Risk Factor

Noémi Tousignant, Science and Technology Studies, UCL

Speaking to the U.S. Democratic National Convention last August, Kristin Urquiza blamed her father's death from Covid-19 on Donald Trump's assurance that "if you had no underlying health conditions, you'd probably be fine." Her previously healthy, 65-year-old father's "only pre-existing condition," Urquiza charged, "was trusting Donald Trump."[i] Back in early March, commenting on the lack of plans for public health, Reuters journalist Gina Chon had called Trump a "rising risk factor."[ii] Months later, Urquiza's accusation was more specific: it was by invoking the risk factor – underlying conditions – to dismiss the need for collective caution and public protection that Trump had turned himself into one.

The risk factor has, historically, been deployed to individualize disease susceptibility and responsibility for its management. In the current pandemic, as an infectious pathogen pervades the spaces between us, stretching – as we breathe – the borders of our bodies and we "absorb the conditions of others,"[iii] it is hard to contend that exposure is a matter of personal choice. Trump-as-risk-factor denotes this shared, political condition of openness to the virus. Yet it also critiques, by inverting, Trump and others' divisive mobilization of the virus's differential lethality.

Early in the expansion of the pandemic, it became clear that the ubiquitous threat of infection was more onerous for those bearing "risk factors," a category that quickly expanded from ailing and older bodies to conditions of work, residence and discrimination. The risk factor fissures the "we" of the pandemic, threatening to splinter any basis for collective action. Naturalizing the risk factor – as a fact of biology and society – can, at best, yield a superficial form of gradated protection. At worse, it justifies inaction. In the latter case, the risk factor delivers, as Sanaura Taylor puts it, "an unabashedly ableist and deeply racialized message" to the "fit" that they are already safe.[iv] It abandons the pre-exposed – by age, capitalism and/or the (re)production of race – to marshal their own, often eroded capacities for self-protection.

Twenty-twenty's pandemic and intensified attention to the vital stakes of racism has also, however, expanded both the authorship of and an audience for politicized accounts of the risk factor. I begin this essay with a brief overview of the emergence of the risk factor as a locus for the privatized management of collective health, and of its critique in epidemiology and medical anthropology. I then turn to coverage of risk inequality in the pandemic, particularly to commentary on its racial underpinnings in the United States (US) as well as in the United Kingdom (UK). I note a growing appetite for forensic accounts of how racism and (racial) capitalism have materialized in unequal bodies, cities and healthcare. Echoing critical health scholarship, these depict the risk factor as neither random nor personal, but as an index of histories of cumulative exposure and under-protection. As such, the risk factor can restore a shared basis for imagining future forms of protection.

Privatizing and Politicizing Risk

The risk factor emerged during the post-war decades as a technique for managing chronic diseases as they became increasingly common in the Global North. Mobilizing new methods in statistical comparison and analysis, epidemiological studies tracked the presence of markers – in the body, such as cholesterol levels, or in behaviors such as smoking – among cohorts who had developed or would develop cardiovascular conditions or cancers. This opened up a new conceptualization of causation. It departed from germ theory's pursuit of single etiological agents. Instead, the goal was to map out a "web" of probable causal contributors – risk factors – and, especially, to identify (in addition to genetic predisposition) those which could be modified.

Risk modification was made, in the new style of preventive medicine and health promotion that emerged in the 1960s and 1970s, a matter of personal responsibility. The responsible subject consulted their doctor to be measured for signs of elevated risk (e.g. high blood pressure), and prescribed risk-regulating drugs (e.g. diuretics) and behaviors (e.g. a low-fat diet). They were also the target of persuasive mass messaging, delivered in much the same genre by states and businesses alike, about the desirability of a healthy lifestyle. The concept of lifestyle had, in the 1950s, been refashioned in the world of commercial advertising. It entered health discourse, writes Nancy Krieger, "imbued with its consumer-oriented individualistic meaning."[v] One influential epidemiological model labelled avoidable risks as "consumables."[vi] Consumption – of pharmaceuticals, foods and fitness – was also promoted as prevention.

