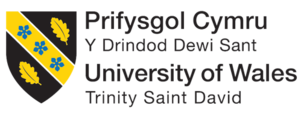
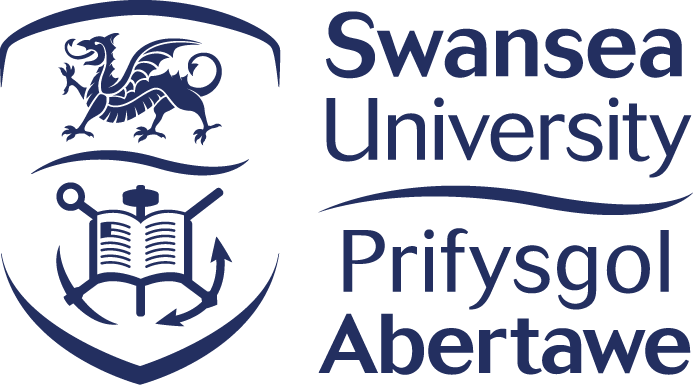
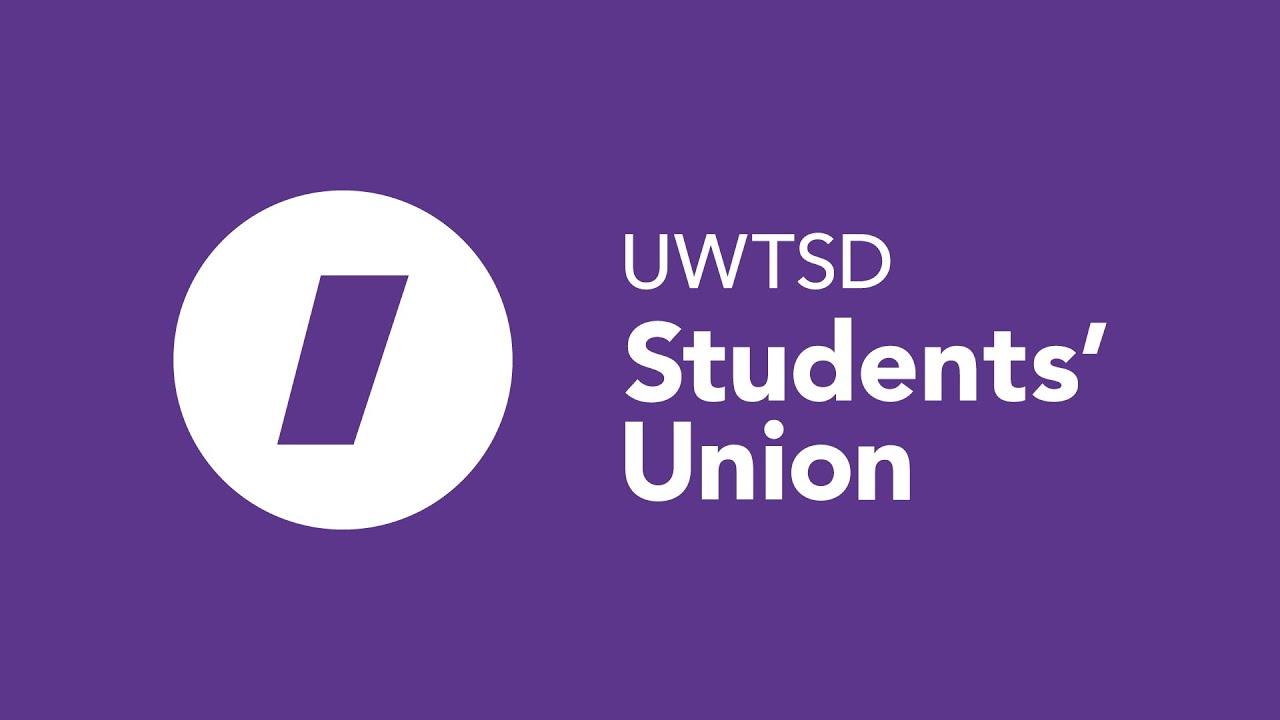
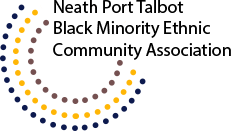
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**Opinions on Test, Trace, Protect and COVID-19 vaccination services** **by BAME and White people in Swansea and Neath Port Talbot**

*Winter 2021*

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**Project**

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# Summary

The report analyses differences between white people and BAME people’s evaluation of their own vulnerability, the NHS Wales Test, Trace, Protect (TTP) and vaccination programme in Swansea and Neath Port Talbot as well as the information sources they use. It is based on the findings of a survey that ran in the winter of 2021. In terms of estimations of personal vulnerability, ethnic differences are pronounced relatively strongly. Few differences persist between the groups in terms of their willingness to get tested for Covid-19, except for in age difference; younger white people and older BAME people have reported to have been tested. Evaluation of the quality of the TTP programme are similar between the groups. Also, both groups look for information in using similar resources, with white people using formal channels to a slightly higher extent, where BAME people turn more often to informal channels. On vaccination, remarkable differences can be denoted. 91% of the white respondents said ‘yes’ to being asked if they would be vaccinated when invited, with 7% remaining unsure. Only 75% of the BAME respondents confirmed to get vaccinated and 20% disclosed being uncertain. This was mainly due to scepticism around the speedy development of the vaccine and its effectiveness. Therefore, ethnicity-tailored approaches would help to address and ameliorate discrepancies in terms of suffering the harmful effects of the pandemic between white and BAME people.

