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Developing Diversity Competent Public Health Professionals:

A Learning Outline

OPHA Access, Equity and Social Justice Committee
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Contents

Introduction

At the 2006 OPHA Annual General Meeting, a resolution on diversity competent public health professionals (Appendix A) was endorsed. As communities in Ontario become more diverse, it is increasingly important for public health practitioners to understand the many dimensions of diversity, what they mean and how these can be key determinants of health.

Public health practitioners must consider the diversity dimensions and social positions of the individuals, families or communities that programs or services intend to serve. This includes:
- increasing access to appropriate health and social services for marginalized groups facing barriers
- ensuring inclusive policies and procedures
- training public health workers to be diversity competent
- hiring public health workers from minority groups
- helping minority communities build supportive networks
- undertaking research into the impacts of the multiple dimensions of social exclusion on the health status of the intended groups
- empowering marginalized groups to participate in developing policy and program responses to the multiple dimensions of social exclusion

This learning outline is a resource that can be used in the delivery of mandatory diversity competence training within public health units. It provides an outline of learning objectives and content to fulfil minimum requirements related to diversity dimensions, social inclusion, and service delivery and programming for improved access by diverse populations. The concepts and illustrations presented are evidence-based and relevant to all public health disciplines.

Currently, diversity training is being considered and implemented in a variety of ways across the province. Some health units already have well-developed training programs with supporting policies and sustainability plans. Other health units are only just undertaking the process of discovering what diversity competence means to their organization. Consequently, it is important that each health unit customize aspects of the outline's contents so that it is reflective of the populations, communities, and groups within their own area.

Ensuring diversity competence training for all public health professionals will assist in achieving effective practices in public health and population health. This learning outline has the potential to stimulate discussion as to how best to proceed within your organization, as we work to achieve the goal of optimal health for all Ontarians.

The Case for Diversity Training

Rationale

In order to meet the challenges of Ontario's increasingly diverse populations, public health professionals will require sustained diversity competence training and ongoing professional development opportunities. Such training will help to ensure that minimum knowledge and expectations are set out for all staff and management in public health units. According to the former Mandatory Standards and Program Guidelines, all public health programs are required to ensure that barriers to accessing information and services were reduced or eliminated. This required constant review of programs and the demographics of populations being served. In addition, mandatory training for all public health practitioners will foster long-term organizational changes resulting in improved social inclusion of all communities served, and will begin to address health inequities experienced by some individuals and groups.

Draft Ontario Public Health Standards (OPHS) have been in development by the Ministries of Health and Long-Term Care, Children & Youth Services, and Health Promotion during 2006 and 2007 with a final draft produced in April 2007. At this time, implementation of these standards is expected to begin early in 2008. The foundations of the standards are based on four principles of: need; impact; capacity; and partnership and collaboration. These principles recognize the diversity across the province and the importance of consideration of local health needs. The draft OPHS go further than addressing access issues, and mandate programs to proactively identify their priority populations and tailor their programs to suit their unique needs and capacities. According to the draft OPHS, priority populations are identified by surveillance, epidemiological or other research studies, to be at higher risk than the general population for a specific health condition or may generally be vulnerable to the impact of disease or poor health outcomes dues to underlying determinants of health. Priority populations are both those populations at risk and those groups for which public health interventions may be reasonably considered to have a substantial impact at the population level.

The Public Health Agency of Canada has identified core competencies for all public health practitioners (Core Competencies for Public Health in Canada: Release 1.0, September 2007). There are 36 core competencies organized into seven categories, of which one category is "diversity and inclusiveness". It identifies three socio-cultural competencies required to interact effectively with diverse individuals, groups and communities. These competencies state that a public health practitioner is able to:
- recognize how the determinants of health (biological, social, cultural, economic and physical) influence the health and well-being of specific population groups
- address population diversity when planning, implementing, adapting and evaluating public health programs and policies
- apply culturally-relevant and appropriate approaches with people from diverse cultural, socio-economic and educational backgrounds, and persons of all ages, genders, health status, sexual orientation and abilities

At the 2006 OPHA Annual General Meeting, a resolution related to diversity competent public health professionals was passed that endorsed the need for mandatory all-staff diversity training for health units across the province. Specifically related to training, the resolution reads as follows: "…local boards of health and Ontario health units to implement all-staff mandatory diversity training reflecting the population that the health unit services; such training to also include, at a minimum, modules on:

- diversity dimensions, including but not limited to a) racial identity, ethnicity and culture; b) new immigrants and refugees; c) sexual orientation, sexual identity, gender, and gender identity; d) Aboriginal communities; e) socio-economic status, class; f) mental and physical abilities; g) language, literacy, education; h) age; i) geographic limitations
- anti-racism, anti-oppression and social inclusion
- service delivery, programming, and organizational changes that lead to better access and inclusion of diverse populations"

We recognize that providing effective and efficient services to the diverse population of Ontario requires more than diversity competency training for public health practitioners. The development of inclusive policies and procedures, and the hiring of workers from diverse groups are examples of other strategies needed in building a diversity competent organization (as outlined in the introduction). The decision, however, was made to keep this document focused on one aspect of the 2006 resolution, that is, the delivery of diversity training.

