THE PERILS OF PANIC: EBOLA, HIV, AND THE INTERSECTION OF GLOBAL HEALTH AND LAW

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This Article explores the connections between emerging infectious diseases, domestic disease panics, global health, and the law by comparing the American response to Ebola to the initial American response to the AIDS epidemic. We demonstrate that in both cases the arrival of a new deadly disease was initially met with fear, stigma and the use of law to “other” those associated with the disease. We begin by reviewing the initial responses to the AIDS epidemic. We then offer a brief history of emerging infectious disease scares over the past few decades, highlighting the problematic rhetoric that paved the way for the Ebola panic. We then review the 2014 Ebola outbreak, noting its similarities and distinctions from the early AIDS epidemic. Finally, we examine United States policies regarding HIV and Ebola in Africa. We conclude with some tentative observations about the relationship between germ panics, law, and public health.

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I. INTRODUCTION

In the fall of 2014, Thomas Eric Duncan, a Liberian national traveling to Dallas, Texas, was diagnosed with Ebola viral disease. 1 Within days, two of his nurses contracted the disease, as did Dr. Craig Spencer, a physician returning from treating patients from West Africa. 2 In the weeks that followed, a full-scale panic erupted in the United States and much of the western hemisphere. Healthcare workers were quarantined, children were barred from school, and four of ten Americans reportedly feared that they or a family member would contract Ebola. 3

The short-lived but intense Ebola panic of 2014 highlights the thorny relationship between domestic public health and global health. In recent decades it has become cliché to note that infectious diseases that arise in the developing world can travel to the developed world. From this truism, many public health experts and human rights advocates may conclude that the promotion of global health is in the self-interest of the developed world. 4 But the reaction to Ebola in 2014 suggests that when panic strikes, the public may draw a less benevolent conclusion: those who live in the developing world are dangerous vectors of contagion needing to be kept at bay.

This Article explores the connections between emerging infectious diseases (“EIDs”), domestic disease panics, global health, and the law by comparing the response to Ebola to the response to the start of the AIDS epidemic. 5 Our analysis

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5 Others have noted some of the similarities between the two epidemics. See, e.g., Gregg Gonsalves & Peter Staley, Panic, Paranoia, and Public Health – The AIDS Epidemic’s Lessons for Ebola, 371 NEW ENG.
demonstrates that in both cases the arrival of a new deadly disease was initially met with fear, stigma, and the use of the law to treat those who were associated with the disease as “other.” Hélène Joffe and Georgina Haarhoff paraphrase Sheldon Ungar when noting that “‘othering’ is a tool used by the media when reassurance is required in the face of alarm.”6 We look to dispel the notion that othering is a necessary, albeit maladaptive, strategy to cope with pandemic paranoia. They add, “‘When Ebola and AIDS are linked, in most cases this serves to amplify the danger posed by Ebola.’”7 We instead aim to link AIDS and Ebola in a way that provides lessons for the United States and the global community when dealing with future outbreak scares.

We argue that the Ebola response was exacerbated by twenty years of warnings by both scientists and the media about the dangers of EIDs, warnings which paradoxically arose partially in response to the HIV epidemic. This is captured by Centers for Disease Control and Prevention (“CDC”) Director Tom Frieden’s remark, “we have to work now so this is not the world’s next AIDS.”8 Although designed to direct attention to a very real problem, and even to draw resources to support health in developing countries, the discourse often reinforces the misperception that people from the developing world, and more generally, people who are perceived of as different, are dangerous carriers of infection. This view, we suggest, may have hindered efforts to respond in an effective and supportive manner to the far larger epidemics of HIV and Ebola that were occurring in Africa. Yet in both cases, law eventually played a more constructive role by rejecting discrimination and the use of coercive measures that lacked a scientific basis. By so doing, law may have worked alongside science to help quell the panic, and thereby pave the way for a more robust support for global health.

We begin in Part II by reviewing the initial responses to the AIDS epidemic.9 We examine the role of stigma in shaping the popular and political responses to the disease and argue that stigma and disproportionate impact on previously ostracized groups delayed progress in identifying the virus, developing appropriate diagnostic screening tools, disseminating appropriate educational materials, and ultimately, treating the condition.

In Part III, we offer a brief history of EID scares over the past few decades, and the problematic rhetoric that paved the way for the Ebola panic.10

In Part IV, we review the 2014 Ebola outbreak, noting its similarities and distinctions from the early AIDS epidemic.11 We examine the early responses to AIDS and Ebola, both of which were characterized simultaneously by fear, stigma, and the use of law to “other” those who were associated with the disease.12 For both HIV and

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7 Id. at 963.


9 See text accompanying notes 21-88 infra.

10 See text accompanying notes 89-130 infra.

11 See text accompanying notes 131-213 infra.

12 See text accompanying notes 125-30 infra.
Ebola, however, law eventually delegitimized the othering, helping to quash the panics and pave the way for more effective global responses.\footnote{See text accompanying notes 131-192 and 199-213 infra.}

In Part V, we examine American policies with respect to HIV and Ebola in Africa.\footnote{See text accompanying notes 214-304 infra.} In the case of HIV, the early response was largely isolationist. As long as the panic persisted, the United States offered little support for HIV prevention and treatment in the countries hardest hit.\footnote{See text accompanying notes 230-47 infra.} Instead, it barred non-citizens who were HIV positive from traveling to the United States.\footnote{See text accompanying notes 226-29 infra.} Only when the panic died down did policy change from neglect to engagement.\footnote{See text accompanying notes 248-68 infra.} Although the federal government never adopted a similarly isolationist stance towards Ebola, that panic may have undermined efforts to address the epidemic in West Africa nonetheless.

In the Conclusion, we offer some tentative observations about the relationship between germ panics, law, and public health.\footnote{See text accompanying notes 305-12 infra.} For over twenty-five years, many infectious disease experts have warned about the very real dangers of EIDs.\footnote{See text accompanying notes 94-111 infra.} Our review of the history of HIV and AIDS suggests that such warnings may have unintended consequences, as fear can impede efforts to address the very problems that are identified by the warnings.

We also suggest that legal rights may play a role in determining the potency and persistence of germ panics, and thus support global health. While some laws relating to HIV and Ebola may have added fuel to the panic, in both cases legal decisions helped to delegitimize othering and lower the temperature.\footnote{See text accompanying notes 75-81, 199-213 infra.} By so doing, law may have worked alongside social and political forces, assurances by health authorities, and advances in science to facilitate a response based more on solidarity than stigma.

II. THE EMERGENCE OF AIDS

A. THE PANIC DEVELOPS

In June 1981, the CDC’s *Morbidity and Mortality Report* noted the mysterious appearance of a previously rare form of pneumonia—*Pneumocystis carinii*—in five gay men in Los Angeles.\footnote{CDC, *Pneumocystis Pneumonia – Los Angeles*, 30 Morbidity & Mortality Wkly. Rep. (1981) (original pagination unavailable).} A month later, the same publication reported that twenty-six young gay men in New York had been diagnosed with Kaposi’s sarcoma, a disease previously found in a much milder form among older men of Jewish and Mediterranean descent.\footnote{CDC, *Kaposi’s Sarcoma and Pneumocystis Pneumonia among Homosexual Men – New York and California*, 30 Morbidity & Mortality Wkly. Rep. 305, 305 (1981).} With the cause of the outbreak unclear, CDC spokesman Dr. James Curran dismissed the threat of AIDS to non-homosexuals, noting that “no cases have been reported to date outside the homosexual community or in women.”\footnote{Lawrence K. Altman, *Rare Cancer Seen in 41 Homosexuals*, N. Y. Times (July 3, 1981), http://www.nytimes.com/1981/07/03/us/rare-cancer-seen-in-41-homosexuals.html.}
By late summer 1981, it was clear that a new and terrible epidemic was destroying the immune system of gay men as well as intravenous drug users. A 1981 New England Journal of Medicine editorial identified immunosuppression as a common mechanism but failed to suspect a novel pathogen as the cause. Despite the attention from the medical community, the public at large did not take notice. But by 1983, as deaths mounted, AIDS “became a household word in the United States.” Although scientists suspected it was caused by an infectious agent, the human immunodeficiency virus (HIV) was not discovered until 1983. By 1985, a test was licensed to determine whether someone was infected, but the disease remained lethal in almost all cases.

