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Negotiating (un)sanitary citizenship

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Negotiating un/sanitary citizenship: the reception of UK government COVID-19 public health messaging by racialised people highly exposed to infection

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ABSTRACT

Governments across the world differently invoked citizen responsibility for responding to the risk of COVID-19 infection. Approaches which focused on changing social practices served to reinforce distinctions between 'sanitary' and 'unsanitary' citizenship. This paper examines citizens' responses to public health policy messaging, exploring as a case study the reception of UK Government messaging about responsible behaviour during the first two years of the COVID-19 pandemic. We examine the public responses to such messaging from narrative interviews with 43 people who became ill with COVID-19. These interviews were with people who identified as members of the minoritised religious and racialised groups, who were most heavily burdened by the impact of COVID-19. Interviewees challenged assumptions that they were 'irresponsible' for having caught COVID-19, and instead directed attention towards the ways in which pandemic guidance was unworkable. Some actively critiqued government messaging, questioning the problematic racialisation of pandemic messaging and challenging individual responsibilisation for the management of the pandemic. Through this analysis we demonstrate the active role of citizens in enacting, and at times resisting, health policy.

Introduction

This paper addresses the ways in which citizens are differentially made responsible for their health through government policy and the impact of this on people's everyday lives. Our focus is the reception of UK government public health messaging about responsible behaviour during the first two years of the COVID-19 pandemic. We examine the responses to such messaging by people from minoritised religious and racialised groups, who were some of the communities most heavily burdened by COVID (Public Health England 2020; UK Office for National Statistics 2021). Through this analysis, we demonstrate the active role of citizens in enacting, and at times resisting, health policy. Our use of the term minoritised throughout the paper (Gunaratnum 2003; Milner and Jumbe 2020) reflects that people are purposefully minoritised by others, rather than naturally existing in society as a minority.

Governments across the world differently invoked citizen responsibility for responding to the risk of COVID-19 infection (Jasanoff et al. 2021). In some countries, such as Taiwan and Australia, COVID-19 was positioned as an external threat that required measures to create barriers between citizens and the virus, such as border controls and use of Personal Protective Equipment (PPE). Other nations, like the UK and the USA, located COVID-19 risk within individual citizen behaviour. These nations identified social practices as the central threat for infection spread, which accordingly had to be controlled through measures such as social distancing in public spaces, careful hygiene practices, limiting the size of gatherings, and locking down the economy and social life. In the latter category of countries, the representation of individual behaviours as COVID-19 risks reflects Hilgartner's (1992) exposition of how policy distinguishes 'objects of risk' (people or things at risk of harm) and 'risk objects' (people or things as causes of harm). This location of COVID-19 risk within social behaviour draws from a conception of modern citizenship in which 'judicious decisions and actions' produce good health (Davis et al. 2021). Health communications associated with this approach are designed to encourage the public to be knowledgeable about risk and act as responsible choice-makers in the face of a threat. Risk avoidance thus comes to mean a 'moral duty', whereby citizens are judged as responsible based on their compliance with expert advice (Lupton, 2013).

Individualising responsibility for risk management during public health crises has been widely critiqued for failing to recognise the unequal distribution of resources to both avoid and redress ill health. Briggs (2003), studying a cholera epidemic in parts of Venezuela in the early 1990s, emphasises how public health institutions demarcated 'sanitary citizens' from 'unsanitary subjects', in ways that deflected the blame upon the people worst hit by disease. Farmer described such blameful narratives as a 'calling card of all transnational epidemics' (2011: 191), with those affected suffering twice, from both illness and discrimination. Blame is typically directed to groups seen as 'vehicles' for infection, typically those burdened because of being most structurally vulnerable to a given illness (Roelen et al. 2020).

During the COVID-19 pandemic in the UK, such individualising discourses of COVID-19 risk have been subject to specific critique. Bambra (2022) has explored the interconnected pathways which link existing social inequality and infectious disease. She raises four domains in which inequality pervades that are relevant to experiences of the COVID-19 pandemic: *unequal exposure* through occupation, access to PPE, and geographic location; *unequal transmission* connected to household size; *unequal susceptibility* due to pre-existing health status; and *unequal treatment* as a result of differential access to healthcare services. The impact of the pandemic in the UK, both in terms of burden of illness and the consequences of restrictions, was accordingly felt most strongly by religious and racially minoritised communities that sit on the intersection of these inequalities (Lawrence 2020; Marmot et al. 2020; Runnymede Trust 2021).

