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The role of civil society organizations (CSOs) as community-based knowledge brokers: A qualitative study with CSOs during the first year of the COVID-19 pandemic in Canada

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ABSTRACT

Background: This study explored how civil society organizations in British Columbia, Canada, obtained, shared, and communicated multilingual COVID-19 information with people whose first language is not English. **Aim:** The aim was to examine civil society organizations' role as community-based knowledge brokers during the first year of the COVID-19 pandemic. **Methods:** Commencing in December 2022, virtual semi-structured interviews were conducted with employees from civil society organizations in British Columbia (*N=15*). **Results:** Civil society organizations played a crucial role in sharing multilingual information with people whose first language is not English. They amplified public health messages, addressed confusion concerning public health orders, and engaged with community members to better understand and address local needs. **Discussion:** Civil society organizations contributed to health communication efforts and succeeded in reaching populations overlooked by mainstream communication channels. **Conclusions:** The COVID-19 pandemic provides an opportunity to reflect on the role of civil society organizations as community-based knowledge brokers that acted as intermediaries to support information-sharing from government public health communications to priority populations. Based on this study's findings, we propose several recommendations to enhance equity-based preparedness, responses, and recovery for health emergencies.

KEYWORDS

Civil society organizations, community-based knowledge brokers, COVID-19, public health communication

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Introduction

The first year of the COVID-19 pandemic in Canada was marked by numerous measures intended to limit the transmission of the SARS-CoV-2 virus. As the COVID-19 evidence base grew, public orders for non-pharmaceutical interventions (NPIs), such as mask-wearing and physical distancing, were updated frequently. Throughout the pandemic, public health actors and government entities primarily relied on mainstream media, such as television, print media, and radio, to communicate public health measures (Nöstlinger et al., 2022). Over time they developed social media strategies, particularly focused on countering misinformation. While such communication methods enabled rapidly evolving measures to be shared widely, they overlooked the distinct needs of several priority populations, particularly people whose first language is not English. Especially in the early stages of the pandemic, with the exception of Quebec, information about COVID-19 was predominantly available in English (Ahmadinia et al., 2022). Furthermore, the vast majority of social media content, such as that shared on Twitter (now X) and Facebook, was in English. The absence of multilingual and tailored information hindered those whose first language is not English in their ability to practice measures like self-isolation (Harris et al., 2021). Additionally, dominant modes of communication failed to recognize that many newcomer populations (for many of which the first language is not English) work in occupations in frontline positions with a greater risk of exposure, and so had a heightened need for information in their preferred language (Gele et al., 2022).

To address gaps like these in health communication, civil society organizations (CSOs) collated, translated, and shared COVID-19 information among priority populations (Suva et al., 2022). CSOs are socially driven, not-for-profit agencies that operate separately from government and business. These organizations advocate for community members, advance shared goals, and can influence policymakers' actions (Gómez, 2018). CSOs that engage with people whose first language is not English provide services that support settlement and integration, employment, housing, and recreation. Moreover, their unique positions as advocates embedded within communities facilitate connections and opportunities for dialogue between decisionmakers and community members.

Literature review

CSOs in Canada are, in general, underfunded and subject to unpredictable funding structures (Jaramillo, 2019). Canadian CSOs are largely dependent on funding from the provincial governments, as their scope of work is often focused on serving specific regions. As a result, funding levels differ across provinces, with great disparities across municipalities (Clément, 2021). Funding limitations force CSOs to diversify their sources of income, rely on volunteers, and minimize administrative costs, with potential implications for their programming and services (Cheng & Yang, 2018). Against this context, the COVID-19 pandemic further complicated CSOs' service delivery, as operating costs and demand from communities increased even as revenue sources dwindled (Haws & Kapelos, 2020).

Research from the first year of the COVID-19 pandemic also highlights how CSOs were active in disseminating knowledge about preventative measures, public health mandates, and local community supports (Buchanan et al., 2022; Smythe et al., 2021). Even in the early stages of the pandemic, CSOs quickly adapted their service offerings to reach community members,

using platforms favored by the populations they serve (Bokore & Premachuk, 2021). The extant literature underscores CSOs' position as trusted sources of COVID-19 information, as well as the novel approaches they undertook to share information with their constituents (Buchanan et al., 2022). These studies have largely explored the information-sharing strategies of nonprofit organizations, including their successes (Gonzalez et al., 2022). Several studies have examined CSOs' experiences in sharing information related to COVID-19 vaccinations (Cáceres et al., 2022; Suva et al., 2022). However, there is little research analyzing CSOs' role during the earlier stages of the pandemic, particularly related to non-pharmaceutical interventions (NPIs). Moreover, few studies have examined the challenges faced by CSOs when sharing and translating multilingual COVID-19 information with people whose first language is not English.

