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Between Post-Racial Ideology and Provincial Universalisms: Critical Race Theory, Decolonial Thought and COVID-19 in Britain

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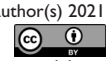

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Abstract

This article looks at the British government's handling of the first wave of the coronavirus pandemic. We argue that to analyse the government's handling of this situation, we need to synergize insights from critical race theory (CRT) with decolonial thought. CRT shows how the pandemic has revealed and exacerbated racial inequalities within Britain, while these inequalities are then explained away through a post-racial ideology. Contrastingly, decolonial thought helps us to understand how Britain practises western and little Englander universalisms; neglecting other countries' successful strategies of handling the pandemic, as they seek to pursue a 'world-beating' strategy to defeat the virus rather than help forge a global solidarity.

Keywords

COVID-19, critical race theory, decolonial thought

For a 'Synergized' Approach to COVID-19

There is a growing interest in the differences between the sociology of race and decolonial thought (Magubane, 2013). We further refine this debate by bringing together insights from decolonial thought with an approach *within* the sociology of race: critical race theory (CRT). We label this 'both and' approach to CRT and decolonial thought as an example of theoretical synergy; a practice that builds collaborations between theoretical paradigms rather than hierarchizing or synthesizing them.

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We put this synergy into practice by considering the British government's handling of the first wave of the COVID-19 pandemic. We argue that CRT shows how the pandemic has exacerbated inequalities within Britain's racialized social system, while these inequalities are then explained away through a post-racial ideology. Through this post-racial ideology, the disproportionate COVID-19 death rate of Britain's racialized minorities is explained away as being the result of 'biological' or 'cultural' factors, rather than being the outcome of unequal material arrangements. We display this reality through focusing on how governmental policy to understand and tackle the COVID-19 death rate of racialized minorities – ranging from the Public Health England (2020a) report on this topic through to the government's multi-million pound 'influencer' scheme – focused more so on supposed cultural and biological rather than *material* factors. Contrastingly, decolonial thought helps us to view Britain's handling of the pandemic in a more transnational manner. In particular, decolonial thought sheds light on how Britain disregarded the Global South's successful responses to the virus through an assumption of western universalism, while a 'little Englander' universalism also led them to disregard other western nations' successful strategies due to the unrelenting belief in British exceptionalism. We display this reality through focusing on the British government's attitude to policies such as lockdowns, face coverings and test and trace.

Epistemic Allies? Decolonial Thought and CRT

While there is a growing interest in the differences between the sociology of race and decolonial thought, there is less conversation between decolonial thought and CRT as a paradigm *within* the sociology of race (Meghji, 2020a). This is partly due to the empirical, conceptual and methodological differences between CRT and decolonial thought. Of course, both decolonial thought and CRT have wide conceptual nets and encompass multiple traditions. For fruitful comparison and synergy, we define CRT via the racialized social systema approach (Bonilla-Silva, 2017), while we are approaching decolonial thought via the 'modernity/coloniality' school (Quijano, 2007).

Conceptually, CRT and decolonial thought disagree over the centrality of colonialism and empire to present day inequalities. Decolonial thought uses the notion of 'coloniality' to stress the continuity of colonial relations. 'Coloniality' refers to how the epistemic and material power relations set in motion during the age of European colonialism still shape the present world (Grosfoguel, 2007). Contrastingly, CRT seeks to study contemporary racism outside of its colonial foundations, moving beyond 'the sins [of the] past (e.g., slavery, colonization, and genocide)' (Bonilla-Silva, 2015: 74). CRT thus stresses that racism only exists because it serves a *contemporary* function with *contemporary* beneficiaries. In order to comprehend this system, we need to analyse its reproduction through specific racial ideologies, practices and contestations that exist beyond colonial legacies (Bonilla-Silva, 2015). This conceptual difference implies a methodological divergence; through studying the 'contemporary foundation' of racism (Bonilla-Silva, 2015: 74), CRT methodologically commits to a presentism. Contrastingly, decolonial thought adopts a much more historical approach, seeking to connect the past realities of colonialism, enslavement and empires with the present day.

