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Covid-19: Racialised stigma and inequalities

Recommendations for promoting social cohesion

Briefing note from Independent SAGE

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Submitted to The UK Government and the People of Great Britain & Northern Ireland by Sir David King, former Chief Scientific Adviser, UK Government, Chair of Independent SAGE

**Covid-19: Racialised stigma and inequalities
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One of the background issues that affects how people from minoritised ethnic groups are able to respond to government messages about COVID-19 concerns the ways in which they are blamed for causing or spreading COVID-19 in ways that stigmatise them. The effect of this is to intensify the inequalities that have become evident with the COVID-19 pandemic. This briefing note explains why racialised stigma and inequalities matter for COVID-19 strategies and makes recommendations to address this.

1. Key recommendations

To combat stigma and the circulation of blame narratives we recommend the following actions from government, local authorities and local public health officers, Public Health England, the media and social media companies and regulators:

Communications

Government and the media:

- Avoid linking disease with particular countries or ethnic groups
- Avoid language that blames and excludes particular minoritised ethnic groups, for example by making prejudicial or pejorative statements based on people's ethnic group.
- Provide explanations that do not make individuals responsible for problems that are caused by their social location.
- The media regulator IPSO (Independent Press Standards Organisation) to provide guidance for journalists about balance in reporting
- To ensure that the media follow the editors' code of conduct on accuracy of reporting and contextualising information

Social media companies and government regulators:

- Enforce their policies by removing racializing conspiracy theories from social media
- Challenge xenophobic, racist, hostile and dehumanising rhetoric. It is especially important that politicians do this explicitly and that social media companies provide counter-narratives
- Social media companies to provide regular updates on their hateful conduct and abuse strategies

Local authorities and local public health officers:

- Discuss regional and local public health differences and strategies in ways that do not stigmatise particular areas and communities
- Co-produce communications with community groups, community champions and local experts

Interventions

Government, Local Authorities and Public Health England:

- Roll-out interventions such as localised mass testing in ways that do not stigmatise particular areas and communities, while still protecting disadvantaged and minoritised ethnic groups
- Treat important festivals associated with minoritised ethnic groups (such as Eid, Diwali, Purim, Sukkot, Hanukah) with as much consideration as Christmas

- Plan medium term increases in investment in social infrastructures and social cohesion in areas of multiple deprivation most adversely affected by the pandemic to prevent social divides from getting worse.

2. Summary

The COVID-19 pandemic has led government, media, and social media to develop narratives to attempt to explain the dangers of [transmission](#). Too often these explanations have generated blame narratives that divide communities into ‘spreaders’ of the virus and those who are vulnerable to such spread. These accounts land in already divided social environments and can lead to increased division, stigma and hate crimes, especially in areas bearing the strain of long-term regional lockdowns and economic disadvantage.¹ Greater divides are likely to lead to worse public health, social and economic outcomes. Therefore, such government and media communications can directly increase the structural racism faced by minoritised ethnic and religious groups. This report presents recommendations for avoiding the fueling of stigma. This is particularly important during the second wave of COVID-19 and in the context of localized mass testing and the vaccine roll-out. Recent research indicates that preventing an increase in social divisions is the most effective route for public health interventions. As recent research shows, areas that are high on the index of multiple deprivation, but which have had investment in social cohesion also have lower rates of transmission of Covid-19.² Greater divides are likely to lead to worse public health and social outcomes.

3. COVID-19 and Stigma

Stigma and Othering processes

Social stigma has been an important factor in the inequalities produced during the coronavirus pandemic. Minoritised ethnic groups have been stereotyped and discriminated against because of perceived links with the disease. These links arise because it is easy to connect fear with people who are already considered ‘other’. This in turn confirms prior negative expectations, fuels stereotyping and blaming, increases discrimination, undermines social cohesion and damages the wellbeing of those subjected to it^{3 4}. Othering representations are intensified by the uncertainty and fear that attend pandemics and exacerbated by structural racism. Othering can diminish social trust in those subjected to it⁵ because they experience exclusion. It can also create barriers to reporting health concerns and create in-group and out-group confrontation and challenges. This can make minoritized ethnic groups less willing to seek health support when they need it and possibly reduce their willingness to engage with public health interventions such as mass testing or vaccines. This may be one of the reasons for the Royal Society for Public Health research finding that people from minoritised ethnic groups were much less likely to say that they would agree to be vaccinated than ‘White respondents’, although they “were especially receptive to offers of further health information from their GP.”⁶ Othering intensifies the challenges they already face due to structural disadvantage such as not being able to self-isolate because of economic pressures, working in exposing roles such as key-workers or providing informal care. The intersection of these factors can affect disease outcomes including from Covid-19 and produce long-term negative effects for minoritized populations.⁷ Better outcomes are produced by effective community engagement and building local acceptability and confidence^{8 9}

