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Public views of and reactions to the COVID-19 pandemic in England: a qualitative study with diverse ethnicities

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ABSTRACT

Objectives To explore public reactions to the COVID-19 pandemic across diverse ethnic groups.

Design Remote qualitative interviews and focus groups in English or Punjabi. Data were transcribed and analysed through inductive thematic analysis.

Setting England and Wales, June to October 2020.

Participants 100 participants from 19 diverse 'self-identified' ethnic groups.

Results Dismay, frustration and altruism were reported across all ethnic groups during the first 6–9 months of the COVID-19 pandemic. Dismay was caused by participants' reported individual, family and community risks, and loss of support networks. Frustration was caused by reported lack of recognition of the efforts of ethnic minority groups (EMGs), inaction by government to address COVID-19 and inequalities, rule breaking by government advisors, changing government rules around: border controls, personal protective equipment, social distancing, eating out, and perceived poor communication around COVID-19 and the Public Health England COVID-19 disparities report (leading to reported increased racism and social isolation). Altruism was felt by all, in the resilience of National Health Service (NHS) staff and their communities and families pulling together. Data, participants' suggested actions and the behaviour change wheel informed suggested interventions and policies to help control COVID-19.

Conclusion To improve trust and compliance future reports or guidance should clearly explain any stated differences in health outcomes by ethnicity or other risk group, including specific messages for these groups and concrete actions to minimise any risks. Messaging should reflect the uncertainty in data or advice and how guidance may change going forward as new evidence becomes available. A contingency plan is needed to mitigate the impact of COVID-19 across all communities including EMGs, the vulnerable and socially disadvantaged individuals, in preparation for any rise in cases and for future pandemics. Equality across ethnicities for healthcare is essential, and the NHS and local communities will need to be supported to attain this.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This is among the largest qualitative studies on attitudes to the COVID-19 pandemic in the UK general public across ethnic groups, ages and religions, adding insights to previous smaller qualitative studies, from a broader range of participants.
⇒ The qualitative methodology allowed us to discuss participants' responses around the COVID-19 pandemic, probing their answers to obtain detailed data to inform needs across ethnic groups.
⇒ Most data collection was undertaken in English and therefore excludes non-English-speaking sectors of the population who may have experienced the COVID-19 pandemic differently.
⇒ We did not obtain the views of older members of the population over 70 years, who were most at risk.
⇒ The data reflect public perceptions 6–9 months into the pandemic when some of the social distancing rules had been relaxed in England; as the pandemic progresses attitudes and needs may well change.

INTRODUCTION

Death rates from COVID-19 have been higher in the UK than many other countries worldwide.[1] The 2020 Public Health England (PHE) COVID-19 disparities report indicated that the risk of dying from COVID-19 was greater in the over 80s, those living in deprived areas and 10%–200% higher among different ethnic minority groups (EMGs) relative to white ethnic groups.[2] Diabetes is a frequent comorbidity in COVID-19-related death certificates in Asian and black patients.[2] Surveillance data and systematic reviews confirm the higher mortality in areas of deprivation and EMGs.[3–5] In a PHE rapid literature review and Skype listening events with national, regional and local EMGs, stakeholders expressed deep dismay, anger, loss and fear in their communities about the

emerging data and realities of EMGs being harder hit by COVID-19.[6] In their view, COVID-19 did not create health inequalities, but rather the pandemic exposed and exacerbated long-standing health inequalities affecting EMG communities in the UK.[6] The 2020 and 'Build Back Fairer', COVID-19 Marmot Reviews, indicated that over the last 10 years health inequalities in EMGs have grown and health improvements have slowed.[7 8] The causes of the disproportionate impact of COVID-19 on EMGs are multifaceted and may include: geographical area, living conditions, culture, employment, economic status and other biological and health-related factors; the solutions to it may be just as multifaceted.[9] The present study aimed to answer the PHE review recommendation for detailed research across a range of ethnic groups and religions to explore in depth their reactions, attitudes and behaviours to the COVID-19 pandemic,[6] to understand barriers and facilitators around the prevention of COVID-19 infections and explore participants' views on what could be done to control the pandemic.

METHODS

This study has been reported in accordance with the Consolidated Criteria for Reporting Qualitative Research.[10] It forms part of a larger study which also explored the attitudes and beliefs of diverse ethnic groups in the UK towards COVID-19 testing and vaccination.[11]

Topic guide development

The semistructured interview guide was informed by the 2020 PHE review of disparities in risks and outcomes for COVID-19,[2] and the theoretical domains framework (TDF) which has 14 domains that help understand an individual's behaviour.[12] The areas covered in the topic guide which mapped to the 14 TDF domains are shown in table 1. The topic guide (see online supplemental material 3) used open questions flexibly and iteratively with probing of questions. Trust was not specifically asked about.

