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SYMPOSIUM ON RACE, RACISM, AND INTERNATIONAL LAW

WHITE HEALTH AS GLOBAL HEALTH

*Matiangai Sirleaf**

With the expansion of European imperialism, public health concerns became globalized, necessitating cooperation with other imperial powers for the treatment and prevention of diseases. This essay traces the role of race and racism in the development of global public health law. It explores the connections, legacies, vestiges, and important disjunctions between tropical medicine and global public health, and considers the primacy given to white health[1] as one of the animating purposes behind the emergence of the global public health regime. The centrality of protecting the health and interests of white people then and now continues to inform the global health agenda. This essay surfaces the role of international law through omission and commission in structuring and reifying racialized hierarchies of care and concern. It concludes that transformational reforms aimed at addressing this legacy are necessary.

Tropical and Colonial Medicine

Tropical medicine was a crucial aspect of colonial subjugation and expansion. For example, French colonial authorities in Senegal used the bubonic plague to further segregationist ends by closely linking the Black population to the disease, since they conceived of Black people as a "barbaric collective that threatened the order and health conditions in the 'European' city."[2] In previous work, I define the "racialization of diseases" as the attachment of racial meaning to ailments based on the racial groups that tend to be socially associated with a given illness.[3] Consequently, even though the infection rate among Black Africans was not any higher than any other racial group, French authorities imposed harsh measures in Senegal, which included "burnings of huts, along with the formation of quarantine camps."[4] They also imposed a *cordon sanitaire* that would segregate the city well after the 1914 outbreak of the plague in Dakar.[5] Similarly, for the British colonial authorities in Sierra Leone, the preferred method of fighting malaria was residential segregation.[6] Several analyses have demonstrated how sanitation concerns were used as a pretext for furthering segregationist ends.[7]

* *Nathan Patz Professor of Law, University of Maryland School of Law, and Professor, Department of Epidemiology and Public Health, University of Maryland School of Medicine, College Park, MD, United States.*

[1] *See, e.g.*, W.C. Gorgas, *The Conquest of the Tropics for the White Race*, 52 J. AM. MED. ASS'N 1967–69 (1909) (President's address discussing the need for malaria control in the Canal Zone to render the Panama Canal suitable for further colonial exploitation).

[2] Liora Bigon, *A History of Urban Planning and Infectious Diseases: Colonial Senegal in the Early Twentieth Century*, 2012 URB. STUD. RES., Art. No. 589758, at 2 (2012).

[3] Matiangai Sirleaf, *Racial Valuation of Diseases*, 67 UCLA L. REV. 1820 (2021).

[4] Bigon, *supra* note 2, at 7.

[5] *Id.* at 7–8.

[6] *See generally* Stephen Frenkel & John Western, *Pretext or Prophylaxis? Racial Segregation and Malarial Mosquitos in a British Tropical Colony: Sierra Leone*, 78 ANNALS ASS'N AM. GEOGRAPHERS 211 (1988).

[7] *See, e.g.*, Richard C. Keller, *Geographies of Power, Legacies of Mistrust: Colonial Medicine in the Global Present*, 34 HIST. GEOGRAPHY 26 (2006).

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Tropical medicine took place in settings that often depended on the coercive power of the colonial administrative state to implement its interventions.[8] Tropical medicine was generative for colonialism. As advances took place in the field, it furthered imperialist ends by enabling troops to better cope with unfamiliar diseases to be healthy to fight Indigenous populations resisting colonial domination and subjugation. Unsurprisingly then, tropical medicine grew to specifically focus on vector-borne diseases and infectious disease control, since these diseases had the greatest implications for the expansion of colonial empires.

Additionally, efforts to improve the health of subordinated populations in internal or external colonies were explicitly tied to racial capitalism, wherein being usable and being a thing of importance is a functional relationship between dominant and subordinated groups.[9] States arguably only developed public health systems to improve the ill health of Black, Indigenous, and other people of color as scientific knowledge expanded to confirm that germs know no color line.[10]

Because disease carrying microorganisms do not differentiate among their victims, those concerned for white health could not afford to ignore Black health. Jim Crow laws in the United States could not prevent germs from measles, tuberculosis, pneumonia, or typhoid from spreading, which necessitated action that included historically subordinated groups in public health interventions.[11] In South Africa, concern for the health and wellness of Black people was driven primarily by their proximity to the white population and the potential negative impact that this might have on white interests.[12] For example, because leprosy was perceived to be a "Black disease," harsh measures were enacted that allowed for compulsory segregation of all lepers due to fears that the disease was spreading and affecting whites.[13] While many Black lepers were detained on Robben Island, white lepers were allowed to remain quarantined at home.

