Podcast: Culturally Driven Health Communications

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Transcript

Introduction

Sarah Clarke: Welcome to the Switchboard podcast. Switchboard is a one-stop resource hub for refugee service providers in the United States, funded by the Office of Refugee Resettlement. Today's podcast is made possible through a partnership between Switchboard and the Society of Refugee Healthcare Providers. The Society of Refugee Healthcare Providers is a nonprofit organization dedicated to improving the health care of refugees and asylum seekers, as well as addressing equity in health care. My name is Sarah Clarke, Executive Director for the Society, and I am your host today.

Today's Speaker

SC: Hello and welcome to today's episode on culturally driven health communications. I'm now going to introduce our guest speaker, Syreeta Wilkins. Many of you know her from her work with the National Resource Center for Refugees, Immigrants and Migrants, or NRC-RIM. She is the communication strategist where she manages communications efforts and leads the creation and dissemination of health communications materials. She has more than a decade of experience specializing in digital media and diverse and multilingual communities. Before she joined the team at NRC-RIM, she led communications for K through 12 public schools.

SC: Thank you so much, Syreeta, for being here, and I will turn it over to you to introduce yourself.

Syreeta Wilkins: Yeah, thank you so much for having me, and thanks to everyone who's here. I'm just going to do a quick intro of NRC-RIM and some of the work I've done. This is the National Resource Center for Refugees, Immigrants and Migrants. You can find us at nrcrim.org. We are funded by the CDC to support health departments and community-based organizations under public health response and immigrant and refugee communities. We started as part of the nation's COVID-19 response, and since then, we've shifted to almost exclusively focus on the public health needs of Afghan newcomer communities.

SW: Some people ask what I do; I say I do a little bit of anything, whatever will be helpful. We're a very small team. But one of my tasks is leading our health communication. When we say we have a health education collection, we have conversation guides to equip bilingual, trusted messengers and community leaders on having conversations with others.

SW: We also feature promising practices. This is [inaudible] Seattle that did a pressure cooker exchange program with Afghan newcomers because the traditional pressure cookers they use often contain lead. We have fact sheets where you can download as a PDF and print off with social media assets and a text message or WhatsApp templates that you can send to people. We have both lead poisoning prevention as well as testing and treatment. Finally, we have audio and video PSAs, which you can watch on YouTube or download the audio

and send on WhatsApp. And we also post the scripts here, including their translations, in case a trusted messenger or another person wants to record it themselves to make it more credible.

SW: All of the branding that we use, from the mosaics to the colors to the photos we selected, were culturally validated when our work with Afghan newcomers. And for the overwhelming majority of our health education items—I'll go to respiratory illnesses because this is such a cute one—we actually did a photo shoot of a real Afghan family, so this is a real Afghan mother with her real Afghan daughter wiping her nose during the photo shoot. It was a candid shot that we happened to get. I felt uncomfortable just picking stock images that were of people who were vaguely Muslim or wearing hijabs or who looked Afghan. Being that I'm not Afghan, I didn't feel like I really could make that decision. So we invested in a photo shoot to get some of these pictures for our material.

Q&A

SC: Thank you so much. A question that I think comes up a lot, especially in light of COVID and with vaccination rates going down, is,

What tips do you have related to communicating the importance of vaccinations, particularly related to attending school?

SW: I used to be a school district administrator before I worked in public health. A lot of the messages that we've found to be compelling, it's not just about avoiding hospitalization and severe illness and death. At this point, a lot of people have gotten COVID-19 and they are familiar with the symptoms. Most people have gotten COVID-19 at least once. Some of the messages we found to be very compelling are protecting yourself so that you don't get so sick that you miss work or school. Being able to provide for one's family has been a consistent theme that has resonated with a lot of immigrant communities, not having lost wages or being able to fulfill your duties. Even if you're not working outside the home, being able to care for your family, to care for children, to take care of your spouse, those sorts of things are going to be really resonant. Education is also important for a lot of immigrant and refugee communities. You might have to keep your child home from school. Those are additional days of learning loss.

SW: But vaccine requirements are decided at the state level, and that includes the exceptions that are available. Some states are more strict or more lenient with the enforcement of these requirements. Focusing on making sure your child doesn't miss school or infect others in their classrooms or the community is going to be resonant.

SW: I also always recommend partnering with schools and school districts. Not every school has a school nurse. Often school districts will share nurses between multiple schools, or they may have a social worker or a health assistant on staff who might be able to help you promote vaccination materials or do education sessions for parents. I think a lot of parents don't want to feel pressure to do something or be told that they have to. And so having education sessions before your flu clinic or before actually recommending vaccines—you know, "What are vaccines and what do they do and why are they important?"—is going to be really helpful for helping people have a more calm approach and more willing to listen. You're just giving them that information before you're advocating for a choice.

