Part 1 The problem

A dark hole sits at the heart of multicultural Australia – the data by-pass on how the COVID19 virus pandemic is affecting our culturally diverse communities. While extraordinarily careful measures have been taken to identify and protect vulnerable Indigenous people, governments in all jurisdictions have been cavalier if not conspiratorial in ensuring they know nothing about our multicultural reality and the disease. This works both for the impact of the disease on communities, and the contribution that communities make to containing or transmitting the disease. Now with the second wave rising in inner northern Melbourne, these issues have suddenly come to the fore with a vengeance. The Victorian government doubled down on multicultural communication, admitting it had only started this a day or so ago (following the release of this article! ) (https://www.sbs.com.au/news/victoria-pledges-to-double-efforts-to-reach-multicultural-communities-in-virus-hotspots)

Despite the national government’s reiterated claim that Australia is the world’s most successful multicultural society (never true and especially not so now), one of the fundamental requirements of a multicultural society, that social facts as they effect social groups should be enumerated and recorded, has been consciously and systematically avoided. In the USA and the UK (https://theconversation.com/coronavirus-weekly-racism-covid-19-and-the-inequality-that-fuels-these-parallel-pandemics-140255) ethnicity or race are clear indicators of vulnerability. In Australia, who knows? The only public commentaries are anecdotal reflections, and a shared belief apparent among the managers of the pandemic in government that for the most part the disease is confined to Anglos either local or travelling in. The first study of the question (https://www.medrxiv.org/content/10.1101/2020.06.03.20121814v1.full.pdf) (based on an online survey through Sydney University) appeared on June 5, where the key findings demonstrated that lower levels of health literacy are associated with poorer practices in health protection. A key indicator of low health literacy even among English readers, was a language other than English spoken at home. Other factors (age etc.) exacerbated this effect.

While multicultural health issues can be quite well researched, and state health agencies usually record data that allows an understanding of the potential cultural and social influences on health and illness, a perfect storm of absence has been generated around the corona virus – and not because as the US President opined, it should be called the China Virus. In the process of preparing this article I used every element of my research network to discover what it would be possible to say with any degree of certitude, while also identifying where and why the data for policy was failing so substantially.

Collecting data

The story apparently begins with the National Notifiable Diseases (https://www1.health.gov.au/internet/main/publishing.nsf/Content/cda-surveil-surv_svs.htm) data base, created in its current form about fifteen years ago, with its associated Surveillance System. The data is collected (https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm) under state public health legislation reflecting the WHO definition of surveillance as “continuing scrutiny of all aspects of the occurrence and spread of disease that are pertinent to effective control”. One would expect that given the social dimensions of this definition, demographic data beyond age, Indigenous status, gender and location would be pertinent. Perhaps but in fact, no such data are not collected on ethnicity, language spoken, or country of birth. Asking the national government what is being revealed by the ethnic characteristics of groups infected by the disease, tested for the disease or under-represented in testing, reveals nothing. No data, no answer. My in-box is replete with “no information” emails from media groups at all levels of government, or as often, no reply.

Perhaps then the testing schedules might help – yet no ethnicity data is collected on individuals tested that is of any use, even though with many hundreds of thousands of tests done this data would be of enormous potential value. What of incidences of infection – over 7000 so far? The schedule that is used to determine the pathway of infection and permit tracing to be pursued, a primary method of controlling disease spread, does include country of birth and language spoken at home. However it appears that these questions only get asked IF an interpreter is required, and it is impossible to discover how many of the 7000+ even used an interpreter. So the assumption appears to be that the spread of the disease is geographic rather than through social networks; in lockdown phase this may be an acceptable proposition, but after that? Given that the correlation of neighbourhood with ethnicity varies considerably, knowing where outbreaks occur does not help adjust strategies for tracing contacts per se through ethnic networks across cities and regions.
Harassment of minorities – is it better not to know?

It has been put to me by many people in the system that it’s good we don’t know the answer to my query, because were such information to leak out it would intensify racism and put hotspot groups at risk of attack, abuse and stigmatisation. It is clear that abusive harassment of cultural minorities, especially but not only Chinese and other Asians, Jews and Muslims, has been intensifying both online and off during the pandemic. When the level of abuse had risen to the point that Australian Chinese leaders were petitioning the government for action, PM Morrison and Minister Tudge came forward, decried the abuse, and while reiterating the claim about the success of Australia’s multiculturalism, proclaimed that racism has no place in Australian society. The victims of abuse were advised to complain to the Human Rights Commission. It is possible then that adequate data might reveal something else – that ethnic communities are missing out on access to adequate testing and disease identification, indicating structural and systemic discrimination exists at the most fundamental level, a finding evident in US studies.

Furthermore, Morrison made reference to the fact that Australian Chinese communities had gone into lockdown and isolation far earlier and with greater discipline than many other groups, thus exemplifying social responsibility in the face of the pandemic. As we now know, the Chinese government has publicly identified Australian racism as a major issue for Chinese citizens thinking of visiting Australia in the future, suggesting they might be safer elsewhere. Last week a coalition of ethnic and Indigenous organisations (http://fecca.org.au/news-events/media-releases/?month_num=6&year_num=2020) called for the reactivation of the Australian Anti-racism Strategy operating before 2015 but cancelled by the Abbot government.

