



Ethnic Communities' Council of Victoria

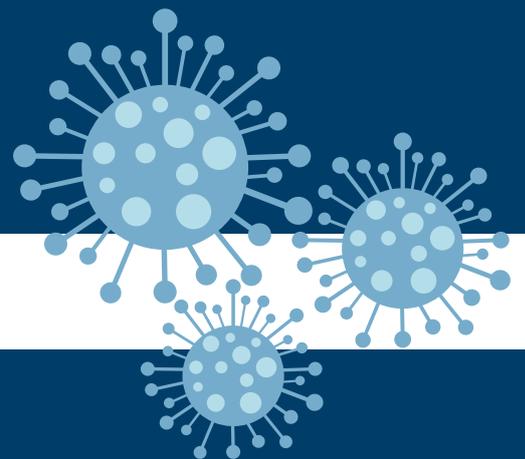
ISSUE BRIEF

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COMMUNICATING ABOUT COVID-19

Health Literacy and Language
Services During the Pandemic

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Introduction

The Ethnic Communities' Council of Victoria Inc. (ECCV) is the voice of multicultural Victoria and the peak advocacy body for eight regional ethnic communities' councils and 220 member organisations, including ethnic and multicultural organisations across Victoria. For over 45 years, we have been the link between multicultural communities, government, and the wider community.

ECCV has a strong history in advocating for the rights of multicultural communities, informing industry practice and influencing Government on a range of issues including health, employment, aged care, cultural responsiveness, equitable access and the wellbeing of families and children.

ECCV's Policy Advisory Committee on Health and Wellbeing (PACHW), made up of multicultural advocates and service representatives, decided that the COVID-19 pandemic presented an opportune time to re-examine a number of important issues that ECCV had raised in previous Policy Papers on health literacy in CALD communities, and access to interpreting services in the Victorian health system.

In order to achieve this, ECCV consulted with several key stakeholders in the multicultural health sector, with individuals and organisations involved in the community response to COVID-19, and examined the results of a survey of health consumers regarding their use of interpreting services. The findings of these consultations and research are presented in this Policy Paper.

Background

In 2012, ECCV published *An Investment Not an Expense: Enhancing health literacy in culturally and linguistically diverse communities*. [1] This paper was created in response to concerns raised by various stakeholders with an interest in the health and wellbeing of culturally and linguistically diverse (CALD) communities, about lower levels of health literacy amongst members of these communities. These concerns were supported by ABS statistics showing lower health literacy amongst overseas-born Australians, with the lowest levels being for recent migrants and those with limited English proficiency. [2] Through a working group comprising members of ECCV's Policy Advisory Committee on Health and Wellbeing (PACHW) and a series of community consultations, ECCV examined the major factors leading to lower levels of health literacy in some CALD communities, and made a series of recommendations about how these could be overcome through targeted strategies and resources.

Lower levels of health literacy were found to inhibit the ability of individuals to make informed choices about their health, leading to less healthy behaviours, higher rates of hospitalisation, difficulties communicating with providers, and poorer health outcomes. These in turn lead to higher costs for the health system as a whole, due to poorer preventative practices and higher rates of illness and chronic disease. The *Victorian Public Health and Wellbeing Plan 2011 – 2015* contained strategic objectives to **"increase the health literacy of all Victorians and support people to better manage their own health"** and **"tailor interventions for priority populations to reduce disparities in health outcomes"**. [3] *An Investment Not an Expense* remarked that although government policy documents focused on patient empowerment and self-management, this shouldn't come at the expense of provider responsibility for culturally-appropriate care.

An Investment Not an Expense also stressed the importance of quality translations and access to interpreting services as key pillars to increasing health literacy and facilitating better engagement of CALD populations with the health system. This recognition led ECCV in 2017 to publish *Our Stories, Our Voices: Culturally diverse consumer perspectives on the role of accredited interpreters in Victoria's health services*. [4] This Discussion Paper looked at how the use of professional interpreters decreased the risk of communication errors and adverse health outcomes, and examined the barriers to enhancing access to language services.

