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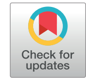
Talking about inequities: A comparative analysis of COVID-19 narratives in the UK, US, and Brazil



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ABSTRACT

Disproportionate mortality and morbidity burdens of the COVID-19 pandemic and coinciding media coverage of public acts of violence perpetrated against people of color in 2020 precipitated reckonings with structural inequities in global, national, and local contexts. This cross-country comparative analysis aims to describe how people voice and make sense race, racism, and privilege in their experiences with COVID-19 infection in the United States, United Kingdom, and Brazil. Anchored by continuous reflection on our individual and collective positionality, we conducted an inductive comparative analysis conceptually situated in intersectionality and critical race theory. Countries used a shared qualitative methodology to collect and analyze 166 narratives of people with experience of COVID-19 infection from 2020 to 2023. We selected 19 cases that illustrate cross-national differences in peoples' acknowledgment and narration of structural privilege and disadvantage in their observations of COVID-19 in their countries and in their personal experiences. People in the US had the most fluency with voicing race directly. In Brazil, while some respondents (especially younger people) demonstrated high racial consciousness, others struggled to identify and talk about racial relationships. In the UK, people voiced racial identifications, though often within white norms of politeness and an accompanying sense of discomfort. The findings overall illustrate moments the interview becomes or does not become a space for voicing social categories and systemic underpinnings of difference in COVID-19 infections and healthcare experiences. We reflect on cross-country differences in historical and contemporary racialized discourse and elaborate on implications of focusing on voicing in qualitative research.

1. Introduction

The global COVID-19 pandemic has magnified the ways that underlying health and social conditions, generations of stress and trauma, and differential access to healthcare create unequal health outcomes. Racially minoritized groups and those who are socioeconomically disadvantaged are more affected in the epidemiological landscape of COVID-19 globally, despite Sars-CoV-2 being universally communicable. Inequities in COVID-19 exposure (Miconi et al., 2021), incidence (Arrazola J, Masiello MM, Joshi S, 2020; Moore et al., 2020; Yancy, 2020), mortality and morbidity (Berger et al., 2021; Pan et al., 2020; Yancy, 2020), experiences of mental health distress (Miconi et al., 2021), and stigma (Bhanot et al., 2021; Miconi et al., 2021; Sukhera et al., 2021) are well-documented.

Concerns about this noticeable bias in COVID-19 risk and outcomes took a more urgent turn due to the convergence in mid-2020 with Black

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Lives Matter (BLM) demonstrations following the high-profile murder of an unarmed Black man, George Floyd, by police on a city street in the United States. Among the many Black lives lost, this highly publicized case catalyzed personal and public reckonings with systemic racism, igniting protests and demonstrations across the US. The reverberation of the BLM movement arrived soon after around the world, including in the United Kingdom and Brazil. In 2020 in Brazil, private security officers of a supermarket beat to death João Alberto, a Brown man buying food with his wife. The Brazilian media associated this case with George Floyd's murder, and as in the US, João Alberto's murder joined a great number of crimes in Brazil linked to structural racism that are less widely disseminated. In the UK, the extensive BLM protests in 2020 were not just about showing solidarity with Black communities in the USA, but the culmination of growing frustration over the Grenfell Tower fire, the Windrush scandal's wrongful detainments and deportations of Caribbean immigrants, and the unequal impact of the COVID-19 pandemic (Joseph-Salisbury et al., 2021).

With increased media attention to injustice and epidemiological differences in COVID-19 health outcomes, the notion of "dual pandemics" of systemic racism and COVID-19 emerged (Gomez et al., 2020; Blackstock, 2021; Jones, 2021). We undertook a cross-national comparison of peoples' narratives of COVID-19 infection to examine what people voice about the intersection of inequities and the global pandemic.

We begin with a brief description of the historical and contemporary context of race and racism in the US, UK, and Brazil and consider contexts of the COVID-19 pandemic including governmental responses and healthcare access. We then describe our analysis, which is informed by both critical race theory and intersectionality, and is rooted in continuous reflection on our positionality. In the findings, we consider how people in the US, UK, and Brazil do, or do not, invoke social categories such as race and class in their descriptions of personal and societal inequities.

We are the first, to our knowledge, to describe voicing of social categories in COVID-19 health experience narratives cross-nationally. Prior work conducted in the US about experiences of race and racism during the 2020 "dual pandemics" found differential directness in emerging adults' reflections on race (Quiles et al., 2023). Cervantes et al. illustrated how adults who identify as Hispanic describe COVID-19 in terms of compounding existing disadvantages (2021). Our findings add to this literature by reflecting cross-national divergences and similarities in people's use of social categories to account for differences in COVID-19 exposures and outcomes.

1.1. *Race and racism in the US, UK, and Brazil: a very brief history*

In a comparison of the social construction and use of racial categories across the US, UK, and Brazil, critical race theory praxis propels attention to the underlying forces of cultural and structural racism embedded in these highly racialized societies (Hicken et al., 2018; Hylton, 2012). We specifically draw on Christian's (2018) concept of racialization emerging within a global racial structural hierarchy entwined with white supremacy. Christian emphasizes colonialism, enslavement, and racial violence as powerful historical underpinnings of racialization. This critical race orientation necessarily informs our understanding of the historical and contemporary racial realities in the US, UK, and Brazil.

Understanding racial inequities in health requires, as Feagin and Bennefeld write, "realistically assessing society's white-racist roots and contemporary structural-racist realities" (Feagin & Bennefield, 2014, p. 7). The US, UK, and Brazil are each characterized by different formative histories of oppression and lasting denial of racism, with power structures that hold whiteness as superior. This commonality has locally-shaped manifestations. "Color blindness" in racial discourse in the US aligns with a post-racial notion of erasing race from contemporary social order (Christian, 2019). In the UK, a celebration of "multiculturalism" preserves white racial status quo under the guise of cultural recognition (Lentin & Titley, 2011). In Brazil, "racial democracy" is a similar form of denial of racism (Ferreira, 2015).