Briefly,
- every community has diverse populations, which means that universal programs will not work for everyone
- universal programs can widen the inequities in health as such programs are often accessed more frequently by the mainstream population
- groups that may be considered marginalized because of factors such as income, ability, ethnicity, immigration status and so on, often experience poorer health outcomes
- in order to effectively serve all members of a community, professionals need to become more aware of the needs and sensitivities of groups within their community
- by engaging diverse groups and developing tailored strategies to address identified issues, barriers can be reduced and/or eliminated
- removal of barriers can contribute to the overall improvement of population health outcomes
- public health workers with diversity competency skills are necessary to ensure that programs and services are inclusive
- diversity training within a health unit can be an initial step in the creation of a supportive environment for staff to develop and enhance their skills and competency regarding diversity, people-centred health promotion and social inclusion

Getting Started

This guide is not prescriptive. Rather it is intended to stimulate planning of diversity training within a health unit. Health units will need to adapt and modify the curriculum as required based upon their unique circumstances.

The Diversity Curriculum contains:

- general learning objectives: based primarily on the Diversity Competent Public Health Professionals resolution (2006).
- core training content: provides basic information related to competencies related to diversity. We encourage health units to cover these issues in more depth, as is relevant to their contexts.
- an annotated bibliography: provides additional resources and information that is useful for expanding beyond the content included in the curriculum.
- sample learning plans: illustrate how the general learning objectives can be adapted to a particular health unit's needs and a format that fulfills core content requirements.

Health units need to identify areas that fit their need and tailor their training accordingly. As such, a starting point will be different for everyone.

When initiating diversity training within a health unit, some planning points for consideration might be:

- What does diversity look like in your health unit?
- Have you done a review of existing programs and services and how they are currently used? Where might improvements be needed?
- How do you create/stimulate support for this type of work (at all levels)?
- How do you get "buy-in"?
- Do you have "champions" from within?
- What about possible resistance? Might this be perceived as just one more change to contend with, or the latest "flavour of the month"?
- Who will initiate this training?
- Is it better to train across the health unit, or start with one service area as a "pilot"?
- Are there adequate (formal and informal) communication systems in place (e.g. e-mail, bulletins, meetings) to keep everyone informed about the training?
- What resources (human, physical, financial) are needed to get underway?
- How will you measure the results of implementation?
- Are there other aspects beyond training that need to be developed simultaneously? e.g. development of policy to support training or aspects of programming; revision of documentation practices and policies
- How do you plan now for ongoing professional development?

NOTE: This outline is focused on the provision of education to develop and enhance diversity competence. It is critical however, to recognize that this material can evoke emotions and reactions from participants from a personal/interpersonal perspective. The

session facilitator needs to be prepared to respond appropriately to what may be presented-e.g. altering the presentation, or providing debriefing time. <u>An Educator's Guide for Changing the World: Methods, Models and Materials for Anti-Oppression and Social Justice Workshops</u> is an example in the annotated bibliography that addresses this issue more fully.

General Learning Objectives

The learning objectives for this training outline have been organized into the three sections as described in the OPHA resolution (2006), prepared by the Access, Equity and Social Justice Standing Committee. The draft Ontario Public Health Standards and the core "diversity and inclusiveness" competencies from the Public Health Agency of Canada have also been taken into consideration in the development of these objectives. As such, they are broadly based.

Each section of the core training content indicates which of these learning objectives is being addressed by the content. We encourage each health unit to select and adapt these objectives to be clear, concise and specific to each particular session, and in the context of their own learning requirements.

Diversity Dimensions
1. to increase understanding and valuing of the dimensions of diversity in order to fully integrate these dimensions into daily individual and organizational practices.

2. to increase/enhance self-reflection and acknowledgement (individual and organizational) of one's own values, attitudes and culture.

3. to become familiar with examples of individual and organizational self-assessment tools that foster increased awareness of diversity.

4. to increase/enhance the use of inclusive language and effective communication skills to foster mutual respect in a diverse environment.

5. to increase understanding of the need for tailored health promotion strategies for diverse population groups.

Anti-racism, Anti-oppression, and Social Inclusion
1. to increase awareness and understanding of the impact of the determinants of health upon the individual, community and population as a whole.

2. to increase awareness and knowledge of the continuum of local data on health disparities.

3. to increase awareness among staff regarding principles of community engagement.

4. to encourage discussion/knowledge exchange that examines barriers and power relations that result in inequities.

Service Delivery, Programming, and Organizational Changes

1. to increase staff skills to work with diverse communities in the provision of programs and services in the community.

2. to ensure that diversity is considered and reflected throughout all aspects and levels of the organization (.e.g. positive imaging, signage for a more welcoming environment).

3. to appreciate the value of clear policies in support of an inclusive, diverse work environment (e.g. use of translation, interpretation, communication support, inclusive language).

4. to appreciate the importance of eliminating health disparities in all aspects of health unit program design, implementation, and evaluation.

Definitions

A few sample definitions are included here. This list is by no means exhaustive and alternative definitions are available on many of these concepts. The importance of each health unit adopting a list of definitions is to develop a shared understanding across disciplines and services within that health unit.

Access: A way of approaching or reaching or entering; the right or opportunity to reach or use or visit. (Canadian Oxford Dictionary, 2000)
Access also incorporates two aspects: client access-that is, the extent, to which consumers are able to secure needed services, and organizational access-the extent to which consumers are represented and/or participate in the planning, development, delivery and administration of those services. (Toronto Public Health, 2001)

Bias: A subjective opinion, preference, prejudice or inclination, formed without reasonable justification, that influences an individual's or group's ability to evaluate a particular situation objectively or accurately; a preference for or against. (Canadian Race Relations Foundation, 2005)

Culture: The mix of ideas, beliefs, values, behavioural norms, knowledge and traditions of a group of individuals who share a historical, geographic, religious, racial, linguistic, ethnic or social context, and who transmit, reinforce and modify these ideas and beliefs, passing them on from one generation to another. A culture is the total of everything an individual learns by being immersed in a particular context. It results in a set of expectations for appropriate behaviour in seemingly similar contexts. (Canadian Race Relations Foundation, 2005)

