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Original Article

The specter of race in global Covid-19 responses: the future is decolonial

Madalitso Z. Phiri

Abstract: The Covid-19 pandemic reified pre-existing inequalities predicated on anti-Black racism, imperial geographical cartography, and the violent language of biomilitarism. In this reflective essay I deploy tools of historical sociology to underscore the importance of race, racism, racialization, and global responses to pandemics. I considerer the following questions. First, how can world society develop ideas and concepts for the imagination of a post-imperial global health regime? Second, can alternative futures be imagined if the monopolistic control of power, global scientific processes and knowledge regime is framed around a problematic lexicography of a Eurocentric totalizing project of being human? Lastly, if there is a scientific consensus that we need alternative futures, what kinds of knowledge is needed to bring about a post-imperial liberated order? The future of global health regime is a decolonial one predicated on a new biopolitics. I provide four paradigmatic approaches to subvert imperial global health: (i) pivoting ecocide in the imperial global health regime; (ii) abandonment of a Eurocentric conceptualization of racial hierarchy and modernity; (iii) disbanding the commodification of public health; and (iv) organizing a new world order through health reparations.

Keywords: anti-Black racism, biopolitics, pandemic, reparations, violence, race, racism, South Africa, Brazil, United States

Introduction

This reflective essay critiques declarations of equality in the rules-based liberal international order during the Covid-19 pandemic. International health experts had predicted that the Covid-19 pandemic is a respiratory disease that would inadvertently spread proportionately following what the liberal discourse frames as the 'universal right to breathe'. Mbembe's critique of the universal right to breathe during the pandemic is incisive. He observes:

> All these wars on life begin by taking away breath. Likewise, as it impedes breathing and blocks the resuscitation of human bodies and tissues, COVID-19 shares this same tendency. If war there must be, it cannot so much be against a specific virus as against everything that condemns the majority of humankind to a premature cessation of breathing, everything that fundamentally attacks the respiratory tract, everything that, in the long reign of capitalism, has constrained entire segments of the world population, entire races, to a difficult, panting breath and life of oppression (1, p. 61).

I partially agree with Mbembe (1) that taking away breath is the genesis of violence that has been unleashed throughout Euro-American colonial

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(This manuscript was submitted on 5 April 2023. Following blind peer review, it was accepted for publication on 17 October 2023.)

Global Health Promotion 1757-9759; Vol 31(2): 43–51; 1211828 Copyright © The Author(s) 2024, Reprints and permissions: http://www.sagepub.co.uk/journalsPermissions.nav DOI: 10.1177/17579759231211828 journals.sagepub.com/home/ghp

modernity. Yet, I depart from his observations deploying my own theoretical reading of Fanon's (25) radical sociogenics. Africa as a continent in global discourses is rendered lifeless by a Euro-American Christian Global Racial Empire that declared itself 'God of humanity' through imperial violence. Colonial modernity rendered the so-called inferior peoples of the world into a 'bastardized Other' whose ontological category exists as diseased in the biopolitics of a hierarchical Global Racial Empire. The mythical and fictitious God-like status that European colonial modernity asserts itself is through the fear of defining, describing as well as condemning the 'darker races' into hell. Long before the pandemic reached Africa, the proverbial 'dark continent', in the global colonial imaginery, had been thrown to the doldrums of death and epistemic impossibility.

This truism was not far from the reality, as the pandemic across Africa and its diaspora followed patterns that are predicated on anti-Black racism, gender hierarchies, geographical apartheid, racialized classes and state sanctioned negation of Black life. This should not be surprising, as imperial violence and problematic motis of the nation-state continues to distribute violence to those political modernity ejected as the 'bastardized Other', such as refugees, casualized workers, e-hailers, women, and LGBTQI+ people in metropole countries and across erstwhile colonized societies. Mindful of these observations, I ask the following questions. First, can the erstwhile colonized peoples develop ideas and concepts for the imagination of a post-imperial global health regime? Second, how can alternative futures be imagined if the monopolistic control of power, global scientific processes, and knowledge regime is framed around problematic ideas of a Eurocentric totalizing project of being human? Lastly, if there is a scientific consensus that we need alternative futures, what kind of knowledge is needed to bring about a post-imperial liberated order?