Understanding race relations in Brazil is particularly illustrative of the myth of racial harmony shared by the three nations of focus in this study. Historically, Brazil had been idealistically positioned as a counter-example to its racialized northern US neighbor (Stanley, 2018). Claiming a "racially innocent history," the nation touted racial mixture and the adoption of a fluid "color system" rather than categories of racial distinctions (Stanley, 2018). Among many critiques of this "racial democracy," the work of prominent Afro-Latin-American feminist scholar and activist, Lélia Gonzalez (1979), critically decolonizes the narrative around race relations in Brazil. She suggests a thesis of "racial whitening, " describing how the racial project in Brazil sought to increase white population while simultaneously perpetuating the myth of racial democracy: "It is because of the articulation between the myth of racial democracy and the ideology of white superiority that one must understand the veiled character of Brazilian racism" (Covin, 1990 citing Lelia Gonzalez & Carlos Hasenbalg, (eds.) 1982, p. 54). Historically, the Brazilian government encouraged migration from Europe to Brazil – a total of 4.67 million migrants between 1820 and 1970. Promoting racial mixing of Brazilians with newly arrived white people served to move Brazil's racial makeup toward whiteness, the highest order social status within the racial hierarchy (Covin, 1990; Vallejo & Canizales, 2016). In more recent Brazilian history, European refugees remain welcome, while Africans and South Americans are not, especially if they are Black ((Salles, M. R. R., Bastos, S. Paiva, O. C., Peres, R. Guimarães, & Baeninger, 2013).

The US and UK contexts share a similar privileging of whiteness and denial of racism. In the US, white people have sustained racialized institutions and benefited from legacies of racial oppression of non-white people (Feagin & Bennefield, 2014). In the UK, in her critique of the notion of a post-racial society, Bhopal (2018) writes about ubiquitous white privilege in institutions and systems.

These socio-political landscapes matter deeply in an investigation of COVID-19 infection experiences. In the US, UK, and Brazil, people of color have long been subject to entrenched racism compromising access to and clinical pathways within public health services and negatively influencing health indicators (Paradies, 2006; Pavao et al., 2012; Priest et al., 2014). Socioeconomic disadvantages driven by systemic racism are also persistent across these three nations. In Brazil, the majority of Black people live in the poorest regions of the cities, with precarious access to health, education, security, employment, transportation systems, and basic sanitation. In the UK in 2020, half of Bangladeshi households were in poverty along with more than 40% of Pakistani and Black households, over twice the rate of poverty of white households (Joseph Rowntree Foundation, 2023). In the US, racial and ethnic disparities in poverty rates are pervasive; in 2021, 19.3% of Black Americans were living in poverty compared to 8.1% of white Americans (Ross & Dorazio, 2022).

Each country, regardless of the particular details of its health and social care systems, has also long had inequitable access to healthcare and widespread disparities in health outcomes. Though the National Health Service in the UK is available at no cost at the point of access, ongoing embedded racism structurally predisposes some to experience worse health and more challenges accessing support (Nazroo & Becares, 2021; Kapadia et al., 2022). In Brazil, racism compromises access to public health services, with higher rates of maternal and infant mortality and chronic and infectious diseases among Black people (Brasil, 2017). Health inequities in the US are similarly pervasive (Baciu et al., 2017).

During the pandemic, these systemic inequities have been additionally embedded in particularly polarized socio-political and healthcare contexts (see Table 1). Global spotlighting of racial marginalization in the BLM protests comes alongside a parallel rise in visible forms of white supremacy. As Christian (2018) argues, in "global Trumpism, Brexit, ethnonationalism, and the practices of states and groups benefitting from Whiteness", we see a strong victimization narrative by dominant racial groups (Christian, 2018, p. 182). Eddo-Lodge (2018) points out the double bind of white people wanting to dismiss that racism exists in the UK, while also being fearful of white people becoming a demographic

Table 1
National contexts.

	Racial demographics[a]	Government response	Healthcare access
Brazil	•The population of Brazil in 2021 is estimated to be 213.3 million inhabitants (IBGE, 2019), of which 42.7% declare themselves White, 46.8% Brown, 9.4% Black and 1.1% Yellow or Indigenous people (PNDA, 2019). •The majority of the Black population belongs to the socioeconomically disadvantaged classes and is concentrated in the poorest regions of the cities. •During the first wave of the pandemic, the risk of mortality from COVID-19 in Brazil was 1.5 times higher among Black/Brown people compared to white people, despite a higher incidence rate among the white population (Martins-Filho et al., 2021).	•The nation's government trumpeted COVID-19 as a democratic phenomenon that affected everyone equally, without distinction of color, gender, or social class. •The federal government hampered the actions of the state government pandemic responses, causing significant delays that limited health and social protection measures to contain the pandemic and its health and social impacts (Centro de Estudos e Pesquisas de Direito Sanitário (Cepedisa)., 2021; Dall'Alba et al., 2021; Ventura et al., 2021).	•The Unified Health System (Sistema Único de Saúde or SUS) is a public national health system. The SUS must cover all Brazilians and legal residents, offering free healthcare to those who need it, with priority to those who are more in need (Paim, 2011). 75% of Brazilians rely on SUS for their healthcare coverage (Tikkanem et al., 2020). •There is also a private system paid by enterprises and individuals belonging to the median- and upper-income classes. Approximately 23% of Brazilians have private insurance (Tikkanem et al., 2020).
UK	•According to the UK national census in 2011 (ONS, 2011), the UK population is estimated as 86% White, 7.5% Asian, 3.3% Black, 2.2% Mixed/Multiple and 1% self-defined as another ethnic group. •Despite notable differences among the minoritized ethnic groups, non-white groups are disadvantaged in area deprivation and housing, employment, and income (Byrne et al., 2020). •During the first wave of the pandemic, the rate of death for COVID-19 was highest among Black Africans, 3.7 times greater than for White British men and 2.6 times greater for women (ONS, 2021).	•The unequal impact of the pandemic was visible through nationally collected data early during the pandemic (ONS 2020). Excess ethnic minority deaths in intensive care were reported in weekly Intensive Care National Audit and Research Centre reports which controlled for area deprivation by postcode (see https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports). •Differences in cases were often attributed to lack of adherence to the guidance and living in multi-occupancy housing. Differences in mortality were attributed to co-morbidities, and specifically individual responsibility for comorbidities, rather than racialized inequalities (PHE, 2020).	•The National Health Service (NHS) covers all UK nationals and legal residents, offering free healthcare to those who need it. •Some people also use private care, often through private insurance schemes. 10.5% of people in the UK have private insurance (Tikkanen et al., 2020).
USA	•According to US Census data in 2021, the US population is estimated to be 76% White, 13% Black or African American, 6% Asian, 1% American Indian and Alaskan Native, 3% Two or more races, and 18.5% Hispanic or Latino (US Census Bureau, 2021). •Whiteness remains a socioeconomically privileged racial category in the US. Many racial and ethnic minority immigrant populations have gained more economic upward mobility than have First Nations People and African Americans. •Black people account for 20% of COVID-19 cases and 23% of deaths (CDC, 2022a, 2022b).	•The federal agency the Centers for Disease Prevention and Control effectively documented dramatic racial differences in incidence and mortality (CDC, 2022a, 2022b). •Differences were attributed similarly as in the UK, but with more explicit linking of mortality differences to comorbidities resultant from past racial differences in access to care. •Governed during the first phases of the pandemic by right-wing populist national leadership, the US experienced a president's rhetoric that suppressed conversation about socioeconomic, racial, and ethnic inequities.	•The US healthcare system is predominantly privatized (in 2020, 66.5% of Americans covered on private insurance) (Keisler-Starkey & Bunch, 2021). •With most Americans on private insurance precariously tied to employment (54.4%), surges in unemployment left many without coverage (Blumenthal et al., 2020; US Census Bureau, 2021).

