May 1, 2020

The Honorable Ed Chau
California State Capitol, Room 5016
Sacramento, CA 95814

Dear Assemblymember Chau:

As scholars and practitioners who study and work on public health and its social, legal, and political effects, we write to express our strong opposition to AB 2261. In a moment that requires significant investments in public health and social welfare to address the pandemic and the manifest inequalities it exposes, this bill threatens to further entrench inequity and divert money from vital public health resources while ushering in a nightmarish future of unprecedented biometric surveillance. Facial recognition is not the solution to this public health crisis, and we hope that you will reconsider the broader implications of endorsing this technology in light of the grave threats it poses to a healthy and diverse democratic society.

Surveillance measures must be informed by public health experts and narrowly tailored to address public health challenges in light of the risks to civil rights and people's safety.

The infrastructure we choose to build in times of crisis will define public health outcomes for decades to come. This moment requires a significant investment in our social safety net and healthcare infrastructure, not in harmful surveillance with at best dubious public health benefits.

This public health crisis invokes a fear similar to that prompted by 9/11, with similar calls for blame and overbroad surveillance measures that will not protect our health and safety. Around the globe and in our own communities, governments are deploying massive surveillance programs including mobile data tracking, apps that record personal contact with others, video cameras equipped with facial recognition, and drones to enforce social-distancing directives. This focus on intrusive, unhelpful surveillance measures diverts resources from necessary and effective publichealth interventions. 9/11 has also taught us that these ineffective measures are difficult to scale back once the crisis subsides, and will disproportionately harm Black and Brown communities.[1]

For these reasons, we reject responses to COVID-19 that could divert investment in proven public health interventions in favor of expanded biometric surveillance, further marginalizing vulnerable populations. Any surveillance measures to address this health crisis must be narrowly tailored to urgent needs, authorized only for the time-period necessary to combat the virus, utilized exclusively by officials who work in the public health sphere, and have evidence-based public health benefits.

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[1] The disproportionate surveillance of communities of color is a corollary of broader crime suppression efforts that target Black and Brown people for traffic stops, arrests and mass incarceration, as well as government tracking and containment regimes that seek to exclude marginalized groups from full democratic participation. *See* Andrew Guthrie Ferguson, THE RISE OF BIG DATA POLICING: SURVEILLANCE, RACE AND THE FUTURE OF LAW ENFORCEMENT (2017) and Dorothy Roberts, *Digitizing the Carceral State*, 132 HARV. L. REV. 1695, 1697 (2019). Black and Brown people, especially women and young people, are also more likely to be misidentified by discriminatory algorithms like facial recognition systems that are built using biased data. *See* Joy Buolamwini & Timnit Gebru, *Gender Shades: Intersectional Accuracy Disparities in Commercial Gender Classification*, 81 PROCEEDINGS OF MACHINE LEARNING RESEARCH (2018); Drew Harwell, *Federal study confirms racial bias of many facial-recognition systems, casts doubt on their expanding use*, Washington Post, Dec. 19, 2019, https://www.washingtonpost.com/technology/2019/12/19/federal-study-confirms-racial-bias-many-facial-recognition-systems-casts-doubt-their-expanding-use/.

Historically, safeguarding public health has been used as a cover to advance racist and xenophobic policies and programs.

The current pandemic comes at a time of historic divisiveness premised on racism and nativism. COVID-19 blame-mongering has fueled those divisions in ways that undercut public health efforts. The recent surge in rhetoric and hate crimes targeting Asian-Americans amidst the COVID-19 outbreak is not the first time that fears about public health have manifested as racial violence and exclusion. Throughout history, the noble goal of protecting public health has been weaponized by both government officials and private actors for nefarious purposes.[2] In the late nineteenth century, U.S. officials stationed at Ellis Island required newly arrived immigrants to undergo mandatory health screenings, citing prevention of communicable disease as a basis for restricting the entry of "undesirable" ethnic groups.[3] In the first few decades of the twentieth century, public health screenings at Angel Island blamed Chinese and Japanese immigrants for bubonic plague, smallpox, and other diseases to justify anti-immigration policy.[4] Congress codified eugenicist fearmongering around the alleged public health implications of immigration by passing the National Origins Act, which imposed a nationality-based quota system to limit the entry of "genetically inferior" races at the nation's borders.[5] In 1906, when the bubonic plague arrived in San Francisco, the weaponized public health response was to quarantine Chinatown, stoke anti-Chinese racism (just one generation after the passage of the 1882 Chinese Exclusion Act), and destroy Chinese owned buildings; only after the failure of this approach became clear did the focus turn to appropriate task of exterminating rats.[6] As part of the Tuskegee experiment from 1932-1972, doctors from the U.S. Public Health Service recruited 400 Black syphilis patients for its study by promising them free medical care, only to intentionally leave them untreated so researchers could observe the natural progression of the disease.[7]