As the public became more aware of the disease, fear escalated. So, too, did stigmatization of, and discrimination against, so-called “high risk groups”: gay and bisexual men, intravenous drug users, Haitians, and hemophiliacs. With the exception of hemophiliacs, these groups had been marginalized and subjected to discrimination prior to the epidemic. Their association with a new, mysterious, and lethal disease only compounded their social vulnerability, as AIDS became identified with “the other.” Even public health officials engaged in othering. Paul Farmer points out that in December 1982, a National Cancer Institute (“NCI”) physician, in regards to HIV, remarked: “[w]e suspect that this may be an epidemic Haitian virus that was brought back to the homosexual population in the United States.”

Throughout this period, members of these so-called high risk groups were portrayed in both the media and popular discourse as if they were responsible for the disease, in contrast to the “innocent victims” that they endangered. In July 1985, Life Magazine’s cover declared, “Now No One is Safe From AIDS,” insinuating that even those who were “innocent” faced dangers. This belief became even more pronounced in 1990 when a young Florida woman, Kimberly Bergalis, was diagnosed with AIDS after receiving dental work.
Another famous “innocent victim” was Ryan White, a young hemophiliac boy who acquired HIV through a blood transfusion; he was diagnosed with AIDS in late 1984. After being expelled from school, White fought to be reinstated and started several educational campaigns, becoming the poster child for the AIDS crisis. White’s case finally caught the attention of politicians; Congress passed the Ryan White Comprehensive AIDS Resources Emergency (“CARE”) Act four months after his death in 1990.

As fear of HIV escalated, so too did discrimination and calls for highly coercive measures. Children were barred from school, and gay men were evicted from their apartments and fired from their jobs. Patients were denied health and dental care; foreigners were barred from entering the United States; and HIV-positive Haitian refugees were detained in Guantanamo Bay. Conservative commentator and television personality William F. Buckley called for the visible tattooing of people who were HIV positive, prompting a similar statement in 1987 from Gerd Pfeiffer, president of the German Federal Court of Justice.

Public officials also debated quarantining people with AIDS, and a ballot measure in California calling for mass quarantines collected almost 400,000 signatures. Such calls provided a powerful disincentive to being tested for HIV. Senator Jesse Helms, for example, remarked “[t]he logical outcome of testing is a quarantine of those infected,” suggesting diagnosis as a means of further ostracization. Paul Drain notes, “HIV taught us that stigma and fear drive people away from both testing and medical attention, which thereby perpetuates transmission.”

Public health practitioners draw a distinction between quarantine, which separates individuals who are suspected of being exposed to a communicable disease, from isolation, which applies to individuals who have been diagnosed with such a disease. See Presidential Commission, supra note 4, at 22-23. So understood, many of the calls for AIDS quarantines were actually calls for isolation. However, public discourse at the time generally did not distinguish between the two practices, as the Helms quote demonstrates.

and discriminated against minorities . . . There is no doubt in my mind that, if the same disease had appeared among Americans of Norwegian descent, or among tennis players, rather than gay males, the responses of both the government and the medical community would have been different."

Indeed, despite the fear, or perhaps because of it, many public officials remained remarkably mute. Most notably, President Ronald Reagan did not mention the disease in public until 1985, four years after the sentinel cases. In contrast, his Surgeon General C. Everett Koop spoke eloquently about the epidemic, but Dr. Koop’s 1986 report linking AIDS to race and racism was quickly undermined by Reagan administration officials. Pat Buchanan, who was then communications director for President Ronald Reagan, referred to AIDS as “nature’s revenge on gay men.”

Politicians also challenged those measures proposed by health officials to fight the epidemic. For example, nine Republican Congressmen wrote to President Reagan attacking AIDS education focused on the use of condoms as “an overly liberal approach to AIDS,” despite the fact that at the time, condom use was a critical component of any effective AIDS prevention strategy. Newt Gingrich, one of those nine Congressmen, remarked, “AIDS will do more to direct America back to the cost of violating traditional values and to make America aware of the danger of certain behavior than anything we’ve seen. For us, it’s a great rallying cry.” Senator Helms, who successfully proposed a 1987 budget amendment to ban federal funding for HIV/AIDS initiatives that discussed homosexuality, defended his position, stating: “We have got to call a spade a spade, and a perverted human being a perverted human being.”

Similar opposition also formed around efforts to promote needle exchange programs, which were eventually shown to reduce transmission among intravenous drug users. In 1988, Congress banned the use of federal funds for such programs.

B. The Panic Recedes

By the late 1990s, the panic had subsided. Four interrelated factors may have played a role (in addition to the fact that all panics eventually burn out). First was the

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53 SHILTS, supra note 24, at 143.
56 Id. at 89-90.
58 BRIER, supra note 55, at 85.
59 Id. at 46.
62 Luthuli, supra note 57.
64 Michael A. Soto & Leon E. Cosler, Evaluation of Public Health Interventions, in PUBLIC HEALTH ADMINISTRATION: PRINCIPLES FOR POPULATION-BASED MANAGEMENT 512 (Lloyd F. Novick et al. eds., 2d ed. 2008). Even as early as the mid-1990s the scientific evidence was suggesting that needle exchange programs could be useful in preventing the transmission of HIV. See Salbu, supra note 63, at 131-49.
creation of a powerful social movement. Those involved demanded greater federal funding for HIV/AIDS research, an easing of FDA regulatory policies to enable faster development and dissemination of drugs, and an end to HIV-based discrimination. As Peter Baldwin explains, “[G]ays were effective actors. Though not held in esteem, they enjoyed above-average levels of education and income. When stricken as a group, they were in a position to act.” Their actions helped move public policy.

A second closely related development was the discovery of effective drugs. In 1987, the first HIV anti-retroviral drug, AZT was approved. Taken alone, it was of limited efficacy, but in combination with the protease inhibitors developed a decade later, outcomes were significantly enhanced. By the late 1990s, AIDS was no longer viewed as an inevitable death sentence. Mark Wainberg and colleagues note that “[HIV research] helped tremendously to mitigate problems of HIV discrimination and stigmatization.”

A third important stigma-reducing factor came via the story of Ryan White, followed by announcements that NBA star Magic Johnson, actor Rock Hudson, and tennis great Arthur Ashe were infected with HIV. Although all three were often portrayed as “innocent victims,” they helped give a face to AIDS that reduced stigma.

The final factor was the recognition of the legal rights of persons living with HIV/AIDS. Early in the epidemic, legal scholars argued that persons who were HIV positive had a disability within the meaning of the Rehabilitation Act of 1973, which prohibited recipients of federal financial assistance from discriminating on the basis of disability. In 1987, the Supreme Court offered support for that position, ruling in School Board of Nassau County v. Arline that the infectious diseases were handicaps (the then statutory term for what later were called “disabilities”) within the meaning of the Rehabilitation Act and that discrimination due to fear of contagion was prohibited by the Rehabilitation Act. Although the Court explicitly stated that it was not deciding whether AIDS was a handicap for the purposes of the Act, it noted that “society’s accumulated myths and fears about disability and disease are as

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67 Baldwin, supra note 66, at 180.
68 Id.
74 Hancock, Jr., supra note 73, at 8.
75 Arthur S. Leonard, Employment Discrimination Against Persons with AIDS, 10 U. DAYTON L. REV. 681 (1985). At the time the statute used the term “handicap” rather than “disability”.
78 Id. at 282 n.7.
handicapping as are the physical limitations that flow from actual impairment.\textsuperscript{79} Congress quickly adopted \textit{Arlene's} reasoning,\textsuperscript{80} making clear in the legislative history of the 1990 Americans with Disabilities Act ("ADA") that the Rehabilitation Act applied to HIV.\textsuperscript{81}

