

# Evaluation of a collective response initiative to engage CALD communities in COVID-19 health communication

## Evaluation Report

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With thanks to the project partners



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# Abbreviations

ACCESS: Access community services

AusHSI: Australian Centre for Health Services Innovation

BSPHN: Brisbane South PHN (Primary Health Network)

CALD: Culturally and Linguistically Diverse

COVID-19: Coronavirus disease

G11: Mater's Refugee Health Advisory Group

HEAU: Health Equity and Access Unit

IWAA: Islamic Women's Association of Australia

MSH: Metro South Health

QACC: Queensland African Communities Council

QLD: Queensland

QPASTT: Queensland Program of Assistance to Survivors of Torture and Trauma

RHNQ: Refugee Health Network Queensland

RE-AIM: Reach, Effectiveness, Adoption, Implementation, Maintenance Framework

TIS: Translating and Interpreting Service

# Executive Summary

## Background

The COVID-19 pandemic has highlighted weaknesses in how Australian health services engage with culturally and linguistically diverse (CALD) communities, and the choice of mechanisms utilised to convey key messages. It is crucial therefore that more is done to partner, engage, and co-design with these communities and their leaders during such times of crisis.

Consequently, in Greater Brisbane, there has been a creative and targeted interagency collective response by organisations, government, community leaders, and other stakeholders to ensure CALD and refugee communities have timely access to accurate and appropriate COVID-19 information. The Australian Centre for Health Services Innovation (AusHSI) partnered with Metro South Hospital and Health Service, Brisbane South PHN (Primary Health Network), Mater Refugee Health Service, and Refugee Health Network Qld to conduct an implementation evaluation of this initiative. The evaluation explores the impact of the initiative in the community, and at the broader interagency level in the early stages of the pandemic, between March and November 2020.

## Evaluation design and methodology

This report presents the findings of the evaluation based on the RE-AIM Framework<sup>1</sup> dimensions of **Reach** into the target population, **Effectiveness** of the initiative, **Adoption** by target settings and groups, **Implementation**, and **Maintenance** over time.

Data collection methods and tools were pragmatic, flexible, and co-designed between AusHSI and the evaluation partners. A range of individuals, including bi-cultural and multilingual staff, collected data. Qualitative data was informed by a question guide and collected from CALD community members and leaders via interviews, phone calls, focus groups, and online surveys. Quantitative data included social media/website analytics, project records, and other relevant implementation documentation. An online questionnaire was also used to collect mixed-methods data about the interagency partners' experience.

## Results

### Implementing communication strategies designed to address the needs of CALD community members

A diverse sample of 51 local CALD community members reported broad reach of COVID-19 information across their communities during the pandemic. Information was accessed from multiple sources, but most frequently sought from within their own communities and via social media. Both CALD community leaders and the Queensland Government were perceived to be credible and trusted messengers of this information. While most community members could access appropriate translated information to effectively meet their needs, there were some issues with quality, timeliness, linguistic sensitivity, and preferred format. Having access to both audio-visual and written information in their native language was important for many participants.

The most frequently reported challenges for community members accessing information were limited access to translated resources, information overload, and dealing with misinformation (fake news). However, enablers such as simple translated audio-visual information, community leaders/groups, regular information delivered by the authorities, and access to social media helped them to access information more easily. Consequently, most CALD community members demonstrated excellent knowledge about measures for preventing the spread of COVID-19 and understood appropriate actions to take in the event of illness. However, reach and effectiveness could still be improved by access to a greater range of language translations in multiple formats, broader dissemination of messaging, personalised information sharing, and engagement and support of more CALD leaders/bicultural workers including establishment of reference groups and community development approaches.

## Implementing health education and engagement with CALD community leaders

A diverse sample of 39 local CALD community leaders reported broad adoption of information sharing across their communities during the pandemic. On average, each leader passed on information to 200 individuals using a wide variety of platforms, mediums, and approaches to target their reach. Almost all leaders reported having to translate and adapt standard COVID-19 messaging for their community, such as creating audio and graphic versions.

The most frequently reported challenges for leaders were a lack of translated resources, information overload, misinformation (fake news), and the digital divide. However, enablers such as smartphones/technology, existing networks and relationships, regular information delivered by government and health authorities, and simple visual messaging helped them to share information more easily and broadly. Consequently, most CALD leaders felt satisfied with the support and skills given to undertake this role. Adoption, reach and implementation could still be improved by providing more training, remuneration, and support for these leaders, as well as early and continued CALD community outreach and engagement.

## Implementing the partnership approach to CALD community engagement

The findings suggest a strong, collaborative, and sustainable partnership has been formed, with tangible benefits for all partners. This has been enabled by existing interpersonal relationships, shared goals, a commitment to process and outcomes, and virtual meeting technology. Partners were challenged by the time and labour-intensive nature of collaboration, but still experienced high levels of satisfaction when taking part. Some work still needs to be done in clarifying and formalising partnership structures and processes, and in better enabling the CALD community voice to ensure partnership sustainability.

## Key learnings

This evaluation clearly demonstrates the benefits of an interagency collective response partnership which engages with and reciprocally educates CALD leaders, their communities and health stakeholders. However, several key learnings will have applicability for the continued pandemic response, as well as the communication of health and government messages to CALD communities more broadly in Queensland and across Australia.

- There is a need for **more diverse language translations** of key messages which are **simple** and understandable, and for these to be **disseminated more widely**.
- It is important that translated messages are **created and shared early**, and available in as **many formats as possible** including audio, video, and graphic versions.
- **Engagement of more community leaders**, community members and bicultural health workers is required, particularly in communities where no formally accredited translators exist. The informal translations independently created and shared by multi-lingual community members were a key component of successful COVID-19 messaging within many communities.
- To support sustainability and adoption, health services need to invest in **training, remuneration and support for CALD community leaders** and members engaged in co-designing, developing, and sharing resources.
- More clarity should be provided around **partnership governance, structures, and processes**, including terms of reference, goals, membership, and ongoing evaluation.
- Authentic engagement with CALD communities and leaders needs to be built and maintained ahead of time using an **embedded community development approach**. Seeking and incorporating their agenda into joint strategies, policy and actions is recommended. Establishment of a **reference advisory group** with diverse community representatives is one practical example.



# Main Report

# Introduction

## Background

Across the world there is increasing evidence that COVID-19 has disproportionately affected people from racial and ethnic minority groups in terms of both infection rates and health outcomes<sup>1,2</sup>. For highly multicultural societies like Australia, protecting these culturally and linguistically diverse (CALD) communities should therefore be a priority. However, the pandemic has highlighted weaknesses in how health services engage with diverse communities and the choice of mechanisms they utilise to convey key messages. Differences in culture, language, and religion all impact understandings and knowledge of COVID-19 and its health implications. This in turn may affect willingness to adhere to government advice and directives. Additionally, most mass public health information lacks cultural awareness and tailoring to languages or communities; is in inaccessible formats; and does not consider varying levels of health literacy. While there is significant complexity in implementing mass public health communication in CALD communities during such a crisis, reaching these communities in a timely and appropriate way is a crucial pillar in Australia's COVID-19 response.

It is important to partner, engage, and co-design with CALD communities and leaders during such times of crisis to communicate health messages and mitigate risks effectively<sup>3</sup>. In Greater Brisbane, there has been a creative and targeted interagency collective engagement response by organisations, government, community leaders, and other stakeholders to ensure CALD and refugee communities have timely access to accurate and appropriate COVID-19 information. This has included nuancing messages for different audiences; facilitating timely translations into targeted languages; co-designing resources; developing plain English information; partnering with communities to disseminate via accepted channels (e.g. social media platforms and religious leaders); trusting and supporting CALD community advocates to engage with their communities; and building capacity of both health teams and CALD organisations and community leaders through virtual meetings and workshops. Evaluation of this response will provide important evidence for health services and governments on the impact, mechanisms and role of community engagement, to improve the dissemination of information and service delivery for multicultural communities, in Queensland and beyond.

## Interagency partnership overview

A close pre-existing collaboration between the three initial partners, Metro South Hospital and Health Service (Health Equity and Access Unit), Brisbane South PHN (multicultural health team), and the Refugee Health Network Queensland (which is auspiced by Mater Refugee Health), commenced discussions in March 2020. Each partner also had close collaborations with other key stakeholders including: ACCESS, QACC, QPASTT, Multicultural Australia, IWAA and refugee health services across all five settlement regions. Refugee Health Network Queensland also convenes a Refugee Health Partnership Advisory Group (Qld) with representatives from government and non-government including close collaboration with the Queensland Health Social Policy and Legislation Branch.

The challenges posed by COVID-19 refocused the work of all key partners. Direct links with communities through initiatives like the settlement agencies' leaders' forums and the Mater's Refugee Health Advisory Group (G11), conveyed concerns regarding access to information. The partnership's response was to engage with all stakeholders and work with Queensland Health to facilitate public health messaging. This informal interagency network was the initial core group but expanded to encompass other stakeholders and communities to address these issues as they emerged. Consequently, the interagency partnership during the COVID-19 response period included a range of decision-makers, community organisations and other stakeholders.

The group was well placed to drive this collaborative response, especially at the initial stages of the pandemic. Whilst the initial response phase was reactive, the coordination and messaging evolved over time. This organic process has yielded some positive outcomes, however there is growing interest to better evaluate and document the process and impact to inform future responses.

## Evaluation scope

The Australian Centre for Health Services Innovation (AusHSI) is a research, advisory and training organisation based at the Queensland University of Technology. Brisbane South PHN, Mater Refugee Health Service, and Metro South Hospital and Health service have commissioned AusHSI to conduct an implementation evaluation focused on their collective efforts in communicating and engaging with greater Brisbane CALD communities during the COVID-19 pandemic. The evaluation explores the impact of the initiative in the community, and at the broader interagency level in the early stages of the pandemic, between March and November 2020.