Recruitment

To attain a diverse ethnic representation of the general public in England and Wales,[11] we purposefully invited EMGs of any generation to participate, and as a comparator White British individuals to two focus groups (FG). During recruitment from June to October 2020 (6–9 months into the pandemic), we monitored self-declared gender, age, religion and ethnicity of participants, and recruited until we had sufficient representation from across major UK ethnic groups and religions. See online supplemental table 1. Participants were recruited via the PHE People's Panel, adverts in Twitter, social media, COVID-19 charities and ethnic minority support groups with chain referral sampling.[13] Participants needed a reasonable level of spoken English or Punjabi; there were no other exclusions. Participants were offered £25 each for their time and contribution.

Data collection

FGs with two to seven participants were conducted via Skype in English, with or without video, with a facilitator and research assistant who took field notes; discussions lasted approximately 60 min. Two Skype interviews lasting 30–40 min were conducted in Punjabi by one researcher. FGs/interviews were audio recorded and transcribed verbatim, Punjabi interviews were translated into English; transcripts were checked for accuracy. Findings were discussed at the end of each FG, and weekly by researchers.

Data analysis

Three researchers analysed the data inductively using thematic analysis with QSR NVivo.[14] Twelve transcripts (44%) were double coded and a coding consensus was reached through discussions. Some transcripts were analysed during data collection to inform adaptations to the questioning schedule. Themes were identified from the data, agreed with the steering group and finalised in a workshop. Overarching themes were created, and with the Michie behaviour change wheel[15] data were then used to finalise immediate and longer term policies and interventions which may help reduce COVID-19. Representative quotes were chosen to expound the themes.

Research group

The research team and steering group included a member of the public, and researchers and healthcare professionals experienced in qualitative research, behavioural science, ethnic minority health, public health including outbreak control and medical microbiology, infectious diseases, guidance and intervention development.

Patient and public involvement

A member of the public was involved in the study steering group from the study conception, inputting into design, methodology, data collection tools and recruitment.

RESULTS

One hundred participants aged 19–88 years were recruited including diverse occupations, 10 different religions/beliefs and 19 (first to fourth generation) ethnic groups including: Asian and East Asian participants, Black, Eastern European, South American, Travellers and White British (online supplemental table 1).

Participants' reactions to the pandemic are structured into three overarching emotional themes: dismay, frustration and altruism. These themes displayed across all ethnic groups are shown in figure 1, with recommended interventions and policies. Additional participant quotes are provided in online supplemental material.

Dismay

Anxiety due to perceived risk of COVID-19

Many EMG participants mentioned their dismay, anxiety or fear about being at increased risk of COVID-19 severe illness. Several participants across ethnicities described

Table 1 Topics explored in the focus groups and interviews mapped onto the theoretical domains framework

Topic discussed with participants	Domain/s within the theoretical domains framework
Tell me about your experiences of COVID-19.	(Non-specific, could elicit multiple domains)
How has the COVID-19 pandemic made you feel?	Emotion
How do you think your experience is different because you come from a BAME/minority ethnic background?	Professional role and identity Social influences
Tell me about how the pandemic may have impacted on the support structures within your circles of friends and family.	Social norms Environmental context and resources
Is there anything you will do differently as a result of this pandemic?	Intentions, goals, decision-making
Tell me about any strategies you have used to try and prevent yourself from catching COVID-19. How confident are you that those strategies will/have worked?	Skills, beliefs about consequences, beliefs about capabilities
To what extent would you consider yourself at risk?	Professional role and identity, beliefs about consequences
What do you think of the recent figures showing higher mortality rates among BAME groups? To what extent has this affected your behaviour?	Beliefs about consequences Environmental context and resources Memory, attention and decision-making
Tell me about any experiences you have of family members at increased risk or are shielding. How has this made you feel? How easy or difficult have you found shielding?	Environmental context and resources, social norms, emotion, beliefs about capabilities
What do you think will happen to those vulnerable groups now that lockdown is being eased?	Beliefs about consequences
What is your experience of the government health messages telling people what to do during this pandemic? Is there anything that you've found difficult/easy about understanding what to do during this pandemic?	Memory, attention and decision-making, social norms, beliefs about capabilities
How easy or difficult have you found physical distancing?	Beliefs about capabilities, skills
How will you decide when to start seeing your friends and family again?	Memory, attention and decision-making, social norms
Have you broken any of the guidelines issued by the government? If so, what did you do and why? (Reassured participants of confidentiality and anonymity)	Environmental context and resources, social influences
What are your thoughts on returning back to work, if applicable?	Intentions, emotion, environmental context and resources
Based on our discussions, what do you feel you need, moving forward?	Environmental context and resources
Government support.	Resources
Their role and other's role influencing their risk of COVID-19 and response to it.	Professional role and identity, social influences, behavioural regulation; reinforcement
The effect of their housing, family and community setting on risk and reactions to COVID-19.	Environmental context and resources Social influences

