Speaking COVID-19: Supporting COVID-19 communication and engagement efforts with people from Culturally and Linguistically Diverse Communities

Holly Seale (h.seale@unsw.edu.au)
University of New South Wales
Ben Harris-Roxas
University of New South Wales
Anita Heywood
University of New South Wales
Ikram Abdi
National Centre for Immunisation Research and Surveillance, Sydney Children's Hospitals Network
Abela Mahimbo
University of Technology Sydney
Ashfaq Chauhan
Australian Institute of Health Innovation, Macquarie University
Lisa Woodland
NSW Multicultural Health Communication Service, University of New South Wales

Research Article

Keywords: pandemic, COVID, community, culturally, ethnically, and linguistically diverse, communication, engagement

Posted Date: February 1st, 2022

DOI: https://doi.org/10.21203/rs.3.rs-1277807/v1

Abstract

Background

Since the emergence of COVID-19, issues have been raised regarding the approach used to engage with culturally, and linguistically diverse (CaLD) communities during this public health crisis. This study aimed to understand the factors impacting communication and engagement efforts during the COVID-19 pandemic from the perspective of key CaLD community stakeholders and opinion leaders.

Methods

Forty-six semi-structured telephone interviews were undertaken with key stakeholders who have an active role (established prior to the pandemic) in the delivery of services and other social support to CaLD communities in Australia.

Results

Seven key themes emerged: (1) the digital divide and how to really connect with people; (2) information voids being filled by international material; (3) differentiating established with new and emerging community needs; (4) speaking COVID-19; (5) ineffectiveness of direct translations of English language resources; (6) Coordination is needed to avoid duplication and address gaps and (7) recognising the improvements in governments' approach.

Conclusion

It is critical that alliances be set up that can be activated in the future to reduce issues around resource development, translation, and dissemination of messages to minimise gaps in the response. Financial assistance must be provided in a timely way to community organisations to support the development and dissemination of culturally appropriate communication materials.

Background

Populations at risk of COVID-19 infection have been diverse and differ in COVID-19 literacy, and social, behavioural, cultural and health practices. In non-pandemic times, people from culturally and linguistically diverse (CaLD) backgrounds may be vulnerable to the factors that contribute to health inequity, including lower health literacy, cultural and language barriers, lower socio-economic status, lack of provider cultural competence, lack of social support and a sense of disempowerment (1, 2). During the COVID-19 pandemic there have been marked racial and ethnic disparities in rates of serious illness and mortality (3, 4). However, the sources of the COVID-19 disparities have been more difficult to analyse, compared to establishing the existence of such disparities (5).

Previously it has been suggested that culture can also interplay with virus spread through behavioural, and societal variances including health-seeking behaviour, and intergenerational cohabitation (6). In theory, several factors may heighten the risk of COVID-19 transmission in CaLD communities including extended family groups living together (large, inter-generational households), higher religiosity, collectivist approaches to childcare and the cultural expectation of family members providing care for each other when sick (7–10). Several authors have also pointed towards socio-economic factors including housing arrangements (multi-occupancy living), income, access to insurance and stable housing, as well as types of occupation (11, 12). Previous work has also identified that residents located in low-income neighbourhoods are less likely to be able to stay home in response to COVID-19. This can relate to work-related demands (13). Workers in certain industries, such as meat processing plants, aged care, and hospitality, have been the most impacted during COVID. These jobs tend to be lower-waged and are usually made up of workers from CaLD backgrounds (14). The Federation of Ethnic Communities' Councils of Australia (FECCA) reported that '40 per cent of skilled migrants still work in lower skilled jobs' across Australia (15). This equates to a higher proportion of people from CaLD backgrounds working in public-facing occupations including retail, transport or service, occupations where there is little opportunity for physical distancing and higher levels of interaction with people.

In April 2020, letters were sent to federal, state and territory health ministers from 16 key organisations including the Ethnic Communities Council of Victoria, Settlement Services International, Migration Institute of Australia, and HOST International, which raised several key concerns about the Australian Governments' COVID-19 responses. They spoke about a lack of consideration for CaLD communities being given, including around access to appropriate and reliable in-language COVID-19 information, and, most specifically, behaviour change advice and directives. Their call to action to the government was to make sure "that CaLD communities are not left behind in their access to and understanding of COVID-19 and are not made more vulnerable than other parts of the Australian community because they have become an afterthought in the rapid response to- curbing infections." To support enhancements to Australia's COVID-19 pandemic response, with a particular focus on communication and engagement with CaLD communities, this study aimed to understand the factors impacting pandemic response efforts from the perspective of key CaLD community stakeholders and opinion leaders.

Methods

Semi-structured in-depth telephone interviews were undertaken with key stakeholders and opinion leaders, of approximately 30-40 minutes in duration, between January- April 2021. The collective term 'culturally and linguistically diverse (CALD)' refers to "the non-Indigenous cultural and linguistic groups represented in the Australian population who identify as having cultural or linguistic connections with their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home" (16). The Human Research Ethics Advisory Panel at the University of New South Wales reviewed and approved this study (HC200776). All of the methods used in this study were performed in accordance with the relevant guidelines, outlined by The National Statement on Ethical Conduct in Human Research, published by the Australian Government.