In addition to the unequal burden of COVID, these groups were also subjected to racialised stigma as a result of their exposure (Independent Sage, 2021). By racialisation, we refer to the process by which meaning was attached to particular bodies and behaviours in public guidance and how this in turn was used to reproduce structural inequalities related to 'race' (Gonzalez-Sobrino and Goss 2019; Mullard, 2021) and religion (Younis and Jadhav 2020). This has manifest in two significant ways. First, in that 'race' itself has been 'rebiologised', with attribution of differences in COVID impact reduced to biological and genetic differences (Lippman 1991; Xue and White 2021), foreclosing exploration of how structural inequities shape risk. Second, in how similar social practices have been racialised and judged differently. A clear

example being widespread critique of groups attending Muslim memorials but greater acceptance of attendance at White Christian funerals (Independent Sage, 2021). A visible consequence of this has been the increase in racialised hate crimes (Runnymede Trust 2021; Schumann and Moore 2023). Ganguli-Mitra et al. (2022) argue that the pandemic amplified existing patterns of disadvantage among minoritised groups, emphasising that structural, interpersonal and institutional racism have shaped the differential impact of the COVID-19 pandemic in the UK.

Critiques highlight how the UK's public health campaigns, which were jointly run by the government and the National Health Service, were silent about this differential impact, despite it being evident from the early stages of the pandemic (see for example Public Health England 2020). French and Monahan (2020) emphasise the flaws of messaging about risk that puts responsibility on individuals, when forms of structural, everyday violence predispose particular groups to the harmful effects of COVID-19 and undercut their capacity to limit these harms. Similarly, Patel et al. (2020) critique how the economically disadvantaged were expected to respond to the pandemic in the same way as those of high socio-economic status. Strange (2022) examines messaging in billboard and poster campaigns in the UK, and how images of these campaigns were shared on social media. He found that all texts served to discursively shift responsibility for the pandemic onto the public, implying that individual carelessness was the main cause for the spread of COVID-19. Similarly, Lennon and Gill (2022), who examined public health messaging in television adverts, argue that pre-existing societal inequalities which might hinder compliance, particularly for the economically disadvantaged groups of society, were minimised in public communications. They found that adverts portrayed a 'good' pandemic subject as one who makes 'moral' and 'rational' decisions to comply with COVID-19 guidelines, and ignored how particular employment, familial or material circumstances could make this challenging. Lennon and Gill argue that where COVID-19 campaigns emphasised risk and fear, as encapsulated in Figure 1 below, this contributed to the stigmatisation of 'non-conforming' citizens.

Figure 1. Prominent images at height of infections include the 'look her/him in the eyes' campaign.
Source: NHS England (https://communication-plan.gcs.civilservice.gov.uk/)

These kinds of critical textual analyses of the institutional discourses in public health campaigns are extremely important as they emphasize the high stakes of the communicative strategies that governments like that of the UK have relied upon during the pandemic. Dias and Deluchey (2020) criticise such rhetoric for inciting semiotic war between those who can comply with COVID-19 policy against those who cannot, while deflecting attention from the necropolitical policies which in fact deepen 'a radically different exposition of lives and bodies to death and disease during the COVID-19 pandemic' (p.14). At the same time, however, there is a need to go beyond analyses of the texts to explore what they actually meant to the citizens they targeted. There has been minimal examination of how the public have responded to pandemic messaging. Research among citizens has focused on who or what the public feels is to blame for originating the pandemic (Hardy et al. 2021), rather than their response to being made to feel responsible for its proliferation. The voices of citizens, particularly those structurally positioned as most likely to be categorised as 'unsanitary', are largely absent.

Our purpose in this paper is to investigate the reception of discourse around sanitary/unsanitary citizenship (Briggs 2003) among those most burdened by the COVID-19 pandemic in the UK. As these people were often from racially and religiously minoritised groups, we pay specific attention to the way in which they discussed the racialisation of public health messaging. Our methods, which we turn to in the following section, enable us to explore what people took from these texts, and what they meant to them in their everyday lives. As such, we contribute to what Nancy Naples (2003) referred to as 'everyday world policy analysis', wherein people, whose lives are regulated by policy, are recognised as knowers with a privileged standpoint of analysis. Analysis of lived experience of policy, especially of 'the social practices and everyday lives of people most affected' by policies (McIntosh and Wright 2019, 457), can insight into the 'political strategy of recognition: giving voice and making the invisible visible as a response to subordination' (p.463). We demonstrate that citizens are not passive recipients of policy, particularly policies that appear to blame them. In so doing, we illuminate the active role of citizens in the enactment of policy, including identifying how public health messaging is questioned, contested and reimagined.

