S. HARRIS ALI

Stigmatized Ethnicity, Public Health, and Globalization

Abstract
The prejudicial linking of infection with ethnic minority status has a long-established history, but in some ways this association may have intensified under the contemporary circumstances of the "new public health" and globalization. This study analyzes this conflation of ethnicity and disease victimization by considering the stigmatization process that occurred during the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS) in Toronto. The attribution of stigma during the SARS outbreak occurred in multiple and overlapping ways informed by: (i) the depiction of images of individuals donning respiratory masks; (ii) employment status in the health sector; and (iii) Asian-Canadian and Chinese-Canadian ethnicity. In turn, stigmatization during the SARS crisis facilitated a moral panic of sorts in which racism at a cultural level was expressed and rationalized on the basis of a rhetoric of the new public health and anti-globalization sentiments. With the former, an emphasis on individualized self-protection, in the health sense, justified the generalized avoidance of those stigmatized. In relation to the latter, in the post-9/11 era, avoidance of the stigmatized other was legitimized on the basis of perceiving the SARS threat as a consequence of the mixing of different people predicated by economic and cultural globalization.

Résumé
Le fait préjudiciable de lier ensemble infection et minorité ethnique est établi depuis longtemps dans l'histoire, mais cette association semble s'être intensifiée d'une certaine manière dans les circonstances actuelles de la «nouvelle santé publique» et de la mondialisation. Dans cette étude, nous analysons cet assemblage d'ethnicité et de victimisation liée à la maladie, en examinant le processus de stigmatisation qui a émergé lorsque le symptôme respiratoire aigu grave (SRAG) s'est déclaré en 2003 à Toronto. Au cours de cette éclosion du SRAG, la désignation des boucs émissaires s'est faite de manières multiples qui se recoupaient les unes les autres : (i) la représentation visuelle de personnes portant des masques respiratoires, (ii) le statut d'emploi dans le secteur de la santé et (iii) l'ethnicité canadienne asiatique ou sinocanadienne. Par ailleurs, la stigmatisation pendant la crise du SRAG a ouvert la voie à une sorte de panique morale permettant au racisme de s'exprimer et de se rationaliser au niveau culturel à partir d'une rhétorique de nouvelle santé publique et de sentiments anti-mondialisation. En ce qui concerne ces derniers, l'emphase portée sur une autoprotection individuelle au sens sanitaire a justifié une mise à l'écart généralisée des personnes stigmatisées. Cette mise à l'écart dans le contexte de l'après-onze septembre a légitimisé le fait d'éviter tout Autre stigmatisé, en s'appuyant sur la perception de la menace du SRAG, vue comme une conséquence du mélange de peuples divers, tel que prêché par la mondialisation économique et culturelle.

During extreme events and disaster situations, many potentially disruptive aspects of individual and group life that normally remain latent in day-to-day life may come to the surface. Extreme events, therefore, provide a unique opportunity—a type of "natural experiment"—to study the "exception" to better understand the "rule" in terms of gaining insights into social structure and behaviour more generally (Stallings 2002). The value of adopting this vantage point is quite evident in the work of sociologists in various traditions, for example, in Durkheim's (1951) classic work on how acts of deviance are functional to society by providing instances and making explicit what exactly the moral boundaries are for a given behaviour. This point is similarly illustrated by Garfinkel's (1967) ethnomethological technique of intentionally violating social norms through "breaching experiments" and observing the reactions of the interactants, in order to gain insights into the nature of our taken-for-granted sense of shared social reality. Extreme events may also serve as "signal events" (Edelstein 2004, 16) that problematize and subsequently politicize and bring to light previously unrecognized, normalized, and naturalized circumstances and conditions that are, in fact, dangerous and require political or social attention. For example, the highly publicized chemical contamination incident in Love Canal, New York brought to light the extent to which toxic contamination was a major environmental health problem throughout the whole of North America (Szasz 1994). The present analysis considers another kind of extreme event, namely a disease outbreak—Severe Acute Respiratory Syndrome (SARS)—in Toronto. The analysis of this event is used as a springboard for discussion in three ways. The first is to explore the general implications that mechanisms of social control and surveillance (within the context of public health) have for ethnic minorities. The second is to help understand the nature of the interactions and reactions to members of certain ethnic minorities during the outbreak. The role of stigma (Goffman 1963) is used to direct and guide this part of the discussion. Finally, at a more conceptual level, the notion of stigma is situated within the contexts of public health practice and globalization to stimulate theoretical developments in ethnicity studies in new directions.

The study presented in this paper was part of a larger research project on "SARS and the Global City" in which other dimensions of the outbreak were investigated, including aspects related to public health governance and disease vulnerability among marginalized communities. As part of this larger research project, a series of 16 unstructured interviews was conducted in Toronto from September 2005 to March 2006 with local officials from Chinese cultural centres, legal aid clinics with an Asian Canadian client base, community health centres, hospitality workers, and domestics. The analysis developed here draws in part from these interview data, but also relies on the various public inquiry commission reports produced shortly after the outbreak by different levels of government, such as the federal report by the National Advisory Committee on SARS and Public Health (Naylor 2003) and the

Ontario Expert Panel on SARS and Infectious Disease Control (Walker 2003). In addition, newspaper articles, as well as other reports, were consulted, and most helpful for our analysis here was one prepared by Leung and Guan (2004) for the Chinese Canadian National Council, entitled "Yellow Peril Revisited: Impact of SARS on the Chinese and Southeast Asian Canadian Communities."

