Diversity Lens Tool kit
A Set of Practical Cultural Competence Assessment Tools and Resources to Help Integrate Diversity in Capital Health Workplaces
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Introduction
The Diversity and Inclusion Lens Tool is a set of questions meant to help Capital Health 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. 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.\(^1\)

**A.1 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 Capital Health patients and their families.

The Diversity and Inclusion Lens Tool is a set of questions meant to help Capital Health 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. 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.\(^1\)

**A.2 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. This applies to our services, relationships, programs, policies, strategies and decisions.

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**.

**A.3 How to use this tool kit**

This tool kit consists of the following three parts:

**Part 1: Lens Tools**—to help assess our current practice and apply the concepts of diversity to our day-to-day work.

**Part 2: Understanding Our Community**—a brief introduction to six of the communities we serve.

**Part 3: Resources**—extra information and knowledge relating to some of the information provided in other sections.

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A.4 What is our framework for the lens tool?

The framework for the lens tools has these three foundations:

1. The 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.

2. 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 needs in services and health outcomes.

3. 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.

The above three bases are the framework for the second part of the lens tools.
1 Diversity Lens Tools
The lens tools are customized for use by Capital Health’s formal leadership teams, such as the Leadership Enabling Team (LET). Use these tools as a guide to enhance diversity, inclusion, equity and cultural competence in Capital Health’s Vision, Mission and Values; Our Promise; Our Promise in Action; and Diversity Strategic Plan Accountability Framework.

A **DIVERSITY LENS TOOL** has been suggested for each of these strategic tools.

**Part 1 consists of these five lens tools:**

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<tbody>
<tr>
<td><strong>1</strong></td>
<td>A self-assessment tool for personal reflection.</td>
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<td><strong>2</strong></td>
<td>A lens for embedding cultural competence, diversity and inclusion in Capital Health’s Vision, Mission and Values.</td>
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<td><strong>3</strong></td>
<td>A lens for embedding cultural competence, diversity and inclusion in Capital Health’s strategic plan, known as Our Promise in Action.</td>
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<td><strong>4</strong></td>
<td>A lens for supporting cultural competence, diversity and inclusion in Primary Health Care policies and structures.</td>
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<td><strong>5</strong></td>
<td>A lens for assessing Capital Health’s organizational progress in reaching the Diversity and Inclusion Strategic Plan outcomes (please refer to the Diversity and Inclusion Strategic Plan Performance Measurement Framework).</td>
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</table>
### Populations to consider

#### Cultural identities and communities
- Aboriginal Peoples (First Nations, Inuit and Métis)
- African Nova Scotians
- Recent immigrants and temporary workers
- Refugees
- Pride health (spectrum of gender and sexual diversities)
- People with disabilities, both physical (such as those with low vision, the blind and the deaf-blind) and mental/emotional

#### Language communities
- Acadians and francophones
- Aboriginal Peoples
- Recent immigrants and refugees
- American Sign Language (ASL) speakers
- The deaf-blind

#### 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

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**Remember**
- Identities intersect
- Avoid stigma and stereotyping
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.

### LEAD SELF

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?

### ENGAGE 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?

### ACHIEVE RESULTS, DEVELOP COALITIONS, SYSTEMS TRANSFORMATION

6. Am I aware of what Capital Health 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 Capital Health?

* 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 #2: Capital Health Vision, Mission and Values Tool

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

OUR MISSION: To be a world-leading haven for people-centred health, healing and learning Capital Health is an academic health sciences network providing timely access to advanced patient care, leading-edge research and training for the current and next generation of health care professionals.

☐ 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 Capital Health serves? What are we doing to recruit, hire and retain culturally diverse staff across Capital Health?

OUR VISION: Healthy People, Healthy Communities

☐ How is our vision of health informed by cultural diversity and the needs of priority populations across Capital Health?

☐ What have we done to ensure health equity for culturally diverse individuals, communities and priority populations?
## OUR VALUES:

### INTEGRITY: This means to act honestly, ethically and morally and to do what is necessary to align our beliefs, words, behaviours and actions.

- 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?

### COURAGE: This means having the strength to challenge the status quo. Courage calls on us, both individually and collectively, to be leaders in doing the right thing for the people, community and planet we serve—to do what is necessary to live Our Promise as we face tough issues and make difficult decisions.

- 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?

### CARING: This means having compassion and concern for someone else in a way that embraces that person’s physical, spiritual, mental, intellectual and emotional well-being. As Our Declaration of Health states, we do this with our hearts, hands and minds.

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

### ACCOUNTABLE: This means taking responsibility for our words and actions in transparent ways. It encompasses sustainability by changing the way we think about our resources, whether they’re people or buildings, dollars or cents, earth or air.

- How open are we to differences?
- How have we accounted for cultural diversity in our values and our work?
INQUISITIVE: This reflects our essence as an academic health sciences network that supports and is eager for knowledge. We value curiosity about finding new ways of being, doing, caring and exploring, and we share our knowledge in the pursuit of improved health and health care, and the systems in which they operate.

- 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?
1.1.4 **LENS #3: Our Promise in Action Tool**

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

### Transforming the Person-Centred Health Care Experience

<table>
<thead>
<tr>
<th>Activity</th>
<th>Question</th>
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<tbody>
<tr>
<td>Strengthen community-based care for chronic disease</td>
<td>How will we ensure that our chronic disease-management outreach and services include culturally diverse approaches for individuals and populations?</td>
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<tr>
<td>Improve the quality of care in transitions</td>
<td>How have culturally diverse individuals and communities been considered in patient instructions and discharge summaries?</td>
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</table>
| Build a culture of customer service                                      | • 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? |

### Citizen and Stakeholder Engagement and Accountability

<table>
<thead>
<tr>
<th>Activity</th>
<th>Question</th>
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| Partner with the public so individuals and communities can play a key role in managing their own health | • 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? |
| Involve patients directly in their 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? |
| Lead public dialogue to address the appropriateness of care              | How have culturally diverse individuals, communities and priority populations been considered in addressing the appropriateness of care? |
### Transformational Leadership

| Improve leadership capacity at all levels | • 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? |
| Strengthen the accountability of employees and physicians | How do performance measures integrate and account for culturally and linguistic competence and the valuation of diversity? |

### Innovating Health and Learning

| Focus on innovation that has benefits for patients and aligns with our mission | What innovations target health equity for culturally and linguistically diverse populations? |
| Strengthen partnerships with learning institutions | 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? |
| Build our capacity for inter-professional research and education | How can we support cultural and linguistic competence within inter-professional teams? |

### Sustainability

| Innovate systems and processes for greater efficiency and quality | • 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? |
This lens tool measures the progress and successes in implementing Capital Health’s strategic plan for cultural competence, diversity and inclusion.

