‘Black African’ identification and the COVID-19 pandemic in Britain: A site for sociological, ethical and policy debate

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Abstract
This paper is a narrative review of the use of collective terminology in relation to race and health in Britain, with particular reference to the ‘Black African’ community. ‘Black Africans’ have been categorised in the 1991–2011 censuses with added free-text in 2021 in response to user demand. However, the UK government is increasingly reporting data for the ‘Black’ pan-ethnicity, especially in the even more generalised ‘BAME’ (‘Black, Asian and Minority Ethnic’) acronym in COVID-19 pandemic reports. The consequences of this practice are addressed. Firstly, with respect to ethical challenges, Black Africans find their conscription by government into the term BAME offensive and do not accept it as a self-descriptor. This labelling, which subsumes Black Africans’ self-assigned ethnicity in the census, and consequent misrecognition may be interpreted as a micro-aggression (a term coined in the 1970s but used here to denote microinvalidation), as suggested in the current black activism of the ‘Black Lives Matter movement’. Secondly, ONS has warned that concealed heterogeneity renders the pan-ethnicities unreliably crude, making them scientifically inaccurate. Analysts are recommended to present ethnic group data for the full census classification where possible for reasons of validity and respect for the patient as arbiter of their ethnic group.
INTRODUCTION

The vocabulary of identity is crucial to the way we live our lives. Recognition by others is formative for such identities, that is, identification as, say, a ‘Black African’ or as gay or as a woman. Theoretical work on identities frequently invokes the concept of ‘agent autonomy’, through which the subject is enabled to conceive and pursue projects, plans, and values (or ‘life scripts’). This core idea connects to debates about structure and agency. Our choices are both constrained and constituted by social practices. As Charles Taylor puts it, a self only exists and an identity only emerges within ‘webs of interlocution’ (Taylor, 1989: 36): our actions belong to the practices that shape them and endow them with meaning and these practices may be the product of institutions and practices external to the self. Thus, sociologists talk of the mutually constitutive character of agency and structure and the recursive nature of their interactions. Appiah (2005: 107) frames the issue thus: ‘…we make up selves from a toolkit of options made available by our culture and society. We do make choices, but we don’t, individually, determine the options which we choose. To neglect this fact is to ignore Taylor’s “webs of interlocution,” to fail to recognise the dialogical construction of the self and thus to commit what Taylor calls the “monological fallacy”.

Ethnic/racial identities are interactional in their construction, processes of group identification and social categorisation being mutually implicated in each other. With respect to ‘race’, it is the ‘external moment of identification’ (Jenkins, 1996) that is important, that is, how other people see us, public image rather than self-image. In other words, racial identifications involve ascription and imposition – a matter of social categorisation – rather than the self and group identifications of ethnicity. Some other distinctions have been recognised. ‘Race’ is widely seen as based mainly on the visible – physical or phenotypical characteristics – while ethnic differences are based on cultural cues. Both ethnicity and race are now widely regarded as socially constructed, standing in opposition to biologically based conceptions of ‘race’. Some scholars choose to dismiss the differences and use ‘race’ and ethnicity interchangeably or submerge one in the other.

However, the structural aspects of status – frequently arising from ‘race’ as a visible marker of status – may be moderated by the interactional world of identity. This may result in a set of complex ethical challenges when identities seek recognition but the failure to name them proves divisive and exclusionary; when terminology offends through ‘lumping’ identities together, especially when such conscription is without consent; and when terminology excludes by virtue of perceived coverage, historical associations with racism, or for other pejorative reasons.