Sampling

Participants included those people who have an active role in the delivery of services via multicultural health and other social support services via migrant resource centres, refugee health services, settlement services, community-based organisations, translation services and primary care settings. In addition, we sought to include people in senior leaderships positions in multicultural health and diversity related activities whether that be through advocacy, policy/program development or research. This principally encompassed personnel such as those from government agencies or CaLD community peak bodies/Councils, and CEOs of community organisations.

This study used a range of national-local-personal approaches to recruit participants. Firstly, an online search of relevant websites was conducted to identify potential participants matching the eligibility criteria. Each potential participant was then contacted via email with an invitation letter. Secondly, interested participants were asked to directly recommend any colleagues who may be willing to participate. Lastly, emails were sent directly to known relevant contacts of the research team who were working in the relevant sectors. An effort was made to recruit at least one person from each of Australia's States and Territories to capture a broad range of views. However, we were unable to recruit any participants from Northern Territory. Participants were included in the study on receipt of informed verbal consent. This study did not collect any identifiable personal information from the participants.

Data collection and analysis

An interview guide was developed and reviewed by the researchers (HS, BHR, AH, IA, AM) to identify key areas of interest for the study. The questions related to the following topics: perspectives towards the current communication approaches being used by the government, factors affecting communication and engagement with CaLD communities, the communication roles and influences of different multicultural services, and suggested options that could be adopted to enhance communication and engagement with CaLD communities around the COVID-19 vaccine program. Questions were asked in an open-ended manner to allow room for expansion. Prompts were only given when the interviewer deemed, they were required to encourage the conversation back to topic. During the interviews, member checking was conducted to ensure that the ideas identified during the early phase of analysis were appropriate. The data were analysed using thematic methods of building codes into themes using the constant comparison approach by HS and AC using NVivo software. Themes were compared within and across the sample and structured around the key interview topics while also allowing inductive and cross-cutting themes to emerge from the interview data. Any differences between the coders were resolved via discussions with the wider team to ensure vigorous analysis.

Results

Fifty-seven people were contacted to participate, of which 46 interviews were undertaken with key stakeholders and informants across Australia. The characteristics of the interviews are described in Appendix 1 using the CORE-Q reporting format (17).

1. The digital divide and how to really connect with people

Prior to COVID-19, outreach activities were largely done face to face via case workers visiting clients, walk-in appointments/consultations, or via group meetings (i.e. with seniors or new mums). Social participation was encouraged: "*language-specific social support groups to citizenship classes, sewing classes, just social classes as well, and lot of information sharing, parenting classes. We had that kiddies playgroups and mothers' groups*" (Interview 1). Following the emergence of localised COVID-19 outbreaks in Australia, participants spoke of the "frantic" need to transfer to virtual or telephone mode to continue the delivery of routine services, and the introduction of meetings via teleconferencing platforms, to support engagement opportunities to replace those face-to-face meetings that needed to be suspended. The purpose of the virtual engagement approaches was to ensure that community members received relevant COVID-19 information including social distancing measures, lockdown requirements, testing recommendations and the COVID-19 vaccination program.

Not having access to a computer or the internet, having low digital literacy or English literacy levels and language barriers were all raised as barriers affecting the community. It was not just the community members themselves that lacked the hardware (computers or modems) or internet access to switch online but also staff members from some community organisations. In these situations, many were heavily reliant on their mobile phones. To support those without the hardware, donated laptops and Wi-Fi dongles were used to ensure case workers and community members could continue to connect. Video conferencing sessions were given to help those in the community who were unsure about how to use Zoom, FaceTime, Viber, WhatsApp or other chat and conference platforms ("*They had taught them how to use some kind of video conferencing so that then they could actually have their meetings*"). Whereas in other settings, telephone contact continued with clients (i.e., those requiring settlement services) and community members: "*for a lot of the older community, it's very one-on-one. We implemented the phone checking service where we were identifying the most vulnerable and providing them support and information*" (Interview 12). In one situation, a community organisation started up a Saturday night free call teleconference service to connect women "*who can't read or write in Somali, but really want to know stuff about COVID."* (Interview 21)

Preference for smartphone-based platforms such as Viber, Facebook Messenger and WhatsApp were reported by participants in comparison to computer-based platforms such as Zoom. Some organisations started to connect with communities via WhatsApp, however they reflected that it took time to set up the connections and the messages were very static.

2. Information voids being filled by international material

It was acknowledged that while Australian mainstream media was a good source of disseminating information at large, participants raised concerns that mainstream media may not reach CaLD communities. Participants spoke about "voids or gaps" occurring during the pandemic in terms of the availability of COVID-19 related news and government information. These gaps were linked to the delays in getting official information translated, or translated materials not being available in all languages. In

almost all interviews, participants spoke about the reliance on overseas news programs or the fact that some community's preference international media that they stream from their country of origin. Concerns were raised that the information coming from overseas did not reflect the situation in Australia nor the rules/recommendations around COVID-19 pandemic control measures. This issue may have led to some communities misunderstanding their risk of COVID-19. For example, early in the pandemic, there were few COVID-19 cases in Africa and so some African people thought they may be protected from the virus just through their ethnicity. Confusion amongst community members regarding the COVID-19 vaccines including about which vaccines are recommended or licensed for use was also linked to CaLD community members watching news channels from abroad.