Background: The SARS Outbreak in Toronto

In late February 2003, a physician from Guandong Province in China, who had treated patients with an unclassified form of atypical pneumonia, stayed at the Metropole Hotel in Hong Kong while attending a nephew's wedding. The physician himself became ill and, during his visit, twelve guests of the hotel became infected with the disease later to be identified as SARS. These guests continued their travels to various locations, including Singapore, Hanoi, Toronto, and other areas of Hong Kong. A seventy-eight-year-old Canadian woman was one such guest, and, soon after her return to her Toronto home, her forty-four-year-old son also became ill. On March 5, 2003, the woman died, while her son died two days later. During the son's hospital stay, many patients and staff were unknowingly exposed to the SARS virus through various pathways.

Within the first month of the outbreak, there were, in total, 13 SARS-related deaths, 97 probable cases, and 1,137 suspected cases in the Toronto area. By the following month, the total number of cases appeared to reach a plateau; and on May 16, 2003, the official pronouncement was made that the SARS outbreak was over (Naylor 2003). One week later, however, a second wave of SARS patients appeared in a Toronto-area hospital, where five patients were quarantined. The exact chain of events that led to this second outbreak (referred to as SARS II) remains unknown (ibid.). By the third week of April 2003, the World Health Organization (WHO) issued an unprecedented travel advisory, recommending that visitors postpone all but essential trips to Toronto. One week later, a delegation that included the provincial health minister and the public health commissioner visited WHO headquarters in Geneva. In response to the delegation's plea, the travel advisory to Toronto was lifted after the WHO was given assurances that the city would intensify the screening of travelers to and from Canada. In the meantime, the city's three Chinatowns remained deserted, while the occupancy rate in Toronto hotels fell dramatically with the cancellation of several international conferences and a plummeting decline in tourists (CBC 2003).

Surveillance and SARS

A defining characteristic of public health strategies in late modernity is an emphasis on enumeration and surveillance as a means of maintaining social order in the face

of potential disruption from health threats (Petersen and Lupton 1996; Fischer and Poland 1998; Petersen 1996; Lupton 1999; Castel 1991; Elden 2003). Specifically, the use of statistics, population profiles, and monitoring in the service of surveillance have become important public health measures through which "populations" can be regulated and controlled through the attribution of risk (Lupton 1995, 174). That is, such measures are used to define the notions of "normality" and "pathology" as applied to groups within the population. As documented by Michel Foucault (1991), this use of medical surveillance as a method of social control has deep historical roots. Traditionally, the control of populations comes under the purview of policing and governmental regulations, but these became supplanted by the European medical establishment during the period of 1720-1800. The influence of medical surveillance intensified during this period because of the need to identify and monitor the health status of the population as part of the battle against leprosy and the plague. In reviewing the work of Foucault, Elden (2003, 242) notes that two different surveillance and control approaches were used with respect to each disease. In the case of leprosy, social control was exercised through the expulsion of the leper from the shared space of the community with the aim of maintaining the purity of the urban environment. On the other hand, in the case of the plague, the "emergency plan" was employed. Here quarantines were imposed (especially in large port areas) as the town became divided into distinct sectors that were patrolled by street inspectors. Detailed reports on each sector were prepared by these officials and kept in a centralized information system for monitoring purposes. This emergency plan strategy resulted in a system of generalized surveillance based on the compartmentalization and control of the movements and activities of sub-populations defined as "pathological." Elden notes that each type of strategy represented a different way of utilizing and controlling space, with each reflecting a different form of political power. With leprosy, the practice of outright exclusion represented a negative form of political power. In contrast, the disciplinary orientation based on strict spatial partitioning, careful surveillance, detailed inspection, and maintaining social order represented a positive form of political power because this type of orientation retains an inclusion-orientation. (See also Sarasin [2008] who discerns a third form of political power in the work of Foucault involving a mixture of security and tolerance related to Foucaults' accounts of smallpox). The response to the SARS outbreak in Toronto clearly paralleled that found during the historic plague period. An illustration of this is found in considering the mode of risk communication employed during the outbreak. Specifically, Torontonians received reports of newly identified SARS cases and a running tally every evening via televised press conferences held by the provincial health officials. Such a practice appears to be a modern variant of the "bills of mortality"—the weekly reports of the number of deaths in each parish of

London caused by the plague in 1665 (Edelstein 2004, 2). The practice also illustrates the modern form of ensuring an inclusion orientation, namely, one predicated upon computerized information systems and communications technologies (King 2002).

In contemporary times, health surveillance involves the tracking of health events or health determinants through the continuous collection of data (Naylor 2003, 92). Once the data are collected, they are analyzed and interpreted, with the results being used to make decisions about issuing advisories, alerts, or warnings. Various strategies were pursued to control the spread of SARS in Toronto, including surveillance and contact tracing, isolation and quarantine, and travel restrictions (Gostin et al. 2003, 3229). From a legal standpoint, the term "isolation" refers to limiting the movement of those who exhibit the symptoms of the disease (i.e., they are patients), while "quarantine" applies to restricting the movement of healthy people (Walker-Renshaw 2003). Once cases were identified by the screening procedure, they were *isolated*, while those found to be in contact with the cases were *quarantined*. In addition, those who had entered the epicenter hospital after March 16 were asked to adhere to a ten-day home quarantine. By the end of the SARS outbreak, Toronto public health had investigated 1,907 separate reports in addition to 220 cases of probable or suspected SARS cases (Naylor 2003, 35).[1]

The use of medical surveillance to identify cases may have important social ramifications for those diseases that differentially affect segments of the population. Of note in this connection is the fact that the surveillance efforts of public health officials may have inadvertently amplified the stigmatization of affected groups (Gostin et al. 2003, 3233).