Twenty years ago, the author (Aspinall, 2001) wrote in the pages of this journal about the challenges of operationalising the collection of ethnicity data in studies of the sociology of health and illness. One of the challenges identified was ‘…the role of the State in the creation of what some commentators have called “fictive unities,” categories… which, although only partially and situationally meaningful to people thus labelled, are nonetheless employed by them in their dealings with officialdom’ (Aspinall, 2001, p. 835). This kind of abstraction, constituted in its recognition by categorisers (as opposed to ethnic group members), tends to be broad and summary as a descriptor and to conceal substantial heterogeneity. The paper also noted a growing consensus of opinion that rejected the term ‘race’ in favour of ethnicity.
At the turn of the millennium, the acronym ‘BAME’ (Black, Asian and Minority Ethnic) had not entered the lexicon of vocabulary used in the UK Parliament, as recorded in Hansard, the full-text official report of all Parliamentary debates, and there were between only 1 and 5 instances of the use of ‘BME’ (Black and Minority Ethnic) annually between 1987 and 1999. There was nothing to indicate that the use of these particularly capacious ‘fictive unities’ would increase exponentially during the first two decades of the new millennium to 138 in 2016 (BME) and 463 in 2020 (BAME). Other collectivities specifically termed ‘fictive unities’ (Werhner, 1991, p. 115), include ‘non-white’ (covering the same population as BAME), ‘black’, ‘Afro-Caribbean’, ‘Asian’ and ‘Islam’, all salient in the UK. The term has also been used in other national contexts, for example Ella Shohat (2002) references ‘Middle Eastern women’ and ‘Latin American gays/lesbians’. Moreover, these acronyms are much more distant from the communities they describe than other collective terminology, surveys showing that scarcely any respondents recognised the acronyms or knew what they stood for. At a lower level of aggregation than the acronyms, pan-ethnic labels like ‘Black’ and ‘Asian’ (racial categories in all but name) were infrequently used by officialdom at the turn of the century, the detailed advice from the Office for National Statistics being to use the granular 16 2001 Census categories: now these pan-ethnicities predominate. In 2001, the Black Lives Matter movement was a dozen years in the future and race was being superseded in the health literature by ethnic group.

The contours of self-defined identity and categorisation externally ascribed (i.e., identification more widely) are frequently brought into sharper relief at times of national crises. Commencing in spring 2020 the UK experienced a major outbreak of COVID-19 (coronavirus) which, by June 2020, had led to the highest excess mortality in Europe. As early as March 2020, commentators were pointing out that minority ethnic communities were being disproportionately affected and a similar picture was emerging in the United States. The first analytical studies showed that the risk of being diagnosed with COVID-19 and of subsequently dying was higher in those in ‘Black, Asian and Minority Ethnic’ (BAME) groups than in White ethnic groups. This paper tracks ‘Black African’ identity (as one of several possible examples) from its first recognition in the Great Britain decennial Census of 1991 to the increasing use by government of pan-ethnicities or collective terms, including ‘Black’. The sudden onset of the COVID-19 pandemic led to a marked increase in the use of terminology that identified the minority ethnic communities in broad, all-encompassing labels: prominent in the concealment or absorption of the Census ethnic options into substantially larger entities or collectivities, were these acronyms ‘BME’ and ‘BAME’. With their rise, recognition transferred – along with power – from distinctive populations like ‘Black African’ to the overarching BAME collectivity catalysed by government, with the consequent erasure of distinct ethnic identities, including cultural Africanness.

**METHODS**

The study uses the method of narrative review to identify relevant literature on the use by government and others of collective terminology, notably the extremely broad BAME and BME acronyms, and its ethical and policy consequences. This is examined with particular respect to Black Africans in Britain. The Web of Science, Science Direct, Scopus and POPLINE databases were searched (including most recent entries), using keywords and Boolean search algorithms encompassing collective terms and acronyms for ethnic groups (‘BAME’, ‘Black, Asian, and Minority Ethnic’, ‘BME’, ‘Black and Minority Ethnic’); terms for the Black African population (‘African’, ‘Black African’); and the ‘Black Lives Matter’ movement (‘Black Lives Matter’, ‘BLM’). Searches were also undertaken on the Office for National Statistics (ONS), Gov.uk, UK Parliament’s Hansard, and UK Government and
Parliament Petitions websites. The findings of these searches were analysed with particular reference to ethical and policy issues.

With respect to theory, the paper draws on Jenkins’ (1996) basic model of the internal-external dialectic of identification that proposes that group identities (as constituted by members of the group) and social categories (the collective external definition by others) are mutually implicated in and feed back upon each other. With respect to ‘race’, that is, the pan-ethnicities, it is the ‘external moment of identification’ that is important, that is, how other people see us, public image rather than self-image.

