty of pandemic crisis. The paper first provides a brief overview of global health governance and the 'trilemma' it poses, namely ill-defined problems, polycentrism and capacity asymmetries. It then proceeds to highlight how policymakers engage in framing in order to cope with uncertainty of international crises. A particular emphasis lies on the role of communication and accountability pressures between policymakers and the public sphere. The third section takes a closer look at the specificities of global health and pandemic governance, and attempts to underline the challenges of crisis management in this regard. It moreover elaborates on the frames of 'securitisation of medicine' and the 'medicalisation of insecurity'. Both are the most relevant and common frames in pandemic crises as they provide a sense of certainty by

categorising epidemic outbreaks and prescribing a particular course of action. However, they foster very different responses. While securitisation acknowledges the crisis as significant threat and prioritises imminent—often military—responses, medicalisation often presents the situation as less urgent but rather as a problem that can be overcome by medicine. The paper further considers the frames of economics, human rights and development that have been identified as relevant in the wider field of global health governance. Fourth, it briefly defines its methodological approach with regards to the aforementioned theoretical framework and the analysis that follows. Fifth, the previously outlined frames are carefully identified and evaluated in the case studies of the 2003 SARS epidemic and the 2014 Ebola outbreak. Through the assessment of their role in the sense-making phase of the evolving epidemic, and through situating them into the larger process of international crisis management, the paper attempts to determine how frame competition impacted the collective response in both cases. Finally, the paper summarises its main findings in a critical discussion.

In order to fully understand governance processes in global health crisis management it must be assessed whose priorities and security are addressed by international collective action, and how uncertainty, public crisis communication and the sense-making phase shape responses. This paper holds that international responses to such transnational crises crucially depend on competing frames and whether the 'winning' frame(s) recognise the crisis as an immediate threat. It moreover asserts that these political frames in turn depend on both the outcome of the contest between domestic and international public pressures (expectations of the public sphere), and the influence of 'politics of accountability' as exercised by policymakers and non-state actors.

This can be argued to be particularly the case for pandemic crises that confront governance structures with a high degree of risk and uncertainty, and thereby make crisis management wide open to politicisation. Global health governance has not traditionally been

linked to framing. On the contrary, the role of social conventions and politicisation processes has been underestimated in their impact on policy outcomes that are largely regarded as rational medical or security decisions. This paper argues that both the uncertainty paradox inherent to pandemic crises and the governance trilemma associated with global health leave the international management of pandemic crises highly vulnerable to the influence of the public sphere. The cases of Ebola and SARS confirm such a hypothesis. The rapid containment of SARS can be attributed to public pressure in reaction to a multiplication of crisis-affirmative securitisation frames and subsequent out-voicing of accounts that downplayed the outbreak. Similarly, Ebola illustrates the impact of the public sphere, as most political frames initially signalled control and little cause for concern. Political framing, however, significantly changed once domestic constituencies and the media became aware of the epidemic. This paper argues that the co-occurrence of public demand for action and changes in political representations of the outbreaks constitutes evidence for a correlation that goes beyond mere timely coincidence.

2. Global Governance and Health

The changing nature of crises and governance in the 21st century has been acknowledged by a large variety of scholars (Rosenau 1992; Held et al. 1999; Linnerooth-Bayer et al. 2001; Wolf 2002). Globalisation has confronted traditionally state-centric diplomacy with the challenge of adapting to an increasing number of non-state threats such as global warming or infectious diseases as well as to the press-ahead by non-traditional actors like NGOs (Acuto 2011). Crisis diplomacy and management of international crises have therefore increasingly become embedded in the broader network of global governance and collective decision-making (Kahler & Lake 2003; Krasner 2004; Boin 2005a; Dingwerth & Pattberg 2006). Global governance describes 'a horizontally organised structure of functional self-regulation encompassing state

and non-state actors bringing about collectively binding decisions without superior authority' (Rosenau 1992; Wolf 2002). Its key features are interdependence and a societal element in global politics that has commonly been absent from the study of international relations (Barnett & Sikkink 2008).

While traditional state-centric hierarchies may have been largely dissolved, global governance still depends on the system of international resources and laws created by policymakers in the past and thereby continues to be influenced by governments at its core (Keohane & Nye 2000; Krasner 2004; Hagendijk & Irwin 2006). Nevertheless there is a reciprocal element to this 'patterned social interaction' between governments and other actors (Kahler & Lake 2003). This paper thus adopts the understanding of global governance as a 'set of authority relationships' with policymakers at the heart of realising global governance outcomes, shifting between principal and agent amidst dynamic societal actor networks (ibid:7-8). Such a definition best captures the social dynamic of global governance processes and the accountability ties between different actors, mainly policymakers and the public sphere. Consequently, the socio-normative dimensions significantly influence international political outcomes, and make it indispensable to assess collective action and coordination problems in addition to the traditional focus on power struggles (Barnett & Sikkink 2008).

This is of particular interest for global health, as one would expect issues that fall into this category to be predominantly scientific, and the required responses hence clearly a matter of medicine. Global health governance however includes anything but well-defined problems (Huynen et al. 2005; Ney 2012). National public health problems no longer exclusively remain within the territorial borders and control of single governments, as changes in socio-economic, ecological, political and institutional factors have altered the contextual determinants of human health everywhere (Huynen et al. 2005). The transboundary, interconnected nature of health

threats as well as their spill-over effects beyond health and medicine, make health governance a particularly intricate affair (McInnes & Lee 2006).

There are, however, three main characteristics that complicate global health governance, namely 'messy' or 'wicked' problems, extensive polycentrism and significant asymmetries (Ney 2012; Frenk et al. 2014). First, health comprises a large variety of ill-defined problems, as it is composed of highly complex components and thereby difficult to define (Ney 2012; Topper & Lagadec 2013). Global health governance is however not limited to disentangling the determinants and dependents of health, and understanding their causal relationship, it must moreover identify the correct problems to respond to (Hodge 2013). Although there are easily-definable problems as well, the risk of prioritising the wrong problems is quite real in the realm of global health and could have disastrous consequences (Mitroff et al. 2004; Frenk et al. 2014). This challenge is however made more difficult, as public health issues expand beyond medicine and science. Global health possesses various social dimensions owing to interdependence with state structures, stability and economics amongst others (McInnes & Lee 2006; Ney 2012; Frenk et al. 2014).

Second, the polycentric nature of global health governance causes further complexity, and thus impedes effective identification of priorities and crisis management. Global health governance—as it is today—largely consists of complex polycentrism, which often takes the form of "unstructured[...,]unregulated pluralism" (Ney 2012:245-255). There are currently a multitude of actors, policies, and measures in the field of global public health, and at the same time a striking lack of transparency and coordination (Buse & Harmer 2007; Sridhar & Woods 2013). Although some may highlight the advantages of a multi-level approach to messy multi-level problems as they exist in health (Hooghe & Marks 2003; Enderlein et al. 2010; Varone et al. 2013), the systemic complexity and 'open-source anarchy' often in fact hamper policy coordination and concerted action (Ney 2012). The result is sub-optimal to poor governance at

best, humanitarian disaster and prolonged health crises at worst (Buse & Harmer 2007; Fidler 2010; Frenk & Moon 2013; Ulbert 2013). Polycentrism certainly does not always produce only negative externalities, but it has to be noted that it quite frequently adds to the 'messiness' of health issues and their regulation.

Third and finally, considerable resource, information and power asymmetries confront policymakers with difficulties. With regards to resources, Frenk et al. (2014) argue that there exists a governance paradox in global health. Whereas problems and disease are largely seen as originating from the Global South, resources and medicines to tackle these health issues are mostly produced and stocked in the Global North. There consequently is an "interconnectedness[...]in[...]causes and effects[...], and interdependence in[...response] capacity" (ibid:95-96). Likewise the ill-defined nature of international health problems and the polycentrism of global health governance foster an asymmetry in information. This can be closely related to the possession of capacity and resources, as the latter facilitate obtaining information. However, some also argue that it is primarily the level of complexity in global health governance that makes information harder to acquire and thereby favours those actors best connected and at the heart of global networks (Fidler 2010; Sridhar & Woods 2013; Frenk et al. 2014). This leads to the third type of asymmetry, namely varying power between actors in global health. There is a growing consensus amongst scholars that Western and developed countries have largely dominated the agenda of global health (McInnes & Lee 2006). The lack of funding for tropical diseases, amongst other examples, demonstrates that the issues highest on the agenda are not necessarily the issues most pressing for the global greater good and the world majority, but rather illustrate that weaker actors and the international community depend on those with the largest capacity and therefore power (McInnes & Lee 2006; Hanhimaki 2008; Cunliffe 2009). It would be wrong however to limit dependency chains to states. This paper

thus asserts that the uneven distribution of responsibility and power in global health can likewise be found in sub- and transnational authority relationships.

Global health governance consequently is a highly complex and uncertain affair. The trilemma of messy problems, polycentrism and capacity asymmetries leaves significant room for interpretation, and thereby opens the floodgates to intense bargaining over governance outcomes as well as to social and political influence on policy responses and collective action. In the next section this paper elaborates on its argument that there is a threefold political response to this trilemma and the challenges it presents international crisis management with. First, it asserts that framing is a reaction to the uncertainty of ill-defined problems and an attempt to somehow make sense of them. Second, it argues that the emphasis on social conventions and the public sphere is a means to manage the seemingly chaotic polycentrism. Third, the paper claims that the focus on accountability, namely politicians' responsibility for society and key principles, is a response to existing asymmetries that allows decision-makers to balance conflicting capacity demands.

