Is it time to retire the label "CALD" in public health research and practice?

In Australian public health research and practice, the label "culturally and linguistically diverse" (CALD) is used to encompass a diversity of birth countries, languages and cultures. This term is routinely used in public health to address diversity, to guide equitable access to health resources, and inform inclusive policies and programs. It influences how health research and services are designed and implemented. However, the label has inherent limitations, and its broad application simplifies and masks disparities within these diverse communities. As researchers, like many others, we have also used the label "CALD" as a form of acknowledgement of diversity in Australia. This perspective article challenges the use of the label, recognising its use in current research and practice, while also exploring the need for a more nuanced approach.

History of the acronym "CALD"

Before 1996, "non-English speaking background" (NESB) was used as a measure of needs and disadvantages tied to cultural factors.[1] In 1996, a meeting of the Council of Ministers of Immigration and Multicultural Affairs agreed to drop NESB from official communications due to its inability to capture the nuances and diverse experiences in these communities, including the inability to differentiate between disadvantaged and non-disadvantaged groups.[1] In 1999, the Australian Bureau of Statistics (ABS) developed the standards on "cultural and language diversity" to identify multicultural populations. The ABS uses a minimum set of primary indicators to describe CALD populations, which include country of birth, main language spoken at home, proficiency in spoken English, and Indigenous status. This is the minimum set and some variables can be omitted if not relevant; for example, Indigenous status can be omitted when focusing on migrant communities.[1] These primary indicators aim to provide a standardised and systematic approach to demographic analysis, allowing for a better understanding of Australia's multicultural population. However, despite this standardisation, the label "CALD" also faces the same criticisms as NESB regarding its effectiveness and relevance in accurately representing diverse cultural and linguistic communities.

A lack of standardised use

Studies apply and interpret CALD indicators variably, hindering the comparability of research findings. A systematic review exploring the definitions of "CALD" used in epidemiological research found variations in how it was defined.[2] Included studies defined "CALD" using different ABS indicators, with some using country of birth whereas others used language spoken at home.[2] This variability can affect policy recommendations, as inconsistent definitions make it challenging to identify which groups require targeted interventions or resources. For instance, researchers have noted that Australian dementia research is not sufficiently inclusive of multicultural communities, potentially resulting in inequitable or culturally inappropriate care.[3,4]

"CALD" homogenises diversity

The application of "CALD" combines a range of cultural groups into one category. Being CALD or not creates a binary distinction that sets the dominant culture or language as the default or norm. This implies a hierarchy that marginalises groups labelled as "diverse" by positioning them as different or "other". This broad stroke not only undermines the unique challenges faced by distinct cultural and linguistic groups but also risks perpetuating stereotypes. This problem was evident during the coronavirus disease 2019 (COVID-19) pandemic, for example, where a poster about using face masks in Victoria incorrectly included information in both Arabic and Farsi, two very distinct languages that share a similar alphabet.[5] Although this represented an effort to meet the urgent demand for COVID-19 information, it compromised the integrity and timeliness, at a time when information was paramount for understanding and navigating the pandemic.

Only applying the "CALD" label can also lead to the misrepresentation of disparities within communities. For example, some population groups already face significant barriers in accessing mental health services due to stigma, lack of culturally appropriate care, and language difficulties.[6-8] By treating these groups as one entity, there is a risk of over-generalising in the planning of services, thus overlooking each community's specific mental health needs.

"CALD" applies a deficit model

Inherent in the "CALD" label is the hazard of making linguistic diversity a barrier rather than an asset. Linguistic diversity as a health asset can enhance the capacity of individuals, groups, communities, populations, social systems and institutions to maintain and sustain health and wellbeing and reduce inequities.[9] For instance, bilingual health workers and community leaders who speak the local languages play a very important role in bridging communication gaps and fostering trust within communities.[10] Research definitions need to strike a balance, without overlooking the broader cultural and systemic contexts, such as socio-economic status, historical influences and power dynamics within which language is embedded.

Moreover, the emphasis on language differences maintains a focus on those communities as the source

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of disadvantage, diverting attention from racism and systemic challenges and placing the onus on the communities rather than the macrosocial determinants of health. The term pulls focus from the broader social determinants of health, such as socio-economic status, education, employment and housing.[11] For instance, as of 31 March 2022, COVID-19 deaths were three times higher in people from more disadvantaged areas in Australia and those born overseas, particularly in North Africa and the Middle East, compared with other Australians.[12] Intersecting factors, including the federal and state and territory governments' failure to effectively engage and communicate with migrants during the early phases of the COVID-19 pandemic and the reliance on migrants to do most of the essential jobs (on a mostly casual basis, therefore lacking paid leave entitlements) have been attributed to these disparities.[13]

Using "CALD" makes assumptions of risk and marginalisation

The label "CALD" paints all individuals subject to its application with a broad brush of vulnerability. This lack of differentiation shifts the focus from those who may genuinely be in need, increasing the blind spots in our approach to support and address the health needs of underserved communities. For example, in our collective work, four out of five authors identify as being from CALD backgrounds, with lived experiences that highlight the need to tell our own stories. Despite our educational backgrounds, we may share some of the challenges often associated with marginalisation linked to our cultural backgrounds; however, we must also acknowledge that our needs are distinct from those who face greater systemic disadvantages. This illustrates our intersecting identities, where different aspects of identity, such as education, race, residency status and cultural background, combine to create complex experiences of both privilege and marginalisation.