Moreover, decolonial thought seeks to forge *spatial* connections which link events in the Global North with happenings in the Global South (and vice versa). In this regard, CRT and decolonial thought have quite different *empirical* scopes. Decolonial thought focuses on the global 'colonial matrix of power', characterized by the material and epistemic domination of the Global South by the Global North (Mignolo and Walsh, 2018). Such a focus shows how events which seem to be benign and liberal in the Global North – such as the emergence of European coffee houses in the 19th century which extended the public sphere, or recent dietary changes in the West towards non-dairy milk substitutes in order to battle climate change – reinscribe coloniality; coffee houses relied on colonial expropriation to acquire coffee in the first place, just as contemporary non-dairy alternatives rely on the exploitation of labour in the Global South (Meghji, 2020b). Contrastingly, CRT studies nationally specific 'racialized social systems', described as particular 'societies that allocate differential economic, political, social, and even psychological rewards to groups along racial lines' (Bonilla-Silva, 1997: 474). The study of these discrete racialized social systems, according to Bonilla-Silva (2007: 192), has to be specific to each nation's 'own racial situations'. While decolonial thought is thus transnational, CRT tends to analyse national racialized social systems outside of their global interlinkages. To this extent, CRT is guilty of a methodological nationalism,[1] described by Go (2009: 783) as the process of 'understanding a "society" [. . .] by looking only within the spatial confines of [. . .] the particular nation-state'.

Of course, despite their inconsistencies it would not be appropriate for us to present CRT and decolonial thought as epistemically hostile to one another. In particular, both traditions of thought are involved in reflexive critiques of academic knowledge production, arguing that *epistemic justice* is a prerequisite for *social justice*.

In CRT, for example, in rebutting what they termed as 'white logic, white methods', Bonilla-Silva and Zuberi (2008: 4) criticized mainstream social science's 'artificial distinction between analysis and analysts'. This CRT critique ties a link between ontology and epistemology, with Bonilla-Silva and Zuberi arguing that the dominant racial group often use knowledge production to rationalize their superior position. Similar to CRT, decolonial thought also links epistemology and ontology. For instance, decolonial thought uses the concept of the 'coloniality of being' to refer to how through colonialism, the colonized were seen to be civilizationally, culturally and biologically inferior to western people (Wynter, 2003). Built into this 'coloniality of being' was also an idea that only this superior western group were 'developed' enough to produce knowledge and critical thought. There was thus an epistemic and ontological link whereby the colonizers, the 'ego conquiro', were construed as the thinking, knowledge-producing subjects, the 'ego cogito' (Maldonado-Torres, 2007).

Furthermore, through their critiques of knowledge production, both CRT and decolonial thought seek to transform wider social relations outside of the academic arenas within which they operate. Thus, both traditions constitute what Collins (2019) refers to as 'critical knowledge projects' in that they believe that through achieving cognitive, epistemic justice, they can also secure material justice. CRT, for example, methodologically emphasizes 'counter storytelling' and scholars of colour 'naming their reality' in order to both '[tell] the story of those experiences that are not often told [. . .] and a tool for analyzing and challenging the stories of those in power' (Solorzano and Yosso, 2001:

475). By similar logic, decolonial thought prioritizes southern standpoints, or 'border thinking' (Anzaldúa, 1987), to centre the critical perspectives of those knowledges and ways of knowing that have been erased or devalued through Eurocentrism.

It is thus not illogical to endorse a pluralism which values both CRT and decolonial thought as disparate traditions. While they have differences, they share the aim to transform epistemic and material inequalities, and while they have different methodological, epistemological and empirical scopes, there is room to use these two traditions in tandem with one another. It is through this relation between CRT and decolonial thought's complementary divergences, as well as through their moments of convergence, that a synergy between the two traditions becomes so fruitful. In this article, we focus on the British government's handling of the first wave of the COVID-19 pandemic to show the benefits of such a synergy.

The Post-Racial Rationalizing of BAME Deaths

> Being Black, or from a minority ethnic background, is a major risk factor. (Matthew Hancock MP, 2020a)

It has been claimed that socio-economic inequality is a 'fundamental cause' of disease, meaning that material inequality – including occupation, housing, poverty and unemployment – are essential variables in individuals' and groups' health (Link and Phelan, 1995). Phelan and Link (2015) and Laster Pirtle (2020) have furthered this argument to claim that if socio-economic inequality is a 'fundamental cause' of disease, and if racial inequality is largely socio-economic, then racial inequality too is a fundamental cause of disease. While this claim was made in the context of the USA, it clearly translates over to Britain, where Black, Asian and Minority Ethnicity (BAME) people are disproportionately represented in poor housing, unemployment, underemployment and poverty (Brynin and Longhi, 2015; Li and Heath, 2020).[2] The financial consequences of the first wave of COVID-19 in Britain exacerbated such socio-economic inequalities. As Hu (2020) shows, in the 'lockdown' between March and July 2020, BAME Brits were 1.2 times more likely than white Brits to experience household income loss during the pandemic. Part of the reason for this exacerbated inequality is that BAME workers were disproportionately located in industries that were closed during the lockdown; indeed, Platt and Warwick (2020) predict that Bangladeshi men are four times more likely, Pakistani men are nearly three times as likely and Black African and Caribbean men 50% more likely than white British men to work in 'shut-down sectors'. Moreover, given the inequality faced by BAME people prior to the pandemic, they were largely not prepared to cope with the economic consequences which they were exposed to; Platt and Warwick (2020) show that only 30% of Bangladeshis, Black Caribbeans and Black Africans had enough savings in lockdown to cover one month of income in case they were laid off (compared to 60% for the rest of the population).

