Race, Racism and Anthropology

Decolonising health inequality in the time of COVID-19

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Abstract

In the United Kingdom, the government's failure to consistently record the race and ethnicity of those who have died from COVID-19 and the disproportionate mortality impact of the virus on Black, Asian and Minority Ethnic (BAME) communities speaks to a systemic failure to account for the interplay between the social construction of race and the lived experience of racism, itself presented biologically as 'poor health'. This failure has run for far longer and far deeper than many would care to admit. In this article, I use my own positionality as a 'Mixed-Race Black' woman to argue that the unique place of medical anthropology to sit at the intersection of the social, political, biological, and ecological means it can provide alternative approaches to understanding the disproportionate impacts of the pandemic and lay some foundations for repair strategies that encompass the patterns, processes, and constructs of health inequality.

Keywords

Introduction

Although anthropologists have written extensively about race and the race concept, anthropological contributions to the study of racism have been unexpectedly modest. As Leith Mullings (2005) points out, this is perhaps a result of anthropology's contradictory heritage. 'On one hand', Mullings argues,

> [anthropology] is the discipline that once nurtured 'scientific racism' and the racial world view that provided a rationale for slavery, colonialism, segregation, and eugenics. On the other hand, anthropology also has a significant antiracist tradition, most notably during and shortly following World War II as racism's genocidal consequences became all too clear (2005, 669).

The apparent exclusion of the study of racism from more recent social and medical anthropology is perplexing given the breadth of work carried out by the discipline. For Mullings, the reason is perhaps an epistemological tension in the discipline that treats race as a socially and culturally defined category as well as an ideology linked to 'modernity' and the establishment of nation states. Mullings draws our attention to an important issue: for many years, anthropologists have warned of the implications of viewing the social relations we unpack as existing only in local or national confines.[1] Most notably, critical medical anthropologists and anthropologists that study structural violence and human rights often express the dangers of an overly relativist anthropology. Just as it did the universalism/relativism debate, anthropology has moved on from binary considerations of tradition versus modernity and the small-scale society versus the nation. That being said, in the area of racism (and as Mullings rightly points out), the discipline appears content to perpetuate that myth. This is largely because of the awkwardness and lack of coherence in acts of theorising race, particularly in medical anthropology. Largely, race has been seen as something different to racism, and has not been treated as the product of it. Race is understood as locally defined, both in terms of communities but also as biological bodies that are products of those local relations. Conversely, racism extends beyond these confines and orientates race as a series of wider socio-political and economic relations. It is therefore important to separate the workings of race from the workings of racism and to identify and explore the spaces wherein the two are conflated. To do this, I offer up my own positionality as a way to reconcile the binary between race and racism.

Recent discussions concerning the disproportionate impact of COVID-19 on Black Asian Minority Ethnic (BAME) communities in the UK and USA demand an

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1   Most notably in medical anthropology by critical medical anthropologists (Baer, Singer, and Susser 2003; Helman 1994).

alternative approach to the study of race and racism in medical anthropology. In this Position Piece, I show how such an approach needs to embrace multidisciplinary and collaborative methods and, in particular, to draw from advances within our own subfields. By drawing on our capacity to explore relational modalities, boundary work, and different forms of embeddedness, we can contribute to a better understanding of the articulations of racism and racialised experiences of health and illness. To demonstrate this, I map out two interdependent sets of relations that I see as structuring racial health inequalities. The first set is concerned with the practice of racism which structures ways of interacting, engaging, and governing ill health among BAME communities. The second set of relations is cognitive and embodied and relates to the intersubjective experience of racism.

