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Submission to the consultations for the establishment for an Australian Centre of Disease Control

Prepared by the MRHP Secretariat

The Migrant and Refugee Health Partnership (MRHP) has been working closely with the Department of Health (the Department) to support the COVID- 19 Vaccination Program rollout to migrant and refugee communities through a communication and engagement strategy and welcome the opportunity through the Partnership to provide input to the consultation process on the Roles and Functions of an Australian CDC.

The Partnership is a Health Peak Advisory Body that brings together health care providers and the community to address systemic barriers to health access for migrant and refugee communities. The Partnership provides a strong focus both on the health system's capability to work effectively with migrants and refugees, and on strengthening health-promoting assets in migrant and refugee communities with a view to improving community health and wellbeing.

Introduction

The Partnership welcomes the opportunity to provide input to the consultation process on the Roles and Functions of an Australian CDC. In this submission, we:

- Comment on the vital role of the CDC as a lead actor in detecting and managing infections disease pandemics and how a culturally responsive lens must be adopted from the outset
- Emphasise the need for a coordinated, agreed and amicable set of relationships between the Commonwealth and state and territory governments
- Make best-practice recommendations based on our experience of health-sector engagement with migrant and refugee communities and its implications for the work of an Australian CDC

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Why do we need a CDC?

Q5. What lessons could be learned from Australia's pandemic response?

The COVID-19 pandemic highlighted the risks faced by migrant and refugee communities, who were disproportionately affected, and the critical roles that they played in medical, community and public health response. This indicates the need to engage proactively and at a structural level with refugees and migrants in developing and rolling out pandemic response. Migrants and refugees faced racism at an interpersonal level and in the media coverage, particularly in the early days of the pandemic. They were often at increased risk of infection due to broader social determinants of health (e.g. being engaged in casual work, being unable to work from home, living in multi-generational households, ineligibility for financial supports due to visa status) which also impacted their ability at times to adhere to government directives around lockdowns, testing, social distancing, and other interventions. The MRHP recommends that a CDC engage with Australia's migrant and refugee community pre-emptively through structural measures so that they are able to address the pandemic threat as a national collaborative response.

Key areas of concern in the COVID-19 pandemic were inequity of access to vaccines, and system level innovations (such as telehealth and home monitoring of positive COVID-19 cases) that were not readily accessible for migrants and refugees due to language barriers, digital access and literacy limitations, which resulted in services often being inaccessible.

While Australia has provided free universal access to COVID-19 vaccinations, this has not ensured access to vaccines for everyone [1]. The equity of the COVID-19 vaccine rollout has been affected by the long-standing barriers culturally and linguistically diverse (CALD) communities face in accessing health services in Australia.

Culturally responsive healthcare systems and service delivery can improve health outcomes via enhancing the knowledge of the health workforce and deliver greater consumer participation. The Australian healthcare system as it stands is complex network of services and settings, involving a mix of health professionals, service providers, funders and regulators and can be extremely challenging to navigate.

This has been a key barrier for CALD communities in accessing the COVID-19 vaccines, particularly during the earlier stages of the vaccine rollout, as people from CALD backgrounds often lack the understanding of Australia's healthcare system to enjoy equitable outcomes. Limited awareness of, and information on, the process to get vaccinated and the clinics available meant that many individuals faced challenges in accessing the vaccine.

Other longstanding barriers repeatedly identified by the Partnership's consultation participants as impacting their access included language barriers and lack of language support, as well as lack of digital access and low levels of digital literacy among some migrants and refugees. The reliance on digital tools to disseminate information, book vaccine appointments, access vaccine records on MyGov and obtain proof of vaccination affected many CALD community members, and required high levels of literacy and digital literacy and

access to reliable internet. This particularly affected those living in remote areas, who were less likely to have access to devices [2, 3], migrant and refugee women, older migrants and refugees. These findings are among those highlighted in a Harmony Alliance, Migrant and Refugee Women in the COVID-19 Pandemic: Impact, Resilience, and the way Forward National Consultation Report. CALD participants in the Harmony Alliance consultations highlighted the additional responsibilities that settlement service providers and female community leaders took on to bridge the digital divide and help people in their communities' book vaccine appointments, obtain vaccine records and access information.