Hinging this "new public health" to private, free market choice was a political process. Krieger argues that Cold War anti-communism oriented American epidemiological methods towards the individual.[vii] The interests of American private practitioners were, as Robert Aronowitz shows, privileged in chronic disease research design and preventive practices, thereby separating it from the now-narrowed domain of public health.[viii] Pharmaceutical manufacturers were influential players, as Jeremy Greene reveals, in defining cardiovascular risk and its management.[ix] Even in the UK, with its National Health System (NHS), lifestyle was the focus of mass campaigns aiming to incite a sense of personal responsibility for risk avoidance.[x] This was, according to Peder Clark, a response to anxieties about "overburdening" the NHS, and part of a more general revisiting of the terms of post-war welfare contract.[xi] Self-prevention was thus framed as a "citizenly duty" to maintain the viability – by keeping the domain of the public as narrow as possible – of the NHS. As an individually modifiable pathway of exposure, the risk factor was also a vehicle for privatizing the management of conditions which, by their rising prevalence and cost, were identified as problems of "public health."

Alongside the dominance of risk factor epidemiology, centered on individual biology and behavior, approaches emphasizing the social nature of risk and disease were developed, particularly to account for group disparities.[xii] Those with the broadest appeal focus on largely depoliticized social or population-level determinants of health.[xiii] More radical frameworks insist that economic systems and unequal distributions of wealth and power produce poor health and premature death. Ecological conditions have, since the 1990s, also been integrated into epidemiological models.

Among these is Nancy Krieger's influential and ambitious ecosocial theory, which seeks to captures the effects of systematic discrimination and environmental racism as much as economic inequality and the systems that produce it. Krieger insists in particular on the need to trace the fine-grained processes and pathways by which "social and material world[s]" are *embodied*, or "literally incorporate[d]."[xiv] As other critical race health scholars have pointed out, embodiment is key to understanding how race is *materialized* – including as differences in life chances – while refuting its *naturalization.*[xv] History is also central. Bodies are in "cumulative interplay" with risky exposures throughout their life-course and even across generations. Spaces of exposure are also constituted in history, as are groups defined and racialized through differential attributions of value, power and resources.

The HIV/AIDS pandemic seems to have spurred Krieger and others to rethink risk as collective and politically distributed. Exposure was initially blamed on individual "risk behaviors," and, in their aggregate form, "risk groups." Critics questioned whether (safe) sex and drug use could be defined as either individual or free choices,[xvi] and whether "culture," and associated risk behaviors, could explain the higher infection rates among poor, marginalized and racialized communities.[xvii] Medical anthropologist Paul Farmer mobilized Johan Galtung's concept of structural violence to point out the deeply embedded constraints on poor Haitians' capacity to avoid HIV exposure and obtain care.[xviii] Working in American inner cities, Merrill Singer and Hans Baer proposed the term *syndemic* to capture how overlapping exposures – to poverty, discrimination, addiction, unemployment as well as pathogens such as HIV and poor nutrition – produced "synergistic… and mutually enhancing" effects.[xix] Various political economies/ecologies of risk models have since been widely mobilised to loosen the grip of individual responsibility as well as genetic hardwiring as explanations for chronic, so-called noncommunicable conditions such as type 2 diabetes, hypertension and obesity.

Although genetics and (cultural) behavior were, predictably, offered as reasons for the racial disparities that surfaced in COVID-19 mortality data in the US and UK, these were also promptly refuted.[xx] Assertions of the lethality of racism proliferated not only in the elite news media, such as *The Guardian* and the *New York Times*,[xxi] but also across the scientific and medical press. Letters, editorials and commentaries point to a "historic convergence" of COVID 19 with the reenergization of Black Lives Matter protests, emphasizing the predictability of disproportional Black death within systems designed to reproduce inequality.[xxii] Limited access to health insurance in the US, but also chronic job, food and housing insecurity, and histories of racism in medical theory, public health and the provision of care, have been widely evoked. Several authors – including the *Lancet* editor Richard Horton – have characterized the current health crisis as a *syndemic*.[xxiii] This means recognizing that "risk factors" not only inflict viral exposure and worsen outcomes of infection but are also generated within longer histories of multiplicative – rather than merely additive – exposures to predation, deprivation and oppression. In a syndemic, the underlying condition is made of multiple, sedimented layers that can erupt into each other.