The racialization of disease was advanced by local governments as well. In early twentieth century California, for example, entire groups of Mexican American workers were targeted by police and public health officials for criminalization, detainment, and deportation under the guise of communicable disease containment.[8] Finally, the forced removal of American Indian children from their families and their relocation to Indian Boarding Schools, including in California, was done in the name of "improving" their "race," causing

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[2] *See generally* Michele Goodwin & Erwin Chemerinsky, *No Immunity: Race Class, and Civil Liberties in Times of Health Crisis*, 129 HARV. L. REV. 956 (2016).
[3] *Id.* at 966-967.
[4] Ivan Natividad, *Coronavirus: Fear of Asians rooted in long American history of prejudicial policies*, BERKELEY NEWS, available at https://news.berkeley.edu/2020/02/12/coronavirus-fear-of-asians-rooted-in-long-american-history-of-prejudicial-policies/(Feb. 12, 2020).
[5] Dorothy Roberts, *Who May Give Birth to Citizens? Reproduction, Eugenics and Immigration*, 1 RUTGERS RACE & L. REV. 129, 132-133 (1998).
[6] David K Randall,. BLACK DEATH AND THE GOLDEN GATE: THE RACE TO SAVE AMERICA FROM THE BUBONIC PLAGUE. New York: W.W. Norton (2019).
[7] Harriet A. Washington, MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT at 178-180 (2006); Abigail Perkiss, Public Accountability and the Tuskegee Syphilis Experiments: A Restorative Justice Approach, 10 BERKELEY J. AFR.-A,. L. & POL'Y 70, 71 (2008).
[8] Christopher Perreira, *Consumed by Disease: Medical Archives, Latino Fictions, and Carceral Health Imaginaries* in CAPTIVATING TECHNOLOGY: RACE, CARCERAL TECHNOSCIENCE, AND LIBERATORY IMAGINATION IN EVERYDAY LIFE 53 (R. Benjamin 1 ed. 2019); Natalia Molina, FIT TO BE CITIZENS?: PUBLIC HEALTH AND RACE IN LOS ANGELES, 1879-1939 (2006).

intergenerational trauma and increased deaths, including from tuberculosis and influenza, of the children themselves.[9]

These heinous acts, often cited as the prime symbols of racism in medicine, represent only a few instances of the systemic brutality Black and Brown, Asian, Indigenous and low-income communities have suffered at the hands of officials claiming to advance public health.[10] Recent reporting on racial disparities in COVID-19 health outcomes, along with rising cases of COVID-19 related anti-Asian hate crimes, illuminate the lingering health-equity implications of such public-health responses driven by racism and fear. We must reject policies that build on this legacy—whether wittingly or unwittingly. Invasive biometric surveillance would endanger the very Californians most vulnerable to our current public health crisis. Where facial recognition is already in use, it magnifies the effects of unjust systems that target Black, Brown, and low-income people—facilitating the deportation of immigrants, criminalization of the unhoused, and expansion of mass incarceration.

Facial recognition is not the solution to this public health crisis.

We remain hopeful that this moment presents a powerful opportunity to further public health by meaningfully addressing structural inequities and promoting collective healing. This requires making significant investments in our public health infrastructure that will help people thrive. Facial recognition technology and the invasive surveillance it gives rise to are antithetical to this advancement of public health and wellbeing. Over the past several years, face recognition systems have been used to target immigrants for deportation, criminalize poverty, facilitate mass incarceration, and surveil participants in lawful protests. The technology has raised serious concerns that its algorithms replicate racism.[11] Despite these harms, tech companies continue to promote flawed fever-tracking technology with built-in facial recognition as a solution to COVID-19, while taking advantage of widespread panic and uncertainty to advance a broader pro-surveillance agenda. There is quite simply no public health justification for a pervasive facial recognition infrastructure.

AB 2261 will subject Californians to the harms of face surveillance precisely at a moment where our collective responsibility to promote public health and protect people is more critical than ever. As the nation looks to California's leadership in regulating big tech and advancing health and justice, we hope the Legislature will take the threat of facial recognition and the lasting societal impact it will have seriously. Because facial recognition technology poses enormous risks to civil rights and equality—while offering no public health benefit—we must oppose AB 2261.

Sincerely,

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[9] Roxanne Dunbar-Ortiz, AN INDIGENOUS PEOPLE'S HISTORY OF THE UNITED STATES. Boston, MA: Beacon Press, (2014); Charla Bear, *American Indian School a Far Cry from the Past*, NPR, https://www.npr.org/templates/story/story.php?storyId=17645287 (May 13, 2008).
[10] Washington, *supra* note 5 at 178-80.
[11] *See*, Osagie K. Obasogie, BLINDED BY SIGHT: SEEING RACE THROUGH THE EYES OF THE BLIND, (Stanford University Press 2013).

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