Integrating culturally, ethnically and linguistically diverse communities in rapid responses to public health crises

Policy Brief

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MIGRANT & REFUGEE HEALTH PARTNERSHIP

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Introduction

The COVID-19 pandemic exposed vulnerabilities in Australia's health emergency management response. At the same time, it also provided a valuable opportunity to gain insight into our preparedness to engage with culturally, ethnically and linguistically diverse (CALD) communities during a public health crisis. The immense diversity of Australia's population is widely recognised, with almost half of Australians either born overseas or born to parents from overseas.[1] Although these Australians are often grouped under the broad category of 'CALD communities', differences in ethnicity, language, culture and religion between and within CALD communities across Australia must be acknowledged and incorporated in health responses. While cultural diversity remains a key strength of Australian society, it also presents a significant challenge in the face of crises requiring sustained community buy-in and cooperation. This is amplified by the strong overseas linkages maintained by CALD communities living in Australia, which can affect domestic responses to public health crises.

This policy brief discusses key learnings emerging from the COVID-19 pandemic in relation to engagement with diverse communities as well as guiding principles for effective CALD community outreach and engagement in the event of future public health crises. For the purposes of this brief, public health crises are considered situations where 'health consequences have the potential to overwhelm routine community capabilities to address them'.[2] This may include outbreaks of infectious diseases as well as natural disasters including bushfires and floods where emergency health management responses are required. The approach to integrating CALD communities in public health crisis responses outlined below draws upon a range of resources developed to support engagement with CALD communities, including 'Best Practice Guidelines: Engaging with Culturally and Linguistically Diverse Communities in Times of Disaster' produced by New Zealand's Christchurch City Council (2012) in response to the Canterbury earthquakes of 2011.

It is clear from the COVID-19 pandemic that effective engagement with CALD communities requires long-term investment to lay the groundwork for a coordinated community response to future public health crises. While the inherent unpredictability of crises means that unexpected developments may derail carefully laid plans and policy responses can have unintended consequences, preparation is key to build and maintain trust in authority during challenging times. Where trust in government may be lacking, efforts are needed to identify and activate networks of information and support to engage traditionally harder-to-reach communities. In particular, local health and social services often have intimate knowledge of the specific needs of their communities, which can help inform the development and delivery of health responses. Above all, there is a need to ensure that engagement with CALD communities during public health crises is responsive to their specific vulnerabilities and taps into their strengths, in addition to addressing general experiences and concerns shared by the wider Australian population.

Lessons from the COVID-19 pandemic

Australia's public health infrastructure is robust, but some areas of engagement with CALD communities have fallen short of public expectations. During the COVID-19 pandemic, distrust in public health bodies emerged from poor quality or delayed translation of materials, the omission of some languages from translated resources and conflicting messages from different sources. Confusion around public health directives contributed to the virus transmission. This environment also facilitated the spread of misinformation about the pandemic, restrictions and possible cures, which were disseminated by susceptible members of CALD communities, as well as the general public.

One of the more obvious examples of inadequate engagement with CALD communities emerged from the lockdown of nine public housing towers in Melbourne, Victoria during a surge in COVID-19 cases in July 2020. Approximately 3,000 residents were suddenly required to quarantine in their homes. Many of the residents were migrants and refugees or from otherwise marginalised communities. Living in densely populated spaces, the potential for cases of COVID-19 to spread rapidly was cited as the reason for the widespread lockdown. While the lockdown was successful in stopping the spread of COVID-19 in affected communities, the handling of the initiative was widely criticised.

A review into the lockdown conducted by the Victorian Ombudsman highlighted a number of issues, particularly in relation to communications and the role of law enforcement in supporting the intervention.[3] It was found that residents were not initially given information on why they were being included in the lockdown, how long the lockdown would last and when they would be receiving COVID-19 tests, with public health directives originally distributed in English only, forcing some residents to translate for others and some to receive no information in their preferred languages at all. Further, the significant police presence exacerbated fear and anxiety for residents, particularly for those with a history of trauma and experience living through civil wars and dictatorships. It also brought to mind existing histories of over-policing and racism against CALD communities living in Victoria.