BAME, black, Asian and minority ethnic.

themselves at '*increased vulnerability*' to COVID-19 due to age, and/or blood pressure, diabetes, obesity and pregnancy so that many had '*not left the house since lockdown*'. Some participants had avoided their supportive '*Community Association meetings and gatherings*' (FG14, Indian), and others reported they were '*going to be* [very] *cautious until we get a vaccine or until the infection is no longer around*' (FG4, South East Asian). Participants highlighted the range of housing and family units within a single community. Those in multiresident or multigenerational households were concerned that they were '*exposed to more* [COVID-19] *just because there's more of you going out and about*' (FG1, Mixed ethnicity); those in public facing roles such as healthcare and public transport echoed these concerns about increased risk.

Effect of the pandemic on health and mental well-being

Several participants reported dismay at not receiving treatment for other illnesses: '*Then I've got a lot of abdominal pain, and now the worst one is a chest pain, but I cannot get treatment, …. And to be honest I've heard of two people who have died in their own houses because they cannot access other treatment, that's a big challenge*' (FG23, Male).

Several participants reported feeling depressed because of 'lockdown' measures. The PHE report highlighting the greater infection rate and mortality from COVID-19 in ethnic minorities, and media response to it, had made EMG participants nervous about any social interaction. Some EMG participants mentioned that since the pandemic '*people would physically step away from*' them '*more than it was before*' (FG7, Chinese). '*I've never experienced*