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# Introduction

## Background

This report focuses on differences between self-identified cohorts of white British and Welsh populations and Black, Asian, and Ethnic Minority (BAME) people in the context of the current Covid-19 pandemic in the Swansea, and Neath Port Talbot area. In particular, this publication reports on differences in terms of these groups’ attitudes towards their own vulnerability (Section 2), their uptake of Covid-19 tests (Section 3), their intention towards vaccination (Section 4) and sources of information about the pandemic (Section 5).

More understanding of the differences and similarities between the groups provides new insights into the effectiveness of current pandemic policies and what alterations of the policies or communication styles could be helpful in reducing suffering and improve compliance with the government guidelines. However, most crucial is the possibility of achieving a better understanding of why people with a Black Asian and Minority Ethnic (BAME) background have been disproportionately affected by the Covid-19 pandemic in comparison to white populations (Public Health England, 2020; First Minister’s BAME Covid-19 Advisory Group, 2020).

The report discusses the findings of the survey in light of people’s responses to the pandemic that reflect compliance with the pandemic policies. It also does so to establish where the local (and also national) government may have overlooked the potential for inequity problems to arise. On this basis, some recommendations are made to consider in pandemic policy development and other plans that address inequality between BAME and white people (Section 6).

## The Survey

The first responses to the survey came in on 29 January 2021 and the final one is dated 13 March 2021. During this time, Wales had been on lockdown that required residents to adhere to regulations that severely restricted people’s mobility. For the majority of the general public, the main ones included:

* a diminished number of reasons to leave the house,
* quarantining and social isolation impositions,
* mask-wearing in indoor public spaces,
* no visitors being allowed in the home, and
* a diminished number of shops were allowed to open.

Exceptions to all the rules were based on demographic, occupational, and other differences. In this period also the Welsh vaccination programme sped up and widened in scope, with the Welsh ‘vulnerable group’ categories 1 to 5 and partly group 6 having received their invitation for their first vaccination.

The survey was open to anyone in the Swansea and Neath Port Talbot area, but it did not seek to reach representational significance. Also, the different demographic categories were not filled and capped at equal or representational quantities. Respondents could leave answers open and choose ‘prefer not to say’ in almost all categories. Therefore, the respondent numbers do not remain the same across questions and answers and do not always make a cumulative fit with the total number. As with any survey method, this survey can make certain claims that are mostly correlative and not causal. There are also certain limitations in the extent to which claims hold up; the report discusses the gaps this leaves as well.

The survey respondents have the following number of characteristics:

Table Survey respondent characteristics.   
(excludes all answers of the category ‘prefer not to say’ and those left blank)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **BAME Including MIXED RACE** | **WHITE Including BRITISH and WELSH** | **TOTAL** |
| **Gender** | Female | 87 | 650 | 769 |
|  | Male | 62 | 148 | 214 |
|  | Non-binary | 1 | 4 | 7 |
| **Age** | 16-24 | 20 | 23 | 46 |
|  | 25-34 | 25 | 82 | 119 |
|  | 35-44 | 47 | 154 | 216 |
|  | 45-54 | 33 | 205 | 251 |
|  | 55-64 | 16 | 181 | 204 |
|  | 65-74 | 10 | 134 | 150 |
|  | 75+ | 3 | 17 | 21 |
| **Ethnicity** |  | Bangladeshi – 64  Pakistani – 27  Indian – 26  Arab – 11  Mixed: White & Asian – 7  Mixed: White & Black African – 6  Black African – 5  Chinese – 4  Mixed: White & Black Caribbean –2  Persian – 1  Arab African – 1 | White British – 790  White Welsh – 20 | Other – 56 |
| **Religion/belief system** | Christian | 18 | 414 | 446 |
|  | Muslim | 98 | 10 | 123 |
|  | Hindu | 13 | 0 | 13 |
|  | Buddhist | 1 | 4 | 7 |
|  | Sikh | 1 | 0 | 1 |
|  | Any other religion | 4 | 8 | 14 |
|  | No religion | 9 | 309 | 331 |
| **Main place of residence** | Swansea | 99 | 494 | 640 |
|  | Neath Port Talbot | 55 | 300 | 366 |
| **Participants (total)** |  | **155** | **800** | **1112** |

# Vulnerability

If and how people consider themselves as vulnerable may suggest what kind of uptake of NHS Wales Test, Trace, Protect (TTP) programme can be expected, and it may have anticipated people’s intention towards vaccination[[1]](#footnote-1). A person’s orientation towards their own vulnerability may also reflect how they think about that of others and behave accordingly, which, in turn, suggests compliance with behavioural pandemic guidelines.

In the survey, the question around vulnerability was asked as “Do you consider yourself to fall under the vulnerable category?” The invocation of ‘vulnerable category’ here alludes to the clinical groups that are ranked relative to the chances to suffer severe illness. These categories emerged in the media to indicate who has been advised to ‘shield’ (staying at home)[[2]](#footnote-2). In the autumn of 2020 these categories were expanded to determine a priority list for the nationwide Covid-19 vaccination effort[[3]](#footnote-3). This section discusses definitions of vulnerability and explores gender, religion, age, and ethnic differences.

