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The shameful dead: Vaccine hesitancy, shame and necropolitics during COVID-19

Fred Cooper, Luna Dolezal and Arthur Rose

On 24 August 2021, the online media platform New Frame published a satirical cartoon by the South African illustrator Carlos Amato. The cartoon depicts several rows of gravestones, each etched with a trope from vaccine-hesitant discourses: 'My body my choice', 'I trust my own immune system', 'Who stands to gain?', 'They developed it too fast', 'Free thinker', 'Did my own research' (Amato, 2021). Whether through circulation of Amato's cartoon or a like-minded perspective on the situation, photographs of home-made Halloween decorations with identical imagery were widely shared on social media later that year (Kronbauer, 2021). This trope – in which the poor judgement of the unvaccinated coronavirus (COVID-19) dead stands as their epitaph – crystallised a nexus of social and political shaming around vaccine hesitancy or refusal in countries with mass vaccination programmes. Frequently, shame has been directed at individuals posthumously; for example, in the online sharing of obituaries for notable or vocal anti-vaxxers (Levin, 2021). While some of the most visible instances of 'death shaming' have been decried, they nonetheless remain as extreme iterations – and a logical product – of a more pervasive culture of shame over vaccination, or lack of it. Rather than paying close attention to the contexts (including a trusting and shame-less engagement with public health messaging and communication) which enable different publics to make informed decisions about vaccination, the 'unvaccinated' have increasingly taken on the characteristics of a shamed population, culpable for the spread of the virus, for other adverse health outcomes produced by a health system under strain, for the threat of future public health restrictions to everyday life, and for their own suffering and death.

In turn, explicit death-shaming has sedimented down into a broader sense of inevitability around deaths that might otherwise be shocking or difficult to ignore. In his work on race, class and slow death in COVID-19, Tony Sandset uses Achille Mbembe's concept of necropolitics to question 'under what conditions do we accept that some lives will end and others will be saved under a pandemic? What kind of power structures allow certain lives to be conceptualized as acceptable deaths?' (Mbembe, 2019; Sandset, 2021: 1415). The machinery of shame, we argue, has been a vital component of necropolitics in the modern world; COVID-19 provides a case study in how shamed behaviour is used to legitimise (and desensitise publics to) specific instances of death, shifting responsibility from the political to the personal. For Sandset, necropolitics dictates who gets to live and die, but also who gets to be grieved; whose deaths are met with outrage and whose are met with acceptance (Sandset, 2021: 1415–1416). Throughout the coronavirus pandemic, people who are ageing, disabled, chronically ill or belong to ethnic minorities have been frequently figured as expendable (Sparke and Williams, 2022). Through the shame attached to vaccine hesitancy and refusal, unvaccinated people have been similarly constructed as a shamed and expendable group, governing how and whether their deaths are publicly grieved, ridiculed or forgotten, and enabling political decisions (such as the complete de-escalation of protective measures) which expose them to harm. A return to 'business as usual' – with relatively high mortality rates continuing – has rested in part on a high proportion of deaths being thought to occur among people who have 'failed to comply' with vaccination. These are shamed deaths, and so are politically and publicly bearable.

In this chapter, we examine recent discourses on vaccine hesitancy, death and dying through a 'shame lens' (Dolezal and Gibson, 2022). Our 2023 book, *COVID-19 and Shame: Political Emotions and Public Health in the UK*, considers the workings of shame in a series of contexts, narratives and experiences, primarily confined to 2020, the first year of the COVID-19 pandemic (Cooper et al., 2023). The present chapter builds on this work by turning its shame lens on a different but related phenomenon that gathered momentum in 2021 with the advent of mass vaccination programmes in some countries. To begin with, we situate our

argument within longer histories of shame, public health and vaccination. This context depended upon an as-yet-unresolved tension between shame as a public health problem and its use as a public health tool, which raises important questions over communication and emotional leverage. Public health narratives which set out to shame vaccine-hesitant populations play a decisive role in framing and justifying instances of shaming in other contexts and situations.

