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THE UNIVERSITY OF
MELBOURNE

Faculty of Arts

Research Unit for
Multilingualism and Cross-
cultural Communication
(RUMACCC)

**Understanding the experiences and
communication needs of culturally and
linguistically diverse communities during
the COVID-19 pandemic**

Understanding the experiences and communication needs of culturally and linguistically diverse communities during the COVID-19 pandemic

A report to the Victorian Government
January 2022

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1. Executive summary

1.1 Project background and purpose

The coronavirus (COVID-19) pandemic has had a major impact on the lives of individuals and of communities in Victoria, as elsewhere in Australia. In response to the virus, the Victorian and Australian governments, as well as other state and territory governments, have introduced a range of measures and restrictions to prevent transmission, including lockdown periods and mass vaccination. They have also made considerable efforts to communicate information about the COVID-19 virus and measures to control its spread.

Health communication is an essential tool for aligning population behaviour with government health policy requirements (Finset et al., 2020; Wild et al., 2020). However, this type of communication does not necessarily involve a linear flow of information from health experts to recipients, nor can it adopt a one-size-fits-all approach. The large flow of information associated with the pandemic poses a problem for its recipients, particularly for communities that are culturally and linguistically diverse (CALD) and may lack the linguistic, health, or digital literacy to fully understand complex and often rapidly evolving messages (see e.g. Shin & Song, 2021). A crucial aspect of health communication is therefore the planning of communication strategies, which can be enhanced by better understanding the intended recipients of the communication, their needs, and the barriers that can prevent them from accessing, engaging with, and trusting health-related information.

This report investigates the experiences and communication needs of 58 CALD community members or leaders/representatives from the following seven groups or groupings currently resident in Victoria:

1. **African (n = 19)**
2. **Pasifika (n = 6)**
3. **Afghan (n = 6)**
4. **Myanmar (n = 5)**
5. **Indian subcontinent (n = 11)**
6. **Arabic-speaking (n = 9)**
7. **Chinese-speaking (n = 2)**

Across these groups there was a high level of ethnic and linguistic diversity, especially in (1) to (5). These seven groups were a specific focus of this study because of a perceived need to understand better the COVID-related information behaviours and requirements of their member communities. Throughout this report, we use the phrase “CALD community member” to refer to people who identify with others with similar ethnic, cultural and/or linguistic backgrounds, and who engage with or contribute to activities in that community. We acknowledge that individuals' contributions may not be representative of the community and that a community is likely to be heterogenous in terms of knowledge, attitudes and practices. The term “community leader/representative” is used to refer to participants who hold a clearly defined role in the community (e.g. represent a community organisation, disseminate information, advocate for the community). Community leaders/representatives are widely perceived by other community members as important people with high standing in their community.

Interviews were conducted to explore how communities and their members within the groupings have followed and received information regarding COVID-safe behaviour, testing and vaccination. Data were also collected on the participants' levels of satisfaction with various aspects of COVID-19 communication, such as frequency of updates, accessibility of information, amount of information provided, as well as access to and adaptation of information for specific cohorts, such as women and the elderly, within communities. Participants were also asked whether their communities have trusted the information that they have received and how messaging can be improved to enhance compliance with COVID-19 guidelines.

The findings of this report are designed to assist the Victorian government and multicultural community organisations in the planning of communication strategies, with the long-term goal of improving healthcare messaging, compliance with public-health guidelines and health outcomes.

1.2 Key findings

The project uncovered different key aspects of CALD individuals' experiences with COVID-19 communication. While many of the experiences are shared across communities, participants' responses also reveal that any COVID-19 communication strategy needs to be nuanced enough to deal with the complex and varied nature of Victoria's CALD communities.

RECEPTION AND PROVISION OF INFORMATION

- **COVID-19 information is available on various topics, although CALD members mostly ask about testing and vaccination.**

Information has been received on various aspects of COVID-19 (e.g. hygiene, compliance with restrictions, social distancing, mask wearing, infection control, monitoring of symptoms). Testing and vaccinations have been topics of particular concern. In view of their members' questions, community leaders have frequently provided members with information on a variety of COVID-related topics, particularly vaccination. Information about testing has not been provided as frequently as has information on COVID-safe behaviour and vaccination.

- **Communities generally prefer receiving information in their community language(s), but not always.**

Communities generally prefer to receive information in their community language(s). However, depending on their language proficiency, some members also access information in English on a regular basis. A trend was observed whereby younger community members often prefer to receive information in English while older community members have a preference for information in their community language(s). Communities which include many members with a high level of proficiency in English (e.g. Indian communities and some Pasifika groups) have more varied findings: some members are more fluent in English than community languages so they would prefer information in English. However, others who are fluent in English would still appreciate in-language resources as people are more likely to pay attention to the message if it is conveyed in their community language(s).

- **COVID-19 information is disseminated in many different ways.**

The most frequently mentioned channels of communication can be ranked as follows: 1) Facebook; 2) other social media (particularly WhatsApp and Viber, and to a lesser extent Instagram); 3) doctors; 4) community organisations; 5) community leaders and community members; 6) community forums and videos; 7) press conferences; 8a) religious organisations 8b) TV news [8a and 8b are equally ranked as they were mentioned by the same number of participants]; 9) websites; 10) radio (including community radio, e.g. SBS); 11) brochures and pamphlets; 12) YouTube; 13) family and friends; 14a)

newspapers, 14b) emails [14a and 14b are equally ranked]; 15) audio recordings (e.g. voice messages); 16) podcasts.

- **Social media are the preferred channels for receiving information. The audio-visual format is the most effective.**

Facebook is the most popular channel for all communities except for the Chinese community, which instead prefers WeChat. Respondents from the African, Pasifika, Indian subcontinent, Arabic-speaking, Afghan and Myanmar communities prefer to receive information via social media. In general, information received through a spoken (e.g. phone calls, community forums) rather than a written channel is preferred, especially by members with lower levels of literacy (in English or in their community languages) as well as by those from a largely spoken rather than written culture (e.g. many African communities). The audio-visual format is preferred by most communities. Specifically, the Afghan, African, Arabic-speaking and Myanmar communities identified videos about COVID-19 as a particularly effective medium for receiving information.

- **Social media are the preferred channels for following¹ information.**

Most participants reported actively seeking out information provided by their respective community organisations on Facebook or WhatsApp. However, the Afghan and Myanmar communities tend to use Viber, instead of WhatsApp, while the Chinese-speaking community uses WeChat and Weibo.

EVALUATION OF INFORMATION RECEIVED

- **Levels of satisfaction with the frequency of updates about COVID-19 are varied.**

Respondents from the Pasifika communities and the Indian subcontinent were generally more satisfied with the frequency of updates to health information than were members of other communities. Levels of satisfaction were lower for participants from the African, Myanmar, Arabic-speaking and Chinese-speaking communities. Some participants commented that considerable delays meant that by the time translations reached the community, the information was no longer relevant.

- **Levels of satisfaction with the quantity of information available are varied.**

Levels of satisfaction were high for participants from the Indian subcontinent and Afghan communities, who reported receiving adequate amounts of information. Respondents from Myanmar communities were also generally satisfied but indicated that more information was required on specific topics such as testing and vaccination. Participants from various African

¹ While “receiving” information is intended as a passive process, “following” information is an active process. In this report we examine both how participants acquired information indirectly via various channels (“receive information”), and also which channels they have used to actively seek out and keep up to date with COVID-19 messaging (“follow” information).

communities reported needing additional information and more precise details about vaccination and testing to counter the misinformation circulating in their communities. On the other hand, participants from Pasifika communities reported receiving too much information, which caused information overload and fatigue.

- **Information is frequently missing in some community languages.**

Participants from several communities reported that translated material was frequently missing. Translations were mainly reported as missing for some community languages, e.g. Somali, Hakha Chin, Hazaragi and Urdu. In-language information was also largely absent for languages such as Telugu and Marathi, spoken by their respective communities from India. More information – in community languages – was sought on specific topics, especially vaccination, particularly for pregnant women, as well as on such topics as how to check in with a QR code, mental health, travel passports, and hotspots.

- **Sometimes information is difficult to access.**

Arabic-speaking, Pasifika and Chinese-speaking participants stated that they had difficulties finding translations on official websites. In some cases, community leaders were not informed of the presence of official translations. Difficulties in accessing and navigating the internet acted as a barrier to obtaining official translations. This was especially true for seniors who lack IT literacy and/or may be illiterate in their own language(s). In general, the more familiar community members were with navigating official websites, the more they were able to access information on COVID-19 and vaccines. Community organisations and leaders often facilitated access to information by sharing resources via Facebook and other social media.

- **Almost all communities have adapted information to the needs of specific sub-groups, particularly women and the elderly.**

Participants reported that women and senior CALD members often faced difficulties in engaging with COVID-19 information, due to issues such as low proficiency in English, low literacy in the community language (e.g. in the case of Hindi speakers), low digital literacy (and thus inability to access information online). Some respondents also indicated that some members of these cohorts accessed unreliable sources (e.g. via satellite television or social media) that spread misinformation. African, Pasifika, Afghan, Myanmar, Indian subcontinent, Arabic-speaking and Chinese-speaking participants regularly indicated that information was adapted by community leaders and organisations to the needs of women and the elderly. Most community organisations also tried to simplify health messages to encourage members to get vaccinated. Organisations targeting Arabic-speaking communities, for instance, adapted official messaging to be in line with the services they offered for women, and provided information on issues related to vaccination that were of particular concern for them (e.g. pregnancy and fertility). In some communities, organisations tried to communicate by

phone with their elderly members. Graphics were sometimes used to make it easier for older people to understand what to do when arriving at a vaccination centre. Chinese community organisations adapted health messaging to the needs of various age groups rather than solely differentiating between two groups - the young and the elderly. Participants in particular from the Indian subcontinent stated that family members or caregivers served as important mediators of COVID-19 information to the elderly.

TRANSLATIONS

- **Official translations have generally been very well-received, but the quality varies.**

Participants reported receiving both good and poor translations of official health material. Poor translations sometimes included grammatical and lexical errors, unnatural or inappropriate word-for-word translations of the original text, or overly technical terminology.

PRINT RESOURCES

- **Print resources need to be short and easy to disseminate via social media.**

Participants preferred short resources with explanatory images, clear layout, and limited text. Longer text-heavy resources that contain technical jargon and have few images are considered far less effective. Having one-page resources with brief dot points and in a format that can be easily shared (such as a JPEG file) over social media helps ensure that print resources can be more widely disseminated and understood.

TRUST

- **Interpersonal communication and rapport are needed to build trust.**

Several factors facilitated community members' trust in health information. A key factor was having messages conveyed by health professionals – especially those known within the community – rather than relying solely on websites or government directives. In general, interpersonal communication and rapport-building were identified as being crucial to creating trust on the part of community members. Community and religious leaders often played an important role in building trust, particularly when they set an example (e.g. by getting vaccinated). Respondents also indicated that cooperation with community leaders, service providers and experts is necessary in order to reach out to the communities and continue to build trust in health information, particularly with respect to the efficacy and safety of COVID-19 vaccines.

While some communities are reported to have high levels of trust with respect to official information, some respondents indicated that members of their communities tended to distrust information from

official government sources. For example, Pasifika community members in the 35-50 age group were reported to distrust government officials and government directives.

Participants from the Arabic-speaking and African communities, as well as from the Indian subcontinent noted that distrust was often related to the spread of misinformation on social media as well as from primary information coming via satellite television from their home country. Information from these sources sometimes contributed to scepticism among some members of the community and led to vaccine hesitancy.

1.3 Recommendations

Drawing on the findings of this project, we identify five key recommendations that governments and/or community organisations can take to improve communications with culturally diverse communities. Outlined in more detail in the conclusion of the main report, these are presented here in short form:

1. Provide more information in more community languages

In-language support is important for all communities, although care must also be given to the provision of information in plain English. More translations are needed for some community languages (e.g. Somali, Hakha Chin, Hazaragi and Urdu). In-language information also needs to be disseminated in other languages for which information appears to be lacking (e.g. Telugu and Marathi). In general, more information is particularly needed on testing and vaccination.

2. Diversify communication channels

Communication channels should include more information sessions, public Q&A forums, peer-to-peer networks and information micro-hubs where community-based health promotion volunteers respond to concerns about COVID-19, testing and vaccination. Community-led initiatives are key - people trust community leaders so they are well placed to be advisors and mediators.

3. Adopt a multimodal approach to disseminating health information

This approach should include the use especially of audio-visual communication, e.g. videos, and infographics, as well as of non-digital forms of communication, such as leaflets and brochures. Text-based material should be short and contain only key information and many visual elements so that it can be easily shared and understood. Support should be provided for improved community liaison initiatives.

4. Ensure high quality, timely translations

Measures should be put in place to allow high quality timely translations of official health messaging and easy access to resources on government websites. Translation quality should be checked by consultants or community leaders before release, to ensure accuracy, readability and cultural appropriateness.

5. Adapt materials and messaging for different groups

Adaptation is crucial, for instance, for women and the elderly, and should be implemented in collaboration with communities. Messaging should address immediate concerns of such cohorts, as well as misinformation. Non-digital modes of communication are also needed to reach some older members of the community.

2. Project background

The large amount of information that has been disseminated during the COVID-19 pandemic has posed difficulties for many in Australia, particularly for culturally and linguistically diverse (CALD) communities, who face particular challenges in accessing relevant up-to-date information due to language and cultural barriers (see, e.g., Karidakis et al 2021. Shin & Song, 2021).

Victoria is among the most culturally and linguistically diverse states in Australia, with more than 260 different languages and 135 different faiths represented in its population (Victorian Government, 2019, p. 10). It is therefore important to understand the communication needs of its CALD population in order to plan appropriate measures to ensure that all inhabitants of Victoria - irrespective of their linguistic and cultural background - have access to appropriate up-to-date and accurate information about the pandemic and public health initiatives to contain the spread of COVID-19.