The Politics of Crisis, the Public Sphere and Accountability Ties

Global governance itself constitutes a complex object of study. It is, however, further complicated by risks and uncertainty of international crises. Faced with some form of perceived threat, uncertainty and urgency—all of transnational scale—policymakers must manage unfolding crises rapidly and effectively (Rosenthal et al. 1989; Boin 2005b). The first part of the process is the sense-making phase: the situational assessment of the risks that are inherent to transnational crises (Boin 2005a; Alemanno 2011). However, policymakers are presented with a dilemma since neither risks themselves nor their spill-over effects can be accurately predicted but may have systemic impacts (Linnerooth-Bayer et al. 2001; Boin 2005b; Van

Asselt et al. 2010). This is particularly relevant in the realm of health where science is expected to have all the answers, but cannot possibly provide certainty where there is none. This 'uncertainty paradox' places crisis decision-making somewhere in the grey area between social construction and rational classification of threats, and arguably blurs the lines between sense-making and meaning-making (Van Asselt & Vos 2006).

Action in view of uncertainty thereby leads to ambiguity (Van Asselt & Renn 2011). In the absence of clear facts "[a]ctors[...]respond to risks according to their own risk constructs and images, yielding several meaningful and legitimate interpretations of risk assessment outcomes" (Keeney 2004). The core features of international crises and their demand for collective responses via the global governance framework thus open the floodgates to politicisation and framing. The different crisis phases are accordingly not as clear-cut. In fact this paper argues that meaning-making—in the form of political frames—may increase in relative importance when sense-making cannot provide a basis for decision-making.

In the absence of clear scientific risk assessment, effective and timely crisis recognition and response depend on the interpretation of signals by those situated at the core of decision-making, namely policymakers (Boin 2005a). Only if there is an official decision to recognise a crisis as such on a global level, collective action can take place and response capacities can be developed to successfully overcome the crisis. Much overlooked in the crisis management literature, societal and network dynamics can have significant effects on this recognition process and thereby on global governance outcomes and collective responses (Van Asselt & Renn 2011). Not only are policymakers faced with uncertainty highly susceptible to base their actions on 'logic of appropriateness'[1], that is, on social norms and foreign policy principles, they are moreover influenced by competing frames and the public sphere (March & Olsen

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[1] **'logic of appropriateness'**: "[...]actors following internalized prescriptions of what is socially defined as normal, true, right or good[...]" (March & Olsen 2008:690). In contrast to **'logic of consequentiality'**: actors orienting their behaviour to expected consequences, results and effectiveness (ibid:701)

1995:30-31; Koenig-Archibugi 2010; Van Asselt & Renn 2011). The public sphere, as illustrated in figure 1, impacts political decision-making in two main ways: indirectly via social conventions, and directly via active framing and promotion of certain policy options (Kratochwil 1989; Wendt 2001; Nelson & Katzenstein 2014).

1. Competing for Access to State Decision-Making: Pressures from Transnational Governance Networks

Source: Author, based on Boin (2005)
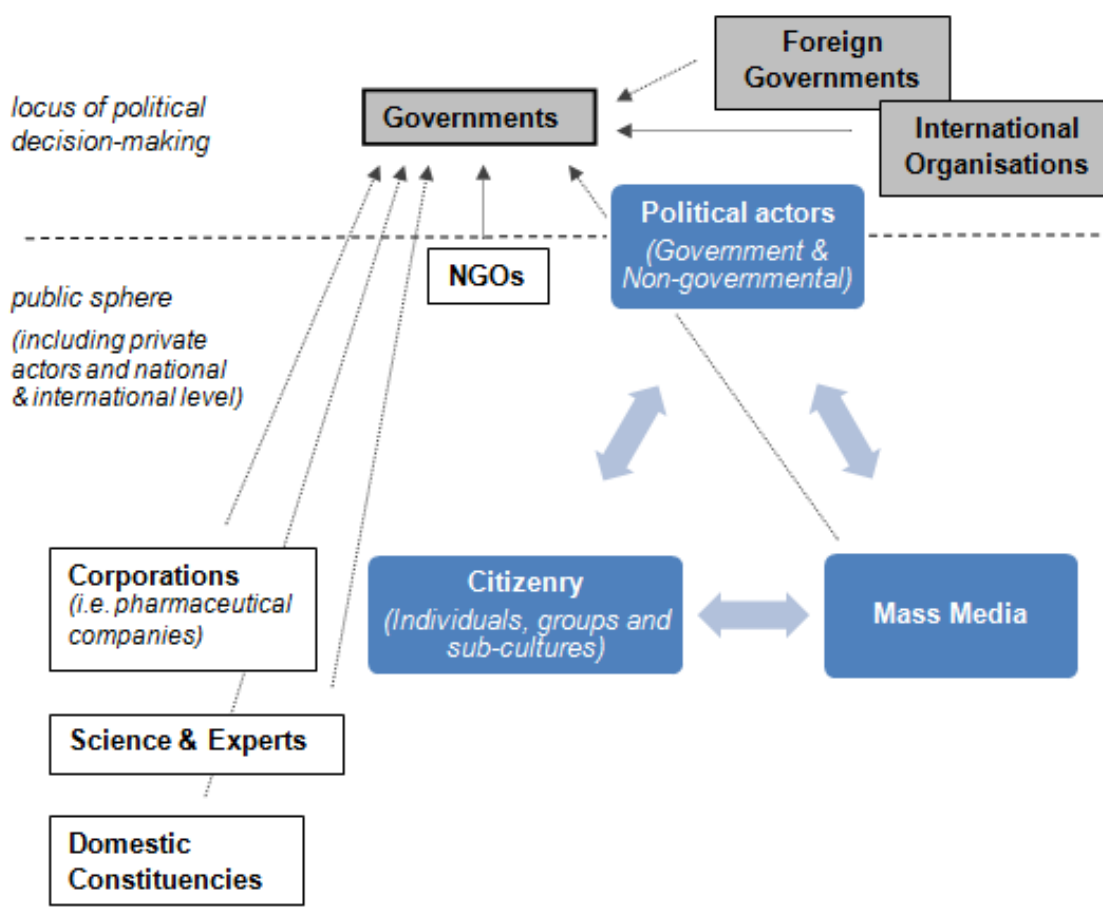
Just like global governance, international crisis management then can be understood as a 'set of authority relationships' in which expectations create pressure (cf. Kahler & Lake 2003). Different actors from both the core of decision-making and the public sphere consequently compete over the governance outcome (Boin 2005c). As science and rational situational assessment cannot provide a satisfactory basis for crisis management decisions, states are faced

with contending pressures from multiple stakeholders, and must balance their obligations between the domestic-international dichotomy (Barnett & Sikkink 2008; Van Asselt & Renn 2011:435).

The key to understanding global crisis management therefore are 'politics of accountability': the relationship between policymakers and the public sphere on domestic and international levels (Drabek 1994:32; Boin 2005c; Grant & Keohane 2005). Governments must accordingly not only address the evolving transboundary crisis, they must respond to public expectations to which they are linked through accountability ties that may be understood as institutionalised public pressure (see figure 1). Policymakers are formally linked to the domestic and international public sphere through democratic and legal structures. Hence, in the sense- and decision-making phase of pandemic crises they must not only interpret uncertainty, they must take into account their ties to the networks and public spheres that empower them to govern (Hooghe & Marks 2008). In this context meaningful communication presents an effective means for policymakers to manage expectations and maintain a domestic and international 'permissive consensus' over the appropriateness of their policy choices (Boin 2005c:92; Van Asselt & Renn 2011:440). The vague, convertible nature of frames helps political actors to do exactly that, signalling responsiveness to societal expectations in their crisis management, and thus balance competing domestic and international pressures. Framing consequently provides a way to avoid public questioning of the accountability and appropriateness of political responses. It is in the best interest of policymakers to pre-empt intensifying pressures from a public sphere that is dissatisfied with the political response, since this could pose a 'constraining dissensus' to their authority and political standing (Drabek 1994; Boin & 't Hart 2003; Hooghe & Marks 2008). Framing is however not limited to policymakers but is conducted by a large range of actors (see figure 1) in the rivalry for favoured governance outcomes.

In sum, when studying transnational crisis management the public sphere cannot be separated from decision-making processes as policymakers are embedded in social conventions and networks and increasingly rely on them in the absence of certainty. The public sphere furthermore provides a shadow of the future that holds policymakers accountable and leads them to consider future consequences when making policy choices. Public diplomacy and international crisis management are therefore closely related, since collective responses to complex crises are essentially influenced by framing and politicisation triggered by the underlying accountability ties between policymakers and the public sphere. Framing, the public sphere and accountability ties can thus be seen as responses to the trilemma of global health governance that is essentially inherent to pandemic crises as well.

Pandemics and Framing: A Matter of Medicine or Security?

Pandemic crises bring together the complex environments of global governance and crisis management, and thereby constitute an extraordinary challenge. Emerging and re-emerging infectious diseases (ERIDs) and related outbreaks have been carefully monitored internationally since the early twentieth century (Zacher & Keefe 2008:33-40). While epidemics refer to regional outbreaks larger than anticipated, pandemics are generalised epidemics that affect several regions and populations (Barreto et al. 2006:193). Despite significant recent improvements in international surveillance systems and the current WHO Global Outbreak Alert and Response Network with its six-phased pandemic approach, definitions remain elusive and thus affects outbreak classification (Heymann & Rodier 2001). Monitoring ERIDs however extends beyond the medical challenge of monitoring pathogens and predicting mutations in order to prevent pandemics. Figure 2 illustrates further factors than can contribute to the (re-) emergence of infectious diseases and add to the 'ill-defined' character

of the crisis. Aggravating the governance trilemma further, limited resources and capacity force policymakers to prioritise and focus coordinated efforts on certain targets (Lai 2012). The identification of root causes and the 'correct' problems however presents a complex challenge in itself.