The passage of the ADA marked a watershed moment for HIV discrimination, providing for the first time broad federal protection against discrimination in public accommodations (including healthcare) and employment. After the ADA, advocates for persons living with HIV/AIDS were able to assert plainly that discrimination on the basis of HIV status was illegal. This message was reinforced in 1998 when the Supreme Court agreed, ruling in \textit{Bragdon v. Abbott}, that a woman who was infected with HIV had a disability within the meaning of the ADA.\textsuperscript{82} Although neither the ADA nor \textit{Abbott} ended discrimination against persons living with HIV, the climate had changed. The public scapegoating of an earlier era was no longer as socially or legally acceptable as it had once been.\textsuperscript{83}

To be sure, other laws that reinforced stigma remained. For example, the ban on immigration of HIV-positive individuals was only reversed in 2009.\textsuperscript{84} Additionally, Congress continues to ban the use of federal funds for needle exchange programs.\textsuperscript{85} Furthermore, the decades-old policy banning blood donation from gay men continued long after the panic, and has only recently been overturned;\textsuperscript{86} many states still criminalize the sexual activity of persons who are HIV positive.\textsuperscript{87}

Despite these continuing signs of stigma, the intense discrimination and scapegoating that marked the earlier period had faded by the start of this century. Only then did the United States become deeply involved in addressing the catastrophic HIV epidemic that was occurring in Africa and other developing countries.\textsuperscript{88}

\textsuperscript{79} \textit{Id.} at 284. Following the decision, the Justice Department reversed its own earlier position and issued a memorandum ruling that HIV infection was a protected status under the Act. \textit{See Memorandum from Douglas W. Kmiec, Acting Assistant Attorney General, U.S. Department of Justice, on Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals to Arthur B. Culvahouse, Jr., Counsel to the President} (Sept. 27, 1988), http://www.justice.gov/sites/default/files/olc/opinions/1988/09/31/op-olc-v012-p0209.pdf [http://perma.cc/WLJ5-M59Q].

\textsuperscript{80} For example, the Civil Rights Restoration Act of 1987 stated that the "term [handicap] does not include an individual who has a currently contagious disease or infection and who, by reason of such disease or infection, would constitute a direct threat to the health or safety of other individuals..." \textit{Pub. L. No. 100-259, 102 Stat. 28, 31-32} (1988). This language limiting the Act’s protection when an individual with an infection creates a "direct threat to others" only makes sense if the individual is otherwise covered by the Act absent the threat.

\textsuperscript{81} \textit{See Parmet and Jackson, supra note 43, at 21-22.}


\textsuperscript{83} \textit{See generally Kriss A. Drass, Peter R. Gregware and Michael Musheno, Social, Cultural, and Temporal Dynamics of the AIDS Case Congregation: Early Years of the Epidemic}, 31 L. & SOC. REV. 267 (1997) (making the important point that the legal affirmation of rights for persons living with HIV/AIDS applied disparately to the more privileged and less stigmatized groups who lived with HIV/AIDS. IV drug users, sex workers, and HIV-positive inmates continued to experience negative treatment from the judicial system.).


\textsuperscript{85} The ban was temporarily lifted in 2009 and then reinstated by Congress as part of 2010 budget negotiations. \textit{See Public Health and Welfare Act of 1988 and Salbu, supra note 63.}


\textsuperscript{88} \textit{See text accompanying notes 248-62 infra.}
III. GERM PANICS, EMERGING INFECTIOUS DISEASES, AND THE OUTBREAK NARRATIVE

The early reaction to AIDS had many of the hallmarks of what Nancy Tomes has termed a “germ panic.” Similar to so-called moral panics, germ panics are characterized by an exaggerated fear of disease, as well as the tendency to blame outsiders or vulnerable groups for the danger. Germ panics may also reflect and reinforce efforts to exercise social control by quarantining people at risk for a disease or criminalizing behaviors perceived to be associated with the germ. All of these elements, including scapegoating, irrational fears, and efforts to exert social control, were present in the American reaction to HIV in the 1980s and 1990s.

According to Peter Washer, “[t]he appearance of AIDS in the 1980s shattered the widely held optimism that infectious diseases were a ‘thing of the past.’” In the epidemic’s wake, infectious disease experts began to recognize that HIV was but one example of a broader problem that quickly became known as emerging infectious diseases. This danger was highlighted in a 1992 report by the Institute of Medicine (“IOM”), *Emerging Infections: Microbial Threats to Health in the United States*, which warned that a variety of social and environmental changes, including global warming, population growth, migration, changes in human behavior (such as increased drug use and changes in sexual behavior), medical practices, and urbanization had created the threat of new infectious diseases. The AIDS epidemic both illustrated and magnified the risk by creating populations of immune-suppressed people highly susceptible to other infections, such as tuberculosis. Due to modern travel, new infections could spread rapidly to the United States and other developed nations. To meet the threat, the IOM called for increased funding for research, enhanced surveillance, greater support for global health, vaccine development, the rebuilding of...
the American public health system, and public education in support of behavioral changes, including changes in sexual behavior and hygiene.99

Following the IOM’s report, scientists and policymakers paid renewed attention to EIDs.100 In 1996, President Bill Clinton issued a Presidential Decision Directive calling for increased surveillance, planning, and coordination between federal agencies to deal with the threat of emerging infections.101 Thereafter, policymakers increasingly presented EIDs as a threat to national security.102 For a time following the anthrax attacks of 2001, concerns about bioterrorism displaced the focus on naturally occurring EIDs.103 Yet, when severe adult respiratory syndrome (“SARS”) struck in 2003, attention turned again to natural threats.104

In many ways, the warnings about EIDs were prescient. Since the initial IOM report, the United States alone has experienced outbreaks of West Nile Virus, multi-drug resistant tuberculosis, methicillin-resistant Staphylococcus aureus (“MRSA”), Hanta virus, and Legionnaire’s disease.105 SARS spread rapidly from China to other parts of Asia and Canada, creating widespread global fear and economic disruption.106 In 2005, scientists warned that H1N9 avian influenza could evolve into a human pandemic, killing millions of people.107 A few years later, the H1N1 influenza virus appeared and quickly became pandemic.108 More recently, Middle Eastern Respiratory Syndrome (“MERS”) spread from the Middle East to South Korea, killing thirty-six people and leading the South Korean government to close many schools and institute broad quarantines.109 Also, in 2015, the mosquito-borne Zika virus spread rapidly in

99 Id. at 113-69.
100 This is reflected by the 1995 launching of a new CDC peer-reviewed journal, “Emerging Infectious Diseases.” See Joseph E. McDade, Polyxeni Potter, & D. Peter Drotman, Emerging Infectious Diseases: 10 Years Running, 11 EMERGING INFECTIOUS DISEASES, 497 (2005).
102 WASHER, supra note 91, at 149.
Brazil, Latin America, and the Caribbean, causing microcephaly, a severe neurological birth defect. And of course, in 2014, Ebola caused devastation in West Africa, and spread to the United States and Europe. Although the scientists who studied EIDs frequently stressed the theme of global interdependence, politicians, the media, and popular culture often used remarkably sensationalistic language to describe the dangers. For example, writing about the risks of a possible influenza pandemic in 2005, the President’s Homeland Security Council warned that, “a modern pandemic could lead to the death of 200,000 to 2 million people in the United States.” In response to a potential calamity, President George W. Bush suggested in 2005 that troops may be needed to quarantine an American city. That same year, journalist and author Laurie Garrett wrote in *Foreign Affairs* that “doom may loom” as a result of influenza. In a similar vein, reports in 2001 about the “Dark Winter” simulation of a possible smallpox attack on the United States noted that the exercise showed that within three weeks of an attack there would be 16,000 cases, the medical system would have “collapsed,” and stockpiles of vaccine would be depleted. “[T]he computer predicted 300,000 victims within three weeks. The government was discussing the imposition of martial law.” To meet the threat, the federal government instituted a smallpox vaccination program and tried to convince healthcare workers to be vaccinated against a disease that had been eradicated in nature. More broadly, policymakers supported “public health legal preparedness,” which included the development of, and competency to use, laws authorizing emergency measures, including quarantines and forced medical treatment.
Popular culture reinforced both the sense of danger and the assumption that strong, tough actions would have to be taken to keep the homeland safe from EIDs. Movies like _Outbreak_ and _Contagion_, as well as bestselling books like Richard Preston’s _The Hot Zone_ and Laurie Garrett’s _The Coming Plague: Newly Emerging Diseases in a World Out of Balance_, inspired fear that diseases like Ebola would arrive in the United States. Such portrayals often followed a common storyline, one that Patricia Wald calls the “outbreak narrative.” In this narrative, the danger of infection is presented as one brought into the United States or the developed world from the developing world by migration or travel.