## Aims and Objectives

The evaluation aims to answer a set of questions designed to determine how successfully the initiative has been able to meet its overarching aim of providing timely, accurate and appropriate health information about COVID-19 to CALD communities.

The objectives of the evaluation are to:

1. Evaluate the effectiveness of implementing communication strategies designed to address the needs of the CALD community during the pandemic
2. Evaluate the effectiveness of implementing formal and informal health education and engagement with CALD community leaders and CALD community organisations
3. Evaluate the interagency partnership approach to CALD communication during the COVID-19 pandemic

# Evaluation design

## Setting and population

The geographical reach of the initiative was initially determined by the pre-existing collaborations with communities in areas with high refugee and migrant background populations, especially communities with low English proficiency and minority languages in the Greater Brisbane region. Greater Brisbane was considered to include Brisbane North, Brisbane South, Logan, Ipswich, West Moreton, Redlands, and Moreton Bay.

The reach expanded to include the refugee settlement regions through the respective health services and local settlement agencies (Toowoomba, Townsville, and Cairns). There was also some reach into Maori and Pasifika communities in the Brisbane South/Logan/Redlands areas based on previous collaborations. The initiative's direct reach into more established CALD communities and to international students was limited and it leveraged on other existing networks e.g., Multicultural Affairs Queensland.

## Scope limitations

While there are many CALD communities in wider Brisbane, this evaluation was limited to CALD community members and leaders living within the boundaries of the initiatives scope described above

(i.e. those most likely to be beneficiaries of its activities). It was not the purpose of this evaluation to assess the reach of information to long established CALD communities outside the reach of this partnership.

## Methodology

### Evaluation framework

Evaluation of implementation is based on the RE-AIM Framework<sup>4</sup>. RE-AIM is a widely cited and rigorously developed implementation evaluation framework developed to assist in the translation of research into practice, policy, and public health impact. It moves beyond effectiveness to consider the implementation processes and program elements that underpin success and sustainability.

RE-AIM comprises five dimensions related to health behaviour interventions which may be assessed at either the individual or setting level: **Reach** into the target population, **Effectiveness** of the initiative, **Adoption** by target settings and groups, **Implementation**, and **Maintenance** over time. A description of each of these dimensions with respect to the current evaluation is provided in *Evaluation of a collective response initiative to engage CALD communities in COVID-19 health communication: evaluation plan*. These dimensions have been used to inform the design of a set of targeted evaluation questions.

### Evaluation questions

To meet the objectives of the evaluation, the following questions will be answered:

1. To what extent has the interagency collective response reached the intended target population of people from CALD communities? Why/why not? (**Reach**)
2. In what ways have the initiatives of the interagency collective response been adopted by CALD community groups and leaders? Why/why not? (**Adoption**)
3. In what ways did the interagency collective response impact CALD communities and their response to COVID-19? (**Effectiveness**)
4. Were the initiatives of the interagency collective response implemented as intended or were they adapted? How much time did they take? (**Implementation**)
5. What aspects of the interagency collective response demonstrate a partnership model which can be sustained over time? How can sustainability be strengthened? (**Maintenance**)

### Data sources and collection

Several types of data were collected to inform the evaluation using a pragmatic mixed-methods design. This comprises retrospectively and prospectively collected quantitative and qualitative data. Outcome measures and data collection tools were designed in partnership between AusHSI and the interagency partners. Descriptions of this process and the agreed data collection matrix can be found in *Evaluation of a collective response initiative to engage CALD communities in COVID-19 health communication: evaluation plan*.

An audit of partnership documents, project records, workshop feedback, social media analytics and meeting minutes was conducted by individual representatives of project partners to collect retrospective data about the initiative's implementation.

Prospective qualitative and quantitative data for this evaluation was collected for the period from 1<sup>st</sup> March 2020 until 30<sup>th</sup> April 2021 by the Refugee Health Network Queensland and its partners. This included a range of individuals including bi-cultural staff, community leaders (formal and informal), organisational representatives of project partners, and the RHNQ COVID-19 project team.

### Question guide

An open-ended question guide (Appendix 1) was used to collect data from CALD community members to obtain a first-hand account of their experience with health communication during the COVID-19 pandemic. A second, similar guide (Appendix 2) was used to collect data from CALD community leaders to understand their experience within the initiative, and more broadly in communicating health information during the pandemic.

These guides were used to facilitate group and individual discussions which occurred in-person, over the phone or via video conference. The questions were translated into the preferred language of the participant by the interviewer. Both guides were also converted into an online Microsoft Forms survey for additional avenues of data collection. The survey link was shared via social media platforms and messages to local CALD communities.

### Interagency questionnaire

An online questionnaire was distributed to interagency partners via REDCap to measure partnership strength and sustainability (Appendix 3). This consisted of the checklist component from the VicHealth Partnerships analysis tool<sup>5</sup>, with the addition of five questions exploring perceptions on partnership satisfaction, benefits<sup>6</sup>, and barriers and facilitators to sustainability.

### Data analysis

Qualitative data obtained from discussions and surveys with CALD community stakeholders was subject to thematic analysis. An experienced AusHSI evaluator read and analysed the notes/responses and derived a set of thematic codes to condense this text into organised and analysable units. These codes were organised by evaluation question where possible (i.e., matched to RE-AIM outcome), however additional themes were allowed to emerge inductively. Themes were revisited in an iterative process as analysis proceeded.

Information derived from the partnership survey and document audit was extracted and compiled in an Excel spreadsheet. It was analysed and reported using descriptive statistics (e.g. frequency, proportion, sum). Qualitative comments from the survey were also subject to thematic analysis and coding.

### Limitations

Recruitment for this evaluation was directed towards CALD community members and leaders living within the boundaries of the partnership's scope. Consequently, the participants in the evaluation would have been those most likely to have been reached with COVID-19 messaging. While this is important in evaluating the impact of the partnership project on CALD communities within its reach, the findings may not be representative of CALD communities outside the reach of this partnership.

# Results

The evaluation was designed to determine how successfully the initiative was able to achieve its three stated objectives by considering the outcomes of reach, effectiveness, adoption, implementation, and maintenance. Key results from the evaluation are presented in Table 1, organised by objective. A detailed description of each of these follows in the remainder of this section.

**Table 1.** Summary of evaluation results

Objective, implementation outcome and research question	Summary of evidence
<p><b>Evaluate the effectiveness of implementing communication strategies designed to address the needs of the CALD community during the pandemic</b></p> <p><b>REACH, EFFECTIVENESS</b></p> <p>To what extent has the interagency collective response <b>reached</b> the intended target population of people from CALD communities? Why/why not?</p> <p>In what ways did the interagency collective response <b>impact</b> CALD communities and their response to COVID-19?</p>	<p>A diverse sample of 51 local CALD community members reported broad reach of COVID-19 information across their communities during the pandemic. Information was accessed from multiple sources, but most frequently sought from within their own communities and via social media. Both CALD community leaders and the Queensland Government were perceived to be credible and trusted messengers of this information. The most frequently reported challenges for community members accessing information were limited access to translated resources, information overload, and dealing with misinformation (fake news). However, enablers such as simple translated audio-visual information, community leaders/groups, regular information delivered by the authorities, and social media, helped them to access information more easily.</p> <p>While most community members could access appropriate translated information to effectively meet their needs, there were some issues with quality, timeliness, linguistic sensitivity, and preferred format. Having access to both audio-visual and written information in their native language was important for many participants. Consequently, most CALD community members demonstrated excellent knowledge about measures for preventing the spread of COVID-19 and understood appropriate actions to take in the event of illness.</p> <p>Reach and effectiveness could still be improved by access to a greater range of language translations in multiple formats, broader dissemination of messaging, personalised information sharing, and engagement and support of more CALD leaders/bicultural workers including the establishment of a community reference group.</p>

Objective, implementation outcome and research question	Summary of evidence	
<p>Evaluate the effectiveness of implementing formal and informal health education and engagement with CALD community leaders and CALD community organisations</p>	<p><b>REACH, ADOPTION, IMPLEMENTATION</b></p> <p>In what ways have the initiatives of the interagency collective response been <b>adopted</b> by CALD community groups and leaders?</p> <p>To what extent has the interagency collective response <b>reached</b> the intended target population of people from CALD communities? Why/why not?</p> <p>Were the initiatives of the interagency collective response <b>implemented</b> as intended or were they adapted?</p> <p>In what ways have the initiatives of the interagency collective response been <b>adopted</b> by CALD community groups and leaders? Why/why not?</p>	<p>A diverse sample of 39 local CALD community leaders reported broad adoption of information sharing across their communities during the pandemic.</p> <p>On average, each leader passed on information to 200 individuals using a wide variety of platforms, mediums, and approaches to target their reach. The most frequently reported challenges for leaders were a lack of translated resources, information overload, misinformation (fake news), and the digital divide. However, enablers such as smartphones/technology, existing networks and relationships, regular information delivered by government and health authorities, and simple visual messaging helped them to share information more easily and broadly.</p> <p>Almost all leaders reported having to translate and adapt standard COVID-19 messaging for their community, such as creating audio and graphic versions.</p> <p>Importantly, most CALD leaders felt satisfied with the support and skills given to undertake this role. Adoption, reach, and implementation could still be improved by providing more training, remuneration and support for these leaders, as well as early and continued CALD community outreach and engagement.</p>
<p>Evaluate the interagency partnership approach to CALD communication during the COVID-19 pandemic</p>	<p><b>MAINTENANCE</b></p> <p>What aspects of the interagency collective response demonstrate an effective partnership model which can be sustained over time?</p> <p>How can sustainability be strengthened?</p>	<p>The findings suggest a strong partnership has been formed, with tangible benefits for all partners. This has been enabled by existing interpersonal relationships, shared goals, a commitment to process and outcomes, and virtual meeting technology. Partners were challenged by the time and labour intensive nature of collaboration, but still experienced high levels of satisfaction when taking part.</p> <p>Some work still needs to be done in clarifying and formalising partnership structures and processes, and in better enabling the CALD community voice to ensure partnership sustainability.</p>

## What were the outcomes of implementing communication strategies designed to address the needs of CALD community members during the pandemic?