RESULTS

Recognition of ‘Black African’ in the decennial census

In the 2011 England and Wales Census, ‘Black Africans’ numbered almost one million (1.8% of the population), larger than the ‘Black Caribbean’ and ‘Other Black’ populations combined. Yet this rapidly growing population group with origins in the UN Development Programme’s listed 46 of Africa’s 54 countries listed as ‘sub-Saharan’ – projected to increase to 2.09 million by 2031 (Coleman, 2010) – was catered for by a single predesignated category in the last three decennial censuses (1991, 2001, and 2011).

The acquisition of an ethnic group question in the 1991 Census – including the tick option ‘Black African’ – followed an extensive programme of field trials and tests commencing in 1975 (Sillitoe & White, 1992). All these tests had a discrete ‘African’ category, except designs tested in October 1986 (‘Black, West Indian or African’) and July 1988 (‘Black’). The 2001 England and Wales Census introduced a new structure that comprised five section headings, that for ‘Black or Black British’ embedding the tick box options of ‘Caribbean’, ‘African’ and a free-text ‘Any other black background’. This structure was retained in 2011, the section ‘Black/African/Caribbean/Black British’ hosting the categories ‘African’, ‘Caribbean’ and open response ‘Any other Black/African/Caribbean background’ categories.

Between 1991 and 2001, the ‘Black African’ group increased in size by 94% and, again, doubled (100%) over 2001–2011. This rapid growth led to a demand among users of census data during the 2000s for a breakdown of this heterogeneous category. The responses to the consultation on 2011 Census topics in England and Wales (Office for National Statistics, 2006) revealed concerns with the term ‘Black African’ that were primarily about masked heterogeneity, as submissions from around a dozen bodies consistently illustrated. For example, the Archbishops’ Council of the Church of England argued that: ‘consideration should be given to the sub-division of the African category to give information on backgrounds in, for example, Somalia, Nigeria and West Africa’. The Census Development Programme carried forward the option to provide the ‘Black African’ category with a free-text box so people could write in more information about their ethnic group. The ONS investigated the feasibility of this option through its ‘Prioritisation Tool’ (ONS, 2009). It took the decision that a maximum of two new categories could be added to the 16 asked in the 2001 Census ethnic group question, out of the 22 candidates that had been identified, including ‘African plus write in’. Seven criteria were selected, and each was scored as low, medium or high level of evidence and with an unweighted and weighted overall score (the criteria relating to the adequacy of write in answers and other census information were given a weighting of 2.5). On this basis ‘African plus write in’, ranking third, only just missed out on inclusion in the 2011 Census question for England and Wales.

As the 2021 Census approached, the candidacy of ‘Black African’ was again on the agenda with respect to its concealed heterogeneity. Again, following a consultation exercise, ONS conducted a
prioritisation evaluation to consider the strength of need for eight requests for new tick boxes (HM Government, 2018). Four tick boxes were taken forward for consideration once the strength of user need evaluation was completed, including ‘Somali’. A series of focus groups followed which included Somali and Black African participants. A ‘Somali’ tick box was seen as unacceptable by Black African and British groups, and by some Somali participants with higher levels of literacy, though in general Somali participants would identify with it. For Somali participants, the ability to identify as African was also important. After further testing, it was decided that in the 2021 Census the ‘Black African’ category will have a dedicated free-text field to capture its diversity, a decision long overdue given the substantial concealed heterogeneity in this category.

Recognition of ‘Black African’ in the 1991 Census (and retained in the 2001 and 2011 Censuses) was a major step forward. Further, the addition of a ‘Black African’ free-text field in the 2021 Census should yield the more granular data requested by census users. However, the identification of ‘Black Africans’ in policy debates on health and health care has been more circumscribed, as they have become increasingly subsumed in overarching collective terminology, thereby putting at risk the gains in the decennial census. Nowhere has this been more conspicuous than in government reports on the impact of the COVID-19 pandemic on minority ethnic groups.

