Racism, Xenophobia, Discrimination, and Health 3

Intersectional insights into racism and health: not just a question of identity

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Intersectionality is a useful tool to address health inequalities, by helping us understand and respond to the individual and group effects of converging systems of power. Intersectionality rejects the notion of inequalities being the result of single, distinct factors, and instead focuses on the relationships between overlapping processes that create inequities. In this Series paper, we use an intersectional approach to highlight the intersections of racism, xenophobia, and discrimination with other systems of oppression, how this affects health, and what can be done about it. We present five case studies from different global locations that outline different dimensions of discrimination based on caste, ethnicity and migration status, Indigeneity, religion, and skin colour. Although experiences are diverse, the case studies show commonalities in how discrimination operates to affect health and wellbeing: how historical factors and coloniality shape contemporary experiences of race and racism; how racism leads to separation and hierarchies across shifting lines of identity and privilege; how racism and discrimination are institutionalised at a systems level and are embedded in laws, regulations, practices, and health systems; how discrimination, minoritisation, and exclusion are racialised processes, influenced by visible factors and tacit knowledge; and how racism is a form of structural violence. These insights allow us to begin to articulate starting points for justice-based action that addresses root causes, engages beyond the health sector, and encourages transnational solidarity.

Introduction

Racism exists everywhere, but its effects are specific and personal. An intersectional approach acknowledges that everyone has unique experiences of discrimination, but that these are shaped by wider, overlapping systems of oppression (or, conversely, privilege), such as racism, sexism, homophobia, or ableism.[1–3] Because "we do not live single issue lives", we cannot reduce the study of the health effects of racism to single-issue factors.[4] In this Series paper, we use an intersectional approach to unpack how the health effects of racism and xenophobia are shaped by intersecting systems of oppression, and what can be done about it. Although experiences of racism are context specific, we can seek to understand commonalities and identify pathways to action across different settings, globally.

This is the third paper of a four-part Series focused on racism, xenophobia, discrimination, and health. The first paper discusses the conceptual framework for the effects of racism, xenophobia, and discrimination on health, with some historical context, and the second paper maps out the pathways leading to poorer health outcomes and health inequities. The fourth paper offers more in-depth guidance for how these issues can be addressed within public and global health. The concept of intersecting systems of power (ie, oppression or privilege) cuts across the Series and is the focus of this Series paper.

Using a case study synthesis approach, we collated five global case studies that explored how systems of oppression affect health and wellbeing, how racism

Key messages

- The concept of intersecting systems of power (shaping oppression and privilege) cuts across the Series, and is the focus of this Series paper
- Intersectionality is a useful but underused tool to understand and act on the health effects of converging systems of power and oppression related to racism, xenophobia, and discrimination
- An intersectional approach allows us to go beyond an examination of single, distinct factors, and focus instead on the relationships between overlapping processes that create health inequities
- A case study synthesis approach was used to bring together five global case studies that explored how systems of oppression affect health and wellbeing, how racism intersects with other forms of oppression to shape these outcomes, and potential avenues for action
- Applying an intersectional lens, a number of commonalities relevant to all case studies emerged, including the role of coloniality, separation and division across shifting lines of identity and privilege, the institutionalisation of racism, the visible and tacit ways in which discrimination operates, and the violence of discrimination across all levels
- These insights opened three starting points for change: addressing root causes, engaging beyond the health sector, and encouraging transnational solidarity

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This is the third in a **Series** of four papers about race and health. All papers in the Series are available at www.thelancet.com/series/racism-xenophobia-discrimination-health

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See Online for appendix

intersects with other forms of oppression to shape these outcomes, and potential avenues for action. We selected case studies to highlight different aspects of racism in relation to skin colour, religion, Indigeneity, caste, and ethnicity. The case studies were not designed to capture all aspects of racism and discrimination, but to simply be indicative snapshots of the complex issues at hand. By identifying commonalities and differences across case studies, we can better understand how racism affects health, which will allow us to formulate and implement effective responses.

This Series paper begins by describing intersectionality as an analytical approach, followed by a synthesis of key themes cutting across the case studies. Summaries of each case study are presented in panels, and full case study details are provided in the appendix (pp 1–22). This Series paper concludes with insights on intersectionality-based action to improve global health responses.

An intersectional approach

Intersectionality helps us to examine human experiences as shaped by the confluence of multiple, interconnected

Panel 1: Australia: racism, Indigeneity, and colonialism

This case study examines how Aboriginal mothers continue to be subjected to harmful health and social approaches that draw on racist and patriarchal settler colonial framings. Indigenous women stand at a particularly fraught intersection at which their knowledge, identity, and culture are positioned as contrary to modern Australia. On the one hand, this view casts Aboriginal women as the architects of their own poor health and that of their children, and on the other hand it implies that they are in need of saving through state interventions. An example of this approach includes the disproportionately high rates of forced removal of children from their mothers during the Stolen Generation (1910–70), the Northern Territory Intervention (2007–12), and the ongoing removal of Aboriginal children by child protection services at a rate 9·7 times higher than non-Indigenous children.[14] Racism also culminates in poorer health outcomes and the avoidable deaths of Aboriginal women in health services.