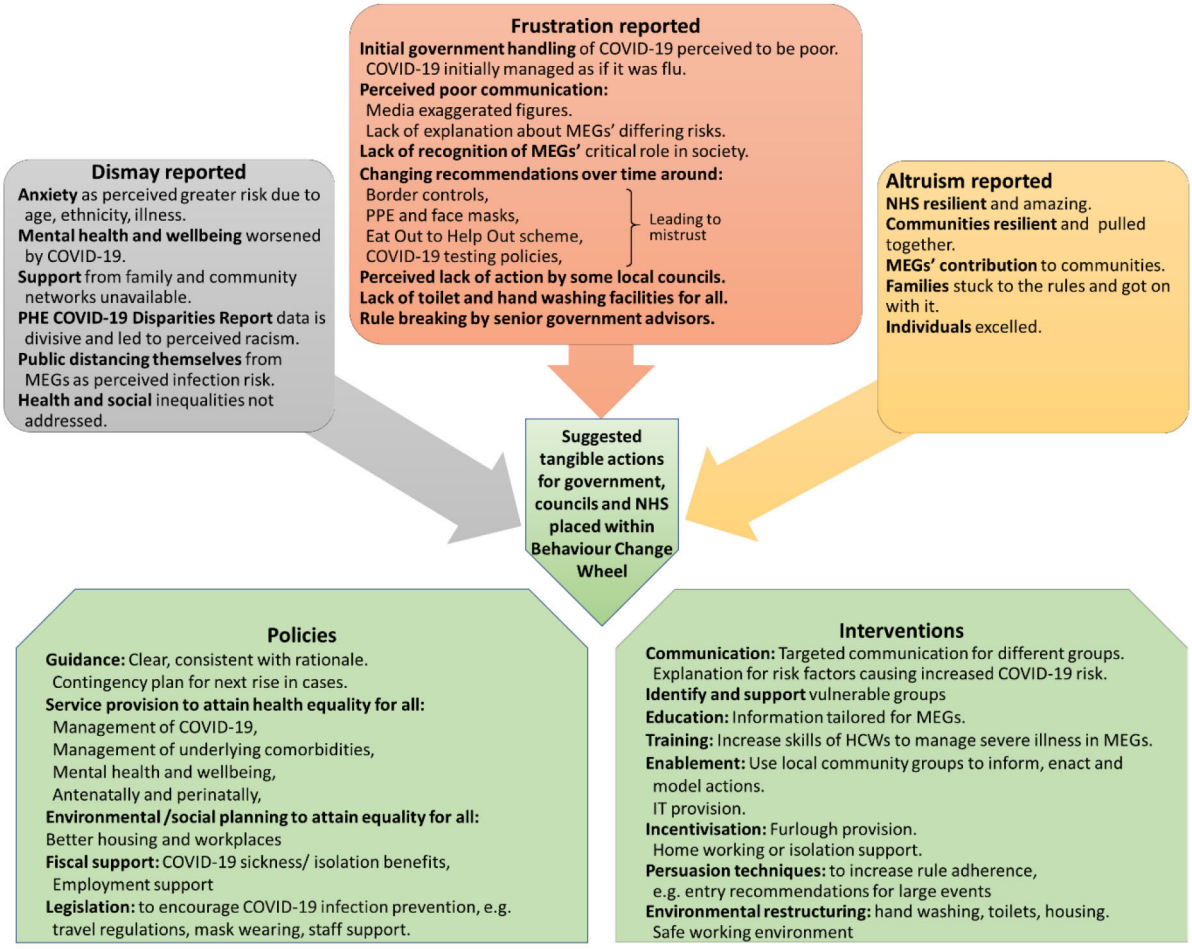

Figure 1 Reported factors contributing to the frustration, dismay and altruism discussed by participants, and suggested actions placed within the behaviour change model[14] as policies and interventions. HCW, healthcare worker; IT, information technology; MEG, minority ethnic group; NHS, National Health Service; PHE, Public Health England; PPE, personal protective equipment.

anything like this in my life, even though I want to go out, I'm too scared to' (FG9, Indian) and this had affected their mental well-being, '*I started feeling sometimes depressed*' (FG13, Arab). EMGs reported the big negative impact that loss of their support networks had on their well-being, '*I think the Asian community, the Hindu community, the temples and the mosque are a big impact on their family and their friends*' (FG18, Indian). '*What I have experienced within this period was worse than any time simply because I don't have family to connect to. There is no support group meetings. So, I felt so isolated … and including being suicidal*' (FG23, Male). One participant perceived they had lost their job as mental illness had caused a short work absence.

Response to increased COVID-19 risk for EMGs

Most participants had heard news showing the greater risk of EMGs contracting and dying of COVID-19; some had specifically heard about the PHE COVID-19 report. EMG participants stated that the report was divisive: '*The government have already divided us, why mention ethnic minority?*' (FG16, Black mixed). This had led to EMGs being kept at a distance by *'non-ethnic minority people* [due to fear of infection]'. Jewish participants had become less anxious since they realised that the poorer outcomes in ethnic minorities excluded them. EMG participants stated that the report increased their awareness of risk of COVID-19 resulting in greater adherence by them to lockdown rules: '*when it came out that BAME* (black and ethnic minority groups) *was worst affected it sharpened people's radars and there were less meetings and stuff* (FG9, Indian).

Some White British participants '*felt really a bit saddened*' by the report, stating it made them reflect on *'the differences, is it kind of genetic? Or is it because people from ethnic minority backgrounds might be more socially deprived or have less access to better health care?*' And in agreement with EMG participants it dismayed them to think there was still such health inequality, *'we're in 2020, you'd think that we're moving towards a more just society'*. Other White British participants wondered if '*lack of communication in the right language*' had contributed to increased infections in EMGs, *'as there's not enough media information around to explain the situation even for English speaking people, I dread to think how well it's been translated for people who don't have English as their first language*' (FG22, White British). Other White British participants reflected that the increased risk of infection

for ethnic minorities was due to '*a large proportion of ethnic minorities that work within the NHS that would have come into contact with people with coronavirus, and lifestyle differences, with big households all living together in some cases*' (FG20, White British). The COVID-19 pandemic highlighted pre-existing inequalities at the same time as the Black Lives Matter Movement (BLMM) gained momentum globally. For many participants, the disproportionate impact of COVID-19 on black communities could be understood in line with the concerns of the BLMM.[16]

Frustration

Belief that figures have been exaggerated

Some participants from across ethnic groups considered that the reports and other COVID-19 EMG figures had been exaggerated or misrepresented by the media as the '*stats were just put as big headlines with no explanation*' (FG16, Black mixed), or stated '*it is just fabricated news that Pakistanis get it more and the English don't. How is it possible?*' (Interview 1, Pakistani). This led to mistrust in the statistics: '*I don't know if I should believe those stats*' (FG10, Bangladeshi). Participants considered the deaths had not been explained: *'There was a bit said in the media eventually, but it wasn't really done the way it should have been done,– for example* [increased infections] *because they were NHS frontline or public facing workers'* (FG19, South East Asian). While those with awareness *'that black and Asian people in particular had certain criteria that was making them more at risk… and nothing was being done*' showed *'frustration and not so much fear for myself, but for the community, for my parents of course*' (FG6, Pakistani).

Contribution of ethnic minorities unrecognised

Many EMG participants reported feeling frustrated by government as the huge contribution of the EMG communities '*didn't really get recognised'. 'Who's on the frontline, who's dying more? it's the people from the BAME communities*'. Participants suggested that greater recognition of EMG communities' contribution *'would actually make everyone feel this is such a great time to be united rather than divided*' (FG9, Indian), and build greater confidence.