The use of collective terms that conceal Black African identity

A major reason for this neglect of the Census options has been the increase in popularity in government departments of acronyms that describe the minority ethnic group population in collective terms. BME (Black and Minority Ethnic) began to gain traction in the early 1980s and, during the period 1987-2020, was the most frequently used collective term in the UK Parliament. However, ‘BAME’ (‘Black, Asian and Minority Ethnic’) recorded its debut in 2004 and, following an upward curve from 2013, displaced ‘BME’ in 2020. A search of the GOV.UK portal (the website for UK government Departments) revealed that, for records published during 2010–2020, results for ‘BAME’ substantially exceeded ‘BME’ (529 vs. 251), making it the government’s collective term of choice for minority ethnic groups. This collective terminology subsumes ‘Black Africans’ in a Black group that is, itself, enfolded into the roomy ‘BAME’ label along with Asians and other groups that are not White.

The growing use of ‘BAME’ has evoked a response from the African community and the wider Black group in Britain in the form of official petitions. Some of these have been supported by African organisations, such as Alt-Africa (born out of a film project with an aim to target African diaspora audiences), and the Afro-Europe Forum, on the grounds that ‘the BAME tag clouds the complexities and issues of individual communities’. In the 4 months, June-September 2020, a total of ten petitions had been submitted to the UK Government and Parliament requesting the banning or review of the term ‘BAME’. Two are live, and the remainder have been rejected (UK Government & Parliament, 2020). A number of these concerned BAME’s encompassing of ‘black’. The petition, ‘BAME does not accurately represent Black people’s needs’, argued that the acronym obscured the real needs of the Black community: ‘When other groups outside of the Black community are included in the same narrative, or considered for employment or for influential positions, it gives an inaccurate representation of Black people that are actually in the quota’. Another petition, to ‘Remove Blacks from the BAME category [as] this type of grouping disadvantages Blacks’, made a similar argument: ‘Black people are put at a disadvantage by being grouped in this way, as organisations can meet their diversity quotas without ever hiring or including any Black people of African/Caribbean descent … organisations can and do on paper claim to have a diverse culture while purposefully excluding persons of African/Caribbean descent which is currently the case’.
Astonishingly, all five petitions submitted in June 2020\(^5\) were rejected on the grounds that ‘the Government’s guidance on writing about ethnicity already states that it does not use BAME or BME for a number of reasons’. The disingenuousness and evident falsity of the statement derives from the fact that this guidance relates only to the work of the Race Disparity Audit, a small unit in the Cabinet Office, and not to government as a whole.

This concealment of African origins in the BAME acronym has led the UK-based African identity campaign group, The African Or Black Question (TAOBQ), in association with The African Coalition, to launch an attack on the BAME terminology ‘which has attained an unprecedented ubiquituousness in its use especially in the current discourse on the disproportionate manner in which COVID-19 is affecting particularly non-Europeans in Britain and elsewhere’ (Black History 365, 2020). This challenge has included the coining of the alternative acronym AAME (‘African, Asian, and Minority Ethnic’). Claudia Webbe, member of parliament for Leicester East, chose to use this novel term on several occasions in the UK Parliament in 2020, asking the prime minister what he intended to do about the disproportionate impact of coronavirus on AAME communities (House of Commons, 2020). Such usage is redolent of how ‘cultural Africanists reject the term ‘black’ because they believe it strips members of the African diaspora of their African roots’ (Modood, 1994).

There has also been an increasing tendency in data reported by government to use the five section headings or pan-ethnicities in the 2011 England and Wales Census (‘White’, ‘Mixed/multiple ethnic groups’, ‘Asian/Asian British’, ‘Black/African/Caribbean/Black British’, and ‘Other ethnic group’) rather than the 18 ethnic group or background tick box options. For example, this is typical of the government’s Race Disparity Audit’s full set of dimensions (some indicators have more than one dimension) drawn mainly from published data (UK Government, 2020). While ‘Black’ is mentioned 373 times in the dimensions, ‘Black African’, ‘Black Caribbean’ and ‘Black Other’ are referenced only 146 times each (that is, a rate only 39% of that of the pan-ethnicities). Many other reports are now using ‘Black’ instead of the three options, such as NHS workforce statistics.