Determinants of health: Definable entities that cause, are associated with, or induce health outcomes. Public health is fundamentally concerned with action and advocacy to address the full range of potentially modifiable determinants of health-not only those which are related to the actions of individuals, such as health behaviours and lifestyles, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environment. These, in combination, create different living conditions which impact on health. (Public Health Agency of Canada, 2007)

Diversity: A term used to encompass all the various differences among people-including race, religion, gender, sexual orientation, disability, socio-economic status, etc-and commonly used in the United States and increasingly in Canada to describe workplace programs aimed at reducing discrimination promoting equality of opportunity and outcome for all groups. Concern has been expressed by anti-racism and race relations practitioners that diversity programs may water down efforts to combat racism in all its forms. (Canadian Race Relations Foundation, 2005)

Equality: The condition of having equal rank, power, excellence, etc. with others. (Canadian Oxford Dictionary, 2000)

Equity/Equitable: Equity means fairness. Equity in health means that peoples' needs guide the distribution of opportunities for well-being. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences and various social and economic conditions, or a result of personal lifestyle choices. Inequities occur as a consequence of differences in opportunity, which result, for example in unequal access to health services, nutritious food or adequate housing. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life. (Public Health Agency of Canada, 2007)

Inclusion: An inclusive society creates both the feeling and the reality of belonging and helps each of us reach our full potential. The feeling of belonging comes through caring, cooperation and trust. We build the feeling of belonging together. The reality of belonging comes through equity and fairness, social and economic justice, and cultural as well as spiritual respect. We build the reality of belonging together by engaging our society to ensure it. (Ontario Inclusion Learning Network, 2006)

Oppression: The unilateral subjugation of one individual or group by a more powerful individual or group, using physical, psychological, social or economic threats or force, and frequently using an explicit ideology to sanction the oppression. Refers also to the injustices suffered by marginalized groups in their everyday interactions with members of the dominant group. The marginalized groups usually lack avenues to express reaction to disrespect, inequality, injustice and lack of response to their situation by individuals and institutions that can make improvements. (Canadian Race Relations Foundation, 2005)

Population health: Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health…The population health approach recognizes that health is a capacity or resource, rather than a state, a definition which corresponds more to the notion of being able to pursue one's goals, to acquire skills and education, and to grow. This broader notion of health recognizes the range of social, economic and physical environmental factors that contribute to health. (Health Canada, 2002)

Priority populations: Priority populations are identified by surveillance, epidemiological or other research studies, to be at higher risk than the general population for a specific health condition or may generally by vulnerable to the impact of disease or poor health outcomes due to underlying determinants of health. Priority populations are both those populations at risk and those groups for which public health interventions may be reasonably considered to have a substantial impact at the population level. (Ontario Public Health Standards, April 30, 2007). Priority populations can include peoples with disabilities, youth, people of low income, the rural population, the lesbian gay bisexual transgendered two-spirited questioning community, Aboriginal peoples, immigrants, refugees, ethno-cultural groups, people with lower literacy levels, and older adults.

Privilege: The experience of freedoms, rights, benefits, advantages, access and/or opportunities afforded members of the dominant group in a society or in a given context, usually unrecognized and taken for granted by members of the majority group, while the same freedoms, rights, benefits, advantages, access and/or opportunities are denied to members of the minority or disadvantaged groups. (Canadian Race Relations Foundation, 2005)

Racism: A mix of prejudice and power leading to domination and exploitation of one group (the dominant or majority group) over another (the non-dominant, minority or racialized group). It asserts that the one group is supreme and superior while the other is inferior. Racism is any individual action, or institutional practice backed by institutional power, which subordinates people because of their colour or ethnicity. (Canadian Race Relations Foundation, 2005)

Social Justice: A concept premised upon the belief that each individual and group within society is to be given equal opportunity, fairness, civil liberties and participation in the social, educational, economic, institutional and moral freedoms and responsibilities valued by the society. (Canadian Race Relations Foundation, 2005)

Systemic discrimination: The institutionalization of discrimination through policies and practices which may appear neutral on the surface but which have an exclusionary impact on particular groups, such that various minority groups are discriminated against, intentionally and unintentionally. This occurs in institutions and organizations where the policies, practices and procedures (e.g. employment systems-job requirements, hiring practices, promotion procedures, etc.) exclude and/or act as barriers to racialized groups. Systemic discrimination also is the result of some government laws and regulations. (Canadian Race Relations Foundation, 2005)

Core Training Content

The core training content is intended for all public health workers within health units. It is presented not as a script, but rather as a listing of content to be considered for inclusion in the presentation of material. This material is not all-inclusive. Health units will need to determine their unique learning needs related to access, diversity and equity, and customize accordingly.

Community Make-up
Learning Objectives: Diversity Dimensions #1
Anti-racism, Anti-oppression and Social Inclusion #1 and #2

A brief demographic picture of Ontario:
- Large data bases can be a starting point for information. e.g. census data, Canadian Community Health Survey. Information is provided on a provincial or regional breakdown basis.

- Census data can only provide limited information about communities.

- Stats Can has a profile of Ontario and its communities from 2001.

- Information from the 2006 census is just becoming available. For example, the population in 2006 was 12,160,282 which was a 6.6% increase from 2001 (accessed July 13, 2007). A breakdown of information into community categories is not available yet.

- Municipalities usually have planning estimates which can be good sources of demographic changes within communities.