Although the outbreak narrative and scientists’ warnings about EIDs served to draw attention to the very real threat of infectious epidemics, they also reinforced the colonial tendency to see the non-Western world as a source of lurking danger, in addition to ancient tendencies to associate diseases with “the other.” Throughout history, societies have placed the blame for new and terrifying diseases on foreigners and those within their society who are perceived as different. According to one Ebola commentator, “[t]he onset of epidemic disease has always incited prejudice, permitting the stereotyping of foreigners, of people of color, as inherently closer to disease: more deserving of death from it.”

By emphasizing the danger of infections emerging from non-Western countries, discourse surrounding EIDs highlighted the association between disease and foreigners. And by insisting that the diseases of the developing world could travel quickly to the developed world, the narrative presented the inhabitants of the developing world as dangerous carriers of disease. In response, the public was likely to call for closing borders and shutting off contact with the developing nations, just as the United States did with respect to HIV. The results were global health policies that sought to contain the danger of EIDs within the developing world, rather than prioritizing the health threats faced by the world’s poorest people.

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124 Randy Shilts presented the genesis of the AIDS epidemic in this fashion, tagging an airline attendant, Gaëtan Dugas, as patient zero and claiming “there’s no doubt that Gaëtan played a key role in spreading the new virus from one end of the United States to the other.” See _Shilts, supra note 24_, at 439.


130 Simon Rushton, _Global Health Security: Security for Whom? Security from What?_ 59 POL. STUDS. 779, 782-87 (2011) (also adding that such policies place disproportionate costs on developing countries, so in effect these countries are asked to subsidize the “health security” of wealthy nations).
IV. THE EMERGENCE OF EBOLA

A. SIMILAR PANICS

Despite Ebola’s starring role in popular discourse, early outbreaks were confined to remote rural regions of Africa.131 These actual outbreaks were initially portrayed by health officials and the media as posing little threat to the West.132 Starting in a small village in Guinea in December 2013, the extent of the outbreak was not reported to the World Health Organization (“WHO”) until the following March.133 Eventually, the epidemic spread to six West African countries, but was most heavily concentrated in Guinea, Sierra Leone, and Liberia. By September 2015, over 11,000 people had died; almost all of them in those three African countries.134

As with HIV, the 2014 Ebola outbreak initially went largely unnoticed, and although some governments and non-governmental organizations (“NGOs”) provided support, it was insufficient to stop an epidemic that was spreading rapidly in three of the world’s poorest nations.135 In June 2014, Médecins Sans Frontières (or Doctors Without Borders) warned that Ebola was out of control in West Africa, but the international community still paid little attention.136 Only in August 2014 did the WHO declare Ebola to be a “public health emergency of international concern” and begin to convene meetings on appropriate responses and acceleration of clinical trials.137

This declaration came shortly after two American healthcare workers who had contracted Ebola in West Africa were flown to the United States for treatment.138 Suddenly Ebola became headline news in the United States.139 Primed by more than two decades of popular discourse warning about the dangers of emerging diseases, especially Ebola, from the developed world, terror quickly took hold.140 Trying to calm...
an anxious public, CDC Director Tom Frieden stated that, “Ebola is a huge risk in
Africa. It’s not going to be a huge risk in the U.S.”

Despite Frieden’s message of containment, a full-scale germ panic erupted after
Duncan and two of his nurses were diagnosed with Ebola. A Google Trends graph
shown in Figure 1, depicts American interest in Ebola as determined by volume of
searches. The graph shows peaks around the four American cases, with nearly flat
lines of interest both prior to the panic and after the chaos has subsided. The four
peaks on the figure generally correlate with the number and timing of Ebola cases
identified in the United States in the fall of 2014. Interest in Ebola at the end of the
three-month period mirrors the interest prior to its arrival into the United States.
Interest in health issues tends to follow this pattern. For example, ALS awareness
peaked in late summer 2014 with the ice bucket challenge, a campaign designed to
promote awareness of, and funds for, ALS by having people dump a bucket of ice
water on their heads. Prostate cancer awareness peaks in November every year due to
campaigns like “Movember” and “No Shave November,” where men grow facial hair
to raise money and awareness for the cause.

As with HIV, people who were associated with the disease bore the public’s
wrath. Paralleling the experience of Ryan White and other HIV-positive children, at
least twenty children across the country were barred from school simply for having
traveled to Africa, even though some were not even anywhere near a region in which
there were Ebola cases. Even healthcare workers were blamed. Members of
Duncan’s care team, who could have been construed as “innocent victims” exposed to
Ebola just by doing their job, were instead chastised for having the audacity to board
a plane or go on a Caribbean cruise after participating in Duncan’s care.

Another important similarity between AIDS and Ebola was the pace of research
and development. As mentioned before, it took several years before HIV was
identified and a few more years to develop a diagnostic test. With Ebola, the
National Institutes of Health ("NIH") was developing a vaccine as early as 2001, but
federal funding was diminished for political reasons, according to NIH director Francis

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141 Tribune Wire Reports, “Infected Ebola Relief Worker Due to Arrive in U.S. Today, CHI. TRIB.

142 See PRESIDENTIAL COMMISSION, supra note 4; Abby Haglage, Ebola Panic is Worse Than The
Disease, THE DAILY BEAST (Oct. 9, 2014), http://www.thedailybeast.com/articles/2014/10/09/ebola-panic-
Were the Worst Predictions A Year Ago, and Did they Come True?, SLATE (Oct. 6, 2015),
http://www.slate.com/articles/health_and_science/medical Examiner/2015/10/ebola_panic_anniversary_pre-
dictions_of_a_u_s_epidemic_didnt_come_true.html [http://perma.cc/E3ST-BNVX].

143 See Figures 2 and 3 for Google Trends related to ALS and prostate cancer awareness, respectively.
If Google Trends graphs were around in the 1980s and 1990s, searches for HIV and AIDS might have
looked similar. Peaks would likely have occurred around the diagnoses of Ryan White and NBA star Magic
Johnson, but in the years prior to Ryan White, we might expect a flat line around zero. By the late 1990s, the
peaks would likely have faded as the panic receded.

144 Wainberg et al., supra note 72.

145 AM. CIVIL LIBERTIES UNION (hereinafter “ACLU”) AND YALE GLOB. HEALTH JUSTICE P’SHP,
FEAR, POLITICS, AND EBOLA: HOW QUARANTINES HURT THE FIGHT AGAINST EBOLA AND VIOLATE THE
ac lu_yale_ghip _- _fear _politics _and _ebola-december.2015.pdf [http://perma.cc/UMH8-B733]. See also Ray
Sanchez, Connecticut Girl Barred from School Amid Ebola Fears; Family Sues, CNN (Oct. 29, 2014),

146 Chris Perez, Ebola Nurse Who Flew on Jet Slams Critics, N.Y. POST (Nov. 6, 2014),

147 Id.

148 See text accompanying notes 29-30, supra.
Collins. Wainberg and colleagues note, “[i]n contrast [to HIV], very little comparable research has taken place with regard to Ebola virus, even though this agent was in fact identified prior to the discovery of HIV in 1983.” Yet, within months of the first diagnosed case in the United States, testing of novel Ebola vaccines resumed in earnest. Stigma, this time surrounding West Africans, as well as the lack of a viable commercial market in Africa, could have slowed Ebola vaccine discovery. But once fear of Ebola rose within the United States, large pharmaceutical companies such as GlaxoSmithKline, Merck, and Johnson & Johnson quickly began to work on vaccine development.