Intersecting axes of oppression

- Settler colonialism: dispossession of Indigenous people from their land, resources, knowledge, and culture[15,16]
- Racism against Indigenous people
- Patriarchy and sexism

Levels at which racism and other forms of oppression operate

- Structural: deep social structuring processes maintain social hierarchies in favour of White, male settlers and consign the Aboriginal mother to the lowest reaches of the Australian social hierarchy, with widespread disadvantage across literacy, education, housing, employment, and poverty[17]
- Knowledge systems: Indigenous knowledge and ontologies are subverted and marginalised—for example, the history and voices of Indigenous people have been sidelined by national higher education curricula[18] and health research[19]
- Institutional: health policy, discourse, research, and service delivery signal the state's benevolent intentions but, in practice, often compound the abasement of the Aboriginal mother (appendix pp 2–5)
- Individual: the body of the Aboriginal mother has a singular and intense intersectional experience resulting in sexual, physical, cultural, and structural violence

Effect on health

- Poorer maternal and child health, including twice as many low birthweight babies born to Indigenous compared with non-Indigenous women, and higher infant mortality (up to 4 times the national rate in the Northern Territory in 2004)[20]
- Premature deaths in the health system, including a maternal mortality rate twice as high as non-Indigenous women;[21] coronial inquiries into their premature deaths in the health system reveal the complicity of the state[22]
- Deaths in custody: Aboriginal women are the fastest growing prison population, and face a disproportionate number of deaths in police custody[23]
- Separation of families through the forced removal of children from their mothers; Aboriginal women face higher rates of child removal by the state[14]
- Long-term, intergenerational psychological sequelae[24]

Potential ways forward

- Aboriginal women can be reframed as agents in their health and wellbeing and as a site of resistance against settler colonialism, racism, and patriarchy; McQuire notes: "our women are not helpless, but on the front lines of battle, and our children are not the objects of neglect but the very reason for fighting in the first place"[25]
- There is a need to further broaden understandings of race, racism, and colonialism as part of the social determinants of health, and how these might undermine research, policy, and service provision
- Indigenous-led health and social services have the capacity to centre Indigenous people and their knowledge and provide holistic culturally sensitive care, putting Aboriginal health in Aboriginal hands[26]
- A steadfast commitment should be made to Black lives, and the recommendations of the 2022 Close the Gap Report should be implemented, focusing on systemic transformation to address racism and protect Indigenous health, wellbeing, culture, and country27,28 specifically, greater attention needs to be paid to priority reform three (transforming government organisations), which seeks to address institutional racism through reforming the relationship between government organisations and First Nations people.

systems of power.[2,5,6] Intersectionality has been used as a tool to understand and respond to health inequities as a result of the interactions between social stratifiers (eg, age, class, ability, gender, geography, Indigeneity, migration status, race, religion, sex, and socioeconomic status) occurring within broader contexts of systems (eg, laws, media, policies, religious institutions, and governments) and structures of power (eg, ableism, ageism, colonialism, imperialism, patriarchy, racism, and xenophobia).[2,3,5,6] An intersectional analysis rejects the notion of inequalities being the result of single, distinct factors, and instead focuses on the relationships between mutually constituting processes that create inequities.[2] Intersectionality also enables us to examine the reverse—ie, the social structures that operate to produce systemic advantage and privilege.[1] Because intersectionality allows us to examine multiple processes simultaneously, it values diversity and respects multiple ways of knowing and knowledge production, and is therefore aligned with transnational feminist and decolonial global health practice.[7,8] Being underpinned by a focus on power and power relations, intersectional approaches have been used to promote social justice and equity. Consequently, intersectional approaches are more than analytical tools, they are tools for action.[9]

To build global insights on the health effects of racism, xenophobia, and discrimination from an intersectional perspective, we asked colleagues from Australia, Brazil, India, South Africa, and Türkiye to develop location-based case studies drawing on their areas of expertise and local knowledge. Author teams in each location reflected on the ways in which different experiences of racism, xenophobia, and discrimination were shaped by intersecting influences, how this discrimination related to broader processes and structures of power, how these experiences were shaped by the historical and contemporary context, and the differential health and social effects resulting from these

Panel 2: Brazil: skin colour and lethal police violence

This case study focuses on lethal police violence in Brazil. Brazil is a country with a long history of racism, expressed, among other ways, through criminal violence, police brutality, and incarceration policies, which preferentially affect the Black population.[29,30] The racial bias connects to generation, gender, education, and social segregation, composing a complex intersectional structure in the conformation of vulnerabilities to lethal police violence in Brazil. In 2018, 75·8% of the victims of homicide and 75·4% of the victims of lethal police violence in Brazil were Black (ie, people who self-identified as Black and Brown, also known as Pardo).[31] In the years 2014 and 2015, three-quarters of the victims of lethal police violence in the city of São Paulo were younger than 28 years according to Municipal Health Department data, or younger than 26 years according to Public Security State Department data. More than half the victims of lethal police violence (58%) had less than 3 years of formal education. In addition to being Black, male, young, and having low education, lethal police violence targets are often residents of peripheral and vulnerable Black areas.[32,33]

