

The Legbala River has its source in a plateau in the northern part of what is now the Democratic Republic of Congo. It runs westwards, joining the Dua River to form the Mongala, which then merges into the Congo. Since the colonial era the Legbala has been known by another name. In 1939, Belgian africanists wrote about this region, stating – in the matter-of-fact tone of empire – that only in the ‘mouths of indigenes’ you would hear the word Legbala: ‘in the geographical language we call it Ebola’.<sup>1</sup> This could well be another story of colonial erasure, were it not for the outbreak, in 1976, of an acute form of haemorrhagic fever in this region. Peter Piot, a scientist then working for the Antwerp Institute of Tropical Medicine, identified the disease and named it after the river – even though the outbreak had originated in a village called Yambuku, 60 miles away.<sup>2</sup> In 2014 Ebola became a globally-recognized word after another outbreak reached epidemic proportions.

What is in a (erased) name? Perhaps it is not so important when we consider the human suffering caused by the latest outbreak of the Ebola virus, which at the time of writing (October 2015) was still ongoing in Guinea and Sierra Leone after claiming more than 11 thousand lives – although the real figures are estimated to be two to three times higher. Nonetheless, this erasure is not insignificant. It can be seen as a metaphor for the ways in which the realities of the global South have been interpreted and addressed: violently suppressed during the colonial era and still mis-recognized. Systematic mis-recognition has led to forgetting or to the imposition of narratives that do not correspond to actual lived experiences. This in turn has impacted upon how injustices and suffering are dealt with.

Erasure and forgetting may seem unlikely starting-points for an analysis of the recent Ebola outbreak. After all, in recent months Ebola has commanded great media scrutiny and public attention, leading to the mobilization of vast human, material and financial resources from a broad range of international actors. Nonetheless, once we go beyond the ‘sound and

fury' of headlines, deeper layers of forgetting begin to reveal themselves. This article argues that media attention and a momentary political anxiety over a particular issue do not necessarily mean that the issue is being adequately addressed. In fact, media and political spectacles can be detrimental to addressing the complex nature of health issues. In the case of Ebola, the spectacle ultimately reflected and exacerbated the neglect that has historically surrounded this disease, as well as the needs and vulnerabilities of the populations that have been mostly affected by it.

The complex pattern of neglect in the case of Ebola must be understood alongside a broader analysis of existing global health governance mechanisms. This argument thus begins by exploring how health issues emerge as something to be governed (or ignored) at the international level. It then investigates the meaning of neglect and how it is produced, arguing that it emerges in the context of power-laden global structures and relations. Because of its deeply political character, neglect can persist under many guises and assume a structural nature – that is, one that exists independently of moments or cycles of attention. Cultural factors are paramount in this story, and the article makes the case for the importance of emotions, and not simply interests, in the definition of health policies and priorities. Specifically, the argument links neglect with an affective process of abjection. Applying these ideas to the case of Ebola, the article argues that the disease was framed as an exotic and racialized phenomenon, in addition to being enveloped in a media and political spectacle that overwhelmingly resulted in a short-term, 'crisis management' modality of response. Meanwhile, deep-seated neglect continued.

### **Neglect and the politics of global health**

How do health issues become matters of international political concern? Inversely, how do they fail to emerge as significant? Since at least the nineteenth century the world has witnessed the development of rules, regimes and institutions seeking to govern health at the international level.<sup>3</sup> More recently, scholars and policymakers have begun to speak of 'global health governance,' defined as the set of 'collaborative activities among states, IGOs, and NGOs that seek to influence the character of particular international problems'.<sup>4</sup>

The idea of global health governance signals an overwhelmingly optimistic outlook for the world's ability to recognize and tackle issues through increased international cooperation, coordination and consensus. For some, stumbling-blocks like insufficient coordination, inadequate allocation of resources or new demands mean that governance periodically readjusts itself in a 'punctuated equilibrium'.<sup>5</sup> Put differently, it adapts and transforms itself in order to better respond to external shocks. For others, governance develops along a 'challenge-response-innovation' continuum with three components: 'physical challenges to health, governance responses to these challenges, and the innovation called forth and needed in the face of new challenges when the old responses failed'.<sup>6</sup> These visions share a belief in the incremental development of cooperative mechanisms, supported by enhanced regulation, standardization of procedures, scientific and technological progress.

This optimistic view has clashed with glaring failures: acute inequalities in health provision, groups excluded from access to healthcare and huge discrepancies in health indicators.<sup>7</sup> One of the ways in which failure reveals itself is neglect, that is, the persistence of issue-areas that are given less attention (by policymakers, funders, the media or the public) than would be expected given their actual burden on individuals and societies. Neglect also pertains to the systematic exclusion of certain groups – defined in terms

of gender, age, race, sexual orientation or class – from the highest standards of healthcare available in a given society. Neglect shows that, for all its sophistication, global health governance is still unable to identify and tackle the problems faced by a significant percentage of the world's population – particularly the problems of the poor and underprivileged.

Neglect is often assumed to be an epiphenomenon of the interests of powerful actors and donors. These interests would shape incentives to commit funding and resources, thus helping to determine what is present (and absent) in the agenda. In this sense, neglect is a function of marginality and lack of power – it is determined by the relative position of the state, region or group in question within global political and economic structures. Whilst this view can be helpful when explaining the reasons why certain issues end up being neglected, it does not tell us much about how interests are formed in the global health agenda. What are the political, social and cultural processes that enable actors' interests to be defined in such a way that certain issues and groups end up being overlooked or inadequately addressed? As Simon Rushton and Owain Williams have put it:

what the literature has not generally done is to interrogate the reasons why these failures continue to be reproduced... The literature frequently tends to jump from describing the institutional architecture to the 'end product' of a policy process without really addressing what structures and determines the policy process.<sup>8</sup>

The question is not simply about identifying the interests that are supposedly at the roots of neglect, but rather about probing into the practices of mis-recognition and erasure that enable these interests to be formed. In other words, understanding neglect requires one to consider the politics of problem definition, that is, the processes through which certain issues become problems whilst others do not.

