Diversity Lens Tool kit

A set of practical cultural-competence assessment tools and resources to help integrate diversity in Nova Scotia Health Authority workplaces

nova scotia health authority

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Introduction

What is a lens tool?

A lens tool provides a way of applying a special filter to our work. In this case, the lens tool encourages us to apply diversity and inclusion concepts to all we do for patients and their families.

The Diversity and Inclusion Lens Tool is a set of questions meant to help staff, physicians, learners and volunteers consider the concepts of diversity, inclusion and equity in the development, revision, implementation and evaluation of programs, policies and practices.

Why have a lens tool?

When the diversity of our staff, patients and families isn't considered, our programs, policies and practices may not appropriately serve all of the people for which they are intended. This can lead to mistrust, delayed healing, misunderstanding and a reduced quality of service. In the end, this hurts our communities and all of us[1].

What is a lens tool kit?

To expand on the above definition…

- A lens tool refers to questions and reflection statements designed to help us take an inclusive and sometimes critical look at what we have been doing, what we want to do and how we want to work.
- A lens tool kit refers to the collection of resources we have compiled, including the following three sections: Lens Tools, Understanding Our Communities and Resources.
- It applies to our services, relationships, programs, policies, strategies and decisions.

[1] Modified from the IWK Lens Tool, iwk.nshealth.ca/sites/default/files/Lens_Tool_Bookmark%20(1).pdf. Accessed October 28, 2013.

How to use this tool kit

This tool kit consists of the following three parts:

Part I: Lens Tools—to help assess our current practice and apply the concepts of diversity to our day-to-day work. Tools are provided for personal reflection, direct care service providers, program development and organizational work.

Part II: Understanding Our Community—a brief introduction to some of the diverse communities we serve.

Part III: Resources—extra information and knowledge relating to some of the information provided in other sections.

By making efforts to read, answer and reflect on the different tools and resources, individuals and teams will increase their ability to provide culturally competent care and offer culturally relevant programs.

Here are some examples of how and when you might use this kit:

- At a staff meeting, individually complete the personal reflection tool (tool #1) and then ask team members to share their responses. You will learn more about each other's cultural backgrounds and how to support each other in different holiday times and other cultural and religious differences that affect sense of belonging.

- If you are developing a new program or policy, go through lens tools #4 and/or #5 at your first meeting to ensure that diversity is included in the work from the very beginning. Questions in these tools can also be used when evaluating a current program. Part II of the kit may help you learn more about our diverse communities.

- Perhaps your work area has received complaints from patients or co-workers about discrimination. Ask staff to answer the questions in the personal reflection tool (#1) as well as tools #2 and/or #3 to assess how care is being provided to all patients. This will help you learn how to be generally more skilled in the area of diversity and cultural competence.

- In orientation sessions for new staff and volunteers, consider taking 15 minutes to look at the personal reflection tool (#1). This will help decide what kind of resources you need to make everyone feel included, regardless of difference.

Remember, we are always making decisions! These tools guide us toward being inclusive in our everyday work and decision making.

Part I: Lens Tools

What is our framework for the lens tools?

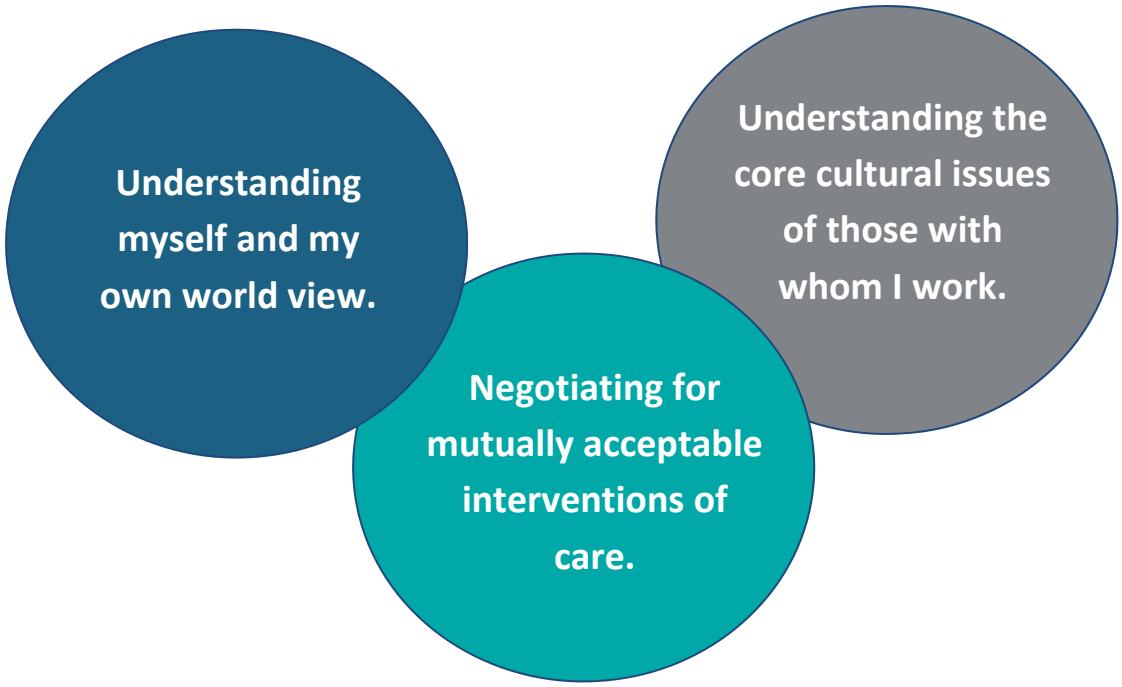
The framework for the lens tools has these three foundations:

Awareness of Our Own Culture: We need to be aware of our own culture and cultural biases. We are unconsciously ruled by the cultures we know and understand, and we make decisions based on this knowledge and understanding. Therefore, in interacting and providing services, we often unconsciously exclude others who don't share the cultural frame of mind from which we operate. By working intentionally to recognize this fact, we can reduce our cultural biases and make more inclusive decisions. Putting our cultural values, beliefs, ideas, thoughts and attitudes in perspective can guide our decision-making to include diversity and cultural competency.

Learning About Others: Diversity is the need to engage others and discover their needs. To be fair and socially just, we must take the necessary time and steps to learn about others and understand how they are being excluded. By engaging them meaningfully, we can work together to meet their health needs.

Improving the Relationship: Cultural competence means continuously seeking ways to improve relationships with people who don't understand or share our own culture, or whom we perceive to be different. To be culturally competent requires us to change our attitudes toward these differences. It also requires us to work at an organizational leadership level to provide the right resources and policies to guarantee equitable health outcomes for all. Health staff and systems must ensure that all polices, programs, services, workplaces and care approaches include and reflect the diversity of the individuals and communities they serve. Culturally appropriate, targeted programs and services must be implemented to reduce health inequities experienced by marginalized and vulnerable populations.

Cultural competence is therefore…



Things to keep in mind when reviewing this information:

- **Resist the practice of "othering."** This is the tendency to classify people or groups in a way that separates them from the whole. An "us" and "them" mentality supports a social hierarchy and power imbalances.

- **Everyone has a unique cultural identity.** Identities also intersect as people often identify with more than one cultural group.

- **There is as much diversity within cultures as across them.** Sex and gender, life stage, social status and other factors mean that no single cultural identity defines a cultural group. Everyone has a unique personality, aspects of shared cultural identity and a common humanity.

- **There is a difference between self-identity and being identified.** No one benefits from having their identity described and prescribed by others. People need to be able to self-identify with cultural groups. They also must choose if general information about a group applies to them. Unfortunately, people's health is partly determined by the identity imposed upon them by others.

  Beware the dangers of stereotyping. A stereotype is a belief or an attitude about a person or group that may not be based in reality. Stereotyping leads to the end of dialogue and understanding. For all of the above reasons, use the information provided here to inform your work but don't use it to stereotype an individual or a group.

Consider All Our Communities

Cultural identities and communities

- ☐ Aboriginal Peoples (First Nations, Inuit and Métis)
- ☐ African Nova Scotians
- ☐ Immigrants and temporary workers
- ☐ Refugees
- ☐ Pride health (spectrum of gender and sexual diversities)
- ☐ People with (dis)Abilities, both physical (such as those with low vision, the blind and the deaf-blind) and mental/emotional
- ☐ European Canadians

Language communities

- ☐ Acadians and francophones
- ☐ Aboriginal Peoples
- ☐ Immigrants and refugees
- ☐ American Sign Language (ASL) speakers
- ☐ The deaf-blind
- ☐ English

- ☐ ***People with literacy/health-literacy challenges***

Cross-cutting considerations

- ☐ Sex and gender
- ☐ People living in inner city, poor, rural or remote communities
- ☐ People living in poverty

Remember

- Identities intersect
- Avoid stigma and stereotyping

Lens Tool # 1: Personal Reflection Tool

Cultural competence begins with a desire to not allow biases to keep you from treating every person you encounter with respect. It requires an honest assessment of your positive and negative assumptions about others. Consider these questions as a self-reflection tool.

Self Awareness

1. Each of us is different. What is my cultural identity?*
2. What advantages or privileges, if any, does this identity afford me in society?
3. How aware am I of how my culture influences my assumptions and actions with colleagues and the families and communities with whom I work?

Learn About Others

4. How does my compassion extend to include differences?
5. How much do I know about the lived reality, health concerns and history of my colleagues and the families and communities with whom I work?

Improving Relationships

6. Am I aware of what my organization already has to offer in support of diversity and inclusion?
7. What actions have I taken that show my ongoing efforts to understand and value difference?
8. How do I plan to become even more skilled in the areas of diversity and cultural competence?
9. What am I going to do to advance diversity and inclusion in my organization?