A diverse sample of 51 local CALD community members reported broad reach of COVID-19 information across their communities during the pandemic. Information was accessed from multiple sources, but most frequently sought from within their own communities and via social media. Both CALD community leaders and the Queensland Government were perceived to be credible and trusted messengers of this information. While most community members could access appropriate translated information to effectively meet their needs, there were some issues with quality, timeliness, linguistic sensitivity, and preferred format. Having access to both audio-visual and written information in their native language was important for many participants. The most frequently reported challenges for community members accessing information were limited access to translated resources, information overload, and dealing with misinformation (fake news). However, enablers such as simple translated audio-visual information, community leaders/groups, regular information delivered by the authorities, and social media, helped them to access information more easily. Consequently, most CALD community members demonstrated excellent knowledge about measures for preventing the spread of COVID-19 and understood appropriate actions to take in the event of illness. However, reach and effectiveness could still be improved by access to a greater range of language translations in multiple formats, broader dissemination of messaging, personalised information sharing, and engagement and support of more CALD leaders/bicultural workers including the establishment of a community reference group.

### CALD community member representativeness (reach)

Fifty-one members of CALD communities participated in the evaluation via online questionnaire (n=42) and interviews (n=9). They identified with 21 different ethnic, faith, refugee, or minority groups and spoke a combination of 28 different languages (Figures 1 and 2). This captures a diverse range of perspectives about the initiative's reach and effectiveness.

## What local Cultural or Faith community/s do you identify with?



Figure 1. Faith and ethnic groups represented by CALD community members

## What languages do you speak?



**Figure 2.** Languages spoken by CALD community members

### How community members accessed information (direct reach)

Community members reported accessing information and health advice about COVID-19 from multiple sources during the pandemic (Figure 3). They most frequently reported seeking information from within their own CALD community including family, friends, groups, and leaders. Social media was also a common source of information, followed closely by Queensland Health’s official sources and news media/press conferences. CALD community members were less likely to use overseas sources or websites to search for information. These findings suggest that targeting communication through CALD leaders was therefore an effective and preferable strategy to reach the desired population.

## How were you accessing information and health advice about COVID-19?



**Figure 3.** Sources of COVID-19 information accessed by CALD community members

## The Queensland African Communities Council (QACC): A reach case study

Due to limitations on the resources and time for data collection, a comprehensive account of reach for all interagency partners could not be attained. However, data collected by the Queensland African Communities Council (QACC) provides a case study on the potential reach which was attained during the pandemic.

### *Indirect reach (how QACC indirectly reached CALD communities)*

QACC had 619 Facebook followers at the time of evaluation who would have indirectly been reached by the COVID-19 response on this platform, whether or not they engaged with the content shared.

### *Intended reach (how QACC intended to reach CALD communities)*

QACC created and/or distributed COVID-19 information to 30 different language groups over the course of the pandemic. This included 60 audio messages which were shared on the QACC radio station. Consequently, there was a large intended reach of this information. Estimates from just 9 of these 30 groups suggest a potential reach of over 7000 CALD community members.

### *Direct reach (how QACC directly reached CALD communities)*

QACC directly reached CALD community members via 6 community forums held between May and August 2020. On average 25-30 community members attended each of these forums. QACC also engaged 84 community leaders via their WhatsApp COVID-19 Taskforce Groups. Additionally, there were 2542 plays across 216 COVID-19 related episodes and updates on the QACC radio station. Facebook analytics also demonstrate clear intended and direct reach of QACC messaging with 32 shares, 580112 reactions and 3058 clicks of COVID-19 related posts. The Facebook reach metric of these posts reported that 36398 unique people saw this content.

## Use of trusted messengers (effectiveness, reach)

Using trusted and credible messengers to deliver information is an important element of effective communication and reach, particularly for CALD communities. Within these communities, there were two clear sources of trusted information which emerged during the pandemic – the Queensland Government and CALD group leaders (Figure 4). Support for messages delivered via websites, social media and press conferences by government sources was strong, as community members trusted the government to provide accurate, expert information. Alongside this was the trust in messages delivered by formal and informal leaders of CALD groups as they were able to take this official information and share it in a language and format community members were able to understand. This included via church congregations, targeted social media groups, phone calls and text messaging. Trust in information from family, friends, social media, and other news sources was considerably lower. Consequently, the work of the initiative to engage CALD leaders appears successful in increasing the delivery of COVID-19 messages to the community via trusted sources.

## Which of these sources or people did you trust the most?



**Figure 4.** Trusted sources of COVID-19 among CALD community members (size of hexagon correlates to greater trust).

### Available in appropriate and accessible formats (effectiveness, reach)

Another key aspect to reach and effectiveness of communication in CALD communities is having information available in appropriate and accessible formats. Findings of the evaluation demonstrated that community members did have access to official written translations via Queensland Health, or other versions which had been adapted and shared by their own community leaders. They mostly understood and trusted these translations, as they came from government sources. However, the quality of these translations was variable, and some lacked linguistic sensitivity. Consequently, many bilingual participants (and particularly youth) reported preferring English versions.

*“Some translations were not very well done and I kept needing to refer to English versions to understand the message for myself but also to ensure that messages I was sharing with networks via email were clear and not causing any confusion” (CALD community member)*

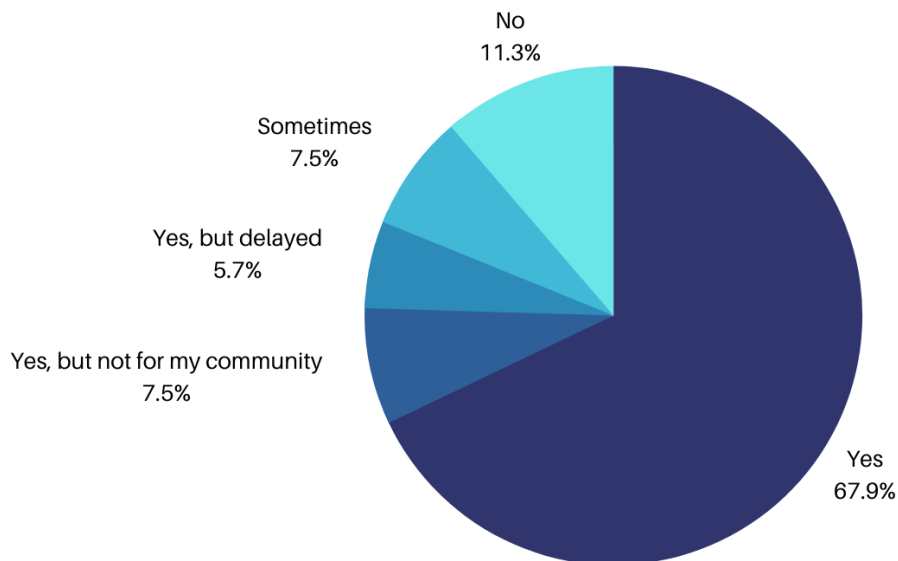
Overall, community members consulted for the evaluation had mixed preferences for messages in audio/video and written formats. Written formats were perceived to be easier to translate and pass on, or to enable reference to the English version. On the other hand, audio versions were easy to understand, and were preferred by those who had low literacy skills.

Among the community members surveyed, there were still some languages which did not have information about COVID-19 (or many other health issues) easily available. These were mostly Chin languages including Falam Chin, Zomi Chin and Hakha Chin, but also Mandingo and Oromo. For some languages (e.g. Karreni) only audio translations were available, however this was acceptable and often preferable for community members.

### Information sharing to meet community needs (effectiveness, reach)

For the most part, CALD community members felt that COVID-19 information had been shared effectively to meet their needs (Figure 5). However, some participants did point out that this would not have been the case for all members within their community. In particular, those who could not read, even in their native language, were considered most disadvantaged. A small proportion of participants experienced a delay in receiving messages/information (particularly audio messaging) which impacted on their knowledge, behaviour, and response at the time. About 10% did not feel that information was shared effectively to meet their needs. This was most often because no translations were available in their preferred language (Karenni and Chin), or they couldn't understand written translations and had no access to simple audio versions. Consequently, while the evaluation suggests that the communication strategies being used during the pandemic were meeting the needs of many CALD community members, there is still more work to be done (see [key learnings](#) section).

### Do you think information about COVID-19 was shared well to meet your needs?



**Figure 5.** Perceived appropriateness and effectiveness of information sharing to CALD communities

### Knowledge, awareness and understanding of COVID-19 preventive health measures and government directives in the CALD community (effectiveness)

A key short-term outcome of effective, appropriate, and accessible messaging facilitated by the initiative would be good levels of knowledge and understanding about COVID-19 and the associated health measures and directives in CALD communities. When questioned in the evaluation, all community members demonstrated excellent knowledge about measures for preventing the spread of COVID-19, listing things such as social distancing, hand washing, staying at home, testing, mask wearing, following guidelines, and isolating when sick. This level of awareness suggests those simple messages had clearly gotten through to those interviewed. When asked hypothetically how they would respond to waking up with a high temperature, sore throat, or a cough most also demonstrated an understanding of this more complex messaging by reporting that they would perform the correct behaviours such as calling a doctor, staying home/isolating, and getting tested. Measuring how this knowledge translates into actual behaviour was beyond the scope of this evaluation.