Hate Crime

At the start of the pandemic, there was an increase in hate crimes¹⁰ against people identified as Chinese because the first place where the coronavirus was identified was in Wuhan, China. Two hundred and sixty hate crime offences were committed against Chinese people in the first three months of 2020.¹¹ This was accompanied by some unsubstantiated reports from UK public figures that the virus was human made in China, paralleling ex-president Trump’s assertion that it is a ‘Chinese

virus'¹². Such pronouncements have a long history. There is, for example, a history of anti-Chinese stereotypes in the USA that construct them as “perpetual foreigners” who are “dirty” and “disease-ridden” that has been mobilised at times when diseases are spreading¹³. This leads to ‘trigger events’, fuelling anti-China and anti-Chinese sentiments evident in media headlines suggesting that half the British population boycotted Chinese goods¹⁴ and conspiracy theories that minoritised ethnic groups as super spreaders of the virus¹⁵.

In the first and second wave in the UK, this stereotyping has shifted to minoritized ethnic and disadvantaged groups. This reflects a long history of British colonialism and stigmatisation of African and South Asian groups that has prioritised protecting metropolitan cities rather than the lives of colonial subjects.^{16 17} In addition, since 9/11, Islamophobia and government Prevent policies have continued the legacy of negative representations of minoritised ethnic groups. These strategies whether inadvertently or not have also fuelled suspicion and created suspect communities who during COVID-19 have been used as a political tool by some politicians to stigmatise an entire population.

Recent hate crime figures from the UK show that the probability of being a victim of hate crime for a Chinese person in London rose from around 3-4 percent prior to Covid-19, to 10 percent in February 2020 and to around 16 percent in March 2020¹⁸.

Misrecognition of Vulnerability

Government communications and policies around Covid-19 are in danger of increasing stigma and hate crimes. Such stigma and hatred take an element of reality—the truth that people from minoritised ethnic groups are two to three times more likely to die from Covid-19 than the general population¹⁹ and uses this as a weapon against minoritised ethnic groups. The data demonstrate that the risk of death from COVID-19 is: 3.29 times higher for Pakistanis than the general population; 3.24 times higher for Black Africans; 2.41 times higher for Bangladeshis; 2.21 times higher for Black Caribbean and 1.7 times higher for British Indians.²⁰ Equally, some people from minoritised ethnic groups live in larger than average households and poorer quality, crowded housing stock, a factor associated with transmission of COVID-19.²¹ So far the government and politicians have not de-escalated media stories that misattribute this structural inequality to ethnicity. These treat ethnicity as causative of greater transmission when transmission is an effect of inequality and social exclusion. Even worse some national and local level politicians have adopted more and less subtle blame narratives. These vary from the explicit claim that minoritised ethnic groups, and particularly Muslims are “not taking [the coronavirus pandemic] seriously enough”²² to the less explicit suggestion that Hindus should “stick to lockdown rules” during Diwali.²³

Differential Recognition

The extensive government and media discussion of how to enable people to have the Christmas they wish while minimising the spread of COVID-19 highlights the marked difference in constructions of different populations. For example, the Secretary of State for Health announced on Twitter that there was going to be a lockdown in the North of England the following day, which was the day of Eid Ul-Adha on Friday 31st July. Since this is as important a Muslim festival as Christmas is a national (Christian) festival, many families had well developed preparations for food and travel that were disrupted without discussion or apology and seemed deliberately discriminatory to some. Similarly, interactions during Diwali were severely limited under national lockdown. This differential recognition of the right to social connection and observance gives greater recognition and rights to secular and Christian citizens than to citizens from minoritised religious ethnic groups.

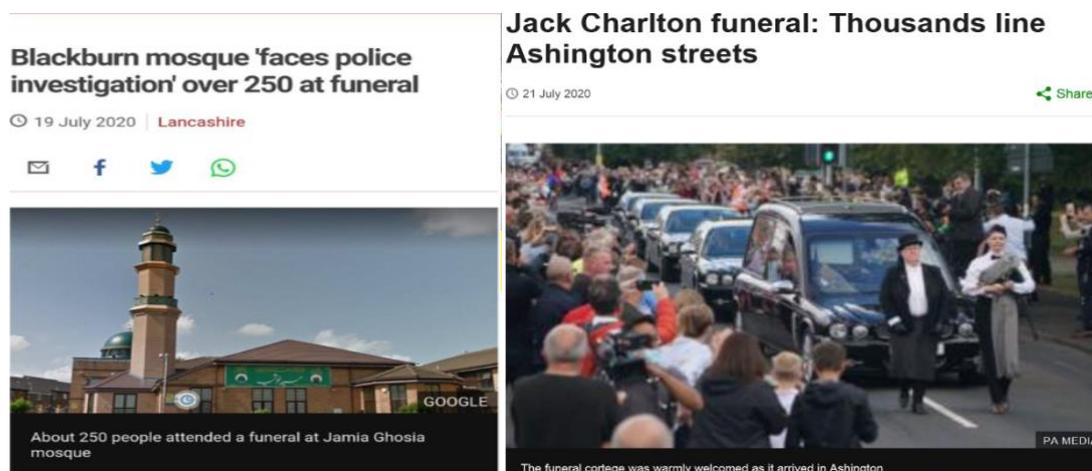
Stigmatising Communications

Equally, the language used to talk about fighting the pandemic is sometimes insensitive in a context where COVID-19 has coincided with the resurgence of Black Lives Matter, sparked by USA police killing

