COVID-19 and the importance of languages in public health

Piotr Blumczynski and Steven Wilson | February 2023 | Policy Paper

- COVID-19 has underlined the importance of good communication strategies in public health. The research project we led has shown that multilingual provision is key to this by ensuring communities – including linguistic minority communities – have access to key public health messages.

- A linguistically inclusive response to pandemics is also crucial to ensuring that levels of trust and, therefore, engagement with public health information and services, are high among diverse communities.

- The inadequate provision for Deaf communities represented a particular failure of inclusion during the COVID-19 pandemic, leading to an 'infodemic' and sense of marginalisation.

- This paper makes a series of language-based policy recommendations to enhance public health strategies. These include the need for government health departments and public health agencies to commission adequate translation of key pandemic information for linguistically and culturally diverse communities, which involves accredited translators working alongside respected cultural and/or religious figures in the relevant linguistic minority community.

- The paper highlights the requirement for health information to be meaningfully *translated* (attuned to the recipients' needs and conditions) rather than merely *transcribed* (mechanically converted into another language).

Public health and multilingualism

As the World Health Organisation (WHO) consistently stated in relation to the COVID-19 pandemic, 'the virus knows no borders and [...] no one is safe until everyone is safe'. The spirit of collectivity that emerged in response to COVID-19 led to a renewed emphasis on the importance of effective communication strategies in public health. Dr Mike Ryan, Executive Director of WHO's Health Emergencies Programme, noted at an emergency

press conference on 28 December 2020 that COVID-19 'is a wake-up call. We are learning now how to do things better, how to do science better, how to do logistics better, how to do training better, how to do governance better, how to communicate better.' A few months later, the *Journal of Communication in Healthcare* published an interview with Mike Ryan and Melinda Frost, the team lead within the Infodemics Management Pillar for WHO's response to COVID-19 (JCIH 2021: 93). Ryan and Frost repeatedly stressed that communication is key to community engagement and trust, all of which represent essential facets of an inclusive and effective response to a pandemic. Funded by a British Academy COVID-19 'Special Research Grant', the project we led, which included researchers from across the world, showed that 'communication', 'trust' and 'engagement' with local and global communities during a pandemic depend not only on the use of clear language in general, but a particular awareness of the importance of linguistic sensitivity in pandemic management (Blumczynski and Wilson 2023). Yet many of the conclusions from our book apply to public health policy more widely. As WHO noted in its 2019–2023 Global Action Plan on 'Promoting the Health of Refugees and Migrants', while 'barriers to accessing health care services differ from country to country', 'they may include language and cultural differences'. More generally, the transnational mobility that characterises the modern world (Koehn 2020) – the multinational, multilingual communities of international cities; the diasporic communities scattered across the world; migrants, refugees and asylum seekers who cross borders; people who become displaced because of climate change or war – as well as the needs of those who speak indigenous, heritage, community or minoritized languages, underline the need for linguistically-sensitive and inclusive public health communication.

WHO has recognised that multilingualism has profound consequences for public health policy and practice. Its most recent resolution on multilingualism, adopted in May 2018, asserted the need for equality among its official languages – Arabic, Chinese, English, French, Russian and Spanish – while licensing external entities to translate and publish its health information in other languages. WHO's major scientific reports are published in the six official languages, as is all material on its website. The organisation recognises that 'Multilingual communication bridges gaps and fosters understanding between people. It allows WHO to more effectively guide public health practices, reach out to international audiences and achieve better health outcomes worldwide. In this way, multilingual communication is an essential tool for improving global health.' Yet NGOs such as Translators without Borders and the Health Information Translations

collaboration still have to develop scientific resources to account for the fact that 'most of the world's population – some six billion people – [have] little or no access to a large body of public health information because it is in English' (Adams and Fleck 2015: 365). The inadequacy of current policy in the UK is illustrated starkly on the NHS national webpage, which states: 'You can translate health information on the NHS website using an online translator. Although online translators can accurately translate individual words and phrases, they may not always be able to interpret the meaning of larger or more complex pieces of information.' One of the lessons of the pandemic is that there is now an urgent need for national and regional governments with responsibility for healthcare to ensure that linguistic sensitivity and inclusion are embedded into policy frameworks.