The evaluation also wanted to explore the attitudes and intentions of CALD community members towards getting the COVID-19 vaccine, as an indication of the effectiveness of messaging around this issue at the time of evaluation (very early in the vaccine roll-out) and into the future. Among respondents there was a mixed response to vaccination, although this is likely no different to that seen in the general Australian population at the time. Many thought the vaccine would be accepted by CALD communities, but the key was to provide members with information in their own language about its importance, as well as to provide clarity about safety and long-term effectiveness. Some community members reported being scared or unsure about the vaccine due to stories that had read or heard in the media. More work also needs to be done to mitigate fake news/misinformation from overseas and social media which may be preferentially sourced as it is delivered in the community members' native language. Sharing positive experiences of CALD leaders/members getting vaccinated was suggested as a potential strategy to improve engagement around this issue.

*“Speaking facts is critical, remind them of how vaccines have helped to eradicate diseases from our home countries. Positive stories about the vaccines as most only pay attention to the negative ones in the media, seeing other people from similar cultural backgrounds and vlog their vaccine experiences” (CALD faith group leader)*

### Challenges experienced by CALD community members (reach and effectiveness)

There were three clear challenges for CALD community members seeking COVID-19 information during the pandemic: limited access to translated resources, information overload, and dealing with misinformation (fake news).

#### *Information overload and conflicting information*

CALD community members reported being overwhelmed by the amount of information which was being shared about COVID-19 and the pace with which it was being updated. Many experienced confusion searching for COVID-19 information on websites, or when obtaining conflicting news from different international, federal, and state sources. It was challenging to know which sources were accurate and trustworthy, and to keep up with frequent updates. Consequently, many defaulted to accessing information from Queensland Health, as they felt confident they could trust this and could easily access it online or via press conferences.

#### *Fake news and conspiracy theories*

Because of this information overload, fake news, conspiracy theories and misinformation also had a negative impact on the CALD community. Language and cultural barriers made it challenging for many to identify accurate information. Consequently, CALD community members became susceptible to fake news and conspiracies spread via social media and word of mouth, particularly when delivered in their own language. This created fear, uncertainty, and scepticism within communities and left unchecked could negatively impact trust in messaging from official sources.

#### *Limited translated resources*

Being unable to understand, read and/or speak English was a significant barrier to effectively engaging with COVID-19 information. While some multi-lingual translations were available via the Queensland Health website and other sources, these were by no means inclusive of the range of languages required. Additionally, the quality of these translations and speed at which they were released could also have been improved.

## Things that made it easier for CALD community members to find out information about COVID-19 (reach and effectiveness)

The most frequently reported enablers for CALD community members seeking COVID-19 information were the presence of community leaders/groups, simple translated information in audio and video formats, regular information delivered by government and health authorities, and social media.

### *CALD community groups and leaders*

Having formal and informal CALD community leaders and active CALD community groups engaged in communicating COVID-19 information made it much easier for community members to receive and understand information. Not only would these leaders be able to obtain the relevant information from reliable sources (usually Queensland Health/Government), but they would also translate, simplify, and share this with their community in accessible formats. Refugee Health, the Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT), Access Community Services, and Multicultural Australia were also singled out for their support including information sessions, translated resources, and calls from bi-lingual/multi-lingual case workers.

*“It is easier when my family members or community leaders explain the info to me in my language”  
(CALD community member)*

### *Information from government authorities*

CALD community members reported that the strong response to COVID-19 information sharing from the Queensland Premier, Chief Health Officer and Queensland Health made it easier for them to access and trust information during the pandemic. This created a range of regular and reliable sources they could access via television, social media, email and online. The Queensland Health website was easy to find and use. The Zoom forum held by the Chief Health Officer talking directly to CALD communities was also well received and a way of increasing trust in the messages being delivered.

*“Queensland Health did a good job, I am very proud to be a Queenslander” (CALD community member)*

*“Having Dr Jeannette Young talk directly to the community was great as she is a doctor and wouldn't lie to the community and was reliable – evidence based information” (CALD community member)*

### *Simple translated information in audio and video formats*

Being able to proficiently read and understand English (or having a family member who could) was of clear benefit for CALD community members seeking COVID-19 information. Beyond this, having concise plain language translations from reliable sources which were accessible in their native language was reported as the largest enabler to effectively engaging with COVID-19 information. Furthermore, having these messages available in either video or audio formats helped those with low literacy skills, and made it easier to share and post information on social media.

### *Social media*

Existing social media channels and online groups within CALD communities made it easier for members to receive targeted, translated, and culturally appropriate messages about COVID-19. They appreciated that information had already been sifted and curated by the leaders/groups on these platforms and could be pushed out to them regularly, rather than having to seek it themselves. Being able to follow health and government officials on social media and be alerted to new information was also an enabler for CALD community members.

## Lessons from CALD community members – what could be improved?

CALD community members displayed overwhelming appreciation for the efforts that had been made by Queensland government and health services during the pandemic. The main suggestion for improving information sharing in the future was to **create and share more language translations from trusted sources**, in a greater **variety of languages**. In particular, they requested Chin languages (Zomi, Falam and Hakha), Karen, Mandingo and Oromo.

There was a need to be proactive in obtaining translations and in **sharing these earlier** to prevent confusion and miscommunication. There was also a clear directive to present messaging in accessible **audio/visual formats** with graphics and pictures.

In terms of information dissemination there were suggestions to use **more mainstream media channels and internet sites**. One creative suggestion was to use QR codes on mainstream/English flyers and posters which could be used to direct people to translations in other languages.

Community members also really appreciated **direct/personalised contact** such as text messages (with videos) and phone calls. There was also a need for more community and **awareness events** (via Zoom or as a small group with an interpreter).

Involving **more CALD community leaders and members, and bicultural workers** in the translation and dissemination process was repeated as key learning for the future due to their ability to reach the community. Aligned with this was a recognised need to **provide more training, resourcing, and support** to these people.

CALD community members also suggested establishing a diverse and **representative community engagement/reference group** which could convey the needs of community in two-way communication with health services, government, and other organisations.

*“I think to make better in the future we need to deliver the information via community leaders to make go to grassroots of ethnic community members in QLD.” (CALD community member)*

*“Those that are seen as leaders in my community are predominantly volunteers. Ensuring our community receives the right information in the most effective way (translations, forums etc.) has been done sometimes at the expenses of an individual. ... - it would be great if more resources were translated, and community leaders were provided with training/resources to be able to support the community.” (CALD community member)*

*“By using communities and give support to their representatives to organize awareness and some trainings by creating groups so that the community members can be informed into their own languages because there are educated people in the communities who are able to give the information in right way.” (CALD community member)*

## What were the outcomes of implementing health education and engagement with CALD community leaders during the pandemic?

A diverse sample of 39 local CALD community leaders reported broad adoption of information sharing across their communities during the pandemic. On average, each leader passed on information to 200 individuals using a wide variety of platforms, mediums, and approaches to target their reach. Almost all leaders reported having to translate and adapt standard COVID-19 messaging for their community, such as creating audio and graphic versions. The most frequently reported challenges for leaders were a lack of translated resources, information overload, misinformation (fake news), and the digital divide. However, enablers such as smartphones/technology, existing networks and relationships, regular information delivered by government and health authorities, and simple visual messaging helped them to share information more easily and broadly. Consequently, most CALD leaders felt satisfied with the support and skills given to undertake this role. Adoption, reach and implementation could still be improved by providing more training, remuneration and support for these leaders, as well as early and continued CALD community outreach and engagement.

### Characteristics of CALD community leaders who participated (adoption)

Thirty-nine CALD community leaders participated in the evaluation via individual interview (n=20), online survey (n=10), and a group interview (n=9). These formal and informal leaders identified with 27 different ethnic, faith, refugee, or minority groups and spoke a combination of 31 different languages (Figures 6 and 7).

## What local Cultural or Faith community/s do you identify with?



**Figure 6.** Faith and ethnic groups represented by CALD leaders

All leaders reported sharing information about COVID-19 and/or government directives with their local communities, suggesting there was broad adoption of the interagency collective response across Brisbane CALD communities. Having such a diverse sample of local CALD leaders involved also allowed for examination of reach, adoption, and implementation from a range of perspectives.

