Extraordinary times call for extraordinary measures. We are facing a global pandemic, a climate catastrophe, an imminent recession and possibly depression. The health of the most vulnerable, and all of humanity is at stake. But there is nothing new, extraordinary or unprecedented about racism, xenophobia and discrimination. The killing of Mr George Floyd, on the back of numerous other deaths of Black Americans at the hands of the police,¹ and the 2-4 times increased mortality risk for minoritised ethnic groups from COVID-19² have brought to light social and structural injustices that have existed for centuries and are derived from the same intersecting systems of oppression. When a single act of violence is captured and amplified on social media, much like the televised US civil rights protests of the 1960s, it brings police brutality into the consciousness of people across the world. It elicits a visceral response and humanity joins together in condemning racism. However, police homicides are a daily occurrence in parts of
the world, and the people who die are usually poor, young, men from othered groups. When it comes to violence, race and gender intersect. This means that Black and minoritised women are at higher risk of sexual and intimate partner violence and Black trans women are over-represented in hate crime murders. Society is built on racial hierarchies, established through colonisation, that pervade structures, histories, politics and ultimately minds. Overt acts of violence are surface-level symptoms of structural and cultural forms of racism that extend far deeper. Under this lies a pyramid of abuse, marginalisation and injustice that exists in every society. The forms of discrimination and the targets may vary: in some societies they are based on race or ethnicity, in others colour, caste, religious beliefs, Indigeneity or someone’s migratory status. However, the underlying oppression that caused these injustices to occur are largely similar. Racism and xenophobia are about division and control, and ultimately power. Together they constitute a structural form of violence that results, at the extreme, in innocent people being murdered.

The COVID-19 outbreak has uncovered a crisis in our social and political fabric extending beyond the outbreak itself: an uncomfortable propensity towards racism, xenophobia and intolerance exacerbated by transnational health challenges and national politics. Internationally, we have witnessed the vilification of particular nationalities, with overt forms of sinophobia. Politically, xenophobia has been weaponised to enforce border controls against particular nationalities and undermine migrant rights. In the UK, minoritised ethnic groups are more likely to contract a COVID-19 infection and, subsequently, face a higher risk of a severe form of illness. Why is this? People from minoritised ethnic groups are more likely to work as key workers in frontline jobs that expose them to SARS-CoV-2, and are more likely to live in overcrowded accommodation, meaning social distancing is not an option. They are then more likely to have barriers to accessing health services, meaning that they present late in a worse condition, and with a higher probability of have underlying illnesses that put them at greater risk of death. In some cases, the existence of these comorbidities lowers the chances for intubation
and ventilation, resulting in a double burden of being more prone to be severely unwell and less likely to receive intensive care.\textsuperscript{9} Beyond these proximal causes of ill health, lie racism and structural forms of discrimination. Marginalised groups are disadvantaged in all the social determinants of health. However, racism is more than this, it is a fundamental cause of ill health.\textsuperscript{10} At all socioeconomic levels, people of colour have poorer health outcomes.\textsuperscript{11} Racism cumulates over the lifecourse leading to activation of stress responses and hormonal adaptations, increasing the risk of non-communicable diseases and biological ageing.\textsuperscript{12} This trauma is also transmitted intergenerationally, and impacts the offspring of those initially affected through complex bio-psycho-social pathways.\textsuperscript{13} The root of these ‘biological causes’ is racism, not race itself. Society is unwell. The symptoms - of racialised violence and excess morbidity and mortality in minority ethnic populations - reflect the cause: an unjust and unequal society. Scientists and doctors, by remaining technocratic and a-political, are complicit in perpetuating discrimination. As a health community, we must do more than simply describing inequities in silos, we must act to dismantle systems that perpetuate the multiple intersecting and compounding systems of oppression that give rise to such inequities and injustices. To this end, we are producing a series of academic papers to centre the complex challenges of racism and xenophobia in the health discourse. We are working with a diverse team of academics and activists globally to highlight injustices, identify solutions, and enact change. Alongside this, we are launching the Race & Health movement,\textsuperscript{1} a multi-disciplinary community of practice of health professionals, academics, artists, and individuals that will continue beyond the social media. Our vision is to provide a catalyst in tackling the adverse health effects of racism, xenophobia and discrimination. Academic outputs on their own are irrelevant. We must use the evidence to

\textsuperscript{1} https://raceandhealth.org/
advocate for change and improvements in health. In this spirit, we are launching a global consultation, asking: What should we do? And how should we do it?

Racism kills, and this is a public health crisis we can no longer ignore. As a health community, where were we? As the hashtags disappear and we start to emerge from the pandemic, even in ordinary times, we need extraordinary measures.

Word count = 891

Conflicts of interest
None

Ethics approval
Not applicable.

Author contributions
DD, SS and GS wrote the first draft. All authors interpreted and critically revised the draft.

Funding
There is no funding for this work.

References
1 Edwards F, Lee H, Esposito M. Risk of being killed by police use of force in the United States by age, race–ethnicity, and sex. Proc Natl Acad Sci U S A 2019; 116: 16793–8.
2 White C, Nafilyan V. Coronavirus (COVID-19) related deaths by ethnic group, England and Wales - Office for National Statistics. Office for National Statistics. 2020; published online May 6. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020 (accessed June 8, 2020).
3 BBC News. Five people a day killed by Rio police in 2019. BBC. 2020; published online Jan
23. https://www.bbc.com/news/world-latin-america-51220364 (accessed June 8, 2020).

4 Stockman JK, Hayashi H, Campbell JC. Intimate Partner Violence and its Health Impact on Ethnic Minority Women [corrected]. J Womens Health 2015; 24: 62–79.

5 Human Rights Campaign. Violence Against the Transgender Community in 2019 | Human Rights Campaign. Human Rights Campaign. https://www.hrc.org/resources/violence-against-the-transgender-community-in-2019 (accessed June 9, 2020).

6 Larsson P. Anti-Asian racism during coronavirus: How the language of disease produces hate and violence. The Conversation 2020; published online March 31. http://theconversation.com/anti-asian-racism-during-coronavirus-how-the-language-of-disease-produces-hate-and-violence-134496 (accessed June 8, 2020).

7 United Nations. COVID-19: UN counters pandemic-related hate and xenophobia | United Nations. https://www.un.org/en/coronavirus/covid-19-un-counters-pandemic-related-hate-and-xenophobia (accessed June 9, 2020).

8 Platt L, Warwick R. Are some ethnic groups more vulnerable to COVID-19 than others. Institute for Fiscal Studies, Nuffield Foundation 2020. https://www.ifs.org.uk/inequality/chapter/are-some-ethnic-groups-more-vulnerable-to-covid-19-than-others/.

9 Overview | COVID-19 rapid guideline: critical care in adults | Guidance | NICE. https://www.nice.org.uk/guidance/ng159 (accessed June 7, 2020).

10 Phelan JC, Link BG. Is Racism a Fundamental Cause of Inequalities in Health? Annu Rev Sociol 2015; 41: 311–30.

11 Williams DR, Priest N, Anderson NB. Understanding associations among race, socioeconomic status, and health: Patterns and prospects. Health Psychol 2016; 35: 407–11.

12 Bécares L, Nazroo J, Kelly Y. A longitudinal examination of maternal, family, and area-level experiences of racism on children’s socioemotional development: Patterns and possible explanations. Soc Sci Med 2015; 142: 128–35.

13 Krieger N. Measures of Racism, Sexism, Heterosexism, and Gender Binarism for Health Equity Research: From Structural Injustice to Embodied Harm-An Ecosocial Analysis. Annu Rev Public Health 2020; 41: 37–62.