Government handling of the COVID-19 pandemic

Participants were mostly negative about the role of government in controlling the pandemic. One participant wondered if the government through their inaction '*were deliberately spreading the virus among us* [the general public]. *I think they wanted 60% to be infected by Corona so that their immune system becomes stronger and they* [the public] *can, protect themselves'* (FG15, Bangladeshi). Another reported, *'the UK government doesn't seem to give a toss'* (FG17, Chinese). Another expressed that government should have managed this pandemic much more seriously and used the experience of '*scientists from an Asian background who have experienced SARS in the past*' (FG3, Mixed ethnicity). Participants mentioned actions the government could have done to slow the pandemic: '*why have they started the quarantine of people coming into the country now* [August 2020] *and not three, four months ago'* (FG15, Bangladeshi). Others reflected that although the government had reacted slowly and made mistakes in the beginning of the pandemic, *'they have now* [in August 2020] *realised that it is really spreading very fast, and they are now taking all possible steps to stop this virus very quickly'* (FG14, Indian).

Belief that messaging is confusing and inconsistent

'*Frustration is the best word that describes the way it was received by us. Messages, were always very, unmatched to the situation. The Prime Minister kept stating like he's backing up everything with science, but I felt like he was very selective in choosing the messages'* (FG11, Europeans). Most participants found the government messaging '*really confusing*' and contradictory. '*I'm a chairman of a patient's group and I get a lot of phone calls,* [asking] *what shall I do, etc. There is no clarity*' (FG18, Indian). This was especially as participants perceived that the advice changed so much from *'You can go to work, - don't go to work, - stay at home*' (FG1, Mixed ethnicity). Inconsistencies and changing guidance around personal protective equipment were a frustration; early in the pandemic, the '*public were told the science doesn't support us wearing face masks*' (FG10, Bangladeshi); *'And then all of a sudden, 12 weeks after the lockdown, "everyone has to wear face masks"'* (FG3, Mixed ethnicity, Train driver). The '*Eat Out to Help Out'* scheme across England in August 2020 was also particularly highlighted by several participants as being inconsistent with Infection Prevention and Control (IPC) rules in other venues, and likely to increase viral spread: *'You can see outside restaurants is a long queue of people waiting. So, they're going to be spreading the virus'* (FG15, Bangladeshi). *'I was in this pub and it was absolutely packed, no masks whatever, and then I walked to the supermarket and it's masks, wide aisles and there's like a* [rule for] *how many people can go in, it just doesn't add up'* (FG22, White British). Participants were '*really annoyed'* by the government defence of an advisor who broke the rules; stating: '*well we've literally been following your guidelines to a T and you've excused this behaviour, it was a bit of a kick in the teeth'* (FG2, Mixed ethnicity).

Attitudes towards PHE

Participants had some criticisms of PHE indicating *'that Public Health England had failed to provide timely, accurate information early enough',* but wondered *'whether there's been political pressure at the top to downplay things and to treat this as Influenza, which it isn't'* (FG3, Mixed ethnicity). Others considered *'Public Health England is doing the best they can but politicians being politicians they scapegoat everybody but themselves'* (FG17, Chinese).

Attitudes towards local government

Although there was one positive comment on council support, others reflected that communities did not feel supported by their local councils. The council '*is for the local people and they're not putting their effort in to help the town*' (FG18, Indian). The Traveller community participants

were particularly critical of councils stating that '*they pass the buck and then nothing gets sorted*' (FG24, Traveller), reporting they failed to allow access to the public toilet with a wash hand basin.

Altruism

The EMG participants expressed that *'people from the* [EMG] *communities were proud that their members were on the frontline'* and that individuals had made a great difference in their local communities '*helping out door to door with services, especially for the elderly'*. Most participants from all groups followed the lockdown and social distancing rules stating, '*when a situation like this arises, that's what you have to do, you just have to go with it'* (FG5, Mixed ethnicity). Others commented how the pandemic had '*brought out the good in people and how they could work as a community*' (FG13, Arab). Most participants were very positive about the National Health Service (NHS), stating from their own experiences, '*I can't fault the NHS, they've done all they can'* (FG22, White British); one participant reported negative experiences around the care of her mother with COVID-19.

Actions requested by participants

Participants across all ethnicities wanted to see similar immediate '*tangible actions*' to prevent the pandemic worsening, and longer term actions to prevent similar major disruption in future waves.

Short-term policy changes

Clear guidance

All participants requested clear COVID-19 guidance to reduce confusion: '*we need some clear guidance, and more clarity from the government, in a way that people can digest'*. Participants also requested a rationale for any guidance as '*transparency* [from government] *moving forward, means that people can make more informed decisions about how to behave and protect themselves and their family'* (FG8, Black ethnicities). Alongside this, participants wanted '*accountability with things that went wrong*' (FG2, Mixed ethnicity). Participants stressed that one set of guidance or information source does not fit all ethnicities or religions or all the individuals within one ethnic group.