[a] Racialized categories across the three countries differ. In this Table, we use the racial categories and conventions common to each local context.

minority. In addition, the pandemic exacerbated existing socioeconomic disparities, increasing the negative impacts of COVID-19 on people's lives and health. As noted in a recent UK report, people were differentially exposed to COVID-19 based on where they lived, the type of accommodation they lived in, their household size, the types of jobs they did, and the means of transport they used to get to work, mirroring longstanding economic and health inequities created by racial discrimination (Nazroo & Becares, 2021). In Brazil, most people who lost their employment or left work during the pandemic were Black (Brasil, 2020) and though the first COVID cases were in more affluent areas of large cities, among people returning from international trips, COVID-19 rapidly spread and took root in socioeconomically disadvantaged communities (Sthel & Silva, 2021). The number of people living in poverty increased in the US during the pandemic, with more disadvantaged areas having higher levels of COVID-19 infections in the early phase of the pandemic (Finch & Finch, 2020). It is in this charged racial context with pervasive socioeconomic inequities that we compare and interpret how people in the US, UK, and Brazil invoke and make sense of social categories in their COVID-19 narratives.

1.2. Systemic racism and intersectionality

Lélia Gonzalez's work is highly relevant to our analysis in exposing intersections of social categories that marginalize and systematically disadvantage certain people. Some of Gonzalez's most well-known scholarship characterizes the multiple oppressions of Afro-Brazilian women (Santos de Araújo, 2016), aligning with many expositions on intersectionality theory (Collins, 2015; Crenshaw, 1989; McCall, 2005; Walby et al., 2012) and empirical examinations of structural inequities associated with certain intersections of social categories (Bowleg, 2012; Stelzer & Kyrillos, 2021). We follow in this intersectional tradition in our critical race theory-informed study of three nations with white supremacist foundations.

In all three societies, there are competing frames to conceptualize and explain intersectional differences. Some capture a more benign representation of contemporary racism, and others a more disturbing,

insidious version penetrating domains of daily life, policy, and government. We draw on multiple theoretical threads of critical race theory and intersectionality to explore how participants make sense of and balance these frames in their own understanding and articulation of difference in the COVID pandemic.

As Freeman et al. demonstrate in their work, complementary frameworks of critical race theory and intersectionality enable examination of systemic inequities and combinations of socially disadvantaged positions (2017). Specifically, by conceptualizing power as a complex social process, we attend to interactions of the multiple sources of oppression (Choo & Ferree, 2010) that undergird health inequities (Hanvisky & Christoffersen, 2008). We focus on the process of categorization, as described by Christensen and Jensen, rather than the categories themselves, in order to compare nations with different social categories (2012). We use inter-categorical approach of re-examining existing categories (McCall, 2005) to explore how people in the US, UK, and Brazil do, or do not, invoke these social categories.

2. Methods

2.1. Approach

We used a rigorous qualitative approach to systematically elicit and analyze heterogeneous perspectives within interviews (Ziebland et al., 2020). We focus largely on lesser heard voices, "centering in the margins" (Schulz & Mullings, 2006).

Critical race theory and intersectionality inform our comparative analysis among nations. We examine and compare invocations of race and intersecting categories as social constructions that order society (Ford & Airhihenbuwa, 2010). We focus on both what is and is not voiced in narratives about COVID-19 experiences, including how people invoke social categories. Maintaining a reflexive practice in all stages of the study, we attend to how research recruitment and interviewing create and define socially constructed categories in each country (Gunaratnam, 2003). We take an inter-categorical approach to intersectionality as method, using existing analytic categories to enable consideration of how "different contexts reveal different configurations of inequality" (McCall, 2005, p. 1791).

All countries in this analysis are part of an international network using the same rigorous qualitative approach to systematically elicit and analyze heterogeneous health and healthcare experiences (Ziebland et al., 2020). Teams in the US, UK, and Brazil each undertook their own studies using this method with the shared aim of broadly understanding peoples' lived experiences of COVID-19. In these initial studies, we did not set out with the intention of exploring experiences of inequities in peoples' narratives; this focus emerged in post-hoc exploratory analyses and discussions.

Each country approached intersectional categories and the complex and often implicit nature of inequity slightly differently in recruiting participants for these country-based studies. The UK team designed a study explicitly focusing on inequities, with recruitment materials and pre-interview conversations noting special interest in learning about diverse experiences across race and ethnicity. In the US, the research team conducted a study aiming for maximum variation, with good representation of lesser heard voices, and in most interviews incorporated specific probes about diversity, equity, and inclusion. The Brazilian team used no specific recruitment frame nor probes, but focused on inequities in analysis. For the cross-national analysis presented here, we combine each study's datasets to create a data corpus which includes both spontaneously volunteered descriptions and responses to specific cues. Because of the complex nature of these cues, however, the notion of spontaneously volunteered narrative is not straightforward, and following Gunaratnam (2003), we contend that race is relationally produced, and thus an implicit part of every conversation.

2.2. Positionality

We reflected individually and as a cross-country team about our positionality as researchers including our "insider-outsider" perspectives and how we prepared to engage with participants (Fenge et al., 2019; Manohar et al., 2019; Olukotun et al., 2021). The US team has two white cisgender women interviewers. The UK team is comprised of three main interviewers: two white cisgender women and an Indian cisgender woman. The Brazil team has five interviewers: four white cisgender women and one white cisgender man. All were based in universities.

