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Smart, A., Williams, R., Weiner, K. orcid.org/0000-0002-5115-8866 et al. (2 more authors) (2024) Ethico-racial positioning in campaigns for COVID-19 research and vaccination featuring public figures. Sociology of Health and Illness, 46 (5). pp. 984-1003. ISSN 0141-9889

https://doi.org/10.1111/1467-9566.13748

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Ethico-racial positioning in campaigns for COVID-19 research and vaccination featuring public figures.

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Acknowledgements

We are grateful for the support of the *Foundation for the Sociology of Health & Illness* (grant reference: RGDA_AS_061221).

Abstract

This paper analyses a set of videos which featured public figures encouraging racially minoritised people in the UK to take the COVID-19 vaccine or get involved in related research. As racially targeted health communication has both potentially beneficial and problematic consequences, it is important to examine this uniquely high-profile case. Using a purposive sample of 10 videos, our thematic content analysis aimed to reveal how racially minoritised people were represented and the types of concerns about the vaccine that were expressed. We found representations of racialised difference that centred on 'community' and invoked shared social experiences. The expressed concerns centred on whether ethnic difference was accounted for in the vaccine's design and development, plus the overarching issue of trust. Our analysis adopts and develops the concept of 'racialisation'; we explore how 'mutuality' underpinned normative calls to action ('ethico-racial imperatives') and how the videos 'responsibilised' racially minoritised people. We discuss two points of tension in this case: the limitations for addressing the causes of mistrust and the risks of reductivism that accompanied the ambiguous notion of community. Our analysis develops scholarship on racialisation in health contexts and provides public health practitioners with insights into the socio-political considerations of racially targeted communications.

Introduction

At the height of the COVID-19 pandemic, several videos featuring public figures appeared across UK social and traditional media, appealing to racially minoritised (e.g., Black and Asian) people to take the COVID-19 vaccine or get involved in related research. One of these was simultaneously ‘aired across all major UK broadcasters in an unprecedented TV moment’ (4sales.com). The video campaigns emerged at a time of alarm about elevated risks and concern about appropriate responses. During the first wave of the pandemic, UK death rates in Black African, Black Caribbean, Bangladeshi and Pakistani groups were 1.9 - 3.7 times higher than the White British group, rising to 4.1 - 5.0 times higher for Bangladeshi and Pakistani groups in the second wave (Office for National Statistics 2021). The first 10 doctors named as having died from COVID-19 were among the racially minoritised healthcare workers who were dying at a disproportionate rate (Siddique 2020; Razai et al. 2021a). At the same time, responses to the UK vaccine programme also showed disparities, with rates of vaccination lower and concerns about the vaccine higher among racially minoritised people (Razai et al. 2021b). The videos featured racially minoritised public figures – celebrities and well-known people in positions of authority – encouraging engagement with research and vaccination.

While the practice of racially targeting health communications is common, such efforts warrant scrutiny as they have potentially beneficial and problematic consequences for racially minoritised people. The case we examine here is especially important due to the unique contexts of the COVID-19 pandemic and the previously unmatched media prominence of the communications, which brought their ambiguous dynamics to centre stage. Furthermore, while high-profile health advocacy aimed at racially minoritised people has been characterised in the US (Epstein 2008; Nelson 2013; Benjamin 2014), it is under-explored in the UK. This paper analyses the content of the videos and examines how racially minoritised people were represented, and what this tells us about the relationship between processes of racialisation and targeted health communications. Our aim here is to understand the necessity, value and importance of the videos, and to critically engage with them in ways that further our academic and practical understanding.

Sociologists of health and illness have long engaged with questions about race, ethnicity and racism (e.g., Ahmad and Bradby 2007), including investigations of the processes and outcomes of racialisation (Smart and Weiner 2018; Williams 2022). This work has often highlighted that racialised health interventions fall prey to problems like essentialism, reductivism, and misidentification, which Aspinall (2021) also found in the UK government response to COVID-19. It has pointed to a context of pervasive 'medical racism' (Washington 2006), with Black feminist work highlighting the intersections of anti-Black racism, sexism, and misogyny (misogynoir) (Bailey 2016), which is structuring outcomes and experiences. For example, Rai et al. (2022) shows that the apparently neutral practices of health research disguise structural and agentic barriers to participation, which can be revealed and understood using Bhambra's (2017) notion of 'methodological whiteness'. In a different context, Fletcher (2021: 1823) highlights that a danger of ethnicity-focussed research in dementia awareness is 'not only that it silences diverse knowledges, but that it ridicules and deliberately attempts to replace those knowledges'. So, on the one hand, ostensibly unbiased practices can be exclusionary while on the other hand, 'ethnicity-focussed' responses risk essentialising difference or reproducing narratives of cultural inadequacy. Our research is located within such contributions, examining evidence from targeted health communications to better understand the ways in which racially minoritised people were represented and how this reflects and (re)produces underlying processes of racialisation.

Our study is a cross-disciplinary approach blending scholarship from the sociologies of health and illness, media, race and ethnicity, and science and technology. Our analysis reveals forms of racialisation at work within interconnected media ecologies. We find appeals to action that blend biomedical authority with ideas about community responsibility and care, all set against a societal backdrop of disparity and mistrust. To contribute to existing scholarship on racialisation in health contexts we explore how a notion of 'mutuality' underpinned processes that racialised responsibility for dealing with health inequalities; and how 'advocacy-oriented' approaches to addressing inequalities create potential points of tension. These insights are also useful to practitioners who are considering if and how to approach the targeting of people from racialised minorities in health communications, in a way that is attuned to vital socio-political considerations.

Background

It is first useful to explain how we mobilised ideas of 'race' and racialisation in our analysis. We begin from the standpoint that race is not an essential quality that simply exists in the world, but is instead ever in-the-making through *racialisation*. Racialisation encompasses social processes that (re)construct ideas of race and racial difference. As such, race has been intimately tied to a colonial system 'of legitimation to justify oppressive and discriminatory practices' (Lentin 2020: 9). Furthermore, racialisation is so quotidian that 'race becomes "common sense": a way of comprehending, explaining and acting in the world' (Omi and

Winant 1986: 13). Representations of race and racial difference in popular culture – including in health communications – are part of racialisation processes.