Methods and materials

This research was a qualitative study, funded by the UK Economic and Social Research Council between 2020-22 (ES/V016032/1). Ethical approval was granted by the NRES Committee South Central – Berkshire (12/SC/0495). We collected a total of 70 interviews. For the purposes of this paper, we have focused only upon the subset of interviews with members of minoritised religious and ethnicity categories (48 participants). We sought to explore diversity of COVID-19 infection – from mild, even asymptomatic infection, through to those who were admitted to Intensive Care – as well as diversity in social positioning, by virtue of race/ethnicity, social class and geographic location within the UK, gender and age. Our intention was to adopt a maximum variation sampling approach while actively foregrounding the experiences of the groups of people who had been hardest hit by COVID-19. Sampling was guided by Malterud, Siersma, and Guassora's (2016) concept of 'information power', which draws attention to the quality as well as quantity of data. In our case, sufficient information power within the sample required accessing as diverse a range of experiences

as possible, while also giving specific attention to the experiences of minoritised and front-line workers who more most exposed to COVID. Recruitment was carried out remotely, through a variety of routes including social media, local, regional and national community groups, professional associations, and snowballing through participants to incorporate a wide variety of experiences and perspectives. The inclusion criteria were broad, as we simply sought to interview a broad range of people who had experienced COVID in the UK. This included those with suspected COVID, as well as confirmed through a test. The only exclusion criterion was being under 18 year's old.

Data collection occurred in 2021. Interviews were conducted online at a time that suited the participant. Interviews were conducted online, in keeping with much anthropological work during the COVID-19 pandemic (Podjed 2021). All interviews were recorded on audio and/or video according to interviewees' preference. The interviews lasted between 45 min and 2.5 h. The first section of the interview invited people to freely relate their own narrative of how they first became aware of COVID-19, their own experience of the illness and its aftermath. The second section included a variety of prompts about how COVID-19 had affected their health and wider aspects of their lives, communities, finances, work, education and family and interactions with health care services. While no direct questions were asked about public health messaging, participants were asked if they felt that guidance was 'workable' within the context of their lives. The majority of interviews (46) were conducted as individual interviews, with one couple interview. A summary of the sample is detailed in Table 1.

Interviews were transcribed and the transcriptions were checked for accuracy. All interview transcripts were imported into specialist computer software for organising textual data for coding (NVivo). Following a broad thematic analysis to gain an understanding of the key issues that ran through the corpus of data as a whole, we conducted a finer-grained analysis of responses to public health messaging using the OSOP (one sheet of paper) mind-mapping approach (Pope, Ziebland, and Mays 2020). Our aim in the analysis was to examine reception of and resistance to blameful public health messaging, exploring people's reception of this policy. The OSOP method involved reading the extracts relating to public health messaging and summarizing all the different issues on one sheet of paper. This summary of the issues was then used as a basis for axial coding to group the ideas into broader themes (Ziebland and McPherson 2006). We then considered how the broader themes could provide

Table 1. Summary of participant characteristics.

Category	Detail	Number
Ethnicity	South Asian	26
	Black	13
	Orthodox Jewish	4
	East Asian	4
	Middle Eastern	1
Gender	Female	30
	Male	18
Age range	20–29	1
	30–39	16
	40–49	12
	50–59	11
	60–69	6
	70–79	2
Occupation	Front line role	20
	Other role	28

explanations for the research question. The question guiding this analysis was: *how did minoritised participants make sense of and respond to official public health messaging about COVID-19 risk management?* Pseudonyms are used throughout the paper.

Findings

We approach our findings in two sections. In the first section, we explore how participants voiced inconsistencies in public health messaging. In particular, they questioned the messaging around responsibilisation of 'essential workers' or 'keyworkers' who could not minimise their exposure. They highlighted how the racialisation of public health messaging exacerbated these workers' experiences of stigma. In the second section, we explore participant reactions to interpretations that people of colour were 'more at risk' of COVID-19 due to biological or genetic factors. Participants refuted this, and instead emphasised how public messaging and the media had tethered COVID-19 risks simplistically to racial identity, with consequences in terms of increased abuse and Othering of minoritised groups. Participants instead foregrounded the structural conditions that placed minoritised groups at greater risk, drawing attention to the government's responsibility for mitigating risk.