Stigmatization and SARS

In his seminal work, Goffman (1963) notes that stigma is an attribute that socially discredits the individual or group. It is, therefore, a relational concept, that is, a notion that necessarily involves reference to at least two parties, namely, the stigmatized individual or group—towards which feelings of disgrace and disgust are directed—and the non-stigmatized "normals." Since the time of this pioneering work, the concept has been refined and, in an excellent review, Link and Phelan (2001) summarize five interrelated components or processes that together constitute the process of stigmatization—labeling, stereotyping, separation, status loss, and discrimination. Each of these components takes on a unique significance within the context of stigmatization associated with infectious disease—some of these will be simply introduced at this point and further elaborated upon later.

The first component refers to the process whereby people distinguish and label human differences. This involves the issue of how a particular human difference is

selected to matter socially and involves what Goffman (1963) refers to as a "mark," that is, a discrediting feature that is observable to others and interpreted as deviant, flawed, limited, spoiled or generally undesirable.[2] Three stigmatizing marks may be identified in the case of SARS in Toronto, namely: (i) the wearing of respiratory masks to cover the face in public places; (ii) employment in the health care sector; and (iii) Chinese-Canadian ethnicity.

Before proceeding further, it should be noted that in a comparative study of the stigma of HIV/AIDS, tuberculosis, and SARS in Hong Kong, Mak et al. (2006) found that the attribution of stigma was a function of controllability, personal responsibility, and blame. That is, first, a determination is made if the person is held personally responsible for his/her illness or whether he/she is deemed helpless in the circumstance; then an inference will be made as to whether the person should be blamed and the extent to which he/she should be stigmatized. Such criteria clearly have greater relevance for a homogenous population, but, as will be discussed, these attribution features will interact with racially-based attributes in a multicultural society such as Toronto. In other words, SARS was what Yang et al. (2007) refer to as a "situational threat"—one in which stigma results from being placed in a social situation that influences how one is treated.

The second component involves the process of stereotyping that occurs through the linking of the labeled person with the undesirable characteristics that form a culturally held stereotype. For example, Briggs (2005, 272) notes that the title of a *New York Times* article on SARS reads, "From China's Provinces, a Crafty Germ Breaks Out" (Rosenthal 2003, 1). The caption has the effect of associating both the virus and the human being with the stereotype of the Chinese as sneaky and/or cunning. Furthermore, in those cases of stigmatization involving infectious disease, such stereotyping builds on the alleged unhygienic sanitary or dietary practices of a particular group—a prejudice that has deep roots that can be traced to "developmentalism" and colonialism.[3]

Third, an "us-them" separation is socially constructed by placing those labeled into distinct categories; that is, an "othering" process occurs (see, for example, Eichelberger [2007] on this process *within* the Chinese-American community itself during SARS). For the purposes of this paper, as alluded to above, medical surveillance, quarantine, and isolation may result in the setting apart of others in a most formal sense, which will obviously facilitate the "us-them" separation.

Fourth, the labeled person experiences status loss and discrimination (both individual and structural discrimination) that lead to unequal outcomes in terms of disadvantages in life chances such as income, education, housing status, and, most relevant to the case of SARS, in terms of medical treatment, health, and psychological well-being.

Finally, all of the above component processes must occur within a context that is contingent upon access to social, economic, and political power; that is, there must exist a power differential between those imposing the stigmatized status and those that are stigmatized because, as Link and Phelan note, "it takes power to stigmatize" (2001, 375). As will be discussed in the final sections of this paper, the power situation that allows the stigmatization of SARS is today influenced by certain ideologies associated with the hegemonic influences of the "new public health" and globalization.

The "SARS Mask" and the Social Construction of Risk and Stigma

The social construction of risk (Hannigan 1995, 92-108) during the SARS outbreak was undoubtedly influenced by the visual image of individuals donning N95 respiratory masks to protect themselves from the contagious spread of the SARS coronavirus. The surgical-type mask is tied around the back of the head and covers the nose and mouth entirely, leaving only the eyes and forehead exposed. Images of individuals wearing these masks were prominently displayed in much of the television and press media coverage of the SARS epidemic in Toronto (and other cities around the world), and the masked visage soon became a poignant symbol of SARS throughout the world. Notably, this occurred despite the fact that, in actuality, the appearance of individuals wearing masks on the streets of Toronto was very rare. Nevertheless, largely through media representations, the mask, in essence, became a type of universal stigma symbol—a "mark"—that conveyed a "spoiled identity" by suggesting the association of that individual (in whatever capacity) with SARS. At the same time, the masked face served as a foreboding symbol that generally raised public awareness and alarm around SARS, embodying the disease and its spread with ominous characteristics.