Risk as History and the Future of Protection

In the urge to offer commentary, and with the virus and future so opaque,[xxiv] many turned, in 2020, to history. But which histories matter? Some caution against the lessons of

pandemics past.[xxv] Others look for insight into ranges and models of societal response.[xxvi] There are accounts of how we humans have made our world pathogenic; the unnatural disaster of the pandemic collides, in 2020, with record-breaking forest fires and tropical storms.[xxvii] Of particular relevance for thinking about the risk factor are histories of austerity, deregulation, corporate profit and the (re)production of race as a source of protection/exposure. These are histories of the shrinkage – or limitation – of the public, and of the concentration of harm via residential segregation, air pollution, job insecurity or insurance coverage. These are histories inscribed into cities, institutions and the *bodies,* making them hosts of the risk factor; a differential capacity to avoid, and to survive, the pathogen.

Several essays published by the *Boston Review* reveal how unprotective systems – such as profit-driven healthcare, segregated cities and anti-statism – not only produce differential vulnerability to the virus but are themselves products of enduring American racism. Amy Kapczynski and Gregg Gonsalves argue that "efforts to expand health coverage […] have also [in addition to free market fundamentalism] always run into the country's deep commitment to white supremacy and racism."[xxviii] Jefferson Cowie traces American resistance to state intervention and its potential (if partial) protections – evident in American pandemic responses– to the historic racialization of freedom as "White."[xxix] Colin Gordon and co-authors show how the profitability of racial segregation in St Louis was bolstered by the sale of White comfort, but subsidized by exactions on Black communities ranging from highway construction and pollution to municipal fines and housing overcharges.[xxx] The latter were thus "delivered to disease by their history."

The Atlantic journalist Olga Khazan offers a stunning take on what this means in a 2018 essay, reposted in 2020 as part of a collection on race. She reports on a year-long investigation, set in Baltimore, into what makes poor, mostly Black neighborhoods pathogenic. She combines the biographical narrative of one young woman who has come to struggle with repeated trauma, food, alcohol, and access to care, with data on the "intimate" routes by which racism "seep[s] into [Black people's] lungs, their blood, even their DNA." The mechanisms range from lead-contaminated and mouse-infested housing, to how stress may accelerate ageing and trigger addiction, and government policies that turned "ghettoes" into frontiers for fast-food market expansion.[xxxi] Reporters have also pointed out that legacies of environmental racism may increase the lethality of COVID-19, for example in the high death rates found in the iconic swathe of Louisiana known as "Cancer Alley."[xxxii] In line with eco-epidemiological approaches, there has been a growing emphasis on how specific *places* – inner-city neighborhoods and industrial corridors, but also poor rural counties, meat-packing plants and migrant worker barracks – not only expose to the virus, but also concentrate and release past exposures to precarity, stressors, and contaminants, acting as accumulators of risk factors.[xxxiii] As an embodied and spatialized product of history, the risk factor cannot easily be shed. As Nancy Krieger warns, "were racial discrimination and poverty to be eliminated in an instant, their embodied health consequences would nevertheless persist for at least one if not several generations for many diseases."[xxxiv] So while many, rightly, call for a radical reimagination of the pandemic's futures, we need also to consider how pasts are embedded into vital fabrics that cannot simply be left at the gate.[xxxv]

