Pandemic Experiences of Minority Ethnic Groups in Swansea, Neath, and Port Talbot

Survey report for the Swansea Bay University Health Board | September 2022

COVINFORM

Swansea University
Prifysgol Abertawe

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

COronavirus Vulnerabilities and INFOrmation dynamics Research and Modelling

@covinform f
covinform-project in
office@covinform.eu ✉
@covinform.eu
www.covinform.eu

Project

Survey designed, set up, and organised by	Swansea Bay University Health Board Neath Port Talbot Council for Voluntary Services Swansea Council for Voluntary Services Swansea University
Data collected and provided by	Swansea Bay University Health Board Neath Port Talbot Council for Voluntary Services Swansea Council for Voluntary Services
Data owned by	Swansea Bay University Health Board Swansea University
Analysis supported and resourced by	*"COronavirus Vulnerabilities and INFOrmation dynamics* *Research and Modelling" (COVINFORM)* *European Union Horizon 2020 research and innovation programme grant recipient under the official full title: SC1- PHE-CORONAVIRUS-2020-2C Behavioural, social and economic impacts of the outbreak response* *Websites:* *COVINFORM Project: https://covinform.eu* *Swansea University subproject:* *https://www.swansea.ac.uk/geography/research-and- impact/cmpr/covinform/*
Authors	**Diana Beljaars**, Swansea University **Sergei Shubin**, Swansea University
Contributors	**Shaz Abedean**, Swansea Bay University Health Board (guidance and overview) **Shadan Roghani**, Neath Port Talbot Council for Voluntary Services (survey design, online and offline survey management, data preparation) **Hannah Sabatia**, Swansea Council for Voluntary Services (survey design and management)
Submission date	28.07.2022 (initial version) 15.09.2022 (revised version)

To cite this report: Beljaars, D., & Shubin, S. (2022). Pandemic Experiences of Minority Ethnic Groups in Swansea, Neath, and Port Talbot. Survey report for the Swansea Bay University Health Board. COVINFORM H2020 Project No. 101016247.

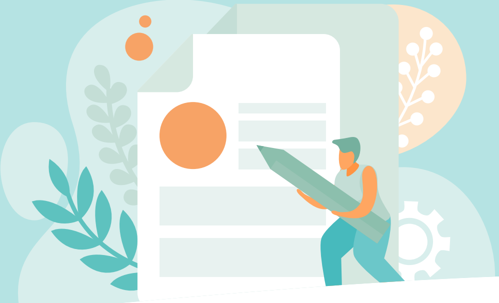
Disclaimer

This project has received funding from the European Union's Horizon 2020 Research and Innovation Programme under Grant Agreement No 101016247.

Table of Contents

Summary **4**
Introduction **7**
  The Survey 9
Section 1: Knowing the pandemic and living through change **12**
  1.1 Reminders of the pandemic: objects/phenomena 13
  1.2 Reminders of the pandemic: places 16
  1.3 Changes to employment situations 17
  1.4 Location of work 18
  1.5 Conclusions 20
Section 2: Mental health and wellbeing **21**
  2.1 Mental struggles 22
  2.2 Changing thoughts about death 24
  2.3 Conclusions 25
Section 3: Social lives and community in pandemic times **26**
  3.1 Socialising at home 27
  3.2 (Local) community 29
  3.3 Conclusions 30
Section 4: Health organisation views during the pandemic **31**
  4.1 Communication and information sources for healthcare 32
  4.2 Attitudes towards health institutions and services 33
  4.3 Access to the health services 34
  4.4 COVID-19 Vaccination 36
  4.5 Conclusions 40
Section 5: Governance of vulnerability in the pandemic **41**
  5.1 Views of governmental interference 42
  5.2 Vulnerability 44
  5.3 Conclusions 46
Conclusions and Recommendations **47**
  References 49

SUMMARY



This report explores the experiences of Black, Asian, and Minority Ethnicity (BAME) (hereafter; minority ethnic, see Box 2) populations in the Swansea Neath Port Talbot area during the COVID-19 pandemic. Minority ethnic populations have often been deemed vulnerable for primarily clinical and social reasons. This report explores differential experiences of the pandemic by these groups and considers the implications for their current and future concerns. It studies the ways in which experiences of minority ethnic populations have changed expectations around pandemic regulations and healthcare responses.

Minority ethnic groups have come to know the pandemic through the new objects added to their daily environments. The kind of changes these groups have gone through in terms of jobs, study, and care roles differ from other population groups. As a result, minority ethnic populations have been impacted in different ways and therefore require different kinds of support.

Ultimately, the report contributes to previous analyses of the ways in which the pandemic shaped relations between healthcare organisations and minority ethnic populations in Swansea Neath Port Talbot. It does so to provide foundational knowledge on which pandemic-related and other healthcare services for these groups can be improved to address the exacerbation of health-based social inequalities in the area.

The report highlights several specific findings:

- The home was a key place that framed the experiences of COVID-19 pandemic. Members of all ethnic groups closely link the space of home with the COVID-19, and stress that its meaning has been altered because of the pandemic. While traditionally home is often associated with safety and refuge, many people with a minority ethnic background considered home as a challenging place that can create new pressures during the pandemic. This was particularly true for people suffering from anxiety or depression, who found home to be a problematic space of alienation that is not always experienced positively.

- At the same time, the pandemic blurred the boundaries of home and the outside world, with COVID leaking into home environments through the media and external visits. Access and use of natural environments was valued by the respondents as they were seen as places least associated with COVID-19. Therefore, provision of open and particularly outdoor spaces can create alternative places of escape and help people to mitigate the adverse impacts of the pandemics.

- Changing employment situations during the pandemic had differential effects in terms of gender and ethnicity. Women often felt negative consequences of changing working patterns, job demands (workload and work–home conflict) and due to increased caring responsibilities, pressures of maintaining work-life balance (burnout and commitment to work), and perceptions of work insecurity. Minority ethnic groups were negatively affected by increased work pressures and workload during the pandemic, which often produced additional strain and anxieties.

- Apart from physical health, the COVID-19 pandemic has also produced differential impacts on psychological wellbeing of populations in the Swansea, Neath, and Port

Talbot areas. The report highlights the gender gap in mental health deterioration during the pandemic, with female survey participants suffering a higher increase in mental distress compared to the male survey participants. Minority ethnic groups tend to suffer a higher deterioration in mental health during the pandemic compared to British White groups, although differences in socioeconomic dimensions can further complicate mental health changes within the minority ethnic groups.

- With minority ethnic populations being at significantly higher risk of death during COVID-19, fear of death produced increased anxiety, stress and feelings of hopelessness and uncertainty among this group. Survey responses highlighted increased awareness of the inescapability and nearness of death and indicated that the pandemic produced heightened sense of social responsibility towards the closest family members and loved ones. Furthermore, respondents realised that COVID deaths are not entirely predictable and not limited to the elderly, disabled, clinically vulnerable, challenging earlier assumptions about the link between high-risk, triggering behaviours and death. For people with previous experience of living with death, the pandemic offered a way to have control over their death and an incentive to discuss potential personal demise with the friends and family.

- Because of the pandemic, changes in social relations and community formation have been profound for many people, including the different minority ethnic groups. Their effects need to be taken into account by the healthcare organisations, as particular lack of connections to supportive communities and social networks is likely to influence their patients' health. Pandemic communications and treatment protocols should not assume that patients can automatically rely on particular communities, even if they can be associated with them due to their ethnicity or social status (i.e. minority ethnic community). In addition, they could list communities and supportive organisations that people might find useful – such communications could help preventing increase in loneliness and feelings of societal alienation.

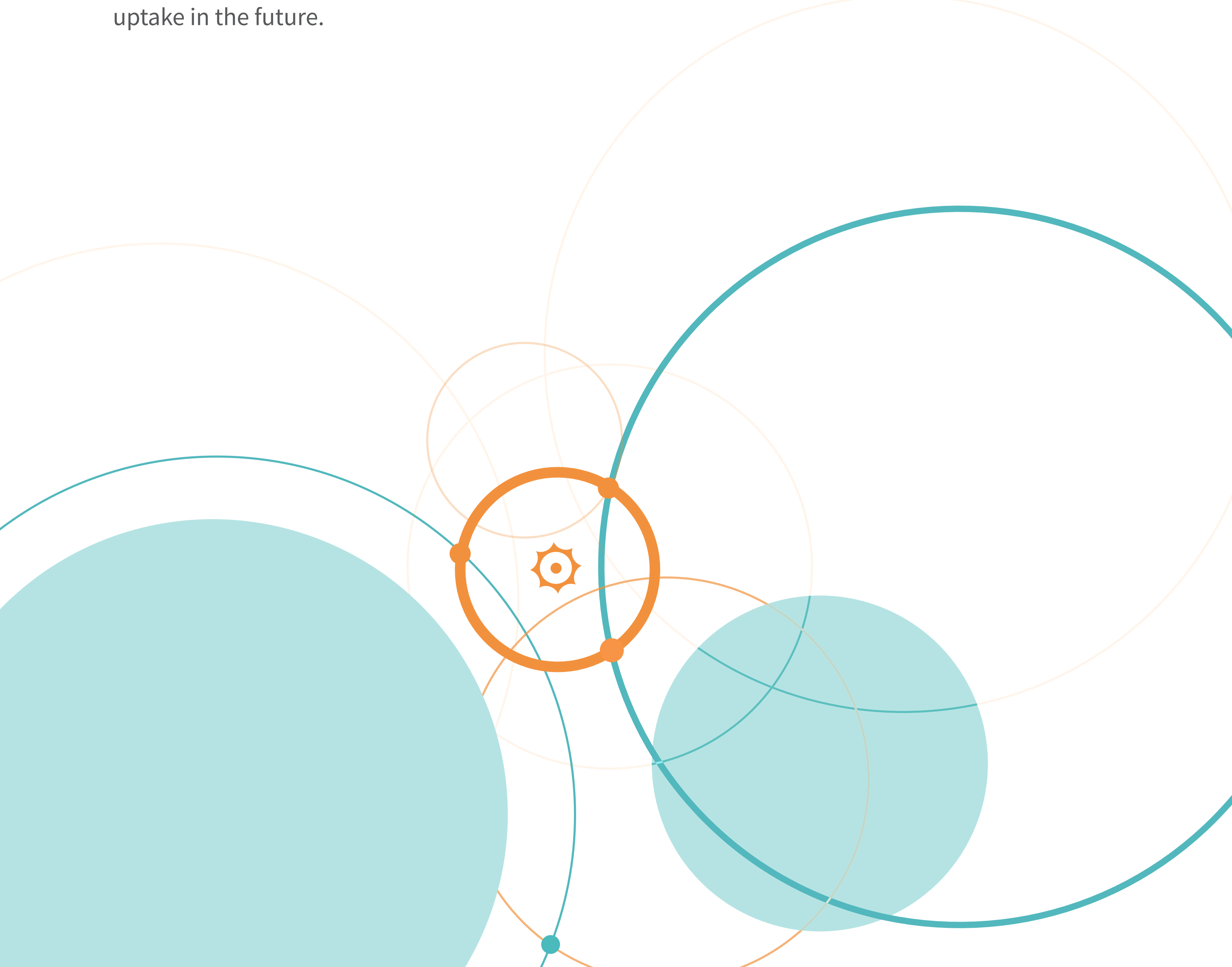
- The NHS and its sub-organisations, including the Health Boards, hospitals, and clinics tend to provide pandemic response at the large-scale level, dealing in quantities or populations. However, healthcare organisations do not often have the capacity to consider individuals with their unique circumstances and offer tailored responses. The healthcare organisations then seem unable to provide the service that is needed by minority ethnic populations as they do not have the capacity and insights to address all – primarily socio-cultural – concerns these populations have.

- Healthcare organisations face a conundrum requiring them to reconcile general and specific approaches. On the one hand, they are tasked with delivering the Welsh government's population-based policies that require generic approaches. On the other hand, they have to balance such generic approach with sensitivity towards different kinds of people and societal groups who differ in experiences, views, needs, and expectations of what they understand as 'good healthcare'.

- At the start of the pandemic, there had been concerns about vaccines' incompatibility with religious beliefs. In particular, these religious factors might be reflected in Muslim groups having lower COVID-19 vaccination rates in the UK (Razai et al. 2021). The survey results suggest that rather than spiritual guidance, science-based advice utilised by the Swansea and Neath Port Talbot's healthcare organisations and specific campaigns focused on minority ethnic populations in these areas played an important role in influencing people's vaccination deliberations.

- All ethnic groups in this survey strongly indicated a perception of vulnerability as also a social, rather than only a strictly clinical phenomenon in the light of the pandemic. In response to such perceptions, new pandemic measures and protocols as well as broader state measures offering state support (benefits, employment support etc.) could reflect this broader vision of vulnerability. New communication about protective measures, healthcare protocols, and vaccination campaigns (such as vaccination priority lists) should also incorporate social vulnerability. This will ensure that different dimensions of precarious experiences are adequately addressed during future pandemics.

- In contrast to governmental agencies that were seen as largely faceless and inefficient organisations, survey respondents judged healthcare institutions more favourably. This may partially be due to the ‘personification’ of NHS institutions through healthcare staff sharing selfies, talking about their experiences, and participating in social media trends on platforms such as TikTok, Instagram, and Twitter. Effectively 'giving healthcare institutions a face', such practices depicted healthcare organisations as ‘heroic’ and instrumental in mitigating the effects of the pandemic. Healthcare organisations refining, and governmental authorities adopting, a ‘personification’ strategy might help to create more trust and to keep up compliance with pandemic measures or to increase the vaccine uptake in the future.



INTRODUCTION

While health crises are not new, on many previous occasions their resolution relies on radical state and healthcare organisations' interventions based on careful preparation and planning. The COVID19 pandemic emerged as a different kind of crisis, which escaped the narrow confines of the medical sphere, and required us to learn from the experiences of multiple groups of people surviving it in many new ways. It produced a significant test in the management of resources (such as masks, tests and vaccines), re-orientation of living conditions and habits, re-evaluation of relationships, and caused unexpected manifestations of support and solidarity, particularly for marginalised groups. The pandemic worked on different scales and caused general questioning of meaning and practice of both health and social interventions. The pre-pandemic policies aimed at preventing the spread of the virus, re-organising populations and changing practices to limit and potentially stop the pandemic did not always work as expected and, importantly, produced differential effects on various population groups.

With COVID19, the state and healthcare organisations found themselves in a learning situation, when the effects of the virus can only be partially understood by collecting ever-changing statistical data. Acting in a "timely" fashion became an important element of response to the pandemic, with the meaning of time in terms of duration (periods of confinement, several COVID waves), norms (time perspectives, future horizons) and patterns (rhythm, tempo of social life) reconsidered. Yet, the demands to "do something" and act quickly on the basis of the growing number of COVID19 cases did not necessarily always prove effective, particularly in addressing the challenges faced by different ethnic groups (see Box 1). This report goes beyond the interpretation of the numbers of cases and statistics describing the potential damage to the economy to focus on the pressing issues faced by the ethnic minority people during the ongoing pandemic (for the terminology describing the groups, see Box 2).

Ethnicity:

Ethnicity can be described as "a form of collective identity that draws on notions of shared ancestry, cultural commonality, geographical origins and shared biological features" (Salway et al. 2014).

Box 1: Definition of ethnicity

In the ever-changing situations and evolving learning conditions of the pandemic, the state authorities and healthcare organisations found it particularly difficult to respond to new challenges that worsen health outcomes for minority ethnic communities. To address this gap, this report considers the pandemic experience of primarily minority ethnic people in the Swansea, Neath, and Port Talbot area. Of all residents in Wales, StatsWales (2021) estimates that, as per 31 December 2021, 4.9% people have a Black, Asian, mixed or multiple ethnic background, with 7.8% in Swansea County and 1.4% in Neath Port Talbot County. These ethnic groups are often grouped together in pandemic compliance analyses in comparison to White groups, which may not only deepen racial prejudice, but also obfuscate internal differences in these groups.

In the situation of learning how to adapt to changing conditions, it is always likely that pandemic responses were targeting population at large, at a very general level so as to optimise the logistics of the hospitals and conditions of everyday life for the majority of people. Such responses were often justified by the rational logic in the context of supposedly scarce public resources (Tyner, 2018). Public Health Wales has been working closely with the Welsh Government in providing pandemic responses, with the overall focus on population management. Similar to other state authorities across the world, the Welsh Government strived to limit the circulation of the virus by controlling population movements and changing everyday social practices, while Public Health Wales (PHW) intervened at the large-scale level (multiplicity of people) in an attempt to manage life and 'health' of general populations. Healthcare organisations in particular faced the difficult task of bridging the gap between the groups of people and service-providers, including those from health organisations and from the local authorities with which they collaborate. The differential infection, severity of illness and death rates amongst various societal groups has demonstrated how difficult it has been to operationalise pandemic policies from the authorities in a way that is efficient for all groups.

Welsh Government terminology around ethnicity in the "Race Equality Action Plan for Wales"

"[T]here was agreement that 'BAME' as an acronym should not be used. The Welsh Government has recently decided to discontinue the use of 'BAME' but to retain the use of 'Black, Asian and Minority Ethnic' in full in all its communications, and when shortened it is to be 'ethnic minority groups' (or communities or individuals). In the absence of agreement, the Steering Group decided to adopt the same approach. It was also agreed that where necessary, this can be shortened to 'ethnic minority'."

Source: https://gov.wales/race-equality-action-plan-anti-racist-wales

UK Government terminology around ethnicity:

"We do not use the terms BAME (black, Asian and minority ethnic) and BME (black and minority ethnic) because they emphasise certain ethnic minority groups (Asian and black) and exclude others (mixed, other and white ethnic minority groups). The terms can also mask disparities between different ethnic groups and create misleading interpretations of data. In March 2021, the Commission on Race and Ethnic Disparities recommended that the government stop using the term BAME. One of the recommendations in the final report on COVID-19 disparities, published in December 2021, was to refer to ethnic minority groups individually, rather than as a single group. This was supported by research commissioned by the Race Disparity Unit (RDU), which found that people from ethnic minorities were 3 times more likely to agree than disagree that the term 'BAME' was unhelpful."

Source: https://www.gov.uk/government/publications/final-report-on-progress-to-address-covid-19-health-inequalities

Box 2: Terminology of minority ethnic groups

Furthermore, generalised responses often meant that minority ethnic groups and their experiences were often side-lined in the practices reinforcing the assumed social norms and acceptable behaviours. In particular, minority ethnic people's health behaviours were often made fit with health behaviours considered to be objectively good or bad and easily measurable (e.g. smoking, tobacco, and alcohol use, particular kinds of physical activity, and diet). Scientific research and reports such as Public Health England's 2018 report on health differences between ethnicities reproduced the set of health behaviours that minority ethnic people tend to underperform in. Other evidence also suggests that “the virus itself does not discriminate – but our society that does” (Clissold et al. 2020:422). To date, several studies also overlooked socio-cultural dimensions of minority ethnic people’s lives that reflect and shape their health outcomes in favourable ways (Public Health England, 2020a).