The image of an individual wearing the N95 mask in the public space is particularly graphic, evocative, and disturbing because it shatters the everyday taken-for-granted sense of reality that most people have concerning the safety of the spaces they occupy in daily life. The use of a respiratory mask outside the hospital setting is obviously not a common occurrence. Thus, the presence of a person wearing a medical mask in public tends to be perceived as "alien"—and, therefore, disruptive of the conventional and comfortable normality of events in everyday public life. In essence, the N95 mask, within the context of the SARS outbreak coverage, functioned as a "rhetorical idiom" (Ibarra and Kitsuse 1993), that is, as an image cluster that endows claims with moral significance (see also Hannigan 1995, 36). Specifically, it was an example of a symbol imbued with a "sense of endangerment"—a threat to one's health and safety.[4]

Content analysis studies of the visual images of SARS in the national newsprint media (i.e., the *National Post* and *Globe and Mail* newspapers and *Maclean's* and *Time* [Canadian Editions] newsmagazines) found that the vast majority of images contained people wearing masks (82.5% [of 120], 57.1% [of 119], 63% [of 23] and 88.2% [of 17] respectively). Furthermore, 50% of the *Post*, 34.5% of the *Globe*, 22.2% of *Maclean's* and 35.3% of *Time* depicted Asian people with masks (Leung and Guan, 2004). The association of masks with Asian people contributed to the racialization of SARS as a "Chinese" disease, and the study concluded, "By labeling SARS as an Asian virus, media sensationalism and its resultant public panic toward Asian Canadian populations have been rationalized and, therefore, justified" (ibid. 13). I will return to this important theme later in this paper, but another aspect of stigmatization that first needs to be considered involves the experience of those in the health care sector during SARS—an important point to consider in reference to the racialization of the disease because the health care sector is one of the few occupational sectors in Canada in which Asian (particularly Asian women) are proportionately represented (interviews: Ontario Nursing Association official, 16 September 2005; Provincial Chief Nursing officer, 27 March 2006).

The SARS Pariah Syndrome and the Health Care Sector

Although the names of individual hospital employees infected with SARS were not disclosed in Toronto, by implication, every hospital employee was publicly perceived as a health risk. As a consequence, all health care workers found themselves stigmatized to some extent (Gostin et al. 2003, 3230). Interviews with health care workers involved in the SARS crisis consistently revealed the high level of stress and stigmatization experienced. Many noted that people were afraid to associate with them (or even with their spouses), and, in many cases, this led to the experience of acute social isolation and ostracism (Walker 2003). Some even noticed that members of the public would cross the street to avoid walking near their homes. The isolation resulting from this SARS pariah syndrome was especially difficult for staff members who contracted the disease because family members were not allowed to visit them in the hospitals, while upon discharge, they were sent directly into home quarantine. Moreover, frequent visits by public health and medical officials dressed in protective gear frightened neighbours and friends and further added to the feelings of alienation experienced by the stigmatized. One health care worker returned home to find that she was no longer welcome there, as her housemates had placed all her belongings outside. The effects of stigmatization also extended to the children of health care workers who were being called by school officials and told to keep their children at home (Walker 2003).

It should be noted that the experiences resulting from the stigmatization described above represented only one aspect of the kinds of psychosocial impacts endured by health care workers. Other psychosocial impacts that arose in being at the frontline of the SARS battle included: the fear of going to work in a hospital; the fear of taking care of SARS patients, which might lead to feelings of confusion, anger, and guilt; and having to deal with the lingering resentment of colleagues who might not have contributed what was expected (ibid.). Furthermore, these psychosocial impacts had to be dealt with in a crisis situation in which health care workers were working excessive hours and double shifts. Added stress was also caused by concerns that workers had about the improper fitting of the N95 masks that might increase their risk of exposure during their work shifts. The severity of the psychological problems experienced is revealed by the fact that a year after the SARS outbreak, dozens of health-care workers in Toronto are still unable to return to work because of psychological trauma (Palmer 2003).

SARS and the Chinese Canadian Community in Toronto

The popular association of SARS with China led to the experience of stigmatization for members of the Chinese Canadian community. Canadian citizens of Chinese origin comprised about 7.5% (348,010) of the 4.7 million people living in the Toronto metropolitan area in 2001 (Statistics Canada 2005), and the city has become the preferred destination of most immigrants from Asian countries to Canada (Li 1998). Historically, the early Chinese settlers who came to Canada to help complete the national railway system were subjected to overt forms of racism such as the Chinese Head Tax and Exclusion Act in the early 1900s. During this period, both law makers and the media described the migration of Chinese immigrants to Canada as the "yellow peril" (Leung and Guan 2004). Such attitudes still prevail today, as sociologists have noted that the Chinese have always represented a source of uncertainty and fear in Canada and have never gained full acceptance as "true Canadians" (Li 1994, 1998).

A recent example of the underlying hostility towards this group is given by Hier and Greenberg (2002) who discuss how the arrival of four boats carrying refugees from Fujian Province, China, in 1999 led to a cultural construction of enemy stereotypes. That is, the event was quickly used by the media, government, and police to criticize Canadian immigration policy, fashioned around fabricated charges concerning the health and security risks that these migrants allegedly posed to Canadian citizens. Under such article headings as "These Refugees and Immigrants Can Kill You" (*National Post*, August 21, 1999) and "Canada's Open Door" (*Maclean's*, August 23, 1999), the media portrayal focused attention on particular allegations informed by themes of risk and a rhetoric of endangerment: the risk of disease the migrants

would bring; the use of Canada as a stop-over for migrants ultimately destined for the United States (hence the risk of increased U.S.-Canada tensions); and an increased risk of organized crime (Greenberg and Hier 2001). This perception of immigrants as threats to public health undoubtedly served as a backdrop to, and subtly influenced, the response to Chinese Canadians during the SARS crisis. Hier and Greenberg (2002) note that, although expressions of explicitly racist stereotypes appear to have dissipated in Canada, they have, in fact, re-appeared in a variety of new racialized discursive articulations which do not make reference to explicit biological or genetic terms. These new discursive articulations are covert in nature and include such stereotypes as "unneighbourly houses," "unusual aesthetic values," "substandard social integration," and "criminality" (examples given in Li 1994, 1998; Tator et al. 1997; Henry and Tator 2000). Extreme situations such as disease outbreaks may, however, serve as the triggering stimulus for the return of more overt forms of racism (Keil and Ali 2006b; Zheng 2005).