As with HIV, othering played a large role in perpetuating misconceptions about the origins of Ebola and its methods of transmission. Many people in the West blamed bush meat, long-consumed in West Africa, for the current outbreak of Ebola. Much like sodomy, many Americans viewed the practice of eating bush meat, the meat from animals hunted in tropical forests, as disgusting, even though bush meat is often the only available source of protein in some parts of these resource-limited countries. Just as with AIDS, many characterized the acquisition of Ebola as “divine retribution” for commission of undesirable acts.

Politicians sometimes fueled the fears and stigmatization, just as they did in the early years of the AIDS epidemic. Physician-turned-Senator Rand Paul stated his belief that Ebola was more contagious than the government was telling the public. Nurse-turned-Congresswoman Renee Ellmers of North Carolina suggested that Ebola had mutated and gone airborne, in spite of scientific evidence to the contrary. Her statement mirrored the fear during the AIDS panic that casual transmission, via

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150 Wainberg et al., supra note 72.
160 Id.
handshakes or toilet seats, was possible. In full campaign mode prior to the 2014 elections, politicians tried to prove they could be tough on Ebola. Mirroring the travel ban imposed on HIV-positive non-nationals, politicians, such as New Jersey Governor Chris Christie, Senator Marco Rubio, and Speaker of the House John Boehner, called for an Ebola travel ban, even though medical experts noted that a ban would have no domestic impact and could worsen the West African outbreak.

Others called for quarantine, much like Senator Jesse Helms had done with AIDS. The U.S. Department of Defense imposed a twenty-one day quarantine for soldiers returning from West Africa. After Dr. Spencer’s diagnosis in New York City, Governors Andrew Cuomo and Chris Christie announced that they would quarantine everyone arriving from West Africa for twenty-one days. Other states followed suit. At least twenty-three states imposed policies more restrictive than the CDC recommended. Duncan’s family was quarantined for a time in the still-contaminated apartment he lived in prior to his hospitalization. The most publicized quarantine of an uninfected individual was that of nurse Kaci Hickox, who was detained in a tent in New Jersey after returning from West Africa. A Google Trends search, replicated in Figure 4, comparing the search term “quarantine” to the last names of the three American Ebola nurses (Hickox, Pham, and Vinson) shows a two-pronged peak of interest in quarantine. The first peak in searches correlates with the timing of Pham and Vinson’s infections and isolation after caring for Mr. Duncan in Dallas, and the second peak correlates with the Hickox quarantine and her subsequent lawsuit. As such, the media frenzy surrounding each nurse’s case may have driven the national discussion surrounding quarantines.

The vitriol continued to pour in against healthcare workers on the Ebola frontline. A Seattle Times op-ed referred to Spencer and Hickox as “callous, self-absorbed bullies.” The National Review Online opined, “[a] more prison-like set-up would have been appropriate for [Spencer].” Describing his experience, Spencer stated: “After my diagnosis, the media and politicians could have educated the public about...”

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161 Wainberg et al., supra note 72.
163 See Salles, supra note 159.
165 PRESIDENTIAL COMMISSION, supra note 4, at 15.
Ebola. Instead, they spent hours retracing my steps through New York and debating whether Ebola can be transmitted through a bowling ball.172 Indeed, the New York City Health Department acted in contradiction of the prevailing public health message that Ebola cannot be casually transmitted by unnecessarily inspecting and sanitizing a bowling alley that Spencer visited prior to his becoming ill.173

As during the AIDS epidemic, health officials insisted that many of the coercive measures the public demanded would be counter-productive. Because Ebola is transmitted only via close contact with infected bodily fluids of patients with active disease, quarantines are generally unnecessary;174 the close monitoring of individuals at risk will suffice.175 Health officials also argued that travel bans would be counter-productive because they would deter healthcare workers from traveling to Africa, where help was desperately needed to stem the epidemic.176

For this reason, the Obama Administration resisted calls for a travel ban and quarantines. However, in response to the growing panic (not to mention the upcoming midterm election in which Ebola was playing a prominent role),177 on October 8, the CDC announced that enhanced screening for Ebola would be conducted at the five airports that receive almost all of the passengers arriving from West Africa, despite the fact that passengers were screened upon leaving those countries.178 Passengers arriving from the affected regions were removed to a screening area where their temperatures were taken and they were questioned and observed.179 Passengers who fit a higher risk profile—for example, having treated patients with Ebola—were subjected to further questioning and followed by local health officials.180

These measures proved inadequate to stem the demand for tougher actions.181 In response, on October 27, the CDC announced interim guidance calling for state health officials to actively monitor people who had direct contact with known Ebola patients.182 Despite the fact that asymptomatic individuals do not transmit Ebola, the

guidance further advised that the public activities of such individuals be restricted. 183 Many states imposed even more onerous policies. 184

Travel bans and quarantines stood to worsen the problem by preventing needed aid and healthcare workers from getting in and out of the affected area. 185 Given the number of healthcare workers that actually contracted Ebola during the provision of healthcare services, fear of the disease was irrational and limited the provision of medical care. 186 Travel bans and quarantines may have also impeded the scientific discourse critical to responding to the epidemic. For example, just a few days before the start of the annual meeting of the American Society of Tropical Medicine and Hygiene in New Orleans, the Louisiana Department of Health announced that individuals who had returned from Sierra Leone, Guinea and Liberia in the prior 21 days should not attend the conference, as they would be confined to their room. 187 This incident eerily recalled the barring of attendees to the 7th National AIDS Forum in San Francisco in 1989. 188

As with Ebola, physicians and other health workers tasked with treating HIV patients in the early AIDS epidemic were also met with fear. 189 Patients called for physician testing for their own protection. 190 Conversely, some physicians even had to be ordered by their superiors to treat AIDS patients, prompting the American Medical Association (“AMA”) to pass a policy stating: “A physician may not ethically refuse to treat a patient whose condition is within the physician’s current realm of competence solely because the patient is seropositive.” 191 In response to Ebola, one physician posted online: “I am a hospital-based physician and frankly, the prospect of caring for an Ebola patient is scary.” 192

The Ebola panic tapered off within months, and so did interest in Ebola in West Africa. Comparing Google Trends searches (Figure 5) for “Ebola US” and “Ebola Africa” highlights this trend. Of note, searches for “Ebola Africa” do not appear to have exceeded searches for “Ebola US” at any point, before, after, or during the panic. Another Google Trends comparison (Figure 6) looking at the search term “Ebola” in the United States and in the three affected countries, Sierra Leone, Liberia, and Guinea, shows that the sheer volume of searches in the United States was paltry compared to searches in the affected countries. More significantly, interest in the West

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183 For this reason, Robert Gatter says “The recommendations in the CDC’s Guidance lack a basis in the science of Ebola transmission.” Gatter, supra note 182, at 378.


185 See Frieden, supra note 176.


189 Altman, supra note 26.


192 Petrow, supra note 5.
African Ebola peaked in the summer, long before the American scare, suggesting a mismatch in priorities.

B. THE PANIC RECEDES

As with HIV, several factors ultimately combined to quell the panic in the United States. Undoubtedly, one was the lack of additional cases. No other infections occurred in the states after Dr. Spencer was diagnosed. Had additional infections occurred, the panic would have likely continued longer.

The 2014 Congressional elections may have also played a role. In the weeks before the election, Republicans lambasted President Obama for being weak on Ebola.193 Once the election was over, media coverage declined precipitously. According to Media Matters, “[i]n the two weeks following the elections, evening broadcast and cable news have only aired 49 total segments related to Ebola.”194 This contrasts dramatically with the 975 segments that were run in the four weeks prior to the election.195

A third contributing factor is the media’s tendency to offer reassurances as an EID outbreak continues. Scholars have noted that, after initially presenting the risk of an outbreak in an alarming manner, the media often offer what Sheldon Ungar terms a “containment package,” which provides the comforting message that the risk is limited to the other.196 By mid-to-late November 2014, such reassuring messages began to take hold, as the press started reporting that monitoring had not uncovered any new domestic cases197 and that transmission in Liberia had begun to slow down.198

In addition, as with HIV, the law may have played a role, first in stirring, and finally in calming, the panic. As noted above, in response to the threat of EIDs, public health officials and policymakers in the United States advocated what came to be known as “public health legal preparedness.”199 This led to an emphasis on the use of emergency powers, including the use of isolation and quarantine, in response to an EID outbreak.200 With this foundation in place, it should not be surprising that many politicians and much of the public were quick to demand the use of such measures in response to Ebola, even though the evidence did not support the need for them.201

193 Jeremy W. Peters, Cry of G.O.P. in Campaign: All is Dismal, N.Y. TIMES (Oct. 9, 2014), http://www.nytimes.com/2014/10/10/us/politics/republican-strategy-midterm-elections.html. This helped to reinforce broader messages about the President’s competence that were central to the Republican election strategy.