The failure to collect data on cultural background and language leaves potentially vulnerable groups without adequate information, and epidemiologists and public health officials without a realistic sense of the landscape in which they need to move. If sanitary social distancing and testing are the key weapons against the disease at least in the short term, then rigorous documentation of how the pandemic is affecting different groups must underpin strategies that seek to protect the vulnerable and ensure potential “spreaders” can take appropriate and rational precautions.

Part 2 What we know but need to know more.

What can be discerned at this early data-scarce stage in investigating the ethnic dimension of COVID19 in Australia? From discussions with various officials ranging from ministerial advisers through NHMRC committee members to parliamentarians, multicultural agency officers, ethnic community workers, and frontline health personnel, a knowledge framework that has bits of information associated with its nodes can be discerned. [more]

The three knowledge networks that co-exist in the COVID19 space encompass: a) epidemiological understandings; b) political economy understandings and c) social communication understandings.

Culture and epidemiology

The cultural epidemiology suggests in Australia that the primary entry of the virus came via five or six pathways. The first were individual arrivals into Australia from countries where the infection had already taken hold. The people came from China, Iran, Italy and maybe South Korea, from which entry was soon shut down. However the second source, through uncontrolled intake, a case of institutional racism lit large and lethal, allowed people from Britain and the USA to enter without control until all entry was shut down later in March. Of the Anglo sources the UK appears to have been the most prolific with China, Iran, Italy and maybe South Korea, from which entry was soon shut down. Of the Anglo sources the UK appears to have been the most prolific with the USA not far behind – Tom Hanks and Rita Wilson being the most infamous examples. The Bondi outbreak among American backpackers (ostensibly transmitted through partying in which $100 bills were shared to sniff substances) was another example of this phenomenon.

However of all cases Anglo-Australians are the most likely patients (either travelling home or acquired locally), not only because they are a large majority of the population, but because in the older age cohorts Anglo-Australian or British reflect the make up of the population forty to fifty years ago, and to some degree the class structure, where more middle class and White populations survive longer than people of colour from working class backgrounds. Then of course there was the Ruby Princess, with its 2500 passengers (the majority apparently Anglo-Australian) and unknown number of its multicultural crew with their Sydney contacts, amongst whom the virus was reproducing with gusto, that flooded into Sydney and spread out from there.

Political economy of ethnic groups

It is at this point we need to understand the cultural political economy of Australia. Ethnic groups are not distributed randomly across either the economy or the landscape, but rather clumped into certain occupations, localities and socio-economic classes. In the USA and the UK higher rates of infection and death among certain ethnic groups reflect the social power of those groups or the lack of it. For those groups concentrated in more poorly paid, casualised, and under-unionised sectors of the economy the onset of the pandemic and the lockdown regimes imposed, especially among women, created catastrophic consequences. Extended and multigenerational families moved in together, overcrowding became more common, domestic violence rose and the possibility of social distancing in the domestic environment significantly reduced. The conditions for self-isolation at home effectively disappeared for many.
Inquiry into the Victorian Government’s Response to the COVID-19 Pandemic

This picture of Australians society has been described as one based on a division between primary and secondary labour markets, first identified fifty years ago by Jock Collins in his “Migrant Hands in Distant Lands”. In simple terms, the primary labour market can be expressed as a large pool of workers with recognised skills, fluency in English, and stable jobs, protected by the trade union movement and with associated benefits. In the pandemic these have been the workers most likely to have been protected to some extent by the JobKeeper and JobSeeker schemes. The secondary labour market reflects the opposite characteristics – lower pay, casualisation, few benefits, poor workplace protection, and in some cases they are undocumented status and highly exploitable. The overwhelming members of that market are immigrant or refugee, or asylum seekers who are the most marginalised. While the majority of migrants are not in the secondary market, the majority of secondary market members are migrants. They are the ones effectively abandoned by the national government.

As should be clear by now, we have very limited information about what has been happening in Australia in relation to ethnic groups, other than that the same social processes and parameters are likely to have been activated here as in the USA and elsewhere. However we do know from anecdotal responses around some hotspots such as retirement and nursing homes, that particular ethnic groups are more likely to be employed in those facilities, at various level of skill. For example nursing homes in the west of Sydney employ many Filipina workers, from cleaners and assistants to nurses. In the north of Sydney Iranians may be more likely to work in those facilities, while in the south it may be Nepalis. On the cruise boats the multinational work forces also fell ill, but we do not know what their socio-cultural networks might be in Sydney and Perth. News reports (https://www.theguardian.com/australia-news/2020/may/09/cedar-meats-cluster-why-aboriginal-workers-are-on-the-coronavirus-frontline) of the cases at Cedar Meats in Melbourne point to the high level of non-English speaking background workers (especially from the Middle East), their low educational backgrounds and fluency in English, and the hazardous work environment. Infected workers have passed on the infection to an aged care worker and a nurse, as well as a school child. The reports of Melbourne’s MacDonald’s infections refer to extended families – most likely immigrant and refugee background.