To fill this knowledge gap, this paper aims to examine the role of CSOs in communicating COVID-19 information to people whose first language is not English in British Columbia (BC), Canada, with a particular focus on the barriers experienced and the strategies used to overcome them. We analyze CSOs as community-based knowledge brokers that communicated information from government and public health institutions to the priority populations they serve. Knowledge brokers act as intermediaries between research producers (i.e., public health and government entities) and end users (i.e., priority populations) to facilitate information-sharing (Dobbins et al., 2009). Key characteristics of successful knowledge brokers include creativity, trust, and commitment (Phipps & Morton, 2013). Knowledge brokers require the ability to understand, interpret, and frame information received from research producers for their constituents (Cvitanovic et al., 2017). They must also communicate complex information to non-experts, a task for which they must understand the context in which they communicate (Martini et al., 2022). Previous research has documented how CSOs shared COVID-19-related information from government institutions to priority populations through the rapid sharing, adapting, and tailoring of information. For many population groups, including recent immigrants, CSOs were the first point of contact for COVID-19 information (Roth, Woo, & Doering-White, 2022). Furthermore, the fact that they were perceived as trusted information sources helped to increase the credibility of information developed by government entities (Ahmad & Hillman, 2021). We build on this research to advance understanding of the role of CSOs as knowledge brokers, with the aim of informing public health partnerships going forward that might foster more effective communication to those whose first language is not English.

In this article we focus on people whose first language is not English, based on findings, as noted above, that these populations encountered unique barriers in the communication of public health information during the COVID-19 pandemic and that they therefore, in the event of a health emergency, constitute priority populations in BC, Canada. More than 1.6 million (of 5.3 million) residents in British Columbia have a first language that is not English or French (Statistics Canada, 2022). The most commonly spoken languages among this population are Punjabi, Mandarin, Cantonese, Tagalog, and Korean (Statistics Canada, 2022). Many people whose first language is not English are also newcomers to Canada. Between 2016 and 2021, approximately 1.3 million immigrants settled in Canada, many of whom were under the age of 65 (Statistics Canada, 2022). Canadian newcomers primarily migrate from India, the Philippines, and China (Statistics Canada, 2023). While the self-reported health status of immigrants is comparable to Canadian-born individuals (McAlpine et al., 2022), immigrants

tend to have inadequate access to health services (Ghahari, Burnett, & Alexander, 2020). Low health literacy, limited translation services, and a lack of culturally competent care all create barriers to care for newcomers and for people whose first language is not English (Lane et al., 2021).

Methods

Settings and participants

To identify CSOs engaged in COVID-19 knowledge-brokering during the first year of the pandemic, we conducted an environmental scan of organizations in BC that work with newcomers, recent immigrants, and people whose first language is not English. We restricted our search to organizations in BC in light of the wide variations between public health measures by province. Individuals who had been working with these priority populations from March 2020 to March 2021 were eligible to take part.

Participants were recruited purposefully via email. In total, we emailed 223 organizations operating across the province to request their participation in this project. Prospective participants received information about the study's objectives, the consent form, and the proposed knowledge translation initiatives. Interviewees were also offered an honorarium for their participation. Prior to each interview, written informed consent was obtained from all individual participants included in the study. Recruitment was concluded at the point when the researchers determined that the same themes were identified among the interview transcripts.

Data collection

Commencing in December 2022, we conducted virtual interviews with fifteen employees (all of the participants who responded favorably to our email and met the inclusion criteria) from CSOs based in BC. Participants worked in immigrant-serving organizations, libraries, neighborhood houses, and ethnocultural community groups. Interviews lasted approximately 45 minutes, were held via Zoom, and were audio-recorded. At the beginning of each interview, audio and visual equipment were checked to mitigate technical issues.

The researchers developed a semi-structured interview guide (see Appendix 1), which participants could ask to view before the interview. Interview questions were developed collaboratively by the research team, and focused on CSOs' experiences finding, translating, and sharing multilingual COVID-19 information during the first year of the pandemic.

For the purpose of this study, we used a narrative research approach to explore the knowledge-brokering experiences of CSOs. Our small sample enabled us to conceptualize their reflections on sharing COVID-19 information with priority populations in a unique time period. Through semi-structured interviews, we explored the CSO employees' personal accounts and stories of the barriers and successes they encountered and the strategies they used to translate COVID-19 information for people whose first language is not English.

Data analysis

Audio files of the interviews were transcribed verbatim using an external transcription service. Each transcript was anonymized, with no reference to or inclusion of identifiable information. Subsequently, the transcribed files were revised by the research team for accuracy. All members of the team had extensive experience conducting, coding, and analyzing semi-structured interview data. The interview transcripts were analyzed using reflexive thematic analysis, as outlined by Braun and Clark (2006). First, the research team familiarized themselves with the data; they then developed preliminary codes, which were grouped to create overarching themes. These included: the CSOs' roles as knowledge brokers during the pandemic (a descriptive theme related to the CSOs' health communications activities); information-sharing barriers (i.e., challenges experienced); and information-sharing strategies (i.e., how the CSOs adapted to meet constituent needs and mitigated challenges). The latter two themes included a number of subthemes, as illustrated in Table 3. Themes were reviewed and discussed by the authors until we reached consensus.