Voicing inconsistencies and paradoxes in public messaging

Frontline work and being seen as a source of spread

Interviewees who were 'essential workers' described the inconsistency between public health messaging about personal responsibility and vigilance for minimising infection, and the sheer risks they faced at their workplaces, expressing the futility of their efforts. Devesh, a Bangladeshi rail worker, describes how he faced insurmountable 'risky situations' in his capacity as an 'essential worker' and the lone earner in his family. In spite of his PPE and barrier, there was no way that he could eliminate the risk of exposure to the hundreds of passengers he would interact with every day:

> *Customers keep coming and going so we don't know who, from whom I got the virus or not. We still tried to remain vigilant during this time, wearing mask, put the barrier on our gate line. It's still so many things like restriction in place but it's still there, the risk. That's what I'm saying because being in my house all that time, no one work, no one go outside in the lockdown. They didn't try a risky situation but every week I had to go to work. So I am the only person who was going outside and coming inside for work and for the shopping, grocery shopping. So maybe I got the virus and I gave the everyone the virus maybe.*

The contradiction between the messaging about personal responsibility for minimising infection, and the responsibilities of 'essential work' were experienced at magnitude for those working in care services. Mabel, a Black British woman, reflects on the paradoxes of being celebrated as a hero for working as a nurse, and then being blamed as a vehicle of spread, due to occupational risks she simply could not avoid:

> *So care workers, there was a point in time we were being, oh how shall I put it, we'd go to the market, the supermarket, they learn you're a nurse. I had – it's funny, in the beginning we were heroes, from being heroes we were hated so much and that's when we're told never to wear a*

uniform in public because some nurses were beaten, abused, verbally abused and all because we were being fed that from the hospital, 'it's spreading Covid, we should live in the hospital, live in the hospital'. So yeah there was that period in time where we were looked down upon for doing what we do, then I'm thinking we're saving lives, your family's lives, so we can resign, we can all resign now and leave your families on their own, so I don't know, it's a funny world we live in. One minute everyone is clapping, the next minute everyone is stoning us.

Neither Devesh nor Mabel were able to change the risks they faced in their roles but noted changes in the public's response to them as workers. In a similar way, Monica, a Black African disability support worker, reflects angrily about how speeches by the Prime Minister, she felt, blamed care workers for all the deaths that happened in care homes. This was not because they were inherently at risk of exposure and onward transmission due to their public-facing work, but because they were incompetent or unskilled, 'useless' or 'rubbish workers' as she puts it:

They give us an online training for the PPE use and you know the temperature check and the blah, blah, blah, blah you know but what's the difference. Ok we all know we, all that this is part of our job every day. You know, I know like what's the level of, you know temperature that is considered as fever. I know how often to take someone's temperature. I know what they could possibly take to reduce you know the fevers so just know things you know like just stop blaming them. And then obviously there was a bit of a national blame as well like from Boris Johnson [laugh] and categorising us like rubbish workers! That is so hurtful, like I wish he could go one day and I wish he could step from his ministerial work. Just go work one day, just work one day in the care home. Boris Johnson was blaming us for so many people that died in the care home…

These accounts highlight that interviewees responded with frustration to the lack of recognition, particularly among those in power, of the challenge of being structurally more exposed to COVID through their occupation. For both Monica and Mabel, the lack of political and public recognition for the risks they were taking in caring for others was itself an act of violence.

Consequences of the racialisation of COVID-19 public health messaging

Participants critiqued how public health communication, in the media and in government NHS messaging, prominently drew upon visual images of people of colour even though, as noted above, they felt that COVID-19 could affect everyone. Grace, a Black Caribbean woman and retired librarian, for example, felt troubled by how these recirculated racialized stereotypes connected with notions of irresponsible behaviour. She directly references television adverts that depicted Black people in the community as potential sources of spread, but which failed to acknowledge the disproportionate representation of Black people in 'essential work':

I think part of the problem the way this pandemic, so-called, had been handled in terms of public service notices, and in terms of information given to the public and the adverts on the TV always showed Black people. It was a Black nurse who was spreading Covid and hadn't washed his hands or something. And then were young Black males on bicycles walking down the street who were going to give Covid to their grandmother who was dying. You know, that kind of thing was very, and nobody said anything. Nobody made any mention of the fact that, you know, there were Black people in the front line in the hospitals dying of Covid, who hadn't been, you know,

behaving badly or doing what they shouldn't be doing, decent workers. But the narrative was Black nurses were spreading Covid, and at the bus stop and so forth people would abuse us and say things like, you know, that it's these Blacks who are spreading the Covid, you know. And you could see where they got that idea from. You know, you could tell that they had been watching the TV and they've seen these adverts.

Grace draws attention to the dangerous lack of nuance in this messaging. She recalled a Black nurse being presented as spreading COVID, with no reflection on the disproportionate death among frontline workers of colour. She defended these people as 'decent workers' rather than irresponsible citizens who 'hadn't washed their hands'. Moreover, she directly correlates this with a rise in racialised abuse, drawing on an example of being accused of spreading COVID at a bus stop.

