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**TWAIL & Global Public Health**

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## **I. Introduction**

COVID-19 travels on societies' fault lines. Inequality has proven to be a major driver of the pandemic and its outcomes. This has been true not only within countries, but also across them. It is not an exaggeration to say that the Global North, especially the United States, has hoarded vaccines and treatments, as well as the right to produce these pharmaceuticals through trade and intellectual property protection. The impact of this has been grave. Not only have countries been unable to access vaccines, these legal barriers have enabled the virus to mutate in to new variants that are ever-more transmissible, making the end of the epidemic seem further and further away. The issue of vaccine access has been further complicated by the sheer capacity that is required of countries to effectively distribute and administer vaccines. The capacity to distribute vaccines has been undermined by centuries of underinvestment in the public health sector stemming from imperial control of colonized territories, to international agreements between lending institutions and formerly colonized countries in the Global South including aid conditionalities embedded in bi- and multi-lateral agreements that limit the fiscal capacity and policy space for national governments to improve the health of their populations.

Until recently, scholars had not examined the dynamics around global public health issues – including deep inequalities in health outcomes within and across the Global North and South – through the critical lens of Third World Approaches to International Law (TWAIL). Yet a nascent but growing literature demonstrates that TWAIL can be instructive for understanding how law structures the global political and economic order to produce health inequalities both within and across countries through maintaining power imbalances, despite liberal claims of the possibilities of equalizing relationships between countries through international law.

## **II. Traditional Accounts of International Law and Global Public Health**

Global public health law and international health law are subfields of international law. Global health law emerged from international health law. It refers to “the legal frameworks” that “structure the contemporary governance architecture for global health”.<sup>2</sup> While international health law has long structured multilateral efforts to respond to the threat of cross-border spread of

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<sup>2</sup> Lawrence Gostin and Benjamin Mason Meier, “Introducing Global Health Law”, *The Journal of Law, Medicine and Ethics*, 47 (2019), 788-793.

infectious diseases, advocates of global health law seek to move beyond the confines of international law to bring a specific focus on justice. Scholars and practitioners in the field believe that evidence-based law and regulations play an important role in promoting health behaviors and outcomes and enabling the provision of equitable health care systems and services.<sup>3</sup> Like the broader field of international law, most writing in global and international health law acknowledges the power differentials in international law, yet still seeks to address them through formalistic rule of law proposals that aim to remedy health inequality at the national rather than international or global levels. Two examples demonstrate this.

First, in the context of law and development, health indicators are seen as a means to assess a country's progress towards quantifiable development goals, such as reducing maternal mortality or the incidence of infectious diseases. Both the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs), for example, contain specific indicators on health, such as the percentage of births assisted by skilled personnel or the number of people living with HIV/AIDS who received antiretroviral treatment, as well as other indicators that would indirectly impact health outcomes. Countries are said to "progress" along the path towards development as particular indicators are met. Yet while the MDGs and SDGs acknowledge the role of foreign aid in facilitating the improvement of indicators such as access to maternal health professionals or HIV/AIDS drugs, they do not acknowledge how the international system structures the *political* nature of aid monies or how it creates and enforces legal rules such as intellectual property rights that in turn can negatively impact health outcomes in the Global South.

Second, human rights institutions frequently take on issues related to health injustice and global health inequalities, which are then spoken of in the register of human rights violations under international law. Human rights reports frequently cite to the Universal Declaration on Human Rights (UDHR), which states in Article 25 that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

Mainstream scholars of international law and human rights view the UDHR and its two companion treaties, the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Social, Cultural and Economic Rights (ICESCR), as foundational treaties in realizing a right to health. The ICESCR contains within it a right to health which has been further expanded in General Comment 14 on the Right to Health. Over time, various human rights bodies have weighed in on how states can further realize the right to health, though in doing so they often avoid sensitive economic and political constraints on the realization of this right due to the delicate balance between human rights organizations and states as participants in the human rights process.<sup>4</sup>

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<sup>3</sup> Ibid. For example, in moving beyond the traditional horizon of international health law, Gostin and Meier argue that global health law includes focus on legal approaches to addressing the combination of new globalized health threats (from dangerous products to communicable *and* non-communicable diseases) new global health actors (not least multinational firms, global NGOs, and other non-state actors) and new instruments of "soft law" (including the array of global policies, strategies and action plans that are deployed in the contemporary arena of global public health).

