Public Health Messaging for Communities from Different Cultural Backgrounds

SPI-B, 22 July 2020

Key points

- COVID-19 has a disproportionate impact on people from Black, Asian and Minority Ethnic (BAME) communities. Risk communication that is culturally appropriate may promote health protective behaviours which can minimise the risk of COVID-19 in BAME communities.

- Translation into a range of suitable languages is necessary, but not sufficient. Co-production and pre-testing of health messages with the target community to identify language that retains the meaning of the core message and considers the cultural context for the target audience is essential. If reading skills are limited, consider using audio files and animations.

- Local authorities need an active BAME engagement cell with health, political, community, legal and academic representatives. This will help them understand issues at a local level and build trust with community partners who can act as a trusted source of communication.

- Messages should be tailored to reflect local realities. Health messages should explicitly consider cultural norms including high risk events (e.g. Eid and weddings), ensure they promote services that are accessible (e.g. multilingual contact tracers) and do not disadvantage the target community (e.g. loss of income due to self-isolation).

- Health messages should be linked with social identities relevant to the target community, highlight risks to specific groups, and include stories from within the local community of the consequences of following and not following guidelines.

- Fear inducing messages should be avoided as, even when health messages are adhered to, stressors remain in the physical environment that are not within the control of individuals from BAME communities.

Extended summary

- COVID-19 has a disproportionate impact on people from Black, Asian and Minority Ethnic (BAME) communities due to increased risk of infection and excess mortality. Higher rates of comorbidities, co-habiting in inter-generational family units, employment in frontline roles and lower health-seeking behaviour may contribute to this increased risk.

- Health messages for BAME communities should be tailored to reflect socio-cultural influences and drivers of behaviour which, at times, may differ from White British communities. Risk communication that is culturally appropriate may promote health protective behaviours which can minimise the risk of COVID-19 in BAME communities. This report provides an overview of key literature and recommendations for developing culturally sensitive health messages for BAME groups.

- A communication strategy which targets capability (knowledge and skills), opportunity (social norms and physical resources) and motivation (analytic decision-making and habit) will convey health messages more effectively than a communication strategy that promotes knowledge alone or increases physical resources without targeting motivation.

- To increase capability, health messages should increase knowledge of risks and benefits of behaviours. Barriers to increasing knowledge include low health literacy and use of vague terms that do not translate well into different languages. Words such as *shielding* and *self-isolation* do not retain the same meaning and cultural context when translated.
    - Co-produce and pre-test health messages with the target community to identify language that retains meaning of the core message and cultural context for the target audience. SPI-B have previously produced guidance on co-production which is available from the GO-Science secretariat.
    - Translate health messages into languages that are accessible for the target community.
    - If reading skills are limited, use audio files and animations to increase knowledge and understanding.

- BAME communities may be less willing to trust government communications on pandemic measures due to historical issues and contemporary perceptions of institutional racism. Health messages are more likely to be received by someone known and trusted within BAME communities. These include faith groups, community leaders and lay health educators such as shop workers and taxi drivers.
    - Multiple credible sources should be utilised as not all members of BAME communities are responsive to faith leaders.
    - Understand and define differences within and between minority groups. Identify credible sources and ensure health messages reflect salient aspects of ethnic identity and experiences.
    - Local authorities should have an active BAME engagement cell with health, political, community, legal and academic representatives. This will help understand issues at a local level and build trust with community partners that can act as a trusted source for hard to reach populations.

- Messages should be tailored to reflect local realities. Localise health messages to consider local people, services, resources, and social and cultural norms of the target community.
    - Health messages should explicitly consider cultural norms including high risk events such as Eid and weddings, which traditionally involve large gatherings, to make the health message more relevant to the target community.
    - Ensure the health message promotes services that are accessible to BAME communities, e.g., include multilingual contact tracers within the NHS Test and Trace service.
    - Ensure compliance with health message does not disadvantage the target community, e.g. loss of income due to self-isolation.