Vulnerability is a concept that can be conceived of in several ways, which reflects the multiple purposes it can serve. It is a condition of all life, both human and non-human, and which therefore provides a fundamental connection between everyone and everything. To be vulnerable is to be open to be affected; through our bodies and via our psyche. By virtue of being mortal and living in human bodies everyone is vulnerable to suffering and death. However, changing contexts marks how at different times, in different places, and in different circumstances we are more or less vulnerable in different ways (see Cole, 2016 for an overview of the conceptualisations of vulnerability).

Within neoliberal societies, vulnerability signals a state best avoided as it connotes weakness, dependency, and helplessness. The pandemic emphasizes precarity of life, as people from every gender, age group, (dis)ability, and ethnicity suffered illness and death. However, it also highlighted how certain groups live with enduring conditions that positions them as more likely to suffer, because of the structural oppressions that are maintained in Welsh and the broader UK society.

Vulnerability in the pandemic is not defined in a singular way by the Welsh government, though in line with the neoliberal State, most of these understandings are attached to individuals. The broadest terms include, for instance, “those at risk of more disproportionate impact from Covid-19”[[4]](#footnote-4), and those who “are likely to be affected the most”[[5]](#footnote-5). These descriptions do not specify what kind of adverse effects infection with Covid-19 might conjure, and could be regarded to encompass a broad range, including socio-economic and educational ones in addition to biological effects. The broadest conception of vulnerability is found on the council level:

*“Some people are especially vulnerable at present, for example:*

* *people who are at increased risk or 'extremely vulnerable’ to coronavirus (COVID-19)*
* *people who are disadvantaged where this has been made worse because of coronavirus*
* *people with low incomes who may have difficulty buying enough food or paying bills*

*Vulnerable people may need extra help, for example to get food or medicines or with other needs. Friends, family or neighbours may be able to help.*

*If you do not have anyone who can help, you may be able to get support from your local authority or voluntary groups.”[[6]](#footnote-6)*

The biological dimension is only one of the three elements here. The second element acknowledges differences in people status in society and the structural inequities that are at play beyond socio-economic status and include socio-cultural disadvantages. These could entail for instance, ethnicity, gender, ability, and class differences. And the third element is specifically wealth-related, framing (im)possibilities for individuals around disposable income. Although these highlight structural elements in people’s lives, vulnerability is seen as function of a person and not as produced within governmental processes and systems that maintain social hierarchies in wealth and socio-cultural status (see Barille et al., 2021)

The conception of vulnerability on which most policy is nonetheless based on the national level stems from the medical conception of vulnerability as people who are “at an increased risk of severe illness from Coronavirus (COVID-19)” and who “are at higher risk of developing more serious symptoms if they come into contact with Coronavirus (COVID-19)”. This conception of vulnerability is channelled through an variety of “clinical conditions which put people at even higher risk of severe illness and make them more susceptible to the most serious effects of COVID-19.”[[7]](#footnote-7) Remarkably, the inclusion of death as potential outcome of infection with Covid-19 is avoided in these descriptions.

## Gender

The Welsh government considers gender to be part of the ways in which biological vulnerability expresses in pandemic times, as males are more likely to get severely ill from infection with Covid-19[[8]](#footnote-8). The respondents’ estimation does reflect this for the white population, in which white men consider themselves more vulnerable than white women across all ages. This is not mirrored in the BAME group that sees BAME men to be slightly less vulnerable. It is not clear on which factors these estimations are based as it does follow the medical understanding of vulnerability. Indeed, other factors will have played a role. For instance, Willatt et al. (2021) argue that women face increased possibility to experience domestic violence, which could be accounted for in the response of all women respondents. Furthermore, having to stay at home takes away the racist microaggressions BAME people face on a daily basis, which could have negated exacerbated vulnerability. As such, assessments of one’s own vulnerability balance medical, socio-cultural, and socio-economic factors.

Figure 1:Vulnerability division along gender lines

The very small white non-binary group does highlight the particularly high respondence of feeling vulnerable to infection, illness, and/or death by Covid-19. As information about vulnerability was encapsulated exclusively in the gender binary, and the lack of data available about the non-binary group reveals a lack in information that could help this group estimate their own vulnerability better. Such information would have helped them to understand how to protect themselves and adjust their behaviours.

## 2.2 Religion

Religion is an interesting factor in considering vulnerability of individuals. In particular organised religion, but also other forms of spirituality, emphasize a person’s membership of a community. This puts an individual’s life in perspective. Governments and public health institutions, such as the WHO have adopted language that living through a pandemic also requires a great awareness of other – familiar and unfamiliar – people aiming to increase people’s empathy beyond their immediate social circles. In 2011 in Wales the umbrella religion of Christianity is most dominant with 58% of the residents subscribing to it, followed by the umbrella term of Islam with 1.5% of the Welsh population, whilst almost a third is non-religious[[9]](#footnote-9).