"I had a conversation with my auntie one day, she watches Greek streaming…, and she was telling me something. I said, "No, that's not exactly the case because here, they're giving us different information." She goes, "Yes, but in essence, it's the same." She was comfortable receiving the information that was coming from Greece without having any clue what Gladys (Premier of NSW at the time) was saying, for example, every morning when she was coming out on TV. (Interview 11)

"The other thing was the absolute confusion, people are really confused about COVID, and that really comes-- It's complicated to understand full stop, but if you consider that most of obviously, everyone in all our communities come from somewhere else, and most of those places in the world have had a very different experience of COVID. I don't think that in New South Wales, we were fast enough to provide the messaging to community, and so we allowed that void to be filled" (Interview 33)

Compounding this issue was that some COVID-19 resources, as they included "technical jargon", which may have been confusing for people with low literacy or health literacy levels, even if English was their first language. Government materials were not available across all languages nor were they always available in simplified English that was "accessible" to communities.

" *There are some communities that are missing the information. If we take example of the South Sudanese community, there's one particularly in Dinka. Dinka is one of the tribes among 64 other tribes. It means you provide information to one tribe, there's 63 missing. That's what I mean by saying, yes, there's some information there, but it doesn't capture everybody. (Interview 1)*.

In some settings, participants spoke about interpreting the information to "make it real". For some communities, information was not available in their local language: "*we can see the Department of Health Information flashed in Arabic and Chinese, but no African languages were available". (Interview 21).* In these situations, it was stressed that community language radio and online information sessions ("Townhalls") delivered in-language were critical. Lastly, there were mixed feelings towards the role that Australia's multicultural and multilingual broadcaster (SBS) played in disseminating information. Some participants described it as being brilliant, others were more reserved in their comments and felt that it failed to capture what was really needed.

“My mother or my auntie, there's no connection to SBS as it used to be years ago. Why would they even go in and watch the Greek news if they can watch the news directly from Greece? Why would I wait for the last night's news if I can watch them live?” (Interview 11)

“Stop wasting money on things like ethnic press and TV. Sure, they do a good job and they're important to a degree, but there is always going to be a gap that you're not going to be able to plug unless you actually get the community to take ownership, and let them do the communication themselves to the people that they're close to”. (Interview 40)

One suggestion that was put forward was to have community leaders talking in-language during the news programs on mainstream media channels or for messages to pop-up. However, others felt this was still missing the mark.

3. Differentiating established, with new and emerging communities needs

There was not a consistent picture when it came to identifying which community groups should have support/resources directed to. Some participants suggested that newly emerging communities (migrant/refugee) would be most at risk from missing out on messages and support services. One key factor contributing to this was the focus on providing translated COVID-19 information to “high volume” community groups versus “high need” groups. Another issue identified was that established communities have ‘infrastructure’ in the form of community organisations, community leaders, in-language newspapers, or radio stations etc. Whereas “*it’s the newly arrived communities that have very little infrastructure who are the most vulnerable, I think. Particularly in small communities like the Rohingya, who have only had a written language since the '80s, and hardly anybody can read those”. (Interview 16).* However, not all participants agreed with this sentiment.

Participants also highlighted that Governments did not consider those individuals who come from cultural groups with oral traditions or who are illiterate in their own language: “*One of the first outbreaks I think in our region was in the meat works, and most of the employees at the meat works work from Karen and Burmese heritage. A lot of people in those communities don't read or write in their own language as well, and so thanks to the local community leaders, we set up a testing site and most people heard of it from word of mouth. That's how, but we do have Karen information that is written, but we also had some videos made*”. Having verbal messages was identified as being critical. In some suburbs, organisations resorted to door-knocking to encourage people to go and get tested.

The ability to navigate websites was also emphasised as an issue for some community members. Especially in the beginning of the pandemic, it was not easy to locate relevant information on the government’s websites. While participants acknowledged that there were improvements, challenges remained for those community members who did not read in English. Even if online information was translated, there was often the requirement to browse the website in English to find the relevant language: “*The really common accessibility issues were languages were ordered. You had to browse in English*

alphabetical order. Look, most people do know the name of their language in English, but you also need to know the other language". Participants noted that not all the COVID-19 resources available online were translated into every language.

4. Speaking COVID-19

Issues around low levels of understanding about COVID-19 (about transmission, testing requirements, vaccination program etc.) and increasing amounts of misinformation triggered some organisations to offer online community forums. These forums were provided for interpreters, case workers, community leaders and often featured bilingual GPs and government officials to provide updated COVID-19 information and to answer any questions. In some settings, these sessions were being held weekly or fortnightly.