Autoethnographic reflections: A 'Mixed-Race' positionality

The argument I advance in this article draws from my involvement, spanning almost 20 years, as an anthropologist and 'Mixed-Race' Black woman in antiracism work in the UK and internationally. Alongside a more conventional career as an ethnographer and university lecturer, I have worked in the fields of race relations and what is referred to in Britain as Equality, Diversity and Inclusion (EDI) from the level of grassroots organisations to the towers of elite multinational corporations and global public-sector agencies. In the spring and summer of 2020, the Black Lives Matter (BLM) protests swept the world at the precise moment that the coronavirus pandemic exposed the depth of racial health inequalities across 'developed' nations. These racial health inequalities (fruits of the inherent racism of public institutions, which I had spent two decades fighting against) laid bare the shortcomings of available anthropological theory for thinking through the unique context of the pandemic and the issues of identity it generated. In our time of COVID-19, neither the claims of the 'colour-blind' and 'multicultural' British health and social welfare system nor of an anthropology struggling with the implications of recent calls for decolonialised, decentred, and provincialised theory and practice could claim a moral or critical high ground *vis-à-vis* their object of intervention and study (c.f. Agier 2016; White 2019; Chakrabarty 2009).

The debates in the press concerning both COVID-19 and BLM seemed to slot people into distinct 'racial' camps upon which and to which things happened. I found myself deeply troubled by this flurry of categorisation; it plunged me back into the existential dilemma of my own positionality, which sits at the intersection of both a biological framing of race as skin colour and its social construction as a political label of affiliation. Labelling myself the much-maligned category of 'Mixed Race' and the politicised category of 'Black is an existential and experiential

choice. That choice rests in the complex accumulation of interrelated aspects of identity formation which itself embodies the relational components of racism. To unravel this is thus not only to unravel myself, but also to unpack some of the problems that underlie how, as an anthropologist, I—and perhaps 'we', as anthropologists—view racial inequality and categorisation more broadly. I grew up being continually asked, 'Where are you from? … No, but where are you *really* from?' and, 'What is your background?' and my answers, which included references to a White parent, never left myself nor my inquisitors very satisfied. In fact, I often, particularly as a child and young adult, came away from these conversations feeling exposed, fraudulent, and even less clear on my positionality in the world *vis-à-vis* my identity. My inquisitors, on the other hand, often simply made up their own minds, some of whom by saying, 'Well, you're not really *Black* then, are you?'

The problem of 'Mixed Race' is whether using it gives legitimacy to the scientifically erroneous and now politically dubious category of 'race'. As Robert Miles (1989) suggests, social scientists should not give credence to the reification of false abstractions such as 'race' (Miles 1989). Rather, their priority should be the analysis of racism and racialisation. The work of geneticists and biological anthropologists undermines the ontological status of 'races' as discrete, immutable, and intergenerationally stable biological entities (Matt Cartmill and Brown 2003; Marr Cartmill 1998; Gravlee and Sweet 2008; Littlefield et al. 1982). Yet, not everyone has bought into this knowledge, and forms of racism that draw on the alterity of being are, for those of us in the know, alive and well. Moreover, essentialised racial identities *do* have their place—for example, as important for political mobilisation against discrimination and disadvantage (utilised, for instance, by the BLM movement).

For my part, I have often wondered if I should follow Jane Ifekwunigwe's (1997) directive toward the reappropriated use of '*métis(se)*'. Her eloquent characterisation moves race beyond its conventional definition. Instead, she uses *métis(se)* to refer to someone who by virtue of their parentage embodies two or more world views—for example, a 'Euro-African' (idem, 131). Her inspirational research explores the complex problem of ideas of place and belonging for people in Britain who are classified as neither Black nor White. She examines ideas of authenticity and lineage among 'Mixed-Race' women, all of which travel some distance towards defining the hybridity of my racialised experienced. Ifekwunigwe points out that '*métisse*' is a concept that works best within the realm of what Gilroy (1993) saw through the metaphor of a crossroad, that special place where unforeseen things can happen. It helps us rethink the dialectical tension between 'cultural roots and cultural routes' and understand the diasporic condition more broadly (Ifekwunigwe, 1997, 131–132). Still, I lean more towards the term in its