Information has been disseminated in a variety of ways to CALD members in Victoria, for example through translation of official government sources into different languages, dissemination of informational videos, and printed resources. However, it has been reported that information may not have always reached and/or been understood by all members of CALD communities in Australia (e.g. Wild et al., 2020). More recently settled migrant groups are a particular source of concern, as they typically have less established communication networks and are therefore at a disadvantage. To improve health communication, it is necessary to understand what communication channels can be used to reach communities and in what language(s) CALD individuals prefer to receive and follow² information.

It is often assumed that providing health-related information and justifying why certain measures should be implemented will ensure compliance with health regulations. This is not necessarily the case. Health communication also needs to be trusted by the targeted audience if it is to be effective in changing health-related behaviours. However, in culturally and linguistically diverse communities, levels of trust in official messaging tend to be lower (see Pym et al., forthcoming). Thus, it is necessary to examine the experience of members of CALD communities with COVID-19 messaging and what barriers or problems they envision in engaging and trusting COVID-19-related information.

The project was conducted in Melbourne from July 2021 to January 2022 and consisted of three phases.

Phase 1 involved data collection from CALD members in Victoria (n = 58) belonging to the following seven groups, in line with priorities identified by the Victorian Government's Department of Families, Fairness and Housing (DFFH): African (n = 19), Pasifika (n = 6), Afghan (n = 6), Myanmar (n = 5), Indian subcontinent (n = 11), Arabic-speaking (n = 9), Chinese-speaking (n = 2). Most of these seven groups have been specifically targeted

² See footnote 1 for an explanation of the conceptual distinction between receiving and following information.

as they typically include large numbers of recently arrived migrants and/or have a large proportion of members with relatively low proficiency in English. As for the Chinese-speaking participants in our sample, they were originally identified because of their association with the frontline healthcare sector, but they also talked generally about community experiences. Participants from all groups were asked, among other things, whether they had adapted information for specific cohorts within their communities, particularly women and the elderly, as these sub-groups (including, e.g. Indian seniors) had previously been identified as priorities by DFFH.

Data were collected through semi-structured interviews. The purpose was to understand how information about COVID-19 has been provided and understood in each community, how effective different communication channels have been, and whether participants have trusted the information they have received. Interview respondents were also prompted to provide feedback on selected print resources and were asked if they had any suggestions for the government and/or community organisations for improving COVID-19 messaging and vaccination uptake.

Phase 2 included transcription and analysis of the interviews. Content analysis was performed to extract themes and trends.

Finally, **Phase 3** involved the preparation of this report.

2.1 Overview of the report

The report is structured as follows.

In **section 3**, we present the study design and explain why interviews were chosen as the method of data collection. After presenting the interview guidelines, we describe how participants were recruited and present our final sample. Finally, we elaborate on how the interview data were analysed.

In **section 4**, we discuss the results of the study. In presenting the results, we identify commonalities in the data across communities. We also report on key differences between communities as well as between different cohorts in the same community.

In **section 5**, we provide some recommendations regarding ways of improving health-related communication with CALD communities and for promoting trust in and engagement with COVID-19-related information.

3. Methodology

3.1 Research design

The study adopted a primarily qualitative design as we sought to identify and interpret the experiences and preferences of participants. It was decided to collect qualitative data through interviews. Interviews are a common method of data collection in research on health communication, as they are useful in examining how individuals “interpret, choose, and evaluate messages and actions related to health” (Donovan et al., 2014, p. 24). They have also been frequently employed in studies conducted on CALD communities, including during the COVID-19 pandemic (cf. Wickes et al., 2021). They are also considered more culturally appropriate than quantitative surveys for communities or individuals that rely more heavily on an oral culture. This was also confirmed by our recent mixed-method pilot study on COVID-19 communication, where we had very low response rates from CALD community members for our questionnaires (see Karidakis et al., 2022).

The interviews were semi-structured in nature. Researchers followed a set of guiding questions and prompts (see 3.2), but the interview format was open-ended, and, as might be expected, deviations from the guidelines were frequent when participants wished to elaborate on additional topics or new and interesting developments emerged. This mode of interviewing is particularly suitable to collect data on complex multifaceted issues such as health communication. Interviews were conducted via the software Zoom and were recorded with the consent of the participants.

Notwithstanding the qualitative focus of this study, some consideration is also given in our analysis of interview data to quantifying observations where this was particularly useful as a way of facilitating the presentation of some results. Care may still be needed when interpreting such statistics; they should be taken as indicative only in a number of cases, given the small sample size and the fact that some participants may not have provided relevant information.

This study was approved by the University of Melbourne Humanities and Applied Sciences Human Ethics Sub-Committee (2057427.2). Participants were assured that the privacy and confidentiality of the collected information would be maintained at all times.

3.2 Interview guidelines

The interview questions were developed to address the research priorities identified by the Victorian Department of Families, Fairness and Housing (DFFH). Participants were invited to answer questions on the following topics:

- Background information about the participant and – if applicable – about the organisation(s) they were part of
- Information about COVID-19 and how it is received/followed³
- Evaluation of messaging about COVID-19 in community languages
- Translations of COVID-19 messaging
- Participants' evaluation of the appropriateness of selected print resources for their own communities (see later discussion)
- Recommendations on how to improve health-related communication and vaccination uptake.

Some questions were asked of all participants; others differed depending on whether the participant identified as a community member or as a community leader/representative. At the end of each interview, participants were asked whether there was anything else that they wished to discuss. The list of questions can be seen in Appendix A.

As noted previously, interviewees were shown print resources on COVID-19 created by the Victorian and Australian Departments of Health. They were asked for feedback on the layout, visuals, and readability of the text. Interviewees were also asked about the quality of translation in cases where they were shown translated materials. The print resources were sourced through the webpage for translated resources on COVID-19 on the Australian Department of Health website (<https://www.health.gov.au/resources/translated>) and from the Health Translations website (<https://www.healthtranslations.vic.gov.au/bhcv2/bhcht.nsf>), an initiative of the Victorian Department of Health that provides translated health resources for the public.

Although there are many COVID-19 materials produced by both the Victorian and Australian governments, four primary resources were evaluated by most interviewees, as indicated in Table 1. Sample pages from these four resources are shown in Appendix B. The Victorian resources were about COVID-safe behaviour, whereas the Australian government resources covered topics related to vaccination. These four resources are distinct, both in terms of their content and style and served as useful case studies to determine the effectiveness and usefulness of different types of print resources for the communities interviewed.

When available, translated versions of these resources were shown to the interviewees. The languages included Punjabi, Dinka, Hindi, Somali, Arabic, Tamil, Burmese, Hazaragi, Farsi, Oromo, Assyrian, Tigrinya,

³ See footnote 1 for an explanation of the conceptual difference between receiving and following information.

Nuer, and Zomi. However, in some cases, interviewees were shown the resources in English as translated resources were not present for some community languages. Table 1 provides some key characteristics of the four resources.

It should be noted that the resources shown to the interviewees were accessed on August 23, 2021. Some resources have since been updated.

Table 1: Breakdown of four print resources shown to interviewees

Resource	Pages	Brief Description
“After your Pfizer (COMIRNATY) vaccine”	3	<p><i>Topic:</i> Vaccination</p> <p><i>Source:</i> Australian Government Department of Health</p> <p><i>Content:</i> Factsheet which provides information that the public should know after taking the Pfizer vaccine e.g. potential side-effects, reporting side-effects, COVID-19 testing following vaccination and the timing and importance of a second dose of the vaccine.</p> <p><i>Style:</i> Text only, without visual aids or cues.</p> <p><i>URL:</i> https://www.health.gov.au/sites/default/files/documents/2021/08/covid-19-vaccination-after-your-pfizer-comirnaty-vaccine-covid-19-vaccination-after-your-pfizer-comirnaty-vaccine.pdf</p>
Simple information on how to get ready for your COVID-19 vaccination (“Before your vaccination”) - factsheets	6	<p><i>Topic:</i> Vaccination</p> <p><i>Source:</i> Australian Government Department of Health</p> <p><i>Content:</i> A factsheet designed as an easy-to-read English resource which provides information that should be known before getting a vaccine e.g. the items one needs to bring to an appointment, what information one has to provide to the professional giving the vaccine, what one should do if they need to reschedule, etc.</p> <p><i>Style:</i> Text plus photographs and graphics.</p> <p><i>URL:</i> https://www.health.gov.au/sites/default/files/documents/2021/07/covid-19-vaccination-simple-information-on-how-to-get-ready-for-your-vaccination-simple-information-on-how-to-get-ready-for-your-vaccination.pdf</p>
“How do I check in?” (QR Check-in)	1 (poster)	<p><i>Topic:</i> COVID-safe behaviour</p> <p><i>Source:</i> Victorian State Government</p> <p><i>Description:</i> A poster explaining how to check in by scanning a QR code.</p> <p><i>Style:</i> Colourful poster with numbered steps and graphics.</p> <p><i>URL:</i> https://www.coronavirus.vic.gov.au/sites/default/files/2021-05/How-do-I-check-in-English-v1.4.pdf</p>
“Protect yourself and family (Cover cough and sneeze)”	1 (poster)	<p><i>Topic:</i> COVID-safe behaviour</p> <p><i>Source:</i> Victorian State Department of Health and Human Services</p> <p><i>Description:</i> A poster containing numbered steps on how to cough and sneeze in a hygienic way to minimise spread of infection (e.g. cough/sneeze into elbow, wash hands after coughing/sneezing, etc.). Created before the pandemic in 2018 to convey information about general infection control.</p> <p><i>Style:</i> Colourful poster with numbered steps and graphics.</p> <p><i>URL:</i> https://www2.health.vic.gov.au/Api/downloadmedia/%7B2D6408F0-991C-430E-8FB0-9AB4DBB6B891%7D</p>

3.3 Recruitment of participants and sample

Between September and December 2021, considerable and repeated efforts were made to recruit participants for the project. Invitations to participate in an interview were sent to 128 community organisations and members via emails using a snowballing approach. Initially, the research group contacted community organisations including member organizations of a COVID-19 WhatsApp group created by the Victorian Government to support the provision of COVID-related support services and information to CALD communities. Additional community organisations and members involved in community support in some way were also contacted via personal networks.

With a final sample of 58 participants, a total of 50 leaders/representatives and 8 members of different ethnic communities were interviewed, giving a response rate of 45% to invitations. About two-thirds of the participants (59%) were male, while 41% were female.

Table 2 (see next page) shows the breakdown of participants representing different communities. There is a wide range of national and ethnolinguistic representation. Although rarely explicit in the table, a number of different religious faiths and organizations are also included, e.g. Christian, Hindu, Muslim and Sikh.

In the African group, the research team contacted organisations representing different communities from a variety of African nations, including in particular South Sudan, Sudan, Somalia, Ethiopia, and Eritrea. The widest-reaching community organisation in this group represented communities from 14 different nations in East (and West) Africa. Other organisations operated as a national representative structure for all individuals or communities from the same country (e.g. South Sudan, Somalia), while in other cases the organisation was specific to one ethnolinguistic community native to a country (e.g. Otuho from South Sudan, Oromo from Ethiopia). In addition to a high degree of language diversity, knowledge of Arabic alongside English was often reported as common in many of the specific communities within this group.

For the Pasifika group, there were community organisations serving the Pacific islands people in general, as well as organisations that targeted specific ethnic communities, including the Fijian community and Indo-Fijian community both from Fiji, and the Cook Islands and Niue community from New Zealand. Bauan (which is the basis of Standard Fijian) was the most widely spoken Fijian variety, with Hindi being the first language of the Indo-Fijians. The native languages of the Cook Islanders and Niuean people are Cook Islands Māori and Niuean respectively. The elderly members of these communities generally prefer using their community languages, while many of their younger members could not speak the languages anymore.

With respect to the Afghan group, there were two representatives, both Hazara in origin, from the Afghan community at large as well as several Hazara community-specific members and leaders. Although we were not able to include interviewees specifically from other ethnolinguistic groups from Afghanistan in this study, our interviewees pointed out that Hazaras form the large majority of Afghans in Victoria. Participants were typically polyglots who spoke English proficiently (three of them were NAATI-certified translators and/or

interpreters working between English and their community languages) and most Afghan community members were reported to predominantly speak and use their community languages, e.g. Hazaragi, Farsi, Dari (the latter is also the main lingua franca in Afghanistan).

Table 2: Interviewees by CALD groups and community

Group	Community	N
African (N=19)	Wider African	1
	South Sudanese	2
	Dinka (South Sudan)	3
	Nuer (South Sudan)	1
	Otuho (South Sudan)	1
	Lopit (South Sudan)	1
	Nuba (Sudan)	1
	Somali	4
	Tigrayan (Ethiopia)	1
	Oromo (Ethiopia)	3
	Eritrean	1
Pasifika (N=6)	Wider Pasifika	2
	Fijian	1
	Indo-Fijian	1
	Cook Islands	1
	Niue	1
Afghan (N=6)	Afghan	2
	Hazara	4
Myanmar (N=5)	Chin	2
	Chin Zomi	1
	Chin Mara	1
	Karen	1
Indian subcontinent (N=11)	Wider Indian subcontinent	1
	Indian	6
	Indian Tamil	1
	Pakistani	1
	Bangladeshi	1
	Sri Lankan Tamil	1
Arabic-speaking (N=9)	Wider Arabic-speaking	1
	Assyrian Chaldean Syriac	4
	Muslim	2
	Egyptian Coptic	1
	Sudanese	1
Chinese-speaking (N=2)	Chinese	2

With respect to participants from Myanmar, the research group contacted community leaders from the Karen community and from different Chin communities, such as Mara and Zomi. Among the Myanmar group, Burmese is the language most commonly shared. However, knowledge of it varies significantly across

different communities. There are numerous community languages spoken by members of the different ethnic communities, including Karen, Hakha Chin, Mara, and Zomi. However, younger members of these communities who were second- or third-generation immigrants tended to speak English in preference to their community languages.