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* *Cultural identity is the identity of a group, culture or individual as far as one is influenced by one's belonging to a group or culture, such as ethnicity, spiritual identification, social and economic class background, residential location and physical ability/disability.*

Lens Tool # 2: Health Care Providers

a) Direct Care Provider Tool [2]

To be used by staff providing direct care such as nurses, occupational therapists, physiotherapists, dieticians, physicians etc.

The assessment elements below (Attitudes and Awareness; Knowledge; Skills) are components for cultural competence providing care.

This is a self-assessment. Cultural competence is an ongoing learning process. As you complete this assessment, note opportunities for change. Refer to the Resources section of this kit to identify your next steps.

A. Attitudes and Awareness			
1 = Very well	2 = Well	3 = Fairly well	4 = Not at all

1. I can identify the cultures to which I belong and the significance of that membership. This includes the relationship of individuals in these groups with individuals from other groups, institutionally, historically, educationally, etc.

2. I know about my own cultural and language heritage and how it may influence my professional and personal biases.

3. I can recognize in a patient/professional relationship when the impact of my attitudes, beliefs and values may be interfering with providing the best service/care to patients.

4. I can identify my emotional reactions, stereotypes and preconceived notions of individuals and groups that are different from myself.

5. I'm aware of my social status and privilege in relation to my clients.

6. I can recognize cross-cultural communication challenges when they occur.

7. I'm aware of the influence of culture, language, literacy/health literacy and social status on patients' self- esteem, information-seeking, patient/family and community self-empowerment.

8. I recognize the effects and the implications of racism, sexism and heterosexism in society and on the care I provide.

[2] Modified from Alberta Health Services, 2009, *Enhancing Cultural Competency: A Resource Kit for Health Care Professionals*, pp. 124–136.

B. Knowledge

1 = Very well 2 = Well 3 = Fairly well 4 = Not at all

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9. I'm aware of the specific cultural knowledge of the diverse populations with whom I work, including world views, healing traditions, strengths, health beliefs and practices, impact of life events and illness prevalence.

10. I can identify differences within cultural groups and can pinpoint individual, as well as cultural, differences.

11. I understand the concepts of culture, cultural competence and safety, health equity, health disparities and social determinants of health.

12. I can identify privileges that I personally receive (or don't receive) in society due to intersections of my race or ethnicity, socio-economic status, sex and gender, sexual orientation, language and physical abilities.

13. I can identify the implications of concepts such as internalized oppression, institutional racism and stereotyping, and how these may impact a patient's self-esteem and patient/family and community self-empowerment.

14. I can describe concrete examples of challenges to access, usage and appropriate care facing those with diverse identities and priority populations within NSHA. I can share alternatives that would reduce or eliminate these challenges.

15. I adequately understand my patients' religious or spiritual beliefs.

16. I understand and respect the diversity of cultural and family influences and the role they play in decision-making and care.

17. I'm mindful of the implications of the language (connotations and idioms) I use and how it might affect others.

18. I know where to access health materials in different languages and at different reading levels. I know how to access health interpreters, cultural health interpreters, ASL interpreters and interveners for the deaf-blind.

19. I know where to access information about community resources and how to make the appropriate referrals.

20. I know where to seek credible health information about the cultures with whom I work.

C. Skills

1 = Very well 2 = Well 3 = Fairly well 4 = Not at all

21. I maintain both personal and professional relationships with people who are culturally different from me. I engage in discussions that allow for feedback about my behaviour concerning cross-cultural issues.

22. When I receive feedback about my culturally related interventions, I'm receptive and willing to learn.

23. I can describe how I sought cultural information and applied it to my practice.

24. I can articulate what, when, why and how I apply different verbal and non-verbal helping responses.

25. I have had training in how to work with cultural health interpreters.

26. I use and practice the teach-back method with my clients to ensure understanding.

27. I know how to accommodate patient preferences in the care process. I practice negotiation skills in approaches to care.

28. I can advocate on behalf of patients who feel they were discriminated against or who need to access NSHA language, cultural, navigation and support services.

29. I have examined and can recognize bias in my assessment and care practices.

30. I work at an organizational level to address, change and eliminate policies that discriminate against others and create barriers to health equity.

b) Health Care Provider Self-Assessment Tool (2)

To be used by anyone working in the health system.

As health care providers, becoming more culturally competent involves assessing our attitudes, values, knowledge and skills (Dunn, 2002).

This means:

- working on changing our world view
- becoming familiar with core cultural issues, especially those relating to health and illness
- learning more about the groups with whom we work
- developing trusting relationships
- negotiating for mutually acceptable and understandable care interventions

For each item listed below, enter **A** = Things I do frequently; **B** = Things I do occasionally;
or **C** = Things I rarely or never do.
Ensure that you can provide concrete examples to justify your score.

This section is for people who work in, make decisions about and decorate public spaces.

Physical environment, materials and resources	Score
1. I display pictures, posters, artwork and other decor that reflect the diverse cultures and ethnic backgrounds of the individuals and families to whom I provide service. 2. I ensure that brochures, magazines and other printed materials in reception areas will interest and reflect the diversity of the community in which I provide service. 3. When using brochures, posters, videos or other media resources for health education, treatment and other interventions, I ensure that they reflect the diverse cultures and ethnic background of the individuals and families to whom I provide service. 4. I ensure that the printed information I provide takes into account the literacy levels of the individuals and families to whom I provide service.	

Communication styles	**Score**
5. When interacting with individuals and families who have limited proficiency in speaking (ASL) English or health-literacy challenges, I always keep in mind that: • spoken English proficiency doesn't reflect reading proficiency, language of origin proficiency or literacy • the limited ability to speak the language of the dominant culture has no bearing on the ability to communicate effectively in one's mother tongue • limitations in English proficiency don't reflect mental or intellectual ability 6. I use cultural health interpreters or Language Line services or sign language interpreters when required or requested. 7. For individuals and families who speak languages other than English, I attempt to learn and use key words in their language so I'm better able to communicate with them during assessment, treatment or other interventions. 8. I understand cultural context for naming/understanding disease and try to be respectful of this in my interactions. In some cultures, stigma is associated with terminal, sexually transmitted and communicable diseases. In some cultures people avoid this stigma by naming the disease by a symptom rather than its medical name; for example, AIDS is sometimes called "the sleeping sickness." 9. I can provide alternatives to written communication, large-print forms for those who use braille or Daisy readers as audio files if a patient needs or requests them.	

Social interaction	**Score**
10. I understand and accept that family is defined in a variety of ways by different cultures, such as extended family members, kin, godparents and same-sex relationships. 11. Even though my professional or moral point of view may differ, I accept that patients and their families are the ultimate decision-makers for the services and supports that will impact their lives. 12. I understand that age, sex, gender and life cycle factors/roles need to be considered in interactions with patients and their families. For instance, a high value may be placed on the decision of elders, the role of eldest male or female in families or the roles and expectations of children. 13. I understand and respect that male-female gender roles may vary among cultures and ethnic groups, which can impact which family member makes the major decisions.	

Health, illness and end-of-life issues	**Score**
14. I understand that the perception of health, wellness and preventive health services have different meanings to various cultural and ethnic groups. 15. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures. 16. I accept that religion and other beliefs may influence how individuals and families respond to illness, disease and death. 17. I understand that grief and bereavement are handled differently among cultures. 18. I seek information from individuals, families and other key community stakeholders to continuously respond to the needs and preferences of the culturally and ethnically diverse communities served by my program or agency. 19. I keep up-to-date on major health concerns and issues for the ethnically and racially diverse clients living in the communities served by my program or agency. 20. I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the communities served by my agency or program.	

Assumptions, attitudes and values	**Score**
21. I recognize and accept that individuals from diverse cultural backgrounds may want to ease into the dominant culture at varying paces. 22. I recognize my own values and biases and avoid imposing them on others. 23. I respond/address the situation in an appropriate manner when I see other staff or clients within my program or agency engaging in behaviours that aren't culturally competent. 24. I screen resources for cultural, ethnic or racial stereotypes and inclusion before sharing them with the patients and their families served by my program or agency. 25. I'm aware of the socio-economic and environmental risk factors contributing to the major health problems of the culturally, ethnically and racially diverse populations served by my program or agency. 26. I seek professional development and training to enhance my knowledge and skills so I can provide the appropriate services and supports to culturally, ethnically, racially and linguistically diverse groups. 27. I advocate for the review of my program or agency's mission statement, goals, policies and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.	

Note: There is no answer key with correct responses. However, if you frequently chose C, you may not demonstrate the beliefs, attitudes, values and practices that promote cultural competence within health. Use these areas as a starting point to advance your own learning.

This Self-Assessment Tool has been adopted from Promoting Cultural and Linguistic Competency, Self-Assessment Checklist for Personnel Providing Primary Health Care Services*, Tawara D. Goode, National Centre for Cultural Competence, Georgetown University Centre for Child & Human Development, University Centre for Excellence.*

Lens Tool # 3: Program Development Tool

This tool is to be used throughout the process of developing a program for the organization. People from diverse cultural groups should be engaged in every step of program development, including the identification of the need for a program, preparation and assessments, action planning, implementation and evaluation. You may decide along the way that multiple programs are needed specifically for cultural communities.

Diverse identities and priority populations within communities should be considered and involved throughout the process**.**

Understand core cultural issues of those I work with and care for

What to do before you start program development (scan, scoping, evidence review, research)

- Have you made it a priority to build reciprocal relationships by participating in events organized by diverse communities? Have you learned about the history of these communities and their citizens' understanding of health? Have you shared any learning opportunities?