We then explore the impact of online eruptions of shame around vaccine refusal and 'hesitancy'. We argue that shaming over vaccination status has harmed both its recipients and their likelihood of vaccine uptake, and represents an unnecessary barrier to healthy choices where many such barriers exist already. Lower vaccination rates are correlated to people with long experiences of structural abandonment and shaming, and often a justified mistrust of political and medical systems. Vaccine shame has to be understood as a problem of health inequalities more broadly, with considerable potential to heighten and exacerbate entrenched processes of disparity and discrimination (Scambler, 2020). Conscious decisions over where, how and what to communicate have been key to these processes, with the myth of 'hard to reach' populations deflecting shame from institutions with a responsibility to communicate effectively.

Finally, we focus on the specific confluence of vaccine hesitancy, 'vaxenfreude', the spectacle of taking joy in the illness or loss of vaccine- or COVID-deniers, and shameful death. Future crises, we suggest, will introduce novel (if historically framed and inflected) relationships between shame and death, just like this one. Critical reflection on the COVID-19 pandemic allows us to anticipate some of the contexts and processes which are likely to condition how and where they land, offering a conceptual framework which can be adapted to emergencies which are (at least partially) unforeseeable at the time of writing.

Shame and COVID-19

Shame is a negative self-conscious emotion that results from apprehensions of having been deemed to have transgressed or broken a social rule or norm, or from being judged to be otherwise

flawed or compromised. Shame is always historically embedded and politically inflected, with what is considered 'shameful' deeply contingent on socio-cultural and political norms. The emotion is profoundly significant for understanding subjectivity, identity and social relations, and is inextricably tangled with structures, values and ideologies (Dolezal, 2015; Lewis, 1992; Lynd, 1958; Zahavi, 2014). For Erving Goffman, shame is a ubiquitous experience, and an ever-present possibility in almost all human interactions. While relatively few lives are shaped in their entirety by the active experience of shame, almost all are shaped by shame avoidance, insofar as the possibility for shame is an unspoken boundary that delimits what is 'appropriate', 'acceptable', 'proper' or 'normal'. Shame therefore plays a central role in the maintenance, and sometimes policing, of social norms (Goffman, 1959). It is an inevitable part of human experience and social relations. However, too much shame can be unhealthy, oppressive and potentially toxic (Bradshaw, 2005; Sanderson, 2015). Instead of facilitating personal, moral and social growth, excessive shame can be destructive, leading to a diminished personal and relational existence (DeYoung, 2015; Harris-Perry, 2011; Nathanson, 1992; Pattison, 2000). Importantly, shame does not have to be consciously or explicitly accepted by the subject – in the sense of agreement that an action, belief or identity is shameworthy – to cause considerable harm.

With the potential to become a deeply negative phenomenon, shame can be a powerful political emotion, mobilised to manipulate, coerce and motivate others. Often, those with high levels of social power attempt to incite shame, through deliberate acts of *shaming*, for purposes of control, conformity, punishment or exclusion (Fischer, 2018). Shaming, as Martha Nussbaum notes, is a stigmatising judgement, where an individual or a group judges and condemns another for transgressing or failing to live up to an ideal or norm that is shared by a community, by society or by a cultural or political grouping (Nussbaum, 2004: 184–186). As shame carries with it the threat of losing social bonds and feeling rejected or ostracised from one's social group, shaming is a powerful means to motivate conformity to particular norms, rules, expectations or standards. In addition, shaming is also a means to publicly perform one's values and standards, or those of one's social grouping (Creed et al., 2014: 280). In judicial and formal punitive contexts (such

as legal judgements and law enforcement), shaming is suggested to serve a pro-social function; it is often assumed that shaming will lead to recognition that one has fallen short of the standards of one's community and then subsequently motivate individuals to make positive changes to bring themselves back in line with the community's values, norms and mores.

Keying into cultural, relational and social concerns regarding belonging, embodied connection, reputation and status, intentional uses of shaming can punish, isolate, oppress, disadvantage or marginalise individuals, groups or populations. Over the last 50 years, the individualising logics of neoliberalism have shifted and intensified what we might call systemic shame, or shame which moves beyond the peculiarities of interpersonal situations and relationships. The convergence between public health imperatives and what Stuart Hall and Alan O'Shea term the 'structural consequences' of neoliberalism, 'the individualisation of everyone, the privatisation of public troubles and the requirement to make competitive choices at every turn', heightens the burden of shame on those unable to fit the ideal of the healthy, self-actualising neoliberal subject (Hall and O'Shea, 2013: 12). The (altered) rubrics of public health work continue to demand attention to determinants of health and illness, at the same time as neoliberal logic situates such determinants with individual decisions rather than structural contexts and processes (Spratt, 2021: 2). For Graham Scambler, the 'weaponisation' of stigma under financial capitalism has 'led to a political "skewing" of social norms of shame and blame', holding people with disabilities and chronic ill-health 'progressively more "personally responsible" for their impairments, shifting [them] in the process from "rejects" to "abjects" ' (Scambler, 2018: 777, 780). Imogen Tyler explains how stigma is 'purposefully crafted as a strategy of government, in ways that often deliberately seek to foment and accentuate inequalities and injustices'. 'Ordinary' people, including those from shamed groups, are conscripted into this machinery, helping to spread or perpetuate shame and acting against their own interests in the process (Tyler, 2020: 18).