The lockdown of public housing towers in Melbourne highlights some of the specific vulnerabilities of CALD communities during public health crises. While the measure was undoubtedly effective in reducing the rapid spread of COVID-19 within the community, the Victorian Ombudsman found that there was a need to restore community trust after this intervention occurred. [4]

Building and maintaining community trust beyond crises is key

Establishing and preserving community trust is an ongoing effort for governments at local, state and federal levels. This is especially the case during a public health crisis where trust in government is critical to achieve community cooperation. For instance, a study of the COVID-19 pandemic response in Europe found that compliance with public health directives increased where people had trust in policymakers, particularly if this trust was developed prior to the crisis.[5] Likewise, developing and maintaining trust in public health systems requires sustained investment outside of crises.

Trust in Australia's public health system occurs on multiple levels. On a personal level, consumers seek out health providers and services that they have confidence in, often drawing on recommendations from personal connections. By extension, trust is also placed in the structures and organisations that provide health care services to CALD communities. On the highest level, authorities responsible for political decisions and policies impacting health systems need to maintain community trust for public health directives to be followed during and beyond crises. Ideally, the decision-making of authorities should reflect current social norms, protect the most vulnerable in the community and be transparently applied.[6]

However, trust does not develop at the same pace for all health care consumers. Those who already have agency, or are empowered to make informed health care choices, may find it easier to trust the institutions that have already benefitted them. Those who are already marginalised in Australian society or have had negative experiences with institutions, including health systems, are less likely to develop each level of trust. This underlines the importance of every interaction with the health system in developing a sense of consumer confidence and mutual understanding.[7]

For many CALD communities living in Australia, trust in authority does not develop from a clean slate. Communities may be disillusioned from previously ineffective engagement with governments at all levels, where their concerns were not resolved or their input not heard. Some outreach may be viewed as tokenistic or disingenuous.[8] Community members from countries with a history of conflict or corruption may also find it difficult to trust authorities in Australia to communicate public health information truthfully and without bias.

Negative interactions with health workers, including experiences of racism and discrimination, may also reduce community trust in the health care system. Health workers should be trained and supported to provide care to CALD communities that is quality, safe and culturally responsive. Other factors influencing the engagement of CALD communities with health services, and by extension their trust in Australia's health system, include health literacy and health systems literacy. Health literacy refers to the skills, knowledge, motivation and capacity of a person to access, understand, and apply information to make effective decisions and take appropriate action.[9] In contrast, health systems literacy is the ability to navigate health settings, including the infrastructure, policies, processes, people and relationships that make up the health system.[10] CALD communities may have lower levels of health literacy and health systems literacy compared to the broader Australian population. Lack of familiarity with the Australian

health system, in addition to language and communication barriers, can further contribute to lower levels of trust among CALD communities. In particular, young adults in Australia have significantly lower rates of health systems literacy, as well as low levels of engagement with health services overall.[11]

Further investment in a diverse health workforce is needed to build and maintain community confidence in Australia's health system, not only in response to public health crises, but as part of a business-as-usual approach. In a highly diverse society, all health care providers must be equipped to provide culturally responsive care to CALD communities, with an emphasis on knowledge, awareness and empowerment. Community outreach by health workers from culturally, ethnically and linguistically diverse backgrounds can help increase the health literacy and health systems literacy of CALD communities, thereby solidifying their trust in Australia's world-class health system. Health workers from CALD backgrounds can also play a key role in supporting critical health messaging when public health crises arise.

Key consideration

Invest in strategies to support the health literacy and health systems literacy of CALD communities, including utilising the capabilities of health workers from CALD backgrounds as trustworthy sources of public health messaging and strengthening the capacity of the health workforce as a whole to provide culturally responsive care.