We noted that interviewer racial concordance created different spaces for discussions of racial differences. In the UK, some minority participants speaking with white interviewers would hedge or soften their discussions of racism, whereas when speaking with [blinded] who is Indian, a shared understanding of lived experience of being racially categorized seemed assumed by participants. In analysis, we reflected on these differences where they shaped the narratives that emerged.

2.3. Sampling

All countries strove for maximum variation sampling (Coyne, 1997) to generate diverse perspectives reflecting a broad range of life and COVID-19 experiences with heterogeneity in geographical location, occupational social class, race and ethnicity, severity of illness, gender, and age group. The UK team interviewed 70 participants drawn from across the UK and focused on recruiting people of color, who are the majority of the sample. Intending to adopt a maximum variation sampling approach while actively foregrounding the experiences of the groups of people who had been hardest hit by COVID-19, the UK team explored diversity of COVID-19 infection – from mild, even asymptomatic infection, through to those who were admitted to Intensive Care – as well as diversity in social positioning, by virtue of race/ethnicity, social class and geographic location within the UK, gender, and age. Recruitment was carried out remotely, through a variety of routes including social media, community groups, and snowballing to incorporate a wide variety of experiences and perspectives. Participants in the UK received a shopping voucher.

The US team interviewed 23 people across the country for two pilot studies about peoples' experiences of COVID and peoples' experiences of long COVID, a wide range of ongoing health issues lasting weeks or months after initial infection with Sars-CoV-2 (CDC, 2022a, 2022b). In the US participants were recruited remotely via flyers, announcements in community groups, snowballing, and a partnership with a research and education practice-based research network. Participants received a gift card.

The Brazilian team interviewed a total of 73 people from five Brazilian cities. This included people affected by COVID, relatives of people with experience of COVID, and front-line primary and tertiary health professionals. Recruitment was carried out remotely, through a variety of routes including a primary and tertiary healthcare database, community groups, and snowballing. There were no incentives for participation in Brazil.

The sample combined across three national contexts is presented in Table 2.

Table 2
Participant Characteristics.

Race/ethnicity	Gender	Age
Identify as person of color (85)	Female (120)	20-29 (19)
Identify as white (81)	Male (46)	30-39 (49)
		40-49 (38)
		50-59 (42)
		60-69 (16)
		70-79 (2)

2.4. Data collection

Each country achieved relevant research ethics approvals before data collection. Interviews, conducted between July 2020 and November 2022, lasted between 60 and 150 min. Nearly all interviews took place virtually and were audio and/or video recorded according to participant preference. All countries shared an approach to interviewing that begins with an open-ended question inviting a participant to share their personal narrative, followed by semi-structured probing questions, iteratively developed and adapted throughout data collection. Prompts included how COVID had affected participants' health and wider aspects of their lives, communities, finances, work, education, and family. The interview guide in the UK included specific prompts about race. In the US, interviewers asked participants about their identities broadly, sometimes probing with specific examples including race, class, gender, occupation, and location (See Lewis Fernandez et al., 2016). In Brazil, interviewers did not ask direct questions about race or identities, but when the narratives referred to these issues, the interviewers encouraged description of those experiences. In our analysis, we considered instances of voicing of race in response to direct prompts and those volunteered organically.

2.5. Data analysis

Audio recordings of interviews were transcribed verbatim in each country. After importing into specialist computer software for organizing textual data, each country team completed their own within-country analyses in the original language of the interview, using inductive and deductive coding. The coding structure was partially based on anticipated themes from the topic guide, such as peoples' exposures to Sars-CoV-2, experiences with diagnoses, and healthcare access. The coding structure was also based on emergent themes identified in early analysis discussions, including codes related to diversity, equity, and inclusion (Pope et al., 2000). The US and Brazilian teams used content analysis for the initial coding approach (Hsieh & Shannon, 2005), while the UK team used thematic analysis and Nvivo software for data management (Braun & Clarke, 2006). The US team used MAXQDA. Each country additionally employed the one sheet of paper (OSOP) mind-mapping approach to organize and make sense of data within each country (Pope et al., 2000). Each team, including all authors, participated in coding and mind-mapping their data before coming together to discuss as a cross-national group.

> When racism was not explicitly mentioned in the interviewees' narratives, we sought discursive clues of social categories (gender, social class, race/color, participation in the community, place of residence, and so on.) that expose people to marginalization and disadvantage. Therefore, the unsaid guided the movement of approximation of narratives with similar meanings to constitute convergent codes within the theoretical frameworks of intersectionality and critical race theory.

We held six 60–120-min dialogic engagement sessions virtually with all authors present and contributing, and assigned ourselves analytic or manuscript-development work between each session (Chapple & Ziebland, 2018). After initial sessions to discuss our national datasets, each country team developed a few in-depth case examples from their data, weaving lengthy verbatims, analytic insights, connections to social theory, and reflections on positionality into illustrative cases. This step in our analytic process enabled the Brazilian team to selectively translate relevant data into English.

Additional author meetings were held to integrate these cases by identifying our cross-cutting themes. During this phase, each country also drew on more data, with additional translation where applicable, to enhance credible representation of cases that surfaced in interviews and add additional case exemplars. We subsequently refined the line of argument by modifying drafts among the writing team.

3. Findings

We now consider the narratives of people with lived experience of COVID-19 infection selected for illustrative potential by each country team. These cases (n = 19), given pseudonyms, illustrate moments when the interview is a space for voicing social categories and systemic underpinnings of difference.

3.1. Voicing

Voicing describes how people invoke and make sense of their own and others' social categories to note differences in experiences. This includes the framing of categories in intersectional ways and the acknowledgment of underlying systemic inequities and oppressive social systems.

