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The Politics of Contagion

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The Politics of Contagion

In Partial Fulfillment of the Requirement for the Degree

Master of Arts

in

International Studies

by

Joseph Young

University of San Francisco

11/23/2016
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Under the guidance and approval of the committee, and approval by all the members, this thesis project has been accepted in partial fulfillment of the requirements for the degree.

Approved:

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Advisor                      Date

_____________________________  ________________
Academic Director        Date

_____________________________  ________________
Dean of Arts & Sciences  Date
Abstract

Contagion events have occurred throughout history leaving death and destruction in their wake. Often sensationalized in movies and shows such as Contagion and The Walking Dead, contagion events are life-altering events filled with gory symptoms and elevated mortality rates. The dangers of contagion events prompted governments to develop agencies with the purpose of preventing and mitigating the risks contagions pose. The Centers for Disease Control and Prevention (CDC) and other agencies across the globe pour millions of dollars each year into eliminating the risk of contagions and making the world a safer place. However, while more resources are dedicated to fighting contagion events than ever before, risk remains and new areas of tension are borne out of disease management.

The Politics of Contagion explores three recent contagion events and unpacks the consequences of each event. The Anthrax contagion of 2001, Ebola of 2014, and the current Zika outbreak are examined as well as the role of the CDC. The Politics of Contagion analyzes the role of policy via the CDC in contagion events and explores its effects or moments of tension. Moments of tension during contagion events can include the creation of risk groups, racism, and economic damages. While we have come a long way from the days of the Black Plague, this analysis highlights the areas where improvement is needed. From the media panic and hostility toward CDC-Ebola policies in 2014 to the current decline in tourism to Zika hotbeds, this text highlights the role policy plays in the creation of these moments of tension.

At the center of this thesis is Foucault’s argument that power resides in every area of life. If power indeed exists everywhere, then power must also lie in the CDC and its policies concerning contagion events. The power is exercised via CDC policies and recommendations and ultimately aids in the birthing of many moments of tension. These moments of tension echo beyond the borders of the United States, and flow throughout the global community. Through analyzing the CDC’s handling of the case studies included in this thesis, I unpack the moments of tension and argue the role of power in the policies, which have the unintended effect of aiding in the creation of moments of tension for both United States citizens and individuals beyond U.S. borders.
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The Politics of Contagion & Power in the Subtle
In the past century, the rise of the nation-state and increasing modes of globalization radically changed the world. From increased global technological connections to the birth of new economic superpowers, scholars have explored many of these changes and advancements. One major change in the past century, which is often overlooked by scholars, is the ways in which we manage and create policies concerning contagion events. At the conclusion of the Second World War, two major health organizations were created with health related purposes including the management and control of contagion events. One of these health governance agencies, the Centers for Disease Control and Prevention, is the focal point of this thesis and research on the politics of contagion.

The Centers for Disease Control and Prevention, or CDC, formed in 1946 in Atlanta, Georgia. The intention of the CDC is to manage disease from an United States-American perspective. In its mission statement, the CDC states to work “24/7 to protect America from health, safety, and security threats, both foreign and in the U.S.” and to “increase the health security” of America (CDC.gov: 2014). The CDC clearly established a link between health and security, which allows the organization to create policies designed to protect U.S. citizens from health-security risks. In the new millennium, a few large-scale contagion events erupted including Avian Bird Flu pandemic of 2009 and the Ebola epidemic of 2014. All recent contagion events had a strong CDC presence with the purpose of controlling the outbreaks to protect U.S.-American lives. The involvement of the CDC and its policies inspired the mission of this thesis, which explores the politics of contagion and epidemic events via the policies of the CDC. As this thesis explores the
politics of contagion, it unpacks the moments of tension that occur when disease and policies meet. Additionally, it highlights the power of the subtle that lives in the CDC policies, which can be an influencing factor in the creation of moments of tension.

Now, before we delve deeply into the research, it is important to define a few key terms that come up frequently in this paper. When I speak of contagion, I am referring to a transmission of a disease with life-threatening potential and how the disease is contained and controlled. By epidemic, I am referring to an upgraded level of contagion where the disease has now affected mass amounts of a civilian population and has crossed national borders where it is infecting new hosts (Young 2016: 2). The phrase “moment of tension” refers to an unpleasant situation that forms out of a number of factors including CDC policy. Examples of moments of tension can include but are not limited to instances of bias, fear-based behavior, and economic damages. Finally, the phrase, “power in the subtle,” refers to the impact seemingly insignificant or overlooked areas of life have in affecting groups of individuals or regions. Examples of subtle powers can include the language we use, our gaze, the things we omit, and countless others.

In highlighting the power of the subtle in the CDC policies, we can understand how moments of tension are birthed. We can also prepare more thoroughly for future contagion events and, hopefully, avoid creating the same moment of tension. It is my intent to show my reader the shades of gray that concern health policy and power. It is paramount that we understand how power can exist in any facet of life and how even the most well-intended policies can influence unpleasant events. It is equally important to
recognize the global power of the CDC and its policies whose consequences can cross borders and ripple across the globe. I hope my reader will take away from this text the importance of health agencies such as the CDC, and understand the areas where improvement can be made. We must manage the risk of contagion, but at the same time create policies that do not harm certain individuals who are sometimes caught in the tension where policy and health-security meet. Before we delve into the research, let us explore the scholarly discourse on the subject.

**Literature Review**

Scholars have crafted a diverse and in-depth body of literature that explores the complexities of the politics of contagion. From the management of major contagion events such as the Ebola epidemic of 2014 and the SARS crisis of 2003 to the historical realities of the phenomena of contagion including the history of the term contagion itself, there is an abundance of scholarly material that illustrates key elements of the politics of contagion. In my analysis of the body of literature encompassing the politics of contagion, I noticed a trend of discourse that, for the purposes of the literature review; I broke down into three categories. The themes of risk, fear, and sovereignty are the dominant players in the scholarly discourse of the politics of contagion. These three themes frequently interlock and give great insight into the complications and effects that are birthed from contagion situations. In these next few pages, I will unearth each theme and unpack many scholarly works that reside in each theme. Let us now explore the first and, perhaps, the dominant theme of risk and its relation to the politics of contagion.
Risk encompasses countless areas of life including natural disaster, warfare, and death. Of course, risk is also deeply intertwined with healthcare and the language of risk is used to highlight countless negative health effects. For instance, the number of cigarettes and the years an individual has smoked increases the risk of an individual contracting lung cancer (Mayo Clinic: 2015). Also, people who live in sunny climates or have had serious sunburns as a child are at a higher risk of developing skin cancer (Mayo Clinic: 2015). Whether it concerns health, disaster, or death it is clear that risk is usually used to describe a negative facet of life, and risk concerning the politics of contagion is no different. In fact, as we will soon see, based on the wide body of literature in this branch of the politics of contagion, scholars demonstrate that risk via contagion is quite broad with risk covering infection, death, and entire groups of human beings.

The creation of risk groups both within and outside the boundaries of a given nation-state increases during times of a contagion according to many scholars. Sargent and Larchanché explore the phenomena of the creation of risk groups based on health concerns in their text Disease, Risk, And Contagion: French Colonial And Postcolonial Constructions Of “African” Bodies. In their research, Sargent and Larchanché explore the lives of Sub-Saharan immigrants that relocated to France and the ultimate “public expressions of threats to national identity, stereotyping, and discrimination” that ensued (Sargent 2014: 458).

The authors researched both the colonial beliefs of an “infectious and contagious” African body and current media and scholarly articles that discuss a prevalence of “infectious diseases among the French immigrant population”, which in turn created a
risk group within French society (Sargent 2014: 462). The authors cite Tuberculosis as an example of how the Sub-Saharan immigrants became a risk group. In their research, the authors found a common belief that TB is a “disease of transplantation” and an “imported pathology,” which fed into the National Front Party’s anti-immigrant message of TB as an “imminent threat” to French society and presenting the Sub-Saharan African immigrants as a risk group of contamination (Sargent 2014: 462). Thus, the authors present a clear view of contagion situations and how groups can be targeted or deemed a risk to society based on health reasons.

Many other scholars explore the creation of risk groups because of contagion events including Polly Price. In her text, Infecting The Body Politic, Price explores the 2014 Ebola crisis and the history of barring immigrants with mental health issues to establish the existence of a risk group of the “undesirable immigrant” that is created on the basis of health (Price 2015: 919). Price illuminates a lack of legal framework to protect the risk group of the immigrant including the absence of a “right to travel” thus establishing that “no state or international organization must ensure that an unhealthy migrant can move from place to place” (Price 2015: 923). Essentially, Price highlights a series of gaps in international law that allow immigrants to be placed in a category of risk on the basis of health and to, ultimately, be treated differently from other groups in society.

When discussing the role of risk in the politics of contagion, it is paramount to bring up Nikolas Rose and his piece The Politics of Life Itself. Rose believes biopolitics is “bound up with the rise of the life sciences, human sciences, and clinical medicine” and
that “contemporary biopolitics is risk politics” (Rose 2007: 1). Rose shows how risk is deeply tied into health by illuminating risk profiling of individuals by the insurance industry. Rose shows how individuals are placed into risk groups based on genealogy, family history of illness, or behaviors such as smoking (Rose 2007: 8). From the current profiling of pregnant women at deemed at risk of a miscarriage to the sterilization of the “feeble minded” deemed a risk to the overall health of the population, Rose shows how risk based on health has been and is still used to treat certain groups differently than others (Rose 2007: 8).

Another scholar examines the role of risk group formation via contagion in a specific case study concerning an Ebola scare in Canada in 2001. Adeyanju, in his text *Not In Canada*, analyzes the case of a Congolese visitor in Ontario who was hospitalized in 2001 with suspected Ebola virus symptoms. In his research, Adeyanju explores the media reaction to the hospitalization and the ultimate tension that spread throughout the community. Adeyanju’s data yielded a high frequency of charged terminology including “Ebola” and “deadly” (Adeyanju 2010: 38). Furthermore, Adeyanju identified evidence of the creation of a risk group by “otherizing” the patient through “embedding the nationality of the patient in the headlines with the word Ebola” (Adeyanju 2010: 40). Thus, Adeyanju establishes the formation of a risk group based on contagion fears and shows how a racial element can become involved in oppressing the risk group; so much so that ultimately a white supremacist group protested outside the hospital of the patient (Adeyanju 2010: 34).
Finally, when examining risk group creation via contagion, it is necessary to explore the psychology of a population during a contagion event. Robin Goodwin explores this branch of psychology in the text *Initial Psychological Responses Influenza A, H1N1* and questioned populations in Malaysia and Europe to find out the populations' perceptions of a few traditional risk groups during times of contagion. The data yielded results of a majority of the Malaysian sample group believing that the homeless and prostitutes carried a higher risk of contracting H1NI than other groups (Goodwin: 2009). Furthermore, the study highlighted that 71 percent of the Malaysian sample group was at least “somewhat concerned” about contracting the virus (Goodwin: 2009). Thus, the study illustrated that judgment on particular “out groups” during times of pandemic could have “implications for the equitable treatment” of the above groups (Goodwin: 2009).

In the discourse surrounding the politics of contagion, risk groups are a main feature and the notion of risk group creation is deeply connected with the second branch of fear. Much of the discourse on the politics of contagion identifies the usage of contagion events as a tactic for fear. The fear that erupts in contagion events can ultimately link with the branch of risk group creation because fear can create a hysteria that can cause bias against groups that are perceived to be a health threat to the general population. Many scholars have analyzed the role of fear in contagion situations and solely focus on the element of fear and not the birth of risk groups. One such author is Martin Pernick, who explores the historical realities of the term contagion and the fear factor that surrounds the term.
In his text, *Contagion And Culture*, Pernick shows how deeply rooted negativity is in the term contagion by illuminating its history, which includes a connotation with “sin and grief” (Pernick 2002:860). Pernick also explores the role of fear in relation to “epidemics and panic” including a direct linkage with disease (Pernick; 2002:861). According to Pernick, it was not uncommon to see “died of fright” on death certificates as recently as the 19th century (Pernick 2002:861). Also, Pernick illustrates how fear and “mass hysteria” almost always accompany epidemics including the Black Death and particularly deadly cholera years (Pernick 2002:861). Pernick argues that “other people” perceived as the source of contagions such as outsiders, immigrants, and minorities can be targeted during an outbreak event (Pernick 2002: 862). Thus, Pernick is able to identify the bond of fear and contagions and link it to the first branch of the creation of risk groups via contagion.