Australia's superdiversity requires multifaceted engagement strategies

Australia's cultural diversity is a point of pride, but also necessitates effective engagement in the context of a public health crisis. There are currently more than 300 languages spoken in Australia today, with the vast majority spoken by migrant and refugee communities.[12] This does not include the variety of dialects, regional accents, and the convergence or divergence of language over time. While Australia's superdiversity is rightly celebrated, there are a number of implications for the development and implementation of public health responses, as well as related engagement and resourcing considerations.

The ways in which CALD communities respond to public health crises are informed by their social context and past experiences. Factors such as age, gender, preferred language, religion, location, migration status, disability, technological proficiency, and level of scientific literacy influence how a person is able to receive and understand public health information.[13] As Marlowe et al. (2018) note, there is a 'growing recognition of the complexities of communities and the importance of understanding these contexts in order to engage and target risk strategies. Community membership is fluid, and identity markers intersect across gender, age, linguistics, culture, community size, and length of settlement. Therefore, a singular approach to communication and engagement does not work for all. For example, older people are less likely to learn a new language, younger generations may more readily embrace technologies, and numerous studies clearly show that how disasters play out can be heavily influenced by gender.'[14]

To address these factors, there is a need to balance the role of government as the sole source of public health information with the preferences of some CALD communities to receive information from other trusted sources.[15] Sources of information for CALD communities vary significantly between cultural and ethnic groups, ages and genders. As the COVID-19 pandemic highlighted, there is no single point of authority within CALD communities. Despite this, there is often an emphasis placed on 'community leaders' without articulating who they are, the roles that they can play and the effectiveness of community leaders in disseminating public health information to fellow community members. It is important to critically examine what is meant by 'community leaders' (who are also at times referred to as gatekeepers, cultural intermediaries and community representatives), rather than using the term as a catch-all for prominent figures within CALD communities.

Community leaders and advocates are often active across a range of issues and some individuals, particularly women, may be better placed than others to broker access to health care and information in the context of a public health crisis. When communities are diverse or spread throughout a diaspora, a singular community leader cannot be reasonably expected to reach every person of their same ethnicity, religion, or language group. In a 2018 study of Afghan participants in the Adult Migrant English Program (AMEP) in South Australia, almost half of surveyed migrant or refugee women could not identify an Afghan community leader or community space within Adelaide who they would go to for further help with settlement or orientation. [16] Further, a survey of 1,392 migrant and refugee women in Australia conducted by Monash University and Harmony Alliance (2021, report forthcoming) found that approximately 30 per cent of respondents under 44 years old reported no trust in religious community leadership (while noting that 59 per cent of survey respondents reported that religion was important in their daily life).[17] Faith leaders may also have limited influence in public health crises as not all religions and faiths have accepted hierarchies or recognised authority figures to influence local health responses.

It should also be recognised that information is not spread top-down from community leaders to community members but horizontally, through a range of sources. Health information is often spread by women who provide advice to their family and close friends, including those who reside overseas. During the COVID-19 pandemic, conflicting information on the spread and impact of the disease, the steps required to mitigate the disease, and potential cures spread quickly from overseas to Australia via social media platforms. Advice given by family and friends can in some instances become more trustworthy than generic information distributed by authorities, due to the close relationship to the source and the way in which the message is framed in terms of authenticity and cultural resonance, thereby creating a discordance in the public health response.

This is not to say that community leaders do not or cannot play an effective role in public health crises and other emergencies. For example, Shepherd and van Vuuren (2014) examined the roles and capabilities of community leaders during the Queensland floods in 2011.[18] They found several promising examples of engagement with community leaders, including:

- disseminating public health messages to those who otherwise would not trust or receive official government sources of information;

- advocating for their community in the crisis and recovery periods;
- providing their community members with culturally appropriate, practical and emotional support; and
- linking the community to messages from mainstream sources, such as where to get government support payments for those directly affected.