- Inclusion of social identities relevant to the target community will minimise the perception of health promotion behaviour as a White, middle class characteristic and minimise fatalistic attitudes that question the relevance and efficacy of health promotion behaviours.
    - Link health messages with social identities other than White and middle class to increase impact on BAME groups.
    - Include evidence which highlights risks to specific groups. This will create the perception that the health problem can affect individuals in this group and may increase willingness to take action.
    - Include stories from within the local community which provide real-world examples of the consequences of following and not following health guidelines.

- If a health message induces fear, it may result in denial or avoidance as a coping mechanism due to low control over external factors, such as working in frontline roles, which could result in developing fatalistic attitudes.
    - Fear inducing messages should be avoided as, even when health messages are adhered to, stressors remain in the physical environment that are not within the control of individuals from BAME communities.

Background

Evidence indicates markedly higher mortality risk from COVID-19 among Black, Asian and Minority Ethnic (BAME) groups [1, 2]. There is a complex interplay between cultural, behavioural and societal differences including lower socioeconomic status, health-seeking behaviour and intergenerational cohabitation which may explain some of these differences [3]. There is a need to share risk communication that is culturally appropriate to encourage uptake of preventative and protective health behaviours to manage the risk of COVID-19 in BAME communities.

Whilst there is increasing evidence of disparities of COVID-19 health outcomes by ethnic group, there is little guidance on how to develop culturally competent preventative public health and risk reduction recommendations [4]. In order to further reduce the differential impact of COVID-19, there is a need for clear guidelines to support anyone with a role in developing or tailoring health communication messages for BAME communities. These guidelines are complementary to previous SPI-B guidance on messaging and the co-production of guidance.

Structural disadvantages contribute to poorer health outcomes among ethnic minority groups both pre- and post-COVID-19 [2]. It is important to note that health messages tailored for specific BAME communities are more likely to reach the intended community but tailored health messages will not resolve the structural disadvantages and wider inequalities that contribute to poorer health outcomes in BAME communities.

Health Communication

The aim of health risk communication is similar for all communities, it is a strategy utilised to help people understand their level of risk and behaviours required to respond to this risk [5].

Guidelines for the development of health messages highlight the importance of matching content to the needs and readiness to change of the target audience. Achieving this requires planning and understanding of the target community. Health messages that do not correspond between content, presentation and research findings means materials are less likely to engage their intended audience, address informational needs, enhance motivation and provide the target audience with skills required to act on their motivation. As a result, written health messages may not be read and, when read, may have no beneficial effects [6].

For health messages to be effective, they need to reflect evidence on the relationship between cognitions such as beliefs and attitudes and specific behaviour. When messages target how people think about the target behaviour, they are more effective in changing that behaviour [7].

Health messages tailored to match personal characteristics are more likely to be effective in changing beliefs, attitudes and behaviour [8]. BAME communities may have different beliefs and attitudes towards behaviours that are influenced by socio-cultural factors [9, 10]. Health messages for BAME communities should be tailored to reflect the range of influences and drivers of behaviour which may, at times, differ from White British communities.

The COM-B model stipulates behaviour occurs as an interaction between three conditions: capability (e.g. knowledge and skills), opportunity (e.g. societal norms and physical resources) and motivation (e.g. analytic decision-making and habit) [11]. Each of these components has an essential role in producing, and therefore changing, behaviour. A communication strategy which targets each of these influences is likely to be more successful than a campaign that promotes knowledge alone or increases physical resources without targeting motivation.

What does evidence tell us about BAME communities and health messaging?

Capability

Comprehension is critical to acceptance and persuasiveness of messages [12]. Health messages should increase knowledge of the risks and benefits of health behaviours. Provision of information with clear instructions about what to do and what to expect will reduce uncertainty and increases likelihood of compliance [13]. Higher levels of literacy result in increased motivation to engage in health protective behaviours [14]. Health literacy skills enable an individual to gather and understand information to make decisions about health [15]. Use of jargon free, unambiguous language that is clearly defined is required as language barriers prevent comprehension of health messages. For example, language barriers have been shown to prevent some South Asian patients from understanding advice on treatment compliance and explains low uptake of screening programmes [16, 17]; and lack of literacy and proficiency in English has prevented members of Black African migrant communities from accessing health promotion information and support [18]. Health messages should be tailored using language that is accessible to different BAME communities. Some members of BAME groups have low literacy in their first language and cannot read health message that have been translated. The use of audio files and animations can increase knowledge and understanding for these groups.