The coronavirus pandemic created new contexts for shame and shaming, but these largely followed well-travelled – if not wholly predictable – routes, frequently accruing around groups with longer histories of being subject to shame, fear and suspicion, often (but

not always) in respect to the spread of disease. At times encouraged by high-profile politicians, people cast shame at members of groups perceived to be particularly infectious – such as medical professionals and people of Asian backgrounds – and policed the behaviour, actions and intentions of others through public censure and opprobrium, often on social media (Dolezal et al., 2021; Fang and Liu, 2021; Marcus, 2020; Tait, 2020). Frequently, experiences of shaming have been cumulative and intersectional, cutting deepest where people and groups with long experiences of being publicly shamed become tangled in newer dynamics of viral shaming (Mayer and Vanderheiden, 2021: 8). The core component of neoliberal shaming, the sleight of hand by which systemic problems are pinned on individual actors, has been extended and heightened over the course of the pandemic.

In the UK, the government repeatedly set out to deflect shame from both their own poor handling of the immediate crisis, and their long complicity in the raft of endemic problems which COVID-19 brought into sharper focus; including the 'slow death' of stark health inequalities among racialised communities (Sandset, 2021: 1412; see also Berlant, 2007). Unsatisfactory rates of infection and death were blamed on individuals ignoring advice, breaking rules, burdening the UK's National Health Service (NHS) with complications, or not using their 'common sense', frequently demonising groups who were already socially disadvantaged (Cooper, 2021; Dolezal and Spratt, 2023). Public health policy and messaging actively directed shame towards the populations it targeted, drawing on some of the most harmful traditions in its history (Cooper et al., 2023).

Public health and vaccine hesitancy

Public health interventions and communications have significant narrative power, telling stories about causation which can puncture or inflame political and public atmospheres around shaming. Where public health work takes explicit steps to destigmatise health challenges or mitigate against the ill-effects of shame, this can be decisive in reducing shame on a broad cultural level. Conversely, where shame is deliberately or unwittingly produced in pursuit of

public health objectives, this helps to legitimise other – and perhaps more extreme – iterations of shame and shaming. One particularly visible example of the effects of public health messaging in producing shame can be seen in the UK Government's 2020 'better health' campaign, which explicitly positioned people with excess weight as making poor lifestyle choices and burdening the NHS (Dolezal and Spratt, 2023). In this instance, well-worn patterns of body shaming in public health were adapted to the COVID-19 context, even as the pandemic placed heightened constraints on the pursuit and maintenance of a 'healthy' weight.

Shame and shaming have inflected much of the public discourse around vaccine hesitancy. A high-profile Twitter debate between Brené Brown and Naomi Klein in May 2021 on the efficacy of shaming in relation to COVID-19 vaccines highlighted some of the core concerns regarding the use of shaming to motivate individuals to take up vaccines, as opposed to the use of shaming to motivate governments to make vaccines more widely available. Shaming, Brené Brown argues, 'is a tool of oppression – it will never be a tool for social justice (or public health)' (quoted in Golafshani, 2022: n.p.). Indeed, the relationship between vaccine hesitancy and shame must be understood in light of the long history, and ongoing ambivalence, regarding the use of shame and shaming within public health. Public health initiatives often use implicit, and sometimes even explicit, shaming as a means to motivate individual or social change in the service of public health. However, the use of shaming is also a highly contested and much criticised practice. Those who defend the use of shame as a tool for positive change point to the fact that it sometimes works; by appealing to an audience's sense of shame around particular behaviours or practices, it has been possible to effect a shift in habits among some of those targeted (Duong, 2021).

