Lost in translation: the importance of addressing language inequities in global health security

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ABSTRACT

Language inequities in global health stem from colonial legacies, and global health security is no exception. The International Health Regulations (IHRs), a legally binding framework published by the WHO, lay the foundation for global health security and state the roles and responsibilities States Parties are compelled to follow to improve their capabilities to prevent, detect and respond to potential public health emergencies of international concern. It includes the submission of a mandatory status report that assesses a nation’s implementation of IHRs. Known as the States Party Self-Assessment Annual Report (SPAR) tool, WHO has made its guidance document available in all six WHO official languages (Arabic, Chinese, English, French, Russian and Spanish). The Republic of Iraq (Iraq) experienced significant challenges during the completion and submission of the 2022 SPAR. This experience demonstrated that translation of English materials to other languages, such as Arabic, is not prioritised and further underscores how scoring of a country’s global health security capacities can be significantly impacted by users’ ability to read and comprehend the materials in English. Not only can this lead to inaccurate SPAR scoring, but it can also lead to the improper allocation of resources and prioritisation of policy developments and/or amendments. By drawing attention to this issue, we aim to inform and advocate for global health security decision-makers to consider opportunities for increasing inclusion and accessibility, especially for requirements under legally binding international instruments.

INTRODUCTION

Language is the primary method of communication that humans use to correspond with each other in local, national, regional and global settings. And although our ability to communicate and connect with others is innate, language is complex and can vary within and among societies. To date, there are more than 7000 languages spoken worldwide with each one containing distinct features, from phonetic to syntactic to discursive.

While language is an example of human diversity, it is also considered a social determinant of health, as barriers in communication can impact health outcomes in different geographical and sociopolitical contexts. Since 1948, the WHO has served as the lead international health agency addressing health inequalities for its 194 Member States. Headquartered in Geneva and maintaining six regional offices, 150 in-country offices and serving nations in one of its six official languages (Arabic, Chinese, English, French, Russian and Spanish), WHO fundamentally accepts the implicit duty of eliminating...
language barriers in order to build strong connections with every Member State and foster global collaboration. The successful advancement of global health security relies heavily on WHO’s role in developing norms and standards for the global health community.

According to WHO, global health security is defined as the activities, both proactive and reactive, that aim to minimise the threat and impact of acute public health events that endanger people’s health across geographical regions and international boundaries. The International Health Regulations (IHRs), which were adopted by WHO’s decision-making body, the World Health Assembly, are a set of legally binding requirements that specify the roles and commitments the 196 States Parties (including all 194 WHO Member States) are compelled to do under IHRs, including detecting, reporting and responding to public health events. IHRs recognise these events, which are influenced by climatic, technological and demographic changes, pose risks beyond national borders and that States Parties bear a responsibility to the global community to contain them before they become public health emergencies of international concern.

To measure IHR implementation on national levels, IHRs require States Parties to conduct annual status reports through the States Party Self-Assessment Annual Report (SPAR) tool, one of four components of IHR’s monitoring and evaluation framework. While the SPAR submission is the only mandatory obligation for IHR compliance and supports global health security efforts, it also serves as a useful tool for States Parties. For instance, it promotes coordination and collaboration between sectors and provides States Parties an opportunity for reflection annually; SPAR evaluates measures of success and progress in IHR implementation and identifies challenges that are impacting health systems strengthening. The SPAR tool, which was recently revised in December 2021 to reflect implications from the SARS-CoV-2 pandemic, is publicly available in all six WHO official languages as well as Portuguese, ensuring that all States Parties have access to the most up-to-date material.

As of September, 186 of the 196 States Parties (roughly 95%) have submitted their SPAR scores for the 2022 calendar year. The Republic of Iraq (Iraq), a member of the Eastern Mediterranean Regional Office (EMRO) region, is a nation with two official languages, Arabic and Kurdish (representing the nation’s two major ethnic groups), and two governments, the Federal Government of Iraq (GOI) and Kurdistan Regional Government (KRG). With an estimated population of approximately 41.2 million inhabitants, Iraq is divided into 18 governorates, three of which represent the KRG in northeastern Iraq. With funding support from the US Defense Threat Reduction Agency, Biological Threat Reduction Program (DTRA/BTRP), our joint team from Georgetown University, Johns Hopkins University and the Ministries of Health (GOI and KRG) established a collaboration targeting IHR compliance in Iraq. This 3-year engagement focused on prioritising efforts towards strengthening and sustaining IHR implementation and compliance both within the Ministry of Health and across a network of relevant ministries and/or directorates for GOI and KRG. In February 2023, Iraq submitted the first ever GOI–KRG joint SPAR, providing a whole-of-country depiction of the nation’s current health system structure. While preparing for and completing the SPAR was a major multisectional, multigovernmental accomplishment for Iraq, and a culmination of a three-part workshop series dedicated to bringing together essential technical leads, multisectional working groups and key subject matter experts from both governments, challenges associated with analysing and responding to the tool itself became apparent and demonstrated language inequities, due to a lack of available materials and resources in all respective WHO languages, exist within global health security.