Trustworthiness

To enhance the trustworthiness and credibility of the qualitative data, several measures were taken. The entire research team read through all the interview transcripts in depth. Prior to and throughout the data analysis, the team engaged in reflexive practice to identify and discuss assumptions concerning the research topic. Furthermore, preliminary results of the research were shared with participants to ensure the validity of the findings. Additionally, the authors used the Standards for Reporting Qualitative Research to enhance the transparency of the research.

Results

CSOs' roles as knowledge brokers during the pandemic

Amid lockdowns and stay-at-home orders across the province, most of the CSOs we interviewed were forced to temporarily close and suspend their services. Pre-pandemic, many had offered programs that were exclusively in-person, providing a physical space in which communities could socialize and connect. However, they did not initially have the infrastructure required for virtual programming. During the temporary closures, the CSOs discussed how they quickly pivoted to online communication tools, namely Zoom, to provide services to community members. An organization serving Japanese-speaking seniors described this transition:

> Before the pandemic it was all in-person, including things like friendly visitations and people coming to the site for consultations or just inquiries, information and referral services. During the pandemic that all stopped. And the first thing we did was, one, to set up our Zoom – what we called Zoom lounge sessions, a weekly Zoom session for members who are able to get on Zoom, to make sure they get the information they needed in Japanese. And then if they have any concerns, they can share that on a weekly basis. For some of our seniors, they weren't familiar with Zoom, so our staff went to their homes and did one-on-one help to set them up (Respondent #2).

In their search for COVID-19 information, the CSOs reported turning to reputable sources such as the provincial government, the federal government, and regional health authorities, and

they often referred clients to these sources. For example, one representative from an organization serving recently arrived newcomers explained:

> The program that I work in is like a health education project. And it helps to increase the knowledge that's related to COVID-19 and any other information that's related to COVID by contacting the workshops, translating the memos, and finding some information. But trustable information from like PHAC [Public Health Agency of Canada] to share with the clients (Respondent #1).

Most CSOs did not have clinical expertise within their organization that would facilitate information-seeking. Instead, they relied on staff members themselves staying informed about public health measures, as well as on information shared by local health authorities. While these connections were less common, some of the CSOs had connections to provincial government entities responsible for disseminating COVID-19 information. One community organization noted that they received information from their health authority and provincial Member of the Legislative Assembly, with whom they had a pre-existing contact (Respondent #13). Additionally, the CSOs created informal networks across the province, allowing the organizations to share information that had been translated by staff members. For example, many organizations depended on the South Asian Health Institute for information in Punjabi. Some also developed directories to connect community members with primary care practitioners and health and social care services.

Table 1. CSOs' primary information sources

- Government of British Columbia/ Provincial Health Officer
- Federal government (e.g., Canada Revenue Agency, Immigration, Refugees and Citizenship Canada)
- Public Health Agency of Canada
- Physicians
- BC Centre for Disease Control
- Regional health authorities (e.g., Vancouver Coastal Health)
- Regional CSOs
- World Health Organization
- Local school districts
- South Asian Health Institute (SAHI)
- WorkSafe BC
- Joint Occupational Health and Safety Committees

The CSOs translated and simplified content to ensure it was relevant to their constituents. In addition, several developed internal FAQ (frequently asked question) pages on COVID-19 as a source to refer to in response to clients' questions. CSOs engaged directly with the populations they serve by disseminating information on platforms commonly used by their clients (Table 2).

Table 2. CSOs' information-sharing strategies and platforms

- WhatsApp
- WeChat
- Telegram
- Newspapers
- Radio
- Virtual conversation circles
- English language courses

- Conference calls
- Newsletters
- Mail
- Brochures
- Flyers
- Emails
- E-newsletters
- Phone calls
- Webinars (live and recorded)
- Workshops (live and recorded)
- YouTube
- Twitter
- LinkedIn
- Facebook
- Printouts
- Posters
- In-person signage
- Fact sheets and FAQ pages
- Webpages
- Zoom calls
- Microsoft Teams calls
- Texts
- In-person/ onsite and community outreach (e.g., home delivery)

Barriers to sharing information

Capacity-related barriers

Though CSOs were successful in engaging with people whose first language is not English, they encountered significant obstacles. One organization described being in "business-survival mode" (Respondent #3) during the pandemic. Interviewees described their experiences of brokering information as "frustrating and uncertain" (Respondent #17). While the information was generally well received by priority populations, finding, translating, and disseminating information promptly was demanding. CSOs received "a lot of emails and phone calls" (Respondent #11), resulting in increased workloads for staff. This was exacerbated by the "confusion around changing [public health] guidance" (Respondent #14). Several interviewees recalled routinely updating and adapting information as soon as new orders were introduced. To meet the community's needs, staff frequently worked extended hours and took on responsibilities beyond their ordinary roles, without additional compensation. One respondent noted they were "working day and night on translations for three or four days…by the time the fourth day comes, something changes" (Respondent #16). Some recalled receiving information and updates "at 2 a.m." (Respondent #15) and subsequently sharing them with clients.