"We've had GPs, we even had an orthopaedic surgeon present weekly COVID updates to audiences, getting the accurate advice, wash your hands, keep your distance, do all that, but also talk about the specifics in the community." (Interview 18)

Other forums were set up to provide updates to local community leaders so they could pass on relevant information to their communities: *"We established what we called the Greater Western Sydney Community Leaders Forum. What we did is we invited community leaders from across Western Sydney. We were having Zoom meetings, initially weekly ones, and we started bringing in the police, for example, to talk about the fines and what was legal or not, health practitioners to talk about the virus. Then we brought in some tax agents to talk about work, the job seeker and job keeper sort of stuff." (Interview 11)*

Whilst resource kits were available from the government to support outreach efforts, criticisms were raised that the kits were just information. What was lacking during the early part of the pandemic were training sessions to support the adoption of the resource kit. As one participant indicated there was a need to provide examples of what other organisations or community groups were doing. Lastly, participants also identified that there was a need to provide training forums for case and settlement workers, as well as translators/interpreters to support their understanding about COVID-19: *"We ran workshops called Speaking COVID, basically. We've focused on engaging with the interpreters in workshops…. We did those bi-language group and we had some content that we talked about what does airborne transmission mean and what's a droplet, and what does isolation mean, and what does quarantine mean, and all of the terms that became really common in that period and explained those in ways that the interpreters could understand so that they could, in turn, interpret them appropriately for the clients." (Interview 16)*

5. Ineffectiveness of direct translations of English language resources

Understanding and acknowledging the different cultural beliefs about illness and about COVID-19 was critical to the development of resources. However, in many settings participants spoke about the fact that COVID-19 education resources were often developed in English and then translated. Potentially as an

outcome, participants spoke about mistrust and misunderstanding amongst community members, linked to the fact that resources were not tailored to their beliefs or practices: *One story that someone told me is true stories of elderly woman in a smaller community who contracted the virus. In that culture, when someone's sick…you go and visit them*". (Interview 18). The problem is that the education resources did not account for these practices. Other participants spoke about the words/phrases that were in translated materials which were nonsensical or gave the wrong message: "*when we hear the media or the government saying, 'We've produced the written material, you really have to be careful on what you're saying because no one's vetted the accuracy of that material. That's where I'm suggesting that it seems on the surface that the right thing's been done, but when you have a look at the content, it's highly questionable*" (Interview 13). As a solution, it was suggested that education resources needed to be developed from scratch with the targeted communities, which are not only language specific, but which also account for the nuances within the community. The videos should include local faces and phrases that are 'known in the community".

"*In other words, you end up with 20 slightly different documents. They're not all the same, but that's okay, as long as the fundamental information is the same, the way it's presented is slightly different*". (Interview 17).

Beyond having resources developed in collaboration with the target community, there is still a need to have bicultural workers available to help with supporting community members understanding of the information. For example, it was recommended that people avoid 'share-plates'. However, for many Arabic-speaking and African communities it is common practice to sit and eat communally, with everyone taking food from a main platter. Therefore, bicultural workers were critically to helping breakdown the messages and to reassure the community that they could still have dinner with their direct family members. These workers do not necessarily have a health background, but they are able to speak the language, read and write in English, and their language. They are seen as having some influence and visibility within their community. In some settings training was provided to the bilingual workers so that they could become the 'face' of the COVID-19 communication strategy, working in partnership with the health officials.

"*We paid our bilingual educators to make calls to people, the networks they had, we give them targets and we say, "Try and call at least 10 women that you can." (Interview 43)*

They also enabled two-way feedback and the capacity to hear from the community members regarding any ongoing issues or factors impacting public health strategies such as testing. While participants spoke of the value of these workers, in reality not all geographic areas had these workers available.

"*We hired eight bilingual workers in various language groups so that they can actually speak to callers to a particular language-specific phone number to ask guidance on COVID-related matters. Not to be a substitute for the COVID line, but to be able to actually call a number and speak to someone in your language*,". (Interview 13)

6. Coordination is needed to avoid duplication and address gaps

The issue of duplication was raised in terms of the development of resources and videos for different community groups: "*What you ended up having was this website with collections of stuff in different languages often saying the same thing, but slightly different. It was a disaster*" (Interview 33). Participants spoke about confusion occurring amongst their community members when there was differing regulations in place across the different states/territories. They also cited confusion when organisations didn't "sing from the same songbook" or when messages were not consistent: "*the service providers might send them something, Department of Health sends them something, and then their workplace sends something else, so it creates a lot of misunderstanding, but it creates a lot of confusion for the young people" (Interview 4).*

To reduce these issues, one participant suggested that it would be great to have a "*one-stop-shop where GPs and community members also could access accurate health information according to language that they could easily search up and share with other members of the community*". In putting for this suggestion, they acknowledge that a huge amount of work was being done to develop resources but that they were not always being stored in an easily accessible format. Being able to identify the different needs of communities, as well as the funding available/needed promoted one state to introduce a community connector advisor, who was tasked with getting organisations to talk to each other. The need for coordination at a state level was also endorsed by other participants who felt that coordination of efforts could not be done at the district level: *"Coordination is really key… It's really important to have functioning networks with good information-sharing and healthy relationships to avoid that". (Interview 14)*