The need for an alternative term

There is no one-size-fits-all solution and language is dynamic, with labels evolving over time. As researchers strive for inclusivity, our language must evolve to encapsulate the richness and complexity of the experiences of multicultural communities. As societal understanding of diversity also deepens, new terms should emerge that are considered more accurate, respectful and reflective of the complexities of cultural and linguistic identities.

Recently, the label "CARM" (culturally and racially marginalised) has gained traction as an alternative to "CALD".[14] Although this shift acknowledges both cultural diversity and racial marginalisation in a way that "CALD" often fails to, as it highlights important issues of racial and systemic inequalities, "CARM" can also inadvertently reinforce a narrative of perpetual marginalisation. Researchers need language that not only recognises marginalisation but also empowers communities by reflecting their strengths, contributions and the multifaceted nature of identity.

It is essential to approach the development and use of labels with sensitivity. We recommend using precise and accurate language when discussing cultural and linguistic diversity, as it leads to more meaningful understanding and engagement with these communities. When choosing alternatives, it is crucial to be aware of the connotations and unintended impacts of each term, as well as the preferences of the individuals or communities being described. Researchers, policy makers and institutions should adopt more specific, participatory approaches to do justice to complexity. Researchers can co-design studies with community representatives to ensure interventions are culturally relevant. Policy makers should use precise language and allocate resources based on the unique needs of subgroups, rather than doing so under broad categories, such as "CALD". Institutions can establish advisory panels to ensure inclusive program development and health communication. The key is authentic engagement with multicultural communities and this engagement needs to be led by the right people, who are best positioned to understand and address their unique challenges. Additionally, staying open to dialogues on evolving language and being receptive to feedback can contribute to more inclusive and respectful communication about diversity. By doing so, we pave the way for a more empathetic understanding that transcends the limitations of existing classifications, and a more accurate reflection of the health disparities and inequities within communities. The Australian Government's decision to expand the ancestry topic in the upcoming census in August of 2026[15] is a significant step in the right direction.

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1 Australian Bureau of Statistics. Standards for statistics on cultural and language diversity. Canberra: ABS, 2022. https://www.abs.gov.au/statistics/standards/standards-statistics-cultural-and-language-diversity/latest-release (viewed Jan 2024).

2 Pham TTL, Berecki-Gisolf J, Clapperton A, et al. Definitions of Culturally and Linguistically Diverse (CALD): a literature review of epidemiological research in Australia. *Int J Environ Res Public Health* 2021; 18: 737.

3 Federation of Ethnic Communities' Councils of Australia. If we don't count it... it doesn't count! Towards consistent national data collection and reporting on cultural, ethnic and linguistic diversity. FECCA: 2020. https://fecca.org.au/wp-content/uploads/2020/10/CALD-DATA-ISSUES-PAPER-FINAL2.pdf (viewed Nov 2024).

4 Low LF, Barcenilla-Wong AL, Brijnath B. Including ethnic and cultural diversity in dementia research. *Med J Aust* 2019; 211:

345-346. https://www.mja.com.au/journal/2019/211/8/including-ethnic-and-cultural-diversity-dementia-research

5 Dalzell S. Government coronavirus messages left 'nonsensical' after being translated into other languages. *ABC News*, 13 Aug 2020. https://www.abc.net.au/news/2020-08-13/coronavirus-messages-translated-to-nonsense-in-other-languages/12550520 (viewed Feb 2024).

6 Youssef J, Deane FP. Factors influencing mental-health help-seeking in Arabic-speaking communities in Sydney, Australia. *Ment Health Relig Cult* 2006; 9: 43-66.

7 Minas H, Kakuma R, San Too L, et al. Mental health research and evaluation in multicultural Australia: developing a culture of inclusion. *Int J Ment Health Syst* 2013; 7: 23.

8 Drummond PD, Mizan A, Brocx K, Wright B. Barriers to accessing health care services for West African refugee women living in Western Australia. *Health Care Women Int* 2011; 32: 206-224.

9 Morgan A, Ziglio E. Revitalising the evidence base for public health: an assets model. *Promot Educ* 2007; 14(2 Suppl): 17-22.

10 Seale H, Harris-Roxas B, Heywood A, et al. The role of community leaders and other information intermediaries during the COVID-19 pandemic: insights from the multicultural sector in Australia. *Humanit Soc Sci Commun* 2022; 9: 174.

11 Marmot M, Wilkinson R. Social determinants of health. 2nd ed. Oxford University Press, 2005.

12 Australian Government. The impact of a new disease: COVID-19 from 2020, 2021 and into 2022. Australian Institute of Health and Welfare, 2022.

13 Davey M, Nicholas J. Covid death rate three times higher among migrants than those born in Australia. *The Guardian*, 17 Feb 2022. https://www.theguardian.com/australia-news/2022/feb/17/covid-death-rate-three-times-higher-among-migrants-than-those-born-in-australia (viewed Feb 2024).

14 Diversity Council Australia. Words at work: should we use CALD or CARM? Sydney: DCA, 2023. https://www.dca.org.au/news/blog/words-at-work-should-we-use-cald-or-carm (viewed Aug 2024).

15 Australian Bureau of Statistics. 2026 Census topic review: Phase two directions. Canberra: ABS, 2023. https://www.abs.gov.au/statistics/research/2026-census-topic-review-phase-two-directions (viewed Nov 2024). ■