Given this socio-economic inequality, and given that such inequality is a 'fundamental cause' of disease, it is no surprise that BAME people have a disproportionately high COVID-19 death rate. Stats from the first wave suggest that all 'ethnic minority' census groups were more likely to die from COVID-19 than white Brits, with Black people's

death rate being four times higher than whites (Public Health England (PHE), 2020a). Nevertheless, despite the COVID-19 death rate facing BAME people, state institutions have denied that such inequality is emblematic of structural racism.

This dismissal of racism shows the need to bring CRT into our analysis. CRT brings attention to how racial inequalities are rationalized through *racial ideologies*. Racial ideologies are 'the racially based frameworks used by actors to explain and justify [. . .] the racial status quo' (Bonilla-Silva, 2017: 15). The central function of racial ideology, therefore, is 'providing arguments to "account for racial inequality"' (Bonilla-Silva, 2020: 2). When we look at how the higher COVID-19 death rate of BAME people is dismissed (as explored in the following sections), CRT brings attention to the ideology of *post-racialism*. Post-racialism holds that structural racism is a mar of the past which we have now transcended (Meghji and Saini, 2018). Post-racialism does not deny the existence of racial inequality, but – as a frame through which people view reality – allows actors to explain racial inequality away as being the result of non-racist events. The COVID-19 death rate of BAME people is interpreted through the ideology of post-racialism in two main ways: historical displacement and cultural pathologization.

Historical Displacement

Post-racial ideology often displaces 'structural racism' to history. Through this frame, British history is construed as following a path of racial progress, whereby equal opportunities laws from the 1960s to the present day have created a racially equitable landscape. This post-racial historical displacement is evident in Public Health England's (2020a) report on the disproportionate COVID-19 BAME death rate. Thus, the PHE report emphasizes multiple times that a reason for disproportionate BAME deaths is because of *historical* racism:

> Historic racism [. . .] may mean that individuals in BAME groups are less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about Personal Protective Equipment (PPE) or risk. (2020a: 5)

> Historic negative experiences of healthcare or at work may mean that individuals in BAME groups are less likely to seek care when needed or as NHS staff less likely to speak up when they have concerns about PPE or testing. (2020a: 13)

> Historic racism and poorer experiences of healthcare or at work may mean that BAME individuals are less likely to seek care when needed or as NHS staff less likely to speak up when they have concerns about PPE or testing. (2020a: 23)

This temporal displacement occludes the *contemporary practices* reproducing negative health outcomes for BAME people, and through these occlusions, state actors and institutions exonerate themselves from playing any role in racial inequality. For instance, taking the above quotes, we see the PHE report mention that 'Historic negative experiences of healthcare', and 'Historic racism [. . .] may mean that individuals in BAME groups are less likely to seek care when needed.' However, we can respond that it was not an historical but a current reality when Kayla Williams – a Black woman from South

London – died after medical professionals continually dismissed the severity of her COVID-19 symptoms. Such cases highlight a structural problem in the National Health Service's diagnosis procedures.

Similarly, while the PHE report claims 'NHS staff [are] less likely to speak up when they have concerns about PPE', we can question why BAME people are disproportionately represented in 'key worker' jobs (both in and beyond the NHS), which disproportionately expose them to the virus. A report by the Runnymede Trust (Haque et al., 2020) suggests that 34% of Black people, and 28% of BAME people – compared to 23% of white people – are classified as 'key workers'. Moreover, in order to actually get to work, BAME people are more than twice as likely to rely on public transport (which poses a high risk of coronavirus transmission) than white Brits, and BAME people *despite, on average, living in smaller properties than white Brits*, are more than twice as likely as white Brits to live in households of four or more people (Haque et al., 2020). Rather than questioning whether key workers are comfortable to 'speak up' about concerns, it is more prudent to critique the structural relations which relegate BAME people to low-paying jobs, make them more likely to be exposed to the virus in order to get to their job and make them more likely to pass on the virus to household members due to overcrowding.

