

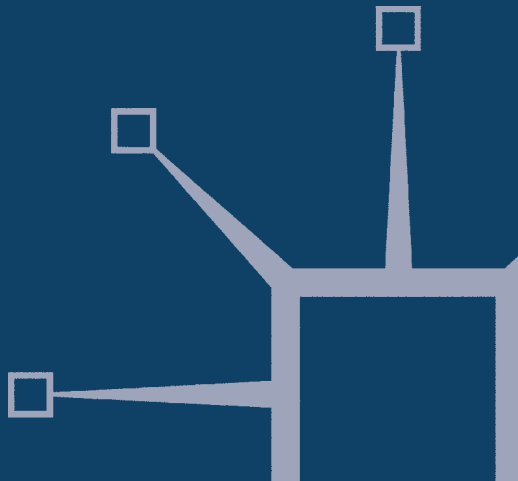
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# Medicine at the Border

Disease, Globalization and Security, 1850 to the  
Present

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Edited by  
Alison Bashford



# Medicine at the Border

*Also by Alison Bashford*

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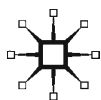
ISOLATION: Places and Practices of Exclusion (*co-edited with Carolyn Strange*)

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# Medicine at the Border

**Disease, Globalization and Security, 1850 to  
the Present**

Edited by Alison Bashford



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# Contents

<i>List of Tables and Figures</i>	vii
<i>Acknowledgments</i>	viii
<i>List of Abbreviations</i>	ix
<i>Notes on Contributors</i>	x
1 'The Age of Universal Contagion': History, Disease and Globalization <i>Alison Bashford</i>	1
<b>Part I World Health: Colonial and National Histories</b>	<b>19</b>
2 Civilizing the State: Borders, Weak States and International Health in Modern Europe <i>Patrick Zylberman</i>	21
3 Yellow Fever Crusade: US Colonialism, Tropical Medicine, and the International Politics of Mosquito Control, 1900–1920 <i>Alexandra Minna Stern</i>	41
4 WHO-led or WHO-managed? Re-assessing the Smallpox Eradication Program in India, 1960–1980 <i>Sanjoy Bhattacharya</i>	60
5 The World Health Organization and the Transition from 'International' to 'Global' Health <i>Theodore M. Brown, Marcos Cueto and Elizabeth Fee</i>	76
<b>Part II National Security: Migration, Territory and Border Regulation</b>	<b>95</b>
6 Where is the Border?: Screening for Tuberculosis in the United Kingdom and Australia, 1950–2000 <i>Ian Convery, John Welshman and Alison Bashford</i>	97
7 Medical Humanitarianism in and Beyond France: Breaking Down or Patrolling Borders? <i>Miriam Ticktin</i>	116

8	Screening out Diseased Bodies: Immigration, Mandatory HIV Testing, and the Making of a Healthy Canada <i>Renisa Mawani</i>	136
9	Passports and Pestilence: Migration, Security and Contemporary Border Control of Infectious Diseases <i>Richard Coker and Alan Ingram</i>	159
<b>Part III Globalization: Deterritorialized Health?</b>		<b>177</b>
10	Drawing the Lines: Danger and Risk in the Age of SARS <i>Claire Hooker</i>	179
11	Biosecurity: Friend or Foe for Public Health Governance? <i>David P. Fidler</i>	196
12	Postcard from Plaguetown: SARS and the Exoticization of Toronto <i>Carolyn Strange</i>	219
13	The Geopolitics of Global Public Health Surveillance in the Twenty-First Century <i>Lorna Weir and Eric Mykhalovskiy</i>	240
	<i>Index</i>	264

# List of Tables and Figures

Table 4.1	Smallpox cases in India and the world, 1950–1977	62
Table 5.1	Total number of PubMed entries under international and global by decade	76
Figure 11.1	Types of public health interventions	205



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# List of Abbreviations

BSE	Bovine Spongiform Encephalopathy
BWC	Biological Weapons Convention
CDC	Centers for Disease Control and Prevention
CEPR	Centre for Emergency Preparedness and Response
CsCDC	Consultants in Communicable Disease Control
CSR	Communicable Diseases Surveillance and Control
CMH	Commission on Macroeconomics and Health
DFID	Department for International Development
EGALE	Equality of Gays And Lesbians Everywhere
EID	Emerging Infectious Diseases
EU	European Union
FCO	Foreign and Commonwealth Office
GPHIN	Global Public Health Intelligence Network
GOARN	Global Outbreak Alert and Response Network
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
ICC	Isthmian Canal Commission
ICRC	International Committee for the Red Cross
LN	League of Nations
MAE	(French) Ministry of Foreign Affairs
MDG	Millennium Development Goals
MDM	Médecins du Monde
MSF	Médecins Sans Frontières
MOH	Medical Officer of Health
NIH	National Institutes of Health
NHS	National Health Service
NGOs	Non-Governmental Organization
ODA	Overseas Development Aid
Oxfam	Oxford Famine Relief Committee
PEPFAR	President's Emergency Plan for AIDS Relief
RF	Rockefeller Foundation
SARS	Severe Acute Respiratory Syndrome
TOPOFF	Top Officials
UK	United Kingdom
UNCTAD	United Nations Conference on Trade and Development
UNFPA	United Nations Population Fund
UNRRA	United Nations Relief and Rehabilitation Administration
US	United States (of America)
WHO	World Health Organization
YFC	Yellow Fever Commission