- Do you know the structure of the community and who needs to be involved in program development?

- Have diverse individuals and priority populations been considered or invited to contribute to the identification of the need. Have health equity, root cause, social determinants of health, and positive and negative impacts to diverse individuals and priority populations been considered?

- Have you considered identity, health beliefs and practices, complementary/traditional providers, family structure/role, foods, community supports and spirituality?

- Have you searched for evidence by sex/gender/culture and disparity (incident/prevalence, diagnosis, risk factors, treatment)?

- Have you considered ways to address areas where there's a lack of local evidence of disparity or disadvantage; for example, through local databases, focus groups and patient surveys?

- Have you identified and explored ways to address priority populations, areas of sex/gender, culture and disparity, such as through poor health status and cultural practices that are different from the dominant culture?

Negotiate for mutually acceptable intervention of care

What is your new program plan?

- ☐ Have diverse individuals and groups been engaged in the development of the program and provided input on draft documents?
- ☐ Have you explicitly noted and addressed possible priority populations, areas of sex/gender, culture and disparity?
- ☐ Have you integrated diversity and priority populations' needs, strengths and differences in intake, assessment, tools, care approaches and communications?
- ☐ Have you considered whether multiple or different programs are needed?
- ☐ Have you reflected diversity in images and content?
- ☐ Have you considered literacy and health literacy?
- ☐ Have you provided multimedia and alternate-format materials such as large print, braille and audio/digital?
- ☐ Have you considered costs, transportation and child-care barriers?

Are you using the following when implementing the program?

- ☐ Are you profiling priority populations, areas of sex/gender, culture and disparity and aligning your program with your organization's strategic plan?
- ☐ Are you using trained interpreters?
- ☐ Are you providing culturally appropriate materials in languages used locally?
- ☐ Are you sharing a diversity of community stories and voices?
- ☐ Are you integrating culture and language in program promotion?
- ☐ Are you building empowerment and basing programs on strengths?
- ☐ Are you engaging community members and local organizations in implementing the program?

Have you considered the following when evaluating the program?

- ☐ Have you engaged priority populations, areas of sex/gender, culture and disparity in assessing effectiveness and whether goals were met or changes are needed?
- ☐ Have you shared information in ways that are easy to read and understand?
- ☐ Have you considered making information available in other languages or through community-dissemination channels?

More information

NSHA Central Zone's Diversity and Inclusion areas of focus: policy.nshealth.ca/Site_Published/DHA9/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=45145

Information and supports to appropriately and respectfully engage patients and citizens, including those from diverse groups: http://www.cdha.nshealth.ca/system/files/sites/317/documents/guide-effective-engagement.pdf

A cultural competence assessment tool for provincial program clinical guidelines: novascotia.ca/dhw/diversity/documents/cultural-competence-assess-tool.pdf

Intersectionality-Based Policy Analysis; *Intersectionality: Moving Women's Health Research and Policy Forward*; Olena Hankivsky, Renee Cormier and Diego de Merich: bccewh.bc.ca/wp-content/uploads/2012/05/2009_IntersectionaliyMovingwomenshealthresearchandpolicyforward.pdf

Lens Tool # 4: Policy Development Tool

You can use this tool when developing a new policy for the organization. Some questions can be used if you are reviewing an existing policy. We encourage you engage with people from diverse communities in every step -- from identifying the issue to implementing the policy.

Identifying the Issue (scan, scoping, evidence review, research)

- Have diverse individuals and priority populations been involved in identifying the issue or reason for the policy?
- What inequities exist in relation to the issue and who is affected? How will the policy benefit some or disadvantage others?
- Have root causes for health inequities, social determinants of health, and positive and negative impacts on diverse and priority populations been considered?
- What is research/data telling you? Have you searched for evidence by sex/gender/culture and disparity (incident/prevalence, diagnosis, risk factors, treatment)?
- What gaps have you identified? Do the expected outcomes bridge the gap or will they increase inequitable situations?
- Have you considered an exception clause or multiple/different policies to address the needs and limitations of different groups or populations?

Implementing the policy

- Are you engaging people from diverse populations and local organizations in implementing the policy?
- Have you shared policy with people affected?
  - Are you providing culturally appropriate materials in languages used locally?
  - Are you integrating culture and language in policy promotion?
  - Are you considering literacy and health literacy?
  - Have you provided multimedia and alternate-format materials such as large print, braille and audio/digital?

Outcomes: What are the outcomes and how do you know the impact on diverse populations?

Evaluation: How will you know you have achieved the outcomes and the policy has made a difference?

Lens Tool #5: Organizational Lens Tools
Looking at Mission, Vision and Values as well as Strategic Plans and Leadership

These lens tools are customized for use by formal leadership teams as a guide to enhance diversity, inclusion, equity and cultural competence in your organization's vision, mission and values; leadership and strategic plans. Some of the tools or questions within the tools can be used for the development of cultural competence in teams.

a) Health Organizational Assessment Tool

This tool assesses general organizational practices by asking questions of best practice to lead cultural competence. The Opportunities for Improvement sections will help set priorities for moving forward.

Reflect on the health-organization leadership components below and note opportunities for change.

In our communications, to what extent do we...
• have training in/use cross-cultural communication skills? • use trained interpreters? • provide culturally appropriate materials in languages that are commonly used locally? • reflect diversity in images and content? • share stories and voices that reflect diversity? • consider literacy and health literacy? • provide multimedia and alternate format materials such as large print, braille and audio/digital? • use community and strengths-based promotion media and strategies? This can be done by tapping into what works for each community, whether it's social media, church bulletins and local newspapers or what the community has already established and works well.
Opportunities for improvement
In our governance and workforce systems, to what extent do we... • recognize the importance of cultural competence and health equity by including them in our vision, mission and strategic-action areas? • ensure that cultural and linguistic diversity are represented in leadership and the workforce? • provide ongoing diversity and cultural-competence training for leaders, employees, physicians, learners and volunteers?

- implement and support the ongoing work of Employment Equity through planning, training, monitoring and staff supports?

Opportunities for improvement

In our engagement with communities, to what extent do we...

- ensure that our decisions about cultural diversity and priority populations are informed by the most up-to-date research, community profiles and data?
- ensure that we engage equitably and respectfully with culturally diverse individuals, communities and priority populations to inform our work?
- collaborate with equity-seeking groups, researchers, services providers, staff and allies who can inform our work in cultural and linguistic competence?

Opportunities for improvement

With respect to staffing and volunteers, to what extent do we...

- recruit, retain and support culturally and linguistically diverse staff at all levels?
- use community-based health workers?
- require ongoing cultural-competence training and supports for staff and volunteers?
- ensure accountability for cultural competence in performance?
- reward individuals who promote cultural competence?
- provide opportunities for and the ongoing monitoring of respectful workplace concerns?

Opportunities for improvement

In our physical environment, to what extent do we...

- consider safety and accessibility?
- integrate diversity and priority populations in images, materials and reflective/spiritual spaces?
- provide easy-to-use signage and information in different languages?
- ensure that staff and/or volunteers are on hand to help with navigation?
- identify, sign and share gender-inclusive washrooms?
- provide accessible spaces for spiritual healing and nourishment?

Opportunities for improvement

With respect to accountability, to what extent do we...

- appropriately and confidentially collect data by sex/gender, diversity and population

identifiers at intake? Ensure that providers receive training in appropriate data-collection approaches? Ensure that data is safely stored and remains confidential?

- base decisions on evidence about diversity, not opinion?
- track and follow up with employment-equity progress?
- track and follow up with respectful-workplace issues?
- ensure that goals and success factors for diversity and health equity are clearly defined, shared and supported?
- identify and monitor accountability for goals and outcomes through budgets, programs, usage data and other means?
- build inclusion into the business-planning process? Into procurement?

Opportunities for improvement

b) Vision, Mission and Values

This tool will help you look at your vision, and the other value statements addressed in it, from a diversity and inclusion perspective. It will also help consider cultural competence, diversity and inclusion in living these values.

Our Mission:

How do we value culturally diverse individuals, communities and priority populations in people-centred health, healing and learning?
Can we identify the cultures to which we belong and the significance of that membership, including the relationship of individuals in that group with individuals from other groups, institutionally, historically, educationally, etc.?
Are we aware of our social status and privileges in relation to the different populations that will be impacted by our mission?
How do we challenge our biases toward our own cultures in setting standards?
How will we enhance access to care for culturally diverse individuals, communities and priority populations?
How does our research focus on and inform us about appropriate and effective care for culturally diverse individuals, communities and priority populations?
To what extent does our staff reflect the cultural diversity of the communities that we serve? What are we doing to recruit, hire and retain culturally diverse staff across the province?

Key points to be included in mission:

Vision

How is our vision of health informed by cultural diversity and the needs of priority populations across the province?
What have we done to ensure health equity for culturally diverse individuals, communities and priority populations?

Key points to be included in vision:

Values

Are we aware of the cultural source of our values?
Do we understand the different meanings our value statements may hold for diverse populations and cultures?
What recent actions have we taken to show that we understand and include culturally diverse beliefs, values and attitudes that are different from our own?

Are we aware of the privileges that benefit us but might not be equally enjoyed or understood by people from diverse backgrounds and realities?
What stand have we taken lately to ensure equity for culturally diverse individuals, communities and priority populations? What can we do to help others be courageous in ensuring equity for culturally diverse individuals, communities and priority populations?

Do we understand the culturally specific nature of expressing caring?
How does our compassion extend to include differences?

How open are we to differences?
How have we accounted for cultural diversity in our values and our work?

Do we recognize the culturally specific nature of the information and application of science?
How can we respectfully show that we're inquisitive when we encounter culturally diverse ways of being, caring, doing and exploring? And how do we accommodate such difference?