<sup>4</sup> See for example Human Rights in Global Health: Rights-Based Governance for a Globalizing World (Benjamin Mason Meier & Lawrence O. Gostin eds., New York: Oxford University Press 2018).

Rather than addressing these structural features of the global system, international law scholars address the global health failures of human rights and development institutions in the register of international law itself. The most influential of these modes of critique is the Framework Convention on Global Health (FCGH). In its draft text, the document states that “The FCGH would bring central concepts of domestic and international right to health obligations developed through General Comments of the Committee on Economic, Social and Cultural Rights and other non-binding or non-internationally binding forums (e.g., national courts) into binding international law.” The Framework Convention was conceived of by scholars in the Global North who sought to create a binding document to aid countries in realizing the right to health. From the perspective of international law, the FCGH is comprehensive and thorough. It supports greater funding for health and commits donor countries to aid. It builds on the commitments of governments to better health outcomes in their respective countries. In the language of international law, it is a progressive document and that could inspire fundamental change if ever adopted. Yet therein lies the rub.

The limitations of this sort of internal critique of health inequality from international law, especially the reliance on state participation, are evident in the absence of an acknowledgement of the role of history, power and the legal structure of the global political economy in the FCGH. This insight has been developed in recent TWAIL scholarship on international health law. As Matiangai Sirleaf notes in writing about pandemics, global health law “is an incomplete regime for conceptualizing and allocating global responsibility for combating epidemics” because the absence of consideration towards “structural conditions in the international system that give rise to states needing to develop core capacities” [to address/respond to disease]. (2018: 293; 295).<sup>5</sup>

### III. A TWAIL Approach to Global Health

The TWAIL critique of the law of international health allows for a deeper and more sustained understanding of the role of international law in reinforcing, rather than alleviating, health inequalities. It does so by providing the possibility of seeing how, as TWAIL scholars assert, international law “reproduces and sustains the plunder and subordination of the Third World by the West.”<sup>6</sup> The ideas that animate what is now called TWAIL are rooted in anticolonial struggles that sought to decenter western ideologies that animated international law and the global ordering that it created.<sup>7</sup> TWAIL scholars position themselves against the idea that international law is a set of neutral rules emerging from treaties and international agreements that are the product of states negotiating the terms of the international legal system as equals.

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<sup>5</sup> Regarding the inadequacies of human rights laws, she writes that the “neglect of the importance of the economic and social sector in international law has rendered already vulnerable countries in the Global South ill-equipped to deal with public health crises posed by epidemics”.

<sup>6</sup> [https://digitalcommons.law.buffalo.edu/cgi/viewcontent.cgi?article=1559&=&context=journal\\_articles&=&seidir=1&referer=https%253A%252F%252Fscholar.google.com%252Fscholar%253Fq%253Dtmail%252Band%252Bglobal%252Bhealth%2526hl%253Den%2526as\\_sdt%253D0%2526as\\_vis%253D1%2526oi%253Dscholar#search=%22twail%20global%20health%22](https://digitalcommons.law.buffalo.edu/cgi/viewcontent.cgi?article=1559&=&context=journal_articles&=&seidir=1&referer=https%253A%252F%252Fscholar.google.com%252Fscholar%253Fq%253Dtmail%252Band%252Bglobal%252Bhealth%2526hl%253Den%2526as_sdt%253D0%2526as_vis%253D1%2526oi%253Dscholar#search=%22twail%20global%20health%22). Also see Vasuki Nesiah on the tie in between colonization and capitalism - <https://www.cambridge.org/core/journals/american-journal-of-international-law/article/decolonial-cil-twail-feminism-and-an-insurgent-jurisprudence/AA2D357CF7DD62BFA10E4B8A0B734C90>

<sup>7</sup> Over time, TWAIL scholars also began to acknowledge that it was important to disrupt the essentialist ideas of the third world and the first world and think beyond sovereign borders. See especially the work of Tony Anghie.

Instead, inequalities in health outcomes between countries exemplify how the structural inequities generated by international law have effects on the lives of individuals. The COVID pandemic illustrates this clearly. While the United States floundered under the Trump administration, the underwriting of vaccine development through Operation Warp Speed, made possible by the financial and technological capacity of the United States, allowed the country to take the lead in the global development of an effective COVID-19 vaccine, thus placing the country on what initially promised to be a transitional phase out of the pandemic. This is while the vast majority of the world remained unvaccinated.