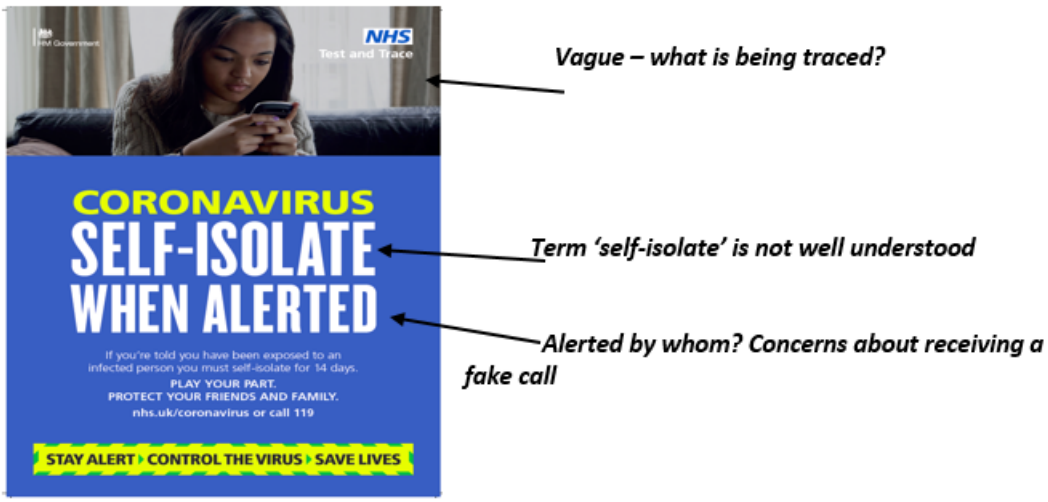
Health messages should take into consideration the impact of gender and traditional family structures as women that are less acculturated to the West are less likely to engage with risk communication messages due to language barriers [19]. Males are key decision-makers in some traditional family structures and should be actively engaged to elicit their views and encouraged to co-produce and promote risk communication messages. In addition, community-based education programmes enable access to BAME communities where health messages using socio-culturally tailored language can be shared resulting in increased knowledge and awareness [19].

Engagement work during the COVID-19 pandemic with representatives from health, community, academic, faith and communication teams within a UK local authority revealed a number of cultural factors may influence access to the NHS Test and Trace service [20]. Barriers to increasing knowledge included use of vague language in official guidance that was not clearly defined. Cultural aspects of language, such as what '*Test and Trace'* could mean for different communities such as migrant refugees, was not considered [see Example 1]. Clarity of what is being traced is required due to the precarious situation of many migrant refugees. Terms such as *'self-isolation'* and *'bubbles'* are not well understood, *'alerted'* has different interpretations and *'shielding'* lacks sufficient explanation to some first-generation BAME communities. Literal translations of these terms do not retain the same meaning and cultural context resulting in abstract terms that are unfamiliar which may result in lack of engagement with the health message. These concepts are integral to the success of the NHS Test and Trace campaign and health messages should be tailored to ensure language has sufficient meaning in the context of different cultures. Health messages should be pre-tested with the target

audience to ensure translations are appropriate and retain the intended meaning of the message [21]. Pre-testing and co-production of health messages with the target community will identify language that could replace abstract words that do not translate well.

The information-motivation-behavioural skills model suggests information to enhance skills is required to perform the target behaviour successfully [22]. It is important to understand whether the target group lack any skills required to translate knowledge and motivation into action. Evaluation of the NHS Test and Trace campaign with a BAME engagement cell revealed insufficient information about the process of engaging with the Test and Trace service [20]. Further information should be included, using non-technical language, outlining the process of each behaviour associated with Test and Trace (and other health messages) [see Example 2]. Overestimations of compliance suggest that members of the public do not truly understand the emergency response processes and procedures that will take place during an extreme event [23]. Specificity in terms of who needs to engage in which behaviour and details of when and how this behaviour will be achieved should also be included to minimise uncertainty of who the message is targeting and the processes and procedures required [24] [see Example 3].