Social communication and ethnic networks

These networks of vulnerability already exist in Australia, but are cloaked with a barrier to identification. Why should this be of concern if identification and tracing can be pursued on a locality basis through voluntary and extensive testing? We have no idea what the rate of testing is, and who may be missing out – and for what reasons. In discussion with frontline health workers they have described the sorts of issues that have arisen that suggest clusters of people who are rarely tested though they may be vulnerable. Three dynamics may be at work.

Most health communication messages in NSW are originated in English and then translated by Health translation services or the State Translation agency, directed by Multicultural NSW – targeting vulnerable communities with limited English skills. Multicultural NSW has a seconded officer working in State Emergency Operations Command with authority to ensure sensitive coverage of ethnic communities. In Victoria ethnic community networks on social media have been widely used to get messages through. Social media penetration declines as the population gets older.

There has been considerable commentary on how different messages from state and federal authorities can cause significant confusion even for fluent English speaking native born Australians. In NSW state messages get processed through state agencies and follow state policies, while the same communities may also be exposed to Federal messages translated by the National health agencies, and through SBS, and get other information from social media. Moreover, many immigrant communities follow social media in their own languages and media streams from overseas, deluged with the variable nature of those messages. (For instance, if you are an elderly Greek what would be your information sources to decide whether to wear a mask or not when going to church, with that option now open?)

For many communities, their social conservatism clearly displayed in their voting during the Same Sex marriage poll, religious leaders provide a guide to appropriate behaviour. Early on in the pandemic messages were delivered in some faith communities about the role that religious piety might play in protecting people from infection, while medical explanations and advice went unheard. In NSW MSNW moved quickly to activate its religious leaders’ forum fortnightly, usually a quarterly event, to ensure that across the range of beliefs in NSW the message of the government was delivered clearly. It also provides grants (https://multicultural.nsw.gov.au/community-support-grants) of $5000 -$10000 to community groups providing essential support services to culturally and linguistically diverse groups.

Social media has also become a space of contestation, as messages ranging from bot trolling and overt racism to academic medical research struggle for the attention of audiences and their networks. Fear and anxiety has grown, with hate speech dividing communities from each other, and fear and “fake news” feeding each other. Communities especially of faith are also seeking ways to protect their members from harassment, through reinforcing social solidarity online, as shown in a recent Scanlon Foundation report (https://scanloninstitute.org.au/sites/default/files/2020-06/Scanlon_Institute_Essay_Edition_1.pdf) detailing the response by religious bodies around the country.

Testing regimes have proven a difficult terrain with unknown impacts. Knowing the ethnic or linguistic dimensions of people who have been tested would allow some scoping of the people who have not been tested, and are therefore at greater risk as both patients and transmitters. Frontline workers told me of such situations. Young Afro-Australian men in western Sydney...
feel that the surveillance of COVID19 lockdown behaviour by police soon became yet another form of harassment, exacerbated by their overcrowded living conditions and poor incomes. Single mothers with children, still working on limited incomes, feared that they would lose what work they had, as slow test processing times meant they had to stay at home in self-isolation until cleared: they feared the self-isolation regimes.

Why we have to do “multicultural” properly

The signs of a second wave are already riffling the not so distant horizon. Official after official told me, becoming astonished in the telling to realise it, that there was no data about ethnic diversity. We are on the edge of something very complex with potentially major “downsides”. It is not just the abandoned asylum seekers whom I see searching for cans in the bins on my local street in order to collect a few coins, or the refugees fed by charities shivering in the cold as winter comes on, or the international students riding through the night for Deliveroo, but the whole edifice of multicultural Australia that has been overcome with shadows.

Hopefully someone will work out that some authority needs to say, “let’s do this right”, and open up the illumination. This must begin by redefining the Notifiable Diseases strategy to recognise Australia as a multicultural society, and soon, so that if/when wave 2 arrives the country is rather better prepared to respond, resist and recover.

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One thought on “Dark data hole leaves multicultural Australia in danger in second wave pandemic.”

1. ravideshpande SAYS:
   AUGUST 8, 2020 AT 11:58 AM
   Dear Andrew,
   Wish i had read this illuminating yet alarming article on June 22. Since then the second wave has shrouded Melbourne and now threatens to spread into other states.
   The abandoned asylum seekers searching for cans might have increased in your street. What definitely has increased is the feeling of unrest, of an impending void like uncertainty amongst the Indians ‘clumped’ together in menial jobs in Sydney. This along with other rapidly changing circumstance will create not only mental distress but a recourse to arms, villainy, and crime. That inevitability is the most worrying aspect of tomorrow for the multicultural society.
   History will always look at the dominant representation of the data and the fears are of a misrepresenation of the problems assailing the multicultural society in Sydney.
   Each paragraph of yours is food for thought and a call to study and understand better the issues at hand.
   Grateful to you for such an eye opener.
   Your comment on Anagha’s page prompted this click on your page. And a journey has begun for me.
   Thanking you,
   Ravi

Reply