# Notes on Contributors

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# 1

## 'The Age of Universal Contagion': History, Disease and Globalization

*Alison Bashford*

*Medicine at the Border* explores the pressing issues of border control and infectious disease in the nineteenth, twentieth and twenty-first centuries, in the 'age of universal contagion'.<sup>1</sup> This book places world health in world history, microbes and their management in globalization, and disease in the history of international relations, bringing together leading scholars on the history and politics of global health. Together, the authors show how infectious disease has been central to the political, legal and commercial history of nationalism, colonialism, and internationalism, as well as to the twentieth-century invention of a newly imagined space for regulation called 'the world'.

This is a modern history of a world with markedly more health, and less acute infectious morbidity and mortality than previous centuries, in some places. It is also the history of a divided world, where the manifestly unequal distribution of the benefits of modern medicine and public health marks the division between North and South, West and East possibly more starkly than any other factor. Thus, analysis of global health raises a history of medicine, but it also raises a history of geopolitics. The geopolitical aspect not only concerns the historical geography of disease itself, but also that of disease *management*: the reduction and prevention of microbes and illness is rarely the only outcome of disease control, even if it is an important one. The chapters collected here squarely address the under-recognized place of disease control in the history of national and international governance, and in the processes of globalization over the modern period. *Medicine at the Border* goes some way towards developing what might be called a world history of the geopolitics of disease prevention.

Infectious disease management often has spatial implications, and uses spatial measures of prevention, reduction and eradication: this is as true in the twenty-first century as it was in the nineteenth century. For this reason, borders of many kinds, and in many places, so often recur in practice: quarantine lines and migration screening, once a stethoscope to the bare chest, now fever scanning at airports; trade barriers against BSE; home isolation



for the suspected carrier of the SARS virus; targeted vaccination in social and spatial circles around a remaining smallpox victim. There is a geopolitics to each of these. But to focus on what happens *at* these borders, is to miss another scale of geopolitics and disease management altogether. For the politics of disease control concerns the governance of *this side* and crucially *that side*, of the border as well. As we shall see, infectious disease control – and the relief and prevention of suffering – has not infrequently been a rationale for all kinds of formal and informal intervention beyond a local jurisdiction, beyond a sovereign state. Over and over again, the aspiration to promote health and prevent disease has resulted in pre-emptive activity beyond the border: European powers sought to intervene in Ottoman rule to prevent the spread of cholera; the US military, followed by the Rockefeller Foundation, embarked on major yellow fever eradication campaigns in Cuba, Panama, Puerto Rico; quarantine lines in Africa offered a clear and politically useful demarcation for new ‘international’ borders between Sudan and Egypt, between Uganda, French Congo and Belgian Congo.<sup>2</sup> This kind of geopolitics of disease prevention continues in the realm of health aid and development:<sup>3</sup> for example, assistance with HIV/AIDS treatment will be given *there* (in the form of aid) but not *here* (in the form of state-funded treatment of refugees). And other kinds of aid workers cross national and political borders defiantly, armed with ideas of ‘humanitarianism’ and ‘universalism’ along with vaccines and antibiotics: they aim for, and try to practice within, a world ‘sans frontières’.

While once disease prevention and geopolitics were simply related, more recently the former has become a vehicle for, and even an instrument of, the latter. The intense twenty-first century manifestations of defensive nationalism, disease and security on the one hand, and global flow, supranational surveillance technologies, actual and imminent world pandemics on the other, suggest a need to think about the provenance of these connections, their effects in the past, and to temper assessments of their alleged novelty, while at the same time recognizing a world linked in time and space in ways altogether new.

Part I of this book, and of this introduction, deals with the connections between national histories and the emergence of international and world health structures over the twentieth century. Authors interrogate the internationalization of world systems of epidemic management, of eradication dreams, of colonization, decolonization and world health governance. The impossibility (and therefore historical inaccuracy) of separating out colonial and national histories in the genealogy of world health becomes apparent. Part II discusses the issue of territorial health regulation, of medico-legal border control and movement of people across national lines, both historically and in the twenty-first century. In Part III, authors pursue aspects of late twentieth and twenty-first century global disease and security. They examine contemporary global epidemic surveillance and

information networks, flows of information, microbes and fear, which increasingly bypass the nation-state, but cannot do so altogether.