### RESULT # 1: Enhanced transformational leadership in cultural competence, diversity and social inclusion.

- What have we learned from the experiences of patients with diverse characteristics at Capital Health? How can we change our policies, programs, services and health relationships as a result of this feedback?

- What positive changes do we see in the data on the recruitment and retention of diverse staff at Capital Health? What are our targets? How will we work to meet them?

- What positive changes do we see in workforce perceptions of belonging and feeling valued by Capital Health? What are our targets? How will we work to meet them?

- What positive changes do we see in the perception of leadership commitment to diversity and inclusion at Capital Health? What are our targets? How will we work to meet them?

### RESULT # 2: Greater engagement of culturally diverse citizens in policies, programs and services

- What progress have we made in terms of engaged decision-making? What are our targets? How will we work to meet them?

- How many new culturally competent community-based programs, services and partnerships have we created that respond to inequities and inclusion needs? What are our targets? How will we work to meet them?

- What positive changes do we see in organizational and community perception of compliance with policies and frameworks for citizen engagement? What are our targets? How will we work to meet them?

### RESULT # 3: Deepened capacity for innovation and learning to inform our work in cultural competence, diversity and social inclusion

- How have we integrated cultural-competence expectations in performance appraisals? What are our targets? How will we work to meet them?

- How often have we updated our community-profile information? Conducted community assessments? What have we learned from this information? How will we use it to improve health equity?
RESULT # 4: Increased achievement of cultural competence in person-centred health

- What positive changes do we see in the use of Language Line services and face-to-face interpretation at Capital Health? What are our targets? How will we work to meet them?

- What positive changes have we made to access to services for underserved populations? What are our targets? How will we work to meet them?

- How satisfied are patients from diverse communities with the care or services they receive at Capital Health? What can we learn from this? How will we use this information to improve health equity?

RESULT # 5: Sustainability—enhanced responsible and wise decisions about resources aligned with Capital Health’s Position Statement on Diversity and Cultural Competence

- Who was included in making responsible decisions about resources and sustainability?

- Are priority-based funding models aligned with/inclusive of the priorities and needs of diverse communities?
LENS #5: Health Organizational Leadership 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.

<table>
<thead>
<tr>
<th>In our communications, to what extent do we...</th>
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<tr>
<td>☐ have training in/use cross-cultural communication skills?</td>
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<tr>
<td>☐ use trained interpreters?</td>
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<td>☐ provide culturally appropriate materials in languages that are commonly used locally?</td>
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<td>☐ reflect diversity in images and content?</td>
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<tr>
<td>☐ share stories and voices that reflect diversity?</td>
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<tr>
<td>☐ consider literacy and health literacy?</td>
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<tr>
<td>☐ provide multimedia and alternate format materials such as large print, braille and audio/digital?</td>
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<tr>
<td>☐ 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.</td>
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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 Capital Health’s leadership and workforce?
- provide ongoing diversity and cultural-competence training for Capital Health 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

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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

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### 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

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

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- 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

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## Lens # 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.

### LEAD SELF

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?

### ENGAGE 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?

### ACHIEVE RESULTS, DEVELOP COALITIONS, SYSTEMS TRANSFORMATION

6. Am I aware of what Capital Health 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 Capital Health?

* 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.
1.2.2 Lens # 2: Direct Care Provider Tool

The assessment elements below (Attitudes and Awareness; Knowledge; Skills) are good practice components for cultural competence in care providers.

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

<table>
<thead>
<tr>
<th></th>
<th>1 = Very well</th>
<th>2 = Well</th>
<th>3 = Fairly well</th>
<th>4 = Not at all</th>
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<tbody>
<tr>
<td><strong>1.</strong></td>
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<td>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.</td>
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<tr>
<td><strong>2.</strong></td>
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<tr>
<td>I know about my own cultural and language heritage and how it may influence my professional and personal biases.</td>
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<td><strong>3.</strong></td>
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<td>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.</td>
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<td><strong>4.</strong></td>
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<td>I can identify my emotional reactions, stereotypes and preconceived notions of individuals and groups that are different from myself.</td>
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<td><strong>5.</strong></td>
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<td>I’m aware of my social status and privilege in relation to my clients.</td>
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<td><strong>6.</strong></td>
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<td>I can recognize cross-cultural communication challenges when they occur.</td>
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<td><strong>7.</strong></td>
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<tr>
<td>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.</td>
<td></td>
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<tr>
<td><strong>8.</strong></td>
<td></td>
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<tr>
<td>I recognize the effects and the implications of racism, sexism and heterosexism in society and on the care I provide.</td>
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</tbody>
</table>
### B KNOWLEDGE

<p>| | | | | |</p>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
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<tr>
<td>1</td>
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</tbody>
</table>

#### 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 Capital Health. 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