Intersecting axes of oppression

- Coloniality: a colonial history influences all aspects of social life, presenting itself in material domination and people's personal experiences
- Racism based on skin colour
- Discrimination based on age
- Gender discrimination and the patriarchy
- Socioeconomic discrimination

Levels at which racism and other forms of oppression operate

- Structural: Brazil carries the legacy of the social and political dynamics of a slave society—for example, current criminal codes and judicial practices reflect racially unequal treatment of Black former slave defendants
- Geospatial: currently, the Black and low-income population living in areas on the urban periphery face the most lethal police violence; the Global Moran Index shows a positive spatial correlation in the distribution of deaths due to lethal police violence and victims' home administrative districts (I=0·25; p=0·001) and a negative spatial correlation between lethal police violence and Human Development Index (I=–0·25; p=0·001)[33,34]
- Institutional: stigma related to young Black men in urban areas is part of a racial selectivity of public security apparatuses, which reproduce centuries of racial oppression against Black people in Brazil; in 2014 and 2015, police were responsible for 6476 homicides in Brazil;[35] in the city of São Paulo alone, 403 cases were reported by the Municipal Health Department and 794 cases were registered by the Public Security State Department
- Individual: racism expressed through criminal violence, police brutality (including lethal police violence) and incarceration policies result, ultimately, in unjust deaths of low-income, young Black men

Effect on health

- Interpersonal violence, including criminal violence and homicide
- Police brutality and lethal police violence
- Mental and physical effect of police violence and incarceration

Potential ways forward

- Intersectionality-informed policies on racism and discrimination in Brazil
- Analysis of social inequities to be carried out in conjunction with a critique of the colonising, capitalist, and globalised system of subordination characteristic in Brazil and other low-income and middle-income contexts
- Including multidimensional social analyses in health inequalities research

interactions. Using group discussions, workshops, and online analysis, we drew out common themes from the five case studies, building an intersectional analysis of how racism, xenophobia, and discrimination affect health. In the analysis we captured four key factors: intersecting axes of oppression; levels at which racism and other forms of oppression operate (eg, structural, institutional, geospatial, community, and individual); effect on health; and potential ways forward. The case studies are presented in five panels, with additional details available in the appendix (pp 1–22).

Case studies were developed between April and June, 2020. We met as a large group in June, 2020, to discuss key issues from each context and start to form initial insights. We (KM, GS, ZZ, and RM) undertook the preliminary analysis and validated final insights with the international team of authors in September, 2020.

Case study insights

The themes below exemplify some common ways that racism, xenophobia, and discrimination intersect with other systems of oppression across different global settings

Panel 3: South Africa: xenophobia, race, and community-led responses to COVID-19

The COVID-19 pandemic shone a spotlight on intersectionality and health in Cape Town, South Africa, where systems of structural and historical oppression are embedded into the very fabric of the city. These issues have played out starkly during the pandemic. A myriad of intersecting social and economic factors have determined people's ability to take steps to protect themselves and their loved ones from COVID-19 and the consequences of a government lockdown aimed at containing the pandemic. Positioned at the front lines, a neighbourhood-level movement of Community Action Networks (CANs) witnessed this pandemic through an intersectional lens.

Intersecting axes of oppression:

- Xenophobia and discrimination based on nationality of origin
- Migration status (documented *vs* undocumented)
- Race and skin colour
- Class
- Coloniality

Levels at which racism and other forms of oppression operate

- Community: in the Gugulethu and Philippi East CANs, the politics of providing support to residents (with separate, sometimes secret, distribution of food parcels required) is carefully navigated to manage tensions between South Africans and foreign nationals; in contrast, residents of more affluent (mostly White) neighbourhoods are able to safely isolate under no threat of food insecurity[36]
- Institutional: the fragility of the health system, characterised by persistent inequity and maldistribution of resources, serves to deepen inequality; in addition, documentation and paperwork is often a way in which marginalised people become further disenfranchised by a system that places untenable demands on people in the name of accountability
- Economic: in the context of massive unemployment in South Africa, much anger and resentment stems from a perception that migrants have taken the low-paying jobs, which are the only accessible sources of income for many working-class Black South African people
- Geographical and spatial: persistent spatial apartheid and xenophobic sentiments were also clear in South Africa's vaccination programme where, despite a policy focus on equity, vaccination uptake was substantially lower in townships and vaccinations were initially available to undocumented people in only one of the country's nine provinces; despite a policy focus on equity, at the time of writing, disaggregated vaccine data was not publicly available, but the inverse care law is probably at play, with racially and socioeconomically marginalised groups (who often have the highest vaccination acceptance rates) the least likely to actually receive vaccinations;[37] in addition, undocumented people were initially unable to access vaccinations due to electronic vaccine data system requirements[38]
- Rhetorical: divisive xenophobic rhetoric is often used to position migrants as public scapegoats, legitimising xenophobic beliefs
- Structural: the roots of xenophobic tensions lie in long histories of settler colonialism, apartheid, and systemic oppression by the capitalist state

Effect on health

- Reduced access to vaccination, health care, and other social services
- Food and housing insecurity
- Social stigma

Potential ways forward

In the context of COVID-19, in which pre-existing forms of marginalisation have been severely intensified, a sensitive and pragmatic approach to intersecting social identities is part and parcel of the community-level support and care fundamental for building a just society from the bottom up.