### **World health: national and colonial histories**

Several historical lines merged to create 'world health' as a problem, a project and a possibility in the twentieth century: colonial medicine, national territorial defense imperatives, international convention and agreement on both trade and disease, regionally-interested organizations. The domain of health and disease regulation was by no means incidental to the consolidation of nineteenth and twentieth-century territorial nation-states and to the related phenomenon of international relations. Historians have rightly detailed the quarantine and so-called 'sanitary' conferences of the mid to late nineteenth century, as the direct precursors to the early twentieth-century international organizations of health,<sup>4</sup> and to the evolution of Westphalian systems in practice.<sup>5</sup> The reverse has also been argued: that a new internationalism created national public health measures. 'It is only against the background of medical internationalism', write Stern and Markel, 'that we can begin to understand the elaboration of the United States Public Health Service regulations on immigrants inspection, quarantine, and vaccination in the early 20th century'.<sup>6</sup>

There was a string of international meetings from 1851, initially taking up the question of cholera, and later plague and yellow fever. As Brown, Cueto and Fee summarize in their chapter, in 1902 an International Sanitary Office of the American Republics was established which became the Pan American Sanitary Bureau. In Europe, the International Sanitary Conference discussed the need for a permanent international body and the Office international d'hygiène publique resulted, based in Paris (1907). After World War I, the League of Nations created an Epidemic Commission to deal with typhus fever in Eastern Europe,<sup>7</sup> and in 1923 the Health Organization of the League of Nations was established with four areas of work: epidemiology; technical studies; study tours; and the 'intelligence' work of the Far Eastern Bureau at Singapore.<sup>8</sup> Alongside the proliferation of formal intergovernmental organizations for health entered philanthropic organizations like the various renditions of the Red Cross, and private US philanthropic organizations, most significantly the Rockefeller Foundation with its International Health Board established in 1913.<sup>9</sup> The World Health Organization succeeded both the League of Nations Health Organization and Rockefeller's International Health Board after World War II.

Zylberman shows the centrality of cholera and the Mecca pilgrimage in shaping the earliest international discussions and agreements over infectious disease, and in establishing precedents for European powers' sanitary intervention into Ottoman-ruled territories and peoples. Zylberman analyzes the complicated relations between European powers and the Ottoman

Empire, where the latter's apparent failure to contain disease and to implement preventive measures was a risk to Europeans. This betrayed it as a 'weak state' and animated European public health officials to act. Zylberman argues that this was 'pre-emption' based on the need for (health) security of Europeans. On the one hand, European powers were increasingly subscribing to Westphalian principles of non-intervention. On the other, they were in practice intervening through a range of colonial and occupying structures, and through a discourse of 'civilization' whereby another state's incapacity to be 'civilized' in a 'sanitary' sense was a justification for intervention.

The nineteenth-century sanitary conventions and the early twentieth-century organizations are most often discussed as the predecessors of later twentieth-century world health. But there is another line of development: colonial medicine and tropical medicine. The study of the 'diseases of warm climates' institutionalized into the discipline of tropical medicine in the late nineteenth century at sites like the London School of Hygiene and Tropical Medicine, the Pasteur Institutes in Paris and the French colonies, and the Johns Hopkins Medical School. As many scholars have shown, tropical medicine was institutionally, politically and intellectually about the large and broad project of colonization,<sup>10</sup> it was always implicated in the (medicalized) question of geography and place. Originally concerned with the health of Europeans and Anglo-Americans 'elsewhere', that is, in colonial situations and in 'the tropics', the discipline gradually developed research and clinical interests in indigenous people, locals, those who were understood to belong to place by virtue of history, and of race, climate, geography and constitution.<sup>11</sup>

This historical scholarship has focused largely on British and French tropical medicine, yet as Alexandra Minna Stern points out, the US history of tropical medicine and colonial medicine merits further attention.<sup>12</sup> Stern examines here the extraordinary success (at one level) of the US military-sanitary campaign in Cuba, which in one year reduced yellow fever morbidity to zero. As a result of that success a similar strategy was implemented in the Panama region, during the building of the Canal between 1904 and 1914. Thereafter, the Rockefeller Foundation assumed real interest in and much control over disease eradication programs across Latin America. The connections in this story between commerce, international relations, US military colonialism, and a philanthropic public health were tight indeed. Stern shows at once an important US axis on which colonial medicine turned, a clear argument for the racial systems which underpinned and were perpetuated by these health campaigns, and a specific example of how tropical medicine was one of the roots of international health.