This report highlights some of these less visible experiences of minority ethnic people, who have been deemed ‘vulnerable’ during the pandemic. It uses these insights to broaden the dominant imaginaries of COVID-19 that are mostly based on White people’s experiences. In addition to better compliance with the regulations, a more diverse understanding of the COVID-19 pandemic could provide new ideas for context-sensitive and diverse healthcare management in crisis times, helping the state to move from one crisis to the next. At the same time, this report cautions against victimising minority ethnic people in any way: both as different groups of people may not deem themselves vulnerable and because victimisation invites interference and dehumanisation (Tyner 2016, Tyler 2020). We want to listen to minority ethnic communities and document their differential experiences of COVID-19 to develop equitable responses to outbreaks of future viruses. The pandemic produced new understandings of what it is necessary to continue keeping Welsh society mindful of the virus in its midst. COVID-19 taught us that it is also necessary to learn from the experiences of different social groups to anticipate the need for potentially new sets of measures that may have to be introduced with new intensities of the virus and its new variants.

The different sections of the report therefore draw a bridge between new knowledge about minority ethnic group in the Swansea, Neath, and Port Talbot area and the hopes, fears, and other feelings of individual people living through the crisis times of the COVID-19 pandemic. After the introduction to the survey on which this report is largely based, Section 1 traces how people have come to know the pandemic and how the circumstances of their daily life activities have changed. Section 2 considers the oft-overlooked impacts of the pandemic on mental health, re-evaluation of the possibility of death and different effects of the government policies on mental well-being of minority groups. Section 3 addresses the changes in people’s social lives during the pandemic and community responses to pandemic-related pressures. Section 4 considers how healthcare organisations introduced and communicated COVID-19 regulations to different publics, responses to such communication (changing attitudes and practices such as vaccinations) and access to health services during the pandemic. Section 5 analyses the changing governance of vulnerability in the pandemic, including policy priorities and compliance with regulations. Finally, the Conclusions summarise the findings from this report and formulate lessons learnt from pandemic responses, particularly from minority ethnic groups.

The Survey

The survey that forms the basis for this report was conducted in the period from 1 November 2021 until 30 March 2022. It had 50 questions that varied between multiple choice answers, slides and Likert scales, and open-ended questions. The questions touched on themes such as life changes, vulnerability, vaccination, health service accessibility, and social relations. Some respondents were approached and filled out paper copies in shops and supermarkets that are often frequented by Black, Asian, and minority ethnic people in the Swansea, Neath and Port Talbot areas. The majority of respondents filled out the survey online on SurveyMonkey, the link to which was distributed via various community organisations. In total, the survey results of 173 people have been included in the analysis. They filled in one of 3 iterations of the survey. The majority of 139 respondents filled in the final iteration that was live from the start of December 2021 until 30 March 2022. As the survey’s first and second iteration did not include all questions asked in the final version, respondent numbers differ per topic.

The respondent group can be characterised according to the following

Location: 104 of the respondents are from Swansea; 21 from Neath; and 29 live in Port Talbot (and 10 outside of this area)

Gender and Age: the respondent group tilts heavily towards women and ages between 25 and 54 (see Figure 1)[1]

Ethnicity: 85% ethnic minorities including mixed and multiple ethnicity and 15% White. The report differentiates between different ethnic groups based on the topic. These will include Black people (with African or Caribbean heritage), White people (Welsh, British, and other white backgrounds), 'Bangladeshi', and/or 'Pakistani', 'Indian', and 'East Asian people' (including Chinese and South-East Asia). All non-white ethnic group categories include mixed heritage; for example, a mixed Black and White background is counted towards the category of Black people.

Religion: The vast majority of the respondents are spiritual. 47% is Muslim, 29% is Christian, 8% presence from Sikh, Buddhist, Hindu, and other beliefs and religions, and 9% people who don't align with a religion or belief.

Education: This is a relatively highly educated cohort: around 60% of the respondents have a Diploma in higher education (e.g. Btec) or a higher degree (e.g. a Masters).

Household composition: With 70%, the respondents overwhelmingly live in above average household sizes[2] of 3,4,5 or more people

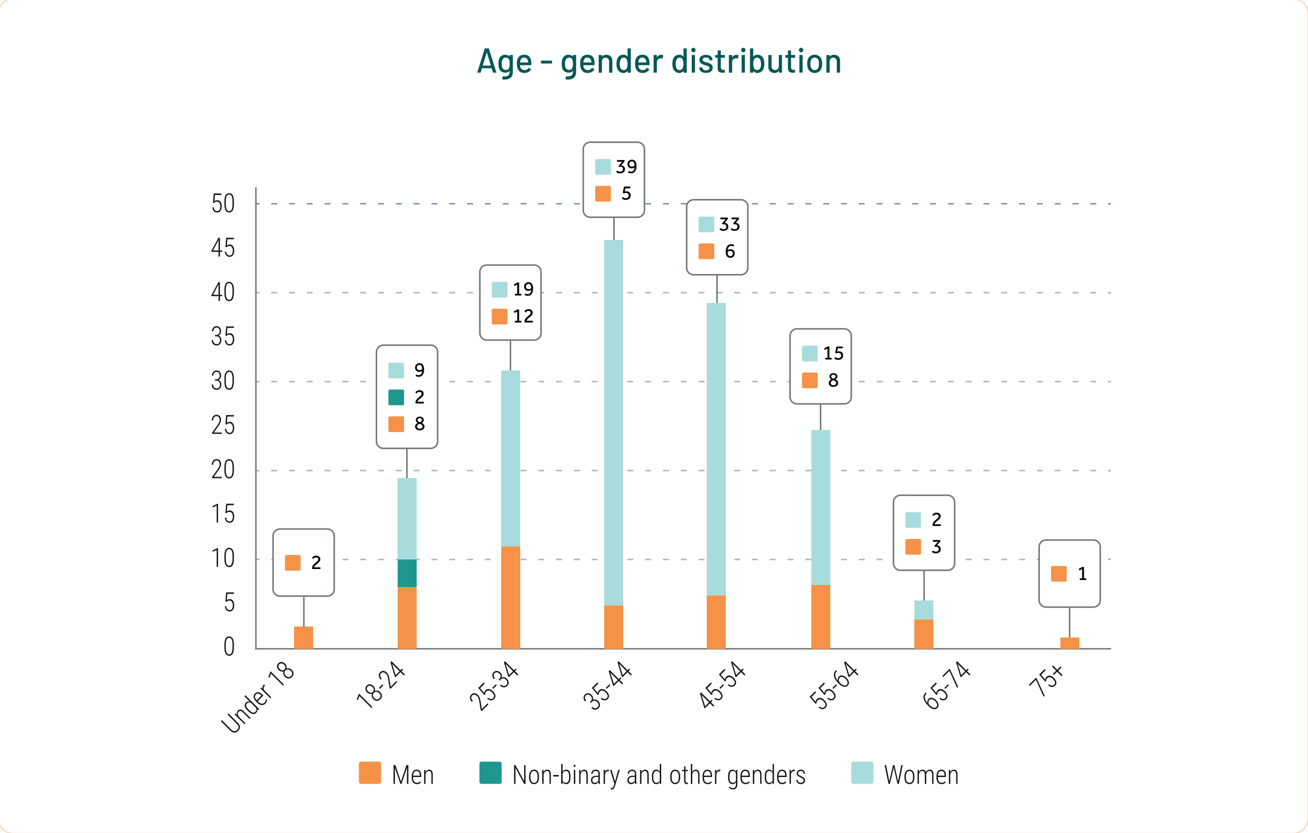


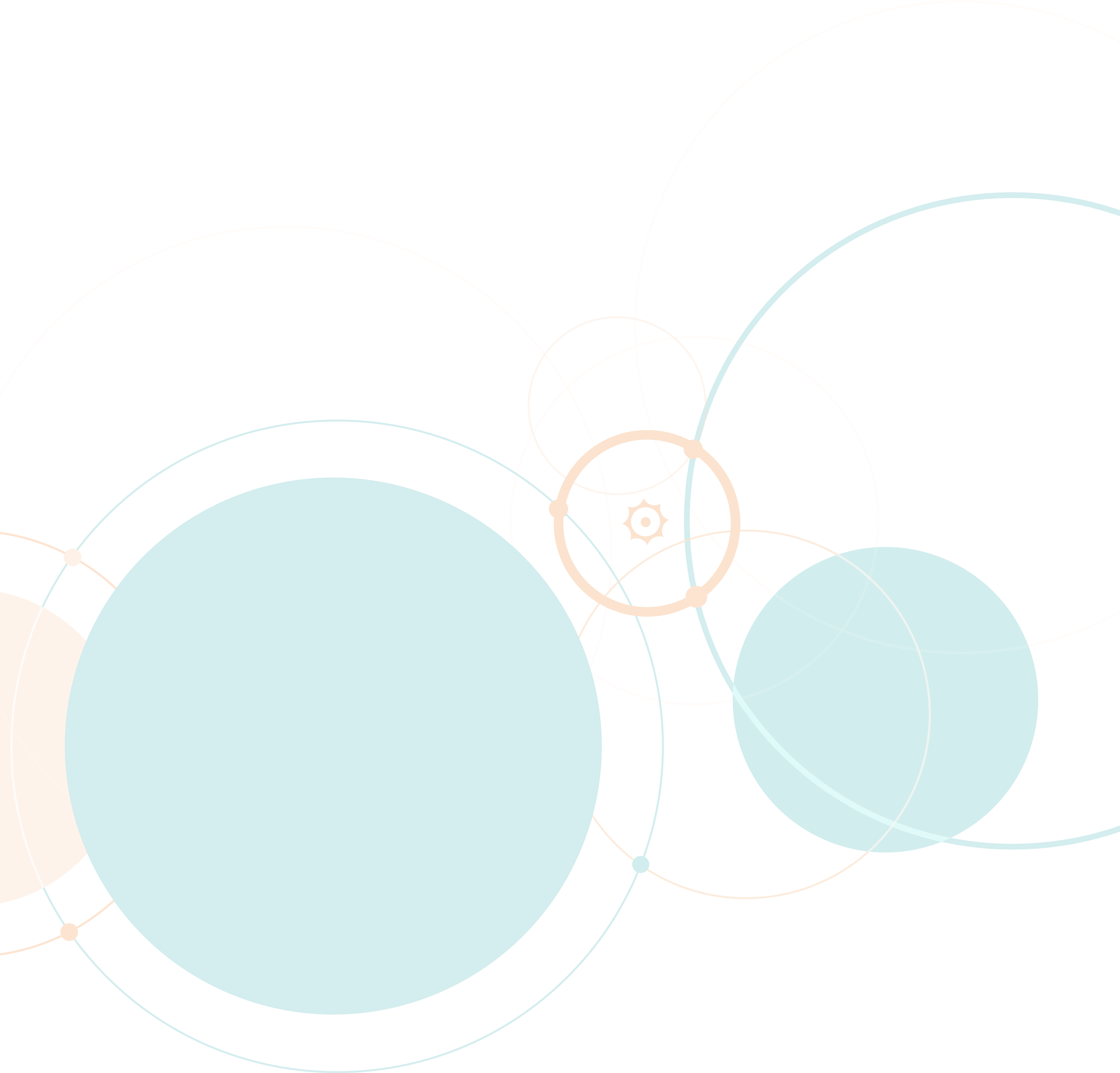
Figure 1: Respondent age-gender distribution

---

[1] The survey is based on gender self-identification, hence trans women are likely part of the category 'women', and people who fall outside the traditional categories are grouped in the 'non-binary and other genders' category. This category includes Intersex, Trans, non-binary, genderfluid and other gender categories.

[2] In Wales, the household size for 2020 was 2,26 people; in Swansea it was 2,20 people and in Neath Port Talbot 2,28 people. Source: StatsWales.

Although this survey is considered as a relatively large cohort, the survey results are not statistically representative of the areas. Therefore, as always in survey-based research, caution should be taken not to extrapolate and generalise the findings. They should be taken as providing indications for future policies and guidance documents, not as evidencing unshakeable, universal truth. Over the past two and a half years, the pandemic situation has changed rapidly, with dynamic forecasts, mathematical models and statistical estimates often complicating the monitoring and evaluation of COVID-19 effects on different groups. Thus, this report should be seen as a documentation related only to a specific period the legacies of which diminish in explanatory weight quicker than our assumptions about other social phenomena.



SECTION 1:
KNOWING THE PANDEMIC AND LIVING THROUGH CHANGE

Various people have had strongly differing COVID-19 pandemic experiences in Wales. Even sharing a profession, having children of the same age, and living in the same neighbourhood does not necessarily indicate that the pandemic has meant something similar to two people. As its impact was so pervasive and touched on so many aspects of people's lives, it is difficult to fully understanding how the pandemic differentially shaped people's present and future. Nonetheless, the analysis of the broader circumstances of an individual's situation and the changes they experienced may provide some insights into their current and future concerns and expectations around healthcare. Such insights could be helpful in providing the data, which are not included in the other, more formal institutional data-gathering exercises. Additionally, these insights could help to anticipate future support needs and indicate how different groups of people would respond to future pandemic measures and regulations.

Sub-section 1.1 traces the objects and events that make people aware of the virus and the changing intensities of the pandemic situation. Sub-section 1.2 analyses how people's spatial lives, their personal geographies create a certain feeling of 'atmosphere' of the pandemic. It addresses the question of duration and placement, exploring when and how people define if they are still going through the pandemic. Sub-section 1.3 explores how people's employment situations have changed (or remained unaltered) during the pandemic and considers the implications of employment changes for their everyday activities and financial situations. Sub-section 1.4 considers how people's work location and possibilities for homeworking produced differential implications for exposure levels to the virus and daily life organisation. The concluding section summarises the findings about the complex knowledge of the pandemic.

1.1
Reminders of the pandemic: objects/phenomena

To better understand how the pandemic has reshaped experiences and expectations around healthcare for minority ethnic populations in Swansea, Neath, and Port Talbot, it is useful to first better understand how people know the pandemic. It has often been said before: we are living in unprecedented times, and a pandemic of this proportion is truly new to everyone currently alive. Knowledge of any new situation stems from moments in which people encounter reminders of the similar past situation, which structure and recreate some possibilities and impossibilities in their present lives. Tracing what creates these moments provides insights into what makes the strongest impression about their lives under pandemic circumstances. This subsection formulates an answer to what makes the pandemic a reality and how they make sense of COVID-19 as a material phenomenon that can be experienced in everyday lives.

When evaluating change, people tend to focus on the appearance and transformation of things that stand out most in comparison to pre-pandemic life. In particular, wearing masks and seeing others wearing or not wearing masks was mentioned most (25% of survey respondents) (see Figure 2). Masks are immediate reminders of the potential of other people being dangerous to be around. Wearing masks assumes that other people could be infectious, or act as a reminder that an individual could be infectious and pose a danger to others. They are visual and tactile representations of the presence or potential presence of the virus, carrying the possibility of illness and even death. The related social distancing practice that reinforces the spatial potential of the virus travelling between bodies, was mentioned by 10% of respondents. Furthermore, hand-sanitising practices, stations, and signs that encourage people to use the fluids were mentioned relatively often (8% of respondents). In particular, Bangladeshi people seem to view these personal protection measures as an extraordinary reminder of the pandemic. Asian and White people stand out more in the alteration of the practical organisation of their daily activities. In particular, changing employment patterns and working from home made a relatively strong impression on these groups, with Asian people stating that their lives were more impacted by education moving online during the pandemic.

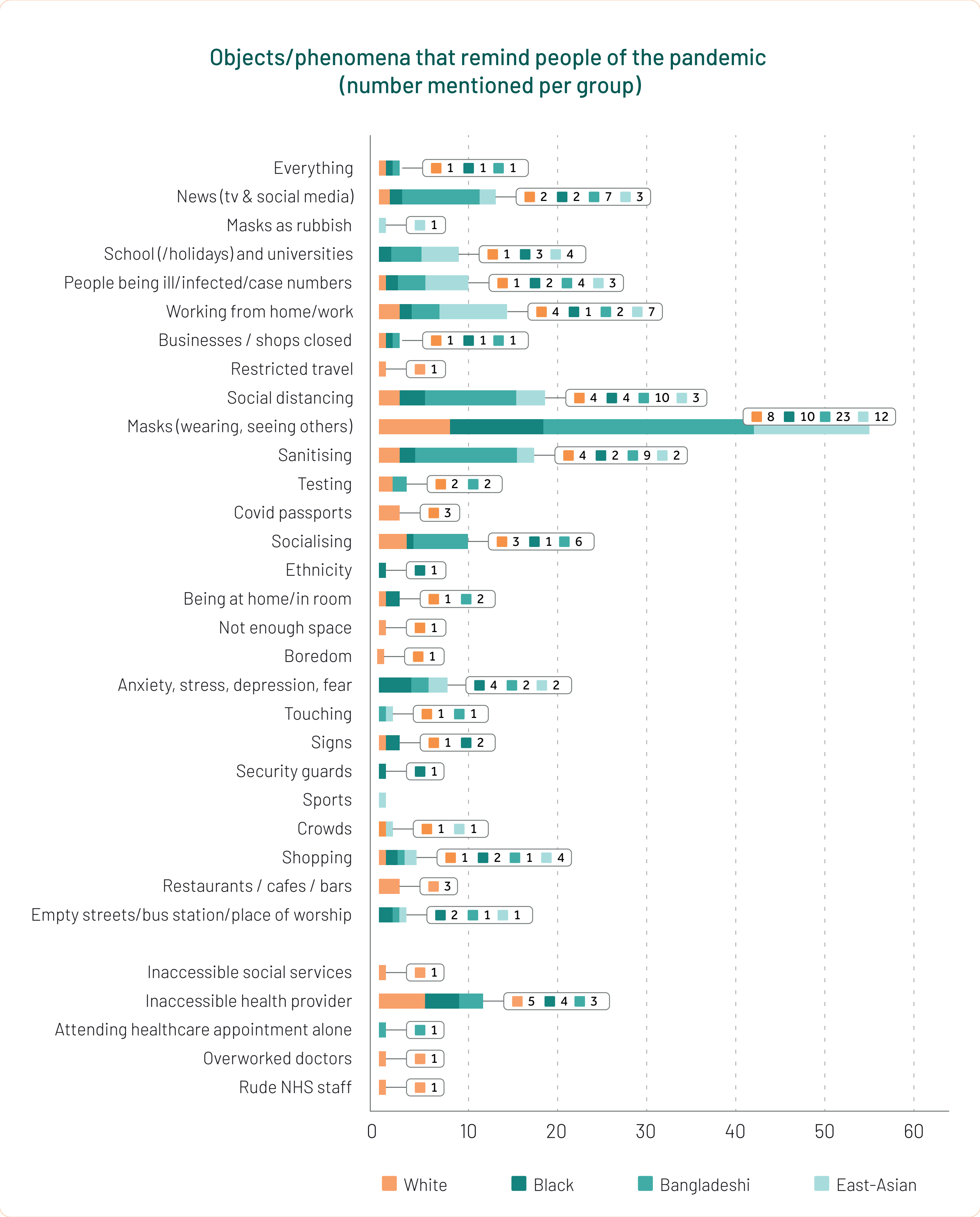


Figure 2: Objects and phenomena that serve as reminders of the pandemic situation

There are several findings that highlight differences in the experiences of the pandemic by minority ethnic and White populations. Minority ethnic populations seem to associate the pandemic with stress, anxiety, and fear more than White populations. This heightened intensity of feelings might be related to news reports about the disproportionate COVID-19 illness and death rates in minority ethnic populations in comparison to White populations (Public Health England 2020; First Minister's BAME Covid-19 Advisory Group 2020). Also, and by extension, it may indicate that minority ethnic people are more mindful of they themselves falling ill or people they knew getting ill or dying because of the virus.