<table>
<thead>
<tr>
<th></th>
<th>1 = Very well</th>
<th>2 = Well</th>
<th>3 = Fairly well</th>
<th>4 = Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.</td>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>When I receive feedback about my culturally related interventions, I’m receptive and willing to learn.</td>
<td></td>
<td></td>
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<tr>
<td>23.</td>
<td>I can describe how I sought cultural information and applied it to my practice.</td>
<td></td>
<td></td>
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<tr>
<td>24.</td>
<td>I can articulate what, when, why and how I apply different verbal and non-verbal helping responses.</td>
<td></td>
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<tr>
<td>25.</td>
<td>I have had training in how to work with cultural health interpreters.</td>
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</tr>
<tr>
<td>26.</td>
<td>I use and practice the teach-back method with my clients to ensure understanding.</td>
<td></td>
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<tr>
<td>27.</td>
<td>I know how to accommodate patient preferences in the care process. I practice negotiation skills in approaches to care.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>28.</td>
<td>I can advocate on behalf of patients who feel they were discriminated against or who need to access Capital Health language, cultural, navigation and support services.</td>
<td></td>
<td></td>
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<tr>
<td>29.</td>
<td>I have examined and can recognize bias in my assessment and care practices.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>I work at an organizational level to address, change and eliminate policies that discriminate against others and create barriers to health equity.</td>
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</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical environment, materials and resources</strong></td>
<td></td>
</tr>
<tr>
<td><em>(Skip this section if you don’t work in an office or a public space)</em></td>
<td></td>
</tr>
<tr>
<td>1. I display pictures, posters, artwork and other decor that reflect the</td>
<td></td>
</tr>
<tr>
<td>diverse cultures and ethnic backgrounds of the individuals and families</td>
<td></td>
</tr>
<tr>
<td>to whom I provide service.</td>
<td></td>
</tr>
<tr>
<td>2. I ensure that brochures, magazines and other printed materials in</td>
<td></td>
</tr>
<tr>
<td>reception areas will interest and reflect the diversity of the</td>
<td></td>
</tr>
<tr>
<td>community in which I provide service.</td>
<td></td>
</tr>
<tr>
<td>3. When using brochures, posters, videos or other media resources for</td>
<td></td>
</tr>
<tr>
<td>health education, treatment and other interventions, I ensure that</td>
<td></td>
</tr>
<tr>
<td>they reflect the diverse cultures and ethnic background of the</td>
<td></td>
</tr>
<tr>
<td>individuals and families to whom I provide service.</td>
<td></td>
</tr>
<tr>
<td>4. I ensure that the printed information I provide takes into account</td>
<td></td>
</tr>
<tr>
<td>the literacy levels of the individuals and families to whom I provide</td>
<td></td>
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<tr>
<td>service.</td>
<td></td>
</tr>
</tbody>
</table>
### Communication styles

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

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.
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.

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health, wellness and end-of-life issues</strong></td>
<td></td>
</tr>
<tr>
<td><strong>14.</strong> I understand that the perception of health, wellness and preventive health services have different meanings to various cultural and ethnic groups.</td>
<td></td>
</tr>
<tr>
<td><strong>15.</strong> I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.</td>
<td></td>
</tr>
<tr>
<td><strong>16.</strong> I accept that religion and other beliefs may influence how individuals and families respond to illness, disease and death.</td>
<td></td>
</tr>
<tr>
<td><strong>17.</strong> I understand that grief and bereavement are handled differently among cultures.</td>
<td></td>
</tr>
<tr>
<td><strong>18.</strong> 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.</td>
<td></td>
</tr>
<tr>
<td><strong>19.</strong> 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.</td>
<td></td>
</tr>
<tr>
<td><strong>20.</strong> 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.</td>
<td></td>
</tr>
<tr>
<td><strong>Assumptions, attitudes and values</strong></td>
<td></td>
</tr>
<tr>
<td><strong>21.</strong> I recognize and accept that individuals from diverse cultural backgrounds may want to ease into the dominant culture at varying paces.</td>
<td></td>
</tr>
<tr>
<td><strong>22.</strong> I recognize my own values and biases and avoid imposing them on others.</td>
<td></td>
</tr>
<tr>
<td><strong>23.</strong> 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.</td>
<td></td>
</tr>
</tbody>
</table>
### Assumptions, attitudes and values (con’t.)

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>24.</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>25.</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>26.</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>27.</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>

**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.
### 1.3.0  POLICY AND PROGRAM DEVELOPMENT TOOL

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

### 1.3.1  Lens # 1: Personal Reflection Tool

#### LEAD SELF

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?

#### ENGAGE 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?

#### ACHIEVE RESULTS, DEVELOP COALITIONS, SYSTEMS TRANSFORMATION

6. Am I aware of what Capital Health 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 Capital Health?

*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.*
1.3.2 Lens # 2: Policy and Program Development Tool

Diverse identities and priority populations within Capital Health should be considered and involved throughout the process.

Understand self

Identification and evaluation development

- What biases might exist in identifying the topic?
  - Have members of the development team participated in cultural competence training and completed the self-assessment? (See pages 27–28)

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

Preparation/assessment (scan, scoping, evidence review, research)

- Have diverse individuals and priority populations been considered or invited to contribute to the identification of policy/guideline or program-development topics, goals and evaluation impacts/outcomes?
- Have health equity, root cause, social determinants of health, and positive and negative impacts to diverse individuals and priority populations been considered?
- 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 special populations, areas of sex/gender, culture and disparity, such as through poor health status and cultural practices that are different from the dominant culture?
- Have you considered identity, health beliefs and practices, complementary/traditional providers, family structure/role, foods, community supports and spirituality?
- Do you know the structure of the community and who needs to be involved in program development?
- 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?
Negotiate for mutually acceptable intervention of care

Program/policy development/action planning

- Have diverse individuals and groups been engaged in the development of the program/policy and provided input on draft documents?
- Have you explicitly noted and addressed possible priority special 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 policy options or 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?

Implementation

- Have you profiled priority special populations, areas of sex/gender, culture and disparity and aligned with Our Promise in Action?
- Have you used trained interpreters?
- Have you provided culturally appropriate materials in languages used locally?
- Have you shared a diversity of community stories and voices?
- Have you integrated culture and language in policy and program promotion?
- Have you built empowerment and based programs/policies on strengths?
- Have you engaged community members and local organizations in implementing the program/policy?
  - Both inside and outside Capital Health:
    - Advocate for and monitoring implementation
    - Communicate the results of the program/policy implementation

Make inclusion and health equity a priority

Evaluation and sharing outcomes

- Have you involved/engaged priority special 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

- Capital Health’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:
  chdintra.cdha.nshealth.ca/departmentservices/citizenEngagement/index.html

- 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
2 Profiles of Diversity in Capital Health
2.0 PROFILES OF DIVERSITY IN CAPITAL HEALTH

This section provides general details about diversity in Capital Health, 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
- African Nova Scotians
- Recent immigrants
- Ethnic origins and visible minority status
- Refugees
- Religion and spirituality
- Pride health (spectrum of sexual orientation and gender identity)
- Sex and gender
- (Dis)abilities (physical and mental)
- Poverty and low social status
- Acadian and francophone Nova Scotians
- Aboriginal Peoples (First Nations, Inuit and Métis)

The information has been gathered from myriad sources, populations and regions. When possible, district-level data has been provided.

2.1 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.
2.2 Languages spoken in the Capital District

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

- 90% of Halifax Regional Municipality residents listed English as their mother tongue.

- French is the second most-spoken language in HRM. More than 10,000 residents (2.6% of the HRM census population) listed French as their mother tongue.

- Arabic is the third most-spoken language. Some 5,175 residents (1.3%) listed Arabic as their mother tongue.

- Other languages listed are Chinese⁴, German, Spanish, Farsi 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.