Bhoomi, a Bangladeshi woman who worked in various jobs, including as a cook in a care home, also reflects on the consequences of this racialized imagery. She talks about racial segregation in British society, and that the media feed into wider existing notions of the Other being inherently a threat and pathologically unsanitary citizens:

I think Covid really affected our community and that's why people are hiding. And they are saying we are 'poison', if you go near people, they are sick. We are very affected. We are the one whose gonna spread the germs around, you know. So, obviously, that's how they, media and the public are portraying the community. If you had never dealt with BME [black and minority ethnic] people, never communicated. You hear this is the news, what do you hear? You hear the negative things. Negative things goes into your head. As soon as you see a BME, a black person on the street, you want to go away from them. They are the most affected person that's it. If you go near them, that's it, you're killed, next day.

Here Bhoomi highlights that a consequence of this racialisation is that people are 'hiding', seeking to avoid being stigmatised targets of abuse for spreading the virus. She argued that the pre-existing social separation of minoritised communities contributed to this, in that negative stereotypes held by White people who had never interacted with people of colour were exacerbated by this messaging. Zainab, a Pakistani woman, builds on this and describes how recurrent images connected particular minoritised groups with disease spread, emphasising how this made them risk objects:

The narrative, the dominant narrative around Covid is laced in racism and bigotry… Frequently what we see is images of a mosque, a masjid in the background and women from a South Asian background. You can identify them from their clothing, a traditional shalwar kameez of a certain age walking along the street and these are the images that are pasted over the voice over of a journalist and the same goes for newspapers. They use this image over and over again. There was also some images on the BBC website of women in hijabs and then references to Covid and they were taken to task by a media pressure group about that. So, these images and this terminology and the connection between Covid is not happening accidentally.

Zainab noticed how imagery drew on racialised characteristics and Muslim symbols, and interpreted this as an active strategy to establish racialised connections with COVID. The next section goes on to explore how participants voiced criticism of these racialised discourses through drawing attention to structural antecedents of COVID exposure and infection.

Questioning and re-framing the racialisation of COVID-19 risks in public discourse

Questioning the disproportionate impact of COVID-19 on minorities

While there was an emphasis in public messaging that COVID-19 can affect anyone, participants were aware of public health communication about the disproportionate impact of the pandemic on people of colour. This contradiction led some to question the way in which race was evoked in public messaging. Mansa, a migrant Black African woman working as a HR professional, questions and rejects the way that the messaging had conveyed that there was something inherent in her skin colour that meant COVID-19 posed her more risk. She asks why the messaging does not convey that it's being a Black person in the UK that increases risk, drawing contrasts with places where Black people are the majority:

> I try to follow it up in a, looking at it in a scientific way and that was, 'Why Black? Is it just because of being Black?'. Is there anything else apart from being Black? What are the other factors that are perhaps unlikely to be impacting the Black and then the virus makes is just, you know, a like, a catalyst to that or…? So I started thinking, obviously I didn't have the answers but I was just rejecting – it can't just be just because you're Black, and then I started comparing because the virus went on to hit the African [continent] where, you know, where the population is all Black, and then 'how come it doesn't, they don't, they're not dying at the same rate as we feel in here?'

Mansa recognises and rejects racialised public narratives that had attributed the disproportionate impact of COVID on minoritised communities to 'genes' and 'biology'. Instead, she sought to foreground the 'other factors' which might contribute to these differences. Bangladeshi couple Bhoomi and Shamik also sought to emphasise that COVID-19 could affect everyone.

> Shamik: Yes, this was exaggerated [the portrayal of Covid risk among people of colour]. They're not telling the true picture. Blaming the BME people. But Covid does not choose who is going to catch the disease [laughs].

> Bhoomi: It's for everybody. You can get it, anybody. It's not like BME.

Shamik and Bhoomi, similarly to Mansa, brought to attention that COVID itself was not predisposed to infect specific racialised groups. A consequence of this biological association of COVID and 'race' was that it risked Othering, as discussed by Pauline, a retired Black Caribbean disability worker. While she accepts personal responsibilities with regard to COVID, she rejects racial discrimination:

> I know there was racism and stuff and that, but Coronavirus has made some people not very nice, and this lady says standing behind me in the shop, 'oh I don't want to stand behind you because you might already got the virus and going to give it to me.' I'm only buying a bottle of milk. I've left my house to walk to buy a bottle of milk, that has got nothing to do with me or the virus or me giving it to you, I'm not touching you, I've sanitised my hands, I've got my mask on from when I leave my house, why? You know why, why is that a problem?