Example 1: NHS Test and Trace resource highlights lack of information due to use of vague language

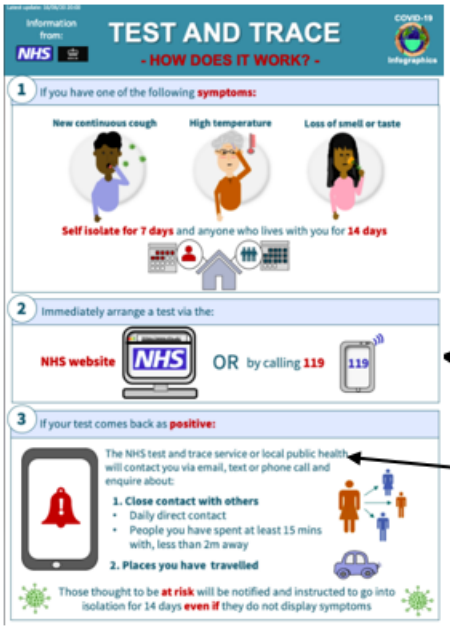


Example 2: NHS Test and Trace resource includes more concrete language and clearer explanation of behaviour that is required

'Stay at home' clearer than 'self-isolate'

Clearer explanation of who needs to engage in behaviour and why

Example 3: NHS Test and Trace health message includes clearer overview of process



Explains what behaviour is required of individual if symptomatic

More information about the process

Example 4: NHS Test and Trace health message translated into a different language

This is more accessible to South Asian communities but only if they can read in Urdu. Not all South Asian community members can read Urdu or English.

Opportunity

Developing risk communication messages using appropriate language may not be enough to achieve behaviour change. Social and cultural norms can facilitate or hinder behaviour change even when the health risk is understood.

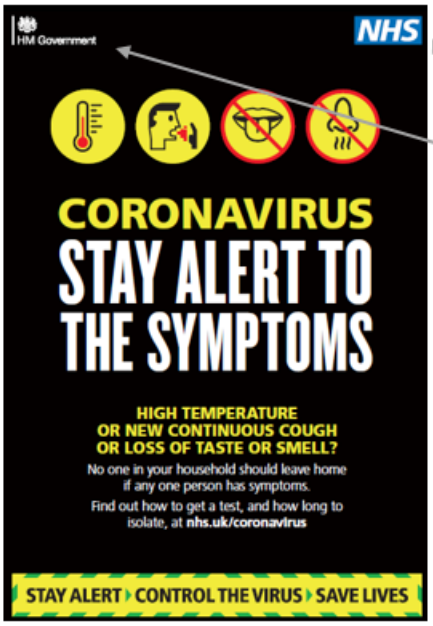
During a pandemic, many racial and ethnic minority communities may be less willing to trust government communications on pandemic measures due to historical issues and contemporary perceptions of institutional racism [25]. Mistrust of government and authorities may result in active resistance to risk communication particularly when messages are perceived as authoritarian from sources that are not trusted [26]. To address this barrier, use of lay educators from within the target community may be more effective. Members of minority ethnic groups are more likely to engage with health messages from someone they know and trust; lay health advisors include natural helpers such as shop workers and local businesses [25, 27].

Preparation before winter should include engagement with minority ethnic groups to build trust between government, law enforcement and health services particularly as social distancing and quarantine measures may be required. Community partners can facilitate this process to understand the social and cultural norms of different communities and act as a conduit to communicate health messages with hard to reach populations including undocumented migrants and communities that are fearful of government authorities [25].