In what follows, we examine the relationship between processes of racialisation and targeted health communications. These communications can be *racialised* artefacts (i.e., constructed in a way that invokes notions of racial difference). They may also do the work of *racialising* (i.e., circulating notions of racial difference that impact on people's ideas and practices). Our study focuses on how the videos, as artefacts, represent the particular qualities of racially minoritised people, but also considers the implications this has for understanding the work of racialising.

We recognise that discussions of UK health inequalities usually centre the terminology of ethnicity, in contrast to the US centring of race. Given our interest in racialisation processes, we use the term 'racially minoritised' in this paper, and elsewhere (Williams 2022), as constructions of group difference not only draw upon notions of race but also 'related' concepts like ethnicity, ancestry and culture (Wade 2014). Where others have referred to ethnicity or ethnic groups, we preserve the original terminology.

Turning to the context of our case, the racial disparities of COVID-19, both in terms of the disproportionate health impacts (Lo et al. 2021) and differences in vaccination uptake (Nguyen et al. 2022), were unsurprising. In the UK and US, there is longstanding evidence of racial health inequalities (Kapadia and Bradby 2021; O'Brien et al. 2020), enduring concern about diversity in health research (Das 2021; Smart 2021) and well-characterised differences relating to public health interventions, for instance in vaccine and various tissue donor programmes (Tessier et al. 2018; Williams 2021). In all these examples, explanations point to the historic and enduring, contemporary impacts of structural racism.

There is an equally long history of attempts to explore and address these inequalities. The US National Institutes of Health (NIH) Revitalization Act (1993) was a landmark shift toward an ‘inclusion and difference’ paradigm (Epstein 2008), which mandated inclusion of minoritised participants in NIH-funded research. Although no comparable legislation exists in the UK, the UK’s medical establishment has arguably been galvanised into action by the Black Lives Matter protests and the unequal impacts of COVID-19, developing new guidance and recommendations for improving inclusion in biomedical research and innovation (e.g., NIHR 2022, Treweek et al. 2021). While health research discourse uses terms like ‘recruitment’ and ‘enrolment’ to describe interactions with potential research participants, some sociologists favour the term ‘conscription’ which enables them to highlight the power and authority of science in such encounters (Montoya 2007; Benjamin 2016). Their framing is useful for our consideration of racialisation processes as it underscores the risks of reification and reductivism that occur when scientific (Benjamin 2014), governmental (Aspinall 2021) or commercial actors (Montoya 2011) strategically identify, label and target health activities, products and communications toward racial groups.

Such targeting in health communications is an established practice in the US (e.g., Guo et al. 2020) and UK (e.g., Saunders 2010). During the COVID-19 pandemic, the UK government advisory committee Scientific Pandemic Influenza Group on Behaviours (SPI-B) published a *Consensus on BAME [Black Asian and Minority Ethnic] communication* to guide health communications (SPI-B 2020). It argued that health communicators should attempt to reflect cultural differences, and recommended they consult with communities to generate appropriate content and modes of communication. However, recent research found that such campaigns in the US could be experienced as stereotyping (El Hazzouri and Hamilton 2019). Indeed, UK state guidance notes that such targeting could have risks like stigmatisation (SPI-B 2020; Gov.uk 2020). These concerns will be discussed further below.

Before exploring these risks, it is necessary to note two relevant aspects of contemporary health communications. One is the intersections between multiple media platforms within a broad media ecology. Traditional or legacy media (e.g., television, radio and print) have long been pivotal to how people engage with health-related matters, through selecting and determining representations of health (Seale 2002). Moreover, new digital media – social media platforms especially – have shifted how different actors engage in consuming and producing media content in complex ways (Tufekci 2013), particularly in health contexts (Henderson and Hilton 2018). Not least, social media have blurred the role of the 'content producer', potentially shifting communicative labour away from traditional media producers to other actors, including patients, families and marginalised communities (Williams 2022).

The second relevant contemporary media context is the use of public figures. Using celebrities in health communications is often suggested as a means for increasing the uptake of health messages, including racially targeted ones (e.g., Guo 2020; Saunders 2010). US scholarship reports racial patterning to the use (Zhou et al. 2020) and impacts of celebrity endorsements (Chen et al. 2019). Indeed, UK advice on targeting health communications suggest conveying information through trusted authority figures from target communities (SPI-B 2020).

Whilst common, targeting is a contested practice that raises multiple concerns. Firstly, efforts to describe and address health inequality with an apparent racial patterning necessarily require engaging with ideas about racial difference. As such, the notion that different groups have a specific and essential *racial* character is reified. This creates a tension between imperatives for addressing variations in health and the risks of (re)producing and reconfiguring racialised thinking (e.g., Epstein 2008). A core concern is that health research and interventions that invoke apparently racially distinct groupings (e.g., 'Black people') reify them using problematically essentialist or reductive ideas about biological or cultural difference (Duster 2015). As such, well-intended targeting may have unintended consequences. It could feed essentialising perceptions about group differences, e.g., health differences are outcomes of endogenous biological or cultural group variation and nothing to do with differences in exogenous social, structural or environmental conditions. This risks the stigmatisation or blaming of groups, clinical misdiagnosis, an inappropriate narrowing of health research and the fanning of racist ideas. It can also impact the nature and quality of healthcare that racially minoritised people receive, with potentially deleterious consequences (Duster 2015).

Additionally, there are concerns that racialised framings of health reflect and (re)produce the structural inequalities that contributed to their initial existence. Brown et al. (2004) explain that 'constituency-based' health social movements emerged to address health inequalities faced by, amongst others, racially minoritised people. Organisations within such movements can vary in goal or strategy, ranging from 'advocacy-oriented' to 'activist-oriented' agendas and activities, with the former working 'within the existing systems and biomedical model' and the latter seeking to disrupt or challenge them (2004: 53). However, such activism itself (re)produces certain social relations and ideas about difference. For example, Williams (2021) points to the 'responsibilisation' of racially minoritised people in stem cell donor campaigns, where the onus for addressing inequalities is located with those experiencing the inequalities, rather than with the state. Social action within such contexts is also racialised, generating 'ethico-racial imperatives' that assert apparent responsibilities people have for 'their community'. Furthermore, there are concerns about the true nature of inclusion work. Benjamin (2014) uncovers the racialised narratives and counter-narratives in stem cell research, where 'diversity outreach' might instead be viewed as 'medical racial profiling'. She has gone on to argue that 'cosmetic representation' does not equal redress (Benjamin 2022).