Leveraging the critique of international law as a instrument of colonial and neo-imperial power, TWAIL advocates for the use of historical methodologies to explore the shifting nature of international law's imperialist tendencies. Drawing on the historical literature on colonialism and public health on one hand, and structural adjustment and public health on the other, the sections below offers a broader political economic understanding of the current state of health care delivery as determined by structural adjustment programs that in turn are enabled by international law and the post-war structure of global political and economic power.

#### **IV. The Past and Present of Structural Adjustment**

Structural adjustment programs emerged in the late 1970s. They have since become centerpieces of the external governance of the economies of ostensibly sovereign developing countries by a few countries in the Global North acting through the International Monetary Fund (IMF) and the World Bank. The term structural adjustment refers to a “referred to a set of lending practices whereby governments would receive loans if they agreed to implement specific economic reforms” (Babb, 2005:200). These loans are made conditional on countries' progress in enacting the required reforms, which are deemed by international organizations the IMF and the World Bank to be necessary for countries to achieve steady economic growth and development. If governments fail to pursue the required policies and meet specific targets laid out in the contractual agreements, then loan disbursements can be halted. Structural adjustment programs thus embody the coercive power of the Washington-based international organizations that are enabled by international economic law.

This approach to dictating development policy to the governments of sovereign states stood in sharp contrast to the relative freedom or ‘policy space’ that recently independent countries were afforded in the period immediately following the conclusion of World War II (Chang, 2002). Global economic governance in the 1950s and 1960s was largely informed by Keynesian ideas of economic management coupled with modernization theories of development. The former afforded a direct role for government in ensuring economic growth and social welfare through fiscal policy and sectoral and industrial planning, while the latter provided the logic of modernization theory which held that, despite often vast heterogeneity in their socio-economic starting points, all countries would follow a similar path to social development, political stability and economic prosperity.

This was generally a period of strong global economic growth, despite the many armed conflicts in the Global South that characterized the misleadingly-named Cold War. Yet the ‘Golden Age of

Capitalism' all came to screeching halt with the twin oil shocks of the 1973 and 1979. The result was a 6-fold increase in the cost of petroleum over the course of the decade, that led to an unprecedented combination of inflation and economic stagnation. Further, Keynesian economic policies that had become the orthodoxy in the Global North were deemed to be inadequate for the economic challenges of the 1970s in countries like the United States. Keynesianism thus lost much of the legitimacy it had enjoyed since its role in rescuing the world economy from the Great Depression.

The economic disruptions of the 1970s were then worsened by the actions of the United States Federal Reserve, which in 1979 instituted a massive increase in interest rates (the so-called "Volcker Shock") that aimed to halt persistently spiraling inflation. This led to massive debt crises across the Global South, particularly in African, Caribbean and Latin American countries, as the cost of debt servicing skyrocketed. More generally, fiscal conservatism, monetarism and the emerging ideology of neoliberalism became the new orthodoxy in countries like the US and the UK, and would herald the beginning a radically different economic policy approach to development in the Global South.

Up to this point the World Bank, and to a lesser extent the IMF, had played relatively benign roles in supporting the development policies and aspirations of third world countries while allowing them to pursue their preferred economic policies, albeit with important exceptions in the late 1960s (e.g. India) and the early 1970s (e.g. Jamaica). This situation changed dramatically following the twin oil shocks. The combination of declining economic growth from structural dislocations in the global economy coupled with suddenly escalating needs for fiscal support following the sudden increase in global interest rates created an immediate role for the IMF and the World Bank, placing these two Washington-based international organizations and the 'structural adjustment' programs that they instituted at the center of international development (and global controversy) for the next three decades.

The term structural adjustment was coined in the late 1970s by then World Bank President Robert McNamara and came to represent a wide suite of economic policies (Babb, 2005). These had a number of a key characteristics.

First, they could be broadly categorized as either macro-level economic stabilization policies, usually led by the IMF, and macro- and meso-level economic and increasingly institutional reforms, generally led by the World Bank, often in concert with regional development banks (such as the African Development Bank, Caribbean Development Bank and the Inter-American Development Bank) and bilateral donor agencies (such as USAID, CIDA, DfID, GTZ and the EC), amongst others.