- Identify the ways in which established forms of marginalisation are intensified by the fragility of the health system (including persistent inequity and maldistribution of resources) and exacerbated by crises such as the COVID-19 pandemic
- Draw on community-level knowledge to better understand how intersecting forms of oppression play out at the hyper-local level, and the best strategies to mitigate these
- Seek out, encourage, and support community-led responses, including alternative accountability practices and models that dismantle, rather than reinforce, barriers to access

to affect health and wellbeing. Although the lived experiences of discrimination are diverse, and we cannot capture all this in a single paper, these case studies show commonalities: how historical factors and coloniality shape contemporary experiences of race and racism; how racism leads to separation and hierarchies across shifting lines of identity and privilege; how racism and discrimination are institutionalised at a systems level and are embedded in laws, regulations, practices, and health systems; how discrimination, minoritisation, and exclusion are racialised processes influenced by visible factors and tacit knowledge; and how racism is a form of structural violence.

History and coloniality

Each case study highlighted the need to understand contemporary experiences of race and racism through a historical lens. Coloniality, the ongoing experience of the process of colonisation, has deeply shaped contemporary race and power relations.[10,11] The colonial power matrix refers to ways that colonisation operates through exerting control over political administration, labour, sexuality and reproduction, and world views.[12,13] The case studies from Australia (panel 1), Brazil (panel 2), and South Africa (panel 3) each show particular aspects of this matrix. The first element—control over political and administrative structures—was evident in the racist colonial logic of the legal system in Brazil and through the enforcement of lethal and non-lethal forms of police violence. The second element—control over labour—was touched upon by the South African case study, which detailed how racist and xenophobic post-Apartheid administrative structures in South Africa resulted in widespread poverty in minoritised groups, competition for scarce resources, and resentment of migrants in the labour force. The third and fourth elements—control over reproduction and world views—are exemplified in the Australian case study, in which the control of Aboriginal mothers over their own reproduction and knowledge was undermined by racist and patriarchal logic (such as White benevolence) in the health and social system that cast them as both the architects of their own poor health and in need of saving. All these forms of colonial power are upheld by systems of authority operating through social and political institutions, including the health system.[13]

Beyond health systems, the production of knowledge in global health and development often reflects a colonial mindset that operates on a hierarchy of knowledge (ie, particular ways of gathering evidence are seen as better than others) and devalues or erases Indigenous health knowledge and ways of healing, leading to a form

Panel 4: Europe and North America: the effect of Islamophobia on access to health care

Deeply rooted in history and geopolitics, religious discrimination in its many forms negatively affects health and wellbeing. This case study focuses on Islamophobia in Europe and North America, but parallels can be found towards people of all religions across the world. Islamophobia—social stigma towards Muslims—is a distinct construct referring to a combination of xenophobia, religious discrimination against those practising Islam, and racism mostly towards people of Middle Eastern or south Asian descent.[44,45] Islamophobia and other forms of religious discrimination deal as much with the perception of people regardless of their faith as they do with hatred of the religion in question.[46,47] In Western countries, Muslim people face an overlap of discrimination because of perceived religion and various marginalising factors relating to migration (including linguistic, cultural, and socioeconomic factors).[47-49]

Intersecting axes of oppression

- Racism based on perceived ethnicity and religion
- Migration status
- Socioeconomic status
- Gender discrimination
- Linguistic and cultural discrimination

Levels at which racism and other forms of oppression operate

- Health system: religious discrimination has an effect at the point of care and through deleterious effects on availability of humanitarian relief, supply of drugs and medical supplies, and health tourism
- Institutional: discrimination is present across traditional and social media, laws, and judicial and criminal justice systems
- State: international bilateral agreements, trade, migration, surveillance, and hate crimes such as arbitrary detention, forced sterilisation, torture, and ethno-religious cleansing[46,50,51]

Effect on health

Islamophobia undermines health equity and affects diverse groups of people in many parts of the world.[44,46,47] The health effects of Islamophobia include:

- Physical health: preterm birth and low birthweight; poorer self-rated health, less physical activity, a less healthy diet, higher BMI; and higher blood pressure and cholesterol[45,48]
- Mental health: internalised stigma and low self-esteem[49]
- Institutional discrimination: reduced access to culturally appropriate health services; surveillance; and arbitrary detention[46,47]
- Violence: interpersonal violence and hate crimes; forced sterilisation; torture; and ethno-religious cleansing[50]

Potential ways forward

- Inclusion and representation of different subgroups of Muslims or Muslim identities in research and policy
- Peer-led support, advocacy, and community building in migrant and religious minority communities

Panel 5: India: caste, gender, and access to safe motherhood programmes

Intersecting systems of oppression at play

This case study focuses on how caste affects access to health care for women from socially excluded groups in India. Janani Suraksha Yojana is a safe motherhood programme that aims to reduce maternal and infant mortality rates through provision of antenatal care, promotion of institutional birth, and extending postnatal care to mothers from low-income families, including from socially excluded groups such as the Scheduled Castes and the Scheduled Tribes. As the lowest in the caste hierarchy, the Scheduled Castes in Indian society have historically faced caste-based social exclusion from economic, civil, cultural, and political rights. Women from this community not only face discrimination based on their gender but also based on their caste identity and consequent economic deprivation.