Working with communities allows integration of knowledge within existing belief structures [19]. Use of religious and cultural organisations may improve acceptability of risk communication in some UK African [28], Bangladeshi [29] and Pakistani [30] communities. Religious leaders and faith groups are integral for challenging cultural norms and promoting healthy behaviour but not all BAME groups are responsive to religious organisations. It is important to understand and define differences within and between minority groups to ensure health messages reflect salient aspects of ethnic identity and experiences [10]. Engagement with local authorities during the COVID-19 pandemic revealed wider

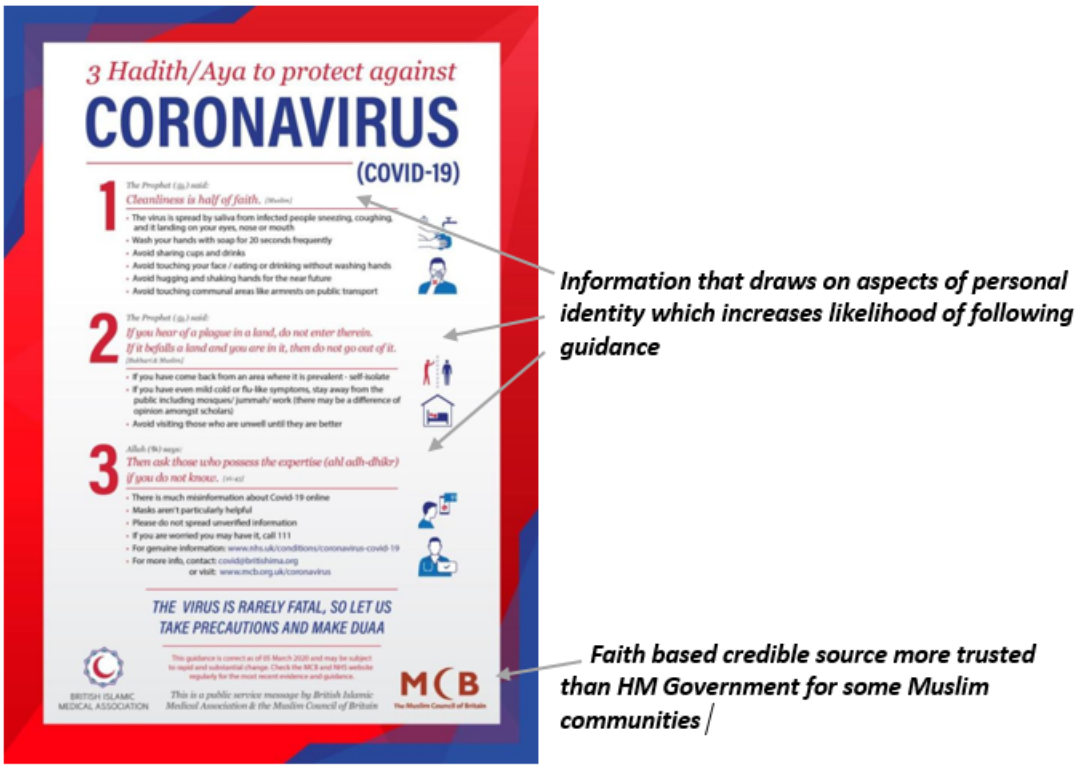
credible sources are required. Advocates for promoting COVID-19 health messages included taxi drivers, restaurant and shop owners. Engaging with communities is essential to identify credible sources as individuals used as a respected and credible source, may not be respected within the target community. The faith sector had an important role sharing COVID-19 guidance with some groups within South Asian communities awaiting directions from their local mosque but the faith sector should not be used exclusively with BAME communities [20]. There are also differences within ethnic minority groups associated with age and generation, with respect for the views of elders often influencing younger peoples' beliefs [10].

Example 5: Source of information may not be trusted



Mistrust towards government and health services due to social and health inequalitites for BAME communities

Example 6: information shared via faith organisation that is more trusted by some BAME groups



Sensitivity to cultural norms within health messages could increase motivation to engage with, and act upon, guidance. Health messages that focus on relational obligations are more persuasive for individuals from collective cultures compared with health messages that focus on personal self- and heighted individual risk [31]. For example, risk communication that highlights the relational obligation to elders in multi-generational households is more likely to promote shielding to protect older family members at increased risk of COVID-19 [20].