In this paper, we suggest two aspects that highlight the importance of languages-focused research to public health policy, namely inclusion and trust.

Inclusion

António Guterres, Secretary-General of the United Nations, affirmed that, while 'we are all in this together', at least in the sense that COVID-19 does not discriminate between people of different gender, race, class, ethnicity or nationality, its effects do: 'We see the disproportionate effects on certain communities, the rise of hate speech, the targeting of vulnerable groups, and the risks of heavy-handed security responses undermining the health response'. Research has shown that language barriers exacerbate these 'disproportionate effects' and their consequences precisely because they are experienced in specific minority communities, including indigenous populations, migrants and refugees, and people with disabilities (Piller, Zhang and Li 2020). For ethnic minority communities specifically, research has highlighted that the pandemic has exacerbated already entrenched health inequities. More generally, communities in many countries, including minority language communities, faced sustained barriers to effective healthcare during the pandemic. Marco Civico, in his 2021 study of 'COVID-19 and Language Barriers', reviewed various strategies across the world to provide multilingual information on the pandemic and the subsequent vaccination campaign. His research pointed (pp. 11–12) to particular deficiencies in the information provided on the NHS websites of all devolved nations in the UK apart from Scotland. At the time of writing the present report, the NHS England website still does not appear to have any multilingual information, while the NHS Wales website contains information in English and Welsh. The Scottish and Northern Ireland NHS websites

have information in multiple languages (26 apart from English in each case), including British Sign Language (BSL) on the NHS Scotland page.

Signing Deaf communities experienced particularly egregious language barriers to accessing healthcare information during the pandemic. According to a review conducted by Open Inclusion, focused on key UK Government and health service websites, apps and social media sites, the vast majority of important COVID-19 information was found to have no BSL interpretation at all, and much information in written format was inadequate to the needs of Deaf readers (Napier and Adam 2023). While government public health briefings in Scotland, Wales and Northern Ireland routinely had on-platform sign language interpreters, access to information for Deaf BSL users in England was not provided by the UK government from the briefing room but only by the broadcaster (BBC). This practice became the subject of a judicial review in the high court, with a charge that it breached the 2010 Equality Act. In July 2021, the court rejected the UK Government's argument 'that Deaf people were not at a substantial disadvantage in not having an interpreter because, amongst other things, they had subtitles' and instead ruled that '[t]here was a clear barrier for a vulnerable and marginalised group, undermining accessibility of information. The message was blocked or scrambled or delayed. … The lack of provision – the provision of subtitles only – was a failure of inclusion, suggestive of not being thought about, which serve to disempower, to frustrate and to marginalize'. The judgement declared that 'the failure to provide BSL Interpreters for the Data Briefings was a Breach of the Cabinet Office's duty to make Reasonable Adjustments'. It was noted that subtitles are not an adequate solution for Deaf BSL users because this fast-moving text containing technical information is given in a language that is not their first and assumes an often-unachievable level of literacy. For information to be accessible and meaningful, it must be *translated* bearing in mind the needs of the intended recipients, not simply *transcribed*. This can be ensured by pre-testing translations with the target community against WHO's AAAQ framework: availability, accessibility, acceptability and quality. These key criteria can only be met when linguistic, cultural, and contextual factors are addressed successfully.