Key points to be included in values:

c) Diversity in Action – Developing Strategic Goals

This lens will help formal leaders ensure that cultural competence, diversity and inclusion are part of decision-making processes when developing the organization's strategic goals.

Person-Centred Health Care	
☐ What do we know about the needs of culturally diverse individuals, communities and priority populations? ☐ How have we adapted care to ensure that these needs are being met? How do we know if we have met these needs? ☐ How have culturally diverse individuals and communities been considered in patient instructions and discharge summaries? ☐ How will we ensure that our chronic disease-management outreach and services include culturally diverse approaches for individuals and populations?	
Notes for potential strategic goals:	
Citizen and Stakeholder Engagement	
☐ What do we know about the assets and needs of culturally diverse individuals, communities and priority populations in managing their own health? ☐ What do we need to do to equitably engage with culturally diverse individuals, communities and priority populations to ensure that health literacy, language and cultural differences are considered in care?	
☐ Who has been trained in cultural competence and safety? In health literacy? ☐ Are interpreter services available and being used? ☐ Are materials available in plain language? In different languages? In alternative formats? ☐ How much do patients understand about their care?	

☐ How do care providers integrate the needs and realities of culturally diverse individuals, communities and priority populations in care delivery?	
☐ How have culturally diverse individuals, communities and priority populations been considered in addressing the appropriateness of care?	
Notes for potential strategic goals: **Leadership**	
☐ How do leadership capacities value language and cultural differences? Cultural and linguistic competence? ☐ What strategies are in place to recruit and support culturally diverse leaders?	
☐ How do performance measures integrate and account for culturally and linguistic competence and the valuation of diversity?	
Notes for potential strategic goals: **Innovating and Learning**	
☐ What innovations target health equity for culturally and linguistically diverse populations?	
☐ How could our partnerships help build equity and inclusion by bridging culturally diverse, health care and academic communities? How could they help people from diverse populations have equal access to health care education and jobs?	
☐ How can we support cultural and linguistic competence within inter-professional teams?	
Notes for potential strategic goals:	

Sustainability	
☐ How have we examined factors such as health literacy, language and cultural diversity in service access and use? Length-of-stay data? Return visits? Outreach? ☐ How are we using equity practices for diverse populations to share societal rewards and reduce social ills and illnesses, and the cost that goes with them?	
Notes for potential strategic goals:	

PART II: Understanding Our Communities

Introduction

This section provides general details about diversity in Nova Scotia, including potential health-disparity information for select culturally diverse groups. What we've presented is a starting point for further investigation and discussion with individuals and communities in order to identify health and language needs and priorities. There's no question that more information is needed, and only the individual or community knows if the generalizations are appropriate.

Highlights in this section include:

- Languages spoken
- Ethnic origins and visible minority status
- Religion and spirituality
- Sex and gender
- Poverty and low social status
- Aboriginal Peoples (First Nations, Inuit and Métis)
- African Nova Scotians
- Immigrants and Refugees
- Pride health (spectrum of sexual orientation and gender identity)
- (Dis)abilities (physical and mental)
- Acadian and francophone Nova Scotians

The information has been gathered from myriad sources, populations and regions.

Things to keep in mind when reviewing this information:

- **Resist the practice of "othering."** This is the tendency to classify people or groups in a way that separates them from the whole. An "us" and "them" mentality supports a social hierarchy and power imbalances.
- **Everyone has a unique cultural identity.** Identities also intersect. People often identify with more than one cultural group.
- **There is as much diversity within cultures as across them.** Sex and gender, life stage, social status and other factors mean that no single cultural identity defines a cultural group. Everyone has a unique personality, aspects of shared cultural identity and a common humanity.
- **There is a difference between self-identity and being identified.** No one benefits from having their identity described and prescribed by others. People need to be able to self-identify with cultural groups. They also must choose if general information about a group applies to them. Unfortunately, people's health is partly determined by the identity imposed upon them by others.
- **Beware the dangers of stereotyping.** A stereotype is a belief or an attitude about a person or group that may not be based in reality. Stereotyping leads to the end of dialogue and understanding. For all of the above reasons, use the information provided here to inform your work but don't use it to stereotype an individual or a group.

Languages Spoken

The following statistics are based on the identification of a mother tongue, which is the first language learned at home in childhood and still understood by the person.[3]

- 94 per cent of residents in Nova Scotia listed English as their mother tongue.
- French is the second most-spoken language in Nova Scotia. More than 30,000 residents (3.5 per cent of the Nova Scotia census population) listed French as their mother tongue.
- Arabic is the third most-spoken language. Some 5,960 residents (0.7 per cent) listed Arabic as their mother tongue.
- Other languages listed are Chinese[4], German, Spanish, and Tagalog.
- Language is embedded in the culture, cultural identity and access to and use of health services and all forms of effective health communication.

Mother Tongue, Nova Scotia (2011)[5]

Single and Multiple Responses		
Language	**Population**	**% of total**
English	836,090	94
French	31,105	3.5
Arabic	5,960	0.7
Chinese	4,325	0.5
English and non-official language	2,855	0.3
English and French	3,035	0.3
German	3,375	0.4
Spanish	1,550	0.2
Tagalog (Filipino)	1,190	0.1
Mandarin	905	0.1
Total reported	***890,290***	***100***

Ethnic origin

According to Statistics Canada's National Household Survey, "ethnic origin[6]" refers to the ethnic or cultural origins of the respondents' ancestors. To be clear, ethnic origin refers to a person's roots and shouldn't be confused with his or her citizenship, nationality, language or birthplace.

- 60.4 per cent of Nova Scotia's population identified as being from the British Isles, which includes those living in the Channel Islands, Cornwall, England, Ireland, the Isle of Man, Scotland and Wales.
- 353,915 (39 per cent) of those surveyed identified as Canadian.

[3] These results are based on the most recent census data (2011) available for Nova Scotia.
[4] Chinese isn't really a language but rather the name of eight different language families. There are more than 292 living languages in China, including Mandarin (identified by 905 individuals in Nova Scotia).
[5] Source: Statistics Canada. 2012. Nova Scotia (Code 12) (table). Census Profile. 2011 Census. Statistics Canada Catalogue no. 98-316-XWE. Ottawa. Released October 24, 2012. www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/index.cfm?Lang=E (accessed May 6, 2013).
Data includes Canadian citizens and permanent residents, as well as persons with a usual place of residence in Canada who are claiming refugee status and who hold study or work permits, as well as any family members living with them.
[6] Statistics Canada. 2013. Nova Scotia (Code 12) (table). National Household Survey (NHS) Profile. 2011 National Household Survey. Statistics Canada Catalogue no. 99-004-XWE. Ottawa. Released June 26, 2013. www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E
(accessed May 6, 2013).

- 154,150 (17 per cent) identified as being of French origin, which includes the Alsatian, Breton and French. Some 20,500 (2.3 per cent) identified as Acadian.

Ethnic Origins, Nova Scotia (2011) [7]

Reported ethnic origin	**Population**	**% of total**
British Isles	547, 230	60.4
Canadian	353,915	39.0
French origin	154,150	17.0
Western Europe (Dutch, German, other)	125,780	13.9
North American Aboriginal	52,930	5.8
Eastern Europe (Polish, Ukrainian, other)	26,515	2.9
Southern Europe (Italian, other)	26,440	2.9
West Central Asian/Middle Eastern	14,715	1.6
African	15,110	1.7
East/Southeast Asian (Chinese, other)	11,365	1.3
Acadian	20,500	2.3
Northern Europe (Finnish, Scandinavian)	14,640	1.6
South Asian (East Indian, other)	5,935	0.6
American (United States)	7,115	0.8
Caribbean	4,215	0.5
Jewish	3,665	0.4
Central/South America	2,380	0.3
Total reported (Nova Scotia)	***906,170***	***100***

Visible Minority Status

The Employment Equity Act defines visible minorities as persons (other than Aboriginal Peoples) who are non-Caucasian in race or non-white in colour.[8]

[7] People answer the question of ethnic origin very differently. Some respondents provide specific ethnic origins, while others choose general responses. This means that two respondents with the same ethnic ancestry could have different response patterns and thus could be counted as having different ethnic origins. It's also possible for people to report more than one ethnic origin in the census. As a result, the numbers in the below table are population estimates only, and the sum in this table is greater than the total population estimate.

[8] Statistics Canada. 2013. Nova Scotia (Code 12) (table). National Household Survey (NHS) Profile. 2011 National Household Survey. Statistics Canada Catalogue no. 99-004-XWE. Ottawa. Released June 26, 2013. www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E
(accessed August 26, 2013).

Visible Minority Status, Nova Scotia (2011)

	Population	% of total
Total non-visible minority population[9]	858,900	93.0
Total visible minority population	**47,270**	**5.1**
Black	*20,790*	*2.2*
Arab	*6,290*	*.66*
Chinese	*6,050*	*.63*
South Asian (East Indian, Pakistani, Sri Lankan, other)	*4,965*	*.52*
Filipino	*1,890*	*.2*
West Asian (Iranian, Afghan, other)	*1,365*	*.14*
Latin American	*1,360*	*.14*
Multiple visible minorities	*1,290*	*.13*
Southeast Asian (Vietnamese, Cambodian, Malaysian, Laotian)	*1,155*	*.12*
Korean	*960*	*.10*
Visible minority not included elsewhere	*720*	*.08*
Japanese	*445*	*.05*
Total	***953,450***	***100***

Religion and spirituality, Nova Scotia (2011)

Spirituality is way of living through which people find meaning, hope, comfort and peace. Religion is one path to spirituality.