Furthermore, inside the idea that it is a 'historic racism' which leads key workers being hesitant to raise concerns about PPE and BAME people being afraid of seeking help is a cultural pathologization. It is implied that BAME people's mistrust and scepticism, due to historical events, is to blame for their higher rates of exposure and death *rather than contemporary racism*. Such cultural pathologization follows the path of many previous pandemics.

From 'Coronaphobia' to the Eid Crisis

Throughout history, health crises often get construed as 'moral crises'. Briggs (2005: 273) highlights this when commenting on how racial hierarchies lead to a construction of epi/pandemics 'in such a way that getting cholera or living in an infected neighborhood constitutes natural proof of a moral failure to conduct oneself in a rational, informed manner'. The reality of those towards the bottom of social hierarchies being pathologized for catching a disease is particularly apparent when we consider Sinophobic violence at the beginning of Britain's first wave. As Gao and Sai (2020: 2) show, the rise of Sinophobic violence in February 2020, resulted in Chinese Brits being 'the most common victims' of racist hate crimes; this rise in anti-Chinese violence was fuelled by a cultural pathologization. Discourses of the 'kung flu' and 'Chinese virus', while global in scope, were deployed in Britain to perceive COVID-19 as a *biological* virus that was emergent from Chinese *culture* (Yeh, 2020). This is why, as Gao and Sai (2020) recount, as the coronavirus was spreading in Britain in February 2020, 'western' consumers avoided eating Chinese food from fear that they could catch the virus from poor hygiene practices, while 'maskophobia' meant that those 'perceived to be Chinese people' wearing face coverings were othered by members of the public.

As well as the rise in Sinophobia, we argue that through framing coronavirus as a 'moral crisis', racial ideologies such as post-racialism have been used by state actors to justify the BAME COVID-19 death rate as being a result of this group's own moral

deficiencies. As the Conservative MP Craig Whittaker articulated: 'If you look at the areas where we've seen rises and cases [. . .] it is the BAME communities that are not taking this seriously enough' (BBC, 2020). Through a post-racial pathologization, the structural conditions of BAME people are ignored at the expense of their supposed cultural values and practices. Consider, for instance, the aforementioned PHE report. Rather than focusing on how BAME people are disproportionately exposed to air pollution which weakens lung capacity and increases likelihood of asthma, or their aforementioned poor economic and housing situations, the PHE (2020a: 7–8) report instead focuses on how BAME people are afraid of being tested:

> Fear of diagnosis and death from COVID-19 was identified as negatively impacting how BAME groups took up opportunities to get tested and their likelihood of presenting early for treatment and care. For many BAME groups lack of trust of NHS services and health care treatment resulted in their reluctance to seek care on a timely basis, and late presentation with disease.

Through understanding racial inequality as having 'cultural' roots, this inequality is then understood to be something that can be cured with cultural, not material, solutions. Thus, if the problem of BAME COVID-19 deaths emerges from BAME people's cultural values and practices, then a way to address this inequality simply becomes to change these cultural values and practices. Indeed, the PHE (2020a: 8) report proceeds down this route, proposing to tackle coronavirus' impact on BAME people not through material measures such as improving housing conditions, tackling local pollution or increasing availability of testing in high BAME-population areas, but through 'community programmes' and 'social cohesion': 'Faith communities played a vital role in engaging with communities and were a trusted source of information, leadership and engagement with many BAME groups and needed to be better engaged in future efforts to build community resilience.' The government endorsed this PHE message. This involved, for instance, spending four-million pounds on tailored messaging to BAME Brits to stay at home, advertising 'stay home' messages in 600 publications with high BAME readerships and funding an 'ethnic minority influencer' programme to advertise lockdown messaging (UK Government, 2020a). In the face of BAME people disproportionately dying from coronavirus, despite having no evidence to suggest that such minorities were especially flouting public health guidance, the state prioritized a programme of cultural pathologization more so than a series of effective material restitutions. This reality is also patent when we consider the cultural pathologization of British Muslims.