Another element serving as a constant reminder of the pandemic was the news and (social) media reports, which were mentioned by all ethnic groups (7% of respondents). White people are often not questioned about their willingness to remain informed about the pandemic, as a result they don't tend to name the news as reminder of the pandemic. In contrast, the Bangladeshi population stands out as being the most aware of the pandemic's presence through the media. While it is often believed that ethnic minority groups are less interested in the pandemic-related news updates, the survey findings may suggest the opposite: these groups do stay informed about the pandemic to a much higher extent than that they are often given credit for. Communication strategies that focus specifically on minority ethnic populations seem to be able to reach these target groups. In particular, minority ethnic people seem to be aware of pandemic communications, which emphasise that ethnic minority groups are more likely to experience severe illness or die from COVID-19. However, the strategies to reduce the spread of COVID-19 could be more effective by addressing the anxieties of these groups more specifically and utilising the objects and situations that remind them of the pandemic.

The ways in which people learn and makes sense of the pandemic often affects the ways in which they envisage a viable solution to COVID-19. The fact that there is a difference between different ethnic survey groups in learning and understanding the pandemic indicates that various survey respondents think differently about what makes 'good' and appropriate solutions. Currently, the set of solutions on offer stems largely from the medical model of illness and health, which are largely rooted in the experiences of white populations. To address 'non-white' solutions (particularly around manifestations of illness, ideas around healthy bodies, and community and food practices) and to avoid overlooking approaches that do not necessarily resonate with white people's experiences, a broader set of potential pandemic responses ought to be considered.

By July 2022, these 'old icons' (i.e. masks, gel, and social distance) of the pandemic have largely disappeared from the public spaces in Wales. In 2021, the disappearance of the visual representations of the pandemic left many people eager to forget the pandemic and move on to a 'normal' life (Li & Meinhof 2021). While it is not possible to predict the timing and epidemiological conditions of the future pandemics, we can analyse the ways in which COVID-19 came to matter and became meaningful to prepare for different, perhaps less restrictive pandemic governance policies. The analysis of people's reactions to the unexpected and frightening effects of the COVID19 pandemic can also help in communicating different presences of the virus and its potentially destructive effects on people's bodies.

1.2

Reminders of the pandemic: places

Referent to the objects, practices, and life moments that remind people of the pandemic, a distinct geography can be recognised. Masks, sanitation practices, and social distancing are bound to public and other shared spaces, but surprisingly, places like the street (9 people commented on this in the survey), shops (10), and supermarkets (14) did not seem to be particularly linked to the pandemic. As can be expected, also noteworthy are the medical spaces of the GP surgery (14), dentist (10), and pharmacy (13). These spaces that are extensions of the healthcare organisations thus seem to be at least mildly associated with the pandemic.

Indeed, masks, sanitation, and social distancing are objects and practices that do not tend to take place in the home, unless when accommodating visitors. The home will therefore likely have been a place that was considered relatively indistinct from the pandemic. Whereas the home is traditionally seen as a refuge, private shelter, and as a safe place from the outside world (e.g. Moore 1984, Dovey 1985, Bachelard 1994) which has been contested on multiple grounds (e.g. Blunt & Varley 2004, Blunt 2005, Blunt & Dowling 2006), in the pandemic, the meaning of 'home' has changed further. Yalçin and Düzen (2021: 10) argue that "during the pandemic, particularly during the lockdown, the boundaries of home expanded tremendously towards inside. Home had to assume a lot more symbolic and metaphorical functions, and thus meanings, than ever." Yalçin and Düzen (2021) also note that "that people adopted culturally congruent attributes of home during the lockdown in order to cope with fears, threats, and normative changes while having to deal with importunate daily routines individually".

During the pandemic, the home was seen a place in which exposure to the virus has been relatively low, except in keyworker households and, to a certain extent, households with children. Nonetheless, watching the news or being on social media using the Wi-Fi at home, and working from home would blur the boundaries of home and the outside world, bringing in the influences of the pandemic within the homely environment. Those (57) people, who mentioned home as a place where they are reminded of the pandemic, represent a group who might have depression and anxiety issues. This may have included particularly people who have been shielding and did rarely leave the home. The emotional burden that comes with residing in a space that is a constant reminder of a crisis is high and is not conducive to creating one's positive mental state (Zolnikov et al. 2021). In contrast, the survey respondents considered natural areas, which are relatively void of other people and pandemic mitigation measures, as least important spaces in which people were reminded of the pandemic. The natural areas were therefore often seen as places of escape for many respondents facing mental health challenges and feelings of isolation imposed by the "stay at home" orders. (Grima et al. 2020). This finding corresponds with the fact that more people took up walking in natural areas during the height of the lockdowns, especially in the beginning of the pandemic during the first lockdowns (Rose et al. 2022).

To conclude, where people spend their days is of crucial importance in terms of their experiences of the pandemic. Strategies to mitigate mental health problems thus ought to incorporate a situational sensitivity and recommend how a mixture of residing in spaces such as the home, natural areas, and shared public spaces, impacts how the pandemic is experienced and what legacies it has for an individual. Provision of open and particularly outdoor spaces that can provide beneficial effects for physical and mental health can help people to mitigate the adverse impacts of the pandemics. Communication strategies around the pandemic regulations thus ought also to be mindful of where people spend most of their time. Additionally, non-medical healthcare advice or psychoeducation ought to include recommendations for people to introduce variations where possible.

1.3
Changes to employment situations

The understanding of how the different minority ethnic populations have lived through the pandemic and form opinions and expectations of the healthcare organisations is, in part, linked to their daily activities and related income and investment in their future through studying. For instance, for people on lower income, health becomes a potentially expensive aspect of life. Similarly, family pressures often mean that health issues do not get picked up or attended to in a timely manner, which might exacerbate them in the long run. When looking at the changes to people's lives during the pandemic, major differences can be noted in the survey data between various ethnic populations. Whereas many Indian people suggested that not much has changed in their daily lives during COVID19, Asian and Arab people stressed a noticeable difference in their lifestyles. For both groups, as well as for Black and White people, we see a decrease in fulltime work and an increase in parttime work. This change has immediate impacts on the household income levels, and with the rising costs of living, it may have resulted in a more precarious financial situation. This is compounded by the higher likelihood that low-paid employees were made unemployed as a result of this crisis, particularly affecting minority ethnic groups (Bell, Gardiner & Tomlinson 2020).

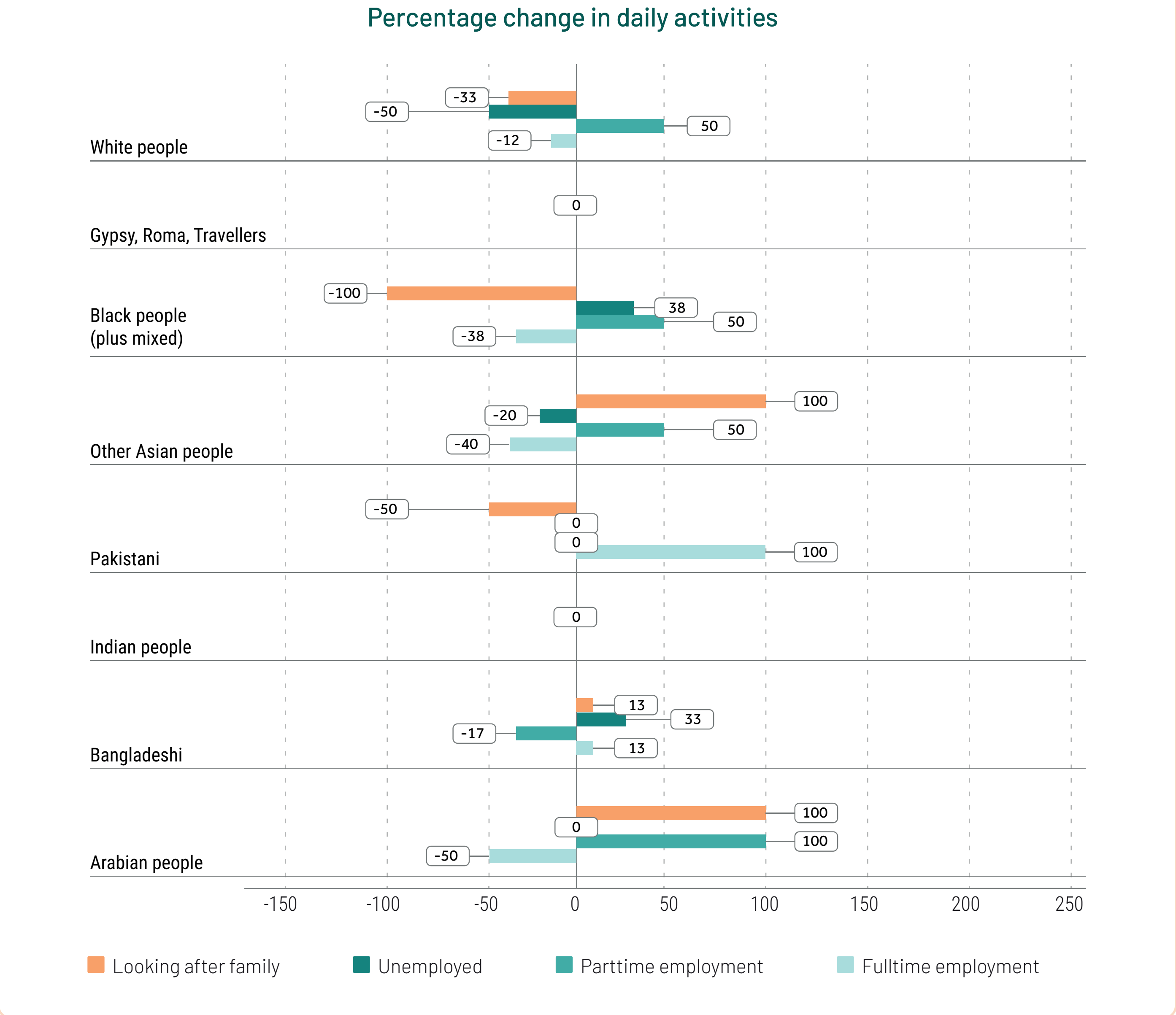


Figure 3: Changes in daily activities

An increase in parttime work may also manifest in people taking up multiple jobs to keep income levels up. With parttime work and unemployment having increased and fulltime work and looking after the family having decreased for Black people, in the survey it seems like this group has been hit hardest in terms of overall income during the pandemic. Also Bangladeshi populations have seen a rise in unemployment, which may not only make these groups economically more vulnerable, it is likely that this rise is accompanied by mental health problems (Hu 2020).

In contrast, Pakistani people reported in the survey higher levels of full-time employment during the COVID-19 pandemic, which may suggest largest overall income rise and reduction in the number of people looking after the family. White people also have increased their working hours during the pandemic, particularly due to the reduction in unemployment rate amongst this group. However, as seen in the case of White populations, such a reduction in unemployment and increased pressures of looking after the family may have resulted in increased unhappiness for being forced to take up work that might not be enjoyable and potentially dangerous due to the increased exposure to the virus. For many ethnic minority groups, such changes to employment situations and increased workload during the pandemic have negatively affected the balance between job demands (workload and work–home conflict) and wellbeing (burnout and work engagement), often producing additional strain and anxieties (Da et al. 2022).

When looking at changes in the circumstances of people looking after the family, considerable gender differences stand out. When asked about life before the pandemic, 13 women categorised themselves as looking after the family and only one man did so. This was a Pakistani man between the ages of 55 and 64 who took up a parttime job despite also being disabled. This is likely to have put extra strain on him as well as on his family, as this unpaid work now also falls on other household members. Likewise, an Arab woman (aged 45-54) also took up more care work despite having a long-term illness or disability. She and two more women changed their daily activities to look after the family. Two young Bangladeshi women (aged 18-24 and 25-34) finished or quit a parttime study and gave up their parttime work, and an Asian woman (aged 35-44) left her full-time paid employment to look after her family. Whilst these changes are not dramatic in statistical significance, they demonstrate that gender imbalance in income and financial dependency has been exacerbated during the pandemic. Broader studies on changing employment situations for women in the pandemic also suggest that changing working patterns had particularly negative effect on working women due to increased caring responsibilities, pressures of maintaining work-life balance, and perceptions of work insecurity (Oo & Lim 2021).

Going through any major change at any time in one's life can be stressful. To have to do so during a pandemic will bring even more pressure, especially with a family to look after. The impacts on people's expendable income, family time, as well as potentially having to do jobs that expose people to the virus to a higher degree and that may not be their first choice brings extra stress in households that have to function in an already stressful environment. These conditions then create complex mixtures of pressures and anxieties that shape people's capacity to comply with (future) rules that restrict activities that take some of the pressure of (Williams et al. 2020). Such changes in people's lives may also shape how governmental agencies, healthcare organisations and their representatives are viewed. Indeed, compared to the profound impact the changes in employment have had on people's lives, the measures introduced by the government agencies might seem almost too benign. As other people will have had their lives much less disrupted, feelings of resentfulness would not be out of place (Fancourt et al. 2020).

1.4
Location of work

In addition to changes in daily activities pertaining to employment, the changes to work location create new circumstances for people to get infected. Ethnicity seems to play a role in determining who had a reduced exposure to the virus by being able to work from home, and who worked in other settings that potentially required them to be around others. Ethnic groups in UK cities tend to differentiate in their job specialisms and careers such as in healthcare and transport. Such differential exposure is likely to have had an effect on the minority ethnic communities. For instance, those being able to work from home can include IT and administrative workers, online marketeers, management and other jobs that also tend to be paid at a higher rate. Those who cannot do their jobs at home include healthcare workers, shop and restaurant personnel, cleaners, taxi drivers, street traders, agrarian and industrial workers, who tend to be waged at a lower rate.

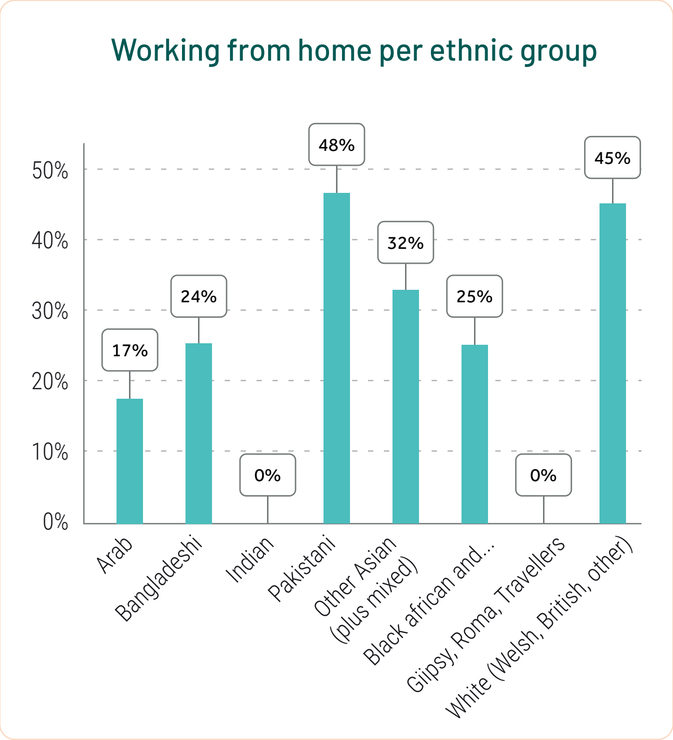


Figure 4: Distribution of people working from home amongst ethnic groups

According to this survey's data, only one in four or less among Black people, Bangladeshi, and Arabian people has worked from home during the pandemic (see Figure 4). This expresses the strong differential exposure to being infected by the virus per specific ethnic group, with Pakistani and White survey respondents having been relatively safe. Nonetheless, working from home presents additional stressors in the work-life balance mentioned before, as well as competing use of space, internet capacity, and need for silence. This is especially important in small apartments or homes of large households, where working from home can create additional pressures.

Whilst working from home decreases the possibility to be infected with the virus, it does not necessarily amount to a better quality of life. Indeed, according to research on the effects of working from home by a Wales-based women's labour organisation, it presents major difficulties in organising one's day (Chwarae Teg 2020). Indeed, this recent study warns that the flexibility offered by many jobs that mandated working from home also meant reduced possibilities for work and broader life to be as separate as it would have been before the start of the pandemic.

In terms of differences in localities as indicated by the survey, Neath and Port Talbot have been very similar in people's requirement to work away from home, whilst people in Swansea have been slightly less likely to work from home during the pandemic. Nonetheless, in all three localities, less than half of the parttime and fulltime paid employment has been done from home. In effect, it may have been possible that over half the working population in Neath, Port Talbot, and Swansea has been exposed to the virus to a higher extent than if they worked from home. In turn, this is likely to have also increased the exposure of household members in the families of these workers, including vulnerable ones. Given that infection and (prolonged) illness puts people's income at risk through hours of work missed, going unpaid or potentially accelerating redundancy processes, people who are already in poverty are more likely to have been pushed into deeper poverty (Bell, Gardiner & Tomlinson 2020). Covid illness and increased poverty may in effect also exacerbate other health problems.

If we consider workforce that requires to be in a shared workplace, urban centres differ from the rural spaces in terms of COVID19 rates. Urban centres, where more people work in shared spaces compared to smaller villages, are more likely to post steeper infection and illness rate increases. This disparity puts extra pressure on healthcare institutions in urban centres like Swansea, as they have less time to prepare for the relatively rapid increases in Covid-19 patients in comparison to the smaller towns Neath and Port Talbot. As minority ethnic populations also tend to live in more urban centres, it increases their levels of exposure to the virus (McFarlane, 2021).

1.5
Conclusions

Black, Asian, and minority and mixed ethnicity groups have come to know the pandemic through the new objects (e.g. masks, hand sanitiser bottles) added to their daily environments. There is a difference among minority ethnic groups in their experience of employment, study, and care role changes during the pandemic. This difference indicates that these minority ethnic groups were impacted in different ways and therefore require different kinds of support. Also, the success of compliance with future regulations might be mediated through the control and management of spaces where the virus is made present (e.g. the home, medical spaces, and supermarkets). If the healthcare organisations can insert associations to themselves in such places (e.g. through logos, other images, and text), this might have positive impacts on their reputation.

The data demonstrates relatively significant changes in people's daily activities and related income levels that are differentiated per group. More detailed insights and strong claims can, however, not be derived from this survey. Increasing working hours have led to increased exposure to the virus, especially if people had to work away from home, which was the case for jobs done by minor ethnic groups. The precariousness of work for many ethnic minorities, who are doing low-paid yet essential jobs, have been exacerbated by the pandemic (Kantamneni 2020). COVID-19 has also exacerbated the inequity in employment, particularly in terms of gendered care work in the home, significantly impacting Asian, Arab, and Bangladeshi women.

The survey also indicates how different ethnicities have differentially defined the pandemic as they have come to know it differently. Some people from minority ethnic groups seem to see their shared social life as having been impacted more vigorously by the alterations in social distancing and socialisation. People's circumstances influenced how they experienced the pandemic and what kind of regulations they saw best fit to respond to COVID-19. These perceptions and expectations of healthcare responses were affected by specific spaces where people spent their daily lives during the pandemic.