A demographic picture of the Health Unit area:
- Statistics Canada has community profiles that have information clustered into census metropolitan areas (CMA) that includes categories such as home language, education, religion, education, employment, family structure, gender, age, visible minority population, Aboriginal population. Community profiles with 2006 data are in the process of release. It must be mentioned that this information is "only one piece of the puzzle".

- Census data can provide only limited information about a community. Additional research methods are needed to provide more depth to understanding the community. Collaborative studies with community organizations to examine the lived experience of income insecurity or to examine the health status of immigrant populations are examples.

- Community agencies, including public health, may have other local information to round out the picture of the community. e.g. health status reports, report cards and snapshots of the community, social planning documents. Start by connecting with the health unit's epidemiologist(s).

- Provincial health status reports may have supplemental information about your community.

- Cultural Interpretation Services (if available in your community) will have other information about languages spoken in the community.

- Observations and evaluations obtained from program and policy implementation will often identify changes in the community before they are reflected in the census.

Understanding Diversity Dimensions
Learning Objectives: Diversity Dimensions #1, #2, #3

The concepts of culture and diversity

- Defining culture is important when discussing diversity dimensions. Much of the literature refers to "culture" in the broadest sense as an all-encompassing concept. However, in some cases, culture is referring to only ethno-cultural groups. Other literature is using terminology focused more on elements of diversity. As we want to emphasize all the contributing factors to culture, we have chosen to use phrases such as "diversity dimensions" and "diversity self-awareness" rather than "cultural self-awareness". In the annotated bibliography, there are many references that use "culture" and "cultural self-awareness" in the broadest sense. Because of that, the content below references both "culture" and "diversity dimensions".

- Definitions of culture have many variations. Most refer to culture in the broadest sense such as the definition from the Canadian Race Relations Foundation which is that culture is "the mix of ideas, beliefs, values, behavioural norms, knowledge and traditions of a group of individuals who share a historical, geographic, religious, racial, linguistic, ethnic or social context, and who transmit, reinforce and modify these ideas and beliefs, passing them on from one generation to another. A culture is the total of everything an individual learns by being immersed in a particular context. It results in a set of expectations for appropriate behaviour in seemingly similar contexts."

- An additional definition from nursing literature is: "the learned, shared and transmitted knowledge of values, beliefs, norms and lifeways of a particular group of people that guides an individual or group in their thinking, decisions, and actions in patterned ways." (Leininger, 1995)

- Anther example of a definition is: "Culture is dynamic, ever evolving and changing, created through individuals' interactions with the world, resulting in ways of naming and understanding reality; shared when individuals agree on the way they name and understand reality; symbolic, often identified through symbols such as language, dress, music and behaviours; learned and passed on through generations, changing in response to a generation or individual's experiences and environment; integrated to span all aspects of an individual's life" (A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia, 2005)

- Further components related to defining culture include:
  - ✓ culture is experiential and learned from birth
  - ✓ culture is a dynamic and continuous process that is influenced by many factors
  - ✓ culture provides an individual with a sense of identity, and a set of rules about how to interact with the world

✓ culture shapes people's viewpoints of institutions, services, power, and social relationships in any given community
✓ we all function within multiple cultures
✓ we operate from a cultural perspective that is unconscious most of the time
✓ culture is shared in varying degrees
✓ although culture is shared, no two people within a culture are identical

- Diversity exists on the basis of many variables that can be visible (e.g. age, gender) and invisible (sexual orientation, religion).

- Self-awareness is the initial step and a critical component in the development of cultural and/or diversity competence.

- Exercises that help promote reflection on one's own personal view of the world, and the examination of beliefs and attitudes are available in the resources cited in the annotated bibliography. Example: a 10 minute exercise to help an individual identify group memberships and begin to develop a picture of the individual's personal culture (Path to Excellent Practice: Embracing Diversity and Building on Strength Participants Workbook, Toronto Public Health, 2006).

- The development of cultural competence is described as that of a continuum. One model depicts a step-by-step process beginning with "unconscious incompetence", developing into "unconscious competence". (Pillar Nonprofits Network Board Diversity Workshop, 2007)

- It is important to distinguish between cultural competence of individual practitioners and that of an organization.

- The National Center for Cultural Competence (2007) states that cultural competence requires that organizations:
✓ have a set of congruent attitudes, practices, polices, and structures that come together in a system or agency and enables professionals to work more effectively in cross-cultural situations;
✓ have the capacity to 1) value diversity, 2) conduct self-assessment, 3) manage the dynamics of difference, 4) acquire and institutionalize cultural knowledge, and 5) adapt to the diversity and cultural contexts of communities they serve; and
✓ incorporate the above into all aspects of policy making, administration, practice, and service delivery and systemically include consumers, key stakeholders and communities.

- Tools have been developed by several organizations for self-assessment (see annotated bibliography). Some starting points are:
  - A Guide for Advancing Family-Centered and Culturally and Linguistically Competent Care (National Center for Cultural Competence, 2007)

- Cultural Competency-A Self Assessment Guide for Human Service Organizations (Cultural Diversity Institute, 2000)
- Organizational Cultural Competence: Self-Assessment Tools for Community Health and Social Service Organizations (Centre for Research in Community Services, University of Ottawa, 2005).

- The level of comprehensiveness and ease of use needs to be assessed by each Health Unit as to which tools are most appropriate for their purposes.

Diverse Populations-Barriers to Access and Inclusion
Learning Objectives: Diversity Dimensions #5
Anti-racism, Anti-oppression and Social Inclusion #4
Service Delivery, Programming, & Organizational Changes #3, #4

- Both inclusion and exclusion are multi-layered, and there are complex connections between inclusion and health. Inclusion has been identified as a primary factor contributing to health and well-being.