As Murray Edelman has argued, 'problems' are not self-evident realities but rather 'ambiguous claims' advanced by different groups, 'each eager to pursue courses of action and call them solutions'.<sup>9</sup> These claims are themselves underpinned by narratives that structure reality in certain ways. Donald A. Schön and Martin Rein have used the term 'frame' to refer to these narratives, conceiving policy debates as 'disputes in which the contending parties hold conflicting frames', the latter determining 'what counts as a fact and what arguments are taken to be relevant and compelling'.<sup>10</sup> Frames shape the nature of 'problems' and 'solutions' by ordering reality in a certain way; they

select for attention a few salient features and relations from what would otherwise be an overwhelmingly complex reality. They give these elements a coherent organization, and they describe what is wrong with the present situation in such a way as to set the direction for its future transformation.<sup>11</sup>

Interests, then, should not be taken as given. It is true that frames can be used to advance interests, but frames also shape interests. According to Schön and Rein, 'it is the frames held by the actors that determine what they see as *being* in their interests... [t]heir problem formulations and preferred solutions are grounded in different problem-setting stories rooted in different frames'.<sup>12</sup>

The corollary is that problem-definition is not merely a value-neutral exercise of identifying self-evident problems. Problems emerge as significant not just because they are 'there', but also because they reinforce assumptions about what is important. Policy choices 'are always statements of values, even if some value positions are so dominant that their influence goes unexamined or so unrepresented that their neglect goes unnoticed'.<sup>13</sup> For Edelman, problem definitions create or reinforce 'beliefs about the relative importance of events and objects', with the result that they end up constructing 'areas of

immunity from concern'.<sup>14</sup> Considering the processes of framing and problem-definition that give rise to certain policy decisions thus allows one to discern how other areas suffer from an absence of policy.

Colin McInnes and Kelley Lee have used framing to look at global health, arguing that visions of the latter reflect 'a particular dominant narrative or set of narratives emphasizing certain types of risks, the interests of certain population groups, the way in which the global nature of the problem is defined, and the need for certain high-level political responses'.<sup>15</sup> A similar point is made by Rushton and Williams, who have suggested that health policies result from the interaction of frames (the 'cognitive foreground') and paradigms, or broad sets of meanings and beliefs from which actors draw when framing health issues (the 'cognitive background'). They write:

In framing an issue, in a particular way, an actor... connects it with a set of deeper paradigms that form the ideational underpinnings of global health governance. These paradigms influence (often unconsciously) the ways in which actors think and talk about global health problems.<sup>16</sup>

Importantly, Rushton and Williams recognize the role of agency and power in this process and argue that the distribution of material and ideational resources impacts upon the capability to frame health problems.

The idea of framing has also been used to study issue-prioritization in global health. Here, Jeremy Shiffman has argued that the ascendance of an issue in the scale of priorities depends, in a first moment, on 'ideational portrayal', that is, on the effective communication of the importance of a certain issue 'in ways that appeal to political leaders' social values and concepts of reality'. In a second moment, institutions are required that can promote and sustain such portrayals.<sup>17</sup> In a previous work, Shiffman and

Stephanie Smith identified a number of factors shaping prioritization, organizing them along four categories: the power of the actors putting forward a particular issue as a health priority (which includes their cohesion, the level of mobilisation around the issue, the existence of a strong leadership and of sustaining institutions); the strength of the ideas, that is, their internal coherence and resonance; the political context, which includes propitious moments for these ideas to be mobilized, as well as a structural context in which they can be mobilized and received; and, finally, the characteristics of the issue, and the possibility of making a credible case for its severity and for the effectiveness of the measures to address it.<sup>18</sup>

By revealing health agendas as sites of framing and political contestation, this literature has begun to unpack interests and policy-agendas in global health. It provides tools for the analysis of issue-prioritization, allowing for an assessment of how certain issues receive attention. More needs to be said, however, about the 'dark side' of agenda-setting: the processes by which issues are left out and made invisible. In order to explore this dimension, the meaning of neglect must first be clarified.

### **The meaning of neglect: harm and vulnerability**

Neglect is a layered concept, which includes not simply the disregard for a certain issue, but also the failure to care in an adequate way – even if such issue is not completely disregarded. In turn, 'to care' may mean different things. On the one hand, it can denote a feeling of empathy: to see a certain problem as something important, something that matters not just for oneself but also for others. On the other hand, 'to care' can also mean to act in a way that effectively tackles the problem. As a result, neglect can pertain to different situations: one in which the issue is simply disregarded (neglect by invisibility); another in which the issue is regarded but not considered

important (neglect by apathy); and yet another in which the issue is considered important but decisive action to address it is not undertaken, either because actors with the ability to shape outcomes are not willing to act (neglect by inaction) or are not acting in an adequate way (neglect by incompetence).