As Ruha Benjamin has pointed out, we cannot dissociate Black death from White life/survival.[xxxvi] When Trump tested positive for COVID-19 days after claiming the virus "affects virtually nobody," only, that is, "elderly people with heart problems and other problems,"[xxxvii] many news sources gleefully listed the president's known risk factors. One commentator added one, "less spoken of [that] weighs heavily in his favor – his socioeconomic status."[xxxviii] Wealth need not translate into the gendered, risk-averting kale salads and masochistic fitness regimes of coastal elites.[xxxix] It also secures prompt access to the fruits of profit-driven medical innovation, such as the brand-name statins that keep Trump's cholesterol levels down, or the experimental monoclonal antibody treatment he was given for COVID-19. Golf may also be restorative. Trump indeed emerged from the hospital a triumphant figure of medical prowess and White hardiness. Up- and down-stream from this show of invincibility lies the exposure of others like Kristin Urquiza's father, just like White suburbs insulate against crime, police hostility, urban dilapidation, bad schools, toxic down-winds and the need for infrastructural reinvestment. The flipside of the risk factor as cumulative exposure, then, might be called *protection by dispossession*.

Even as 2020 pulls to an end, the pandemic choice is often presented as an either/or between strict lockdown and "let er rip." Both strategies are criticized for how they reproduce pre-existing distributions of risk, amounting, in different ways, to a "politics of *differential vulnerability.*"[xl] Staying-at-home was quickly shown to be unequally protective; it also depends on the continued exposure of already under-protected workers, defined as key or essential but treated as disposable.[xli] Conversely, to tolerate wide exposure is to sacrifice the most vulnerable – the risk-factor bearing – at the altar of collective, as much economic as biological, survival, with, as some have pointed out, a clear eugenic resonance.[xlii] The sovereignty of the market threatens, in any case, to overwhelm any kind of barrier against the virus – put up only as a form of catch-up biopolitics after years of cuts to public health, a manifestation of the weakness rather than the excesses of state power.[xliii]

The risk factor should guide the distribution of protective tools such as PPE, sick pay, tests and vaccines.[xliv] But it could also drive the *design* of more expansive, care-oriented and reparative modes of protection. I use reparative not in the naïve and problematic sense of aspiring to fix disabled bodies and ecologies, but rather, following Sanaura Taylor, of acknowledging that the "disabled are us."[xlv] This means recognizing that the individualized, privatized risk factor has failed us all, as the prevalence of chronic, disabling conditions keeps rising, and as contaminants flow into our air, food systems and bodies. But it also means reckoning with a collective debt to those whose overexposure has accumulated in their bodies, homes and jobs as risk factors for future hazards, while generating profit, security and advantage that some of us are protected by. The naturalized risk factor leads to either minimized or paternalistic protections; in both, vulnerability is deployed as a dividing line. A politicized risk factor implicates us all in the distribution of (un)protection, proposing a common ground for working towards a more livable world. Examples of this are the recent call for Black reparations as a public health strategy,[xlvi] and previously, for a "new politics of care"[xlvii] and for its merging with a Green New Deal.[xlviii] For Mayor of London Sadiq Khan, it is necessary to "forge a new social contract that advances the twin causes of racial and economic equality."[xlix] While a more recent British Labour-party commissioned review urges regulating Black overexposure to infection as a matter, among others, of occupational health, housing rights and education reform.[l] These are ways of getting closer to the

conditions needed for what Amy Kapczynski and Gregg Gonsalves call "social immunity… woven of the ways we interact and care for one another."[li]