Colonial Medicine to Global Health

In the first part of the twentieth century, there were about thirteen international agreements on global health.[14] Colonial powers prioritized global health because they wanted to coordinate sufficiently restrictive quarantine regulations that would facilitate the unimpeded expansion of imperial trade without exposing their populations in the mother country to diseases from colonial territories.[15]

European colonizers prioritized defensive measures against contagion from racialized and "diseased" territories when formulating the global health regime. Adrien Proust, one of the leading French voices during the International Sanitary Conferences, authored several works on "the defense of Europe" against exotic diseases.[16] The 1892 Convention solely addressed cholera due to concerns that the Suez Canal could be a conduit for the

[8] Randall Packard, A History of Global Health: Interventions into the Lives of Other Peoples 14 (2016).

[9] Achille Mbembe, On the Postcolony 187 (A.M. Berrett et al. trans., 2001) (2000).

[10] *See* Andrea Patterson, *Germs and Jim Crow: The Impact of Microbiology on Public Health Policies in Progressive Era American South*, 42 J. Hist. Biography 529, 536 (2009).

[11] *Id.* at 537.

[12] Saul Dubow, Scientific Racism in Modern South Africa 170 (1995).

[13] Harriet Deacon, *Racism and Medical Science in South Africa's Cape Colony in the Mid- to Late Nineteenth Century*, 15 Osiris 190, 204 (2000).

[14] WHO, Proceedings of the Special Committee and of the Fourth World Health Assembly on Who Regulations No. 2, at 1 (1952) (discussing the background to the International Sanitary Conferences and any resulting treaties from 1851 to 1938).

[15] Norman Howard-Jones, *The Scientific Background of the International Sanitary Conferences 1851–1938*, 1 Hist. Int'l Pub. Health 11 (1975).

[16] Howard-Jones, *supra* note 15, at 82.

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introduction of cholera from India to Europe.[17] Consequently, the 1893 Convention required state parties to inform each other without delay if any outbreaks of cholera occurred within their territories.[18]

Additionally, European powers feared that Muslim pilgrims returning to Europe posed a serious threat, following a cholera epidemic in Mecca.[19] The Sanitary Convention of 1894 was thus singularly dedicated to the pilgrimage to Mecca.[20] Similarly, following a serious epidemic of the plague in India, some Europeans were anxious that their other colonial territories might be affected.[21] Subsequently, the International Sanitary Convention of 1897 added the plague as a disease warranting international prioritization and notification.[22]

These treaties exemplify how colonial powers shaped not only the emergence of the global health regime, but what diseases deserved international attention and prioritization. This was also reflected in the International Sanitary Convention of 1926, which modified the 1912 Convention and required international notification for the first confirmed cases of cholera, the plague, yellow fever, as well as smallpox and typhus.[23] Notably, there were millions of cases of typhus in Poland and the Soviet Union following World War I. The expansion of the list of diseases that deserved international recognition under the 1926 Convention coincided with the importance given to these diseases in the Global North.

During the 1930s, the *Aedes aegypti* mosquito was endemic in parts of southern Europe, and several outbreaks of dengue arose as a result.[24] Subsequently, thirteen European countries agreed to prioritize the prevention of the spread of dengue under the International Convention for Mutual Protection Against Dengue.[25] It was not as if diseases prioritized by these treaties were the only diseases afflicting populations globally.

Members of the new League of Nations also endeavored to "take steps in matters of international concern for the prevention and control of disease."[26] Yet, commentators concluded that, "as compared with what it has done for other parts of the world . . . the Health Committee of the League of Nations itself has done remarkably little for the African continent."[27]

It was not until the 1944 modification of the International Sanitary Convention that the global public health regime began requiring state parties to send epidemiological information for diseases not pre-ordained as significant by Western capitals.[28] Under the 1944 Convention, state parties were to send so far as possible regular notifications of communicable diseases in their countries.

The multiple overlapping obligations from earlier conventions led to a complex situation where some states were parties to some instruments and not others.[29] In 1969, the WHO Health Assembly revised, consolidated, and renamed the International Sanitary Regulations the "International Health Regulations." The basic premise of the system remained the same—notification requirements for named infectious diseases, which would then trigger

[17] *See* International Sanitary Convention of 1892, Art. 4 (Jan. 9, 1892) (noting measures to prevent cholera).

[18] International Sanitary Convention of 1893, Title I (Apr. 15, 1893).

[19] *See* Howard-Jones, *supra* note 15, at 73.

[20] International Sanitary Convention of 1894 (Apr. 3, 1894).

[21] *See* Howard-Jones, *supra* note 15, at 78.