In a submission presented to the provincially commissioned SARS Inquiry Commission, a representative from the Asian Canadian Labour Alliance (ACAL) remarked: "We have witnessed the ugly reality of racism that is always hidden just beneath the surface of our so-called tolerant society, and it is always ready to strike at the first opportunity available" (Walker 2003). Leaders from the Chinese Canadian community noted a growing tide of "anti-Chinese" sentiment in Toronto and in the country as a whole, and called upon federal and provincial officials to take action to stem this tide. Just as the Fujiian-Chinese migrant incident triggered opportunities for racially-based sentiments to come to the surface, the SARS outbreak did so as well. Several incidents raised by the ACAL spokesperson and others in the Chinese Canadian community reveal the extent of these reactions.

The ACAL spokesperson related numerous instances of racially-based actions that had taken place during the SARS crisis: seats beside passengers with an Asian appearance remained vacant in crowded subway trains and buses; several Asian Canadian tenants were told to move out by their landlords; a government official visiting a nursing home caring primarily for Chinese Canadian seniors insisted on wearing a mask during her entire visit to do routine testing and commented to the nursing home staff that she only wore the mask at that particular institution; domestic workers from the Filipino Canadian community were laid off; staff from the Canadian Immigration and Refugee board insisted on wearing masks only during those hearings involving people of Chinese descent, despite the fact that all such applicants had to have been in Canada for at least two years prior to their hearing (this practice was dropped after a formal complaint was lodged by ACAL). Furthermore, the Chinese Council of Canadians noted that it had received several racially-based messages that singled out the Chinese community for the outbreak (Sorensen 2003).

Remarks made by public officials were also tainted by racial bias. For example, one member of the provincial legislature for a Toronto-area constituency openly suggested that the SARS crisis in the city was the result of federal immigration policy, while the provincial Energy Minister mockingly coughed upon entering a media scrum, at which point a journalist jokingly asked if the coughing was part of the government's new communication strategy to "give the media SARS." The politician deadpanned, "I enjoyed my trip to Asia." Although he later apologized for his remark, ACAL noted that the social repercussions of the exchange were already evident (Rider 2003).

Racially-based expressions were also directly experienced by Chinese Canadians at the interpersonal level. For example, a family member of a SARS patient remarked: "People treat us like monsters. They say we eat like rats and that we live like pigs." Another member of the Chinese Canadian community noted: "If you cough, people look at you funny. They're wrapping this thing on the Chinese because it started in China. It is really unfair" (Sorensen 2003). One woman whose mother and brother died of SARS even spoke of experiencing discrimination during the cremation of her brother: the funeral home director refused entry to her husband, but later relented when he realized that he would not otherwise receive payment (ibid.).

Those of Asian background with jobs in the health care sector faced stigmatization on two fronts. As alluded to previously, nursing is one of the few professions in Canada in which people of Chinese and Filipino descent were well-represented. However, some of these nurses and health care workers had to contend with suspicion from their colleagues, to the point that they even felt pressure to cut ties with their own ethnic communities to prove that they were "clean" (interview: Toronto nurse, September 2005).

Stigmatization also had an impact on the economy of Chinatown as restaurants in the area reported a drop of 60-80% during the SARS crisis and for several weeks thereafter (ACAL 2003). It was noted, however, that although a total of $150 million (CDN) had been set aside by the three levels of government for marketing and advertising campaigns to attract tourists back to the stigmatized city, "not one cent has gone to Chinatown to help these workers or businesses" (ibid.).

To counter the SARS-related racial paranoia that developed, ACAL (2003) urged the provincial health ministry to set aside funding for public education campaigns that would provide accurate and consistent information. The emergence of racial paranoia frequently occurs in what are referred to as situations of "moral panic" (Cohen 1972). In moral panic situations, a scapegoat or "folk devil" emerges and serves as an identifiable object onto which social fears and anxieties are projected. Consequently, an individual or a group of individuals is perceived in a pejorative way by the general public because the "folk devil" is held responsible for introducing the threat (Goode and Ben-Yehuda 1994, 22, cited by Ungar 2001, 281). As Hier

observes, however, the object of the panic is not the folk devil *per se*. Rather, the folk devil merely symbolizes an "ideological embodiment of deeper anxieties, perceived as 'a problem' only in and through social definition and construction" (2003, 6). The stigmatized as a folk devil in the case of SARS was, therefore, a social construction—one which directs us to the cultural dimension of racism—and is intimately connected to other racialized discursive articulations, such as those associated with an anti-immigration ideology. For example, Martin Collacutt (2002) alleges that family reunification policies give larger ethnic groups (such as Chinese Canadians) an advantage over smaller groups, thus threatening Canada's commitment to diversity—a fallacious argument that ostensibly hides a more general anti-immigration sentiment.