However, there is strong evidence in the global public health literature that campaigns using shame, blame or stigma to motivate individuals are often counter-productive. These shame campaigns can easily compound or exacerbate negative health outcomes and ill health, especially for members of groups that are already vulnerable, marginalised or living with health inequalities. As Robert Walker argues, 'explicit shame is best avoided as its effects are unpredictable' (Walker, 2014: 52). Reliably predicting how shaming

will affect an individual or group is difficult. It seems clear, however, that shaming is more likely to harm communities and individuals that already have long experiences of public and structural shame; for instance, those who live in poverty, live with chronic illness, obesity or mental ill health, or who are minoritised or marginalised in other ways. Shaming also runs the risk of eliciting defensive responses and decreasing receptivity to public health advice, as recipients reject shame and lose trust in institutions and experts (Brewis and Wutich, 2019a). Reviewing evidence from global public health campaigns on hygiene, obesity and mental illness, the medical anthropologists Alexandra Brewis and Amber Wutich concluded that 'shame in all its forms needs to be removed from the public health tool kit, because it too easily misfires' (Brewis and Wutich, 2019b: 188).

This fundamental tension in how public health systems approach shame has been reflected in research on vaccination status. A 2017 article in the *Journal of Law, Medicine & Ethics*, 'Shaming vaccine refusal', set out to 'weigh the potential harms' of 'shaming (also known as denormalizing) vaccine refusal, creating or reinforcing social norms against vaccine refusal by characterizing it as a selfish act based on fears unsupported by facts' (Silverman and Wiley, 2017: 570). Although the authors, Ross Silverman and Lindsay Wiley, acknowledged that shame was a difficult and potentially counter-productive emotion with serious consequences, they concluded that 'refusal of vaccines is not so all-encompassing [as, for example, severe mental illness] and shaming vaccine refusal is not so identity spoiling as to be inescapable'; it offered a form of temporary stigmatisation that could be left behind by those marked out. Indeed, such a transformation – from fleeting shame to social reintegration – was the crux of the mechanism by which a modest application of shame effected behavioural change (Silverman and Wiley, 2017: 577). Shaming public health strategies, Silverman and Wiley noted, 'do not yet cross the line into the harsh social shaming that some private commentators have adopted' (Silverman and Wiley, 2017: 578).

Setting aside the point that shaming public health messages create fertile conditions for more overtly unpalatable scenes of shame, Silverman and Wiley's characterisation of vaccine shame as a shallow or fleeting phenomenon has not been borne out by

subsequent events. As a pandemic with vast political, social and cultural repercussions, COVID-19 allowed for the mobilisation of discourses on national duty which, while not new, have saturated everyday life to an arguably distinctive extent (Kohlt, 2020). In this atmosphere of hyper-visibility, judgement and surveillance over vaccine decisions, hesitancy has been weighted in ways that have the potential for long-lasting changes to identity, feelings of shame and loss of trust in medical and political systems.

The 'line' that Silverman and Wiley drew between public health rhetoric and the shaming methods deployed by private actors has also at times been a confection. In a 2021 article published in *Vaccine*, the journal of the Japanese Society for Vaccinology, an interdisciplinary team of Yale academics explored the effects of what they termed 'persuasive messaging to increase COVID-19 vaccine uptake intentions' (James et al., 2021). Testing a series of narratives on vaccination and vaccine refusal for their efficacy in convincing participants to accept the vaccine, they argued that 'effective public health messages would also increase people's willingness to encourage those close to them to vaccinate and to hold negative judgments of those who do not vaccinate' (James et al., 2021: 7159). Two of the three most effective narratives trialled, or what the authors described as 'the most promising messages', were 'Not Bravery' and 'Community Interest + Embarrassment'. These titles become clearer when their corresponding messages are reproduced:

> Community Interest + Embarrassment: Imagine how embarrassed and ashamed you will be if you choose not to get vaccinated and spread COVID-19 to someone you care about.
>
> Not Bravery: People who refuse to get vaccinated against COVID-19 when there is a vaccine available because they don't think they will get sick or aren't worried about it aren't brave, they are reckless. By not getting vaccinated, you risk the health of your family, friends, and community. There is nothing attractive and independent-minded about ignoring public health guidance to get the COVID-19 vaccine. (James et al., 2021: 7160)