My aim in this reflective essay is to underscore the importance of treating race as a scepter when responding to pandemics. I achieve this by foregrounding a historical sociology of race, imperial genocide, and pandemics. Opposed to the current imperial health policy regime, I advocate for a decolonial health regime predicated on a new biopolitics from the position of the subalterns themselves. I provide four paradigmatic approaches to subverting imperial global health: (i) pivoting ecocide in global health regimes (ii) abandonment of a Eurocentric conceptualization of racial hierarchy and modernity; (iii) disbanding the commodification of public health; and (iv) organizing a new world order through health reparations.

Medical anthropology and the genesis of imperial genocide

The diabolical connection between racism, biopolitics, science, and pandemics has always been an intimate one since the onset of colonial modernity. But what exactly is *Racism* and *Colonial Modernity*, and how do these twin social artifacts manifest themselves in global scientific responses to pandemics? Race as a categorical imperative was constitutive from the onset of what the African American critical scholar, West (2), understood as the 'Age of Europe'. By Europe, we mean Edmund Husserl's description of a place that is 'not as it is understood geographically, as on a map, as if thereby the group of people who live together in this territory would define European humanity. In the spiritual sense, the English Dominions, the United States, Canada, Australia, South Africa, New Zealand, clearly belong to Europe . . . Here the title 'Europe' refers to the unity of a spiritual life, activity, creation, with all its ends, interests, and endeavors, with its products of purposeful activity, institutions, and organizations' (3).

Racism is not merely a discourse, but a practice which produces certain *knowledges* of the colonized, and, indeed, exploited, that makes the practice of domination, restructuring, and having an authority on the colonized (4). Race as a categorical principle of ordering world society emerged towards the end of the 15th century, and simultaneously created a global system that distributes violence, difference, and domination. Racism, Magubane (4) notes, is thus both a specific term, as in dehumanizing of a whole people, and a global social practice, that is, elevating Europeans and/or White people into 'lords of humanity'. Racism absolved the perpetrators of institutionalized injustices by blaming the victims. Race is the mask of class in the final analysis (4). This institutionalized articulation of racism as global apartheid provides us with a lexicography on how a world predicated on anti-Black racism has responded to pandemics.

Colonial modernity, on the other hand, refers to a totalizing global project of domination without consent that pivots Euro-American worldviews and values, predominantly organized around capitalist economic institutions, draconian laws, violence, force, and manipulation, exerting itself through patterns of obliterating the Black race across politics, society, cultural affiliations, symbol formations, and norms which influence global scientific flows. It was achieved through the institutionalization of White supremacy as a Global Racial Polity, as the late critical philosopher, Mills (5), articulated throughout his scholarship. White supremacy produced its 'bastardized Other', a 'Global Jim Crow' (6) predicated on anti-Black racism. The reproduction of White identity was further cemented through anti-Black preferential immigration policies, eugenics, and social engineering projects of whitening in settler colonial societies, such as the United States, Canada, South Africa, Brazil, Australia, and New Zealand (7).

It is a forgotten fact that, during the Enlightenment Era, armchair philosophers, such as Locke, Hume, and Kant, had made it a habit to speculate about the inferiority of Africans and Asians, which they attributed, among other things, to *biology*, climate, despotic governments and, of course, ignorance of Christian virtue (4). The Enlightenment Era consolidated and coalesced hegemonic ideas about 'race' and 'biology' that have found frequent expressions in the lexicon of biopolitics and, thereby, how the world responds to contemporary global pandemics. Europe's sadistic infatuation to prove the infantalization of the Negroid race produced sub-disciplines in the medical and biological sciences, such as phrenology, eugenics, and racial hygiene, leading to entrenched perspectives of a hierarchical humanity. These polarizing views were publicly aired in a debate between two French doctors at the peak of the pandemic when the Research and Development project of Covid-19 vaccines and trials was to be implemented. Jean-Paul Mira, head of intensive care at Cochin Hospital in Paris, suggested: 'If I can be provocative, shouldn't we be doing this study in Africa, where there are no masks, no treatments, no resuscitation?' 'A bit like as it is done elsewhere for some studies on HIV/AIDs. In prostitutes, we try things because we know that they are highly exposed and that they do not protect themselves' (8).