<table>
<thead>
<tr>
<th>Language</th>
<th>Population</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>348,515</td>
<td>90.2</td>
</tr>
<tr>
<td>French</td>
<td>10,155</td>
<td>2.6</td>
</tr>
<tr>
<td>Arabic</td>
<td>5,175</td>
<td>1.3</td>
</tr>
<tr>
<td>Chinese</td>
<td>2,195</td>
<td>0.6</td>
</tr>
<tr>
<td>English and non-official language</td>
<td>1,895</td>
<td>0.5</td>
</tr>
<tr>
<td>English and French</td>
<td>1,465</td>
<td>0.4</td>
</tr>
<tr>
<td>German</td>
<td>1,250</td>
<td>0.3</td>
</tr>
<tr>
<td>Spanish</td>
<td>1,135</td>
<td>0.3</td>
</tr>
<tr>
<td>Persian (Farsi)</td>
<td>1,125</td>
<td>0.3</td>
</tr>
<tr>
<td>Tagalog (Filipino)</td>
<td>910</td>
<td>0.2</td>
</tr>
<tr>
<td>Mandarin</td>
<td>810</td>
<td>0.2</td>
</tr>
<tr>
<td>Russian</td>
<td>695</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Total reported</strong></td>
<td><strong>386,200</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

³ These results are based on the most recent census data (2011) available for the Halifax Regional Municipality area (similar to, but slightly different from, the CDHA catchment area).
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 810 individuals in HRM).

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.
2.3 Ethnic origin

According to Statistics Canada’s National Household Survey, “ethnic origin” 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% of HRM’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.
- 141,235 (37%) of those surveyed identified as Canadian.
- 63,195 (16%) identified as being of French origin, which includes the Alsatian, Breton and French. Some 8,045 (2%) identified as Acadian.
- 55,185 (14.4%) identified as western European (Austrian, Belgian, Dutch, Flemish, Frisian, German, Luxembourgers and Swiss).
- 17,665 (4.6%) identified as Aboriginal, which includes First Nations (14,050), Inuit (715) and Métis (3,270).

<table>
<thead>
<tr>
<th>Ethnic Origins, Halifax Regional Municipality (2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported ethnic origin</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>British Isles</td>
</tr>
<tr>
<td>Canadian</td>
</tr>
<tr>
<td>French origin</td>
</tr>
<tr>
<td>Western Europe (Dutch, German, other)</td>
</tr>
<tr>
<td>North American Aboriginal</td>
</tr>
<tr>
<td>Eastern Europe (Polish, Ukrainian, other)</td>
</tr>
<tr>
<td>Southern Europe (Italian, other)</td>
</tr>
<tr>
<td>West Central Asian/Middle Eastern</td>
</tr>
<tr>
<td>African</td>
</tr>
<tr>
<td>East/Southeast Asian (Chinese, other)</td>
</tr>
<tr>
<td>Acadian</td>
</tr>
<tr>
<td>Northern Europe (Finnish, Scandinavian)</td>
</tr>
<tr>
<td>South Asian (East Indian, other)</td>
</tr>
<tr>
<td>American (United States)</td>
</tr>
<tr>
<td>Caribbean</td>
</tr>
<tr>
<td>Jewish</td>
</tr>
<tr>
<td>Central/South America</td>
</tr>
<tr>
<td>Total reported (HRM)</td>
</tr>
</tbody>
</table>

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6 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.
2.4 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.  

<table>
<thead>
<tr>
<th>Visible Minority</th>
<th>Population</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>13,780</td>
<td>39.3</td>
</tr>
<tr>
<td>Arab</td>
<td>5,525</td>
<td>15.8</td>
</tr>
<tr>
<td>Chinese</td>
<td>4,620</td>
<td>13.2</td>
</tr>
<tr>
<td>South Asian (East Indian, Pakistani, Sri Lankan, other)</td>
<td>3,995</td>
<td>11.4</td>
</tr>
<tr>
<td>Filipino</td>
<td>1,320</td>
<td>3.8</td>
</tr>
<tr>
<td>West Asian (Iranian, Afghan, other)</td>
<td>1,205</td>
<td>3.4</td>
</tr>
<tr>
<td>Latin American</td>
<td>1,025</td>
<td>2.9</td>
</tr>
<tr>
<td>Multiple visible minorities</td>
<td>1,090</td>
<td>3.1</td>
</tr>
<tr>
<td>Southeast Asian (Vietnamese, Cambodian, Malaysian, Laotian)</td>
<td>900</td>
<td>2.6</td>
</tr>
<tr>
<td>Korean</td>
<td>845</td>
<td>2.4</td>
</tr>
<tr>
<td>Visible minority not included elsewhere</td>
<td>445</td>
<td>1.3</td>
</tr>
<tr>
<td>Japanese</td>
<td>290</td>
<td>0.8</td>
</tr>
<tr>
<td>Total reported (HRM)</td>
<td>384,330</td>
<td>100</td>
</tr>
<tr>
<td>Total non-visible minority population</td>
<td>349,295</td>
<td>90.9</td>
</tr>
<tr>
<td>Total visible minority population</td>
<td>35,040</td>
<td>9.1</td>
</tr>
</tbody>
</table>

2.5 Religion and spirituality

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 HRM citizens identify as Christian (71.5%). Catholic (31.6%), Anglican (13.1%) and United (11%) are the predominate Christian subgroups.
- 25% of HRM survey respondents indicated that they have no religious affiliation (95,630 people).
- 7,535 (2%) identified as Muslim.
- This is followed by those identifying as Buddhist (0.4%), Hindu (0.4%), Jewish (0.3%), Sikh (0.09%) and traditional (Aboriginal) spirituality (0.01%).

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9 Total non-visible minorities includes individuals who identify as Aboriginal, as well as all others who don’t identify as a visible minority.
2.6 Aboriginal Peoples: First Nations, Inuit and Métis

- According to Statistics Canada, 10,073 individuals identified as Aboriginal in Capital Health (2011).

- Of this total, 6,121 identified as First Nations (61%), 3,180 as Métis (32%) and 267 as Inuit (3%).

- Of all District Health Authorities in Nova Scotia, Capital Health has the largest number of individuals reporting Aboriginal identity.  

- The Mi’kmaq are the founding people of Nova Scotia and remain the predominant Aboriginal group in the province.