Cultural considerations include the perception of personal capability to adhere to advice when cultural practices, such as social interactions with high numbers of visitors in the home, present a challenge to social distancing and self-isolation guidelines. This may create an environment where an individual has high self-efficacy (belief they can follow self-isolation guidelines), high response efficacy (belief that self-isolation is an effective strategy to manage COVID-19) but a high response cost (cost of self-isolation is too high due to importance of cultural norms of visiting family and friends) [32]. Restrictions on cultural practices are response costs that must be taken into account when developing health messages for BAME communities. Risk communication messages should explicitly address cultural norms of visiting family and friends and high-risk events such as Eid gatherings and weddings, or higher risk activities such as sharing food. Health messages that provide evidence of the benefits of following guidelines could minimise the perception of high response costs of engaging in behaviours that are not aligned with social and cultural norms.

Perceptions of costs play an important role in determining compliance with official guidance [33]. BAME communities are more likely to be socioeconomically disadvantaged than White communities,

in part, due to long-standing structural inequalities [34]. Financial implications of health messages should be considered, such as the impact of deprivation, as concerns about loss of income is a potential barrier to engaging with the Test and Trace service [20]. BAME communities are more likely to live with family members at increased risk of COVID-19. Physical challenges of isolating in a multi-generational home with one bathroom or kitchen requires time and planning of activities to maintain social distancing and isolation in this environment [20]. Messages should be tailored to reflect local realities such as living in multigenerational households and ensure compliance with the health message does not disadvantage the target community, e.g. loss of income due to self-isolation.

Motivation

Risk communication that includes information relevant to the group an individual identifies with increases engagement and message persuasiveness as this can increase perceptions of social support and self-efficacy [35, 36] and minimise the perception of engagement with health promotion as a White, middle-class characteristic. Groups may feel conflicted and hold fatalistic attitudes about the relevance and efficacy of health promotion behaviours if it is not aligned with their social identity [37]. Inclusion of social identities other than White and middle class, such as cultural or religious identity [see Example 6], is required to increase engagement with health messages [38].

Risk communication should challenge fatalistic attitudes in minority ethnic groups. Fatalistic attitudes and beliefs influence self-management behaviour of some BAME communities that adopt alternative behaviours recommended by social networks [39] and may contribute to health inequalities in Caribbean, African, Indian, Pakistani, and Bangladeshi women [40]. Some ethnic minority women describe the use of alternative medicine and prayer as a first-line strategy that might delay help-seeking. Health messages should include information about health risks tailored to specific groups as this will increase how susceptible an individual feels to the health threat and increase willingness to take action [32]. Some first-generation minority groups with limited English rely on individuals in 2nd and 3rd generation BAME communities to convey COVID-19 health messages. It is important for 2nd and 3rd generation groups to understand their personal risk of COVID-19 and how this can be managed, and the differential risk (if any) to older family members, to convey the health message accurately [20].

Culturally congruent health messages result in positive attitudes and stronger intentions to perform health behaviours. White British participants, with a stronger promotion focus, are more persuaded by gain-framed messages whereas East-Asian participants, with a stronger prevention focus, are more persuaded by loss-framed messages [41]. Message appeals using testimonials from patients that have recovered from an illness can increase willingness to engage in health protective behaviours in Black women [40]. Some local authorities have raised concerns about how to frame COVID-19 health messages that are acceptable to different BAME communities. Strategies include increasing how serious the threat is perceived by an individual by sharing stories from within the target community of individuals that have survived or lost a loved one and providing clear guidance on how to reduce the risk [32]. Guidelines are more likely to be adhered to when the consequences of action or inaction are understood and individuals believe the recommended response will be effective in reducing the threat [32]. Evaluation of a Test and Trace resource revealed the message assumes the benefits of engaging with this service are known. This implicit assumption should be avoided and benefits of following guidelines should be stated explicitly within the health message.

Fear inducing messages should be avoided as, even when health messages are adhered to, stressors remain in the physical environment that are not within the control of individuals from BAME communities [26]. For example, people from BAME communities are more likely to work in frontline roles which increases their exposure and risk to the infection. If the message induces fear, it may result in denial or avoidance as a coping strategy and lead to fatalistic attitudes.

Health messages targeting minority groups should be developed with sensitivity to potentially high levels of conspiracy beliefs and designed specifically to dispel those beliefs [43]. Delays in producing tailored health communication can leave a vacuum that can be occupied by misinformation and mistrust [44].