Religion and spirituality have deep connections to health, influencing health beliefs and practices during stress, illness, dying and death, as well as birthing and postpartum rituals. For some cultural groups, food rituals are an important part of religious holidays and celebrations.

- A majority of Nova Scotia citizens identify as Christian (76.2%). Catholic (32.9%), Anglican (13.1%) and United (11%) are the predominate Christian subgroups.
- 25% of Nova Scotia survey respondents indicated that they have no religious affiliation (197,665 people; 21.8%).
- 8,505 (.93%) identified as Muslim.
- This is followed by those identifying as Buddhist (0.2%), Hindu (0.2%), Jewish (0.19%), Sikh (0.04%) and traditional (Aboriginal) spirituality (0.06%).

[9] Total non-visible minorities includes individuals who identify as Aboriginal, as well as all others who don't identify as a visible minority.

Religion, Nova Scotia (2011)[10]

	Population	% of total
Buddhist	2,205	0.2
Christian	690,460	76.2
Catholic	298,270	32.9
Anglican	100,120	13.1
United Church	109,700	11.0
Baptist	80,815	8.9
Other (Christian Orthodox, Lutheran, Pentecostal, Presbyterian, other)	55,555	6.1
Hindu	1,850	0.2
Jewish	1,805	.19
Muslim	8,505	.93
Sikh	390	.04
Traditional (Aboriginal) spirituality	570	.06
No religious affiliation	197,665	21.8
Total by religion	***906,171***	***100***

[10] According to Statistics Canada, religion refers to the person's self-identification as having a connection or affiliation with any religious denomination, group, body, sect, cult or other religiously defined community or belief system. Religion isn't limited to formal membership in a religious organization or group. Those without a religious connection or affiliation can self-identify as atheist, agnostic or humanist, or they can provide another applicable response. Data source: Statistics Canada. 2013. Nova Scotia (Code 12) (table). *National Household Survey (NHS) Profile. 2011 National Household Survey.* Statistics Canada Catalogue no. 99-004-XWE. Ottawa. Released June 26, 2013. www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E (accessed July 2, 2013).

Aboriginal Peoples: First Nations, Inuit and Métis

Definitions:

Aboriginal People: The descendants of the original inhabitants of North America. The Canadian Constitution recognises three groups of Aboriginal people – Indians, Métis and Inuit. These are three separate people with unique heritages, languages, cultural practices and spiritual beliefs.

Aboriginal Rights: Rights that some Aboriginal peoples of Canada hold as a result of their ancestors' long-standing use and occupancy of the land. The rights of certain Aboriginal people to hunt, trap and fish on ancestral lands are examples of Aboriginal rights. Aboriginal rights vary from group to group depending on the customs, practices and traditions that have formed part of their distinctive cultures.

Band: A body of Indians for whose collective use and benefit lands have been set apart or money is held by the Crown, or declared to be a band for the purposes of the *Indian Act*. Each band has its own governing band council, usually consisting of one chief and several councillors. Community members choose the chief and councillors by election, or sometimes through custom. The members of a band generally share common values, traditions and practices rooted in their ancestral heritage. Today, many bands prefer to be known as First Nations.

First Nation: A term that came into common usage in the 1970s to replace the word "Indian," which some people found offensive. Although the term First Nation is widely used, no legal definition of it exists. Among its uses, the term "First Nations peoples" refers to the Indian peoples in Canada, both Status and non-Status. Some Indian peoples have also adopted the term "First Nation" to replace the word "band" in the name of their community.

Inuit: An Aboriginal people in Northern Canada, who live in Nunavut, Northwest Territories, Northern Quebec and Northern Labrador. The word means "people" in the Inuit language — Inuktitut. The singular of Inuit is Inuk.

Métis: People of mixed First Nation and European ancestry who identify themselves as Metis, as distinct from First Nations people, Inuit or non-Aboriginal people. The Métis have a unique culture that draws on their diverse ancestral origins, such as Scottish, French, Ojibway and Cree.

Status Indian: A person who is registered as an Indian under the *Indian Act*. The act sets out the requirements for determining who is an Indian for the purposes of the *Indian Act*.

Non-Status Indian: An Indian person who is not registered as an Indian under the *Indian Act*.

Reserve: Tract of land, the legal title to which is held by the Crown, set apart for the use and benefit of an Indian band.

Off-reserve: A term used to describe people, services or objects that are not part of a reserve, but relate to First Nations.

Did you know?

- 33,845 individuals identify as Aboriginal in Nova Scotia (Statistics Canada, 2011). Of this total 65 per cent identify as First Nations, 30 per cent as Métis and 2 per cent as Inuit.
- The Mi'kmaq are the original people of Nova Scotia and remain the predominant Aboriginal group within the province.
- Nova Scotia has 13 Mi'kmaq First Nations and 34 reserve locations across the province.
- A growing portion of the Aboriginal population resides in urban HRM. [11]
- Mi'kmaw, and other Aboriginal languages are spoken in Nova Scotia.
- Aboriginal peoples have high rates/risk of high blood pressure, diabetes, heart disease, stroke and higher rates of HIV/AIDS, STDs, Hep A and C and cancer.
- In 2011, the Mi'kmaq Maliseet Atlantic Health Board (MMAHB) Chiefs re-identified Mental Health, Addictions and Elder Care as health priorities and named Investing in Children and Youth as a new health priority area.

Learning more:

- **Truth and Reconciliation Commission: http://www.trc.ca**
- Mi'kmaq Native Friendship Centre: http://www.mymnfc.com
- Confederacy of Mainland Mi'kmaq: http://www.cmmns.com
- Union of Nova Scotia Indians: http://www.unsi.ns.ca
- Native Council of Nova Scotia (provides a range of services primarily to Aboriginal people living off-reserve): http://ncns.ca
- Atlantic Policy Congress (APC) of First Nations Chiefs Secretariat: http://www.apcfnc.ca
- Atlantic Aboriginal Health Research Program: aahrp.ca

Documents:

Truth and Reconciliation Commission Report of Canada: http:/www.trc.ca

Confederacy of Mainland Mi'kmaq (2011). Mi'kmaw Resorce Guide: www.cmmns.com/publications/MIKMAWRGWeb.pdf

See *Reports and Documents* section of APC Health: http://www.apcfnc.ca/en/health/healthhome.asp

[11] NS Office of Aboriginal Affairs.

Loppie Reading, C and Wein, F (2009). *Health Inequalities and Social Determinants of Aboriginal Peoples Health.* National Collaborating Centre for Aboriginal Health. Online, available at: ahrnets.ca/files/2011/02/NCCAH-Loppie-Wien_Report.pdf

National Aboriginal Health Organization (2008). *Cultural competency and safety in First Nations, Inuit and Métis health.* Online, available at: www.naho.ca/documents/naho/english/factSheets/culturalCompetency.pdf

Aboriginal Health Legislation and Policy Framework in Canada Fact Sheet (2011). Online, available at: www.nccah-ccnsa.ca/en/publications.aspx?sortcode=2.8.10&publication=2

Acadians and Francophones

- In census data, more than 31,105 listed French as their mother tongue.
- The number of Francophone residents in Nova Scotia is 34,580, 3.8 per cent of Nova Scotia's population, with an additional 96,165 residents having knowledge in both official languages.
- Most Francophone residents are concentrated in the Acadian and Francophone regions of Isle Madame, Cheticamp, Clare, Argyle and Halifax.
- French is the second most-spoken language in Nova Scotia after English.
- 20,500 (2.3 per cent) of Nova Scotians identify as Acadian.

Acadian and francophone health

- The history and lived experience of discrimination (phobias, segregation, stereotyping) contributes to marginalization, oppression and low social status. For some, this is exacerbated by the loss of their language and culture. These burdens, either separately or combined, often impact the mental and physical health of individuals, including an increase in stress, depression and high-risk behaviours.
- Communication challenges include medical records, prescriptions, forms and written health materials not provided in French. Signs and posters about the availability of services in French aren't promoted well enough in health care facilities. There's also a shortage of francophone health care providers. The written information in French that is available isn't always provided in plain language. Interpretation services aren't always available or widely provided. The prominent role of spirituality and faith isn't always considered in care.

More information

Nova Scotia Office of Acadian Affairs: gov.ns.ca/acadian/fr/index.htm

Le Réseau Santé–Nouvelle-Écosse: reseausantene.ca/English.htm

Fédération acadienne de la Nouvelle-Écosse: fane.ns.ca

Nova Scotia Department of Health, French Language Services: gov.ns.ca/health/fls/default_en.asp

African Nova Scotians

- African identity is represented by three distinct groups:
    - Indigenous (have no country of ethnic origin other than Canada)
    - Caribbean immigrants
    - Immigrants from the African continent

- 81.4 per cent of African Nova Scotians were born in the province, while 8.2 per cent were born elsewhere in Canada. 64.8 per cent of the population has lived in Nova Scotia for three generations or more.

- 8 per cent of African Nova Scotians today are immigrants, coming primarily from West Africa, the Caribbean and Bermuda, East Africa and the United States.[12]

- According to Statistics Canada (Ethnic Origin, 2011), 20,790 individuals identified as Black in Nova Scotia.

- There are more than 48 distinct African Nova Scotian communities across Nova Scotia. Sixty-six percent of African Nova Scotians live in Halifax.