Contrary to what is presented as the neutrality of the liberal regime of safeguarding human life, ideas that champion Social Darwinism and eugenics never left Euro-American modernity. The Black body was historically produced as a site of scientific experiments exempted from pain and suffering. Colonial discourses have continued to organize biopolitics across the centuries – through forced sterilizations, racial hygiene, eugenics, and genocidal responses to pandemics, such as HIV/AIDS. For most people of the erstwhile colonized, the triumph of the liberal international world order in 1945 has meant living under the violence, brutality, and exclusionary practices of Euro-American fascism under the guise of safeguarding global humanity. The aesthetics of Blackness exists parallel to a global apartheid agenda under the pretext of going practices of neo-colonial's 'inclusive violences' and domination. Colonial violence is, indeed, the violence of fascism enmeshed in the contemporary Global Racial Empire.

From the doldrums of the historically produced 'bastardized Other', Black Radical Theorists have always provided counter-hegemonic ideas espoused in the 'Age of Europe' that championed medical apartheid and genocide. Ramose intimates: '[I]t is a known fact that science has classified and categorised human blood. Every human being is a potential donor or receiver of its blood group. Thus, blood is there to be shared in safeguarding the lives of one another as human beings. We are yet to find human beings with literally and empirically proven 'black' or 'blue' blood flowing in their veins and arteries' (9, p. 4). He goes on to say, 'The assumption of medical science is that whatever is medically proper for a patient with a specific illness is medically appropriate for all other human beings suffering from the same disease. If this were not so, then medical science would have no legitimate claim to science because it would go against the hallowed though questionable criterion of 'objectivity'' (9). In the current dispensation of colonial modernity, however, 'the objectivity of science exempted medical science from prejudice against Africans, Negroes, or Black human beings' (9, p. 4). In the case of this group of human beings,

'medical science denied them agency and rather opted for wilful ignorance as well as prejudicial rationalisations' (9). Unsurprisingly, responses to the pandemic followed problematic ideas under the aegis of colonial modernity.

Aesthetics of Black breath during the pandemic: South Africa, Brazil, the United States

Black breath during the pandemic was constituted around what Fanon (25) coined as 'theft of air' and 'combative breathing'. Vectors of violence embedded in approaches to a racialised medical anthropology were ubiquitous across settler colonial societies, such as South Africa, Brazil, and the United States. Black aesthetics continued to be legislated under state-sanctioned violence, generating disproportional distribution of mortalities, infections as well as segregated social effects through imposed global lockdowns. While some scientists had predicted very high death rates, many African countries were hard-hit by the negative effects of hard lockdown. Precariate work became more overt especially those working in the informal sector. Disruption of global supply value chains led to food scarcity a dystopia that millions on the African continent continue to live with four years after the pandemic.

It was South Africa, on the African continent, whose health architecture is enmeshed with institutions of settler colonialism, that was the epicenter of the pandemic. I have already intimated elsewhere, that, in South Africa, Covid-19 was a pandemic of racial capitalism (10). Under the guise of 'saving all lives', severe restrictions imposed during lockdown championed the militarization of health policy as well as the abstraction of the 'social' from the ambits of responses to the pandemic. South Africa's response to the pandemic was at best paradoxical (due to a colonially informed discourse), which revealed disproportional distribution of the pandemic: 'One Virus Two Countries' (11). Black life became more disposable to the negative effects of the pandemic. Friedman suggests that most scientists in South Africa are firmly embedded in 'First World' South Africa. Some of the decisions endorsed a science that was highly contested in both the United States and the United Kingdom (11, p. 35). Yet, this medical policy elitism was championed, as South African policy elites chose one 'science' over others which might have offered an alternative to mounting case numbers and fatalities (11, p. 56). This elitist approach to health policy protected the lives that are catered for in the private tier of South Africa's segregated commodified healthcare provision. The gulf between public and private social provisioning has never been wider. Prior to the pandemic, 50% of total health expenditure was spent on 16% of the population covered by medical schemes, while the other 50% is spent on 84% of the population in the public sector (12). Friedman (11) further suggests that these scientists adopted, without much reflection at all, the view which we would expect from professionals in a country divided into two realities, and in which the national debate reflects the experiences and attitudes of the 'First World' minority, not the 'Third World' majority (p. 56). Further, the health pandemic exacerbated the social pandemic that created conditions of destitution, precariousness, and indigence. Of the approximately three million net job losses between February and April 2020, women accounted for two million, or two-thirds of the total, even though, in February, they accounted for less than half of the workforce (47%) (13).