analytical framing as '*métissage*', described by Lionet (1989) as a site of undecidability and indeterminacy, where solidarity, one way or the other, becomes a principle of political action (idem, 6). For I am not of two contrasting cultures that blend nationality, language, ethnicity, and place into something generative and new. My known heritages are of the same social and cultural inculcation, received in similar fields of British practice; the fundamental distinction between them was the relative experience of anti-Blackness for one parent and the hostility toward representations of gender, and later sexuality, for the other parent. My own racial indeterminacy derives from my skin colour and other features alone. I inhabit what Minelle Mahtani (2001) terms a 'mobile paradoxical space', which defies any sort of absolute characterisation (idem, 185). Yet, of course, that does not stop people from trying to characterise me anyway or denying my own attempts at that project. What it signifies is that a large part of my own racial identity is constructed through the representations of it by others. As such, my indeterminate racial identity is continually being made and unmade within the loop of 'relational phenomenology'. Yet that need not be as gloomy as it sounds. Indeed, for Mahtani's interlocutors, their ability to cross over the demarcations of racial divides made it easier for them to transcend other social cleavages, which enabled different forms of commonality to come to the fore (idem, 187).

In this Position Piece, then, I offer a position on the confluence of the disproportionate impact of COVID-19 that seeks to unravel two modes of enquiry to which anthropology can contribute. The first is concerned with racial categorisation and is drawn, in part, from my own positionality, which sees appropriation and reappropriation of racialised categories as encapsulating the dilemmas of living in racist societies, within which minorities are in part compelled to use the terms of their inequality in order to change their experiences of inequality. I have written about this kind of dilemma, although not in relation to race or health, as it plays out among different castes within a Dalit (ex-untouchable castes) community in rural Rajasthan (Mullard 2010; 2014).

For example, after 17 months of ethnographic research, I observed the ways in which Dalit communities and anti-caste activists in rural Rajasthan—devastated by a period of temporary suspension of their main source of income, open-cast mining—sought alternative strategies for employment. Those who wanted to make use of affirmative action policies, or 'reservations' as they are known in India, recognised themselves as among the 'scheduled caste', a government category that includes special provisions and quotas for previously untouchable communities. Other interlocutors used the shared experience of daily wage labour and unemployment to mobilise as a 'labour class' to protest the closures, while others sought refuge in 'traditional' or what I term 're-traditionalised' caste occupations that entailed the reification of their employment choices as 'natural'

and historically grounded in an 'honourable' past, which positioned others—namely those who took different routes to work—as 'different sorts of people'.

The second mode of enquiry is more amorphous and is well-served through a consideration of relational phenomenology. The sociologist Will Atkinson (2016), in characterising the influences and works of Pierre Bourdieu, neatly puts forward an overview of relational phenomenology that I think forms the analytical foundation underpinning the first mode of enquiry. Briefly, relational phenomenology draws on questions of epistemology and the conceptualisation of how we can 'know' the world and whether an objective 'truth' is ever possible; the affective drivers of our behaviour and the relevance of concepts such as 'human nature'; and the relationship between theory and practice, which is best characterised by Bourdieu's concept of 'habitus'. I will reserve a closer inspection of these interlocking aspects of relational phenomenology for another time; for now, I wish to focus on the practice and manifestations of them—that is, the problem of essentialisation and how it has characterised much of the discussion surrounding race, racism, and COVID-19.

I propose that the two modes of enquiry that form the relations behind essentialisation structure the very basis of human sociality; we are, after all, constantly placed in an equivocal position where we must reject any essentialist, reductionist framing on the one hand, but, on the other, are also driven to 'strategically essentialise'[2] both ourselves as individuals and bodies and the groups within which we claim a home or for whom we seek justice. Relational phenomenology allows us to unpack this process as part of an attempt to understand our entangled selves, which are co-created through embodied intersubjectivity on the one hand and an open presence in the world on the other.