For the Indian subcontinent group, we sought to recruit leaders and members of communities that originally came from South Asian countries including India, Sri Lanka, Bangladesh, and Pakistan. It is worth noting that several organisations representing Indian seniors were also included. One participant worked with various communities from across the Indian subcontinent and has been categorised as belonging to the wider Indian subcontinent community in Table 2. Overall, most members of the Indian subcontinent communities are fluent in English and use both English and their respective community language/s, such as Hindi, Punjabi, Tamil, Urdu, Bengali (Bangla), etc. However, many seniors from the Indian subcontinent and those with less fluency in English (such as Sri Lankan Tamil refugees and asylum seekers) predominantly use their community language/s whereas younger members from these communities typically have far less fluency in their respective community language/s and are most comfortable using English. It should be noted here that the languages from the Indian subcontinent listed in Table 4 in section 4.2.1 only reflect those most frequently used by the participants who were interviewed. However, these languages are among the most common languages from the Indian subcontinent spoken at home in Victoria.

The Arabic-speaking group consisted primarily of individuals serving communities who have arrived from countries where the primary and national language is Arabic. These participants were mainly from Middle Eastern countries such as Iraq and Syria (Assyrian Chaldean Syriac community), Egypt (Egyptian Coptic community) and Lebanon. Arabic was typically the main spoken and written language used by the communities in question, although people from some communities in this group often also used their own community language, e.g. Assyrian, especially in spoken communication. It also included a Sudanese Arabic community organisation since Sudan is officially Arabic-speaking. Two interviewees were from organizations representing the wider Muslim community in one way or another, but with a significant Arabic-speaking constituency which they were also able to speak about.

The Chinese-speaking group consisted of two medical experts working in frontline industries, who were both associated with an organisation representing registered medical practitioners with a Chinese background from different countries and regions in Asia. Mandarin Chinese and Cantonese were the primary languages spoken by the community, while Simplified and Traditional Chinese were used for written communication.

3.4 Transcription and data analysis

The interviews were transcribed verbatim and were checked by the research team. Transcriptions were then coded by critical theme using specialist software. This helped to facilitate the detailed analysis of interview content allowing for the thematic presentation of results below.

3.5 Limitations

Due to the short-term nature of the project and the considerable difficulty in recruiting participants during and following Victoria's extended lockdown in the second half of 2021, the final sample does not have an equal representation of communities. Respondents from the Indian subcontinent and African communities, for instance, outnumber other respondents. On the other hand, there is significant ethnic and linguistic variation within each of these two groupings. Although Afghan respondents were not initially contacted due to the political turmoil in Afghanistan, we were later able to recruit six participants. It is also notable that the sample has an over-representation of community leaders/representatives in comparison to community members, as the former were generally the first point of contact.

Despite the heterogeneity in sample size for the seven groups targeted in this study, there are at least five respondents for each, the only exception being the two Chinese-speaking participants who worked in frontline healthcare. Understandably, we were not able to increase the number of participants in this category, due to the demands and pressures of COVID-19 and lockdown on frontline organizations and workers at the time.

It should also be noted that the sample only includes participants who were able to speak English, since all interviews were conducted in English. While this undoubtedly creates a bias, most of these interviewees were able to speak on behalf of their community (including individuals who only spoke the community languages), as they often had a clear role as representatives in their communities and – despite not being community leaders – acted as mediators of COVID-19 information.

4. Results

4.1 Preliminary considerations on the presentation of the results

Results are presented by theme, on the model of previous reports (e.g. Wickes et al., 2021). In the discussion of each theme, general trends across communities as well as community-specific differences are discussed. These are supported with participant quotations to explain trends in the data in greater depth. Hesitations and repetitions have been removed from the quotations when not meaningful. Table 3 shows the notation used to identify participants' quotes.

Table 3: Notation used for the identification of quotes

CALD community	Notation used for the identification of quotes
African	AfrInt + number of selected interview
Pasifika	PasInt + number of selected interview
Afghan	AfgInt + number of selected interview
Myanmar	MyaInt + number of selected interview
Indian subcontinent	IndSInt + number of selected interview
Arabic-speaking	AraSInt + number of selected interview
Chinese-speaking	ChSInt + number of selected interview

In some cases results are also quantified and presented in graph format in order to facilitate the recognition of trends and patterns in the data.

4.2 Reception and provision of COVID-19 information

The participants reported on the reception and provision of COVID-19 and vaccine health information in their respective communities. Community members received information pertaining to COVID-safe behaviour, testing and vaccination. Key areas related to COVID-safe behaviours included the provision of details on hygiene, compliance with restrictions, social distancing, mask wearing, infection control, and monitoring of symptoms:

Extract 1: "Yeah, we have been actually engaged with the government authorities and particularly in the health department, giving us all the information during the outbreak, how people will observe the rules, including of monitoring the symptom of the of COVID when you are coughing or and all other symptoms. And what you can do if you feel unwell and also washing your hands and so forth." (AfrInt11)

Extract 2: "Since day 1, it was all about, you know, sanitisation, you know, masks and how do you use masks, the importance of masks and then. And all the changes of constitutions and the, you know, regulations and easing and blocking and restrictions of movement that always translated and that was all received." (AraSInt50)

Most community organisations reported providing information about a range of COVID-related topics including COVID-safe behaviour and testing; they also provided information to educate the community about testing and the support available in the event that a community member and/or their families contracted

COVID-19. Another focus was on vaccination, particularly in response to community members' questions and concerns regarding the safety of the vaccines on offer, the logistics of how to obtain a vaccine. Information was also provided to encourage hesitant community members to get vaccinated:

Extract 3: "We educate the community about testing vaccinations, but also where to get support if they were to, I mean, caught up in a situation where one family members has got COVID." (AfrInt39)

The provision of information on testing was not reported as frequently as was information on COVID-safe behaviour and vaccination. Participants from the African, Indian subcontinent and Chinese-speaking communities reported providing information on the necessity for testing, testing locations, and what to do once a positive test is received:

Extract 4: "So we just tell them about where to get tested. We listed all the locations that are closed by it with the community, the vaccination sites that are closed to the community." (AfrInt39)

Extract 5: "This multilingual video first said that testing is free because people had a fear that, Oh, do I have need to have a Medicare card? How much does it cost, especially for parents? ... So we said COVID testing is free." (IndSInt17)

4.2.1 Language(s) in which information is received

Table 4 (see next page) shows the languages in which CALD community members prefer to receive or follow COVID-19 and vaccine health information. The wide range of languages reflects the complex multilingual nature and histories of our sample of communities.

Communities generally showed a clear preference for information in their own languages. However, younger community members tended to receive information in English while older community members preferred a community language:

Extract 6: "Somali language, and also in English. Also, because the community, there's a lot of young people who are born here, so their language is English. So both of them we use and also we use an Arabic background. Some of the community, they understand the Arabic language." (AfrInt52)

Most communities received resources in both English and their community languages. In instances where information was not available in the community language, the information was often translated by the community organisations themselves or by bilingual community members to cater for the needs of the wider community (see section 4.4 below on translation of official sources):

Extract 7: "So we cannot find in the community language all those updates, so we need to translate them. We need to take them and summarize them and translate them." (AfgInt36)

Extract 8: "We translate the information in three languages. We do part in Arabic, part in Dinka and part in English". (AfrInt11)

In some cases, the choice of language was highly variable. While there may be an official preference for a traditional community language, for example Assyrian rather than Arabic, in practice communities were sometimes more comfortable dealing with written and/or official information in the language of national communication, such as Arabic, which is dominant in the country of origin. In other cases, the national language may not be well-known to different communities from the same country. For instance, literacy in Burmese was highly variable across the groups originally from Myanmar. Community size could also be a factor: while Nuba and Lopit are very small communities for whom Arabic was identified as preferable, the much larger Nuer and Dinka communities from South Sudan also wanted information in their community languages (alongside English and Arabic).

Table 4: Languages in which communities prefer to receive or follow COVID-19 information

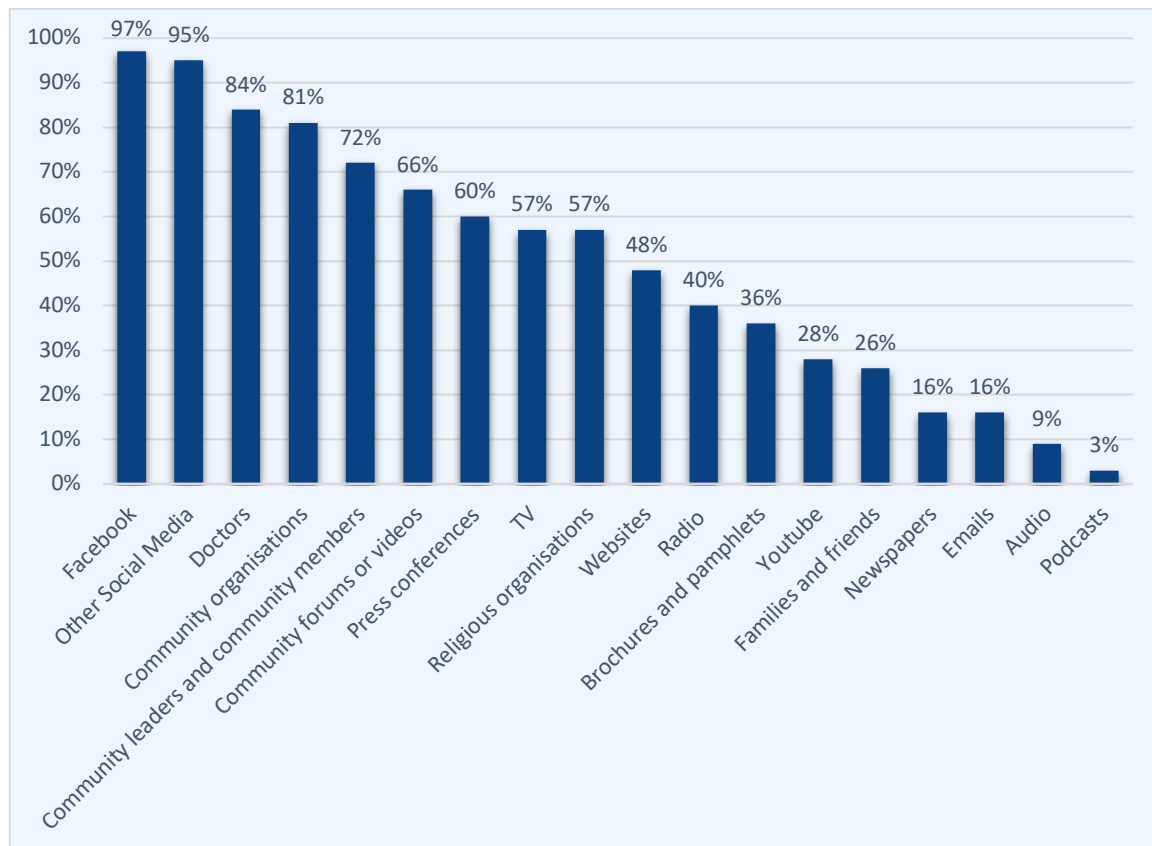
CALD community	Specific national or ethnic community	Preferred languages
African	Wider African	Arabic, Dinka, Nuer
	South Sudanese	Nuer, Dinka, Arabic, English
	Dinka	Dinka and Arabic (elderly), English (young people)
	Nuer	Nuer, English
	Otuho	Otuho, Arabic, English
	Lopit	Arabic
	Nuba	Arabic
	Somali	Somali, English (young people)
	Tigrayan	Tigrinya
	Oromo	Oromo
	Eritrean	Arabic (written); Tigray and Tigrinya (orally)
Pasifika	Wider Pasifika	Samoan, Tongan, English
	Fijian	English, Bauan (= Fijian)
	Indo-Fijian	English, Hindi
	Cook Islands	Cook Islands Māori
	Niue	Niuean, English
Afghan	Afghan	Dari, Hazaragi
	Hazara	Hazaragi
Myanmar	Chin	Hakha Chin, Burmese
	Chin Zomi	Zomi, English (young people)
	Chin Mara	Mara
	Karen	Karen, and Burmese.
Indian subcontinent	Wider Indian subcontinent/Indian	English, Hindi (many seniors, those with less fluency in English), Punjabi (many seniors, those with less fluency in English)
	Indian Tamil	English, Tamil (many seniors)
	Pakistani	English (majority) Urdu (those with less fluency in English)
	Bangladeshi	English, Bengali/Bangla (seniors, those with less fluency in English)
	Sri Lankan Tamil	English, Tamil (refugees, seniors)
Arabic-speaking	Wider Arabic-speaking	Arabic
	Assyrian Chaldean Syriac	Arabic, Assyrian/Syriac
	Muslim	Arabic, English
	Egyptian Coptic	Arabic, English
	Sudanese	Arabic
Chinese-speaking	Chinese	Mandarin, Cantonese

4.2.2 Where COVID-19 information comes from: most common channels, their effectiveness and community preferences

4.2.2.1 Channels of communication used

The participants reported drawing on a wide range of communication channels to source COVID-19 and vaccine-health information. The most frequently cited channels reported by our sample of some CALD interviewees are ranked in Figure 1.

Figure 1: Most frequently cited channels of communication



Given the restrictions placed on face-to-face interactions, most communities had resorted to using social media, which was the most common communication channel the communities relied on. Facebook, in particular, was used to update communities on COVID-19 issues, including vaccine health information. A number of community organisations across the Pasifika, Afghan, African and Myanmar groupings, provided translations of these updates in their community languages:

Extract 9 “But what we translate, ... we put those translations on our page, on our Facebook page.”
(PasInt14)

Other communities used Facebook as a platform for the dissemination of video material recorded in community languages. Videos, posted on Facebook, ranked relatively high as a channel of communication, given some community members’ preference for accessing and following audio-visual material on social media platforms:

Extract 10: “We did videos in various languages talking about, please get vaccinated. So if you go to the[ir] Facebook page. ... So I have done one in Bengali. My colleagues have done it in Hindi, Punjabi, Telugu, Kannada, Tamil. There has been [one in] Marathi.” (IndSIInt13)

Another social media platform that was frequently used was WhatsApp:

Extract 11: “We have a WhatsApp group where we have people actively engaged, discussing and exchanging information and consuming information as well.” (AfrInt12)

In comparison, Viber and Instagram were generally less frequently used, albeit with some important exceptions: Afghan and Myanmar community members expressed a strong preference for Viber. In the case of the former, this was particularly true for women and families. With respect to the latter, this was a more general preference. Instagram on the other hand was more commonly used by younger cohorts across communities.