> On one end of the spectrum you may have ethnic minorities in low socioeconomic status groups, but on the other end you'll have people who are very well educated, who are the key workers, who are the doctors and nurses and a lot of ethnic minority people fall into that category as well. (FG5, Mixed ethnicity)

Support of employment

Participants supported the furlough scheme: '*our company was really happy* (with the furlough scheme), *and they wanted to keep everyone to make sure everyone is working, nobody is unemployed*' (FG15, Bangladeshi). However, participants indicated unemployment issues were *'going to be hard over such a long time*' and that all ethnicities '*would need support to get back to work, …via a recruitment office or something like that*' (FG13, Arab).

Immediate interventions

Communication through different channels

Participants requested *'more campaigns educating the public, to disseminate information that is readable and digestible, because most people just get their information from the media. Tackling that would really help people build confidence in the government and the organisations that are responsible for looking after their health'* (FG8, Black ethnicities). Participants suggested that: '*Outreach at council level would be really helpful for the community right now'* (FG6, Pakistani). One participant highlighted the importance of local ethnic minority radio stations and community leaders to get across appropriate messaging. Another highlighted the need for information technology (IT) support for lower income groups as *'they don't have access to technology… Some of them don't have money to have internet in their house,* [or] *proper equipment to* [join] *their support group now we are online'* (FG23, Female).

Work with local communities to increase understanding and optimise support

EMGs were particularly vocal that to help unite communities they wanted their community groups, local charities and community centres recognised and involved in the development of any immediate interventions. They stressed the importance of using the learning from local community leaders about '*the grass roots people that you need to connect with*', and to have *'a contingency plan ready and waiting if the second wave does come'* (FG19, South East Asian).

Interventions to increase adherence to rules

Many participants across ethnicities discussed the need for greater '*enforcement and mandating* [of lockdown] *rules'*. The interviews had taken place shortly after a key government advisor had broken COVID-19 rules and there had been no repercussions for them; there needed to be equality of policing across all levels including those in senior government roles. Many participants across ethnicities considered that there should be *'heavier fines or something for those who are breaking COVID-19 rules'* (FG14, Indian), with something *'in place so people actually believe that something will happen to them if they don't abide'* (FG20, White British). Many reported that younger individuals were following the COVID-19 guidance less rigorously. *'They* [the police] *could have been stricter everywhere, stricter in the inner-city area where* [young] *people are gathering together as they're* [young people] *behaving like there's nothing happening'* (FG14, Indian).

Longer term policy changes to increase social equity

Most groups wanted to see the government taking long-term action to address inequalities in terms of class, ethnicity and race, because *'until you've got equity and equality in terms of class and race, I think you're always going to have health inequality'* (FG6, Pakistani).

Healthcare policies

Participants indicated that the needs, comorbidities and risk of COVID-19 and death of different ethnic groups were very different. '*The NHS clearly needs to change, and it needs to be much more specific with how it deals with different races. Black people are different from Asian people, or different from Chinese people, and this BAME thing doesn't work*' (FG3, Mixed ethnicity). For example, '*there's a 20% increase in diabetes within the South Asian community, so we need to tackle that*' (FG18, Indian). Major risks of health disparities were highlighted in maternal mortality:

> I always kind of knew about the stats that black women are five times more likely to die in childbirth than white women. I think you need a partner there to advocate for you [throughout] and support you. So, I do really feel sorry for women giving birth without their partner. (FG2, Mixed ethnicity)

Participants considered perinatal risks were greater during the pandemic as partners were only allowed to support mothers in the final stages of labour.

Long-term interventions

Training for healthcare workers

Healthcare participants worried about training around managing critical illness in different ethnic groups:

> We're not taught how things manifest differently because of the colour of your skin, so I think that's why a lot of the time people are mis[treated]. And I think that's a big thing with COVID as well, …we're not taught the differences so, we have to go out of our way to see the differences, so I think that [training] would be a really good thing that Public Health could make sure happens. (FG2, Mixed ethnicity, Medical student)

Long-term environmental restructuring

Participants highlighted that the needs of multiresident households, public-facing workers and travellers needed to be considered in future planning. '*How can we avoid the communities* [in multiresident housing] *getting infected more. I've seen flats where there are two different families with two or three kids each sharing three rooms. I don't see any sides ready to do what it takes*' (FG11, Male). Traveller participants reported that the government were not providing for their basic needs: '*it should be automatic that every authority, should go out and provide a water bowser toilet, access to gas and wood*' (FG24, Traveller).