195 Id.

196 Ungar, supra note 132, at 48-52.


199 See text accompanying notes 119-20 supra.

200 Mariner et al., supra note 120, at 351-65; Parmet, supra note 120, at 95-99.

Nevertheless, in at least one notable case, the law offered an important and constructive counterweight to the rush to scapegoat. This occurred in the case of Kaci Hickox. Ms. Hickox had gone to Sierra Leone to treat Ebola patients, and she had the bad fortune to return to the United States via Liberty International Airport shortly after New York Governor Andrew Cuomo and New Jersey Governor Chris Christie announced that they would quarantine all healthcare workers who had had patient contact in the affected West African countries for twenty-one days. Even though she tested negative for Ebola, Hickox was kept for several days in a tent outside a New Jersey Hospital.

Unlike the many other healthcare workers who were quarantined, Hickox publicly criticized her detention and obtained legal counsel. After she did so, New Jersey health officials allowed her to travel to Maine, where state officials sought a quarantine order. On October 31, Maine judge Charles LaVerdiere rejected the state’s request. Noting that Hickox “generously, kindly and with compassion lent her skills to aid, comfort, and care for individuals stricken with a terrible disease,” he remarked that “we owe her and all professionals who give of themselves in this way a debt of gratitude.” Finding that Hickox was cooperating with active monitoring, did not show any symptoms of Ebola, and was not infectious, Judge LaVerdiere concluded that the State had not met its burden “to prove by clear and convincing evidence that limiting Respondent’s movements to the degree requested is ‘necessary to protect other individuals from the dangers of infection.’” Judge LaVerdiere also noted that “misconceptions, misinformation, bad science and bad information” were being spread about Ebola, and that “people are acting out of fear and that this fear is not entirely rational.” Given the fear, he advised Hickox to “guide herself accordingly,” and granted the State’s request for an order requiring Hickox to submit to active monitoring, though she was already doing so voluntarily.

The Hickox case, which was widely reported in the media, represented only one lower court’s opinion. It was also an unusual case, in that courts have rarely reviewed quarantine orders issued—perhaps because few have been issued—against relatively privileged individuals. Hickox’s case was important, nonetheless, because the court’s opinion underscored that fear alone did not justify the use of highly coercive public health powers. Rather, like the Supreme Court in Bragdon, Judge LaVerdiere reaffirmed that the science mattered. Scapegoating was not a legally-sanctioned public

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202 Id.
203 See Hodge, supra note 169, at 367-68.
204 Researchers from Yale University and the ACLU concluded that during the outbreak, at least 40 individuals in the U.S. were formally quarantined, and at least 233 individuals either went into quarantine or had their movements severely restricted in the absence of formal quarantine orders. Many of these informal quarantines were effectively coercive in that individuals faced official pressure. ACLU AND YALE GLOB. HEALTH JUSTICE P’SHP, supra note 145, at 29. The researchers found it impossible to determine the exact number of people quarantined, as states did not make that information public. Id. at 27-28.
206 Id.
207 Order Pending Hearing, supra note 175.
208 Id.
209 Id.
210 Id.
211 Id.
212 See Kathryn Staiano-Ross, Quarantine, 187 SEMIOTICA 83 (2011).
213 The opinion can be interpreted as suggesting that fear alone warranted the order for active monitoring.
health strategy. Whether that reminder helped to dissuade other health officials from seeking quarantine orders, we cannot know. But by mid-November, the panic receded.

V. EBOLA AND THE UNITED STATES

A. INTRODUCTION: THE UNITED STATES’ HUMANITARIAN RESPONSE TO AFRICA

Perhaps the most striking similarity between HIV and Ebola is that both diseases exacted a far heavier toll in Africa than in the United States. Despite the fact that HIV (unlike Ebola) killed hundreds of thousands of Americans, the disease’s impact was far greater in many African countries, with prevalence rates of over twenty percent in Botswana, Namibia, and South Africa. This disparity between the magnitude of the threat was even more pronounced during the 2014 Ebola epidemic. Despite the panic, no one infected in the United States died of Ebola. In contrast, over 11,000 people died in West Africa. The outbreak also exacted a heavy economic toll there. The short-term impact of Ebola in West Africa is estimated to have cost the region from $2.2 to 7.4 billion in 2014 alone.

The panics that have ensued around EIDs, however, have often obscured interdependence. When panic erupts, stigma replaces solidarity. Domestically, this is evidenced by acts of private and public discrimination, as well as an excessive resort to highly coercive public health laws. Internationally, this is marked by isolationist policies that attempt to keep the disease out, rather than support its eradication in the hardest hit areas. As Ungar wrote about the Western response to an earlier Ebola outbreak, “[t]he strategy of othering is a direct counterpoint to the theme of globalization.”

B. THE EXTENT OF AIDS IN AFRICA

The initial American policy towards global AIDS conformed to this script. Although epidemiological data are lacking from the early period, the virus was likely well entrenched in many parts of Africa by the late 1970s and early 1980s. For example, approximately sixty-one percent of prostitutes in Nairobi in the early 1980s had HIV. In Uganda, HIV infection of pregnant women peaked in 1991 at approximately twenty-one percent. By 1995, ninety-one percent and eighty-six percent of Ugandan men and women, respectively, knew someone who had AIDS, indicating the incredibly broad scope of the virus. The virus was also becoming

216 CDC, supra note 134.
218 Id. at 2.
219 See Ungar, supra note 6, at 52.
221 Id.
223 Id. at 716.
deeply entrenched in West and Southern Africa. By the 1990s, Botswana had the world’s highest HIV infection rate at thirty-five percent of adults.\textsuperscript{224} Seven out of eight countries with the world’s highest infection rates were in the Southern region of Africa and remain there as of 2013, with rates of infected fifteen to forty-nine year olds between twelve and twenty-seven percent.\textsuperscript{225}

Despite the magnitude of the African epidemic, the initial American response was isolationist. During the peak of the AIDS panic in 1985, the Department of Health and Human Services (“HHS”) suggested adding AIDS to the list of “Dangerous Contagious Diseases,” which would have barred the granting of visas to people who were infected.\textsuperscript{226} HHS reasoned that “AIDS represents a very serious threat to the public health and should be a basis for denying immigrant visas.”\textsuperscript{227} The State Department initially opposed this; Deputy Secretary of State John Whitehead warned that it would undermine the WHO’s efforts to fight AIDS, directly contradicting the WHO’s position that there was no need for travel restrictions.\textsuperscript{228} Around the same time, Attorney General Edwin Meese announced the testing of all immigrants and federal prisoners for HIV.\textsuperscript{229}