A data revolution

Q6. What are the barriers to achieving timely, consistent and accurate national data?

Q7. What existing data sources are important for informing the work of the CDC, and how could existing data bodies (national, state and territory) be utilised and/or influenced by the CDC?

The most significant barrier is the lack of and inconsistent, legislation to enable data sharing and linkages across the nation including Commonwealth as well as states and territory governments. Even when legislation permits data sharing, entrenched risk aversion in government agencies hinders desirable data exchange from occurring. Sufficient resourcing and infrastructure to enable timely access to data for policy decision making and research will be essential in the development of the CDC [4]. The lack of availability of primary care data in health service data remains a major challenge.

The National Preventive Health Strategy acknowledges that priority population groups may not be measured nor represented equally in data sets. This is particularly relevant for people from migrant and refugee communities, who may be underrepresented in datasets, may not see a category that represents their identity, or may be excluded entirely from surveys and data research based on English-language ability or lack or engagement with data-gathering institutions. Further, it sets a target for improved collection of demographic information in national datasets for priority populations to ensure differences in health and wellbeing outcomes can be measured. This needs to be a key focus and priority around data for the CDC.

To understand populations in Australia the CDC needs to engage with these groups as a priority. Data collection alone changes little, there must be adequate investment in the collection of data where there is currently insufficient data to allow for appropriate disaggregation. [5, 6]

The CDC should be conscious of existing datasets that may be inconsistent or incomplete, and seek to address these with policy advice or data harmonisation projects. we recommend the collection of datapoints such as "country of birth", "year of arrival", "language spoken", and "cultural background" to be included or standardised across federal and state datasets in

order to ensure that data captured is accurate and enables clear conclusions to be drawn about vulnerable migrant and refugee populations. The ongoing Multi-Agency Data Integration Project (MADIP) is one example of data aggregation where certain nuances may be lost due to the inconsistent collection of these demographic markers. Some data sources will also exclude people who are not Australian citizens, such as those on temporary visas. This will have a demonstrable impact on the health services made available to those populations; during the COVID-19 pandemic, many people were rendered ineligible for assistance packages or unfairly impacted by air travel restrictions. [7,8]

Data collected on vulnerable communities must be collected, stored, used, and shared only according to the highest ethical and security standards. Trust in the CDC's management of data will enable research in CALD communities to be undertaken in a way that is collaborative and culturally responsive.

Q8. What governance needs to be in place to ensure the appropriate collection, management and security of data?

Q9. How do we ensure the CDC has the technical capability to analyse this data and develop timely guidance?

Q10. How can the CDC ensure collaboration with affected populations to ensure access to, and the capability to use, locally relevant data and information, particularly as it relates to First Nations people?

The CDC must be adequately resourced (financial and personnel) to ensure it can provide the appropriate technical and analytical outputs that will be expected of it. It should leverage external expertise already available in Australia and this can be actioned through outsourcing to accredited agencies (universities or research institutes) with expertise in particular fields to undertake the work commissioned or required by the CDC.

Any collaboration with affected populations should be undertaken with cultural responsiveness and cultural safety embedded in the undertaking. Where possible, resources should be translated, and consultations should take place in-language with the assistance of NAATI-certified translators and interpreters.

Initiatives such as the COVID-19 Vaccine Ambassadors Program grants were able to provide a bridge between multicultural organisations, local information and experiences, and the directives of the Victorian Government. In this same vein, the CDC should directly support the integration of migrants and refugees into their workplans through targeted training for all levels of public health response including leadership, and standard protocols for outreach and implementation that are founded on engagement. This enables community leaders to co-create programs that are more effective to their local context and experiences, increasing effectiveness and engendering trust.

National, consistent and comprehensive guidelines and communications

Q11. How can the CDC establish itself as a leading and trusted national body that provides guidance to governments based on the best available evidence, and participates in generating that evidence?