‘Black African’ Identification and the COVID-19 Pandemic in Britain

The rapid increase in the use of ‘BAME’ by government has nowhere been more conspicuous than in the focus by the Department of Health and agencies over recent months on the greater risks experienced by Black and Asian groups in Britain in the COVID-19 pandemic. One recent Public Health England report on the impact of COVID-19 mentioned BAME 217 times without defining the term other than spelling out the acronym (Public Health England, 2020a). It referenced ‘BAME populations’, ‘BAME groups’, ‘BAME communities’, ‘BAME people’, ‘BAME households’, ‘BAME staff’ and ‘BAME’ as a noun. In a preceding review of disparities in risks and outcomes (Public Health England, 2020b), PHE used BAME around a dozen times in one short chapter. This usage counts as what Ian Hacking (1986) termed ‘kinds of person’, brought into being by the creation of labels for them. It elevates the deployment of the term to the status of bureaucratic institution, with the cachet of normality and authority.

The concealed heterogeneity in terms like ‘black’, ‘BME’ and ‘BAME’ and uncertainty about which groups they capture has resulted in a fragmented and partial picture of the experiences of the ‘Black African’ community in the pandemic. When ONS released COVID-19 related deaths by ethnic group for England and Wales, ‘black’ males and females, when compared to the White group, had the highest age-adjusted rates (odds ratio, 3.3 and 2.4, respectively) and fully adjusted (odds ratio, 2.0 and 1.4, respectively) rates (ONS, 2020).
In Public Health England’s publication on disparities (PHE 2020b), the dozen ethnicity indices for COVID-19 outcomes were all reported for the ‘black’ pan-ethnicity. Only two specific measures were provided for Africans: in the period 21 March to 8 May 2020, the number of death registrations from all causes for migrants in England, when compared to the same period for the average of the years 2014 to 2018, was highest (4.5 times higher) for those born in Central and West Africa. Being born abroad may incur additional barriers in accessing services related to language and cultural differences. Only an analysis of survival using multivariate modelling was reported for the granular ethnic group categories. The second Public Health England (2020a) report makes extensive and ubiquitous use of the ‘BAME’ acronym to report the findings of a rapid literature review and stakeholder engagement exercise.

Thus, in these public health reports, the risk status of Black Africans is masked by the data for overarching collectivities like ‘black’ and BAME. Studies by researchers and independent research institutes have presented a more nuanced and informative picture of the impact of COVID-19 on minority ethnic groups through the use of the granular census categories, rather than the large and somewhat abstract labels of government. Platt and Warwick (2020, p. 2) argue: ‘Analysis of ethnic disproportionalities in health outcomes that aggregates groups together masks much of the story with regards to ethnic inequalities, and limits the scope for understanding why they have come about. Moreover, simply comparing mortalities with overall populations fails to take account of key characteristics of different groups that we would expect to lead to different outcomes in the aggregate, such as demographics and place of residence. Accounting for these factors is necessary to understand the true scale of disproportionalities as a starting point for thinking about policy responses’.

The need to disaggregate collectivities like ‘Black’ applies to both the epidemiology of the coronavirus pandemic and the factors contributing to greater risks among minority ethnic groups with respect to morbidity and mortality. Aldridge et al., (2020) used NHS data on patients with a positive COVID-19 test who died in hospitals in England from 1st March to 21 April 2020, undertaking indirect standardisation of these data. After adjusting for age and geographical region, an increased risk of death (standardised mortality ratio) was found for Black African (3.24; 95% CIs 2.90–3.62), Black Caribbean (2.21; 95% CIs 2.02–2.41), Pakistani (3.29; 95% CIs 2.96–3.64), Bangladeshi (2.41; 95% CIs 1.98–2.91) and Indian (1.70; 95% CIs 1.56–1.85) minority ethnic groups. Similarly, after taking account of the role of age and geography, Platt and Warwick (2020) reported that Black African hospital fatalities are 3.7 times as high as those of the White British group, Pakistani deaths 2.9 times as high and Bangladeshi deaths twice as high. The Indian, Black Caribbean and ‘Other White’ ethnic groups also have excess fatalities, compared with the White British group.

With respect to the factors that might have contributed to the adverse outcomes of COVID-19 in minority ethnic groups, the use of statistical collectivities like ‘BME’ and ‘BAME’ may be concealing important differences with respect to risk exposures. For example, PHE (2020a, p. 21) report findings that in the BAME community ‘overcrowding can lead to increased COVID-19 transmission as individuals within the household are unable to effectively self-isolate’. However, 35% of Black Africans were living in overcrowded accommodation, based on number of rooms, in 2011. This was the highest proportion across all 18 Census categories and twice that for Black Caribbean (18%) (Aspinall & Chinouya, 2016).