SC: We've had many questions from service providers who are very interested to know,

What major barriers do you face in developing these culturally sensitive materials? How did you overcome them? Along with, how much is the community involved in your creation process?

SW: Yes, the answers to those two questions are very similar. But we have a few topics that are a little sensitive, like we have a sexual and reproductive health toolkit. We have health education on women's wellness where we talk about pelvic exams, and then also Afghan men for women's wellness, because we know that a lot of times Afghan men are involved in health care decision-making with their female family members. When you click this, we have videos and scripts available for those messengers who may want to re-record. We have the slides available with those scripts.

SW: We have a health education collection on mental health and stress. We know that there's a lot of stigma around mental health in Afghan communities—in every community, honestly. And so we actually framed it around managing stress in a new country, because we heard from our partners that stress management and acknowledging the stressors that come with moving across the world, learning a new language, learning different health or education systems, you know, those are all very stressful. It happens to everyone, and there's certain things you can do to help cope with stress. If you're having trouble coping, who might you call?

SW: This is a fact sheet that we did. We're talking about stress management and incorporating Afghan cultural references. So, for example, instead of avoiding caffeine so that you can sleep better, we talk about drinking tea with just spices and nuts because that's a comforting way of staying connected to your heritage while in the U.S. We suggest Attan dancing, which is a national dance of Afghanistan. And we also promote kite flying because it's a common pastime in Afghanistan and it's been banned by the Taliban. Having people engaged in this practice in the U.S. is both reminiscent of positive memories from back home, honoring people who are still there, and incorporating things like exercise, spending time with loved ones, making a routine, and other things that are important for stress management.

SW: And so those are some of the ways that we've done this that have been centered on Afghan communities. And the way that we do this is honestly through those partnerships. We work very closely with the International Rescue Committee, and for COVID-19, we also work closely with the Migrant Clinicians Network and other folks where there's no one on our direct core team that's Afghan. And so we really want to know from refugee resettlement providers, "What are you hearing from offices? What are clients asking about?" And then talking to Afghan people and saying, "What are some Afghan cultural references that we can incorporate into our mental health education and brainstorm about this?"

SW: We also have a cultural validation process. We create these materials, translate them, design them, and then they go through a cultural validation process where somebody from the community double checks the translation that it's not only accurate but culturally relevant. They look at the photos and the symbols. They look at these to be like, "Would an Afghan layperson understand that this means drinking water or that this means dancing or that this means breathing?" These kinds of symbols don't necessarily translate across cultures.

SW: The way we are sensitive to issues in certain cultures and the way that we involve the community is the same. We do listening sessions with either Afghan people or people who work very closely with them, and then we do a cultural validation process to make sure that we got it right. The community is involved in both strategies.

SC: It is amazing, and I wish we could do it with every health communication material.

SC: A lot of researchers in society right now are talking about, could we harness AI to help translate some of these health communication materials? I receive questions daily such as, "I need something translated into Congolese Swahili about epidurals," and that's a very specific topic. We collectively have not gotten around to translating every health topic you possibly could. Could you use AI? But then you've detailed beautifully how important it is, and when you're creating health communication material, you're involving the community at every step, including with translations and cultural validation.

What are your thoughts on, does AI have a place?

SW: It can, and with a caveat. I'm going to put a big asterisk there, because there have been studies done about the effectiveness of AI in doing translations. But from what I recall, is that these machine translations can do okay at common European languages like French and Spanish. And so I do not recommend using AI or machine-assisted translations. However, I think AI can be a really effective strategy for making sure that you're using plain language. And so before you send something to translation, if you put it in AI and say, "Can you simplify this for me?" or "Can you make it at a sixth grade reading level?" they might have suggestions to work around some of that medical jargon so your translations can be more effective.

SW: And that needs to be something that is checked. Maybe revise it for you in English so that you have a better draft to send a translation, but you need an English speaker or possibly a medical professional or somebody who's really well versed in the health topic just to make sure that it's still medically accurate.

SW: Side note is that certain AI bots have repeated misinformation about health topics that's really racist, for example, that Black people have thicker skin or feel less pain. That's why it's important to double check your work when using AI. I've asked AI, you know, it'll tell me something, and I'll say "Cite your sources," and I will go and make sure that AI summarized it correctly.