Background

Drawing upon questionnaires at two large public hospitals, an online survey and a focus group, ECCV was able to gather a clearer picture of how culturally diverse Victorians saw the role of interpreting in the health system. The paper highlighted that members of CALD communities were not always aware of the risks of adverse health outcomes when interpreters were not used, and that many in the community were unaware of their rights to access free interpreting, and that interpreters were bound by a Code of Ethics guaranteeing privacy and confidentiality. The paper also notes that interpreters were not always provided by health services when required, concerns about a limited supply of interpreters in new and emerging community languages, and a general lack of data about other aspects of the demand for and supply of interpreters during engagements with the health system by consumers not fluent in English. *Our Stories, Our Voices* encouraged the Victorian Government to deliver on the commitment it made in *A Fairer Victoria* to improve access for culturally diverse communities to language and health services as part of its commitment to ensuring equitable healthcare access for all Victorians. [5]

Recent Trends in CALD Health Literacy

There is no clear evidence to indicate whether levels of health literacy have improved in CALD communities since the publication of *An Investment Not an Expense* in 2012. Recent ABS publications have not examined health literacy from the perspective of recent migrants or people whose first language is not English, unlike *Australian Social Trends* published in 2009, which showed lower health literacy amongst overseas-born Australians and those with limited English proficiency. It is likely that there has been a small improvement in CALD health literacy over the last 5-10 years through work by organisations such as the Multicultural Centre for Women's Health, the Centre for Culture, Ethnicity and Health, and the Water Well Project. However, community groups that ECCV spoke to emphasised that new communities are always arising and need dedicated outreach. Concern was expressed that not enough has been done to engage growing groups like the Karen and Syrian communities.

Some multicultural organisations are funded directly by the Department of Health and Human Services (DHHS) or through Primary Health Networks (PHNs) to teach health literacy, but ECCV is concerned that funding is generally short-term and is not being provided in a systematic manner. It is important that these programs are properly evaluated, and that learnings and challenges arising from them are shared. The work of these programs is vital and must be built upon, with programs targeting specific communities expanded to reach others.

Recommendation 1

That the Victorian Government provide increased and ongoing funding for multicultural and ethno-specific community organisations to provide local, community specific, health-based education initiatives.

Health literacy applies to individuals, to populations groups, and to organisations. Victorian Government policy documents such as the *Victorian Public and Wellbeing Plan and the Victorian Health Priorities Framework 2012 - 2022* [6] have focused on patient empowerment and self-management as a means to increasing the health literacy of individuals and communities, and while ECCV supports this approach, we emphasise that it must not come at the expense of provider responsibility for culturally competent care.

is important that all health providers understand and acknowledge their own obligations to continually monitor and improve their health literacy. Tools such as the *Enliven Organisational Health Literacy Self-assessment Resource* [7] can help organisations to assess their progress towards meeting the attributes that characterise health literacy. The *Enliven* resource emphasises the barrier that language can play, and that a key to organisational health literacy is accessibility to people with limited English proficiency.

Development of accessible materials for people with limited English skills is a key pillar of improving health literacy. This includes written materials, and other objects such as signs, maps and directories, being provided in plain English and translated into appropriate community languages. The *Enliven Health Literacy Resource* notes that:

Aside from ensuring that ... communication is cognisant of the health literacy demands of service users more generally, organisations should identify, translate and make accessible in various formats, including print and electronic media, vital documents in local community languages other than English. [8]

An Investment Not an Expense emphasised the need for plain English materials to be provided in a variety of formats, including audio-visual materials, with minimal jargon and with diagrams, pictures and symbols wherever possible. A number of organisations have developed such resources, such as the “Women’s Business” flip charts developed by Cancer Council Victoria with the Multicultural Centre for Women’s Health. [9] A similar approach should be taken with translated materials, where images, audio and video can often create attention and have a much greater impact on a target audience than text alone.