Extract 12: “Yeah, we have a Viber group, which has almost 300 members, and that’s a women’s Viber, mainly women are part of it”. (AfgInt35)

Extract 13: “I have to say, like community leaders on Instagram, are most specifically young people, and therefore they’re getting influenced by that in the positive way, in the most positive way possible and most informed way more.” (IndSIInt23)

CALD members who had access to community radio tended to source COVID-19 and vaccine health information from radio as well as from social media outlets. Members of African and Arabic-speaking communities in particular reported their members using community language radio:

Extract 14: “Yes, mainly they follow ... there are community radios here.” (AfrInt18)

Extract 15: “Twenty one percent, twenty-one-point six percent. They’re getting their information from SBS Arabic.” (AraSIInt20)

Doctors were ranked the third most common communication channel the communities used to source and disseminate COVID-19 and vaccine health information. This was particularly evident for communities from Africa and the Indian subcontinent. These communities tended to invite doctors to present at information sessions that were designed to raise awareness of COVID-19 and vaccination in community languages and also to dispel any misinformation that was circulating in the community:

Extract 16: “We invite the doctors to our sessions. We do have the GP speaking our own language. We invite to talk about the vaccination and talk about the how important to be, you know, awareness about the COVID.” (AfrInt25)

Extract 17: “We had a webinar which was called as vaccine Myth busters. In which what we did was we actually invited some prominent doctors who happened to be Indians.” (IndSIInt17)

Community organisations were also identified as playing an instrumental role in the provision and dissemination of COVID-19 and vaccine information. A member from the African community highlighted the

importance of information being disseminated by community leaders and organisations as it facilitates the building of trust in the messaging (see section 4.6 on trust and behaviour change):

Extract 18: “Really helps if the information from the government comes through community leaders and community organisations.” (AfrInt18)

Similarly, a participant from the Indian subcontinent reported on the role of community organisations in providing information that had been adapted to the needs of the community, so that the message received is comprehensible:

Extract 19: “So I think all the communities, ... they also adapted their communication strategy to be more inclusive so I can see that playing a huge role because it makes sure that we’ve all been giving and given information in a way that makes sense to us.” (IndSInt23)

A representative of an Arabic-speaking community outlined outreach activities their organisation was involved in to address the needs of the community:

Extract 20: “Yeah, we’ve been engaging with the community through phone call, face-to-face or through social media to reach out to them to address their needs.” (AraSInt42)

Respondents from the African, Indian subcontinent, Arabic-speaking and Myanmar communities reported that religious organisations were influential in the provision of COVID-19 and vaccine information; however, their outreach was sometimes limited because they were unable to operate during the extended lockdowns in Victoria:

Extract 21: “But in the church, we still preach in the community. We are still free and the task force team, and they also preach to the community that this vaccination is good and we have to welcome the vaccination to the community.” (AfrInt58)

Extract 22: “There are many churches, mosques and gurdwaras [Sikh temple], et cetera. But because of lockdown, they can’t gather. There is no congregation, so they don’t go there. They don’t meet people.” (IndSInt15)

All participants reported that community leaders and members were influential as mediators managing information flows into the community. They often took on the role of language brokers by translating and relaying key health messages:

Extract 23: “So to explain what the government’s saying and what are the requirements that need to be done by particular people (...) that’s where the Dinka language come in and that’s where Arabic come in...” (AfrInt11)

Press conferences and updates via television were most commonly used by communities from Africa and the Indian subcontinent. A member that identified as an African community leader reported that receiving reliable and accurate information via press conferences and official governmental sources was important to ensure it was then passed on to community members:

Extract 24: “But mostly for me, I wanted to make sure because I’m one of the community leaders, I wanted to get to the source of the reliable and correct information here from press conference, what the government say.” (AfrInt25)

Similarly, an interviewee from the Indian subcontinent reported that press conferences on television were frequently followed by members of the community:

Extract 25: “Every day at 11 o’clock. there is a news conference on the TV, which probably everybody watches and eagerly waits for the date on the restrictions will be modified, relaxed and on that day.” (IndSInt17)

The extent to which press conferences and television as channels of communication were used was dependent on communities’ level of English proficiency, which often proved to be a barrier to understanding televised health messages:

Extract 26: “I don’t know, look press conferences in general, you have a small minority of the community who are actively engaged. It has jargon in it that most of our community won’t understand.” (AraSInt1)

The use of state and federal websites to source information were often cited as channels of communication used by CALD members as well as more global sources such as the World Health Organization:

Extract 27: “I know that people use coronavirus website, you know, DHS, Victorian, DHS, the federal government, DHS website and things like that. Department of Health and Human Services and things like that.” (IndSInt27)

Extract 28: “The World Health Organization has been a really important one for those who are trying to dispel myths.” (AraSInt1)

However, computer literacy issues also posed a barrier to accessing official information for some communities, as their members “struggle to use [Department of Health] website” (AfrInt11) (see 4.3.4 for a more detailed discussion).

Some communities reported that brochures and pamphlets were accessible channels of communication due to their wide availability in public places. However, other community members reported this material, when in printed form, had not reached their communities:

Extract 29: “They are already displayed everywhere, whether in public areas and also the churches and all in other public places.” (AfrInt11)

Extract 30: “Nothing much has come through the councils or as information from the government in the post or anything...” (IndSInt16)

Around a fifth of the community members cited accessing YouTube, talking with family and friends and reading newspapers to be informed about COVID-19 and vaccine health information. The channels that were

reported to be used less frequently included email, audio recordings, and podcasts (e.g., on social media or on SBS).

4.2.2.2 Preferred communication channels and formats for following information

As is clear in Table 5, most participants expressed a strong preference for (actively) following COVID-19 and vaccine health information via social media channels. Facebook and WhatsApp were commonly used by most community members to follow information sent by their respective community organisations. Other social media channels mentioned included Viber, which was used by the Afghan and Myanmar communities, and Weibo and WeChat, used by the Chinese-speaking community.

Table 5: Preferred channels for following COVID-19 and vaccine health information

Communities	Preferred Channels for following information
African	Social media (Facebook, WhatsApp), TV
Pasifika	Social media (Facebook), radio
Afghan	Social media (Facebook, WhatsApp, Viber)
Myanmar	Social media (Viber, Facebook)
Indian subcontinent	Social media (Facebook, WhatsApp), TV
Arabic-speaking	Social media (Facebook, WhatsApp), press conference
Chinese-speaking	Social media (Weibo, WeChat)

4.2.2.3 Preferred communication channels and formats for receiving information

Table 6 illustrates a similar trend for preferred channels and formats for receiving information, with social media featuring prominently for all communities.

Table 6: Preferred channels and formats for receiving COVID-19 and vaccine health information

Communities	Preferred channels and format for receiving information
African	Religious and community leaders, social media (Facebook, WhatsApp), audio recordings, video
Pasifika	Social media (Facebook), community leaders
Afghan	Video, social media (Facebook), community leaders, community forums (information sessions)
Myanmar	Social media (Viber, Facebook), video, community & religious leaders
Indian subcontinent	Social media (Facebook, WhatsApp), Community leaders, Family, Doctors, TV
Arabic-speaking	Video, social media (Facebook, WhatsApp), community leaders
Chinese-speaking	Social media (WeChat), news sources

As above, the specific social media channel/s differed depending on the community with Facebook being a common channel for all communities except the Chinese-speaking community, which instead preferred

WeChat. Moreover, many participants from the African, Pasifika, Indian subcontinent, Arabic-speaking, Afghan and Myanmar communities highlighted community members' preference for receiving information from community leaders. Video was also mentioned as a highly preferred and effective format for receiving information by participants from the Afghan, African, Arabic-speaking and Myanmar communities. In general, receiving information through some kind of oral rather than written channel was preferred particularly by those who had lower levels of literacy (in English or their own language/s) and also by many who came from a predominantly oral rather than written culture (as is the case for many African language communities).

Extract 31: "They want to hear something some information particularly that comes from the leaders. ... word of mouth is very important, yes." (IndSInt15)

Extract 32: "It's videos, videos on social media, on Facebook and also the information sessions, if depending on the topic. So having a community gathering where they can, they can ask questions if they have. So those are the preferred methods." (AfgInt35)

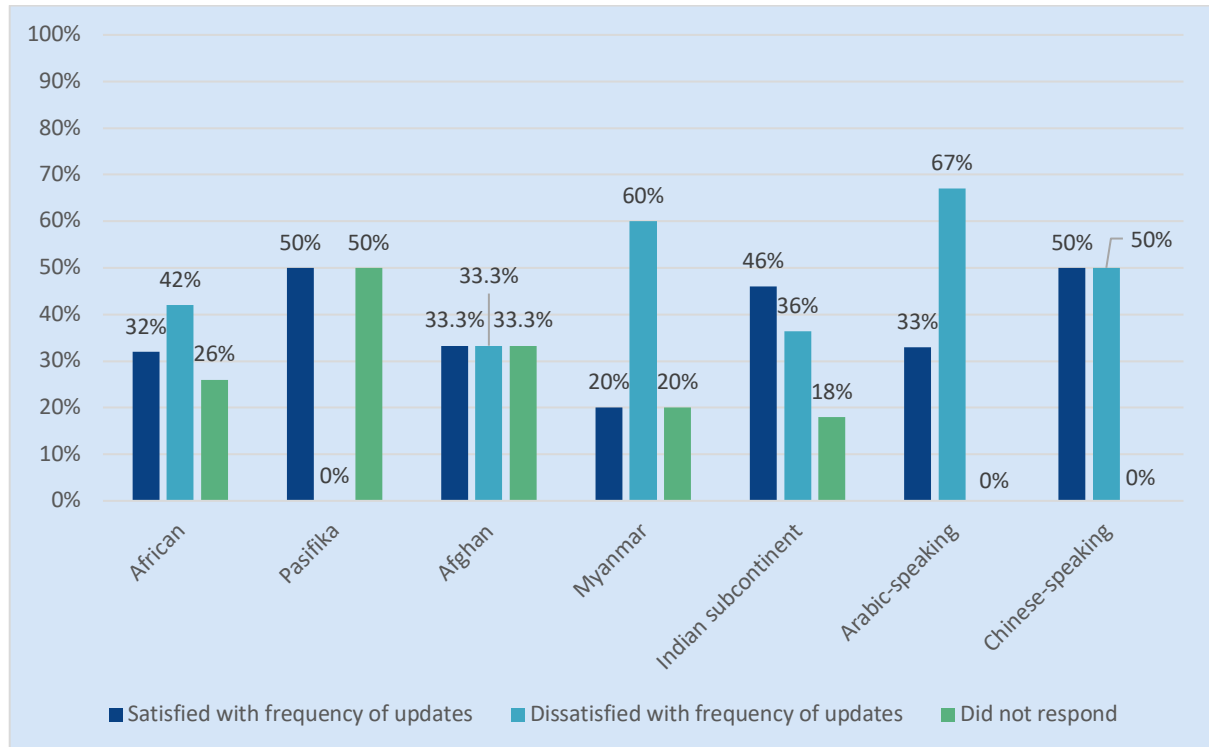
Extract 33: "I think WhatsApp is really effective. It's also immediate, and people will see and respond to others in the groups." (AraSInt32)

4.3 Evaluation of COVID-19 messaging

4.3.1 Frequency of updates

Participants offered mixed responses with respect to levels of satisfaction with frequency of updates of COVID-19 and vaccine health information from official sources. The results are presented as percentages in Figure 2. As can be seen, some respondents did not provide information on this matter.

Figure 2: Level of satisfaction with frequency of updates received.



Participants from Pasifika communities and the Indian subcontinent reported relatively higher levels of satisfaction regarding the frequency of updates they received than participants from other communities:

Extract 34: “There’s always update and on the DHHS website, so when that is updated, then we update the information that we put on out on our Facebook page.” (PasInt22)

Extract 35: “I could get the information every other day actually I get information sometime every day as well from different sources like. Well, it will come from the health department one day, other day it will come from the multicultural affairs ministry, another day it will come from...premier’s office and things like that...” (IndSInt8)

Levels of satisfaction with frequency of updates for health information were lower for participants from African, Myanmar, and Arabic-speaking communities. Participants reported that contributing factors were the considerable time lag between changes to restrictions made and corresponding updates received and the need to look for relevant information proactively:

Extract 36: “I don’t think it’s sufficient. I think that there’s a time lag. And again, there’s a reliance on proactive community members to find that information” (AraSInt1)

Extract 37: “I know there’s a lot of information on the DHS website in Chinese. I think it’s not updated as regularly as people sometimes. I think it’s a bit out of date or the translation is not ideal.” (ChSInt10)

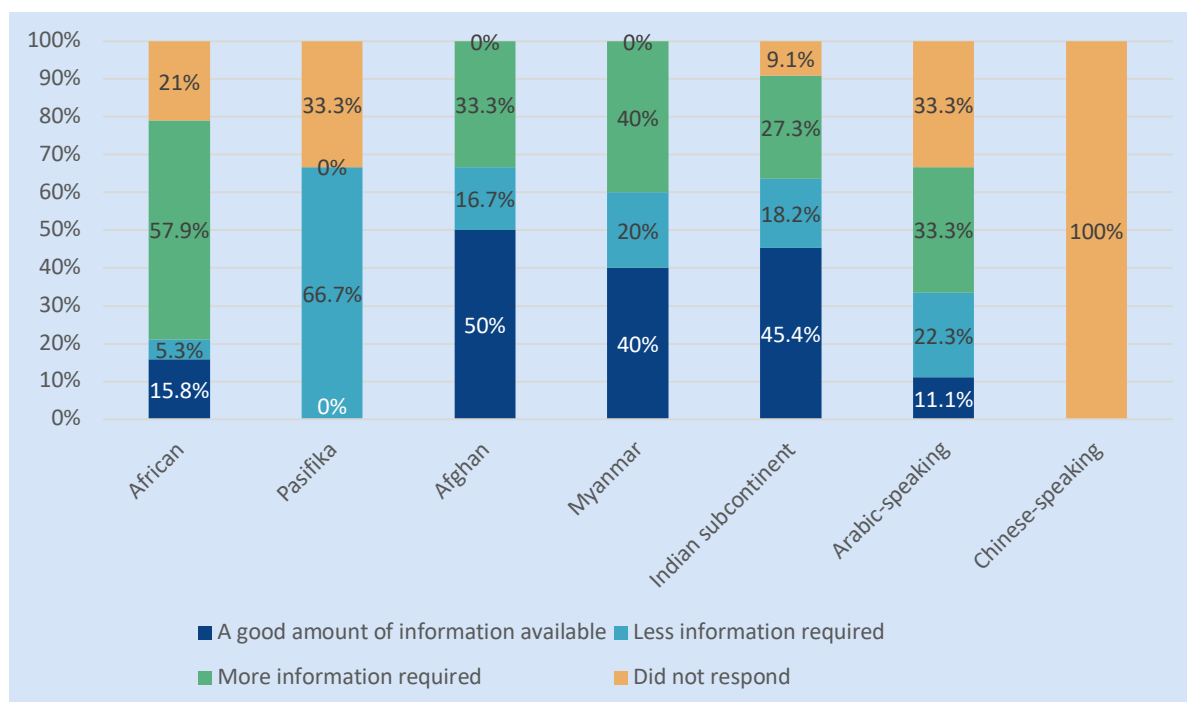
The considerable delay in the provision of translated material in community languages was identified as a challenge and the information received was deemed ineffective since by the time translations reached the community, the information was out-of-date. For example, this was a challenge that was mentioned with respect to translations provided in Dari and Hazaragi:

Extract 38: “When the Victorian government makes an announcement, that information is not translated, at least for several days, and then by the time it’s translated, it’s old news or there’s already some other changes.” (AfgInt35)

4.3.2 Quantity of information available

With respect to the quantity of information available regarding COVID-19 and vaccine health, participant responses were varied and depended on each community’s context and specific communicative needs. The results of those who responded can be seen in Figure 3. Percentages are used to display trends in the data. As can be seen, some participants (e.g. the two Chinese-speaking participants) did not provide information on this matter.