Magnusson and Zalloua also discuss the relation of fear and contagion in their text *Contagion: Health, Fear & Sovereignty*. Magnusson and Zalloua highlight that contagion is frequently used as the “metaphor of choice” for a series of non-health related events including global financial crises, immigration, obesity, divorce, fast food, and radical Islam (Magnusson & Zalloua 2012: 4). The authors seek to understand what happens when the term contagion evolves beyond its original meaning and begin to “contaminate other discourses in the social and humanities” (Magnusson & Zalloua 2012:4). The text features a chapter written by Pricilla Wald, who is also able to link the fear factor surrounding contagion with the formation of risk groups. Wald explores a mythical and awe-inspiring quality that initially surpasses the fear factor around viruses
and cites the example of a researcher describing Ebola under a microscope as “a gorgeously wrought ice castle” that was “totally pure” (Magnusson Zalloua & Ward 2012:102-103). However, this mythical quality bestowed on contagions also enhances their demonic nature, which is often associated with perceived carriers in addition to the virus itself (Magnusson Zalloua & Ward 2012:103). Thus, Ward shows how contagion as a tactic for fear is able to create risk groups including her examples of “gay men and Haitians during the early years of HIV, Asians during the SARS outbreak of 2003, and Mexicans and U.S. Americans during the H1N1 outbreak of 2009” (Magnusson Zalloua & Ward 2012:103).

While many scholars studied the spread of fear from a contagion event, Sherry Towers analyzed the role of the media in the spread of fear during a contagion event. In her text, *Mass Media and the Contagion of Fear: The Case of Ebola in America*, Towers researched Twitter data and contagion related Internet search during the initial weeks of the 2014 Ebola outbreak. Tower’s data yielded a spike in contagion fear during the Ebola outbreak and that a single news segment on Ebola yielded “tens of thousands of Internet searches in the American population” (Towers 2015:10). Thus, Towers research highlights the spike of an atmosphere of fear during a contagion event.

The element of fear in a contagion situation was also explore by Li Ping Wong and I-Ching Sam in their text *Behavioral responses to the influenza A(H1N1) outbreak in Malaysia*. Wong and Sam conducted telephone interviews of residents in various provinces in Malaysia during the summer of 2009 to explore the participants understanding of the H1N1 virus and their level of fear towards the virus. The data
yielded 41.1 percent of respondents were “slightly fearful” of the virus, and 32.1 percent of respondents were “fearful” of the virus (Wong & Sam 2011:25). Furthermore, the study found a “significant positive correlation between the level of fear with the number of health-protective behaviors and impacts” taken by participants (Wong & Sam 2011:28). Thus, the authors demonstrate that the existence of fear surrounding a contagion event and how the higher the fear factor becomes, the more it will have behavioral effects including avoiding public places and avoiding consuming certain foods (Wong & Sam 2011:28).

Fear and risk group creation are key staples in the discourse on the politics of contagion, and both have a strong relation to the third branch concerning sovereignty. Sovereignty is a dominant branch in the discourse on the politics of contagion because contagion events can be seen as a threat to the sovereignty of a given nation-state. Many scholars focus on sovereignty, in particular, because within much of the rhetoric during contagion events is a call for strengthened national security to protect citizens from the health security threat of a given disease. While some scholars focus on some of the outcomes of the politics of contagion including the bias that comes from the creation of risk groups, Andrew Price-Smith solely focuses on the merger between national security and contagion in his text *Contagion and Chaos: Disease, Ecology, and National Security in the Era of Globalization*.

Price-Smith explores a series of case studies including the Spanish influenza pandemic of 1918-19, the HIV crisis in Sub-Saharan Africa, and the SARS outbreak of 2003. Price-Smith argues, “the health of the body politic contributes directly to the
functionality of the apparatus of governance” and “epidemics present a direct threat to the power of the state” (Price-Smith 2009:1-2). For instance, Price-Smith shows how the governance of Canada was affected by the SARS contagion of 2002-03 through budget cuts to the public health sector that led to a cut in staff (Price-Smith 2009:147). With fewer scientists investigating regional disease, Canada faced less staffing at hospitals, numerous quarantine violations, and ultimately a failure to keep the contagion from spreading (Price-Smith 2009:147). Thus, Price-Smith illuminates the stress contagion events pose to the power of a nation-state in that contagions have the power to erode confidence in the power of a given nation state to handle a crisis effectively.

Another author uses the 2014 Ebola epidemic to illustrate the linkage between the politics of contagion and sovereignty. In *Epidemics, national security, and US immigration policy*, Robbie Totten explores the United States classification of Ebola as “a national security priority” as opposed to a humanitarian concern and its implications (Totten 2015:199). Totten discusses the three pillars of contagion policy designed to protect the sovereignty and security of the US, which include policies that restrict entrance to foreigners suspected of carrying a dangerous disease, quarantines of immigrants thought to carry a dangerous disease, and the authority of the President to halt all immigration during a contagion event overseas (Totten 2015:203). Thus, Totten shows the how the nation-state views contagion as a concern to sovereignty and security, and ultimately, how immigrant risk groups can be created out of necessity to preserve sovereignty.
One more scholar that highlights contagions relation to security and sovereignty is Samuel Cohn. In his text, *Plague and prejudice*, Cohn illustrates the elements of threat to the sovereignty of a nation-state that are birthed in contagion events. Cohn explores the violence and unrest that erupted in countless historical examples of contagion and discusses the switch that occurred in the 19th century from the “other” being on the receiving end of violence to the dominant classes becoming the new target (Cohn 2016:34). During the cholera outbreak of the 19th century, “cholera riots” broke out with masses of civilians who were “driven to madness over the reported cruelties to cholera patients”, invaded a quarter of the city and plundered shops, stoned citizens, and beat the deputy governor to death (Cohn 2016:34). Thus, Cohn shows how contagion events can trigger elements of unrest that have the capability to disrupt the security and sovereignty of a nation-state. Furthermore, his discusses of targeted risk groups illustrate how targeted groups during contagion situations have the power to strike back, which can harm the security of the nation-state.

While the above scholars provided an excellent overview of the politics of contagion, I am interested in exploring specific health management agencies and their handling of contagion events. All of the above authors highlight the tensions and undesirable aftermaths that arise from contagion situations, but not enough is said about the management and policy aspect of contagion control. In fact, much of the discourse on the politics of contagion completely ignores the role of disease management agencies in contagion events and only focuses on the undesirable aftermaths including the branch of fear and the branch of risk group creation, which is a major gap in the literature that I will
address. As many scholars demonstrated, contagion has had a negative connotation for centuries and many early examples such as the Black Plague and the cholera outbreak of the 19th century created what scholars would describe as chaos and bias. However, in recent years major health organizations such as the Centers for Disease Control and Prevention have stepped in with the purpose of improving global health and mitigating contagion risk. Yet, even with these organizations, tensions continue to emerge, which begs the question; are the policies and the handling of contagion events by the CDC sufficient in combating the moments of tension that occur in contagion events?

One scholar who is deeply intertwined in the purpose of my research is Michael Foucault. In his text, *The History of Sexuality*, Foucault explicitly states, “Power is everywhere” (Foucault 1978: 93). For Foucault, power is not “acquired, seized, or shared, something that one holds onto or allows to slip away; power is exercised from innumerable points (Foucault 1978: 94). Thus, power flows our world like a river, touching and transferring its presence to everything it encounters. If according to Foucault, power is everywhere, then power must also exist in the subtle moments. The subtle can be the unintended consequences of seemingly innocent choices or the language we use that can be unknowingly charged. It is this subtle power, which I believe resides in the policies of the CDC and the ways in which the organization handles contagion events. The subtle power of the CDC’s policies can influence groups of people, the media, and many other facets of life.

Certain scholars, such as James Hodge, would discredit the importance of the above health organization for reasons including the lack of power that the CDC has to
enforce its recommendations during emergencies (Hodge 2015:356). But, there is a broader power that health agencies hold and it deserves exploration. The language these organizations use during contagion briefings, the policy measures they recommend during outbreaks, and the ways in which they address the moments of tension that arise during epidemics have the power to cross borders and impact the lives of citizens across the globe. The literature available provides an abundance of knowledge on the politics of contagion, but many key questions remain. How exactly does the power in the subtle of CDC policies effect different arenas of life Does the CDC do enough to combat the undesirable elements that arise in contagion events? And finally, is the current ratio of individuals caught in the tensions of the politics of contagion worth the cost of eliminating a contagion? I hope that my data and case studies will provide answers to these questions and fill the gaps in the discourse on contagion management.

Methodology & Research Design

As mentioned in the literature review, this thesis takes a broader view of the politics of contagion. While other scholars merely explored the aftermath of contagion events, I explored the policies of the CDC, which I believe assist in the birthing of these moments of tension. To fully appreciate the bigger picture of the politics of contagion, this thesis takes a qualitative framework to highlight the politics of contagion and the power in the subtle. The research includes an analysis of three unique case studies of which the CDC was deeply involved. Because the politics of contagion is something that cannot be entirely explored in a quantitative framework, ample examples of scholarly discourse are planted throughout the case studies to enforce the theoretical framework of
the study. The Anthrax event of 2001, the Ebola epidemic of 2014, and the current Zika outbreak are explored in this study in addition to the involvement of the CDC in each contagion event.

Beginning with the case of Anthrax, we explore America’s first incident of bioterrorism. This event occurred just weeks after the September 11th terrorist attacks where wounds were still fresh and citizens had a heightened awareness of the risk of terrorism. The CDC quickly labeled the event a bioterrorism attack and the organization remained deeply involved in the event for its entirety. This case study demonstrates aspects of the politics of contagion including the creation of risk groups and the usage of contagion as a metaphor for fear. The case study explores the fear-based rush on Ciprofloxacin and the creation of a Muslim risk group during the attacks. Data analyzed and used in this case study include CDC policy briefings and FBI hate-crime statistics. Additionally, a theoretical framework is maintained by including relevant scholarly works throughout the case study.

Moving onto the second case study, we fast-forward 13 years to the Ebola epidemic of 2014. This event was mainly concentrated in a few Sub-Saharan nations, but also played a limited role in the United States and Europe. Again, the CDC was a strong presence in the epidemic and had specific policies developed relating to the event. The creation of an African risk group and the birth of a fear-factor via the media are explored in this study. Data analyzed include the media coverage of the epidemic by three major American news agencies and public opinions obtained from the comment sections of
reputable news agencies. Additionally, scholarly theories are sprinkled throughout the case study to maintain a theoretical aspect to the text.

Finally, we end our journey in the present with the exploration of the current Zika outbreak. This case study differs from the previous two in that the phenomena of risk regions as opposed to risk groups in explored. Additionally, biopolitics and access to abortion are unpacked in the study. Data used include hotel statistics in Zika regions and scholarly work to balance out a theoretical framework. This case study is particularly interesting as it is the only contagion of the studies that is largely non-lethal. Yet, we still see the emergence of moments of tension during the event, which is linked back to the theory of power residing in the subtle.

The above studies were carefully selected to explore the politics of contagion and the power in the subtle. By examining specific CDC policies and the moments of tension during the events, we can link the two together via the power in the subtle. This research was made possible by major news organizations including CNN, FOX News, and MSNBC. Additional sources include Gilt Travel, the FBI, and the CDC policies and briefings. Theorists who specialize in power such as Foucault and Nikolas Rose add to the discourse in addition to the countless scholars included who focus on the specific contagion events. The blend of theoretical scholars coupled with hard data illuminates the politics of contagion and demonstrates how relevant Foucault’s theory on power still is to this day.

**Anthrax in America: Bioterrorism & the Muslim Community**
In 2001, a series of events shattered the idyllic image of America that many American’s held. On September 11th of 2001, hijacked commercial airliners slammed into The World Trade Center, The Pentagon, and a field in Pennsylvania killing thousands of civilians in the deadliest terror attack in the history of the United States. Al-Qaeda, an extremist group headed by Osama Bin Laden, claimed responsibility for the attack and the United States marched into two wars in the Middle East. The ensuing wars coupled with the 9/11 attacks led to many instances of bias against the Muslim-American community, which we still see the effects of today.

One major event in 2001 that is often neglected is the Anthrax attacks that terrorized the East Coast of the United States for the latter part of 2001. The Anthrax attacks of 2001 were the first instance of a bioterrorism attack on the United States, and this contagion event created moments of tension that still resonate today. The CDC was a major presence in the Anthrax attack investigations, which as a result, aided in two major moments of tension. Anthrax as a metaphor for fear and the creation of the Muslim community as a risk group that owned responsibility for the Anthrax attacks were major consequences of the contagion event, which the CDC played a role. The data in this case study will illuminate the Anthrax fear that gripped America and the consequences the Muslim community faced as a result. Before we delve too deeply into this case study, it is important to properly unpack Anthrax and the climate in America during the fall of 2001.