The history of world health cannot be understood as anything but merged formations of colonial, national, and 'world' politics, played out on specific local ground. Stern's case study shows how these public health

campaigns were often simultaneously about the nation (US security and commerce) about colonization and colonized people and places (Cuba, Panama) and about emerging meanings of 'international' (Rockefeller's public health interventions across Latin America). Indeed the Rockefeller Foundation, through its extraordinary level of funding and influence was a hinging factor between colonial medicine and international health, shaping, for example, *both* 'colonial' institutions like the London School of Hygiene and Tropical Medicine *and* 'international' institutions like the League's Far Eastern Bureau in Singapore, and indeed the League of Nations itself.<sup>13</sup> Sanjoy Bhattacharya's study of another eradication campaign, the famous instance of the eradication of smallpox in India, shows again the complicated interplay between the local, the national and the international. Challenging received stories of the victorious prominence of WHO personnel, Bhattacharya details the tense and complicated politics and pragmatics of local implementation and of the Indian government's investment in eradication. Rather like Patrick Zylberman's analysis of the problem of 'intervention' on the part of the European powers into the Ottoman Empire, the smallpox eradication campaign was one which constantly encountered tensions between the international body and the sovereign authority and interests of the nation.

That Stern writes of the Panama Canal and Zylberman of the Suez Canal suggests that national borders are not the only territorial demarcations at work in this history of global health and disease control. This is not only about nations, but also about the formation of geopolitical 'regions'. These were often regions of colonial influence, often less formally demarcated than nations, but not exclusively so: Coker and Ingram's discussion of Europe as a contemporary health region is a case in point. Alongside the development of 'international' institutions like the Paris Office or the League of Nations Health Organization were expressly regional institutions, such as the Pan American Health Organization as well as the League's own Far Eastern Bureau based in Singapore.<sup>14</sup>

A shifting lexicon is significant here. Brown, Cueto and Fee explore the changes from 'world health' to 'international health' to 'global health', focusing on the fortunes of WHO since 1948. Weaving together the politics and pragmatics of the Organization and its leaders, as well as changing understandings of 'health' from, for example, disease eradication to primary health care, they show the use of the discourse of 'global' for a renewal of WHO as an organization. Brown, Cueto and Fee's chapter contributes to what is currently a fairly thin historical scholarship on WHO, in contrast to the rich historical work on the League's organizations, and on the International Health Board.<sup>15</sup> Their work opens up further questions about 'the international' to be historically (and geographically) scrutinized. For example, at the beginning of the twentieth century, 'international' often signified Europe: the so-called 'international' health organizations (at least

the early examples like the Paris Office and the League of Nations Health Organization) were at core, in orientation, and in interest, regional European organizations. This is not to diminish their significance, and certainly not suggested in ignorance of ventures like the Far Eastern Bureau, the influence of non-European personnel, and the intermittent inclusion of the Americas. Rather it is to suggest that the primary drive of the Health Organization, like the League of Nations itself, was the reorganization of Europe, and both internal and external European security (including colonial possessions and mandated territories). The point is that European-based organizations and meetings in this period could apply the label 'international' in a sustained way, whereas American regional efforts were geographically marked as 'Pan American'. It is salient that, as Brown, Cueto and Fee show, the 1902 International Sanitary Office of the American Republics became after World War I the Pan American Sanitary Bureau and then the Pan American Health Organization. Likewise, Pacific-rim organizations were marked geographically as 'Pan Pacific' (for example the Pan Pacific Science Congresses). There is an opportunity here to apply historian Dipesh Chakrabarty's call to 'provincialize Europe' in our discussion of European 'international' health organizations, and to think about the history of regionalization, as well as colonialism and nationalism, in the development of a twentieth-century global health.<sup>16</sup>

If 'international' at the beginning of the twentieth century stood broadly for 'Europe', by the decades of decolonization after World War II, 'international' in the domain of health came to mean the health of 'developing' countries: largely infectious disease prevention and eradication programs in the so-called third world.<sup>17</sup> In a strange turn, it was at this point that 'international' health fully inherited tropical and colonial medicine; or to put it another way, tropical medicine itself was decolonized. And yet numerous scholars – not least Weir and Mykhalovskiy in their chapter on geopolitics and public health surveillance – argue that later twentieth-century world health administration has inherited this history of health and colonization, and retains a strongly neo-colonial character. Obijifor Aginam suggests that this colonial inheritance has created a world health culture oscillating between 'global neighbourhood' and 'universal otherhood'.<sup>18</sup>

### **National security: territory, migration and border regulation**

The geopolitics of disease prevention has often operated through, and linked, nationalism and the policing of sovereign territory. From the early nineteenth century both maritime and land borders became closely regulated places for the inspection of the goods of commercial exchange, as well as vessels and animals. This is why, in many modernizing bureaucracies, quarantine officials were typically located within the broader government office and power of 'customs'. But nineteenth-century quarantine law

typically governed the movement and traffic of goods, animals *and* humans. With the emergence of European nation-states and their colonial extensions over the nineteenth century, and with increasingly bureaucratized administrative government, disease was checked by border inspections of people – their bodies, their identity and their documents. The documents of health, of being disease-free (or more likely coming from a disease-free town or region) existed as a system prior to the widespread use of identity documents (the passport or the visa, for example). Thus one of the factors which made jurisdictional (increasingly meaning national) borders meaningful was the checking of health documentation and of people's bodies for signs of infectious disease, and indeed, for signs of disease prophylaxis – vaccination. These procedures made borders more than abstract lines on maps, but a set of practices on the ground.