- Despite overall improvements in population health, health disparities continue to exist.

- A range of barriers exists that prevent people from receiving and participating in meaningful and appropriate services and supports, or from being included in services and community life.

- Health Canada's document, "Language Barriers in Access to Health Care" (2006), groups barriers into categories of information barriers, environmental barriers, social/attitudinal barriers, cultural barriers, financial barriers, and policy/practice barriers. Using these groupings can be an effective starting point for discussion about barriers within your own community and about Health Unit programming.

- Some examples from the above categories of barriers include:
  Information barriers: information written at a high literacy level or that is highly technical; inadequate or inappropriate signage; information on accessing services is not generally known or available.
  Environmental barriers: physical barriers such as public transportation that is not barrier-free; lack of interpreter services for those who are deaf or hearing impaired; inaccessible room layouts; unwelcoming environment; any location with safety concerns.
  Social/attitudinal barriers: general expectations such as older adults are asexual, that people that receive social assistance are not interested in working
  Cultural barriers: lack of sensitivity to the individual; stereotypical views of groups; lack of awareness and/or sensitivity to cultural issues.
  Financial barriers: services not covered by OHIP; lack of health insurance; fees for services.
  Policy/practice barriers: organizations may have mandates, policies, rules, procedures that create a barrier for service users.

- Social exclusion can be experienced on an individual and community level. Certain groups or individuals cannot participate fully in life due to inequities in access to resources.

- Usually those who require accommodation are unlikely to approach the organization to request accommodation. It is more likely that they will simply

feel unwelcome, consider not participating, or will be unable to do so. Since there is no simple formula for alleviating all barriers and not all needs are apparent, it is important to find out from those involved if there is a way to maximize their participation. Refer to the Inclusive Communities Toolkit (2004) listed in the annotated bibliography for more details.

- The willingness to identify barriers within an organization and then to address and reduce those barriers is a key action in becoming more inclusive.

- The document, An Inclusion Lens-Workbook for Looking at Social and Economic Exclusion and Inclusion (2002) provides another tool to examine elements of inclusion such as adequate income, reduced disparities, human rights, access, ability to participate, valued contribution, belonging, empowerment.

- Inclusion is a process as well as an outcome.

- A sense of belonging, of inclusivity, is a significant factor in the development of a healthy community. Count Me In! is an example of an initiative that is focused on the connections between inclusion and health. "The health of a community or population requires equitable access to the determinants of health. The social determinants of health such as income, housing, employment and education both create and are created by the feeling and reality of belonging."

- The Count Me In! initiative provides further description related to inclusion as characterized by the feeling and reality of belonging.
  The feeling of belonging:
  - being accepted for who one is without judgements, being able to ask for and give support, being given responsibility, being part of a community
  - feeling of mutual respect, belonging, self-esteem, trust, comfort, courage, connection with neighbours and community, empowerment, togetherness, as well as being heard and listened to, and welcomed
  The reality of belonging:
  - structures that are anti-racist, demonstrate diversity, are connected, where everyone has a place and can 'play' a role, where doors are opened and no one is left behind
  - services that provide opportunities, are equitable, provide education for all, are accessible, encourage growth
  - behaviour such as body language like a smile or eye contact, kindness, communicating in any language and in any way, culturally sensitive, empathy, team work, tolerance, value each others' gifts

Common Principles of Working with Diverse Populations
Learning Objectives: Diversity Dimensions #5
Anti-racism, Anti-oppression and Social Inclusion #1, #4
Service Delivery, Programming, & Organizational Changes #1, #4

The following are the common set of principles that contribute to increasing diversity competence in an organization.

- Being aware and having insight into one's own culture, beliefs, attitudes, behaviours, and communication style and how they can potentially affect relationships with different priority populations.

- Having a good understanding of the principles of community engagement and community participation. Consultation with community leaders can be an excellent starting point. Involving community members, or at least consulting with them, can help to determine aspect of any particular issue or project such as if there is a need, how to proceed, what they see as working. Consultation with other organizations that serve and/or advocate for any particular community or priority population adds to the perspective.

- Identifying strengths within the population.

- Allowing time to develop relationships and trust within any given community or partnership. Take into consideration any previous interaction between the community and your health unit, and what the consequences were (whether positive or negative). The community may have had negative experiences with other government workers leading to trust issues.

- Recognizing that there are no "experts", but only those who may have already developed a greater understanding of a particular environment or people and perhaps found ways to acknowledge their unique strengths. Be willing to ask questions, keep an open mind to all information and feedback, and be receptive to constructive criticism. Try to develop a multi-perspective view by suspending judgement and seeing through others' eyes.

- Developing understanding of the role that power and privilege plays in working with diverse populations. Health practitioners have power in relationships, whether or not they feel powerful. Develop an awareness of how the socio-political system operates with respect to those who are not part of the dominant culture.

- Recognizing that resources are fundamental to achieving equity, and so the manner in which resources are allocated and how access to these resources is provided needs to be considered on a continual basis.

- Developing ways to tailor approaches to work effectively with different priority populations. Concepts that reflect the dominant culture are often not directly

transferable to work with diverse populations. Tailored communications that are culturally sensitive and relevant to the community are more effective because of their specific appeal and are more clearly understood.

- Recognizing that your health issue may not be high priority for this specific community at this particular time. By first addressing the priority health issue identified by the community, it may help to build trust and open doors to future work on other health issues.

