AusHSI Australian Centre for Health Services Innovation

QUT

Executive summary

Background

The culturally and linguistically diverse (CALD) COVID Health Engagement Project (CCHEP) was created to amplify the voice of Queensland's CALD communities in the development of strategies to overcome barriers these communities faced in accessing appropriate health services and health information during the COVID-19 pandemic. It aims to reciprocally engage and empower CALD communities and service providers to enable an effective response to COVID-19, access to appropriate services and resources, and build health system capacity and community resilience.

CCHEP is a partnership driven initiative funded by Queensland Health and managed by the Refugee Health Network Queensland which is auspiced by Mater Refugee Health. It is supported by eight partner organisations and focusses on providing advice, coordination, and connection between Queensland Health and CALD communities in Queensland.

CCHEP works with the community to co-design plain English and in language information and resources and share these in culturally appropriate ways. It also listens to community and providers to identify emerging and ongoing needs and provide feedback and advice to Queensland Health. The project also aims to improve COVID-19 testing and vaccination rates in CALD communities. Finally, CCHEP supports community-led grass root initiatives related to COVID-19 health communication.

The Australian Centre for Health Services Innovation (AusHSI) was engaged by the Refugee Health Network Queensland to independently evaluate the CALD COVID Health Engagement Project in 2022.

This evaluation examines the implementation, effectiveness, and sustainability of CCHEP across CALD communities and community leaders, community services and health providers, Queensland Health, and partner organisations. The transferability of CCHEP's reciprocal engagement approach is also considered.

The evaluation employed a mixed-methods approach using an established evaluation framework. A comprehensive approach captured information about the project, process, and context in which CCHEP is delivered, using both objective and subjective measures of impact. Data sources included:

- Qualitative project and reporting data routinely collected by CCHEP including flexi-funding documentation, newsletters, reports, and administrative records
- Quantitative social media and website analytics
- Individual and group qualitative interviews with CCHEP stakeholders representing community, health, government, and project roles
- Peer researcher qualitative interviews and discussions with CALD community members and CALD community leaders
- Survey responses (quantitative and qualitative) from partners and external stakeholders who collaborate with CCHEP
- Survey responses (quantitative) from the online Program Sustainability Assessment Tool
- Online qualitative diary entries completed by CCHEP implementors

To address recall bias, selection bias, or other limitations, data from multiple sources have been analysed and compared (where appropriate) to inform findings.

Key findings

This evaluation clearly demonstrates the benefits of CCHEP's approach of reciprocal engagement and support of CALD leaders and their communities, as well as health, community, and government stakeholders. The ongoing partnership with community leaders and key partners, 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. Providing holistic, culturally appropriate access to COVID-19 healthcare has also improved testing and vaccination outcomes for these communities.

Importantly, CCHEP has been able to demonstrate how to practically implement a philosophy and process of engagement with refugee and CALD communities. There was a clear impetus from all stakeholders to continue, as well as replicate, this type of reciprocal engagement approach in the future. CCHEP has contributed to growing recognition that communicating with CALD communities is a significant component of public health messaging, rather than a niche need. Establishing sustainable social and organisational infrastructure to nurture connections and engagement with diverse communities across the state should be a key focus of future work.

In addition to the above, multiple learnings emerged from this evaluation which have applicability for the continued pandemic recovery, as well as the communication of health and government messages to CALD communities more broadly.

Accessing COVID-19 information and healthcare
CALD communities in Queensland were most often accessing and receiving accurate medical and government messaging from official sources. Such high use of government COVID-19 resources by CALD communities has not been observed in other Australian regions.
It may be important to invest in and consider the important role GPs could play in health communication for CALD communities in the future given their high levels of trust and accessibility within this population.
Data suggests that the communities with the largest increase in vaccination rates in Queensland from late 2021 to early 2022 were those where the most work was done by CCHEP to drive engagement.
CCHEPs work had a ripple effect through CALD family, community and organisational networks which amplified the reach of information sessions, resource sharing, community leader engagement, vaccination hubs and social media groups beyond initial recipients.
Service provider benefits
Health and community service providers experienced better relationships with CALD community members as CCHEP had already built trust and provided cultural support.
CCHEP has significantly improved the effectiveness and appropriateness of Queensland Health's approach to communicating with CALD communities. Queensland Health should be considered an exemplar of how organisations across all sectors can listen to and meaningfully engage with CALD communities.
CCHEP worked successfully with Queensland Health to establish a process to improve the quality and timeliness of Plain English messaging and translations for CALD communities.
CCHEP's success contributed to a decision by Queensland Health to expand its multicultural team in the disability and multicultural health unit.

Reciprocal engagement approach
The underlying approach to community engagement demonstrated by CCHEP (using COVID-19 as a case study) should be sustained and translated into other clinical areas and government sectors.
Key principles and processes of CCHEPs engagement approach included respecting and remunerating community; partnering with whole community, not just using leaders; not relying on translations but taking a multi-modal and multi-channel approach to messaging; co-designing resources and initiatives with partners and community; performing strength-based work; using a relational/developmental approach; and demonstrating the importance of engagement though action and evaluation.
CCHEP was effective in making CALD leaders feel valued, heard, and empowered via roles in project governance, flexi-funding initiatives, regular two-way government forums and by remuneration for their time. These types of approaches build trust and should be sustained in the future to successfully engage with community leaders.
While maintaining inclusion of community leaders in CALD health engagement is important for building trust, projects must avoid overburdening them. Care must be taken to avoid an over reliance on leaders to deliver messaging to whole communities.
The flexi-funding model was effective in creating action and support for grassroots, community-led COVID-19 and health engagement. It demonstrates that resources are most effectively used when the development is led by the community to address identified issues of need. A continued commitment to flexi-funding principles and processes for CALD community engagement would support long-term community development, and relationship building.
CCHEP resulted in a shift in power and trust towards communities to decide what was required and when and how to be supported. This came for an embedded understanding of a need to work differently, and that community are experts with the required knowledge to address their own problems if adequately supported.
Partnerships and connections
The frequent, timely and open way leaders were connected with each other, and with government stakeholders in engagements was critical for CCHEP's success and adoption. The creation of a space for all communities to come together and learn from each other and create solutions was also valued.
It will be important to provide funding and support to nurture the partnerships established across the breadth and depth of the project to maintain a foundation of social infrastructure that can be reactivated to engage CALD communities and stakeholders in a future crisis.
Core components and principles of CCHEP
CCHEP brought social policy on top of health and economic policy approaches. The six defining features of CCHEP's appropriateness and effectiveness are: 1. a specialised, dedicated core project engagement team; 2. experienced cross-sector leadership, embedded in a health service and existing networks; 3. complementary and coordinated response from invested partners; 4. existing trust and connections to and within community; 5. a willingness of stakeholders to be led by community; and 6. flexibility in funding and ways of working Any future iteration of CCHEP should seek to retain these three key features at its core.