**History of Anthrax & its Use in 2001**

Though the Anthrax attacks of 2001 were an unprecedented use of biological warfare, Anthrax itself is not a new phenomenon. Anthrax is an infectious disease caused
by gram-positive, rod-shaped bacteria known as Bacillus Anthracis, which dates as far back as biblical times (CDC.gov: 2015). Anthrax appears in the Book of Exodus via the fifth and sixth plagues inflicted on Egypt, which included the death of livestock and boils (Sternbach: 2003). From the Middle Ages to modern day, cases of Anthrax have continued to emerge and infect new hosts. In the 18th and 19th centuries, cases of inhalation Anthrax commonly occurred in mills where workers were exposed to contaminated animal fibers (Sternbach: 2003). Depending on the form of Anthrax, symptoms can include nausea, headache, fever, trouble breathing, shock, and other complications that can lead to mortality if untreated (Mayo Clinic: 2015). While cases of Anthrax occurred naturally for centuries, nations would soon discover the power of cultivating and weaponizing biological agents.

During the Cold War, an Anthrax contagion emerged killing dozens of Russians. In April of 1979, a total of 94 cases of human Anthrax, both gastrointestinal and cutaneous, occurred near a Soviet military microbiology facility in Sverdlovsk (Sternbach: 2003). Of the 94 cases, 64 were fatal, and the Soviet government blamed the outbreak on tainted meat sold via the black market (McNeill 2010: 45). However, an international team of researchers that later investigated the outbreak concluded: “an unintended release of Anthrax spores in aerosol form from a biological weapons facility had descended on the city” (McNeill 2010: 45).

Anthrax, along with Smallpox and other deadly diseases has been heavily researched and cultivated for weapons purposes by governments across the globe for decades. However, there have been no instances of widespread use of Anthrax by
governments engaging in war. In fact, in 1980, Phillip Brachman of the CDC published a review of inhalation Anthrax dismissing any cause of concern against the threat of the disease. The report illustrated a decline in case of Anthrax in America during the 20th century and concluded that Anthrax was “now primarily of historical interest” (Sternbach: 2003). Unfortunately, the CDC’s dismissal of the threat of Anthrax would be proven wrong in the fall of 2001 during America’s first bioterror attack.

Nearly 3,000 civilians were killed on September 11th, 2001 in the deadliest terror attack on U.S. soil. Shortly after the attacks, the intelligence community determined that 9/11 hijackers were affiliated with the Al Qaeda terrorist organization. Many Americans were in a state of shock and feared that more attacks could be on the way. The sense of unease rose with the subsequent Anthrax attacks and the crash of American Airlines Flight 587, which eventually was proved to be the result of mechanic issues as opposed to terrorism. However, the Anthrax outbreak that stumped investigators for years following the attacks was a terrorist attack that elevated the existing tension with the Muslim-American community.

The first case of Anthrax contracted via the attack was diagnosed on October 4th, 2001. Robert Stevens, a tabloid photo editor at American Media, came in contact with a white powdery substance later determined to be Anthrax via mail (CCR 2002: 1). At this point, Anthrax was virtually unknown by many U.S. doctors. So much so that the first two Floridian case, Robert Stevens and Ernesto Blanco, initially were misdiagnosed as pneumonia (CCR 2002: 6). While there was understandably a lot of confusion
surrounding the outbreak at the local level, the control and understanding of the attack was not much better at the health governance level.

The CDC scrambled to assess the damage of the outbreak and make recommendations to keep the American public safe. As the weeks went on and fall turned to winter, 22 civilians would contract the Anthrax contagion; 5 of which would perish. During this time, the public’s fear exponentially grew. A biological attack on America seemed to be something out of a Hollywood movie for many Americans, so fear and panic were a natural reaction to an unnatural event. Fear is a powerful tool that has the power to dramatically alter the behavior of those exposed to something they deem frightening. A close friend described her experiences living in the DC area during the Beltway Sniper killings.

“It was crazy…I mean, people were obviously scared. No one knew where the shots were coming from, and since many of the attacks happened while people were walking to their cars, you saw people start to zig zag…like with an alligator. You would pull into a Macy’s parking lot, and all you would see is people holding their shopping bags and running in a zig zag to and from their cars. Everyone did it. I did it…. That’s just what they said we should do so now it seems crazy but when you’re scared you’ll do strange things to protect yourself” (Akiyama: 2016)

Fear certainly is a powerful emotion that can affect the ways in which individuals cope. The Anthrax attacks of 2001 are no exception, and the actions of the CDC had consequences that influenced the fear-factor mentality during the outbreak.

**In Cipro We Trust**

In Cipro we trust, a line made famous by Tom Brokaw during his nightly news program serves as a key feature of the Anthrax attacks. In perhaps what is the most
tangible example of a fear-factor was the mass antibiotic frenzy that enveloped the public during the weeks of the attacks. During the 2001 Anthrax attacks, the CDC recommended the use of the antibiotics Ciprofloxacin and Doxycycline as first-line therapy (CDC.gov: 2001). The typical treatment for an individual with cutaneous Anthrax was a 7-10 day regimen of the antibiotic, but cases affiliated with the bioterrorism attacks were recommended to remain on antibiotics for 60 days (CDC.gov: 2001). Sixty days is a long time to remain on an antibiotic and is typically reserved for serious illnesses such as Lyme disease. Given the serious nature of Anthrax and high mortality rate, it is understandable that the CDC recommended the antibiotics for an extended period.

However, the recommendation of the CDC created a large demand for Ciprofloxacin. Pharmacies located in areas in close proximity to the attacks saw a significant rise in Ciprofloxacin prescriptions. Both Walgreens in Florida and CVS and Rite Aid in New York City reported a large spike in Ciprofloxacin sales during the attacks (Petersen: 2001). In fact, sales were so high at some Walgreens that some stores ran out of the drug and were not able to restock for up to two days (Petersen: 2001). Also, Merck-Medco reported a sizable increase in Ciprofloxacin prescriptions during the attacks. Before September 11th, the company filled an average of 8,000 to 10,000 Ciprofloxacin prescriptions per day (Petersen: 2001). But, during the Anthrax attacks the number grew to 12,000-14,000 per day and peaked at 18,000 per day after NBC announced that one of its employees had contracted Anthrax (Petersen: 2001).

As for the CDC, the agency illuminated the extent of Ciprofloxacin usage during the attacks in a November 2001 report. According to the CDC, approximately 32,000
individuals were prescribed antibiotics to guard against Anthrax, but only 5,000 people were believed to be in need of the antibiotics (CCR 2002: 54). Additionally, one in five people prescribed the Ciprofloxacin regimen reported non-lethal side effects (CCR 2002: 54). Non-lethal side effects of Ciprofloxacin include sun sensitivity, rash, and diarrhea, but there are a few more concerning and potentially lethal effects of the drug. According to the U.S. Food and Drug Administration (FDA), serious side effects of Ciprofloxacin include an increased risk of seizures, allergic reactions causing difficulty breathing or closing of the throat, rupture of a tendon, and severe tissue inflammation of the colon (FDA.gov: 2015). The elderly and those with existing mental illnesses are at an elevated risk of adverse effects to the drug, which has a well-documented history of serious effects (Krucoff: 2001).

One of the most famous cases is that of Diane Ayres who woke up delirious in an emergency room six hours after taking her first Ciprofloxacin dose for a urinary tract infection (Krucoff: 2001). Ayres has since been diagnosed with manic-depressive illness, which was triggered by the antibiotic (Krucoff: 2001). Lisa Baldwin also took a prescribed Ciprofloxacin dose for a urinary tract infection and has since battled many negative side effects. Since taking the medication, Baldwin experiences chronic blurred vision and muscle pain, which has left her unable to work or play with her grandchildren (Krucoff: 2001). The above cases highlight the dangerous nature of Ciprofloxacin, and the pause health government agencies should give to recommending such a drug.

Scholars also condemned the rush on Ciprofloxacin during the outbreak. Daniel Freidlin in his text Just Say No: The Cipro Craze and Managed Care, highlights the
downside of mass antibiotic prescription. Freidlin states, “The more people who don’t have bacterial infections take antibiotics, the less effective the drugs are when treating real problems, including tuberculosis, pneumonia, and bad colds” (Freidlin: 2002). Furthermore, Freidlin estimates thousands of Americans treated themselves with Ciprofloxacin during the 2001 attacks out of fear and without reporting the use to the CDC (Freidlin: 2002). Freidlin’s exploration of drug resistance is especially important given the growing concern over superbugs.

A superbug is a highly aggressive bacteria or infection that is resistant to treatment by most or all antimicrobials. Megan Johnstone discusses the rise of superbugs and the moral significance of antimicrobial resistance. Johnstone cites a 2000 WHO warning that stated the misuse of antimicrobials over many decades put the world at risk of returning to a “pre-antibiotic age” (Johnstone 2016: 2079). Additionally, the WHO warned, “Diseases caused by drug resistant microorganisms pose a more deadly threat to human life than war” (Johnstone 2016: 2079). In her text, Johnstone highlights the “growing threat to human life” posed by superbugs and explores the moral dilemmas posed by reckless antibiotic use (Johnstone 2016: 2080).

Thus, we can unpack a moment of tension birthed from Ciprofloxacin usage during the 2001 attacks. During the attacks, the evidence yields a dramatic spike in Ciprofloxacin prescriptions. While some of the adverse effects of the drugs were displayed immediately in the form of muscle pain and other ailments, the role of excessive Ciprofloxacin use contributing to future superbugs is not yet known. While Ciprofloxacin is still an effective drug in many cases, a superbug outbreak in 2015
illuminated the effect of overutilization of antibiotics. In less than a year, 243 cases of shigella sonnei were diagnosed in the United States (RT.com: 2016). According to the CDC, 90 percent of the shigella sonnei bacteria were resistant to Ciprofloxacin, which highlights the issue of overutilization of antibiotics. When recommending an antibiotic, it is paramount to anticipate both the immediate concerns and the issues that could arise down the road. The overuse of antibiotics, both during the 2001 Anthrax attacks and in subsequent contagions is a moment of tension that holds the power to create superbugs and diminish the utility of our antibiotic stock.

Now, one cannot argue the recommendation of the CDC concerning the usage of Ciprofloxacin in Anthrax related cases. However, the CDC’s policy aided in the fear-factor surrounding the outbreak not because of what it recommended, but what it omitted from its reports. In each of its briefings on the outbreak, the CDC was silent on the rampant and unnecessary use of Ciprofloxacin and other antibiotics. Not once, in the numerous Anthrax reports or briefings did the CDC express concern or try to quell the growing abuse of antibiotics. The closest the CDC engaged on the matter was during a press briefing on November 14th, 2001. An excerpt is provided below.

Question from Ira Dreyfus with AP Radio: “I've heard from patients who say that conditions that they used to have treated with Cipro are no longer being treated with Cipro because doctors are saying they can't get it because all the Cipro's going to anthrax, and I'm kind of curious to see what you folks might know about that?”

Response from Dr. Gerberding of the CDC: “With respect to your question about access to Ciprofloxacin, there are ongoing episodes of antibiotics shortage that we've been experiencing in the United States over the past several years for a variety of reasons. The supply of Ciprofloxacin that we have access to through vendors and through the stockpile suggest to us that there's no issue of shortage. There have been localized examples where antibiotics have been hoarded,
particularly after the 9-11 World Trade Center crisis in New York City. For a period of there were some folks there that had difficulty getting Ciprofloxacin from their local pharmacy. But, in general, the supply of these drugs is keeping up with the demand. We are also putting more emphasis on using Doxycycline as a drug for prophylaxis of B. anthracis exposure because the organism is sensitive to Doxycycline, just as sensitive as it is to Ciprofloxacin, and we don't use Doxycycline for a lot of other conditions. So we can preserve and protect our supply of Ciprofloxacin, but, more importantly, preserve and protect other bacterial susceptibility to it (CDC.gov: November 2001).

Essentially, the CDC dismisses the blame of a shortage of Ciprofloxacin and attributes shortages multiple causes. Furthermore, the CDC acknowledges some individuals might have had trouble acquiring the antibiotic at their local pharmacy, but that the overall supply was still keeping up with demand. Later in the briefing when a reporter asked if it was wise to give out the drug so widely given the possibility of adverse events, shortages, and side effects; the CDC responded, “We don’t want to be using these drugs, willy-nilly, or unnecessarily” (CDC.gov: November 2001).

However, on the recommendation of the CDC, the antibiotics were given out unnecessarily. Again, according to the CDC 32,000 people were given Ciprofloxacin with only 5,000 determined to be truly in need of the antibiotic. This means that nearly 85 percent of the patients unnecessarily were prescribed and consumed the medication. Now, some may think the over-prescription is not a big deal, but we must remember the powerful nature of the drug. David Flockhart, chief of clinical pharmacology at the Indiana University School of Medicine, describes Ciprofloxacin as “a big gun whose benefits outweigh its risks in certain circumstances” (Krucoff: 2001). Ciprofloxacin is a dangerous drug for certain individuals, which was recommended and prescribed in mass quantities by the CDC during the outbreak.
The CDC’s communication concerning Anthrax and Ciprofloxacin was a moment of tension, unintentionally created by the CDC, which had tangible effects on supply and overutilization. This moment of tension highlights the power in the subtle and relates to Foucault’s theory of power. Foucault states, “Power is not something that is acquired, seized, or shared, something that one holds onto or allows to slip away; power is exercised from innumerable points” (Foucault 1978: 94). Thus, the innumerable nature of power dictates its movement through every ebb and flow of life and its residency in every arena of life. Since power is everywhere, we can say that there is as much power in the communication we use as with what we omit from our communication. Using Foucault’s theory of power we see the CDC as an agent of power because of the knowledge it holds and shares. In its communication and policies concerning Ciprofloxacin, a subtle power emerged, which influenced a fear-induced hoarding of the drug and potentially influenced long-term effects on the birth of superbugs.