However, duplication was not always framed as having a negative impact on pandemic efforts as in some instances having multiple videos outlining the public health requirements or promoting the COVID-19 vaccine, may be useful as each community organisations will 'add their own jargon" and will have a close relationship with the community they serve (especially important in places with strong regionalism). As one participant stated: "*In Queensland, we have quite strong regionalism and people in the region are sometimes sick of being told what to do by Brisbane all the time. The decisions are from Brisbane in an urban area and they don't always understand what's going on out there*". It was acknowledged that if bottom-up approaches like this are going to be done, it is critical that health experts are involved also to ensure the messages are accurate.

7. Recognising the improvements in governments' approach

Participants raised concerns that early in the pandemic the Australian and state governments did not seem to have plans for multicultural communities. Issues were raised with governments but that there wasn't the sense that organisations were 'heard'. Participants acknowledged that the government was

only "*15 minutes ahead of us in terms of the decisions and in terms of the roll-out, in terms of policy. A lot was happening, and it was very quick. They just didn't take their time, and maybe they didn't have that time*. (Interview 12). At a regional level, local government organisations took it upon themselves to undertake rapid consultations with community members in order to understand their perceptions of the pandemic, as well as their concerns. Using this information, they were able to influence the local district response including the visual and digital resources.

"*The advantage of this was because the community came on board in terms of what should go in, how should it be said, we were able to address the immediate fears and concerns of communities. We were able to have their people as the front face, so we could get the messages across. (Interview 43).*

Two events were signalled as the triggers for the governments revising their approaches. The first event spoken about was the hard lockdown that occurred in nine public housing towers in inner-Melbourne, where there were significant delays in preparing and distributing materials about the lockdown in community languages and an absence of interpreters. The second event was the issue regarding the translation of COVID-19 materials and the mix up in languages including one document which had Farsi and Arabic mixed together. As one participant indicated, at that point: "the Department of Health said, "Well, okay, let's get this done properly and listen." Following those events, COVID-19 advisory groups were set up focused on multicultural communities which brought together academics, practitioners, GPs, and community members.

This sense of a shift in the government's approach from mid-2020 was a consistent message across all the interviews. As one participant suggested "*they very clearly heard the message from communities, which is stopped doing it to us and start doing it with us*". Representatives from different community organisations spoke about meeting with federal ministers/policy advisors via Zoom meetings. While there appeared to be improvements, issues were still raised regarding the responsiveness of the different government teams including the policy versus communication teams.

My criticism of the Department is that the policy side or the policy team is switched on, and they're with it, they're listening to the advice that we're giving them. We're on the same page. Whereas the communication team, we keep saying the same thing over and over and over again. In the meetings they say, "Yes, that's a good idea and we'll go away", and we just keep seeing the same mistakes come up. We just see things as basic as make sure that English material is in plain simplified English before it goes to the translators. I think I've said that about 12 times.(Interview 40)

In the initial phase, funding was made available however it was directed towards peak bodies as opposed to going directly to the community. It was on the peak bodies to organise the distribution of funds via multicultural COVID-19 community grants, which local organisations could apply for to support local activities. For example: "*one community ended up getting some funding,… the women were very keen to watch the news and find out what happened, but the news is all in English. They had someone who was taking the announcements… three or four days' worth and putting it into one chunk of text and having that translated and then shooting that out via WhatsApp or WeChat or something, one of those platforms,*

to all of the members of the community group. (Interview 16). Lastly, criticisms were made of the funding that was directed towards consultants and creative agencies, as opposed to giving the money to the community to produce local tailored content: "*just give the money to the communities. They know the communities best, they know what the issues are. It's targeted, they're very local."* (Interview 40)

Discussion

By undertaking interviews with stakeholders involved with providing support to people from CaLD backgrounds, we were able to gain a rich understanding of key challenges encountered around communication and the attempts being used to engage with community members regarding the pandemic public health measures and restrictions. Our study results echo the concerns that were raised by multicultural networks and consumer council reports published since the start of this pandemic (18–20). The remaining of this paper will focus on consolidating the key lessons and reflecting on lessons learnt to inform ongoing pandemic efforts and revisions to pandemic plans/guidelines. These lessons will centre on three key areas: (1) partnerships and governance processes; (2) supporting community ambassadors; and (3) funding support and mechanisms of distribution.