- Nova Scotia has 13 Mi’kmaq First Nations and 34 reserves across the province. This includes Capital Health reserve locations in Cole Harbour (off Caldwell Road in Dartmouth), Sheet Harbour and Beaver Dam (50 kilometres east of Musquodoboit) as part of what is now the Millbrook Reserve.

- A growing portion of the Aboriginal population lives in urban HRM.  

- Mi’kmaw and other Aboriginal languages are spoken across the Capital District.

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12 NS Office of Aboriginal Affairs.
Aboriginal health

- Must be understood from the context of *Health Inequalities and Social Determinants of Aboriginal Peoples Health.*
- Jurisdictional challenges and gaps relating to coverage, services and programs. Assumptions about this that inhibit provision of services.
- High rates/risk of high blood pressure, diabetes, insulin resistance (women), heart disease and stroke.
- High rates of chronic obstructive pulmonary disease (COPD) and vulnerability to infectious diseases.
- Lower life expectancy at birth for males and females.
- Higher rates of HIV/AIDS, STDs, Hepatitis A and C, cancer and disability.
- 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.
- 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. Supports for the disabled were also named as a potential future priority.
- Infants have higher rates of otitis media (middle ear infection), SIDS, accidental injury, asthma and fetal alcohol spectrum disorder.
- There’s a lack of cultural safety for Aboriginal clients in mainstream health systems.

More information

- Confederacy of Mainland Mi’kmaq: cmmns.com
- Union of Nova Scotia Indians: unsi.ns.ca
- Native Council of Nova Scotia (provides a range of services primarily to Aboriginal people living off-reserve): ncns.ca
- Nova Scotia Native Women’s Association: facebook.com/nsnwa
- Atlantic Policy Congress (APC) of First Nations Chiefs Secretariat: apcfnc.ca
- Mi’kmaq Native Friendship Centre: mymnfc.com
- Mi’kmaq Rights Initiative: mikmaqrights.com
- Atlantic Aboriginal Health Research Program: aahrp.ca

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13 Health information based on Canadian data and is not Nova Scotia specific.
2.7 Acadians and francophones

- 10,400 individuals in Capital Health identified as French only in the 2011 short-form census. This is the second-highest number of French speakers in the province outside of Southwest Health (10,650).

- Capital Health has the highest number of individuals (1,491) who identify as bilingual among all DHAs.

- French is the second most-spoken language in HRM after English. In census data, more than 10,000 residents (2.6%) listed French as their mother tongue.

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

- Le Réseau Santé–Nouvelle-Écosse: reseausantene.ca/English.htm
- Fédération acadienne de la Nouvelle-Écosse: fane.ns.ca
2.8 Recent immigrants and refugees

Recent immigrants

• Most recent immigrants to Nova Scotia live in Halifax, although they also live in every District Health Authority in the province.

• According to 2011 census data, 31,245 people identified as immigrants in HRM (8.1%), 348,350 as non-immigrants (90.6%) and 4,775 as non-permanent residents (1.2%).

• Of a total of 384,330 individuals in HRM reporting visible minority and immigration status, 37,640 (9.8%) identified as first generation (born outside of Canada), 34,905 (9.1%) as second generation and 311,785 (81.1%) as third generation or more.

• The number of immigrants coming to Nova Scotia from Europe is dropping, while more are emigrating from Asia, Central America, Africa and the Middle East. Given the broad origins of individuals from these countries, it’s difficult to generalize about all of the health needs of the latter group.

Immigrant health

• Most immigrants are healthy when they arrive in Canada, but many experience poorer health over time. Culture shock, loneliness, homesickness and the inability to find rewarding work may lead to stress and depression.

• New immigrants may be unemployed or underemployed. Stress related to the difficulty in getting career credentials from their home country recognized and searching for work strongly affects health.

• Discrimination has been known to profoundly impact the health of racially visible immigrants and their families. An overall history and lived experience of discrimination (phobias, segregation, stereotyping) contribute to marginalization, oppression and low social status. For some, this is exacerbated by the loss of their language and culture. These burdens, either separate or combined, often impact the mental and physical health of individuals, including an increase in stress, depression and high-risk behaviours.

• Communication barriers (language, literacy, health literacy) and cultural differences, traditions, beliefs and values are not always understood nor valued by mainstream health systems.

Refugees

• Between 180 and 200 Government Assisted Refugees (GARs) are resettled in Nova Scotia annually. In addition, roughly 25 refugee claimants and 20 privately sponsored refugees make Halifax their home each year.

• In HRM, these GARs hail mostly from Bhutan, Iraq, Afghanistan, Ethiopia, Eritrea and the Democratic Republic of the Congo. The privately sponsored refugees come mainly from Ethiopia, Columbia and Iraq.

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Refugee health

- A recent study estimates that, based on a two-year service model, a refugee health clinic in Halifax would provide primary health care service to about 500 refugees at any given time.

- Refugees come from areas of the world where there is war, violence, trauma and political or cultural oppression. As a result, they may experience post-traumatic stress, an anxiety disorder that can occur after a traumatic event.

- Refugees may have lived in several countries before arriving in Canada, including in refugee camps. They may be in poor mental or physical health due to inadequate food, water and health and dental services.

- Unemployment leads to poverty, stress, food insecurity and other issues.

- Refugee health is more made complex by the language, health literacy and cultural barriers existing within primary health care services. The failure to provide interpretation and culturally competent practices inhibits access to services and makes it harder for refugees to navigate the health care system.

- The most commonly reported health issues among new refugees include infectious diseases, parasitic infections, under-immunization, nutritional deficiencies, mental illness/distress, poor oral health and hearing loss.\(^\text{16}\)

More information

- Immigrant Settlement and Integration Services (ISIS): isisns.ca
- ISIS Immigrant Health Clinic Project: isisns.ca/settlement/immigrant-health-clinic-project
- Interim Federal Health Program: ifhp-pfisi.ca
- Multicultural Association of Nova Scotia: mans.ns.ca
- Metropolis: community.smu.ca/atlantic/index_e.html
- YMCA Centre for Immigrant Programs: ymcahrm.ns.ca/Locations/YMCACentreforImmigrantPrograms.aspx

Documents


- Refer to the wide range of documents on the Atlantic Metropolis Centre’s website: community.smu.ca/atlantic/working_papers_e.html

Additional resources

- Double Precarity: Experiences of Former Seasonal Agricultural Workers Who Settle in Rural Nova Scotia (Mervyn Horgan and Saara Liinamaa, 2012)

- Towards Attracting and Retaining Newcomers in Halifax Regional Municipality (Frank Palermo and research team, 2012)

2.9 **African Nova Scotians**

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

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

- 8% of African Nova Scotians are immigrants, hailing mainly from West Africa, the Caribbean, Bermuda, East Africa and the United States.