The authors also identified key areas of concern emerging from the use of community leaders to facilitate information sharing and engagement.[19] Some leaders omitted or filtered information, either due to a perception that it was irrelevant to their community or to make information less stressful. Additionally, some community leaders were unable to effectively interpret the public emergency information due to gaps in their own knowledge or comprehension. This is an issue of particular concern when relying on community leaders to disseminate health information in the event of a public health crisis. Public health crises can also create opportunities to enhance social trust among vulnerable or marginalised communities, including refugee cohorts. In a study of refugee men affected by the 2011 Queensland floods, Correa-Velez et al. (2014) found that participants with greater exposure to the floods were more likely to report increased trust in their neighbours and the Australian community more broadly.[20] The authors highlighted that a sense of community can emerge during the recovery period from a public health crisis, leading to greater social capital for some groups.

While community leaders can play an important role, the value of using multiple channels of communication to reach CALD communities is supported by research on how migrant and refugee women in Australia prefer to receive health-related information. Lee et al. (2013) found that there is significant diversity among migrant and refugee women in relation to their preferred format of receiving health care information. Migrant women showed a preference for online posts (81 per cent) and community newspapers (75 per cent), whereas refugee women preferred talks in English classes (93 per cent) and ethnic radio (60 per cent).[21] There was also variation when factoring in the length of time the individual had resided in Australia and their connections to their ethnic community, which often acted as a conduit of information.

When providing public health information to culturally, ethnically and linguistically diverse communities, it is crucial that interpreted or translated material is linguistically and culturally appropriate. There are unique problems that could arise in complex public health situations. There may be clinical terms that are difficult to translate directly (e.g. 'viral load'), incompatibility of concepts (e.g. Western medicine practices compared to traditional medicine practices) and socio-cultural barriers that can alter the meaning of translated materials (e.g. referring to 'churches' instead of 'places of worship').

It is unreasonable to expect authorities to translate public health content into all languages spoken in Australia, particularly during a public health crisis where circumstances and information change quickly, and high-quality translations require time. However, it is important to cater for as many communities as reasonably possible in order to reach critical mass. Rather than targeting translations based on the statistical prevalence of speakers, it is important to also consider the demographics of Australia's CALD communities, including their age profile, year of arrival, language spoken at home and existing English proficiency. In the

2016 Census, 820,000 migrants indicated that they had 'poor English proficiency'.[22] These are the community members who may be more vulnerable in public health crises if there is no targeted engagement strategy. This is particularly the case if community members are not literate in their own language due to limited access to educational opportunities in their country of origin. Simply translating public health information may not be enough to reach these communities; instead, a combination of methods including voiceovers, animations and messages over ethnic radio may be more effective.

Public health messages should be crafted to consider a range of factors, which may include age, gender, preferred language, religion, location, migration status, disability, technological proficiency, and level of scientific literacy in the communities targeted by the engagement strategy.[23] However, it should be acknowledged that there are limitations to the data available on the cultural diversity of communities in Australia. Many datasets relied upon to inform public health planning in relation to CALD communities are relatively old and do not capture newer communities in Australia. Further, the process of data collection often depends on the digital literacy and English proficiency of respondents involved, which means relevant information about some communities may not be adequately captured. It is therefore important to ensure adequate real time information is sought from health and social services currently providing services to the community at the time.

Social media is a useful tool in public health messaging, particularly in providing updates during emergency situations, monitoring public discourse and crowd-sourcing information to corroborate official sources.[24] However, as noted above, the use of multiple communication channels may prove more effective in reaching CALD communities. For example, some individuals living with disabilities, those with lower levels of digital literacy and older Australians may be disadvantaged by public health messaging that is heavily skewed towards online distribution. Over-reliance on internet-based systems like smart phones and QR codes for contact tracing or online applications for financial assistance can inadvertently exclude those with low technological proficiency, which often intersects with migrant and refugee communities.[25]

While the format and target audiences of CALD engagement strategies require careful consideration, the tone of the message is equally important. Effective engagement with CALD communities should draw on commonalities, not differences, to emphasise the shared experiences and values of all Australians in responding to public health crises. As demonstrated during the COVID-19 pandemic, certain CALD communities felt stigmatised by rhetoric in relation to the origins of the virus. An Australian National University survey conducted in October 2020 found that 84.5 per cent of Asian-Australians reported experiencing at least one form of discrimination during the pandemic.[26] Ongoing investment in anti-racism education and strategies can provide a solid buffer against the racialisation of public health crises, but public health messaging that avoids the use of othering language is key.