Figure 3: Satisfaction with quantity of information available. Data are displayed as percentages.



Respondents from the Indian subcontinent and Afghan communities reported receiving adequate amounts of information in various forms. This was also the case for participants representing Myanmar communities;

however, they also noted that more information was required for specific topic areas including testing and vaccination.

Extract 39: “There is enough. There is enough. I think there is adequate information in various forms.” (IndSInt16)

Extract 40: “Testing and vaccination, for me, I think it’s a little bit we need more. We need more information. And like when and when can I be vaccinated? And then our community’s younger generation, so they are young and those who are over 60. It is like this and they are like thirty or forty. So our turn did not come yet. When can we be vaccinated?” (MylInt5)

A notable exception were participants from various African communities who reported the need for additional information with respect to finer details, particularly around vaccination and testing, with a view to countering misinformation and conspiracy theories circulating in the community:

Extract 41: “We know, a bit of information about the vaccine itself, but the vaccine itself, what the vaccine ingredient for, we don’t know this information, what’s in this vaccine?... anyone know what’s exactly in the vaccine? the way they’re testing the COVID symptoms, we don’t know, we just go and get in the queue and take sample for you, and there is some information missing, we don’t know them. So we really need more information.” (AfrInt30)

Extract 42: “I think we need more works on the vaccination because there are so many conspiracy theories ongoing circulating like you will be dying after two years or something like that ... These things should be clarified, you know, not for everyone but many people, because there are so many misinformation ongoing.” (AfrInt54)

On the other hand, participants representing Pasifika communities reported requiring less information, with a perceived sense of information overload resulting in COVID-fatigue:

Extract 43: “I think there's too much information. They don't want more information. All they want is the information to be correct when it's posted.” (PasInt6)

As discussed in greater detail in section 4.3.5, community leaders also summarised and provided the most relevant points to their community members in order to ensure they were not overwhelmed by this information overload:

Extract 44: “I do snapshots of what's important, what's not important, what we're focusing on. Because a lot of times there's a lot of like information overflow on different websites. So I just take a snapshot of what's really important and just put enough for somebody to read and understand without reading a whole page. So I just do that. And so I make the every few days. So it's not constantly in your face because look, it does your head in.” (PasInt21)

4.3.3 Information missing

Interviewees discussed the kind of information that was perceived to be missing from the official sources they received. As can be seen from Table 7, participants expressed the desire for information to become available on specific topics which could vary across communities. The need for additional resources on vaccination

ranked highly, including information related to the impact of vaccination on pregnancy, the ingredients of the vaccines, the different types of vaccines available, more detailed information on the benefits of vaccination, etc. Respondents also pointed out the need for further information on checking-in, mental health, travel passports and hotspots, and there was a strong preference for this information to be available in community languages.

Table 7: Information missing from resources received

Communities	Information missing
African	Vaccination; audio information of translated material; translated material into Somali
Pasifika	Vaccination
Afghan	COVID-19 and vaccination information translated into Hazaragi; high quality video content
Myanmar	Translated material in Zomi, Hakha Chin; vaccination; checking-in; mental health
Indian subcontinent	Vaccination, vaccination and pregnancy, quarantining; translated video resources on vaccination in Urdu; information on who to seek further advice from (e.g., community leaders; GPs); information on how immune system works
Arabic-speaking	Responses to FAQs; travel passports information on hotspots; mental health
Chinese-speaking	Information on hotspots

Extract 45: “In terms of vaccination, it’s been a lot of questions being raised. vaccination because people have different opinions and they have a concern or fear about the vaccination. So educating more the public in terms of that would be nice.” (AfrInt40)

Extract 46: “How does it affect a mother who’s eight months pregnant? You know what happens to a lactating mother? What happens if you’ve had a miscarriage? What happens if you are in your trimester? What happens if you fall seriously ill?” (IndSInt13)

Participants from several communities also stated that translated material in their respective community languages was missing. The languages for which more translations were requested included Urdu, Somali, Hakha Chin, and Hazaragi:

Extract 47: “So Somali community is large, so we don’t get that much. That’s why we translate from our side because we know it’s important.” (AfrInt18)

Extract 48: “Yes, there are things that are missing, and that’s, I continue to say is the audio formats of information being generated. ... Now, if the government were to supply those information in mother tongue for every information that is released in those different languages, that would have been very, very ideal.” (AfrInt12)

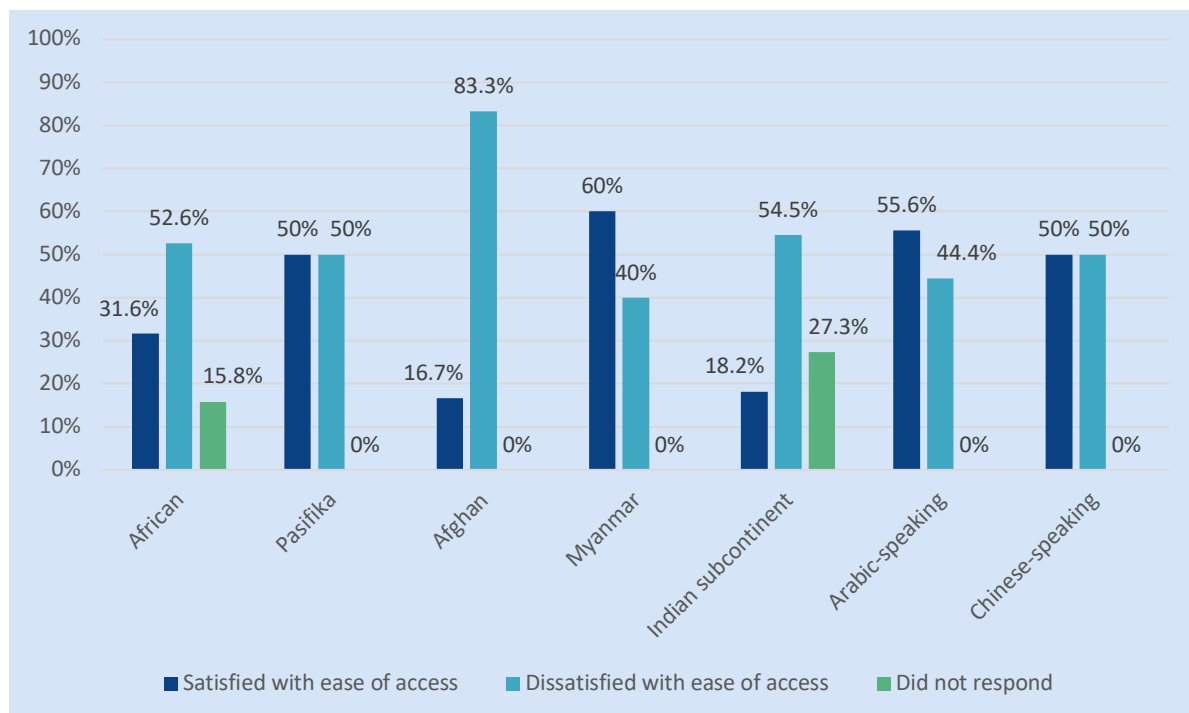
Additionally, with respect to Indian languages, it was reported that translations were largely absent for languages such as Telugu and Marathi. Although community members from the Indian subcontinent are

typically fluent in English, they would prefer to receive information in their community languages as well, as such translations are perceived to be more impactful.

4.3.4 Ease of Access

The participants discussed how easy or difficult it was to access official COVID-19 and vaccine health information. They offered mixed responses, citing different barriers. The results are presented as percentages in Figure 4. It can be seen that some participants did not respond.

Figure 4: Ease of access to COVID-19 and vaccine health information



Arabic-speaking, Pasifika, and Chinese-speaking participants reported that locating relevant translations on official websites was particularly challenging:

Extract 49: “I keep coming back to the translations and whether we’re providing that. I struggle to find and I know it exists, I just can’t find it. It’s never sent to me. It’s never shared with me. I struggle to find information that’s been already resourced for culturally diverse communities. So it’s not accessible.” (AraInt1)

Extract 50: “And they keep posting information on the COVID-19 web page, but it’s hard, you know, when you go on that web page, you try to look for that information. You have to click there, there, there, there, there just to find either one-line information or two-lines information. It’s so difficult to pilot yourself through traffic to get that information.” (PasInt14)

Other participants referred to access to the Internet being a barrier to locating health information. This was particularly the case for the elderly who are not computer literate or may not be literate in their own language:

Extract 51: “The only thing that I think is barrier is maybe if they don’t have access to the internet or if they are not like able to download it or not able to go to Facebook or have pages. So that is a bit tough.” (AfgInt26)

Extract 52: “But if we’re talking about, you know, people who are 60 plus, it’s [not] accessible for them because the majority of them, they are illiterate, they don’t have it skills, they don’t have language skills ...” (AraSInt20)

Conversely, younger members of CALD communities were reported to experience no barriers to accessing information online as they were technologically savvy:

Extract 53: “But for young people, for other, you know, who don’t have engagement with service providers, with mainstream services, they are, you know, capable to access this information straight away from their mobile phones, from their iPod, from their, you know, tablets, depending on the age of, you know, people.” (AraSInt20)

It was also generally the case that as community members became more familiar with navigating official health websites, they were better able to access COVID-19 and vaccine health information. As mentioned in 4.2.3, the preference for the use of Facebook as a communication channel meant that community organisations and leaders tended to utilise this portal for the dissemination of information, which resulted in community members being able to easily access relevant information and resources:

Extract 54: “But before when I started, I had no idea. Yes. And there wasn’t. But now there is, because I know where to look, where to source the information from.” (PasInt21)

Extract 55: “So, yeah, it’s easy to access, so we have our community, Facebook, we can post it there. So everyone has smartphones so they can see it easily if they have the interest...” (AfrInt54)

4.3.5 Provision and adaptation of information for specific groups

4.3.5.1 Issues faced by specific groups within the communities

Participants were asked whether they were aware of any issues about providing COVID-19 information to specific cohorts in their communities, such as the women and the elderly. Most respondents identified some issues that both groups had faced in engaging with COVID-19 information.

With regard to women, a key issue identified by a number of participants related to access to reliable and trustworthy information. More specifically, a respondent from the Arabic-speaking group noted that there was a portion of women in suburban areas that did not have access to information online due to limited digital literacy. These women mostly relied on peer-to-peer information that may not always be reliable:

Extract 56: “It [information] is not getting to the community, and we don't we don't necessarily appeal to them through social media. A lot of these people are your aunties and cousins who are in suburban areas who don't access social media. They talk to each other. They rely on their own community to receive information. They rely on peer to peer information. So if one person spreads one lie, you can pretty much guarantee that's going to 100 different [...] women as an example.” (ArSpInt1)

Even when women could access information online, the reliability of the sources consulted could still be an issue. Respondents from Arabic-speaking communities indicated that women in the 25-40 age cohort were often hesitant (especially about vaccination), particularly because of misinformation circulating online:

Extract 57: “And that's where we're seeing the biggest barrier at the moment is between that 25 to 40 year old range who are having a lot of hesitancy because of the information they're getting from the people who they follow and sitting in an echo chamber of information that perpetuates what they want to hear, because that's what social media is.” (ArSplnt1)

Respondents from the African and Afghan communities noted that lack of English proficiency and lack of or limited literacy in English represented key issues inhibiting women’s engagement with COVID-19 information:

Extract 58: “Some women are not speaking English.” (AfrInt11)

Extract 59: “women who either have difficulty in terms of accessing the information or in terms of internet, in terms of the language, so we are helping with that.” (AfgInt26)

One interviewee from the Indian subcontinent noted that lack of literacy levels in Hindi was a key barrier for recent migrants, who could only rely on oral rather than written communication in their community language:

Extract 60: “I've got in mind about 10, 15 ladies who recently has come in the last five 10 years. Now they will feel comfortable in Hindi, but they can understand, they can speak Hindi. But if you give them in writing something, they won't be able to read”. (IndSInt15)

Lack of digital literacy was also mentioned as a key issue for CALD elderly members from various communities:

Extract 61: “We find a lot of the elderly can't use the Internet.” (ArSplnt1)

Lack of English proficiency was also a considerable issue for the engagement of elderly CALD individuals who did not have access to in-language translations. This was particularly concerning for those who could not count on the support of young family members in providing translations of official messaging:

Extract 62: “Some families, some parents also don't have their kids' support in translation or for translating or interpreting. So those parents really need it.” (MyaInt19)

Low proficiency in English and unfamiliarity with the variety of English spoken in Australia were also identified as a barrier for the engagement of Indian seniors, particularly individuals from a rural or agricultural background who arrived in Australia as adults/parents:

Extract 63: “This particular group, which migrated as parents, you know, they don't know and they don't know much English at all, and they won't read anything in English.” (INInt16)

Extract 64: “[Low proficiency in English] was the biggest handicap. especially people coming from the rural background or in the agricultural field and all this. But still, a majority of people who come at this

age are very ..quite hesitant in understanding the language here and pronunciation. That's another thing which is different than the language English spoken in India.” (INInt9)

One respondent indicated that many Indian seniors watch channels from the homeland or YouTube to keep updated about COVID-19, with concern expressed about the accuracy of the information accessed in this way:

Extract 65: “I don't know, because they follow more what they hear from the Indian channels, from from YouTube and so on. And all that information is not reliable. And it it is quite, you know, wrong in some ways.” (INInt16)

4.3.5.2 Adaptation of information

Table 8 shows that all participants reported that health information was adapted to the needs of specific groups within their communities.