DISCUSSION

Key findings

Dismay, frustration and altruism were reported by all our participants during the first 6–9 months of the COVID-19 pandemic. They considered that government handling of and communication around the pandemic had been confusing. The PHE COVID-19 disparities report had exacerbated this dismay and frustration as the disparities in mortality had not been explained well, had amplified the insufficient action to reduce health inequalities and these perceptions just ostracised EMGs more. Participants indicated that in the short term government policies should include clear COVID-19 guidance, with a contingency plan for the next rise in cases. Information, education and support tailored for local communities and ethnic groups with clear communication and IT provision where needed. Health, social and housing inequalities needed to be addressed in the longer term.

Comparison with existing literature

Social stigma and discrimination

The social stigma reported by many EMG participants in this study is concerning, and aligns with reports from health workers, people coming from abroad and those in quarantine.[17] Community leaders in Canada identified that poor working conditions facilitated viral spread among marginalised groups, and the role of anti-black racism in response to higher rates in EMGs.[18] This study also referred to the BLMM and suggested it was an opportunity to change towards equity and fairness in health, and overall quality of life. We also acknowledge that there may be subtle cognitive biases contributing to participants' experiences, which can be difficult to identify alongside more overt prejudices, but are prevalent in modern society.[19] Thus, an important strategy to tackle stigma, discrimination and subtle prejudices is policies that reflect the lived experiences of racialised populations in a meaningful way, which was a strategy noted by participants.[20]

Health

Our participants' request for more information for groups with health comorbidities to help explain their increased risks of COVID-19 and what they can do has been echoed in other studies, including carers of diabetic children and pregnant women.[17 21–23] General practitioners like our participants have also expressed their concern about 'collateral damage' resulting from routine care being postponed or limited due to COVID-19[24 25]; this effect is likely to be greater in ethnic minorities who already have poorer healthcare access. The social isolation and closure of services exacerbated social and mental health problems across all ethnic groups in our study and others,[23 26] but especially affected marginalised, vulnerable groups,[27 28] 'non-whites', younger adults (aged 18–30) and women.[29] The concerns of participants about increased risk of maternal mortality in ethnic minority women have been confirmed.[30 31] The Commission on Race and Ethnic Disparities 2020 Report echoed many of our participants sentiments and stated the importance of building trust, promoting fairness, creating agency and achieving inclusivity to attain equity across communities, including further research around maternal deaths in EMGs.[31] In October 2021, the newly launched Office for Health Improvement and Disparities, suggested by the

commission, stated that '*Health disparities across the UK would be tackled through a new approach to public health focused on preventing debilitating health conditions'*, and in line with our participants' suggestion would involve '*community leaders, charities, industry experts and key employers to act on wider factors such as work, housing and education*'.[32]

Guidance

Our participants discussed the need for clear transparent guidance, as they, like others, were frustrated by changing rules.[33 34] Constantly changing news and information in Australia led to public confusion and distress.[35] Additionally, research indicates that changing guidance, breaches of lockdown among influential figures or communicating with unwarranted certainty around COVID-19 or vaccination leads to less compliance and/or trust in the information by readers compared with providing consistent information, and including uncertainties.[33 36–38]

Involving community groups

The importance for communities, government, guidance, advice and the media to harness the achievements of individuals, families and the NHS has also been highlighted in other studies.[39] In Kerala, India, where COVID-19 mortality was lower than other areas of India, the backbone of their strategy was community participation and local leadership which mobilised community self-help groups.[40] Our participants and others[33] stress involving local community groups in information development to allow adaptation of interventions for populations and risk groups with different opportunities, privileges, access to healthcare and IPC adherence.[18] In October 2020, the UK government announced an additional £4 million for COVID-19-targeted messaging for EMGs and a new '*Community Champions'* scheme to fund work with grassroots advocates, and community groups from impacted communities.[41] The COVID-19 Scientific Pandemic Insights Group on Behaviour advised where community trust is low community champions can be a key pillar to support IPC measures,[42] as they can reach and support isolated or marginalised individuals, help communicate health messages,[42 43] reducing health inequalities.[44]

Environmental and social policy

Large households, work environment and greater social interactions put our participants at increased risk of COVID-19. In a March 2020 UK survey, EMG participants and others from disadvantaged backgrounds reported they would be less able to work from home or self-isolate, suggesting the existence of structural or financial barriers to adopting preventive behaviours in these groups.[45] Decreasing the risk of contracting COVID-19 across all ethnicities going forward may need a government policy examining town and social planning leading to environmental restructuring facilitating IPC. This includes easy access to handwashing stations in homes, work, all food providers and shopping centres; and toilet facilities as our Travellers mentioned.