There is an intricate set of 'pandemic geographies' that can be detected from the survey. Firstly, the objects that remind people of the virus tend to be in shared public spaces. Secondly, places that remind people of the virus and where they learn about the extent of COVID-19 tend to be private, homely spaces, where intensities of pandemic-related anxiety are also highest. Thirdly, spatial networks of differential exposure to the virus tend to have their intensities peak in urban shared spaces where jobs that are disproportionately filled by minority ethnic people and are low paid. Overlaying these geographies suggests that minority ethnic people are much more likely to be exposed to the virus due to their disproportionate presence in low-paid, urban, frontline jobs, which increase the existing socio-economic inequalities. At the same time, minority ethnic populations do not always have enough workable understanding of the virus, opportunities to work safely from home or ability to access decent jobs, which contributes to the pandemic pressures they experience. These economic and structural inequalities, which exacerbate job circumstances and contribute to the discrimination of minority ethnic groups within the workforce, should therefore be considered carefully with the development of new protective pandemic-related measures.

SECTION 2:
MENTAL HEALTH AND WELLBEING

Mental illness creates conditions where people feel to have reduced or no control over their lives, which deprives them of finding meaning in their social relations, work, hobbies, and future. As a subject under governmental regulations, mental illness represents a diminished possibility to make viable policy for them, as the ‘rational’ structures of meaning are less capable of predicting what a mentally ill person does and wants (Goldman & Grob 2006). A crisis event, such as the COVID-19 pandemic, is associated with starkly increased numbers of people who are becoming mentally ill. Whilst resident compliance with regulations is needed more than ever, the pandemic also causes less capacity for the population to do so. Indeed, it is more difficult to understand what measures are introduced at what speeds, for what reasons, and address what populations have the desired effects. The realities of groups who have already been marginalised in government policies before the pandemic are already less represented in policy, which reflected in the negative mental health changes for minority ethnic groups in the UK (Daly et al. 2020). As a result of the pandemic, increased mental illness and drop in mental health in the different marginalised minority ethnic populations is likely to diminish these groups’ chances of fair representation in social policy even further. This section explores how minority ethnic people have experienced changes in their mental wellbeing and how they have reconsidered notions of death and dying. To this end the section considers if new ways of finding connection with these groups and determining potential responses by healthcare organisations and mental health services from voluntary sector organisations to the changing mental health experiences of minority ethnic people.

2.1

Mental struggles

Whilst healthcare organisations have primarily functioned to help people recover from the illness of the COVID-19 virus, they have also seen additional requests for support related to individual's psychological wellbeing. Such support is particularly needed for the well-documented pandemic-related mental health problems in the UK that manifest in (heightened) anxiety and depressive symptoms (Proto & Quintana-Domeque 2020). Similarly, in the Chinese context, Li et al. (2020) suggest that the greater the perceived severity is of the virus, the poorer mental health outcomes can be expected. Therefore, it is necessary to understand what the most important mental health pressures are faced by people during the pandemic. This understanding will help to optimally organise healthcare policies and institutional services to meet these mental illness needs when they can no longer be managed by the affected people themselves. Beyond the obvious reduction of immediate suffering, pressures on people's jobs and family life, as well as the prevention of suicide, mental illness impacts pandemic policy adherence. As Lee et al. (2021) argue in the context of Hong Kong, people who are mentally unwell tend to adhere to the pandemic measures more strongly than others, because they respond to clear structures and regulations that address the direct fear of the virus and getting ill. They suggest that people who fall into this category might even take the precautionary measures 'too far' and require specific care and support. Manifestations of these fears include not leaving the home, not visiting friends and family and avoiding crowded places. These responses to COVID-19 regulations by affected individuals put severe strain on their lives and impede possibilities for recovery.

On average, in the Swansea, Neath and Port Talbot area, and over the November 2021 to March 2022 period, survey respondents have indicated that they felt midway between extremely happy and extremely lonely: 52 on a scale ranging from 0 (extreme loneliness) to 100 (extreme happiness) of aggregate feelings over the two weeks prior to partaking in the survey. At the same time, there are noteworthy differences along the gender lines and between ethnic groups in describing their psychological health during the pandemic. Clinical definitions of vulnerability to the virus predict that men experience a higher deterioration in mental health as they require more support to reduce the risk of severe illness and death as compared to women (Proto & Quintana-Domeque 2020). However, in our survey this prediction of mental health deterioration does not quite work as men score on average a relatively high 62 points on the happiness scale. Women, who are deemed less clinically vulnerable to severe illness and death, seem more vulnerable to exacerbating mental health problems, as their rating is 52 on the happiness scale. In general terms, this reflects Thibaut and Van Wijngaarden-Cremers' (2020: np) findings who explain that the gender gap in mental health deterioration during the pandemic exists because of "the specific psychological and psychiatric risks faced by women both as patients and as workers in the health sector, the increased risk of violence against women at home and at workplace and, finally the risk run by children within their families." Recent research in the Welsh context found that during the pandemic women largely lost their support networks and saw alterations in childcare expectations, which negatively affected their mental health:

> ***"The fact that somehow women were expected to balance these different roles successfully, you know, dealing with the childcare at the same time as doing their jobs you know, somehow stretching the workday beyond belief and being able to be always present in different forms, so while supporting children's remote learning, at the same time doing things which are supposed to do their job somehow, at the same time, is sort of an impossible combination."***
>
> (Chwarae Teg representative, 2022)

In turn, the people with other gender expressions that participated in the survey have been doing a lot worse with two reporting depression and anxiety alongside an average rating on the happiness-loneliness scale of 30. It should be noted that this gender category is often left out of clinical pandemic information and guidance, which results in people with other gender expressions experiencing being left out of the protective measures introduced by the Welsh government and NHS.

In addition, the survey suggests that minority ethnic groups of Asian people (excluding Indian, Pakistani, and Bangladeshi) are most content, averaging at 62 on the happiness scale, closely followed by Pakistani people with 60 and Bangladeshi with 59. Accordingly, Black people and Indian people tend to drive the difference in mental health experiences during the pandemic: these groups both average at 46 on the happiness scale. Overall, minority ethnic groups tend to suffer from a higher deterioration in mental health compared to British White groups (Proto & Quintana-Domeque, 2020). Whilst along social lines minority ethnic people had been denoted as more vulnerable to severe illness with COVID-19 than White people, the susceptibility to mental illness is more complex with strong differential outcomes along ethnic lines. This suggests that mental health support in the pandemic needs to be designed and organised to target ethnic groups differently and with great sensitivity to gender difference.

Depressed people’s experience of accessing mental health support or counselling from the NHS was starkly divided with the half of survey respondents suggesting their pre-pandemic appointment patterns were easy to access whereas the other half found it difficult. Moreover, people new to these services reflected this differential experience with the ease or difficulty of gaining access. In territorial terms, people in Swansea seem to be able to access these services slightly easier than those in Neath or Port Talbot. Improvement of access can therefore be made for the broader population, with special emphasis on the accessibility of services in the Neath and Port Talbot area.

2.2

Changing thoughts about death

As of 2 September 2022, the number of people who have died when Covid was a contributory factor has reached 10,714 in Wales, with Swansea council posting the third largest number (1,112) of COVID-related deaths behind only Rhondda Cynon Taff and Cardiff (Duffy, 2022). Since March 2020, the Office for National Statistics has recorded 7,588 more deaths in Wales in comparison with the five-year, non-pandemic average. This has had several implications for how the pandemic was experienced, what lasting legacies it leaves, and how healthcare services ought to improve. Death has been a central theme in the experience of pandemic times for many people, which prompted increased anxiety and fear of possible personal demise and feelings such as hopelessness and uncertainty. Menzies and Menzies (2020: np) therefore concur that "treatment programmes in mental health may need to broaden their focus to directly target the dread of death". Reflecting the experience of the survey respondents, many people reported knowing several others in their social circles and communities who have passed away. Even for those who do not personally know people who have died after being infected with the virus, death has been on their mind in more intense forms due to widespread information in the media. Survey respondents remarked on the intensification of feelings of anxiety, fear, and depression in relation to the fear of death in broadly four themes:

1. ***Nearness of death:*** As the survey suggests, the most common theme in shifting thoughts around death during the pandemic encompasses the realisation that death is not always preceded by long periods of time or a period of illness. Rather, respondents have found death to possibly happen "at any time" or even "now" and be "closer" than they previously thought. Appealing to their sense of safety and protection, death is perceived as being "near" or "closer to home", which is perceived as "cruel" and "daunting". Equally, according to the qualitative comments in the survey, death takes place "anyhow" and alluding to its inescapability, one "can't avoid it". In addition, in relation to ideas about living a fulfilled life, the COVID-19 pandemic made people particularly worried about dying "early".

2. ***Social absence:*** Another set of new thoughts about death entails life after people have died and concerns about those who continue living. Alluding to a sense of social responsibility, it worries many people that their loved ones/ family may struggle to cope without them. These thoughts reflect increased stress, fear and anxiety about COVID-19, which involve taking on the grief and sense of loss for another person.

3. ***Randomness of victimisation:*** This theme entails the realisation that COVID deaths are not entirely predictable and not limited to elderly, disabled, clinically vulnerable, and unfit people. Survey respondents who do not belong to such groups seem to have been triggered in having new thoughts about their own death, as it seemingly "happens to everyone", including "strong", "fit", "healthy", and "young" people. Diverting from previous associations between high-risk, triggering behaviours and death, many respondents recognise the pandemic as the time when broader human life is at risk. Many respondents attempted to receive psychological equanimity by admitting that death can also happen "easily". The protective 'layer' of safety rules and behaving according to what they can conceive of as self-preservation, seems to suddenly be insufficient anymore to postpone one's death.

4. ***Confirmation of presence:*** This reported type of feeling about death during the pandemic was mentioned most by respondents who have had death as regular and consistently present element in their lives before the pandemic. This would pertain mostly to people who have had suicidal thoughts or who possibly have had to work through a death-related personal trauma, such as the death or illness of a loved one or their own illness or disability existing

> before the pandemic. As other studies suggest, the virus may have become another reason for generalised anxiety and thinking about death (Pérez-Mengual et al. 2021), particularly as a way to have control over their death, which is also evident among our survey respondents.

Strategies to cope with these pandemic pressures increased and intensified thoughts about death and its nearness and inevitability. According to the survey results, during the pandemic people seem to pray more and speak more with family and friends in relation to the fear of death. One respondent stated that "I wrote a message for my kids, making my Dad smile because life is so short we not guaranteed today let alone tomorrow" (Muslim woman, aged 45-54). Thinking about death expresses symptoms related to anxiety, depression, and post-traumatic stress disorder (Murphy et al. 2021), with respondents in our survey reporting prevalent feelings of sadness and paranoia, which tend to be accompanied by problems with sleep.

In conclusion, the COVID-19 pandemic has at least temporarily reconfigured ideas about death, which can alter what circumstances and risks are associated with dying, what kind of behaviours are perceived as dangerous, and what kind of response is viable. Perceptions of and attitudes towards death also change depending on the type and tone of messages in pandemic communication to which people are likely to respond. Public Health Wales, health boards and other healthcare organisations ought to take note of such changes – even if perhaps minute – when communicating new policies, support services, and other requirements to the public. Particularly pertinent seems to be the renewed realisation of the inevitability of death and the speed at which it can occur. Defying notions of old age, ill health, and disability as leading to imminent demise, bodies that are more vital (young, healthy, and abled) during the pandemic seen more within reach of death than ever before. Such concerns do not only affect a specific individual but may extend to the younger and fitter family members who had been considered relatively far removed from a possibility of an 'early' death.

2.3
Conclusions

The pandemic has clearly conjured strong affective responses from the people in Swansea, Neath, and Port Talbot. It seems like the clinical vulnerabilities and reasons for protective measures provided a structure around which people considered big questions around their life and death. In particular, reflections around the theme of death tend to evade the expectations set up by the existing clinical structures. Circumstances surrounding death include multiple traumatic characteristics and make the most profound impressions on the survey respondents. However, the varied mental health effects of the COVID19 pandemic across different ethnic, gender, and, to an extent, cultural groups need to be noted and taken into account in the healthcare responses. There is a substantial heterogeneity in psychological reactions among minority ethnic groups to the pandemic and death. This brings up challenges to the blanket health interventions targeting minority ethnic groups as combined. Such interventions may then be unlikely to offer sufficient support and incite compliance with the new regulations.

These new sensitivities might thus introduce new set of themes around which healthcare organisations and the government have to centre future pandemic responses and cautionary messages. Such themes could include more personal and generational elements to the group-based clinical vulnerabilities that have filled many of the cautionary messaging to date, if compliance with them drops. In addition, according to the 'A Good Death' project run by Cambridge University, provisions of mental health support in the pandemic could be altered to specifically aim to reflect and deepen thoughts and feelings about death and encourage people to normalise conversations about dying within people's personal relationships (Davies 2022).

SECTION 3:

SOCIAL LIVES AND COMMUNITY IN PANDEMIC TIMES

How people thought about the introduced pandemic measures and how well they complied with them is a crucial aspect in the success of pandemic measures and the resulting pressures on healthcare institutions. Their thoughts and compliance are strongly mediated by people’s social circles and the cultural attitude of the communities they identify and discuss the pandemic with (Tunçgenç et al. 2021). In turn, changes in how people perceive their social lives could also have implications for pandemic measure communications by healthcare institutions.

3.1
Socialising at home

The immediate social circle of people, who share a house, is an important component framing their pandemic responses. Overall, the survey results are remarkable in showing a very differentiated picture of pandemic experiences for various groups socialising at home. Large household sizes increase exposure to the virus to all household members if the household does not shield. People of almost all household sizes have seen a reduction in the quality of their social relations during the pandemic. Changes in the quality of social relations tend to be interrelated with changes in people's mental health. The survey results seem to reflect similar findings reported in the Gadermann et al.'s (2021) study in Canada. Reporting on the first wave in May 2021 and before vaccinations, they found that people's mental health generally declined, but that it was specifically pronounced for almost half of the parents living with children under the age of 18. These adults witnessing a decline in mental health were also more likely to have increased alcohol consumption during the pandemic. The survey underpinning this report was live a year after the vaccination period had started and by that time people had experienced multiple lockdowns in Wales. Therefore, they likely developed successful coping mechanisms and implemented sustainable transformations of their social relations, such as developing new and maintaining existing connections through messaging apps and social media.

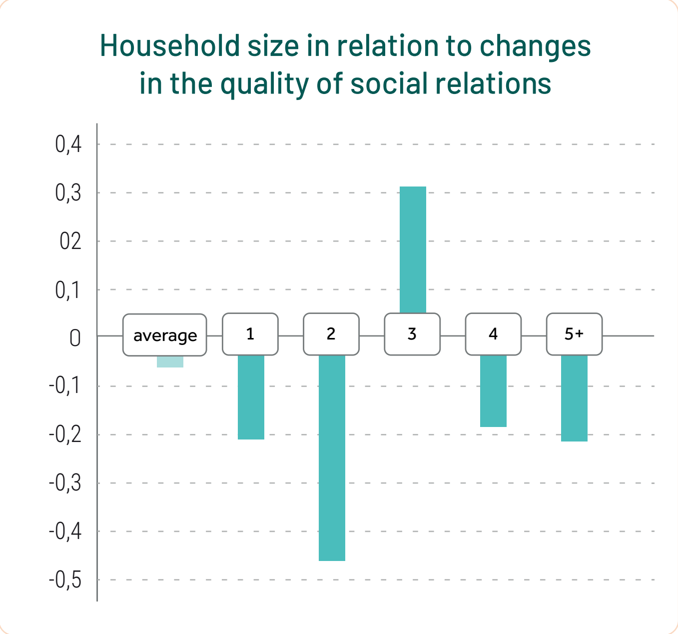


Figure 5: Social network quality according to household sizehome amongst ethnic groups

Survey respondents who lived in 3-person households seemed to have the best mental health, scoring a 63 on the happiness scale, which rose to 69 if they were with another adult and had one child between the age of 0 to 5. Parent couples with one child aged 6-15 struggled significantly more as they scored 51 on the happiness scale. Families of 4 or 5 members with multiple children under the age of 16 did remarkably well, reporting a happiness rate of 64. A possible explanation of the contrasting scores may be that larger families may be less likely to be able to shield and keep more in touch with others on a face-to-face basis, whereas two-member households and single occupants, especially without children may have not been able to keep their social relations in the same way.

In addition to household size, Okabe-Miyamoto et al.'s (2021) study suggests that the range of people who shared a house during the pandemic impacted significantly on their social relations. Looking at different kinds of household members, this study found that households with partners living together are more conducive to supporting social connections during the social distancing measures period than households which did not include partners or spouses. Research by Diener and Seligman (2002) state that "being in a relationship is one of the strongest predictors of connection and well-being" (cited from Okabe-Miyamoto's 2021: 12). Therefore, it is less likely that mental health services are needed to support people who live with their partner. However, several survey respondents contended that their relationship deteriorated and that they have split from their partner during the pandemic. The survey outcomes also suggest that people who have shared their home with one other person, presumably in most cases their partner, saw the strongest deterioration of their social relations. Very often the experiences of people, who have broken off their relationship during the pandemic, were compounded by a reduced social network they can fall back on. As a result, people who separated during the pandemic represent a vulnerable group that health services in Swansea, Neath, and Port Talbot need to be attentive to.

Ethnic group	Asian people (26)	Arab people (7)	Bangladeshi (30)	Black people (24)	Indian people (9)	Pakistani (10)	White people (18)
Percentage of social media (Instagram and/or Facebook) use to communicate with social relations	65%	57%	57%	38%	56%	60%	78%

Table 1: Social media use for pandemic purposes per ethnic group

All different ethnic groups used various digital means to stay in touch with their family and friends during the pandemic. Whatsapp was the dominant communication app amongst all groups, with White people standing out in their frequent usage of Facebook Messenger. Indeed, when looking at the use of social media to remain in touch with one's social network, White people also stand out with 78% of respondents mentioning the importance of Facebook in their social interactions. The distribution of misinformation via social media is well-documented (see Rocha et al., 2021), and the possibility for being confronted with misinformation on Instagram, Twitter, and Facebook is high for all ethnic groups (Depoux et al. 2020). Whilst people of minority ethnic origin are seen as more susceptible for misinformation than White people in the UK (Goldsmith et al., 2022), on average, the White survey population seems to have spent more time on social media (i.e. Instagram and Facebook) and are therefore more exposed to fake news, misinformation and misleading critical voices.

3.2
(Local) community

Community organisations have done fantastic work in attending to people's practical, food-based, religious, and mental health needs during and between the lockdowns in the Swansea and Neath Port Talbot area. For instance, a community cohesion representative explained that several ethnic minority groups were active in applying for funding to address a shared concern they struggled with:

> *"So, the mosque previously used to provide hot food during Ramadan when you're breaking fast, but the Mosque there was shut. Usually it was the communities, the masses, you know, they come in, they're giving the money to cover the food costs. But because people are not using the Mosque, they struggled to raise that fund. So, we then applied for some funding, and I assisted them to apply to bring some funds in to give food to homeless people, to refugees, asylum seekers, to those people who are relying – international students as well, and Muslim students. So, they could come in take a hot food packet."*

The pandemic measures prohibiting people to come to the Mosque and giving donations face-to-face meant that it could not provide its pre-pandemic (normal) services, which left groups of Muslim people without hot food. In addition to Local Area Coordinators who organised volunteers to bring prescription medication to shielding people, organisations such as the 'BAME Mental Health Network', and the various foodbanks in Swansea and Neath Port Talbot provided support where the local authorities could not. As such, these voluntary and community-based organisations filled a support gap that was caused by the pandemic measures and that had not been realised by formal organisations.