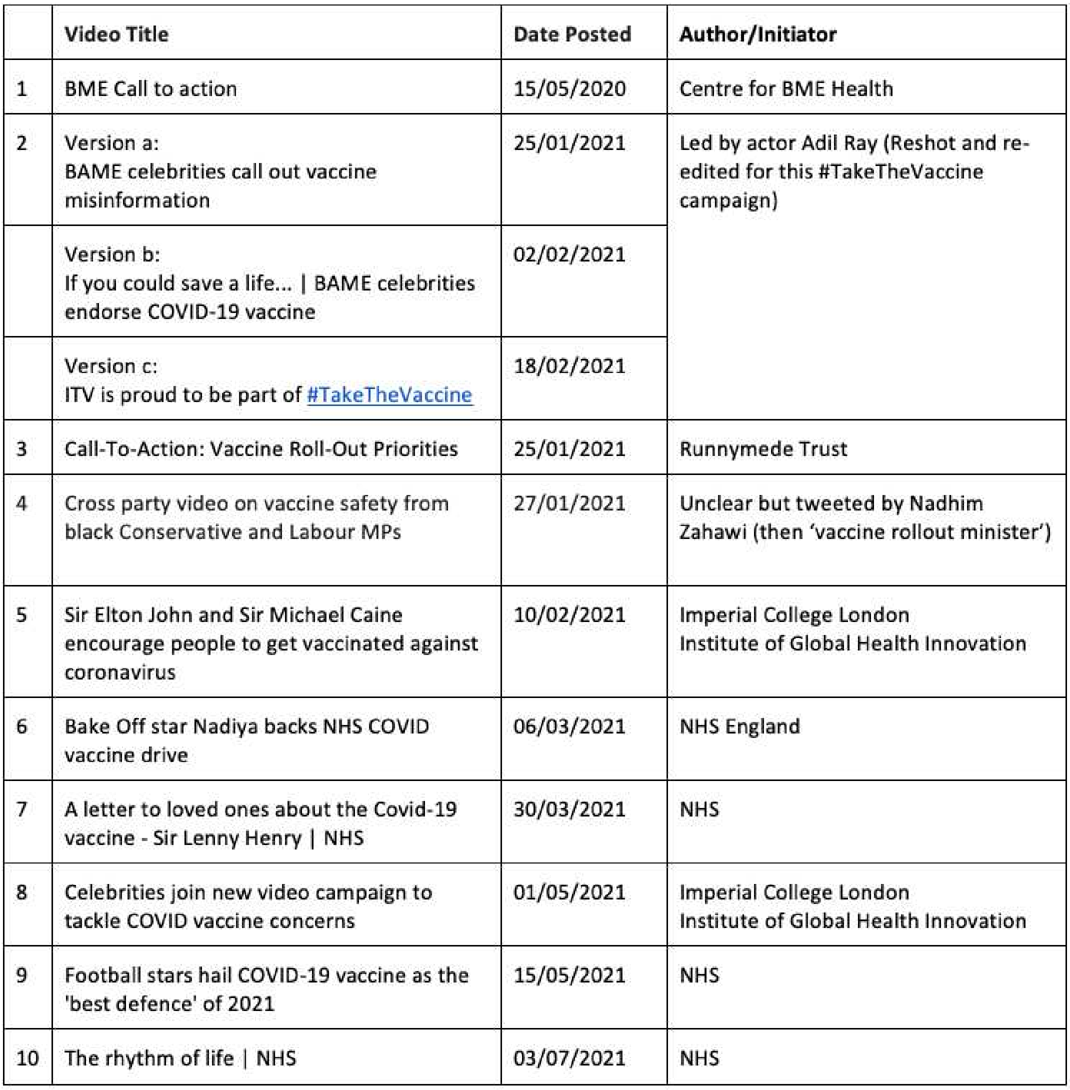
In sum, health communications targeted at racially minoritised people not only reflect societal inequalities but also participate in processes of racialisation, forming part of the socio-cultural framework in which ideas about race and racial difference are used, reproduced and reconfigured. The literature cited above contains examples ranging from clinical trials recruitment, public health campaigns and appeals for stem cell donors. Our case, appeals relating to COVID-19 research and vaccination, has not been previously examined. It is an especially important example, given the pandemic's urgent and widespread health threats and the need to examine the consequences of the way that responses to these threats were racialised.

Various UK initiatives addressed apparent racial inequalities during the pandemic, but what caught our attention were high-profile videos of public figures encouraging participation in research and vaccination. We examined these to ask: how were racially minoritised people represented and what concerns about the vaccine were expressed? Examining these questions will elucidate the processes and outcomes of racialisation, allowing us to explore how racially minoritised subjects are constituted, problematised, and approached in efforts to make health research and interventions more inclusive.

Methods

We used purposive sampling (Ritchie et al. 2003) to select videos based on the criterion that they employed public figures to promote COVID-19 vaccines and research in the UK.[1] We identified 10 videos featuring celebrities from film, sport and television, Members of Parliament, faith leaders, campaigners, scientists and health professionals. Our sample began with the most prominent videos, but to ensure comprehensiveness, we systematically searched media database LexisNexis using keywords (such as celebrities, BAME, COVID) to find other potential videos, each of which was evaluated for eligibility (e.g., excluding those not including public figures).[2] See Table 1 for all included videos.

Table 1: List of sampled videos



	Video Title	Date Posted	Author/Initiator
1	BME Call to action	15/05/2020	Centre for BME Health
2	Version a: BAME celebrities call out vaccine misinformation	25/01/2021	Led by actor Adil Ray (Reshot and re-edited for this #TakeTheVaccine campaign)
	Version b: If you could save a life... | BAME celebrities endorse COVID-19 vaccine	02/02/2021	
	Version c: ITV is proud to be part of #TakeTheVaccine	18/02/2021	
3	Call-To-Action: Vaccine Roll-Out Priorities	25/01/2021	Runnymede Trust
4	Cross party video on vaccine safety from black Conservative and Labour MPs	27/01/2021	Unclear but tweeted by Nadhim Zahawi (then 'vaccine rollout minister')
5	Sir Elton John and Sir Michael Caine encourage people to get vaccinated against coronavirus	10/02/2021	Imperial College London Institute of Global Health Innovation
6	Bake Off star Nadiya backs NHS COVID vaccine drive	06/03/2021	NHS England
7	A letter to loved ones about the Covid-19 vaccine - Sir Lenny Henry | NHS	30/03/2021	NHS
8	Celebrities join new video campaign to tackle COVID vaccine concerns	01/05/2021	Imperial College London Institute of Global Health Innovation
9	Football stars hail COVID-19 vaccine as the 'best defence' of 2021	15/05/2021	NHS
10	The rhythm of life | NHS	03/07/2021	NHS

We were especially interested in videos targeting racially minoritised people, which – as we discuss in our findings section below – was obvious in some instances, but less clear in others.