Communication
Learning Objectives: Diversity Dimensions #4
                            Service Delivery, Programming & Organizational Changes #1, #2

Effective communication skills
- Culture and communication go hand-in-hand. It is almost impossible to send a message that does not have at least some cultural content-whether it is the words themselves, or the way that they are said, or in non-verbal signals that accompany them. It also is not possible to receive a message without it passing through the filter of one's own cultural perspective.

- We have individual communication patterns that we often use automatically without much conscious thought.

- Misunderstanding and misinterpretation of content and intent are relatively common frustrations when communicating with others.

- There is a need for developing an understanding of one's own preferred communication style, its strengths and limitations, and how it affects colleagues and clients. (Embracing Cultural Diversity in Health Care: Developing Cultural Competence, RNAO, 2007)

- To effectively communicate, there is a need for awareness of the range of different communication styles, and to be able to use those skills, depending on the situation.

- Limitations in communication do not reflect intellectual capacity of the person trying to express thoughts, opinions and emotions.

- There are several ways to demonstrate a commitment to reaching understanding:
    - ✓ approach the situation with respect for the individual
    - ✓ use active listening techniques, including non-verbal cues
    - ✓ be willing to ask questions
    - ✓ keep trying to communicate even when you make a mistake
    - ✓ acknowledge that you want to learn more

- There are other aspects of communication to consider beyond words. e.g. level of emotion, use of touch (and whether in private or public), facial expression (what people do with their head, eyes, eyebrows, mouth, nose, chin), eye contact, use of silence, use of gestures, amount of personal space, concept and consideration of time, level of directness, and so on.

- Consider the need for cultural interpretation in any given situation. Professional interpretation provides many advantages and benefits. Use of family and friends to interpret can severely hamper the sharing of information or the development of a relationship. For example, use of family and friends is not appropriate when discussing confidential health issues such as those related to communicable diseases.

- Edward Hall proposed a theoretical framework of low-context and high-context oriented communication styles that is widely cited in cultural communication literature. Neither a "low context" nor a "high context" communication style is preferable; rather the contrast in styles illustrates the potential for miscommunication.

- **Low-context** (or direct) communication is a style of communication in which there is a reliance on words, and those words are explicit. The goal of most communication is focused on getting or giving information. Non-verbal cues are not key to understanding, and you do not need to "read between the lines". What is said is more important than how it is said. People "say what they mean and mean what they say". A good personal relationship is not essential to getting the job done. Criticism is straightforward and it is okay to say "no", and to confront people when needed. This communication style can be reflective of a more individualist, heterogeneous society. Canada, the United States, Germany and Scandinavian countries tend toward lower-context communication.

- **High-context** (or indirect) communication is less reliant on the meaning of words and is less explicit, as the intent and meaning of the message is more dependent on the context. Meaning is embedded in how something is said, including what is not said. Much is implied but little needs to be said. The goal of communication is building relationships, maintaining harmony and saving face. A personal relationship is a prerequisite to getting the job done. Confrontation is avoided, and saying "no" is difficult. A high-context communication style often reflects a homogeneous, collectivist society. Aboriginal peoples and Asian countries may tend to have high-context communication styles. (The Healthcare Professional's Guide to Clinical Cultural Competence, 2007; Culture Matters-The Peace Corps Cross-Cultural Workbook, 1997)

Inclusive language and environment
- One definition of inclusive language is "language which includes and reflects the diversity of our communities in an accurate and respectful way. Inclusive language refers to how people speak, write and visually represent others, as well as intonation, body language and other forms of non-verbal communication. Inclusive language positively reflects the richness of diversity of the community by acknowledging the lifestyles, experiences, and values of a wide diversity of people. Inclusive language is more appropriate because it avoids false assumptions about people regardless of their gender, marital status, ethnicity, ability, and age thereby permitting dialogue that includes everyone by acknowledging differences." (Inclusive Language, Diversity Services and Aboriginal Health Program, Calgary Health Region, 2005)

- The Inclusive Language booklet from Calgary Health Region is one example of a tool that encourages active thinking about the language that is commonly used, as well as providing examples of how to use inclusive language.

- The power of language cannot be underestimated. That power can have a positive or negative impact.

- Language is continually evolving; there is a need to be aware of ongoing language changes so that the language we use continues to be inclusive.

- It is usually recommended that written materials be at a grade 6 literacy level or less.

- The environment has factors that may be exclusionary and act as barriers such as:
    - location (is it in the neighbourhood or relatively close by? easy to get to by bus, walking or bicycle? is it accessible to those with disabilities?)
    - signage (is it clear? easily understood? is there a need for other languages on signs? are illustration/pictures reflective of cultures and ethnic backgrounds?)
    - educational materials (what is the literacy level? are there materials in languages other than English? have a range of learning styles been considered so that there are options other than print?)
    - financial (is it possible to assist with transportation and/or childcare?)

Community Engagement
Learning Objectives: Diversity Dimensions #4
*   Anti-racism, Anti-oppression and Social Inclusion #3*

- A population health approach promotes the participation of all Canadians in developing strategies to improve health.

- Community engagement can be defined as 'the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests or similar situations with respect to issues affecting their well-being (CDC, 1997).

- Community engagement promotes the exchange of ideas, information and resources between community members and public health professionals. There are multi-faceted approaches to community engagement.

- Community can have diverse meanings and can include individuals, groups, organizations, associations or informal networks that share common characteristics.

- It is important to engage people in the processes that influence the conditions that make them healthy or not (Ontario Prevention Clearinghouse).

- Community engagement ensures Canadians have the opportunity to have meaningful input into the development of health priorities, strategies (Health Canada).

- Given the multi-factorial nature of health problems (including environmental and social factors), community engagement and partnerships allow broader solutions to complex health problems to be forged.