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2. Factors Involved in the (Re-)Emergence of Infectious Diseases

Source: Morens et al. 2004:245

- Breakdown of public health measures
- Climate and weather
- Changing ecosystems
- Economic development and land use
- Human demographics and behaviour
- Human susceptibility to infection
- Intent to harm
- International travel and commerce
- Lack of political will
- Microbial adaptation and change
- Poverty and social inequality
- Technology and industry
- War and famine

Unfolding pandemic crises can therefore only be fully understood as "multiple subjective 'sense making processes'" (Topper & Lagadec 2013:13). Global health crises are wide open to framing and what Ney (2012) calls 'patterns of exclusion and out-voicing' as certain narratives outcompete others. This is particularly relevant as different narratives set different priorities or governance outcomes, and second, trigger different responses, that is, means to realise the governance outcome. In the realm of ERIDs it is the 'outbreak narrative' for selected infectious diseases that has largely dominated global governance (McInnes & Lee 2006; Scoones &

Forster 2008). Although framing plays a major part in enhancing response and governance capacities it has been largely understudied in the realm of global health (McInnes et al. 2012).

Arguably one of the most relevant, albeit contested, frames is the *securitisation of health* (Kamradt-Scott & McInnes 2012). As policymakers face pressures from both the domestic and the international, securitisation is a frequently applied means to frame issues as urgent and requiring immediate action. If an epidemic outbreak is presented as an imminent political and security threat that requires rapid protection, its prioritisation can be effectively justified (Buzan et al. 1998; Balzacq 2005, 2011). If political leaders are able to securitise certain health concerns, as was the case for pandemic influenza in the 1990s, a sense of crisis fosters the need for public leadership and acceptance of related policy responses (Boin 2005c; Kamradt-Scott & McInnes 2012). It likewise justifies military and security-focussed measures to solve problems. The controversy however lies in the vague nature of security itself (De Waal et al. 2010; McInnes & Rushton 2010). Should policymakers prioritise national or international security? Or should they focus efforts on protecting human security (and if so, health, environmental or food security)?

A second prominent frame in the sphere of ERIDs is the *medicalisation of (in)security* (Elbe 2010; 2011). Medicalisation essentially adds a medical angle to global politics—some claim it even transforms global health governance and the understanding of security itself (Elbe 2011). By addressing health as a primarily scientific issue, responses focus on medical solutions and place crisis management largely in the hands of medical experts and health professionals (ibid.). Elbe holds that large parts of global (in)security have become attributed to medical topics. However, this paper holds that there may be a flip side to medicalisation frames, as they could be applied to downplay a situation. When the handling of the situation is seemingly moved out of the political arena and the problem itself is presented as scientifically quantifiable, there may be less of a feeling of urgency and security crisis. Drawing on the

literature on risk and uncertainty, medicalisation frames can be seen as a reaction to the governance dilemma of action in the absence of certainty. This paper thus sees them as tools to either stage an outbreak as a medical crisis—thus promoting medical responses such as vaccine development—or as means to downplay disease to a scientific problem that does not require a large-scale response but rather can be solved by medicine.

There are a number of other frames that can be found in the realm of global health. In addition to a primary focus on securitisation and medicalisation, this paper further considers the narratives of economics, human rights and development in its analysis. *Economics* is a rather broad frame that is especially controversial in the realm of global health (Amariglio 1990; Ney 2012). Framing health as a matter of choice and economic competition subordinates crisis management to market theories and considerations of competitiveness and efficiency (Mc Innes et al. 2012; Ney 2012). The response to an epidemic outbreak thereby becomes subject to the outcome of economic cost-benefit analyses with a particular focus on the scarcity of resources.

Human rights frames approach global health very much from the other end of the spectrum. Such frames understand public health as a fundamental right, as opposed to a choice or commodity (Hunt 2004; Hunt & Backman 2008; Ney 2012). An epidemic outbreak would accordingly be framed in the context of social norms and human rights such as the entitlement to basic health needs (McInnes et al. 2012). Human rights arguments hence largely revolve around moral and cosmopolitan responsibilities (Ney 2012).

Finally, the *development* frame is probably the most contested narrative amongst the ones outlined in this paper. In line with existing power and resource asymmetries it presents global governance issues in dichotomous terms of 'developed/'developing' and 'First World/Third World' (Escobar 1995, 2004; McInnes & Lee 2006). The development frame therefore particularly addresses the aforementioned governance paradox of persisting asymmetries in

world politics by largely attributing negative traits to the Global South, and positive ones to the Global North (McInnes & Lee 2006). ERIDs would consequently be framed as a matter of poor infrastructure or low development and responses then must focus on development aid and material support from the developed world.

All of these frames may be applied to serve different purposes. On the one hand powerful states may well have the resources to tackle a crisis of global scale, yet they may lack the will to do so (Argyris & Schön 1996; Moynihan 2008:352). Framing crises in a certain way could thus allow governments to escape responsibility and shift the burden of collective crisis response away from themselves (Stern 1997:78; Boin & 't Hart 2003:548; Boin et al. 2005:120; Bedford & Huang 2009). Alternatively, political narratives can also provide powerful tools for fostering a certain policy response and enhancing collective capacity. The outcome depends on the frame that succeeds in out-voicing others, and whether it acknowledges the crisis as such and favours an international response or not. Although the abovementioned frames have been outlined with regards to policymakers, they are likewise applied by the public sphere to pressure governments into adopting a particular narrative and promoting it on the global level, as will be shown in the analytical sections.

3. Methods

Although states certainly still play a central role in the architecture of the international system as its core decision-makers and rule-setters, security-focussed neorealist perceptions fail to fully grasp global health governance despite their acknowledgement of the role of domestic politics in shaping state behaviour (cf. Keohane & Nye 2000; Schweller 2004, 2006). Global health is certainly impacted by both power relationships and competition as well as cooperation and collaborative institution-building (McInnes & Lee 2006; Zacher & Keefe 2008). Drawing

on the earlier outlined understanding of global governance as a 'set of authority relationships' this paper however points to societal dynamics as essential element in explaining global governance outcomes, particularly in light of the uncertainty paradox that pandemic crises present. It consequently adopts a 'material-discursive' perspective that sides rather with the social constructivist position, understanding policymakers as part of social authority relationships with the public sphere (Wendt 1992). Existing studies of global health governance have widely focused on technical and institutional aspects (Kay & Williams 2009), whereas the need for ideational studies has only recently been pointed out (Shiffman 2009; McInnes et al. 2012). This paper thus emphasises ideational factors in shaping foreign policy outcomes but reserves the right to include explanatory variables beyond social constructivist tenets. It understands 'crisis' and 'risk' as concepts both socially constructed as well as real probable threat scenarios.

The paper thus assesses framing and public diplomacy, informed by the public sphere, in their impact on state-level interests in international collective decision-making. It claims that politicisation and public sphere dynamics significantly shape governmental policy preferences in global crisis management processes. To take the argument one step further, it asserts that collective crisis response in the field of global health even depends on public support in large parts, perhaps more than on scientific risk assessment or political considerations about capacity. Pandemic crisis management hence may be strongly distorted and protracted by frame competition. This paper accordingly states that policy outcomes must be understood as the result of a contest between various frames rather than rational situational assessment, and that global health governance is essentially characterised by authority relationships and accountability ties between policymakers and the public sphere. Framing hence provides the means by which actors bargain over possible outcomes.

The cases on which these arguments will be tested have been chosen on a most-similar systems design basis (George & Bennett 2005). Although the regions and countries affected actually vary, the institutional context and medical conditions of the unfolding crises are similar. Under the WHO six-phased classification scheme, both the 2003 SARS epidemic and the 2014 Ebola epidemic qualified as phase five and thereby should have triggered comparable immediate international containment efforts. The divergent outcomes—effective collective response in the case of SARS and crisis protraction with regards to Ebola—are therefore especially striking. Following traditional realist and liberal arguments of power relations and institutional regimes, the difference is even more surprising, as the revision of the International Health Regulations (IHR) subsequent to SARS in 2005 should have provided for even better surveillance and response capacity in the later Ebola epidemic. Yet the contrary was the case. In order to test how accurately framing can explain this difference in outcomes the paper has engaged in process-tracing for both cases. Relying on content analysis it consequently summarises the respective frames applied by officials and actors involved at different times and key moments. However, the time span to be assessed in the case of Ebola has been limited to the first nine months of the outbreak, as this includes the launch and initial evolvement of the international response. The evidence evaluated consists of primary sources such as official documents, statements, and media articles, as well as secondary-source academic accounts, and has been arranged according to the frames outlined above.