While it is understandable to use Ciprofloxacin to treat a contagion as aggressive as Anthrax, the CDC created a moment of tension by not properly communicating with the public. Again, not a single briefing from the CDC on the Anthrax outbreak sought to combat the over-prescription and hoarding of the antibiotic. Though there are no deaths known that are linked to the antibiotic use during the outbreak, we can see the danger that was birthed from the CDC’s policies and subsequent lapse in communication. As discussed, many pharmacies reported shortages of Ciprofloxacin during the fall of 2001 with some pharmacies running out of the drug for as long as two days. It is possible that
because of the shortages, patients who truly needed Ciprofloxacin for ailments unrelated to Anthrax went without treatment.

During times of crisis, proper communication is key in avoiding moments of tension. The CDC and its Anthrax policies were effective concerning those exposed to the disease. However, its lack of initiative in quelling public concerns and proper antibiotic education to the general public led to a dangerous situation. With an absence of guidance on the risks associated with unnecessary antibiotic usage, a perfect storm occurred during the outbreak that strained medication supplies and jeopardized the health of countless healthy, non-exposed citizens. The absence of proper communication also influenced the second major area of tension during the outbreak, which was the creation of a Muslim risk group.

**Fear, Risk, Contagion & Muslims in America**

The Muslim community in America became a risk group on September 11th, 2001 when Al-Qaeda affiliated terrorists’ murdered nearly 3,000 civilians. Since the 9/11 attacks, many Muslim-Americans with no affiliation with terror networks experienced bias and hate crimes committed against them. Now, the CDC cannot be blamed for the atrocities committed against the Muslim community post 9/11. However, the way the CDC handled the investigation and its correspondence with the public likely had the unintended consequence of aiding in the creation of a Muslim risk group. One of the main areas of concern is the language the CDC used during the investigation, and the power language has to influence individuals.
Bioterrorism and terrorism became key terms during the CDC investigations and briefings. On October 25th, 2001, Julie Gerberding of the CDC described the outbreak as frightening; “This is a biological attack and we have no experience with this” (CCR 2002: 44). The terms bioterrorism, terrorism, attack, suspicious and other charged terms were rampant in briefings. The chart below highlights some of the language use in CDC briefings during the attacks.

**Figure 1: CDC Frequency of Charged Language Use**

The above chart illustrates the frequency of commonly used charged terminology in CDC briefings during the outbreak. We can see the term “suspicious” trailed off early on in CDC briefings peaking the week of October 26th with nine occurrences. However, “terrorism” and “bioterrorism” rose steadily during the attacks peaking the week of
November 16th with 20 occurrences. The prevalence of the term “terrorism” in CDC briefings is important because of the specific connotation of the term during that period.

Using Foucault’s theory that power is everywhere means power also resides in the language we use. The power of language and charged language is discussed by Newman and Genevieve Birk in *Counterbalance: Gendered Perspectives on Writing and Language*. Birk states, “Before expressed in words, our knowledge both inside and outside, is influenced by the principle of selection and the principle of selection determines which facts we take in” (Logan 1997: 184) The words we select hold power and usage of charged language “shapes our attitudes and values even without our conscious knowledge” (Logan 1997: 191). Essentially, Birk argues language shapes our knowledge and conscious and charged language can impact individuals regardless of their awareness. We can link Birk’s theory of charged language to the prominence of charged language in the CDC briefings. Bioterrorism, attack, and risk may have been realities concerning Anthrax in 2001, but these terms hold power. These terms can embed in the psyche of those exposed and conjure images of an assailant without examining all the facts.

Remember, only weeks before Al-Qaeda affiliated terrorists committed a massive terrorist act on U.S. soil and in the following weeks the media and government focused on the connection between terrorism and certain Middle Eastern nations. It is important to note that not once during the Anthrax investigations were there evidence of Al-Qaeda as the perpetrator of the bioterrorism attacks. Yet, we see numerous examples of government officials planting the seed of Al-Qaeda involvement in the mind of the
public. On whether the Anthrax attacks had a connection to Al-Qaeda, John Ashcroft responded, “We should consider this potential that it is linked” (CCR 2002: 28).

President Bush is quoted, “We have no hard data yet, but it is clear that Bin Laden is a man who is an evil man…I wouldn’t put it past them…he and his spokesmen are bragging about how they hope to inflict more pain on our country (CCR 2002: 31). And, Tommy Thompson, of HHS, described a “well-financed terrorist group” as having the potential to concentrate the Anthrax (CCR 2002: 34).

During the numerous instances of government officials hinting at Al-Qaeda involvement, the CDC remained silent. The CDC was focused on the medical side of the investigation and deflected questions pertaining to the criminal investigation. In a press briefing on November 15th, 2001, a reporter asked if the CDC had any comment or reaction to the news of several federal officials leaning towards a “lone nut” source for the Anthrax attacks (CDC.gov: November 2001). The CDC responded that it was not focusing on that particular aspect of the investigation and that the criminal aspect was more of the FBI’s domain (CDC.gov: November 2001). While it is understandable that the CDC desired to remain neutral on the criminal aspect of the attack, neutrality left a gray area as to the responsible party.

Even with numerous individuals showing the unlikelihood of an Al-Qaeda relationship with the attacks, the CDC remained neutral. Jeanne Guilleman, an Anthrax expert, claimed “Neither cases look like full-blown bioterrorism…it looks more like a Unabomber” situation (CCR 2002: 27). Intelligence officials at the CIA also expressed doubt concerning international involvement; a senior official is quoted, “Everything
seems to lean to a domestic source. Nothing seems to fit with an overseas terrorist type operation” (CCR 2002: 45). However, the CDC remained relatively silent and continued to leave all options open. Jeffery Koplan, the CDC director, claimed the deliberate release of the Anthrax by terrorists was one of the several possibilities under investigation; he stated, “We have that on the list” (CCR 2002: 18).

Unfortunately, the combination of charged terminology such as “terrorism” coupled with neutrality regarding the responsible party aided in creating a Muslim risk group during this time. Again, the CDC is not directly responsible for the risk group creation as a number of factors went into creating the risk population. However, there are subtle consequences in the language used by the CDC. By remaining neutral and frequently using charged language, the CDC sent out a message to the public that there was a chance that foreign terrorists affiliated with Al-Qaeda were responsible for the Anthrax attacks. Leaving a gray area concerning the perpetrator aided in allowing the public to cast their critical gaze on the Muslim-American population.

Again, we can cite Foucault’s theory on power because if “power is everywhere,” then it also resides in the silence and the ambiguity of the CDC briefings. Power certainly lived in the CDC’s neutrality and prevalence of using charged language in its briefings, but there certainly wasn’t intent to create a Muslim risk group. We can examine the work of Franz Fanon to unpack another form of power, which aided in the creation of the Muslim risk group. In *Black Skin White Masks*, Fanon explores the theory of otherization and cites the experience of a black man living in a white man’s world.
Fanon describes the white world as “the only honorable one,” which barred him from participation (Fanon 1986: 114). He linked his “blackness” to a “uniform” of which battered him down with “tom-toms, cannibalism, intellectual deficiency, fetichism, racial defects, and slave ships (Fanon 1986: 112-14). Fanon is describing the otherization of a black man in a white society. For Fanon, otherization is an experience where he, the minority in a predominantly white society, is labeled and falsely categorized because of his skin color. Otherization is a form of power to Fanon because it allows an entire group to have their realities created based on skin color.

Fanon’s theory of otherization can be linked to other groups including Muslims during 2001. All of the 19 hijackers on September 11th were from the same region and shared a similar race and features. Though not all Arabs are Muslim, many are perceived by Westerners to be Muslim because of their appearance and otherization. Fanon explains, “The Jew can be unknown in his Jewishness...he is not wholly what he is...he can sometimes go unnoticed” (Fanon 1986: 115). According to Fanon, a Jewish man can go unnoticed because his skin color, if white, does not subject him to the same otherization that it would to someone of another skin color. Thus, since many Arabs have a complexion that otherizes them, Western society can otherize them as Muslims.

Much like Fanon’s experience of linkage to terrible stereotypes such as cannibalism, Arabs can experience false stereotypes because of otherization. Since September 11th, many have experienced bias because of an otherization, which labels them as an extremist or terrorist. During the Anthrax attacks, many hate crimes were committed against Muslims. On September 27th, 2001, a note was left on a Yemeni man’s
windshield saying “we’re going to kill all (expletive) Arabs” and two days later the man was shot to death (Southern Poverty Law Center: 2011). Also, on November 2\textsuperscript{nd}, 2001, a Seattle mosque was set ablaze and on November 7\textsuperscript{th}, 2001, three white men shouted racial slurs and fired gunshots at a man they believed was of Arab descent in California (Southern Poverty Law Center: 2011). To show fully the extent of the abuse directed at the Muslim community in 2001, we can explore the chart below.

\begin{figure}[h]
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\includegraphics[width=0.5\textwidth]{fbi-hate-crime-statistics.png}
\caption{FBI Hate Crime Statistics (1999-2004)}
\end{figure}

The above chart illustrates the FBI records of hate crimes committed against Catholics, Protestants, and those of the Islam faith over the course of a five-year period. While hate crimes committed against all three groups remained relatively low in 1999 and 2000, hate crimes against those of Islam faith skyrocketed to over 500 cases. The spike in attacks against those of Islam faith coincides with both the 9/11 attacks and the Anthrax attacks, which many suspected Al-Qaeda to be responsible. While the CDC is
not responsible for the hate crimes against the Muslim community in 2001, I hope to show the linkage between the language of the CDC and the moment of tension, which birthed a Muslim risk group.

Unfortunately, many government officials including President Bush attempted to link Al Qaeda to the Anthrax attacks. Though there was no evidence supporting claims of foreign terror involvement, the CDC remained neutral when it could have easily said how insignificant the chance of Al Qaeda involvement was. The CDC’s neutrality and charged language were not the sole cause of the Muslim risk group creation nor was it the reason behind the hate crimes committed following the attacks, but it was an aggravating agent that ultimately aided in the alienation of the Muslim-American community. It is also worth noting that though many suspected Al-Qaeda involvement in the Anthrax attacks, beliefs of foreign terror involvement were eventually squashed. In 2010, the FBI closed the Anthrax case and named Bruce Ivins the prime suspect. Ivins, a Caucasian government employee, and U.S. citizen, killed himself in 2008 (Shane: 2010). Ivins had no known affiliation with any overseas terror organizations, and it appears he acted alone in the attacks. The attacks were ultimately the work of a “lone nut”, a term the CDC shied away from in spite of mounting evidence.

Overall, the CDC conducted a thorough investigation and did a fine job considering the uncharted territory of a bioterrorism case. The purpose analyzing the 2001 one Anthrax attacks isn’t necessarily to criticize the CDC’s handling of the investigation. Rather, it is to explore the subtle consequences of CDC policies and how they have to power to cultivate moments of tension. Certainly, the CDC did not intend for
their language and recommendations to create a fear-based rush on Ciprofloxacin or aid in the creation of a Muslim risk group. However, without substantial education on the nature of the disease and risks of unnecessary antibiotic use, many pharmacies reported shortages of Ciprofloxacin and sales of the drugs skyrocketed in the weeks of the attacks. Additionally, the charged language used in briefings coupled with evasiveness and neutrality regarding the responsible party did not help the tensions with the Muslim-American community.

These moments, though unintended, highlight the power that exists in the subtle. Foucault illustration of the existence of power in all facets of society resonates with the CDC’s handling of the 2001 Anthrax attacks. Because power exists everywhere, it can interconnect with other areas of power including Fanon’s otherization. The constant flow of power creates subtle moments where tensions can emerge, especially during times of crisis or fear. The fear surrounding the Anthrax outbreak and the moments of tension that occurred are not black and white issues. They are shades of gray with many factors that facilitated their creation.