The realities of global apartheid became more apparent when South Africa had 'identified' a new variant of the coronavirus – omicron. Harvesting knowledge from years of active research, development, and training in dealing with tuberculosis, it was a logical conclusion that South African scientists could provide a lead in this area. Instead of commending scientists for enhancing scientific collaborations that could inform the world's approaches to the pandemic, South Africa and the whole of southern Africa was subjected to travel bans imposed by Western countries. This was despite the fact that some countries on the travel ban were nowhere close to the epicenter of the pandemic, such as Malawi and Zambia. This move, however, justified the geographical racism that has been informed by colonial cartography enforced by the Mercator projection of the world. The Mercator projection of the world map continues to reproduce imperial violence and, thereby, how Africa is categorically condemned to a zone of disease, war, and indigence and not a zone of scientific collaboration and knowledge production.

Such projections of the world abstract the interrelatedness, visibility, and resilience of Black life on the African continent and across its diaspora. In Brazil, for example, vulnerable populations, such as low-income families, single mothers, the elderly, Blacks, indigenous peoples, and other minority groups, were the most affected by the pandemic (14). Before the inception of the Covid-19 pandemic, the social assistance Bolsa Familia Programme (BPF) was dubbed 'The Silent Revolution of the Global South' to alleviate poverty and inequality (15). It was estimated that the level of extreme poverty would be between 33% and 50% higher without a social assistance program such as the BPF. Coupled with the distribution of assets, such as 'affordable' public housing, education, and healthcare, the program had contributed to reducing income inequality, accounting for 12 to 21% of the recent sharp decline in Brazil's Gini co-efficient (16). Brazil, however, is a country with the largest Black diaspora with a complicated unacknowledged history of how the trajectories of health and social policy are enmeshed in fiendish discourses of *racialisation* and hierarchical social citizenship.

The Brazilian Research Network on Food and Nutrition Sovereignty and Security (*A Rede Brasileira de Pesquisa em Soberania e Segurança Alimentar e Nutricional – Rede PENSSAN*) conducted a survey to assess food security in Brazil in the context of the Covid-19 pandemic (17). The survey shows that less than half of Brazilian households (44.8%) were food secure (2021). While 55.2% of households were experiencing some level of food insecurity, 9% of households were facing hunger (severe food insecurity). Out of a total of 211.7 million Brazilians, 116.7 million were experiencing some level of food insecurity, 43.4 million did not have enough food, and 19 million were facing hunger (17). When regional inequalities are accounted for, the pandemic of hunger reifies Brazil's racial and geographical hierarchies. Households with income of up to half of a minimum monthly salary per capita faced severe food insecurity at levels 2.5 times the national average. Close to 25% of residents in the north and north-eastern households reported monthly incomes of less than quarter of a minimum monthly salary per capit, compared with 10% in the south-southeast and central west regions (17). Further to this, severe food insecurity was higher among households headed by women, or by men or women self-declared as being Black or Brown, or with fewer years of schooling. Among households where the pandemic had led to job loss or increased debt, nearly 20% were facing severe food insecurity. Households with residents who had applied for and received government emergency assistance were affected by moderate or severe food insecurity at levels three times the national average (17).

