

The Politics and Policy of Ebola

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It was a dark and stormy night in mid October in Boone, North Carolina. I was late for a gumbo dinner that my co-editor was hosting at his house in honor of a visit to the area by Barbara Walthall, the managing editor for *PS*. Wind gusts exceeding 50 mph were forecast, and rain was coming down in sheets. I wasn't quite sure the mountainside wouldn't wash down on me before I got to Phillip's house. "Too bad for Barbara," I thought, "she missed the fall colors by just one day."

A radio program on the Ebola crisis in western Africa distracted my attention. The reporter was profiling a health-care worker who wanted to volunteer for service in the area, but her application had been delayed for weeks while she was shuttled back and forth between government and nongovernmental organizations, her application was processed and reprocessed, and even after she was approved, she was told that she could not be deployed for at least a month. The thrust of the story was clear: the listener was supposed to be outraged that bureaucratic incompetence and delay would only exacerbate what had already become the most severe international public health crisis in memory.

Instead, my editorial antenna kicked in, and it struck me that political scientists might react very differently to this health-care worker's tale of woe. Recruiting, training, and deploying personnel to a rapidly changing crisis zone with severe infrastructure challenges and located thousands of miles away is a highly sophisticated dance. Yet completing this task in only four weeks struck me as quite impressive. I wondered if my colleagues would agree with me.

That evening, I pitched the idea of a "Spotlight" on Ebola to Phillip, Barbara, and Celina, our editorial assistant. We agreed on a possible timeline, and I agreed to try to identify some potential contributors.

The effort began the next day, and one of the names that I kept encountering was Ruxandra Paul, a recent PhD and a college fellow at Harvard University who works on issues of markets and international migration. Ruxandra graciously agreed to pen an essay quickly.

Fast forward a few days after the effort had begun. A missive from Ken Sherrill, emeritus professor at Hunter College was sent to Steven Rathgeb Smith, the executive director of APSA, with the requisite long list of additional recipient addresses. Citing his own coauthored article on political science and AIDS written 22 years ago with Robert Bailey and Carolyn Somerville (1992) (we are academics after all!), Professor Sherrill asked:

Twenty-two years later shouldn't our profession be in a better position to say meaningful things about a terrible disease that affects marginalized populations, arouses emotions of terror, fear and disgust that is readily used to isolate and worsen the

condition of the powerless, etc. How and what, if anything, have we learned from AIDS about caring for people and communities in need, about strategies for prevention and cure, etc? The fate of civil liberties in times of crisis? New forms of community organizations?

Steve sent the e-mail to me, and I saw a golden opportunity. In the famous words of Captain Renault, this was the beginning of a beautiful friendship.

I quickly paired the emeritus professor with the postdoctoral fellow, and Ken and Ruxandra agreed to solicit essays, write their own contributions, and provide editorial leadership for this special spotlight, "The Politics and Policy of Ebola."

Along with my co-editor and the *PS* editorial team, our thanks go out to both of them for their tireless efforts. They have worked with each author, providing input under very tight deadlines, and have been instrumental in bringing this important set of essays to print. We owe them our gratitude.

This result is the kind of rapid and timely coverage that only *PS* can provide. We hope that other groups of scholars may consider indentifying and contributing to topical Spotlight sections in the future.

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INTRODUCTION

Ruxandra Paul, *Harvard University, guest editor*

Kenneth Sherrill, *Hunter College, CUNY, guest editor*

Ebola is characteristic of an epidemic that can swiftly escalate into a global health crisis. International cooperation, institutional adaptations, and policy harmonization are required to contain the cross-border spread of any contagious and lethal disease. This involves not only intergovernmental coordination and the intervention of international organizations, but also synchronization of state efforts with subnational response frameworks at the regional and local level. It engages non-state actors, including civil society [nongovernmental organizations (NGOs)] and market actors, such as pharmaceutical companies and commercial airlines.