In the US, the majority of participants voiced social categories in direct terms. Invocations of whiteness were particularly illustrative in the US data because of peoples' awareness of white privilege, which is critical in examining systemic racism's negative effects on health of people of all racial groups (Feagin & Bennefield, 2014). Recalling that all interviewers, and the majority of US interview participants, are white, there is clear invocation of whiteness as a social category. This category intersects with other categories associated with privilege, such as class and *cis*-gender, even for people for whom the directness in voicing privilege seems new and still somewhat uncomfortable. The laughter of Gwen, a white cisgender woman in her 60's living in a rural area, for example, conveys some self-consciousness – "I think I was very fortunate to be white, middle-class, insured person when I got COVID [laughing]" – but also a (perhaps new-found) fluency articulating intersectional social categories. Cases from the US suggest some familiarity with voicing white privilege and invoking intersectional categories. People of color's narratives in the US similarly include intersectional social categories, in even more direct discussion of systemic advantage and disadvantage, especially with respect to health and social systems (see Francesca and Miguel's narratives below). Despite differential personal connectivity to structural racism, cases in the US overall demonstrate a certain directness in voicing race.

In the UK, people similarly reflect on their racialized privilege, and there are suggestions that some white people are acquiring fluency with recognizing white privilege. Lucy expresses a similar self-consciousness as Gwen above: "it [COVID-19] wasn't really worrying for us. [er] We, we knew that we were, you know, in the fortunate white background where our kids were probably gonna be fine with it so [um] yeah it wasn't, it wasn't really a concern if the children caught it." Other participants further stumbled with verbalizing and making attributions to their and others' social categories. Particularly when speaking with white British interviewers, people of all racial backgrounds often seemed to maintain a cultural standard of politeness, invoking racialized identities more indirectly (Eddo-Lodge, 2018). Eric, a Black African, cisgender male, gay, refugee participant in the UK, described there being a more nuanced and emphatic public discourse about race (including invocations of critical race theory in popular media) in the US: "In America you know, you learn more about Black movements, civil right movement and things like that. But in the UK, you know, we don't know about Black movements." Eric attributes more explicit racial discourse in the US to a social movement more present in public discourse in a context.

In Brazil's color-based racial system, the racial identifications people voice – people with the same skin tone might identify as "white" or "Black" – seem complexly embedded in historical challenges associated with the privilege and power associated with whiteness. People who self-identified as Black or Brown seemed more likely to then voice inequities, with participants involved in Black health advocacy showing particularly high racial consciousness, whereas people who did not self-identify their races might attribute racial differences to other social determinants such

as social class. One young Black woman describes her sibling's experience:

> What made that doctor look at [my brother] and tell him he didn't need to be tested? We were in the middle of a pandemic …// When you look at statistics and epidemiological bulletins, there is no coincidence. You know who died the most, who was mostly neglected. You know for whom was denied health care... People from the Black population already have very precarious access to health compared to others. In the pandemic, this only worsens because generally, because of structural racism, people will understand that those lives are worthless.

Expressions of intersectional privilege are evident in the Brazilian sample, as in the US and UK, but not always associated with whiteness. Clara, a young Brown woman married and without children, was admitted to a private hospital: “I have the privilege of being able to have the health insurance, of being able to pay for my consultation out of pocket. I have the privilege of being able to pay for medication.” Clara recognizes the social capital inherent in having health insurance and the ways this enables her to navigate the system more easily. Generational differences are also more apparent in the Brazilian sample than in the US and UK, with younger people more versed in using racialized language in their narrative organization of their experiences. Among all the Brazilian cases, sometimes even if people express observations of difference that suggest recognition of injustice, attributions to racism are not always voiced, with explanations instead focused on class inequalities. As Lelia Gonzalez notes, “it is because of the articulation between the myth of racial democracy and the ideology of white superiority that one must understand the veiled character of Brazilian racism” (translated from Gonzalez, 1979). Even so, the findings suggest Brazilian voicing of racism is increasing, especially among younger generations.

3.2. *Who is affected by COVID*

Interviewees in the US, UK, and Brazil noticed differences in COVID-19 prevalence and to varying degrees invoked social categories to make sense of those differences. Cross-national differences in how, and to whom difference can be voiced are further examined in this section.

3.2.1. *Difference consciousness*

Peoples' awareness of difference often came from perceiving how social categories are invoked in public spaces, including in government public health messaging, media representations, and their own social networks. Denise in the UK describes how Black race and COVID-19 were represented in public media and the influence of this platform on race relations:

> The adverts on the TV always showed Black people. It was a Black nurse who was spreading COVID and hadn’t washed his hands or something. And then were young black males on bicycles walking down the street who was going to give COVID to their grandmother who was dying … people would abuse us and say things like, you know, that it’s these Blacks who are spreading the COVID, you know. And you could see where they got that idea from… because they are deliberately putting it out there that we are the ones who are spreading this thing.

In this reflection, Denise, who is a Black African-Caribbean woman in her 60s, connects racialized representations in pandemic messaging to direct acts of abuse, the responsibility for which she attributes to a disembodied powerful ‘they’ – the people who designed COVID public health messaging. Denise's comments illustrate how structural racism – a root cause of disproportional representation of Black and Brown people in public-facing, 'essential worker' jobs such as transport workers, carers, nurses, etc. (Public Health England, 2020) – drives blame of some groups for having and spreading COVID more than those who could work from home. Denise links the public messaging to her experiences of racism with some directness, displaying confidence voicing that may be result of being an older woman with a history of experiencing racism in the UK.

Aspects of Denise's experiences with pandemic messaging in the UK align with narratives from Brazil. In Brazil, there was minimal speculation about the origins of racialized differences in COVID. Valentine, a Black woman, expresses perplexity rather than fear or anger about numbers of Black deaths on public epidemiological bulletins: “Wow, it doesn't add up; if there's more white with [COVID] than Black, why are more Black dying than white?”. As with Denise, Valentine raises questions about the presentation of information and discourses, assuming a critical perspective that identifies structural racism. Denise's and Valentine's positions are notably different from most interviewees in the UK and Brazil, who appear to have some hesitancy characterizing discussions of difference.

In the US, public reporting of COVID-19 inequities is largely absent from peoples' narratives, despite the ubiquity of media reports of racial and ethnic differences in COVID-19 mortality (see Table 1). Instead, peoples' perceptions of who was infected by COVID are drawn from observations of their own social circles. Marianna, a Hispanic woman in her late 20s who had COVID in May 2020, remembers being in a virtual work meeting with her white coworkers during this time: “the illness portion was really happening to other people … no judgment to my coworkers, but it just didn't occur to them that somebody on the team might have COVID.” Though more interpersonal, these acknowledgments of difference represent a similar othering of some as susceptible, and others as safe.