It thus becomes clear that neglect is more than just the invisibility of an issue. It is also about a moral landscape in which that issue is deemed as something that does not matter, and about a political arena in which effective solutions are not imagined and mobilized. By placing neglect within a moral and political context, this understanding also allows us to reach an important preliminary conclusion: neglect does not just happen; it is made to happen. At the crux of the production of neglect it is always possible to locate human agency and choices. Issues are rendered invisible in certain ways, by certain actors and following certain purposes. Along similar lines, neglect by apathy is the result of processes that shape the sphere of moral obligation – apathy is in fact a denial of empathy and a failure to care about the plight of others. In turn, neglect by inaction is not simply absence of action – rather, it can be more aptly described as denial of response. Finally, neglect by incompetence also forces us to consider how resources are allocated and to question why adequate responses are not devised or applied.

As has been mentioned, neglect pertains not simply to particular diseases, but also to determinants (economic, social, infrastructural) and to groups. A disease can be considered neglected when it is not studied well enough, for example, or when decisive steps are not taken to address it (neglected tropical diseases would be an example). A determinant is neglected when its role in outbreaks, disease incidence or people's ability to deal with the occurrence of disease is not recognized or addressed (for instance, the quality of health-systems). A group is neglected when it is systematically placed in a position of vulnerability to disease, or is excluded



from high-quality and affordable healthcare (example: undocumented migrants).

In sum, neglect can be defined as a sustained process of making invisible a problem or condition, and/or the denial of resources necessary to understand or address it – this being at odds with the burden that this problem or condition has on individuals and societies. Neglect can happen as a combined effect of the actions/inactions of different actors: policymakers, donors, the media and the general public.

This discussion points to the importance of seeing neglect as intertwined with broader dynamics of harm and vulnerability. On the one hand, neglect is a form of harm and also acts as a multiplier of harm. Harm is conceived here as more than a physical injury – that is, the occurrence of a particular disease and its lasting effects. Harm also pertains to other kinds of injuries. One of them is psychological harm related to the stigmatization and disrespect for the dignity of those suffering from neglected health problems. It is also possible to speak of a public dimension of harm, which pertains to damage being done to the very institutions that are responsible for avoiding harm. In this sense, neglect reinforces public harm by leading to the absence of adequate mechanisms and institutions that can prevent and tackle certain diseases. Finally, we can talk of structural harm in relation to neglect: this pertains to situations when groups are neglected not exactly by the absence of rules and institutions, but rather by the fact that existing ones are skewed and place groups in positions of subordination or disadvantage.<sup>19</sup>

On the other hand, neglect is connected with vulnerability: a group's or individual's susceptibility to harm, but also the inability to 'bounce back' and deal with harm. Neglect is an important factor in the reproduction of vulnerabilities because it entails differentiated exposure to disease and an unequal distribution of capabilities to deal with it. The neglect of a certain disease may lead to less resources being available for prevention and cure,

and therefore to immediate vulnerabilities, that is, to more people being exposed. Vulnerability may also be potential, when individuals or groups are socially and economically positioned in such a way that their health is prone to being inordinately affected by the slightest changes in circumstances and by decisions they cannot control or predict. These potential vulnerabilities go a long way in determining the incidence of a disease and its ability to decisively impact – or even cut short – the lives of those affected.<sup>20</sup>

It becomes clear that neglect involves the existence of groups that are systematically privileged in relation to others; and the presence of unequal relationships. Importantly, because neglect materializes in both immediate and more structural forms of harm and vulnerability, overcoming neglect necessarily encompasses more than superficial attention. The latter can only be expected to manage or contain immediate forms of harm and vulnerability, whilst leaving deeper problems intact.

### **The production of neglect: abjection**

This article has stressed the importance of the ideas that construct health problems in certain ways, whilst foreclosing other kinds of framing. Understanding the production of neglect requires an engagement with the broad political imagination in which certain policy options emerge as possible and desirable. Common explanations of neglect, focused as they are on rational actors that bring their (predefined) interests to the table in a strategic effort to maximize their own utility, often overlook an important dimension of the political imagination that enables neglect. This dimension is affect.

Emotions play an important role in world politics.<sup>21</sup> Neta C. Crawford has argued that the role of emotions can be witnessed at different levels. On the one hand, emotions impact upon actors' perceptions of others' motives, thus shaping the content of relations. On the other hand, emotions also have

effects at the level of cognition, that is, on actors' definitions of their interests and courses of action. This is because emotions influence the processes through which actors gather and process information about their environment; their calculation of risks, costs and benefits; and their ability and receptivity to dialogue with other actors.<sup>22</sup>

Research on emotions usually considers engagement, that is, how actors establish relations within an affective context. The analysis suggested here is somewhat different: it assesses how emotions foster non-engagement or disengagement. Crucial for an affective analysis of neglect is abjection, defined as the act of casting away something or someone, but also to the process of debasing or rendering despicable. Abjection refers to the dynamics through which certain groups are framed or emerge as alien (that is, outside the sphere of moral obligation); disgusting (triggering an unpleasant emotional reaction); and beyond any possibility of improvement. Abjection is an unavoidable feature of the cultural context in which certain groups are made invisible and some actors become emotionally desensitized to the needs and suffering of less privileged others. This understanding of abjection allows us to place the focal point squarely on groups: it is not simply about neglected issues, but also about the invisibility of certain groups as they are affected by these issues.