On a world basis (but, as we shall see with some most interesting exceptions), immigration law and public health law became connected in the late nineteenth and early twentieth centuries. This was a regulatory response to the phenomenon of mass movement, of circulating diasporic labor, of migrants, pilgrims, and refugees. A considerable body of scholarship details the health clauses – the 'loathsome disease' clauses as they were often called – in immigration law of various jurisdictions.<sup>19</sup> In Europe, cholera and the Mecca pilgrimage constituted the 'eastern question' as a 'health question'.<sup>20</sup> In the US, Russian-Jewish migration embedded quarantine screening in entry procedures,<sup>21</sup> while on the west coast and elsewhere in the nineteenth-century Pacific, Chinese indentured laborers and gold-seekers were singled out for regulation. Chinese Exclusion Acts emerged from the 1880s onwards, cementing ideas about, and joint regulation of, race, disease, territory and nationalism. Ironically, in the 1950s and 60s, decolonizing nations throughout South East Asia borrowed migration law from the 'colonial-settler' nations, and wrote similar health clauses into their new national statutes.<sup>22</sup> Through the implementation of these powers, national populations were literally shaped, territories were marked, and inclusions and exclusions on all kinds of bodily criteria were implemented.

But policing national territory was rarely about complete exclusion, historically or currently. Rather, in both quarantine and immigration domains, it was usually about monitoring entry and selectively including. Recently historians have shown the close connections between border screening processes and precarious inclusion into territory and civic identity: a rich historiography of health and citizenship is emerging. Both Fairchild and Shah have demonstrated this on either side of the US continent. Decades of migrant health screening at Ellis Island, New York, did not rest on any sort of legitimate microbiological or epidemiological rationale, Fairchild argues. Rather, it performed a more complex function of initiation into an industrial culture.<sup>23</sup> On the west coast, Shah has shown how initial exclusion of Chinese in the late nineteenth century, became a

provisional incorporation of Chinese communities into the US civic body by the 1920s and 30s, but one dependent on 'standardizing Chinese conduct and living spaces according to American hygienic norms'.<sup>24</sup>

In this book, several extensions to this scholarship are offered, as well as new case studies which detail interesting exceptions to the 'exclusion' model. In a study of health screening in the United Kingdom and Australia, Convery, Welshman and Bashford compare the quintessential instance of national medico-legal border control (Australia) and, as it turns out, one of the most exceptional instances (the UK). Elsewhere, Bashford has elaborated the deep significance of quarantine and health clauses of immigration restriction acts to the demarcation and defense of Australian territory (as an island-continent), to Australian nationalism and specifically to the White Australia Policy. These had a very particular manifestation and connection to nationalism in Australia, but, as she has argued, the conflation of health and immigration border screening with the element of racial exclusion was 'rather more ordinary than extraordinary' for the period (of the early to mid-twentieth century).<sup>25</sup> Until recently, the United Kingdom's history was starkly different. Certainly in the UK, there has been a long popular (and sometimes expert) linking of contagion, race, disease and dreams of exclusion and cultural/racial homogeneity, but this was not rendered into law and official policy in the way that was so common elsewhere (not only Australia, but the US, Canada, New Zealand for example). There has been minimal formal linking of health and immigration powers in the UK. This highlights that in the world history of 'medicine at the border', it was the colony-nations of settlement and importantly the destinations of the Chinese diaspora in the nineteenth century which created the legacies of joint health and immigration law and regulation. This history of UK 'exceptionalism' is an interesting reversal of the more usual center-periphery dynamic of colonial/imperial history. But as these authors show, and as Coker and Ingram demonstrate in their chapter on more recent developments, the future may look very different indeed. In the last few years, the UK government and opposition have sought to bring the UK 'into line' as it were: they are flagging for implementation what is known as 'the Australian model' of rigid pre-entry screening for various infectious diseases.