- Based on the National Household Survey (Ethnic Origin, 2011), 10,683 individuals identified as being of African origin in Capital Health, the highest number of any DHA in the province. Of this total, 815 identified as being of Central and West African origin; 1,395 as North African; 1,465 as Southern and East African; and 7,008 as other African origins.\(^\text{17}\)

- According to Statistics Canada (Ethnic Origin, 2011), 2,832 individuals identified as being of Caribbean origin in Capital Health, the highest number of any DHA in the province. Of this total, 495 identified as being of Barbadian origin, 815 as Jamaican, 340 as West Indian and 1,180 as other African origins.


\(^{17}\) Source: Office of African Nova Scotia Affairs.
African Nova Scotian health

- Discrimination has been known to profoundly affect the health of racially visible Nova Scotians and their families. An overall history and lived experience of discrimination (phobias, segregation, stereotyping) contribute to marginalization, oppression and low social status. For some, this is exacerbated by the loss of their language and culture. These burdens, separately or combined, often impact the mental and physical health of individuals, including an increase in stress, depression and high-risk behaviours.

- Differences in food, family and extended family influences, as well as the prominent role of spirituality, aren’t always recognized or valued by health systems.

- There are high rates of and mortality from hypertension, diabetes, cardiovascular disease, coronary heart disease and stroke.

- Diseases, treatments and symptoms on Black skin aren’t often considered.

- There’s a high rate of sarcoidosis, anemia, systemic lupus, sickle cell disorders, asthma and lactose intolerance.

- For women, there’s a higher than average incidence of fibroids.

- For men and women, there’s a high incidence of and mortality from cancer.

More information

- African Canadian Health Network of Nova Scotia: africancanadianhealth.weebly.com
- African Nova Scotian Affairs Integration Office (HRM): halifax.ca/Intergovernmentalaffairs/africanNSaffairs.html
- Health Association of African Canadians: haac.ca
- African Diaspora Association of the Maritimes (ADAM): adamns.ca
- Black Cultural Centre for Nova Scotia: bccns.com

Documents


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

18 Much health information is based on U.S. studies with qualitative or testimony-based evidence only available in Nova Scotia/CDHA.
There are several ways to describe this community, including rainbow, sexual minority, GLBTIQ (gay, lesbian, bisexual, transgender, intersex, queer) and LGBTQTTIQQA (lesbian, gay bisexual, transgender, transsexual two spirit, intersex, queer, questioning, asexual). This diverse group has a wide range of health care needs.

Studies show that from 5% to 10% of any population belongs to this community. It’s difficult to accurately assess the size of this community because it’s an invisible culture in that individuals are in different stages of their coming-out process and identities are changing.

**Sexual orientation** has to do with who we are romantically, emotionally and physically attracted to. Everyone has a sexual orientation. Some common labels are lesbian, gay, bisexual, queer, asexual, pan-sexual and straight.

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

### Health: sexual orientation

- The history and lived experience of discrimination (phobias, segregation, stereotyping) contribute to marginalization, oppression and low social status. These burdens, separately or combined, often impact the mental and physical health of individuals, including an increase in stress, depression and high-risk behaviours.
- Communications barriers may exist due to a lack of understanding and intolerance.
- It’s difficult and, at times, unsafe to disclose sexual orientation in health settings.
- There’s often a delayed use of health services, including prevention and screening, due to experiences of bias, discrimination and mistrust.
- Few health services appropriately meet this community’s needs.
- Certain sub-populations such as seniors may be separated from their life partners or feel forced into hiding their sexual orientation while interacting with health care or long-term care professionals.
- Same-sex couples and same-sex parents aren’t included or reflected in forms services, health materials and care plans. It’s common for health care providers to assume that all patients are heterosexual.
- Gay men are more likely to experience eating disorders and may be at increased risk of hepatitis and anal, prostate, testicular and colon cancer.
- Lesbians may be at increased risk of certain types of cancer, such as breast or gynecologic. They may also have unique fertility-treatment needs.
- Members of this community may have strong non-traditional social and family support networks that are extremely important to their health and well-being.

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19 Most health information in this section has been sourced from the Gay and Lesbian Medical Association: glm.ca.org.
We assume that a person’s gender is based on the sex they’re assigned at birth; for example, babies who are assigned male at birth will be boys/men and females will be girls/women. However, this assumption isn’t always accurate, and there is much more diversity in gender identity than there is in assigned sex.

For transgender people, 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 normal or expected for their perceived gender or assigned sex in a given culture.

More information
- Pride Health: cdha.nshealth.ca/pridehealth
- Nova Scotia Rainbow Action Project: nsrap.ca
- Canadian Rainbow Health Coalition: rainbowhealth.ca/english/index.html
- Nova Scotia Rainbow Action Project: nsrap.ca
- Canadian Rainbow Health Coalition: rainbowhealth.ca/english/index.html
- Youth Project: youthproject.ns.ca
- TransAction Society of Nova Scotia: facebook.com/TransActionNS
- TRANSform Healthcare: facebook.com/TRANSformHealthCare or transformhealthcarens.wordpress.com
- Queer Health Research NS: facebook.com/qhrns
- Gay and Lesbian Medical Association: glm.org

2.11 (Dis)abilities

- 2006 data shows that 20% of Nova Scotians were affected by some form of mental or physical disability, as compared with 14.3% 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 a disability.

- An estimate of disability rates within Capital Health for individuals age 15 and over was determined by taking Nova Scotia rates and applying these to the Capital Health population. This results in the following type and rates of disability (estimates) for Capital Health: pain (52,136 individuals, 16.1%), mobility (51,812 individuals, 16%), agility (49,869 individuals, 15.4%), hearing (23,963 individuals, 7.4%), seeing (12,629 individuals, 3.9%), learning (11,010 individuals, 3.4%), memory (19,860 individuals, 2.6%), speech (7,772 individuals, 2.4%) psychological (6,477 individuals, 2%) developmental (2,590 individuals, 0.8%) and other (1,943 individuals, 0.6%).

- Seniors comprise 70% of the visually impaired in Nova Scotia due to conditions such as macular degeneration and glaucoma.