Table 8: Provision and adaptation of information for specific groups

Communities	Provision and adaptation of information for specific groups
African	elderly, women, community members in public housing
Pasifika	elderly
Afghan	women
Myanmar	elderly, women
Indian subcontinent	elderly, community members with limited English proficiency (refugees and recent arrivals), international students
Arabic-speaking	elderly, women
Chinese-speaking	elderly, community members by age group

Almost all community groups suggested that information should be tailored for the elderly and women. For example, African community organisations tended to rely on spoken communication, often contacting their elderly members via telephone. They also tailored health messaging to include graphics to help elderly African community members understand what to do when arriving at a vaccination hub. Arabic-speaking communities also adapted official messaging to be in line with the services they provided for women.

Extract 66: “For the elderly... we talk to them or through telephone calls, they are calling the various homes.” (AfrInt43)

Extract 67: “We assume that because of the elderly that cannot read, for instance, and then what to do when you get to a vaccination centre? We have adapted those to be in graphics for the elderly.” (AfrInt12)

Extract 68: “We adapt it to what’s relevant to our service delivery. So it would be like a flyer where we’ll talk about our women’s support line that we’re setting up, what services we provide if we’re still doing material aid. If women need cultural and emotional support, we also sometimes we’ll write what languages are we have on staff. So we take that information, but then we adapt it to what meets the needs of the organization and what our services are.” (AraSInt32)

Participants representing the Indian subcontinent reported that information for elderly community members could be disseminated through their family members and carers:

Extract 69: “A lot of elderly in our community are sort of guided by their children or people, you know, in their family. So for us to reach to the elderly in our community, we need to go through their, you know, maybe children or people who are looking after them.” (IndSInt7)

Some of the communities reported tailoring information for different cohorts in other ways. Participants from the Indian subcontinent, for instance, discussed how they targeted international students with relevant information regarding vaccination, since students were typically not aware that vaccines were available to them for free or they ensured that information was provided in language for the elderly, new arrivals, refugee and asylum seekers.

Extract 70: “We have actually talked about on my webcast about international students, please get vaccinated because it is free.” (IndSInt13)

A representative from the African community made reference to elderly community members living in public housing who depend on language-specific information to understand COVID-19 and vaccine messaging:

Extract 71: “Specifically the people who are living in the public housing they really need, they depend on the language, information in language because there are elders there.” (AfrInt18)

Most community organisations also simplify health messaging to encourage community members to engage with the message, including for vaccine health messaging. They simplified messaging by summarising the key points only, using dot-points that were easier to read and thus understand, explaining unfamiliar terminology (which was sometimes translated or transliterated directly from English) and consistently using plain everyday language. In addition, one participant mentioned modifying the messaging by adapting factsheets into a poster format and making it culturally appropriate for members by integrating visuals such as photographs of community leaders:

Extract 72 “[...] it was also the way that the text and the posters were presented. We may we got like a graphic designer to create, you know, like Pacific patterns, and we would use that as the backdrop. Or we would use a poster we would use the face of...we would have photos of trusted members of our community and then we would put their faces on the poster.”(PasInt37)

The simplification of messaging was especially critical to engage community members with lower literacy levels:

Extract 73: “I try to simply simplify as far as possible because we want to impress on people like, as I said, we want them to have vaccination, to convince them, so put in very simple terms that you need vaccination.” (IndSInt15)

Extract 74: “So in most cases, depending who translates it, which translate that we need to make our own amendments to make it understandable for the community. So sometimes that direct translation

might not be understandable for the community. So we have to convey the meaning of what that sentence or what that terminology means for the community.” (AfgInt35)

4.4 Translations

4.4.1 How translations have been received

Translations of official health messaging pertaining to COVID-19 and vaccinations have generally been very well received by most community members. The majority of the participants said their communities responded positively to receiving information in their community language and that providing information in-language was more important for non-English speaking community members or members with low-English proficiency:

Extract 75: “Yes, the people who don’t speak English, they like material in Dinka. But someone who speak English, it’s not important.” (AfrInt11)

Many participants mentioned that they produced their own translated resources for community members rather than solely relying on disseminating official translations. One of the primary reasons for this was the fact that official translations were not produced quickly enough, preventing the timely dissemination of critical health advice. Thus, community leaders reported being proactive in taking it upon themselves to translate the rapidly changing information that was being disseminated by official sources, which was once again was received positively by the community:

Extract 76: “When the Victorian government makes an announcement, that that information is not translated, at least for several days, and then by the time it’s translated, it’s old news or there’s already some other changes. So that’s why we try to fill that gap.” (AfgInt35)

Extract 77: “As soon as this changes, it gets translated straightaway and my people are happy.” (PasInt22)

Other reasons for producing their own translated resources included the limited number of official translations available in their language, being unaware that the official translations existed as they were not readily accessible or available to them, and issues with the quality of official translations (see 4.4.2). Many participants also pointed out that they produced their own translated resources because they had to adapt the information (in form and content) to be most appropriate for their community members (see 4.3.4). For example, given the preference of community members for spoken rather than written communication, many participants reported creating translated audio and video materials.

It was suggested that official messaging was even more effective when it was relayed in community languages by community leaders or members, as these mediators were perceived to be cultural brokers and trusted sources of information:

Extract 78: “But if someone in their own culture is telling them the information, then they will listen because. I guess it’s someone they trusted.” (PasInt14)

Community leaders were reported to take on a gatekeeping role, limiting the flow of information that was considered too dense or technical to mitigate confusion amongst the community:

Extract 79: “We did not share this because the information would be confusing for the community I think, because first there’s too much technical terminology is used about SARS-CoV-2 and spike and Pfizer and the Comirnaty.” (AfgInt35)

In a few isolated cases, participants reported that official translations for some community languages were not in the community’s preferred language or were difficult to understand as they were too technical:

Extract 80: “They say we don’t understand it. It’s too hard. It’s not Hazaragi.” (AfgInt36)

4.4.2 Quality of translations

When reporting on the quality of official translations, the participants offered mixed responses, suggesting that they had received both good and poor translations of official health promotional material. For example, a participant representing the Arabic-speaking community reported positive reception of official translations:

Extract 81: “But yeah, I don’t feel there’s any issue with the translation. Yeah.” (AraSIInt42)

Besides the occasional grammatical and lexical errors, participants identified the more pressing issue as being the tendency to receive literal or word-for-word translations. This was deemed problematic when the intended message was not conveyed:

Extract 82: “Grammar mistakes are sometimes there, but it’s mainly mistranslation of the terminologies that they use.” (AfgInt35)

Extract 83: “A lot of the messaging that gets translated directly from government messages doesn’t quite align with language because, you know, you have to understand, like English doesn’t translate literally into a lot of languages.” (AraSIInt32)

Extract 84: “The government had Pacific translated material on their Corona website. But when I read it, I was like, even I couldn’t like, we can’t understand that kind of translation because the government was getting translators to translate literally, you know, word for word and it won’t make sense.” (PasInt37)

In at least one case it was also reported that problems with translations stemmed from the use of vocabulary from closely related languages, which might not have been appropriate in the given context:

Extract 85: “People who are speaking these languages. Especially Hazaragi and Dari. They some of them, they have spent time in Iran. So Persian is very close to Dari and has already, so they’re being mixed up. They are using different words from the other language. So if they can pay more attention to that, that would be good.” (AfgInt26)

In another case, a participant from the Indian subcontinent reported finding interpreted messages nonsensical:

Extract 86: “A big mistake is there. that actually some people even don’t look at this Tamil interpreted messages, because it doesn’t make sense.” (IndSInt8)

There was also an instance where terminology was deemed inappropriate or offensive. For example, the term “Pfizer” is reported to come across as offensive in some Pasifika languages and there is thus a preference for using the tradename “Cominarty”:

Extract 87: “And then, Pfizer, in my language, my culture, it’s offensive to say that word. Pfizer... We refer to it as Comirnaty because when I ask you to come and get vaccinated Pfizer. You know, to say that word, I’m asking you for something else that’s very offensive.” (PasInt3)

4.5. COVID-19 Print Resources

As noted in 3.2, participants were also asked to evaluate a sample of print resources in terms of readability, layout and visuals, and quality of translations.

4.5.1. Readability

Participants identified the following elements as contributing to or detracting from the readability of a resource:

Technical vocabulary: The use of highly technical language and medical jargon was identified as limiting the readability of resources for members of their communities. For example, the use of undefined specialist terms such as “SARS-CoV-2” and “spike protein” in the “After your Pfizer vaccine” resource was noted by all participants as being inaccessible to many in the community. Participants also pointed out that certain medical terms could have been simplified (e.g. “insomnia”) and that the interchangeable use of technical terms (e.g. “Comirnaty” and “Pfizer”) could prove confusing for readers:

Extract 88: “If I don’t have medical knowledge, some level of medical knowledge, I would have been lost in the amount of medical terms and technical terms that have been used in these documents.” (AfrInt12)

Extract 89: “Even insomnia struggling to sleep? No, let’s not use it. That’s not common. Like would..., my parents would never say, “Oh, I’m suffering from insomnia”. You’re like, “Oh, I didn’t have a great sleep last night”. “I’m struggling to sleep”.” (AraSAInt32)

Density of text: Participants also commented on the density of text (the amount of text on a page) when discussing the readability of the resources. Resources that were text-heavy with long sentences and limited visual cues such as bullet points or bolding (as in the case of the “After your Pfizer vaccine” factsheet) were noted as being overwhelming and unengaging for community members. The importance of providing simple and concise information to ensure readability for community members was stressed by many participants:

Extract 90: “Yeah, it looks like to me, too many texts and congested. No one is going to read all these things. So to be simplified on the main points should be written.” (AfrInt54)

Extract 91: “So that very information is very heavy and not easy to navigate.” (PasInt14)

Length of Resource: Participants also commented on the length of resources, generally noting that resources longer than one page (especially those that were text-heavy such as the “After your Pfizer vaccine” factsheet) would not be very effective or even would not be fully read by most community members:

Extract 92: “Long, it’s too long. Yeah, the shorter the resource, the better it is, especially given we have so much information out there.” (IndSInt7)

4.5.2 Layout and visuals

The inclusion of simple visual elements such as images and colours were responded to positively by all participants. For example, participants responded favourably to the poster “Cover your cough and sneeze” as visuals featured prominently:

Extract 93: “I like the flyer in terms of how bold it is and visually, it’s very appealing.” (PasInt21)

Extract 94: “I think it’s very clear, very clear for our community because the visuals, the photos, it’s very clear about how to protect themselves.” (AraSInt20)

Some noted that the accompanying images were especially helpful for those with limited fluency in English as they could engage with the poster without having to read the actual text:

Extract 95: “You can walk past and you can understand it straight away rather than having to stop and read the fine text.” (ChSInt45)

In contrast, participants noted that the lack of visuals in the “After your Pfizer vaccine” resource detracted from its effectiveness. Overall, many highlighted the importance of including images in resources and limiting and/or simplifying the accompanying text:

Extract 96: “If you could include some pictures and a bit more brightness, maybe there would be. Attract people more to read through that and maybe reduce the text and put some pictures in, there might be helpful.” (IndSInt24)

The importance of using images to clarify messaging was also underscored in the case of the “How do I check in?” resource. Many commented that including a photo of an actual QR code would have improved the resource.

However, participants also noted that visual elements that were confusing or did not have any communicative function should be removed. This was seen primarily in responses to the “How do I check in?” resource:

Extract 97: “Yeah, I don’t like this one as much because some of the like the clouds are just distracting. What’s the, I don’t see the purpose of having a cloud apart from being distracting.” (ChSInt45)

It should be noted that a few participants felt that actual photographs (as opposed to drawings) would be preferable as they would resonate more with community members:

Extract 98: “Cartoons don’t really appeal to us, you know, and the animation, it’s more about having a real face in there.” (PasInt37)

Extract 99: “But usually, you know, for community members, they prefer something it should be, you know, like a true photo.” (AraSInt20)

Interviewees pointed out the importance of ensuring that images and photographs were culturally representative and sensitive in order for community members to be able to connect with the resource. Some provided positive feedback on the inclusion of photos of people from a diversity of cultures in the “Before your vaccination” resource, whereas others suggested that the resources could be made more effective for their community members:

Extract 100: “Yeah, I like the use of really simple visuals as part of this particular campaign and a really diverse set of people represented.” (AraSInt1)

Extract 101: “It’d be good if we had like a community leader or someone a member [...] actually getting the shot.” (PasInt6)

Some participants felt that layouts that were more complicated could be confusing for some members of their community, especially the elderly. This point was made with reference to the “How do I check in?” resource, which included numbered steps as well as arrows pointing to alternative options:

Extract 102: “This one shows to where because there’s an arrow coming from the person going down, so you have to follow that arrow and that arrow goes to another place again and then, you know, arrows they have to follow. You know, elders might be having a difficult. It’s better to have just one, two, three something like that.” (AfrInt18)

Participants also commented on the font used in the resources. Some said the font size was too small for certain resources, especially those that had a mixture of font sizes such as the “How do I check in?” resource.