State and territory Health Departments as well as local Council bodies often have a better understanding of their jurisdictions and their needs. Additionally, many CALD communities have specific media outlets (such as ethnic radio broadcasts) that can also be leveraged for public health messaging. This can apply to rapid response in public health crisis, but can also be built over time with messages on non-communicable diseases or any changes to health system eligibility or services.

The cultural diversity within Australia is a point of pride and thus necessitates innovative engagement in the context of a public health crisis. As of 2021, 5.8 million people speak a language other than English at home, encompassing over 400 languages from around the world; of these, 15.1% of respondents had low English language proficiency.[8] This superdiversity requires the creative development and implementation of public health responses from the CDC, 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 can receive and understand public health information [9, 10].

The CDC must centre the importance of understanding there is nuance in contexts- 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 [11, 12].

The CDC can increase health literacy and health systems literacy by developing a communications strategy that uses the principles of ‘plain English’ to deliver public health messaging to diverse audiences. It is important that health systems literacy is embedded in this, in order to encourage trust and improve navigability of Australia’s public health system.

Q12. To what extent should the CDC lead health promotion, communication and outreach activities?

Q13. Are there stakeholders outside of health structures that can be included in the formulation of advice?

In CALD communities 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 [12]. 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 [12].

- some leaders omitted or filtered information, either due to a perception that it was irrelevant to their community or to make information less stressful, and
- some were unable to effectively interpret the public emergency information due to gaps in their own knowledge or comprehension.

As aforementioned, while the format and target audiences of CALD engagement strategies require careful consideration, the tone of the message is equally important. To have effective engagement with CALD communities the CDC should invest in frameworks which draw on commonalities, not differences, to emphasise the shared experiences and values of all Australians in responding to public health issues and crises. Co-design of programs with affected communities will ensure that the resources and communications are culturally responsive, easily understood, and accompanied by images that reflect the community.

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 [12]. Ongoing investment in anti-racism education and strategies should be a priority of the CDC as it 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.

The Australian CDC should also maintain records of available population data to ensure that new and emerging communities receive public health messaging, recognising their unique vulnerabilities and the potential for fewer community information networks to be pre-established.

World-class workforce

15. How could a CDC work to ensure that our public health workforce is prepared for future emergencies, both in Australia and abroad?

Continued strategic investment in a CALD 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. The existing and emerging bilingual and bicultural workforce has enormous potential to bring CALD perspectives into healthcare and provide culturally safe practices, as we explore in our paper 'Building on Strength: Developing Australia's Bilingual and Bicultural Health and Care Workforce'. While bicultural and bilingual health personnel already contribute significantly to the sector in terms of providing culturally responsive care, they should not be expected to carry this work without sufficient support from health service structures.

The CDC should promote cultural responsiveness as a core competency across training in health workforce- both in clinical and policy roles. To adequately service a highly diverse society and furthermore in a global context, all health care providers must be equipped to provide culturally responsive care, with an emphasis on knowledge, awareness, and empowerment- this understanding needs to be foundational to the CDC in how it approaches health workforce.

Through recognising the work being done by bilingual and bicultural workers and the potential yet to be realised, the CDC should engage in training and skill-sharing with migrant and refugee community members to equip them to become the public health leaders of the future. The CDC should explore ways to utilise the unique positioning of migrant clinicians as a conduit between public health and the community- one way being registering more migrant health personnel and in particular focus on the role and engagement of nurses in this space.

The value CALD health workers bring to engaging with communities who may typically be outside of the mainstream is high. Community outreach by health workers from CALD 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. These findings are among those highlighted in our 'Conversation Guide on COVID-10 Vaccinations'.

Along these considerations, the CDC will need to consider barriers faced by health workforce participation when examining health equity. More can be found in the policy brief, 'Building on Strength: Developing Australia's Bilingual and bicultural Health and Care workforce.'

We encourage the CDC to include a field epidemiology training arm as other CDCs do, with a focus on training applied epidemiologists and health communication specialists from refugee and migrant background. Multilingual skills in the public health workforce should be regarded as an asset, rather than a useful but non-essential attribute of the health workforce. A further focus of the CDC should be the systematic inclusion of migrant and refugee health workers, recognising their contributions and potential should not be siloed solely as implementers of programs specific to their background but as public health leaders who are able to work across any health programming.