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Health of people with disabilities

- The history and lived experience of discrimination (phobias, segregation, stereotyping) contributes to marginalization, oppression and low social status. These burdens, separately or combined, often impact the mental and physical health of individuals, including an increased risk of stress, depression and high-risk behaviours.

- In some cases, individuals with disabilities may report adverse health conditions and lower levels of physical activity as compared with other Canadians.

- Main considerations include:
  - Need for enhanced communication through the use of ASL interpreters, assistive devices, audio resources, large print and clear language documents, TeleTypewriter (TTY) and caption TV sets and so on.
  - Increased awareness among providers of the need for supports and services, including knowledge and training in ASL.
  - Misdiagnosis of other disabilities.
  - Lack of accessible health-care services, facilities and transportation options.
  - Lack of support workers in hospice and palliative care settings.
  - Higher than average unemployment leads to low income. High cost/lack of access to supportive devices of hearing aids and replacement parts and other assistive devices.
  - Not all people who are deaf or hard of hearing use or understand sign language, especially those who become deaf/hard of hearing later in life. Nor are they necessarily part of deaf culture. There are resources available to help health care providers communicate more effectively with people who have hearing difficulties through the 25 Nova Scotia Hearing and Speech Centres.

More information


- In Nova Scotia, ASL interpreting is available free to deaf clients and is covered by Medical Services Insurance (MSI). Contact the Society for Deaf and Hard of Hearing Nova Scotians in Sydney (for Cape Breton) and Halifax (for mainland Nova Scotia).

- 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): cnib.ca/en/ns-pei/Pages/default.aspx. Users of CNIB services can also access resources from the national CNIB library. This library operates in a manner similar to a public library, lending braille and audio materials postage-free to clients. Only 10% of library clients read braille; most use CDs or the Internet.

- Nova Scotia Hearing and Speech Centres: nshsc.nshealth.ca

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

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

- Brain Injury Association of Nova Scotia: braininjuryns.com
2.12 Poverty and low-income status

• Socio-economic status (SES) is a person’s position in society and the social class to which they belong. Income and education levels, as well as occupational status, are often used as indicators of SES, although they don’t determine SES and aren’t perfect indicators.

• Income and social status are often seen as the most important determinants of health. As we earn more money and move up the social ladder, our health status typically improves. However, Canadian sociologists have found 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.

• 17.3% of children in Nova Scotia were living in families with incomes below the After-tax Low Income Measure (AT-LIM) in 2011, compared with 14.3% AT-LIM in Canada. 40% 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 of 2013, some 21,760 Nova Scotians visited food banks, with children comprising 32% of that number. This is an increase of 28.6% from 2008. (2013 Hunger Count).

• Low-income rates are higher among diverse groups such as seniors, single parents, First Nations, the disabled, recent immigrants and African Canadians. Women are also disproportionately represented in low-income statistics. The health effects of low income and education are often greater in groups that 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 a small gap between rich and poor have a better overall health status than those with a larger gap.

• 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; social supports; health insurance to pay for vision care, dental care and medication; and health information, among other things. 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 fewer opportunities we have to enjoy life and engage fully in society.

• In Canada, inequity from poverty and exclusion has a greater impact on health than the personal health choices people make in their daily lives, such smoking or physical activity.

• The influence of income during childhood is important to an individual’s future health. Children who grew up in low-income families tend to have poorer health status even if later in life their income and social status improve.

• Nova Scotia, New Brunswick, Prince Edward Island, and Newfoundland and Labrador have more social, economic and health inequities than the rest of Canada and higher chronic-disease rates.
More information


3 Resources
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.\(^{21}\)

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.\(^{22}\)

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.\(^{23}\)

Cultural competence requires that organizations:\(^{24}\)

- 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.\(^{25}\)

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.”

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\(^{24}\) National Center for Cultural Competence, 2006: 2.

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.”

**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.

**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, unavoidable, unfair and unjust.

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

### 3.2 Diversity at Capital Health

**What is Capital Health doing about diversity?**

- Engaging diverse communities through dialogue and focus groups. We’re building this input into Capital Health’s plans for the future.
- Working to improve cultural health-interpretation services to help ensure equitable health care.
- Conducting research to collect local health data from diverse populations to inform decision-making.
- Offering cultural competency education to staff and physicians.
- Building and sustaining diverse partnerships with organizations and community groups.
- Embedding diversity and inclusion in organizational strategies.
- Offering sacred spaces that are inclusive of different faiths, religions and spiritual beliefs.

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To support this work, you can

- refer to the Culture Vision database through Library Services.
- access trained cultural health interpreters’ information by contacting Nicole Holland, Interpretation and Language Services and French Language Services co-ordinator, at 902-473-1909 or nicole.holland@cdha.nshealth.ca.
- share your stories about diversity and health by contacting Margaret Angus, Marketing and Communications, at 902-473-2726 or margaret.angus@cdha.nshealth.ca.
- connect with others who are passionate about diversity and inclusion through committee work or attend a Cultural Competence Education Session. Contact Mohamed Yaffa, Capital Health’s co-ordinator of Diversity and Social Inclusion, at 902-473-1326 or mohamed.yaffa@cdha.nshealth.ca.

3.3 Capital Health Position Statement on Diversity and Cultural Competence

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.

Endorsed by the Leadership Enabling Team, Sept. 27, 2011.
3.4 Capital Health Primary Health Care Cultural Competency Statement

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

- Source: Capital Health Primary Health Care (2012). *Primary Health Care Competency Framework*. Halifax, N.S.
### 3.5 Canadian Nurses Association Position Statement

#### Promoting cultural competence in nursing

Culture refers to the processes that happen among individuals and groups within organizations and society and that confer meaning and significance. CNA believes that cultural competence is an entry-level to practice-level competence for registered nurses. CNA believes that cultural competence is the application of knowledge, skills, attitudes and personal attributes required by nurses to maximize respectful relationships with diverse populations of clients and co-workers. According to the position statement, “Underlying values for cultural competence are inclusivity, respect, valuing differences, equity and commitment.”

CNA believes that cultural competence is “a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enables [them] to work effectively in cross-cultural situations.” It’s a component of quality practice environments that leads to improved health outcomes for clients, nurses and systems. Practice environments that are conducive to safety and quality reflect cultural diversity.

Cultural diversity is the variation of cultural factors among people. It “does not simply refer to difference but rather implies difference from the majority, which is assumed to be the norm.” Successfully integrating cultural diversity requires an atmosphere of “acceptance and respect” as it can be a “catalyst for generating new ideas, knowledge, partnerships, productivity and creativity.”