Julia Kristeva engaged with the concept of abjection whilst discussing subject-formation. Departing from other psychoanalytical writings, she argues that our subjectivity – sense of self – is sustained not by desire but by the exclusion of others. Nonetheless, exclusion is not the same as objectification, given that between the subject and the object there is still a bond of desire. The relation between the subject and the object is more complex than that. Kristeva writes:

There looms, within abjection, one of those violent, dark revolts of being, directed against a threat that seems to emanate from an exorbitant outside or inside... It beseeches, worries, and fascinates desire, which, nevertheless, does not let itself be seduced.<sup>23</sup>

Abjection is presented as an ambiguous fascination, insofar as the abject is something that simultaneously beckons and repels. As Kristeva notes:

abjection is above all ambiguity. Because, while releasing a hold, it does not radically cut off the subject from what threatens it... But also because abjection itself is a composite of judgment and affect, of condemnation and yearning...<sup>24</sup>

The abject, then, lies at the margins of the self and emerges as its opposite. However, the abject is not completely separable because it permanently unsettles and threatens to disrupt the integrity of the self. As Iris Marion Young put it, the abject 'provokes fear and loathing because it exposes the border between self and other as constituted and fragile, and threatens to dissolve the subject by dissolving the border'.<sup>25</sup>

The importance of abjection for an analysis of neglect can be gleaned in Young's account the mechanisms of oppression, which for her is 'enacted through a body aesthetic, through nervousness and avoidance'.<sup>26</sup> According to Young, instances of oppression like racism and sexism persist despite the adoption of anti-discrimination laws by becoming embodied and unconscious. In her words,

oppression persists in our society partly through interactive habits, unconscious assumptions and stereotypes, and group-related feelings of nervousness and aversion. Group oppressions are enacted in this society not primarily in official laws and policies but in informal, often unnoticed and unreflective speech, bodily reactions to others, conventional practices of everyday interaction and evaluation, aesthetic judgments, and the jokes, images, and stereotypes pervading the mass media.<sup>27</sup>

For Young, interactions between groups are underpinned by emotional dynamics of attraction and aversion. Specifically, oppression is supported by a process through which certain groups are rendered abject – that is, different, alien and loathsome. She writes:

When the dominant culture defines some groups as different, as the Other, the members of those groups are imprisoned in their bodies. Dominant discourse defines them in terms of bodily characteristics, and constructs those bodies as ugly, dirty, defiled, impure, contaminated, or sick.<sup>28</sup>

In sum, when thinking about neglect in global health one must engage with the cultural and emotional processes through which interests are defined in tandem with an anxiety over (certain kinds of) groups and bodies. These groups and bodies are not simply marginalized or excluded. They are portrayed as morally tainted and a source of moral pollution. They are also deemed irredeemable, beyond possibilities of improvement. Taken together, these features mean that abject groups are placed outside the sphere of moral concern.

### **Framing Ebola: security and crisis**

The neglected, then, is the abject. It may be invisible but it is not totally absent. In fact, the neglected can be present – albeit in specific ways. The 2014 Ebola outbreak can be seen as a powerful illustration of how neglect yields a particularly complex combination of visibility and invisibility. At first glance, this would seem to be an issue that emerged out of neglect. But once we go beneath the veneer of superficial attention, neglect begins to reveal itself in its multifaceted nature.

The outbreak began in December 2013 in Guinea, with the WHO being officially notified in March 2014.<sup>29</sup> After international pressure, the WHO declared Ebola a 'public health emergency of international concern' in August of that year.<sup>30</sup> The following month, Médecins sans Frontières made an appeal for a robust civilian and military intervention to tackle the epidemic.<sup>31</sup> This framing of the outbreak raises a number of questions. To begin with, there was insufficient recognition on the part of the media, the public and even certain policymaking sectors that this was not a 'new' or 'unprecedented' challenge. Even though Ebola was, up until recently, a minor issue in the global health agenda, it is far from new. Between 1976 and 2012 there were 28 reported outbreaks of the virus in several African countries – namely Cote D'Ivoire, Democratic Republic of Congo, Gabon, South-Africa, Sudan and Uganda. Due to systematic underreporting, it is almost certain that the total of 2387 cases and 1590 deaths in these outbreaks is but a portion of the actual number of casualties.<sup>32</sup> Ebola has been a recurrent problem in some regions of the African continent in the past decades – more precisely, it has been allowed to remain a problem.

Even though the WHO knew of this long history of Ebola outbreaks, it ended up framing the outbreak using the same tools used for dealing with 'emerging infectious diseases'. By declaring the outbreak a public health emergency the WHO was doing more than just describing a problem – it was inscribing Ebola as a particular kind of problem. The figure of the 'public health emergency of international concern' is part of the 2005 International Health Regulations and typifies a novel way of approaching health issues in the international sphere. In this new reasoning, the focus is placed not on actual diseases but more precisely on 'events' that can constitute future risks. As Lorna Weir and Eric Mykhalovskiy have argued, we have witnessed a 'fundamental shift from surveillance of the certain to vigilance of public health risk'.<sup>33</sup> This introduces a strong 'interpretive dimension' into the

reporting of health issues, which are conceived as 'both known and unknown'.<sup>34</sup> There was not only a strong subjective dimension in the framing of Ebola, but also the recognition that what mattered in the response was not simply what was happening on the ground, but also what could be envisaged to happen – the scenarios that were developed around the disease.

In practice, Ebola was framed as an emerging crisis and configured as a risky event that demanded the calculation of an unknown future. This happened to the detriment of seeing the outbreak from a broader perspective, that is, as the result of a series of events and conditions that stretch out into past choices and inactions. Seeing Ebola as an emerging crisis hindered a comprehensive engagement with the conditions that gave rise to the problem in the first place. What of the social and economic conditions that have turned Ebola into an endemic feature of this region? And the weak and inefficient health systems that have rendered some West-African countries unable to cope?<sup>35</sup> And the low levels of trust between politicians and the public, which, at least in the case of Liberia, seem to have considerably weakened the ability of health authorities to alter the trajectory of the epidemic?<sup>36</sup> Finally, what about the global context in which the outbreak emerged, and the structural inequalities therein?<sup>37</sup> These questions were not given sufficient attention and arguably are not receiving sufficient attention now, as the world turns to the development of pharmacological 'magic bullets' in the form of vaccines.