This deployment of shaming to reduce vaccine hesitancy clearly went beyond chasing the transitory shame attached to a perceived bad judgement call. This kind of shame –directed explicitly towards the

person behind the behaviour – is sticky and difficult, belittling and damaging. While the logic behind this messaging is that saturating the recipient in shame will cause their decision to not be vaccinated to become socially untenable, theorisations of both shame and vaccine refusal suggest the opposite is just as (if not more) likely. Shame can cause the shamed party to reject the basis (ideas, evidence, authority, ideology) on which they were shamed, hardening what might have otherwise been a passing opinion or habit. Uses of shame to create behavioural change can never fully anticipate what form shame avoidance might take; permanently losing trust in the source of the message, for example, or closer personal identification with the object of shaming (Golafshani, 2022). Shame is an identity-forming emotion, not a quick behavioural fix. Likewise, Elisa Sobo encourages us to comprehend vaccine refusal as an act of becoming. Although it 'generally entails various important critiques (of the political economy, biomedicine, etc.)', she argues, it is also 'a highly social act—an act that, each time it is undertaken, reinforces social belonging by vitalizing community ties' (Sobo, 2016: 345). In her work on the parents of autistic children, Chloe Silverman has also demonstrated how anti-vaccination sentiment can be crucial to self-perceptions of 'good parenting', with scepticism over scientific evidence viewed as a kind of 'moral imperative' (Silverman, 2012: 225). These kinds of complex emotional and relational stakes in vaccine refusal are not fertile ground for communications which pivot on shame. If public health messages on COVID-19 vaccination seek to create a brief and clarifying experience of shame, then this is unlikely to land in the expected way. Instead, they risk harms of a longer duration, with complex repercussions for health; or, in the worst case, a shamed death. In a context where vaccine hesitancy is widely shamed, dying with COVID-19 fixes shame securely in time, obviating the possibility of recantation or return.

'Vaxenfreude' and the shameful death

In the public health messages discussed above, the 'vaccine hesitant', here a homogeneous and undifferentiated mass defined only by hesitation or refusal, were not just recipients of communications which set out to shame them into behavioural change. In the

assertion that 'effective public health messages would also increase people's willingness to … hold negative judgments of those who do not vaccinate', unvaccinated people became the intentional victims of a broader project of affective engineering (James et al., 2021: 7159). Encouragements to vaccinate, in this sense, pivoted explicitly on the creation of a shamed out-group, going hand-in-hand with encouragements to negatively value those who declined or demurred. The use of shame as a tool of persuasion carries the seeds of a deeper erosion of sympathy, shading into ridicule and scorn; when shaming tactics fail to result in the desired-for change, the shame that they deploy does not simply dissipate easily or without harm. In the case of vaccine shaming, it resulted in a phenomenon which has been usefully termed 'vaxenfreude', in which any claim to a generative use of shame was largely abandoned.

A contraction of 'vaccine' or 'vaccination' and the widely-known German word 'schadenfreude', the feeling of taking joy in the pain or difficulty of another, vaxenfreude joined a growing list of what Amanda Roig-Marín describes as 'coroneologisms', new and resonant words thrown up by experiences of the coronavirus pandemic (Roig-Marín, 2021). In other work, we have discussed the origins, use and consequences of the term 'covidiot' as a means of casting shame (Cooper et al., 2023). Brought to prominence in September 2021 by Tyler Weyant, an editor at the US politics website POLITICO, 'vaxenfreude' denoted 'the joy the vaccinated feel when the unvaccinated get COVID-19'. Weyant named vaxenfreude to write against it; he described it as a 'dark spirit', rooted in smugness and judgementalism, a problem which underlined the disintegration of collective empathy and community spirit supposedly present at the beginning of the pandemic (Weyant, 2021: n.p.). Indeed, the social psychologist Colin Leach has argued that gloating and schadenfreude are exacerbated as a result of political polarisation: 'When it's a serious rivalry, which is what politics is these days, it's not just taking a little pleasure in somebody's misfortune … it's seeing your enemies suffer because of what they believe. This is the sweetest justice, and that's partly why it's so satisfying to the other side' (quoted by Levin, 2021: n.p.).