## What languages do you speak?

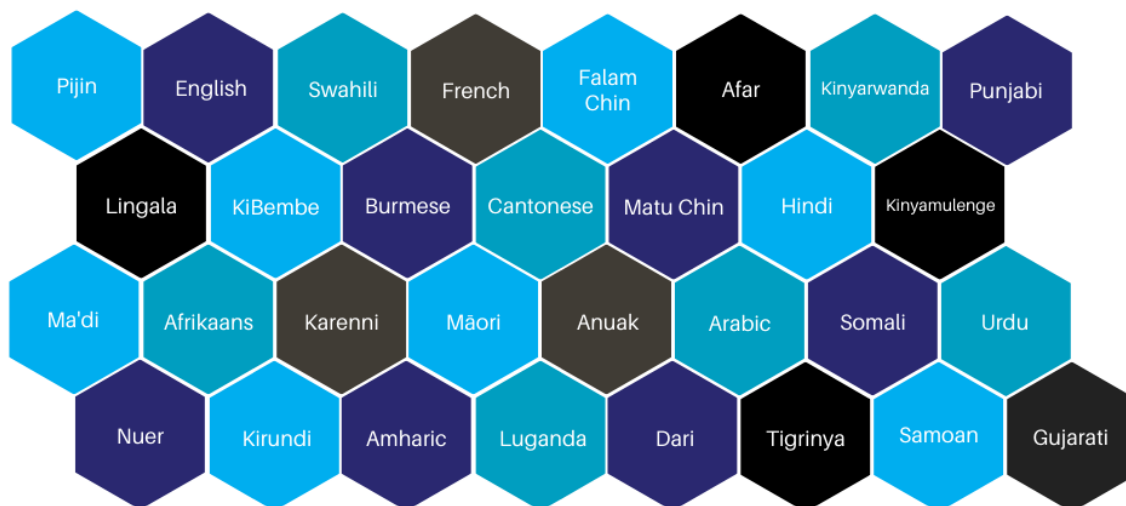


Figure 7. Languages spoken by CALD leaders

### How leaders shared information (reach)

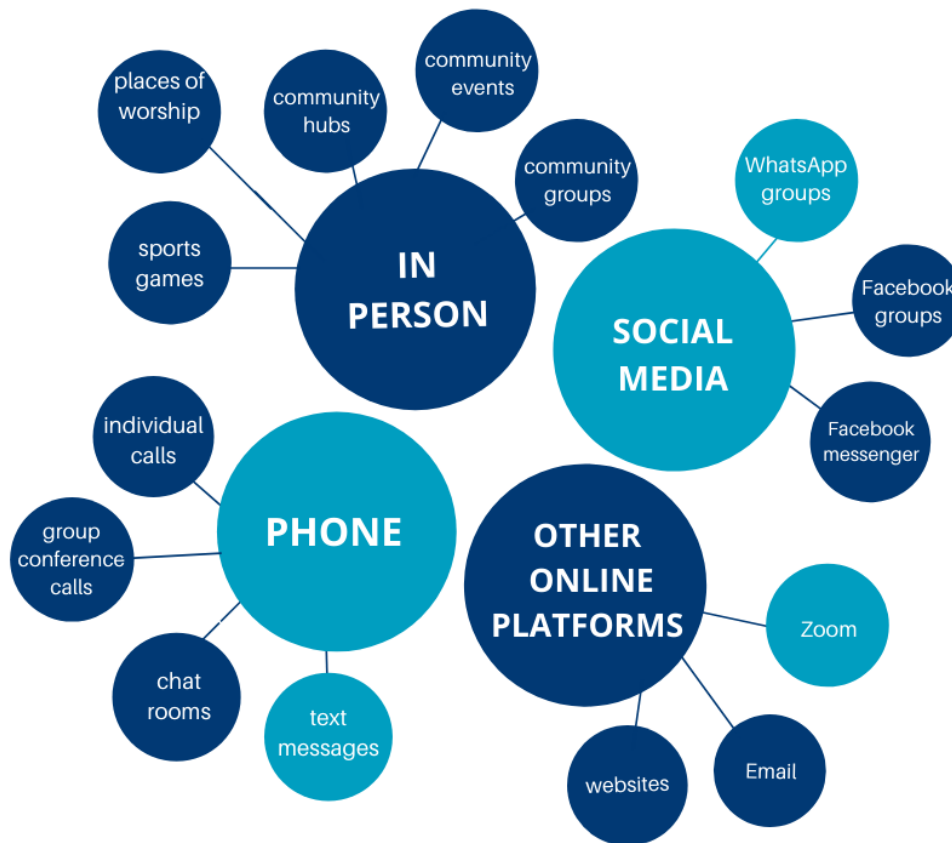
While community leaders often received COVID-19 information directly from Queensland Health or one of the initiative partners (e.g., G11), sometimes they sourced information themselves. In either case they circulated this information across a wide variety of platforms using different mediums and approaches to reach community members (Figure 8). Phone calls, text messages, Zoom, and social media (largely WhatsApp) were the most frequently used dissemination methods. Primarily, leaders listened to and spoke with their communities, and created and/or shared simple written, audio, and video translations of existing information. They also shared English language videos and resources where appropriate.

*“I received translated information via Mater G11 Coordinator or via Queensland Health or other organisation or community leader and then I passed it on via social media. I put the information in our Viber group. I also shared some translated documents via text or WhatsApp and we made audios of the written information and they were helpful.” (CALD ethnic group leader)*

### The number of CALD community members leaders shared information with (direct and indirect reach)

For the 24 leaders who shared information about the reach of their messaging, the estimated number of community members they each reached ranged from 10 to 1000. This accounted for direct and indirect reach pathways including phone calls, text messages, church groups, online forums, and social media sharing and engagement. On average however, each leader estimated they had reached almost 200 community members (mean = 193). Many leaders reported that their reach had increased during the pandemic due to greater community engagement with social media, and people not knowing where to turn for help. One translated video even went global with engagement reported in Canada and America. Some community groups and leaders had even broader reach, for example QACC reported social media and other information sharing statistics well into the 10000s (see [case study](#)).

## How did you share information and communicate about COVID-19 in your community?



**Figure 8.** Methods used by CALD leaders to share information (*light blue represents most frequently used methods*)

### How messaging was adapted (reach, implementation, and effectiveness)

Almost all CALD leaders reported having to adapt standard COVID-19 messaging before sharing it with their communities. The extent of adaptation varied, but most commonly it was translating messages into their own language and then turning these into text, graphic, video, or audio versions to share. Most often these were made short and concise, with leaders just sharing the key points within messages. The other important adaptation was simplifying messages into “everyday language” for clarity and understanding. Some CALD leaders even reported changing terms to be more culturally acceptable within their community (e.g. mask to mouth cover). It was common for leaders to enlist the help of other CALD community members, particularly those with a medical background, to help with this process to ensure information was shared correctly and effectively.

The process of disseminating messages also had some key adaptations – it was not simply a case of mass information sharing within communities. Rather, delivery of messages was tailored to the various types of recipients and often conducted in a personalised manner (e.g. those could not read were given audio messages, personalised WhatsApp messages were sent, personal phone calls for those with low digital literacy). Finally, some leaders even used their own personal experiences with COVID-19 or vaccination to help others understand the importance of their message.

*“I got the resources from Queensland Health and summarised this information and looked for the main concern for the community and then I shared it via written format or also calling my community members.” (CALD ethnic group leader)*

## Challenges experienced by CALD leaders (reach, effectiveness)

The most frequently reported challenges for CALD leaders in communicating COVID-19 information were a lack of translated resources, information overload, misinformation (fake news), and the digital divide.

### *Lack of translated resources*

Having to access and then translate English health information into their own language was a major challenge for community leaders. Leaders from smaller CALD communities were particularly affected by this issue. Difficulties were also experienced with translating medical terminology and making information understandable and acceptable for their own community. This was compounded by the fact that community leaders were not often remunerated for their time to undertake these translations.

### *Information overload, misinformation, and trust*

Many CALD leaders expressed the difficulties they had dealing with both the quantity and pace of COVID-19 information during the pandemic. There was rapidly changing information available from an overwhelming number of sources and they struggled to discern which ones they could trust and pass on to their own communities. Many also commented on the challenge of “fighting the other noise” of fake news, conflicting messages, and misinformation spread via social media or overseas sources. This led to some CALD leaders fearing that they wouldn’t be able to build trust within the community or would not be perceived to know enough to deliver messages. Media coverage about the negative actions of several CALD individuals also distracted from the ability to effectively communicate and build trust.

### *The digital divide*

Leaders reported that effectively delivering COVID-19 information to CALD community members without internet connected phones and devices was challenging. Even if community members could go online, they often experienced difficulties joining Zoom or accessing information through official websites due to low technological literacy. This was mostly an issue for the elderly members of CALD communities but did not apply to them exclusively. In these cases, communication had to be done in-person or over the phone, limiting reach and effectiveness.

## Enablers experienced by CALD leaders (reach, effectiveness)

The most frequently reported enablers for CALD leaders in communicating COVID-19 information were smartphones/technology, existing networks and relationships, regular information delivered by government and health authorities, and simple visual messaging.

### *Technology and social media*

By far the most frequently reported enabler to effective communication was the presence of smart devices and the internet, and their associated online communication platforms such as text messaging, Zoom, WhatsApp Facebook and Messenger. This meant that CALD leaders could expand the reach of their communication broadly and deliver information with the required speed to community members. It also meant that information could be easily accessed by those who required it. Moreover, it allowed for two-way flow of information with community members being able to ask questions and seek information easily in a non-threatening environment. The shift in the broader Australian community towards utilisation of technology during the pandemic meant that acceptance of communication via these platforms was high.

### *Existing networks and relationships*

Having existing networks within and between CALD communities was perceived to be a strong enabler for effective communication. Not only did this mean that there were clear channels for disseminating information (e.g. existing community WhatsApp group) but also that there was already an established level of trust in the leaders of these networks. For example, church leaders making announcements to their congregations was perceived to be an effective communication strategy.

*“I was able to pass on that information in native language plus they knew that the information was coming from someone they could trust” (CALD ethnic group leader)*

*“We are not formal community leaders but people saw us as a natural leader so are trusted by some members of the community” (CALD ethnic group leader)*

### Information from government authorities

The strong media response to COVID-19 information sharing from the Queensland Government and Queensland Health was a clear communication enabler for CALD community leaders during the pandemic. It meant that leaders had local sources of information they could trust, delivered regularly in accessible locations and formats. This was even more useful when this information had already been transformed into plain language summaries or multi-lingual translations. Additionally, the meetings and information sessions that Queensland Health officials participated in with CALD leaders and communities helped build trust and buy-in, making it easier to communicate information. Finally, the information provided directly to leaders by Mater and Multicultural Australia was also reported to be enabling.