According to the survey results, for many people these initiatives introduced or strengthened existing community ties and social belongingness. At the same time, some survey respondents remark on not feeling part of a community and/or feeling left out. For instance, a Romani woman (35-44) states that "I'm disabled so not involved with much in the community". A non-binary person contends that "I have few people I remain in contact with and they are my community". And a Muslim man between 25 and 34 years of age who has a minority (other) Asian ethnic background added to the survey that "It's not easy to make friends with local people and sometime[s] I feel there is still subtle racism". Echoing Zhai and Du (2022), those people who do not fit neatly into particular categories around which community organisations form seemed to have struggled more during the pandemic. A non-binary survey respondent with a queer sexuality and other intersecting vulnerabilities explained that "because of my sexuality and my gender, I feel sad, lonely, trouble relaxing, feeling nervous, anxious or depressed. Becoming easily annoyed or irritable". Therefore, it remains important for public healthcare organisations to not assume that similar social vulnerabilities affect similar people, but that any vulnerability can impact vastly different people in terms of age, ethnicity, religion, and sexuality and gender.

3.3
Conclusions

Measures that focus on the individual and are not accompanied specifically by group-based measures could be insufficient in reducing the spread of Covid and protecting people from infection, severe illness, and death. Indeed, this study echoes Gadermann et al.'s (2021) assertion that "population-level responses are required to adequately respond to families' diverse needs and mitigate the potential for widening health and social inequities for parents and children." In addition, the Welsh Government's measure to form a social bubble for people living alone ought to be considered for extension to 2-person households to relieve mental struggles of people who live in a 2-person household and who are ending their relationship or marriage.

Communities and community organisation have performed a crucial role in the pandemic. They highlighted the need for and organised the provision of support for particular groups in situations that did not quite fit into the blanket pandemic protocols and measures that were aimed at broader populations. On the one hand, these initiatives provided crucial support for many (primarily minority ethnic) people to get through the lockdowns without seeing their physical and mental health deteriorate. Healthcare organisations could learn from this past experience and consider offering ad-hoc support during future pandemics, as such measures will be able to address some of the needs of the minority ethnic groups. On the other hand, communities and community organisations are not inclusive of everyone. People who do not identify with any such organisation may have seen exacerbated mental health concerns. Healthcare organisations need to be sensitive in addressing such concerns and develop more targeted policies for 'hard-to-reach' and often-excluded groups. Communications that target such individuals disconnected from community networks could help to prevent exacerbation of loneliness and feelings of alienation, as well as help to improve vaccination rates.

SECTION 4:

HEALTH ORGANISATION VIEWS DURING THE PANDEMIC

The healthcare institutions have played a crucial role in a pandemic. Indeed, healthcare organisations, including the Welsh health boards, hospitals, as well as community health services and GP surgeries have heightened their importance as 'mediators of life'. Especially during the lockdowns and peaks in the number of infections, hospitalisation and mortality rates, life of ordinary residents in Wales was very much structured around staying clear of the healthcare organisations and depending on them only in times of illness and during formal testing and vaccination rounds.

To understand the relations between minority ethnic people and the healthcare organisations and their (potential for) interaction, this section traces how the healthcare organisations have become known by them. Such insights can contribute to explanations of differences in compliance with the pandemic measures and shed light on knowledge gaps that could improve the health services for these groups.

4.1
Communication and information sources for healthcare

How healthcare organisations communicate with the people in their areas of jurisdiction provides insights into how people get to know them. The sources people use or do not use to retrieve information about their (ill)health, symptoms, or healthcare procedures frame their perceptions of healthcare system and requirements imposed on patients requiring medical attention. Communication also shapes their potential understanding and compliance with the pandemic regulations and measures.

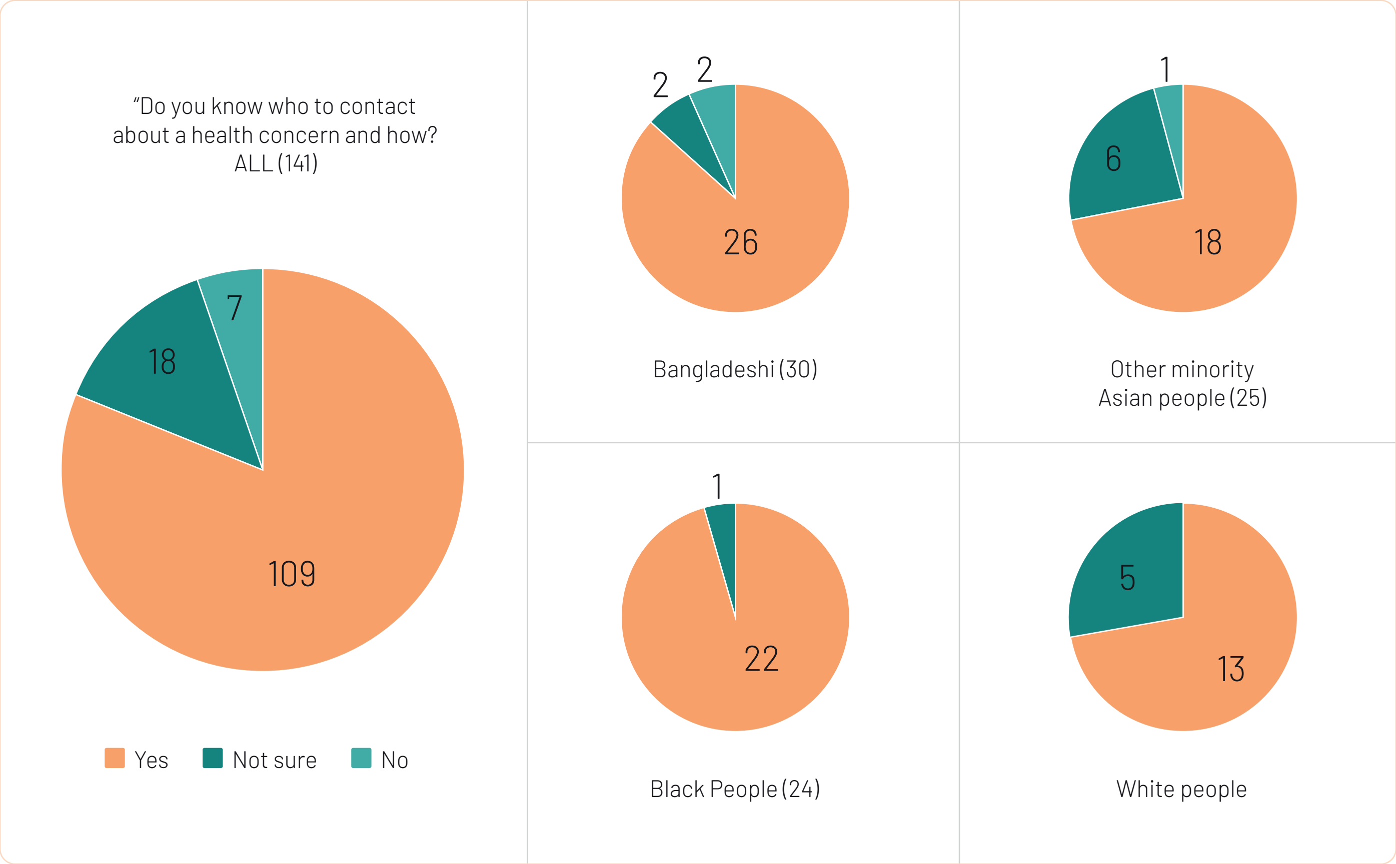


Figure 6: Certainty about sources of information about health concerns per ethnic group

There are some disparities along ethnic lines in knowledge and confidence of where to turn to address health concerns (see Figure 6). Black people are most certain where to turn for advice with only one survey respondent not being sure where to find useful advice. Asian and White people show considerably less certainty about who to contact, with less than 75% of both survey groups not having that clarity. The common assumption that minority ethnic populations (as a whole) would not know where to find vital services (Public Health England 2021a) is not reflected in the results of this survey. In particular, a large majority of Black and Bangladeshi people show great awareness of the mechanisms and sources of health support they can receive. This could indicate that even though people belonging to these minority ethnic groups know where to find the right information, they may not act on the advice with the same speed as other (e.g. White) populations, which is found to contribute to their higher mortality rate, in particular for men (ONS, 2021). In turn, this hesitancy of using healthcare information is potentially born from earlier adverse personal experiences of minority ethnic people in healthcare facilities in Wales and/or media reports of unsafe situations in clinical settings (Saltus-Blackwood and Kaur-Mann, 2005).

The majority of survey respondents in the Swansea, Neath and Port Talbot areas (86) tend to rely on the health information sources provided as the 111

NHS support service, 86 respondents tend to use the 'Ask my GP' system, and the NHS website would be visited by 78 respondents (see Figure 7). Such generic systems tend to be most trusted to contain answers to pandemic-related health questions. Respondents are likely to be familiar with these systems from before the pandemic, and use them as the go-to sources for pandemic information. In addition, 51 survey respondents searched for pandemic health services and support online, presumably using a search engine or social media, which has the potential to be redirected to websites with misinformation. However, all respondents who reported searching for health-related answers online also acknowledged using the 111 NHS service, the NHS website, and Ask my GP system. These results suggest that people seem to corroborate information about their health condition and the services available from different sources.

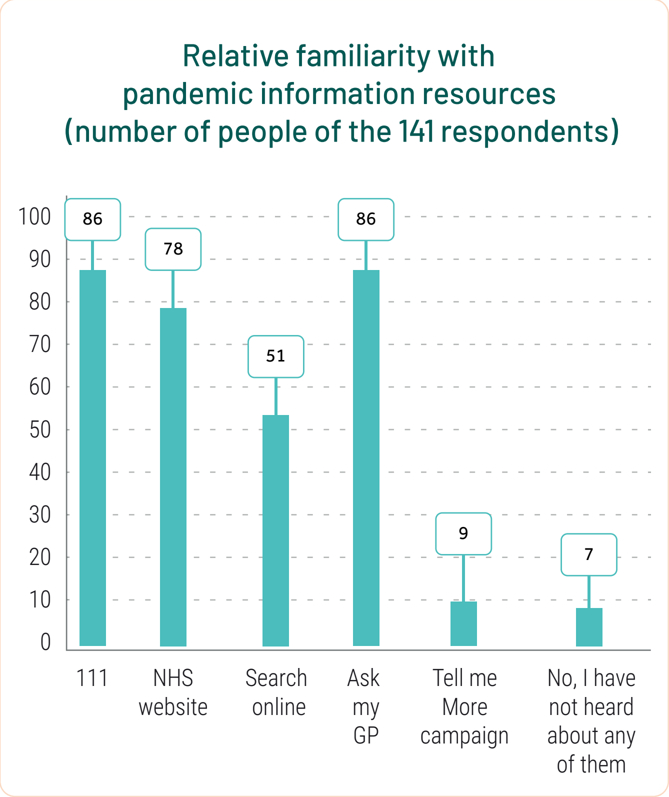


Figure 7: Familiarity with pandemic information sources

Of the dedicated and targeted information and communication service for minority ethnic people from the Swansea Bay University Health Board, only a small group reported familiarity with the 'Tell Me More' campaign (9 respondents). Actioned by the 'BAME Coronavirus Vaccine Forum', this campaign aims to "encourage take-up of the Covid-19 vaccination by signposting to honest and accurate information from medical practitioners, faith leaders and other trusted sources, so that members of our Black Asian and Minority Ethnic communities can make informed decision" (Tell Me More, 2022). Except for one man in his early twenties, all respondents were women over the age of 35 of varying belief systems. In terms of ethnicity, 4 Bangladeshi, 2 Black people, 1 Asian person, 2 White people, and 1 undisclosed ethnic person mentioned knowing about the campaign. These results demonstrate limited use of the campaign materials to date, particularly by the minority ethnic groups it targeted. Nonetheless, whilst the number of respondents who know about the campaign seems low, these people – mostly women – are likely to have further influenced others in their decision to get the vaccine or not, including their family members and friends.

General knowledge about different health information outlets varied among the survey participants, with 27 of the 141 respondents indicating no knowledge of the 111 NHS service, the NHS website, or Ask my GP system. Within these results no specific ethnic minority group, gender, or age group stands out, although they include all three Gypsy, Roma, and Travellers, who completed the survey. This group is largely made up by people who are unemployed, or left work to take care of the family or because they were chronically ill. Although less informed people tend to have access to online, televised, and radio-broadcasted communications about the pandemic, their comparatively limited understanding of practical sources of health-related advice can be related to their lack of access to workplace safety, risk assessment and behavioural advice available to others who maintained employment during the pandemic (Trougakos et al. 2020).

4.2
Attitudes towards healthcare organisations and services

Besides the real accessibility of healthcare for infected and ill people during a pandemic is, one of the most important aspects of managing a pandemic is the trust people have in the healthcare institutions. In Wales, Public Health Wales, the Health Boards, the hospitals, and community healthcare services, such as GP practices, pharmacies, and health visitors have played an important role in organising the healthcare response. Throughout the pandemic it has been clear that the Welsh health services struggled to cope with the societal need.

People seem to have more positive associations and a more solid belief in receiving help from the healthcare organisations in comparison to governmental agencies (see Section 5). To a large extent, the healthcare organisations are considered to consist of individuals rather than being a more or less ‘faceless’ institution. Healthcare organisations, the Health Boards, Ambulance services, and healthcare managers and workers are often seen as composed of people who have had a very difficult job to do during the pandemic. These organisations sit between the Welsh and UK governments and follow the imposed rules, while also having some agency in the execution of the pandemic guidance. More negative perceptions of the healthcare organisations and hospitals present them as organisations with certain tasks that they did not execute very well during the pandemic.

Out of all survey respondents, 35 people reported having increased difficulties trusting the healthcare organisations. These people differ from a group who find it difficult or impossible to trust the Welsh and UK governments (see Section 5). Echoing the survey study conducted by Asaria et al (2021), this survey suggests that most people who think more negatively about the healthcare organisations are those who have had bad personal experiences with the health services during the pandemic. In addition, these negative perceptions reflect in this group being more likely to not having been fully vaccinated, having a problem with Covid-19 vaccination, or not liking vaccination more generally. A third of this group had one or several medical conditions themselves and were thus the population that is most dependent on the healthcare organisations. One Swansea-based Pakistani male respondent, aged between 55 and 64, who had been a regular health services user stated: “I’ve not had my appointments on a regular basis and it’s been hard to see your consultant”. Such dependence and frustration with the health services is not conducive to developing trust in them. Lower levels of trust are very likely to translate into lower levels of compliance with pandemic measures, in particular vaccination (Vergara et al., 2021). Indeed, another survey respondent (Mixed Asian/White male 45-54 years old from Swansea) argued that they “lost confidence in their judgement and can no longer trust their ethical standards or judgement” and saw others to align with anti-vaxx ideology.

In the health system an individual is cast as a universal, generic patient, which makes the Welsh NHS less responsive to the choices of a particular person and restricts the scope of personal trust between patients and medical professionals expected in the traditional models of good practice (Owens, 2015). Annemarie Mol (2002) explains that in healthcare settings people perform different roles, which includes that of a (generic) patient. To be a ‘good’ patient and to make the healthcare practice ‘successful’ means to demonstrate a certain set of behaviours and talk a certain kind of language that fits with the doctor’s expectations of understandable behaviours and language. People who are more accustomed to assuming the ‘right’ behaviours and use the ‘right’ language are more likely to have a smooth health service experience. The content of healthcare services offered during the pandemic reflects the values and language of the NHS managers and doctors, who tend to be white, middle-class, British, and mainly English-speaking. People who do not fit within these frameworks, practices and expectations found it more difficult to fit the mould of the ‘good’ patient, with the important qualities of intimacy of healthcare are lost and standards diminish (Owens, 2015).

4.3

Access to the health services

Of the 139 survey respondents, 57 reported difficulties with accessing health services in the pandemic (see Figure 8) for two main reasons. The data confirms statistical reports from the Welsh Government about long appointment waiting times as main reason for relatively inaccessibility of care in NHS hospitals. In March 2022, out of the Wales-wide waiting list of 172,153 people, almost 19,000 people had been awaiting their appointment in the Swansea Bay University Health Board area. This number is down from 20,475 patients waiting for an appointment in November 2021 but up from 13,185 in March 2020 at the start of the pandemic (StatsWales, 2022).

Furthermore, the market ideals, greater reliance on administrative protocols and managerialist strategies used in the NHS over the last 15 years eroded the culture of intimacy between the patients and health professionals, so that patients with difficult personal circumstances, emotional or mental problems felt more disengaged from the process of care (Owens, 2015). In the survey, many respondents from ethnic minority groups spoke about their relative disenchantment with the health services due to the erosion of empathy and trust by depersonalising medical practices. As such, the possibilities for interactions between the services and the populations they serve were often curbed by the institutions themselves.

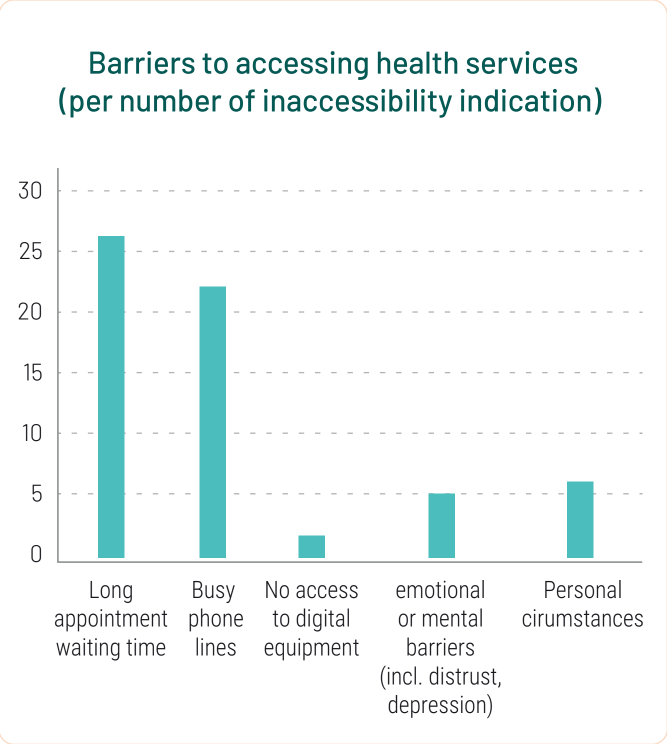


Figure 8: Inaccessibility of health services during the pandemic

4.4
COVID-19 Vaccination

Another way of judging people's perceptions of the pandemic can be derived from their attitudes towards getting the vaccine against COVID-19. Acceptance of vaccination upon its availability suggests that people consider the virus to be too dangerous not take action. This response also suggests that people consider the vaccine to be an efficient measure in mitigating illness and avoiding death. Such acknowledgement of vaccine's efficiency is the result of the relatively successful formal and informal pandemic communication. As the survey did not take into account the winter booster, nor the spring booster for clinically vulnerable groups, the data may provide an outdated view on people's perception of the COVID-19 vaccines. Also, the infection waves of December 2021 to early January 2022 and then the March and summer 2022 peaks have affected how people see the vaccines as key element in living in pandemic times. Indeed, as chances are high for people to have been infected since partaking in the survey, their attitude may have changed on reflection.