There is power in the subtle and the subtle actions of the CDC, though unintended, did create moments of tension for the public. The CDC did acknowledge the investigation had some issues. In responding to criticism, the CDC is quoted, “People are somewhat surprised we’re learning this on a day to day basis…you always wish you knew on day one what you know on day twenty” (CCR 2002: 44). The CDC does not make mention of any of the moments of tension that were birthed out the attacks or the subsequent investigation. Ultimately, the CDC’s policies and handling of the Anthrax...
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investigation is a testament to the power of the subtle and the unintended consequences that can come out of simple decisions. Unfortunately, though unintended, these consequences have the power to create panic and damage domestic communities and those beyond U.S. borders.

**The Ebola Epidemic of 2014: Otherization & Distrust**

On December 26, 2013, a two-year-old Guinean boy fell ill with a mysterious disease, which included symptoms of vomiting and fever; and two days later he was dead (WHO: 2014). It would later be determined that the toddler was patient zero in the deadly 2014 Ebola outbreak that claimed the lives of over 11,000 people. The epidemic birthed a panic, which enveloped the globe, particularly the West. Moments of tension during the outbreak included fear of the African other, bias, calls for nationalism, and government distrust; and these were central features in America during the outbreak. Much like the Anthrax attacks of 2001, the CDC was deeply involved in the Ebola epidemic of 2014, and its policy contributed to some of the above moments of tension. Before we delve too deeply into the CDC policy and its aftermath, let us explore the origins of the outbreak and spread of the virus.

Ebola is a virus that is believed to be airborne and often initially contracted by humans via bats (CDC.gov: 2014). There are five strains of the Ebola virus, all of which highlight the African nations prone to the virus including the Sudan Ebola virus and the Côte d’Ivoire Ebola virus (CDC.gov: 2014). Symptoms of the virus include fever, severe headache, fatigue, stomach pain, vomiting, and unexplained bleeding (CDC.gov: 2014). Much like Anthrax in 2001, Ebola was not a new phenomenon in 2014. The first known

After the Guinean toddler died from Ebola virus complications, the disease quickly spread throughout the village and greater Guinea. The disease ravaged Guinea, Liberia, and Sierra Leone, prompting the World Health Organization’s (WHO) involvement. In August of 2014, the WHO advised that the Ebola outbreak in West Africa constituted an “extraordinary event and public health risk to other states” (WHO.int: 2014). Additionally, the WHO recommended that a “coordinated international response” to the disease was essential to combat the international threat of the Ebola virus (WHO.int: 2014). Just weeks after the WHO advised on the growing international threat of the virus, the disease arrived in the West and panic ensued.

Initially, the Ebola virus arrived in America in a controlled manner. On behalf of the United States government, infected American humanitarians were airlifted from the epicenter of the outbreak and brought to the United States for treatment. Though the humanitarians were treated without incident, there was growing concern regarding flights arriving from Africa into the West. Throughout the epidemic, the CDC remained firm on its policy concerning travel. The CDC called for “active monitoring” of travelers from Ebola hot zones, which included daily reporting of measured temperatures and Ebola symptoms for 21 days after the last potential exposure (CDC.gov: 2014). However, the CDC was against a travel ban, which would hinder the movement of people within the most heavily affected areas. Dr. Thomas Frieden, Director of the CDC, posted a lengthy statement on FOX News during the epidemic concerning why a travel ban was the wrong
call: “A travel ban is not the right answer. It’s simply not feasible to build a wall – virtual or real – around a community, city, or country. A travel ban would essentially quarantine the more than 22 million people that make up the combined populations of Liberia, Sierra Leone, and Guinea.” (FOX News: 2014). The CDC’s policy regarding travel during the epidemic and its aversion to preventing a travel ban became a major point of contention of the media. In turn, this policy of the CDC birthed the first moment of tension, which included a media fear-factor, calls of an inept CDC, and a government powerless to stop an impending deadly outbreak on American soil.

The Ebola Media Frenzy

The media coverage of the Ebola epidemic was inescapable. During the peak months of the disease and especially after the first Ebola patient was airlifted to America, Ebola segments dominated Fox News, NBC, and CNN. Additionally, during this period Ebola articles were found in nearly every major newspaper. Initially, the coverage focused on the rising death tolls in Africa and how difficult it was becoming to manage the disease. However, as the disease progressed and awareness of its threat to the West increased, the media’s coverage became more intense and critical of the CDC. Below is a sampling of media coverage of the epidemic.

<table>
<thead>
<tr>
<th>Date</th>
<th>News Agency &amp; Commentator</th>
<th>Statement</th>
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<tbody>
<tr>
<td>7/3/14</td>
<td>CNN- Hala Gorani</td>
<td>“(Ebola) is a really big problem” “No cure...90% death rate”</td>
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<tr>
<td>8/3/14</td>
<td>Fox News- Dr. Glover</td>
<td>“We should be concerned” “WHO declared (Ebola) an international public health emergency” discusses a CDC plan for “quarantine”</td>
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<td>10/3/14</td>
<td>FOX News- Andrea Tantaros</td>
<td>“We (US) are not equipped to handle this” “In these countries (African) they do not believe in traditional medical care” “Witch doctor...Santeria.”</td>
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<tr>
<td>10/6/14</td>
<td>CNN- Dr. Alexander Garza</td>
<td>Ebola is the &quot;ISIS of biological agents&quot; “spreads throughout and kills innocent people. “National security issue ...treat it like a form of terrorism ...protect the homeland (America)...protect the American public.”</td>
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<tr>
<td>10/7/14</td>
<td>Fox News-Gretchen Carlson</td>
<td>Suggests we should not trust the government (CDC) to handle Ebola because they have made errors in other areas (secret service slip up) “people scared that government agencies responsible (to handle Ebola) might not be up to the task”</td>
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<tr>
<td>10/10/14</td>
<td>CNN- Rand Paul</td>
<td>“We have underplayed the risk of this (Ebola)...not unreasonable to suspend commercial flights...worldwide contagion”</td>
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<td>10/11/14</td>
<td>FOX News- Elizabeth Hasselbeck</td>
<td>“Why are we letting people in” “secure the borders” shut down flights” “temporarily seal off border”</td>
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<td>10/13/14</td>
<td>CNN-Interview with various neighbors of Ebola Victim</td>
<td>“Pretty alarming...pretty concerned now” (James Guajardo: neighbor) “owner of local gym says clients are on edge” (CNN reporter) “I'm nervous...pray for me” (Jacob Deluna: electrician that worked on nurse's neighbors apartment) &quot;It's scary....seems like it may be more contagious than the doctors are saying” (Clint Rabe: local electrician)</td>
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<td>10/13/14</td>
<td>Fox News-Bill O'Reilly</td>
<td>Why is the government not protecting us (from Ebola)? “Very contagious disease” “very worrisome” “there is no</td>
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compelling reason why West Africans should be admitted into the USA when there is an Ebola epidemic raging there” “this is a national security issue” “CDC director is not being candid...he should resign” Ebola policies are “stupid” “irresponsible” and put “Americans at risk” O’Reilly is asking for “common sense”

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<th>Date</th>
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<td>10/14/14</td>
<td>Fox News- Laura Ingraham with the hosts of Fox &amp; Friends</td>
<td>Laura Ingraham condemns Tom Frieden (CDC director) “he shrugs off common sense” “best way to stop this is to stop people from coming in...he shrugs that off” (Ingraham) “this is deadly serious” “American lives are on the line” “more concerned with how to stop it in West Africa than how to stop it here” “had there been a travel ban Thomas Duncan wouldn’t have gotten into this country (America) (Male host Fox &amp; Friends)</td>
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<td>10/16/14</td>
<td>Fox News- Congressmen Ed Royce</td>
<td>“There isn’t an inalienable right to travel or tourism to the US...that’s a privilege.” “Its common sense to issue a time out for visas” “Contain it there (Africa)” “self-evident”</td>
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<td>10/17/14</td>
<td>MSNBC-Senator Dennis Ross</td>
<td>“Great deal of concern” (CDC handling of Ebola) “banning those flights” “don’t issue visas to travelers abroad” “banning of these flights” “We know the source” (Africa) “not issuing visas”</td>
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<td>10/19/14</td>
<td>CNN-Ted Cruz</td>
<td>“Biggest mistake is we continue to allow open air flights from countries that have been stricken by Ebola” (Cruz) “Common sense” (Cruz) “CDC gave her the green light to do that” (Cruz on infected nurse boarding a commercial flight)</td>
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<td>11/11/14</td>
<td>MSNBC-Compilation of other network coverage of the outbreak</td>
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<td>“Ebola scares popping up across the country” (Megan Kelly)</td>
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<td>“Ebola...mess” (Jeanine Piero)</td>
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<td>“ISIS supporters encouraging the use of Ebola as a weapon to kill us Westerners” (Unknown blond reporter FOX)</td>
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<td>“Ebola on the backs of ISIS” (Unknown male FOX reporter)</td>
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<td>“not self-quarantining” (Megan Kelly)</td>
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<td>“Is Ebola President Obama’s Katrina” (Don Lemon CNN)</td>
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<td>“Ebola as Obama’s Katrina” (CNN reporter)</td>
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<td>“many are frightened and angry that Ebola may spread across the USA” (O’Reilly)</td>
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<td>“panic...you don’t want us to panic...I don’t want us to die” (Jeanne Piero)</td>
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**Figure 3: Sampling of Media Discourse Concerning Ebola in 2014**

Clearly, there is the element of fear throughout the above examples of media coverage. Take for example the comments of Andrea Tantaros in which she otherizes the African healthcare industry by claiming Africans only use methods of magic to treat
disease. Her claims of witchcraft and Santeria in the African health field illustrate both a fear factor of an inept African other and convey a false narrative of African culture to the audience. Mike McGovern, in his text *Bushmeat and the Politics of Disgust*, explores a similar narrative of a skewed view of African culture. In his text, McGovern analyzes the role of Vice Media in the coverage of the Ebola epidemic. In their coverage, bushmeat consumption among Africans takes center stage with the central theme of Ebola residing in exotic animals, which are then consumed by Africans causing a pandemic that “liquefies the victim’s internal organs” (McGovern: 2014). Contained in the media coverage is abundant sensationalism and a critical gaze on African culture as people that Americans can observe and exclaim, “They eat that?!” (McGovern: 2014).

McGovern also discusses the feelings of disgust that consumption of monkeys or bats instills in many individuals while the consumption of American game does not garner the same horror. As McGovern points out, Western media tends to sensationalize and cast a critical gaze on African culture. Much like the Vice coverage, we can see in the above chart a number of examples of sensationalism and misinformation that otherizes Africans. In the above examples, we can also see a general sense of panic including a description of Ebola as the “ISIS of biological agents” that rapidly spreads and kills innocent civilians. Sherry Towers and colleagues examined the role of media in public fear during the 2014 Ebola epidemic. Using Google Trends during the period of peak media coverage of the Ebola epidemic, Towers explored users searches of terms and phrases including “Ebola,” Do I have Ebola,” and “Ebola symptoms” (Towers: 2015). The study yielded a large spike in Google searches for the above phrases during the time
of peak media coverage. As we can see in the chart above, the barrage of fear-driven language was an ongoing feature of the epidemic. As shown in Tower’s study, the coverage of the media has the power to spread the fear of the epidemic throughout the public.

While fear and otherization were staples of the coverage, another central feature of news coverage was open anger towards the CDC’s handling of the epidemic. In many of the segments, the news anchors or the interviewees implored for a travel ban, which would prevent citizens of West African nations from accessing the United States. One of the most vocal critics of the open travel was Ted Cruz who slammed the CDC in a CNN interview. Cruz claimed the CDC had made a “serious mistake” by allowing someone with Ebola to board a flight. Furthermore, Cruz demanded a halt in the issue of visas and travel to the United States from West African nations. In fact, Cruz mentioned the dire need for a travel ban over six times in a short interview and slammed the CDC for its lack of “common sense” on the issue.

Additionally, the media was furious with Tom Frieden and the CDC for its lack of stringency in hindering the movement of people from the most heavily affected countries. The data shows that much of the media believed the CDC demonstrated a “lack of common sense” concerning its handling of the epidemic. At least four of the examples in the chart harp on a lack of common sense in the handling of the epidemic, while many others refer to the irresponsibility of the government concerning the epidemic. So, from a simple CDC policy on travel, we see a moment of tension grow in the form of the deterioration of trust between the media and the CDC.
To some, these moments of tension may seem unimportant, especially since the media has a history of casting a critical gaze on a given entity during times of crises. However, these moments of tension that evolve unintentionally hold the power to morph into bigger areas of concern. As demonstrated in the data, the media took off with the idea of a necessity for a West African travel ban. Additionally, charged language was prevalent during the epidemic, which aided in the growing fear-factor. Unlike during the Anthrax attacks where the CDC mainly used the charged language, during the Ebola epidemic much of the charged language was used by the media in its coverage of the impending danger of the virus and the lack of “common sense” the CDC policies demonstrated.