A different exception to the dominant history of the exclusionary capacity of border screening and territorial nationalism, is the case of France. In an important study, Miriam Ticktin details a counter discourse to exclusion in the French political and philosophical tradition of universalism and humanitarianism, expressed in the history of 'medical humanitarianism'. She details the history of Médecins Sans Frontières (MSF) within this tradition, and the reach of the idea of medical humanitarianism (as well as MSF personnel) into French government and law. Partly because of the character of French colonialism which incorporated colonial land and people into

France itself, and partly because of the philosophy and idea of 'the universal' (and therefore the diminution of territorial, sovereign or civic human difference), the French government recognizes the right of sick people to make a claim to be treated within France. If other national histories are dominated by the idea that illness, defect, and disease render people ineligible for, or unlikely to receive, entry, in France the reverse is the case. And if in so many other contexts historically, a 'public charge' argument has been written into immigration law (that is, if the person is likely to become a cost to the community through health and welfare dependence they may be refused entry or deported) the French case certainly represents the reverse principle. But as Ticktin shows, there is a subsidiary history of colonial relations also at work in French medical humanitarianism. Rather like Shah's precariously included Chinese-US citizens,<sup>26</sup> people residing in France on grounds of their illness must remain ill, in order to literally stay: despite a rhetoric of universalism, they must remain in a position of dependency in, and on, the French state, never quite equal, never quite citizens.

While Convery, Welshman and Bashford compare the Australian and UK systems of health screening, it is also worth thinking about the French and British instances comparatively. In the French case, there is legal principle for positive action: the law provides for entry on the grounds of illness, on the principle of universal medical humanitarianism. In the UK, there is no such pro-active law or regulation, but much the same thing happens in practice. That is (at least for the moment) people diagnosed with, for instance, tuberculosis on entry are not excluded and made to undertake treatment in their country of origin at their own cost (as in the Australian case), but may indeed enter the UK, and will be followed up at their local destination, by their local health service. What adds a further layer to these histories of illness, exclusion and inclusion is the current phenomenon of so-called 'health tourism', wherein some nations are more open than others, to this particular kind of border crossing: certain *kinds of* (monied) sick people are temporarily admitted. Indeed scholarship on the current phenomenon, which is economic in nature, and turns on complicated and not necessarily one-way axes of North-South, East-West, could profit from being historicized in terms of nineteenth-century colonial 'health tourism'.<sup>27</sup>

Canada, like Australia, has strict screening policies and shares a not dissimilar history of conflated health and race exclusions, although one far less well known internationally. And yet both Canadian provincial and federal law imposed versions of immigration restriction acts that incorporated various kinds of health criteria, which were race-based in implementation and intention. Here, Renisa Mawani looks at a recent turn in this link between territorial policing and medical policing in Canada – the 2002 Immigration and Refugee Protection Act and the (new) provision for the mandatory HIV testing of all immigrants. These measures, she argues, while



determinedly race neutral, are nonetheless often race specific in effect. Border security, she shows, is problematically coming to be promoted as a primary preventive health measure, as if it were comparable to domestic distribution of health resources and preventive education campaigns.

Epidemiologist Richard Coker has argued against the efficacy of border screening for disease prevention and management.<sup>28</sup> Here, with geographer Alan Ingram, he explores disease and migration regulation in the European Union and in the UK. In a field which often prioritizes the spread of acute disease, in particular SARS and imminent bird flu, Coker and Ingram insist on the need to keep scholarly watch on the politics of management of chronic infectious diseases – HIV/AIDS, tuberculosis and malaria. Like Mawani, Coker and Ingram draw attention to dubious (in public health terms) distinctions drawn between medical humanitarianism as part of foreign policy and the avoidance of medical humanitarianism as part of domestic health policy. The former is politically expedient ‘good’ aid, while the latter is politically inexpedient health funding of ‘foreigners’ as asylum claimants or as intending migrants. There is, then, a strange disjunction between promoting health aid elsewhere and the increasing refusal to treat (for free) those people when they are in the UK. This is part of the long history of the geopolitics of disease management, about people being considered properly *in their place*, or improperly *out of place*.

### **Globalization: deterritorialized health?**

Chapters in Part III of this book place these histories of global geographies of disease and disease management, of borders, nationalism, and internationalism, in the present. This section deals directly with new formations of security, international relations and public health, which are nonetheless derivative of this history. By the 1990s, as Brown, Cueto and Fee show, the nomenclature of ‘global’ health began reliably to replace ‘international’ health in the context of ‘new and re-emerging diseases’ and of economic globalization. This usage of ‘global’ has intensified after the experience of SARS, anthrax bioterrorism, and threats of avian flu. In other words, microbial threats became ‘global’ when they have impacted, actually or potentially, on the ‘first world’, and in particular on the US.

Scholarship on globalization typically draws a distinction between ‘international’ (where the administrative and legal unit of the nation is always present) and ‘supranational’, ‘transnational’ or ‘global’ (where organizations or systems do not rely on or refer to the nation as a basic defining unit). Globalization is, by one definition: ‘the acceleration and intensification of mechanisms, processes, and activities that are allegedly promoting interdependence and perhaps, ultimately, global political and economic integration’.<sup>29</sup> Global economic forces, it is argued, undermine the independent capacities of the sovereign nation-state, and the territorial basis of

the Westphalian system is threatened because 'social space is no longer mapped in terms of territorial places, territorial distances and territorial borders'.<sup>30</sup> Instant communication, daily global mass movement, financial cyber-transactions that are 'placeless', have, over the last decade created a radically new world that is 'supraterritorial' or, as is often claimed, 'deterritorialized'. Other commentators and scholars understand 'globalization' as economic and cultural 'westernization'.