Similarly, this report also states that ‘individuals from BAME groups are more likely to work in occupations with a higher risk of COVID-19 exposure; this includes the health and social care workforce, as well as cleaners, public transport workers and retail workers’. This ‘could potentially … lead to an increased risk of Covid-19 transmission, morbidity, and mortality’ (PHE, 2020a, p. 16, 22). This suggested enhanced risk has recently been confirmed by an antibody seroprevalence study (Ward et al., 2020). Essential workers, especially those with public-facing roles, had increased
seroprevalence. Persons working in residential care facilities (care homes) with client-facing roles had a prevalence of 16.5% (95% CI 13.7, 19.8) and healthcare workers with patient contact a prevalence of 11.7% (95% CI 10.5–13.1), with 3-fold (3.09; 2.51, 3.80) and 2-fold (2.09; 1.86, 2.35) odds of infection, respectively, compared with non-essential workers. These odds place Black Africans at particular risk. In the 2011 Census, the Black African group had one of the highest proportions (53%) of men in low-skilled occupations, along with Pakistanis (57%) and Bangladeshis (53%). These figures compared with 37% of men in the general population. 39% of Black African women were employed in human health and social work activities, substantially higher than for Other Asian (31%), Black Caribbean (29%), Other Black (27%) and White Irish women (25%) comprising the largest proportions (Aspinall & Chinouya, 2016).

Finally, Black Africans have been disproportionately affected by the COVID-19 pandemic by virtue of where they live. The pandemic has affected London more than any other region. The seroprevalence study (Ward et al., 2020) found the highest prevalence was in London (13%), varying from 2.8%–6.6% in the other eight regions. The 2011 Census recorded that 58% of the Black African population in England and Wales lived in London, a higher proportion than for other minority ethnic groups, but a fall from the 79% recorded in the 2001 Census.

In spite of disproportionate exposure in the pandemic and excess mortality, Alloh (2020) wrote in a rapid response to the British Medical Journal that ‘no study has focussed on Black-Africans and the severity of COVID-19 outcome among individuals from this group … We feel it is time that policy address this long-overdue inequality in health among BAMEs and African population in particular. It should not be expected as normal that these groups are worse hit by COVID-19 or any other diseases’. Only one study has been identified in literature searches that focuses on the experiences of a specific Black African community of descent in the COVID-19 pandemic (Mbiba et al., 2020). Its insights into the experiences of Zimbabwe health and social care workers strongly support an approach that focuses on the diverse ethnic communities concealed in the ‘Black African’ category.

Ethical and Policy Challenges in the context of the ‘Black Lives Matter movement’

A number of sociological and ethical concerns can be identified that relate to the concealment of Black African identities in pan-ethnicities (‘Black’) and collective terms like BME and BAME and are key to the ‘Black Lives Matter movement’. These relate to the use of self-ascribed census ethnic group data that is then mapped to high-level collective identifiers to which the individual ascribing their ethnic group has not consented and therefore labels Black Africans in a conscripted manner. A further concern is the utility for policy purposes of ethnic group data that has been assembled at a higher level of aggregation than the census categorisation.

When Professor of Communication and Ethnic Studies Rachael Griffin addressed an audience at the University of Utah, the University’s Office for Equity and Diversity observed in a post on ‘#BlackLivesMatter and the Politics of Racial Mis/Recognition’ that her scholarship ‘…theorizes #BlackLivesMatter discourses as demands for humanizing recognition that represent a continuation of historicized labour to contest racial oppression. Anchored by the Hegelian assertion that mutually affirming recognition fosters humanisation, these discourses respond to racial misrecognition (e.g. stereotypes, micro-aggressions, stigma, racism) which has profound consequences for people of colour ranging from devaluation to dismissal to death’.¹ Thus, when the ‘Black Lives Matter movement’ is presented as a demand that recognition needs to be humanised and dehumanising misrecognition
eliminated, our society’s inability to respond to these demands presents us with an unsatisfactory marker of racial progress.