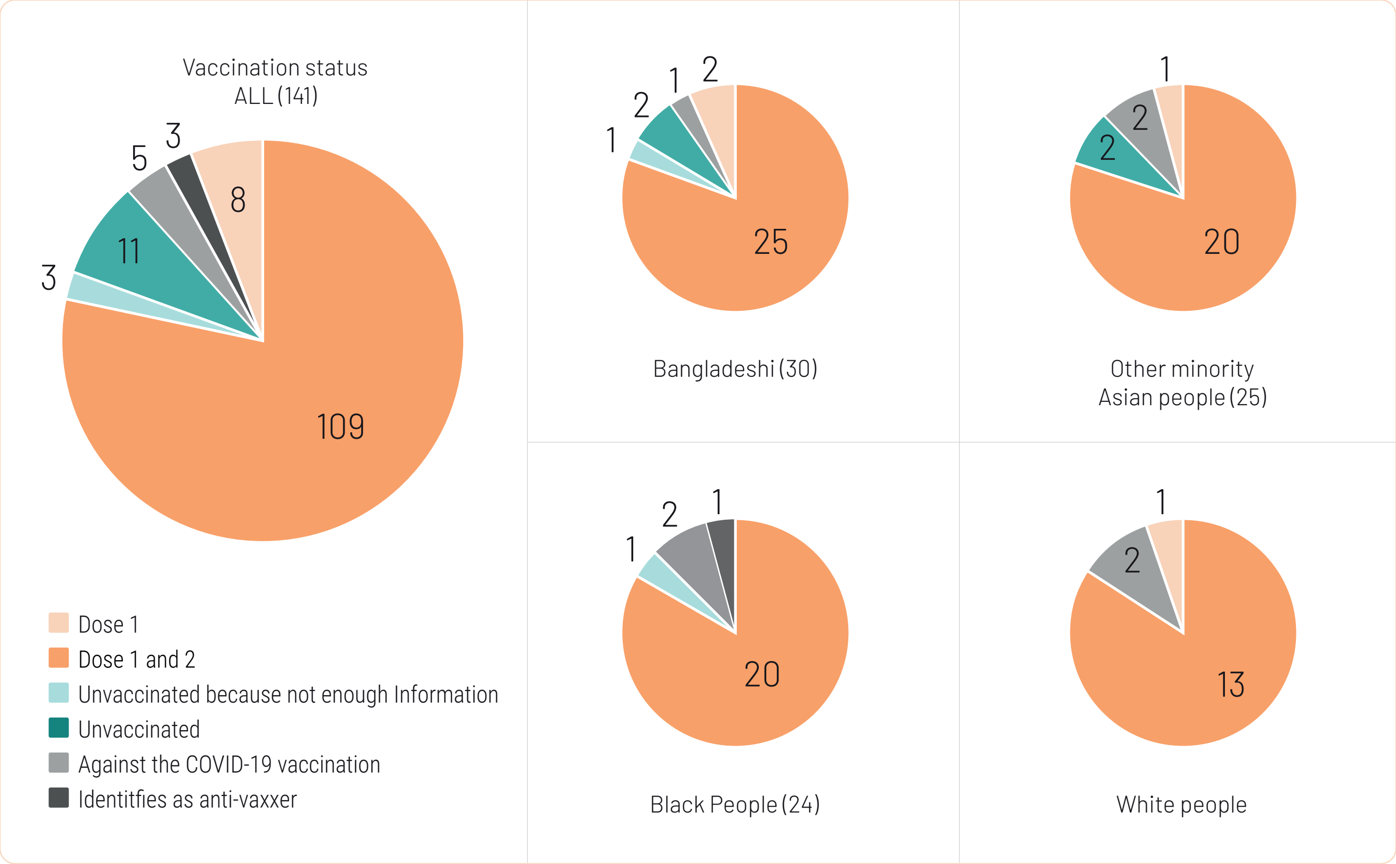


Figure 9: Vaccination uptake per ethnic group (Nov 2021 - Feb 2022 period)

Many of the respondents to the survey had been fully vaccinated at the time of participating between November 2021 and March 2022, which was the period when the first and second vaccine doses were administered in Wales. The survey findings do not suggest that Black people in the Swansea, Neath, and Port Talbot area may be less likely to be vaccinated for COVID-19 (see Figure 9). As this finding contrasts many other studies (ONS 2022, O'Dowd 2021, SAGE 2021) it is likely that the survey has attracted a respondent group skewed towards taking up the COVID-19 vaccine. Regardless, whilst some news outlets[3] suggest that the low uptake might be due to ignorance, Black toxicologist Professor Winston Morgan warns against such takes. In relation to the COVID-19 vaccine uptake, he argues (2021: np)

[3] Up to 47% of 'at risk' ethnic minorities in Birmingham have not had vaccine | Daily Mail Online | see here

> *“For many in Black communities, having the choice to either take or reject medical care is often empowering in itself. This is because Black people in the UK also look to the experiences of Black people across the African diaspora to inform decisions and to ensure the same issues don’t happen again. The 40-year-long US Public Health Service Tuskeegee [sic] syphilis experiment, is one glaring example of why trust is low.”*

To increase the vaccination rates for this group and other ethnic groups, vaccination campaigns that take these group-based, structurally discriminatory realities into account may be more successful. Such campaigns ought to contain information that does not only address the benefits to this person, but also discuss how Black people can trust how these histories are not repeated in the development and production of the COVID-19 vaccines.

On people’s experience of the vaccination processes, the pandemic survey suggests that on average, the satisfaction level was a 7.8 out of 10; so well above average. Respondents from Neath were most satisfied with a score of 8.6, followed by respondents from Swansea with 7.9, and people from Port Talbot scored 7.7. The survey does not pinpoint differences between different ethnic and gender groups that explain differences between respondents’ satisfaction. Of those with a 0-5 score, two respondents reported a bad experience because of side effects, whilst others who had side effects were still generally happy with their vaccination. Two others were not happy about the location of the vaccination centre. On average, therefore, people were very accepting of the location of their vaccination (GP surgery, pharmacy, and mass vaccination centres). The overwhelming majority reported satisfaction derived from “kind” and “helpful staff”, “quick”, easy”, and “efficient procedures”, “good” locations. A Bangladeshi woman (aged 45-54) from Swansea answered: “It was planned well, social distancing took place and I was looked after”.

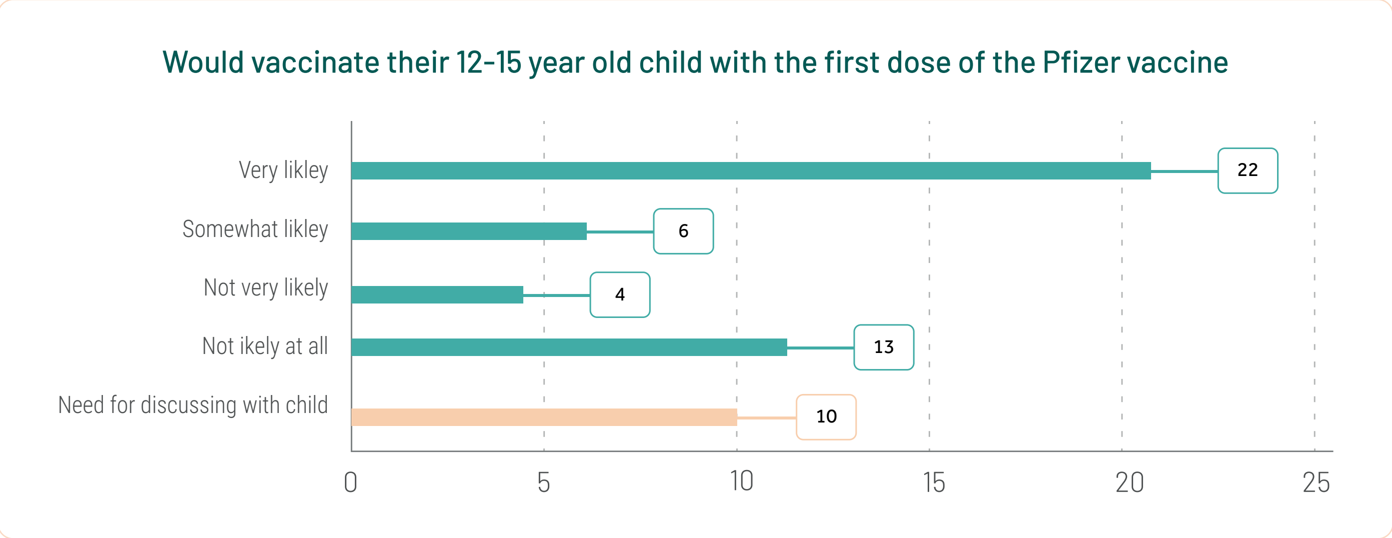


Figure 10: Vaccination willingness of 12-15 year-olds

Of those who have children under the age of 16 and know that for 12–15-year-olds the first dose of the Pfizer vaccine was made available, the majority stated that they were likely to send their child for vaccination (see Figure 10). However, 31% of the survey respondents who indicated having considered this option for their child were not likely to do so. Reasons for this decision include most prominently side effects, lacking information, and medical risk (see Figure 11). These concerns seem to indicate too many uncertainties and bodily discomfort with not enough to gain to balance these reported vaccination effects for this group. Addressing these issues could include reducing uncertainties by providing more information, offering advice to reduce the potential discomfort, and emphasising the advantages of vaccination, for instance in social terms. Respondents from the Swansea and Neath Port Talbot area also indicate their desire to discuss vaccination with their child and take into account their child’s wishes. Therefore, to help making vaccination choices, communication strategies that seek to increase the vaccination awareness for the individuals with children should also target the children themselves.

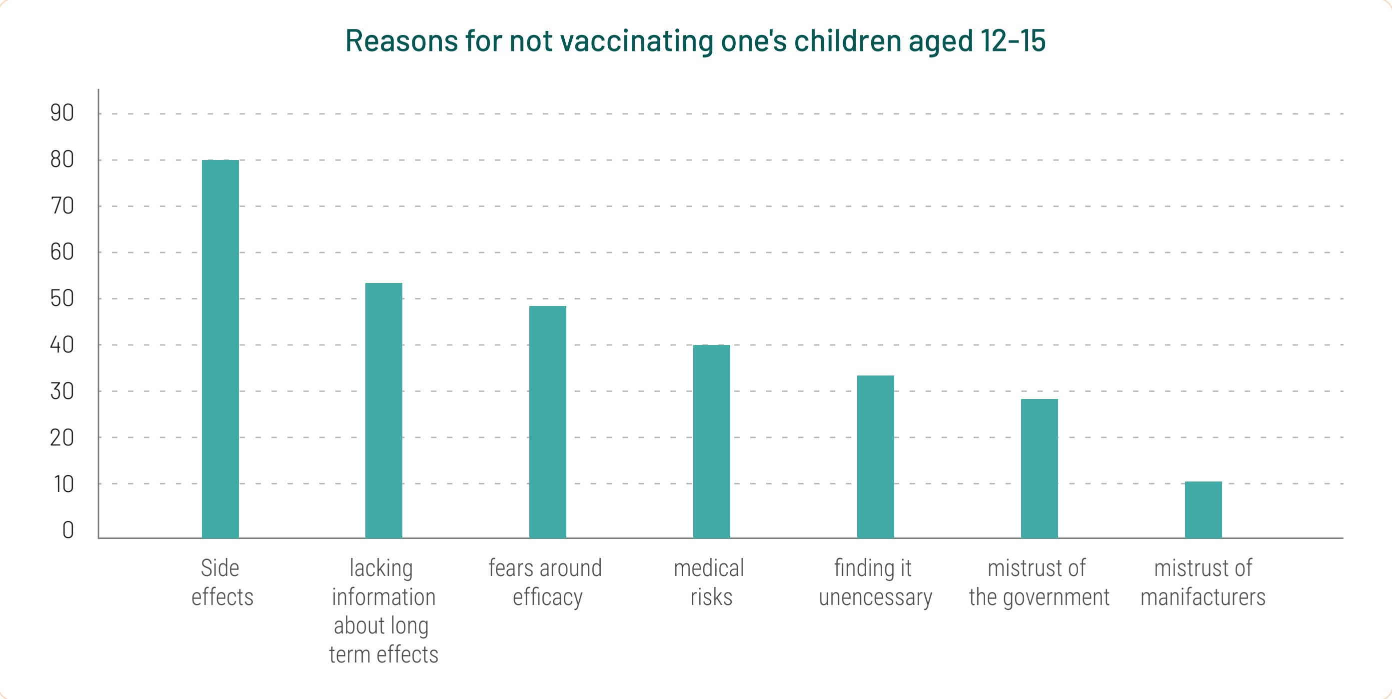


Figure 11: Reasons for refusing vaccination possibilities for 12–15-year-olds

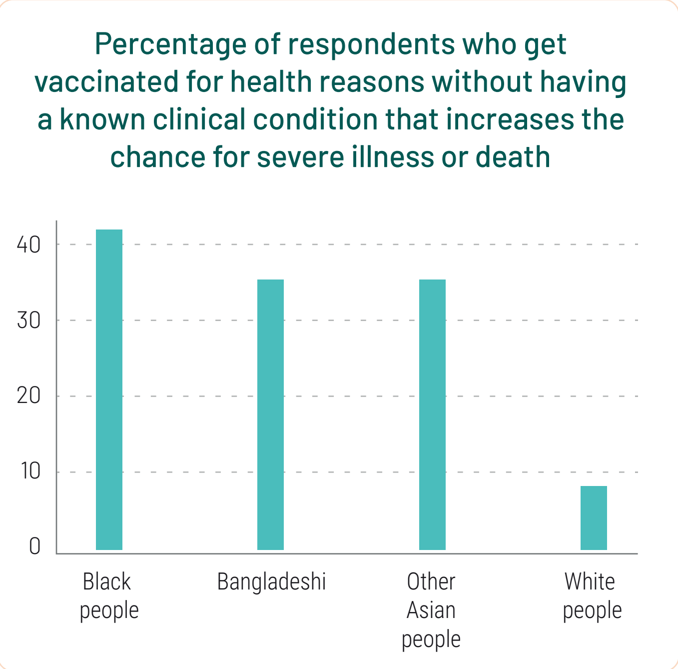


Figure 12: Health reasons as motivation for vaccination for people without pre-existing medical conditions

People who had the COVID-19 vaccine did so predominantly for health reasons (37%), for the protection of others (25%), and to be able to travel safely (15%). As such, vaccination decisions seem to be largely driven by a mixture of concerns focussing on oneself, people around oneself (familiar or unfamiliar) and issues of practical convenience. Survey respondents who chose to accept the offer of the vaccine for health reasons are not all clinically vulnerable (see Figure 12), which suggests that pandemic-induced fears and anxieties may have played an important role in this decision. From the figure it becomes clear that Black respondents who did not have pre-existing medical conditions were most motivated to get vaccinated compared to other ethnic groups.

There was no significant variance (only 3%) in the acceptance of vaccination across survey respondents with different religious and spiritual beliefs. The survey results contrast with the findings of the broader studies across the UK, where Muslim religious groups demonstrated lower COVID19 vaccination rates in comparison to the Christian religious groups (Razai et al. 2021). While there were originally some concerns about vaccines' incompatibility with religious beliefs, it appears that science-based guidance utilised by the Swansea and Neath Port Talbot's healthcare organisations and specific campaigns focused on minority ethnic populations in these areas played an important role in influencing people's vaccination deliberations.

Ethnicity did make a sizeable difference in considerations about vaccination. What becomes visible in the survey data is that Bangladeshi, Black people, and White people tend to list multiple reasons for vaccination (see Figure 13). This is particularly noticeable in comparison to White people, who are more strongly led in their vaccination decision by two factors: health reasons and protection of others. Multiple justifications for vaccination among many minority ethnic groups indicate higher confidence in reaching such a decision, because vaccination can address several concerns at once. Despite minority ethnic respondents being more cautious than White people in deciding to become vaccinated, when they do decide, their decision is firmer, and they align it with the range of reasons outlined in the vaccination campaigns.

The survey suggests that for the Bangladeshi group vaccination is often required as a part of their job, which makes them more likely to get vaccinated in comparison to other groups. In the Swansea and Neath Port Talbot region, Bangladeshis are more likely to be frontline workers and thus face higher levels of exposure to COVID19. In fact, out of the 8 respondents of the survey who required it for work, four were Bangladeshi, one Pakistani, one Black person, one Asian person, and one White person; 6 were women and 2 men, and half were over the age of 45.

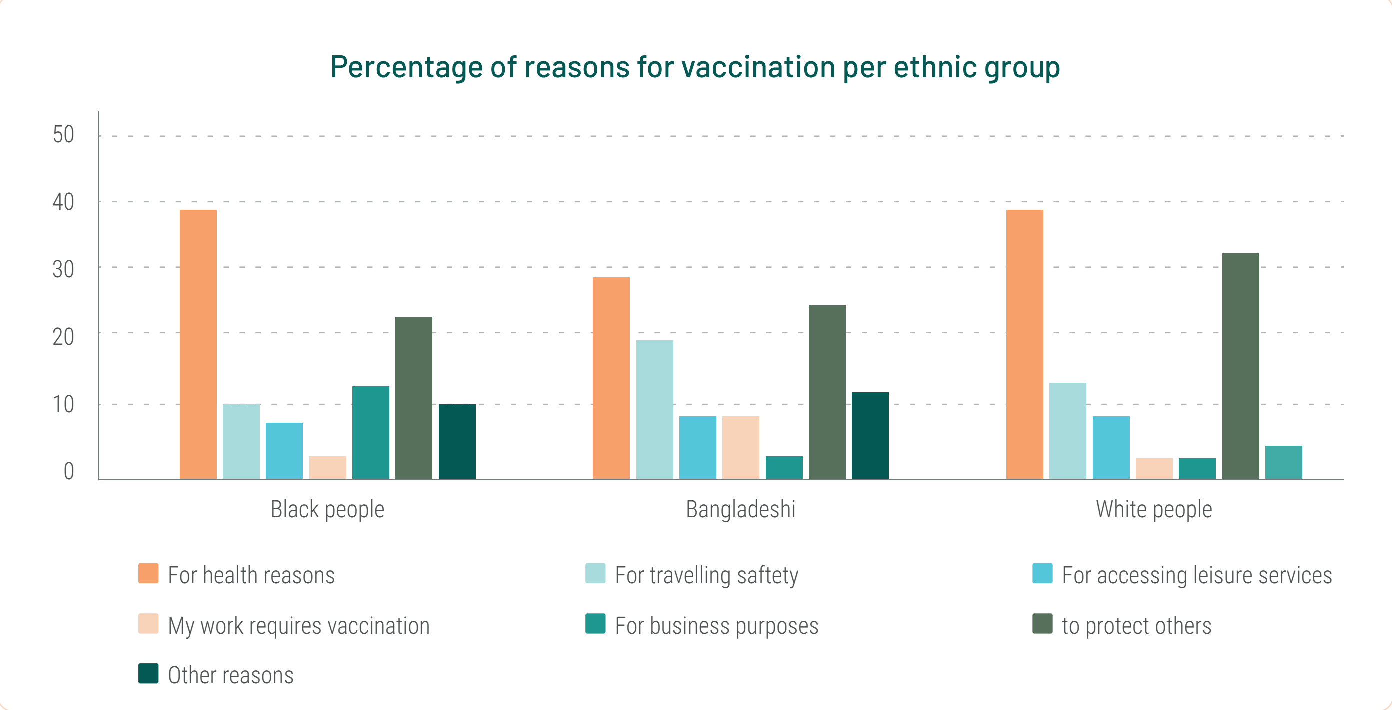


Figure 13: Reasons for COVID-19 vaccination per ethnic group

The category ‘other reasons’ for vaccination is of crucial importance here, as it holds arguments that are outside the current knowledge range about what moves people into accepting the vaccine for themselves. As both the need for vaccination and priority vaccination categories are derived from logic that works within White Western and secular cultures of conventional biomedicine (Hornsey et al. 2020), alternative reflections about vaccination and perceptions produced by minority ethnic groups can often be overlooked as a part of ‘other reasons’ in their decision-making. In our survey, Bangladeshi, Indian people, and people with other Asian backgrounds represent 13 of the 18 survey respondents (11% from the total 141 people) who cited ‘other’ reasons for vaccinations. These reasons can include higher perceptions of risk, different communication from community leaders, and differential decision-making power within the household (Iyengar et al., 2022). It is important to understand these other reasons, given they can strengthen the vaccination campaigns for current and future booster campaigns. If minority ethnic people would be given a choice of what vaccine (e.g. Astra-Zeneca, Pfizer, Moderna, Janssen etc) they could be persuaded (Asaria et al. 2021).