The day after Weyant coined 'vaxenfreude', an article in *The Week* connected it specifically with shame and death, reproducing the testimony of a funeral director in Pennsylvania who reported

that families were requesting that COVID-19 be left off death notices (Weber, 2021). Drawing heavily on Weyant's piece and an episode of the National Public Radio (NPR) podcast *All Things Considered*, the article cited research on grief undertaken by Ken Doka, Senior Vice President of the Hospice Foundation of America. For Doka, specific kinds of death, and their subsequent mourning by relatives and friends – are 'disenfranchised', a process through which death is 'tinged with a supposed moral failure and mourners fear judgment from others' (Sholtis, 2021: n.p.). Where mass vaccination gathered momentum, dying with COVID-19 came to be qualified by vaccine status, inflecting political and cultural stories around death – as well as instances of actual death – with varying degrees of grievability.

A measure of this grievability can be taken in the emergence of social media forums that aimed to shame people across the scepticism spectrum. The r/HermanCainAward subreddit (dedicated section of the user-driven website Reddit), named after a Republican politician who died of COVID-19 after opposing masking mandates), the *Sorry*AntiVaxxer.com website and the @CovidiotDeaths Twitter handle documented cases of people 'who made public declaration of their anti-mask, anti-vax, or Covid-hoax views, followed by admission to hospital for Covid'.[1] Using a combination of posts and memes posted to social media, contributors would reconstruct the decisions of their targets into narratives, complete with a developed dramatic irony that found an eager and vindictive readership. The sites were premised on the idea that these hospitalisations or deaths were deserved, and the people they involved were stupid. In this sense, they contributed to a growing sense that to die of COVID when unvaccinated was to die a shameful death. According to Allan Kellehear, such a death involves '[d]ying too soon and from a stigmatising disease, or taking so long to die when you are old so that you become confused, unmanageable and unrecognisable to friends or other professionals … styles of dying that are both uncertain, ambiguous and a spoiled activity for all participants involved'. Parallels can be seen in the shame attached by homophobic political and medical responses to dying with acquired immunodeficiency virus (AIDS), or the 'sympathy difference' in dying with cancers widely understood to be products of lifestyle choices (Kellehear, 2007: 214). At face value, the shaming perpetrated in forums like

r/HermanCainAward adds a conditional to the general stigma associated with catching COVID-19. If someone has chosen not to get vaccinated, then this choice spoils their 'style of dying' and they deserve the opprobrium of others.

Under this new rubric, those who had died having refused the vaccine were deemed less grievable than those who died despite receiving it or before it was offered. The vaccinated/not-yet-vaccinated death fulfilled a narrative arc in which the dead person could usually be straightforwardly construed as the victim (of course, this is complicated somewhat by other iterations of culpability and shaming over pandemic behaviour or pre-existing health). Conversely, the vaccine refuser is the knowing architect of their own misfortune, responsible for their own fate and tarnished further by the act of having exposed others to either direct viral harm or the myriad challenges of an ongoing pandemic. Narratives that seek to shame the unvaccinated, however, seldom bother to complicate matters by considering the conditions under which 'personal choice' is exercised, or by distinguishing between homogenising characterisations of the 'anti-vaxxer'. Individual choice is imagined to be paramount. And yet, as other scenes of the pandemic demonstrated, individual choice is always constrained by circumstance; the rationale of the person concerned with side effects is conflated with that of someone who denies the severity of the disease, or the vocal denier is conflated with the quiet abstainer. More than simply 'dying too soon and from a stigmatising disease', dying while unvaccinated was a shameful death because the dead person had chosen this for themselves, and this choice had consequences for other people.

Studies that explicitly set out to understand vaccine hesitancy, however, emphasise the complexity of factors and contexts which frame and govern 'individual' decisions to accept vaccines. 2021 research into hesitancy over childhood vaccines in the Philippines (with COVID-19 as the backdrop but not the focus) used spoken testimonies from parents to demonstrate a raft of interconnected barriers to vaccination. The team divided these into 'individual barriers', including 'perceived lack of information', conflicting religious or cultural beliefs, 'competing time demands' and the traumatic fallout from a historic dengue fever vaccine controversy; 'interpersonal and community barriers', which factored in

opposition to vaccines from household heads, community leaders and neighbours; 'health system barriers', including lack of trust and logistical problems (such as waiting times and appointment scheduling); and 'superstructural barriers', including poor or non-existent access to transport, bad weather and COVID-19 (Landicho-Guevarra et al., 2021: 6). Carlos Amato's cartoon did at least represent multiple reasons for refusal, but they were all relegated to the realm of decontextualised choice; contrary and opinionated people who thought they knew better, but were wrong. This is hardly what emerges here, or in any detailed and thoughtful work on refusal and hesitancy.