In their survey of communicative needs and challenges of Deaf signers in England, Napier and Adam (2023) discovered that over half of their respondents found official UK Government information about COVID-19 (including official restrictions, lockdown rules, etc.) 'difficult or impossible to understand', and almost two-thirds 'were worried about

their personal health, safety and well-being as a result of a lack of accessible and understandable government information'. Consequently, many of them had to seek alternative ways of obtaining health information, turning to family, friends, NGOs and community groups – at the risk that the content received through these channels may not be (entirely) correct, current, reliable or official. A small-scale study of Deaf signers in Flanders (Rijckaert and Gebruers 2023) highlighted precisely these and similar concerns. The COVID-19 pandemic has been accompanied by an infodemic: its excessive volume required effort and skill to identify and prioritise relevant elements. In this context, videos in Flemish Sign Language, developed voluntarily by a Deaf-led media company were received as 'clear, concise, comprehensible and easy to process compared to other news sources' (Rijckaert and Gebruers 2023: 184). Adequate language quality and quantity – ensured by using professional interpreters who are also meaningfully connected with the Deaf community (for example, by being Deaf themselves) – were found to be key elements building the credibility of the message, and subsequently trust in its reliability.

Trust

English is the established lingua franca of science and 85% of early articles on COVID-19 were published in English-language journals (Taskin et al. 2020). From the onset of the coronavirus pandemic, the majority of scientific papers coming from China were published in English. While such scientific monolingualism may assist with the efficient dissemination of information at a global level, it also has major implications for WHO 'and for local communities who are mistrustful of Anglocentric models of disease prevention being imposed on them (which itself can feed into suspicion of vaccines and other health interventions)' (Arnaldi, Engebretsen and Forsdick 2022: 5). At the same time, language differences and communicative breakdowns can fuel distrust in official health measures and messaging. Pym et al. (2023) highlight the difference between 'thin trust' and 'thick trust' in relation to healthcare. The former is based on degrees of unfamiliarity or ignorance, and as a result might be invested in official translators or officials. By contrast, the latter 'usually involves cultivating interpersonal relationships that develop over time and on several levels' (Pym et al. 2023: 111). Pym et al. make reference to the chief health officer in the Australian state of Victoria, who conceded that cross-cultural communication in multilingual communities was not 'as simple as handing out translated pamphlets … you do need that community leadership [and] community champions' (121). Pym et al. thus stress the role of local community

organisations and leaders in both verifying the linguistic quality of translated materials and offering them a level of endorsement (for example, by relaying them in their own press outlets or on social media).

As part of a strategy to ensure effective multilingual provision of public health information, officials in many nations have worked with influential cultural figures not merely to disseminate key information in local languages, but to foster partnerships in crafting messages that would garner the trust of local communities. All elements of the AAAQ framework need to be secured: quality information must not merely be available and accessible but also acceptable. Such a comprehensive translation effort often involves arts-based communities. As Dr Alex Gasasira, WHO Representative to Zimbabwe, explained: 'Our best defence against COVID-19 […] is information. […] When people pay attention to the science and wear masks, do social distancing and keep hygiene by washing hands frequently, we hold the pandemic at bay.' But, he added, 'typical public health education' has its limits: 'The posters, the radio spots, the social media, the work with journalists to share accurate information – that's all helping. […] But some people still just don't pay attention. We need to tune into their frequency, too.' As a result, Zimbabwean artists were featured in an hour-long virtual concert which included COVID-19 prevention messages because, as the UN Resident Coordinator's Office (RCO) in the country put it: 'In a word, they're trusted'. Similar community engagement projects took place across the globe, including in Bolivia and Kenya. Rather than simply disseminating official translations of core public health messages, community partnership projects facilitate trusted cultural figures to work with local communities to present information in a language, mode and format that are engaging and culturally sensitive. In Haiti, for example, where there remain significant levels of distrust in international organisations following the cholera outbreak of 2010, the result of contamination by infected UN peacekeepers, public health messages about COVID-19 prevention were coordinated by the Haiti Response Coalition but led by local rappers, musicians and cartoonists, and disseminated in French and Haitian Creole. Such initiatives illustrate the importance of interconnected local, inclusive, linguistically-sensitive and community-generated public health campaigns.