Second, these programs were informed by a distinctly neoliberal logic of state-market relations. Structural adjustment programs were predicated on the assumption that countries fell in to crisis due to excessive government control of the national economy and failures to follow market signals.<sup>8</sup> The programs thus provided emergency financial support but with typically strict conditionalities that sought a radical revamping of the structure of national economies in line with

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<sup>8</sup> The literature here is vast, but for orthodox perspectives that informed the IMF and World Bank approach see for example Krueger (1974, 1983, 1990) and Bhagwati (1982, 1986).

market-based principles. ‘Get the prices right’ was the economic policy mantra of the 1980s. In this respect, neoliberal structural adjustment programs represented a complete U-turn from Keynesian economic management that had been ubiquitous in developing and industrialized countries from the end of the Second World War through the mid-1970s.

As noted earlier, structural adjustment programs had two principal components that reflect a division of labor between the IMF and the World Bank. Stabilization policies aimed to address immediate balance-of-payments crises that arose when the outflow of foreign exchange greatly exceeded inflows, such that countries faced the risk of losing the ability to purchase essential imports such as fuel, food and productive inputs to the domestic agricultural and manufacturing sectors. Emergency loans from the IMF were designed to shore up national finances, but attached conditionalities such as sharp fiscal spending cuts and currency devaluation to allow domestic currency valuations to move towards ‘market’ rates.

While the IMF was responsible for short-term macroeconomic stabilization, World Bank interventions ranged from macro-level structural reforms that ranged from economic liberalization (e.g. trade and investment) to various legal reforms, particularly from the 1990s onwards (e.g. focusing on property rights and contract regimes and ‘strengthening’ the ‘rule of law’), meso-level sectoral reforms, from fiscal spending cuts to privatization and increasingly, micro-level interventions through social welfare programs that aimed to directly target individuals, sometimes entirely bypassing governmental structures that ironically had been weakened by structural adjustment programs themselves.

### ***The Impact of Structural Adjustment Programs on Global Health Outcomes***

Considering structural adjustment programs as part of the history and context in which international and transnational law on global health occurs is key to understanding differences in health outcomes across countries. On nearly every metric, countries in the Global South perform poorly relative to those in the Global North. This pervasive inequality is exemplified by the fact that some illnesses and diseases, such as polio, have been completely eradicated in industrialized countries yet remain present in the developing world.

Kentikelenis (2017) offers a valuable conceptual framework for understanding the relationship between the structure of the international economic order and global health. It identifies three pathways through which structural adjustment programs can shape public health outcomes: (1) policies that directly target health systems; (2) policies that indirectly impact health systems; and (3) policies that affect the range of other socio-economic factors that public health scholars collectively refer to as social determinants of health. Each of these mechanisms is further elaborated below, while discussion of their underpinnings in international law follows after.

One of the principal ways that structural adjustment programs directly affect health outcomes is through impacts on levels of health care financing. As noted above, economic stabilization measures typically entail fiscal spending reductions, which can have a direct impact on the level and quality of health services provision. This occurs through reductions in wages or staffing in the health sector, or through a shift away from public health services provision towards individual user fees. More generally, structural adjustment programs often require decentralization of health

services governance by national level government authorities, which can weaken the capacity for national-level coordination and thus introduce an array of inefficiencies. Decentralization is often coupled with a rise in private sector provision of health services as the state-owned health sector shrinks, whether due to reduced levels of health sector finance or outright privatization of areas of the public health system, all of which can impede access as the poor may face higher healthcare costs.

Secondly, structural adjustment programs can indirectly affect health outcomes through a number of macroeconomic mechanisms. For example, currency deregulation as part of stabilization efforts can increase the prices of imports, including essential medical equipment and drugs. Relatedly, trade and capital account liberalization can reduce government tax receipts, with knock-on effects on the level of fiscal resources that are available for health-related spending. Important indirect health effects can also arise from privatization of state-owned enterprises, which has been a major part of structural adjustment programs over the past four decades. While privatizations can lead to short term fiscal gains, they can also entail medium-long term revenue losses depending on the fiscal outlook of the state-owned entities in question. Privatization also tends to result in workforce reductions under private (many times foreign) management, and thus loss of income and health benefits for former SOE employees.

