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The experience of South Sudanese migrant families during the COVID-19 pandemic in Melbourne

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Melbourne's South Sudanese community is a new migrant community. Like my family, the majority have resettled in Australia under the humanitarian program for refugees, between 2001 and 2005. This is a low socioeconomic group with a median age of 33 years.¹

The global experience of the coronavirus pandemic (COVID-19) shows that low socioeconomic groups are more negatively impacted. This is the experience for the South Sudanese community in Victoria, many of whom live in communal households, work multiple jobs and are further disadvantaged through speaking little or no English.

Although I am a doctor, educated in the University of Melbourne, Harvard University and the University of Oxford, I share the lived experiences of other members of my community. I lived in a refugee camp for more than a decade and shared the challenge of sudden transition into Australia. Current and future pandemic responses need to consider factors affecting similar communities. This commentary reflects on the author's experience as a member of this group and as a clinician who works in this community, with a view to informing health and economic policies, health services planning and media ethics.

Trust is an important tenet for the pandemic response

Trust between communities and authorities is arguably the most important tenet for the pandemic response. Besides compliance with physical distancing, self-reporting for contact tracing and the acceptance of a potential vaccine are contingent on trust. Trust requires sensitivity in public communications about the pandemic. It is essential that media coverage does not besmirch specific cultural

groups or seek scapegoats for public health failings. It was neither necessary for contact tracing nor for risk mitigation when some Australian media outlets sought to ascribe outbreaks or breaches of restrictions to individual cultural groups. The recognised reasons for increased risk in pockets of Australian society are socioeconomic, not genetic, just as for similarly disadvantaged groups in the UK.² No official pandemic response policy classifies risk on the basis of genetics, and the attempts to do so, whether in popular or scholarly publications, suggest efforts at obscuring the effects of racism.³

Melbourne's militarised lockdown of apartment towers, in July 2020, hobbled collaboration between authorities and at-risk minority communities.⁴ Members of the South Sudanese community in Victoria have experienced war and breaches of human rights, engendering prejudice toward members of the military and police force. This was compounded by negative media attention before the pandemic, which attributed individual behaviour among delinquent youths to the entire South Sudanese community. These used a pejorative term, 'African gangs', to create community prejudice. This tendency for racial profiling by some members of the media was a prelude to justifying police-supervised pandemic measures. Consequently, individuals from disadvantaged communities with symptoms of COVID-19 may present for tests, but police supervision makes them reticent about revealing their potential contacts.

Trust building is a two-way process, and effective community engagement is essential. Members of my community have often confided in their community members, including those working in an

official capacity. This has been evident in the large number of private inquiries I have received from members of my community seeking information about the pandemic or vaccines against COVID-19, despite the official communication on government websites, television and other news outlets. Therefore, people working as contact tracers, policy developers and communication specialists should reflect at-risk communities. Policies would benefit from representative perspectives, diverse languages would improve the reach of policy communication, and compliance would be greater with culturally representative contact tracers.

The SBS programs tailoring official health messages from the Australian Government in more than 65 languages have been a critical step, as has the involvement of health practitioners from target communities. Clinicians in Victoria's South Sudanese community targeted health messages through social media. This important, but often unacknowledged, subset of health professionals helped educate a community that was apprehensive, especially when the mainstream society was alarmed by fear and disinformation. Official support for initiatives to enhance community engagement and address misinformation is useful, not only for ensuring accurate messaging, but also as a basis for continuing health promotion in the post-pandemic period. In a past initiative involving the author,⁵ this tailored approach improved hepatitis B screening and immunisation in the South Sudanese community in Australia.

Care services need to be tailored and remotely accessible

Enhanced telehealth services⁶ and tailored official health messages helped culturally and linguistically diverse (CALD) groups, including South Sudanese. However, disruption to healthcare, which included delayed cancer diagnosis and treatment for chronic health conditions,⁷ appeared greater among CALD groups, as in the following example.

On 11 October 2020, I received a text message from a medical friend with whom I had trained at Melbourne Medical School. A surgical service in Victoria had made a new diagnosis of breast cancer in a woman of South Sudanese background. Despite Victoria's diverse population, this

The author has stated the following conflict of interest: The author is a member of the South Sudanese community in Victoria, and has been advisor to the Australian Government. This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

surgical team had little experience with patients who couldn't communicate well in English, had low health literacy, and were experiencing structural barriers to access care,⁸ particularly during the lockdown. The team members were having difficulty explaining the diagnosis and treatment options with the patient and acknowledged their limited experience working with South Sudanese people. In the Australian South Sudanese community, children often have better English language skills than their parents, resulting in reverse responsibility in navigating the healthcare system and explaining health advice.