*“I was getting the information directly from Mater G11 so I didn’t have to filter through lots of information. If I had to check if it was relevant or not then I would have to take a lot more time” (CALD ethnic group leader)*

### Simple visual messaging

Having messages with artwork, graphics and animations helped CALD leaders to communicate COVID-19 information more effectively. It was also important to keep these messages short and simple. This meant that messages were easier for community members to understand, more engaging, and easy to share digitally.

### CALD community leader satisfaction (adoption)

The evaluation aimed to assess if leaders felt supported in these roles as intermediary messengers during the pandemic, and if anything could have been done to better support them. Despite reporting significant challenges communicating information during the COVID-19 pandemic, most CALD leaders felt satisfied they were given enough support and skills to undertake this role. In particular, they felt that working collectively in the initiative was a good approach, as it provided an opportunity to share challenges, learn from each other, and be supported. Various Zoom sessions and WhatsApp groups for leaders were highlighted as useful supports, as were the online community leaders’ forums and resources/support provided by Access community services, faith groups and other partner organisations. Importantly, leaders felt that they were being included in the pandemic response with regular meetings and communication with health officials, hospitals, and frontline staff.

*“This gives opportunity for me as community leader to voice out issues or ideas and contribute towards improvements” (CALD ethnic group leader)*

Several areas could still be addressed to improve CALD leader satisfaction and increase potential adoption of the initiative in the future. First would be to address the lack of time and resources experienced by many in this role. There was not only a lack of remuneration for leader time and experience, but also for obtaining translation and graphic design to assist in effective dissemination. Remuneration will also let leaders know that they are a valued part of the initiative and its activities.

*“Community leaders do a lot of volunteering but giving them financial incentive will give them ownership and enable them to maintain activity” (CALD ethnic group leader)*

Finally, some CALD leaders did still experience isolation during the pandemic and felt there was more work to be done in establishing and maintaining outreach to these communities.

## Lessons from CALD community leaders – what could be improved?

More could be done to **train, remunerate and support CALD community leaders**. This in turn would increase the number of leaders who would like to get involved.

More health information needs to be provided in **audio and visual formats**, and as easy fact sheets to assist with communication.

More **diverse translations** need to be available with widespread advertising about how to access these (e.g. TV or radio advert).

**Engagement with CALD communities** and leaders needs to be built and maintained ahead of time to earn trust and build relationships. There needs to be more outreach into their spaces and events. Additionally, a **reference advisory group** with diverse community representatives could be formed and used to seek and implement feedback.

## How effective was the interagency partnership approach to CALD communication during the COVID-19 pandemic?

To establish if the interagency collective approach resulted in valuable, collaborative, and sustainable partnerships between stakeholders, the evaluation examined the quality and strength of partnerships using an online questionnaire to capture quantitative and qualitative measures. The questionnaire was circulated to 27 individuals representing key interagency partners including health and government organisations, and community, refugee, ethnic, and faith groups. Thirteen of these stakeholders returned complete data.

The findings suggest a strong partnership has been formed, with tangible benefits for all partners. This has been enabled by existing interpersonal relationships, shared goals, a commitment to process and outcomes, and virtual meeting technology. Partners were challenged by the time and labour intensive nature of collaboration, but still experienced high levels of satisfaction when taking part. Some work still needs to be done in clarifying and formalising partnership structures and processes, and in better enabling the CALD community voice to ensure partnership sustainability.

## How were the initiatives of the interagency collective response implemented?

Data about implementation of the partnership's activities was captured in a graphical timeline via retrospective review of project documentation from March to October 2020 (Figure 9). The findings demonstrate significant inputs and outputs as part of the collective response including regular meetings, community and leader information sessions, newsletters, and 15 official translated resources from Queensland Health during this time-period. This timeline is not exhaustive but is meant to demonstrate the breadth and type of activities which occurred.

The formal partnership members also worked collaboratively with other organisations at this time. For example, Multicultural Affairs worked closely with Queensland Health and the RHNQ to fund an Australian Red Cross Community Connector role at the beginning of the pandemic to strengthen and support the capability of community organisations across the state when responding to community needs. This role had a two-way function of providing advice to government on gaps in information and support to communities through the pandemic.

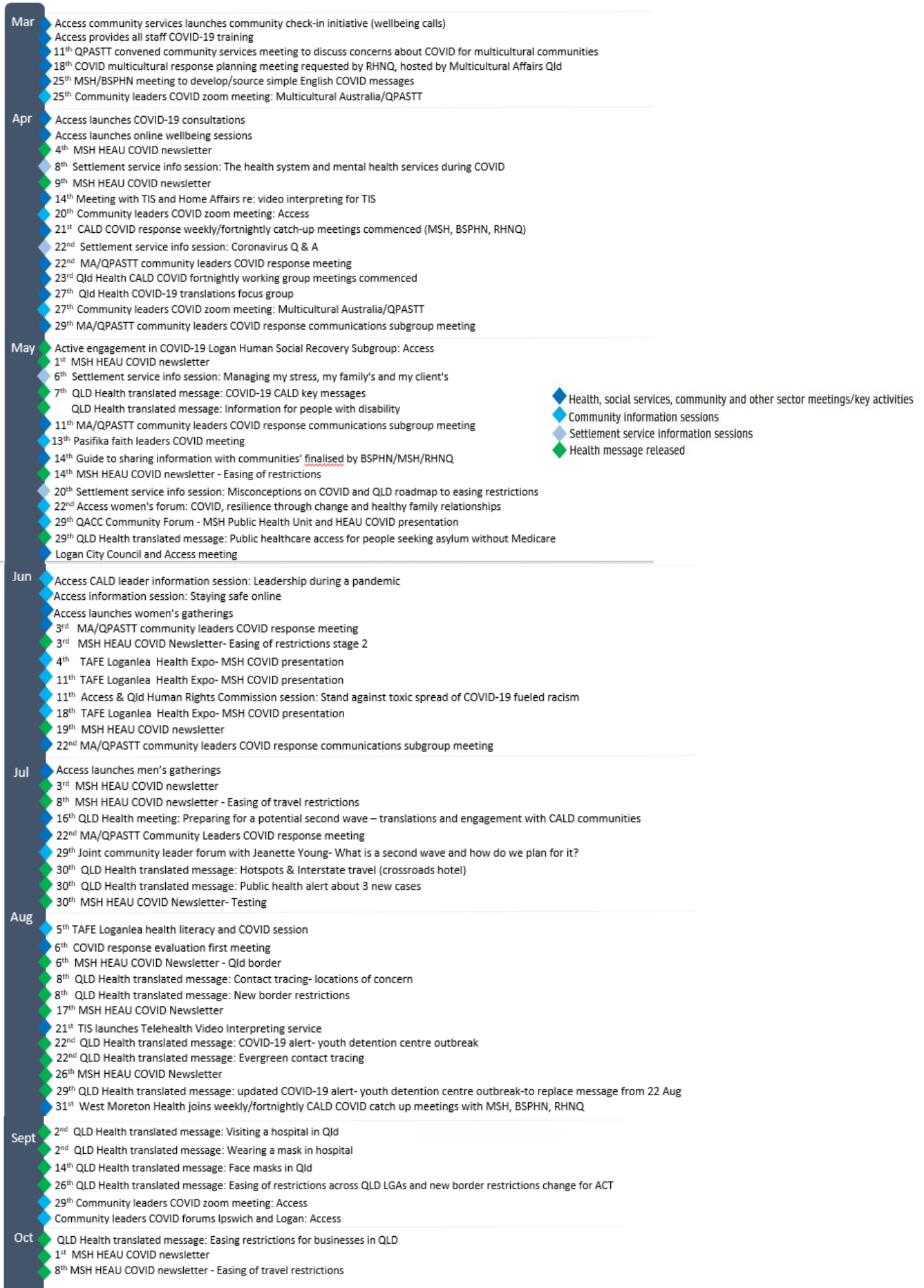


Figure 9. Timeline of implementation for the partnership's collective response

## What aspects of the interagency collective response demonstrate an effective partnership model? (implementation, maintenance)

### Partnership strength

The VicHealth Partnership Analysis Tool was incorporated into the questionnaire to evaluate partnership strength and sustainability. The tool examines partnerships across seven key areas including: partnership need; choice of partners; skills and support; planning; implementation; minimising barriers; and reflecting and sustaining.

Cumulative results across all domains indicate that a partnership based on genuine collaboration has been established, with the overall score ranging from 131-164 across partners (mean score = 140 out of 175). Scores were high across all partnership domains, but stakeholders were most confident in “determining the need for the partnership” which focused on common interests, clear goals, partner sharing and commitment, and cost-benefit of the partnership (Table 2).

**Table 2.** Aggregated results of VicHealth Partnerships Analysis Tool

Domain	Score
Max score per domain = 25	N=13; Mean (Range)
Determining the need for the partnership	22.8 (20-25)
Choosing partners	20.6 (18-25)
Making sure partnerships work	19.1 (17-24)
Planning collaborative action	19.8 (14-25)
Implementing collaborative action	20.0 (18-22)
Minimising the barriers to partnerships	18.5 (15-21)
Reflecting on and continuing the partnership	19.6 (18-22)
<b>TOTAL* (max score = 175)</b>	<b>140 (131-164)</b>

#### Checklist score

35–84: The whole idea of a partnership should be rigorously questioned

85–126: The partnership is moving in the right direction, but will need more attention to be really successful.