COVID-19 as a global pandemic has disrupted these two modes of sociality (and many others) and, in doing so, has exposed the fundamental contradictions of our existence. By making ourselves comprehensible in the world, we draw on structuring principles that both elevate and subordinate, essentialise and deconstruct, and everything that lies between. The pandemic has undeniably revealed just how cruel we have been in this project and how that cruelty makes some of us more ill than others. Following Agustín Fuentes (2019), I argue that, given the breadth and depth of medical anthropology to encompass the numerous threads of the discipline (social, biological, evolutionary, and historical), it can be a key site of productive theoretical and methodological insight into the intersections of the social construction of race, the lived phenomenological experience of racism, and racism's biological presentation as ill health. The problem is that medical anthropologists who do study these intersections are often themselves

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2   I use the term 'strategic essentialism' in the way it was originally intended by Gayatri Chakravorty Spivak (1993).

caught in local confines, and news of their work is slow to trickle out to policymakers and healthcare professionals. Moreover, those that do examine these intersections are often anthropologists of colour. Understanding the relations of racism requires a recognition that epistemology is embedded in particular fields of power that subordinate certain types of knowledge and certain types of knowledge producers. It requires consideration of White supremacy and anti-Blackness and acknowledgement of the ways in which these ideas are interwoven into public health discourse and practice. Moreover, the need for these considerations extends to medical anthropology itself. We need to recognise 'our' own complicity in the production of particular types of knowledge and the subordination of others. My own identity as a Mixed-Race Black woman pivoting on the edges of classification, subject to many representations but claiming few, may provide an insight into the possible reticence among medical anthropologists to fully claim race and racism worthy subjects of study. In contrast, the undeniability of racism's presence, its existential and observable reality, is perhaps unsettling for a discipline still caught in the swing of the nature/culture pendulum.

In this Position Piece, then, I survey the readiness of medical anthropology to broach the intersections of racism, biology, and health that the pandemic has put centre-stage and suggest ways that we can create useful dialogue with policymakers and professionals.

The case of COVID-19 in the UK: Statistics and policy responses

In April 2020, the UK Office of National Statistics (ONS) showed that Black, Asian, and minority ethnic (BAME) people, irrespective of gender, were over four times more likely than White people to die of COVID-19 in England and Wales. Moreover, when the statistics were controlled for socioeconomic status and pre-existing health conditions, the mortality rates were still over twice the mortality rate of White people. A report from the Institute of Fiscal Studies, an independent 'microeconomic' research institute in the UK, highlights this disparity between different ethnic groups. It showed that the number of per-capita COVID-19 hospital deaths is highest among Black Caribbean communities, where it is three times that of White populations. Moreover, once they had controlled for age, gender, and geography, they 'expected' that ethnic minority communities would have fewer per-capita deaths when compared to White British populations. When they were proven wrong by the data, the authors expressed surprise (Platt and Warwick 2020, 3). The evidence instead showed the rates were comparable. For example, after controlling for age and geography, they found that Black Caribbean populations were 1.7 times more likely to die from COVID-19, Bangladeshi

communities were twice as likely, Pakistani communities 2.7 times, and Black African communities 3.5 times (Platt & Warwick 2020).

Given these disparities, we are left wondering whether there are any biological variables that underpin this stark inequality in COVID-19 deaths. In an attempt to explore some genetic and phenotypic aspects of health, the biological anthropologist Gillian Bentley (2020) ultimately concludes that any possible markers that impact on respiratory infection cannot explain the disproportionate rates of COVID-19 susceptibility among BAME communities; we are instead advised to look toward structural violence as the cause (Bentley 2020, 4).