Third, structural adjustment programs can have major effects on health outcomes through social determinants of health. In this instance, structural adjustment programs, and the havoc they wreaked on public health infrastructure can themselves be considered a social determinant of health. Social determinants of health is an approach that challenges the view that health outcomes are products of individual level factors and behaviors, including biological factors like genetics.<sup>9</sup> Instead, the focus is on identifying the socio-economic and legal mechanisms through which health outcomes are shaped by social risks and conditions that individuals, households, and communities face at home, school, and work.<sup>1011</sup> This insight can be dated back to the early twentieth-century work of W.E.B. DuBois, who identified the relationship between poverty, racism, and health inequities, arguing that “[t]he Negro death rate and sickness are largely matters of [social and economic] condition[s] and not due to racial traits and tendencies.”<sup>12</sup>

Once the underpinnings of the social determinants of health have been elaborated, the pathways through which these are affected by structural adjustment programs become clear: rising unemployment coupled with a tattered social safety net leads to deepening poverty, with attendant negative health outcomes. These are exacerbated by increased health costs from the direct effects

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<sup>9</sup> The social determinants of health approach also aligns with critical literatures challenging the purported relationship between race and health as being an outcome of fundamental genetic differences between individuals and further forming the basis of racial categories and thus predictors of health outcomes, as opposed to the role of social structures, ideas that have their roots in colonial science.

<sup>10</sup> For an overview of the theoretical and empirical foundations of the social-determinants-of-health approach, see Nancy Krieger, *Epidemiology and the People's Health: Theory and Context* 163--201 (2011).

<sup>11</sup> See, e.g., Paula Braveman & Laura Gottlieb, *The Social Determinants of Health: It's Time to Consider the Causes of the Causes*, *Pub. Health Reps.*, Jan.-Feb. 2014, at 19, 20–22 (“A large and compelling body of evidence has accumulated, particularly during the last two decades, that reveals a powerful role for social factors—apart from medical care—in shaping health across a wide range of health indicators, settings, and populations.”).

<sup>12</sup> Gilbert C. Gee & Chandra L. Ford, *Structural Racism and Health Inequities: Old Issues, New Directions*, 8 *Du Bois Rev.* 115, 116 (2011) (second alteration in original) (quoting W.E. Burghardt DuBois, *The Health and Physique of the Negro American*, 93 *Am. J. Pub. Health* 272, 276 (2003)).

of structural adjustment programs discussed above. Further, rising food costs and concomitant shifts in the composition of the food basket stemming from trade liberalization (which can lead to increased imports of lower quality foodstuff including processed foods, dumped meats, etc.) have negative nutritional effects, particular on children. Countries also become more vulnerable to global food price shifts as the proportion of imported products in food basket increases.

These negative impacts on social determinants of health are felt through other channels as well, such as reduced access to housing arising from cuts to public sector financing as well as institutional and legal reforms that reduce tenant security. Similarly, environmental effects such as poor air and water quality often arising from ‘pro-market’ approaches to environmental governance, from human displacement, to water table depletion and increased use of chemicals as part of agricultural sector reforms. And finally, all these can be exacerbated by weakened social bonds at the community level and mental health impacts of economic disruptions at the individual level.

Though critical scholars have long argued for recognition of the structural bases of inequitable health outcomes,<sup>13</sup> the social determinants of health approach only began to be integrated in to mainstream policy and institutional responses to health inequalities in the 1980s, and much of this initial was in the United States.<sup>14</sup> It wasn’t until the 2000s that the social determinants of health approach began to enter global public health discourse and practice. The World Health Organization (WHO) formed the Commission on the Social Determinants of Health with the goal of “tackling the social causes of poor health”<sup>15</sup> in the “spirit of social justice.”<sup>16</sup> The Commission focused on global health inequalities between developing and industrialized countries, identifying a range of structural factors that impact individual health outcomes from the economic aid provided in bilateral assistance [structural adjustment programs?] to intrahousehold dynamics that leave some family members unable to address health issues.<sup>17</sup> The conclusion of the report offered the grim summary that “social injustice is killing people on a grand scale.”<sup>18</sup>

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13 For a longer history dating back to the 19th century see Raphael D. Social determinants of health: present status, unanswered questions, and future directions. *Int J Health Serv.* 2006;36(4):651-77. doi: 10.2190/3MW4-1EK3-DGRQ-2CRF. PMID: 17175840. (tracing the phrase “social determinants” to the 1996 publication Tarlov, A. Social determinants of health: The sociobiological translation. In *Health and Social Organization: Towards a Health Policy for the 21st Century*, ed. D. Blane

et al. Routledge, London, 1996. WEB Dubois also write about addressing social concerns to better health of the Black community. <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.93.2.272>

14. For a history on the rise of focus on the social determinants of health, see generally Paula Braveman, Susan Egerter & David R. Williams, *The Social Determinants of Health: Coming of Age*, 32 *Ann. Rev. Pub. Health* 381, 382 (2011).