In addition, COVID-19 vaccination has not been a demographically consistent phenomenon. Already giving the lie to easy attributions of blame and shame, a complex nexus of barriers and demotivating factors has been complicated further by clear disparities in vaccine uptake along pre-existing lines of marginalisation and exclusion, particularly (but not exclusively) in terms of experiences of structural racism. Multiple studies in the UK have established that members of racialised groups have been more likely to be vaccine hesitant than those who identify as white British, often by a considerable margin. This point is well documented, as are the factors which are used to explain it: heightened barriers to access; higher perceptions of risk; decreased levels of confidence and trust in medical systems, politicians and the vaccines themselves; and culturally specific factors such as travel restrictions or concern over specific ingredients (Chaudhuri et al., 2022; Gong, 2022; Kasstan, 2021; Scientific Advisory Group on Emergencies, 2020; Woolf et al., 2021). These factors, the studies note, are also significant in understanding the greater hesitancy of groups whose members are otherwise structurally disadvantaged.

Behind this sanitising language, however, is a series of deeper historical challenges. The problem of 'access' misconstrues a generalised system of racist discrimination; the problem of 'trust' elides long histories of harm and neglect in medical research and practice (Phiri et al., 2021: 2–3; see also Limb, 2021). Vaccine hesitancy among members of racialised minorities can be understood as yet another product of structural racism, joining the 'slow death' of pre-existing health inequalities and the necropolitics of sanctioned exposure to COVID-19, in dictating who gets to live or die, and

which deaths are grieved or accepted (Ford, 2020; ONS, 2022; Qureshi et al., 2022; Sparke and Williams, 2022). Indeed, they are all parts of the same equation. In a pandemic where ethnic minorities have been repeatedly shamed both for supposedly spreading the virus and for dying from it in greater numbers, the undifferentiated shaming of the vaccine hesitant has the effect of 'heaping blame on shame' (Scambler, 2020: 79).

Writing on the 'acceptability' of specific kinds of pandemic death, Sandset cites a short passage taken from Judith Butler's 2006 work, *Precarious Life: The Powers of Mourning and Violence*. In it, Butler suggests that the 'differential allocation of grievability … operates to produce and maintain certain exclusionary concepts of who is normatively human'. Sandset develops this point into an argument over what he terms the 'state of acceptance', or 'how we have come to accept that certain lives will be more vulnerable' (Butler, 2006: x; Sandset, 2021: 1415). Rather than the 'exceptional state[s] of emergency' explored by Mbembe in his original formulation of necropolitics, Sandset theorises acceptance as the legitimising affect of necropower (Sandset, 2021: 1415). Vaccine shaming, we argue, has been a crucial component of political and public acceptance over continued deaths from COVID-19 – for example, in the emergence of terms such as 'pandemic of the unvaccinated' (Zamir and Gillis, 2023) – allowing government actions to expose both vaccinated and unvaccinated people to ongoing harms. This represented a crucial development of the shaming narratives which emerged in the early stages of the pandemic, in which shame over high rates of infection and death were deflected away from the state and towards the contravention of public health guidance, a lack of common sense, and pre-existing conditions and habits (such as poor diet and insufficient exercise) which made serious or fatal illness more likely. These had always been attempts at saving face, mobilised to draw the focus away from acute and chronic political and ethical failures (Cooper et al., 2023).