Furthermore, the organizations' information-sharing experiences often extended beyond public health and preventative measures, since they also shared information about immigration, travel, and financial relief available to clients. Though most CSOs had greater workloads and responsibilities during the pandemic, they maintained a strong commitment to engaging with priority populations. The pandemic also allowed organizations to reach

community members in novel ways through the increased and widespread use of digital communication tools.

The increased workload was exacerbated by a reduction in staff capacity. Due to organizational closures and funding changes imposed by the pandemic, some of the CSOs endured layoffs. Others were forced to reduce staff status from full-time to part-time. This increased CSOs' reliance on unpaid labor through volunteers' personal commitment to serving their community. Volunteers received training to check in on clients and share COVID-19 information, but they were also responsible for "checking government pages and bringing that information to people" (Respondent #9), typically relying on personal resources (e.g., phones, laptops) to carry out tasks. Amid staff layoffs, administrative costs increased for several organizations, including the cost of online communication tools (e.g., Zoom licenses), printing materials, and the postage required to send COVID-19 information printouts directly to clients' homes.

Lack of information resources

Most CSOs found it difficult to find multilingual COVID-19 information, particularly in the early stages of the pandemic when "nothing was translated yet" (Respondent #11). When seeking information, some directly received updates from health authorities' mailing lists or connections to governmental bodies, but most engaged in proactive information-seeking. Many referred to municipal-level sources and regional health authorities rather than provincial and federal sources, noting that information was more likely to be translated at the regional level.

Alternatively, they contacted CSOs located in other regions to obtain translated information. However, they struggled to find information that met all their client's needs, citing that "nowhere near any of the languages that you're seeing, they're [government public health communications] not able to capture all of them" (Respondent #3).

The CSOs confronted gaps when information-seeking. This was, in part, due to "a presumed idea [within government public health communications] that the residents of BC live a certain way, and that we're all kind of in the same situation, which is not true" (Respondent #3). The same respondent faced additional challenges when they received questions from clients about measures like quarantining:

> Just thinking of the restrictions on like, your household and how many people. Well, there's a lot of people, especially clients that we have, that have families that are larger and also don't have the spaces in the same way to quarantine (Respondent #3).

Responding to questions about restrictions proved difficult. One respondent explained,

> I [was] just afraid that what we given out is wrong, because the data is keep updating, so it's not wrong, but it's old, don't want to give them old information. And then I'm scared they'll ask me something that I don't know, because to be honest, I don't know who I can reach out to, other than the government website (Respondent #5).

Participants reported feeling stressed and anxious about the responsibility of translating complex health information, as they were not public health specialists. Moreover, participants' perceived lack of centralized information meant staff had to direct community members to disjointed resources and services which "people didn't know about" (Respondent #12).

Misinformation and disinformation

One of the most profound barriers was the diverse information sources, particularly from clients' "home countries or whatever group chats that they were in" (Respondent #8). Clients often referred to information from their country of origin because of its language accessibility and their perceptions that this information was trustworthy. One respondent reflected,

> People asked a lot of questions pertaining to, like if it was different in Canada, than what they were hearing from family and friends back home. Like "I've been told that it's like this in like India, for instance. Is it like that happening in Canada? Or why are the rules different?" (Respondent 2).

Responding to conflicting information from the clients' countries of origin was burdensome because staff "couldn't study all the information from different countries or different cultures" (Respondent #5).

Population barriers

The CSOs that participated in this study were serving clients who were experiencing numerous social and economic inequities, resulting in low literacy levels both in English and in their first language, as well as low health and digital literacy. Staff found it challenging to find simplified, translated information that was accessible for clients with lower literacy levels (Respondent #3). One CSO director explained,

> we have a fair amount of clients with very low or no literacy levels in their own language, and English. And so when the information is all in writing, and you're not hearing, you're not getting a lot of verbal information, it makes it a lot trickier (Respondent #3).

CSOs that served older adults experienced barriers related to digital literacy. One respondent explained:

> Originally, we had trouble reaching those [older] folks, so then that's why we started the telephone program... But some people just didn't get the idea of teleconferencing. They participated a few times and they withdrew or some people said, no, I'm not interested... some of them are hard of hearing or they're starting to develop symptoms of dementia" (Respondent #4).