4.5.3 Quality of Translations

The reported quality of the translations differed depending on the target language and the resource. Some typical issues with translated resources included the following:

Literal Translations

As identified in section 4.4.1, many participants commented that the resources translated into their language appeared to be word-for-word renditions. They were not natural, fluent texts and sometimes they did not make sense in the target language. A member from the African community responding to the Oromo translation of the “How do I check in?” poster emphasised the importance of culturally appropriate translations:

Extract 103: “Directly translates this topic, ... It lacks some kind of target-language culture... so the perceiver may be or the person who reads this information maybe understand in different ways, in different things.” (AfrInt40)

Inappropriate translation equivalents

Some participants also pointed out that the equivalents for certain words or phrases were overly formal and not typically used in everyday conversation. This impacted how understandable and accessible the resources

were. For example, in response to the phrasing in the Hindi translation of the “After your Pfizer vaccine” resource, a participant from the Indian subcontinent observed the following:

Extract 104: “It is too formal. “praksha prabha” is something I really have to get inspected by a Hindi expert. To make this understand to a common man, I would not use that word... So, you know, I’m pretty sure they have. If you go to Google and translate “after-effects” in Hindi, it may come as “praksha prabha”. (IndSInt17)

Use of unfamiliar English words

Conversely, translations for some of the community languages retained untranslated English words that could be unfamiliar for some community members. For example, a member from the Myanmar community commented on the translation of the “Cover your cough and sneeze” poster and said the inclusion of the word “paper towel” would not be familiar to some elders in the community:

Extract 105: “And you know, the number four, he or she reviews paper towel. And some parents not know what is paper towel and then dryer.” (MyaInt19)

Moreover, as pointed out in 4.5.1, the use of highly technical language in the “After your Pfizer vaccine” resource would be unfamiliar for many community members, especially those with limited fluency in English. The same terms in English were often maintained in the translated versions without any corresponding explanation. Participants from the Afghan and African communities pointed out the serious issue this caused for comprehension of the resource by community members:

Extract 106: “So now the explanation without ... see how many English terms are used here. Yes, yes. They are not understandable either in English or in the LOTE. Ok, so this has to be something in plain language, free of English terms or technical terms.” (AfgInt33)

Extract 107: “Because that word should have been explained properly in Dinka and they leave the English ... and they explain Dinka and highlight the part and use the equivalent. Because it would not be one single word but would be a description of the word in Dinka.” (AfrInt43)

Incorrect target language

Translations of the “After your Pfizer Vaccine” factsheet that had been labelled as “Hazaragi” were in fact in closely related Dari, with consequences for comprehension. A participant from the Afghan community pointed out that this mislabelling had been identified for other officially translated audio-visual resources on COVID-19 too:

Extract 108: “They mostly do Dari, but they say it’s Hazaragi. Hazaragi is, you know, more simple. But Dari is more professional, academic, you know, office kind of language. So the women in the community don’t get it.” (AfgInt36)

4.5.4 General feedback

Overall, participants responded most positively to short resources with informative images, clear layout, and limited text such as the “Cover your Cough and Sneeze” poster and felt that longer text-heavy resources which contained technical jargon and had limited images (such as the “After your Pfizer vaccine” factsheet) were far less effective. Participants also reported that some messaging was better represented in audio-visual format. This is in line with the communities’ preferred channels for receiving and following information via video. Some participants highlighted that the preferred channels of communication they used to disseminate information to their community members – primarily social media such as Facebook and WhatsApp – meant that short one-page resources with brief dot-points and visuals would be most readily accessed:

Extract 109: “This [“After your Pfizer Vaccine”] is very important information, but then again, if you’re sharing it through the mode of communication that we normally communicate through, it is not going to be accessed. It’s not as accessible. So maybe having... this information and sharing the, you know, some dot points of this on a flyer and then asking people to click the link to get further information would help.” (IndSInt7)

Moreover, participants pointed out that having resources in a format that can be easily shared over social media (such as an image file) ensured that print resources could be disseminated widely by community leaders and organisations:

Extract 110: “JPEG, because you can share it, you can share JPEG of the image and the image in an WhatsApp or Viber or Facebook, but PDF, you can share it on WhatsApp or Viber, but they don’t see it as a photo. They see it as an attachment.” (AfgInt35)

4.6 Trust in the information received

4.6.1 Trust in information and behaviour change

The participants reported various factors that facilitated or inhibited the level of trust their communities had in the pandemic health information they received. What became apparent was a split between communities described as trusting or distrusting official messaging.

On the one hand, some participants expressed the idea that their communities trusted the information they received from official sources:

Extract 111: “I think they do [trust official messaging]. No issue.” (MyaInt19)

Positive factors facilitating the communities’ trust was having messages delivered by health professionals and community leaders rather than relying solely on government websites or directives:

Extract 112: “But I think they trust more maybe a health professional rather than a government website or government directive.” (ChSInt10)

Extract 113: “They [community leaders] have been vital. They have been the main sort of point of information for a lot of people. Some people don't even look at the TV or sometimes, you know, the newspaper, but they would rely heavily on the community leaders that are out there and would listen to them and their advice.” (IndSInt7)

The dissemination of translated material was a positive factor in building trust in vaccine health messaging. This was reported for the African communities, which saw a rise in numbers of members choosing to be vaccinated following the availability of in-language material:

Extract 114: “But at the point where information began to roll out, translated information in other languages became available to, they're more comfortable to then begin to go for vaccinations and the numbers are showing that.” (AfrInt12)

On the other hand, there also appeared to be a level of distrust, at least in some specific communities, in information sourced from official governmental sources. This might have been exacerbated by what was perceived by affected community members from Arabic-speaking and African communities as the mishandling of the lockdown of housing commission flats in Victoria during 2020, when certain CALD community members felt unfairly targeted:

Extract 115: “We saw from the lockdown of the commissioning flats in Flemington last year that there was there was an element of racialisation in how that was taken and perceived and managed and controlled. And so the distrust has exacerbated from that particular point.” (AraSInt1)

Pasifika community members in the 35-50 age group were also reported to be distrustful of government officials and government directives:

Extract 116: “And I find that a lot of the ones that find it hard to believe government and government directions are the ones in the age group, like in the mid-thirties or thirty to between 30 and 50. That’s the age group that find the struggle a little bit with government.” (PasInt22)

A member from the India sub-continent community pointed to mixed messaging surrounding the different vaccines as a factor that contributed to community members experiencing distrust of official vaccine health information:

Extract 117: “The mixed messaging is the biggest problem. Every day the government changes, you know?... Yep, you know, AstraZeneca is good, next day they are saying, OK, no, AstraZeneca is not good.” (IndSInt13)

Extract 118: “And there are there are the minorities that don’t believe in vaccination, either because of their religious belief or they too scared, some of them too scared to get jabbed. They just they just don’t like needles. Yeah, some of them are that and some of them for religious belief.” (PasInt14)

A final factor that was cited as a source of concern for participants from the Indian subcontinent and Arabic-speaking communities was the sourcing of information from social media or satellite television from the home country. The information from these sources contributed to some community members’ scepticism and resulted in vaccine hesitancy:

Extract 119: “Yes, I think there is a problem. A lot of them are watching because on YouTube and other channels, the TV news channels, for example, in India... there’s a certain level of scepticism about vaccines and about what strategies should be utilised. And but, of course, that’s all information for an audience there. But people are consuming that here and thinking it applies here as well. So that is definitely a concern. I think it should be a concern for governments. Yeah.” (IndSInt2)

Extract 120: “And that’s where we’re seeing the biggest barrier at the moment is between that 25 to 40 year old range who are having a lot of hesitancy because of the information they’re getting from the people who they follow and sitting in an echo chamber of information that perpetuates what they want to hear, because that’s what social media is.” (AraSInt1)

4.6.2 Strategies adopted by community organisations to build trust

Participants mentioned a number of strategies that community organisations have employed to facilitate the building of trust. A majority identified the need for interpersonal communication and contacts and the need to build rapport with the community over the long term. The ongoing direct connections with the community that had been established pre-COVID-19 then helped facilitate trust within the community. Cooperation on a number of levels was also recommended, with community leaders, service providers and experts working together to reach the community and continue to build trust, particularly in the efficacy and safety of the COVID-19 vaccine:

Extract 121: “I don’t think it’s as much of a strategy as us just having worked in the community and built rapport over the number of years, the face-to-face work that we’ve done in programs and running events and sort of the staff, I think for us, it’s our staff that have those direct connections and links with communities that builds trust.” (AraSInt32)

Extract 122: “That’s why there is all of these concerns and a lot of questions around it. So and that’s why we need to work together. So we as community leaders and also service providers within the community and also the experts within the community. So we can actually say, no, this is OK. So you can actually accept it and try to do that. No harm in it.” (AfrInt11)

The participants reported that community and religious leaders were instrumental in building trust in the community, particularly when they led by example. Many participants pointed to religious leaders acting as role models, e.g. by posting pictures on social media of their own vaccinations for their communities to see. Ensuring information flows through religious leadership is another means of building trust, particularly for communities that have a level of scepticism or distrust of information sourced from governmental sources:

Extract 123: “And they are influencers in their own right with their communities, particularly when we’re talking about mosque-based communities, the leaders of those mosques. People are looking at them. So when they’re posting pictures like a picture of them getting the vaccine, that’s seen as impactful, because people go, well, I have a lot of respect for that person. If that person believes this, then it’s the right thing to do.” (AraSIInt1)

Extract 124: “[...] people trust the community leaders or church leaders, priests, because of that. You know, whenever a priest tells you to do something or not to do something that is high priority of getting listened by the member. So it was effective deterrence sermons coming from the church or some information coming out from the church leaders were effective and will be also effective in the future. So like using influence, influential people like priests and leaders and elders is a good way of reaching the grassroots.” (AfrInt54)

It was mentioned that social media were used in a cautious and sensitive manner and community organisations acted proactively by monitoring comments on social media platforms, with destructive or misleading comments being deleted. Other communities ensured that posts on social media were from reputable sources:

Extract 125: “So we use social media in very sensitive way, just not open to everyone, but in a very sensitive way. ... Sometimes if the comment, which is very destructive, we delete that comment.” (AfrInt44)

Extract 126: “If I see a message that’s being shared that doesn’t have any authentic source, I always call it out and I let them, you know, before you share any misinformation or information that’s not backed by some like authentic sources, please don’t share in my group or share with people here.” (IndSIInt7)

It was repeatedly mentioned that information had to be not just available in community languages but should be in plain language. Trust-building is further facilitated if the health messaging is delivered by a community leader or doctor, as they are deemed to be trustworthy:

Extract 127: “We need to be speaking their language, simple language, and from a trustworthy person to make them feel they are loved, they are cared for. So they feel like, oh, someone is caring for us, so we should listen.” (AfgInt36)

Extract 128: “Oh, yes, for sure, especially Indian doctors themselves, like they can get information from an Indian doctor, they’re more likely to believe it. ... And so I do see there being a real trust with doctors who have the same cultural background as you.” (IndSIInt23)

It is important to keep in mind that some communities experienced distrust of governmental information coming from official sources particularly when communities had experienced the past impacts of colonialism:

Extract 129: “And I think that just comes like generationally with what happened in India, with the English and the Indians and being white and brown is two separate people. I think there’s that bit of like lack of trust there, still.” (IndSInt23)

In another instance, a participant from the Pasifika community discussed the importance of enhancing trust by ensuring information flows through to elders first who then disseminate information to the community:

Extract 130: “So that’s why I target the senior citizen, the elderly first with the with the information, because that’s how the information will get on to the younger ones.” (PasSInt22)

Community trust in official messaging was also undermined by misinformation, primarily found on social media outlets. The term “infodemic” has been coined to highlight the dangers of misinformation (wrong, misleading information) and disinformation (the dissemination of deliberately false information) (cf. World Health Organization, 2020). Community members who were generically identified as “aunties and cousins in suburban areas” tended to rely on interpersonal communication with peers for sourcing COVID-19 and vaccine health information. This was deemed to be potentially problematic as misinformation on social media can become rife when spread within the community:

Extract 131: “A lot of these people are your aunties and cousins who are in suburban areas who don’t access social media. They talk to each other. They rely on their own community to receive information. They rely on peer-to-peer information. (AraSInt1)

5. Final remarks and recommendations

The rapid spread of COVID-19 and new COVID-19 variants has been accompanied by a stream of constant and changing information from multiple sources that CALD communities have had to navigate. This constitutes a problem not just for the creators of the messages but also for the intended recipients, particularly for those community members who may not have the necessary linguistic, health and literacy skills to navigate the constant influx of information.

While the CALD communities investigated shared many experiences (e.g. preference of social media as a channel for receiving/following information, preference for audio-visual format, need for resources in community languages, need to adapt materials to specific groups within each community), there were clear differences in their experience with COVID-19 messaging (e.g. issues of trust in government information, ease of access to resources, availability of translations, etc.). As a result, there is a need for a nuanced approach on the part of governments that takes into account different needs and issues.

It is hoped that this overview of the issues and barriers identified by communities in engaging with COVID-19 information can assist the Victorian government and multicultural community organisations in the planning of communication strategies, which should be done by working closely with communities themselves. The participants recommended various principles to improve health communication and facilitate crisis communication procedures for their CALD communities. Based on their insights and the findings of this report, the following recommendations, presented in shorter form in the executive summary, can be made:

1. Provide more information in more community languages

In-language support is important for all communities, although care must also be given to the provision of information in plain English. More translations are needed for some community languages (e.g. Somali, Hakha Chin, Hazaragi and Urdu). Information also needs to be disseminated in other languages for which information appears to be lacking (e.g. Telugu and Marathi). In general, more information is particularly needed on testing and vaccination.

