Language Matters

Fostering Solidarity in Risk Communication during COVID-19

by Dr Tom Rausch

Language strategies for health workers and other risk communicators
The GET Consortium functions as a multi-sector response mechanism to health threats to the African continent. It is a public health think tank and implementation organ with the goal of providing recommendations on strategies and policies to African Governments and agencies, establishing research and building capacity through carefully prioritized culturally sensitive initiatives and projects.

The Author

Dr Tom Rausch is a Research Fellow and GET’s Communication Manager. He received his Ph.D. in Applied Linguistics from Queen Mary University of London. He specializes in health and risk communication during public health emergencies in socio-culturally diverse contexts. His further research interests include intercultural communication, organizational communication and the public learning and understanding of science.

@tomjrausch  trausch@getafrica.org
Introduction

Over the past few months, SARS-CoV-2 has been spreading around the globe infecting over 3.5 million people and affecting us all. When fighting a pandemic assuring solidarity within communities and among nations is crucial as effective disease response requires collaboration that sets aside self-interests. The WHO explains that managing health risks during infectious disease outbreaks requires a ‘collaborative model of dialogue and engagement’* to make sure that health professionals, political stakeholders, the media, and the general public work together during the outbreak.

Language matters. Language can be a valuable resource for cooperation and coordination when we face risks: through specific language strategies, we can foster solidarity. We are all united in the fight against this coronavirus and it is important to highlight that we are all in this fight together while backgrounding elements that may otherwise differentiate us.

When designing risk communication campaigns, every detail counts and something as seemingly small as a word may be the difference between success and failure. Therefore, it is particularly important for health workers, political stakeholders and professional leaders to be aware of the language we use. This document introduces 4 linguistic strategies that have been found to improve feelings of solidarity and may be of specific use when communicating risk in culturally diverse contexts during the response to Covid-19.

Strategy A: Strategy of Condescension

Strategy B: Avoiding Blame

Strategy C: Shared Backgrounds

Strategy D: Using Pronouns

Note

The strategies that are introduced here are of course complex and every language strategy needs to be tailored to the context that it is used in. There is not one size that fits all. This document aims to increase your language awareness. We invite you to consider the effect that small changes to the words we use may have on our audience. We are happy to answer any questions, discuss any of these strategies and see how they may be adapted to your situation. Please reach out to the GET Team at trausch@getafrica.org.
In our societies, we find language hierarchies that dictate what language should be used when. At the top of the hierarchy, we may, for example, find the national languages or, in the context of science, this may be English. For example, if scientists want to publish a scientific paper, in most cases, they have to write in English.

The French sociologist Pierre Bourdieu explains the 'strategy of condescension' as follows:

*It consists of deriving profit from the objective relation of power between the languages that confront one another in practice [...] in the very act of symbolically negating that relation, namely, the hierarchy of the languages and of those who speak them.*

His basic idea is that language can be viewed in economic terms: some languages may be more ‘valuable’ in certain situations than others. The strategy explains that there are situations where we may derive profit from choosing a language that is not the established choice.

In an address to the nation in 1988, the former Senegalese President Abdou Diouf decided to hold parts of the address in Wolof, a local language spoken natively by 40% of the population and as a second language by most others. He decided against only using French, the dominant language for official purposes in the country. Research found that specifically, the non-francophone people in Senegal responded very positively to this decision**, which illustrates that going against established language hierarchies may be fruitful in certain situations.

In 2015, the Honourable Commissioner for Health Prof Akin Abayomi gave a presentation at a GET workshop with Ebola survivors in Liberia. He decided to give his presentation in Creole instead of English, the language usually used at such events. He was aware that the survivors were more proficient in Creole and he adapted his language use to his audience. As one of the GET members present at the workshop described it, “it was amazing the switch, it made such a big difference. They looked at us like they are actually here because they care about us”.

By adapting our language use, we can foster solidarity between us and our audience as we are able to appeal to them through the rejection of the established language choice and the use of the shared language practices that may usually be considered as ‘inappropriate’.

During processes of health and risk communication in our communities, we can shift away from the established language of science or national languages and use the local language practices. That way we cannot only make sure that the people understand what we are saying, after all, medicine and science can be very complicated, but we can also foster feelings of solidarity with the people. We can show that we share a cultural background and it removes a barrier between the health worker and the patient.

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Avoiding Blame

On 27th March, the World Health Organization held a press briefing in which it underlined that countries and agencies should avoid blaming each other for elevated Covid-19 numbers as this may lead to countries under-reporting their cases.

Explicitly criticizing people and organizations may at times be necessary during outbreak response to identify and point out mistakes and weaknesses and to improve measures, but it may also threaten relationships between agencies, people and governments. We must strike a delicate balance and consider language strategies that allow pointing out problems without damaging relationships and trust. Below we will look at 2 techniques through which we can move away from focusing on who is to blame and emphasize the weakness or problem itself, instead.