Following news of the disproportionate impact of COVID-19 on BAME communities in the media and elsewhere, in May 2020 the British government launched a review to explore the disparities in both risk of contracting the disease and mortality outcomes. This review (Public Health England [PHE] 2020) also included accounts from BAME communities affected by the disease. Initially scheduled for release at the end of May, the government delayed publication of the final report amid fears that its findings could 'stoke tensions' in the wake of the BLM protests, which were taking place at that time. Following public pressure, the government released the report on 2 June 2020. Although the report confirmed the coronavirus had indeed thrived upon and exacerbated health inequalities, it failed to adequately account for the lived experiences of BAME communities and to take into account BAME people's recommendations for reducing the disparity. Instead, the report assumed the causes to be such things as 'culture' and 'language', and concluded that these differences posed barriers to accessing or understanding healthcare provision (Public Health England 2020, 40). Such conclusions reify the alterity of ethnic minorities, further placing the blame upon them.

Critical medical anthropologists have, for some time now, warned of public health approaches that focus on behavioural models of health that extract communities of colour from their lived realities, communities, ecologies, and the macrostructures that shape them (Harper 2004; Singer 1989; 2014). Instead, the report's framing of the disproportionality stuck to rigid classifications of different minority groups with little attention paid to the disparities within them. For example, within the category of African Caribbean alone there are different sets of experiences at play, such as whether one is first, second, or third generation. Moreover, nowhere in the data is the disproportionate impact of COVID-19 on the 'other ethnic group' or 'mixed' categories given the same coverage as more recognisable nationality-based classifications—and, where they are recorded, huge discrepancies in the data emerge. For example, the ONS report published on 7 May 2020 shows that during the period from 2 March to 10 April, these combined groups accounted for 936 of all recorded National Health Service deaths, putting *us* in third place after

Black and South Asian. In the same report, the ONS's own statistics provide a wholly different picture, with a death count of only 385 for mixed and other groups (ONS 2020, 3). As someone who has had to routinely class themselves as 'other' or 'mixed' in the standard Government Statistical Service harmonised principle,[3] I am left wondering whether this aspect of the disproportionality refers to me too. The woeful failure to discuss this inequality, allow space to self-identify, or to add more nuanced categories to these forms means that a more granular vision of the true extent of the disproportionate impact of COVID-19 on ethnic minorities (in all their forms) is lost.

Many of the over 1000 BAME contributors (e.g., Iacobucci 2020) who supplied evidence and put forward recommendations to the UK government's review on racial disparities in COVID-19 deaths felt it was a whitewash (Stephenson 2020). Further tensions mounted when details of an earlier draft that included a section on how racial discrimination was a contributing factor to vulnerability to COVID-19 had been circulated within government, only to then be excluded from the final draft (Iacobucci 2020, 1). It was again only following sustained public pressure from BAME community groups that the government published a second report containing the excluded data, albeit with the disclaimer that conclusions reached about racial inequality went 'beyond the data'. Even so, health experts commented that the second report presented a more accurate picture of how COVID-19 affected ethnic minorities—for example, Professor Andrew Goddard, president of Royal College of Physicians, released a statement in favour of its findings and recommendations, noting that 'it remains unclear to us why this element of the report did not accompany the earlier [...] review' (Goddard 2020).

It is clear that the first PHE report was framed through the lens of a statistical epistemology that abstracted the multifarious experiences and identities of Black, Asian, and 'other' minority groups, lumping them into the familiar public health rubrics of barriers to access, culture, and language, all of which constitute racist discourses that remove the agency of the very people they ostensibly aim to support.

A full account of why the UK government was reluctant to publish the BAME COVID-19 PHE review in the context of the BLM protests, why it redacted its sections on racial inequality, and why it excluded BAME groups' recommendations is not possible to provide here. Instead, I use the case as a point of departure for exploring tensions between the practice of racism that structures ways of researching, governing, and treating BAME health and the persistent refusal to

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3   This is government guide on how to collect data relating to ethnicity. (Government Statistical Service 2015).

understand the embodied, intersubjective experiences of people of colour in Britain.