To examine the representation of racially minoritised people and concerns about the vaccine we undertook a qualitative content analysis of the form and substance of the videos (Berger 2000). All videos were transcribed. We followed Spencer et al.'s (2003) 'analytical hierarchy' model to develop a thematic analysis by developing a coding framework that mixed a priori interests with emergent codes (Brooks et al. 2015). A priori codes were drawn from existing knowledge of the academic field of racialisation (e.g., racial classifications and nomenclature) and likely concerns (e.g., mistrust). The authors independently read the transcripts to identify emergent codes and met to agree. LC used Nvivo to systemically code the dataset and produce reports of key themes. Analysis was then conducted by AS and LC to identify key descriptive patterns and typologies within themes (Spencer et al. 2003), including for example the range of 'concerns' and the sources and nature of accompanying 'assurances'. This analysis stage also identified points of interrelation in the dataset (Spencer et al. 2003), for example, how notions of diaspora emerged in both characterisations of 'community' and in 'assurances' against fears of mistrust. The team crossed-checked this analysis to ensure completeness and consistency. Our explanatory account (Spencer et al. 2003) was developed by the team across a series of meetings, drawing on existing theories such as the operation of 'ethico-racial imperatives' (Merz and Williams 2018; Williams 2021), and Brown et al.'s (2004) conceptualisation of health activism.

As our findings focus on representations in video content, our analysis is bound by the constraints of media content analysis; we are unable to make claims about audience interpretations or producer intent (Bell 2001).

Findings

Our findings help us to explore issues of racialisation by revealing how racially minoritised people were represented, using two broad themes: '*communities*' and '*concerns* *and assurances*'. Data in the '*communities*' theme portrays groups as being at risk, while having a sense of collectivity that could be marshalled in response to the threats of COVID-19, and of not taking the vaccine. Data in the '*concerns and assurances*' theme portrays the issues that were reportedly limiting engagement with vaccination, and the framing of responses to them. Before presenting those themes, it is necessary to describe the videos.

The videos

This description of our dataset reveals the more and less overt ways in which videos appeared aimed at racially minoritised audiences; variations in style from early 'home-made' videos and later, more polished content; and how the constellations of organisations and individuals involved in the videos could be understood to be engaging in health advocacy work.

Our discussions about whether a video targeted racially minoritised audiences centred on factors like title, creator, media coverage, participants and content. Some examples were straightforward (e.g., the title 'BME Call to action' or descriptions that noted their audience as the 'British Bangladeshi community'). Others were less clear; if videos included people of colour, did this make them 'targeted', or might this depend on those individuals' prominence in the video? Video 5 was the only example that did not include any people of colour. The uncertainties we faced about what 'counted' as targeting also raised deeper quandaries.[3] Importantly, however, confronting these uncertainties fed into our findings; it revealed the various registers through which racialised appeals to audiences might be being made, and their potentially ambiguous nature.

We observed variations in the focus, origins and style of videos. The first video encouraged participation in research, while the remainder focused on vaccination. The earliest videos originated from the smaller, minority-focused groups or organisations (e.g., Centre for BME Health, 'BAME celebrities'), while later videos were produced by larger organisations (e.g., NHS, Imperial College London). In terms of style or form, most videos comprised edited-together headshots of people talking to camera accompanied by soft music; however, some later videos had distinctive styles, centring on comedy and musical theatre. Production quality improved over time. Earlier videos appeared 'home-made', with poorer sound and video quality, featuring contributors speaking from home into smartphones in both landscape and portrait orientations. The shift from lower to higher quality likely reflects the early pandemic 'work from home' arrangements, and the relative resources of larger organisations, whose later contributions could also reflect their slower pace of work.

Videos also involved different, potentially shifting, constellations of social actors. On one level, videos were created by various individuals and organisations (including scientists, politicians, actors, campaign groups, and healthcare or educational organisations) who brought together public figures, sometimes from different social realms (celebrities alongside scientists or healthcare workers). They were also constructed within, and shared across, a broad media ecology. For example, Video 2 was an early 'home-made' example that began life on social media but was eventually aired simultaneously on multiple UK television channels. This synchronous communication was publicised as 'a first in British media history' (4sales.com), indicating its perceived importance. This video was organised by actor Adil Ray, who enlisted other 'BAME' celebrities to address concerns and 'misinformation'. A different type of constellation can be seen in Video 7, where the NHS partnered with a celebrity known for public interventions on racism. This was written by and featured actor Sir Lenny Henry (who is actively engaged in issues of media diversity), and was more professionally produced and emotionally charged, with a narrative appealing to family members. These examples represent advocacy-oriented work. The former was a ‘grassroots’ social media campaign amplified by traditional broadcast media. The latter, an established healthcare organisation working with a celebrity well-known for speaking about racial inequality.

Communities

Having provided an overview of the dataset, we move to the first theme – community. ‘Community’ or ‘communities’ appeared frequently in the video transcripts as referents to groups. The data below shows that these communities were represented as facing specific risks in health and social exclusion. They were also portrayed as key in responding to the crisis, including in ways exposing them to risk. Ideas about common characteristics or experiences were invoked, seemingly to persuade people to get vaccinated or get involved in research, for their own sake and for that of the group as a whole.

In relation to health risks particularly affecting racially minoritised people, communities were described as being at increased risk of death or ill-health, for example: ‘Black and Asian communities have been disproportionately impacted by this awful virus’ (Video 3: Maurice McLeod). These risks were connected to patterns of employment, urban living and social inequalities. For example: ‘Many in our community have suffered the most, largely due to our efforts on the front line, at the NHS or as key workers’ (Video 2a,b,c: Moeen Ali).