2. Diversify communication channels

Communication channels should be diversified to disseminate information to different communities (and within communities, e.g., according to age group). It is important to include more information sessions, public Q&A forums, peer-to-peer networks and information micro-hubs where community-based health promotion volunteers champion COVID-19 and vaccine-related messaging in their respective languages and respond to concerns about COVID-19, testing and vaccination. Community-led initiatives are key. Community representatives that are engaged by the government to disseminate information should be from a cross-section of people from the community, including men, women, young people and the elderly.

3. Adopt a multimodal approach to disseminating health information

This approach should include the use especially of audio-visual communication, e.g. videos, and infographics, as well as of non-digital forms of communication, such as leaflets and brochures. Health messaging in print and online should be in simple English, easily accessible, community-led and culturally and linguistically appropriate. Effort should be made to create text-based materials that are short, contain only key information and include helpful visual elements (e.g., pictures, diagrams). In particular, information in audio-visual format such as videos are identified as very effective and easily shared across different social media platforms. Support for community organisations should be provided to allow for the employment of liaison officers to reach members of the community through digital and non-digital modes of communication.

4. Ensure high quality, timely translations

There must be high quality timely translations of official health messaging into community languages, including those under-represented in official translations to date (see languages mentioned in point 1). This is to ensure that translations reflect the changing reality of COVID-19 and the directives that are in place at a given time. Translation quality should be checked by consultants or community leaders before release, to ensure accuracy, readability and cultural appropriateness.⁴ This recommendation is consistent with news reports from SBS (August, 2021) and ABC (August, 2021) reiterated the challenges faced by communities having to contend with outdated translated COVID-19 information, particularly with respect to changing advice regarding the eligibility for specific vaccines.

5. Adapt materials and messaging for different groups

Women and senior CALD members have often had difficulties in engaging with COVID-19 information, due to issues such as low proficiency in English, low literacy in the community language (e.g. in the case of Hindi speakers), and low digital literacy (and thus inability to access information online). Some respondents also indicated that some members of these cohorts accessed unreliable resources (e.g. via satellite television or social media) that spread misinformation. Materials and messaging need to be adapted to the needs of these groups in consultation with communities. In-language resources and tailored webinars providing information about the specific issues or concerns raised by specific cohorts in the community (e.g. COVID-19 during pregnancy, vaccination for pregnant women and the elderly etc.) are needed (cf. GENVIC & MCWH, 2021). Women, for instance, have been particularly worried about the effect of vaccination on pregnancy and fertility (see also previous research conducted by GENVIC & MCWH, 2021). Health information in community language(s) should specifically address women, as well as the elderly and their carers, who often act as language brokers. Non-digital modes of communication are needed to reach some older members of the community: elderly individuals, including Indian seniors, require direct oral communication (e.g. via

⁴ It is important to note that this research has not independently evaluated the translations done in the community groups and thus offers no recommendation concerning the viability of translations completed by community representatives in preference to professional translators.

telephone) due to low digital literacy and low literacy in the community language. Measures should also be put in place to support those who cannot rely on the support of family.

Fischer (2008, p. 217) notes that “[a]ll too often emergency personnel assume that because the information was disseminated, the intended recipients have received it, understood it, and responded to it in the desired fashion”. It is not a given that community members will listen to, understand, and act upon the health information they receive in a linear fashion. Other variables come into play that impact on the comprehension and reception of information. Trust in government and its messaging varies by community and within communities (for some it is not an issue). However, community leaders, both secular and religious, are reported to be trusted and can serve as effective communicators of government advice and information.

The five recommendations listed above are in line with the requirements set by the *Multicultural Victorian Act 2011*, which emphasise the importance of multicultural communications and culturally sensitive service delivery. They are also consistent with the commitments outlined in *Victoria's Multicultural Policy Statement* (2019, p. 28), which among other things stresses the importance of providing health information in languages other than English, thereby ensuring that people from diverse communities have improved access to resources in their language.

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Appendices

Appendix A: Interview guidelines

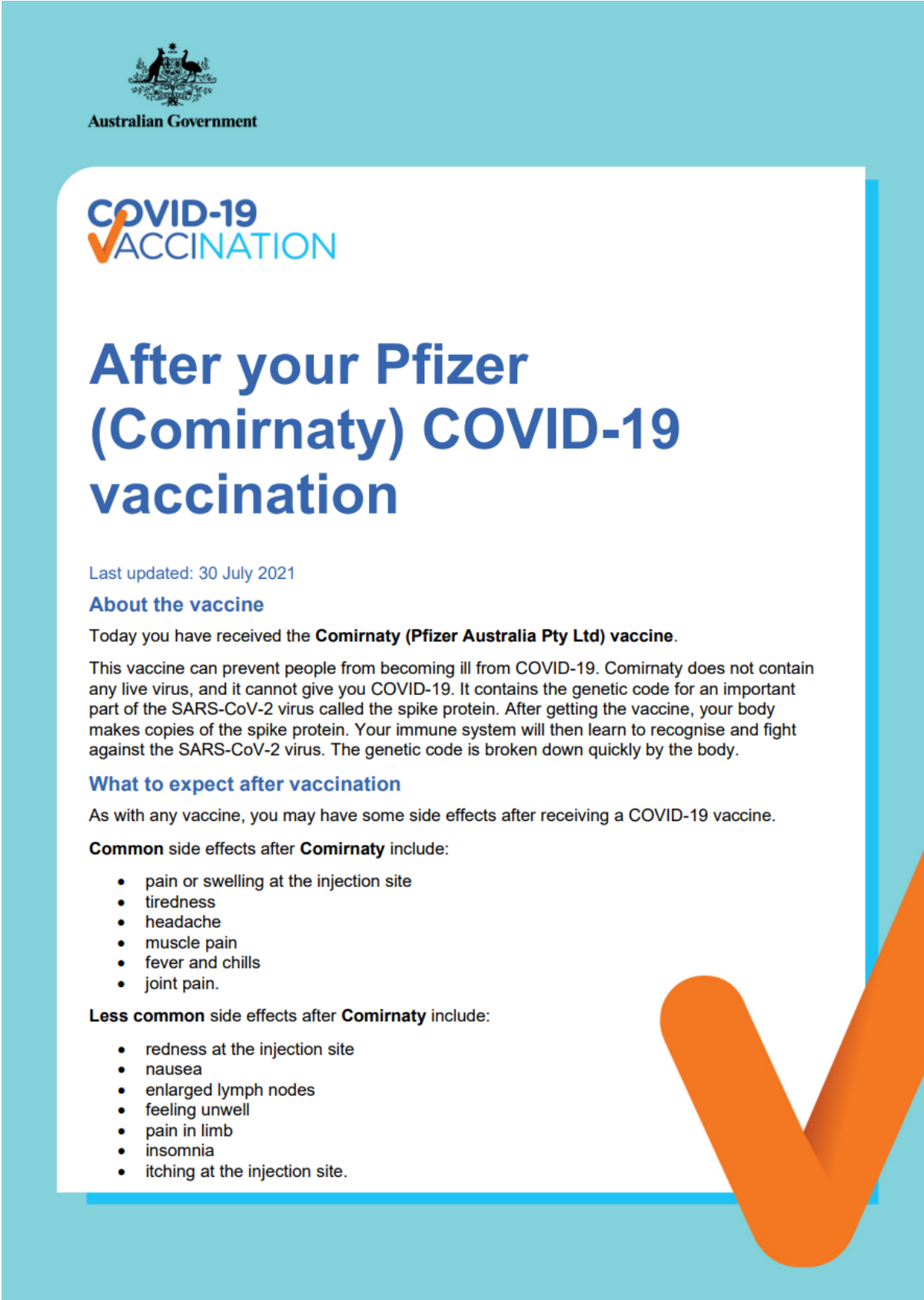
For ease of presentation, we use the term “community” in the singular form here. It is important to note, however, that participants were asked about *all* the ethnic communities they belonged to or worked with. Similarly, they were invited to give their feedback on the availability of COVID-19-related materials in *all* their languages.

Background information about the participant and their organisation(s)	
1) What community are you part of?	
2) What is your role in the community?	
3) Can you tell me about your current role in the community?	
Community member	Community leader/representative
4) What languages do you and your community speak and use?	4) What languages do community members speak and use?
Information about COVID-19 and how it has been received/followed	
5) In which languages have you received or follow COVID-19 information?	5) In which languages have people in your community received or followed COVID-19 information?
6) Is there a preferred language that you have for receiving information?	6) Is there a preferred language that your community has for receiving information?
7) What information have you received concerning the pandemic in your language(s)?	7) What information has your community received concerning the pandemic in your language(s)?
8) Where does the COVID-19 information you receive come from?	8) Where does the COVID-19 information that your community receives come from?
9) Do you also rely on information received from other countries? In what ways?	9) Do you know whether your community members also rely on information received from other countries? In what ways?
10) How do you prefer to follow information about COVID, testing and vaccines?	10) How does your community prefer to follow information about COVID, testing and vaccines?
11) Do you prefer to receive information about COVID, testing or vaccines in any particular way?	11) Does your community prefer to receive information about COVID, testing or vaccines in any particular way?
12) How effective have different information channels (e.g., TV, radio, Facebook and other social media) been in spreading COVID-19 information in your language(s)?	
Evaluation of messaging about COVID-19 in community languages	
13) How often is the information about the COVID-19 pandemic, including testing and vaccination in your language(s) updated?	
14) Would you like more or less information about COVID-19, testing and vaccination? Why?	14) Would your community like more or less information about COVID-19, testing and vaccination? Why?
15) Is the information in your languages easy to access?	15) Is the information in your languages easy to access?
16) Is there any information missing in your language(s) that you would like to receive?	16) Is there any information missing in your language(s) that your community would like to receive?
17) Are there any specific issues about providing COVID-19 information to women and/or the elderly in your community? Is COVID-19 or vaccine health messaging adapted for specific groups in your community/communities (e.g. the elderly and women)?	


18) Do you have any comments about the type of language that you see in translations relating to COVID-19?	18) Do you or other community members have any comments about the type of language that they see in translations?
19) In your opinion, has the translated material been received well by you and/or the community you are part of?	19) In your opinion, has the translated material been received well by the community you work with?
20) Do you trust the information you receive? Why? Do you change your behaviour as a result? <i>Go to Question 22</i>	20) Does your community trust the information they receive? Do they change their behaviour as a result? 21) What strategies does your organisation use to build this trust?
Evaluation of visual materials	
22) After having a look at some visual resources in English and/or in your language(s) (see Table 2), please comment on: a) their layout and use of visuals b) their readability (i.e. how easy they are to understand) c) the quality of text (including the quality of the translation, if applicable)	
Recommendations on how to improve health-related communication and vaccination uptake	
23) How can health messaging be changed to improve any of the following: a) understanding of COVID b) following/sticking to COVID-safe rules c) uptake of vaccination	
24) In your opinion, how can trust about the vaccine and willingness to be vaccinated be improved in your community?	

Appendix B: Print resources (sample pages)

1. “After your Pfizer (COMIRNATY) vaccine” (page 1 of 3)



The image shows a sample page of a COVID-19 vaccination leaflet. At the top left is the Australian Government crest and the text 'Australian Government'. Below this is the 'COVID-19 VACCINATION' logo, featuring a large orange checkmark. The main title is 'After your Pfizer (Comirnaty) COVID-19 vaccination' in large blue font. Below the title, it says 'Last updated: 30 July 2021'. The section 'About the vaccine' explains that the vaccine is Comirnaty (Pfizer Australia Pty Ltd) and describes how it works. The section 'What to expect after vaccination' lists common side effects (pain or swelling at the injection site, tiredness, headache, muscle pain, fever and chills, joint pain) and less common side effects (redness at the injection site, nausea, enlarged lymph nodes, feeling unwell, pain in limb, insomnia, itching at the injection site). A large orange checkmark is positioned in the bottom right corner of the leaflet page.


Australian Government

COVID-19
✓VACCINATION

After your Pfizer (Comirnaty) COVID-19 vaccination

Last updated: 30 July 2021

About the vaccine

Today you have received the **Comirnaty (Pfizer Australia Pty Ltd) vaccine**.

This vaccine can prevent people from becoming ill from COVID-19. Comirnaty does not contain any live virus, and it cannot give you COVID-19. It contains the genetic code for an important part of the SARS-CoV-2 virus called the spike protein. After getting the vaccine, your body makes copies of the spike protein. Your immune system will then learn to recognise and fight against the SARS-CoV-2 virus. The genetic code is broken down quickly by the body.

What to expect after vaccination

As with any vaccine, you may have some side effects after receiving a COVID-19 vaccine.

Common side effects after Comirnaty include:

- pain or swelling at the injection site
- tiredness
- headache
- muscle pain
- fever and chills
- joint pain.

Less common side effects after Comirnaty include:

- redness at the injection site
- nausea
- enlarged lymph nodes
- feeling unwell
- pain in limb
- insomnia
- itching at the injection site.

2. “Before your vaccination” (page 1 of 6)



Australian Government

COVID-19 VACCINATION

Before your vaccination



The Australian Government wants as many people as possible to have the vaccination in 2021.

But not everyone can have the vaccination at the same time.



People who are most at risk of catching the virus and getting very sick from the virus will get the vaccine first.

When it is your turn, you can book an appointment at a place that offers the vaccine.

You might need to wait until you can get an appointment.

3. "How do I check in?" (page 1 of 1)

How do I check in?

1
Use the camera on your phone to scan the QR code



2
Enter your name and phone number

You might need to download the **Service Victoria** app.



----->



You will only need to download this app once. **Then follow the prompts to submit your details.**

If you don't have or can't use a smartphone,
a staff member or someone at the venue can help you check in using the QR code.



Why is it important to check-in?

Using QR codes to check in wherever you go helps contact tracers to contain outbreaks. Your information will only be used for contact tracing.



4. "Protect yourself and family (Cover cough and sneeze)" (page 1 of 1)

Protect yourself and your family

Cover your cough and sneeze



1

COVER your mouth and nose with a tissue when you cough or sneeze.

Put your used tissue in the rubbish **BIN**.

2



3

If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, **NOT YOUR HANDS**.

WASH your hands with soap and running water. Dry your hands thoroughly with a disposable paper towel or hand dryer.

4



Stay germ free and healthy