While this paper expects to identify a multitude of comparable frames, and find timely coincidence of certain frames and according responses, this can only be regarded as preliminary evidence for a correlation. Other external variables cannot be dismissed from having had a causal effect on collective action or the (re-)adjustment of frames. The conclusions therefore are only tentative and further studies are required to validate the explanatory power of framing and public pressure in health crisis management.
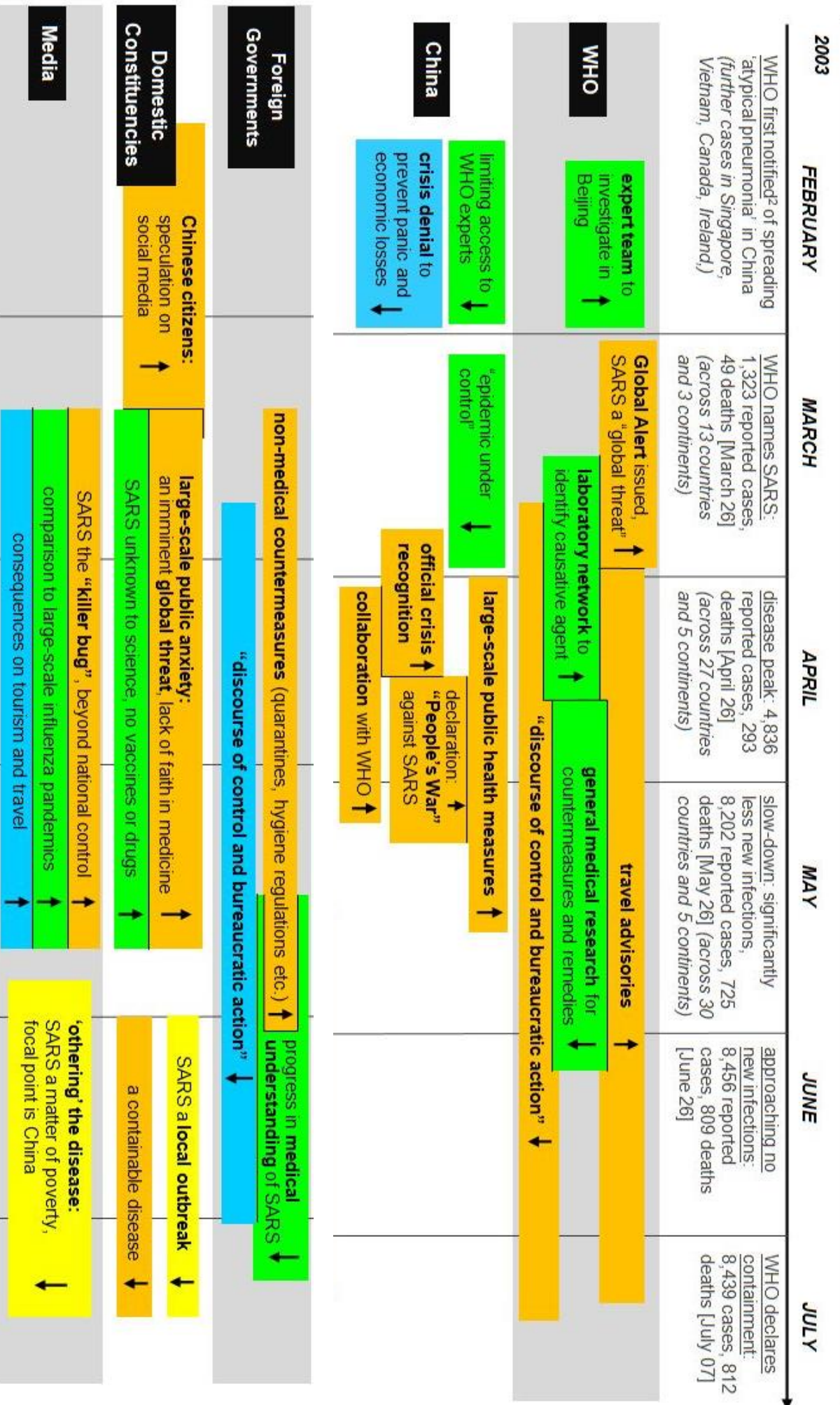
4. Pandemic Crises Revisited

When SARS and Ebola broke out, they both similarly qualified as phase five epidemics (out of six possible phases of the WHO pandemic classification), and should have triggered immediate collective action (WHO 2009). Response should have been direct, comprising rapid international containment measures, "indivdual societal and pharmaceutical measures" and the activation and implementation of contingency plans (WHO n.d.). Yet both crises were perceived and managed very differently. Whereas SARS was prioritised as a "global threat" right from the beginning (WHO 2003b,c), Ebola was downplayed to a minor outbreak by the WHO (Samb 2014). Whereas SARS was strongly presented as a crisis, Ebola was initially presented as a containable health risk. Whereas one was largely securitised, the other was mainly medicalised. This paper argues that framing was crucial to the kind of response both epidemics received, and that the contending frames were significantly driven by the public sphere. Frame competition in the cases of SARS and Ebola was summarised in figures 3 and 4 to provide a conjunctive overview across time. The following sections proceed to elaborate more comprehensively on the different types of crisis representations: securitisation, medicalisation, economics, human rights, and development.

Legend Figures 3 & 4:

Types of Frames

🟧 Securitisation   🟩 Medicalisation   🟪 Human Rights   🟦 Economics   🟨 Development

Effect on Risk Perception

↑ crisis-augmentation   ↓ crisis-containment

3. Chronology of Frames during the Outbreak of Severe Acute Respiratory Syndrome (SARS)[1], February – July 2003

Source: Author, based on WHO (2003[1]) and further references used in section 4.1

2003 — FEBRUARY — MARCH — APRIL — MAY — JUNE — JULY

WHO first notified[2] of spreading 'atypical pneumonia' in China (further cases in Singapore, Vietnam, Canada, Ireland,)

WHO names SARS; 1,323 reported cases, 49 deaths [March 26] (across 13 countries and 3 continents)

disease peak: 4,836 reported cases, 293 deaths [April 26] (across 27 countries and 5 continents)

slow-down: significantly less new infections, 8,202 reported cases, 725 deaths [May 26] (across 30 countries and 5 continents)

approaching no new infections: 8,456 reported cases, 809 deaths [June 26]

WHO declares containment: 8,439 cases, 812 deaths [July 07]

WHO

expert team to investigate in Beijing

Global Alert issued, SARS a "global threat"

laboratory network to identify causative agent

general medical research for countermeasures and remedies

"discourse of control and bureaucratic action"

travel advisories

China

limiting access to WHO experts

crisis denial to prevent panic and economic losses

"epidemic under control"

official crisis recognition

collaboration with WHO

declaration: "People's War" against SARS

large-scale public health measures

Foreign Governments

non-medical countermeasures (quarantines, hygiene regulations etc.)

"discourse of control and bureaucratic action"

progress in medical understanding of SARS

Domestic Constituencies

Chinese citizens: speculation on social media

large-scale public anxiety: an imminent global threat, lack of faith in medicine

SARS unknown to science, no vaccines or drugs

SARS a local outbreak

a containable disease

Media

SARS the "killer bug", beyond national control

comparison to large-scale influenza pandemics

consequences on tourism and travel

'othering' the disease: SARS a matter of poverty, focal point is China

[1] the figure does not explicitly capture NGOs, science and experts, business and corporations due to their minor role played in public framing

[2] first cases of SARS believed to date back to November 2002 (Guangdong Province, South China)

4. **Chronology of Frames during the Outbreak of Ebola Virus Disease (EVD)[1], March – November 2014**

Source: Author, based on WHO (2014d, 2015b) and further references used in section 4.2

Timeline / WHO situation data (2014):

- **MARCH** — first Ebola cases acknowledged[2], WHO notified (Guinea, spread to Liberia)
- **APRIL** — outbreak qualifies as WHO pandemic phase 5
- **MAY** — 383 reported cases, 211 deaths (spread to Sierra Leone)
- **JULY** — 1,201 report. cases, 672 deaths (spread to Nigeria)
- **AUGUST** — first non-African nationals infected, 3,707 cases, 1,808 deaths (Spain, US, UK, Germany, Senegal)
- **SEPTEMBER** — collective response launched, 6,553 reported cases, 3,083 deaths (across 10 countries, 3 continents)
- **OCTOBER** — outbreak declared over in Senegal and Nigeria, 13,540 cases, 4,941 deaths
- **NOVEMBER** — slow-down: incidences stable or declining, 15,935 reported cases, 5,689 deaths

Actors / Frames:

WHO: outbreak "relatively small still" → case investigations → Ebola an "internat. health emergency" → outbreak: pandemic potential → scale historically unprecedented → protraction due to "poverty, dysfunctional health systems"

NGOs/Experts: French scientists confirm Ebola is causative agent → laboratory cooperation in testing samples → MSF: "unprecedented spread" + reinforcement of staff and equipment → influx of NGOs into affected countries: health equipment and services → MSF: Ebola "out of control" → approval of experimental drugs → Ebola response irresponsibly slow → neglect due to focal point in third world → calls for governmental civil and military support → experimental therapy research → clinical tests: experimental drugs → containment a matter of resources

UN: severe econ. consequences → Ebola "threat to internat. peace and security", UNMEER created → threat to livelihoods/ basic human needs

Governments: Guinea reports outbreak to WHO → Mauritania and Senegal close borders → Ivory Coast closes borders → US funds research on remedies → social media: uncertainty + threat → outbreak scale due to deficiencies of developing countries → heightened anxiety, public demand for national responses → airport screenings → WHO shortcomings

Domestic Constituencies: no existing effective vaccine or drug → national impact and cases

Media: lack of resources and capacity → corp. reluctance to invest in vaccine development

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[1] the figure does not explicitly capture business and corporations due to their minor role played in public framing. They were however largely involved in research on drugs and vaccines, collaborating with governments and non-state actors.