Recognizing that cultural issues are intertwined with socio-economic and political issues, CNA is committed to social justice as central to the social mandate of nursing. CNA believes that in every area of practice, nurses must not discriminate on the basis of a person’s culture.

Cultural safety is both a process and an outcome, with the goal of promoting greater equality. It focuses on root causes of “power imbalances and inequitable social relationships in health care.” Cultural safety “includes cultural awareness, cultural sensitivity and cultural competence.” CNA considers cultural competence and cultural safety as prerequisites to working effectively in global health. CNA welcomes further research on cultural safety in the Canadian health care context.

CNA believes that the responsibility of supporting cultural competence is shared among nurses, employers, educators, professional associations, regulatory bodies, unions, accreditation organizations, government and the public.

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28 Varcoe & Rodney, 2009, p. 141
29 Aboriginal Nurses Association of Canada (ANAC), Canadian Association of Schools of Nursing (CASN) and Canadian Nurses Association (CNA), 2009 CNA, 2010a; Registered Nurses’ Association of Ontario (RNAO), 2007; World Health Organization, 2009
30 Clients may be individuals, families, groups or populations
31 RNAO, 2007, p. 19
32 Ibid, p. 70
33 Ibid
34 Ibid
35 Srivastava, 2007, p. 13
36 International Council of Nurses, 2007, p. 2
37 College of Registered Nurses of Nova Scotia, 2006, p. 1
38 ANAC, CASN & CNA, 2009; Kirkham and Browne, 2006, as cited in Browne et al., 2009, p. 168
39 RNAO, 2007, p. 70
3.6 Responsibilities

- **Nurses** in all areas of practice are accountable for acquiring and incorporating cultural competencies in client and co-worker relationships. **Nurses’ unions** are responsible for promoting concepts of culture and diversity within their membership and health care workplaces. They provide representation under collective agreements and legislation related to many forms of discrimination and promote cultural competence through human rights work and diversity committees.

- **Employers** are responsible for creating environments that value diversity. They should organize and evaluate physical and psychological structures/systems that support and promote cultural awareness, sensitivity and safety.

- **Educators** are responsible for integrating concepts of cultural competence and diversity into their curricula. They should promote cultural competence among faculty members and students.

- **Regulatory bodies** are responsible for establishing standards and guidelines that promote cultural competence. **Professional associations** are responsible for advocating for cultural competence. Both of these organizations should demonstrate cultural competence in relationships with their members.

- **Accreditation organizations** are responsible for developing and implementing indicators for valuing diversity and for providing culturally competent care within health care organizations.

- **Governments** are responsible for:
  - fostering a climate of acceptance
  - enacting legislation to protect individuals’ human and cultural rights\(^{40}\)
  - ensuring that health care organizations provide culturally competent care
  - providing funding to provide culturally competent and safe care and to conduct research related to diversity in the health care workplace

- **Individuals** are responsible for choosing what information they share with health care providers (beliefs, values, behaviours) that will impact their health care.

3.7 Background

Canada’s cultural diversity is growing. “Data from the 2006 census is clear: the Canadian population is increasingly diverse and, according to Statistics Canada projections, the racial, ethnic, linguistic and religious diversity of the country will continue to increase. These changes present new challenges to government institutions as the needs of Canadians also change with the diverse population.”\(^{41}\)

In 2008, 8.4% of Canada’s nursing workforce graduated from an international nursing program. British Columbia and Ontario have the highest percentages of internationally educated registered nurses at 15.8% and 12.35%, respectively, while New Brunswick and Newfoundland and Labrador have the smallest, with both at 1.5%.\(^{42}\) Anecdotal evidence suggests that the face of Canada’s working nurses doesn’t reflect the diversity of the population it serves.\(^{43}\) Nurses’ organizations strive for human resource plans that reflect cultural diversity and demographics.

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\(^{40}\) Office of the United Nations High Commissioner for Human Rights, 1966

\(^{41}\) Citizenship and Immigration Canada, 2010

\(^{42}\) Canadian Institute for Health Information, 2009

\(^{43}\) ICN, 2004
While cultural competence is an important concept, it can sometimes overlook systemic barriers, which makes it challenging to fully address health care inequities. Cultural safety, however, “promotes greater equity in health and health care [because it addresses the] root causes of health inequities.” \textsuperscript{44}

“Cultural safety is a relatively new concept that has emerged in the New Zealand nursing context.” \textsuperscript{45} It’s predicated on understanding power differentials inherent in health-service delivery and redressing these inequities through educational processes. “Cultural safety will continue to hold value for nursing practice, research and education when used to emphasize critical self-reflection, critique of structures, discourses, power relations and assumptions, and because of its attachment to a social justice agenda.” \textsuperscript{46} It “could be an important means by which equity and social justice might be operationalized.” \textsuperscript{47} Further research on cultural safety within the Canadian health care context is welcomed.

Nurses in Canada are well positioned to promote cultural competence with clients and co-workers. A number of projects, initiatives, studies and guidelines are being developed on local, provincial/territorial, regional and federal levels to recommend ways to promote and embrace cultural competence and safety in nursing. For example, the CNA social justice gauge is one tool to help nurses develop and assess health equity in programs and policies.\textsuperscript{48}

\section*{References}


\textsuperscript{44} CNA, 2010b
\textsuperscript{45} Browne et al. 2009, p. 167
\textsuperscript{46} Ibid, p. 177
\textsuperscript{47} Ibid, p. 171
\textsuperscript{48} CNA, in press


See also


• Joint position statement with the Canadian Federation of Nurses Unions: Practice Environments: Maximizing Client, Nurse and System Outcomes (2006)

### 3.9 Other Useful Links and Literature

#### Links

- Centre for Addiction and Mental Health (CAMH) Health Equity: [camh.ca/en/hospital/about_camh/health_equity/ Pages/health_equity.aspx](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](calgaryhealthregion.ca/programs/diversity/diversity_resources/library/ library_master.htm)
- Aboriginal Cultural Safety Initiative: [ahc.ca/aboriginal-culture-safety](ahc.ca/aboriginal-culture-safety)
- Cultural Safety Modules, University of Victoria: [web2.uvcs.uvic.ca/courses/csafe/index.htm](web2.uvcs.uvic.ca/courses/csafe/index.htm)

#### Literature


For more information, contact Diversity and Inclusion at 902-473-1326