Anthropology has had a long connection to medicine—it is and has been the study of different medical systems, articulations of healthcare, health outcomes, and ethnomedical beliefs. The work of critical medical anthropologists, for example, has been exemplary in highlighting the relationships between wider structures of inequality and health outcomes (Singer et al. 1992; Dressler, Oths, and Gravlee 2005). Despite this, there has still been a dearth of work done on theorising racism in the discipline.

Living as a racial minority takes its toll physically. Nowhere have we seen this more clearly than in the disproportionate impact of COVID-19 on ethnic minorities.[4] However, the policy responses to the statistics fell short of recognising the relationship between racism and ill health. Black feminist sociologist Heidi Mirza, in the inaugural webinar for the UK-based Stephen Lawrence Research Centre[5] on 8 June 2020, highlighted how the debate around the statistics had 'essentialised' race into something that is seen to be wrong with 'us' that itself explains why 'we' are more susceptible to COVID-19. Dr Natalie Darko, a researcher based at the Centre for BME Health at Leicester University, pointed while speaking at the same event to the ways in which this exclusion can be shown to be deeply systemic in medical practice: BAME communities, she reminded the audience, have been historically absent in clinical trials. The current medical understanding of the effectiveness and safety of health interventions for BAME communities is generally quite poor,[6] as has been indicated by a number of studies (Hussain-Gambles 2003; Symonds et al. 2012; Gill and Redwood 2013). Additionally, during the height of the pandemic, a decision was made to stop recording race or ethnicity on coronavirus death certificates in the UK, raising further questions about the efficacy of the 'colour-blind' state and its role as a passive bystander. [7]

What is clear is that disparities in disease, diagnosis, and treatment among UK BAME communities extend beyond the confines of the current pandemic and

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4   First highlighted in *The Guardian* and *The New York Times* in 2020 and later in academic journals and in national health statistics published by organisations such as the ONS.

5   Named after a young Black man who was stabbed to death in London by a gang of White youths in 1993. The poor handling of the case by the police initiated a large-scale inquiry into the British police force. Known as the Macpherson Report, it concluded that the police and crown prosecution service were institutionally racist. This report then paved the way for new race relations legislation that placed the first ever legal duty on all public-sector agencies and organisations to tackle race discrimination. In fact, one of my first jobs in race relations involved developing training materials for public-sector organisations on how to implement this new legislation.

6   It is important to recognise that the relocation of many clinical trials to the Global South in recent years does not equate to increased clinical trials with BAME representatives in the Global North.

7   Moreover, racialised treatment of BAME communities stretches beyond the confines of the COVID-19 pandemic. For example, recent studies in reproductive healthcare show how Black women are five times more likely than White women to die due to pregnancy complications (Knight et al. 2019).

collectively contribute to a structural violence towards BAME communities in the UK. Such failings reveal the persistent awkwardness of discussing racism among public health officials, policymakers, and providers, which goes on to obfuscate the true state of health and the true COVID-19 death count among BAME communities. This awkwardness or complicity is a matter of life and death for communities that are disproportionately affected by the virus.

Encouraging a dialogue on racism: A growing contribution from anthropology

Medical anthropology is well placed to address some of the issues of categorisation, but we also need to be vigilant on how we perceive racism in the discipline and begin to claim it as a structuring force in our world. Surveys of how anthropology as a discipline understands racism have revealed a lack of consensus around key concepts. Although this problem has been noted more widely among physical and biological anthropologists (Matt Cartmill and Brown 2003; Marr Cartmill 1998; Gravlee and Sweet 2008; Littlefield et al. 1982), there is a growing literature on this topic among medical anthropologists. Ann Morning (2011) highlights how there is still very little consensus on the constructed nature of race and that neither race nor racism have been presented 'as a lens through which everyday people can make sense of racial stratification' (Morning 2011, 235)—an issue that I argue deserves fuller investigation.