Translated materials are too often simply direct translations of English language resources, and do not take account of cultural differences and differences in how languages function. Translated resources can often be hard to understand for people from migrant backgrounds who are themselves not fully literate in their first language or who are fluent in dialects beyond standardised languages. There is in general too much reliance on machine translations, which have proven to be of unreliable quality. Translated materials produced early in the COVID-19 period, such as those generated by DHHS, were generally such direct translations. More innovative and accessible resources were developed by community organisations, as will be examined later in this paper.

Further steps to improve the health literacy of individuals, communities and organisations must be informed by better data. It is important for the Federal Government, via the ABS, to again examine the health literacy of migrant and refugee communities, to gain an understanding of levels of health literacy across different populations. Likewise, health providers should regularly assess their cultural responsiveness and regularly consult with their patients about how well they understand the information provided to them.

Recommendation 2

That the Victorian Government provide support for healthcare providers to improve their cultural responsiveness through agreed standards, measures and self-assessment and via consultations with consumers.

Access to quality professional interpreting is a critical enabler of successful engagement with the health system for people with limited English skills. *Our Stories, Our Voices* examined how Victoria's interpreting system was functioning in 2017. Key conclusions were:

- Many CALD Victorians did not understand the risk of miscommunication and adverse health outcomes when family members provided interpreting.
- Quantitative data was lacking about how often interpreters were requested by patients, and what proportion of requests were met.
- Health Services do not always offer interpreters to patients when they are required.
- Approximately 10% of community members from CALD backgrounds were unaware of their rights to access free interpreting and of their rights to privacy and confidentiality.

Our Stories, Our Voices drew upon a 2016 consumer survey conducted by Northern Health of its language services program. This survey takes place every two years with only minor variations, allowing the results from 2020 to be compared with those from 2016 and 2018 to analyse whether there have been changes in how communities in one part of Melbourne use language services in a health context. The 2020 survey was significantly bigger than the 2018 one, with 551 respondents in 2020 compared to 228 in 2018. Northern Health will be publishing the results in detail in a research project, but preliminary analysis reveals similar responses and conclusions to the previous surveys.

Most survey respondents indicated that they found it hard to communicate with their healthcare provider, with more than three-quarters saying that they always needed an interpreter. Many said that although they have enough English for daily conversation, they struggle with conversations in a clinical setting. This suggests that many CALD Victorians overestimate their level of English proficiency and encounter difficulties when trying to comprehend technical medical terms. The majority of respondents had lived in Australia for more than ten years, demonstrating that interpreting is not just a requirement for recent migrants.

About two-thirds of respondents sometimes used a family member to interpret for them when visiting health services. Given the option to explain why they did this, most highlighted a lack of trust in the quality and professionalism of interpreters. This indicates that many community members don't fully understand that interpreters are professionals, and that a strict Code of Ethics requires interpreters to be impartial and accurate, and respect the patient's privacy and confidentiality. However only 5% of respondents had not used an interpreter when visiting a health service at least once, with the majority indicating that this was because they preferred to use family members.

When asked who requested the interpreter, responses were evenly split between health services staff, the patient or their family, and the GP. As GPs should always be aware of the importance of interpreting, it is concerning that in the vast majority of cases the interpreter requests came from elsewhere. Ideally, a GP should always indicate whether an interpreter is required at the time of hospital referral. When this does not occur, the first appointment is either completed with the help of a family member, contrary to government policy, or with no interpreter at all, compromising the health outcomes of patients with limited English proficiency, and ultimately leading to increased costs due to patients often having to return to hospital for additional appointments.

Almost all patients who used a professional interpreter said that they would ask for one again in future. A small number of those who said that they wouldn't use one indicated that this was because they were trying to improve their English. This is encouraging and reinforces the need for greater assistance for migrants with limited English skills to learn the language.

Recommendation 3

That all migrants, including those already resident in Australia, be given the opportunity to access free English language classes beyond the initial five-year settlement period as part of the expansion of the Adult Migrant English Program, and be offered support to ensure that their income and employment is not affected as a result of attending classes.

Asked to highlight the helpful and unhelpful aspects of interpreter engagement, survey respondents mentioned the greater confidence they gained and understood from what the doctor was saying to them, and that the doctor understood them.