African Nova Scotian Health[13]

- Racism has been known to profoundly affect the health of racially visible Nova Scotians and their descendants. An overall history and lived experience of discrimination, the "isms", phobias, segregation and stereotyping contributes to marginalization, oppression and low social status. For some, this is exacerbated by loss of language and culture. These burdens, separately or intersecting, often impact the mental and physical health of individuals within populations, including increasing the risk of stress, depression and high risk behaviours.
- Difference in food, family and extended family influences and prominent role of spirituality not always recognized or valued by health systems.
- High rates of and mortality from hypertension, diabetes, cardiovascular disease, coronary heart disease and stroke.
- Diseases, treatments and symptoms on black skin not often considered.
- High prevalence of sarcoidosis, anemia, G6PD deficiency, systemic lupus, sickle cell disorders, asthma and lactose intolerance.
- For women, higher than average incidence of fibroids.
- High incidence of and mortality from cancer – for example colon cancer and prostrate cancer.
- Increase in the past 10 years of African Caribbean and Black community members who have tested positive for HIV. Between 2002 and 2011, African, Canadian and Black communities in Nova Scotia account for the second largest race/ethnicity at 10.3% of all HIV cases in Nova Scotia from 2001 to 2011.

[12] Source: Office of African Nova Scotia Affairs.

[13] Much health information is based on US studies with qualitative or testimony-based evidence only available in Nova Scotia/CDHA.

Learning more

African Canadian Health Network of Nova Scotia: http://africancanadianhealth.weebly.com

Office of African Nova Scotian Affairs (Nova Scotia):
http://ansa.novascotia.ca/

African Nova Scotian Affairs Integration Office (HRM):
www.halifax.ca/Intergovernmentalaffairs/africanNSaffairs.html

Health Association of African Canadians: www.haac.ca

African Diaspora Association of the Maritimes (ADAM): www.adamns.ca

Black Cultural Centre for Nova Scotia: www.bccns.com

Documents:

Kisely S, Terashima M, Langille D. (2008). A population-based analysis of the health experience of African Nova Scotians. CMAJ. Sep 23;179(7):653-8. doi: 10.1503/cmaj.071279.

Search also the extensive publications by Dr Wanda Thomas Bernard and Dr Josephine Etowa.

Population Health Assessment and Surveillance, Department of Health and Wellness, Government of Nova Scotia, *Surveillance Report on HIV/AIDS in Nova Scotia: 1983 to 2011.*

The (Dis)abilities

- In 2010 the United Nations developed a Convention on the Rights of Persons with Disabilities. As it states, the 650 million people in the world living with disabilities—about 10 per cent of the world's population—lack the opportunities of the mainstream population. They encounter a myriad of physical and social obstacles that: prevent them from receiving an education; getting jobs, even when they are well qualified; accessing information; obtaining proper health care; getting around; and "fitting in" and being accepted.

- The conventions says that persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

- 2012 data shows that 18.9 per cent of Nova Scotians were affected by some form of mental or physical disability, as compared with 13.7 per cent of Canadians. This is the highest rate of disability of any province in Canada.

- Between 2001 and 2006 disability rates increased in all provinces, including Nova Scotia. This was partly attributed to an aging population and an increased social acceptance of reporting disability.

- An estimate of Nova Scotia disability rates for individuals age 15 and identified in 2011 census data are:
    - pain (104,750 individuals, 13.7 per cent),
    - mobility (76,380 individuals, 10.0 per cent),
    - flexibility (79,360 individuals, 10.3 per cent),
    - hearing (36,460 individuals, 4.8 per cent),
    - seeing (29,940 individuals, 3.9 per cent),
    - learning (18,700 individuals, 2.4 per cent),
    - memory (19,480 individuals, 2.5 per cent),
    - psychological and/or mental (34,110 individuals, 4.5 per cent)
    - developmental (3,920 individuals, 0.5 per cent)

Learning more

Convention on the Rights of Persons with Disabilities, United Nations, 2010, http://www.un.org/disabilities/

Disability and Inclusion Based Policy Analysis, Institute for Research and Development on Inclusion in Society (IRIS), (2012), www.irisinstitute.ca

Nova Scotia Disabled Persons Commission: http://disability.novascotia.ca

A Blueprint for Action: To Achieve Equitable access to Employment Opportunities for Persons with Disabilities in Nova Scotia, The Report of the Nova Scotia Persons with Disabilities Employability Table, March 2014, http://abilityhere.ca/publications/

Choice, Equality and Good Lives in Inclusive Communities: A roadmap for Transforming the Nova Scotia Services to Person with Disabilities Program, June 2013. https://novascotia.ca/coms/putpeoplefirst/docs/SPD_Transformation_Plan_and_Roadmap.pdf

Many resources, including health resources and communication aids, are available to the blind and visually impaired community through the Canadian National Institute for the Blind (CNIB): http://www.cnib.ca/en/ns-pei/Pages/default.aspx. Users of CNIB services can also access resources from the national CNIB library.

Accessible Transportation, HRM: www.halifax.ca/Accessibility/AccessibleTransportationServices.html

Society of Deaf and Hard of Hearing Nova Scotians: www.sdhhns.org

Brain Injury Association of NS: http://braininjuryns.com

Poverty and low social status

- Socio-economic status (SES) is a person's position in society—the social class they belong to. Income and education levels as well as occupational status are often used as indicators of SES, although they do not determine SES and are not perfect indicators.
- Income and social status are often seen as the most important determinants of health. As we earn more income and move up the social ladder, health status typically improves. Canadian sociologists have found, however, that while relatively good social mobility takes place in the middle, people at the lower end of the social ladder tend to get stuck. Income and social status are also influenced by other social determinants of health such as race and gender.
- In 2011, 17.3 per cent of children in Nova Scotia were living in families with incomes below the AT-LIM (After-tax Low Income Measure). This compares with 14.3 per cent AT-LIM in Canada. Forty per cent of poor children live in families with at least one full time wage earner. This is an upward trend. (2013 Report Card on Child and Family Poverty)
- In March 2013, 21,760 Nova Scotians were helped by food banks, of which 32 per cent were children. This is an increase of 28.6 per cent from 2008. (2013 Hunger Count)
- Low income rates are higher among diverse groups such as seniors, single parents, First Nations, the disabled, immigrants and African Canadians. It is important not assume that because someone belongs to one of these groups, however, they are poor. There is a concern in these communities that some health care providers treat everyone as if they cannot afford coverage for certain treatments, they have common diseases etc. Women are also disproportionately represented in low income statistics.
- The health effects of low income and education are often greater in groups who have faced a long history of racism, exclusion and marginalization. The more a person reflects the dominant cultural and language groups in a society, the higher their social status and the better their health (and vice versa).
- Societies with less of a spread between rich and poor have better overall health status than those with a wide spread between the two groups.
- Living on a low income means less access to food, especially nutritious foods such as fresh fruits and vegetables; adequate housing; wellness resources such as recreation facilities, health and wellness programs etc; social supports, health insurance to pay for vision care, dental care and medication; and health information, among other things. But the sum of the effects of these inequities can result in a form of stigmatization and social and physical isolation from others. This isolation increases the already poor health status.
- The lower our socio-economic status, the less choices and opportunities we have to enjoy life and engage in all that society has to offer.
- In Canada, inequity—through poverty and exclusion—has more impact on health than the personal health choices people make in their daily lives such as smoking or physical activity.

- The influence of income during childhood years is important to future health. Individuals who lived in low-income circumstances during childhood tend to have poorer health status even if later in life their income and social status improve.
- The provinces of Atlantic Canada have more social, economic, and health inequities than the other Canadian provinces. They also have higher rates of chronic disease.

Learning More:

Social Determinants of Health: The Canadian Facts, Juha Mikkonen and Dennis Raphael (2010), http://www.thecanadianfacts.org/The_Canadian_Facts.pdf

2013 Report Card on Child and Family Poverty in Nova Scotia: 1989-2011, Lesley Frank, Canadian Centre for Policy Alternatives Nova Scotia, http://www.policyalternatives.ca/offices/nova-scotia

Hunger Count 2013, Food Banks Canada (2013) http://www.foodbankscanada.ca/Learn-About-Hunger/Publications/Research.aspx

Sex and/or Gender

Biological sex identifies a person as female, male, or intersex – it's the physical characteristics of a person including things such as sexual and reproductive anatomy, chromosomes and hormones.

Sex is about our anatomy. The assignment and classification of people as male or female based on physical anatomy at birth.

Gender is about our personal identity and is not always aligned to our physical anatomy. Gender Identity is our internal sense of who we are**,** our internal sense of being male, female, both, neither or somewhere in between. Gender identity refers to the internal experience of a person that cannot be determined by others.

In dominant Western society, gender is typically understood within a binary – that is two rigidly fixed options: boy/man or girl/woman. A society or culture makes up the roles and relationships, traits, behaviours, values, power and influence appropriate for boys/men and girls/women at a particular point in time.

Sex and gender are each to be considered along a continuum rather than a binary of male/man and female/woman. Using a male/man or female/woman binary does not include the diversity that exists such as people who are trans gender, intersex and many other identities and experiences.

Society defines different expectations for men's and women's work (paid and unpaid), roles and responsibilities, access to and control over resources, and decision making.

Sex/gender inequalities result in women and trans people being unable to fully take part in society and realize all of their economic, political, and social potential. As a result, they are not fully able to contribute to national, political, economic, social, and cultural development and to benefit from the results. Gender inequalities are also linked to widespread global human rights abuses of women and girls as well as trans people. Gender inequities often lead to health inequities.

It is also important to keep in mind that the intersection of multiple forms of oppression and gender, such as racism, homophobia, or transphobia, further excludes and marginalizes groups of women, girls and trans people. Sex, gender-and diversity-based analysis is an effective approach.