Some clients who were not comfortable with technologies were discouraged from participating in information-sharing activities like webinars. Similarly, unfamiliarity with the Canadian health system, particularly for those who were new to Canada or had experienced barriers accessing health services, meant that CSOs encountered challenges when countering misinformation from other sources. Some clients expressed "mistrust with doctors [and] the medical system" (Respondent #10), with another respondent noting that clients often "just heard what they want to hear" (Respondent #5) and were not open to learning about health precautions.

Information brokering strategies used by CSOs

Increased technical and translation capacity

Several CSOs noted that the shift to virtual services required additional time and capacity for staff to become familiarized with online software and programming. However, developing these capacities enabled CSOs to host virtual digital literacy classes to enhance clients'

understanding of virtual tools. Where available, organizations lent out laptops and/or iPads to overcome barriers to online access. Concurrently, organizations also expressed how having "multiple modes of communication" (e.g., printouts, posters, phone calls) helped with reaching people who "weren't online" (Respondent #4). They often considered the needs of the different population groups they served, and who would not be able to receive information if it was shared on a single channel.

In the absence of multilingual COVID-19 information, several CSOs translated information for priority populations. Most engaged their own staff to take on the role of translating information, while others had to pay external translators. Paid translation services were noted as an additional expense incurred, and CSOs seldom had grants to cover the cost. At times, CSOs found it challenging to translate technical information, denoting that "some things were difficult to simplify" (Respondent #14). One respondent explained,

> For some information, the regular one, for example, for washing the hands and wearing the mask, or for some kinds of this information we can do by ourself. But we checked two or three times with other Farsi speakers as well. And compared with other websites that have the same information (Respondent #11)

Organizations "took pride in being a centralized place" (Respondent #14) whereby they delivered services to clients, responded to questions about COVID-19, and provided opportunities to connect with communities. Some attempted to address their clients' information gaps by creating and posting multilingual educational content on YouTube.

Enhance communication networks

CSOs used existing and developed new networks to facilitate public health communications. One organization hosted "weekly conference calls" (Respondent #9) in which attendees could ask questions and receive up-to-date and standardized information, providing real-time and two-way communication. Others hosted webinars with medical doctors (MDs) to provide clinical expertise from a trusted source. Moreover, organizations that offered English as a Second Language courses tailored their content to teach about COVID-19 transmission and preventative measures. One respondent explained,

> Because we do EAL [English as an additional language] and stuff like that, so the staff member from that program already has many connections throughout and they also do English tutoring. So, they had a network of people they were able to reach. And plus our staff happens to be very multicultural and diverse, so being able to get a few different languages, or the main ones, at least, to start, and stuff like that, was obtainable (Respondent #6).

Furthermore, CSOs connected community members with other organizations to fill service gaps, acknowledging that one organization could not serve all populations' demands.

> Oftentimes people would send us information. So like our community, work, sort of colleagues that work at different institutions, they would send us information whenever they had it created in other languages. And then we kept pretty close tabs on what the government was producing. So it was just sort of part of our daily sort of, "Hey, what is out there right now?" (Respondent #4).

A frequently visited information source was the South Asian Health Institute (SAHI), an innovative and culturally informed initiative that works with community stakeholders to address health issues disproportionately impacting South Asian communities. Many CSOs noted how SAHI supported their information-sharing efforts as it created and disseminated multilingual COVID-19 information. For example, SAHI conducted direct outreach in places of

worship to share culturally competent information and help multigenerational families understand self-isolation orders (South Asian Health Institute, n.d.).

In addition to using a multipronged approach to share information, several CSOs implemented innovative information-sharing strategies. Others conducted direct outreach by preparing culturally appropriate meals and delivering them to clients' homes, along with translated information sheets about public health orders. CSOs also partnered with other nonprofit agencies, local businesses, and places of worship to provide information and answer questions onsite.

Modeling behaviors

Organizations amplified public health messages by modeling behaviors. For example, several interviewees mentioned that their organizations themselves implemented, and frequently updated, COVID-19 safety plans mandating the use of masks and signage to keep patrons and staff at least six feet apart. When clients visited their facilities, they witnessed how others acted in compliance with these measures, asked questions, and adopted modeled behavior. CSOs also relied on visual cues and non-linguistic communication tools (e.g., graphics, photos, physical gestures) to enhance the accessibility and the comprehension of COVID-19 information. Through such interactions, CSOs worked to address confusion regarding preventative and public health measures.