[22] International Sanitary Convention of 1897, Chs. I–IV (Mar. 19, 1897).

[23] International Sanitary Convention of 1926, Art. 1 (June 21, 1926).

[24] Francis Schaffner & Alexander Mathis, *Dengue and Dengue Vectors in the WHO European Region: Past, Present, and Scenarios for the Future*, 14 Lancet 1271, 1271 (2014).

[25] International Convention for Mutual Protection Against Dengue Fever, 1935.

[26] Covenant of the League of Nations, Art. XXIII (1920).

[27] E. Thornton & A.J. Orenstein, *Co-ordination of Health Work in Africa*, *in* Report of the Pan-African Health Conference Held at Johannesburg, November 20th to 30th, 1935, 208–09 (1936).

[28] *Compare* International Sanitary Convention of 1944, Art. 5A, *with* Art. 5B.

[29] P.G. Stock, *The International Sanitary Convention of 1944*, 38 Proc. Royal Soc'y Med. 309, 311 (1944).

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an international response that imposed travel and trade restrictions to contain the spread of disease. While the names of the treaties and the substance changed incrementally over the years, the prioritization of white interests in their enactment remained constant.[30]

Back to the Future

Unlike predecessor institutions, the World Health Organization was to be global not just in name but in substance. Its constitution states that, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[31] Yet, the current regime under the 2005 International Health Regulations does not refer to historic or ongoing racial discrimination in public health or medicine.[32] This failure to engage explicitly with race obscures the role of racism and subordination in global health.[33]

The Regulations ignore the structural conditions in the international system that give rise to and limit the ability of states to develop core capacities. The Regulations assign primary responsibility for implementing health measures to combat infectious diseases to national authorities.[34] State parties have a legal obligation to develop better functioning health systems to detect, surveil, report, verify, and respond to disease;[35] and are also legally obligated to cooperate to help build health capacities.[36] Yet, the Regulations do not specify how this should be operationalized. Thus, legacies of subordination and continued inequities that have rendered states vulnerable to epidemic and pandemic diseases are unaccounted for in the Regulations. Regrettably, some of the proposed amendments to the Regulations from the United States tend to narrowly focus on bolstering early detection efforts without sufficient attention to historical vulnerabilities and lack of capacity.[37]

Moreover, the present system provides state parties with substantial opportunity to make choices shaped by implicit or explicit racism. For example, during the COVID-19 pandemic, some states made decisions informed by "outdated but persistent settler-colonial conventions that have mapped illness and disease on to racialized peoples and certain geographic regions."[38] The World Health Organization declared COVID-19 a public health emergency of international concern on January 30, 2020, and consistently "advise[d] against the application of travel or trade restrictions to countries experiencing COVID-19 outbreaks."[39] However, by February 27, 2020, thirty-eight countries had already reported measures "that significantly interfered with international traffic in relation to travel to and from China or other countries, ranging from denial of entry of passengers, visa restrictions, or quarantine

[30] *See* World Health Org., Resolution WHA26.55 209 Official Records, 29 (1973) (amending the IHR's provisions relating to cholera). *See also* World Health Org., Resolution WHA34.13, 217 Official Records, 21, 71 and 81 (1974) (amending the IHRs to exclude smallpox following its eradication).

[31] *See* WHO Constitution, pmbl., July 22, 1946, 14 UNTS 185 (*entered into force* Apr. 7, 1948) [hereinafter, WHO Constitution].

[32] *See generally* World Health Org., International Health Regulations (2d ed. 2005) [hereinafter, IHRs of 2005] (note the absence of a reference to race).

[33] *See generally* Matiangai Sirleaf, *Entry Denied: COVID-19, Race, Migration & Global Health*, 2 Front. Hum. Dynam. 1 (2020).

[34] IHRs of 2005, *supra* note 32, Art. 4.

[35] *Id.*, Annex I.A (detailing the core capacity requirements for surveillance and response).

[36] *Id.*, Annex I(A)(3) ("State parties and WHO shall support assessments, planning and implementation processes . . . .").

[37] *See, e.g.*, World Health Org., Strengthening WHO Preparedness for and Response to Health Emergencies: Proposal for Amendments to the International Health Regulations (2005), Seventy-Fifth World Health Assembly Provisional Agenda Item 16.2, WHO A75/18 (Apr. 12, 2022) (proposing substantial amendments to Articles 5, 6, 9, 10, and 11, among others).

[38] Sirleaf, *supra* note 33, at 1.

[39] World Health Org., Updated WHO Recommendations for International Traffic in Relation to COVID-19 Outbreak (Feb. 29, 2020).