Partnerships and governance processes

Throughout this pandemic, the issues of information/resource overload and duplication of efforts have been contrasted with issues regarding the ability of community members to access resources that are culturally tailored and in relevant modes of delivery. To try and reduce these issues in future events, one possible strategy is to develop a management plan to support the response efforts focused on CaLD communities. A similar document is available to support the emergency response management and operations focused on Aboriginal and Torres Strait Islander populations (21). It outlines the roles and responsibilities for the critical partners including federal, state and territory governments, as well as sector support organisations. Importantly it outlines the need for coordination, with emphasis placed on identifying appropriate ways to engage with sector organisations and community stakeholders, to establish meetings for regular updates and sharing of important information, and for establishing systems to build trust. Lastly, it also recognised the need to provide funding for dedicated surge capacity to support relevant workers. The need for an advisory group was established early and included Public Health Medical Officers and leaders from the Aboriginal Community Controlled sector; Aboriginal Health Services; state and territory government public health and medical officials; Aboriginal communicable disease experts; the Australian Indigenous Doctors' Association; and the National Indigenous Australians Agency.

In comparison, the need for a dedicated and tailored management plan for CaLD communities has not been historically outlined. Coming into this COVID-19 pandemic, Australia's response was historically guided by Australian Health Management Plan for Pandemic Influenza (AHMPPI) (22), which was last updated in August 2019. This document acknowledged the need for Australia's public health response to be guided by the need to ensure equity in the provision of care, recognizing the cultural values and

religious beliefs of different members of the community. However, beyond that reference, the only other acknowledgement of the need to bring in other sector parties was linked to the delivery of the pandemic specific immunization program, with the recognised need to have education sessions delivered by CaLD community groups. With the emergence of COVID-19, came the release of an updated response plan, the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19 Plan) (23). The document was published very early in the pandemic, and only referenced the need for potential support to be provided to remote and rural communities (including remote and rural Aboriginal and Torres Strait Islander communities) if needed. However, it took until December 2020 until an advisory committee was constituted focused on CaLD communities (24). The advisory committee is constituted for the duration of need (with an extension currently given until the end of 2021) and has three separate working groups focused on communication, vaccination, and data. As outlined in the terms of reference, the advisory group will provide advice to the Department of Health on the 'experience of culturally, ethnically and linguistically diverse people and communities in relation to the COVID-19 pandemic'. Beyond the COVID-19 pandemic, there is a need for a national advisory board to be created earlier in pandemics and large-scale emergences to support meaningful partnerships and to streamline the dissemination of communication and resources in a timely way. It could also have greater oversight into how funding is used to support communication efforts, as well as to signal to governments where barriers remain. The need for a national advisory group has been recently echoed by others (25).

At a state or district level, the value of having an interagency collective response was outlined in a report focused on the network response that occurred in Queensland (26). The initial core group was based on pre-existing collaboration between hospitals, health services, primary health networks and refugee health networks, with additional partners brought in representing key multicultural agencies, settlement services, and community councils, and government. The aims of this informal interagency network were to engage with all stakeholders and work with Queensland Health to facilitate COVID-19 public health messaging. An evaluation of the interagency collective approach highlighted that a strong partnership between the agencies has been formed and that there was high level of satisfaction, despite the time requirements (26). In terms of deliverables, the interagency collective demonstrated significant inputs and outputs as part of the collective response including regular meetings, community and leader information/training sessions, newsletters and translated resources. One of the partners involved with the collective response stated that: "*We have achieved a great amount collectively in an ever-changing environment with multiple players and complexities. This could not have been achieved without the partnership approach*." (26) It was however acknowledged that more work needed to be done to clarify the clarifying and formalizing partnership structures and processes. While these partnerships may have also been in place in other settings around Australia, to the best of our knowledge this was the largest, representing a broad scope of partners. Understanding the enablers, as well as the structures and strategies that could strengthen the partnership would assist other States to introduce these collectives for both pandemic and non-pandemic emergencies.

Supporting community-based ambassadors

The need to support CaLD community leaders, faith leaders, multilingual and settlement sector workers to be able to communicate about COVID-19 was a key message that came through all the interviews. These practitioners have been described as the "conduit between the Government and communities", based on the role they play in ensuring that messages were accessible, meaningful, and effective for communities (18). The need to provide opportunities for education and/or training was identified early by some of the stakeholders we interviewed and acted on, with virtual meetings organised by local health districts, and by state health departments. But there was certainty no real sense whether these information/training sessions were available across all States/Territories or consistently delivered to all sectors.

The need to provide the latest information on COVID-19, as well as medical and community resources to community leaders, was highlighted in an article by Panagis Galiatsatos and colleagues (27). The article outlined a program that commenced in early March 2020 for faith community leaders which involved twice weekly 60 minute long conference calls (27). Beyond providing information to participants, the calls also provided an opportunity to voice concerns and ask questions. As the pandemic continued, the spectrum of participants extended to representatives from religious communities, senior centres, hospitals and other health care centres, community service organizations, and the local government. Beyond supporting the understanding around COVID-19 of those on the calls, the authors also identified that the information from the community calls were being "*shared by phone calls, texts, and e-mails. Other participants have shared the information with caregiver support groups, book clubs, community associations, Sunday school classes, and colleagues*" (27).