16. How could the CDC support and retain the public health workforce in reducing the burden of non-communicable disease?

A key target of the National Preventative Health Strategy is at least 5% of total health spending be dedicated to investments in preventative health. The success of this NHPS goal is tied to the mission of the CDC- playing a role in coordination, standard and policy setting and monitoring outcomes. Health workforce is a key consideration when evaluating how this can be done and looking to skilled migrants is one way to achieve this.

International partnerships

Q20. What role should the CDC undertake in international engagement and support internationally, regionally or domestically?

An Australian CDC will undoubtedly be called upon as a global resource and be an important institution regionally.

Given the work currently underway by governments globally and the WHO, an Australian CDC will need to partner closely with the associated organisations to ensure its workforce development initiatives are both consistent with international standard-setting but localised for national and jurisdictional implementation.

Disinformation and misinformation linked to concerns over vaccine safety and efficacy were both a domestic and global phenomenon. The CDC will be required to combat global sources of disinformation and misinformation that are spread through global digital networks, and therefore will need to have a global voice.

Information sharing and reciprocity with the WHO and other CDCs will be valuable, not only for global health but also for Australia's capacity to respond to any domestic threats. When WHO were looking to develop global clinical standards for how to provide health care to

migrants and refugees, they came across the Competency Standards Framework Culturally responsive clinical practice: working with people from migrant and refugee backgrounds developed by the MRHP. From here in collaboration with the Partnership have created the Refugee and Migrant health: Global Competency Standards for health workers.

Australia is already recognized as a global leader in culturally responsive health care practices, and this is a key skill the CDC should seek to leverage.

Wider determinants of health

Q24. How could the CDC work in partnership with at-risk populations and associated health sectors, including First Nations people, people with a disability and older Australians, to ensure their voices are included in policy development?

The COVID-19 pandemic demonstrated how the impacts of public health crises do not affect all Australians equally and **the time to build equity into quality accountability** is now. Calls to make health care more equitable are not new.

The rallying cry of many at-risk populations is that there should be 'nothing about us without us'- indicating that collaboration and active participation in policy development is not only wanted but needed. The CDC is in a unique position to establish collaboration and co-design as key principles for policy-making and public health decision-making.

Q25. How can the CDC best deliver timely, appropriate, and evidence-based health information to culturally diverse and/or at-risk populations?

Establishing and preserving community trust is an ongoing effort for governments at all levels. The Partnership recognises this is especially the case during a public health crisis where trust in government is critical to achieve community cooperation. The CDC needs to understand CALD communities are not homogenous, and to reach as many individuals as possible, it is important to consider how different cohorts of the community will receive and process public health messaging [14].

Messages should be crafted to consider age, gender, preferred language, religion, location, migration status, disability, technological proficiency, and level of scientific literacy in the communities being targeted by public health campaigns [14,15]. Public health institutions must find tailored ways to communicate with young migrant and refugee individuals, emphasising that healthcare in Australia is accessible, confidential, impartial and culturally sensitive.

Negative interactions with health workers, including experiences of racism and discrimination, may also reduce community trust in the health care system and by default distrust of health messaging. 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

Q26. How should the CDC engage across sectors outside its immediate remit (including portfolios with policy responsibility for wider determinants of health, culture, and disability)?

In addition to engaging with state and territory health departments, the CDC should recognise the role that the professional medical colleges play in influencing the health workforce. The Migrant and Refugee Health Partnership has demonstrated its ability to work across the wider health sector in order to achieve public health outcomes for migrant and refugee communities. The Partnership recognises the role that medical Colleges (RACGP, RANZCOG, ACCRM, and many others) play in the development of health practices and training regimes, and therefore what role they play in developing and implementing culturally responsive public health responses. As previously mentioned, the Partnership's "Competency Standards Framework: Culturally Responsive Clinical Practice: Working with People from Migrant and Refugee Backgrounds" has been endorsed by a wide range of medical Colleges and continues to be a foundational document for other work in this space. The Partnership also has working relationships within the settlement sector that reaches across CALD communities, recognising that health and wellbeing should be considered in a holistic sense during the initial stages of a person's settlement journey in Australia.