[2] first case dating back to December 2013 (Guinea), cause of death attributed to Ebola only in retrospect

The 2003 SARS Outbreak

> *"Within days, an international effort led by the World Health Organization (WHO) had massed scientific expertise to fight the mystery illness and avert the nightmare scenario of an uncontrollable pandemic sweeping the globe."*
> - BBC (2003)

> *"I used to believe everything the government told me. But now, after SARS, I will weigh everything the government says very carefully, and I'll judge how much of it is true."*
> - Chinese SARS victim (Murphy 2003)

Known as Severe Acute Respiratory Syndrome, SARS was first officially detected in China in February 2003 although earliest cases can be traced back to November 2002 (Global Alert and Response 2003). The local outbreak of the epidemic quickly developed into a full-fledged global outbreak with 8,096 cases of infections across 29 countries and five continents, causing an estimated 774 deaths (ibid.; Smith 2006). SARS took the international community by surprise as it had not previously been identified as an emerging infectious disease and thus was only referred to as 'atypical pneumonia' in its early stages (WHO 2003c; Wallis & Nerlich 2005:2630). Despite this, it triggered an unprecedented collective response by the international community and the disease was contained accordingly quickly within 8 months by July of the same year (WHO 2003a; Mackenzie & Merianos 2013).

Securitisation

SARS was heavily securitised from the beginning. While most actors sought to boost the sensation of crisis, the Chinese government initially applied a strategy of denial and information-gatekeeping both from its citizens and the international community (Pomfret 2003; Tai & Sun 2007:995-96). However, the Chinese stance on collective action changed significantly throughout the evolution of the epidemic (see figure 3). Attempts to de-securitise the crisis lasted until April 2003 when China officially declared SARS a national threat (Tai & Sun 2005:996). The change of heart interestingly coincides with the emergence of a multitude

of strong international securitisation frames. The first securitisation moves can be seen in the public expression of anxiety and heightened speculation about the extent of the health threat. Due to the refusal of the Chinese government to admit the unfolding crisis and collaborate, the Chinese public turned to the international sphere via social media and the internet (Huang 2004; Thomson & Yow 2004). Citizens, health professionals and NGOs thereby securitised the outbreak through the global dissemination of information and spreading their concern about the scale of the epidemic (ibid.; Fidler 2004a; Wong & Leung 2008). This public constraining dissensus rivalled the government's non-crisis frame, and thus significantly contributed to the crisis acceptance of Chinese policymakers (Fidler & Batman 2004:114; Tai & Sun 2007).

In addition to securitisation frames by the Chinese public sphere, SARS became increasingly understood as a security crisis through the build-up of international political pressure on China. Shortly after the WHO had first been notified of the spread of atypical pneumonia in February, it issued a global alert and declared SARS a "global threat" (WHO 2003b,c). National governments followed almost immediately, as domestic constituencies expressed large-scale anxiety about the potential spread of the epidemic (Smith 2006:3117-18). It is striking that the bulk of national counteraction to the epidemic consisted of non-medical measures like simple hygiene regulations, quarantines and travel restrictions (Wallis & Nerlich 2005:2636; Smith 2006:3114-15). These traditional security responses hence debatably present a reaction to public concerns that medical measures would be ineffective since SARS presented a new disease without vaccines or drugs (Smith 2006:3117-18; Zacher & Keefe 2008:162-63). The uncertainty related to the crisis and its effect on securitising moves is likewise reflected in the frames of the media. Subsequent to the WHO global alert the media adopted a rhetoric of force and panic, as it portrayed SARS as 'killer bug' and 'major danger' (Wallis & Nerlich 2005:2632-34). When SARS approached its peak around April, so did securitisation frames. The WHO had begun to issue travel recommendations, national

governments expanded safety measures and engaged in transparent case reporting, and the media prioritised the severity and deterritorialisation of the epidemic by presenting it as a war (ibid.; Chan et al. 2003; WHO 2003d,f,g; Fidler 2004; Smith 206:3114).

This overwhelming number of securitisation frames precedes a shift in China's official position. The attitude towards SARS by Chinese officials changed, practically overnight, from one of denial to labelling the epidemic a significant national threat and adopting the international "[...]discourse of control and bureaucratic action" (Wallis & Nerlich 2005:2636). The predominance of global security-crisis frames, and a lack of strong rival frames arguably caused this shift. As the result of the international public and political framing consensus, the WHO was able to formulate a rather uncontested definition of SARS as an imminent global threat (ibid:2632). In April 2003 China thus launched large-scale public health measures, declared a "People's War against SARS", and joined the WHO-led international response (SARS Expert Committee 2003; WHO 2003j,k; Tai & Sun 2007:996-97; Mackenzie & Merianos 2013). The epidemic slowed down in the following month and was declared contained a few weeks later in early July (WHO 2003a).

Medicalisation

Alongside securitisation, medicalisation frames contributed significantly to effective international crisis management. Framing SARS as a medical source of insecurity had an interesting effect on collective action, however, as medicine could not provide effective solutions. Little was initially known about the pathogen and the disease in general, and there was no remedy for it (WHO 2003m). Hence policymakers largely used medicalisation and the uncertainty paradox as frames for crisis-augmentation (medical cause, no medical cure) and as justification to engage in securitisation measures. Medicine frames consequently reinforced security frames by heightening the sensation of crisis and urgency.

When the WHO first medicalised the disease outbreak as a potential crisis in February 2003, and deployed an investigation team, the Chinese government counter-medicalised SARS as a local outbreak under control and significantly restricted the investigations (Cunningham 2003; WHO 2003l). When the medical uncertainty became publicly known, China however ceased to medicalise the crisis and proceeded to securitising moves and non-medical securitisation measures (Smith 2006:3116). This paper argues that this shift correlates with crisis-augmenting medicalisation frames by domestic constituencies and the media. Anxiety levels had already been especially high and faith in medicine especially low due to the experiences of 09/11 and past ERIDS (ibid:3118-19). Consequently the scientific uncertainty surrounding SARS rendered widespread fear inevitable. It translated into strong public medicalisation frames that dramatised the insecurity of the disease (ibid:3114).

Public health concerns and the medical insecurity of SARS however mainly provoked a political retreat to established security measures. Although the WHO initiated scientific collaboration across laboratories and medical experts worldwide, there was no other medical action it could take while waiting for the identification of the causative agent (WHO 2003e,m). As research for vaccines and therapies continued but remained fruitless, policymakers applied classical measures like quarantine and isolation in order to contain the disease. Medicalisation frames were hence mostly applied in the beginning of the crisis to highlight uncertainty and thereby involve the polycentric global health networks, arguably to solve capacity asymmetries. Medicalisation thus fostered two kinds of responses. First, it sparked a medical one, as governments, NGOs, experts and pharmaceutical corporations engaged in active collaboration to tackle the scientific uncertainty of the disease (WHO 2003e,l). Medicalisation therefore enabled a pooling of resources and the production of global public goods for health (GPGH) including monitoring procedures, information dissemination and remedy research amongst others (Fidler 2004a,b). Second, frames of medicine were somewhat applied towards

the end of the epidemic to de-escalate the crisis and provoke non-medical action. In the absence of a cure for SARS, policymakers framed medical knowledge about disease severity and spreading rates as a basis for traditional securitisation measures (Wallis & Nerlich 2005:2636; Smith 2006:3115).

This neatly illustrates the reciprocal dynamic between policymakers and the public. Political control frames addressed public concerns and soon caused a sharp drop in public anxiety and crisis-augmentation frames. As security measures were put in place against SARS and case numbers began to decline, medicalisation accounts very much reflected public confidence in containment efforts and renewed faith in medicine by signalling control and crisis de-escalation (Wallis & Nerlich 2005:2633-36; Smith 2006:3118).

Economics

Although SARS was mostly framed in terms of securitisation and medicalisation, economic considerations likewise affected the international response. China's discourse of control and its initial denial of the epidemic could be regarded as protective measures (Tai & Sun 2007:996). Albeit not publicly, the Chinese government thus framed SARS as an economic problem that could result in financial losses if it became internationally known (ibid.; Smith 2006). Underlying economic frames can moreover explain part of China's large-scale initiative of public health measures in April 2003, after it had officially recognised the crisis. The massive launch of traditional countermeasures certainly helped to halt the disease. However precautions like airport screenings and temperature measurements have been argued to have had no significant impact on containment apart from reassuring the public, and limiting investment flight (Forney 2003; Smith 2006:3116).

Interestingly economic motives were similarly present in the frames of actors relatively distant from the outbreak. Amidst the uncertainty of the sense-making phase around March

2003 the global public sphere regularly framed SARS as an economic crisis. Business predicted heavy losses and effects on the stock market in case of crisis-protraction (WHO 2003l). The media similarly framed the outbreak in terms of its economic impact by reporting on SARS-induced limits to travel and tourism, and sharp declines in public travel and demand for cross-border economic activities (Wallis & Nerlich 2005:2633; Smith 2006:3117-18; Zacher & Keefe 2008:60-61). Although governments did not actively frame SARS as an economic crisis, this paper asserts that the political security responses and rapid countermeasures were partly informed by a cost-benefit policy analysis that rendered immediate action necessary to contain economic losses. The "discourse of control and bureaucratic action" that policymakers applied on both WHO and national levels should accordingly not be reduced to an exclusive securitising move, as it captures several layers of public pressures and expectations (Wallis & Nerlich 2005:2636). Nonetheless economic considerations must not be overemphasised in the role they played for the international collective response. Taking into account the widespread domestic travel bans and restrictive measures concerning cross-border movement, securitisation frames certainly outweighed economic ones and hence outcompeted responses focussed on economic motives (Smith 2006:3115).