Beyond ensuring community leaders and other stakeholders can receive the latest guidance about the situation and to ask questions, there is also the need to consider broader training opportunities during pandemics or other emergencies, as well as ways to expand the potential pool of practitioners rapidly in response to pandemics and health emergencies (28, 29). Potential focus areas for training could be around strategies that support communication, talking about vaccines and addressing misinformation effectively. Other potential areas could be around developing resources for the community which account for health literacy needs.

'Community ownership' was a phrase that was repeatedly used by participants during the interviews, with emphasis placed on engaging communities in the development and testing of messages (and images) and audio/visual materials. The need for bottom-up communication approaches which involve stakeholders and tailored materials, has been repeatedly echoed in the published literature (and by our participants), as it enhances enhance accessibility, usability, and inclusiveness (25, 30). A bottom-up approach starts with understanding the targeted community, what are their information needs and what information/resources will satisfy these needs. This also means engaging different community actors including the community and faith leaders, as well as those seen to be trustworthy and relevant (31). However, these processes require funding to support the resources and time of people involved. It is also critical that local public health units work closely with community actors to ensure that the health messages are accurate and reflect recommendations. Issues have been reported during the COVID pandemic regarding the accuracy of messages, the variability in health messages translated by

community leaders, as well as situations where the values/beliefs of community leaders have not aligned with the health experts and government policy and so conflicting messages, for example around the COVID-19 vaccine have been promoted. In some situations, anti-vaccination messages have been sent out by religious leaders. To reduce this occurring, it is suggested that health units and governments work closely with the community leaders, whereby community leaders and representatives write the materials for their community and then the resource is fact checked by the senior medical advisor.

Lastly, while participants spoke about the close networks that they have with community leaders and other ambassadors, concerns were still raised about how actively governments (federal and state) are engaging with these actors. It is critical that efforts are taken to explore the feedback mechanisms being used and to ensure that feedback is being collected (and integrated into policy/revisions to strategies) from all of the different CaLD communities, as well as across urban, regional and remote areas. One suggestion is to establish WhatsApp groups with community ambassadors or community volunteers to collect questions, suggestions, and concerns. However, collecting this information is not enough, it also needs to be discussed and shared across the sectors of the response.

Conclusion

During the COVID-19 pandemic there have been issues around the poor quality and delays in the materials available to communities, as well as conflicting messages. Given the latest Omicron surge and recent policy changes in light of increasing COVID cases, it is important that time is taken to capture these key lessons and use them to strengthen Australia's, as well as international, pandemic plans to ensure that future responses are equitable and appropriate resourced. It is critical that alliances be set up that can be activated in the future to reduce issues around resource development, translation, and dissemination of messages to minimise gaps in the response. Financial assistance must be provided in a timely way to local organisation to support the development of culturally appropriate communication materials. Not all communities require translated materials, and so it is important that tailoring and targeted approaches are used to ensure those community members who may be more vulnerable in public health events are not left behind.

Declarations

Competing interests: None

Ethics approval and consent to participate: The Human Research Ethics Advisory Panel at the University of New South Wales reviewed and approved this study (HC200776). All of the methods used in this study were performed in accordance with the relevant guidelines, outlined by The National Statement on Ethical Conduct in Human Research, published by the Australian Government. Informed verbal consent was collected from all participants.

Consent for publication: Not applicable

Availability of data and materials: Available upon request from the primary author.

Funding: Not applicable

Authors' contributions: HS was responsible for the design of the study, for conducting data collection and analysis; BHR, AH, IA, AM and LW supported the development of the study and interpretation of the findings. AC supported the analysis of the transcripts.

Acknowledgements: The research team wish to thank the participants for their support of this study.

References

1. Derose KP, Escarce JJ, Lurie N. Immigrants and health care: sources of vulnerability. Health Aff 2007;26:1258–68.
2. Johnstone M-J, Kanitsaki O. Engaging patients as safety partners: Some considerations for ensuring a culturally and linguistically appropriate approach. Health policy 2008;90:1–7.
3. Rossen LM, Branum AM, Ahmad FB, Sutton P, Anderson RN. Excess Deaths Associated with COVID-19, by Age and Race and Ethnicity - United States, January 26-October 3, 2020. MMWR Morb Mortal Wkly Rep. 2020;69(42):1522–7.
4. Bhaskar S, Rastogi A, Menon KV, Kunheri B, Balakrishnan S, Howick J. Call for Action to Address Equity and Justice Divide During COVID-19. 2020;11(1411).
5. McLaren J. Racial Disparity in COVID-19 Deaths: Seeking Economic Roots with Census Data %J The B.E. Journal of Economic Analysis & Policy. 2021;21(3):897–919.
6. Jocelyn T-M, Oluwatoyin A, Layschel K. Examining Social Determinants of Health, Stigma, and COVID-19 Disparities. Healthcare (Basel). 2020;8(168):168.
7. Mugadza HT, Mujeyi B, Stout B, Wali N, Renzaho AMN. Childrearing Practices Among Sub-Saharan African Migrants in Australia: a Systematic Review. Journal of Child and Family Studies. 2019;28(11):2927–41.
8. Benfer EA, Vlahov D, Long MY, Walker-Wells E, Pottenger JL, Gonsalves G, et al. Eviction, Health Inequity, and the Spread of COVID-19: Housing Policy as a Primary Pandemic Mitigation Strategy. Journal of Urban Health. 2021;98(1):1–12.
9. Pan D, Sze S, Martin CA, Nazareth J, Woolf K, Baggaley RF, et al. Covid-19 and ethnicity: we must seek to understand the drivers of higher transmission. 2021;375:n2709.
10. Martin CA, Pan D, Melbourne C, Teece L, Aujayeb A, Baggaley RF, et al. Predictors of SARS-CoV-2 infection in a multi-ethnic cohort of United Kingdom healthcare workers: a prospective nationwide cohort study (UK-REACH). 2021:2021.12.16.21267934.
11. Gross CP, Essien UR, Pasha S, Gross JR, Wang S-y, Nunez-Smith M. Racial and Ethnic Disparities in Population-Level Covid-19 Mortality. Journal of General Internal Medicine. 2020;35(10):3097–9.