We can see many examples of charged language in the above media broadcast analysis. From Laura Ingraham’s categorization of a “deadly serious” outbreak that put American lives in danger to Jeanine Piero’s claim of ISIS plans to use Ebola to murder Westerners, news anchors did not shy away from language that had the potential to instill fear in the viewer. We can also explore the use of charged language in print media during the epidemic. Below is a month-by-month analysis of the trends of charged language used in articles by major news organizations including CNN, Fox News, MSNBC, and NBC.
Figure 4: Charged Language in Ebola Media Coverage

In the above chart, a rise in charged language during the Ebola epidemic is illustrated. We can see that the frequency of the word “die” and its synonyms had the greatest increase, peaking at over 70 instances in October. “Risk” and its synonyms also rose steadily while the term “outbreak” and its synonyms initially rose, but then dropped off in October. Die, outbreak, risk, and their synonyms are charged because they are based on fear. These words have the power to cultivate panic among their audiences. We can look back at Martin Pernick’s *Contagion and Culture* to solidify the power of language. Pernick explored the term contagion and its evolution throughout the years. In ancient times, contagion was often associated with negative connotations such as sin or grief (Pernick 2002: 860).

Throughout history, Pernick shows a constant negative association with the term contagion, which is often entangled with “epidemics and panic” (Pernick 2002: 861). Much like Pernick’s research of language and the term contagion, modern language also...
holds power. Each word in the above graph signifies the potential of danger. For the Western audience, the above articles catered to, these words had a subtle power that further exaggerated the fear-factor surrounding the epidemic.

Within the growing climate of fear was a sense of impending doom for America. Articles were littered with a language of death and suffering, while news anchors relentlessly pounded the CDC’s handling of the outbreak and demanded a travel ban. The CDC expressed numerous times the difficulty of contracting the disease, as it is not an airborne contagion. At the same time, the media wondered whether the virus could become airborne and discussed the threat of a virus mutation and the potential for more deaths (Fox Health: 2016). The CDC frequently mentioned its safety nets in place to monitor travelers that could carry the virus while the media asked if bioterrorists could harness Ebola to attack America. One article claims that all a terrorist would need to make a “dirty bomb” is a bag of vomit, and they would have the power to inflict havoc on the American people (Vlahos: 2014).

For all the work the CDC did to try to ease the mind of the public, the media counteracted with hypothetical situations and claims of CDC recklessness by not enforcing a travel ban. Theresa MacPhail, a medical anthropologist, explores the dangers of the media-induced fear-factor that erupted in 2014. She explains that by hyping up the danger of a single disease, other dangers can be neglected. She cites the vast sum of money poured into research for a deadly strain of influenza, which she describes as “probably good” but MacPhail asks whether we adequately prepared for the spread of other dangers like dengue fever or Chikungunya (Horgan: 2014). The same could be said
about the 2014 Ebola epidemic. While the epidemic certainly was a concern, the constant media attention could have distracted personnel from other diseases that potentially risked the lives of civilians.

MacPhail criticized the role of media in the 2014 outbreak describing their coverage as “not great overall” (Horgan: 2014). She explains that there is “always money to be made in fear-mongering” and that though “it is easy to get caught up in the drama of outbreaks,” it is important to “take a step back analyze the bigger picture” (Horgan: 2014). However, as demonstrated in the above data, the media appeared to ignore the bigger picture and engage in a large-scale campaign of fear. MacPhail was particularly critical of the media fear mongering concerning African culture. The discussion of bushmeat, burial practices, and Santeria was described as “cultural problems that promoted the spread of Ebola” (Horgan: 2014). With an ongoing campaign of fear in the media, which heavily otherized the African people coupled with an abundance of charged language, a situation for potential bias began to brew.

Though the CDC believed it could effectively monitor traveling through temperature readings, the media was skeptical. Many anchors discussed the vast number of travelers and the difficulty of monitoring each and every person who enters the United States. They claimed that all it would take was a single passenger to slip through the cracks and catastrophe could erupt. The moment of tension from the CDC’s travel policy reached its tipping point when Thomas Duncan, a Liberian with the Ebola virus, legally entered the United States and spread the disease to two Dallas nurses.

Thomas Duncan & African Risk Group Creation
On September 20, 2014, Thomas Duncan arrived in Texas after flights from Belgium and Liberia. A few days prior to his flight, Duncan shared a taxi with a pregnant neighbor. During the ride, the woman fainted, prompting Duncan to carry the woman and assist her (Gostin: 2014). Duncan did not disclose his encounter with the pregnant woman, who died of Ebola shortly after the encounter, to airport officials (Gostin: 2014). Shortly after arriving in Dallas, Duncan visited the Texas Health Presbyterian Hospital complaining of Ebola-like symptoms and reported his recent travel from Liberia (Gostin: 2014). Duncan was initially sent home with antibiotics, but after returning a couple of days later with deteriorating health, he was admitted in the hospital and placed in isolation (Gostin: 2014). In spite of treatment for the Ebola virus, Thomas Duncan died on October 8th of 2014, and days later Nurse Amber Vinson and Nurse Nina Pham tested positive for the virus.

The inevitable Ebola contagion in American society that the media promoted for weeks had finally occurred. The media continued its outcry for a travel ban, and the public’s anger grew, especially concerning Thomas Duncan. Many were furious at Duncan and the CDC for his presence in America, which is demonstrated in the following graph.
Figure 5: Public Opinions of Thomas Duncan & Ebola in America

The above graph illustrates a breakdown of discourse found in the comment sections of major news articles on Thomas Duncan and his battle with Ebola. An overwhelming majority of the sample took a critical view of Duncan. Many referred to Duncan as a “liar” who should be prosecuted for bringing the Ebola virus to America, while others labeled him as a “selfish man.” Just over 16 percent of respondents placed blame on the CDC and government. Many expressed a lack of confidence in the CDC’s ability to handle the Ebola epidemic. One commenter believed the head of the CDC should face prosecution for bringing Ebola to America, while another claimed the CDC was responsible for “bringing disease into America.”

Only a little over nine percent of the sample expressed support for Duncan and even fewer were supportive of the government and the hospital that cared for Duncan.
The vast majority of the sample had harsh words for the all three parties, and racial undertones were abundant throughout the analysis. In addition to calling Duncan a liar, much of the language describing Duncan gave him a villain-like persona. Described as “Ebolaman,” a “despicable individual” that brought Ebola to “an actual civilized country,” Duncan was thought by many to be well aware of his sickness and without concern for the safety of American citizens.

The demonic view of Duncan spread to a generalization of Africa as a whole for much of the sample. Africans were described as “losers” and Liberians were believed to be diseased from eating “dirty rotten monkeys.” In the following quote, one commenter attempts to illustrate the difference between the West and Africa and injects race into his argument.

“Africa was in good shape, socially, economically, etc. when the white colonial powers ran the place. The British and French tried to civilize and uplift the natives. The Belgians finally got their stuff together after a bit of nastiness under King Leopold. And, when the European colonial powers left, they left behind functioning economies and societies. Today, except for South Africa, all sub-Saharan black Africa is a giant, violent, dysfunctional version of Newark, New Jersey. South Africa is still functioning. Gotta be a reason in there somewhere.”

To the commenter and many in the study, Africans were to blame for Ebola, and it would be their cross to bear. Bringing the disease to America was regarded as intentional to most and terroristic to many others. The few who expressed support for Duncan tried to highlight that Duncan did not know that he was infected with the virus, and that Ebola was not only an African virus or concern. Unfortunately, the fear factor surrounding the epidemic allowed for the demonization of Duncan and birthed substantial bias towards Africans and those perceived of being African.
The demonization of Duncan is the central focus of Emma Cohen’s piece *The 2014 Ebola Epidemic and Racial “Othering.”* Cohen discusses an article written by the nephew of the late Thomas Duncan of which the underlying message is “people of color receive inferior medical treatment in the United States, and had Thomas Eric Duncan been a white man with health insurance, he likely would have survived” the Ebola virus (Cohen 2015: 4). Cohen explores the “historical, geographical, and psychological circumstances that have created a foundation for racial othering of Africans with relation to disease.” (Cohen 2015: 5). As Cohen describes, Duncan and fellow Africans are widely “stigmatized” because of a belief that they are somehow different from the “in-group.” (Cohen 2015: 5).

Otherization is not a unique phenomenon to the 2014 Ebola epidemic. Susan Sontag, in *Illness as Metaphor*, links sickness to other. The other is “perceived as morally inferior, different, and vulnerable,” which counters how the healthy wish to think of themselves (Mongoven: 2014). This otherization and stigmatization would explain the outpouring of negativity that Duncan experienced from the public. To the Western masses, Duncan was a stranger who did not belong. He was a bearer of disease and imminent threat to the lives of United States citizens.

While otherization was a growing concern, panic and distrust of the CDC took center stage after Amber Vinson, a nurse who contracted Ebola via Thomas Duncan, was able to board a commercial flight to Ohio. Before boarding her flight back to Dallas, Vinson called the CDC to report her fever of 99.5 and confirm whether she was able to travel via air given her care of Thomas Duncan (Davidson: 2014). The day after returning
Young 57

to Dallas, Vinson was diagnosed with the Ebola virus. Frontier Airlines Flight 1143, the plane Vinson traveled, flew five more times the following day until Vinson’s diagnosis was confirmed (Davidson: 2014). Below is a chart illustrating the public reaction to the Vinson case.

![Public Opinions of Amber Vinson & Ebola in America](chart)

**Figure 6: Public Opinions of Amber Vinson & Ebola in America**

The above chart illustrates the comments of individuals concerning the Amber Vinson case. In this case, the key element of frustration shifts from the patient to the agency, which differs from the Thomas Duncan case, where Duncan was the main target of critics. The data yielded that 72 percent of respondents took an anti-CDC viewpoint, while 25 percent expressed frustration with the patient. Many were dumbfounded that the CDC allowed Vinson to fly and played with the title of the CDC calling it the “Can’t do it Correct” Center or the “Criminal Debacle Center.” The overall theme of the comments
indicated the CDC was “incompetent” and that Dr. Frieden should have been fired immediately.

Amber Vinson also bore some criticism with respondents calling her “reckless” and demanding the revocation of her nursing license. However, the criticism of the patient was much less frequent and severe than with Thomas Duncan. Concerning Vinson, there were no known racial attacks or attacks on her character. The few who criticized her focused on how as a nurse “she should have known better,” but there was no belief among respondents that she deliberately boarded the plane knowing she had the virus. With Duncan, the criticism was overwhelming and a complete character assassination. To the majority, he was a liar who intentionally brought his disease to the United States. Racial and anti-African sentiments were common among those who criticized Duncan.

Much like Edward Said, in his text *Orientalism*, Thomas Duncan becomes the other. According to Said, “The real Orient provoked a writer to his vision; it rarely guided it,” which resonates with the case of Thomas Duncan (Said 1979: 22). The West determined Duncan’s reality and deemed him a radical other, an agent of disease. Duncan’s otherization was a consequence of the politics of contagion because fear coupled with policy can create moments of tension. The world saw a similar case play out in Canada over ten years earlier. Charles Adeyanju in his text *Not in Canada* describes the case of a Congolese tourist who was suspected of carrying the Ebola virus while visiting Canada. The negative scrutiny of the tourist became so intense that a white
supremacist group protested in front of the patient’s hospital and distributed anti-immigration pamphlets (Adeyanju 2010: 34).

Both the unnamed Congolese tourist and Thomas Duncan were otherized and determined a threat to the ”in-group.” In both cases, there is a common denominator of African citizenship and extreme bias. Vinson did experience some harsh words, but it mainly revolved around her professionalism as opposed to race. Though Vinson, Duncan, and the Congolese tourist were all black, Vinson was a United States citizen. Perhaps, her citizenship protected her from the tension of otherization during the outbreak. While Vinson did not experience the same level of otherization, the fear surrounding the contagion needed another target for the masses to focus on. Now, the target was the CDC and those in charge of the organization.

The CDC was now the “other” of which the American public determined its realities and motivations. Trust eroded and many saw the CDC as an incompetent enemy that threatened the public with its incompetence, much like Duncan’s “selfishness” threatened the public. We can see that the deterioration of trust and otherization that occurred during the Ebola epidemic are moments of tension, which are birthed out of a fear-factor. These moments of tension are only further aggravated by the policies of health governance agencies like the CDC. Again, there is power in the subtle, and the seemingly insignificant or well-intended decisions of the CDC aided in the creation of the above moments of tension.

By dismissing a travel ban, the CDC created a policy that it believed made the disease less of a threat to the countless uninfected individuals trapped in the epicenter of
the outbreak. The CDC believed it’s monitoring of the epidemic was sufficient and that they would be able to identify infected individuals before they could gain access to the United States. However, the CDC underestimated the fear-factor surrounding the epidemic and did not anticipate the subsequent moments of tension. The CDC did not intend for a character assassination with racial notes of Thomas Duncan, nor did it anticipate the backlash after the case of Amber Vinson. But, these moments of friction did occur, which highlights the power that lies in the subtle, and the ability for this subtle power to impact individuals on a global scale.