In the run-up to Eid, for instance, the government made use of their daily 5 p.m. briefings to encourage Muslims to abide to the social distancing rules, with the Chief Medical Advisor Professor Whitty, on 22 April daily briefing, emphasizing: 'People will have to adapt these celebrations – the joyful celebrations – around the current social distancing rules. Everybody knows what those rules are and they remain the same for every community This is to protect the whole community. All communities.' Beyond these public broadcasts, the government also launched a social media scheme titled 'Celebrate Eid at home this year and help control the virus' (UK Government, 2020b). Commentators pointed out the hypocrisy of the government's focus on Eid, given that at the same time

images were circulating of largely white Victory Day street parties, visits to the beach and gatherings flouting social distancing guidelines; indeed, it is also worth noting that the UK government later temporarily relaxed coronavirus guidelines for those celebrating Christmas (aside from those living in 'tier 4' areas). Nevertheless, despite this inconsistency, the government further accelerated their focus on Muslims on 31 July, the eve of Eid al-Adha, when they imposed lockdown restrictions on a series of northern town and cities that had large Muslims demographics (including Greater Manchester, parts of West Yorkshire and East Lancashire), with the health secretary, Hancock, claiming these lockdowns were needed due to 'households gathering and not abiding by the social distancing rules' (quoted in ITV News, 2020). While Hancock denied this was deliberately targeting Muslims, we can wonder why measures were put in place that prevented households from meeting one another in their homes – at a time where many Muslims would want to celebrate with their families – but different households *could* meet each other in indoor restaurants and pubs. While Muslims were not explicitly mentioned in the justification for these local lockdowns, therefore, the timing and application of the policy suggests that 'race looms large in these seemingly nonracial discussions' (Bonilla-Silva, 2020: 3).

As seen in this case of this Muslim-focused social policy, cultural lifestyles are seen as a key dynamic in state understandings of the BAME COVID-19 death rate. Through this focus on cultural lifestyles, moreover, the myth can be reproduced that the high BAME COVID-19 death rate is a consequence of their own *biological* composition – their rates of diseases, diabetes, obesity, diet and so on, all of which relate to their deviant or 'different' cultural lifestyles. At its very extreme, this post-racial rationalization makes it appear as though BAME people simply have a secret 'race gene' that makes them more likely to die of COVID-19. Such reasoning is evident in the many times medical experts, politicians and journalists constantly treat 'race' as an independent variable in their analysis of COVID-19 mortality rates. The PHE (2020a: 23) report, for instance, claims that ethnicity is 'independently associated with COVID-19 mortality', leading to an essentialist understanding of race which enabled journalist Beth Rigby (2020), for instance, to question whether 'BME people [should] be shielding as they are potentially more vulnerable and at greater risk of catching and dying from coronavirus?' Through adopting this essentialist concept of race, the state exonerates itself from providing socio-economic restitutions to those racialized people whose *material circumstances* put them at risk of disease. Thus, in June, Hancock (2020b) already suggested that prioritizing BAME people in a vaccine rollout would be a likely successful policy of addressing the BAME death rate, while the equalities minister Kemi Badenoch reproduced the idea that the problem was 'inside' BAME people rather than their social location by calling on employers to carry out 'risk assessments' of their BAME staff (UK Government, 2020a). Connectedly, underlying such a call for risk assessments was a view that BAME people's cultural lifestyles have certain biological consequences that make them more prone to dying of coronavirus. Such reasoning is adopted in the PHE (2020a) report on BAME deaths, through their claims that diabetes, obesity and high blood pressure put them at higher risk of dying from COVID-19. Even after this PHE report, the same organization reproduced the idea that BAME diets and lifestyles put them at risk of dying from COVID-19 due to high rates of diabetes and hypertensive disease – citing the fact that

Asians and Black people were 43% and 45% more likely than whites to have such comorbidities (PHE, 2020b). Within this post-racial frame, we see how the BAME death rate is construed as being a consequence of 'natural' phenomena – genetics and biology – rather than *material* relations which themselves have 'biological' effects.

Of course, the fact that so many BAME people have died of COVID-19 in Britain is also representative of the fact that Britain – compared to most other countries – has handled the pandemic especially poorly. At the time of revising this article in January 2021, for instance, per capita Britain has the highest infection rate. While CRT enables us to analyse how this poor handling of the coronavirus, with its disproportionate effect on BAME people, is explained away as via post-racial ideology, in order to fully comprehend the state's handling of the first COVID-19 wave through a global, comparative perspective, we also need to incorporate elements of decolonial thought.

Coloniality and COVID-19

Throughout their handling of the pandemic, the British government have stated their approach is 'led by the science'. Inside this claim is the supposition that science is objective and free from political agendas. However, decolonial thought encourages a scepticism of any claim to such epistemic universalism. It is this blind faith in epistemic universalism embodied in Britain's handling of the coronavirus that we focus on in this section, starting with the concept of the coloniality of knowledge.