Throughout the pandemic, Jair Bolsonarro's right-wing populist politics weaponized the state, cementing a culture of scientific denialism that led to higher fatalities in states and communities that are predominantly inhabited by Black and Brown people. Such responses to the pandemic further entrenched the idea that Brazil is divided on two fronts, whereby the north and north-eastern states (such as Bahia and Pernambuco), which occupy a totalizing discourse, are condemned to the zone of 'non-being'. In contrast, southern and south-eastern states (such as São Paulo and Porto Alegre) have achieved the teleological goal of 'Brazilian modernity and civilization'. Since the inception of the Covid-19 crisis, Brazil was one of the hardest hit countries in the world accounting for close to half a million fatalities. Such elitist and divisive approaches to the pandemic also reverberated in the narrative of civilizational exceptionalism and populism that bedevilled not only Brazil but also the United States. The global paradox is that polities that promoted the myth of civilizational exceptionalism (such as the United States, United Kingdom, and Brazil) inadvertently became the epicenters of the pandemic.

In the United States, under covert political rhetoric of White nationalism, the pandemic was initially referred to as the 'China Virus', by the then-leader of the 'Free World', Donald Trump. However, Kanngieser and Samudzi highlight subtle practices of ongoing American healthcare apartheid and White supremacy under the guise of liberal progress. They accent, '[t]he disregard of immunocompromised chronically ill and disabled peoples speaks to larger ideological and material practices of disability discrimination, racism and eugenics that define disabled life as valuable only in its sacrifice' (18). Pre-existing material conditions, such as housing discrimination, environmental decay, gentrification, and commodified health provision, necessitated conditions of inequality where African Americans and First Nations were disproportionately affected

in the pandemic. First Nation communities had the highest crude Covid-19 mortality rates nationwide – about 2.8 times as high as the rate for Asians, who have the lowest crude rates (19). The Center for Disease Control notes that Indigenous American deaths were often undercounted, with the latest research suggesting the true mortality rate for this group could be around 34% higher than official reports (20). As of April 2022, 142,361 African Americans were known to have lost their lives to Covid-19. There were 1,431 new deaths reported among African Americans for the last full month of data (March 2022), which is a 74% decrease from the preceding month (5,431) (20). This reflects the responses to state-sanctioned violence that was used under the trope of promoting the social good in this untransformed settler colonial state. Contrary to the promotion of the social good, Kanngieser and Samudzi further suggest: '[i]n both the United States and United Kingdom, as in Italy, critical care consultants spoke about having to limit who would receive medical equipment such as ventilators, creating a discourse that rationalised and normalised the disposal of sick, elderly and disabled patients' (18). This cements exclusionary practices that are intrinsic to ongoing subtle racialized social determinants of health that are enmeshed in the make-up of the United States as a bastion of segregated healthcare provisioning in the world.

The tropes of exclusionary approaches were further reified in the regime of intersectional state-sanctioned violence through the Medical Industrial Complex as well as the Prison Industrial Complex in the United States. The United States incarcerates around 2.3 million people in prisons, which is the highest across all developed countries. According to the National Association for the Advancement of Colored People (NAACP) (21), Black men are incarcerated at five times the rate of White men and Black women at double the rate of White women (21). African Americans experienced 14.3% of all deaths, while they represent 12.6% of the population (21). These disproportional rates are no different from the effects of the pandemic itself. Black bodies are subjected to legislated state-sanctioned violence exemplified through a failed American social and political project. Accounting for the politics of health, '[T]here is an increased rate of chronic illness associated with incarceration that continues even after release and chronic illnesses are the leading cause of death within prisons - attributed to the extremely poor healthcare available' (18).

The Prison Industrial Complex in the United States exists as the final stage of state-legislated negation of Black life. Thus, the Covid-19 pandemic produced a negation of life on two fronts: the right to exist in a healthcare regime that renders Black life nonexistent, and citizenship rights curtailed in a polity whose political institutions are predicated on anti-Black racism and settler colonialism. At the peak of the pandemic, Kanngieser and Samudzi made poignant observations: 'The Ohio prison system alone accounts for more than 20% of the state's total novel coronavirus cases, and it is spreading rapidly – 'like wildfire' – through correctional facilities in epicentral New York and other states. But rather than de-carcerating institutions en masse, incarcerated people in New York state are sewing masks for hospitals (when most do not have their own), producing hand sanitizer in light of widespread shortages, and digging mass graves' (18).