The reduction of Ebola to a discrete crisis event – and a risk potentially leading to a catastrophic scenario – was heightened by the underlying process of securitization that is visible in the call for a military intervention. According to the securitization perspective, an issue is securitized when it is framed or emerges as an existential threat demanding extraordinary (normally undemocratic) measures.<sup>38</sup> The securitization narrative is underpinned by a fear-based imaginary, which is concerned with the protection of the integrity of the political body in the face of exogenous

elements. The presence of a securitization modality goes a long way in explaining the preoccupation with securing borders, controlling international circulation and establishing sanitary cordons that characterized the response to the outbreak – which in turn echoes a long tradition of demarcation and self/other distinctions in the history of international health.<sup>39</sup>

The securitized modality of response interacted with the crisis narrative in the framing of the outbreak. The crisis narrative overlaps with securitization because the presence of an existential threat is also assumed. However, whereas securitization is underpinned by the externalization of threat (disease is something foreign to the political body that must be contained and kept at bay), the crisis narrative is more strongly focused on internal elements. Narratives of internal decay, degeneracy or vulnerability – and the anxiety they create – are an intrinsic element of the crisis narrative.<sup>40</sup> In the case of Ebola, this took the form of an anxiety about the uncontrollable nature of existing social and economic processes. The threat was not simply Ebola, but also the inherent vulnerabilities in the globalized world – particularly in its more developed regions – with complex networks in which humans, non-humans, goods and information circulate at great speed.

In sum, the framing of the Ebola outbreak contributed to rendering the phenomenon visible in certain – and very limited – ways. Both narratives were markedly solipsist: whilst in the securitization frame the primary concern was the protection of the (Western) self vis à vis a threatening other, in the crisis frame the emphasis was laid on the inherent vulnerability of the self, which left it exposed to disruption. In both cases, the regions, populations and individuals that were mostly affected by the disease were merely the background, or secondary characters, in a narrative about the West and its travails. Neglect thus manifested itself in the invisibility of the groups mostly affected by the disease, as well as of the social and economic conditions that made the outbreak possible.



## **Ebola and the faces of abjection**

The framing of the Ebola outbreak laid out the conditions for the abjection of certain groups. The same process that briefly brought the populations in West Africa to the limelight also shaped the limited ways in which they were seen: helpless victims, anonymous faces arousing momentary pity, distant others in wretched lands, reiterations of a familiar story of 'African despair'.

To start with, the framing of Ebola obfuscated the gendered nature of the problem. As Sophie Harman argues in her contribution to this Special Issue, women have been 'conspicuously invisible' in the framing and in responses to the outbreak. A similar point has been made by Olena Hankisvsky, who has called for the recognition of intersectionality in the analysis of Ebola. She writes:

the dynamics of the epidemic cannot be reduced to single foci or explanatory factors. Geography (including urban/rural location), race, gender, and socioeconomic status operate together in a synergistic fashion to shape the experiences of those affected...<sup>41</sup>

The perspectives of feminism and intersectionality question the quality of attention that Ebola received, allowing us to recognize how superficial it actually was. They highlight the extent to which the framing and coverage of the outbreak were not able to conceive its victims as something other than an undifferentiated mass. Concrete experiences, specific vulnerabilities and their social, economic and cultural background were largely overlooked.

In addition to this, there are elements to suggest that abjection was also present in the constitution of certain groups and practices as alien, exotic and disgusting. In August 2014, American weekly news magazine *Newsweek* ran as its cover story an alarmist account of the evolving Ebola outbreak. Instead

of privileging the unfolding human suffering in West Africa, the magazine chose to focus on the dangers of the import of 'bushmeat' into the US and Europe, the 'secret' trade of monkey meat that could become Ebola's 'backdoor' into the West. A similar story appeared in news outlets in the United Kingdom and Sweden. Ebola was thus linked to backward African practices that were deemed exotic and disgusting.<sup>42</sup> This corresponds to a broader process of racialization of this disease, which cannot be separated from the ensuing stigmatization of West Africans living in the West. As Kim Yi Dionne and Laura Seay have noted:

[t]he Ebola outbreak highlights ethnocentric and xenophobic understandings of Africa. Current American reactions continue a long history of viewing Africans and the African continent as a diseased, monolithic place. Framing Ebola as a disease that affects 'others' has a negative impact on attitudes toward immigrants as well as public health responses.<sup>43</sup>

The framing of Ebola in Western media cannot be separated from a persistent anxiety over certain kinds of groups, their supposedly different and disgusting behaviour, and the threat they present to the integrity of the political community. This was supported by an underlying narrative of the African continent as a place of 'tragedy', despair and helplessness, about which little can be done except preventing problems from spilling over to more ordered regions of the world. The same forces that attracted the attention of the West ultimately led to aversion.

In a clear instance of abjection, then, Ebola was framed as a racialized African problem deriving from backward practices and requiring a mixture of surveillance and containment. This happened to the detriment of seeing the outbreak as a problem of global health governance – of inequality, injustice and the systematic reproduction of the vulnerability of certain groups.

Neglect thus manifested itself in the re-inscription of the conditions for apathy and inaction. As populations in West Africa were placed outside the sphere of sustained moral concern, the framing of Ebola led to the denial of action that could address the deep-seated structures that were at the root of the problem.