Hier and Walby (2006) note that two analytical paradigms may be discerned in the study of racism in Canada. The first tends to focus on the social politics of redistribution of resources, including the economic. When members of a minority are blocked from receiving, or gaining access to resources, discriminatory practice is likely to play some role. The second paradigm focuses on the cultural politics of recognition and tends to analyze racism in terms of the lived subjectivities and phenomenal reality of everyday life. Although the former does come into play in the SARS outbreak incident in terms of the lack of government funds directed towards Chinese Canadian businesses most affected, most of the impact of the conflation of ethnicity and health stigmatization was felt in the many instances of racism experienced by members of the Asian Canadian community (as briefly reviewed above). In particular, these instances reveal how those racist sentiments that are found acceptable by the dominant group and verbalized during private conversations, but not in the public sphere of everyday interaction (Zamudio and Rios 2006), found explicit expression during the outbreak. It is not unreasonable to expect that such expression was rationalized or legitimated on the basis of a perspective that rationalizes "othering" as a means of self-protection. That is, stemming from the conflated status of ethnicity and disease, a form of "segregationist racism" results, in which marked attempts are made by the dominant group to distance itself physically and socially from visible minorities (ibid.). Segregationist racism acts at the level of what Homi Bhabha (1994, xvi) refers to as "symbolic citizenship" in which the dominant group must have some criteria to discriminate between the "good" migrant and the "bad" migrant, or to decide which cultures are "safe" and which are not. Bhabha notes that this prejudiced discernment is made through a surveillant culture of "security." In this connection, the stigmatization of the Chinese Canadian community and of health care workers during the SARS outbreak can be understood in terms of a social construction that is implicitly and tacitly informed by larger ideological currents of what has been referred to as the "new public health" hegemony (Sanford and Ali 2005; Keil and Ali 2006b), as well as a reaction to perceived threats of globalization in a post-9/11 era.

Stigmatized Ethnicity in the Context of Public Health

Goffman (1963, 139) notes that the stigmatization of individuals can serve as a means of social control of racial, ethnic, and religious groups. Seen in this light, stigmatization, as expressed through racialization, represents one mechanism through which social control is exerted. The connection of racialization to social control raises an important issue related to power and politics that is worth considering from a sociological point of view. Social theorists such as Foucault (1991) and Bourdieu (1984) note that social control may be embedded in established knowledge systems that legitimize structures of social inequality. As such, the members of a dominant group may implicitly make reference to institutionalized and widely held knowledge systems to lend an "official" or authoritative voice to their position and to justify their imposition of a stigmatized status on others. Stigma, therefore, can only be understood in terms of the convergence of culture, power, and difference (Parker and Aggleton 2003). This understanding has particular relevance when considering the interplay among public health, as a "scientifically"-based endeavour having authoritative appeal, infectious disease, and stigmatized ethnicity. Briggs (2005, 276) notes that racialization is hardly an isolated process because, in reality, racial categories "intersect" with other forms of subordination. This intersecting quality of racialization is illustrated, for example, in Packard's (1989) argument that a tuberculosis epidemic—that was rooted in exploitative labour conditions in the South African mining industry—provided an initial rationalization for apartheid. A second example may be found in the history of Vancouver's Chinatown. Anderson (1992) documents how Chinatown was set apart and vilified in the nineteenth and early twentieth centuries as a site of vice, corruption, disease, and danger (see Craddock 2000, and Shah 2001, for similar analyses in the context of San Francisco). As the abandonment of Chinatown during the SARS incident in Toronto attests, this stigmatization of people and place may now occur on the basis of a different rationale—that is, one informed and justified by the "new public health" discourse on risk and surveillance.

Emanating from the sanitarian movement at the turn of the century, the strategies of the "old" public health discourse tended to focus on issues relating to public hygiene—for example, sanitation, overcrowded living conditions, hazardous work environments, maintaining clean streets, and so on (Garrett 2000). In contrast, today these "health promotion" strategies target lifestyle and risk factors in disease onset. This latter emphasis forms the basis of the "new" public health. Formalized in the influential Lalonde Report (*New Perspectives on the Health of Canadians*) in 1974, the "new" public health approach directed attention away from an exclusive and traditional biomedical orientation concerning health care towards one based on the "health fields" of: lifestyle, health care organization, human biology, and the environment.

With the institutionalization of the "new" public health approach, however, attention has gradually shifted to an emphasis on changing behaviours on the individual level in order to prevent illness (Hancock 1986). Although recent efforts have been made to address the tacit "blaming the victim" assumption embedded within the new public health philosophy (see, for example, Labonte and Penfold 1981; Baum 1999, 1990), the individualist tendency still persists. In this connection, Armstrong (1995; see also Petersen 1996) notes that because the emphasis is on monitoring individual behaviours and lifestyle, the new public health strategies are simply modern extensions of the types of surveillance tactics noted by Foucault (i.e., the monitoring and social control of populations through individual level data and statistics). Furthermore, Petersen and Lupton (1996) contend that attempts at broadening the focus of the new public health to consider the psychological, social, and biophysical elements of health has led to an increased level of scrutiny wherein very few areas of social life remain immune to regulation of some kind. For example, "life-style surveys" are frequently used to gather data about many aspects of personal life for the calculation of "risk"; this includes data concerning many aspects of life, such as those related to leisure activities; level of exercise; the extent of social and sexual contact; the intake of fats, fibre, sugar, alcohol, and tobacco; body weight; blood pressure; and cholesterol (Bunton 1992; Petersen 1996). New public health strategies now tend to intervene in such areas as community development, personal skills development, the control of advertising "unhealthy" dangerous consumer products, and the regulation of urban space (for example, the "Health City projects"). What should be noted about these efforts are that they offer new opportunities for the monitoring and periodic screening of sub-populations (Petersen 1996, 49). Surveillance forms of this type are essentially risk-profiling techniques which enable the identification and formal recognition of many more categories of "at risk" populations and "risky" situations. That is, the scope of what is to be defined as "pathological" (as opposed to "normal") has in effect been expanded by such techniques.