Intersecting axes of oppression

- Caste and untouchability
- Gender discrimination
- Socioeconomic discrimination

Levels at which racism and other forms of oppression operate

- Individual: Scheduled Caste and Scheduled Tribe groups face direct exclusion due to their so-called untouchability, which leads to social, economic, and political marginalisation[62]
- Institutional: socially excluded households face discriminatory attitudes, denial of admission to health care and medical treatment, and inadequate or poor quality medical treatment that results in poorer health outcomes (appendix pp 9–10)[62,63]
- Geographical: clustering of socially excluded communities in hamlets that tend to have lower levels of infrastructure and less access to health-care facilities (appendix pp 9–10)
- Structural: the structure of the caste system in India is a manner of social stratification that profoundly shapes the way that power and resources are distributed across society

Effect on health

- Access to care: lower access to institutional childbirth (78·3% for Scheduled Caste groups *vs* 82·9% for upper caste groups)[64]
- Poorer maternal and child health outcomes, including the prevalence of severe anaemia (Scheduled Castes 1·3%; Scheduled Tribes 1·2%; and upper castes 0·7%) and infant mortality (Scheduled Castes 45·2; Scheduled Tribes 44·4; and upper castes 32·1 per 1000 livebirths; appendix pp 9–10)[65]
- Lower life expectancy: Scheduled Caste men live 11·4 years less than upper caste men, and Scheduled Caste women live 14·6 years less than upper caste women (appendix pp 9–10)

Potential ways forward

- Availability of primary health care and Anganwadi Centres in the Scheduled Caste hamlets along with recruitment of health-care service providers from socially marginalised communities
- Development of administrative rules to enforce health visits to Scheduled Caste localities and houses
- Framing of regulations (and administrative guidelines) against discrimination faced by Scheduled Caste mothers in various forms in terms of accessing health services
- Conduction of public awareness campaigns against discriminatory practices

of epistemic injustice.[13,39] The devaluation of local knowledge further erases or devalues experiences of people who are minoritised and contributes to the normalisation and perpetuation of harmful practices.

Contemporary global public health discourses such as the social determinants of health rarely consider the long-standing processes and modern day consequences of coloniality, and what they mean for the health experience and outcomes of individuals today (including access to culturally appropriate, high quality, affordable health care).[40] Ahistorical approaches to health policy, service delivery, and research that neglect the role of coloniality are problematic, and risk contributing to adverse effects on health outcomes for people most affected. To address this issue, there is an opportunity to include an understanding of history and coloniality in the social and structural determinants of health, and to embed this understanding in health research, policy, and service provision.[40,41]

Separation and hierarchies

Case studies highlighted how separation and hierarchies occurred across shifting lines of identity, as a consequence of cultural, historical, and political forces. Central to separation and hierarchies was othering, the construction of differences between groups of humans and the differential allocation of power and resources to these groups, and the naturalisation of these differences through social hierarchies.[42,43] Othering was most prominent in the case study on Islamophobia (panel 4)—over centuries, group differences have been constructed based on religious identity and used to justify systematic discrimination, persecution, and other forms of violence. This othering has translated to substantial health and social harms, particularly for people living in continental Europe and North America.

Although the drivers of inclusion or exclusion are sociopolitical in nature, they often manifest spatially.[52] In the case studies from Brazil (panel 2), India (panel 5), and South Africa (panel 3), the localisation of health and social disadvantage within or on the outskirts of low-income and minoritised groups in urban areas were examples of the ways in which intersecting axes of discrimination coalesce to demarcate groups and concentrate vulnerabilities. For example, in South Africa, forced removal of Black

populations from urban areas to rural areas was a key strategy of Apartheid, and the re-urbanisation in the 1980s and 1990s resulted in a spatial apartheid in which Black communities lived in defined informal or semi-formal settlements within or on the outskirts of towns and cities. In Brazil, the disproportionately high rate of lethal police violence against young Black men is concentrated geographically in urban and peri-urban areas of distinct social disadvantage. In India, authors outline the localised nature of caste-based health discrimination, whereby segregation and division have been operationalised through a deeply rooted caste system. In South Africa, authors highlight the effect of settler colonial practices and Apartheid on the continued untransformed spatial segregation of cities. This spatial segregation has ramifications for community health activism in highly unequal urban settings such as Cape Town, South Africa, where xenophobic tensions intersect with other forms of systemic discrimination such as race and class and concentrate health and social vulnerabilities in particular urban areas. The remnants of harmful policies and practice (such as Apartheid and the caste system) manifest in continued physical divisions and the continued geographical concentration of disadvantage. However, most health literature fails to interrogate the structural root causes of why these spatial inequities exist.[53]

Borders have been central to upholding racist hierarchies and driving subsequent health inequities.[54] Historically, borders have been used to contain and constrain socially marginalised groups, such as the creation of ghettos to concentrate Jewish people by force and law in medieval and subsequently Nazi Europe.[55] In the case studies, exclusion of marginalised groups such as Muslim migrants (panel 4) has been underpinned by nationalist rhetoric and the political construction of physical and conceptual borders to demarcate "us" and "them".[56] This divisive rhetoric reappears in different forms during times of crisis: for example, centuries-old antisemitic tropes appeared during the pandemic depicting the global COVID-19 pandemic as a result of Jewish conspiracy, and anti-Asian racism reached shocking levels.[57,58] The role of bureaucracy in upholding boundaries is apparent in the South African case study, in which systems of accountability and documentation serve to exacerbate health and social vulnerabilities by placing untenable paperwork demands on people seen as outsiders to prove their "worthiness" to access vital services. Furthermore, divisions were often exacerbated under conditions of scarcity, whereby minoritised groups were pitted against each other to compete for scarce resources without addressing underlying drivers of poverty and marginalisation.

