TRUST & DISEASE PREVENTION:

COMMUNICATING HEALTH MESSAGES WITHIN CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) COMMUNITIES

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Members of Culturally and Linguistically Diverse (CALD) communities make different vaccination decisions, and those decisions are affected by a number of social determinants of health, as findings of a recent study show (Ahmed et al., 2021a). A number of conditions must exist so that members of CALD communities can effectively *consume* information about vaccination, *contemplate* the decision to vaccinate, *motivate* themselves to vaccinate, and *act* on their vaccination decision. Different social, economic, and political conditions can serve as facilitators or barriers to the ability of CALD community members to effectively maneuver from knowledge to contemplation, motivation, and action. In this policy brief, we discuss vaccination decisions of members of four CALD communities: Arabic-, Bengali-, Chinese- and Spanish-speaking in the U.S. Members of these communities occupy different positions on the socio-economic spectrum. They reported wide variations in vaccination decisions and their ability to obtain health information that informed vaccination decisions. We unpack policy implications of these findings, and we suggest lessons learned and policy solutions that would remove barriers and leverage facilitators to prevention measures during COVID-19 and beyond.

To Vaccinate or Not to Vaccinate: A Decision Fraught with Impediments

CALD communities' experiences during COVID-19 provide invaluable lessons for effective communication of disease prevention messages and in reaching different members of CALD communities in future crises. Vulnerabilities produced by different socio-economic and political conditions often create a debilitating state

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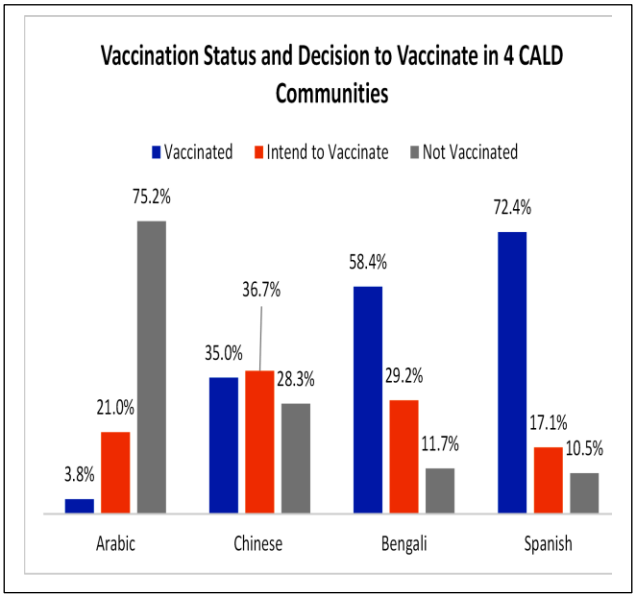
of disempowerment and reinforce complacency and lack of action. The compounding factors of poverty, lack of English proficiency, and low educational attainment are overly represented in the demographic profile of members of the Arabic-speaking CALD community who reported significantly lower vaccination rates than their Chinese, Bengali, and Spanish counterparts (3.8% versus 35%; 58.4% and 72.4%, respectively).



Several determinants can influence vaccination. Acquiring knowledge and consuming such knowledge about the vaccine, its efficacy, and any potential side effects require the ability to obtain information that is accurate, clear, in a language that one can trust, and conveyed in a manner that one can relate to for facilitating consumption. Such a proposition requires that the information be expressed in a language one can understand and is congruent with the values and belief systems one holds. Consumption of information may not take place if the information is conveyed in English only and in a monocultural lens and does not resonate with one's worldview. Information about COVID-19 vaccination was mostly available in English and Spanish only in the U.S, including online and hotline outlets, and often required digital literacy skills to consume the information fully because of a reliance on online diffusion of information and vaccination appointments (Jameel & Chen, 2021; Luu, 2021; Pradhan, 2021.)

Consumption of information also is a function of being able to trust the source of information. Pre-migration experiences, a history of medical bias and racism, and anti-immigration policies that vilified immigrants, whether documented or not, have created a climate of distrust of institutions of government and the healthcare system (Gonzalez et al., 2021). Distrust creates a formidable wall that hinders the ability of information to infiltrate many CALD communities and prevents its effective consumption.

Once one consumes vaccine information effectively and contemplates vaccination, there is a need for logistical feasibility. For CALD communities who are on the end of the socio-economic spectrum and are holding hourly wage jobs, there is a poverty of time that often accompanies the poverty of resources needed to make ends meet. Therefore, the possibility of time off from work to acquire vaccination is often an insurmountable one (Bloch et al., 2021; Hernandez, 2021). Geographic reach can also create an impediment when CALD community members do not have access to transportation and reside in rural areas which have been less likely to have access to vaccines (Thomas et al., 2021).

Assuming that motivation is activated, and a decision is made to act on such motivation and acquire vaccination, CALD community members who do not have immigration documentation are faced with requests to present identification cards, social security numbers and/or insurance verifications which render the decision to act futile and drive CALD community members away (Persaud, 2021).

The intersections of multiple forces in the lives of CALD community members create a sense of powerlessness, helplessness, and resignation, a learned behavior (Abraido-Lanza et al., 2007) that hinders the progression from knowledge consumption to contemplation, motivation, and action. Adverse social determinants of health create an avalanche that complicates access to life-saving vaccination and other preventive health measures.