The separation of those infected or exposed to SARS from the healthy is certainly warranted to avert the risk of transmission of this infectious disease, but, as Gostin et al. observe, such a practice also has the potential for using public health as a "subterfuge for discrimination" (2003, 3233). Thus, for example, one U.S. court invalidated an early twentieth-century quarantine in San Francisco that operated exclusively against the Chinese community, noting that the public health officials had targeted this community with an "evil eye and an unequal hand" (ibid.). Expanding on this notion, Lupton (1995, 117) notes that, historically, the "risky" persona has been cast in public health discourse in terms of attributes such as gender, social class, ethnicity, and sexual identity. Thus, certain social groupings—such as the poor, the working class, women, non-Europeans—as well as certain geographical locations—for example, slums, working-class neighbourhoods, the African continent—have been designated by Western societies as the contaminating "other" towards which public health measures are directed (ibid. 174). According to Petersen and Lupton (1996), the perspective of the "contaminating other" has become consolidated in contemporary times with the advent of the "new public health" and, as will now be discussed, this has implications for the manner in which the experiences of the SARS outbreak were felt by those in the Asian Canadian community.

Stigmatized Ethnicity within the Context of Globalization

The stigmatizing effects of the new public health techniques have a particular currency within the context of globalization—a period in which the migration of different people from around the world is said to have intensified (Shamir 2005). As Briggs notes, "narratives about epidemics make racial inequalities seem natural—as if bacteria and viruses gravitate toward populations and respect social boundaries" (2005, 272). For this reason, it is perhaps not surprising that infectious disease control and immigration regulations have always had a close affinity. This affinity is based on the fact that both public health and immigration are concerned with the effects and regulation of space and movement and the administration, security, and permeability of borders (Bashford 2002, 352)—where borders refers to both the boundaries of the body (with reference to infectious disease spread) and the territorial unit (with reference to the movement of people). Today, the biopolitics of movement within the age of globalization takes on new significance. Dean affirms that today biopolitics is not only about managing health, sanitation, propagation, longevity, and lifestyle—as emphasized in the work of Foucault and his adherents—but now also involves an international dimension. That is, biopolitics should now include that which governs the movement, transitions, settlement, and repatriation of various populations—including refugees, migrants, guest workers, tourists and students (1999, 100, cited by Bashford 2002, 348-349).

Recently, in the post-9/11 era, new opportunities have arisen for the convergence of different types of threats, thus giving rise to new forms of stigmatization that are based on the type of overlap between public health, infectious disease, and ethnicity reviewed in the previous sections. First, the threat of infectious disease has recently garnered much greater public attention. In part, this was an outcome of the interactions among the American scientific community, public health officials, and defence experts who collectively put forth the argument that "new and emerging diseases" represented a serious threat to national security, international development, and global public health (King 2002). This argument in turn reflected "American anxieties about living in a globalizing world, in which the assumptions and institu-

tions of the Cold War era no longer seemed adequate to the task of ensuring the safety and interest of U.S. citizens" (ibid. 764). The resultant emphasis on security that was adopted to address the infectious disease threat was also directed towards the threats that were associated with terrorism and the movement of "outsiders" in a highly globalized and mobile world. In this light, Shamir writes of the development of a pervasive "paradigm of suspicion" that conflates the perceived threats of crime, immigration, and terrorism. For Shamir, the key issue is how individuals and groups are classified according to perceived threats and risks, and especially on the role of technology and statistical means involved in operationalizing these classifications and creating elaborate forms of such distinctions. The use of technical means to track possible security threats may dovetail with similar measures used during disease outbreaks to track a virus (see, for example, van Wagner 2008, for further discussion of this in the context of SARS in Toronto in relation to the associated social and legal ramifications). This conflation of national security and public health has particular implications for the nature of stigmatization under the contemporary conditions of neoliberalization and globalization.

First, it should be noted that the techniques of contact tracing, quarantine/isolation, and surveillance may be thought of as traditional techniques of infectious disease control, dating back centuries to the days when ships where quarantined to port. What is different today is that the employment of these "old" public health techniques have different effects within the context of the new public health and neoliberal globalization. The neoliberal tendency to withdraw various state services originally intended to protect the collective welfare has led to many changes. Most notably, within the realm of public health, it has induced the emergence of a prevailing cultural norm that holds that it is solely the individuals' responsibility to protect themselves from risk, thus absolving the state of any responsibilities in regard to collective health, while at the same time downloading the costs of public health to the individual (Petersen 1996, 4). Such a norm tends to individualize the risk and leads to a more defensive orientation that has significant implications for the stigmatization of others who are conceived of not only as health threats, but as racialized health threats. Thus, for example, it was reported that a Chinese Canadian women was told to "go back to your own country and stop transporting diseases here" (Leung and Guan 2004, 19). Furthermore, as expressed by some members of the Asian community, there was disappointment that the government's SARS recovery plans did not include any anti-racism programs but only emphasized economic recovery—and then only for businesses outside Chinatown (ibid. 22), again illustrating the withdrawal of the state from protective collective welfare functions.