15. Commission on Social Determinants of Health---What, Why and How?, WHO, [https://www.who.int/social\\_determinants/thecommission/finalreport/about\\_csdh/en](https://www.who.int/social_determinants/thecommission/finalreport/about_csdh/en) [<https://perma.cc/EW8S-XN69>] (last visited Jan. 25, 2021).

16. Comm’n Soc. Determinants Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health---Final Report of the Commission on Social Determinants of Health* (2008) [hereinafter, *Closing the Gap*].

17. *Closing the gap*, supra note 12.

18. *Id.* at 36.



These social conditions thus encompass a range of economic and environmental factors that shape inequitable health outcomes within and across countries, including education, employment, income and social protection, housing and physical insecurity, access to health services, and gender, racial, ethnic and caste discrimination and social exclusion.<sup>19</sup> Crucially from a critical legal perspective, structural causes of health inequities are not only socioeconomic and environmental. The legal system also produces the background conditions that generate health disparities and poor health outcomes among vulnerable populations, many of which are exemplified in post-colonial contexts. A TWAIL perspective allows us to shed light on the ways in which legal rules at the domestic and international levels shape all of the aforementioned social determinants of health, from employment relations and working conditions to access to decent housing and clean water. International law facilitates these outcomes by enabling some actors, such as international development organizations and multinational corporations, to exert significant power over others, such as governmental bodies, workers and consumers in the Global South.

## V. The International Law and the Colonial Management of Infectious Disease

While it is not possible to offer a complete history of the role of law in the international management of infectious disease, a few examples paint a picture of the management of disease as a way to forward economic dominance and colonial enterprise through international law. Taking a TWAIL perspective this long history destabilizes international law as a source of resistance and puts it in critical perspective as a tool of domination and subjugation.

The Contagious Diseases Acts provides an example of how public health was an essential element of colonial governance. In the 19<sup>th</sup> century, concern over contagious diseases in the colonies took hold among the British. In response, the British government passed the Contagious Diseases Acts (CDAs) in 1864, 1866, and 1869.<sup>20</sup> Largely concerned with sexually transmitted infections among the armed forces, the acts sought to regulate prostitution in England in the colonies. CDAs gave broad authority to regulate prostitution in England<sup>21</sup> and in the colonies for the purpose of controlling the spread of venereal disease.<sup>22</sup> The CDAs mandated check-ups for women ordered to periodic examinations by a judge.<sup>23</sup> Prostitutes were specifically targeted by the CDAs.<sup>24</sup> Those who were found to have a venereal disease were detained at the hospital and treated.<sup>25</sup>

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19. See *id.* at 166.

<sup>20</sup> *Id.* at 14 n.1.

<sup>21</sup> The acts applied to “military stations, garrison and seaport towns.” Margaret Hamilton, *Opposition to the Contagious Diseases Acts, 1864-1888*, 10(1) *Albion: A QUARTERLY JOURNAL CONCERNED WITH BRITISH STUDIES* 14-27, 14 (1978)

<sup>22</sup> The driving rationales behind the acts shifted over time and are difficult to isolate. As argued by Judith Walkowitz, the acts may have been driven by concerns over sexuality in the Victorian period as well as venereal disease. JUDITH WALKOWITZ, *PROSTITUTION AND VICTORIAN SOCIETY: WOMEN, CLASS, AND THE STATE* 70 (1980). However, the acts themselves were pushed forward by the impact of venereal disease on the army. See *id.* at 71–75.

<sup>23</sup> The Contagious Diseases Prevention Act 1864, 27 & 28 Vict. c. 84 & 85, §§ 12–14 (U.K.).

<sup>24</sup> The Contagious Diseases Acts, 1866/1869 Section 15-16. The 1866 Act states (“Where an information on oath is laid before a justice by a superintendent of police, charging to the effect that the informant has good cause to believe that a woman therein named is a common prostitute...The justice present, on oath being made before him substantiating the matter of the information to his satisfaction, may, if he thinks fit, order that the woman be subject to periodical medical examinations...for the purpose of ascertaining at the time of each such examination whether she is affected with a contagious disease.”)

<sup>25</sup> The Contagious Diseases Prevention Act 1864, 27 & 28 Vict. c. 84 & 85, §§ 12–14 (U.K.).