Furthermore, the survey results indicating the necessity for having been vaccinated for people to travel vary depending on ethnicity. Listing this necessity as more important, Bangladeshi and Asian people stand out from other groups. This finding potentially reflects the higher potential for these groups to have a migration background and having family in other countries, which they were unable to visit during the periods in which travel was severely restricted to Bangladesh and other Asian countries.

4.5
Conclusions

The social contract between populations and the authorities that organise post-COVID recovery has been challenged. This was particularly due to the diminished availability of services and possibilities for trusting the healthcare organisations. In the beginning of the pandemic the health institutions were set up as 'objects' that needed protection, referring to their own vulnerability to succomb to the pressures of getting ill people through the NHS. This took largely place through healthcare staff sharing (exhausted) selfies, talking about their (often harrowing) experiences, and participating in social media trends on platforms such as TikTok, Instagram, and Twitter. This effectively 'gave healthcare institutions a face', and depicted the institutions efforts as 'heroic' and instrumental in mitigating the effects of the pandemic. Such further 'personification' of the NHS as a national treasure in contemporary British culture diminishes the possibilities to critically re-think institutional healthcare practices and pandemic responses. Considering how to mediate the needs of the NHS vis-à-vis the people who need healthcare, a representative from a South Wales Health Board and local authority argues the following:

> *"So my take on it would be that the right thing to do then, is to message to people that we need to look after vulnerable people in society. And supporting the NHS is a key way to do that. And to not overwhelm the NHS, so that it isn't unable to support people who really need it. So, I think the messaging around supporting NHS was the right thing to do."*

The NHS as organisation with its multifaceted functionalities thus seems to be imagined as ultimately good and supportive in nature and is posited as the only option to save the lives of people at risk from dying of the virus. However, this imagination does often not correspond with the experiences of many people attempting to access the health service. In particular with regards to the waiting times, many people remain in extreme discomfort waiting for their surgery (see the case of a *woman in pain*), going without any treatment (such as in the case of *Tourette syndrome*) or dying in the process of seeking medical help (see the case of *Kenneth Shadbolt, 94*, who died waiting on an ambulance). The NHS and its sub-organisations, such as the Health Boards, hospitals, and clinics can only address people at the large-scale level of populations, but do not often have the capacity to offer personalised approach and address specific problems experienced by individuals with their unique circumstances.

As a result, the healthcare organisations do not exactly provide the service that is needed by minority ethnic populations as they do not address differential concerns these populations have. Impersonality is an unintended condition of the recent changes faced by the NHS (Owens, 2015), which leads to limited possibilities for tailored institutional responses to the needs of ethnic minority populations, particularly under the austerity conditions and increased cost-saving and efficiency drives. When healthcare organisations prioritise equality (everyone deserves the same treatment) in delivering healthcare, such approach creates the presumption that everyone would equally benefit from these treatments. However, as vaccination campaign demonstrated, such generalised approach does not quite address specific needs and concerns of minority ethnic populations, who require health messages and caring practices sensitive to their specific community needs and respectful of their specific ethnical positions around medical interventions (UK government, 2020).

SECTION 5:
GOVERNANCE OF VULNERABILITY IN THE PANDEMIC

In the pandemic, the Welsh government and local authorities need to be seen as putting in place the right measures for the right and understandable reasons at the right times that are most effective in raising compliance with the new regulations. Indeed, public trust is an important factor shaping health responses to the pandemic, because people trusting the government are more likely to follow the advice of public healthcare organisations and comply with the pandemic regulations (Marien and Hooghe, 2011). This section considers how the Welsh government and local authorities have created the context for healthcare organisations' pandemic strategies, policies and protocols. Section 5.1 considers how the government shaped its interference with people's lives to prohibit the rapid spread of the COVID-19 virus in Wales. Section 5.2 juxtaposes the governmental positions with people's understandings of what vulnerability to the pandemic means to them.

5.1
Views of governmental interference

In pandemic times, the governmental authorities, in all their appearances; ranging from the Welsh Government to the local authorities and local Councils, play a crucial role. According to the Coronavirus Action Plan for Wales (2020) the virus has been the central entity guiding governmental pandemic policies:

> *"The Welsh Government is responsible for the public health response to the coronavirus pandemic in Wales. It is doing this by exercising its legal powers to impose restrictions that prevent or slow the spread of coronavirus, and by overseeing the Welsh NHS"*
>
> (Government website 5/5/2020)[4]

The focus on controlling the spread of Covid-19 virus relegates the actual lives of people to a lower priority. In that regard, managing the virus means managing human populations in Wales. Protecting the entire populations by committing to keeping the virus out of Wales in Welsh policies has not been a possibility after the UK Government initially allowed the COVID-19 virus to spread within the British population.

In addition to the respondents' views of the healthcare organisations (see Section 4) the respondents were also asked to consider the governmental agencies. Positive views offered by the respondents are largely based on seeing the Welsh Government and the Councils as consisting of individuals and people who had a difficult job, whereas more negative views see the Welsh Government and the Councils as organisations with certain caring tasks that they did not execute very well. The majority of the survey respondents did consider the governmental responses as 'good' and 'very good'. Differences in attitudes to government responses between ethnic groups did not emerge in striking ways in the survey.

The survey respondents who have difficulties trusting the Welsh and UK governments form a relatively small group (25 in total), but they share some characteristics. Firstly, this group is more likely to have a problem with COVID-19 vaccination or vaccination more broadly (see also Asaria et al. 2021). Secondly, they are also very likely to have seen a decrease in the scope and intensity of social relations with others (family, friends, partners), but on average, they report virtually the same happiness (54% vs 52% rating on a 0-100 scale). This group also tends to think negatively about the health services, but they are divided in how they rate access to the health services.

Also mentioned in the survey were other more classical neoliberal tropes of the Welsh government and implicated local Councils being too slow and communicating "confusing" and/or "disjointed" messages (Bangladeshi woman, aged 45-54 from Port Talbot). Without specification and in speculative fashion, these comments might have gotten at differences in messaging from the healthcare organisations, which may be explained by the different rhythms of governmental regulation change; both as diverting from pre-pandemic slower rhythms, and by the different speeds at which new regulations and measures have been issued and lifted during the pandemic. Indeed, in the beginning of the pandemic, news about the COVID-19 virus developed rapidly, which resulted in an apparent flood of impactful and never-seen-before restrictive and protective measures after the winter months of 2020 in which not much seemed to happen. Indeed, according to Chen et al. (2021) the speed of governmental responses has often affected the perceptions of the effectiveness of government actions. Where difficulties of reacting quickly to new pandemic challenges, the government's ability to fend off COVID-related deaths increased.

One of the main issues survey respondents had with the Welsh Government was the open border with England where different rules were in place through most of the pandemic after 23 March 2020. Potentially motivating this response was the way in which the virus seemed to have become 'ungovernable', eluding the regulations via people

---

[4] https://gov.wales/welsh-governments-role-and-responsibilities-coronavirus | see here

who behave in line with another government system in England. In terms of jurisdiction and the denotation of what rules counted where, the difference between Wales and England was clear in people's perceptions and remained unchanged throughout the pandemic. However, for some respondents it was frustrating that English people would cross the border and not stick to the often-stricter set of rules in Wales. Some survey respondents highlighted that having a border but not being able to use it to protect people in Wales was "ridiculous" (White woman, aged 45-54 from Neath).

Some survey respondents also brought up the difference between the UK government's messages and those of the Welsh Government to such an extent that people thought that it "should be the same rules across UK not different nations" to avoid confusion (White woman, aged 45-54). Remarkably, the UK government was deemed least trustworthy by the respondents, followed by the Welsh Government, but many people were more positive about the local Councils. These local governments were more understood to consist of "extremely hardworking" (White man, aged 45-54) people who "did their best". The lockdown parties and generally negative public appreciation of Boris Johnson and several of his cabinet members and aides were also mentioned as negating people's trust in the UK government.

Also, some survey respondents noted the complexity of the pandemic, and argued that they understood the governance of the pandemic has multiple opposing sides that fulfilled multiple and opposing functions. Many survey respondents suggested that the UK government could have done better and worse in many ways. This finding testifies of the difficulty of determining what is good and bad during the evolving pandemic situation, when decision-making and choices about "too much" or "not enough" intervention were affected by changing scientific evidence. For instance, difficult questions came up around the trade-off between the prevention of deaths, reduction of the spread and protecting vulnerable people with imposing restrictions on people's lives (Flaatten et al. 2020). For many survey respondents, the pandemic surpassed what was normal, and challenged their understandings of what was acceptable and what not.

The pandemic lacked any benchmark to which survey respondents felt that they could measure what was happening and how they should feel about it. Oftentimes, comparisons with other countries and evaluation of which country did worse in terms of numbers (mortality and infections) served as the benchmarks, which helped people to understand the extent of the pandemic. However, as the infection numbers and death toll has been changing rapidly, such comparisons seem to be less useful than in the beginning of the pandemic as people learnt about the multiple differences between how different countries measured and chose priorities in their pandemic governance. This complexity may also contribute to an explanation as to why for many people the pandemic did not really change how they viewed the governmental institutions. Instead, pandemic experience may have confirmed their various pre-pandemic beliefs about the governmental institutions.

5.2
Vulnerability

England where different rules were in place through most of the pandemic after 23 March 2020. Potentially motivating this response was the way in which the virus seemed to have become ‘ungovernable’, eluding the regulations via people

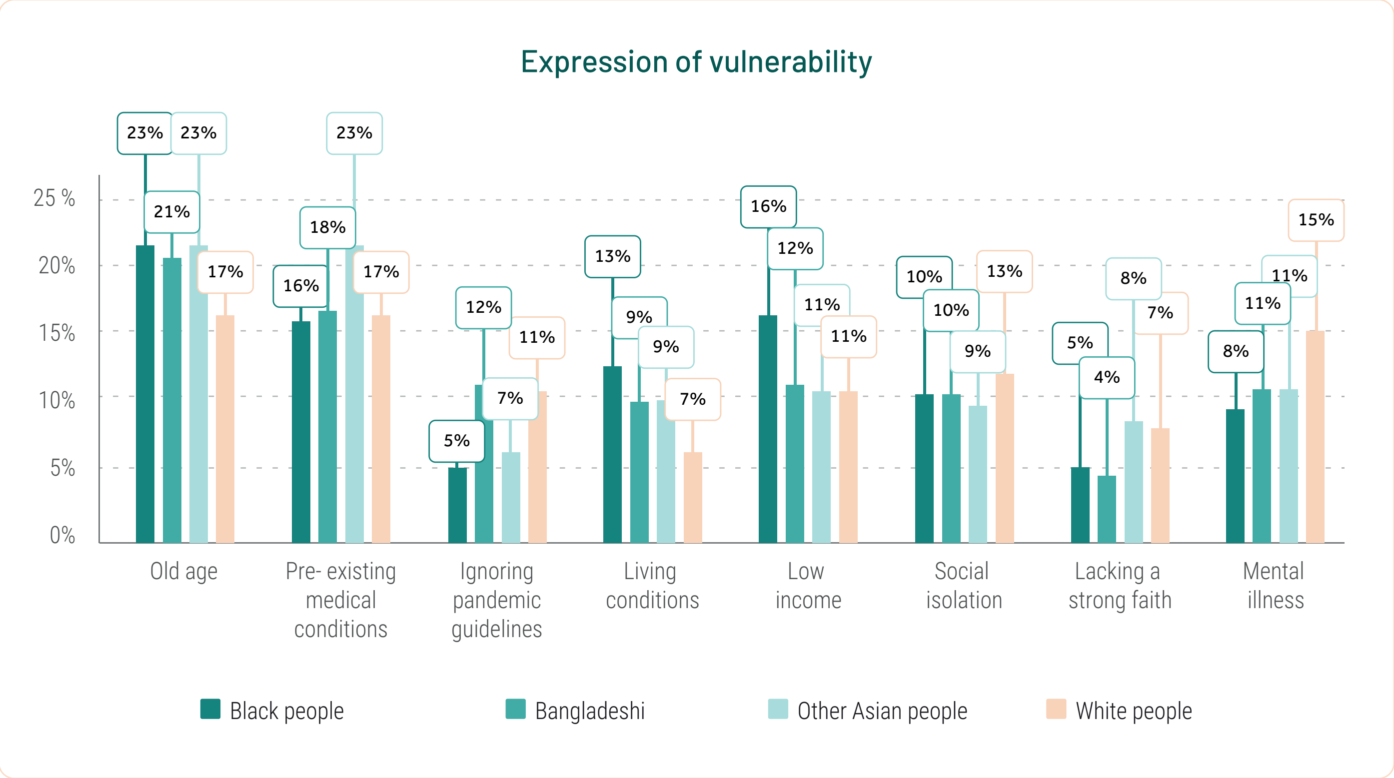


Figure 14: Explanations of vulnerability per ethnic group

Vulnerability has several explanations that reflect who is deemed responsible for a potentially dangerous situation. From the graph (Figure 14), it is clear that people of different ethnicity think differently about what makes people vulnerable in the pandemic. It seems that the survey respondents are also very much concerned about more social expressions of vulnerability. Throughout the pandemic, COVID-19 policies have consistently emphasised clinical vulnerability over other kinds. Overall, this emphasis on the clinical vulnerability is reflected in the priorities listed by the survey respondents. The alignment with the healthcare organisations’ insistence of clinical vulnerability consisting of elevated age and pre-existing medical conditions is reflected in many people views across the groups. However, given the prominence with which the clinical definitions of vulnerability have featured in governmental communications and the media more broadly, it would be expected that respondents’ answers would strongly reflect these medical views. In comparison with other ethnicities, Black people’s views reflect the clinical indication of vulnerability most strongly. This could suggest that they demonstrate the most awareness of the healthcare organisations’ formulation of the dangers to themselves, or their close contacts if they have an elevated age and/or such indicated medical condition. This reflects minority ethnic communities pointing out that they are not ignorant of the dangers and what solutions (in particular the vaccine) could work protectively (Morgan 2021). However, given the disproportionate representation of the Black people in COVID-19 deaths in the UK (Public Health England 2021a), the findings suggests that this group likely remains vulnerable to severe illness or dying because of disproportionate exposure to the virus.

A comparison between white people and the different minority ethnic groups reveals that contrary to other analyses, white survey respondents seem least aligned with the clinical expression of vulnerability as they score lowest on determining that people are primarily vulnerable in the pandemic. White people tend to associate elevated age or diagnosis with a medical condition that accelerates the damaging effects of the virus on the body. Figure 14 shows that White people also stand out in their consideration of people's social isolation and mental health problems as compounding vulnerability, and to a slightly lesser extent also in linking vulnerability and the non-compliance with the pandemic rules. These three elements include the social and psychological circumstances over which individuals are often seen to have some degree of control over. In addition, White people score lowest on income and living conditions, which are rooted more in socio-economic circumstances that are less under the control of individuals and are likely class related. These findings suggest that White populations see vulnerability in pandemic circumstances as slightly more manageable by individuals and as less framed by local communities and Welsh society in a broader sense. This is in contrast with Asian people who consider living conditions and low income as particularly important in defining vulnerability: they reflect a more communitarian view in which vulnerability in the pandemic is more rooted in social inequities. Furthermore, the Bangladeshi people’s concern with people ignoring the rules and being vulnerable because of that may reflect a sensitivity towards the role of the authorities in the pandemic.

In conclusion, vulnerability emerges within the knowledge systems that reflect a particular view of the world. When the knowledge systems employed in the pandemic are narrow, the definition and mobilisation of vulnerability in policies and protocols is also limited. Holding on to a narrowly defined vulnerability risks overlooking other processes that render people more likely to suffer and fall ill with COVID-19. Therefore, the survey demonstrates that the ways in which vulnerability is defined differs between societal. It does not only provide insights into how people apply the past and current rules to themselves and others, which clearly differs between ethnic groups. It also provides an insight as to what future pandemic-related measures and healthcare policies and protocols would be complied with most by what groups. The coupling of more social expressions of vulnerability with the clinical definitions could be reflected in vaccination campaigns, which would suggest a revision of priority vaccination groups as well as specified state support for marginalised groups.

5.2
Conclusions

Healthcare organisations are connected with governmental agencies through their shared role in shaping people's lives and their pandemic experiences. In a situation when a person seems to have lost control, these authorities offer help in re-establishing their sense of control and safety. Even though governmental agencies and the health services have been collaborating throughout the pandemic, how the former group is perceived can be a good indicator of how the healthcare organisations are deemed to perform in the pandemic. The personification of healthcare staff (especially in the beginning of the pandemic) may have been pivotal in the portrayals of healthcare organisations as "heroic" and instrumental in mitigating the effects of the pandemic. Such depictions are contrary to the portrayals of governmental agencies as less personable and efficient. Healthcare organisations refining, and governmental authorities adopting, a 'personification' strategy might help create more trust keep up compliance with pandemic measures or increase the vaccine uptake in the future.

Healthcare organisations need to be mindful of their unproblematic and unquestionable adoption of the government's understandings of pandemic-produced understandings of vulnerability. If the pandemic-related measures and protocols are primarily developed by White people (as they dominate senior management positions in British and Welsh organisations), they are likely to adopt a 'White view' of vulnerability. Such a view does not necessarily acknowledge the damage caused by racially discriminatory medical knowledge formation (Washington 2008, Powell et al. 2022), such as in the case of Henriette Lacks (Skloot 2010) nor actively combat racial bias in current-day clinical practice (Morgan 2020, Gee & Ford 2011). This survey indicates that such dominant White views are not always shared across other ethnic groups in terms of topic and degree of importance (see also Public Health England 2020a).

CONCLUSIONS AND RECOMMENDATIONS

In the pandemic, healthcare organisations and governmental agencies need to be seen as putting in place the right measures for the right and understandable reasons at the right times for the measures to be most effective. Although the policies and protocols to date take into account societal difference for such measures to work out best, policies could be tailored more to the needs of specific ethnic groups. In particular, this report suggests that making blanket decisions for people with a minority ethnic background as one social category would result in missed chances in terms of providing more effective pandemic healthcare experiences for these groups. Institutional thinking needs to be married up more with experiences of different ethnic groups. Such co-ordinated approach should acknowledge the social histories of different social groups, particularly with regards to their relations with various authorities and processes of marginalisation. Pandemic responses need to consider not only individuals and their personal histories but also address their dynamic socio-economic circumstances, daily geographies of marginalisation, and cultural anxieties, as well as uneven power relations with authorities and within biomedicine and clinical institutions. Therefore, in the creation of new pandemic guidelines, we need to be mindful about assumptions that express broader understandings of vulnerability and health-related behaviours, drawing on the experiences of people whose needs these policies attempt to address.