### **The spectacle of Ebola**

By resulting in the abjection of West African populations, the framing of Ebola led to a modality of response based on crisis management: emergency preparedness, surveillance, control and containment. This reactive, short-term approach was made possible by the very nature of the media cycle: noise followed by boredom, hysteria followed by apathy, feeding off the short attention-span of contemporary consumer societies organized around 'the production and consumption of images, commodities, and staged events'.<sup>44</sup> As Douglas Kellner has noted, the advent of 24/7 news channels has meant increasing competition for ratings and advertising. This has forced information to be more exciting, more visual, fusing codes of entertainment into journalism. News coverage of events thus becomes more sensationalist; at the same time, it becomes superficial and short-termist, as high ratings require sources of excitement to be permanently recycled. It comes as no surprise that in Western media the Ebola outbreak ended up being treated as staged event, a dramatic occurrence punctuated by ritualistic moments: images from infirmary wards, nameless individuals in mourning, the health workers in biohazard suits, the rioting crowds, somber declarations in Washington and Geneva, the arrival of Western personnel. This is a familiar narrative, repeated countless times in news and films, and discarded as soon as its attention-grabbing effect starts to wear off.

This is also an age of social media, and social networking platforms like Twitter, Facebook and Instagram contributed to the visibility of Ebola. Once again, one needs to consider the kind of visibility that was afforded by these platforms, and to question the extent to which such visibility was in fact a form of obfuscation and abjection. A study of images posted in November 2014 with the 'Ebola' tag found that images on Instagram overwhelmingly treated Ebola as joke material (42%) or were unrelated to the disease (36% of images tagged 'Ebola' featured other things such as motorbikes). On Flickr, the situation was somewhat different, with a greater attention to health professionals (46%) but scarce attention given to images containing factual information (6%).<sup>45</sup> This survey provides further indication that Ebola became visible in ways that did not increase public awareness and engagement with the problem, but rather enabled its appropriation as a form of self-validation and entertainment.

Guy Debord's writings on the spectacle add an important political edge to this discussion of visibility enmeshed with distraction. Debord defined the spectacle not simply as the accumulation and consumption of images, but rather as 'a social relation among people, mediated by images'.<sup>46</sup> On the one hand, the spectacle says more about the dominant order that it does about the people and problems it refers to: as Debord put it, the spectacle is 'the existing order's uninterrupted discourse about itself, its laudatory monologue'.<sup>47</sup> On the other hand, the spectacle shapes how this dominant order engages with its 'others'. The correlative of the spectacle is the spectator – a passive, reactive and indifferent consumer of marketable images.<sup>48</sup> The excitement created around issues, by depending upon the repetition (and eventually discarding) of familiar tropes, becomes a veneer for banalization and forgetting.

This does not mean that the spectacle does not have political effects. Banalization becomes a depoliticizing tool that obfuscates the reproduction of

unequal relations and ultimately serves the interests of privileged groups. As Debord notes, the spectacle becomes a tool for domination:

The society which carries the spectacle does not dominate the underdeveloped regions by its economic hegemony alone. It dominates them *as the society of the spectacle...* <sup>49</sup>

Spectacles may be staged events, but their effects are very real for the individuals affected, inasmuch as they help to shape their position vis à vis those actors with the capacity to shape outcomes.

In the case of Ebola, the spectacle reinforced the different modalities of neglect mentioned above: invisibility, apathy, inaction and incompetence. The outbreak was made invisible by a ready-made narrative that said more about the developed world, its anxieties and needs, than about the actual disease and the populations suffering from it. The effect of framing Ebola through the prism of a spectacle was, paradoxically, that the problem receded in the midst of a succession of images. The spectacle may have brought Ebola to our screens, but it presented Ebola as a theatrical event and a spectator-sport. Whilst making us feel that we were face to face with it, it also created a reassuring separation. Thus, in addition to perpetuating apathy and inaction, the spectacle has foreclosed the development of adequate competences and long-term strategies for preventing and dealing with future outbreaks.

## **Conclusion**

Ebola is neglected. The 2014 outbreak in West Africa signified the re-inscription and entrenchment of this neglect. This article explored Ebola from the standpoint of neglect in global health, embedding the latter in the context of political structures and relations. It also argued that neglect should not be

considered mere invisibility, but rather a process of making something invisible and denying adequate response.

The standpoint of neglect is important because it helps us understand how Ebola was made invisible and why the response to this outbreak was inadequate. The argument emphasized the importance of the affective dimension, focusing in particular on the dynamics of abjection – a mixture of attraction and repudiation – that accompanies neglect and that was present in the case of Ebola. The article showed that the neglect of Ebola was paradoxically exacerbated by its enveloping in an intertwined narrative of security and crisis. This was supported by its framing as a media and political spectacle.

Understanding neglect can have a positive impact in responses to future outbreaks. Coming to terms with the complex processes through which neglect is produced is crucial for developing adequate response mechanisms. These certainly require short-term strategies aimed at containing crises, but also need to include the broader social, political and economic transformations that a lasting solution to the problem requires. This is why we need alternative framings of Ebola that consider power inequalities, the relations between groups and the production of harm, vulnerability and structural violence in the international sphere.<sup>50</sup> We also need to highlight the persistence of ‘mutually reinforcing systems of colonialism, racism, neoliberalism, globalism, imperialism, xenophobia, and sexism.’<sup>51</sup> These shape in a decisive way perceptions of health problems and of the moral worth of certain regions and groups – thereby impacting upon the incidence of disease and conditioning responses to it.