In terms of religion, the respondent group is rather diverse; in the BAME group the overwhelming majority is religious, whereas around 40% of the white group is secular. The findings suggest that in the white group religiosity can be associated with convictions of vulnerability. Being non-religious could indicate a greater belief in one’s own capacity to protect oneself against infection, illness, and/or death. The non-religious group of the BAME respondents is similar to the white contingent, but is too small to interpret. Estimations of vulnerability in these secular groups might mostly be derived from the biomedical chart of conditions and diseases that are limited to individual bodies. However, Christianity as most dominant religion in the white population in the survey and Islam as the most popular one in the BAME population is fairly similar, even though white Muslims distinguish from all groups in their relatively high conviction of vulnerability.

Figure 2: Vulnerability division along religion, faith, and belief system lines

Considers themselves vulnerable   
to a certain extent  
(percentage of (total number))

A reason for not finding oneself to be vulnerable from a religious point of view is the belief that one’s faith is decided by a God or deity, which takes away worries about infection, illness, and death to a certain extent. Potentially reflecting the low estimation of personal vulnerability of BAME Hindus, the fear of death is negated by the belief in incarnation or other kinds of afterlife in other religions and belief systems. This makes considerations about vulnerability less prominent, which could prompt people to argue that they are not necessarily more vulnerable than the next person. Simultaneously, as places of communal worship have been closed for periods, not having one’s religious community to support or gain support from may have added to feelings of being vulnerable. Indeed, such feelings may have been compounded for people who have been shielding because of their medical vulnerability when places of worship have been opening up again, as the Welsh government policy states that these people should still avoid congregations[[10]](#footnote-10).

As Harriet Sherwood from the Guardian (2020) argues, the pandemic crisis also disrupted certain traditional and social boundaries that kept communities of particular faith apart, which made possible that communal moment of spirituality became a new transient but hopeful element of life. She mentions Rev Pat Allerton’s (a Church of England vicar) public prayer in front of a London hospital as creative of such a moment. One such moment may have been provided in the Swansea, and Neath, and Port Talbot area. On 23 March, ‘Covid Memorial Day 2021’ was officiated by Catholic priest and a health board chaplain Jason Jones and organised by Swansea Bay University Health Board[[11]](#footnote-11). Such moments that celebrate union may have positive effects on how isolated, and thus vulnerable, people feel.

## Age

Differences did emerge between white and BAME people in terms of age and whether a survey respondent considered themselves vulnerable to a certain extent. With ascending age, the graph shows a gradually increasing slope for the white respondents. However, in particular the BAME age groups of 16 to 24 and 45 to 54 year olds should consider themselves more vulnerable than their white counterparts according to clinical Covid-19 illness estimations. This can, for instance, be mediated by the kind of jobs they do which renders them more or less vulnerable as well as by the kinds of information sources they use and the relative emphasis on the vulnerability of BAME people in those news items.

Figure 3: Vulnerability division along age-group lines

All respondents over 65 years of age should officially count themselves as vulnerable, but clearly this is not the case, with the exception of BAME people who are over 74 years of age. An explanation for these groups that do not all find themselves vulnerable is the comparison they may make with others in the same age group who live in care homes (see the Welsh government’s guidance on care home visits[[12]](#footnote-12)). It is no secret that elderly care home residents died at disproportionate rates, and this group makes up a third of the registered Covid-19-related deaths in Wales in October 2021[[13]](#footnote-13). Those with elevated age who live outside these care home conditions may thus consider themselves less vulnerable because of the extreme vulnerability their peers in care homes seem to be in. Such a comparative estimation indicates a socio-situational priority rather than an estimation based on their own biological characteristics. Estimations of this comparative kind could very well have underpinned the answers of all respondents to an extent, and these may have influenced how people complied with the pandemic regulations.

## Ethnicity

The term ‘BAME people’ or ‘people with a BAME background’ has been used since the first reports on Covid-19 deaths[[14]](#footnote-14) that put emphasis on the unequal death rate of white people as opposed to non-white people. The term BAME congregates many different ethnicities which helps to bring to light how non-white people face more difficulties at the hands of the pandemic than white people. However, it obscures the internal differences within the BAME category. The graph below does some work to demonstrate how this internal difference also spills over in people’s estimation of their own vulnerability. Even between populations that are relatively closely affiliated in ethnic terms, such as Indian, Pakistani, and Bangladeshi people, there are relatively strong differences in how vulnerable individuals consider themselves. However, some categories utilised in the survey denote nationalities rather than ethnicities, for example the ‘Chinese’ and ‘White British’ and ‘White Welsh’ versus ‘Arab’, and ‘Persian’ categories. This prohibits ‘cleaner’ comparisons between the groups in this survey, but also highlights how ethnicities and nationalities often collapse into each other.

In the BAME group mostly the smaller ethnic respondent groups divert in extremity from an average in the 30-40% range. This cannot be interpreted as representative and this outcome might be explained by a self-selecting group drawn to fill in the survey. Nevertheless, the different Black populations (the blue tones in the graph) seem to consider themselves more vulnerable than other groups, aside from Persian and Latin-American populations. With slight overlap, the mixed ethnic respondents also consider themselves rather vulnerable, which potentially highlights how rigid categorisations of ethnicity are not helpful for those who fall in between or belong to multiple ones. This leads to people having to make their own estimations as to how they fit in the ethnic categorisations utilised in discussions around vulnerability in the media. More in-depth research needs to be conducted to make more precise statements.