This is a view that has been expressed by a growing number of scholars. Madowitz and Boutelle (2014), for example, argue that the use of the term ‘non-white’ is unethical with respect to cultural sensitivity in diverse populations. The possible harms they identify with the definition are that ‘it reiterates the idea that the racial standard in American society is white, and therefore, all other races should be measured using ‘white’ as a reference point…For a child or adult in the United States, having one’s self defined by not being in the historical ‘in group’ may be harmful for general well-being, as has been discussed in terms of chronic exposure to racism’. They continue: ‘The use of the term ‘non-white’ could be interpreted as ‘racial microaggression,’ a subtle but negative or invalidating interaction involving a person’s race’. Along with other types of racial microaggressions, including ‘microassaults’ (explicit racial derogations of a verbal or non-verbal kind) and ‘microinsults’ (hidden insults to the recipient), these are often a constant part of the affected person’s daily experience. They may have a significant effect on their well-being and participation and contribute, collectively, to processes of structural racism.

This critique of ‘the general concept of ‘white’ as the default and accepted racial category in American society’ (p. 308) is redolent of that of Black British Academics with respect to the collective term BAME: ‘The terms ‘BME’ and ‘BAME’ should be problematised since they homogenise people from a variety of different ethnic and cultural backgrounds and reproduce unequal power relations where White is not a visible marker of identity and is therefore a privileged identity … they mask inequalities as they are experienced by different racialised ethnic groups. The use of these terms reinforces racial inequality by maintaining White ethnic identity as privileged. Since “White” is never named as an identity, it continues to be normative so that people of colour only exist in a marginalised position that is de-centred by whiteness’.2

The texts cited above are part of a wider set of studies that have focussed on inclusive language around race and ethnicity, sociological literature on ‘reflected appraisals’ (individuals’ perceptions of how others see them) (Khanna, 2004) and the theme of racial misrecognition (Aspinall & Song, 2013). Among 65 young people interviewed in the Mixed Race Identities study, 17 interviewees experienced misrecognition and this jarred with how they saw themselves and was a recurring concern in their day-to-day lives. A higher proportion of part-Black respondents (almost half) felt misrecognised than any other mixed group. Clearly, being labelled with a collective term like BAME which members of minority ethnic groups find offensive and not a descriptor of themselves falls within this category of experienced misrecognition and its negative consequences.

A second major ethical and policy challenge concerns the way these issues play out in a UK policy context highlighted by the COVID-19 pandemic. The use of aggregates of census ethnic group/background categories, either in the pan-ethnicity ‘Black’ or other collective terminology and acronyms, is unsatisfactory as England and Wales’s Office for National Statistics (ONS) developed, tested and validated the classification for a total of 18 ethnic groups in 2011 (16 in 2001) – embedded under the five broad sections – and it is to these detailed groups that persons self-assigned their ethnicity. A classification comprising only the five pan-ethnicities was not tested. ONS (2003) has advised users to ‘present ethnic group data in as much detail as possible’, arguing that ‘broad headings such as ‘Asian or Asian British’ will mask important distinctions, such as those between the Indian, Bangladeshi and Pakistani ethnic groups’ and of the need ‘to distinguish between each of these groups wherever possible’. The substantial heterogeneity concealed in each of the sections renders the pan-ethnicities unreliably crude.

An ethical dilemma arises as the majority of datasets that were used by Public Health England to report on ethnic disparities in the COVID-19 pandemic were not ethnically coded. They were
populated with ethnic group from the Hospital Episode Statistics database using record linkage methods: ‘Ethnicity was assigned to all datasets by linking, using NHS number and date of birth, to the latest recording of ethnicity in the Outpatient Hospital Episode Statistics (HES) or the HES Admitted Patient Care data set’ (Public Health England, 2020a, p. 71). These datasets include confirmed cases, hospitalisations, deaths in confirmed cases and deaths compared to baseline mortality rates (excess mortality).