Recommendations

A communication strategy that targets capabilities, opportunities and motivations of communities from different cultural backgrounds is more likely to reach the intended audience than a communication strategy which promotes one component of the COM-B model, such as capability, as this excludes important determinants of behaviour. Each of these components interact, for example, promoting opportunity can influence motivation and enacting a behaviour can alter motivation [11]. A health communication strategy tailored for communities from different cultural backgrounds which includes stories that personalise experiences (reflective motivation) and are delivered by people that the target audience relate to (social opportunity), can increase understanding (psychological capability) and intention to comply with health protective behaviours.

The British Psychological Society has developed guidance to optimise policies and risk communication [45]. Table 1 illustrates how this guidance can be tailored to BAME communities by considering cultural influences on behaviour.

Table 1. The British Psychological Society's Behavioural Science and Disease Prevention: Psychological Guidance Tailored to BAME groups

Guidance	**Tailored to BAME communities**
Minimise the 'I' and emphasise the 'we'.	Draw on interdependent cultural norms to highlight benefits of protecting family and community.
Deliver messages from a credible source in relatable terms to the target audience.	Identify credible sources from within the community including lay health advisors such as local business owners, shop workers, taxi drivers, and faith and community leaders.
Create worry but not fear.	Threat perception is likely to increase if health messages include real world examples from within the target community. Include evidence of increased risk to specific communities but do not induce fear as there may be stressors outside of the control of BAME communities, such as structural inequalities, which may lead to denial, fatalistic attitudes and avoidance behaviours.

Identify what influences each preventive behaviour and ensure policies, messaging and interventions target all relevant drivers.	Behavioural drivers are linked to: health literacy, use of unambiguous language that has cultural relevance and meaning; on-going community engagement to develop trust, appropriate channels for sharing health messages; and culturally congruent information that highlights risks specific to different BAME communities.
Clearly specify behaviours and their effectiveness.	Avoid technical language. Use simple language to make information more accessible for communities with English as a second language. Provide clear advice and instructions on behavioural actions and their related outcomes. Ensure the health message takes into account localised information to avoid unintended consequences such as having services with no multi-lingual support.
Avoid unintended negative consequences.	There is risk of stigma and stereotyping when policies and health messages target only BAME communities. Reinforce the need for collective action from all communities, BAME and non-BAME, to minimise the risk of hostility towards specific communities. Share positive messages and examples of BAME communities following guidelines, making sacrifices and continuing to work on the frontline to keep essential services going, to highlight wider factors that contribute to increased risk.
Create clear channels of access for health literacy.	Provide information using different channels including posters in the physical environment, social media particularly for younger generations as they often share health message with older generations with limited English, audio files for BAME groups that have low reading literacy in their first language, and infographics and animations. Health messages should be consistent to avoid confusion.
Use behavioural scientists and the psychological evidence base to support the Covid-19 response.	Include experts at a national and local level to contain the virus using behavioural science strategies. Draw on existing evidence to develop policies and interventions that target cognitions and behavioural influences on BAME communities.
Make a pledge to work together, through a multidisciplinary approach.	All local authorities should have an active BAME engagement cell which includes representation from all sectors including health, community, council, faith and academia. This will facilitate community partnerships, develop trust and help to understand issues at a local level which can inform the development of meaningful health messages for BAME communities. Engage with BAME communities to generate the evidence-base to identify barriers and facilitators of the COVID-19 response.

Research Priorities

The following areas require additional research:

1. A rapid review of evidence identifying behavioural influences on BAME communities and health protective behaviours.

2. Qualitative engagement with BAME communities is required to understand how government messages around COVID-19 were received including sources of information, capability, opportunity and motivation for each recommended behaviour.

3. A translational tool is required to support national and local communications teams to develop health messages with BAME communities during the current pandemic and beyond.

4. Disseminate findings from previous research to local BAME engagement cells, to ensure they understand the principles around capability, opportunity and motivation for BAME groups. This could be achieved with local BAME engagement cells that meet regularly to understand the local context and build trust which is important for acceptance and adherence of health messages.

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