Alongside the spread of disease, the CDAs were understood to embody Victorian morality, in particular the impetus towards the regulation of women's bodies for the purposes of the state.

During this period of colonial rule, the goal of infectious disease management was largely to protect European colonizers from contracting diseases from "native" colonial subjects. In the case of the CDAs, advocates of the acts often cited the health of British troops as a key rationale for the laws.<sup>26</sup> It was through public health that colonizers governed territories and populations. These efforts are clear from the mid 19<sup>th</sup> century onwards as international agreements between empires were forged in settings like the International Sanitary Conferences, first convened in Paris in 1851 with subsequent meetings in a range of metropolitan centers including Constantinople (1866), Vienna (1874), Washington, DC (1881), Rome (1885), Venice (1892), Dresden (1893), Paris (1894), Venice (1897) and again Paris (1903). The latter meetings are particularly monumental in the history of international health law as they resulted in the first globally binding agreements on the response to global disease spread (Venice 1897) and ultimately saw the drafting and ratification of the first International Sanitary Regulations (Paris 1903).<sup>27</sup> These agreements were enabled by participants' shared imagination of African and Asian territories as disease-ridden coupled with their common objective of restricting the spread of diseases like the bubonic plague through troop and other personnel movements as well as goods trade between the colonies and Europe. Political, economic and military factors have thus long formed the core logic of colonial public health governance.

More than one hundred years later, as colonization has formally ended in most parts of the world, new forms of global health management have emerged, albeit often through neocolonial development structures. Contemporary global hegemony and international organizations charged with global health management have replaced former imperial powers in maintaining power imbalances that underpin persistent global health inequality between the Global North and Global South. Legal and institutional continuity is evident in the contemporary architecture of global health governance. The International Sanitary Regulations of the late 19<sup>th</sup> century led to the International Health Regulations in the early 20<sup>th</sup> century, which in turn set the stage for a new mode of international health law that would be institutionalized with the creation of the World Health Organization (WHO) in the wake of World War II. The WHO, with the support of other UN bodies, was empowered with the constitutional authority to challenge national sovereignty in carrying out its mandate to respond to global public health threats. These powers included the design of regulatory norms, and harmonized surveillance and reporting systems for infectious disease control.<sup>28</sup> Yet despite holding the legal authority to supersede individual rights when deemed necessary, the WHO has rarely deployed its formal powers. Instead, the WHO faces many of the challenges of other international organizations that ultimately are products of a state-based system. Such are the limitations of international law, as TWAIL scholars have argued. The noble objective of multilateral coordination towards ensuring the global public good gives way to the reality of structure of the global political economy, with powerful states and increasingly, non-state actors, ultimately shaping the governance of global health.

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<sup>26</sup> As argued by Walkowitz, statistics produced about venereal disease amongst soldiers played a large role in justifying the CDAs. See Walkowitz, *supra* note 24, at 75.

<sup>27</sup> Gostin and Meier, 2020; Alexandre White, Global Risks, Divergent Pandemics: Contrasting Responses to Bubonic Plague and Smallpox in 1901 Cape Town, *Social Science History* 42, Spring 2018, pp. 135–158.

<sup>28</sup> Gostin and Meier, 2020:790.

HIV/AIDS provides a valuable example. In 1990s and early 2000s, as AIDS began to ravage the Global South and in particular parts of Sub-Saharan Africa, the United States became the largest funder of the HIV/AIDS health response. Through the Leadership Against Global HIV/AIDS, Tuberculosis and Malaria Act of 2003, also known as the President's Emergency Plan for AIDS Relief (PEPFAR), the US government channeled funding and other resources to countries in need of aid. The dedicated funds, however, entrenched the role of American multinationals from pharmaceutical companies to condom manufacturers as primary beneficiaries of the law. PEPFAR made it mandatory that countries had to purchase supplies from US firms. The law also made American cultural and religious values an imperative. A product of the conservative George W. Bush administration, PEPFAR included increased funding for faith-based organizations and the promotion of abstinence-based sexual health education.<sup>29</sup> Though some resources were dedicated to strengthening health systems, PEPFAR funding did not prioritize deep structural issues of weak health infrastructure in recipient countries; instead, it became known for establishing parallel health programs to deliver AIDS care while ignoring broader health concerns.<sup>30</sup> Healthcare systems in many countries ultimately became reliant on international NGOs such as the Bill and Melinda Gates Foundation, which would become the primary sources of healthcare finance delivery of healthcare products and services.