- Several frameworks exist that depict the level or continuum of community engagement. The level of participation can range from very little involvement (i.e. informing/educating which sometimes appear as token consultations), consultations, engagement to a community-initiated process. The annotated bibliography contains several references about community engagement.

- There is a need to use strategies tailored to specific population groups. Ideally, examples can be drawn from within your own Health Unit that illustrates some strategies from work that has already been done with particular groups. A possible exercise to use during training sessions would to discuss and critically appraise these local examples. During the exercise, the focus could be on how to maximize community engagement and participation.

- Another source of examples is The Health Communication Unit (www.thcu.ca) which has case studies from around the province. Refer to the Ontario Prevention Clearinghouse (www.opc.on.ca) with the Health Promotion Resource Centre for additional case studies.

Benefits of community engagement include:
- ✓ Engaging diverse communities can help set local health priorities and ensure service/program development reflect local needs.
- ✓ Community priorities are recognized and incorporated into a shared agenda.
- ✓ Engaging the community increases the likelihood that services and programs will be planned and implemented in a culturally sensitive and inclusive manner. It increases access by making services/programs more acceptable.
- ✓ Building capacity for individuals and communities to increase control over factors that influence health and well-being.
- ✓ Building on strengths and assets that exist within the community.
- ✓ Engaging diverse communities leads to the development of a broad range of creative responses to local health needs.
- ✓ Efficiency which allows for greater coordination of resources, activities and efforts, and reduces the duplication of efforts and resources.
- ✓ Sharing of resources and sharing of power equates to greater equity and social justice for further development, enabling, and increasing access.
- ✓ Enhanced community understanding of the role of public health that can build trust and credibility.

Skills required for engaging communities effectively:
- Coalition building and community mobilization skills are required. For example: when getting started you need to develop a clear picture of what you are addressing; acquire knowledge of formal and informal networks that exist in the community; appreciate community assets; engage the communicate early in the process; foster common goals and a shared vision; recognize that it needs to be community driven, not a structure imposed from the outside.
- Maintaining and sustaining strategies foster ongoing community participation and will maximize results.
- Refer to the annotated bibliography for literature related to community mobilization and coalition building.

Development of Personal Competence
Learning Objectives: Anti-racism, Anti-oppression and Social Inclusion #4
Service Delivery, Programming & Organizational Changes #1

- Each individual within the health unit has a role to play in the development of a diversity competent organization.

- There is a range of reasons that contribute to individual motivation for becoming a diversity competent practitioner.
  - ✓ job satisfaction that comes from the development of new skills or the enhancement of existing skills
  - ✓ desire to maintain current professional knowledge
  - ✓ desire to practice according to national core competencies
  - ✓ knowledge that you are participating in the delivery of programs in and inclusive and equitable manner

- For those interested in developing personal competence, here are some action steps for consideration:
  - ✓ reflect on your own level of self-awareness, your own cultural aspects and the potential impact these may have on your practice
  - ✓ participate in professional development opportunities related to diversity, including increasing knowledge and skill building programs
  - ✓ start building a network of contacts
  - ✓ find a mentor
  - ✓ take advantage of any opportunity to work with a diverse community or some of its members
  - ✓ start a personal journal for ongoing reflection
  - ✓ keep a file of activities undertaken for self-monitoring
  - ✓ consider making development of personal competence skills part of the learning plan of your performance appraisal or annual professional development plan
  - ✓ ask lots of questions
  - ✓ do individual reading (professional, non-fiction, fiction) that presents a range of diverse and cultural perspectives
  - ✓ engage in dialogue with your colleagues about the concepts of diversity
  - ✓ write a contract with yourself about specific actions you would like to take within a certain time frame
  - ✓ any action can be as unique as each individual

- Several of the resources listed in the annotated bibliography contain tools and exercises that are pertinent for individual use.

- A health unit can demonstrate commitment to the development of personal competence by offering a diversity training program that is available to all staff. Commitment of the organization is also shown by keeping a collection of diversity resources available and current for use by individuals and teams.

Policies and Standards

Learning Objectives: Service Delivery, Programming & Organizational Changes #3

- There are several documents outlining legislation and standards that you may wish to access for background context.

- Some participants may not be aware that such standards exist and that they in fact govern our actions. Level of detail provided is very much dependent on the participants and priorities of each session.

- Canadian Bill of Rights (1960)

- Ontario Human Rights Commission (established in 1961)

- Ontario Human Rights Code (1962) and Canadian Human Rights Act (1981)

- Canadian Charter of Rights and Freedoms (1982)

- Employment Equity Act (1986)

- Multiculturalism Act (1988)

- Ontarians with Disabilities Act (2001)

- Existing city/county/regional policies

- Health Unit specific policies

Time Frame

What is realistic and achievable for each health unit will vary according to their needs and circumstances. For the material suggested in the "Core Training Content" section, a minimum of one day (either one full day or two half-days) is strongly suggested. Supplementary modules, specific to particular priority populations, or more in-depth examination of the key concepts will require extra time.

The sample presentation outlines that follow are each for a 3-hour session. The outlines do not include actual content, but are examples of possible ways to organize information.