The lack of work done on racism in medical anthropology is perhaps linked to our own awkwardness when it comes to reconciling what appear at first glance to be irrevocable ontologies within the subfields of the discipline.[8] I would argue, however, that the breadth of work medical anthropology is engaged in lends itself well to generating new theoretical and practical questions that can elucidate the historical, social, embodied, and biological entanglements of racism and, in doing so, confront the very questions of essentialism and identity.

Illustrating this capability, Jane Ifekwunigwe and her colleagues (2017) recently carried out a qualitative assessment on the different approaches to race, and by extension racism, among American anthropologists. They aim to go beyond the simple assertion that 'race is a social construct', yet still exhibit the lack of consensus on what 'race' means. In unpacking the various perceptions of race, they categorised them (that is, the perceptions) within the heuristics of 'the constructors', 'the shifters', and 'the reconcilers', and charted those different approaches on a continuum. At one end of the spectrum are the constructors, who

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8   I mention this from the perspective of an anthropologist working in a 'broad-based' department encompassing social, medical, and evolutionary subfields. It suits me to be at the intersections of epistemologies, but this is not the case for everyone.

recognise that race is a social construct and a historical artefact. Toward the centre are the shifters, who build on the constructors by acknowledging the practices of race and add that race is a political tool; a lived social reality; a self-ascribed identity marker; and an ideology that impacts structural, institutional, and cultural racism. Finally, at the other end of the spectrum are the reconcilers, who agree with both the constructors and shifters but further add that race is also informed by and informs biology (Ifekwunigwe et al. 2017, 425). Reconcilers are helping to elucidate the root causes of racial disparities in healthcare delivery and outcomes, and highlight that a radical makeover of medical education on race and racism is long overdue (Ifekwunigwe et al. 2017). This, Ifekwunigwe et al. argue, is because reconcilers highlight how, while the experiences of enduring racism and living within a racialised society have an impact on health, race *itself* does not cause health disparities. This is an important contribution as it embraces the tension in anthropology that Lauren Leve (2011) highlights. For Leve, there is an awkwardness in anthropology that arises from giving weight to self-representations of identity whilst simultaneously revealing the social, economic, and political contingencies that brought them into being (Leve 2011). Instead, I would argue, one can reclaim and reappropriate race as a term that defines a racist ideology rooted in skin colour, just as I have done for myself. By claiming it, we are not giving race credence but challenging the concept as an embodied experience, which is important for those of us who visually straddle identities but still experience racism.

The anthropologists Carol Mukhopadhyay and Yolanda Moses (2014) similarly highlight this tension within the discipline of anthropology as a general 'lack of clarity about what anthropologists mean when they say races aren't biologically real. Biology has played a role in the cultural invention of what we call race … And race, or rather, one's racial designations, socially, can have enormous biological consequences, such as on one's health status' (Mukhopadhyay 2014, 2). Harrison (1995) notes that the problem with the 'no biological race' position has led to the pervasiveness of discourses within anthropology that largely exclude any account of racism from critical debates of difference and instead often prefer terms such as 'ethnicity' as a substitute (Harrison 1995). This substitution further perpetuates the idea of race as a fixed category on and to which things happen, with ethnicity becoming something more fluid (you can have multiple ethnic allegiances, for example). Ethnicity is, therefore, an active concept whereas race is reduced to a passive, indelible, and consequently objectified state of being. Moreover, race and ethnicity are often used interchangeably in health research and, if they are defined at all, these definitions are relegated to the endnotes of articles (Gravlee and Sweet 2008).