This article began with the story of a misnamed river, a metaphor of erasure. Unlike the river, the Ebola epidemic is not a natural phenomenon but a human-made one. Certainly, the virus is a natural entity, but the epidemic was allowed to happen and to develop because of human actions and

inactions. A river flows regardless of what we call it, but the trajectory of disease can and does change as a result of words, ideas and choices.

## Bibliography

- Benatar, S. (2015) "Explaining and responding to the Ebola epidemic." *Philosophy, Ethics, and Humanities in Medicine* 10, no. 1 (2015): 1-3.
- Bleiker, R. and Hutchison, E. "Fear no more: emotions and world politics." *Review of International Studies* 34, Supplement 1 (2008): 115-135.
- Buzan, B. Wæver, O. and de Wilde, J. *Security: A New Framework for Analysis*. Boulder: Lynne Rienner Publishers, 1998.
- Cooper, A.F., Kirton, J.J. and Stevenson, M.A. "Critical Cases in Global Health Innovation." In *Innovation in Global Health Governance: Critical Cases*, edited by A.F. Cooper and J.J. Kirton, 3-20. Farnham: Ashgate, 2009.
- Crawford, N.C. "The Passion of World Politics: Propositions on Emotion and Emotional Relationships." *International Security* 24, no. 4 (2000): 116-156.
- Debord, G. *Society of the Spectacle*. Detroit: Black & Red, 1983.
- Dionne, K. Y. and Seay, L. "Perceptions about Ebola in America: Othering and the Role of Knowledge about Africa". *Political Science & Politics*, 48, no. 1 (2015), 6-7.
- Edelman, Murray. *Constructing the Political Spectacle*. Chicago: University of Chicago Press, 1988.
- Epstein, H. "Ebola in Liberia: an epidemic of rumors." *New York Review of Books* 61 (2014): 91-94.
- Farmer, P. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley: University of California Press, 2003.
- Fidler, D.P. "The Globalization of Public Health: The First 100 Years of International Health Diplomacy." *Bulletin of the World Health Organization* 79, no. 9 (2001): 842-849.
- Hankivsky, O. "Intersectionality and Ebola." *Political Science & Politics* 48, no. 1 (2015): 14-15.
- Hay, C. "Crisis and the structural transformation of the state: interrogating the process of change." *The British Journal of Politics & International Relations* 1, no. 3 (1999): 317-344.
- Huber, V. "The unification of the globe by disease? The International Sanitary Conferences on cholera, 1851-1894." *The Historical Journal* 49, no. 2 (2006): 453-476.
- Kellner, D. *Media Spectacle and Insurrection, 2011: From the Arab Uprisings to Occupy Everywhere*. New York and London: Bloomsbury, 2012.
- Kristeva, J. *Powers of Horror: An Essay on Abjection*. New York: Columbia University Press, 1982.
- Kruk, M.E., Myers, M., Varpilah, S.T., et al. (2015) "What is a resilient health system? Lessons from Ebola." *The Lancet* 385, no. 9980 (2015): 1910-1912.



- Leach, M. "The Ebola Crisis and Post-2015 Development." *Journal of International Development* 27, no. 6 (2015): 816-834.
- Linklater, A. *The Problem of Harm in World Politics: Theoretical Investigations*. Cambridge: Cambridge University Press, 2011.
- Mackenzie, C., Rogers, W. and Dodds, S. "What is vulnerability, and why does it matter for moral theory?" In: *Vulnerability: New Essays in Ethics and Feminist Philosophy*, edited by C. Mackenzie, W. Rogers and S. Dodds, 1.29. Oxford: Oxford University Press, 2014.
- Martin, E. *Flexible Bodies: The Role of Immunity in American Culture From the Days of Polio to the Age of AIDS*. Boston: Beacon Press, 1994.
- McGovern, M. "Bushmeat and the Politics of Disgust." *Fieldsights - Hot Spots, Cultural Anthropology Online*, <http://www.culanth.org/fieldsights/588-bushmeat-and-the-politics-of-disgust> (2014), last accessed 16 October 2015.
- McInnes, C. and Lee, K. *Global Health and International Relations*. Cambridge: Polity Press, 2012.
- Médecins Sans Frontières. *MSF International President: United Nations special briefing on Ebola*, 2014. <http://www.msf.org.uk/node/26146>.
- Mercer, J. "Human nature and the first image: emotion in international politics." *Journal of International Relations and Development* 9, no. 3 (2006): 288-303.
- Price-Smith, A.T. and Huang, Y. "Epidemic of Fear: SARS and the Political Economy of Contagion." *Innovation in Global Health Governance: Critical Cases*, edited by A.F. Cooper J.J. Kirton, 23-48. Farnham: Ashgate, 2009.
- Rochefort, D. A. and Cobb, R. W. *The Politics of Problem Definition: Shaping the Policy Agenda*. Lawrence: University Press of Kansas, 1994.
- Rushton, S. and Williams, O.D. "Frames, paradigms and power: global health policy-making under neoliberalism." *Global Society* 26, no. 2 (2012): 147-167.
- Schön, D. A. and Rein, M. *Frame Reflection: Toward the Resolution of Intractable Policy Controversies*. New York: Basic Books, 1994.
- Seltzer, E. K. et al. "The Content of Social Media's Shared Images about Ebola: A Retrospective Study." *Public Health* 129, no. 9 (2015): 1273-1277.
- Shiffman, J. "A social explanation for the rise and fall of global health issues." *Bulletin of the World Health Organization* 87, no. 8 (2009): 608-613.
- Shiffman, J. and Smith, S. "Generation of political priority for global health initiatives: a framework and case study of maternal mortality." *The Lancet* 370, no. 9595 (2007): 1370-1379.
- Tanghe, B. and Vangele, A. "Region de la Haute Ebola. Notes d'histoire (1890 - 1900)." *Aequatoria* 2, no. 6 (1939): 61-65.
- Weir, L. and Mykhalovskiy, E. *Global Public Health Vigilance: Creating a World on Alert*. New York: Routledge, 2010.