Figure 4: Vulnerability division along ethnicity lines

# 3. Testing

Testing for Covid-19 infection is one of the most important tools with which the pandemic is monitored by the Welsh authorities. In people’s personal lives, tests can provide clarity of their body’s health, in the sense that it allows continuation of life as planned upon receipt of a negative result and allows a person access to treatment upon infection. It can also initiate a shift in people’s behaviour in terms of them mingling with others. A positive test result allows for legal absence from work and, for some people, sick pay from work. For others it may mean loss of income, increased costs for day care for children, and/or an inability for continuing to provide care. All these examples influence people’s willingness to get tested.

Of the 1009 respondents who filled in the survey, 394 had been tested, which amounts to 39% of the cohort. Of this group, 98 people tested positive, which is almost a quarter of those who got tested and accounts for almost 10% of all survey respondents. It is not clear how often people have been tested. Therefore, the possibility that some people may have been tested multiple times and others have been tested once was not registered by the survey. Of the white population, 324 of the 796 respondents said they had at one point been tested at NHS testing site, which is 41% of the entire white group. Of the BAME respondent group, 48 of the 153 people had been tested. This comes down to 31% of the overall group. At the time the survey was live, NHS lateral flow/antigen home tests were developed, and their free mass distribution came two months after, which means respondents still fully relied on making the trip to a mass testing centre, rather than doing tests at home. This section discusses testing in the context of gender and age, and considers opinions about the Welsh government’s Test, Trace, Protect (TTP) programme.

Inquiry into the usage of the testing services in the Swansea, and Neath Port Talbot area says something about people’s knowledge about symptoms and sense of urgency and anxieties around potential infection. For instance, respondents who have been fearful about being infected and become ill might have seen the merit in getting tested, so that if infection was confirmed, treatment would start sooner and chances of survival would theoretically be higher. It also says something about the respondents’ faith in biomedicine, their understanding of the provision for care in Wales, and how they see personal responsibility in a pandemic. Indeed, whereas in the case of infection one’s illness would not impacted by a test, the outcome of the test would impose certain moral obligation onto a person, such as staying at home. Getting tested thus indicates how open people are to run the risk of being restricted in their behaviour if they would test positive.

The fact that people state to have or have not been tested implies, however, little without more contextual insights. Aside from what it might say about these rather ‘stable’ factors mentioned, people differ in their exposure to the virus for different reason, which influences the decision to get tested on the basis of many elements in their lives. For instance, the following:

* **Household composition**; people who live with many others, for example big families and co-habiting students have a higher chance of becoming infected than those who live alone or in a pair. Therefore, the former groups are more likely to have a reason to get tested.
* **Job**; exposure to the virus is mediated differently through different jobs as working from home gives less reason to suspect infection than working in a supermarket.
* **Vulnerability**; as mentioned before, people regard themselves as more or less vulnerable in different ways, which may have an effect on the threshold to get tested.
* **Care**; being cared for, receiving institutional care, or providing care in the personal or institutional context is also likely to increase the chances for people to get tested.
* **Medical expertise**; the presence or absence of medical or clinical experts in one’s social circle could also lead people to get tested more or less likely.
* **Access;** the access people had to be tested at a nearby Covid-19 test location will have had a strong impact on whether or not people had the possibility to be tested. Not having a car, internet, or the digital skills to book an appointment will have deterred people from getting tested up until the moment the survey was open.
* **Anxieties**; medical and clinical anxieties that prevent people from seeking medical assistance and is not necessarily coronavirus-related is likely to have a dampening effect on people’s willingness to get a PCR test. These feeling may have been exacerbated in the beginning of the pandemic when the PCR tests were widely considered to be rather uncomfortable.

Different outcomes of respondents’ admission to have been tested for Covid-19 can therefore not readily be interpreted in terms of adherence to the TTP programme or hesitancy that is entirely related to a person’s attitude. Various aspects of a person’s context are therefore also of crucial importance in deciding and organising to get a Covid-19 test.

## 3.1 Testing and Gender

Men have been dubbed to be more vulnerable to severe illness on infection with Covid-19 than women. If this clinical vulnerability would translate into a lower or higher threshold for testing, men would be more keen to get tested at least once. However, this is not reflected in the graph. Many reasons are viable here, and many explanations for individual circumstances can be provided. However, according to Galasso et al. (2020) this outcome aligns with their conclusion that women are more likely to agree with and comply with the Covid-19 measures and rules.

Public Health England’s study (2020) furthermore suggests that BAME men are perceived as more likely to be infected and fear discrimination as they have experienced stigma around this. This is likely to be a compounding factor for some BAME men to not get tested. Guidance and incitement to get tested thus requires a gender-sensitive approach in public health policies and communication styles.

Figure 5: Divisions of usage of Covid-19 testing facilities along gender lines

## 3.2 Testing and Age

For White British and Welsh survey respondents age demonstrates a declining amount of people who have been tested. This pattern is not replicated by the corresponding BAME age groups. Until the age of 55, BAME people were less likely to have been tested for COVID-19: a trend that continued in an inverted manner. This could be explained by the higher likelihood that older BAME people live in the community with their family for longer than their white counterparts, and that they might feel more exposed to the virus, which would merit testing. As older white people are more likely to live in isolation than their BAME counterparts it would reduce their need to get tested.