Key consideration

Undertake proactive and timely consultation with stakeholders from CALD backgrounds in the event of a public health crisis, to inform the development of effective, culturally appropriate engagement strategies with CALD communities.

Equity should be a primary consideration in policy responses

As the COVID-19 pandemic has shown, public health crises do not affect all Australians equally. The pandemic and economic recession disproportionately impacted the economic standing of women. According to the Grattan Institute (2021), women lost more jobs than men (8 per cent of women versus 4 per cent of men at the height of the crisis); their unpaid work increased by an extra hour a day, particularly in response to remote learning; and they were less likely to receive government support.[27] Those on temporary visas faced heightened vulnerabilities as they were unable to access many services that were offered over the COVID-19 pandemic response. Migrant and refugee women were especially impacted by a lack of access to financial assistance, as others in their community or family groups who may have supported them previously were also affected by the economic downturn during the pandemic. [28]

Equitable public health responses appreciate the specific vulnerabilities that individuals and communities may face in the context of a public health crisis. Those engaged in insecure work, on temporary visas, with low or no English proficiency or limited family support are more likely to experience negative economic outcomes during periods of high unemployment. A health equity approach recognises that socioeconomic determinants of health, including broader social, cultural and environmental conditions like housing, education and work [29], all contribute to disparities between population health outcomes. As part of recovery efforts from a public health crisis, it should be acknowledged that some communities may require more support than others. Pauly et al. (2017) note in their qualitative study of health leaders in Canada, 'there is the expectation that everyone should be treated equally, but that equal treatment is not adequate for achieving equal outcomes. Achieving equal outcomes in health therefore requires that some receive more resources and services than others.'[30] Consideration of CALD communities should be incorporated into Commonwealth and state and territory planning for future public health crises to support equitable responses.

Targeted policy responses addressing the specific needs of CALD communities must also appreciate the diversity within and between communities. Inherent differences in culture, ethnicity, religion and language among CALD communities means that a one-size-fits-all response is unlikely to be effective. While some communities may have the ability to mobilise and utilise their own resources and expertise in response to a public health crisis [31], others may require more assistance. For example, CALD communities living in regional and remote areas may face additional barriers to accessing government support and services. Tailored campaigns to raise awareness of available supports, including in different languages and culturally appropriate formats, can help ensure that CALD communities are not left behind in public health responses. Engagement with local health providers, including GPs, also presents a two-way channel of communication where services can provide access to insights from communities that may not be captured through other sources, while community members can receive trusted information from local networks.

More research and consultation is needed to identify the needs, vulnerabilities and strengths of CALD communities in the context of a public health crisis in order to develop tailored policy responses. Emerging from the COVID-19 pandemic, insights into compliance behaviours highlighted the importance of considering incentives and costs shaping people's actions in response to government-issued public health guidelines. For example, one study by Clark et al. (2020) found that concern for one's own health was an important predictor of voluntary compliance with COVID-19 public health measures.[32] However, it should be noted that many CALD communities are collectivist in nature, rather than individualistic, which could mean that concern for the health of family members may be a more significant behavioural driver in public health crises. Further research should focus on the specific factors influencing the compliance of CALD communities with public health measures to develop effective and targeted messaging.

Key consideration

Incorporate the specific needs of CALD communities – including consideration of intersecting factors such as age, socio-economic background, gender identity, disability, geographic location (particularly regional and remote areas) and migration status – in planning and responses to public health crises.

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