Thus, a patient of ‘Black African’ (or of any other) ethnic group attending as an outpatient or admitted to hospital would self-identify and assign his/her ethnic group as part of the clerking process, on an understanding that such data collection would facilitate their care and perhaps that they had consented to the NHS using this information in research and audit studies. However, the NHS then uses this information to populate ethnic group in a range of other datasets likely to be immediately unrelated to the patient’s care. In so doing this, bureaucratic process will change the person’s self-identified ethnic group from ‘Black African’ to ‘Black’, ‘BME’, ‘BAME’ or something else. Thus, the patient is now identified in a way that is different from their self-assigned ethnic group and to which they have not contributed and for a use unlikely to be known to the patient. This transition or reassignment may result in the patient being described in a way that they find unacceptable or offensive, as noted with Black Africans’ discomfort in being described as ‘black’ or BAME.

The validity and utility of this transition requires scrutiny. Collective terms lack specificity. ‘BAME’, for example, combines 14 census ethnic categories, including four ‘mixed/multiple’ groups. For any one category – such as ‘Black African’ – or even pan-ethnicities like ‘Black’ this acronym with its substantial concealed heterogeneity will be a poor proxy and scientifically inaccurate. For example, where ethnic subcategories concealed within these collective terms systematically correlate with differences in outcomes, these disparities will remain hidden and therefore not amenable to policy interventions to address them. The scale of the heterogeneity will also mean that the acronym, itself, will lack utility and validity as a collective term, a vocabulary embodying large or sweeping generalities. There is also the accompanying risk that the all-embracing differences identified at this level will give rise to stereotypes or ‘naturalised’ racial/ethnic characteristics that will be assumed to apply to all the encompassed groups, whereas, in reality, such differences are meaningless statistical abstractions, ostensibly presented as hard objective averages. Moreover, given the finding that health improvement interventions are most effective when targeted on granular categories and ‘the type of ethnic groups captured by intervention efforts appeared to be tied to the spaces they occupied’ (Liu et al., 2012, p. 108), the use of the census ethnic categories should be prioritised.

CONCLUSION

Over the last two decades, our language to describe minority ethnic groups has changed at an unprecedented rate. The acronym BAME had not registered in official sources at the turn of the millennium. Two decades later, it is the government’s term of choice, despite widespread hostility from minority ethnic communities and a substantial lack of understanding of what the acronym stands for. The mainstreaming of the term has been catalysed by Public Health England’s ubiquitous use of the acronym in the context of the COVID-19 pandemic. Such terminology is characterised by its exteriority, ascribed by categorisers rather than derived from group identifiers. It also exemplifies the role of the State in the creation of ‘fictive unities’, manufactured collectivities that lump together multiple ethnic group identities and cultures. Such usage has resulted in the erasure of specific ethnic identities like ‘Black African’ and has precluded investigation of the separate issues they face. The language of BAME offers a convenient shorthand for those who are discriminated against by virtue of their
physical appearance, but such administrative usage is at the cost of confusion, ambiguity and a lack of understanding. Moreover, it raises serious ethical issues for members of minority ethnic communities who find such terminology, into which they have been conscripted, unacceptable and offensive. While ‘Black Lives Matter’ is theorised as a demand for humanising recognition, the use of this unfortunate terminology may be seen as mislabelling, stereotyping and dehumanising misrecognition.

ACKNOWLEDGEMENTS
I am grateful to the reviewers for their informative comments.

AUTHOR CONTRIBUTION
Peter J. Aspinall: Conceptualization (lead); data curation (lead); formal analysis (lead); investigation (lead); methodology (lead); writing–original draft (lead); writing–review and editing (lead).

DATA AVAILABILITY STATEMENT
All data cited in the report is available in data extract format to other researchers.

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ENDNOTES
1 ‘#BlackLivesMatter’ and the Politics of Racial Mis/Recognition. Accessed at: https://www.nowplayingutah.com/event/blacklivesmatter-politics-racial-misrecognition/.
2 Black British Academics. Racial Categorisation and Terminology. Accessed at: https://blackbritishacademics.co.uk/about/racial-categorisation-and-terminology/.

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How to cite this article: Aspinall, P. J. ‘Black African’ identification and the COVID-19 pandemic in Britain: A site for sociological, ethical and policy debate. Sociology of Health & Illness. 2021;43:1789–1800. https://doi.org/10.1111/1467-9566.13317