The high number of young white people (aged 16-24) who had done a COVID-19 test could be explained by them having been in more situations that would make them feel more exposed to the virus, such as (mass) social events, co-habiting, and working in people-facing jobs. The likelihood of having been in a situation in which they would potentially be infected is compounded by students going through the early lockdowns in shared accommodation. University students tend to be overrepresented by white people, which may contribute to the difference in the testing rates among white and BAME 16–24-year-olds.

Figure 6: Divisions of usage of Covid-19 testing facilities along age lines

## 3.3 Appreciation of TTP provision

How people value the provision of the NHS Wales Test, Trace, Protect programme can indicate something about their attitude towards vaccination and testing. A critical or skeptical opinion of this scheme could, for instance, imply that people do not trust the safety or efficiency of testing. Such an opinion of the scheme might also say something about how useful they regard it as crucial element of the Wales strategy to eradicate Covid-19 and reinstate a form of normality.

Figure 7: Division of opinions on the TTP programme along ethnic lines

As indicated in the graph below, there are virtually no differences between BAME and white populations in their valuation of the TTP programme; white people seem only marginally more content with the programme than BAME people. Between the three major BAME groups, Bangladeshi, Indian, and Pakistani people, Pakistani people seem to be most positive about the scheme, the Indian group more outspoken in more extreme valuations (both positive and negative). The opinions of Bangladeshi people seem to be skewed towards a more negative appraisal of the TTP provision. What might be behind this cannot be inferred from the survey.

Figure 8: Opinions on the TTP programme within large BAME groups

# 4. Vaccination

After distancing from other people, vaccination against Covid-19 is the second most important measure to slow down transmission and reduce severe illness. Vaccination against Covid-19 has been framed as a self-protective and community-protective measure. As it has been heralded as gateway to a return to ‘normal’, local councils and health boards are under a lot of pressure to deliver an excellent organisation of the vaccination programme. Likewise, for residents, becoming vaccinated has almost become regarded as a civil duty, perhaps more so than any other measure.

The open text responses to the survey questions about the respondent’s intention to get vaccinated do not represent individual respondent answers, because not all respondents provided a reason, and some provided multiple ones. Intentions towards vaccination are subject to change, and do not provide a fitting indication of the actual uptake of the vaccine. Given that this survey was live between January and March 2021 and the vaccination programme has peaked in the spring and summer of 2021, intentions may have changed to reflect a more positive uptake, as with time confidence in such programmes tend to increase. People’s intention towards vaccination may also have changed with the various forms the pandemic has taken over the spring, summer, and early autumn 2021. Ideas about booster shots and the vaccination of children is also likely see changes on a temporal basis.

The brief and mildly superficial analysis permitted here can highlight some basic distinctions between the concerns about vaccination held by white and BAME populations. Of those who had not been offered the vaccine yet when filling in the survey, 91% of the white respondents said ‘yes’ and 7% was unsure, whilst 75% of the BAME respondents confirmed to get vaccinated and 20% remained unsure. These percentages do not change when incorporating the uptake of the vaccine by those who had already been offered the vaccine. This uncertainty and refusal of the vaccine by BAME populations reflects the results in similar surveys (e.g. Freeman, 2020). The discrepancy is important knowledge as people who hesitate can be drawn to all directions and might be more open to consider misinformation about the vaccine or the virus in their decision to get vaccinated. This BAME group is not overrepresented in vaccination rates by a particular ethnic background, age group, gender, or religion.

Table :Reasons for refusing or doubting to take the offer of a vaccine in the past or future

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **White people** | | **BAME people** | |
|  | Reason mentioned | Percentage of all reasons mentioned | Reason mentioned | Percentage of all reasons mentioned |
| Has not made a decision yet/need more information | 5 | 9% | 6 | 24% |
| Fertility-related (trying to conceive or are pregnant): | 4 | 7% | n/a | n/a |
| Underlying health conditions | 7 | 13% | 2 | 8% |
| Awaiting medical advice | 1 | 2% | n/a | n/a |
| Was unwell when appointment offered | 1 | 2% | n/a | n/a |
| Sceptical of the technology and its rapid development | 19 | 35% | 5 | 20% |
| Sceptical of vaccine effectiveness for themselves | 4 | 7% | 3 | 12% |
| Supply/practical issues with the vaccine | 1 | 2% | n/a | n/a |
| Worried about physicality of side-effects (illness, suffering) | 6 | 11% | 4 | 16% |
| Risk of side-effects causing problems (e.g. with work) | 1 | 2% | n/a | n/a |
| Body is expected to ward off the virus without extra help needed | 4 | 7% | 2 | 8% |
| Covid/pandemic sceptic | 2 | 4% | 1 | 4% |
| Against their religious beliefs | n/a | n/a | 1 | 4% |
| Is a family decision | n/a | n/a | 1 | 4% |
| **TOTAL** | **55** |  | **25** |  |

In both the white and BAME groups especially the speedy development of the vaccine and the related effectiveness were met with scepticism. As it can be assumed that most people are not experts on the development of vaccination programmes, the way the biomedical sciences have behaved to produce the Covid-19 vaccines is clearly at odds with the public perception of their normal workings. Underpinning the hesitancy, more time to develop a vaccine seems to equal a more trustworthy product, and explanations of pooling of resources and immediate mass shift of expertise towards this vaccine development have not taken away these worries. For white people the concerns seem to centre slightly more around biomedicine; as pivotal in the technology and in one’s personal medical circumstances. This is less pronounced in the answers of BAME people and might point towards a heavier weight of social, cultural, and spiritual aspects of life that would be interfered with by the vaccine or the decision to get vaccinated.