Human Rights

Moral framing was largely absent from the crisis evolution. Instead, securitisation and medicalisation were prioritised, very much at the expense of human rights frames. Although NGOs and scholars initiated discussions about human rights in conditions of quarantine and isolation, it did not succeed as a dominant crisis frame but was outcompeted by others (Fidler 2004b). Securitisation frames in favour of containment measures out-voiced human rights frames in the public sphere (Gostin et al. 2003; Smith 2006:3120). Human rights accounts were thus outcompeted by public prioritisation of action over ethical deliberation.

In the political sphere the absence of human rights frames highlights the WHO's "managerial" approach to tackling the crisis by providing collaborative guidance rather than hierarchical leadership (Wallis & Nerlich 2005:2637-38). In contrast to taking ownership of the international collective effort and identifying itself as top authority, WHO discourse was marked by cooperative phrasing. Wallis & Nerlich (ibid:2637) summarise how official documents situate the WHO alongside governments, "'working with' or 'supporting' national authorities' in a 'collaborative effort' and 'partnership" (cf. WHO 2003h). This arguably relates back to the capacity asymmetries in global health governance, as collective action depends on national resources and cooperation between actor networks (Fidler 2004b). Human rights frames—cosmopolitan arguments about governmental human rights obligations and moral responsibility—could have significantly undermined the political will of some governments to engage in collective action (Wallis & Nerlich 2005:2637-38). Other frames were consequently more effective in shaping the international response to SARS.

Development

Development frames were of little significance for the actual international response to the SARS outbreak. They however played a relatively important role towards the end of the epidemic in the containment of public anxiety, and politics of accountability. As the disease had slowed down by May 2003 and case numbers indicated that the focal point had been China, foreign domestic constituencies and the media framed SARS as a Chinese crisis rather than a global one (Muzatti 2005; Smith 2006:3118). By attributing the epidemic outbreak to conditions of poverty and unhygienic conditions in China, public spheres from industrialised countries effectively 'othered' SARS as a matter of development (Wallis & Nerlich 2005:2635-36). This paper claims that policymakers adopted development frames in a similar manner in the aftermath of the crisis to shift the responsibility burden of the crisis away from themselves.

Following the containment of the disease in July, the WHO published a report about 'inadequate plumbing' in China as crucial to the emergence of the epidemic (WHO 2003i). While it would be wrong to impute burden-shifting to the WHO, its report framed inadequate infrastructure and practices in the region as a root cause for the outbreak. This constitutes a development argument as it quite clearly situated the international response in contrast to regional neglect (WHO 2010).

In light of their accountability ties to the public, politicians hence framed SARS as a disease that could be relatively easily contained. This is particularly interesting in conjunction with applied medicalisation frames and the lack of a remedy. Portraying the scale of the outbreak as a development issue could arguably present an attempt to balance scientific uncertainty and absent medical means to counteract the epidemic. Along with securitisation frames, development frames would then consequently constitute coping mechanisms for the uncertainty paradox. By presenting SARS as a containable, 'third world' disease, development frames reinforced political control frames and securitisation moves. In the post-crisis phase they thereby became governmental means for signalling action and responsibility to the public, and de-escalating the public crisis perception.

In A Nutshell

There are three striking observations concerning the international management of the 2003 SARS outbreak. First, the role of the public sphere was essential in boosting international political responses. Collective action rather reflected public fear than actual global potential of SARS, as the bigger part of all infections occurred in China (WHO 2003n). The public sphere further played a crucial part in pressuring the Chinese government to join collective containment efforts. A public constraining dissensus led China to alter its mode of denial and recognise the outbreak as a crisis. Second, the prominent frame and thereby response to the

inherently medical crisis was securitisation. On the level of the public sphere, mainly domestic constituencies and the media, high anxiety and framing of the epidemic as a threat created considerable pressure on policymakers. Likewise on the level of decision-makers, securitising moves reflected public concern. Many public health measures were predominantly means of reassurement and remained very limited in their direct impact on disease control.

Despite the obvious need for a medical response to cure SARS, medicalisation frames mostly played a secondary role. Medicalisation of the outbreak focused largely on highlighting the lack of scientific knowledge and what medicine could not provide at the moment: an effective remedy. Medical frames further sparked the feeling of urgency and public fear, and thereby contributed to the initiation of collective action. This paper claims that SARS illustrates how policymakers reacted to public concerns and engaged in securitising moves as the seemingly only viable response in light of the medical uncertainty. Third, frame competition during the SARS crisis revolved mainly around crisis- and non-crisis accounts between the Chinese government and the international community, as well as between policymakers and the public sphere. The course of the outbreak has illustrated the influence of the public sphere on policymakers and their crisis management on domestic and global levels. It ultimately led to a growing global consensus on SARS as an international emergency that exerted significant public and political pressure on non-crisis frames. Subsequent to such large-scale politics of accountability, China finally adapted their frame to the predominant securitisation one. The case of the 2003 SARS outbreak has thus shown how different frames compete with one another until a dominant frame has established itself. It has further highlighted the role of the public sphere in driving the frames adopted by policymakers, and hence deciding the kind of response a crisis receives.

The 2014 Ebola Outbreak

> *"The world, including WHO, was too slow to see what was unfolding before us."*
>
>   - Dr. Margaret Chan (2015),
> Director-General of the WHO

> *"None of us have ever been involved in anything of this magnitude, complexity and potential severity before."*
>
>   - Dr. David Nabarro (2015),
> UN special envoy for Ebola

> *"The flexibility and agility for a fast, hands-on emergency response still does not sufficiently exist in the global health and aid systems."*
>
>   - Joanne Liu (2015), president of
> *Medicins Sans Frontieres* (MSF)

The WHO was first notified of Ebola in March 2014, after it had broken out in Guinea and spread to Liberia (CDC 2014a). The human-to-human virus transmission across two countries in one WHO region should have clearly signalled the evolving pandemic crisis (WHO 2009). However Ebola was only officially acknowledged and heavily securitised a full four months later in August 2014 (cf. figure 4). By then the death toll had already exceeded the 700 deaths caused by the 2003 SARS outbreak by more than twice as many fatal cases (WHO 2015b). Despite large-scale international action pledges following WHO crisis recognition, the global response only kicked in relatively slowly and was unable to effectively halt the epidemic that has only recently begun to slow down (see tables 5 and 6). A further eight months later, in April 2015, total cases have reached 26,000, with 10,823 lethal infections (WHO 2015a). Although potential vaccines are undergoing clinical testing, an effective cure is not expected before the end of 2015 (WHO 2015c). Meanwhile the international community has admitted it had been "ill-prepared" for the Ebola crisis and that it faced problems of capacity (WHO 2015d). However, there is evidence that the protraction in collective response may to large parts be attributed to first, economic considerations concerning the impact on the economies of affected

countries, and second, an underlying lack of interest in the epidemic due to its focal point in the

developing world (Nierle & Jochum 2014; WHO 2014f).

---

5.   Total Cases of Ebola, April 2014 – April 2015

Source: Mackay (2015), based on WHO data

West Africa Ebola virus disease outbreak (EBOV/Mak): ALL CASES
Cumulative curves combining case numbers from Guinea, Liberia, Sierra Leone, Nigeria, Senegal, USA, Spain, Mali, UK
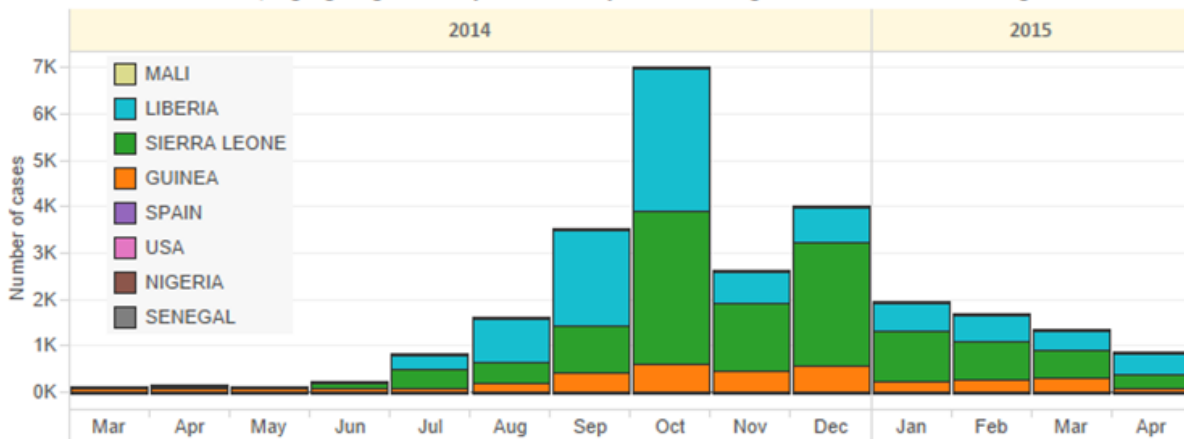

---
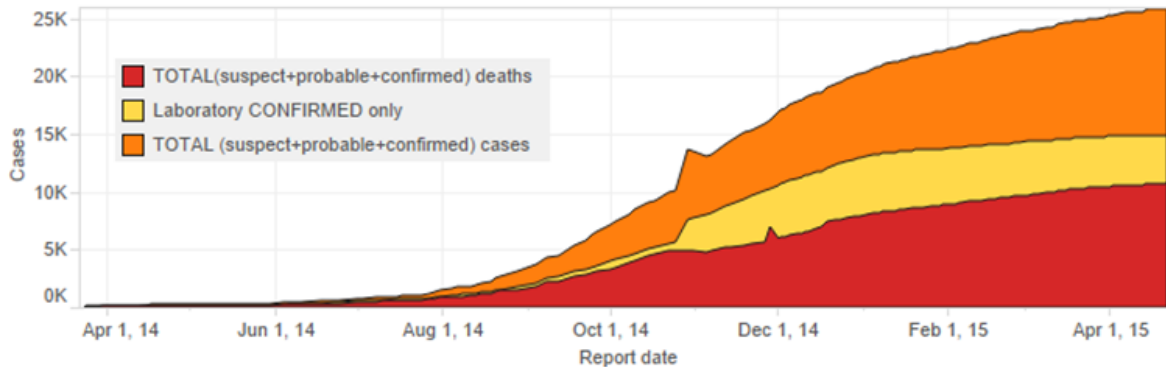
6.   Total Monthly Cases of Ebola, March 2014 – April 2015

Source: Mackay (2015), based on WHO data

West Africa Ebola virus disease outbreak
Total (suspect+probable+cofirmed) cases by MONTH using date of WHO Situation Reports/Summaries.
Does include non-EVD cases, highlighting that many other initially similar looking diseases circulate in the region.