SW: So yes, I do think that it can be used as a tool, but not directly for translation purposes. Every translator that I've worked with, which has been many, but my masters is in translation and linguistics, the overwhelming majority of the translators that I've talked to have said, if you give them something that AI translated or that Google translated and say, "Could you prove this for us or can you check this for me?" ninety-nine percent of the time they're going to say, "No. It'll take less time for me to redo it from scratch than it will be for me to check this for you." So using AI with cultural validation doesn't always work, but I do think AI could be a tool to prepare your materials for translation.

What means of communication have you found to be useful for community members who either are not able to read in English or their preferred language or, like you said, maybe they can read, but their chosen way of taking in information is not through reading?

SW: Thank you. I like to really focus on oral traditions because talking about somebody as illiterate is really a deficit base. And even saying that somebody is pre-literate assumes that they want to be literate. And that's not always the case either, but oral expression is a completely legitimate way of communication, and I think that it's something we need to respect.

SW: We found videos to be really effective. We are very popular on Burmese YouTube. Do not ask me why. I don't know. You look up our videos and they might have, for some of the more, like Kinyarwanda, a few dozen views or maybe a hundred, and you look at our Burmese videos and there's thousands of views that we're able to look in our analytics and they're coming from the U.S., but they're also coming from Nepal. And so it's telling

me that people are watching these videos on both sides of the pond, which makes me so happy. We've found that folks who do have, you know, with Burmese folks, tend to have a more oral tradition or didn't have the opportunity to access formal education in their home countries, are really enjoying those videos.

SW: With COVID-19, we didn't get a lot of traction with our videos. We've had certain strategies on YouTube like posting the script in the YouTube description so that it shows up higher on the search. We tried promoting the videos with Facebook and Instagram ads.

SW: With our Afghan health portfolio, we switched from having separate flyers and videos to making them one and the same. You're handing out this flyer that a person can scan and listen to the information. That has been effective.

SW: Some people have said refugees don't have smartphones or don't know how to use that technology. I don't think that's true across the board. Many refugees and immigrants have access to smartphones and they either know how to use their technology, their teenage children might know how to use the technology, or if they're working with a case manager or patient navigator, they also can help them with that. So I still think it's worth doing.

SW: We also make the audio files available because we've heard of people sending those on WhatsApp. People who have smartphones but prefer not to read will often send audio messages back and forth. That's one way to send health information in a way that everyone can access.

SW: Finally, I do think it's worth investing in trusted messengers. I know for COVID, we had key messages for faith leaders to put in their sermons or for non-Christian religions, whatever speeches they're giving to their congregations that help support oral delivery of information on the community.

I always love when you share the example of the woman who owned the—what was it, a clothing boutique? Can you tell everyone?

SW: So when you think of trusted messengers, a lot of people think of faith leaders or they'll think of among communities like elders, or maybe you'll think of, when we're talking about schools, maybe it's teachers and principals, but it's also people who I think are frequently overlooked. And there is a woman in Tucson, Arizona, and she was a nurse in her home country, perhaps Benin or Togo. She was a nurse in her own country and now she runs this pan-African boutique. She had these tons of WhatsApp groups where she would send, when she got new fabrics or new accessories that were trending, she would send them out to all these different WhatsApp groups that she had of people in the community. The health department partnered with her to send information to her customers about COVID-19 vaccine, or maybe even not talking to them about the vaccine but saying, "Hey, I got these new products. Do you want to come to my store this week?" And then having the health department there giving out information to people who are visiting the store. I think that trusted messengers—keep a really open mind of who could be a trusted messenger because so many people are connected.

SW: There's another example. I was talking to somebody in Vermont, and she told me that in a lot of the smaller rural towns, there's Chinese takeout places, very common in small-town Vermont to have these. There was a delivery person for these Chinese takeout places who had all the Chinese takeout delivery people on the WhatsApp group. And so that person ended up sending messages and information on WhatsApp to their fellow

Chinese takeout delivery people. We have traditional and simplified Chinese on our website that you can download.

SC: I loved those examples. Thank you. I think it's important to remember when we're doing health communications, just stay creative, because you can get bogged down in all the science and the medical and trying to make sure you're getting health information out there and feeling like it's not being received. And so it's just nice to remember that you can get really creative with it.

SW: I'm in a group called Outdoor Afro. If anyone's familiar with it, it's for Black folks who like doing things in the outdoors. There was somebody in my group who hadn't had a COVID vaccine or just going on a hike. They would do these socially distanced hikes during COVID, and she hadn't had a COVID vaccine. And at the time, I was volunteering at a vaccine clinic and I ended up hooking her up with one, getting her an appointment. So there's some of these social groups and things like that where it's really important to keep an eye out for these different ways that you might be able to disseminate information.