In response to the genetic and biological racialisation of COVID, several participants actively raised paradoxes in public health guidance which resulted in some people being less protected from exposure than others. We discuss these across the next two sections.

Protecting others but not being protected by the state

Public health messaging asked citizens to make sacrifices in order to protect one another from COVID-19. Participants noticed inconsistencies between the changes they were being asked to make, and support they received from the state in return. Eva, a Jewish charity worker, talks about the 'luxury of staying safe' – the pretence that everybody has comparable levels of resources to be sanitary citizens:

> People have to work because they've got to, you know, pay the bills and so, you know, some people don't have the luxury of working from home. Some people don't have the luxury of staying safe, you know.

Dania, a British Pakistani woman with young children, discusses the difficulties her family found themselves in during the first lockdown in the UK in early 2020. Her husband, a taxi driver working for a prominent gig economy company, had no work. There was no furlough scheme for workers like him, who were classed as self-employed. They were being asked to protect others, but there was no government safety net to meet their immediate needs for basic survival:

> I don't work. I've got two young kids so that was a big strain on our family and obviously work wise, we did not know what was going on you know, taxis were obviously essential so they were allowed to continue to work but it was absolutely dead, nobody was taking any taxis anywhere at all during the day or not, so me and my husband, we'd be working right through the nights and mornings, just everything crazy, just trying to get a few customers in, like, to get, you know, get the money, at that point the furlough wasn't even completely established with what was going on with money and if self-employed people would get anything.

Dania highlights having to undertake additional work to maintain an income, risking exposure, in the absence of public protection being extended to self-employed workers. Meerab, a British Pakistani man who also worked as a taxi driver, reflects similarly on the challenge of protecting others while maintaining his livelihood. He quotes NHS England public health messaging directly, word for word – 'the government is saying "stay home"' – and continues, 'I've got my rent to pay', posing the question 'who is going to cover my cost?'. This recognises the incompatibility of the sacrifices being asked of citizens in the absence of equivalent protection from the state.

> My sisters, everyone keep phoning me, finding out how am I doing every day. Still telling them, 'Still sick, still sick.' Blah blah blah. So they was telling me, 'We told you don't go to work. Stay home.' But, at the same time you need to work. You need to pay your bills. The government is saying, stay home. 'Okay', I said, 'okay, I'd rather stay home. It's no problem, but I've got so many bills to pay. I got my rent to pay. Who's going to cover my cost?'. So it's not easy to stay home. Unless you're financially well off, you can't stay home. You have to, it's a do-or-die situation [laughs bitterly]

Meerab describes his situation as 'do-or-die', illuminating a paradox in the actions he can take. Returning to work could exacerbate his ill-health and expose him to further COVID infection, whereas not working could harm his livelihood. The inconsistencies between the personal sacrifices he and others were being asked to make and the lack of enablement were also pronounced with regard to minimising spread within households, as we now explore.

Challenge of minimising spread in multi-generational household

In a similar way as with the challenges of maintaining a livelihood and avoiding exposure, another paradox that participants articulated was in minimising spread in multi-generational households, especially when children were mixing at school. British-Pakistani community worker Kiran discusses the limits of personal protective efforts in these contexts:

> It is so hard to shield, to lockdown because I think a lot of people live in large, extended households so they have the grandparents, the parents, the, the kids, the grandkids, so there's a lot, so the symptoms could have got passed onto anyone and it's like, how much measures and precautions are you going to take? How can you tell a five-year-old that, 'when you go to school, make sure you sanitise every five minutes?'. Even though the teachers are following the government guidelines, you don't know what the child might touch and then they might come and touch their parents and their parent might come home and touch something that your father touches. So we don't know how it got passed on, to be honest.

Vijul, a British Bangladeshi community worker, goes further and refutes the racialised criticisms levelled at British Asians within mainstream British discourse, particularly the notions of that 'Asian' families were more likely to spread COVID because of living in extended households. She emphasises absence of choice about social interaction – having to go to work, because low income jobs *cannot* be done from home – and resists the suggestion that Asian community rejected public health instructions to reduce social contact.

> Asian people are very careful, some people said 'oh Asian people go there, oh they, they went to their friends house or sister house' but they're not. I think in my area is I like nearly six or seven months my friends are not coming to my house, we are not going to their house we just sitting outside because we are very careful, we just go for shopping in Tesco or grocery shopping but we, we careful but some people because is, sometimes they got from their husband because their husband going to work or like restaurant or some, lots of people taking from that another place to home.