Securitisation

As in the 2003 SARS outbreak, securitisation played an important role in the 2014 Ebola

epidemic. In contrast to SARS, security frames accentuating the emerging crisis were however

much more isolated in the initial phase of the disease spread, and largely outcompeted by frames that downplayed the situation. Governments closest to the outbreak first made securitising moves. When Guinea notified the WHO in March 2014, Mauritania and Senegal closed their borders to keep out the health threat (CDC 2014a; Johnson 2014; Ndiaye 2014). Additionally, locally involved NGOs—predominantly *Médecins sans Frontières* (MSF, Doctors without Borders)—strongly framed Ebola as a quickly developing security threat of "unprecedented" spread (MSF 2014a). NGO action further signalled securitisation, as GPGH, namely equipment and staff, were stocked up in affected countries to meet the menace (ibid.). Securitisation frames and containment efforts remained however almost single-handedly limited to NGOs in the initial phase. Both were visible in the large-scale GPGH deployment to the front lines in West Africa, and increasingly serious statements about the scale of the crisis (CDC 2014c; MSF 2014b).

Interestingly, large parts of the public sphere were unaware of the epidemic in the first four months of the outbreak. Whether not a concern or simply an issue off the radar, Ebola remained widely absent from public discourse amongst foreign domestic constituencies and the media until August 2014 when the WHO declared the disease an "international health emergency" (Chan 2014; Doyle 2014; Leetaru 2014; WHO 2014a). While initial securitisation was met with contrary accounts of crisis-minimisation by the WHO, the sudden international acknowledgement of the epidemic in August combines three developments. First, it was the point at which the first cases of Ebola appeared outside West Africa, with infected nationals from Spain, the U.S. and the UK (BBC 2014c; Henry & Stobbe 2014; RTVE 2014). Second, the epidemic came under public scrutiny, as international media and citizens started to see it as a security threat of potential impact beyond West Africa (Chan 2014; Leetaru 2014). Public fear was further fuelled by NGO accounts of Ebola as "out of control" (MSF 2014b). Third, governments took up securitisation frames domestically and internationally. The WHO

declared Ebola a global crisis in mid-August and admitted to have underestimated the scale of the outbreak (WHO 2014a,e). A few weeks later the UN Security Council (UNSC) reinforced the crisis-sensation by calling the epidemic a "threat to international peace and security", and creating the UN Mission for Ebola Emergency Response (UNMEER), the first ever UN mission established in response to a health emergency (UNSC 2014). Consequently, the correlation between the public sphere and policymakers contributed to the emergence of a collective response, as securitisation frames multiplied amongst the public and thereby exerted growing pressure on decision-makers.

Subsequent to the initiation of a global crisis response in August 2014, collective action—driven by the public sphere—can be divided into two phases. First, once securitisation had emerged as the predominant frame of Ebola by late August, it took a rather normative form, that is, speech acts, and only later was turned into physical securitising moves with boots on the ground. The first phase subsequent to the crisis recognition until late September was rather marked by strong security rhetoric rather than action. Despite extensive securitisation and pledges of aid and containment, governments remained relatively inactive (BBC 2014b; Nierle & Jochum 2014). Ebola was paradoxically framed as the "most severe acute public health emergency seen in modern times" (WHO 2014g), while the international response remained largely limited to reinforced surveillance (WHO 2014e).

The second phase set in by late September, after security speech acts had not triggered significant collective action, and a second wave of public anxiety formed. Reports of failed global responsibility, lack of governmental commitments, and WHO capacity shortcomings heightened concerns about the emerging threat (BBC 2014b; Doyle 2014; WHO 2014h). The increasing public demand for action can be seen in the explicit call for civil and military support to NGOs in affected regions instead of financial pledges (McPhun 2014). The spiralling social media interest in Ebola (Krisch 2014), and public polls in the U.S. and Europe further reflected

growing fear, as more than two thirds of citizens expected more containment measures and government action (DGN 2014; Washington Post 2014; WZ 2014). Public pressure to introduce quarantines and airport screenings reached its peak in October 2014, and was picked up by politicians shortly after (Al Jazeera 2014; Carey 2014; Higgins 2014; Millard 2014). Airport screenings and travel restrictions were imposed in many industrialised states (CDC 2014e; NHS 2014). Several states began to send troops to support long called-for by NGOs and African governments (Mason & Harding-Giahyue 2014). On the global level the UN finally deployed UNMEER to West Africa to support national security measures and non-medical containment efforts like isolation and quarantining (UN 2014). All of these constitute hard-power security responses to the Ebola outbreak. This paper asserts that the final international response and collective action was a result of the build-up of public pressure to react to the unfolding crisis. Strong securitisation frames eventually triggered material securitising moves in the form of military responses.

Medicalisation

Ebola had been known to science since the 1970s (WHO 2015e). This arguably made the disease more prone to become downplayed via medicalisation, as four decades of previous outbreaks had been succesfully overcome (WHO 2012). Indeed, most governmental frames of medicine served crisis-minimisation purposes at first. When French scientists confirmed Ebola as the causative agent around late March 2014, and NGOs began to warn of the potential impact, the WHO called the emerging epidemic "relatively small still" (CDC 2014b; Samb 2014). By May, independent NGOs and experts engaged in laboratory cooperation that could be considered crisis-augmenting medicalisation moves (CDC 2014c). Per contra, the WHO had begun to send experts of its own to the affected countries but framed the action as control and investigation rather than acknowledgement of the unfolding crisis (WHO 2014i).

Until the WHO declaration of a health emergency in August 2014, the international political response to crisis concerns consisted of strong underplaying medicalisation frames. Domestic constituencies only became aware of the outbreak and the lack of effective treatment in July (Krisch 2014; Zacher & Keefe 2008:162-63). This paper hence sees a correlation between early public medicalisation accounts marked by anxiety, and governmental medical framing and official crisis recognition starting in August. While phase I of collective action presented more of a speech act regarding securitisation measures, it showed extensive medicalisation moves as policymakers framed crisis-resolution as finding a remedy for the disease. Domestic governments consequently funded research and cooperated heavily with pharmaceutical companies and independent experts (CDC 2014d). On the global level, the WHO approved early-stage clinical tests of experimental drugs in light of the disease severity and the "high level of public fear and anxiety" (WHO 2014f,g).

When it became clear that no vaccine would be ready before 2015 however medicalisation responses began to lose out against growing public anxiety and demand for securitisation alternatives (WHO 2015f). While frames of medicine continued to be applied by several actors, a significant increase in securitisation frames can be observed from September 2014 onwards. It marks the beginning of phase II of collective action, when securitisation moves largely crowded out medicalisation frames.

Economics

Albeit less publicly visible, economics frames played an important role in both the protraction and stimulation of a collective response. Leaked internal WHO documents only recently revealed that economic considerations might have caused the WHO to hold off an emergency declaration in the build-up of the crisis (Cheng & Satter 2015). It appears the organisation was

well-aware of the potential scale of the outbreak, but hesitated to officially acknowledge it due to concern over the economic consequences on Ebola-affected countries (ibid.).

Whilst economics merely formed the underlying frame for WHO (in)action up to August 2014, it soon became a catalyst for the international crisis response. In September the UN warned of the severe impact of the outbreak on food prices and thereby further sparked public demand for action (FAO 2014). Additionally the WHO declared the containment of Ebola a matter of resources (WHO 2014f). This is particularly relevant in consideration of securitisation frames that fuelled a sensation of crisis and urgency. As WHO shortcomings and capacity gaps were picked up by the public sphere around the same time, one could argue that the organisation reacted to accountability ties, and thus attempted to pre-empt public discontent. The combination of framing Ebola as a severe international threat and its containment as a matter of resources certainly contributed to the beginning of actual collective action in the form of a pooling of resources and boots on the ground. Economic frames consequently helped to overcome capacity asymmetries and thereby rendered an international response possible.

Human Rights

Similar to the case of SARS, the human rights discourse played a minor role amongst competing frames during the Ebola outbreak. NGOs unsurprisingly took the lead in applying human rights frames as moral leverage on governments and the WHO. Accounts of 'collective irresponsibility' were quite common from August 2014 onwards (Nierle & Jochum 2014). Rights frames argued that the security-focussed Ebola response denied basic human rights and pointed out the human consequences of border closures and quarantines, as both prevented access to health workers and GPGH (ibid.; Oxfam 2014).