Communication is essential: decision makers need to exchange information on a constant basis, while, at the same time, educating and informing the general public about the disease. State-citizen communication ensures that the public correctly understands the risks associated with the outbreak and knows how the disease is transmitted. Information campaigns can reduce public anxiety while keeping the population educated

2003 SARS epidemic (Eichelberger 2007), people immigrating to America often are singled out as disease threats. The first diagnosis in America in September 2014 increased the perception of Americans' vulnerability to Ebola. As predicted by psychology research (Faulkner et al. 2004), this increased vulnerability amplified negative reactions to those heuristically associated with Ebola (i.e., Africans).

Negative reactions to increased disease vulnerability yield more xenophobic attitudes. This prejudice can engender support for more restrictive immigration attitudes (Hainmueller and Hopkins 2014). Such xenophobia is evident in ongoing calls for travel bans from the Ebola zone, despite the fact that there are no direct flights to America from the area and there is no evidence that travel bans would be effective.

The history of Americans associating immigrants and disease and the implications for attitudes toward them should sensitize us to the impact of othering African immigrants during the current Ebola outbreak. Othering in an epidemic is particularly harmful because it may compel people to reject public health instructions (Eichelberger 2007). We could argue that stereotyping may be a good thing;⁶ however, lessons from the AIDS epidemic raise caution about the framing of disease using racial or ethnic boundaries (Lieberman 2009).

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NOTES

1. This calculation is from the World Health Organization (2014).
2. Similar stories ran in other US publications (e.g., *Bloomberg*, *Businessweek*, and *Time*) and in British and Swedish newspapers.
3. The Mercator projection—still the most popular—makes Africa appear equal in land area to Greenland, which actually is approximately 1/14th the size of Africa.
4. Many other examples of xenophobic responses in the wake of Ebola are available at <http://www.africandefense.org/blog> (accessed November 1, 2014).
5. Scientists estimate the incubation period for Ebola—that is, the time from infection to presenting symptoms—to be from 2 to 21 days.
6. For example, if Texas Presbyterian Hospital staff initially suspected Ebola when Liberian Thomas Eric Duncan first sought care there, he might have received earlier treatment for Ebola.

Although the risk of contracting Ebola in America remains virtually zero, emotions such as fear, anxiety, and disgust contribute to gaps in knowledge about the disease, support for restrictive policies, and increased prejudice. These relationships are reciprocal: emotions influence politics and politics, in turn, influences emotions. Therefore, understanding the influence of emotions provides insight into the politics of Ebola and guidance for officials and policy makers.

Emotions influence people's attention. More than 90% of the public knows that Ebola is transmitted through direct contact with bodily fluids, but barely 50% know that an individual must be sick to be contagious (Hamel, Firth, and Brodie 2014). Explaining how Ebola is transmitted involves talking about disgusting things: blood, vomit, feces, urine, or other fluids must enter through an open wound or mucous membrane (e.g., the mouth). This conjures images like orally ingesting another person's vomit or diarrhea. Disgust focuses attention on and enhances the memory of a repulsive object or event (van Hooff et al. 2013): because the images are disgusting, people are more likely to remember them—at the expense of other relevant knowledge about transmission.

Disgust also produces avoidance (Rozin, Haidt, and McCauley 2010). Whereas this may keep people from contact with bodily fluids, it also may keep them from listening to further information and instead encourage cognitive distance from this disgust-eliciting topic. Thus, officials who want to increase public knowledge may be more successful if they first discuss showing symptoms before bodily fluids. Although disgust still may draw attention to the latter, this simple intervention could improve medical and political communication.

Emotions also influence policy preferences and prejudice. Anxiety, for example, increases support for restrictive policies such as quarantines (Gadarian and Albertson 2014). Whites, Republicans, and Hispanics all reported double-digit increases in concern about Ebola, as well as increased support of quarantining or refusing US entry to people traveling from affected African countries (Pew 2014; YouGov 2014a; b). These responses to disease often shape responses to associated people or groups; for example, Herek (2002) connected the fear of HIV/AIDS to anti-gay prejudice. Similarly, disgust increases prejudice toward outgroups (Faulkner et al. 2004), and anger triggers negative racial attitudes in whites (Banks and Valentino 2012). These studies suggest a heightened prejudice toward those associated with Ebola and/or affected African nations. Restrictive policies are not necessarily prejudicial; however, they are, by definition, exclusionary. They reinforce boundaries between certain bodies (i.e., "infected" from or in Africa) and others (i.e., "clean" from or in America), which reflects a history of feared contamination from black bodies (e.g., see Novkov 2008).¹