Global infections patterns disproportionately affected groups that colonial modernity has defined as the dehumanized 'Other': Blacks, refugees, undocumented migrants, Indigenous people, and the disabled. These groups of people were the hidden faces of fatalities within the ambits of safeguarding the mythological 'better life for all'. In South Africa, argues Canham, 'before the virus became a black condition, fears of contagion had become racialised and classed' (22, p. 301). Canham further raises the paradoxical questions of Black existence under the gaze of White supremacy. He notes that, during the pandemic, the irony was, of course, that 'there was a universal consensus that the virus began in China but in the logic of racism, Africans were a convenient scapegoat' (22).

Those most loathed in society are seen as always infected. 'What does it mean to always be infected by viral plagues?' To always be death bound?' (22, p. 302). Butler's (23) concept of 'grievability' facilitates a sophisticated understanding of the ways in which frames intersect with modes of recognition and power to surface and (re)enact social arrangements that render some bodies more grievable than others. For a particular body to be recognized as dead, Butler argues, we must first have validated that body as human and living. Not all lives are validated as living, and this alerts us to the idea that mourning (the validation of lives lost) is stratified,

psycho-social, and deeply political (23). As Butler further intimates, statistical observations are insufficient to explain pandemic outcomes, 'but we can assume that one reason is that within the so-called common world the loss of Black life is simply not considered as worrisome or grievable as the loss of white life (often described simply as 'human life')' (23, p. 4). The pandemic further reified the biopolitics that inform the disposability of Black life and its bioethical limitations. Canham accents, 'If Covid-19 leads to overwhelmed lungs, how different is this from death through being submerged and drowned in the floods or in the deathly Mediterranean crossings by Africans reaching for Europe? Death is death and we are all destined to its stranglehold. But Black death has a particular logic. It is always in excess. Black people always die disproportionately more. Death always latches onto existing social fissures of inequality. In the calculus of death, health outcomes are racialised' (22, p. 303).

The regime that governs the biopolitical aesthetics of Black life is woven with the preservation of values that entrench a Global Racial Empire and inadvertently, White supremacy. In this regime, Blackness exists as an ontological category that is pathologized and diseased. There is no future of a liberal health regime and inadvertently, world society without decolonization. Hence, the Black Radical Tradition always imagined a post-imperial polity in what Du Bois understood as the 'Gift of Sight' (24) from the erstwhile colonized peoples. Decolonization, as Fanon (25) exegetically espoused, is a process of replacement of the old world order with a 'New Humanity' that is born from the position of those who have been historically wronged and ontologically produced as the colonialized and diseased 'Other'.

Conclusion: toward a decolonial health regime

There is no global social justice without epistemic justice (9, p. 13). To decolonize the global health regime requires that world society pivots intellectual archives and quitodian encounters of the erstwhile colonized whose raison d'être is to dismantle the imperial health regime. Decolonization must produce 'a New Humanity' transforming the objects of exploitation, which were under colonialism, into free humans. I reflect on what this imagined decolonial future of global health regime entails.

First, if global health justice is to be achieved through a flawed global governance architecture's ability to prosecute genocide, then the definition of genocide needs to, at minimum, include ecocide as a recognized act. Contemporary neoliberal global hierarchical racialized capitalism thrives on the divorce of human and nonhuman ecologies, which has inadvertently led world society further toward the Anthropocene epoch. Assuming causal relationship between pandemics, environmental determinants of health and humanity then we need to re-constitute the social, political, and environmental. There is currently no international crime of ecocide that applies in peacetime, only in wartime, covered by the Rome Statute (26). It was originally planned to be included in the Rome Statute and support by many states, but was removed due to objections by the United Kingdom, France, and the United States (26). The global energy complex is based on an extractive model where carbon capital and green capitalism are exploited through diabolical approaches that are championed by neoliberal ecofascists. While there is no global consensus as to complex causalities of the coronavirus, there is suspicion from countries in the Global South that just transitioning to net zero is fictious. These positions are sustained by the hypocrisies of an imperial global governance regime. Satgar suggests that the United States has been dominated by carbon capital, which is closely tied to ruling financial interests, it has failed to provide decisive leadership in the United Nations multilateral processes, from the Kyoto Protocol to the Paris Climate Agreement. Normative assumptions of capitalist growth are predicated on a system of extraction and the divorcing of the human from the nonhuman world (27). In the Global South, as Satgar intimates, the positions emboldened by imperial positions necessitated a 'catch-up carbon development', which ensured fossil fuel spigots remained open over the past 20 years to meet the needs of China, India, and other G20 countries. Billions for a just transition promised to countries that did not cause the climate crisis have not materialized (27, p. 97). Ending ecocide will start with a recovery of the idea of a Global Commons that usurps the promulgation of Euro-American fascism as 'lord of humanity'. World society should, rather, think about politics as transpolitics: ensuring workers go beyond narrow economistic demands,