The global intellectual rights regime was also a major source of contention between the Global South and the Global North in the HIV/AIDS crisis. The agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) under the World Trade Organization (WTO) provides a framework for the protection of intellectual property, most notably in the case of health, of patents on drugs. The TRIPS regime allows owners of pharmaceutical patents to monopolize the production and sale of drugs, while the broader trade regime sanctions differential pricing across countries. This structure of global governance enabled pharmaceutical companies in the US, Europe and Japan to charge higher prices for drugs in poor countries while the WTO enforced restrictions on the production of generic versions of branded drugs that would cost significantly less. While the TRIPS regime does allow for "compulsory licensing" of drugs in the case of domestic health emergencies, the financial and technical barriers to producing drugs severely limits the effectiveness of this measure embedded in the treaty agreement, as does the political costs of challenging the global hegemony. At best it has allowed for a few countries in the developing world with pharmaceutical producers with the requisite capabilities and governments with the political capital, such as in Brazil, India and South Africa, to produce lower cost alternatives. It has hardly proven to be a solution to the broader issue of structural inequalities and global governance inadequacies.

Today a similar dynamic is at play with the COVID-19 pandemic. The US government has once again dedicated billions to health aid,<sup>31</sup> making it the largest donor of COVID-19 relief amongst OECD countries. As healthcare systems in the Global South faltered the US government dedicated funds through the COVID-19 Response and Recovery Act. Once again, however, the law did not address the need to bolster or restructure flailing health sector infrastructures in recipient countries.

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<sup>29</sup> On the politics of HIV/AIDS, see Ahmed (forthcoming).

<sup>30</sup> See research on vertical vs horizontal funding, for example <https://pubmed.ncbi.nlm.nih.gov/24197405/>

<sup>31</sup> <https://www.oecd.org/newsroom/covid-19-spending-helped-to-lift-foreign-aid-to-an-all-time-high-in-2020-but-more-effort-needed.htm>

Instead, as vaccines took center stage in the global COVID-19 response, resources have been focused on vaccine access and distribution. Yet this aid has been conditional on countries purchasing vaccines from producers in the Global North at high cost and restricts recipient countries from producing generic versions of the vaccines domestically, despite the extreme public health crises they face. These conditional restrictions are again reinforced by the TRIPS intellectual property rights regime, illustrating how developing countries are constrained by the combination of global political economic structures and the strictures of international law. Further, international efforts to address this issue through donor coordination and public-private partnerships have floundered, as the disappointing collaboration between the international public-private organization Gavi, the Vaccine Alliance, and the WHO which created the COVID-19 Vaccine Global Access (COVAX) Facility has shown.<sup>32</sup> Finally, even where countries have managed to acquire vaccines, distribution has been a major challenge given the weakening of health systems infrastructure following decades of funding constraints under structural adjustment and neoliberalism, as discussed earlier.<sup>33</sup>

## **VI. Conclusion: TWAIL and Global Health Law**

In the early stages of the COVID-19 pandemic, one might have hoped that with the international scientific cooperation that resulted in the breakthrough of sequencing the virus in January 2020, coupled with the promise of mRNA technologies that had been waiting in the wings for two decades, vaccine development would be swift and the world would soon be inoculated. That would be a reasonable prediction in the context of an airborne virus that crosses international borders easily making crystal clear that humans exist in a global community. Instead, the world has observed a deep resistance to ensuring equitable access to vaccines, therapeutics and other forms of health care services and equipment (from personal protective equipment to ventilators) that could alleviate suffering around the world. The answer at least partly lies in the deeply institutionalized structure of management and control of the Global South by the Global North through public health. The TWAIL approach allows us to unpack these dynamics of struggle and domination, as well as the legacies of colonization, that coproduce vast inequalities in global health outcomes.<sup>34 35</sup>

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<sup>32</sup> For an excellent critical geography analysis of the role of private financial sector players in shaping, and profiting from, the COVAX facility to the detriment of actual vaccine delivery to countries in need, see Sarah Hughes-McLure and Emma Mawdsley, “Innovative Finance for Development? Vaccine Bonds and the Hidden Costs of Financialization”, *Economic Geography*, 2022.

<sup>33</sup> <https://www.nature.com/articles/s41541-021-00323-6>

<sup>34</sup> <https://www.jstor.org/stable/25659346?seq=1>

<sup>35</sup> See for example David Kennedy, 2016, *A World of Struggle* (Princeton University Press).