Institutionalisation

The institutionalisation of racism and discrimination occurs at a systems level and is embedded in laws, regulations, practices, and social systems.[59–61] Institutionalisation is often shaped by a pervasive colonial mentality. In our case studies, the institutionalisation of racism and discrimination was evidenced by: the normalisation of police brutality and lethal violence against young, low-income Black men in Brazil (panel 2); the subjugation of Indigenous Australian women in health and social systems (panel 1); the abuse and disrespect of Indian women from socially excluded groups, rooted in the idea of these women being "untouchable" (panel 5); and the exclusion of Muslim people from health systems in North America and Europe (panel 4). In South Africa, migrants face health and social discrimination "at the hands of a clumsy and archaic bureaucracy, as well as the often inherently xenophobic interpretations of policies and legal rights" (appendix p 14; panel 3). These systems subconsciously bias people by imparting messages about who matters, and in turn who is worthy of respectful treatment.

Specific to health, systemic racism is instilled through professional training and education, with the conditioning and learning of Whiteness (and maleness) as the norm. Systemic racism assumes superiority individually, ideologically, and institutionally of one group over another.[66] Thus, proximity to Whiteness becomes the idealised standard. In Australia, medicine and health institutions were instrumental in aiding the racial state and federal policies to "breed out Blackness".[67,68] Aboriginal children were forcibly removed from their families and communities to erase their Aboriginality, causing substantial intergenerational trauma.[68,69] Discriminatory practices such as these have substantial implications for health and wellbeing, affecting health outcomes such as substance use, mental health, education, living conditions, social support networks, and cultural identity.[68–71] In India, upper caste groups were considered superior and faced less discrimination and fewer barriers to accessing health care within the health system. Individuals from privileged identities might not perceive themselves as racist or discriminatory, but can still benefit from systems that privilege their identity (eg, White, upper caste, citizen) over others (eg, non-White, lower caste, undocumented migrant).[1]

Understanding institutional and systemic injustice and oppression in its various manifestations—and the historical roots of these systems—is important. When systemic or institutionalised injustice remains unspoken or accepted, an unethical culture of implicitly privileging particular groups is fostered. However, when individuals and groups point out systemic injustice and inequities, the dominant culture is made accountable, worth is shared, and we are able to grow as a society.[66]

Visibility and the body

Discrimination, minoritisation, and exclusion are racialised processes, influenced by visible factors of skin colour and religious customs, and through tacit knowledge of individuals' and groups' caste, migration status, and

ethnicity. These divisions are shaped by intersecting identities of gender, age, and socioeconomic status, as well as institutions and structures that uphold racist norms.

Both visible and less visible attributes can be used to form stereotypes that can contribute to fear and false perceptions, perpetuate othering of particular population groups, and lead to exclusion from the health system. The social stigma, xenophobia, stereotyping, and racism towards Muslims can be amplified by visible markers of identity, such as women who wear a hijab or burqa in public.[72] Some people who look or dress differently for cultural reasons might also face discrimination based on visible factors even if they do not identify as Muslim. This conflation of race and religion has been deemed problematic for those profiled under this blanket generalisation. The health effects of Islamophobia are extensive (panel 4): literature shows a range of adverse physical and psychological health effects from religious stigma, discrimination, and stereotyping.[73–75]

It is difficult to interrogate aspects of visibility and racist discrimination without also recognising the central role of the body as a site of struggle "in which social constructions of differences are mapped onto human beings".[76] The body is the primary means through which people express themselves externally as community members and political actors.[76] Conversely, the body integrates various signals—physical, mental, and social—from various levels of one's surrounding socioecological context, biologically embedding a particular pattern of exposure to privilege or oppression, which determines individual health and, in turn, determines the patterns of health and disease that occur in response to racism at a population level.[54,77] As such, it is argued that the structural determinants of health are in fact not distal, but are "intimately encountered and embodied, day in and day out".[54]

The body, as the locus of political control[78] and colonisation,[79] was recognised in numerous ways through the case studies. For example, in India, constructs of touchability and untouchability have patterned societal relations for centuries. Health care, by its nature, is focused on control and treatment of the sick body. Under a positivist biomedical model of disease, practitioners look to discover and fix a pathology, to map the distribution of illness, or to count the number of bodies inflicted by a particular pathology.[80] This model neglects the complexity of lived human experiences and the ways in which these are historically, politically, and socially constructed. A purely biomedical focus on fixing a pathology might cause more harm than benefit—and confer a form of violence on the body—if an individual's experiences, preferences, and values are not taken into account.