Table 3. CSOs' information-sharing barriers and strategies

<table>
<tr><th>Information-sharing barriers</th><th>Information-sharing strategies</th></tr>
<tr><td>- Capacity-related barriers
- Constrained staff capacity
- Time required to translate and share information
- Translating technical information
- Finding staff and volunteers to translate information in all required languages
- Responding to questions</td><td>- Increased technical and translation capacity
- Lending laptops and iPads to clients
- Hosting digital literacy classes
- Tailoring COVID-19 information
- Relying on volunteers to translate and share information
- Developing FAQ sheets
- Developing informal networks with other civil society organizations to facilitate information-sharing</td></tr>
<tr><td>- Lack of resources
- Finding multilingual information
- Lack of centralized information sources
- Insufficient grants and funding to cover translation costs</td><td rowspan="2">- Enhanced communication networks
- Attempting to stay up to date with information in other countries
- Inviting doctors to webinars in order to respond to questions and concerns
- Referring clients to trusted and reputable information sources
- Developing directories to connect community members with local resources
- Staying informed with changing public health guidance</td></tr>
<tr><td>- Misinformation and disinformation
- Mistrust with the medical system
- Conflicting information from different countries</td></tr>
</table>

- Population barriers - Low literacy levels - Low health literacy levels - Low digital literacy levels - Limited access to digital devices - Motivating clients to join webinars about COVID-19	- Modeling behaviors - Creating and updating safety plans - Complying with public health guidelines onsite/ in offices - Using visual cues and non-linguistic communication tools

Discussion

This study provides insight into how CSOs sought information about COVID-19 and how they subsequently translated and shared information with people whose first language is not English during the first year of the pandemic. Our findings build on previous research examining COVID-19 responses by some CSOs, namely settlement agencies, to support newcomers and culturally and linguistically diverse communities (Seale et al., 2022). Interviews with CSOs illustrate the impact of the COVID-19 restrictions on their service delivery, and how their adaptability enabled them to maintain community connections via virtual communication tools. However, this proved challenging, as many newcomers have low digital literacy and limited access to digital devices (Clarke et al., 2021). Despite this, CSO employees, many of whom are multilingual and themselves have lived experience as immigrants, were willing to take on greater responsibilities, heavier workloads, and tasks unrelated to their position.

In the first year of the pandemic, CSOs struggled to obtain information about COVID-19 that was multilingual, yet culturally appropriate. The absence of culturally appropriate messaging that considers communities' diverse health needs can affect NPI compliance, particularly in a context of globalized information-sharing in which it was easy to access information in one's first language that originated from a different context, with potentially different public health needs and therefore potentially different communications (Seale et al., 2022). CSOs' information-seeking experiences were further complicated by a lack of bi-directional communication between CSOs and government bodies or public health institutions. Since CSOs did not have a designated point of contact, staff were required to stay up to date with public health orders on top of their formal work responsibilities. Staff were also unable to clarify the accuracy of their translations with contacts from public health. These findings indicate that anxiety and concerns raised by CSOs could have been mitigated by communication channels between traditional public health messengers and organizations directly serving priority populations in order to capitalize on the ability of CSOs to provide translations in multiple languages. CSOs also faced notable information gaps at the provincial and federal levels. As a result they were reliant on regional-level COVID-19 communications, such as those provided by SAHI. While SAHI primarily serves Fraser Health, one of five health authorities in British Columbia, their effective communication strategies emphasize the need for comparable institutes throughout the province.

Though this is seldom acknowledged, CSOs have a wealth of knowledge about policy issues and problems that impact their community members. Additionally, they understand the social context of the stakeholders involved in transferring knowledge (Phipps & Morton, 2013). The

CSOs' position as trusted community leaders allowed them to informally adopt the role of community-based knowledge brokers during the pandemic (Suva et al., 2022). CSOs embodied the characteristics of knowledge brokers by harnessing innovative measures to rapidly adapt and share evolving public health guidance with priority populations, including determining and utilizing preferred communication means. CSOs also exemplified knowledge-brokering traits of flexibility, accessibility, and reliability (Phipps & Morton, 2013). Despite their increased workloads and organizational disruptions, they succeeding in addressing and responding to community members' concerns about inaccessible COVID-19 information. Moreover, CSOs brokered connections to other services and resources (Cáceres et al., 2022), including financial relief, that had not been directly communicated to these communities. Their engagement with priority populations had the potential to influence the uptake of information and the adoption of NPIs through behavior modeling and multichannel information-sharing. As demonstrated by evidence on impact evaluation, CSO-led initiatives have been found to enhance accountability, increase transparency, and improve government responsiveness to community members' needs (Cholera, Falusi, & Linton, 2020).

As community-based knowledge brokers, CSOs promoted reputable sources of information and addressed conflicting COVID-19 information from their clients' countries of origin, indirectly supporting their health literacy levels. Health literacy is defined as the ability to access, understand, and evaluate health information and to use this information to make decisions about one's health (Mitic & Rootman, 2012). Previous studies underscore that in Canada, many newcomers have lower health literacy levels compared to their Canadian-born counterparts (Ng & Omariba, 2014), yet there are few initiatives targeted at reducing this disparity. This study draws attention to CSOs' role in brokering health information and indirectly enhancing newcomers' health literacy levels. The findings also highlight CSOs' significant contributions to communications during health crises in prioritizing health literacy needs by tailoring and simplifying complex and technical information. CSOs bridged the gap between the information needs of culturally and linguistically diverse communities and top-down information-sharing from formal public health communications (Bhalla et al., 2022).