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Sources of Trusted Information

Recent research by the authors shows the sources of trusted information that members of four CALD communities who received a COVID-19 vaccination or decided to vaccinate use. Figure 1 lists the percentage of individuals and sources of trusted information they use in the four CALD communities. For the Arabic-speaking respondents, the majority (57.7%) indicated that they rely on social media for trusted information, followed by print and digital media in their native language. In addition, community organizations and community leaders are also significant sources of trusted information.

Health Information Source	Arabic n=26	Bengali n=68	Chinese n=43	Spanish n=68
Print media/native language	57.7%	39.7%	30.2%	39.7%
Digital media/native language	42.3%	47.1%	72.1%	48.5%)
Ethnic TV and radio	34.6%	48.5%	20.9%	54.4%
Social media	65.4%	42.6%	37.2%	38.2%
Faith based organizations	26.9%	26.5%	2.3%	36.8%
Community leaders	38.5%	22.1%	0.1%	38.2%
Community organizations	42.3%	45.6%	16.3%	41.2%
Friends and family	42.3%	50.0%	39.5%	35.3%
Doctor	0.0%	0.0%	0.0%	1.5%

For the Bengali-speaking respondents, friends and family rose to the top as a trusted source of information (50%), followed by ethnic TV and radio and digital media in their native language. The Chinese-speaking survey participants overwhelmingly reported that digital media in their native language was a trusted source of health information (72%). In contrast, the majority of Spanish-speaking respondents (54%) relied on ethnic media and TV as a trusted source of health information. These findings have valuable implications for reaching CALD communities with accurate and clear health messages that can motivate, inspire and enable action and for counteracting health misinformation and confusion.

Policy Implications

Due to the compounding impacts of socio-cultural and political forces, poorly resourced community environments, and a healthcare system that is not equipped with the resources to effectively meet their unique linguistic and cultural needs, members of CALD communities face serious vulnerability. Their vulnerability intensifies at times of disasters and crisis. The following are recommendations for policy and practice derived from lessons learned from the COVID-19 experience.

1. *Integrating CALD-Community Needs in Disaster Response Planning*

Disaster response planning needs to incorporate the needs of CALD community members. Planning needs to be informed by the perspectives of CALD community members and by their experiences. Emergency preparedness plans need to be able to effectively and swiftly mobilize and activate response at the local level without leaving any community behind (Chandra et al., 2011). Instead of focusing only on the top 5 or 10 languages spoken by CALD community members, plans must integrate the needs of everyone in disaster response so that in future health crises, outreach is deepened and broadened. One life is too valuable to lose.

2. Mapping Community Assets and Risks

Effective planning requires an understanding of community assets and risks. Community assessments need to map each community's organizational landscape and identify at-risk CALD community members' needs. Social and professional networks are critical community assets, and horizontal and vertical mapping of such networks is critical (Chandra et al., 2011) in effective mobilization and the call to action in the event of health crises.

3. Promoting Community Building, Organizing and Collaborative Governance

Engagement of members of social and professional networks in disaster response planning cannot only ensure effective disaster response but can also lay the groundwork for improving interconnectivity and cohesion in a community. Communities where there is interconnectedness and social cohesion can mobilize their resources effectively at times of crisis, while those that are fragmented have a more difficult time doing so. Access to services and a perceived sense of social support increase when individuals are members of organized and connected communities (Magsino, 2009; Putnam, 2000).

Engaging local community members in planning, response, and mitigation ensures that plans are implemented effectively. Citizen involvement can inform planning, community organizing, network, and asset mapping, risk mitigation, outreach, service delivery, and communication of culturally and linguistically appropriate health messages.

4. Budgeting for CALD Community Members' Needs

Meeting the needs of CALD community members amid a disaster requires dedicated funding that can be used to provide a culturally and linguistically appropriate response--a response that neutralizes the threats of social determinants of health outcomes. In addition to dedicated funding, equitable budgeting entails integrating the needs of the most vulnerable members of the community in budget plans and realizing that one size does not fit all. Effective plans that address the different needs of CALD community members target eliminating disparities that are socially produced.

5. Building Capacity and Improving Coordination

Community-based organizations fill the gap between the government and the people by providing services that the government is not able to provide. They are often the bridge builders who alleviate the impacts of poverty, provide critical English language learning and workforce development to members of CALD communities. By virtue of their position as grassroots organizations, they are of and for the community. Investing in building the infrastructure of organizations at the local level is a critical element of disaster and emergency preparedness.

However, strategic management of these investments is also crucial to ensure that services are provided equitably, eliminating waste or duplication and targeting gaps in services. "Throwing money" at the problem rarely works unless accompanied by thoughtful planning that addresses existing needs. Strategic planning must target investments to ensure coverage of services to all members of CALD communities.

6. Strengthening Accountability Mechanisms

Legal frameworks mandate the provision of language and cultural assistance to healthcare. COVID-19, however, exposed serious flaws in the system. A study by the authors of healthcare professionals' perspectives on serving CALD communities during the pandemic revealed that language assistance was often neglected (Ahmed et al., 2021b). Enforcement of these legal mandates and institutionalization of Culturally and Linguistically-Appropriate Standards (CLAS) are critical to disaster response planning.

7. Culturally and Linguistically Appropriate Outreach and Information

Evidence-based practices include using culturally and linguistically competent health navigators (i.e., community health workers or health advisors) to reach vulnerable communities. It also means utilizing community and faith-based organizations to conduct the outreach since they are the bridge builders to these communities and have the trust capital to motivate and activate vaccination decisions. There is a need to move beyond the one size fits all paradigm and provide targeted outreach that takes the vaccine to each CALD community that is hard to reach.

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