3.2.2. *Accounting for difference*

Regardless of how people became aware of racial differences in COVID-19 infections, in all three countries people invoked racial categories in making sense of these differences. For some people explaining difference to white interviewers in the US and UK, biological essentialism of race features prominently. Rajiv, a British Indian man in his late forties in the UK reasons that genetics must explain disparities in COVID infections: “Obviously the gene sequences are different, you know, like in ethnic minority whether it's because Black or it's different in a white man and a white woman as well…more prone to this like I think minority people are.” Joan, a white woman in her 50's living in a rural area of the US, describes her Black in-law's vulnerabilities in similarly biological terms: “Black people typically have…They have the sickle cell anemia.” In these attributions of racial differences to biology, explanations related to systemic oppressions perpetuated by structures of power are absent.

Anusha's narrative in the UK rejects these theories of biological underpinnings of risk, explaining difference in terms of circumstances. A British Indian female, Anusha notes differences in exposure due to social circumstances, reflecting on why people working in public-facing occupations, the majority of whom are racial minorities, were more affected by COVID in the UK:

> It sort of makes you think, is there something genetically wrong with me? Am I catching this, am I more vulnerable to this, because my gene makeup is different? And no it isn’t, it’s because of your circumstances. You know, we’re all the same genetically, it’s just what you have to do. Unless I can catch it, because I don’t go anywhere, from the person who’s stacking shelves.

Anusha describes a progressive reflection on differential impacts of the pandemic, starting with genetic causes and then quickly rejecting these and drawing on exposure. She identifies a structural aspect to this differential impact, but does not proceed further to voice the underlying reasons for structural disadvantage.

An example from the US illustrates a more explicit accounting for difference with structural factors than Anusha's narrative. Francesca is a Hispanic woman living in a low-income urban area and working in health research. Working remotely during the pandemic, she says she “never

had the thought that I'm special or [COVID is] not something that is going to affect me." Living at the margins of privilege and systemic inequities, Francesca reflects on the structural determinants of risk that distinguish her from work colleagues, who ordered in groceries and left the city for their vacation homes. She describes differences between her home and health research professional communities:

> I live in a low-income to middle neighborhood. [Um] And we are—like this neighborhood is, like, the essential workers. [Um] And so I think that that contributes to it as well. Like I'm, and I always hate like separating things by like race and ethnicity but, for the lab that I work with, I'm pretty much the only minority. And of the entire group, I'm the only person who got COVID.

Francesca invokes intersectional categories of class and race/ethnicity in alluding to structures such as segregated neighborhoods that created the circumstances for greater COVID exposure.

Similar intersectional identities are also evident in narratives from Brazil. Elisa, a Black woman in her 30s, working as a Family Nurse Practitioner in a municipality near Rio de Janeiro, explains why intersectional identities are critical to fairly prioritizing the vaccine rollout:

> Let's start with the older people. The Black elderly population doesn't age like the rest: 95, 96 years old, no! Our life expectancy is much lower, so naturally, this has already selected the white folk to go ahead. Health professionals, the same thing, especially those with higher education, most are white. For a long time it was debated: what is the health professional, what is the health worker. Because for many people, it made sense to vaccinate the physician and the nurse, but the cleaning staff did not get it! Well, who is cleaning up the COVID sector of the health services? Who's carrying the dead body bag?

Elisa offers an indictment of the deadly intersectional inequities she observes in occupational exposure to COVID-19. Elisa's perspective on how this system has "naturally" "already selected" white people to be prioritized over Black people acknowledges systemic roots of inequities in COVID experiences. Both Francesca in the US and Elisa in Brazil recognize that the intersectional social identities that disadvantaged them were not random, but by design, shaped by structures and institutions of power.

After grappling to account for difference in COVID-19, people responded to health situations in different ways. In the US, Miguel, a Hispanic man in his 40's, remembers striving to protect his family members when he had COVID:

> I started having [um] family members, both in the US, and Mexico a minimum of two family members or close friends [um] that were dying from COVID per month…My mom wanted to drive out. My mom is 82, she wanted to drive out when I had confirmed with the pneumonia…I'm like, "No. There's no way on the face of the Earth you are coming to get me."

In contrast, in Brazil, people describe responses to the high prevalence of COVID in certain communities most often in terms of banding together. Zezé, a Black cisgender woman in her early 60s, works in the Brazilian Unified Health System as a community health agent in primary health care on the west side of Rio de Janeiro. She describes the solidarity of her network of involved community members and family members coming together to provide assistance financially by covering medication costs and finding employment for Zezé's husband:

> I didn't lack things. It was my sister's help with medication; most COVID-19 survivors take manipulated medication and supplements, physical therapy, which I would never do, a good angel took over the costs...my brother-in-law called my husband to work with him in the (southeast) state of Espirito Santo...(To make money), he spent a month working there with a heavy heart of concern for me."

Zezé's narrative illustrates lacking voiced awareness of the intersectionality of her race/ethnicity and social class as a Black woman living without her salary and social protection during the pandemic. Community members and family members created a protective network, even with her family living far away. Sophia, a 38-year-old Brown woman who was unemployed during the pandemic and lived with her two daughters, also describes multiple sources of support:

> I had three friends who helped me, one would buy me things at the market, another would bring me food, and another would go there to clean the house, right? I even told her this: "girl, you don't need to clean… And then she cleaned, played with my daughters, you know, put clothes to wash, this in the first five days I couldn't do things… There in Porto Alegre, there is not so much. But here in Colombo, there is, you know, love for others, help, you know?

In Brazil, there is historical lack of public provision for the poorest people, who count much more on their informal social network – close families, friends, neighbors, and community organizations – for assistance in multiple areas of life. These strategies adopted during the pandemic as solidarity enabled a sense of empowerment and belonging in the absence of adequate government response to COVID.

Cross-national comparison of narratives about peoples' susceptibility to COVID and risk of infection reveals how people become aware of and account for difference. While a few offer biological explanations and speculations, many people invoke intersectional social categories and strengthened commitment to solidarity to make sense of differences in COVID-19 prevalence across social categories.

3.3. Accessing care for COVID

People described the importance of social categories in relation to their reading of healthcare as well as in their personal experiences, including noting how providers and systems of care receive certain categories and intersections. Social categories that other people placed upon them were more challenging for people to account for, though still articulated, especially in the US cases.