SC: Right. I love these examples. On a related note, Syreeta, as I know you get asked a lot,

How do you know your health communications are working? How do you know you're reaching people? How do you know it's working?

SW: So it's hard because they used to say, like 10 years ago, somebody needs to see a message seven times before they really internalize it. Something on a park bench, a bus stop, a billboard, a social media ad, and then their friend might recommend it. That's until it gets to the point where you really internalize it and you start thinking about it and remembering. And so I think that it's hard to point to this flyer that I made and whether that made a difference for somebody, because even if they decided to get a vaccine after looking at this flyer, they might have already had a conversation with their faith leader, and they've already talked to their spouse about it, and they might have already gotten their kids vaccinated. There might be so many things that happened before they made that decision.

SW: We did a retrospective evaluation of some of our health communications work that we did for COVID-19. We did some things like materials testing where you'd show people our materials and stuff from health departments or CDC and say, "Which one do you trust more? Which one do you prefer?" Or "What information is missing that you wish you had?" Do that on the front end as you're testing your materials before dissemination, or you could do it retrospectively to say, "Would this have helped? Yes or no? Why or why not?" That sort of thing.

SW: We track website traffic, the number of downloads of all of our resources, views, how long a person viewed it, at what point did they drop off? We have all this data of all the ways that our materials were accessed, but it still doesn't give us enough information. Even if our YouTube video in Kinyarwanda got 20 views and our YouTube video in Burmese got 2,000 views, fewer people speak Kinyarwanda in the United States than Burmese. What do you expect? Maybe the 20 people who saw it in Kinyarwanda told all of their friends and family about it and it actually ended up being really impactful, and we don't have a way to measure that. Or if somebody downloaded our flyer one time and then made 2,000 copies and handed it out at all these community events, we don't have a way of measuring that per se.

SW: How do you know if they're effective? I think you can get a good idea from the cultural validation process that you go through in having the community vouch for you and saying, "Yes, this is relevant. Yes, this is

culturally appropriate. This is visually attractive for people in my community." And that's going to give you a good indication that you're starting out in the right spot.

SW: We've even heard things like, we had a booth at NARHC, but they said that they showed our women's wellness videos to a group of Afghan women and that the overwhelming majority of them decided to get their pelvic exams because of these videos. What stories like that that on just like 20 Afghan women got pelvic exams or had their women's wellness visit because of these materials and stories like that that we don't always hear, but it gives me that satisfaction that we're doing good work.

SC: Right, that's wonderful. It does go to show because we talk about this with health care navigation too. A lot of it does have to be localized, so you guys are providing the health communication materials and then it's part of this.

SW: Yes, we had a mothers-for-mothers program, a health meetup group for immigrant and refugee mothers. Is this flyer about COVID-19 vaccines working? You might not be able to say "yes" or "no," but you can probably do surveys of people who participated in the health meetup groups and where these flyers were distributed, and that can help inform whether the flyers contributed to a positive outcome. You could say, "You did these health meetup groups and then 50% of people got their vaccines afterwards. Is that because of the flyer?" We can't really say, but it maybe was because of the overall initiative that you're running through your health department or community-based organization.

Syreeta, what would be your advice to people if they want to start creating health communication materials for their clients or their patients? What organizations should they look at for guidance or how should they start?

SW: I have a few recommendations. We have a lot of resources on our website. For example, we have this communications toolkit created during COVID, but you can use these for anything. For example, how to do cultural validation and translation and review. We have a toolkit made in collaboration with the International Rescue Committee. Information on working with social media, creating effective translations. We have some promising practices about working with trusted faith leaders to get information out or agricultural workers in rural communities. A lot of these were created for COVID, but they're evergreen and you can use them for anything.

SW: In our community engagement toolkit, we have information on conducting focus groups or identifying community partners. That's going to really help you get started. HRSA has a database of health education materials that you can download. The Department of Health and Human Services uses HRSA to support federally qualified health centers that often serve immigrant and refugee communities or people who accept Medicaid. There are databases where you can get some health information. Some of it's in other languages.

SW: If a community-based organization has some messages or a flyer that's working really well, how can you work with them to expand dissemination to schools or other partners so you can really be that facilitator and really promoting the expertise that already exists in communities?

Conclusion

SC: Thanks for joining us today, Syreeta, in sharing these fantastic tips on creating health communication materials. Everyone should make sure to check out the NRC-RIM website at nrcrim.org.

SC: If you are a resettlement service provider and are looking for more materials on refugee health, you can check out the latest resources available on the Switchboard and Society websites. Don't forget to listen to the other episodes in the Newcomer Health series. Thank you for tuning in.

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