12. Benitez J, Courtemanche C, Yelowitz A. Racial and Ethnic Disparities in COVID-19: Evidence from Six Large Cities. Journal of Economics, Race, and Policy. 2020;3(4):243–61.
13. Weill JA, Stigler M, Deschenes O, Springborn MR. Social distancing responses to COVID-19 emergency declarations strongly differentiated by income. Proceedings of the National Academy of Sciences. 2020;117(33):19658.
14. Bucci N. Meatworks and Coronavirus: The 'Domino Effect' from Victoria's Abattoirs Pushing Covid-19 Case Numbers Higher ABC News. 2020 26 July.
15. Federation of Ethnic Communities' Councils of Australia. FECCA Submission into Issues Facing Diaspora Communities in Australia Canberra 2020.
16. Woodland L, Blignault I, O'Callaghan C, Harris-Roxas B. A framework for preferred practices in conducting culturally competent health research in a multicultural society. Health Research Policy and Systems. 2021;19(1):24.
17. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care. 2007;19(6):349–57.
18. Migration Council Australia. Supporting COVID-19 Vaccination Program rollout to migrant and refugee communities in Australia. Canberra, Australia; 2021.
19. Local Government Multicultural Network. NSW JULY 2020 CALD COVID SUMMIT REPORT. Sydney, Australia 2020.
20. Miles R. Issues, barriers and perceptions about the COVID-19 vaccine among culturally and linguistically diverse communities in NSW. Sydney, Australia; 2021.
21. Australian Government Department of Health. Management Plan for Aboriginal and Torres Strait Islander Populations,. Canberra, Australia; 2020.
22. Australian Goverment Department of Health. Australian Health Management Plan for Pandemic Influenza (AHMPPI) Canberra, Australia 2019
23. Australian Goverment Department of Health. Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19). Canberrra, Australia; 2020.
24. Culturally and Linguistically Diverse Communities COVID-19 Health Advisory Group. Canberra2021 [
25. Wild A, Kunstler B, Goodwin D, Onyala S, Zhang L, Kufi M, et al. Communicating COVID-19 health information to culturally and linguistically diverse communities: insights from a participatory research collaboration. Public Health Research & Practice. 2021.
26. Abell B. Evaluation of a collective response initiative to engage CALD communities in COVID-19 health communication. Brisbane, Queensland: Queensland University of Technology 2021.
27. Galiatsatos P, Monson K, Oluyinka M, Negro D, Hughes N, Maydan D, et al. Community Calls: Lessons and Insights Gained from a Medical–Religious Community Engagement During the COVID-19 Pandemic. Journal of Religion and Health. 2020;59(5):2256–62.

28. Mistry SK, Harris-Roxas B, Yadav UN, Shabnam S, Rawal LB, Harris MF. Community Health Workers Can Provide Psychosocial Support to the People During COVID-19 and Beyond in Low- and Middle-Income Countries. 2021;9(800).
29. Yadav UN, Mistry SK, Ghimire S, Schneider CH, Rawal LB, Acharya SP, et al. Recognizing the roles of primary health care in addressing non-communicable diseases in low- and middle-income countries: Lesson from COVID-19, implications for the future. J Glob Health. 2021;11:03120-.
30. Local Government Multicultural Network. NSW July CALD COVID Summit Report Sydney, NSW; 2020.
31. Porat T, Nyrup R, Calvo RA, Paudyal P, Ford E. Public Health and Risk Communication During COVID-19—Enhancing Psychological Needs to Promote Sustainable Behavior Change. 2020;8(637).
32. Cortis N, Blaxland M. The profile and pulse of the sector: Findings from the 2019 Australian Community Sector Survey Sydney, NSW; 2020.
33. Migration Council Australia. Integrating culturally, ethnically and linguistically diverse communities in rapid responses to public health crises. Canberra, Australia; 2021.
34. Komaric N, Bedford S, van Driel ML. Two sides of the coin: patient and provider perceptions of health care delivery to patients from culturally and linguistically diverse backgrounds. BMC Health Services Research. 2012;12(1):322.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- Supplementary1.docx