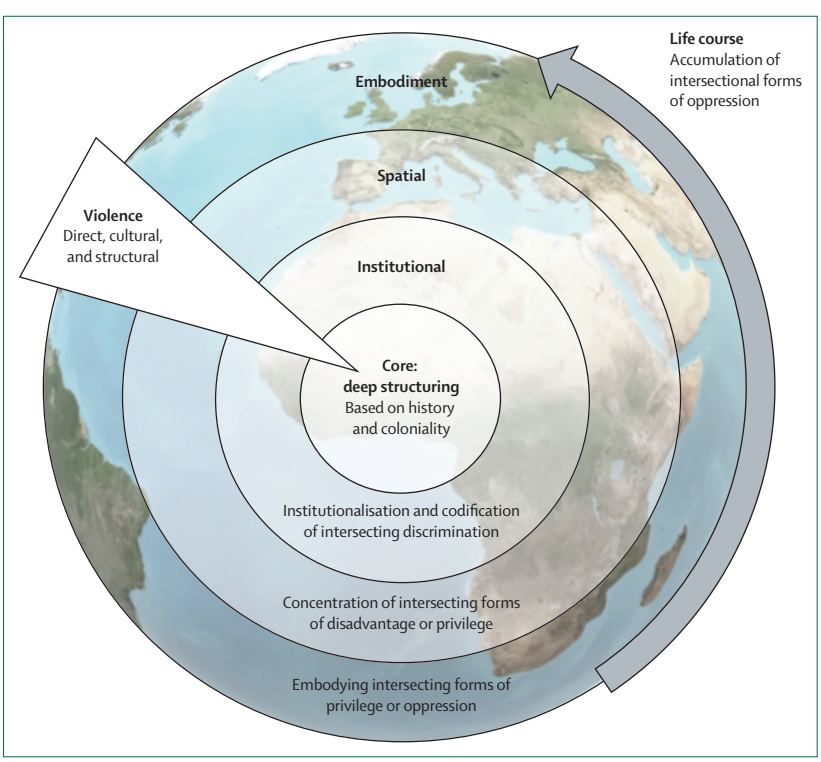

Figure: **Racism as an intersectional system of oppression**
The diagram represents a socioecological system, with different forms of intersectional oppression operating at or across each layer. At the core of the model is deep structuring, linked to history and coloniality. Next is the institutionalisation of intersecting forms of discrimination. Subsequently, spatial concentration of intersecting privilege or disadvantage. On the outside of the sphere is embodiment of intersecting oppression. These forces accumulate over the life course. Violence (direct, cultural and structural) cuts across each layer.

Violence

Violence—direct, cultural, and structural[81]—was at the centre of all case studies. Direct forms of violence occurred within a broader environment that facilitated violent norms and behaviours. For example, authors discuss overt police violence disproportionately affecting young Black men from poor urban areas in Brazil. This issue was shaped by a broader culture of violence in Brazil that facilitated police violence. Likewise, the contemporary experience of violence by Aboriginal women in Australia was shaped by historical protectionist policies that facilitated state violence against Aboriginal people.[82]

Violence was also structural in nature, operating through institutions and systems to uphold divisions or impede those who needed services from accessing them.[53] The occurrence of structural violence was evident in South Africa, where state actions—including withholding of services for undocumented migrants—contributed to xenophobic tensions and, in turn, perpetuated a cycle of violence and xenophobic attacks. The failure of the South African Government to uphold basic conditions for its citizens bred resentment of migrants, who are considered a threat in the context of competition for scarce resources. In the health system, structural violence affected the health and wellbeing of women from Scheduled Castes throughout their pregnancies. Women from Scheduled Castes might be kept in socially segregated or unfurnished spaces, receive less attention from trained professionals, face verbal or physical abuse, encounter staff who refuse to

touch their newborn babies for cleaning and immunisation, and face higher out of pocket expenses (appendix pp 9–10).[63] Further, health-care centres themselves are often positioned outside of Scheduled Caste residential areas, further restricting access to and use of care. Similar structural violence at the health system level based on religious stigma was described in the case study on Islamophobia, highlighting barriers to access to care including more limited access to prenatal care and screening tests among Muslim migrants in North America and Europe.[45,48,83]

Discussion

The case studies show some commonalities in the ways that discrimination and minoritisation operate to affect health and wellbeing. The figure outlines these processes as an intersectional system of oppression. At the core of this system is the deep structuring practices influenced by history and colonialism (eg, how a colonial logic was used to establish a social hierarchy based on imposed categories of race, gender, language, and Indigeneity). Subsequently, racism and intersecting patterns of power relations are institutionalised and codified into political, legal, educational, and other institutional practices. These power relations are reflected in the health system, which implicitly upholds a particular social hierarchy based on the intersections of race, ethnicity, caste, gender, sexuality, ability, and other social identities. Next, discrimination and oppression manifest spatially through the concentration of advantage or disadvantage in geopolitical areas. Spatial discrimination also includes the imposition of borders and the use of bureaucracy to demarcate groups seen as worthy or unworthy of resources or power. The surface level of the figure represents the body and any visible attributes. Beneath the skin, the body integrates complex signals from the wider environment across all layers of the socioecological system. The entirety of these signals are embodied by each individual in unique ways, and the culmination of these influences across the life course sets the trajectory for health or illness. Cutting across all levels of intersectional systems of oppression is violence. Intersectional theory emerged from studying violence against women of colour.[6] Although the most apparent manifestation of racism is direct physical violence, a more pervasive violence of inequity and discrimination occurs across each layer of the system, culminating in health and social disadvantage. This process is known as structural violence, the social (ie, economic, legal, and political) structures that prevent individuals or groups from achieving their full potential.[81] In this way, intersecting forms of injustice at all levels of the socioecological system that lead to ill health or health inequity can be conceptualised as forms of structural violence.