During this period, and even later, the type of moralistic approaches to sexuality and reproduction that influenced domestic responses to HIV/AIDS also impacted the American global response. For example, in 1984 President Reagan signed the “Mexico City Policy,"\textsuperscript{230} which restricted recipients of American financial assistance from using their own money to perform abortions, lobby their government for legalization, or conduct educational campaigns on the issue.\textsuperscript{231} Critics labeled it a “global gag rule” that forced many organizations to restrict their services.\textsuperscript{232} As a result, many family planning clinics in Africa that provided HIV and AIDS care were forced to close or significantly curtail their practices.\textsuperscript{233} Because of the high rates of HIV and AIDS among pregnant women, and the inherent connection between family planning and HIV/AIDS, this policy had a significant impact on Africa’s ability to combat the disease.\textsuperscript{234} The Mexico City Policy was first instituted by President Ronald Reagan in 1984, rescinded by President Bill Clinton in January 1993, reinstated by President George W. Bush in January 2001, and rescinded again by President Barack Obama in January 2009.\textsuperscript{235} Of note, each of the last three presidential actions were done in the first month of their respective presidencies, highlighting the controversial and politically polarizing nature of the policy.\textsuperscript{236}

\begin{thebibliography}{9}
\bibitem{224} Jeff Gow, The HIV/AIDS Epidemic in Africa: Implications for U.S. Policy, 21 HEALTH AFF. 57, 60 (2002).
\bibitem{226} Brier, supra note 55, at 79. As discussed above, this ban eventually came to pass. See text accompanying note 235 infra.
\bibitem{227} Id. at 105.
\bibitem{228} Id.
\bibitem{229} Id. at 107.
\bibitem{230} Family Planning and Population Assistance Activities, 48 C.F.R. § 752.7016(b) (1986).
\bibitem{232} Id. at 189.
\bibitem{233} Id. at 199-200.
\bibitem{234} Id. at 209.
\bibitem{236} Id.
\end{thebibliography}
By the late 1980s, epidemiological data demonstrated the massive scope of AIDS and HIV worldwide. In response, the State Department established the AIDS Technical Support Program. Its major objectives were: (1) STD reduction; (2) condom social marketing; and (3) behavior change communication. The AIDS Technical Support Program was woefully underfunded, allocated just sixty-eight million dollars in 1986 to be utilized between 1987 and 1992. Looking at the magnitude of the epidemic that was unfolding, a State Department memo in 1989 warned, “[i]n Africa, AIDS has the potential to devastate entire societies, erasing the hundred-year old impact of modern European technology and thrusting whole nations back into the early iron age.”

Around the same time, the American media began to take note of the intense suffering in Africa. Perhaps as a result, in 1989, AIDS relief work received its own line in the federal budget, marking the first significant increase in American attention to global AIDS. Still, an internal State Department evaluation between 1987 and 2002 acknowledged that the United States needed to do more. Gradually assistance increased. Between 1987 and 1990, United States shipments of condoms to Africa increased five-fold. In 1991, the United States Agency for International Development (“USAID”) developed 650 different HIV/AIDS programs in seventy-four different countries. The next year it granted $168 million to AIDS Control and Prevention (“AIDSCAP”), which worked in forty-five countries over the next five years.

American support for HIV prevention and treatment in Africa began to accelerate as the domestic panic receded. With effective drugs becoming available and the domestic crisis calming, activists in the United States were able to turn their attention and efforts to the catastrophe confronting Africa. In 1998, one year after the Bragdon decision, the Clinton Administration pledged $100 million for an initiative called Leadership and Investment in Fighting an Epidemic (“LIFE”), designed to slow the spread of HIV in sub-Saharan Africa, improve the quality of care given to infected individuals, and care for AIDS orphans. Two years later, Vice President Al Gore promised that international AIDS relief work was a high priority, and requested an additional $150 million from Congress in 2001 to combat AIDS in Africa. That same year, President Clinton signed the Global AIDS and Tuberculosis Relief Act,
which promised $400 million to combat AIDS and other infectious diseases around the world. Not long after, President George W. Bush pledged $200 million to the United Nations Global AIDS fund. Although greater than earlier outlays, these commitments paled in comparison to the amount needed.

It was not until 2003 that the United States made a significant monetary commitment to global AIDS. In 2003, President George W. Bush announced the President’s Emergency Plan for AIDS Relief (“PEPFAR”) and pledged ten billion dollars over five years to fund global HIV and AIDS response. Although not without its critics, PEPFAR enabled delivery of HIV/AIDS education, care, and prevention to very poor countries struggling with the virus. Between 2003 and 2008, $20.4 billion was sent to PEPFAR; in 2008, Congress reauthorized PEPFAR for as much as forty-eight billion dollars through 2014.

### Table 1

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<thead>
<tr>
<th>Year(s)</th>
<th>US pledges to the Global Fund (in billions)</th>
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<tr>
<td>2001-2007</td>
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<td>2008-2010</td>
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<td>2011-2013</td>
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From the beginning, PEPFAR worked in tandem with the Global Fund, which was established in 2002 to combat HIV/AIDS, tuberculosis, malaria and other infectious diseases (see Table 1 for a breakdown of American contributions over the years). In some countries, these two programs fund as much as ninety percent of HIV programs. Despite their interconnection and interdependence, PEPFAR and the

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253 Id.
254 Id.
258 Id.
259 Id.
260 See GOSTIN, supra note 256, at 146-48, 324 (discussing the Global Fund and its relationship to PEPFAR).
Global Fund have different models of action. PEPFAR grants the United States an in-country presence, delegating funding to specific activities and closely monitoring the money’s implementation and effectiveness. The Global Fund, in contrast, relies more heavily on partners within the affected country, thereby allowing it to manage its response. Interestingly, the better public health infrastructure created by the presence of PEPFAR and the Global Fund in nations such as Nigeria and Côte d’Ivoire may have protected those countries against Ebola.

Critics rightly point out numerous continuing inadequacies in the magnitude and nature of the American response to AIDS in Africa. American support for the intellectual property rights of pharmaceutical companies, for example, counteracts efforts to obtain and distribute drug treatments for Africa. Still in sharp contrast to the early period, the United States is now heavily engaged in the fight against global HIV/AIDS. Although causality cannot be established, this engagement only became fulsome after the domestic panic ended.

D. THE UNITED STATES’ RESPONSE TO EBOLA IN AFRICA

Ebola, as noted earlier, has long played a leading role in EID discourse. Nevertheless, American engagement with Ebola was initially limited. The first documented human cases of Ebola occurred in 1976 in Zaire (now the Democratic Republic of Congo). Of those 318 infected, 280 died. Over the next two decades the outbreaks remained small and isolated. Then in 1995, Ebola reemerged to claim the lives of 250 people (out of 315 cases) in Zaire; twenty-five percent of those cases were healthcare workers. Soon after the mysterious outbreak began, the CDC sent a team to investigate the cause. Once Ebola was confirmed, USAID’s Foreign Disaster Assistance (“OFDA”) authorized $25,000 to local NGOs to help contain the outbreak. Specifically, this money was “for the purchase and transport of disposable

260 Id. at 1416.
261 Id.
263 See notes 278-79 infra. A full discussion of the limitations of US policy toward HIV is beyond the scope of this article.
265 Some critics argue that efforts that emphasizing HIV/AIDS U.S. global health efforts remain focused on diseases that have the potential to spread to the U.S. and other developed nations, rather than illnesses that burden people living in low income countries. See Rushton, supra note 130, at 782-84.
266 See text accompanying notes 121-24 supra.
268 Id.
269 Id.
protective clothing, plasma, body bags, and essential medicines and supplies.\textsuperscript{276} The OFDA also requested that the Department of Defense airlift sterile needles, plasma, hospital gowns, and other supplies to the affected region.\textsuperscript{277}

There were many issues with the CDC’s response to this outbreak. The CDC team’s effectiveness was hindered by a lack of communication, transportation, and insufficient personnel.\textsuperscript{278} Money was also an issue—one week into the response the team requested $781,000 to allow six doctors to work in Zaire for three months.\textsuperscript{279} Finally on May 23 (two weeks after the team arrived), OFDA allocated $750,000, and USAID’s Bureau of Global Programs Field Support and Research contributed $43,000.\textsuperscript{280}

In 2000 to 2001, the United States aided a Ugandan outbreak that infected 425 people and killed 224.\textsuperscript{281} However, funds were again a problem; by December 2000 (the middle of the Ugandan Ebola outbreak), the CDC had already exhausted its resources through its simultaneous assistance to Saudi Arabia, which was dealing with a different hemorrhagic fever.\textsuperscript{282} Later, through USAID, the Emerging Pandemic Threats Program, EPT-1, and subsequently EPT-2, program partnered with Ugandan agencies to address Ebola in 2011, along with several different outbreaks of other infectious diseases within the country.\textsuperscript{283} EPT-1 was also actively involved in the West African Ebola epidemic of 2014.\textsuperscript{284}

In the years following 9/11 and the anthrax attacks on the United States mail system, the American policy regarding Ebola focused more on preventing its spread to the states (especially via bioterrorists) than on preventing or treating outbreaks in Africa. For example, in his 2003 State of the Union address, President George W. Bush announced what became Project Bioshield, which, by its very name, pointed to the United States’ containment policy, stating:\textsuperscript{285}