- WHO Ebola Response Team "Ebola Virus Disease in West Africa — The First 9 Months of the Epidemic and Forward Projections." *New England Journal of Medicine* 371, no. 16 (2014): 1481-1495.
- Wordsworth, D. "How Ebola got its name," 2014. <http://www.spectator.co.uk/life/mind-your-language/9349662/how-ebola-got-its-name/>.
- World Health Organization "Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa," 2014. <http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/>.
- World Health Organization. "Ebola virus disease - Fact sheet N°103," 2015. <http://www.who.int/mediacentre/factsheets/fs103/en/>.
- Young, I.M. *Justice and the Politics of Difference*. Princeton and Oxford: Princeton University Press, 2011 (1990).
- Zacher, M.W. and Keefe, T.J. *The Politics of Global Health Governance: United by Contagion*. Houndmills: Palgrave Macmillan, 2008.

---

<sup>1</sup> Tanghe and Vangele, "Region de la Haute Ebola. Notes d'histoire (1890 – 1900)," 61, my translation.

<sup>2</sup> Wordsworth, "How Ebola got its name."

<sup>3</sup> Huber, "The unification of the globe by disease?"; and Fidler "The Globalization of Public Health."

<sup>4</sup> Zacher and Keefe, *The Politics of Global Health Governance*, 15.

<sup>5</sup> Price-Smith and Huang, "Epidemic of Fear."

<sup>6</sup> Cooper, Kirton and Stevenson, "Critical Cases in Global Health Innovation," 7.

<sup>7</sup> Farmer, *Pathologies of Power*.

<sup>8</sup> Rushton and Williams, "Frames, paradigms and power," 152.

<sup>9</sup> Edelman, *Constructing the Political Spectacle*, 15.

<sup>10</sup> Schön and Rein, *Frame Reflection*, 23.

<sup>11</sup> Ibid., 26.

<sup>12</sup> Ibid., 29, emphasis in the original.

<sup>13</sup> Rochefort and Cobb, *The Politics of Problem Definition*, 8.

<sup>14</sup> Edelman, *Constructing the Political Spectacle*, 12.

<sup>15</sup> McInnes and Lee, *Global Health and International Relations*, 34.

<sup>16</sup> Rushton and Williams, "Frames, paradigms and power," 148.

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- <sup>17</sup> Shiffman, "A social explanation for the rise and fall of global health issues," 610.
- <sup>18</sup> Shiffman and Smith, "Generation of political priority for global health initiatives."
- <sup>19</sup> Linklater, *The Problem of Harm in World Politics*, 49-61.
- <sup>20</sup> Mackenzie, Rogers and Dodds, "What is vulnerability, and why does it matter for moral theory?"
- <sup>21</sup> Mercer, "Human nature and the first image"; Bleiker and Hutchison, "Fear no more."
- <sup>22</sup> Crawford, "The Passion of World Politics."
- <sup>23</sup> Kristeva, *Powers of Horror*, 1.
- <sup>24</sup> Ibid., 9-10.
- <sup>25</sup> Young, *Justice and the Politics of Difference*, 144.
- <sup>26</sup> Ibid., 149.
- <sup>27</sup> Ibid., 148.
- <sup>28</sup> Ibid., 123.
- <sup>29</sup> WHO Ebola Response Team, "Ebola Virus Disease in West Africa."
- <sup>30</sup> World Health Organization, "Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa."
- <sup>31</sup> Médecins Sans Frontières, "United Nations special briefing on Ebola."
- <sup>32</sup> World Health Organization, "Ebola virus disease - Fact sheet N°103."
- <sup>33</sup> Weir and Mykhalovskiy, *Global Public Health Vigilance*, 126.
- <sup>34</sup> Ibid., 128, 136.
- <sup>35</sup> Kruk et al, "What is a resilient health system?."
- <sup>36</sup> Epstein, "Ebola in Liberia."
- <sup>37</sup> Benatar, "Explaining and responding to the Ebola epidemic."
- <sup>38</sup> Buzan et al. *Security: A New Framework for Analysis*.
- <sup>39</sup> Martin, *Flexible Bodies*.
- <sup>40</sup> Hay, "Crisis and the structural transformation of the state".
- <sup>41</sup> Hankivsky, "Intersectionality and Ebola," 14-15.
- <sup>42</sup> McGovern, "Bushmeat and the Politics of Disgust".
- <sup>43</sup> Dionne and Seay, "Perceptions about Ebola in America", 6.
- <sup>44</sup> Kellner, *Media Spectacle and Insurrection*, xiv-xv.
- <sup>45</sup> Seltzer et al., "The content of social media's shared images about Ebola".
- <sup>46</sup> Debord, *Society of the Spectacle*, §4.
- <sup>47</sup> Ibid., §24.
- <sup>48</sup> Kellner, *Media Spectacle and Insurrection*.

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<sup>49</sup> Debord, *Society of the Spectacle*, §57, emphasis in the original.

<sup>50</sup> Leach, "The Ebola Crisis and Post-2015 Development."

<sup>51</sup> Hankivsky, "Intersectionality and Ebola," 15.