Globalization, disease and its management are related in several ways. First, the transborder nature of microbes and disease, has been, without question, augmented with the frequency of travel. Second, there has been considerable use of supranational, fully global technologies and networks to track disease outbreak, as Weir and Mykhalovskiy discuss. Third, the deep investment in the 'development' idea of international health and world health, whereby the third world is developed in line with first world sanitary and health conditions as a way to secure disease-free regions, represents the 'westernization' dimension of globalization, for all its benefits in terms of morbidity and mortality. This latter aspect recalls, of course, Zylberman's argument on civilization and sanitary pre-emption.

For these reasons and more, historians of public health need to further enter scholarly discussion on globalization. They need to complete the third side of a scholarly triangle. On one side, there is a considerable literature on globalization, disease and health in the contemporary world.<sup>31</sup> On a second, there is increasing scholarly interest in thinking about globalization historically, a recent extension of both imperial historiography and world historiography.<sup>32</sup> But the connecting side of the triangle is underdeveloped: the historical study of disease and its management as part of the historical process of globalization. Again, while there is some historical discussion which picks up the idea of globalization and *disease* (especially in world historiography)<sup>33</sup> there is less on the idea of supranational disease *management*, 'supranational' public health, as it were.<sup>34</sup> The histories of 'international hygiene', 'international health', and 'world health' are certainly an aspect of a strictly international history (that is a history of international relations and 'internationalism'),<sup>35</sup> but they are also important sites to examine the emergence of ideas about the 'world' in world health, or 'the globe' in globalization.<sup>36</sup>

Globalization scholars often insist on the diminution of geography and territorial borders, but most authors in this collection argue for their ongoing significance. On the one hand, we learn from chapters in Part II of the long legacy of national border control for public health which the twenty-first century inherits. And we also see that, if anything, this historical legacy of territorial medico-legal border control is recently consolidating. On the other hand, however, the last two decades have indeed offered 'deterritorialized' methods of surveillance, methods not based on national territorial security, or on the (literal) ground of border surveillance. Weir

and Mykhalovskiy study closely GPHIN, the Global Public Health Intelligence Network. Radically shifting from the 'world health' tradition and history of sharing nationally-secured epidemiological information, GPHIN has used global news/information/internet sources to pick up the possibility of disease outbreak: it deploys the supranational 'network' of the internet, rather than the geographical line of governmental border surveillance. But Weir and Mykhalovskiy conclude (as indeed did GPHIN personnel) that this information gained supranationally, was then ineffectual unless it could be verified by an authorized international body, the WHO. Originally bypassing the nation-state, and the conventional international order, GPHIN found that it could not do so altogether.

World health has been centrally about information flow and exchange, from its origins in the nineteenth-century sanitary conferences and in the knowledge-machines of imperial infrastructure. 'Epidemiological intelligence' as it was often called was, in many ways, the first imperative of the various early international organizations for health and for the prevention of infectious disease. Yet media and communication exchange is not only about the sharing of epidemiological knowledge between experts, but also the proffering of advice from experts to 'the people' about how a disease should be prevented or minimized.

Two chapters on SARS highlight the persistence of the national and local in a supposedly globalizing world, and the significance of perceptions of security and safety, risk and danger, generated by strategic and sometimes accidental coalitions of national and international agencies, local and global media. In a sharp cultural study of SARS in Toronto, Strange explores the intense public relations/international relations efforts to re-package the city as clean and safe. The representation of Toronto was a deeply commercial question, in that the city had traded for years on its reputation as both clean and safe, and found itself momentarily a dangerous place and a 'pariah state', as well as fully 'exoticized' in its sudden link with the 'epicentre', China and Hong Kong.<sup>37</sup> Strange shows how the historic linking of Chinese diasporic communities with disease returned to shape the cultural response to SARS in North America. But this story was not a straightforward repetition of past Chinese discriminations and exclusions, for Toronto had also long packaged and traded itself as a multicultural city, an ethnically 'diverse' city. And so, as Strange details, the city's PR managers – professional semi-oticians – found themselves with an odd and difficult representational problem. How to manage competing perceptions of safety and risk, the exotic and the secure, in this moment of intense global surveillance?