---

[i] Among numerous reports of her testimony, Paul LeBlanc, "Woman who lost father to Covid-19: 'His only preexisting condition was trusting Donald Trump'," CNN, August 18 2020, https://www.cnn.com/2020/08/17/politics/kristin-urquiza-democratic-national-convention-coronavirus-father-trump/index.html, accessed 29 November 2020.
[ii] Gina Chon, "Breakingviews – Donald Trump is Rising Risk Factor in Virus Battle," Reuters, 11 March 2020, https://fr.reuters.com/article/us-health-coronavirus-breakingviews-idUSKBN20Z0GR,
[iii] Sanaura Taylor, "What Would Health Security Look Like?" *Boston Review*, May 28 2020, http://bostonreview.net/class-inequality-science-nature/sunaura-taylor-what-would-health-security-look
[iv] Ibid.
[v] Nancy Kriger, *Epidemiology and the People's Health*, Oxford: Oxford University Press, 2011: 147.
[vi] Ibid., 150.
[vii] Ibid., 140.
[viii] Robert A. Aronowitz, "The Framingham Heart Study and the Emergence of the Risk Factor Approach to Coronary Heart Disease, 1947-1970," *Revue d'histoire des sciences* 64, no.2 (July-December 2011): 263-295.
[ix] Jeremy A. Greene, *Prescribing by Numbers: Drugs and the Definition of Disease*, Baltimore: Johns Hopkins University Press, 2008.
[x] Virginia Berridge, *Marketing Health: Smoking and the Discourse of Public Health in Britain*, 1945-2000, Oxford: Oxford University Press, 2007.
[xi] Peder Clark, "'Problems of Today and Tomorrow': Prevention and the National Health Service in the 1970s," 33, no.3 (2020): 981-1000.
[xii] Krieger, *Epidemiology*, 179.
[xiii] For example, in the WHO Commission on Social Determinants of Health, formed in 2005.
[xiv] Krieger, *Epidemiology*, 214.
[xv] E.g. Clarence C. Gravlee, "How Race Becomes Biology: Embodiment of Social Inequality," *American Journal of Physical Anthropology* 139 (2009):47-57; Amade M'Charek, "Beyond Fact or Fiction: On the Materiality of Race in Practice," Cultural Anthropology 28, no.3 (July 2013): 420-442.
[xvi] E.g. Elizabeth Fee and Nancy Krieger, "Understanding AIDS: Historical Interpretations and the Limits of Biomedical Individualism," *American Journal of Public Health* 83, no.10 (October 1993): 1477-1486.
[xvii] E.g. Tania Poteat, Gregorio A. Millett, LaRon E. Nelson and Chris Beyer, "Understanding COVID-19 Risks and Vulnerabilities among Black Communities in America: the Lethal Force of Syndemics," *Annals of Epidemiology* 47 (2020): 1-3.
[xviii] Paul Farmer, "On Suffering and Structural Violence: A View from Below," *Race/Ethnicity: Multidisciplinary Global Contexts* 3, no.1 (Autumn, 2009): 11-28.
[xix] Merrill Singer and Hans Baer, *Critical Medical Anthropology*, Boca Raton, London and New York: CRC Press, 2018 (1995): 213.
[xx] A widely circulated examples is: Clarence Gravlee, "Racism, Not Genetics Explains Why Black Americans Are Dying of COVID-19," *Scientific American Blog Network*, June 7, 2020, https://blogs.scientificamerican.com/voices/racism-not-genetics-explains-why-black-americans-are-dying-of-covid-19/. See also Ruha Benjamin, "Black Skin, White Masks: Racism, Vulnerability & Refuting Black Pathology," Department of African American Studies, Princeton University, April 15, 2020, https://aas.princeton.edu/news/black-skin-white-masks-racism-vulnerability-refuting-black-pathology; Keeanga-Yamahatta Taylor, "The Black Plague," *The New Yorker,* April 16 2020, https://www.newyorker.com/news/our-columnists/the-black-plague.
[xxi] Winston Morgan, "Genetics is not why more BAME People die of Coronavirus: Structural Racism is," *The Guardian*, 4 July 2020, https://www.theguardian.com/commentisfree/2020/jun/04/genetics-bame-people-die-coronavirus-structural-racism; Charles M. Blow, "The Racial Time Bomb in the Covid-19 Crisis," *The New York Times*, April 1 2020, https://www.nytimes.com/2020/04/01/opinion/coronavirus-black-people.html.
[xxii] See, for example, the opinion pieces collected under the topic "Race and Medicine" in the *New England Journal of Medicine*. Other examples include Gareth Iacobucci, "Doctors call for Action on Racism in Wake of Covid-19 and the Death of George Floyd," *BMJ*, doi: https://doi.org/10.1136/bmj.m3607 (Published 16 September 2020); Rohan Khazanchi, Charlesnika T. Evans and Jasmine r. Marcelin, "Racism, not Race, Drives Inequity Across the COVID-19 Continuum," *JAMA Netw Open.* 2020;3(9):e2019933. doi:10.1001/jamanetworkopen.2020.19933; Jennifer Abbasi, "Taking a Closer Look at COVID-19, Health Inequities and Racism," *JAMA.* 2020;324(5):427-429. doi:10.1001/jama.2020.11672.