As these extracts indicate, our interviewees had noted and been impacted by public messaging and it had often left them with questions: about the inconsistencies between the personal sacrifices expected of them, and the lack of support for these sacrifices by the government, and the impossibility of containing spread in multi-generational households. Narratives of genetic susceptibility or of cultural traits served to downplay the unequal burden of participation in 'protecting others' faced by minoritised groups.

Reframing the narrative

Participants voiced problems with how responsibilised 'sanitary citizenship' imagined a certain kind of citizen with particular resources available to them to minimise risk, whereas in their own day-to-day realities they shouldered compulsions to face risk. Participants responded in diverse ways to these narratives. Some interviewees accepted the overarching emphasis on individual responsibility, but rejected blameful narratives in relation to themselves, particularly those that were racialised. Others, meanwhile, sought to reframe the narrative about responsibilised sanitary citizenship, drawing attention to the government's responsibilities as a pandemic actor.

Zainab, the British Pakistani-origin journalist and city councillor whom we introduced above, expounds that UK public health messaging was inconsistent, contradictory, impenetrable and impractical. She feels that it placed the onus of responsibility on individuals, while superficially presenting a facade of national leadership and public institutions protecting its citizens:

I also feel that it's shocking that a government is trying to absolve responsibility for taking control of a pandemic and busy telling people that actually your behaviours are on you. If you want to do something, you should do something. If you don't want to do something, don't do it. Beyond wearing a mask and washing your hands and social distancing which nobody understands what social distancing means. This is the concept that makes no sense to anyone. These were the three key messages that kept being pumped out but then there were things like, "well if you want to go somewhere, you can go somewhere but if you don't want to go somewhere, don't go somewhere." Just absolutely ridiculous and very dangerous and the whole ethos of that messaging is to blame people individually for a pandemic rather than taking responsibility for a well-messaged clearly defined public health strategy that is going to save lives. It's just damning and I feel that for those people who are sceptical of the medical profession anyway or who are scared quite frankly you know, they, they – that's very confusing and very damaging.

In this extract, Zainab emphasises the challenge of individual decision-making in the absence of effective leadership. A consequence of this she identifies is further mistrust of the UK medical system among those who may have had an existing fraught relationship. Interviewed later in 2021, Rabbi Friedberg, an ultra-Orthodox Jewish spiritual leader, reflects similarly on how, when the government removed all formal restrictions in July 2021, this shifted responsibility for managing vulnerability entirely to citizens:

When things relaxed in July or August it was actually quite traumatic for us, because we suddenly had to say to ourselves, "okay, how far are we going to take this now?" Because we don't have to do all these things, but actually we've got really used to it, because we've had to do all kind of risk assessments and we've been on the front lines of, when we have had Covid cases and we've had to go speak to Public Health England and bodies we are we are all too aware of the risks, and actually, are we comfortable going to indoor gatherings? Do we feel like we shouldn't be wearing masks? Are we comfortable having people in our home? Are we comfortable with all these things? And I think we probably have almost fluctuated perhaps between extremes of feeling that, just because the government wants the economy to open doesn't mean, for us, from a religious perspective it's always been about the threat to life. You know, why are we allowed to close our synagogues, denying people the most basic religious practices, because of threat to life. So just because the government decides it's more important for the economy to reopen or schools to reopen, doesn't mean that the threat to life has receded, in which case we would have a religious duty to take precautions.

In this extract Rabbi Friedberg raises that the 'threat of life' of COVID had not receded for his community at the point when the government reduced protections, recognising that this shifted further responsibility onto individuals and community leaders to minimise risk. More critically again, Maureen, a Black British nurse, directs her anger at the government 'twisting' the narrative – suggesting that people are doing risky behaviours rather than discussing poverty. People working in highly exposed jobs and living in high occupancy houses were not doing this 'through choice'.

Being somebody from the Black community to suffer horrendous inequalities, and Covid just highlighted how bad it was but it wasn't to do with the fact that we were making, we were at risk of, we were doing risky behaviours, it was part of the bigger agenda of our health inequalities. And the government have had an opportunity to address it and they haven't really addressed it,

so again we were kind of like, I just find this government so corrupt but again, they were just using information just trying to twist it. Whereas they weren't dealing with the proper issues, which was about that the, you know, the poor, you know, they were likely to be working in and having poor incomes. They were living in, you know, multi-occupancies because there were two-bedroom family, housing six or seven people, you know. It wasn't through choice. It's, you know, and nothing has been done about that.