The *coloniality of knowledge* refers to how the global dominance of the West is partly epistemic – it involves an erasure or devaluation of 'other' ways and forms of knowing and knowledge (Grosfoguel, 2007). Through this western 'epistemicide', the religious, political and cultural beliefs and practices of those in the Global South – including theories of humanism, sexuality, gender and political rights – are recast as merely superstition, 'magic', tradition or pre-modern, rather than being legitimate knowledge systems. Inside the coloniality of knowledge, therefore, is a supposition of western universalism – a supposition that western knowledge systems are supreme.

Within Britain, however, western universalism is only one side of the coin. While Britain was (and is) a key player in the (re)production of western universalism, it simultaneously purports an even more myopic 'little Englander' universalization. While the 'little Englander' label has typically been construed as a foreign policy position, we suggest seeing it as an *epistemic* position. The little Englander spirit produces specific *knowledge* about Britain and Britain's history, whereby Britain is represented as a miniscule island that managed to create a global empire through its unrivalled work ethic, philanthropy and esteemed civilizational values (Gopal, 2019). Moreover, not only does the little Englander position produce knowledge, it also propagates a hierarchy and valuation of *other knowledges*; just as how western universalism implies a superiority of western knowledge, so does the little Englander position imply a superiority of 'British' knowledges.

It is this double-edged sword of both a western and a little Englander universalism which has deeply influenced the British government's handling of the pandemic. In particular, this is visible when looking at Britain's refusal to learn from other countries' pandemic strategies, its pursuit of 'world-beating' technologies at the expense of

transnational solidarity and its consequent prioritizing of individualistic 'liberalism' over the safety of citizens' lives.

Learning from Each Other?

Central to the decolonial ethic is to move away from hierarchizing different epistemic traditions, and instead foster dialogue between divergent traditions to improve our understandings of the world (Grosfoguel, 2007). By contrast, Britain's handling of the first COVID-19 wave involves a reversal of this collaborative ethic.

Take Britain's policies on face coverings. Throughout the first wave, the wearing of face coverings in public was never mandatory in Britain, aside from on public transport and within shops. This is despite evidence that COVID-19 is airborne, and that wearing a face covering can effectively reduce the transmission of the virus (Greenhalgh et al., 2020). Yet, if we look at countries that have kept their COVID-19 death rate relatively low – mostly from the Global South – each of them made face coverings a key priority in the early stage of their response. For instance, Vietnam (with no recorded deaths) and Venezuela (with 89 recorded deaths) mandated the wearing of face masks in public in March, South Korea (with 289 recorded deaths) in May and in Taiwan (with seven deaths) they even created a nationwide app that allowed for citizens to locate where to buy face masks. Indeed, in countries such as China and Hong Kong, face masks were even provided for free so that they were more easily accessible. By contrast, even as face coverings have been made mandatory on public transport and in shops in Britain, the onus is still on individuals and workers to buy these resources themselves.

Part of the reason why it took so long to make it a policy to wear masks in shops is because the British government's insistence that there is 'no evidence' that such a policy reduced the transmission of coronavirus. A key scientific advisor to the government – Professor Van Tam – claimed that the wearing of such masks was based more on South-East Asian cultural norms than any scientifically rational studies (Bloom and Shadwell, 2020), while the World Health Organization's (WHO) executive director claimed that: 'there is no specific evidence to suggest that the wearing of masks by the mass population has any potential benefit' (Howard, 2020). This is despite, for instance, Dr George Gao, director-general of the Chinese Center for Disease Control and Prevention, advising the United States and European countries to mandate face coverings in March (Cohen, 2020). However, it is here that we see the added problem of the 'little Englander' universalism. While the WHO originally dismissed the value of face coverings, and while most European countries endorsed this rejection, the WHO and these other European countries changed their policy upon emergent evidence. The WHO, for instance, revised their statement saying that 'the use of masks, both home-made and cloth masks, at the community level may help with an overall comprehensive response to this disease' (Ting, 2020), while countries such as Germany, Spain, France, Italy, Greece and Belgium all mandated the wearing of face masks in public spaces prior to England. Not only did Britain turn its back on the face-covering strategies endorsed by countries from the Global South, but they equally shunned 'western' approaches.

In the same spirit of thought, we can also consider strategies such as mass-testing, and 'track and trace' systems. In mid-March, the WHO were pushing the motto of 'Test, Test,

Test'. However, Britain largely shunned these calls for such high-testing methods, with the Deputy Chief Medical Officer Jenny Harries (quoted in Staunton, 2020) defending the position that this advice was only for poorer countries:

> The clue for WHO is in its title. It is a World Health Organization and it is addressing all countries across the world with entirely different health infrastructures and particularly public health infrastructures. We have an extremely well-developed public health system in this country and in fact our public health teams actually train others abroad.