[xxiii] Richard Horton, "Offline: COVID-19 is not a Pandemic," The Lancet, September 26 2020, DOI:, https://doi.org/10.1016/S0140-6736(20)32000-6 which was reported by the *Financial Times*, *Al Jazeera* and *Reuters*. For more in-depth commentaries focusing on racism in the U.S., see Clarence C. Gravlee, "Systemic Racism, Chronic Health Inequalities, and COVID-19: A Syndemic in the Making?" *American Journal of Human Biology* https://doi.org/10.1002/ajhb.23482; Poteat et al., "Understanding COVID-19."
[xxiv] Tim Christaens, "Must Society be Defended from Agamben?" *Critical Legal Thinking*, March 26 2020, https://criticallegalthinking.com/2020/03/26/must-society-be-defended-from-agamben/
[xxv] Christos Lynteris, "Didactic Historicism and the Historical Consciousness of Epidemics," *Somatosphere*, March 6, 2020, http://somatosphere.net/forumpost/didactic-historicism-historical-consciousness-epidemics/; Guillaume Lachenal and Gaëtan Thomas, "COVID-19: When History has no Lessons," *History Workshop*, March 30 2020, https://www.historyworkshop.org.uk/covid-19-when-history-has-no-lessons/.
[xxvi] E.g. Alex De Waal, "New Pathogen, Old Politics," *Boston Review*, April 3 2020, http://bostonreview.net/science-nature/alex-de-waal-new-pathogen-old-politics.
[xxvii] Kate Brown, "The Pandemic is not a Natural Disaster," *The New Yorker*, April 13, 2020, https://www.newyorker.com/culture/annals-of-inquiry/the-pandemic-is-not-a-natural-disaster.
[xxviii] Amy Kapczynski and Gregg Gonsalves, "Alone Against the Virus," *Boston Review*, March 13 2020, http://bostonreview.net/class-inequality-science-nature/amy-kapczynski-gregg-gonsalves-alone-against-virus.
[xxix] Jefferson Cowie, "Is Freedom White?" *Boston Review*, September 23, 2020, http://bostonreview.net/race/jefferson-cowie-is-freedom-white.
[xxx] Colin Gordon, Walter Johnson, Jason Q. Purnell and Jamala Rogers, "COVID-19 and the Color Line," *Boston Review*, May 1 2020, http://bostonreview.net/race/colin-gordon-walter-johnson-jason-q-purnell-jamala-rogers-covid-19-and-color-line.
[xxxi] Olga Khazan, "Being Black in America can be Hazardous to Your Health," *The Atlantic*, July 2018, https://www.theatlantic.com/magazine/archive/2018/07/being-black-in-america-can-be-hazardous-to-your-health/561740/. See also, for a longer historical view, Gus Wezerek, "Racism's Hidden Toll: In America, How Long you Live Depends on the Color of your Skin," *The New York Times*, August 11, 2020, https://www.nytimes.com/interactive/2020/08/11/opinion/us-coronavirus-black-mortality.html.
[xxxii] Sophie Kasakove, "'Cancer Alley' has Some of the Highest Coronavirus Death Rates in the Country," *Vice*, July 4 2020, https://www.vice.com/en/article/pke94n/cancer-alley-has-some-of-the-highest-coronavirus-death-rates-in-the-country.
[xxxiii] "Mapping the Politics of Care," http://newpoliticsofcare.net/; Megan Molteni, "Why Meatpacking Plants have Become Covid-19 Hot Spots," *Wired*, May 7 2020; Migrant Workers Alliance for Change, "Unheeded Warnings: COVID-19 & Migrant Workers in Canada," June 2020, https://migrantworkersalliance.org/wp-content/uploads/2020/06/Unheeded-Warnings-COVID19-and-Migrant-Workers.pdf; Lauren Leatherby, "The Workd Virus Outbreaks in the U.S. are Now in Rural Areas," *The New York Times*, October 22, 2020, https://www.nytimes.com/interactive/2020/10/22/us/covid-rural-us.html.