3.3.1. Racism anticipated in healthcare

People of color in all three nations expressed fear of not being well cared for given racism in healthcare and specific rumors they heard about COVID. People in the US describe being always on the alert for racism in their healthcare experiences. Antonne, a Black man in his 50's hospitalized for COVID-19 in a suburban area of the US, questions whether a "weird vibe" he got from a doctor might be "a racial thing." Lacresha, a Black woman in her 40's who had COVID-19 while visiting family in the Southeastern US, affirms "racism do play a part in your healthcare. I really believe that." Rumors about COVID-specific care experiences were present in the UK made people hesitant to seek care. Faith, a Black female nurse in the UK shared, "You know, if you're old and especially you're from a Black and ethnic minority community, they don't really care. They just leave you at one side." Similarly, Valentine, whose mother died of COVID in a public military hospital in Brazil, was explicit in calling out systemic racism as a cause of mortality. Describing how her whole family had COVID, she declares:

> Structural racism is embedded in society. So you're going to have the displeasure of encountering racism somewhere, sometime. And depending on the context you run into, lousy luck is devastating because it will result in death. In health, then, it's a lot of death.

3.3.2. Racism personally encountered

Though people articulated unequivocally the anticipated ways racism challenges healthcare outcomes, the impacts of racial categories on personal healthcare experiences were less explicitly voiced.

In Brazil, even those with health insurance, who may have previously

been guaranteed a single room to stay in at the hospital, no longer had this privilege. Claudia, a white woman, reflects on her stay in the hospital: “Wow, everything is missing, and we are in a private hospital, in a state-of-the-art hospital and it's missing.” The realities of the pandemic disrupt Claudia's assumed privilege.

In the US, people's ability to have choice in how and where to seek care opened possibilities for greater personal reflection on the ways social categories directed those choices. Miguel expresses explicit awareness of his intersectional identities as an educated professional Hispanic gay man. He invokes others' perceptions and use of social categories in describing why he experienced poor care when trying to get tested for COVID – “You're ignoring me because I'm in a hoodie and sweatpants. You're ignoring me because I'm Hispanic. You're ignoring me because what have you.” When Miguel tested positive and then became more gravely ill, he decided to drive 2.5 h to be admitted for double lung pneumonia in another state where he felt his intersectional identities would not be a threat to his health:

> Culturally, ethnically, I needed to know that I was going to get the quality of care that just being there… [LOCATION] [um] is a predominantly white, Anglo [um] demographic with a certain [um] racial stigmas, racial [um] stereotypes, things like that. [Um] I think in addition to that, I think one of the other things for me was being a gay male…And so, I didn't feel comfortable checking myself into a hospital where, not only was I sick, but I was going to be battling with somebody over whether I speak English…100%, that there was no reservation, that it sort of felt like my health was 100% dependent upon being in a diverse area, or diverse providers [um] where I wasn't a 1 in 100 type of statistic.

Case examples in the UK similarly demonstrate acknowledgment of racism's effects on health outcomes, through more indirect voicing of systemic inequities. Eric, a young gay man and refugee working as a healthcare professional, struggled to get medical services to take his father to the hospital when he was seriously ill with COVID. Reflecting on his father's subsequent death, he believes if his father had been treated earlier it may have saved his life. Eric draws on his intersectional identities as he speculates on the roots of differential access to services. He is explicit about not being taken as seriously as white counterparts even when they are equal in all other respects, but hedges that is it not ‘discrimination as such’: “because it's a Caucasian country, people may have more affiliation with that, with a, with Caucasian people.” He notices that, while in some ways the support provided by the state is better in the UK than in his country of origin, after a while it becomes clear that as a refugee “I'm not getting as much as I should”.

Across all three national contexts, the effects of racism on personal healthcare experiences were less explicitly voiced, though still present in peoples’ reflections on their own care and the care of family members. People invoked intersectional identities of class and race/ethnicity as they verbally explored potential root causes of differential treatment.

4. Concluding discussion

Our cross-national comparison, informed by critical race theory and intersectionality, reveals similarities and differences in voicing inequities, suggesting what people can express about identities in their COVID-19 narratives. Across all countries, people invoked social categories in describing and making sense of difference, often drawing on intersections of multiple identities. People of color in the US, UK, and Brazil had some fluency describing racism in healthcare, particularly in less directly termed manifestations of “discrimination” and “stigma.” Open dialogue about systemic ways race has historically and cotemporally ordered society to put marginalized groups at greater risk was present, but more rare and often less explicit.

We observed differences across nations with respect to how people narratively made sense of difference in their accounts of COVID-19 experiences. In Brazil, while some people (especially younger ones), demonstrated high racial consciousness, others struggled to identify and talk about racial relationships, particularly in the face of strong historical promotion of racial democracy. In the UK, people voiced racial identifications more clearly, though often within white norms of politeness, shaped by interviewer dyads, and with accompanying discomfort. People in the US had the most fluency with voicing race directly.

Mindful of our positionality as researchers, the findings suggest opportunities and limitations in each national context regarding what might be voiced in health experience interviews about COVID-19. In listening inductively to our data, we were attuned to the coded nature of inequity in narratives (Gunaratnam, 2003). We understanding voicing to be a relational act between interviewer and interviewee. At the same time, deep discussions of each nation's political contexts enabled us to learn about distinct racialization histories in each country. We speculate that each country's racial histories mediate, to some extent, when, how, and in what ways people speak about social categories or remain silent. Here, we elaborate upon a few of those contextual differences in national racial discourse.

In the US, public scholarship and media has increasingly exposed the country's legacy of systemic racism (Hannah-Jones, 2021) and its contemporary manifestations in mass incarcerations and police killings of Black cisgender and transgender men and women. During the pandemic, headlines such as “America's Racial Reckoning” (2022) reflected growing societal and interpersonal discussions about inequity and privilege. Perhaps not inconsequentially, narratives from the US had more explicit examples of voicing and linkages of social categories to both privilege and disadvantage.

Media representations in the UK have tended to diminish the lasting legacy of British colonialism and involvement with slavery with respect to long-term consequences in the global economic and political order. A recent government inquiry into racism claimed that structural racism no longer exists in the UK (Sewell, 2021). This was met with fierce criticism, citing the differential impact of the pandemic precisely as evidence of ongoing racialized inequities (Runnymede, 2021). UK discourses over the epidemiology of the COVID-19 pandemic with regard to race, initially started with biomedical speculations about how non-white people had risk factors including diets lacking in Vitamin D, type two diabetes, and obesity (PHE, 2020). Simplistic cultural explanations such as multigenerational living were also common justifications for racial disparities in COVID-19 epidemiology (as critiqued by Bear et al., 2020). The dominance of biological and cultural explanations has been periodically punctured by public discussion of how the pandemic had revealed and exaggerated existing racial injustice. Though their language was sometimes less direct than in the US cases, interviewees from the UK invoke social categories in ways that seem to acknowledge systemic factors that marginalize certain groups of people.