Despite insistence that this WHO advice was only for 'less developed' (i.e. previously colonized or non-western) nations, evidence suggests testing was an effective strategy regardless of a nation's wealth. As the WHO pushed the motto of 'Test, Test, Test', South Korea was testing roughly 20,000 people a day for coronavirus; at the same time, Singapore was testing an even greater ratio of their population (Palma, 2020). By contrast, in April, while nations like Germany were ramping up their mass-testing programmes, Britain was only testing around 10,000 people per day and declared that mass-testing was not a priority (Roberts and Donnelly, 2020). Moreover, the nations effectively dealing with the coronavirus with mass-testing programmes also coupled their strategy with effective 'track and trace' methods. In March, for instance, South Korea used GPS phone tracking, surveillance camera records and credit card transactions in order for the Centres for Disease Control and Prevention to issue warnings to the public, in real time, if they had come into contact with an infected person; a similar strategy was used by Singapore in its 'TraceTogether' app. By contrast, while Italy, France and Germany all developed their own iterations of these track and trace apps, Britain claimed it would have one ready in May – and yet it was not released until September (with the help of Google and Apple). Despite the government regularly claiming through the first wave that the app would be 'world-beating', the technology has been riddled with problems including the fact that tracers fail to get in touch with one in eight people who test positive for COVID-19 (Lewis, 2020). These claims of providing 'world-beating' technology, nonetheless, show the next way that myopic universalisms characterize Britain's handling of the pandemic, as they seek to establish themselves as the leading force in the battle against the virus rather than seeking an effective transnational solidarity.

Global Superpower or Global Solidarity? Liberty or Life?

In their handling of the pandemic, the British state turned their back on the possibility of transnational solidarity in their quest to be seen as a global 'virus-fighting' superpower. While Cuba was sending its doctors to countries across the world – from Italy and Azerbaijan, through to South Africa and Andorra – in order to help nations cope with the pandemic, Britain was instead chasing its (non-existent) 'world-beating' COVID-19 track and trace app. Of course, as noted, there was nothing 'world-beating' about this app, but the language of 'world-beating' raises an important question. At a time where thousands of people across the globe are dying, and where 41 African countries collectively have 2000 working ventilators compared to over 150,000 in Britain (Maclean and

Marks, 2020), why does Britain treat other nations as competitors to be overpowered with world-beating technologies, rather than fellow inhabitants of the world that are dying of a pernicious virus?

Asking this question pushes us towards an analysis of the little Englander universalism. The representation Britain has of itself is as a global superpower that brought democracy to the majority of the world – a myth of 'Anglobalization' (Gopal, 2019). Within this myth of Angloblization, Britain is seen as the benevolent fighting-force for good who freed the enslaved (but never played a role in their enslavement), rid the globe of fascism (because the empire did not deny human rights to its colonized subjects) and granted independence to the colonies while incorporating them into a prosperous commonwealth (while never infringing upon their independence in the first place). We saw the driving power of this little Englander universalism in events such as Brexit, where the strong belief in British superiority allowed for political elites to craft a narrative of the EU eroding British sovereignty and self-determination in their project of trying to create a 'country called Europe' (Johnson, 2016). Through this unrelenting belief in British superiority, political elites saw the EU as infringing upon Britain's *freedom* (thus why MP Anne Widdecombe (2019) described the decision to leave the EU as a 'slave revolt'). It is this 'skewed' understanding of freedom, again emerging from a little Englander universalism, that encouraged Britain to turn its back on any possible global solidarity.

Consider Britain's delayed imposition of a 'lockdown'. Since Wuhan was locked down in late January, countries across Asia rapidly introduced similar measures in order to reduce the transmission of COVID-19 – this included both 'full scale' lockdowns but also policies that we saw in South Korea and Hong Kong where large gatherings were banned, educational institutions shut down and public spaces and sporting events were closed off. Eventually, of course, European nations took heed of this requirement to 'lockdown' the public – with France, Italy and Spain all entering this period in early March. Concurrently, however, the British government dismissed these transnational lockdowns as draconian and unnecessary (Channel 4, 2020), with senior members of the government arguing such measures were driven by populist politics rather than scientific evidence (McGuinness, 2020). Indeed, weeks later when the British government decided that a lockdown was necessary, Boris Johnson again referred to the measures as 'draconian'. However, between this first dismissal of lockdown, and the eventual realization that these measures may indeed be effective, the British government left the coronavirus to spread through the country. As per old-school liberalism, while the virus started spreading across Britain in the first wave, the so-called *freedom* from governmental restrictions was thus seen to be more valuable than the actual lives under threat from the virus. Boris Johnson (quoted in O'Donoghue, 2020) directly evoked this concept of liberty when he was probed on the possibility of shutting down public transport across England, replying: 'We live in a land of liberty, as you know, and it's one of the great features of our lives that we don't tend to impose those sorts of restrictions on people in this country.' Again, the link between coloniality and Britain's handling of the coronavirus is evident here. Stemming from the little Englander universalism, Britain has always seen itself as a champion of 'liberty' and freedom – though this 'liberty' has always been unequally stratified according to different valuations of different people's lives. In the