While this experience and our paper focus on a specific experience in Iraq, it adds to the ongoing conversations that focus on decolonising global health and addressing global health’s lack of reach, diversity and inclusivity. Another key aspect of these conversations to discuss and consider is global health’s accessibility. This specific term is less frequently encountered in discussions of decolonising global health, and yet fundamentally relates to these concepts. Calling out global health inequities that are associated with power imbalances and colonial legacies is not a new phenomenon. That being said, part of our duty as global health researchers is to share the incidents, we encounter during our research to inform and advocate for change. Our encounter highlights how challenges in access, inaccurate assumptions and colonial legacies also have major repercussions in global health security.

IMPLICATIONS OF LANGUAGE INEQUITIES IN GLOBAL HEALTH SECURITY

Global health security is an imperative pillar of global health. The SPAR tool provides a mechanism to annually review and assess States Parties’ health systems and compliance towards IHR. While WHO has conducted extensive analysis, participated in drills and their corresponding after-action reports, and convened various commissions to help determine key gaps in meeting IHR obligations one topic has yet to be addressed; access to IHR guidance documents in native languages. A WHO-EMRO summary report from the 2017 regional meeting for the National IHR Focal Points (NFPs) outlines a key challenge in conducting the Joint External Evaluation (JEE), an external evaluation of national IHR compliance, of a lack of access to documents in appropriate languages. However, no recommendations to translate documents into additional languages were listed, instead it was recommended that States Parties take the responsibility to share national best practices related to IHR implementation via the IHR regional bulletin. In addition, previous requests at regional stakeholder meetings calling for the mapping of technical resources that are
available in the region, the development of modalities to make these resources available and accessible for all, and the translation of WHO guidelines into different languages have also been documented.\textsuperscript{19,20} While these challenges, along with other more capacity-building objectives, have been documented over the years, little has been done to address the language barrier.

Our multilingual experience in preparing and completing Iraq’s 2022 SPAR demonstrated that while States Parties have access to the same SPAR guidance document, they do not receive the same support to accurately assess and complete the SPAR. Specifically, they do not have access to translated materials that have undergone sufficient quality control to ensure there is accuracy in what is being communicated in the documents. This highlights a major obstacle in health systems strengthening and the power imbalances that arise from language barriers and colonial legacies. While the SPAR guidance document might be available in all six WHO official languages, our experience demonstrated how the translation of English materials to other languages is not prioritised and, in fact, a disservice. Specifically, during Iraq’s completion of the SPAR, we found that there were difficulties in language comprehension for both native English and Arabic speakers; GOI and KRG teams referred to both English and Arabic versions of the SPAR guidance document to compare translations and determine the best wording to select the most appropriate indicator scores under each capacity. Translating IHR materials from English into Arabic and Kurdish results in various interpretations for the same word. For example, words such as: must, should and encourage in English can be interpreted and then translated in different contexts.

Clearly, global health materials are not only still heavily published in English,\textsuperscript{15} but also not readily available. To wit, our team discovered that none of the 20 supporting documents published by WHO and cited in the SPAR guidance document to provide States Parties with additional information and assist them with scoring were available in all six official languages (given in table 1). In addition, and specific to our research experience in the EMRO region, only two of these 20 supporting documents were available in Arabic.

Approximately 1.453 billion of the total global population speaks English, making it the most spoken language around the world. However, roughly 26% (373 million) of these people are native speakers, meaning English is a learnt language for the majority of people who can speak it.\textsuperscript{21} The lack of access to supporting documents in all six WHO official languages to assist with completing the SPAR, given in table 1, has major implications in the broader scope of global health security; it impacts a country’s ability to prepare for and conduct a proper self-assessment. It does not encourage people with different personal and cultural identities to form connections with one another, which ultimately hinders global collaboration the exact opposite of WHO’s duty of eliminating language barriers to build strong connections among States Parties.\textsuperscript{22} Through our experience, we encountered how the scoring of capacities is significantly impacted by its user’s ability to read and comprehend the materials in English. Without having access to properly translated materials to complete the SPAR, this limitation not only impacts SPAR scores but also hinders States Parties’ demonstration of the global health security capabilities they truly have. Inaccurate scoring can lead to underestimations of capabilities and thereby not giving States Parties the credit they deserve. It can also lead to overestimations of capabilities on national and international levels, creating a false sense of safety, security and preparedness against the next global health threat. On a national level, underestimations and overestimations impact a nation’s ability to modify or develop new legislation, laws and/or policies that aim to improve health systems strengthening. On an international level, unreliable SPAR assessments can impact a nation’s scoring on other global health security frameworks such as the Global Health Security Index, which heavily relies on publicly available information. In addition, they influence how a nation is perceived regionally and globally, which can hinder opportunities for partnerships, collaborations or requests for technical and/or financial assistance from governmental or non-governmental organisations.