Risks were also reflected in claims about communities being less involved in research or in vaccination programmes. Some were factual statements, such as: ‘people in the Black, Asian, ethnic minority community are twenty per cent less likely to take up the vaccine’ (Video 8: Sir Lenny Henry). Other videos framed this pattern of reduced involvement in more emotive language, invoking a risk of social exclusion, as in: ‘We want you to be safe. We don't want you to be left out or left behind’ (Video 7: The Rt Rvd Rose Hudson-Hall).

In the face of these risks, however, communities were represented as making social contributions by actively confronting the crisis, such as: ‘Our community has played our part’ (Video 2b: Konnie Huq). These contributions highlighted people putting themselves at risk in order to make a social contribution. This was often family members working in healthcare and science, or participants in medical research, in the UK and abroad. For example: ‘Many of whom are our relatives. Many of whom have made the ultimate sacrifice to protect the people of this country from this pandemic. And the thousands who volunteered to be part of vaccine trials, so that we know it’s safe and works for people of all ethnicities’ (Video 3: Adjoa Andoh). This connection to family is similarly emphasised in this sequence in video 2a,b:

> Adil Ray: […] we have such immense pride when a family member becomes a doctor or a nurse. We’ve so much respect for them. They need our respect, now, more than ever. They need our help.
>
> Sadiq Khan: Today those doctors and scientists have found us a way forward: a COVID vaccine.

In this sense, the notion of community captured ideas of relatedness that appeared to range from close relatives to a wider diaspora.

Communities were also represented as having common values, experiences or characteristics relevant to responding to the crisis. These commonalities were based on duty, faith, trust and diasporic connections. Duty to community was suggested as a group trait, for example: ‘Looking after others and serving our community is what we do. That’s how we’ve been brought up’ (Video 2a,b: Adil Ray; Video 2c: David Olusoga). Faith activities were among things people could return to after being vaccinated, such as: ‘Just one simple step will mean we can once again eat, drink, pray and hug together’ (Video 2a,b,c: Ria Hebden). Trust was signalled as a concern, for example: ‘We know [...] that it’s hard to trust some institutions and authorities’ (Video 7: Sir Lenny Henry); this issue will be explored further in the next sub-section. Diasporic connections were mentioned in relation to relatives abroad being vaccinated, and to contributions to vaccine research and development; for example: ‘India is one of the global leaders in vaccine manufacturing. Your relatives in this part of the world are alive today because of their trust in vaccines’ (Video 2b: Boman Irani). They were also mentioned in response to concerns about trust, which will be explored in the next sub-section.

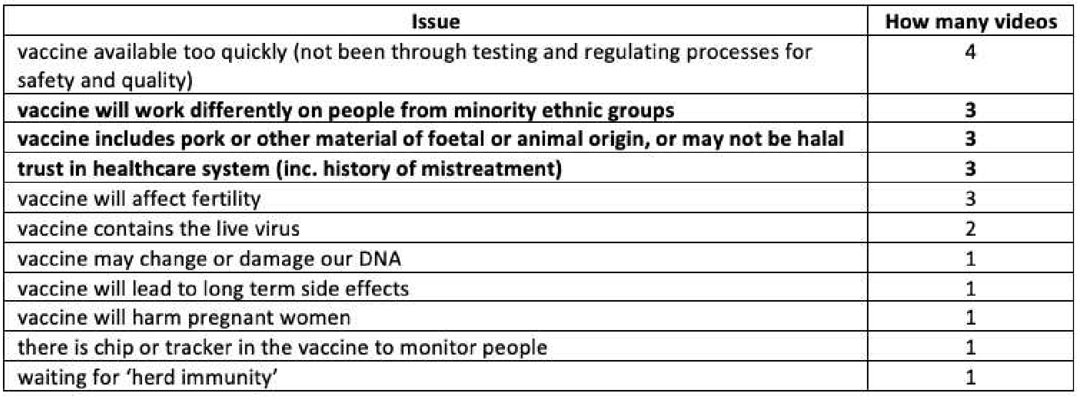
Some arguments for engaging with vaccines and research centred on the suggestion that it would be beneficial to individuals and communities. Benefits to communities were used as a reason for taking the vaccine, for example: ‘…let’s all try and support our community and take the vaccine’ (Video 8: Navine Chowdhry). Community in this context was often used alongside ideas about togetherness, for example: ‘we all need to take the COVID-19 jab. It’s all of us in this together’ (Video 7: Naomi Ackie). It was also accompanied by ideas about family and mutual protection, such as: ‘We need to protect ourselves, our families and our communities and the only way we can do that is by taking the vaccine’ (Video 3: Yvonne Coghill). A similar motive for engagement was given for involvement in research; it was explained that ‘few people from these communities are putting themselves forward’, so people who identify as Black, Asian or minority ethnic were encouraged to ‘please come forward, and the sooner you do it, the more lives we can save now’ (Video 1: Omid Djalili).

Concerns and assurances

In addition to establishing the collective ground of ‘community’, data below show that the videos represented racially minoritised people as having various concerns. While relatively few of these appeared specific to minoritised groups, the issue of trust arguably intersects with other concerns to make them racially inflected. When concerns were voiced, they were mainly paired with immediate assurances or rebuttals invoking the authority of institutional science. The notable exception was the issue of trust which, though given more credence, was nevertheless rebuffed.

Eleven issues were raised, with variable frequency across the videos occurring (see Table 2). The most were covered in videos 2 (n = 10) and 8 (n = 5).

Table 2: List of issues expressed in the videos



Issue	How many videos
vaccine available too quickly (not been through testing and regulating processes for safety and quality)	4
vaccine will work differently on people from minority ethnic groups	**3**
vaccine includes pork or other material of foetal or animal origin, or may not be halal	**3**
trust in healthcare system (inc. history of mistreatment)	**3**
vaccine will affect fertility	3
vaccine contains the live virus	2
vaccine may change or damage our DNA	1
vaccine will lead to long term side effects	1
vaccine will harm pregnant women	1
there is chip or tracker in the vaccine to monitor people	1
waiting for 'herd immunity'	1

Three issues were ostensibly specific to racially minoritised people (marked in **bold** in Table 2). The first was that the vaccine may work differently, for example: 'there is no scientific evidence to say that the vaccine is any less effective in people from ethnic minority backgrounds' (Video 8: Navin Chowdhry). A second was that the vaccine may be religiously inappropriate, as in: 'The vaccine does not include pork or any material of foetal or animal origin' (Video 2a,b,c: Nazir Afzal). A third concern, only expressed by Black contributors, was about trust. This was linked to historic and contemporary experience of discrimination, such as: 'I do understand the concerns people have around the vaccine, the history of Black and Brown bodies being used for science, the misinformation and maybe lack of trust for government, especially on the rollout too' (Video 3: Maurice McLeod). While other concerns listed in the table were less obviously specific to racially minoritised people, worries about the legitimacy of the drug approval processes, potential side effects and surveillance all suggest a lack of trust in institutional science or more broadly, the state.