The wide celebration of the vaccine as a magic bullet, eclipsing complementary measures organised around behaviour, access to spaces or hygiene, greatly raised the (already considerable) stakes on individual dissent (Farrar, 2020). In framing vaccination programmes as a 'race against the virus', public health rhetoric posed even temporary hesitation as a loaded and potentially

shameful act (Channel 4, 2020; Durbin, 2021). A small series of acts of refusal, deferment or omission became life- and death-defining, as in the reproduction of anti-vaccine or vaccine-sceptical social media posts as a kind of extended suicide note (Bruenig, 2021). Even in far less overtly shaming discourses, unvaccinated deaths have been systematically unmoored from their deeper contexts. With confusion persisting over mortality rates by vaccine status, and early disparities increasingly more difficult to separate cleanly, the existence of a significant number of deaths which are plausibly (within individualising logics of blame and shame) the fault of the deceased has the effect of contributing to a state of acceptance over all continuing COVID-19 deaths. The closest parallel this phenomenon has is the fallacy that COVID-19 'only' has serious effects on the old, disabled or chronically ill. Although it is clear that this notion of expendability enclosed significant components of shame, the problem of direct blame was mostly absent from the equation, even as specific lives were explicitly discarded and devalued (Aronson, 2020; Pring, 2021). In the case of the unvaccinated, the machinery of shame around vaccine hesitancy and refusal shifted them into the necropolitical zone of acceptable death. This process had consequences for the vaccinated as well as the unvaccinated dead, skewing perceptions of grievability even around those who, by the pro-vaccination standards of public health, had done everything right.

How did shaming discourses around vaccine hesitancy inflect experiences of dying? As Doka's notion of disenfranchised death (cited in Sholtis, 2021: n.p.) suggests, the cultural and political framing of specific experiences of dying and grief has significant repercussions for how these processes are lived. Kellehear notes how shame is internalised by sufferers in the (often long and drawn-out) process of dying, making the experience 'painfully worse than the physical and medical settings ruthlessly dictate'; cathartic experiences of grief, both individually and collectively, are further conditioned by the shame dynamics which surround the cause and manner of death (Kellehear, 2007: 218). A recent Lancet Commission report has explored and (re)asserted the need to properly value death and dying; the extreme circumstances of the pandemic have taken us even further away from anything vaguely recognisable as a 'good death' (Sallnow et al., 2022). People have

died in jarring and abject ways: before they grew old, on ventilators, and on video calls with relatives (Weir, 2020). The shame that accrued around dying from COVID-19 – let alone dying unvaccinated from COVID-19 – worked to further exclude those left behind from a relational experience of mourning, isolating them further in their grief.

The concept of shameful death, here, can only take us so far. While the dying might experience shame related to their decisions, once they are dead it can only be those who live on who can experience shame *on their behalf*. Far from being a metaphysical thought-experiment, there were numerous cases of people being overwhelmed with difficult emotions when they found relatives listed as r/HermanCain awardees or *Sorry*AntiVaxxer.com targets (Judkis, 2021). They also produced empathy with the shamed party. In a *Slate* article in September 2021, Lili Loofbourow explored the 'unbelievable grimness' of the r/HermanCainAward subreddit. Moving beyond the superficial critique of 'death-shaming' present in similar commentary, Loofbourow noted that it made room for something largely absent elsewhere, in the form of a detailed and extensive record of what it's like to die with COVID-19: 'what hundreds of stories about deaths told through mean-spirited screenshots reveal is that the disease—when it gets bad—is worse than even the most pro-vax person really understood'. Loofbourow conceptualised the r/HermanCainAward as an 'anti-persuasive' space, a characteristic which – paradoxically – underpinned the only power it had to persuade (Loofbourow, 2021: n.p.).

This returns us to one of the central arguments behind our rejection of shame as a public health tool, and criticism of discourses which encourage it in wider public behaviour; it is impossible to determine exactly how and where it will land, and precisely what effects it will have. While the act of shaming can be read as an attempt to assert control, it is also an act of unintentional relinquishing, of releasing dangerous emotions into the wild. Although our discussion of shame and death has been largely confined to the problem of vaccine hesitancy in the COVID-19 pandemic, the lessons we draw – about how shame in public health can help to frame harmful eruptions of public shaming, and how these can enter into feedback loops with the politics of dying and grief – will continue to resonate in future crises, whether economic, political, military,

viral or environmental. While neoliberal logics frame discourses on (and experiences of) choice, safety, health and illness, some deaths will be freighted with shame, devalued and subject to political and cultural acceptance; regrettable but not grievable, at least not in the sense defined by Butler (2006). If crises can also be opportunities, critical reflection on the contexts and harms of shame during COVID-19 can better equip us to understand how they might play out next.

Note

1 u/HubrisAndScandals, 'r/HermanCainAward', Reddit. Available at: www.reddit.com/r/HermanCainAward/ (accessed 4 July 2022).

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