As a Mixed-Race race anthropologist, I would argue my positionality is far from indelible or passive, but rather is something that is constantly being altered, represented, and received in a variety of ways. My indeterminacy is both my privilege and my curse in this regard. What it does provide, however, is a lens through which to follow Laura Nadar's call to study the culture of power rather than the culture of the powerless; that is, the culture of the colonisers rather than that of the colonised (Nadar 1974, 289). The field of public health is rooted in power relations that stem back to ancient Greece and Rome and its practices are enmeshed in ideas of civilisation and the role of the state (Porter 1994). As the British Black Studies Professor, Kehinde Andrews, asks in a Channel 4 television interview (Guru-Murthy 2020), why are we so surprised that racism plays such a fundamental part in COVID-19's aetiology?

Adia Benton's (2016) research among humanitarian workers in Sierra Leone provides a useful lens through which to explore the issues facing public health in England. Benton charts the complex relationships within professional humanitarian and development work, which, like health policy response and development, is often situated within particular fields of practice. She shows how the experience of African expatriates working in African countries in which they are not 'native' highlights the ways in which these fields of practice subordinate certain types of knowledge and experience over others. She reveals how White privilege in the humanitarian sector assumes that because of the sector's libertarian 'civilising' roots, all humanitarian workers must share a particular vision of the work they do. Benton highlights the spaces where ideas about the subject requiring humanitarian development deviate from the White Eurocentric ideals of the sector. These spaces, Benton argues, reveal the deeply racist culture of humanitarian development and the extreme precarity of the African expatriate humanitarian workers who are forced to bend to its will. The sites of privilege underpinning this assumption, she argues, are part of a humanitarian racial politics that extracts actors from their lived realities while expecting them to conform to the racist structures of everyday humanitarian professional practice (Benton 2016). Benton's work points to the multiple ways in which racism is experienced and how these may conflict with or contradict the visions of large philanthropic institutions.

Contemporary race theorist Frank Dikötter (2008) argues that racism is not a uniform phenomenon; it is not fixed or static, but rather interactive. And while this is a good starting point, as well as an argument that continues as an established analytical frame in anthropology (see the multiple moralities and multiple responsibilities of Fassin [2011; 2008] and Trnka and Trundle respectively [2017]), it is easy to fall back into the relativist trap of the comparative accounting of difference. It is of course important to recognise that the local provides the unique timbre or accent to racist expressions, but it is not the final destination. The

problem with demarcating difference is that in its extreme it runs the risk of disjoining and deactivating relations between human beings that extend beyond their confines. These extending relations travel deeper into the core of a global racism and the actions of those who challenge it. Thus, the final component of a relational view of race and the practice of racism is that they are entangled in embodied intersubjectivities, both conscious and unconscious, and as such are structured by the interplay of historical inequality and its biological presentations. The contextual manifestations and their implications are only rendered meaningful because they exist as part of wider, more embedded sets of structural relations for which the perpetuation of difference serves. Perhaps it is in understanding racism as relational and as an intrinsic element of the global structures of inequality that we can, as medical anthropologists, understand health inequality among BAME communities and identify the persistence of an essentialised understanding of race, as opposed to a situated one, as the very thing that maintains it.

Conclusion

In this Position Piece, I posit that a relational view of racism is made up of two key interconnecting elements. The first suggests that inequalities relate to interests; dispositions; and ways of thinking about, engaging with and distancing, exploiting and governing, admitting and administering those seen as racially distinct—and, by extension, privileging those who are seen as dominant (cf. Goldberg 2009). We saw this in action in the UK government's PHE response to recording and responding to the adverse impacts of COVID-19 on BAME communities. Moreover, when one unpacks the lived experiences of BAME communities and the various recommendations put forward by the community in the second PHE report, viewing racism as relational becomes even more important. This is because we can begin to talk of *racisms*—the multiple ways in which racism may be articulated and felt. As a Mixed-Race Black woman always feeling betwixt and between possible racial categories, this makes sense to me.

Acknowledgements

under review. Her significant contribution to the study of health inequalities has had far-reaching impact. In honour of this, I have kept my use of the present tense when referring to her work because, for many of us, it will live on in our own.

About the author

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