This study confirms the vital knowledge-brokering role undertaken by CSOs as social spaces and information hubs throughout the pandemic. Although CSOs endured a range of challenges – including layoffs, rapidly changing public health orders, and insufficient multilingual information – their innovative approaches empowered them to serve priority populations. The CSOs we interviewed often worked beyond their organization's mission to fill service gaps for priority populations. CSOs offered new programming, like digital literacy classes, to meet community members' needs. In addition, they prioritized platforms that their clients were comfortable and familiar with, such as WhatsApp and WeChat. Some CSOs facilitated remote connections, as well as direct community engagement, when possible. Furthermore, the pandemic allowed some CSOs to expand their outreach and meet clients using low-barrier and alternate means (e.g., phone calls). CSOs also broadened their reach by developing partnerships with other nonprofit agencies to increase options for clients. Such partnerships facilitated information-sharing across CSOs, which helped to address inadequacies in official communications.

Limitations

Due to the limited number of responses to interview requests, we interviewed few organizations serving rural and remote communities in British Columbia. In addition, this study does not capture those organizations that may have played a crucial role in sharing COVID-19 information with priority populations but were forced to shut down due to restrictions imposed by the pandemic and funding cuts. However, although our sample was relatively small, the CSOs we interviewed provided reflections and insights into their experiences seeking, translating, and sharing COVID-19 information with people whose first language is not English.

Future research

Given CSOs' position as knowledge brokers, future research should examine their role in countering misinformation and disinformation. Furthermore, it is imperative to understand how priority populations' information needs may have changed over time, particularly at the time when COVID-19 vaccines were made available to the public. Greater attention should be devoted to how priority populations used this information to inform their health-seeking behaviors during the pandemic. In particular, research is needed to discern whether CSOs' knowledge-brokering influenced behavior change (e.g., mask-wearing, physical distancing, social isolation) among priority populations. To better support CSOs in responding to health emergencies, studies should explore how they would like to be engaged by government entities and public health institutions around future emergent health threats.

Conclusions

The COVID-19 pandemic provides an opportunity to reflect on the successes and challenges faced by CSOs. When stay-at-home orders were implemented across the province, CSOs quickly shifted their service delivery to online formats. Despite the lack of multilingual COVID-19 information in the early stages of the pandemic, these organizations assumed a role as community-based knowledge brokers by filling gaps in the health communication efforts undertaken by government entities and public health agencies. They also adapted to meet community members' needs, even as they faced funding limitations, operational changes, and increased staff workloads. By utilizing multipronged, innovative, and tailored communication strategies, CSOs brokered COVID-19 information to people whose first language is not English.

Equitable responses to future health emergencies must include multilingual information about preventative measures and public health guidance available from the start. As illustrated by this research, CSOs played an important role in ensuring priority populations had clear, easy-to-understand COVID-19 information amid ever-changing public health mandates. Building on our insights, greater efforts are required to engage CSOs and to ensure they have the resources necessary for seeking and sharing health information with the communities they serve.

Recommendations

The results of this study have implications for multisectoral health communication collaborations between CSOs, public health institutions, and government entities. Based on this study's findings, we propose several recommendations to enhance equity-based

preparedness, responses, and recovery in the event of health emergencies in the Canadian context.

Preparedness

To enhance preparedness for health emergencies, government entities should strengthen relationships with CSOs. Given their role as community-based knowledge brokers, CSOs can bridge connections between decisionmakers and community members. The level of engagement should align with CSOs' capacity, and may include opportunities such as ad hoc meetings, working groups, or formal committees. Furthermore, provincial governments should develop funding pools that can be rapidly deployed in the event of a health crisis to support CSOs' health communication work. These funding opportunities will support CSOs' work as knowledge brokers and may help them to avoid temporary service closures.

Response

Information should be available in all the languages required by community members. During health emergencies, public health agencies and government entities must ensure that information is clear, simplified, and easy to understand. Government public health communications should utilize more visual tools, such as images, drawings or diagrams, and employ a suite of media platforms (e.g., radio, social media, webinars) to reach priority populations.

At the regional level, mechanisms should be established to facilitate information-sharing between health authorities and CSOs – including opportunities both for CSOs to expand health authorities' communication reach and for health authorities to validate the information translated and tailored by CSOs. It would also be helpful to create relationships between healthcare practitioners and CSOs to enhance their capacity to communicate health information with the public. The fact that both CSOs and healthcare providers are credible sources of information underscores the need to collaborate in order to frame and codevelop culturally appropriate health messaging (Bhalla, Boutros, & Meyer, 2022).