Ho-fung Hung (2004) notes that the organized responses to SARS could be classified along two lines. The first, referred to as the "globalist response," is predicated

on the idea that fighting a global disease requires a global response in which nations and officials at all levels must cooperate and coordinate their response. With this orientation, attention becomes focused on the task at hand (i.e., preventing the global transmission of disease) instead of on the political question of where to place the blame. Consequently, the entire chain of transmission warrants public health attention. In contrast, the "anti-globalist" response focuses only on one point in the viral transmission chain, namely, the point of origin. As such, the originating culture and society are blamed for the pandemic, and actions are taken specifically against that culture/society, with the reasoning being that the pandemic can only be stopped by isolating that particular culture/society and avoiding all contact with members belonging to it. Hung (27) goes on to note:

> This suggested solution is antithetical to the globalization process, and akin to global apartheid. For whereas actions that isolate people showing symptoms of a contagious disease can be called a quarantine, actions that indiscriminately isolate a whole culture and society as well as the people from there should be called apartheid.

Therein lies the obfuscated distinction between quarantine as a health measure and avoidance as a racially motivated action.

Issues involving stigmatized ethnicity, especially as they relate to public health threats, will undoubtedly increase in significance in the future with the intensification of globalization (and, most notably, with the pending threat of avian flu—see, for example, Keil and Ali 2006a; Davis 2005). This will be particularly true for large cosmopolitan centres that are often home to people from around the world. It has been found, for example, that the diffusion of the SARS coronavirus followed a circuit of human flows that networked the worlds' "global cities"—all of which are characterized by the presence of numerous diaspora communities (Ali and Keil 2006). In this light, the study of the relationship between ethnicity and infectious disease is one lens through which the politics of race and the workings of multiculturalism in a city may be studied (Keil and Ali 2006b). The transmigration of people and the flow of human beings among societies of the world will likely intensify with increased cultural, economic, and political globalization, thus increasing the potential for disease spread (Barret et al. 1998; Davis 2005; Galea et al. 2005; IOM 1997; McMichael 2001). However, it has been noted by Sarasin (2006, 220) that under such circumstances—

> There is clearly an intensified exchange and global spread of pathogenic microorganisms along the path of migration. Yet, isn't this exchange just as pronounced, or even more so, in worldwide tourist traffic? Can we really be certain immigrants have so many more infectious diseases as to justify our fear of them, whereas business travelers, sex tourists,

> students, and all the other millions who cross international borders everyday are somehow less affected by them? SARS has taught us differently.

Sarasin further warns us that infectious disease may very well represent the "metaphorical core of globalization" in a post-9/11 world in which, increasingly, the "other" is perceived in terms of a viral invader conceived of, not only as a health threat, but as a threat in many other senses as well, be it defined in terms of terrorism, economics, culture, or politics. In this sense, ethnic stigmatization may not only represent the manifestation of "othering" at the level of social interaction, but as the first step towards a more troubling process of demonization that may ultimately contribute to the potential creation of a moral panic. Thus, the conflation of stigmatization ethnicity and health threats will likely take on a new and unique significance under contemporary globalized circumstances.

Conclusion

The tacit and latent symbolic boundaries separating the dominant group and visible minorities are silently reproduced in the everyday interactions of civil society. Extreme events, however, afford the opportunity for negative sentiments to become visible and to violate these boundaries, as evidenced, for example, by the onset of racially-based actions and words. Such developments are particularly evident during disease outbreaks. One of the features of the epidemic disease is its transgression of boundaries, and, during disease outbreaks, lines are drawn to make these boundaries material in the form of quarantine (Zheng 2005), as has historically been done in Chinatowns throughout North America. Today, the individualizing tendencies of the "new public health," coupled with socially negative reactions to the inclinations towards a "borderless" world brought on by globalization, has led to new justifications for the imposition of stigmatized status, one which further strengthens the association of ethnicity with disease. For these reasons, the relationship among stigmatization, ethnicity, and health must be given much more careful consideration by both analysts and policy-makers, lest we risk a return to a more unjust and intolerant society.

Notes

1. It is also worth noting that one of the key recommendations from an influential commission inquiry report into the SARS outbreak in Toronto pertained to the establishment of a central public health agency designed to coordinate efforts across different sectors (Naylor 2003). In response, the newly established Public Health Agency of Canada emphasized an increase in surveillance capacity in many of its' constituent branches, including Infectious Disease and Emergency Preparedness, Health Promotion, and Chronic Disease Prevention, and Public Health Practice and Regional Operations (see www.phac-aspc.gc.ca), with a concomitant loss in collective empowerment and community capacity building.

2. Link and Phelan (2001) prefer the term "label," rather than "mark" or "attribute," because they wish to emphasize that the identification and election of the particular feature for social attention is not exclusively a characteristic of the stigmatized individual, but the product of a relational social process.

3. According to Escobar (1995), the bias of developmentalism is based on political involvement in development and the institutional promotion of development as a means of improving life in poor countries, which in turn is predicated on the notion of modernity in which the West self-characterizes itself in opposition to "others" and "elsewheres" that are imagined to not be modern (Robinson 2006, 4).

4. Interestingly, Baehr (2008) notes that this same mask connotes a different meaning in the context of Hong Kong, where the donning of the mask was conceived of in positive terms as a cultural norm was established that if one were ill, but not wearing a mask in public, than one was not fulfilling his or her responsibility to the community of protecting others. That is, the stigmatized individual would be the ill person who was not wearing a mask to protect others in public.

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S. HARRIS ALI is associate professor in the Faculty of Environmental Studies at York University. His research areas include the socio-political dimensions of environmental health issues and environmental disasters, particularly among vulnerable groups. His most recent research investigates the implications of disease outbreaks for race/ethnic relations in a globalized, post-9/11 era. He is co-editor (with Roger Keil) of *Networked Disease: Emerging Infections in the Global City.*