The open text survey answers and answer options on offer in the survey miss more complex, nuanced, and not always tangible experiences of BAME people, who are medicalised and receive care or treatment. This builds on violent histories of biomedicine vis-à-vis Black people in terms of its eugenicist roots in the late 1800’s that systematically sought to physically, morally, and intellectually elevate the white race at the expense of the black race. These painful histories also build on the experiments on Black people, such as the Tuskegee Syphilis Study[[15]](#footnote-15) traces of which are still detectible in modern-day biomedicine. For instance, the belief that Black people would have a higher pain threshold is still current (Hoffman et al., 2016) in addition to other discriminatory practices. Although these experiences may not be profound and disruptive in the moment, accumulating over a lifetime does erode trust and faith in the healthcare system and in the state. Whilst a lack of trust and faith in the healthcare system is beyond the Covid-19 vaccine and coronavirus pandemic, these are contextualised by these sensibilities.

# 5. Sources of information

The complexity and dynamic nature of the pandemic has required a lot of engagement with changing information for people. This put pressure on authorities to produce up-to-date information that is accessible all. For several groups in Welsh society, this was a relatively smooth process, whereas for others pandemic information it was much harder to act on[[16]](#footnote-16). For instance, crucial information for people with learning disabilities was difficult to obtain, which required community groups to step in and provide Easy Read versions (All Wales People First, 2020).

To better understand how decisions are made to get tested, how to comply with pandemic regulations, and how one’s sense of vulnerability becomes a reality, the survey included questions on what information channels respondents used. In the survey, not much difference exists between the white and BAME populations. White people did seem to use the official channels of the Public Health Wales, NHS, and local authority website slightly more. BAME people seem to rely a bit more on less formal information streams, such as Whatsapp, email, and ‘multi-ethnic TV’. Nonetheless, Facebook seems to be a favoured by white people a little bit more than by BAME people. Still, this platform was used with similar interest as the BBC website was used, whereas other social media platforms seemed much less interesting to obtain pandemic information. The category ‘mainstream TV’ is interesting here, as this might infer the proportion of people who watched a press conference of First Minister Mark Drakeford and/or Prime Minister Boris Johnson at least once.

Figure 9: Information channels about the pandemic: testing, isolation, and support

For Covid-19 tests specifically, the NHS and Public Health Wales websites seemed to have been most informative for white and BAME people, although more so for white people. Interestingly, white people also listed the radio as resource for testing. This might be a group of people who have the radio on regularly and/or for longer periods in the day. This can include a population who work in particular jobs that have the radio on in the background, for instance in construction, front offices, and taxi drivers. However, BAME people also work in these jobs, so it is difficult to say why this medium is not deemed relevant by this group. A strong reliance on radio as a medium to provide information about Covid-19 tests to residents of Wales may inadvertently exclude BAME people.

Figure 10: Information channels about the pandemic: testing

Further considering any differences between the three ethnic groups that are best represented in the BAME cohort brings to light differences in what resources of pandemic information these groups consult. Given the low number of Indian and Pakistani respondents, not many strong claims can be made. Mainstream TV, the NHS and Public Health Wales website are most important information sources for all groups, with the BBC website closely following. However, in cumulative form also the less formal mediums of Facebook and Whatsapp seem to have been important for Bangladeshi people in particular. Given that also the Indian group seem to partially rely on Whatsapp, on which misinformation is more easily spread (Kigler-Vilenchik, 2021), this might expose these groups to misleading information[[17]](#footnote-17). In almost all cases in which Whatsapp was listed as a resource, mainstream tv and official information channels were also listed. This suggests that Whatsapp does not feature as the only information source, which reduces the possibility for Bangladeshi people to be swayed by misinformation. The usage of Facebook as the only resource or in combination with Whatsapp is rare in all three groups.

Figure 11: Information resource differences between three BAME groups

To caveat these responses, the categories on offer are not similar in nature and kind. For instance, the category ‘Newspaper’ and ‘News local’ and ‘News national’ overlap significantly but cannot be merged. Also, some categories are news sources, whereas others are mediums or technologies, for instance Whatsapp and Facebook that organise the ways in which people find information. A news item from The Sun can be posted by a family member on Facebook, which troubles the choice of resource indication. In addition, information is only important for a person at the moment it becomes relevant. People may have learnt about the TTP provision in Swansea, and Neath Port Talbot, but will likely search again when they suspect infection. Furthermore, it has to be taken into account that information may be confirmed through several channels. For instance, people may read an article about regulations on WalesOnline, but only take it as true or helpful after having checked with a family member who works in the NHS. Also, other sources not listed here may also be relevant for particular groups.