Experiences during the COVID-19 pandemic highlighted the necessity of adopting an intersectional collaborative model of working [3,10]. Specifically, as it relates to CALD communities, it was made 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- and this cannot only come from engaging with health services [14,15]. Health is a product of all functions of society and collaborative partnerships must be a core feature of design whereby the CDC builds and fosters these networks. World Health Organization (WHO) guidance recommends leveraging the strengths from across all sectors, and communities, into a united response to contain the disease and reduce its societal impact [16]. These would include sectors most commonly at the coalface of providing services: ministries of education, employment, housing, infrastructure, and social sector, as well as private and nongovernmental actors [17]. More can be found in the policy brief, 'CALD communities in public health crisis'

The inherent unpredictability of crises means 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 (ie, housing, education) often have intimate knowledge of the specific needs of their communities, which can help inform the development and delivery of health responses.

Research prioritisation

Q27. Should the CDC have a role in advising on (or directly administering) funding or prioritisation of public health and medical research?

MRHP supports the approaches highlighted in the discussion paper making clear the current thinking on the connections between existing research communities and the CDC:

- To ensure the highest possible quality of advice and policy recommendations across its sphere or responsibility, it is essential that the CDC establishes and maintains a close relationship with leading public health research organisations and the research sector as a whole. This evidence driven policy advice and practice will be a fundamental building block for the credibility of the agency.
- Finally, an important potential role of the CDC is to communicate and influence research funding priorities for Australia's key health and medical research agencies such as (but not restricted to) NHMRC and MRFF. In this way publicly funded research investment can be steered in the direction of research questions of highest priority to the public health issues as identified by the CDC. In addition, the CDC might be well placed to ensure that research that is classified as public health might in fact be closer to the relevance and priorities in public health than might be the case currently relating to research funding labelled in this way.

The Partnership reiterates the importance of ensuring *Health Equity* is a cornerstone research area of interest to the CDC. Historically, less attention is paid to health equity concerns and the relationship between existing socio-economic inequalities and the spread and scale of infectious disease pandemic [18,19] Such as how existing socio-economic inequalities interact with and exacerbate case rates, symptom severity, morbidity, and mortality; these continue to remain significantly under explored linkages. Better understanding the social nature of (emerging) infectious disease pandemics will ultimately help reduce the burden of disease and better equip responses to pandemics.

The CDC Project

Q28. How could the success of a CDC be measured and evaluated?

The MRHP reiterates the importance of understanding health inequity and how this impacts the lives of migrant and refugees accessing and receiving services and health outcomes of those communities. The COVID-19 pandemic exposed longstanding structural drivers of health inequities and to understand how to navigate future health emergencies and pandemics necessitates an examination of these same key structural determinants and how they contributed to disproportionate impacts felt by migrant and refugee communities during

at the height of the pandemic. The siloing of technical advice from the social determinants of health were an identified gap in the US CDC COVID-19 response [20].

Success should be evaluated through how the CDC integrates the need for health systems to address social determinants of health to ensure access for all- particularly migrants and refugees. This can be realized through allocating organisational resources from the start to support efforts to measure inequalities and ensure health equity is a strategic priority of the CDC. This can be measured and evaluated by partnering with community, collaborating with its members and concurrently, providing targeted, customised materials and approaches that are culturally responsive. Both activities have long been a recognized cornerstone of efforts to improve public health.

Community engagement, collaboration and partnerships are at the heart and core of public health. It is essential to the CDC in achieving health equity for all.

Conclusion

MRHP appreciates the opportunity to make this submission and commends the Government and Department for undertaking what is an important and historical step for Australia. We are committed to elevating the voices and concerns of migrants, refugees, and other CALD communities by to improving health access, experience and outcomes and welcome the establishment of an Australian CDC. Health is everyone's business, and the Partnership is committed to continuing our close collaboration and support of the Government and Department in this work.

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