

LESSONS ON EXCLUSION FROM PAST PANDEMICS

We need far more engagement with marginalised groups to avoid making the same mistakes and perpetrating the same injustices over and over



I have three pandemic stories about health inequity. The first is a painful, family one. In July 1961 in Moshi, Tanzania, my aunt died of hospital acquired smallpox caused by the variola virus five days after giving birth to her newborn son, who died a day later.

She left behind her devastated family and a 13-months-old daughter. She had been immunised while at school, so we don't know what happened. We know that some vaccinations in East Africa at that time were unsuccessful because the liquid vaccine had to be refrigerated otherwise it became inactive within three days.

The smallpox vaccine was produced in Nairobi or England and it is possible that temperatures were not maintained during shipping or when the vaccine was transported to distribution centres or health clinics. It could also be that a more severe form of smallpox was present in Tanzania at the time.

Closer to home, there were the smallpox epidemics of 1789, 1829–32 and the 1860s in Australia (McWhirter, 2009). Smallpox arrived with settlers 15 months after the First Fleet arrived in Australia. Macassans were originally blamed for its arrival, but there was no smallpox in Macassar at the time of the First Fleet. Smallpox was widely believed to have come from Asian countries because Asians were thought to be

diseased and different. However, smallpox was endemic to Britain and to a lesser degree, Europe. The three epidemics had a major impact on Aboriginal populations but less so on European settlers.

Smallpox was managed in different ways in the various Australia colonies. Vaccinations became available during the 1829–32 epidemic, but there was no legislation with regard to smallpox in Aboriginal communities.

Rather than being made compulsory, vaccination occurred in an ad hoc manner if an individual settler or doctor was concerned about an Aboriginal person. In Victoria, where I live, the smallpox epidemic of the 1860s had a devastating impact on Aboriginal people. In the racial hierarchy of the time, white settlers were seen as superior to Aboriginal people and people of colour. Aboriginal people were thought to be already at risk of dying, both individually and as a 'race', and were not seen as a threat, a vector of disease or of being in need of a public health response.

Chinese people were also seen as inferior and unsuitable for integration into colonial society. However, they were seen as a threat to British dominance, by virtue of their industriousness and because their numbers swelled through the gold rush era and they were characterised as a source of disease.

A smallpox outbreak in 1857 in Melbourne singled out Chinese people as the source and, despite it being traced to a sailor from Liverpool, led to demands for the compulsory vaccination of Chinese people. An outbreak of smallpox in 1887 was attributed to Indian hawkers or to recently arrived Chinese people. The Tasmanian Chinese Immigration Act 1887 required all Chinese entering the colony to be compulsorily vaccinated, and this was carried out by the Superintendent of Vaccinations, CE Barnard, even as the practice was being challenged among the European population on the grounds of contravening individual liberty.

And now to the present — in Victoria, where I live, where the unfair structural arrangements in our society have been exposed. Nine public housing towers with high populations of migrants and people of refugee background in North Melbourne and Flemington were put in lockdown without notice (Ghumkhor, 2021). This racialised response was also seen in Sydney, where people in the western suburbs were policed heavily compared to the eastern parts of the city.

These past and present examples show that although we might be in the same boat, 'some people have yachts and superyachts' (Siouxie Wiles). There are the global inequities of vaccine

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distribution, as evident now in terms of COVID-19 as in my aunt's time.

At the time of writing this, Canada had a total vaccination rate per 100 people of 155.67 while Tanzania had a rate of 1.63, compromising the effectiveness of vaccination as a public health strategy (Carey, 2021). We know that this massive disparity will have far reaching impacts. Low vaccination rates mean that the virus will continue to spread and increase the risk of new variants emerging globally.

Considering health equity would ensure that the places that needed the vaccine the most could be supported with resources.

This is true also of Australia, where there was a lack of prioritisation of vaccine supply for the people with the most need (e.g. essential workers in precarious work, people living in high density housing). An equity lens would require targeting people living in 'LGAs of concern' with early intervention to promote understanding of restrictions, vaccine uptake, and COVID-safe work practices (Reeders, n.d.)

The second and third examples show how race and racial hierarchies have played a part in how infectious diseases are managed in settler colonies like New Zealand and Australia. Fuelled by fear, we have turned to carceral responses and policing particular areas rather than making

public health responses toward equity. These responses rather than community led solutions have been traumatising and reduced trust in population groups that are already distrustful or disengaged from health services (Liddle, 2021). The lack of financial assistance for international students and essential workers spread across different contexts has also exposed how some communities are seen as less worthy of respect or care.

Bringing in an equity lens reveals the limitations of health communication during the pandemic. Firstly, health messaging has not always been accessible for people from culturally and linguistically diverse communities. Initial messaging did not consider fluency in a language other than English, low health literacy or diverse work and social contexts that such communities live in, such as the prevalence of precarious essential labour, irregular shift work or multi-generational households.

The pivot to digital technologies has posed yet another challenge for marginalised communities. Whether for accessing online consultations, using apps to check in at venues and facilities using QR codes, to home schooling and working from home, the mandatory use of unevenly distributed technology has widened existing health inequalities.

Once again, the assumption that middle-class, English speaking communities are the Australia public health needs to serve has prevented us from achieving positive outcomes for all. We need far more engagement with marginalised groups and to welcome their participation in producing healthy outcomes for their communities if we don't wish to repeat the exclusions of the past.

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