\section*{WHAT CAN BE DONE TO ADDRESS LANGUAGE INEQUITIES IN GLOBAL HEALTH SECURITY?}

It is evident that having accessible, comprehensive guidance for IHR implementation in all six WHO languages is critical. To see real progress in making global health security more inclusive, it is fundamental that researchers, institutions, agencies and organisations are aware of language inequities, reflect on their implications and seek to change the language barrier.\textsuperscript{15} This can be accomplished in a number of ways. On an individual level, researchers must ensure they have simultaneous translation, translated materials for their partners and/or participants, and are keen on learning the language in which they work.Translations must be done by individuals who have some technical experience in health systems topics, and the requirements for proper implementation, and are familiar with the intricacies of the local language. Not only will this remove language barriers, but it will foster global partnerships and future study opportunities. On an organisational level, WHO needs to first and foremost fulfil its duty as the lead on IHR and ensure all of its published materials are available in its six official languages. In addition to increasing the availability and accessibility of materials, WHO needs to prioritise the translation of these materials. This can be accomplished through the establishment of secured funding and resources for a department that is dedicated solely to the translation of materials. Another way to address language barriers is to allow States Parties to submit their SPAR scores in one of the six WHO languages (instead of limiting submission to English) as well as establishing a
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<th>WHO-published supporting documents referenced in SPAR</th>
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<td>1 Gender mainstreaming for health managers: a practical approach</td>
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<td>4 WHO manual for organising a national external quality assessment programme for health laboratories and other testing sites</td>
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<td>5 WHO simulation exercise manual: a practical guide and tool for planning, conducting and evaluating simulation exercises for outbreaks and public health emergency preparedness and response</td>
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<td>6† Country COVID-19 intra-action review (IAR): facilitator’s manual, 28 April 2021</td>
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<td>8 Toolkit for monitoring health systems strengthening: service delivery</td>
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<td>9 2018 Global reference list of 100 core health indicators (plus health-related SDGs)</td>
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<td>10‡ Guidelines on core components of infection prevention and control programmes at the national and acute healthcare facility level</td>
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<td>13 Global progress report on WASH in healthcare facilities: fundamentals first</td>
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<td>17 International health regulations (2005): a guide for public health emergency contingency planning at designated points of entry</td>
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†One other language: Portuguese.
‡One other language: Thai.
IHR, International Health Regulation; SDG, Sustainable Development Goals; SPAR, States Party Self-Assessment Annual Report; WASH, water, sanitation and hygiene.
department that offers language support to States Parties in all official languages.

It is increasingly recognised that global health decolonisation efforts require a major paradigm shift, necessitating practitioners to continually consider the discipline’s colonial history, hierarchies, power dynamics and the systemic structural and institutional issues that allow inequities, including those associated with language, to perpetuate. It also requires practitioners to continuously challenge the status quo. Our global health security experience is but one example. That being said, our research should serve as a catalyst for future analyses on the impacts of language inequities (and/or other imbalances) in global health security, and corresponding corrective actions. For example, States Parties from all six regions should share their experiences and recommendations for completing and submitting the SPAR, whether that be via the annual WHO regional meetings for NFPs or through another publicly available platform. In addition, a comprehensive effort to assess and address the language inequities associated with the JEE, highlighted as a challenge in reports over 5 years ago, is critical.

CONCLUSION

Focusing on the language inequities in global health security that stem from a lack of prioritisation, the purpose of this piece was to reemphasise the importance of making global health security a more accessible subdiscipline. Global health security is a naturally collaborative field and this research experience was a reminder that while progress has been made in addressing colonial legacies, the global health community as a whole still has a way to go with being inclusive; what we communicate and how we communicate it matters.

Each year, States Parties must begin preparations for the upcoming SPAR submission cycle more than 4 months prior to the submission deadline, before reporting on IHR implementation capacities for the previous calendar year. Through our experience, we are hopeful that the language inequities in global health security will be addressed in order to have short-term impact. An immediate action we recommend is for States Parties to coordinate with their IHR NFPs to advocate for language inclusion and accessibility (ie, promote for quality translation of necessary materials for SPAR completion and submission) at their upcoming regional meetings. In addition, we challenge influential members, institutions, agencies and organisations in our area of work to make sure their actions that aim to promote global health equity align with their words.

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Contributors Our project was designed and implemented with key country focal points, our co-authors (MJA, AZ, KM), in this submission. In the process we engaged multiple ministries through advocacy and outreach in a collaborative manner. Our Iraqi partners served as experts in IHR, health systems, local/national politics and programs while our high-income country researchers with extensive experience of conducting, leading, or organising international research collaborations involving low- and middle-income countries (ASF, AGL, CJS, EMS) secured funding, co-designed the project and conducted the initial phases of data collection and analysis. Of the seven co-authors three are from our low-income country (Iraq) while the remaining four are from the US and Canada.

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