of George Floyd by kneeling on his neck. For example, the Prime Minister wrote in his column in the *Mail on Sunday* on 28 November 2020:

“We have almost as many Covid patients in our hospitals as we had in the April peak; we have deaths running, alas, at several hundred per day; and with the real prospect of the NHS being unable to cope, we simply cannot let our foot off the throat of the beast. On Wednesday we can and must come out of lockdown, and we will. But we cannot afford to let things rip.”²⁴

Another way in which the coronavirus pandemic has been used to intensify the stigmatisation of minoritised ethnic groups results from certain parts of the media reporting events such as gatherings for funerals, in ways that negatively stereotype minoritised ethnic groups, as in the example below from the same media outlet, BBC News online, two days apart²⁵:



The focus on Muslims apparently breaching the pandemic rules, serves to other them, with no focus on breach of rules for the Jack Charlton funeral, which is populated with real people, rather than just a building. This constitutes implicitly hostile discourse of a kind that has been increasingly adopted by, for example, mainstream politicians²⁶, and risks sparking racist violence towards scapegoated groups²⁷.

Similarly, when Northern lockdowns were imposed from July to October, the rules on preventing household mixing were picked up by politicians and the press and associated with greater levels of transmission in minoritised ethnic multigenerational households.²⁸ These, therefore, fuelled blame narratives.

Inciting the Far Right

The racialised negative stereotyping associated with Covid-19 has been utilised by the far-right and those who sympathise with this ideology to peddle hate, with such narratives entering mainstream discourses and becoming normalised²⁹. The global pandemic can be viewed as a trigger event. Trigger events are often followed by spikes in offline intergroup conflicts, but research³⁰ indicates that events of sociocultural importance can also have an impact on online communities and group cohesion, fostering and improving networking, group culture, and offline hate expressed by far right groups. As a result, far-right discourse is now impacting narratives in the mainstream media as well as offline. For example, statements that implicate minoritised ethnic groups in being super spreaders of the virus and as more likely to flout lockdown rules contradicts narratives praising minoritised ethnic groups for being on the front lines in serving the NHS and the country during the pandemic. Allegations that

certain groups may not be taking the pandemic seriously are likely to help to foster divisions and serve to increase recruitment to far-right causes.

Another key concern about stigmatising political messaging is how the far-right can use such statements to whip up fear amongst communities as lockdown measures are eased. Conspiracy theories are not only used as a tool to “explain” what is (believed and claimed to be) unexplained³¹, they can be used in contradictory ways for different people and at different times³². In the context of COVID-19, this can be seen in, on one hand, the far-right shaming of Muslim and Jewish groups for supposedly not adhering to the rules, for spreading the virus or even being the origin of it, and on the other hand, for people on far-right protests not being seen to wear any masks or adhere to physical distancing protocols³³. This apparent contradiction reflects the adaptive nature of conspiracy theories and how easily they can be used to attack or blame whoever is perceived as the current enemy.

“Anti-lockdown” events³⁴ can serve to create and to foster division since times of chaos and uncertainty, and “normative windows” (periods in which new social norms are being developed, but are still fragile³⁵) help to “spread the word”, to recruit new members and supporters³⁶ and to increase the perceived legitimacy of such arguments³⁷. In that context, it is unhelpful that the Department of Health and Social Care has put out a message that it is open to local authorities to decide whether or not to:

“focus on particular ethnic minority communities, [where there have been high death rates](#), if there was evidence they were more at risk or that an outbreak had originated in one community, with priority groups decided by local councils and directors of public health”³⁸.

This implicitly blames minoritised ethnic groups for local infections and promotes assumptions that those (minoritized ethnic) groups with a higher proportion of people who have coronavirus infections must have been more likely to have misbehaved and broken pandemic rules. Such formulations go against WHO advice to avoid language that fuels stigma and disrespect and strengthens false associations between the disease and other negative factors. The WHO argues that making such stigmatising associations can drive people away from getting screened, tested and quarantined³⁹.