feminists beyond women's oppression, and environmentalists beyond specific environmental problems (27, p. 105). The current capitalist ethos can be replaced by a democratic socialist system that values the interrelatedness and spirituality of human and nonhuman ecologies.

The second point is the abandonment of a Eurocentric totalizing idea of the 'universal man', which justifies the violence of Euro-American modernity. Du Bois made a poignant point that Black people live with a tortured two-ness or what he termed 'double consciousness' (24, pp. 128–173). Life on the other side of the veil is governed under the precepts of White supremacy; whereas the other side of the veil is lived under the fullness of Black humanity expressed through the gift of 'Second Sight'. 'Second Sight', as Rabaka has elaborated, provides Blacks with a window into the 'two worlds within and without the Veil', and it also enables them to begin the dialectical process(es) of revolutionary decolonization and human liberation by critically calling into question double consciousness (24, p. 143). This social project is occupied with a radical idea of dismantling the totalizing idea of the 'European man', so that a 'self-conscious humanhood' emerges. Decolonization starts with a change of the consciousness of the colonized, a far-reaching, and fundamental goal. The changing of the colonial structure entails that all social relations are fundamentally transformed into new, higher unity, beyond the original position, assuming the radical opposite of everything that colonialism was, its violence, its brutality, suppression, racism, and its unfreedom (28).

The third point is to disband the idea of commodification of public goods such as health. The current health regime privileges the commodification and financialization of society. The regime that governs intellectual property rights thrives on the commodification of science and medicine. Neoliberal healthcare jettisons the idea that knowledge and scientific discoveries thrive on collaboration and not its corollary, competition, and violence. Billions of people live under dystopian conditions that have been wrought by imperial health planning, eugenics, and population control. All this feeds into a capitalist and genocidal ethos that seeks to eliminate the 'Other' in parallel to a mythical liberal approach that champions the preservation of life for 'all humanity'. In contrast to a dystopian capitalistic approach of global public initiatives, the other side of the coin is that, throughout the pandemic, scientists and medical practitioners resisted this idea, 'from public-access of medical data sets to the open-source software used to visualise and model virological data to the digital communications infrastructure that has allowed scientists to collaborate freely across the globe, there is a great common of knowledge, mutual aid and solidarity that underpins and nurtures the foremost scientific endeavours of our time' (29).

Fourth, the future of the global health regime can only continue to exist if we think about healthcare/health promotion as '*worldmaking*'. Those who have historically been constructed in the world as the 'bastardized Other' also occupy the racial hierarchy as the 'Diseased Other'. The cancer of colonialism spreads its cells to their sicker cells. However, imaginaries of the global healthcare regime that is rooted in violence should be thinking of it as an emancipatory project that champions a post-imperial world order free from *domination* (30). This means conceptualizing healthcare as reparations predicated on a constructive view of justice. Conceptualizing the global health regime through the constructive view of justice removes the impetus of its normative instruments. The contemporary African philosopher Táíwò (31) opines that most theorizing about reparations treats it as a social justice project – either rooted in reconciliatory justice focused on making amends in the present or focusing on the past, emphasizing restitution for historical wrongs. Neither approach is optimal; rather, Táíwò (31) advances the case for reparations rooted in distributive justice, which he refers to as the 'constructive' view of reparations.

Declaration of conflicting interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

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