Policy recommendations

Public health policies developed at national and regional levels should be conceived and delivered with sensitivity to local cultural and linguistic communities. Based on our research and related studies (e.g. Krystallidou and Braun 2023), we offer the following specific policy recommendations in a UK context, though we suggest that the principles underpinning these conclusions are applicable (with proportional adaptations) to other countries with significant multilingual populations too.

- Government health agencies and departments should liaise with the Office for National Statistics (or equivalent) to identify significant – defined as over 100,000 speakers – linguistic minority communities nationwide.

- As part of the Civil Service procurement process for the translation of key public health messages, and in order to ensure that quality, accessibility and trust are maximised, government health agencies and departments should stipulate that respected cultural and/or religious figures or organisations in the relevant linguistic minority community form part of the translation process. These figures or organisations must jointly approve the final communication with the accredited translator(s) and be paid at commensurate consultancy rates.

- Health messages must be meaningfully *translated* (attuned to the recipients' needs and conditions) rather than merely *transcribed* (mechanically converted into another language). This should be ensured by pre-testing translations with the target community for AAAQ: availability, accessibility, acceptability and quality.

- Government health agencies and departments should, through Civil Service procurement mechanisms, ensure adequate provision of health information for Deaf communities. In particular, written materials or subtitles cannot be considered viable alternatives to sign language interpretation.

- Best practice in multilingual public health communication should be shared with other nations through, for example, strategic roundtables at the World Health Assembly, the decision-making body of WHO.

Further reading

Arnaldi, Marta, Eivind Engebretsen and Charles Forsdick. 2022. 'Translating COVID-19: From Contagion to Containment', *Journal of Medical Humanities*.

Blumczynski, Piotr and Steven Wilson (eds). 2023. *The Languages of COVID-19: Translational and Multilingual Perspectives on Global Healthcare* (London: Routledge).

Napier, Jemina and Robert Adam. 2023. 'Prophylactic Language Use. The Case of Deaf Signers in England and Their (Lack of) Access to Government Information during the COVID-19 Pandemic', in Blumczynski and Wilson (eds), pp. 161–178.

Piller, Ingrid, Jie Zhang and Jia Li. 2020. 'Linguistic Diversity in a Time of Crisis: Language Challenges of the COVID-19 Pandemic', *Multilingua*, 39.5: 503-15.

Pym, Anthony et al. 2023. 'Community Trust in Translations of Official COVID-19 Communications in Australia. An Ethical Dilemma between Academics and News Media', in Blumczynski and Wilson (eds), pp. 110–127.

Rijckert, Jorn and Karolien Gebruers. 2023. 'A Pandemic Accompanied by an Infodemic. How Do Deaf Signers in Flanders Make Informed Decisions? A Preliminary Small-scale Study', in Blumczynski and Wilson (eds), pp. 179–196.

Resources

Adams, Patrick and Fiona Fleck. 2015. 'Bridging the Language Divide in Health', *Bulletin of the World Health Organization*, 93: 365–66.

JCIH Editorial Team. 2021. 'The "Science of Trust": Why We Need a Multi-faceted Approach to Inform, Engage and Empower Communities during COVID-19 and beyond', *Journal of Communication in Healthcare*, 14: 93–98.

Koehn, Peter H. 2020. *Transnational Mobility and Global Health. Traversing Borders and Boundaries* (London: Routledge).

Krystallidou, Demi and Sabine Braun. 2023. 'Risk and Crisis Communication during COVID-19 in Linguistically and Culturally Diverse Communities: A Scoping Review of the Available Evidence', in Blumczynski and Wilson (eds), pp. 128–144.

Taskin, Zehera, Guleda Dogan, Emanuel Kulczycki, and Alesia Zuccala. 2020. 'COVID-19 Research for the English-Speaking World: Health Communication during a Pandemic', *Medical Letter on the CDC & FDA*, 14 June.

Cite this article

Blumczynski, Piotr and Steven Wilson. 2023. 'COVID-19 and the importance of languages in public health'. *Languages, Society and Policy*.