They appreciated the greater accuracy in communication, and how this overcame their unfamiliarity with medical terminology. Many said that the interpreters were more professional and respectful of confidentiality than they had expected. These were similar to the responses from 2018, but one new point that several respondents made was that they appreciated the importance of interpreters from a psychological point of view, and that their involvement had helped reduce the stress and anxiety experienced during appointments.

Few respondents indicated any reasons that interpreters had been unhelpful. The few issues that were raised in this regard included: a small number of female respondents expressing a continued preference for female interpreters; some interpreters having accents that were hard to understand; that using interpreters disincentivised the learning of English; trust/confidentiality; and increased waiting times while interpreters were sourced.

15% of respondents indicated an unawareness of their right to access professional interpreters free of charge, with members of new and emerging migrant communities more likely to say that this was the case. The number of respondents saying “yes” when asked if they knew that interpreters were bound by a Code of Ethics increased slightly from 2016 to 2018 to 2020, although it isn’t entirely clear if the meaning of the question was understood by all respondents. Either way, with only a little over half of respondents answering “yes”, this is clearly still an issue. ECCV believes that a campaign should be instituted to raise awareness of the Code of Ethics for interpreters amongst CALD communities. Even something as simple as multilingual posters being placed in health centres could do a lot to inform communities about the Code of Ethics, what it incorporates, and that there are serious disciplinary consequences for interpreters who do not abide by it.

Recommendation 4

That the Department of Health and Human Services institute a campaign to raise awareness in CALD communities of the AUSIT Interpreters and Translators Code of Ethics and Code of Conduct.

The Northern Health survey indicates that there remains a somewhat limited, superficial understanding of interpreting amongst CALD community members. However comprehensive data about demand for and supply of interpreters is still lacking, and ECCV believes that healthcare providers should be assisted to update patient record systems to capture this information. This will enable a better picture to emerge about whether requests for interpreters align with Victorian community demographics, and how closely supply matches demand.

Recommendation 5

That all health services use patient record systems that enable and require data to be collected about each patient’s preferred language, whether they request the use of an interpreter, and whether one is provided.

Community confidence in interpreting would be enhanced by ensuring that in-house language services departments are large enough to facilitate access to interpreters. It is important that pay and conditions are sufficient to attract skilled professionals and make translating and interpreting attractive career options.

COVID-19 has seen an increase in clinical consultations taking place over the phone and by Telehealth, with consequent increase in demand for phone and video interpreting. It is encouraging that these methods are being increasingly used to ensure interpreting is provided for remote medical consultations, although some service providers have raised concerns with ECCV about the difficulties they face accessing timely interpreting in these situations. [10] ECCV's consultations with community organisations have also raised concerns that lack of digital literacy, access to data and, in some cases phone credit, is hindering the use of phone and video interpreting by vulnerable community members. ECCV hopes that the Victorian and Commonwealth governments will continue to make increasing digital literacy and access to data a priority, especially for older Victorians.

Health Literacy, Language Services and COVID-19

The health literacy of Victorians has been tested like never before during the current pandemic. COVID-19 has underlined just how important it is that community members receive accurate and accessible information that allows them to make informed decisions about their health. The unprecedented lockdowns and restrictions that the government has instituted to stem transmission of the virus have added another dimension to the requirements of culturally tailored information provision. Many members of the multicultural sector have expressed concern that lack of accessible information for CALD communities likely contributed to the second wave of COVID-19 infections in housing estates, aged care residences, and workplaces.

The need for public health resources to be translated into community languages was identified by the government, health and community sectors at the outset of the pandemic. DHHS to its great credit acted promptly on this and began translating many of its resources about basic hygiene, social distancing, COVID-19 symptoms and testing, and placing them on its website. However, the lack of a clear dissemination strategy meant that community members were often unaware of these resources and did not access them.

Given the urgency of the situation, many community members began undertaking their own translations by developing material for their communities. A member of the Islamic Council of Victoria reported to ECCV that they created brochures in about ten different languages to distribute to public housing residents following the lockdown of the Flemington and North Melbourne estates. When these were distributed, many residents said they were the first in-language resources they had seen.

