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14th December 2023

Re: SHELL COVID Inquiry response

ISSUE: We welcome the opportunity to respond to the *Commonwealth Government COVID-19 Response Inquiry*. In our response we directly address terms of reference (TOR) #8 (as below)

TOR #8: Mechanisms to better target future responses to the needs of particular populations (including across genders, age groups, socio-economic status, geographic location, people with disability, First Nations peoples and communities and people from culturally and linguistically diverse communities).

Improving public health communication for priority populations: Health literacy and the COVID-19 pandemic response
The COVID-19 pandemic represented an unprecedented test of the capacity of state and federal agencies to communicate evolving public health information rapidly and effectively. In Australia it proved very challenging to achieve effective communication for people with diverse health literacy, culture and language and this resulted in important gaps in communication in these groups.

The Sydney Health Literacy Lab's COVID-19 research https://www.sydneyhealthliteracylab.org.au/covid19-publications/category/COVID-19 provides evidence and examples to support a strengthened public health communication response in the future that is relevant to TOR #8. A brief summary of some of this work is described below.

Health literacy disparities: Health literacy refers to the personal skills and capacities as well as the informational and organisational environment that enables people to find, understand and use health information and services to manage their health. Australians with lower health literacy levels and those who spoke a language other than English at home had poorer understanding about COVID-19 symptoms, prevention, and social distancing measures, and were more likely to endorse COVID-19 misinformation (McCaffery et al 2020; Dodd et al 2021; Pickles et al 2021). Some underserved groups also experienced greater psychological and financial impacts of COVID-19 (Muscat et al 2022) in addition to the well documented poorer COVID-19 health outcomes (AIHW 2022).

The health literacy environment: COVID-19 created a challenging information environment, and for much of the pandemic, Australian COVID-19 public health information was complex, with information translated into languages other than English often hard to find or unavailable (Wild et al 2021; Seale et al 2022). Much information was written at a level of English suitable for people with higher education (e.g. school reading grade 11/12 or higher) rather than the level recommended to enable a general audience to read it easily (Grade 8) (Mac et al 2021). While this improved over time, the availability of translated information was inconsistent and not always up to date. Some translated materials were 'uncontextualised text-heavy resources' and therefore difficult to understand (Seale et al 2022).

The distinct needs of different culturally and linguistically diverse communities: Different communities had unique needs for COVID-19 messaging. For example, there were distinct patterns in the types of COVID-19 information sources people used (e.g. some groups found much of their information from overseas whereas others relied on the Australian news media, Ayre et al 2022). There were also important differences by age (e.g. young groups obtained information via social media, while older groups relied on family and community members, Ayre et al 2021). Understanding how people from different communities access health information and then utilise these communication channels is crucial for effective health communication and good health literacy. Recognising also that patterns of communication are dynamic and need regular

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monitoring is important. Embedding work to understand communication channels across diverse communities would be ideally integrated early into any pandemic communication response.

Misinformation and health literacy: We found a consistent association between misinformation beliefs with health literacy and digital health literacy across 3 national Australian surveys between April to July 2020, with stronger endorsement of misinformation also associated with younger age, male gender, lower education level, and speaking a language other than English at home (Pickles et al 2022). A further study of younger adults in Australia aged 18-49 years (who had not been vaccinated at the time of the survey, July-August 2021) found high endorsement of misinformation with up to **two thirds of participants agreeing with at least one misinformation belief about COVID-19 vaccines**. Misinformation beliefs were significantly associated with lower health literacy, lower education, less knowledge about vaccines, lower perceived personal risk of COVID-19, as well as lower confidence and trust in government and scientific institutions (Pickles et al 2021, Nickel et al 2022).

Strategies to address health literacy and working with priority populations include:
There are a range of strategies that can be adopted to support better public health communication to diverse communities as those described in TOR#8.

1. Systematic adoption of best practice health literacy approaches in health communication and uptake of organisational health literacy frameworks (as described https://www.cdc.gov/healthliteracy/index.html) and summarised in a review paper by McCaffery et al (2023).
2. Community-based and evidence informed approaches described by Zachariah et al (2022) demonstrate community models for working effectively with the culturally and linguistically diverse community in Western Sydney. This model operated by creating networks to work responsively with trusted community advisors, community champions and in partnership with academic researchers providing evidence on specific community needs.
3. Health literacy sensitive health information design informed by behaviour change research (e.g. Bonner et al 2023) to support behavioural health advice.
4. Providing support for locally led co-designed projects with small grants for projects that address health literacy needs for different priority populations. Using existing community-based mechanisms to provide local input can help deliver resources that strengthen health literacy in local communities. Successful examples of this occurred during the COVID-19 pandemic, when small grants were awarded and overseen by Aboriginal Community Controlled Health Organisations (Stanely et al 2021) and the Federation of Ethnic Communities' Councils of Australia (FECCA 2022).
5. Utilising social media channels and understanding what works to communicate to different sectors of the Australian population.

Your sincerely

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On behalf of the SHeLL COVID research team*

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