Historically in Brazil, people of color have been absent from media representations, or depicted in racist terms. During the pandemic, however, there was no lack of explicit media examples of racial violence in Brazil: massacres, murders by beatings of Black citizens, dispossession of housing, negligence, mistreatment, and transphobic crimes, especially of Black lives. The necro politics of the Brazilian State identified in the actions and omissions of the federal government are inserted in a broader history of eugenicist projects in a country committed to the whitening of the population (Dall’Alba et al., 2021). The Brazilian parliament carried out an investigation that recommended the indictment of federal authorities, government aides, and companies for numerous crimes committed during the pandemic, including crimes against humanity (Ventura et al., 2021). Even so, there was no social mobilization in Brazil against such a situation, like those seen in the US, and, albeit to perhaps a lesser degree, in the UK. Differences in racial literacy between younger and older people in the Brazilian cases perhaps reflect some of the changes in societal discourse around racism in Brazil. Cases in Brazil also clearly expressed intersectionality in their narratives (Hicken et al., 2018; Hogan et al., 2018). As Lélia Gonzalez helps conceptualize, the

associations between multiple identities create certain vulnerabilities and privileges reflected in the illness experiences of cases from Brazil.

Intersections of COVID-19 with reckonings with racism present an inflection point in the research canon. Consciousness around the intersection of racism and the COVID-19 pandemic has been raised in all three of the countries included in this analysis. At the same time, this inflection point has manifested more concretely in some countries than in others. In the US, there has been definitive shift in funding calls with federal and local agencies centering an equity focus (Collins, 2021). In the UK, the focus on equity has manifested as a call for more participant involvement in research, and for more research on issues that matter to racial minorities (Treweek et al., 2020). In Brazil, BLM resonated within the larger Black movement, but did not take hold with much force in the Brazilian society. The manifestations were clearly confined to small circle of engaged people. At the same time, there was some great academic production on the intensification of social and racial disparities caused by the pandemic (as example, see Silva, 2021). However, the mobilization around integration of equity into research was not widespread in Brazil, perhaps due to power of the myth of racial democracy to shape the way social inequalities are voiced in the country.

We did not conduct these interviews with the intention of searching for or probing on cross-national inequities in peoples' narratives. Rather, these aspects of people's COVID-19 narratives emerged in our cross-national discussions, as we identified cases of voicing racism and privilege in our three national contexts. Our findings are thus not a definitive or comprehensive treatment of race during the dual pandemics nor an extension of critical race or intersectionality theory, but rather a seed to cultivate in the continual endeavor of addressing societal inequity. Our cross-national analytic process and participants' experiences demonstrate both the complexities of social categories and their utility for examining how people understand their experiences in terms of structural factors when drawing on intersectional categories. As Gunaratnam captures in an exposition on voicing racial identifications (Gunaratnam, 2003, p. 3):

> If we are to take seriously, and also interrogate, ideas about ‘race’ and ethnicity as socially produced, relational and given particular situated meanings through individual experience, then narratives of identity are of critical importance. Such accounts are important as sites where we can explore analytically the relations between social and subjective processes of ‘race’ making and where we can examine the relations between theory and lived experiences of ‘race’ and ethnicity.

Our experiences conducting this analysis suggest generating strong rapport with participants can create safe and open spaces where exploring topics related to inequities directly becomes more possible.

Our suggestive findings raise rich questions for sustained exploration in future narrative research, including work focused on theory development. The cross-country similarities and differences we explore in this analysis begin to signal what questions we might ask about racism, privilege, and inequities based on what we have learned so far about voice – and lack of voice – in each context.

One key area for further exploration is positionality (Kohl & McCutcheon, 2015) and the co-production of race consciousness (Gunaratnam, 2003). Though some reflections on these issues certainly underlie the empirical findings we present in this article, they warrant full elaboration on what might invite or impede discussion of inequities in lived experience narratives, including reflection on gender and sexuality. Most members of research teams and participants in this study identified as female, a potentially significant observation given the gendering of issues of racism (Sidanius et al., 2018). For example, the stigma-by-prejudice-transfer effect (Sanchez et al., 2017) suggests that white women feel threatened by racism towards other historically stigmatized group members such as Black people. A gendered lens may also hold explanatory power in accounting for inequities in COVID-19 exposures, given gender differences in who holds essential worker jobs in healthcare (Wenham, 2021). In addition, the illustrative cases we selected in this analysis who were male also identified as gay. Pedulla argues that rather than gay men of color experiencing compounding marginalization, being gay results in less discrimination (Pedulla, 2014). Black and Hispanic men who are gay may be “whitened” to seem less stereotypic of their racial groups and more affluent (Petsko, & Bodenhausen, 2019). As noted in our analysis, peoples' experiences and fluency with voicing must be interpreted within the contexts of their broader intersectional identities including class, gender, and sexuality. For example, in the cases of the men described above, Miguel's identity as a professional working in healthcare afforded him certain knowledge and abilities to access care, whereas Erik had no options. Further exploration of participants' intersectional identities and the influences of researchers' intersectional identities on the data collection and analytic processes will be more fully undertaken in a subsequent article.

We hope the findings presented here may encourage the global qualitative research community to structure research studies with an inequities frame, inviting open discussion of intersectional identities in both unstructured and structured parts of interviews and similarly influencing other data collection techniques. Future work can take up how, when, and by whom to raise issues related to systemic racism directly in qualitative data collection, including the development of probing questions to further explore voicing of structural determinants (on this, see Rai et al., 2022). Qualitative studies have begun to examine experiences of minority groups during the pandemic, including exacerbated racism, risk of infection, and poor-quality healthcare experiences (Cervantes et al., 2021; Karlsen & Nelson, 2021). Understanding how and when people express social categories in experiential narratives enhances our ability to draw attention to difference in ways that mitigate stigmatization and promote naming inequity.

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Declaration of competing interest

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