Health: Women, Trans* People and Men

- Gender roles and stereotypes lead to women, trans people and men working in different occupational groups leading to different exposure to risk and illness.
- Women's and trans people's unequal social and economic status affects their health. For example, women bear a higher burden of unpaid caregiving and domestic work.
- Women account for the majority of the paid health-care and social services workforce, which leads to higher stress and poor health.
- Women and trans people are more likely than men to be victims of violence and abuse.
- Women make up the majority of users of the health system because they have babies, care for others, live longer than men, and so on.

- Women form the majority of the poor in Canada and around the globe. Women's and trans people's poverty affects their health in many ways.
- Women and trans people face discrimination, stereotypes, and bias; history of marginalization, exclusion, and oppression. Experiences of individual and systemic racism
- Women and trans people have a higher risk than men of depression and stress
- The incidence and prevalence of many diseases and health concerns differ for women and men (for example, women are twice as likely as men to require hip replacement surgery), and specific groups of women more likely to experience certain illnesses (for example, First Nations and Inuit women have diabetes rates nearly five times than those of other women and higher rates than First Nations and Inuit men)[36]
- Triple work day (paid work, unpaid work, and community work): leads to stress and illness
- Trans people often experience communication barriers due to lack of understanding and intolerance
- Trans people find it difficult and at times unsafe to disclose gender identity in health settings and few health services meet the needs of this group
- Trans people have delayed use of health services and have reduced use of preventative screening
- Transgender parenting is not always considered
- There are hormone and sex reassignment assessments and therapy needs

Recent research with lone mothers in NS:

- Health: Chronic fatigue, osteoarthritis, migraines, diabetes, asthma, cancer
- Mental wellness: Anxiety, depression, bi-polar disorder or manic depression, stress and mental exhaustion. Feelings of isolation and exclusion due to their own or their child's health status.
- Lack of nutritious foods and diet due to limited income
- Housing: poor quality, limited space and unsafe, stigmatized neighborhoods.
- Low income, discrimination and disempowerment in attempts to navigate social welfare and/or support systems.

***** *We use trans to mean anyone who may not feel they are the gender that they were labelled at birth. People who are trans* may also use the labels transgender, transsexual, gender non-conforming, gender variant, genderqueer, gender fluid, pangender or they may not see themselves as fitting into the binary gender structure*

Learning more

Sex and gender-based analysis e-learning resource: http://www.dal.ca/diff/Atlantic-Centre-of-Excellence-for-Womens-Health/e-products/sgba-e-learning-resource.html

Atlantic Centre for Excellence in Women's Health (2013). *Rethinking Health Inequities: Social and Economic Inclusion (SEI) and Lone Mothers in Atlantic Canada:* www.dal.ca/content/dam/dalhousie/pdf/ace-women-health/live/ACEWH_rethinking_health_inequities_SEI_lone_mothers_Atl_Can.pdf

Atlantic Centre for Excellence in Women's Health (2013). *Rethinking Women and Healthy Living in Canada:* www.dal.ca/diff/Atlantic-Centre-of-Excellence-for-Womens-Health/projects-and-publications/healthy-living/healthy-living-report.html

Websites

Atlantic Centre for Excellence in Women's Health: www.acewh.dal.ca (no longer operating as of 2013 but website still active with resources)

Canadian Women's Health Network: www.cwhn.ca

Gender and Health Promotion Studies Unit: gahps.hhp.dal.ca

Trans Health Guide - http://www.cdha.nshealth.ca/pridehealth/trans-health-guide

pride Health

There are several ways to describe this community, including the Rainbow community, sexual minority community, GLBTIQ (gay, lesbian, bisexual, transgender, Intersex, queer) or LGBTTTIQQA (lesbian, gay bisexual, transgender, transsexual two spirit, intersex, queer, questioning, asexual. It is a very diverse community with a wide range of health care needs.

- Studies show that from five to 10 per cent of any population belongs to this community. It is very difficult to accurately assess the size of this community as it is an invisible culture—individuals are in different stages of their own "coming-out" process and identities are fluid and changing.

Sexual orientation is who we are romantically, emotionally, and/or physically attracted to. Everyone has a sexual orientation. Some common labels are lesbian, gay, bisexual, queer, asexual, pansexual and straight.

Gender identity is our internal sense of being male, female, both, neither or somewhere in between. Gender identity refers to the internal experience of a person that cannot be determined by others.

Health: Sexual orientation[14]

- The history and lived experience of discrimination, the "isms", phobias, segregation and stereotyping contributes to marginalization, oppression and low social status. These burdens, separately or intersecting, often impact the mental and physical health of individuals within populations, including increasing the risk of stress, depression and high risk behaviours.
- Communications barriers due to lack of understanding and intolerance
- Difficult and at times unsafe to disclose sexual orientation in health settings
- Delayed use of health services including prevention and screening due to experiences of bias, discrimination and mistrust.
- Few health services appropriately meet needs
- Certain subpopulations, such as seniors, may be removed from life partners or forced back into hiding their identity when interacting with health or long-term care system
- Same-sex couples and parenting are not included nor reflected in forms services, health materials and care plans. Heterosexuality is often assumed.
- Gay men: more likely to experience eating disorders and may be at increased risk of hepatitis and cancer (anal, prostate, testicular or colon).
- Lesbians: may be at increased risk of cancer (breast, gynecologic).
- Lesbians also have specific fertility treatment needs.
- May have very strong, non-traditional social and family support networks that are extremely important to their health and wellbeing.

[14] Most health information in this section is sourced from the Gay and Lesbian Medical Association: http://www.glma.org/

We assume a person's gender is based on the sex they are assigned at birth (e.g. babies assigned male at birth will be boys/men and females assigned at birth will be girls/women). However, this assumption is not always accurate and there is much more diversity in gender identity then there is in assigned sex.

For transgender individuals, gender identity or expression differs from their assigned sex. This can include people who are gender variant or gender nonconforming who have a gender expression that differs from what is considered normative or expected for their perceived gender or assigned sex in a given culture.

Health: Transgender – please see Sex/Gender information sheet in this tool kit

Learning more

prideHealth: www.cdha.nshealth.ca/pridehealth

Nova Scotia Rainbow Action Project: www.nsrap.ca

Canadian Rainbow Health Coalition: www.rainbowhealth.ca/english/index.html

Nova Scotia Rainbow Action Project: www.nsrap.ca

Canadian Rainbow Health Coalition: www.rainbowhealth.ca/english/index.html

Youth Project: www.youthproject.ns.ca

TransAction Society of Nova Scotia: www.facebook.com/TransActionNS

TRANSform Healthcare: www.facebook.com/TRANSformHealthCare or transformhealthcarens.wordpress.com

Queer Health Research NS: www.facebook.com/qhrns

Gay and Lesbian Medical Association: http://www.glma.org/

Immigrants and Refugees

Definitions

Refugee – a person who is forced to flee their homeland for fear of persecution.

Convention refugee – a person who meets the refugee definition in the 1951 Geneva Convention relating to the Status of Refugees. This definition is used in Canadian law and is widely accepted internationally. To meet the definition, a person must be outside their country of origin and have a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.

Asylum-seeker – a person who has left their country to another, seeking or applying for protection. Until a determination is made, it is impossible to say whether the asylum-seeker is a refugee or not.

Refugee claimant – a person who has made a claim for protection as a refugee. This term is more or less equivalent to asylum-seeker and is standard in Canada, while asylum-seeker is the term more often used internationally.

Government Assisted Refugee (GAR) – a refugee who has been offered a permanent home in a country while still outside that country. Refugees resettled to Canada are determined to be refugees by the Canadian government before they arrive in Canada (whereas refugee claimants receive a determination in Canada). Majority of refugees are Government Assisted Refugees and make about 9 to 13 % of all immigrants to Canada.

Immigrant – a person who has settled permanently in another country. Immigrants choose to move, whereas refugees are forced to flee. The majority of immigrants come under the Economic Class as investors, entrepreneurs and skilled worker.

Permanent resident – a person who has been granted permanent resident status in Canada. The person may have come to Canada as an immigrant or as a refugee. After three years of living in Canada, a permanent resident may apply to become a Canadian citizen.

Landed immigrant – this term, still sometimes used, has officially been replaced by the term "permanent resident."

Refugees – Did you know?

- From 2008 to 2012, Nova Scotia welcomed 997 refugees, averaging almost 200 a year.
- Source countries for Government Assisted Refugees (GAR) changes from time to time. For the past several years, in Nova Scotia, GARs have been arriving mostly from Bhutan, Iraq, Afghanistan, Ethiopia, Eretria, the Democratic Republic of the Congo and more recently Syria. Privately sponsored refugees (fewer in number) are mainly from Ethiopia, Columbia, Iraq and Syria
- From 2008 – 2012, the majority of refugees, 63.8 per cent, reported no ability to communicate in English or French.
- Of all refugees arriving in Nova Scotia from 2008-2012, 46.4 per cent were between the ages of 25-64 with 51 per cent under the age of 25.
- Refugees come from areas of the world where there is war, violence, trauma, or political and cultural oppression. As a result, refugees may often experience post-traumatic stress—an anxiety disorder that can occur following a traumatic event.
- Refugees may also have lived in several countries before arriving in Canada, including refugee camps. This, as well as trauma, means they may arrive in poor mental or physical health, having lacked access to food, water, and health/dental health services.

Immigrants – Did you know?

- Nova Scotia welcomed 2,370 immigrants in 2012, an 11 per cent increase from the previous year.
- The proportion of immigrants coming to Nova Scotia from Europe is on the decline, while the number of immigrants from Asia, Central America, Africa, and the Middle East is on the rise. The UK is consistently the largest sources of immigrants and USA and China are also major sources.
- The average age of immigrants coming to Nova Scotia between 2008 and 2012 was 29.9 years. During this same time period 20.6 percent of total immigrants landing were aged 0-14.
- English was the most common first language spoken by immigrants to Nova Scotia, followed by Arabic.
- Most immigrants are healthy upon entry into Canada, but many experience poorer health over time. Culture shock, loneliness, racism, homesickness, and inability to find rewarding employment lead to stress and depression.
- Communication barriers (language, literacy, health literacy) and cultural differences, traditions, beliefs and values are not always understood nor valued by mainstream health systems.