The assurances or rebuttals that accompanied concerns predominantly drew authority from institutional science, e.g., that the vaccine has been 'robustly tested by some of the world's best scientists and data analytics experts' (Video 4: Adam Afriyie). This included naming UK health organisations that supported the vaccine like the Royal College of Obstetricians and Gynaecologists, or more general mentions of regulatory standards, for example that 'COVID-19 vaccines have gone through the same strict processes and regulations as other vaccines' (Video 2a,b,c: Sanjeev Bhaskar). Some public figures made statements of fact about the science, such as: 'it's important to understand that the vaccine does not contain the live virus itself, only harmless elements from it' (Video 2a,b: Rageh Omaar), which were sometimes followed by instructions to consult a professional, as in: 'Pregnant women are not excluded from the vaccine, but should discuss their case with the doctor' (Video 2a,b,c: Bhavna Limbachia). Other times, contributors' medical credentials were used to emphasise their authority, such as: 'I want you to trust me as a doctor giving you this information' (Video 6: Dr Saliha Mahmood).

Other less common strategies for assurance included invoking religious authorities, as in: 'lots of different halal regulatory bodies have told us that it's completely halal and safe to take the vaccine' (Video 6: Dr Saliha Mahmood). Humour was used to make one concern appear ludicrous: 'There is no chip or tracker in the vaccine to keep watching where you go. Your mobile phone actually does a much better job at that' (Video 2a,b,c: Romesh Ranganathan). Audiences were also warned about unreliable information sources, for example: 'There are distracting voices in our Black and minority ethnic communities spreading doubt and alarm. Listening to those voices only will rob us of the need to live flourishing lives with our families and friends' (Video 3: The Rt Rvd Rose Hudson-Hall).

Concerns about trust were less specifically about the vaccine and were represented differently to other issues. It was common to see the word ‘understanding’ and other valorisations that lent the concern credence, such as: ‘We understand the genuine history of mistrust some Black people will rightfully feel’ (Video 4: Clive Lewis).

People were encouraged to overcome concerns about trust in different ways. One was a request to lay it aside due to the seriousness of the crisis: ‘now isn’t the time for conspiracy theories. Over 100,000 British people have died from this virus’ (Video 3: Maurice Mcleod). Another was to appeal to racial justice: ‘Don’t let your concerns be the thing that widens racial inequality in our society’ (Video 7: Sir Lenny Henry). A third was to implore people to take the vaccine: ‘I do understand the concerns people have […] but I do urge everyone to take it’ (Video 3: Patrick Vernon). A fourth was to invoke connections to community and diaspora as a reason to be trusting, as in:

> ‘But, we’re asking you to trust the facts about the vaccine from our own professors, scientists and doctors involved in the vaccine’s development. GPs, not just from here in the UK, but from all over the world, including Africa and the Caribbean’ (Video 7: Adrian Lester CBE).

In the previous section of this article, mistrust and diasporic connections were shown to represent community characteristics; in the above extract, these facets are assembled in a way that seeks to inspire trust in vaccines.

Discussion

Having shown how racially minoritised people were represented and which concerns were expressed, we reflect on racialisation, including: how ideas about ‘mutuality’ underpin normative calls to action (‘ethico-racial imperatives’); how videos were a form of advocacy that reflected racially minoritised people’s responsibilisation, arguably blunting more critical engagement with the causes of mistrust; and how the frequent, ambiguous use of ‘community’ carries the risk of being reductive.

Racialisation, ‘mutuality’ and ethico-racial imperatives

Targeting racially minoritised audiences in health communications is usually linked to ideas about ‘authenticity’ (Guo et al. 2020), specifically the contention that an audience and speaker’s apparently similar racial identities can provide common ground for making information more credible, legitimate, or authoritative.

Our analysis shows how representations of racialised identities constructed this sense of common ground. These signalled shared ‘negative’ experiences (e.g., health risks from working on ‘the front line’, risk of social exclusion and wariness due to legitimate mistrust) alongside more ‘positive’ framings (e.g., pride in contributions to society or responses to the crisis, and apparently shared values like commitment to family, community and faith). This twinning reflects Modood’s (2005: 57) formulation of identifications that encompass potentially linked ‘modes of oppression’ and ‘modes of being’. Portraying racially minoritised people’s characteristics and experiences empathetically might be seen to position the contributors as credible spokespeople, lending them the authority to encourage supposedly reticent audiences to engage in research and vaccination.

In terms of racialisation, we suggest that fostering ‘authenticity’ is joined by another important effort: establishing ‘mutuality’. This has two elements: creating an ‘us’ bond between ‘messenger’ and ‘recipient’; and, creating a second bond between that recipient and other ‘people like us’ who the recipient is invited to imagine will benefit from their decision to participate. This is not only about articulating a sense of common ground (as described above); it is also about suggesting that a sense of ‘sharedness’ generates a responsibility to act in the interests of one another and the whole group. For example, the plea in the videos that ‘they need our help’ not only points to collective similarity (we are the same), but also implies mutual responsibility (we owe things to each other). Such mutuality may gain strength when it is mobilised in contexts of oppression or discrimination, notwithstanding the fact that racially minoritised identities are demonstrably multi-layered, dynamic and intersectional (Song 2003). Pointing to collective similarity can invoke peoples’ racialised subjectivities, drawing people together by creating a sense of the shared identity. Pointing to mutual responsibility introduces an ethical component of common duties, benefits and liabilities. This makes the appeals to mutuality ethical as well as racialised; that is, ethico-racial.