[xxxiv] Krieger, *Epidemiology*, 226.
[xxxv] Arundhati Roy, "The Pandemic is a Portal," *Financial Times*, April 3, 2020, https://www.ft.com/content/10d8f5e8-74eb-11ea-95fe-fcd274e920ca.
[xxxvi] Ruha Benjamin, "Black Afterlives Matter: Cultivating Kinfulness as Reproductive Justice," *Boston Review* (Republished from Adele Clarke and Donna Haraway, *Making Kin not Population*) http://bostonreview.net/race/ruha-benjamin-black-afterlives-matter.
[xxxvii] Timothy Bella, "'It Affects Virtually Nobody': Trump Incorrectly Claims Covid-19 isn't a Risk for Young People," *The Washington Post*, September 22, 2020, https://www.washingtonpost.com/nation/2020/09/22/trump-coronavirus-young-people/.
[xxxviii] Jamie Hartmann-Boyce, "Donald Trump has been Diagnosed with COVID – Let's Talk Risk Factors," The Conversation, October 2, 2020, https://theconversation.com/donald-trump-has-been-diagnosed-with-covid-lets-talk-risk-factors-147387
[xxxix] Jia Tolentino, "Athleisure, Barre and Kale: The Tyranny of the Ideal Woman," The Guardian, August 2 2019, https://www.theguardian.com/news/2019/aug/02/athleisure-barre-kale-tyranny-ideal-woman-labour.
[xl] Danele Lorenzini, "Biopolitics in the Time of Coronavirus," April 2 2020 (in themoment)
[xli] Shaun Ossei-Owusu, "Coronavirus and the Politics of Disposability," *Boston Review*, April 8 2020
[xlii] (Romer and Laterza. Btihaj Ajana, "Immunitarianism: Defence and Sacrifice in the Politics of Covid-19," Author's Preprint Available at OSF: https://osf.io/ax5mt, doi: 10.31219/osf.io/ax5mt
[xliii] Joshua Glover, "The Rise and Fall of Biopolitics: A Response to Bruno Latour," *In the Moment*, March 29 2020
[xliv] On vaccines, see: Nicholas St. Fleur, "Health Experts Want to Prioritize People of Color for a Covid-19 Vaccine. But How Should it be Done?" *STAT*, November 9, 2020; Ross Lydall, "BAME Londoners should be on Priority List for Roll-out of Covid-19 Vaccines, says Sadiq Khan," Evening Standard, November 17 2020, https://www.standard.co.uk/news/health/bame-londoners-priority-list-covid-vaccines-sadiq-khan-b72379.html.

[xlv]Taylor, “Health Security.” See also Taylor, “Black Plague.
[xlvi] Mary T. Bassett and Sandro Galea, “Reparations as a Public Health Priority – A Strategy for Ending Black-White Health Disparities,” *New England Journal of Medicine*, November 26, 2020, DOI: 10.1056/NEJMp2026170.
[xlvii] Gregg Gonsalves and Amy Kapczynski, “The New Politics of Care,” *Boston Review*, April 27, 2020, http://bostonreview.net/politics/gregg-gonsalves-amy-kapczynski-new-politics-care.
[xlviii] Taylor, “Health Security.”
[xlix] Sadiq Khan, “More BAME People are Dying from Coronavirus. We Have to Know Why,” *The Guardian*, April 19 2020, https://www.theguardian.com/commentisfree/2020/apr/19/bame-dying-coronavirus-sadiq-khan.
[l] Baroness Doreen Lawrence, “An Avoidable Crisis: The Disproportionate Impact of Covid-19 on Black, Asian and minority ethnic communities,” https://www.lawrencereview.co.uk/, accessed November 29 2020.
[li] Kapczynksi and Gonsalves, “Alone with the Virus.”