Whilst the Welsh NHS had several plans set up to deal with a pandemic, this report suggests that such preparedness cannot account enough for societal diversity (especially minority voices). In fact, preparedness plans may have offered a false sense of certainty and security about what steps to take at what time and for what purpose. The report suggests that different societal groups know the pandemic in different ways: through varying objects, spaces, social experiences, kinds of vulnerability, and differential anxieties. Indeed, biological knowledge of the pandemic encompasses the interaction of the virus with one body and as shaping a destructive kind of relation between bodies. This type of knowledge is relevant for the development of medication and other material biological disruptions of the virus, including testing, medication and vaccination to prevent loss of quality of life and life itself. Illness and death are, however, much larger concerns as they pertain to broader life experiences of different socio-cultural groups and individuals. Equally important is understanding what gets people into situations in which they get ill, in combination with the analysis of ideas and understandings of what health, illness, and death means.

Pandemic knowledge by minority ethnic individuals and groups will not only always differ from the institutional knowledge in terms of organisational priorities, which often regulate the capacities of NHS hospitals and GP surgeries to handle a sudden stream of ill people. How minority ethnic groups understand the pandemic differs vastly between the clinical and social aspects, with these groups putting strong emphasis on the social repercussions of living in pandemic times. At its core, the pandemic is not only a medical problem – it is profoundly social. In addition to clinical prescriptions of healthcare services, social prescriptions that can address a diversity of anxieties and social circumstances should play a larger role.

To address inequities emerging from the pandemic in healthcare services, we have to accept that preparedness is only possible to a limited extent. As it is impossible to foresee the future, even when employing extensive evidence-based models, the future is never rational and plans can never be fully rationalised accordingly. It is crucial to keep asking critical questions about processes that create differential levels of exposure to the COVID-19 virus and its socio-economic effects amongst different groups. Heeding such differences in planning for the future casts further doubt on the applicability of pandemic policy logic that works on White groups to minority ethnic groups. In one way or another such rationality and logic are always underpinned by certain unexamined assumptions (e.g. having access to hygienic sanitation). Pandemic policies thus ought to be less singularly determinate, instrumental, and rational. To remain aware of new phenomena emerging, such as Long COVID and pandemic-related mental health issues, healthcare responses to the pandemic could be seen as flexible arrangement of solutions rather than prescriptive and regimented policies. Such flexible approach can help to produce a shifting collection of practices applied to address different and emergent challenges, by and for different and new actors, and including unexpected and experimental mechanisms. The findings from this report point towards the need for shaping pandemic regulations as ‘playlist’ of experimental techniques that can be applied to different situations, at different speeds, and to address different groups in society.

Ultimately, there is a necessity to change our understanding of the pandemic as a crisis expressed through increasing and decreasing numbers of material bodies to an event affecting multifaceted (emotional, spiritual, ethnically diverse) human beings. The findings present the multiplicity of pandemic experiences expressed not only through their scale, but also through their dynamic intensities of happiness, fears, joys, and grief. As such, any future pandemic-related measures and protocols ought to take these varying intensities into account.

REFERENCES

Asaria, M., Costa-Font, J. and Akaichi, F. (2021). Why some ethnic groups are more likely to refuse the COVID vaccine (and what we could do about it). (*https://blogs.lse.ac.uk/covid19/2021/10/21/why-some-ethnic-groups-are-more-likely-to-refuse-the-covid-vaccine-and-what-we-could-do-about-it/*), Accessed 7 July 2022.

Bachelard, G. (1994). *The poetics of space*. Boston: Beacon Press.

Baumer, T., Phillips, E., Dhadda, A., & Szakmany, T. (2020). Epidemiology of the First Wave of COVID-19 ICU Admissions in South Wales—The Interplay Between Ethnicity and Deprivation. Frontiers In Medicine, 7.

Bell, T., Gardiner, L., and Tomlinson, D. (2020). *Getting Britain working (safely) again: The next phase of the Coronavirus Job Retention Scheme*. Resolution Foundation Briefing Notes (May 2020).

Blunt, A. (2005). Cultural Geography: Cultural Geographies of Home. *Progress in Human Geography 29*(4), pp. 505-515.

Blunt, A. and Dowling, R. (2006). *Home*. London: Routledge.

Blunt, A. and Varley, A. (2004). Geographies of home. *Cultural Geographies 11*(1):3-6.

Chen, D., Peng, D., Rieger, M.O. & Wang, M. (2021). Institutional and cultural determinants of speed of government responses during COVID-19 pandemic. *Humanities & Social Sciences Communications 8*(171)

Chwarae Teg (2020). *COVID-19 Women, Work and Wales*, Policy and research reports (September 2020)

Clissold, E., Nylander, D., Watson, C. and Ventriglio, A. (2020). Pandemics and prejudice. *International Journal of Social Psychiatry*. 66(5):421-423.

Da, S., Fladmark, S.F., Wara, I., Christensen, M. and Innstrand, S.T. (2022). "To Change or Not to Change: A Study of Workplace Change during the COVID-19 Pandemic" *International Journal of Environmental Research and Public Health* 19(4): 1982.

Daly, M., Sutin, A., Robinson, E. (2020). Longitudinal changes in mental health and the COVID-19 pandemic: Evidence from the UK Household Longitudinal Study. *Psychological medicine*, 1–10.

Davies, L. (2022). Find better ways to talk about death, (*https://www.cam.ac.uk/stories/BeyondThePandemic_agooddeath*) Accessed 12 June 2022.

Diener E, Seligman MEP. (2002). Very happy people. *Psychological Science* 13(1):81–4.

Depoux A, Martin S, Karafillakis E, Preet R, Wilder-Smith A, Larson H (2020). The pandemic of social media panic travels faster than the COVID-19 outbreak. *J Travel Med* 27(3)

Dovey, K. (1985). Homes and homelessness. In: Altman, I. and Werner, C. eds. *Home environments*. New York: Plenum Press.

Duffy, S. (2022) "Covid in Wales: What do the stats tell us?" BBC News, *https://www.bbc.co.uk/news/uk-wales-52380643*

Evidence and ethnicity in commissioning (EEiC) (2013). Thinking Clearly. What is ethnicity? (*https://drive.google.com/file/d/1U9Nni_gy_n77QzC_f_z1LOW_YeQXs1AR/view*) Accessed 12 July 2022.

Fancourt, D., Steptoe, A. and Wright, L. (2020) The Cummings effect: politics, trust, and behaviours during the COVID-19 pandemic. *Lancet*, 396(10249), pp 464-465.

First Minister's BAME Covid-19 Advisory Group (2020). *Report of the Socio-Economic Subgroup*. (*https://gov.wales/sites/default/files/publications/2020-06/first-ministers-bame-covid-19-advisory-group-report-of-the-socioeconomic-subgroup.pdf*) Accessed 4-10-2021.

Flaatten H, Van Heerden V, Jung C, et al. The good, the bad and the ugly: pandemic priority decisions and triage *Journal of Medical Ethics* 2021;47:e75.

Gee, G. C., & Ford, C. L. (2011). Structural racism and health inequities: Old Issues, New Directions. *Du Bois review: social science research on race*, 8(1), 115–132.

Goldman, H.H. and Grob, G.N. (2006). Defining 'Mental Illness' In Mental Health Policy. *Health Affairs* 25(3): 737-749

Goldsmith, L.P., Rowland-Pomp, M., Hanson, K., Deal, A., Crawshaw, A.F., Hayward, S.E., Knights, F., Carter, J., Ahmad, A., Razai, M., Vandrevala, T., Hargreaves, S. (2022: preprint). The use of social media platforms by migrant and ethnic minority populations during the COVID-19 pandemic: a systematic review. (*https://www.medrxiv.org/content/10.1101/2022.02.07.22270579v1*) Accessed 24 June 2022.

Grima, N., Corcoran, W., Hill-James, C., Langton, B., Sommer, H., et al. (2020). The importance of urban natural areas and urban ecosystem services during the COVID-19 pandemic. *PLOS ONE*, 15(12): e0243344.

Hornsey, M.J., Lobera, J., Díaz-Catalán, C. (2020). Vaccine hesitancy is strongly associated with distrust of conventional medicine, and only weakly associated with trust in alternative medicine. *Social Science & Medicine* 255 (June): 113019.

Hu, Y. (2020) Intersecting ethnic and native–migrant inequalities in the economic impact of the COVID-19 pandemic in the UK, *Research in Social Stratification and Mobility:* 68, 100528

Iyengar K.P., Vaishya, R., Jain V.K., and Ish, P. (2022). BAME community hesitancy in the UK for COVID-19 vaccine: suggested solutions *Postgrad Med J*, 98: e134–e135.

Kantamneni, N. (2020). The impact of the COVID-19 pandemic on marginalized populations in the United States: *A research agenda, Journal of Vocational Behavior*, 119: 103439

Lee A.T.C., Cheng G.W.H., Lin C., et al. (2021). Do people with mental health problems have lower adherence to precautionary measures in COVID-19 pandemic? A cross-sectional observational study in Hong Kong. *BMJ Open 11* (8): e046658.

Li, Y. and Meinhof, M. (2021). Imagining pandemic as a failure: Writing, memory, and forgetting under COVID-19 in China. In: Pollock, J.C. and Vakoch, D.A. *COVID-19 in International Media*. Taylor & Francis.

Li, J.B., Yang, A., Dou, K., Cheung, R.Y.M. (2020). Self-Control Moderates the Association Between Perceived Severity of Coronavirus Disease 2019 (COVID-19) and Mental Health Problems Among the Chinese Public. *Int J Environ Res Public Health*. July 4;17(13): 4820.

Marien, S. and Hooghe, M. (2011). 'Does Political Trust Matter? An Empirical Investigation into the Relation between Political Trust and Support for Law Compliance', *European Journal of Political Research*, 50:2, 267–91.

McFarlane, C. (2021). Repopulating density: COVID-19 and the politics of urban value. Urban Studies, *https://doi.org/10.1177/00420980211014810*

Menzies, R. E., & Menzies, R. G. (2020). Death anxiety in the time of COVID-19: theoretical explanations and clinical implications. Cognitive behaviour therapist, 13, e19.

Mol, A. (2002). *The Body Multiple: Ontology in Medical Practice*. Durham: Duke University Press.

Morgan, W. (2020). Coronavirus: its impact cannot be explained away through the prism of race. The Conversation, May 28, 2020 (*https://theconversation.com/coronavirus-its-impact-cannot-be-explained-away-through-the-prism-of-race-138046*) Accessed on 6-7-2022

Morgan, W. (2021). Poor vaccine take-up in BAME communities is not just down to hesitancy. The Conversation, March 1, 2021, (*https://theconversation.com/poor-vaccine-take-up-in-bame-communities-is-not-just-down-to-hesitancy-155691*) Accessed on 6-7-2022

Moore, B. (1984). *Privacy: Studies in social and cultural history*. New York: Sharpe.

Murphy, M. and Moret-Tatay, C. (2021). Personality and attitudes confronting death awareness during the COVID-19 outbreak in Italy and Spain. *Frontiers in Psychiatry*,12: 627018.

O'Dowd, A. (2021). Covid-19: Black people over 80 in England are half as likely as white people to have been vaccinated. *BMJ*, n357.

Office for National Statistics (2021). Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 24 January 2020 to 31 March 2021 (*https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethniccontrastsindeathsinvolvingthecoronaviruscovid19englandandwales/24january2020to31march2021*)

Office for National Statistics (2022). Deaths involving coronavirus (COVID-19) among health and social care workers (those aged 20 to 64 years), England and Wales, deaths registered, 9 March 2020 to 28 February 2022. Report Reference number: 14379.

Okabe-Miyamoto K, Folk D, Lyubomirsky, S, Dunn EW (2021). Changes in social connection, during COVID-19 social distancing: It's not (household) size that matters, it's who you're with. *PLoS ONE* 16(1): e0245009.

Oo, B.L., and Lim, B.T.H. (2021). Changes in job situations for women workforce in construction during the COVID-19 pandemic. *Construction Economics and Building*, 21(2), 34–57.

Owens, J. (2015), Creating an impersonal NHS? Personalization, choice and the erosion of intimacy. *Health Expectations*, 18: 22-31.

Pérez-Mengual, N., Aragonés-Barbera, I., Moret-Tatay, C., & Moliner-Albero, A. (2021). The Relationship of Fear of Death Between Neuroticism and Anxiety During the Covid-19 Pandemic. *Frontiers In Psychiatry*, 12.

Powell, R.A., Njoku, C., Elangovan, R., Sathyamoorthy, G., Ocloo, J., Thayil, S. et al. (2022). Tackling racism in UK health research, *BMJ*, 376:e065574.

Proto, E. and Quintana-Domeque, C. (2020). COVID-19 and Mental Health Deterioration Among BAME Groups in the UK. CESifo Working Paper No. 8449, (*https://ssrn.com/abstract=3662057*), Accessed on July 7th, 2022.

Public Health England (2018). Local action on health inequalities Understanding and reducing ethnic inequalities in health. PHE publications, gateway number: 2018264 (*https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf*), Accessed on July 4th, 2022.

Public Health England (2020). Disparities in the risk and outcomes of Covid-19. *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf*, Accessed 4 October 2021.

Razai, M.S., Chaudhry, U.A.R., Doerholt, K., Bauld, L. and Majeed, A. (2021). Covid-19 vaccination hesitancy *British Medical Journal*, 373: n1138

Rocha YM, de Moura GA, Desidério GA, de Oliveira CH, Lourenço FD, de Figueiredo Nicolete LD. (2021). The impact of fake news on social media and its influence on health during the COVID-19 pandemic: a systematic review. *Z Gesundh Wiss*. Oct 9:1-10.

Rose, M., Heddon, D., Law, M. O'Neil, M. Qualmann, C. & Wilson, H, (2022). #WalkCreate: Understanding Walking and Creativity during COVID-19. (*https://walkcreate.gla.ac.uk/wp-content/uploads/2022/05/WALK-ART-report.pdf*) Accessed 27 June 2022.

Salway S, Carter L, Powell K, et al. (2014). Race equality and health inequalities: towards more integrated policy and practice. *Race Equality Foundation Better Health Briefing Paper 32*. Race Equality Foundation 2014:4

Scientific Advisory Group for Emergencies (SAGE) (2021). Factors influencing COVID-19 vaccine uptake among minority ethnic groups, 17 December 2020. (*https://www.gov.uk/government/publications/factors-influencing-covid-19-vaccine-uptake-among-minority-ethnic-groups-17-december-2020*), Accessed 13 July 2022.

Senedd Cymru (2021). Coronavirus: equality issues (*https://research.senedd.wales/2020/04/15/coronavirus-equality-issues/*) Accessed 1 July 2022.

Skloot, R. (2010). *The Immortal Life of Henrietta Lacks*. Pan.

StatsWales (2022). Ethnicity by area and ethnic group. (*https://statswales.gov.wales/Catalogue/Equality-and-Diversity/Ethnicity/Ethnicity-by-Area-EthnicGroup*) Accessed 1 July 2022.

Thibaut, F. and van Wijngaarden-Cremers, P.J.M. (2020). Women's Mental Health in the Time of Covid-19 Pandemic. *Front. Glob. Womens Health* 1:588372.

Trougakos, J.P., Chawla, N., and McCarthy, J.M. (2020). Working in a pandemic: Exploring the impact of COVID-19 health anxiety on work, family, and health outcomes. *Journal of Applied Psychology*, 105(11), 1234–1245.

Tunçgenç, B., El Zein, M., Sulik, J., Newson, M., Zhao, Y., Dezecache, G., & Deroy, O. (2021). Social influence matters: We follow pandemic guidelines most when our close circle does. *British Journal Of Psychology*, 112(3), 763-780.

Tyler, I. (2020). *Stigma: The Machinery of Inequality*. Zed Books.

Tyner, J. (2016). *Violence in Capitalism: Devaluing Life in an Age of Responsibility*. Lincoln, Nebraska: UNP – Nebraska.

UK Government. (2020). Factors influencing COVID-19 vaccine uptake among minority ethnic groups. (*https://www.gov.uk/government/publications/factors-influencing-covid-19-vaccine-uptake-among-minority-ethnic-groups-17-december-2020*) Accessed 14 Feb 2021.

Vergara, R.J.D., Sarmiento, P.J.D., Darwin, J. and Lagman, N. (2021). Building public trust: a response to COVID-19 vaccine hesitancy predicament, *Journal of Public Health*, 43(2), e291–e292.

Wales COVID-19 Evidence Centre (2022). A rapid review of innovations to address inequalities experienced by women and girls due to the COVID-19 pandemic. Report number RR00027

Washington, H.A. (2008). *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. Harlem Moon.

Williams, S.N., Armitage, C.J., Tampe, T., Dienes, K. (2020). Public perceptions and experiences of social distancing and social isolation during the COVID-19 pandemic: a UK-based focus group study. BMJ Open 2020;10: e039334.

Yalçın G.M. & Düzen N.E. (2021). Altered Meanings of Home Before and During COVID-19 Pandemic. *Human Arenas* 27 (Jan): 1–13.

Zhai, Y. and Du, X. (2022). Disparities and intersectionality in social support networks: addressing social inequalities during the COVID-19 pandemic and beyond. *Humanit Soc Sci Commun* 9, 143.

Zolnikov TR, Clark T, Zolnikov T. (2021). Likely Exacerbation of Psychological Disorders from Covid-19 Response. *J Prim Care Community Health*, Jan-Dec;12:21501327211016739.

The COVINFORM project

Acronym	COVINFORM
Title	COronavirus Vulnerabilities and INFOrmation dynamics Research and Modelling
Coordinator	SYNYO GmbH
Reference	101016247
Type	Research and Innovation Action (RIA)
Programme	HORIZON 2020
Topic	SC1-PHE-CORONAVIRUS-2020-2C Behavioural, social and economic impacts of the outbreak response
Start	01 November 2020
Duration	36 months

Contact

office@covinform.eu
www.covinform.eu
@covinform.eu
covinform-project
@covinform

Consortium

SYNYO GmbH (SYNYO), Austria
Magen David Adom in Israel (MDA), Israel
Samur Proteccion Civil (SAMUR), Spain
Universita Cattolica del Sacro Cuore (UCSC), Italy
SINUS Markt- und Sozialforschung GmbH (SINUS), Germany
Trilateral Research LTD (TRI UK), UK
Trilateral Research LTD (TRI IE), Ireland
Kentro Meleton Asfaleias – Center for Security Studies (KEMEA), Greece
Factor Social Consultoria em Psicossociologia e Ambiente LDA (FS), Portugal
Austrian Red Cross (AUTRC), Austria
Media Diversity Institute (MDI), UK
Societatea Națională de Cruce Rosie Din România – Romanian Red Cross (SNCRR), Romania
University of Antwerp (UANTWERPEN), Belgium
Sapienza University of Rome (SAPIENZA), Italy
University Rey Juan Carlos (URJC), Spain
Swansea University (SU), UK
Gotenborg University (UGOT), Sweden