Studies of racialisation in other health contexts have pointed to the use of ‘ethico-racial imperatives’ that encourage people to feel responsibility for ‘their’ racial or ethnic community (Williams 2021). Our data analysis revealed such imperatives in the overarching appeal to collective responsibility: that communities were at risk, and while people may have concerns, they should take the vaccine for their own good and for the good of others, especially family. Indeed, contributors regularly used personal plural pronouns ‘we’, ‘our’ and ‘us’ to address audiences and encourage them to act in the mutual interest of the collective (as in, *our* community has suffered, *our* scientists helped develop the vaccine, *we* must protect *our* communities). Moreover, there could be great flexibility to this, with a sense of racialised duty pitching relatedness at the scale of the household all the way to diaspora.

While invoking ethico-racial imperatives may potentially be effective in addressing health needs, one consequence is that racially minoritised people are ‘responsibilised’ for addressing the inequalities they face (Merz and Williams 2018; Williams 2021). Responsibility is distributed onto those affected by inequality at the cost of critical intervention into the systems perpetuating it, a point we pick up below.

Videos as racially responsibilising health advocacy

Our study suggests that the videos were a form of health advocacy, indicating that responsibility for addressing the unequal impacts of COVID-19 had fallen on those facing the increased risks. The earliest, ‘community-led’, videos in our sample reflect an ‘activism-oriented’ response to racialised health inequalities (Brown et al. 2004). In a context of fear and alarm, these videos highlight a gap in official responses; an effort to reflect the concerns of people whose interests were not being represented. They centred the concerns of those who questioned whether the vaccine was designed for, or safe for, ‘them’, if it fitted with their religious values. However, other characteristics of the response can be understood using Brown et al.'s (2004) notion of 'advocacy-oriented' action, which in this context aligned the interests of racially minoritised people with the state's biomedical response to the crisis. Later videos were produced or distributed by large organisations; and even the early videos were entangled with the state response to the pandemic: the Centre from BME Health video was supported by the UK government-funded National Institute for Health and Care Research; the 'black' MPs[4] were working at the highest level of national politics; and, Adil Ray's video was eventually broadcast across national television. Furthermore, the concerns expressed in all the videos were largely rebuffed by reference to institutional science (for example, that the science and its oversight by the state was sound). Even where mistrust based on racism was validated, the message was that not trusting the scientific establishment on this occasion would be individually and collectively harmful.

These findings provoke various critical reflections. Firstly, it appears dissonant to validate feelings of mistrust while also asking they be set aside. The message was broadly: your concerns are either unfounded or misplaced – you should trust in state-approved science. This was, in effect, telling people to be trusting in order to overcome mistrust. In February of 2021, a *BMJ* editorial listed potential sources of mistrust (Razai et al. 2021b), and a study published later in the year recommended that attempts to encourage engagement risked aggravating or perpetuating mistrust if they failed to address past and ongoing discrimination (Woodhead et al. 2021). However, there was little depth to the engagement with mistrust in the videos, perhaps because it would have made it difficult to then ask for it to be set aside. Even if the producers had wanted to meaningfully unpack deep-seated mistrust, there are manifest difficulties in doing this alongside addressing present and imminent risks to life in short, widely shared video addresses. In place of a deeper reflection on mistrust, we found various strategies at work: legitimising the feelings; warning against ‘conspiracy’; appealing to racial justice as a higher ideal; highlighting the pandemic’s calamitous nature; and invoking the trustworthiness of scientists of colour. These strategies connect back to ‘mutuality’: an implied bond between ‘messenger’, ‘recipient’ and other ‘people like us’. The hope seemed to be that trust concerns would be neutralised if people of colour are doing the science, or communicating about it in a way that signals common interests.

Moreover, the institutionally-embedded ‘advocacy-oriented’ response of these videos appears to blunt criticality. While inequality and mistrust were acknowledged, there was little reflection about why these conditions exist. Such silence is noteworthy. Petteway (2023) points to the inherent contradictions of racial health equity discourses that fail to interrogate racialised power dynamics, whilst Benjamin (2014) argues that racialised messaging around health technologies risks being seen as ‘minstrelsy’ when it fails to address the underlying inequalities that give rise to necessarily racialised approaches. This is not our accusation against videos that appear to come from a place of care, and which emerged from within ‘communities’ amid genuine fears, or in official responses featuring public figures with reputations for addressing inequalities. Yet if people are engaged only for the immediate problems around COVID-19 research and vaccination, without including a more substantial critique of historical and continuing injustice, we question whether this is sufficient to do the redressal work that is manifestly needed.

We might also ask whether using public figures in this manner would gain such widespread attention in other contexts of racial health inequality, such as campaigns for blood donation to address perennial disparities in sickle cell disease. The fact that this issue was picked up by state health institutions and amplified by media must be understood within the context of the global COVID-19 crisis and racial differences in health outcomes and vaccine uptake. But it is also worth recalling Bell's (1980, cited in Gillborn 2008: 32) concept of interest convergence – that racial inequalities are addressed when they coincide with 'white self-interest'. During the pandemic there was state concern about racist tropes relating to the origins and spread of the virus (The Commission for Countering Extremism 2020) and instances of racial 'blaming' for the imposition of lockdown measures (Clarke 2020). In such contexts, improving vaccination rates among the racially minoritised can also be understood as meeting the interests of social stability for the majority population in a way that more perennial issues like tissue donation might not.

Community as ambiguous and reductive

While the term community was frequently used, it was unclear what specific communities were being referred to. The term Black was sometimes used, and some early videos were labelled with aggregated racialised identifiers (e.g., 'BAME celebrities'), but specific ethnic minorities were named only once (media releases accompanying Video 6 refer to 'British Bangladeshi'). *Community* appears to serve as a 'catch-all' term left to 'float free' so that audiences could interpret it however they saw fit. Arguably, 'community' not only aligns with identification to specific racialised groups, but it also speaks *across* groups, gesturing to the shared experience of being racialised as other than white.