COVID-19 pandemic response measures have restricted in-person attendance at many clinical services. For this woman, family members or trusted friends were unable to accompany her to medical appointments. She was removed from her social network, unable to harness social media for support, and had limited access to a trusted network within her community. Furthermore, this surgical service did not have face-to-face Dinka interpreters and the team stated there were often none available by telephone, despite attempts to arrange them in advance. The surgical team had worried that, given communication barriers, the care they wished to offer might not be culturally appropriate. The team had unsuccessfully reached out to "a couple of community health centres as well as the Cancer Council". I subsequently connected the team with a certified female interpreter within Melbourne's South Sudanese community, observing confidentiality for this sensitive diagnosis in a member of a small, close-knit community.

This example underscores the importance of tailored services required during normal times, but even more so during the pandemic. Instead of restricted, ad hoc services, there is a need for a readily accessible pool of linguistically diverse interpreters across health services. The casual employment arrangements of these services mean that they weren't suitably supported alongside other essential services during lockdowns in Melbourne, nor suitably remunerated on the JobSeeker program. Many casual workers had to move to other employment opportunities during the pandemic. A readily available and permanent pool of interpreters, who are considered essential for access to health services by people of CALD backgrounds, could improve flexibility and accessibility.

Socioeconomic policies need to be fit for purpose

Limited opportunities for employment cause economic insecurity among humanitarian migrants. Their households are often in a fragile financial state, crowded, and face a rising cost of rent, higher risk of unemployment and the uncertainty of casual jobs. Roles in low-skilled jobs, such as abattoir workers, cleaners, and personal attendants in aged care facilities are common among members of such households. The low-skilled nature of these jobs also puts people at higher risk of redundancy. Clusters of COVID-19 linked to a Melbourne abattoir posed an infection risk to members of impoverished households who could not afford the lost income that would result from self-isolating, and suspended factory operations terminated critical income for these households.

Members of disadvantaged households often work multiple jobs, as a single income stream proves insufficient. Where the JobKeeper program supported only one of these jobs, such households became more vulnerable when having to comply with one-site workplace policies. Members of these households were conflicted between optimising income through work at multiple sites and wanting to protect their family members during the pandemic. Therefore, full-time equivalent pay for the actual hours worked is superior to a policy that assumes equal opportunities in the job market.

In the same vein, the prevalence of service jobs among new migrants predisposes them to a higher risk of COVID-19. Cleaning services, aged care, and other healthcare settings involve close contact with other people who are often vulnerable to infection; these jobs carry a higher risk of workplace infection than many other positions. They are jobs that cannot be done remotely and travelling between sites, often on public transport, is a necessity.

Furthermore, new migrant families were often without the means to support the home education of their children during the lockdown. The majority of parents lack English language skills and are unfamiliar with the Australian education system. School-aged children were expected to have computers, internet access, a dedicated space for study, and guidance and supervision from their parents. However, many such households are

overcrowded, and children lacked suitable supervision as their parents needed to leave home to work. These households often had unreliable or no internet access. Therefore, new migrant children were at greater risk of being left behind where policies assumed equal resourcing for all young Australians.

Recommendations

- Media commentary should be sensitive and not fray social fabric, as this would be counterproductive to the pandemic response and the general wellbeing of Australians.
- Minority or disadvantaged groups should be represented in policy development, communication and implementation to enhance trust and policy impact.
- There should be official support for community-based health promotion initiatives, and official messages should be tailored for optimal reach.
- Care services should be tailored and made accessible through measures such as a permanent pool of certified interpreters, rather than causal ad hoc staffing.
- Economic supports should be expanded in recognition of the unique challenges that members of disadvantaged groups face in the job market, particularly the inability to sustainably depend on a single income stream.

Conclusion

Pandemic response measures have been devised with the best intentions, but their effectiveness depended on how they were implemented and how their effects were experienced. New migrants, such as the South Sudanese community in Victoria, are at a unique disadvantage with some of these measures. Media commentary that has reinforced racial prejudices, the militarised lockdown of crowded households, insufficient economic supports and poorly targeted messaging are among the shortcomings. Unless approached with sensitivity, pandemic response measures can reinforce distrust among communities, thereby limiting the capacity of public health measures such as contact tracing and the willingness to participate in vaccination programs. Going forward, the design and implementation of pandemic measures must be conducted in consultation with affected communities and tailored to address the risk factors and societal issues impacting CALD communities.

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