

# Ebola Outbreak: The Latest U.S. Government Lies. The Risk of Airborne Contagion?

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Global Research, October 01, 2014

Region: [sub-Saharan Africa, USA](#)

Theme: [Science and Medicine](#)

*We begin with the Public Health Agency of Canada, which [once](#) (as recently as August 6) stated on its website that:*

“In the laboratory, infection through small-particle aerosols has been demonstrated in primates, and airborne spread among humans is strongly suspected, although it has not yet been conclusively demonstrated ([1](#), [6](#), [13](#)). The importance of this route of transmission is not clear. Poor hygienic conditions can aid the spread of the virus.”

No more; the “airborne spread among humans is strongly suspected” language has been [cleansed](#):

“In laboratory settings, non-human primates exposed to aerosolized ebolavirus from pigs have become infected, however, airborne transmission has not been demonstrated between non-human primates

[Footnote1](#) [Footnote10](#) [Footnote15](#) [Footnote44](#) [Footnote45](#).

Viral shedding has been observed in nasopharyngeal secretions and rectal swabs of pigs following experimental inoculation.”

Are we to suppose that very recent and ground-breaking research was conducted that indicated there is no longer reason to “strongly suspect” that airborne Ebola contagion occurs? Surely, the research was done three weeks ago, and we only need to wait another couple of days until the study is released for public consumption. Feel better now?

If not, perhaps the 9/30 words of the Centers for Disease Control accompanying the Dallas Ebola case will provide some solace. Or, perhaps those words just contain another pack of U.S. Government lies. Let’s investigate.

Before addressing the [CDC’s Statement](#), we should articulate some pivotal Ebola Outbreak facts we’re apparently not supposed to mention or even think about, since they’ve been buried by the Government/MSM complex. So, consider this from an [earlier](#) Global Research contribution by this author, drawn from a [2014 New England Journal of Medicine article](#):

“Phylogenetic analysis of the full-length sequences established a separate clade for the Guinean EBOV strain in sister relationship with other known EBOV strains. This suggests that the EBOV strain from Guinea has evolved in parallel with the strains from the Democratic Republic of Congo and Gabon from a

recent ancestor and has not been introduced from the latter countries into Guinea. Potential reservoirs of EBOV, fruit bats of the species *Hypsignathus monstrosus*, *Epomops franqueti*, & *Myonycteris torquata*, are present in large parts of West Africa.<sup>18</sup> It is possible that EBOV has circulated undetected in this region for some time. The emergence of the virus in Guinea highlights the risk of EBOV outbreaks in the whole West African subregion...

The high degree of similarity among the 15 partial L gene sequences, along with the three full-length sequences and the epidemiologic links between the cases, suggest a single introduction of the virus into the human population. This introduction seems to have happened in early December 2013 or even before.”

The take-home message is that we now confront a brand spanking new genetic variant of Ebola. Furthermore, we still have no idea at all how the “single introduction of the virus in the human population” of West Africa occurred. And, the current Ebola outbreak appears to be orders of magnitude more contagious than previous outbreaks. It also presents with a [fatality count](#) that far exceeds all previous outbreaks combined. But it’s certainly not airborne, so who cares about nit-picking details such as these!

In spite of the above facts, we are supposed to believe that all questions regarding the current Ebola outbreak can be answered with exclusive reference to what has occurred in connection with previously encountered—in terms of genetic composition—and known—in terms of initial outbreak source—Ebola episodes.

Here are a couple of questions. When was the last time an Ebola outbreak coincided with instructions to U.S. funeral homes on how to “[handle the remains of Ebola patients](#)”? Not to worry, since Alysia English, Executive Director of the Georgia Funeral Homes Association, is quoted (click preceding link) as saying “If you were in the middle of a flood or gas leak, that’s not the time to figure out how to turn it off. You want to know all of that in advance. This is no different.” So it’s just about being prepared, you see. Of course, nothing resembling this sort of preparation has ever transpired alongside any other Ebola outbreak in world history, so what gives now?

“Oh, it’s because we now have that Ebola case in Dallas.” True, but this response suffers from two fatal defects. First, we’re not supposed to worry about one tiny case as long as it’s in America, right, since according to the [CDC on 9/30](#):

...there’s all the difference in the world between the U.S. and parts of Africa where Ebola is spreading. The United States has a strong health care system and public health professionals who will make sure this case does not threaten our communities,” said CDC Director, Dr. Tom Frieden, M.D., M.P.H. “While it is not impossible that there could be additional cases associated with this patient in the coming weeks, I have no doubt that we will contain this.”

If the U.S.’ strong health care system (which is apparently far superior to hazmat suits) is so effective at containment, what explains the funeral home preparations again? If U.S. containment procedures are so superb and the virus is no more contagious than before, what difference does it make whether the case is in Dallas, Texas or Sierra Leone? To be sure, maybe the answers to these questions are simple, and it’s just about corrupt money and the like.

However, the corrupted money explanation isn't very plausible (at least on its own) either, for the very simple, and extremely disturbing, reason that the "funeral home preparations" article was [first published on 9/29 at 3:36 PM PST](#)—a day before the Dallas case was confirmed positive. Of course, this makes the following language at the very head of the article all the more eerie:

"CBS46 News has confirmed the Centers for Disease Control has issued guidelines to U.S. funeral homes on how to handle the remains of Ebola patients. If the outbreak of the potentially deadly virus is in West Africa, why are funeral homes in America being given guidelines?"

If the rejoinder is that "well, people thought the Dallas case might turn out positive", the reply must be that there were several other cases, in places like Sacramento and New York, that might have turned out positive, but resulted in neither funeral home preparations nor a rash of CDC "[Ebola Prevention](#)" tips (wash those hands, since they're running low on hazmat suits!)

Hopefully, you are in the mood for two more big CDC lies, because they really are quite important. From the 9/30 CDC statement: "People are not contagious after exposure unless they develop symptoms." This is a lie for three basic reasons. First, the studies that inform the CDC's professed certainty on this issue relied upon analyses of previous outbreaks of then-known known Ebola variants. The current strain, as stated here early on, is novel—genetically as well as geographically. Second, the distinction between "incubation" and "visible symptoms" is a continuum, not discrete in nature; a few droplets might not be rain, but they're not indicative of fully clear skies either—so the boundary drawn by the CDC is, like nearly everything else the U.S. government does, arbitrary. Third, as even rank amateurs at statistics know, previous outbreaks have consisted of too few cases to confidently rule out small but consequential probabilities of asymptomatic transmission—completely leaving aside the fact that we have a new genetic variant of Ebola to deal with.

The last major CDC lie mentioned in this article is the claim, repeated ad nauseam, that "infrastructure shortcomings" and the like is wholly sufficient to explain the exponential increase in the number of cases presented by the current outbreak. We should believe that only when presented with well-designed multivariate contagion models that properly incorporate information about Ebola outbreaks and generate findings that socioeconomic differences as between West Africa and other regions of Africa (such as Zaire) alone can fully explain observed differences associated with the current outbreak. It seems to this author that we should strongly doubt that the current contagion can be fully explained without at some point invoking features of the novel genetic strain.

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