Whether, the CDC recommended a travel ban or dismissed a ban, it is likely that moments of tension would have occurred. However, it is important to plan and have an awareness of the moments of tension to minimize any potential negative impacts, which the CDC failed to accomplish. Every decision the CDC makes, the language they use, and the policies they create all have the subtle power to create moments of tension. In Michael Foucault’s *The History of Sexuality*, claims “the ancient right to take life or let live was replaced by the power to foster life or disallow it to the point of death” (Foucault 1978: 138). In other words, Foucault highlights a shift from an explicit power to an implicit, subtle power.

In the case of Ebola, we see the rise of bias, otherization, and the decay of trust with the CDC. Using Foucault’s placement of power, we can categorize these moments of tension as the later subtle power. The CDC’s policies did not set out to create otherization or the destruction of government trust. However, Foucault’s belief of a subtle power is a gateway for the birth of unintended consequences. Foucault explains, “If
genocide is indeed the dream of modern powers, this is not because of a return of the ancient right to kill; it is because power is situated and exercised at the level of life, the species, the race, and the large-scale phenomena of population” (Foucault 1978: 137).

Thus, power is everywhere. The masses, the media, the interpretation of policies, and throughout every facet of contagion events exists an elusive power that can affect the lives of millions of individuals. In the 2014 Ebola epidemics, we saw the subtle power in the policies, which caused a trickle down effects to the media and the masses. This subtle power ultimately created otherization, bias, and loss of trust.

The subtle power during the 2014 Ebola epidemic is also discussed in Akhenaten Tankwanchi’s *Ebola, Thomas Duncan’s Death, and the Biopolitics of Disposability*. Tankwanchi explores the implicit bias and black disposability during the epidemic in which the “in-group” harbors “prejudice towards members of other groups, either unconsciously or unwillingly” (Tankwanchi: 2014). He cites 80 percent of whites and Asians show anti-black bias and uses the example of the neglect of Ebola epicenters in Africa as an implicit bias towards Africans, which deemed them disposable (Tankwanchi: 2014). In examining the data, we see an outpouring of negativity directed towards Africa, Thomas Duncan, and the CDC. Had the Ebola epidemic not occurred, perhaps these negative sentiments would not have been voiced, but the contagion combined with the moments of tension birthed from policy created an environment where bias and beliefs of disposability ran rampant.

The endless chants of “liar” directed at Duncan, the common belief Duncan was a bad person who deserved death, and the evisceration of the CDC because of its travel
policy show the status of power in the subtle. This subtle power coursed through the CDC policy and took hold of the media and public, and eventually manifested the moments of tension discussed above. Understanding the power in the subtle will not eliminate the moments of tension, but it can help to minimize the effects. The Ebola outbreak of 2014 highlights the power in the subtle and is a learning opportunity to explore how to prevent racial instances and protect trust during a time of crisis. The critical gaze of the media and public will continue to exist, but understanding it and preparing for its inevitable display will help the credibility and trust with the CDC now and in cases of future contagions.

**Zika: Tensions & Tourism**

The Zika virus is an interesting case as it is largely non-lethal and since it is an ongoing contagion event. Zika, like malaria, is often contracted via the bite of an infected mosquito (CDC: 2016). Once infected, the virus can be transmitted via sexual intercourse, blood transfusion, laboratory exposure, and from mother to fetus during pregnancy (CDC: 2016). Though the symptoms of fever, rash, and joint pain are less severe than those of the preview case studies; the virus’s effect on newborns is causing great concern among citizens globally. Newborns exposed to the Zika virus are at an increased risk of development abnormalities including hearing loss, impaired growth, ocular issues, and central nervous system defects (Frazer 2016: 10). Research also points to Zika as a cause of Microcephaly in infants, which is a condition where the head of the infant is significantly smaller than expected in relation to the size of the rest of the infant (Frazer 2016: 10).
Additionally, there is no current vaccine or cure for the Zika virus aiding in the unease of the public. As in the Ebola and Anthrax contagions, the CDC is deeply involved in the fight against the spread of the Zika virus. Though the Zika virus is an ongoing issue both abroad and in the United States, we are beginning to see the early stages of moments of tension related to the virus and the CDC policies associated with it. From abortion rights to the tourism industry, the Zika virus and policies relating to it currently shape discourse and influence current affairs. Before we delve into the moments of tension, it is important to examine the history of the Zika virus and the areas at the epicenter of this contagion event.

**History of the Zika Virus & Current Epicenter**

Again, like Anthrax and Ebola, Zika is not a new phenomenon. Zika was discovered in 1947 with the virus isolated among the Rhesus macaque population (Kindhauser 2016: 677). In 1952, the first human cases were discovered in Uganda and the United Republic of Tanzania (Kindhauser 2016: 677). During this time, the virus was detected in a few other nations including Egypt, Malaysia, and Vietnam (Kindhauser 2016: 677). In the following decades, the virus moved out of Uganda and across West Africa and eventually into Asia (Kindhauser 2016: 677). Still, there were no outbreak situations in humans, and the virus was quite sporadic in its infection of hosts. In 2007, the Zika virus arrived on the island of Yap in the South Pacific and caused the first large outbreak of the virus (Kindhauser 2016: 677). At least 185 cases of Zika were reported in Yap during the outbreak, though no deaths or hospitalizations were reported.
A few more outbreaks occurred in following years, but not to the magnitude of the current epidemic.

The current outbreak of Zika is a major concern for the Americas and the Caribbean. Since May of 2015, Zika infections in Northeastern Brazil rose to over 1,500,000 cases (Wahid: 2016). Other epicenters of the ongoing outbreak include Venezuela, Paraguay, Guatemala, Mexico, Honduras, El Salvador, Colombia, and Panama (Wahid: 2016). While the United States is not dealing with the same severity as many other nations, Zika is a concern, especially in southeastern states. Zika infection via mosquito transmission was first reported in the Miami neighborhood of Wynwood in 2016. The presence of Zika-bearing mosquitoes in this neighborhood is especially troubling given the frequent travel of its residents to places in the Caribbean and Latin America (Lockwood 2016: 4). Cases in Florida have continued to grow in recent weeks, and the virus has spread to other areas including Miami Beach and Tampa Bay (Lockwood 2016: 4). This disease has also become a major issue in Puerto Rico where it is estimated by the end of the year, 1 in 4 people will have been infected by the virus (Lockwood 2016: 4). With a rapidly growing outbreak and scores of infected, the early stages of moments of tension are formulating.

**Abortion Rights & Epidemic**

One of the biggest concerns of the Zika virus is its effect on pregnancies. It is estimated that .95 to 13.2 percent of Zika-affected pregnancies “may be at risk of severe congenital central nervous system pathology” (Lockwood 2016: 5). Given the risks and life-long effects of infants harmed by the Zika virus, discussions concerning abortion and
tensions between pro-life and pro-choice are beginning to emerge. One of the most fascinating moments of tension is the discourse on Zika and abortion in Brazil. The CDC does not have a policy concerning abortion, but the CDC’s coverage of the dangers of Zika to the fetus has been aggressive during the outbreak. Perhaps, the CDC’s strong education on the dangers of Zika birthed a new dialogue surrounding abortion rights.

In Brazil, a robust Catholic nation, abortion is a taboo. Abortion is illegal in Brazil except in cases of rape, anencephaly, or when the life of the mother is jeopardized by the pregnancy (PRI’s The World: 2016). Overall, policies on abortion in South and Central America are among the most restrictive in the world. The CDC is deeply involved in the fight against Zika in Brazil and has a number of recommendations specific to Brazilian women. These recommendations include advisory for pregnant women to discontinue travel to areas in Brazil below 6,500 feet (CDC: 2016). Other recommendations for women in Brazil include strict prevention methods to thwart mosquitoes and special guidelines for sexual intercourse with partners that have recently traveled to Zika zones in the country (CDC: 2016). Concerning Brazilian women, the CDC has an entire page dedicated to Zika awareness, preventions, and danger to the fetus.

As more and more women learn about the virus and its life-long effects on the child; an increase in the push for legal and safe abortion grows in Brazil. An increasing number of women’s groups in the country are pushing back against the strict abortion laws. In August, an organization dedicated to ending unsafe abortion presented a legal challenge to the Supreme Court with the argument that “Brazilian Government’s policies
on Zika and microcephaly had breached women’s human rights” (Boseley: 2016). Brazil pushed back with lawmakers developing stricter additions to existing abortion laws. Conservative lawmakers plan to create a legal framework where women would be sentenced to more than four years in prison for aborting a fetus with microcephaly (PRI’s The World: 2016).

Nikolas Rose would classify the government’s role concerning Zika and abortion as anti-risk biopolitics. In his text *The Politics of Life Itself*, Rose discusses a history of risk politics, which very much relates to the current abortion struggle in Brazil. Rose claims biopolitics, “tends to individualize human worth and discriminate against, constrains, or excludes those found biologically abnormal or defective” (Rose 2007: 2). He expands, “Some locate the wish to control the biological make-up of the population at the very heart of modernity, and elimination of foreign bodies and population purification is immanent within biopolitics” (Rose 2007: 2). We can relate Rose’s theory to the Nazi regime in Germany. During the Nazi rule, scores of “foreign bodies” were eliminated including the Jewish people and Gypsies to purify the German population. In essence, Rose illuminates the potential for state power in the arena of eugenics.

The role of the Brazilian government runs in opposition to Rose’s theory. Thus, I label their handling of the Zika-abortion debate as anti-risk biopolitics. The Brazilian government is not concerned with the potential risks and future complications of the many Zika pregnancies in the country. Because of a strong religious influence in Brazilian culture and governance, the risk of the Zika children does not outweigh their disdain for Rose’s location of power in risk biopolitics. Now, this is not an accolade to
the Brazilian government’s handling of the Zika-abortion debate; merely, it is an observation of their aversion to risk politics on the basis of religion.

However, the government’s stance on abortion and biopolitics runs counter to the beliefs of the countless pregnant women who are infected with the Zika virus. While the number of women seeking illegal abortions has always been high in Brazil, the figure dramatically increased in 2015. In 2015, the number of women who sought treatment for a botched abortion outpaced the number of women who receive legal abortions by 100 to one (McDonald: 2016). Wealthier women seeking to abort a Zika pregnancy usually can find an individual able to assist in a clandestine medical procedure, but for the countless women without financial means, the options are grim including black-market abortion pills, abortion teas, inserting sharp objects into the uterus, and other forms of self-harm (McDonald: 2016).

Again, the CDC is not directly responsible for the abortion tensions in Brazil. For decades prior to the outbreak abortion was illegal in the country and many women sought illegal abortions to end unintended pregnancies. But, the CDC’s education directed at Brazilian women and the significant risks of Zika to unborn children aids in the birth of this moment of tension. Once again, the power lies in the subtle. By educating Brazilian women on the dangers of Zika and the life-long effects children with microcephaly face, the CDC subtly influenced the abortion debate. Brazilian women, armed with knowledge given by the CDC coupled with other influencing factors, began to push back at the restrictive abortion laws. Again, the CDC and its policies are not directly responsible for this movement. Other influencing factors could include growing awareness of neighbors
or family members with health complications from botched abortions or first-hand
experience with a child diagnosed with microcephaly.

As Foucault says, “Power is everywhere; not because it embraces everything, but
because it comes from everywhere” (Foucault 1978: 93). Thus, in the case of Brazilian
abortion concerning Zika, the CDC is an agency of knowledge that holds some of the
power because it directed its knowledge at Brazilian women. It is the subtle power of the
CDC compiled with the endless other Zika powers, both subtle and explicit, that shape
the continuing discourse on Abortion in Brazil and globally. Though the debate is in its
early stages in Brazil, perhaps we will see new Zika inspired abortion debates in other
places including the United States.

While abortion is legal in the United States, there is a deep history of conservative
lawmakers that try to hinder abortion access to women. The Zika virus and its effects on
children have not hindered the conservative movement to thwart abortion access. Take
for instance Florida Senator Marco Rubio who stated, “I believe all life is worthy of
protection of our laws…and when you present it in the context of Zika or any other
prenatal condition, it’s a difficult question and a hard one…but if I’m going to err, I’m
going to err on the side of life (Caputo: 2016). With the Zika virus just beginning to
encroach on Florida, it is unknown whether there is or will be a spike in abortions. But,
the CDC will no doubt be an agent of power and knowledge for Miami locals concerning
Zika and its risk.

Certainly, we can see the potential for a moment of tension in the United States
between abortion activists and conservative lawmakers concerning Zika and
microcephaly. Whether its abortion discourse in Brazil or here in America, it is important to acknowledge that power is everywhere, especially in the subtle. The CDC may be a neutral entity concerning abortion rights, but its distribution of knowledge concerning Zika effects becomes a subtle power that is and likely will continue to influence to debate on abortion in many nations.