# 6 Recommendations

Overall, the survey findings resonate the findings of other reports and the anticipated and evidenced concerns for pandemic inequities voiced by the First Minister’s BAME Covid-19 Advisory Group, community and third sector organisations, scholars, and the Welsh government itself. The Welsh government and local councils have set up several initiatives to counter these processes. For instance, the Welsh government initiated the ‘Self-Isolation Support Scheme’[[18]](#footnote-18) on August 7th, 2021, which helps alleviate the effects of poverty during the pandemic. However, people who are not on a defined set of benefits but do struggle financially or may lose (one or more than one of) their job(s) as a result of having to self-isolate, are not eligible, which exacerbates the vulnerability of certain people. Whilst such solution goes a long way, it remains partial and does not fit seamlessly onto the deeper-rooted problems the pandemic conditions have brought to light, exacerbated, or created. The survey outcomes that detect differences and lack of differences between white and BAME populations in the Swansea, and Neath Port Talbot area attests to that. On this basis several recommendations can be made.

In terms of estimations of personal vulnerability, ethnic differences are pronounced relatively strongly. Therefore, ethnicity-tailored approaches are necessary to address and ameliorate the harmful effects of such estimations, whilst safeguarding behaviour that keeps the spread of the virus at its lowest. More research is needed to further crystalise the differences between white and BAME populations in the Swansea and Neath Port Talbot area to formulate effective policy.

The national and sub-national governance focus of vulnerability on *people* or *individual persons* takes away attention from how they became vulnerable before and remained so during the pandemic. This is understandable, given the importance of the medical understanding of vulnerability that is linked to the biological body. However, this focus takes away from the processes that have allowed people to remain in a vulnerable societal position to persist. In other words: it takes away from who does the “disadvantaging” of groups and/or allows it to continue. This is true for multiple protected characteristics, but in the context of this survey, this is particularly relevant for ethnicity. Therefore, pandemic policies related to individual persons to a certain extent obscure the group workings of societal inequities at play in the Swansea, and Neath Port Talbot area.

Increased attention to how combinations of policies have different effects on different societal groups, and on how the operationalisation of governance works out in practice may help resolve the exacerbated vulnerable position people find themselves in during the pandemic. By extension, policies aimed at ameliorating suffering during and after the pandemic ought to pick up on these elements. This survey starts to visualise these structural inequities with regards to ethnicity, and follow-up surveys or new studies should explore this further[[19]](#footnote-19).

The vulnerability estimation was linked to individuals in the survey, as is aligned with the vulnerability definitions in policy reports. However, whilst some differences can be attributed to the BAME element of respondents, it remains unclear what produces them on other levels. Focussing on BAME individuals and policies that ameliorate pandemic pressures and reduce their chances of contracting, getting ill, and dying from the virus, or being negatively affected in other ways is therefore important. However, pandemic-related and structural improvement for this group also requires a focus on these people’s specific circumstances. Such a focus provides more insight into why BAME people may be more exposed to Covid-19, why illness through infection may have profound consequences and disrupt their own lives and that of others to a (much) higher extent than white people with similar demographic characteristics. Gaining more insights into these discrepancies requires more information on socio-economic status and occupation in the local area[[20]](#footnote-20), as well as on persisting, but seemingly elusive, racist structures.

Although relatively speaking few differences persist between the groups in terms of their willingness to get tested and where they look for resources on the pandemic, some structural issues seem to be overlooked and are not captured in the survey. With a willingness to test for Covid-19, differences between white and BAME populations are mostly expressed in age. And although it is difficult to interpret what that means in terms of difference to exposures or other reasons for the need to get a Covid-19 test, it does suggest that generational differences could also to play an important role. This may translate in differences in understanding of the relevance of certain technologies in life in the pandemic, including that of biomedical technologies.

Vaccine hesitancy as a term that is often used to indicate the lower uptake of the vaccine by BAME people, which frames it as the reluctance of a group sought in individual experiences that are palatable for non-BAME people to understand. Such a framing, and solutions such as having celebrities that are part of these groups encourage BAME people to get vaccinated, brush over this deep-rooted mistrust of biomedicine and the state (Morgan, 2021). Policy and vaccination initiatives that openly take these structural discriminatory realities seriously may be more successful in increasing the vaccination rates for this group.

In conclusion, the survey opened up understanding of differences between BAME and white populations in the Swansea and Neath Port Talbot area and in Wales more broadly. It is very likely that BAME populations have suffered disproportionately from the effects of the Covid-19 pandemic through particularly harmful combinations of circumstances. Further research is needed that explores these combinations of circumstances and compounding issues that BAME people face during the pandemic and will likely face after the pandemic to diminish damaging legacies of the pandemic inequities.

As is the case for any survey, given answers are ‘snapshot truths’, the data is only useful on a temporal basis that quickly deteriorates in relevance. Therefore, research for policy ought to incorporate longer periods. In particular, it should reveal understandings of what causes shifts in people understandings of TTP, vaccination, and/or resource use. In addition to ethnicity, the pandemic experience is framed by people’s religion, age, and gender in certain ways, and shifts in attitude towards TTP and vaccination can likely be linked to certain defining moments in their lives. Such moments could be traced in media reports of particular incidents, such as rail ticket officer Belly Mujinga’s death[[21]](#footnote-21), but also of media reports about changes policy. It needs to be taken into account that such changes could be immediately related to the pandemic, such as furlough schemes, travel restrictions, and shop closures, but also to other aspects of governance, such as housing, benefits, and employment rights. Even if such changes are deemed relatively small, they can set off a reaction based on compounded pressures.

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