Sample Presentation Outline #1

Topic: Introduction to Diversity Competence

Length: 3 hours

Goal: to provide an introduction to the concepts of diversity, access and equity

Learning Objectives:
i.   participants will increase their knowledge and understanding of the definition of, and the multiple aspects of culture
ii.   participants will increase their knowledge of local community diversity and needs
iii.   participants will have the opportunity to engage in self-reflection and personal awareness activities
iv.   participants will increase their understanding of priority populations, including barriers to access
v.   participants will develop a plan to enhance diversity competency skills within their practice

Introduction (15 minutes)
i.   Access and equity-what and why
ii.   Objectives for the session

Who Makes Up the Community We Serve? (15 minutes)
i.   A brief demographic picture of Ontario
ii.   A demographic picture of the Health Unit area

Understanding Diversity Dimensions (45 minutes)
i.   The concept of diversity
ii.   Self-reflection/personal awareness exercises

Break (15 minutes)

Working with Priority Populations (45 minutes)
i.   Barriers to access and inclusion
ii.   Common principles

Developing Personal Competence (15 minutes)

Summary/Closing (15 minutes)
i.   Debriefing comments
ii.   Setting the stage for the next session
iii.   Evaluation

Sample Presentation Outline #2

Topic: Developing Skills and Strategies

Length: 3 hours

Goal: to promote awareness and knowledge of basic skills and strategies for the development of diversity competence

Learning Objectives:
i.   participants will increase their understanding of differences in communication patterns
ii.   participants will increase their knowledge of inclusive language principles
iii.   participants will increase their understanding about the community engagement process and its importance to public health practice
iv.   participants will continue the development of their personal diversity competence plan

Introduction (15 minutes)
i.   As a continuation from the first session: any comments, questions, issues?
ii.   Objectives for this session

Communicating Clearly (45 minutes)
i.   Effective communication skills
ii.   Inclusive language and environment
iii.   Exercise (e.g. "check-up" for exclusionary language in print materials; practise re-write of information into clear language; scenario analysis for communication barriers)

Break (15 minutes)

Community Engagement (75 minutes)
i.   Benefits
ii.   Principles of engagement
iii.   Tailoring of strategies
iv.   Scenarios/case studies

Developing Personal Competence (15 minutes)

Summary/Closing (15 minutes)
i.   Debriefing comments
ii.   Future diversity competency plans within the Health Unit (if such plans are in place; or opportunity to get input from participants to develop plans)
iii.   Evaluation

Related Considerations

Each health unit will also need to consider how to continue to address the issue of equal access and diversity on an on-going basis beyond the initial mandatory training, for example:

- how to build diversity training into new staff orientation
- how to keep the issue and concepts alive relative to staff's daily work
- what is needed to support training so that ongoing, sustained change will result
- the examination of programming and policies to meet standards related to equal access.

Specifically, some questions might be:

- What do we know of the health status of the community? And is the health status reviewed/reassessed regularly?
- What type of information is available on the community? More than census? Qualitative information?
- Have barriers faced by diverse populations been identified?
- Has there been an organizational self-assessment done regarding cultural competency? Should there be one?
- Are there community experts on diversity that can be consulted?
- Is the workforce of the health unit representative of the diversity within the community?
- Are there internal policies and procedures in place to support application of strategies related to diversity?
- In addition to staff and management, do we want to include this learning for students and volunteers affiliated with the health unit?
- Beyond the educational component, is it possible to develop contacts within the health unit to promote sharing of skills and knowledge between staff members (e.g. a list of staff who speak languages other than English, a list of staff who will act as "lead" or contact for diversity issues for each service area or department)?

Even though this outline focuses on training, the annotated bibliography includes references about frameworks, assessment, policy and evaluation for those who wish to pursue any of these aspects.

Appendix A
OPHA Resolution: Diversity Competent Public Health Professionals
(2006)

Resolution #1:

THEREFORE BE IT RESOLVED that the position paper, "Diversity Competent Public Health Professionals" be adopted as the position of the OPHA.

Resolution #2:

WHEREAS boards of health are required to provide mandatory public health programs that are accessible to people in special groups for whom barriers exist

WHEREAS the Ottawa Charter for Health Promotion states that health promotion focuses on achieving equity in health and reducing the differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential

WHEREAS the Health Council of Canada states that Inequalities in Health is the number one health problem in Canada

WHEREAS the Ontario government's Capacity Review Committee report of the organization and capacity of the public health system recommended the adoption of public health core competencies, of which socio-cultural competence is a key domain area

WHEREAS public health practitioners continue to experience the pressure of meeting growing complex needs of diverse populations

WHEREAS social exclusion of groups facing oppression and barriers results in poorer health outcomes

THEREFORE BE IT RESOLVED that OPHA call upon local boards of health and Ontario health units to implement all-staff mandatory diversity training using best practices related to knowledge translation and reflecting the population that the health unit serves; such training to also include, at a minimum, modules on:

- diversity dimensions, including but not limited to a) racial identity, ethnicity and culture; b) new immigrants and refugees; c) sexual orientation, sexual identity, gender, and gender identity; d) Aboriginal communities; e) socio-economic status, class; f) mental and physical abilities; g) language, literacy, education; h) age; i) geographic limitations;
- anti-racism, anti-oppression and social inclusion;
- service delivery, programming, and organizational changes that lead to better access and inclusion of diverse populations.

BE IT FURTHER RESOLVED that OPHA implement diversity training within its organization, including workgroup members, staff, project staff and Board of directors

BE IT FURTHER RESOLVED that OPHA call upon academic institutions that provide public health training to develop and increase curriculum related to diversity, access, equity and social inclusion

BE IT FURTHER RESOLVED that OPHA call upon the Ministries related to public health to develop and implement standards to ensure equitable access to public health programs and services

BE IT FINALLY RESOLVED that OPHA call for the inclusion of ongoing diversity, anti-oppression and social inclusion training in all forms for all health professionals through professional development through professional organizations.

The complete position paper and above resolutions can be found on the OPHA website (*www.opha.on.ca*).

Appendix B: Annotated Bibliography