My budget requests almost $6 billion to quickly make available safer and more effective vaccines and treatments against agents like smallpox, anthrax, botulinum toxin, Ebola and plague . . . We must rebuild America’s capacity to produce vaccines by committing the federal government to the purchase of medicines that combat bioterror.\textsuperscript{286}

Following the passage of Bioshield \textsuperscript{287} and the subsequent debate over Bioshield II \textsuperscript{288} in 2005 (which was proposed but not passed), NIH support for Ebola research

\textsuperscript{276} Id.
\textsuperscript{277} Id.
\textsuperscript{278} Id. at 16-17.
\textsuperscript{279} Id. at 17.
\textsuperscript{280} Id.
\textsuperscript{281} CDC, supra note 270.
\textsuperscript{284} Id.
\textsuperscript{288} Project BioShield II Act of 2005, S. 975, 109th Cong. (2005). This bill was introduced on May 9, 2005 in a previous session of Congress, but was not enacted.
rose from $17.09 million in 2003 to $58.62 million in 2010, only to fall back to $42.49 million by 2013.\footnote{289} During this same time period, President Bush added Ebola to the list of communicable diseases subject to quarantine and border entry restrictions.\footnote{290} Programs such as the Emerging Pandemic Threats Programs continued USAID’s mission to prevent, detect, and control potentially harmful emerging human or zoonotic infections.\footnote{291} In a similar vein, the US supported and signed the World Health Assembly’s 2005 International Health Regulations which required nations to report on disease outbreaks within their borders and authorized nations to implement controls aimed at keeping travelers (and microbes) out.\footnote{292}

Although American policy during the first decade of the twenty-first century focused on keeping the homeland safe,\footnote{293} the risks of EIDs (other than HIV/AIDS) to the populations within developing countries were not completely ignored. For example, programs such as the Pandemic Influenza and Other Threats program, operated through USAID, sought inter alia to minimize the global impact of existing pandemic influenza threats.\footnote{294} In 2014, USAID launched EPT-2, which aims to minimize the impact of pandemic threats on human health and economic/social stability.\footnote{295}

E. THE UNITED STATES’ HUMANITARIAN RESPONSE TO EBOLA IN WEST AFRICA

As noted above, the 2014 Ebola outbreak and panic played out in a more abbreviated time span than did the AIDS epidemic. And in stark contrast to the HIV epidemic, the United States addressed the international crisis during the peak of the panic. During the late fall of 2014, for example, the United States mobilized troops and sent them to Liberia to build hospitals.\footnote{296} In addition, thousands of volunteers and officials from various domestic agencies went to West Africa to assist in a variety of ways.\footnote{297}

The United States government also decided to provide financial support during the panic. In early November 2014, President Obama requested $6.2 billion from Congress, most of which was approved.\footnote{298} Although the proposal asked for over two billion dollars in funding for USAID and other agency support for Ebola detection and response in West Africa, much of the funds were to be used for increasing domestic

290 Exec. Order No. 13295, 68 Fed. Reg. 17255 (2003). As noted earlier, this was the period in which lawmakers emphasized the need for public health legal preparedness. See text accompanying notes 119-20 supra.
292 Rushton, supra note 130, at 787-89.
293 See id.
294 USAID, supra note 239.
295 USAID, supra note 291.
preparation and vaccine development. The money was also directed at creating fifty Ebola treatment centers in the United States, buying more HAZMAT suits, and increasing travel monitoring.

The United States also made several Ebola-related donations to the WHO between March 2014 and September 2015. The CDC gave over $22 million; the Department of State contributed $1.35 million; the Defense Threat Reduction Agency gave over $13 million; and USAID donated approximately $74 million. All told, the United States was the largest international donor with respect to Ebola. Although these contributions occurred during the panic, in contrast to the case of HIV, there are several reasons to believe the panic nevertheless undermined efforts to address the real epidemic that was occurring in Africa. First, a large percentage of American dollars expended on Ebola were devoted to domestic preparedness—in other words, to prevent or respond to a highly unlikely domestic outbreak rather than the actual epidemic in Africa. In effect, the fear engendered by the panic helped to focus efforts on protecting the homeland rather than preventing suffering in the region most affected. Second, the imposition of quarantines and talk of travel bans deterred health professionals from traveling to Africa to provide needed medical care. Researchers from Yale University and the ACLU reported that although “exact numbers on how many were discouraged from volunteering by the quarantines are unavailable, . . . we do know through direct conversations as well as data from international medical groups that the prospects of being unnecessarily quarantined dissuaded many healthcare workers from volunteering to go to West Africa.”

Another concern is the possibility that the United States’ commitment to Ebola prevention and treatment in Africa will wane, now that the panic is over. In effect, because the panic came and went in such an accelerated time, it remains possible that the long-term engagement we have witnessed with respect to HIV/AIDS will never have the chance to take root for Ebola. Indeed, despite all of the sound and the fury in the fall of 2014, the true danger is that the United States will return to its isolationist stance on international health. Panic, we suspect, does not provide firm footing for engagement.

VI. CONCLUSION

The fear of infection can be a powerful motivator. In an ideal world, the fear of EIDs should remind those of us in high income countries of our mutual dependency with populations in low and middle income nations. It should then encourage us to develop policies that would safeguard the health of those who are most at risk of EIDs, as well as our own.

In the real world, however, the fear of EIDs is as likely to create panic as it is to create solidarity. This appears to have happened both at the start of the AIDS epidemic

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299 Id.
303 See text accompanying notes 285-92 supra.
304 ACLU AND YALE GLOB. HEALTH JUSTICE’SHIP, supra note 145, at 31.
305 See PRESIDENTIAL COMMISSION, supra note 4, at 5-6.
and during the 2014 Ebola outbreak. In both cases, fear led to stigmatization and scapegoating. As a result, domestic policies “othered” those who were ill and international policies emphasized containment rather than compassion. In the case of HIV, only after the panic quelled did a more robust and lasting international response occur. Whether it will follow in the case of Ebola remains to be seen.

Almost twenty years ago, while reviewing the HIV epidemic, Jonathan Mann noted the critical role that human rights played in providing the foundations for human health. In the years since, the relationship that Mann witnessed has become widely accepted. Commentators and even policymakers understand that the protection of rights within a nation can support the health of people within that nation. They also often accept that respect for human rights implies that nations are obliged to support global health. But the discussion is far less apt to consider the relationship between the human rights of populations within high income countries and the health of populations in less wealthy countries.

The stories of the Ebola and HIV panics within the United States offer different perspectives: the rights of individuals within a wealthy country may affect the health of populations within less wealthy countries. As long as othering continues within high income countries, solidarity across borders may be compromised. If so, cases such as those of Ryan White and Kaci Hickox may play a far more important role in global health than has been previously recognized. By delegitimizing that othering, these cases and the stories they tell may assist scientists and healthcare workers in making global health policies that are based more on solidarity than containment.

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306 See Davtyan et al., supra note 158.
307 Id. at 2.
308 See text accompanying notes 248-61 supra.
311 For an early discussion of this point with respect to HIV, see generally Lawrence O. Gostin & Zita Lazzarini, Human Rights and Public Health in the AIDS Pandemic (1997).
APPENDIX

FIGURE 1: GOOGLE TREND MAP OF EBOLA INTEREST IN THE UNITED STATES FROM SEPTEMBER TO NOVEMBER 2014

FIGURE 2: GOOGLE TREND MAP OF ALS INTEREST IN THE UNITED STATES SINCE 2004


FIGURE 3: Google Trend map of “Movember” interest in the United States since 2004.

FIGURE 4: Google Trend map comparing interest in quarantine to the names of 3 Ebola-associated nurses.

**Figure 5:** Google Trend map comparing searches in the United States: “Ebola Africa vs. Ebola US”\(^{317}\)

![Google Trend Map](image1)

**Figure 6:** Google Trends map looking at Ebola searches in the United States as compared to searches in affected nations\(^{318}\)

![Google Trend Map](image2)

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