This ambiguity is problematically reductive. Responses to COVID-19 that ‘lumped’ together differently racially minoritised people using the aggregated term BAME have been criticised for being crudely inaccurate and conscripting people into pan-ethnic categorisations incompatible with their self-identifications (Aspinall 2021). In our data, a moment of disaggregation surfaced where concerns about trust were voiced only by Black contributors. This was suggestive of variability in differently racialised people’s histories and experiences. Work on anti-Black medical racism for example has revealed the ‘experimental operations’ on enslaved Black women in the history of gynaecology, alongside examples like the US Public Health Service Tuskegee Syphilis Study and the Henrietta Lacks case (Washington 2006; Nelson 2008). Discussions of mistrust among both Black Americans (Willyard 2020: S65) and Black Britons (Skyers et al. 2017: 33-35) often connect these examples of exploitation and mistreatment to contemporary experience of inequality and discrimination in society at large. The videos convey the pertinence of mistrust to Black Britons, signalled to audiences via the racialised identity of those voicing the concern.

This kind of positioning raises questions about how racialised representations work and how they might be interpreted. For example, while mistrust is also experienced by British Asians (Smart 2021), this is not obviously ‘represented’ in the videos. What might this mean for how audience members react, especially where there was ambiguity about what ‘community’ meant and where aggregations like BAME were used? For example, do audience members give greater credence to messages that come from speakers who they perceive to be ‘equivalent’ to themselves, perhaps both in terms of what they look like and how they have identified themselves? Furthermore, where there is no clear disaggregation, there also seems to be a risk of reductivism, where differently racialised people’s concerns and experiences get presented as applying to all. In the case of racialised mistrust this seems especially important, as while the pandemic starkly highlighted the issue, related research also revealed many uncertainties about its nature, dynamics and variability (Allington et al. 2023).

Evaluating the effectiveness of the videos is beyond the scope of this work, but it is possible to situate them within other related analyses. There is evidence that 'matching the identities of endorsers and receivers' in US COVID-19 vaccination endorsement campaigns did not increase interest in or intent to vaccinate (Gadarian et al. 2022: 501). However, the videos we analysed shared common ground with recommendations made in Hussain et al.'s (2022) review of UK studies for 'overcoming COVID-19 vaccine hesitancy among ethnic minorities'. Studies in the review commonly supported using 'tailored communications' via both traditional routes and online platforms, and for partnering with community leaders, community champions and healthcare professionals. This said, Hussain et al. (2022) warn that communications should be transparent about the causes of concern and the social contexts underlying mistrust (amplifying Woodhead et al. 2021). From our analysis, while we recognise that public-figure videos produced during a crisis face limitations in nature and form, we echo the recommendation for greater transparency. Furthermore, additional research on the complexities of racialised mistrust would help to increase understanding and potentially improve health communications.

Conclusion

Our work contributes a UK-based study to a field that has previously focussed on US examples, providing insights of academic and practical relevance. We explored how racially minoritised people were being represented in targeted video campaigns and what concerns about the COVID-19 vaccine were expressed. We unpacked how racially minoritised people were framed as part of a specific (though often ambiguous) ‘community’, complete with values and duties. We found representations that invoked shared experiences of positive social contributions or community values against a backdrop of marginalisation and inequality. Whilst relatively few of the expressed concerns appeared specific to racially minoritised groups, those that did focussed on whether the vaccine had accounted for ethnic variability in its design, manufacture and safety, and on the overarching matter of trust.

The videos adopted, after Brown et al. (2004), a broadly advocacy-oriented approach, in that they aligned with the authority of institutionalised science to provide assurances or rebuttals for the expressed concerns. The common framing was in terms of care, duty and responsibility. While these approaches can be partly explained by the pandemic context of fear and uncertainty, they can also be opened to critical reflection through the lens of racialisation.

One aspect of racialisation processes in the videos was representations which generated ‘authenticity’, centring the racialised subjectivities of contributors to construct a common ground from shared experience. Another aspect of these processes was appeals to ‘mutuality’ – a notion of racialised ‘sharedness’ which encouraged responsibility to act in the interests of one another and the whole group, creating a sense of duty by invoking ideas of relatedness, both near (family) and far (diasporic). In this sense, racially minoritised groups were ‘responsibilised’ at a moment of crisis.

Moreover, expressed concerns were generally rebutted by requests to ‘trust in medical science’, but this jarred against the recognition that mistrust was one such concern. The consequence was that some contributors simultaneously validated mistrust while asking the audience to set it aside, which they did by claiming common racialised interests. The lack of reflection in the videos on why mistrust exists in the first place arguably limits the integrity, and potentially the appeal, of the content. There were also tensions in the ambiguities of the discourse of ‘community’, the commonplace, catch-all term that may avoid having to name specific racially targeted audiences, but can mask variability in histories and experiences, and risks over-simplification and stereotyping. Research is required to better understand these deep-seated and nuanced issues, one benefit of which would be a firmer platform for creating appropriate and effective targeted health communication.

Given that our analysis has focussed solely on representations, further research could focus on audiences, not only addressing specific questions about the ‘effectiveness’ of such videos but also seeking to understand the consumption, reception and interpretation of issues like trust, scientific authority, the use of public figures and claims to mutuality. Other research might excavate the aims of content producers and the contexts that shaped the videos. For example, were the videos from formal health organisations like the NHS a reaction to the community-led response, or were they already ‘in the pipeline’? Alongside our analysis, such studies would provide a strong evidence-base for the practitioners who aim to engage racially minoritised people in health communications in the UK.

Judging the ‘transferability’ of our analysis to other contexts is difficult. While this particular instance of racialised, public-figure led, health advocacy garnered unique media attention, it is not clear that this strategy would bear similar results in ostensibly less urgent contexts that do not so clearly align with the interests of the racialised majority. Nonetheless, we have developed potential conceptual generalisations about the nature of ‘mutuality’ in racialised health communications which may be useful for examining, understanding and addressing racialised health inequalities in the UK and elsewhere.

Endnotes

[1] We gained institutional ethics approval to use publicly available online materials without approaching video contributors. This follows Williams et al. (2018), as our data was posted by public figures making public-facing statements or from organisational accounts.

[2] See supplementary data files: Data File 1 for key words used in the search, Data File 2 for full details of sampled videos and Data File 3 for all considered videos and reasons for inclusion/exclusion.

[3] One way to investigate the targeting of videos was to judge whether the public figures were people of colour. Such observer-assigned racial categorisation is methodologically and morally problematic. While our judgments (refracted through our different racial positions as an authoring team) attempted to understand how racialised messaging *might* be being

conveyed in the materials, we were uncomfortable with assigning people, and thus we have not attached racial labels to people in this paper.

[4] This video did not capitalise ‘black’, so we retained this styling.

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