19th century, for instance, Britain construed itself as a champion of liberty through its leading the abolition of enslavement – despite the fact that it was simultaneously accelerating the reach of its empire (Gopal, 2019). Similarly, in the post-war period, Britain saw itself as saving the people of the world from the evils of Nazism, while practising the same 'tactics' as the Nazis on its colonized subjects (Getachew, 2019). Since its construction as an empire, Britain has always claimed to be a defender of liberty and freedom, it is just that the way liberty and freedom are defined has always been provincial, whereby the liberty of a few champions the death of others. This is the same logic that underlined Britain's slow response to the first wave of the pandemic, whereby the most vulnerable members of society – the disabled, the poor, those living in overly crowded homes, the elderly, those with health conditions – had to face the threat or reality of death, such that others could retain their individual liberties.

Concluding Discussion: Decolonial Thought, CRT and the Coronavirus Crisis

The COVID-19 pandemic is an ongoing health crisis. As such, this article has modestly attempted to bring a social scientific perspective to a crisis *which we are still experiencing*. In this respect, we are not attempting any 'reactionary' criticism, but rather a demonstration of how long-standing traditions in the social sciences – decolonial thought and CRT – can have helpful insights into our present situation. We argue that balancing the use of decolonial thought with CRT enables us to tease out national specificities in racialized social systems while embracing a historical, transnational, focus on coloniality.

In this line of thought, we argued that Britain's handling of the coronavirus pandemic displays the need for a synergy between CRT and decolonial thought. CRT shows us how the first wave of the pandemic exposed and exacerbated inequalities in Britain's racial hierarchy, while these inequalities were then explained away via post-racial ideology. This post-racial rationalization involves neglecting the structural arrangements which make BAME people more prone to catching and dying of COVID-19, and instead explains these infections and fatalities as being the result of biological or cultural factors. In a complementary coupling, decolonial thought allows us to appreciate the more historical, transnational dimensions of Britain's response to the pandemic. For instance, such decolonial thought traces how the British state's handling of the pandemic reflects a coloniality of knowledge – characterized through western and little Englander universalisms – embodied in the way that Britain neglected other nations' successful strategies of virus management. Such decolonial thought shows how Britain pursued a 'world-beating' response to the pandemic, at the expense of forging a global solidarity, highlighting how the British state is more concerned with its global status than the status of the globe itself.

While this article has focused on the coronavirus pandemic in Britain, therefore, we hope that its theoretical agenda can be stretched far beyond this empirical case. The COVID-19 pandemic is just one of many events that highlight how we need to balance nationally specific, present-based analysis of social processes alongside an historically informed, transnational lens; using *both* critical race theory *and* decolonial thought in

tandem with one another can offer fruitful pathways for such analyses. There are multiple other social phenomena that require such balanced analysis – from the climate crisis which at once reproduces global and national hierarchies, through to political populisms which draw on both colonial nostalgia and presentist racial ideologies, and western capitalism which requires an exploited proletariat 'at home' just as much as it needs 'edge populations' in the Global South for its reproduction. The balance between CRT and decolonial thought offers an avenue for such analyses, and indeed, focusing on these empirical case studies can itself serve as a springboard for thinking about the conceptual and methodological differences that lie between CRT and decolonial thought.

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Notes

1. An extension of this argument is that CRT is also guilty of a national myopia in which the USA is the only target of empirical analysis (Meghji, 2020a). Through this lens, CRT is criticized as a US-centric paradigm, as opposed to decolonial thought which – as Anzaldúa (1987) states – stems from those at the borders of the colonial world system.
2. The term 'BAME' is regularly used in British public discourse; while we are aware of the disparate – albeit connected – forms of racialization that affect and construct different social groups, we use 'BAME' in this article when the data suggest there are clear material divides between the white population and all other people of colour.

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