Learning more

Immigrant Services Association of Nova Scotia (ISANS): www.isans.ca

Refugee Health Clinic, 6960 Mumford Road, Halifax, N.S.

Halifax Refugee Clinic (for legal help), 5538 Macara Street, Halifax, N.S.
http://halifaxrefugeeclinic.org

Multicultural Association of Nova Scotia: www.mans.ns.ca

YMCA Centre for Immigrant Programs:
www.ymcahrm.ns.ca/Locations/YMCACentreforImmigrantPrograms.aspx

Documents:

Taking a New Collaborative Approach to Refugee Health in Nova Scotia (2011): www.isisns.ca/wp-content/uploads/2010/06/RefugeeHealthClinic_Report2011.pdf

Refer to the wide range of documents on the Atlantic Metropils Centre website:
http://community.smu.ca/atlantic/working_papers_e.html

PART III: Resources

Concepts and definitions

Culture is a way of life that's characterized by such factors as ethnicity, language, religion, sex, socio-economic class, professional status, age, sexual orientation, group history and life experiences.

Cultural competence in health care is the ability to care for patients with diverse values, beliefs and behaviours, including tailoring delivery to meet social, cultural and linguistic needs.[15]

Cultural competence embraces the importance of culture; the assessment of cross-cultural relations; vigilance toward the dynamics that result from cultural differences, including issues of power, privilege and oppression; and the expansion of cultural knowledge. It enables and empowers clients to improve their lives by building on their strengths and that of their communities and adapting services to meet their culturally unique needs.[16]

Cultural competence isn't simply a technical skill, problem-solving approach or communication technique. It requires a fundamental change in the way we think about, understand and interact with others. Because culture is dynamic, shared and continuous, so is cultural competence. It's a process of "becoming," not an end to be reached.[17]

Cultural competence requires that organizations:[18]

- have a defined set of values and principles and demonstrate behaviours, attitudes, policies and structures that enable them to work effectively across cultures.
- have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge and adapt to the diversity and cultural contexts of the individuals, families and communities they serve.
- incorporate the above in all aspects of policy-making, administration, practice and service delivery and systematically involve consumers and families.

Generally, **cultural safety** involves creating an environment that is safe for people, where there is no assault, challenge or denial of their identity or needs. It's about shared respect, meaning, knowledge and experience—of learning together with dignity and truly listening.[19]

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[15] Betancourt J., Green A., Carrillo J. and O. Ananeh-Firempong (2002). Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care. *Public Health Rep.* Jul-Aug; 118(4):293-302.

[16] Bernard, W.T. and Moriah, J. (2007). Cultural Competency: An Individual or Institutional Responsibility? *Canadian Social Work Review,* Vol. 24, No. 1: 87

[17] Dunn, AM (2002). Culture, Competence and the Primary Care Provider. *Journal of Pediatric Health Care,* 16 (3): 105–110.: 106–107.

[18] National Center for Cultural Competence, 2006: 2.

Cultural safety supports self-determination, where safety is determined by the patient, not the system. Cultural safety moves beyond cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and relationships with colonizers, as they apply to health care.

> "The concept of **cultural safety** evolved as Aboriginal people and organizations adopted the term to define new approaches to healthcare and community healing. Much of the literature confirms that a definition of cultural safety should include a strategic and intensely practical plan to change the way healthcare is delivered to Aboriginal people. In particular, the concept is used to express an approach to healthcare that recognizes the contemporary conditions of Aboriginal people which result from their post-contact history. In Canada, Aboriginal people have experienced a history of colonization, and cultural and social assimilation through the residential schools program and other policies, leading to historical trauma and the loss of cultural cohesion. The resultant power structure undermined, and continues to undermine, the role of Aboriginal people as partners with healthcare workers in their own care and treatment."[20]

Health equity is the absence of systematic disparities in health, or the major determinants of health between groups. Equity has an ethical dimension and is related to human rights. It supports the right to receive the highest attainable standard of health, as indicated by the health status of the most socially advantaged group.

Diversity is differences among people, whether they're individuals or groups. It includes but isn't limited to differences in age, ability, culture, ethnicity, gender, geographical location, language, physical characteristics, race, religion, sexual orientation, socio-economic status, spirituality and values.

Ethnicity is the common social, cultural, linguistic or religious heritage of a group of people.

Ethnocentrism is the tendency of individuals to believe that their way of viewing and responding to the world is the most correct, natural and superior one.

Health disparity occurs if a health outcome is seen in a greater or lesser extent between populations. Race, ethnicity, gender, sexual identity, age, ability, socio-economic status and geographic location contribute to someone's ability to achieve good health.[21]

Health inequity is the presence of systematic health disparities among social groups that have different levels of underlying social advantages or disadvantages that lead to health differences that are unnecessary, avoidable, unfair and unjust.

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[19]. Nursing Council of New Zealand (2002). *Guidelines for Cultural Safety, the Treaty of Waitangi, and Maori Health in Nursing and Midwifery Education and Practice.* nursingcouncil.org.nz/culturalsafety.pdf.

[20] Brascoupé, S. and C. Waters. (2009). Cultural Safety: Exploring the Applicability of the Concept of Cultural Safety to Aboriginal Health and Community Wellness. *Journal of Aboriginal Health*. naho.ca/jah/english/jah05_02/V5_I2_Cultural_01.pdf.

[21] U.S. Department of Health and Social Services (2010). *Healthy People 2020.* healthypeople.gov/2020/about/DisparitiesAbout.aspx.

Race is a group characterized by specific biological traits, including skin colour and skeletal hallmarks.

Diversity at NSHA

To support this work, you can:

- Refer to the Culture Vision database through Library Services
- Access trained cultural health interpreters for patients, clients and families
- Share your stories about diversity and health
- Connect with others who are passionate about diversity and inclusion through committee work or attend a Cultural Competence Education Session

Links and Literature

Links

Nova Scotia Department of Health, *Diversity, Social Inclusion and Cultural Competence*: gov.ns.ca/health/primaryhealthcare/diversity.asp

Centre for Addiction and Mental Health (CAMH) Health Equity: camh.ca/en/hospital/about_camh/health_equity/Pages/health_equity.aspx

Diversity Resources, Alberta Health Services: calgaryhealthregion.ca/programs/diversity/diversity_resources/library/library_master.htm

U.S. Office of Minority Health, *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice:* thinkculturalhealth.hhs.gov/Content/clas.asp

Aboriginal Cultural Safety Initiative: aht.ca/aboriginal-culture-safety

Cultural Safety Modules, University of Victoria: web2.uvcs.uvic.ca/courses/csafety/mod1/index.htm

For an example of a health professional cultural competence statement, visit Canadian Nurses Association, http://cna-aiic.ca/~/media/cna/page-content/pdf-en/ps114_cultural_competence_2010_e.pdf

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Appendix A

Capital Health Position Statement on Diversity and Cultural Competence

The following position statement was developed in September 2011 by then Capital Health, now Central Zone of NSHA:

Capital Health embraces diversity and is committed to providing culturally competent care, programs and services. This will move us toward an equitable health system for all.

We define diversity as differences among people, both individuals and groups. Diversity includes differences in age, ability, culture, ethnicity, gender, geographical location, language, physical characteristics, race, religion, sexual orientation, socio-economic status, spirituality and values.

Cultural competence acknowledges and respects the diverse personal and cultural values of patients, clients, families, staff and citizens.

As a culturally competent organization, we commit to:

- creating a safe, welcoming and inclusive environment.
- involving diverse citizens and communities in program development, implementation and evaluation, from acute care to community programs.
- developing a workforce that reflects the communities we serve.
- providing ongoing education and training in cultural competence to staff, physicians, learners and volunteers.
- advocating for and conducting research that is culturally competent. This will help us identify health inequities.

Everyone at Capital Health has a responsibility to contribute to an equitable health system for all citizens.

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Endorsed by the Leadership Enabling Team, Sept. 27, 2011.

Appendix B

Primary Health Care Cultural Competency Statement

NSHA (Halifax, Eastern Shore, West Hants)

Primary health care providers embrace diversity and work as a team to plan and deliver culturally competent primary health care services and programs.

Descriptors:

- recognizing and respecting the diverse personal and cultural values of patients, citizens, family, staff and community
- valuing and respecting a person's unique definition of family
- providing primary health care that is respectfully delivered and responsive to cultural health beliefs, practices, lived experiences and linguistic differences
- involving and working collaboratively with culturally diverse citizens and communities to design, implement and evaluate targeted, accessible, relevant and effective health initiatives in all aspects of primary health care
- using cultural health-interpretation services to accurately relay and receive what is communicated between the primary health care provider and the patient, citizen, family or community
- reflecting diverse populations in communication materials
- informing, increasing and facilitating culturally appropriate screening for chronic diseases including but not limited to diabetes, cancer, cardiovascular disease, hypertension and sickle cell anemia
- maintaining up-to-date demographic, cultural and epidemiological profiles of service communities in order to effectively plan and provide services that respond to the populations being served by considering:
    - ability
    - culture
    - ethnicity
    - age
    - gender
    - geographical location
    - language
    - physical characteristics
    - race
    - religion and spirituality
    - sexual orientation
    - socio-economic status
    - values

Key source documents

Capital Health (2011). *Capital Health Diversity Position Statement*. Halifax, N.S.
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