127–175: A partnership based on genuine collaboration has been established. The challenge is to maintain its impetus and build on the current success.

In particular, there was unanimous agreement between partners that:

- there is a perceived need for the partnership in terms of areas of common interest and complementary capacity
- the perceived benefits of the partnership outweigh the perceived costs
- there is an investment in the partnership of time, personnel, materials, or facilities
- there is a core group of skilled and committed (in terms of the partnership) staff that has continued over the life of the partnership
- there is a clear need for and commitment to continuing the collaboration in the medium term.

### Satisfaction with partnership

Stakeholders all expressed strong satisfaction with the partnership, with the mean satisfaction score 85 out of 100 (Figure 10).



**Figure 10.** Satisfaction of stakeholders with the interagency partnership (*light blue represents range of responses, red line represents mean response*)

Participants found the partnership to be rewarding, effective and enjoyable. This was exemplified in the written feedback received alongside this question:

*“It has been an incredibly rewarding process to work with so many key stakeholders and the communities. Respect for the diverse skills and connections of each partner.”*

*“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.”*

*“I really enjoy working with all the partnership - we are a tribe of people with similar values and commitment, broader connections, and ability to advocate for better access for CALD communities.”*

*“[The partnership] was one of the best things to happen as a result of COVID.”*

### Perceived benefits of partnership

A question from the New York Partnership Assessment Tool was used to assess the perceived benefits to individuals and groups of participating in the partnership. All partners reported multiple benefits across skills, impact, community benefit, and relationships, as displayed in Figure 11. For many, this was achieved even without receiving additional financial support from the partnership.

### What were the enablers to the partnership?

Stakeholders repeatedly highlighted several key enablers which made participation in the partnership easier for them and their organisation. The first of these was having **pre-existing interpersonal relationships** between many of the partners which had created an immediate level of trust once the COVID-19 response partnership was established. This meant that participants felt the partnership was open, transparent, and collegial from the beginning. Alongside this, the **commitment shown by all partners** to the collaborative process was a strong enabler. This was driven by having a **shared goal and motivation** to improve access and outcomes for CALD and refugee communities. Being able to capitalise on virtual technology and **meet via Zoom** also made it easier to participate in the partnership, as it provided equity for attendance, saved travel time, and meant no costs were incurred.

Other enablers were reported by individual participants such as the partnership producing products that were directly related to their current work; appreciation of the diversity of skills; and the focus on innovation and flexibility amongst partners.

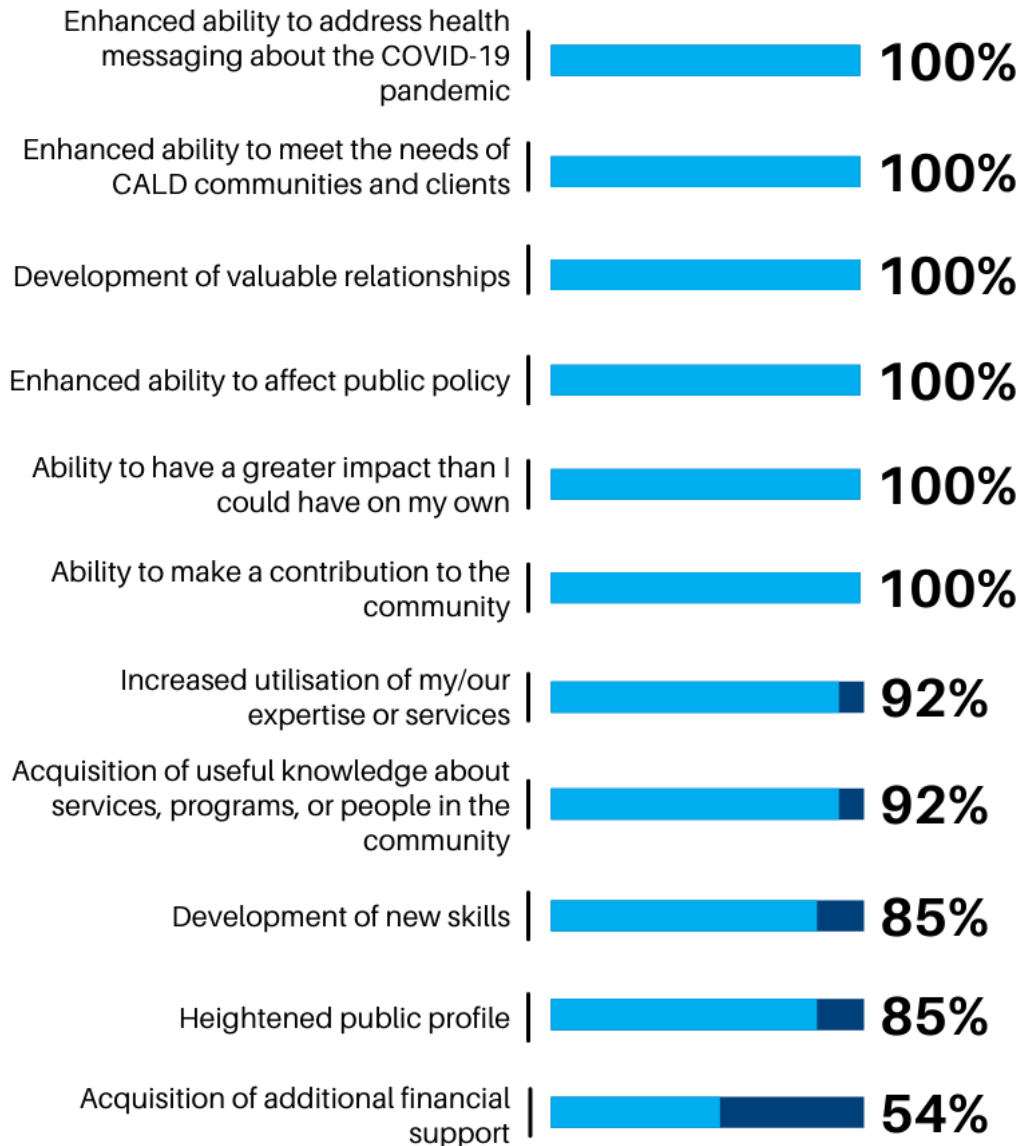


Figure 11. Reported benefits of partnership participation (n=13)

### What challenges did the partnership present?

When asked about the barriers and difficulties experienced while participating in the partnership, one common theme was clear. The **time and labour intensive nature of collaboration**, and the impact that had on other work and personal commitments, was the major challenge faced by partners.

*“Although necessary, the partnership and its work has been labour intensive as we try and do a lot of things in a very fast paced and changing environment. This happens in addition to our usual work.”*

Other challenges touched on by participants were the difficulty of being inclusive of all partners all the time, the constantly changing environment/needs, occasional confusion and tension around communication pathways, and a lack of resources.

## Can the partnership be sustained? How can this be strengthened?

Encouragingly, the VicHealth Partnerships Tool highlighted that partners felt confident in reflecting on and continuing the partnership (Table 2, 19.6/25), and many wanted to continue the partnership's regular meetings. However, examination of individual questions within the tool raised some key sources of concern in terms of creating a successful and sustainable partnership.

- Only 23% of participants agreed that differences in organisational priorities, goals and tasks have been addressed
- Only 23% of participants agreed that there are formal structures for sharing information and resolving demarcation disputes
- Only 31% of participants agreed that processes common across agencies had been standardised (e.g. referral protocols, service standards, data collection and reporting mechanisms)

These issues were those reflected when partnership members were asked directly about what improvements could be made to sustain the partnership. The key change was to provide more **clarity and formalisation** around partnership governance, structures, and processes, including terms of reference, goals, membership, and ongoing evaluation. This will be important for managing expectations, maintaining relationships, managing disputes, allocating time/resources, and providing recognition. At the same time, it would assist in formalising the commitment by organisations (vs individuals). Efforts to engage, explore and enable the presence of **CALD community voice** centrally within the group, was also highlighted as key towards strengthening the partnership in the future.

## Conclusion

This evaluation clearly demonstrates the benefits of an interagency collective response partnership which engages with and reciprocally educates CALD leaders, their communities, and health stakeholders. The ongoing partnership with leaders, and tailoring of health message format, language, and dissemination methods, had strong impacts on the reach, appropriateness, and effectiveness of COVID-19 information within these communities. While implementation of the partnership's activities was challenging, time consuming, and complex, it was ultimately rewarding for those involved. There was a clear impetus from communities, leaders, and other partnership stakeholders to continue this type of approach to information sharing in the future.

## Key learnings

Several key learnings emerged which have applicability for the continued pandemic response, as well as the communication of health and government messages to CALD communities more broadly. Acting on these should help to increase the reach, effectiveness, adoption, implementation, and maintenance of information sharing.

- 1 There is still a need for **more diverse language translations** of key messages, and all of these should be **simple** and understandable.
- 2 It is important that translated messages are **created and shared as early as possible** to prevent confusion and available in a **range of formats** including audio, video, and graphic versions.

3

Tailored/translated messaging needs to be **disseminated more widely**, using not only more CALD leaders and organisations, but also **mainstream media** sources like TV and radio.

4

**Engagement of more community leaders**, community members and bicultural health workers is still required, particularly in communities where no formally accredited translators exist. The informal translations independently created and shared by multi-lingual community members were a key component of successful COVID-19 messaging within many communities.

5

To support sustainability and adoption, health services need to **invest in training, remuneration and support for CALD community leaders and members** engaged in co-designing, developing, and sharing resources.