As the pandemic has run its course, and levels of restrictions have regularly altered, many community members have reported immense difficulties in comprehending different levels of restrictions. There have been instances where individuals were unaware that they were not permitted to travel beyond 5km to pick up their donated food supplies, and of failure to comply with COVID-safe practices. Community organisations, many small and volunteer-led, have often struggled to keep up with the provision of information.

Nonetheless many members of CALD communities have done amazing work to promote public health and provide clear information during the pandemic. Ethnic seniors' clubs have played a critical role in providing information and support to their communities, including by undertaking translations and interpreting, conducting welfare checks, and distributing resources that encourage mental and physical wellbeing. [11]

Government engagement with CALD communities has often been through community leaders, often self-identified and not necessarily seen as leaders by all members of their communities, and generally to the exclusion of particular cohorts including women and young people. [12]

It is important that all government and community organisations work with the professional workforce from the multicultural sector as a conduit to trusted engagement and knowledge dissemination within CALD communities. Everyone working with target communities should ensure that messaging is truly understood. Asking "yes or no" questions about whether people have comprehended information is not sufficient. Best practice is to ask open questions to truly determine if information has been understood and to ensure that this information feeds back into future communication strategies.

Appropriate resources for each community can only be developed in consultation with that community, or, ideally, by providing support for community members to develop their own resources that are both engaging and culturally appropriate. As mentioned, text-heavy documents are unlikely to be widely read. Tailored resources for each community, involving images, graphics, audio and videos are greatly preferable. For example, a song in Dinka providing information about the coronavirus by South Sudanese artist DingAnyai has, as of 28 September, been viewed 23,000 times on YouTube, whereas the Dinka translation of the Chief Medical Officer's official health advice on the DHHS YouTube channel has been viewed 178 times. [13]

Information packaged in short, graphical formats can create an impact far greater than any number of pages of text. Young people, in particular, respond to memes, when these contain images and humour. A good meme can spread rapidly around the community. Accurate information provided in such formats, ready for distribution through social media or on YouTube, is the most efficient method of reaching deeply into communities quickly.

Recommendation 6

That the CALD Communities Taskforce proactively engages community members to make innovative audio-visual resources promoting public health messages and safety during COVID-19.

Case Study: Public Housing Lockdown

The most critical phase of Victoria's COVID-19 response came with sudden lockdown of approximately 3,000 residents in nine public housing towers at the start of July. Although there were clearly urgent public health reasons for this action, the lockdown was extremely distressing for residents, and ECCV believes that this distress could have been reduced with a considered communication strategy from the Victorian government.

Residents of the towers, many of whom are from Muslim and/or African backgrounds, have reported that at the time they did not understand the reasons for the abrupt lockdown, and that the sudden arrival of large numbers of police at their place of residence caused a great deal of anxiety and fear. With no immediate information available, many residents began scouring social media such as Instagram for news or tried to communicate with family members overseas to understand what was happening to them.

Several mainstream organisations such as the Red Cross were engaged to provide information, food and other items to residents, but no ethno-specific organisations were engaged. Instead a number of community-led organisations, informally led by the Australian Muslim Social Services Agency (AMSSA) and Islamic Council of Victoria, banded together of their own initiative to organise culturally appropriate supplies of food and other necessities. Operating from a local mosque in North Melbourne, the community response quickly gained traction on social media, and hundreds of people volunteered their support and donated food.

This informal coalition engaged with residents online, arranged remote meetings for them with doctors that they trusted and understood, and helped DHHS to encourage residents to access the COVID-19 testing that was provided onsite. The Multicultural Centre for Women's Health was engaged by DHHS to provide information to residents through phone calls from their bicultural/bilingual health educators team. Through the efforts of these organisations trust was slowly re-built and a flow of accurate information to residents established.

The episode is both a warning of the stresses than can arise when communities with lower health literacy do not receive timely and accessible public health information, and an example of how trusted community organisations can successfully engage with communities and establish a flow of information to improve knowledge of how to stay safe and healthy.