While migrants and refugees have historically been the problematized population in terms of global infectious disease, SARS problematized the tourist and the business traveler. One of the important facets of the SARS episode in 2003 was that it crystallized for those few months, and onto the everyday tourist and traveler, many of the spatial techniques of prevention

and surveillance used more diffusely and permanently on migrants and refugees all over the globe. Claire Hooker details how the fascinating epidemic unfolded and offers an analysis of how authorities mobilized both 'old-fashioned' public health models (whereby the 'dangerous' were isolated in the quarantine tradition), and newer risk-based models (where 'at risk' groups were acted upon). On the one hand, authorities looked to the past and borrowed clumsily from old coercive quarantine controls. On the other, these prompted a future-looking 'preparedness planning' mentality, where health risk-minimization measures dovetailed with newly rigid national security measures. Hooker explores how health professionals have taken on the 'new normal' of constant bio-preparedness. Evident in each of these chapters is SARS as an epidemic of fear, in which the perception of security becomes as important as actual security.

The 2003 timing of SARS, as the follow-up to the 2001 attacks on the US and anthrax and smallpox scares in 2001/02, meant, of course, that terrorism, bioterrorism and epidemic disease became conflated. This occurred both intuitively at popular levels, but also deliberately at expert and institutional levels, especially but not only in the US. As Fider argues, public health and 'homeland' security are increasingly twinned, as geopolitical and geo-epidemiological issues. The newly intense bio-preparedness imperative threatens to dominate public health priorities, both nationally and globally. Yet the link to 'terrorism' of current 'bioterrorism', while certainly intense at the moment, is less novel than is often claimed.<sup>38</sup> We learn from chapters in this book that these concerns are often only apparently new, and are better conceptualized as recent manifestations of pre-existing clusters of modern concerns to do with territoriality, security and communicable disease. If European intervention into Ottoman territory to regulate the Mecca pilgrimage was 'pre-emption' as Zylberman argues, it was also 'bio-preparedness'. And we see from Stern's work that programs for health security have, often enough, squarely involved the military. Current policy emphasis on 'homeland' (that is territorial) security, needs to be understood as the latest expression of an enduring link between disease and national defense.

## **Conclusion**

The chapters in this book detail various historically specific but returning logics and measures through which security from disease has been sought: programs of movement restriction and quarantine at local, national and global levels; programs of eradication by disinfection and vaccination; 'pre-emptive' public health action, including the implementation of primary health; the conflation of migration barriers and health barriers; surveillance of people and of information flow. Jointly, the chapters both draw and qualify a historical shift from absolute measures (of

quarantine) to relative measures (of surveillance), from territory-oriented policing to network-oriented technologies, from old cordon sanitaires on sites of commercial exchange to a world where trade barriers double as lines of hygiene.<sup>39</sup> Inescapable is a sense of the intertwining of the national, the colonial, the international and the global in public health of the modern period. The national *was* the colonial, the colonial was already, the global. These spaces of regulation and movement did not emerge in a neat sequence, but as overlapping modern social and political formations. The interconnections between commerce, colonialism (military and cultural), national self-interest and a deeply politicized public health reveal the long past of current organizational, funding and discursive links between aid, development, foreign policy and disease management. This is both a historical and a historiographical point, suggesting the need further to link previously disparate literatures.

‘Nothing can bring back the hygienic shields of colonial boundaries. The age of globalization is the age of universal contagion’, write Hardt and Negri in their now famous book *Empire*.<sup>40</sup> Yet these collected chapters suggest a rather more complicated historical connection between colonialism, hygiene barriers, globalization and (what is missing in their formula) nationalism. In fact, we can profitably rearrange these elements. The age of colonization is better understood as the (first) ‘age of universal contagion’.<sup>41</sup> We can see that nineteenth-century colonial boundaries were minimal compared to the exclusionary and segregative capacity of twentieth-century national boundaries. And in fact it was *lack of* regulation, the *absence* of ‘hygienic shields’ which most characterized the colonial world flow of people, goods, and disease. It was rather more the ‘age of nationalism’ which embedded ‘hygienic shields’ into border regulation. Further, the ‘age of globalization’ – the world post-HIV/AIDS, post-multidrug resistant TB, West Nile Virus and SARS – might be ‘global’ in terms of disease spread, but is also characterized by increasingly intense regulation at national borders. Medicine at the national border, indeed, is not really being ‘brought back’, it is spreading and deepening from places where it never went away. As SARS revealed, and as pandemic influenza may, medico-legal border control both haunts and challenges the trend towards transnational globalization.

## Notes

- 1 M. Hardt and A. Negri, *Empire* (Cambridge Mass: Harvard University Press, 2001), p. 136.
- 2 H. Bell, *Frontiers of Medicine in the Anglo-Egyptian Sudan, 1899–1940* (Oxford: Clarendon Press, 1999), p. 4.
- 3 See F. Cooper and R. Packard (eds) *International Development and the Social Sciences: essays on the history and politics of knowledge* (Berkeley: University of California Press, 1997).
- 4 N. Goodman, *International Health Organizations and their Work* (New York: Churchill Livingstone, 1971); N. Howard-Jones, *International Public Health between the two world wars: the organizational problems* (Geneva: World Health