Human rights framing can however likewise be found amongst policymakers. In early September 2014 the UN Food and Agricultural Organisation (FAO) framed Ebola as a threat to

livelihoods and basic human needs, which could be argued to underline the danger for both basic human rights and human security (FAO 2014). In the same month, preceding material securitising moves, the UN applied human rights frames in its resolution establishing UNMEER. The UNSC situated the epidemic in a "wider political, security, socio-economic and humanitarian dimension[...]" respectively (UNSC 2014). It is striking however that national governments largely refrained from using rights frames, and instead focussed on the threat aspect of the disease via a 'humanitarian disaster'-rhetoric. Merely a few single states spoke of moral and cosmopolitan obligations, humanity's "debt" to Africa (Cuba), and the need for "solidarity" (Morocco) (ibid.).

Human rights arguments curiously only permeated domestic constituencies and the media subsequent to the launch of collective action. When according public voices emerged from November 2014 on, the respective rights frames however carried a heavy accountability-focus as they raised questions about equality, and neglect of moral and legal responsibility. After the media began to highlight WHO shortcomings and obstacles to an international Ebola response in September, it soon picked up on corporate reluctance to press ahead in vaccine research, as pharmaceutical companies hesitated due to the slow-down of case incidents and remaining infections mostly in low-income countries (BBC 2014b; Doyle 2014; Lloyd 2014). The multiplication of rights frames in the public sphere possibly correlates with strong political moral statements. The WHO respectively expressed its concern about corporate "commercial considerations" outweighing saving lives (Lloyd 2014). Similarly, UN Secretary-General Kofi Annan publicly condemned the fortress mentality of the West, as he traced back the initiation of collective action to Ebola cases in advanced economies (BBC 2014b). There are of course links to development frames here, but the moral indignation about the protraction of collective action and measures for crisis-resolution renders it impossible to dismiss human rights frames. While it goes beyond the scope of this paper to assess the course of the crisis management in

2015, it appears human rights frames reflect a growing constraining dissensus on the international level and marked the beginning of 'politics of accountability' by the public sphere.

Development

In the build-up of the Ebola crisis and the first phases of the international response, development frames provided strong means for 'politics of accountability', exercised by both the public sphere and policymakers. First, and mostly applied by the public sphere, they increased pressure to act on policymakers, often in conjunction with human rights arguments. By late August 2014, NGOs and experts framed the slow international response to Ebola in West Africa as a consequence of Western predominance of collective action, and an according lack of interest in the developing world (Nierle & Jochum 2014). As the crisis wore on and it became progressively clear that the international response was significantly flawed, global development frames multiplied. In October Kofi Annan pointed to the development bias and neglected global responsibility of politicians when he stated that "[…]the international community really woke up when the disease got to America and Europe." (BBC 2014b). The media echoed these development frames a few weeks later when they framed the slow progress in vaccine research as lacking interest of Western companies to invest in a cure for a 'developing world'-disease (Lloyd 2014). In contrast to such deliberate framing, domestic constituencies indirectly contributed to the emergence of development accounts. Heightened anxiety soon provoked trends of xenophobia amongst many citizens in the Global North (Okolosie 2014; Sanburn 2014). The public 'othering' of Ebola as a crisis largely limited to West Africa and its citizens possibly raised the expectations of national measures, maybe not to fully contain the epidemic but to at least keep it out of the 'own' country.

In this context, political development frames reflect such public accountability politics. From October onwards many governments claimed that (infra-) structural deficiencies in West

Africa presented the main reason for the rapid spread and large scale of the outbreak (Salaam-Blyther 2014). On an international level, the WHO explained the response protraction and inefficacy with a "formidable combination of poverty, dysfunctional health systems, and fear" in West Africa (Chan 2014:1185). Although it expands beyond the scope of this paper, there is evidence that development framing continues to play an important part in accountability politics after 2014. In an official statement in early 2015, Dr. Margaret Chan, the WHO's Director-General, referred to "[f]actors of culture, history, geography, and weak road and health infrastructure[...]" as creating " a mix of opportunities that the virus quickly exploited." (Chan 2015). Whether these arguments can constitute an effective strategy for accountability politics *vis-à-vis* the public sphere remains yet to be seen when the outbreak is finally contained.

In A Nutshell

The case of the 2014 Ebola outbreak confirms the initial hypothesis about the influence of the public sphere on international collective action. As long as the epidemic was off the radar of large parts of the global public sphere, the WHO underplayed the crisis and framed it as a relatively small medical issue. Securitisation and crisis-augmentation frames remained limited to NGOs and experts until late July 2014 when the disease had already been raging for five months. It is striking that official international crisis-acknowledgement in August, coincides timely with beginning public attention and growing anxiety. From July through November a steady increase in public fear across foreign populations can be observed. This paper argues that the international response to the outbreak was a reaction to this development and can be divided into two phases.

Phase I of collective action set in when the WHO declared Ebola an international health emergency in August. The following weeks until October can roughly be attributed to phase I of the global response. It was marked by crisis-acknowledging frames amongst policymakers.

In this phase however action mainly took place in the realm of medicine as politicians engaged in heavy medicalisation moves by funding research on the disease and potential remedies. By contrast securitisation remained largely limited to speech acts, as political discourse securitised the outbreak but triggered little actual security-focussed measures.

This changed drastically when the collective response to the outbreak moved to phase II around October 2014, and reversed the dominant frames and their roles. As medical measures had proven ineffective, security frames multiplied and political action shifted from medicalisation moves to securitisation moves. Airport screenings, quarantines, and further publicly visible health measures were introduced nationally, while globally the WHO and the UN pooled GPGH, and deployed troops to West Africa to support local containment efforts.

This paper sees a striking correlation between these phases of collective action and the underlying waves of public anxiety and crisis-affirming frames. A look at the further course of the Ebola response would arguably confirm these findings. There is a further timely coincidence between the slow-down in case incidences at the end of 2014, a decline in public fear and scrutiny outside of West Africa, and an abatement of collective capacity-engagement and containment efforts. Despite stable or declining infection rates in many affected countries, weekly case incidences accordingly increased again for Guinea, Liberia, and Sierra Leone in early 2015 (cf. CDC 2014). Further research focussing on the international crisis management in 2015 would be necessary to identify the dominant frames and possibly confirm the correlation between diminished public pressure and a decrease in collective action.

5. Discussion and Conclusion

This paper has attempted to show how meaning-making via framing and politicisation can impact sense-making and thereby international crisis management. Accountability ties between

policymakers and the public sphere can arguably better explain political responses to pandemic crises than rational situational assessments. While the process of frame competition is certainly important, the paper has focussed on its outcome: the effect of frames on collective action. The cases of SARS and Ebola demonstrate that public health is crucially subject to politicisation, as medical and technical problems are 'translated' into a social context that is dominated by security-concerns. In both outbreaks, domestic and international public pressure and expectations largely determined which frames policymakers chose.

As SARS had been previously unknown when it broke out in early 2003, high levels of scientific uncertainty and public anxiety exerted significant pressure on policymakers to react quickly and capture public concerns. The unprecedented collective containment effort cannot be justified by infection rates since the epidemic focussed largely on China after an initial outside spread. By contrast the impact of the public sphere can explain the rapid global response to SARS. SARS illustrates how a large degree of convergence between public pressures can help outcompete existing rival frames and enhance collective action. Early Chinese frames that sought to downplay the crisis via medical and economic arguments were rapidly outcompeted by an overwhelming majority of crisis-affirmative securitisation frames that emerged on domestic and international levels.

On the contrary, the collective response to Ebola was dragged out, arguably due to a lack of public pressure, as crisis-affirmative accounts remained few and limited in the first few months of the outbreak. Opposite to SARS, Ebola had been around for decades, and hence— when public calls for action set in—the international response initially focussed on medicalising the disease, reacting to public concerns about the absence of a cure. Public sphere frames are moreover reflected in the second phase of global crisis management. Subsequent to the multiplication of securitisation accounts of Ebola by various non-state actors and domestic

constituencies, political collective efforts moved on to large-scale military and non-medical countermeasures.

Notwithstanding the success of public accountability politics on policymakers—China specifically in the case of SARS, the WHO in the case of Ebola—other causal factors cannot be disregarded and certainly played a role as well for global frame convergence and collective action respectively. Further research into the strength of alternative explanations is needed. Power- and capacity-considerations may for instance also have had an impact on China's frame shift, since the main resource burden of collective action was shouldered by the UK and the U.S., not China (Wallis & Nerlich 2005). Likewise, the main burden of the international Ebola response was carried by the U.S., and may have exerted pressure on other governments to step up their own contributions. This paper consequently suggests additional studies to test the validity and weight of its arguments for broader global governance processes. As SARS and Ebola represent a specific type of crisis (health/pandemic), future case studies could assess the hypothesis across different kinds of crises (natural or endemic, economic, humanitarian, financial).

However, the arguments made in this paper already carry certain validity. The links between accountability, the public sphere and politics have been highlighted continuously in academic discourse and are well-established. Additionally global governance and diplomatic crisis literature has been pointing out the deficiencies of state-centric analytical perspectives to global processes today. Nevertheless crises have mostly been examined from an actor-focused angle evaluating those at the heart of decision-making and diplomacy: policymakers. This paper asserts that there has been a neglect of taking into account the impact of the public sphere on crisis diplomacy and outcomes of interstate bargaining. It cannot be denied that the human element in crisis management makes completely rational action impossible in light of uncertainty. When faced with the complexity and uncertainty of unfolding crises that require

global governance, individual policymakers are highly susceptible to pressure from the public sphere. Evaluating competing interests and frames may therefore offer a more elaborate account of crisis management and collective action, as political frames become important as sense-making vehicles within broader global governance processes and can best explain policy responses.

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