**Zika & Tourism Tension**

Though the Zika-abortion debate is a more subtle moment of tension, the CDC’s policies regarding Zika has had a much more tangible impact on travel. The Zika virus’s timing and location are quite problematic for the tourism industry. Currently, the Zika virus is affecting many popular tourist destinations including Puerto Rico, Mexico, and Miami. Additionally, the 2016 Summer Olympics took place in Rio de Janeiro, Brazil during a time of peak outbreak. Many of the most heavily affected areas depend on tourism revenue for their economies, but estimates for tourism in Zika regions are disappointing. The World Bank estimates the “disease will cost the world 3.5 billion dollars in 2016, mostly because of people avoiding travel to areas where the virus is being actively transmitted (Muchmore: 2016).

The CDC has many recommendations concerning travel to areas with an active Zika presence. For example, both in Brazil and Mexico, the CDC issued a level two alert for Zika and issued special guidelines for pregnant women including avoiding travel to areas under 6,500 feet (CDC: 2016). Additionally, the CDC issued special guidelines relating to the 2016 Rio Olympics. Pregnant women were advised by the CDC not to attend the Olympics (CDC: 2016). Furthermore, if the partner of the pregnant woman
must attend the Olympics, the women were advised to either use condoms or entirely avoid intercourse for the duration of the pregnancy (CDC: 2016).

The policy of the CDC coupled with a general fear of the virus appeared to influence many athletes to back out of the event entirely. Jason Day, Dustin Johnson, Jordan Spieth, Rory McIlroy, Vijay Singh, Milos Raonic, Simona Halep, Tomas Berdych, Karolina Pliscova, Tejay van Garderen, and Stephen Curry are just a sample of athletes that did not attend the Rio games because of Zika concerns (Palazzo: 2016).

Many others athletes that attended the games took additional precautions because of Zika fears. For instance, Greg Rutherford, a British long-jumper, decided to freeze his sperm prior to traveling to Rio (Palazzo: 2016). Rutherford’s girlfriend discusses her Zika fears and cites the “100 plus medical experts who stressed the games should have been moved to prevent the spread of the disease” in her decision not to attend the games and the couple’s decision to freeze Rutherford’s sperm (Palazzo: 2016).

Zika fears coupled with medical professionals and CDC travel warnings for the region appeared to spook spectators as well. Though 88 percent of the 6 million tickets for the Rio Olympics were sold, only 25 percent of the tickets were sold to international tourists (Ansari: 2016). Previous Olympics such as the London Olympics of 2012 saw a higher yield in ticket sales and a strong performance concerning international tourism. During the games, London reaped an average of 1,290 pounds per Olympic visitor compared to the average 650 pounds spent by other visitors (The National Archives: 2012). Most of the visitors to the London Games were residents of European nations, and an equal share came from the United States and other nations (The National Archives: 2012).
The robust tourism figures for the London Games are likely in part to a lack of fear and policy surrounding the event. During the 2012 Olympics, there were no ongoing epidemics that posed a threat to the games, which cannot be said about the 2016 Olympics.

Specific figures on tourism and revenue during the games are likely still in the process of being gathered. However, given the low percent of international travelers to the games, it is likely the results will be significantly lower than those of the London Olympics. Now, the CDC’s policies on travel cannot be solely blamed for the tension of lackluster international ticket sales and numerous athletes who backed out of the games. Another source of tension was certainly the media, which is highlighted by Daniel Baker in his text *Zika Virus and the Media*. Baker highlights the bombardment of fear-induced media coverage of the Zika virus and claims there is a “delicate balance between providing important health information and scaring the public” (Baker 2016: 275). Baker cites a deluge of articles with titles such as “Fears Over Spread of Zika Virus Grow in the Caribbean” and “Public Health Agencies, Hospitals Prepare for Potential Zika Spread” (Baker 2016: 275).

As in any epidemic, fear is a factor in the creation of moments of tension. However, the CDC’s policies concerning travel to the Olympic games and other Zika regions do hold a subtle power. The subtle power can be explored in its Miami guidelines. The CDC recommends pregnant women refrain from travel to the Miami Beach area and dissuades travelers from unnecessarily visiting all parts of Miami-Dade County and Wynwood, Florida (CDC: 2016). It appears once the CDC locates the
presence of Zika-bearing mosquitoes and active cases in a given region; it recommends similar limitations for travel to that particular region. With ample CDC travel warnings in place coupled with strong media coverage, we are beginning to see an adverse effect on tourism in Zika hot zones. The chart below illustrated the current situation in the tourism industry in areas with Zika presence.

**Figure 7: Analysis of Zika & The Hotel Industry**

In the above chart, we see the progression of discounted hotels offered on a luxury travel site for eight weeks in 2016. From August 19th till October 7th, the total offered sales on gilttravel.com were analyzed and investigated to determine the percent and average discount for hotels in areas with a Zika presence. While the total number of hotels in Zika regions and the number of United States hotels in Zika regions fluctuated from week to week, the average discount on Zika hotels mainly rose. The average
discount remained over 40 percent for six of the eight weeks and rose by over seven percent from the starting point of 39 percent to its ending point of 46.20 percent. Even the numbers that fluctuated showed a high presence of discounted hotels in Zika areas. Each week, the total percentage of hotels in regions with known Zika activity was hovered around or above 25 percent of the total sample for that particular week. The data illustrates a prominence of sales for hotels in Zika-affected areas and demonstrates a spike in the average discount as the weeks passed.

Now, in observing the percent of U.S. based hotels in Zika regions, we initially see a rise in the earlier weeks in the study followed by a steady drop off. However, the percentage of U.S. based hotels in Zika regions remained a consistently sizable portion of the sample for the duration of the analysis. Cumulatively, 28.6 percent of the hotels in the United States during the study were located in Zika regions with the vast majority in Miami Florida followed by a smaller percent in neighboring Floridian cities and Puerto Rico. The high percentage of discounts for hotels in Zika regions illustrates a lack of demand for hotels in certain areas such as Miami Beach and Mexico. The cumulative discount for hotels in the Zika-affected areas was over 42 percent, which could illustrate a lack of demand for the product. The lack of demand could be influenced by a number of different factors. But, given the Zika presence, the media attention, and the CDC policies on travel it is likely that Zika and its tension facilitators played a role in lowering the demand for hotels in these regions.

Again, the CDC’s travel policies concerning Zika are not solely responsible for the diminished demand for tourism in Miami, Mexico, Brazil, and other areas with a
known Zika presence. The heavy media coverage also bears responsibility for any adverse effects on tourism. But, the CDC’s policies are a piece to the puzzle and have unintended effects tourism, which are not yet fully known. It is known that many of the Zika-affected regions rely heavily on tourism for the wellbeing of their economies. For example, the hotel industry in Puerto Rico is 7 to 10 percent of the island’s GDP (Kim: 2016). Florida is also a major tourist destination with Miami-Dade country attracting millions of visitors each year. In 2014, 14.6 million visitors visited Miami and added nearly 24 billion dollars into the Floridian economy (Muzenrieder: 2016). As already mentioned, The World Bank estimates the Zika virus will lead to billions of dollars in losses for global economies. Though specific figures of lost tourism revenue for Zika-affected areas will likely remain unknown for the foreseeable future, the impact of security risk via disease will be a factor in the 2016 global tourism statistics.

Bruce Prideaux studies the concept of security risk and its impact on tourism in his research paper *Factors Affecting Bilateral Tourism Flows*. Prideaux explores the relationship between risk and tourism in four categories including political tensions, concerns for personal safety, fear of crime, and health epidemics (Prideaux: 2005). He cites the negative impact of the September 11th attacks on American and global tourism, and the harm political instability inflicted on the growth potential of the Mexican tourism industry (Prideaux: 2005). Prideaux also examines the role of disease in tourism by unpacking the 2003 SARS epidemic. Prideaux explains the role of security and risk in relation to the Chinese tourism industry during the outbreak. He explains the uncertainty generated by the SARS epidemic fueled a decline in Chinese tourism in which “Hong
Kong hotels experienced a vacancy rate of 80 percent” during the peak of the outbreak (Prideaux: 2005).

Using Prideaux’s theory of security risk on tourism, we can theorize Zika will have a tangible impact on global tourism. Like SARS in 2003, Zika is a security risk, which many people will try to protect themselves from its infection potential. Already, we can see the early effects of the Zika security risk, which has manifested in steep hotel discounts in Zika-affected regions. The security risk of Zika is influenced and further aggravated by constant media prodding and the policies of the CDC that warn against travel to Zika regions. These dynamics that interact with the CDC policies on Zika highlight the power in the subtle.

There is no single factor that can be attributed to any negative tourism impacts associated with the Zika virus. However, the CDC’s policy on travel coupled with other aggravating agents such as the media birthed a moment of tension, which is interacting with international tourism. We are seeing this moment of tension play out domestically and flowing over U.S. borders and into foreign nations. In the case of tourism, power is subtle because power is everywhere. The power lies in many areas including Zika fear, media coverage, and the knowledge produced by the CDC. There is no doubt that the CDC isn’t intentionally trying to harm tourism in places such as Miami and Rio de Janeiro. However, the knowledge they produce in their policies and recommendations play a subtle role in influencing the decisions of tourists, especially when the power in the policies interact with the media’s power and the power of fear.
Since Foucault believes power exists in all facets of life, it is paramount to understand how the subtle and seemingly small decisions can have massive impacts on other areas of life. The CDC is a well-respected agency and what they recommend matters. But what the CDC conveys in its policies has the power to influence areas most wouldn’t immediately think. Understanding the power of the policies is the key to preparing for the unintended moments of tension including the debate on abortion and tourism impacts. It may not be possible to completely alleviate these moments of tension, but we do have the power to prepare for them. In understanding the power in the subtle including CDC policies, perhaps, we can better predict future moments of tension for both the current Zika outbreaks and epidemics yet to manifest.

**Conclusion**

In this study, we traveled fifteen years and explored three very different contagion events. Each event led to different moments of tension, but the power in the subtle remained constant. We can cite the power of the subtle in the language used by the CDC in its briefings during the Anthrax attacks of 2001. We can also cite the power of the subtle in the CDC’s Zika travel ban and its policy for open travel during the Ebola epidemic. Though unexpected and likely unintended, these policies had tangible effects on people and places in many regions. The creation of a Muslim risk group in 2001 and diminished tourism in Zika-affected areas are just a few of the effects of the subtle power encompassing CDC policies.

The purpose of this paper is not to condemn the CDC or its handling of contagion events. On the contrary, I believe the CDC does an excellent job in managing
unbelievably difficult situations. However, it is important to recognize areas that could use improvement. Though the CDC does not aim to assist in the creation of moments of tension, it is a part of the creation of these moments because of the subtleties. Foucault believes power is everywhere, which means it must also lie within the subtle and unintended. The CDC and its policies are not directly responsible for the creation of risk groups and fear-factors, but seemingly insignificant details like language and travel recommendations do hold power, which can effect citizens of the United States and those beyond U.S. borders. It is this power that must be understood to prepare better and prevent future moments of tension during contagion events.

While I am satisfied with the research of this thesis, there were a few limitations encountered during the study. Firstly, due to time constraints, I was unable to conduct interviews, which would be helpful in showing the full extent of the moments of tension. Additionally, the Zika case study, though fascinating, is still an active event. Its status as an active event prevents us from knowing both the extent of the effects of the CDC policies and whether more moments of tension will erupt based on CDC policies. With that said, this research is a relatively new branch in the discourse on global health and contagion events, which will hopefully be built upon further by other scholars.

The research in this study raises a number of questions that deserve exploration. Scholars could examine the Zika crisis at its conclusion to explore the policies and complete moments of tension. Because power is everywhere, scholars could build upon this research and explore the endless other features that assisted in the creation of the moments of tension explored in this study. Perhaps, one of the most fascinating
facilitators of the moments of tension was the media and its coverage of Ebola and Zika. It is likely future scholars could write an entire dissertation on the media and the power it has in influencing moments of tension during health crises.

While my research focused specifically on the CDC policies and a subtle power, it also highlighted the importance to critically look at events. Shades of gray are important in analyzing health events and all aspects of life because the each event is not black and white. I hope my research shows the importance of agencies like the CDC because contagion events do have the power to harm countless individuals and hinder the security of the nation-state. But, there is a need to create health security without harming groups of individuals or regions in the process. From Muslims and Africans to tourism in Miami Beach and San Juan, there are many examples of people and places caught in the space where security and contagion policies intersect. It is paramount that organizations such as the CDC work to protect all groups and regions during contagion events. It is equally important to recognize that the policies and recommendations of the CDC hold the power to alter the lives of countless civilians, both local and global. Only by understanding the subtle power that resides in CDC policies can we go forth and achieve health security for the entire global population.
Work Cited


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