Financial and employment support

The financial pressure of COVID-19 on populations and especially disadvantaged groups has also been highlighted by others.[17 23 34 43] By autumn 2020 when this study was completed the job furlough scheme introduced in March 2020 helped protect *'at risk jobs across the UK by providing employees with incentives to keep staff employed'*; national data indicated more than half of those furloughed had returned to work by mid-August 2021.[46] Our participants indicated the likely need for ongoing employment support after the furlough scheme ends to retain jobs.

Increasing compliance with COVID-19 rules

Our participants expressed a belief that the laws introduced by government should be enforced more. However, an enforcement-based approach can dilute the public's voluntary commitment to comply, so-called 'control aversion'.[47] German population enforcement lowered likely compliance with COVID-19 social distancing and vaccination.[47] Control aversion is greater in younger adults; if there is lack of clear rationale for the rules, or a perception that the government does not trust the general public.[47] Thus, although legislation and policing may be appropriate in some instances, it is better avoided and replaced with enablement and support, or incentives.

Strengths and limitations

Data collection in only English or Punjabi was a key limitation for this study. While the participants were able to relate stories of language barriers impacting relatives or friends, the study would have benefited from data collection in other languages; however, we had limited staff resources.

The use of social media for recruitment and Skype and telephone data collection may have excluded participants with poor digital access. However, we did seek to minimise this by recruiting participants through charities who identified participants from lower socioeconomic backgrounds with poor internet access.

Unanswered questions, future research

It is important to obtain the views of those underrepresented in this sample, that is, non-English-speaking EMGs and over 70 years old or their carers, as these groups had the greatest morbidity and mortality associated with the pandemic. Service providers, government, PHE successor bodies and councils should be shown the results to obtain their response to the public's attitudes to handling of the pandemic and explore how they can improve the management of the pandemic through its next stage. As the pandemic progresses, further local community exploration with EMGs will be needed to understand the specifics of local situations to optimise policies and interventions.

Implications

To improve trust and compliance future reports or guidance should clearly explain any stated differences in health outcomes by ethnicity or other risk group,

including specific messages for these groups and concrete actions to minimise any risks. Messaging should reflect the uncertainty in data or advice and how guidance may change going forward as new evidence becomes available. A contingency plan is needed to mitigate the impact of COVID-19 across all communities including EMGs, the vulnerable and socially disadvantaged individuals, in preparation for any rise in cases and for future pandemics. To minimise inequalities and racism these plans should promote collective identity and share positive, supportive and non-judgemental communication.[48] Equality across ethnicities for COVID-19 and healthcare is essential, and the NHS and local communities will need to be supported to attain this.

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Contributors CM suggested the work, had substantial contributions to the design of the work (helped develop protocol, interview questions); attended two focus groups, reviewed the analysis, drafted all versions of the manuscript and critically revised the drafts. CM is also guarantor for the study. ES collected the data; had substantial contributions to the analysis and interpretation of the qualitative data; contributed to all drafts of the manuscript, providing quotes and interpretation, and critically revised it. AT had substantial contributions to the analysis and interpretation of the qualitative data; and critically commented on versions of the manuscript. AKam had substantial contributions to the design of the study (recruited participants); collected the data; had substantial contributions to the analysis and interpretation of the qualitative data; and critically commented on versions of the manuscript. RBS had substantial contributions to the design of the study (development of protocol, drafted interview questions); collected the data; and critically commented on versions of the manuscript. AKai checked the quality of the data; had contributions to the interpretation of the qualitative data; and critically commented on versions of the manuscript. DML had substantial contributions to the design of the work (helped develop protocol and interview questions); reviewed the analysis; and critically commented on versions of the manuscript. MPat had substantial contributions to the design of the study (recruited participants); reviewed the analysis; and critically commented on versions of the manuscript. IC-M, RS, CSB, LN and JG had substantial contributions to the design of the work (reviewed interview questions); reviewed the analysis; and critically commented on versions of the manuscript. MPar and LS contributed to the design of the work (reviewed interview questions); reviewed the analysis; and critically commented on versions of the manuscript. LFJ managed the project study from start to end; led the analysis and interpretation of the qualitative data; had substantial contributions to the design of the study (led on the development of protocol, gained ethics approval, drafted interview questions, recruited participants); led the collection of data; had substantial contributions to the analysis and interpretation of the qualitative data; and critically commented on the versions of the manuscript. All authors gave final approval of the version to be published and have agreed to be accountable for all aspects of the work.

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Competing interests AKam participates in the UK Scientific Advisory Group for Emergencies (SAGE) behavioural science subgroup SPI-B. The views expressed are those of the authors. LFJ and CM have been involved in the review of PHE/UKHSA COVID-19 guidance.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

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