Recommendations

Recommendation 1: That the Victorian Government provide increased and ongoing funding for multicultural and ethno-specific community organisations to provide local, community specific, health-based education initiatives.

Recommendation 2: That the Victorian Government provide support for healthcare providers to improve their cultural responsiveness through agreed standards, measures and self-assessment and via consultations with consumers.

Recommendation 3: That all migrants, including those already resident in Australia, be given the opportunity to access free English language classes beyond the initial five-year settlement period as part of the expansion of the Adult Migrant English Program, and be offered support to ensure that their income and employment is not affected as a result of attending classes.

Recommendation 4: That the Department of Health and Human Services institute a campaign to raise awareness in CALD communities of the AUSIT Interpreters and Translators Code of Ethics and Code of Conduct.

Recommendation 5: That all health services use patient record systems that enable and require data to be collected about each patient's preferred language, whether they request the use of an interpreter, and whether one is provided.

Recommendation 6: That the CALD Communities Taskforce proactively engages community members to make innovative audio-visual resources promoting public health messages and safety during COVID-19.

Conclusion

High levels of individual, community and organisational health literacy are necessary to ensure that all community members have equitable access to health services and have the knowledge to make informed decisions about their health. The COVID-19 pandemic has placed a spotlight on the health literacy of all Australians, especially new migrants and people with limited English proficiency. Despite some positive initiatives and programs, addressing health literacy levels of some groups could have helped avoid ramifications during the recent spread of COVID-19 in Victoria.

Access to accurate and culturally tailored in-language materials is a key component of improving the health literacy of CALD communities. Under-utilisation of interpreters by Victorians with limited English also provides a barrier to proper engagement with health services, and this in part is driven by a lack of awareness of the importance of professional interpreting, of the exact nature of their roles, and of the ethics which guide accredited interpreters in their work.

ECCV believes that governments at all levels, healthcare providers and the multicultural sector, should take advantage of the current focus on community health and inclusion of diverse communities to develop strategic partnerships aimed at improving the health literacy of CALD communities, raising awareness of the importance and role of professional certified interpreters, and engaging community members in the development of innovative responses about how to stay safe and connected during the COVID-19 pandemic and beyond.

Endnotes

- [1] Ethnic Communities' Council of Victoria, 2012, *An Investment Not an Expense: Enhancing health literacy in culturally and linguistically diverse communities*
- [2] Australian Bureau of Statistics, 2009, *Australian Social Trends, cat.no. 4102.0*, Canberra
- [3] Victorian Department of Health, 2011, *Victorian Public Health and Wellbeing Plan 2011–2015*, p.4.
- [4] Ethnic Communities' Council of Victoria, 2017, *Our Stories, Our Voices: Culturally diverse consumer perspectives on the role of accredited interpreters in Victoria's health services*
- [5] Victorian Government, 2006, *A Fairer Victoria: Progress and Next Steps*
- [6] Victorian Department of Health, 2011, *Victorian Public and Wellbeing Plan and the Victorian Health Priorities Framework 2012 - 2022*
- [7] Enliven, 2013, *Enliven Organisational Health Literacy Self-assessment Resource*
- [8] Enliven, p.25.
- [9] Cancer Council Victoria, *Women's Business*
<https://screeningresources.cancervic.org.au/uploads/files/Aboriginal-cervical-flip-chart.pdf> [Accessed 28 September 2020]
- [10] For more on this, see ECCV's Submission to the Parliament of Victoria's *Inquiry into the Victorian Government's Response to the COVID-19 Pandemic*
- [11] For more information see Ethnic Communities' Council of Victoria, August 2020, *Connecting CALD Seniors during the COVID-19 Pandemic*
- [12] See for example Pro Bono Australia article "*The government's talking to migrant community leaders, but where are the women?*" [Accessed 1 October 2020]
- [13] See DingAnyai's song at <https://www.youtube.com/watch?v=eN00SGiw4ZM> and the DHHS health advice in Dinka at https://www.youtube.com/watch?v=8qwjy_f4so&list=PLbha5HB_rfeDIQgc39HfP08nYrAIRDzK2&index=4