A. Nominalization

Through the process of ‘conversion’, a verb is turned into a noun. For instance, we can convert ‘to understand’ into ‘understanding’. Consider the following two formulations.

1."The politician does not understand that it is important to securely store coronavirus samples."

2."There is no understanding that it is important to securely store coronavirus samples."

As we converted the verb ‘to understand’ into the noun ‘understanding’, we were able to point out that we need to improve the understanding that samples need to be stored securely without having to name who lacks this understanding. It allows us to criticize while avoiding personally attacking individuals.

B. Passivization

Passivization transforms an active sentence into a passive sentence, which allows us to shift the actor of an action to the back of a sentence or the actor is left out entirely. Considering an example will make things clearer.

1.Active voice: "Those people were hiding the bodies of the Ebola victims."

2.Passive voice: "The bodies of the Ebola victims were being hidden."

In the passive voice, the speaker is able to shift the problem at hand to the beginning of the sentence: the bodies of the Ebola victims. The key message is that there was a counterproductive practice taking place due to cultural traditions and it is not helpful to explicitly blame the people who did it, as this may drive a wedge between the people and health workers. Instead, it is more important to understand the cultural root of the problem, why this practice exists and how to manage it.

Of course there are times during emergency response where we need to explicitly point out who is responsible for ineffective measures. However, sometimes it is also crucial to protect solidarity and maintain relationships with people and institutions.
During health and risk communication, it is important that local risk communicators show that they share the same culture and come from the same communities. Researchers have found that communication supported by personal experiences rather than solely being based on reasoning or opinion holds a higher persuasive effect* and conversational formats such as narratives have found to be perceived as more believable than highly academic formats**. This means that if we want our audience to adopt a certain risk-avoiding behaviour, our success rate of persuading the listener increases if we include personal experiences and highlight our shared culture and background.

Let us consider the following extract taken from a public health campaign led by a health worker we will call Ada:

“We eat bats. We eat little mammals and rodents. It’s an important source of protein for us. With the current prices at the market, I can’t always afford expensive meat such as cow or lamb. Bush meat is an important part of our diet. Therefore we must adopt safe ways to prepare bats and rats for example. We must make sure to prepare them in boiling water and really cook them through.”

Ada explains that she relies on bush meat as a source of protein and she underlines the shared struggle that she is not able to afford more expensive types of meat. This allows her to highlight the culture and background she has in common with the audience she is trying to convince to adopt a certain behaviour. She signals solidarity with the people; she shows them that they face the same struggles. This helps her build rapport and trust with the people she is communicating with.

Building rapport and trust with the local community has been identified as a critical requirement for understanding the local views and as a crucial element in effective outbreak response***. Similarly, it is crucial that those in charge of managing health risks ‘should act in ways that merit the trust of risk bearers’****. By showing that we share a culture for example, we can foster this trust and build up solidarity with the people we are addressing. Telling such stories enables us to provide “true accounts” about aspects of our life and experience, which creates ‘an aura of trustworthiness’* and solidarity as researchers have put it.

Using Pronouns

This final section focuses on the use of personal pronouns (I, you, we, they, us, my, etc.) during health and risk communication. We use pronouns all the time without always being aware of the power and effect they may hold. Research has shown that ‘we’ and its variants ‘our’, ‘ours’ and ‘us’ can represent the coalescence of the voice of the person with the voice of the people*. It enables speakers to underline that they are part of the community they are talking to or about.

If we go back to Ada’s example in the previous section, we can take a closer look at the beginning of the extract:

**Option 1**: We eat bats. We eat little mammals and rodents. It’s an important source of protein for us.

Ada uses 3 personal pronouns in this extract (2x ‘we’ and 1x ‘us’). In this case, it is clear that the pronouns refer to the speaker and the community that she is addressing. Ada is able to present herself as the voice of the community she is describing, which allows her to signal solidarity with them. The pronouns group together the health worker and the people she is addressing in her risk communication campaign. This signals that they are in this together and they all have to work together to fight against the spread of a virus. Let us compare Ada’s words to two potential alternative ways of phrasing the same message:

**Option 2**: You eat bats. You eat little mammals and rodents. It’s an important source of protein for you.

**Option 3**: They eat bats. They eat little mammals and rodents. It’s an important source of protein for them.

Both of these sentences carry the same core message: the people of the addressed region rely on bush meat for their protein intake. However, options 2 and 3 employ different personal pronouns. They do not include Ada in the community that she is addressing.

This ‘minor’ linguistic change creates a sense of distance between the health worker and the community and may even create a sense of blaming the community. This sense of distance may lead to lower levels of trust and decreased feelings of solidarity between the people and the speaker. The audience may even feel attacked, which can lead to defiant and defensive behaviour, which is counter-productive. During health and risk communication, every detail may be the difference between success and failure and we need to set ourselves up as well as possible to succeed.

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