Intersectional approaches are justice oriented and have been used to promote practical action.[7] In this Series paper, intersectional learning about racism and health has allowed us to make sense of a complex issue to begin to articulate solutions. Intersectionality helps to identify the most powerful people and the most vulnerable people in each context and the deeper reasons behind this hierarchy, to begin to mitigate and rectify vulnerabilities. Using an intersectional analysis, case study authors highlighted a number of inroads for effective intervention, including: focusing on intersectional stigma and discrimination as a framework to develop programmes to prevent lethal police violence and support civil and humans rights (Brazil); using an ecosystem approach to change, in which complementary actions target different levels of the health system to shift discriminatory norms and practices (India); and promoting alternative futures through place-based community support networks, which promote solidarity, care, and mutuality (South Africa). The fourth paper of this Series focuses on actions to remedy the health effect of racism and xenophobia. Here, we articulate some starting points for health and justice-based actions.

Action across borders

Through the turmoil of the last few years, we are seeing emerging actions to address racist and colonial systems, underpinned by a rise in popular awareness globally. This awareness is exemplified by Black Lives Matter, a transnational movement articulating a global decolonial, antiracist vision.[84,85] However, transnational struggles against racism are not new; Black and minoritised activists have long recognised the connections between various forms of racialised oppression, including that of colonial rule, and have leveraged international alliances to support antiracist struggles throughout the 20th century.[85,86] These international movements have been informed by grassroots initiatives, often led by Black and working-class women.[85–87]

Focus on root causes

These radical visions have not necessarily translated to mainstream global health and development initiatives. In fact, it has been argued that the imposition of technocratic solutions has served to further entrench globalised health inequities. Neocolonialism refers to the use of foreign initiatives such as conditional aid to advance the interests of wealthy nations, often worsening the divide between high-income and low-income countries and continuing systems of exploitation rather than rectifying them.[88,89] More recently, the Millennium and Sustainable Development Goals have articulated a vision of a fairer and healthier world, but have been criticised for neglecting root causes of inequities, ignoring power, and sidelining local and Indigenous knowledge.[90–92] Antiracism interventions in health such as workplace unconscious bias training can also be criticised for addressing the surface manifestations of racism without tackling the roots of racist systems or transforming power differentials.

Ultimately, unjust differences in morbidity and mortality will not be reduced by simply improving access to services or promoting health education—the entire system needs to be understood and changed. Beyond single issue

analyses, authors suggest tackling the root causes of oppression in conjunction with a critique of the colonial, capitalist, and globalised system of subordination.

Engaging beyond health

Although our research focused on health, our results signal the fact that understanding and addressing racism from an intersectional perspective requires going beyond the field of health to engage wider perspectives. Health is created and upheld by factors within and outside of the health system: it is a political choice, shaped by interlocking social and structural determinants, which are influenced by historical and geopolitical events, which in turn shape institutional cultures and individual and community behaviours. Health is merely one institution plagued by structural racism: a comprehensive antidote to racial health disparities will require collaboration across sectors of housing, education, transportation, criminal justice, and environmental justice. A structural approach is required to make lasting change.

Conclusion

In this Series paper, we drew on five case studies to understand how intersecting systems of oppression affect health and wellbeing, and what can be done about it. Although experiences of racism are context specific, there are commonalities in how racism operates to affect health and wellbeing, including the role of coloniality, separation and division across shifting lines of identity and privilege, the institutionalisation of racism, the visible and tacit ways discrimination operates, and the violence of discrimination across all levels. Often, health services and research fail to interrogate the structural root causes of why health inequities exist and to situate analyses historically, politically, and structurally. Unjust differences in morbidity and mortality will not be reduced by simply improving access to services or promoting health education; it is the deeper patterns of injustice that must be first understood to be changed.

Contributors

The analysis was led by GS, KM, ZZ, and RM. Case studies were led by national author teams: CW and DS in Australia; MTC, MFTP, and MVR in Brazil; MM and NS in India; LB, MR, PS, SV, and EW in South Africa; OK in Türkiye; and BE and AS in the UK. DD provided conceptual oversight and editing. The author team comprises 18 people of whom 15 identify as women. Between us we hold 11 nationalities and originate from low-income, middle-income, and high-income countries. Our group comprises academics, activists, clinicians, implementers, and community network representatives. Members of our team identify as Indigenous and First Nations people, as migrants, and as belonging to minoritised communities.

Declaration of interests

DD is the co-founder and lead of the Race & Health collective within UCL. DD is a recipient of the Wellcome Trust grant on climate and racial justice (grant number 24687/Z/21/Z). All other authors declare no competing interests.

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