This group-centric emphasis is evident in immigration's general salience: during the American "outbreak," those who identified immigration as the most important national issue increased from 6% to 9% (YouGov 2014a; b). Republicans exhibited the largest increases both in concern about Ebola (i.e., 16 points) and naming immigration the top issue (i.e., 7 points, nearly double) (Pew 2014; YouGov 2014a; b). Because the risk of contamination

remains negligible, these preference shifts are more likely to be responses to emotions—and the media coverage designed to provoke them—than actual danger.

Political science offers unique insights about the influence of emotions. Policy makers, scientists, and the media can use these insights to inform their actions and communication to increase public knowledge, implement policies, and resist prejudice.

Understanding the influence of emotions provides insight into the politics of Ebola and guidance for officials and policy makers.

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NOTE

1. Whites also are subject to these policies, but the logic holds: a person is quarantined only if potentially *contaminated*.

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EBOLA, ANXIETY, AND PUBLIC SUPPORT FOR PROTECTIVE POLICIES

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Recent polling of Americans shows that public concern about Ebola has grown since the first cases arrived in the United States—with 4 in 10 Americans saying that they are worried about family members contracting Ebola (Frankovic 2014; Hamel, Firth, and Brodie 2014). The symptoms associated with Ebola are frightening, and the death rate in this current outbreak is very high,

reaching 70% in certain places (Centers for Disease Control and Prevention 2014). Ebola anxiety, while potentially misplaced and harmful, has an effect on public policy (Carey 2014; NPR 2014).

Based on work that we have done on other public health anxieties, such as smallpox and the H1N1 flu, we expect that Ebola anxiety leads people to seek protection from diseases that may cause harm to them or their families. In 2011, we worked with YouGov to

run an experiment with a representative sample of 600 Americans. These participants were randomly assigned, with some reading a news article about a (fictional) smallpox outbreak that occurred 25 years ago in Cleveland (the "past smallpox" condition) and with others reading an ongoing (fictional) smallpox outbreak in Cleveland (the "present smallpox" condition). News about a current smallpox threat significantly increased respondents' feelings of anxiety compared to reading about a past outbreak.

To combat a smallpox outbreak, both the World Health Organization and the CDC recommend vaccination, isolation of patients diagnosed with the disease, and decontamination of clothing, bedding, and other personal property. All recommendations are similar to the procedures for fighting Ebola (with the exception of a potential Ebola vaccine, which is still in development). These policies are designed to offer protection yet also entail limitations on free movement, participation in public life, and the potential loss of property. In times of health fears, support for these types of restrictive policies increases.

After reading the article, we asked respondents in the 2011 study how much they supported a number of emergency powers that have been proposed by state officials to be used in the event of a smallpox outbreak based on a five-point scale from "strongly oppose" to "strongly support." We found that respondents who had read a story about a present outbreak of smallpox were the most supportive of emergency powers.

Figure 1 shows how anxiety over a smallpox outbreak made respondents significantly more likely to trade privacy, free movement, and even property for safety. The figure shows the average level of support for the smallpox policies among both high-anxiety respondents and low-anxiety respondents. Anxiety makes respondents 16% more willing to require others to be vaccinated, 20% more willing to undergo a medical examination, 12% more likely to quarantine suspected smallpox patients, 13% more likely to isolate those with smallpox, and 15% more likely to destroy property contaminated by smallpox.

In our study, respondents read newspaper stories that offered dry, factual accounts. In contrast, some in the US media have amped up the level of fear associated with the Ebola outbreak through sensationalist coverage of highly improbable events, such as airborne transmission of Ebola and its use as a bioweapon by the Islamic State. Finally, in our smallpox study, no politicians used health issues for electoral gain. Senator Rand Paul (R-KY)

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