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for returning travelers."[40] A newspaper in France even carried the headline "Yellow Alert" on its front page.[41] Moreover, the understanding of the disease as racialized and "foreign" constrained the space for consideration of community transmission within the United States.[42] The racialization of COVID-19 led to public health law and policy decisions that assumed that the virus was engaged in racialized transmission efforts, checking documents and nationalities to determine whom to infect next.[43] This was evident in the overreliance on blanket travel bans as a magical solution to stop the spread of a highly infectious novel disease concomitant with the lackadaisical approach to implementing screening measures at airports in the United States and elsewhere.

Early reactions were not merely efforts at disease containment. The racial and colonial logics influencing COVID-19 law and policymaking were evident in innumerable ways throughout the course of the pandemic. A prime example, was the swift decision by countries in the Global North to cut off southern African countries following South Africa's genomic sequencing of the Omicron variant.[44] Instead of being rewarded for tracing and alerting the world to a variant that was already circulating in continental Europe,[45] the United Kingdom, and the United States,[46] the European Union and others were hasty to make decisions informed by "Afrophobia," as the president of Malawi termed it.[47] One newspaper published a literal depiction of the racialization of diseases—replete with brown viruses with exaggerated phenotypical Black features traveling on a boat with the South African flag toward European shores.[48] This fear of the racialized other and their diseases is a powerful reminder of how the history of diseases and responses to diseases is linked to politics of racial exclusion and subordination.

Conclusion

The COVID-19 pandemic has created an opening to not only recognize, but to potentially reshape the relationship between race and global health. Early efforts to draft an international treaty for "pandemic preparedness and response to build a more robust global health architecture"[49] provide some possibilities.

In earlier work, I argue for the expansion of the common but differentiated responsibilities principle to the challenges posed by highly-infectious diseases.[50] The principle has two main elements: (1) common responsibility describes the shared obligations of two or more states towards the protection of a particular resource; and (2) a range of different burden-sharing arrangements that take into account each nation's particular circumstances, especially its ability to prevent, reduce, and control the problem.

Encouragingly, the WHO's Conceptual Zero Draft released in February 2023 embraces the principle of common but differentiated responsibilities and capabilities in pandemic prevention, preparedness, response, and recovery of health systems.[51] The Zero Draft clarifies that "States that hold more resources relevant to pandemics,

[40] *Id.*

[41] Mokoto Rich, *As Coronavirus Spreads so Does Anti-Chinese Sentiment*, N.Y. TIMES (Feb. 3, 2020).

[42] Sirleaf, *supra* note 33, at 6.

[43] *Id.* at 7.

[44] Joe Hernandez, *African Leaders Condemn Travel Restrictions as Omicron Variant Spreads Globally*, NPR: GOATS AND SODA (Nov. 30, 2021).

[45] *Omicron COVID Variant Was in Europe Before South African Scientists Detected and Flagged It to the World*, CBS NEWS (Nov. 30, 2021).

[46] President Biden (@POTUS), TWITTER (Nov. 29, 2021, 12:03 p.m.).

[47] African (@ali_naka), TWITTER (Nov. 28, 2021, 5:03 a.m.).

[48] *The Newspaper La Tribuna de Albacete and Its Cartoonist Apologise for a Cartoon*, JR MORA (Nov. 24, 2021).

[49] WHO Press Release, Global Leaders Unite in Urgent Call for International Pandemic Treaty (Mar. 30, 2021).

[50] *See generally* Matiangai Sirleaf, *Responsibility for Epidemics*, 97 TEX. L. REV. 285 (2018).

[51] WHO, Conceptual Zero Draft for the Consideration of the Intergovernmental Negotiating Body at Its Fourth Meeting, WHO A/INB/4/3 (2023).

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including pandemic-related products and manufacturing capacity, should bear, where appropriate, a commensurate degree of differentiated responsibility."[52] It stipulates that prioritization is "required of the specific needs and special circumstances of developing country [p]arties, especially those that (i) are particularly vulnerable to adverse effects of pandemics; (ii) do not have adequate capacities to respond to pandemics; and (iii) potentially bear a disproportionately high burden."[53] If operationalized, this principle could help address issues of racialized structural inequities in ways that other frameworks do not. The Zero Draft embraces other principles that would help to address past and continuing effects of racism in global public health,[54] like equity, solidarity, and inclusiveness.[55]

It remains to be seen whether reforms will be truly transformational. My hope is that bourgeoning efforts to decolonize global public health and to address racial inequities will not be ephemeral.

[52] *Id.* Art. 4(8).

[53] *Id.*

[54] *Id.* Art. 4(8).

[55] *Id.* Arts. 4(4), (5), (9).

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