Over-policing

The fact that unsubstantiated beliefs have impacts on populations is demonstrated by findings that the London Metropolitan police faced claims of bias and hard-line forms of policing, because officers enforcing the coronavirus lockdown were more likely to issue fines to people from minoritised ethnic groups than to white people. Between 27 March and 14 May 2020, black people were twice as likely to be fined and Asians 26% more likely than would be expected given the size of their populations, while white people were 23% less likely to be fined⁴⁰. In turn, this disproportionality serves to raise suspicions that minoritised ethnic groups are generally devalued, not respected, and unfairly treated.

Overall, this intensification of stigmatising public language, far right activity and over-policing leads to a breakdown of social cohesion and public trust. Research shows that divisions between groups are increasing in areas with local lockdowns where there are no concerted efforts to invest in social cohesion and that trust increases where there is.⁴¹ It is vitally important that this issue is addressed because minoritised ethnic groups already face health disparities and exclusion that adversely affect them. It is well established that there are ethnic disparities in health care and health outcomes with black women being five times more likely to die in childbirth than their white counterparts⁴² and only in 2020 has a manual for recognising what diseases look like on dark shades of skin been produced (by a black medical student)⁴³. A review commissioned by the government from Public Health England suggests that racism, discrimination, and social inequality are contributors to the increased risk of death from covid-19 among ethnic minority groups⁴⁴ At present, these effects are being intensified

and more equal outcomes and trust can only be achieved by adopting new communications and non-stigmatising forms of intervention.

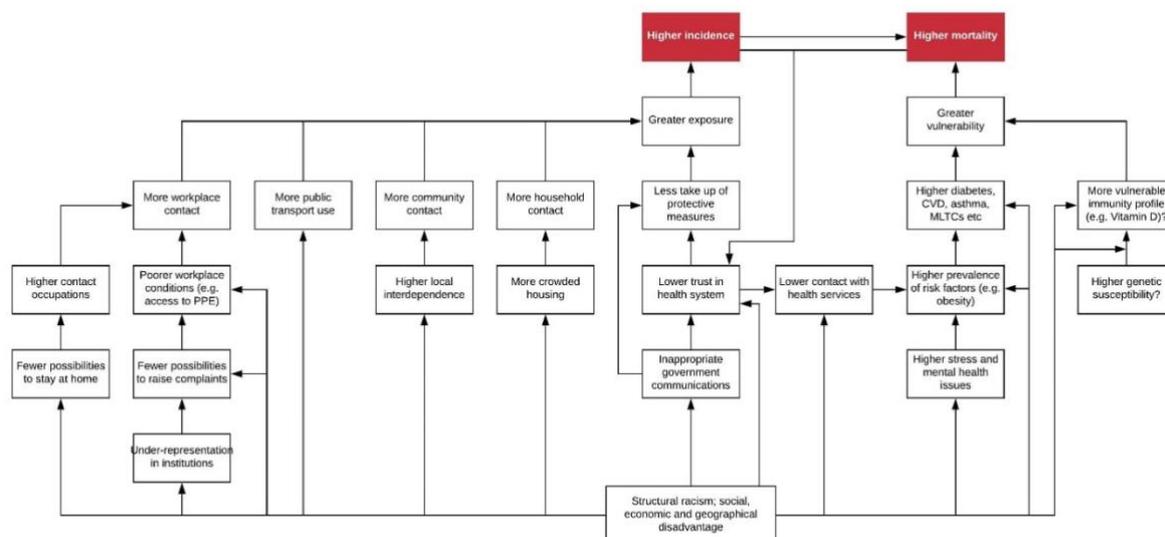
4. Ways Forward

An important outcome of the coronavirus has been the recognition of the social inequalities it has both produced and exacerbated. In order to (re)build a cohesive society in the post-covid-19 period, government, local authorities and public health bodies as well as the media and social media will have to ensure that their communications, policies and practices disrupt the social stigmatisation of minoritised ethnic groups that has produced social exclusion and hate crime. In particular, this requires that they refrain from linking disease (or other problems) with particular nations or ethnic groups and, instead, use language that does not stereotype or stigmatize minoritised ethnic groups or individualise structural processes. This is not simply a passive process in that it also requires government, media and social media explicitly to oppose the use of xenophobic, racist, and hostile rhetoric, including by removing posts that negatively racialise ethnic minorities from social media.

The policy decisions to be taken also require that interventions, as well as communications, do not stigmatise areas, communities and minoritised ethnic groups. This process will be facilitated by collaborative knowledge exchange and public engagement with community groups, community champions and local experts.

5. Appendix

Val Curtis mapped possible routes to explaining how ethnicity and disadvantage come to constitute important factors influencing risk of serious illness and death from Covid-19 for the IndieSAGE Behavioural Advisory Group (BAG). With many thanks to Val who, sadly, died on 19 October 2020.



6. Acknowledgements

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Professor Imran Awan conceived of this paper and produced the first draft.

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Following the science