6

Health services need to develop authentic partnerships with communities, invest time and resources to collaborate, and identify areas where additional resources and support are required. This engagement needs to be built and maintained ahead of time using an **embedded community development approach** that enables and privileges the wisdom and knowledge of communities to earn trust and build relationships. Seeking and incorporating their agenda into joint strategies, policy and actions is recommended. Establishment of a **reference advisory group** with diverse community representatives is one practical example.

7

More clarity should be provided around **partnership governance, structures, and processes**, including terms of reference, goals, membership, and ongoing evaluation.

The importance of engaging, trusting and supporting community leaders/bicultural workers; the early sharing of tailored messages in multiple formats; using the virtual environment and other accessible communication channels; and placing CALD voices on advisory groups, has also been highlighted in recent work with CALD communities in New South Wales<sup>7</sup> and Victoria<sup>3</sup>. Consequently, it is likely the findings of this evaluation are broadly applicable to CALD community engagement across many regions of Australia. Furthermore, if other jurisdictions have having pre-existing interpersonal and interorganisational relationships with trust built between key stakeholders, these could be capitalised on to create similar collective response partnerships for future crisis response efforts.

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# Appendix 1

## Question guide for CALD community members

### Demographics

1. What local community(s) are you a part of/do you identify with?
2. What languages do you speak?

### Reach questions

I'm just going to ask you now to think back to early last year, and the start of the COVID-19 pandemic:

1. During the pandemic, how did you get information and health advice about COVID-19?
2. Which of those sources or people did you trust the most?
3. What made you decide to trust that person/information?
4. What was hard about finding out information and health advice about COVID-19? (*prompts: what about the impact of fake news?*)
5. What made it easier to find out information and health advice about COVID-19?
6. Was information from the Government available in your preferred language and relevant to your community? (*prompt: oral or written versions? Was it poorly translated? How did you know it was from the government?*)
7. Do you think information about COVID-19 was shared well to meet your needs?
8. How could health or government information shared to you and your community be improved in the future?

### Effectiveness (knowledge/behaviour) questions

I'm now going to ask you some questions about COVID-19. We just want to understand your thoughts about the virus:

1. What are some of the things that you can do to stop the spread of COVID-19?
2. Now, imagine you woke up tomorrow with a high temperature, or sore throat, or a cough – can you tell me what would you do?
3. If a vaccine which can help prevent COVID-19 is approved by the Australian government, would you get it? (*prompt: If no, why not? What would you need to see or hear to be convinced to take the vaccine?*)

That's all of the questions I have today. Do you have any questions for me?

Thank you for your time.

# Appendix 2

## Question guide for CALD community leaders

### Demographics

1. What local community(s) are you a part of/do you identify with?
2. What languages do you speak?

### Evaluation questions

I'm just going to ask you now to think back to early 2020 and the start of the COVID-19 pandemic:

1. How did you hear about/become involved with this project?
2. What do you think worked well to engage community leaders?
3. How did you share information and communicate about COVID-19 in your community?
4. What did you do to adapt COVID messages or information to better help your community accept or understand it? (*prompt: did you have to change words, did you have to deliver information in a different format, did you have to use other people to help you?*)
5. How many people do you think you reached with that information? (approximate numbers okay)
6. Is this your usual numbers you reach or did you increase your reach because of COVID-19? (*prompt: how did you increase your reach? Why did you increase your reach? What made it successful?*)
7. What did you find difficult about sharing COVID-19 information to your community?
8. What made it easier to share COVID-19 information to your community?
9. Did you feel supported in this role? What could have been done better? (*prompt: did you have the skills, confidence, resources, time, training?*)
10. How could we get more community leaders to participant in a project like this?

That's all of the questions I have today. Do you want to ask me anything?

Thank you for your time.

# Appendix 3

## REDCap partnership survey

Page 1

### Evaluation of partnerships formed in COVID-19 interagency CALD response

During 2020 you were part of an interagency collective to communicate and engage with culturally and linguistically diverse (CALD) communities in greater Brisbane during the COVID-19 pandemic. The aim was for organisations, government, community leaders, and other stakeholders to work together creatively and collectively to ensure CALD and refugee communities had timely access to accurate and appropriate COVID-19 information.

This work began from a close pre-existing collaboration between the three initial partners: Metro South Hospital and Health Service (Health Equity and Access Unit); Brisbane South PHN (multicultural team); and the Refugee Health Network Qld (which is auspiced by Mater Refugee Health). Each partner also had close collaboration with other key stakeholders who joined the partnership as issues emerged. This organic process has yielded some positive outcomes, however there is growing interest to better evaluate and document the process and impact to inform future responses. The Australian Centre for Health Services Innovation at the Queensland University of Technology has been contracted to provide an independent evaluation of this collective response, including the success of any partnerships formed.

You have been asked to complete this survey as we believe that you played a role in this collective partnership response. This survey aims to reflect on the partnerships established, develop a clearer idea of the success of the partnerships, and focus on ways to sustain partnerships into the future.

Your answers to the questions are confidential, and will not be shared in identifiable form with anyone in your organisation/group or elsewhere. We will however, be reporting the results of all aggregated surveys. All the responses will be anonymised.

If you would like more information about this survey please contact Bridget Abell (bridget.abell@qut.edu.au).

**In this first part of the survey, you are asked to rate the success of your partnership in terms of each statement below. They are organised into seven areas that define key features of a successful partnership for health promotion. The scale ranges from strongly disagree to strongly agree. Please think about your own experience as part of this interagency collective and rate your level of agreement with each of the statements below.**

#### 1. Determining the need for the partnership

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
There is a perceived need for the partnership in terms of areas of common interest and complementary capacity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is a clear goal for the partnership	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is a shared understanding of, and commitment to, this goal among all potential partners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The partners are willing to share some of their ideas, resources, influence and power to fulfil the goal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The perceived benefits of the partnership outweigh the perceived costs

## 2. Choosing partners

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
The partners share common ideologies, interests and approaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The partners see their core business as partially interdependent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is a history of good relations between the partners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The partnership brings added prestige to the partners individually as well as collectively	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is enough variety among members to have a comprehensive understanding of the issues being addressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 3. Making sure partnerships work

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
The managers in each organisation (or division) support the partnership	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partners have the necessary skills for collaborative action	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are strategies to enhance the skills of the partnership through increasing the membership or workforce development	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The roles, responsibilities and expectations of partners are clearly defined and understood by all other partners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The administrative, communication and decision-making structure of the partnership is as simple as possible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

#### 4. Planning collaborative action

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
All partners are involved in planning and setting priorities for collaborative action	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partners have the task of communicating and promoting the partnership in their own organisations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Some staff have roles that cross the traditional boundaries that exist between agencies or divisions in the partnership	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The lines of communication, roles and expectations of partners are clear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is a participatory decision-making system that is accountable, responsive and inclusive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

#### 5. Implementing collaborative action

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
Processes that are common across agencies have been standardised (e.g. referral protocols, service standards, data collection and reporting mechanisms)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is an investment in the partnership of time, personnel, materials or facilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Collaborative action by staff and reciprocity between agencies is rewarded by management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The action is adding value (rather than duplicating services) for the community, clients or agencies involved in the partnership	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

There are regular opportunities for informal and voluntary contact between staff from the different agencies and other members of the partnership

6. Minimising the barriers to partnerships					
	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
Differences in organisational priorities, goals and tasks have been addressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is a core group of skilled and committed (in terms of the partnership) staff that has continued over the life of the partnership.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are formal structures for sharing information and resolving demarcation disputes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are informal ways of achieving this	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are strategies to ensure alternative views are expressed within the partnership	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Reflecting on and continuing the partnership					
	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
There are processes for recognising and celebrating collective achievements and/or individual contributions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The partnership can demonstrate or document the outcomes of its collective work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is a clear need for and commitment to continuing the collaboration in the medium term	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are resources available from either internal or external sources to continue the partnership	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

There is a way of reviewing the range of partners and bringing in new members or removing some



**In this part of the survey we will ask you some questions about your own experience and satisfaction in taking part in the collective partnership response. Please feel free to write as much as you wish in your response to the following questions.**

What have been some of the barriers/difficulties you have experienced while participating in this partnership?

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This could be at a personal or organisational level e.g. diversion of time and resources away from other work, insufficient influence in partnership activities

What factors have made participation in the partnership easier for you and/or your organisation?

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This could be at a personal or organisational level e.g. use of virtual technology, financial support, alignment with current work

So far, how satisfied have you been with participating in the partnership?

drawbacks greatly exceed benefits completely satisfied

(Place a mark on the scale above)

Any comments about your satisfaction with the partnership?

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What suggestions (if any) do you have about making the partnership sustainable over the next 2-3 years?

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**For each of the following benefits, please indicate whether you/your group has or has not received the benefit because of participating in the partnership:**

	Yes	No
Enhanced ability to address health messaging about the COVID-19 pandemic	<input type="radio"/>	<input type="radio"/>
Development of new skills	<input type="radio"/>	<input type="radio"/>
Heightened public profile	<input type="radio"/>	<input type="radio"/>
Increased utilization of my/our expertise or services	<input type="radio"/>	<input type="radio"/>
Acquisition of useful knowledge about services, programs, or people in the community	<input type="radio"/>	<input type="radio"/>
Enhanced ability to affect public policy	<input type="radio"/>	<input type="radio"/>
Development of valuable relationships	<input type="radio"/>	<input type="radio"/>
Enhanced ability to meet the needs of CALD communities and clients	<input type="radio"/>	<input type="radio"/>
Ability to have a greater impact than I could have on my own	<input type="radio"/>	<input type="radio"/>
Ability to make a contribution to the community	<input type="radio"/>	<input type="radio"/>
Acquisition of additional financial support	<input type="radio"/>	<input type="radio"/>

Other benefits to participation or comments about benefits

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