Maureen's critique directly foregrounds poverty as the driver of COVID, as opposed to individual responsible or irresponsible actions. Common to all the participant responses was a desire to challenge the distribution of responsibility between individuals and the state, as we now draw out in our concluding discussion.

Discussion

This study has emphasised how citizens respond to, and sometimes reject, public messaging, questioning its motives and how it variously frames them as objects of risk or risk objects (Hilgartner 1992). People whose lives are regulated by policy are knowers who can articulate an 'everyday world policy analysis' (Naples 2003). Jasanoff et al. (2021) note that the public are 'not simply biomedical entities but also, as many states have discovered, citizens with interests, rights, and ways of imagining their relationship with the state independent of the strictures of public health controls' (p.9). Focusing on the people 'most affected' by policies (McIntosh and Wright 2019, 457) we draw together commonalities ranging from trenchant critique to 'bad-people-exist-but-I'm-not-one-of-them' (p.460) narratives. Common to the strident and complicit responses was a deflection of responsibility from themselves as individuals.

We have examined everyday narratives about how citizens from most-affected socio-demographic groups, who themselves became ill with COVID-19, made sense of and responded to messaging that they were responsible for managing the spread of COVID-19. There was clear awareness of the racialisation of pandemic messaging, which attributed irresponsibility to individual behaviours of racialised bodies (Gonzalez-Sobrino and Goss 2019; Younis and Jadhav 2020). They challenged these assumptions, which they understood as victim-blaming, and instead directed attention towards both their compliance with guidance, and the ways in which guidance was incompatible with protection from COVID-19, particularly in the context of 'essential work' and multi-occupancy housing. Their discussions reflected Strange's (2022) observation that pandemic messaging reinforced 'the individual's responsibility to the nation (but not vice-versa; this is not a "two way street")' (p.6),

In addition to rejecting irresponsibility, participants also rejected the 'rebiologising' of race, whereby differences in COVID impact were reduced to biological and genetic differences (Lippman 1991; Xue and White 2021). Recognising different experiences of racialised bodies across countries made visible that minoritised communities in the UK were worse hit by COVID not because of inherent genetic differences, but because of structural inequity that exposed them to risk. In this respect, inequalities, rather than individual actions, were clearly voiced as a key driver of COVID-19 spread. Following Briggs (2003), these narratives demonstrated that citizens do not simply imbibe their positioning as 'unsanitary'. Our analysis highlights the tension between public health messaging that figures the public as risk objects, and narratives of illness experience which seek to displace that status.

This work builds on other scholarly contributions which have articulated the fundamental inequalities that drive differences in pandemic experiences (Lawrence 2020; Marmot

et al. 2020; Runnymede Trust 2021; Ganguli-Mitra et al. 2022). Whereas work on the role of public health messaging within these inequalities has been largely textual (French and Monahan 2020; Patel et al. 2020; Strange 2022; Lennon and Gill 2022), we move forward in three ways. First, we foreground the reception, rather than the delivery, of public health messaging. Where other work has highlighted racist attribution of blame as a key factor in understanding the differential impact of COVID-19 (Dias and Deluchey 2020), our analysis offers insight into how messaging itself was read as racialised. Second, we demonstrate the role of citizens in re-reading policy discourse. Interviewees challenged the attribution of blame upon them as individuals, in some cases through complicity with this discourse but by exceptionalising themselves, and in others, signalling a clear understanding of structural impediments to risk avoidance, calling out how people are unequally exposed to and protected from COVID-19. Three, we identify ways in which the pandemic has not only been shaped by inequality (Ganguli-Mitra et al. 2022) but has exacerbated it. Participants described racialised experiences of abuse, stigma and segregation. While other studies have recognised the increase in official racialised hate crimes (Runnymede Trust 2021; Schumann and Moore 2023), this paper contributes to increasing the visibility of everyday racialised violence that resulted from pandemic messaging.

A strength of this study was its breadth and effort in maximum variation sampling, which centred a wide range of voices from racial and religious minorities. While broadly representative, there are nonetheless perspectives that we did not incorporate, such as the stories of those with insecure immigration status, people who were insecurely homed, and those with primary languages that were outside of the linguistic skill-set of the research team. Despite these limitations in scope, we surface the tensions regarding long-term inequality and a resistance to state interventions that blame citizens for ill-health. Further research could examine resistance in further detail, analysing the intersections of identity at which strident resistance to labels of unsanitary citizenship becomes a possibility.

Ethical approval

The study received ethical approval from the NRES Committee South Central – Berkshire (REC reference number 12/SC/0495).

Acknowledgements

We would like to thank the participants who shared their stories for this research.

Disclosure statement

The authors have no competing interests to declare.

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