Recovery

In the current context of Canada's post-pandemic recovery, there are considerable opportunities for supporting CSOs' role as knowledge brokers. This necessitates increased funding streams for CSOs at both provincial and national levels. Such funding pools should be dedicated to undertaking health communication efforts, and could be leveraged to cover the cost of direct outreach, translation services, and health promotion campaigns. Increased funding could also enable CSOs to engage community leaders (e.g., faith-based groups) to support knowledge translation activities. In addition to funding streams, CSOs should have access to training opportunities in knowledge mobilization. Training courses should center on sharing health information, on strategies for countering misinformation, and on resource mobilization during health emergencies.

Lastly, CSOs deserve greater recognition and appreciation for their tireless contributions and ongoing initiatives to support priority populations. Their community-driven work is often underappreciated and underfunded; however, this research draws attention to the

commitment of staff dedicated to serving community members amid the COVID-19 pandemic and beyond.

Data availability statement

The qualitative interview data used to support the findings of this study are available from the corresponding author upon request.

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Conflicts of interest

The authors declare no conflicts of interest.

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Ethics approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee (Simon Fraser University #30001360) and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Consent to participate

Informed consent was obtained from all individual participants included in the study.

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Appendix 1: Interview Script

Intro script: Firstly, thank you for agreeing to participate in this study. As the consent form notes, you can withdraw from this study at any time and if you do not want to answer any questions, you can indicate to pass and move on to the next one. Through this project, we hope to highlight the role of civil society organizations in sharing health information, including information about COVID-19, with newcomers and people whose first language is not English. Although we cannot guarantee concrete results, we are committed to mobilizing this research to underscore the need for health information to be culturally relevant and tailored to meet the needs of these priority populations.

The interview will last approximately one hour. Please note that:

- Your participation in this interview is voluntary. You may choose to answer or not answer any of the questions and you may end the interview at any time.
- We confirm that we will keep your identity confidential throughout. Your data will be coded, and we will not publish your name or any identifying information.
- We do not anticipate any risk to you from participating in this research. If you feel there is any risk, please let us know so we may address it.
- The research outputs, including the report, will be made available to you.

Do you have any questions?

Do you give consent to participate in the interview? [*Interviewer to note in writing if consent is given.*]

Do I have consent to record the interview? After the interview, the file will be uploaded to a password-protected storage site. You can also turn off your camera and change your display name. [*Interviewer to note in writing if consent is given.*]

May I also take notes during the interview? [*Interviewer to note in writing if consent is given.*]

Introductory questions

1. Please provide a brief overview of your role and your organization's work to support newcomers and/or people whose first language is not English.
2. Did your organization's service or program delivery change due to provincewide COVID-19 restrictions, such as stay-at-home orders or physical distancing?
    a. If so, how did they change?

COVID-19 information-sharing between March 2020 – March 2021

We'll now move into some questions about COVID-19 information-sharing. We are interested in discussing your experiences during the first year of the pandemic. This includes when COVID-19 was first declared a pandemic in March 2020, to when Canadians began having access to vaccinations in March 2021.

1. Did you (or your organization) provide information about COVID-19 (e.g., transmission) and public health measures (such as hand washing, physical distancing, and stay-at-home mandates) to the populations you work with? communicate information about COVID-19
    a. If so, what information did you share about COVID-19? Public health measures?
2. What were your organization's top three sources of information for COVID-19 and public health measures?
    a. How did you share this information?
3. What types of information did newcomers and people whose first language is not English seek out?
    a. Can you discuss their preferred information sources (e.g., WhatsApp, news or newspapers)?
    b. Was there specific information about public health measures that these communities were searching for?
4. Did you find it easy to find multilingual information about COVID-19 preventative measures, such as isolation, mask-wearing, and physical distancing?
    a. If not, how did you obtain this information?
    b. Did your organization translate COVID-19 information into different languages?
5. What was your experience sharing information about COVID-19 with newcomers and/or people whose first language is not English?
6. When guidance and measures changed about COVID-19 (e.g., from changing numbers of social interactions), how did your organizations share this information?
    a. How was your organization alerted of these changes?
    b. How did you adapt this information?
7. What information gaps did you perceive when sharing information with newcomers and/or people whose first language is not English?
8. What were the limits you experienced when sharing information about COVID-19 with newcomers and/or people whose first language is not English?
9. What strategies or approaches helped you (or your organization) share information with newcomers and/or people whose first language is not English?
10. Do you have any other information you would like to share or any other comments you would like to add to help us understand your experiences?

Do I have your permission to contact you if I need to clarify anything from our interview or inform you about the findings of our research to share feedback?

If there are no further comments, we can conclude the interview. Thank you for your time today. Please reach out if you have any questions or concerns moving forward. You can find

all of our contact information in the informed consent form, here is the link once again _____ (added to the Zoom chat).

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