Challenging Exclusion to Build Inclusive and Accessible Rural Health Services

Lisa Bourke, Olivia Mitchell, Zubaidah Mohamed Shaburdin and Mujibul Anam

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Acknowledgements

We acknowledge and pay respect to the Traditional Owners of the lands upon which our campuses are situated and across the Goulburn Valley Region where this research took place. We would like to pay our respects to the Elders past, present and emerging.

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Introduction

Why is this approach different?

Many health services are striving to be more inclusive of all patients and clients. This is important in order to ensure that all local residents have access to health services and feel comfortable and respected when using them. It is often those most reluctant to use health services and/or those disengaged from services who need care the most (Durey & Thompson, 2012; Luchenski et al., 2018; Malatzky et al., 2018). Frameworks are needed to support health professionals and services in how to provide care for culturally diverse groups, particularly in rural areas where a single service may serve a diverse range of service users (Malatzky et al., 2018a). It is hoped that the framework presented here provides this and supports rural health services to cater to all residents in their catchment.

Health services have adopted other frameworks aimed at inclusion of specific groups or worked with particular groups to increase inclusion of them. Health services have engaged in training about First Nation and other health service user groups, translated health information into other languages, developed processes for service users with experiences of family violence and strived to provide access for people who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and non-gender binary (LGBTQIA+). All of these initiatives have assisted to increase inclusion within mainstream health services.

However, these approaches are often difficult to implement and hard to sustain. They tend to focus on awareness of differing cultural beliefs and practices as well as the health needs and outcomes of these groups (Downing & Kowal, 2011; Malatzky et al., 2018b). This tends to treat each group as homogenous, without acknowledging the diversity within groups or that many people have multiple identities (Luchenski et al., 2018); for instance, a young person may have a disability or English may be a second language for a transgender person.

Furthermore, the focus of these approaches is on the service user as different rather than on the cultures, systems or approaches of the service itself. Health professionals are also cultural beings and their cultures, and the cultures of health services, shape how care is provided. Most importantly, existing frameworks do not address the underlying reasons for exclusion or engage staff in the reasons why inclusion is important in improving health outcomes. Before strategies for inclusion of specific groups can be effectively implemented within health services, the barriers to inclusion need to be addressed (Malatzky et al, 2018a).

Therefore, this framework and toolkit are presented as a pre-inclusion process to prepare health services and professionals for specific inclusion approaches. It encourages health services to commit to a journey of inclusion, engage with health service users, promote discussion and reflection among staff, and implement small changes to become a service that is responsive to their users’ diverse needs, cultures and identities.

Having said this, there is no recipe, set of activities or singular approach to inclusion work. Health services must work to challenge practices that their users identify as exclusive and create systems and structures that welcome service users and encourage staff to adopt inclusive approaches. The framework presented in the next section outlines such an approach and the following toolkit provides activities and resources that may be used to implement the framework.
Part A — The Framework

Framework to challenge exclusion
in rural health services

Introduction to the Framework

Researchers from the Department of Rural Health at The University of Melbourne have developed an approach for health services to challenge existing assumptions and practices that are exclusionary. This integrates the voices of diverse local residents and prepares the service for new practices aimed at inclusion. This approach is based on work with four rural health services over five years where many lessons were learned from successes and failures. Learnings from this work culminate in the framework presented in Figure 1.

This framework aims to prepare health services for inclusion by challenging exclusion. In particular, it focuses on questioning assumptions, stereotypes, practices and systems that discourage or disrespect particular people. It also encourages practitioners and services to be guided by service users and to reflect on the cultural assumptions embedded in health care. This framework can be used as a first step to prepare health services for inclusion frameworks. Following, specific inclusion approaches for particular groups will be more easily adopted.

The framework is presented in three phases.

1. **Foundational concepts:** Phase 1 identifies five foundational concepts that the framework draws upon. These concepts make clear the aims and approach to the processes involved. When adopting this framework, understanding of these concepts is important.

2. **Tenets beginning the framework:** Phase 2 identifies six tenets that health services need to adopt to begin implementation of the framework. These tenets need to be adopted by health service leaders so they can be embedded within the health service.

3. **Actions to address exclusion:** Phase 3 identifies six actions that health services can undertake to challenge exclusion. The actions are underpinned by the foundational concepts and tenets. Each action needs to be planned as appropriate for the local context and will likely contain many smaller steps. Further, while these actions have been presented as six sequential steps, in practice the order of actions may vary, more than one action may be undertaken at a time and some actions may require repeating. This flexibility allows the service to implement the process in the most contextually relevant ways that work for the health service and their communities.

As you work through this framework, it is important to understand that each of these phases overlap, that change is a process requiring all phases but not necessarily in a linear order. Each phase, and components within each phase, will be revisited. The Toolkit provides readings, resources and activities to assist implementation of the framework.

We are interested in your use and experience with the framework and toolkit. As a result, we welcome feedback to Olivia Mitchell at olivia.mitchell@unimelb.edu.au.
Figure 1: Framework to Challenge Exclusion in Rural Health Services

The Foundational concepts:
1. Cultural humility underpins inclusive practice
2. Exclusion needs to be challenged to become inclusive
3. Change involves challenging relationships
4. CQI is useful in health service change
5. Voices of health service users drive change

Tenets beginning the Framework:
1. Commit to a long-term journey
2. Expect resistance to change
3. Whole of service approach
4. Make clear the reasons for change
5. Health professionals & clients bring their culture
6. People centred care

Actions to Address Exclusion
- Challenge exclusion to prepare for inclusion
- Organisational commitment
- Engage with local residents
- Honest assessment
- Action plan
- Structural change
- Reflection and conversation
Phase 1—Foundational Concepts

These five concepts outline the ways of thinking about change in a health service to challenge exclusion. The foundational concepts underpinning the framework are explained here.

1. **Cultural humility underpins inclusive practice**: The concept of cultural humility is particularly important as this is the goal of the framework. Cultural humility is about learning to reflect on and be humble in our culturally-assumed ways of doing things; to think and ask about what others know, need and expect during healthcare, and be willing to discuss different perspectives, cultures and practices (Tervalon & Murray-Garcia, 1998).

   Tervalon and Murray-Garcia (1998, p. 117) state *cultural humility* incorporates “a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.” Thus, a cultural humility approach encourages all health service staff to reflect on their own cultural assumptions and position of power (Dudgeon et al., 2014; Foronda, 2020).

   Cultural humility is not an easy concept and requires ongoing learning and reflection. The following videos give good examples of cultural humility in health care settings:
   - [https://study.com/academy/lesson/cultural-humility-definition-example.html](https://study.com/academy/lesson/cultural-humility-definition-example.html)
   - [https://www.youtube.com/watch?v=SaSHLbS1V4w](https://www.youtube.com/watch?v=SaSHLbS1V4w)

2. **Exclusion** is “ways of naming’ the collective processes that work to deprive people of access to opportunities and means, material or otherwise, to achieve well-being and security in the terms
that are important to them” (Peace, 2001, p. 34). Exclusion is multi-dimensional, dynamic, relational and underpinned by unequal power relations, where those excluded are repeatedly disempowered in diverse ways when seeking, negotiating and utilising health care (Freeman et al., 2020; McIntosh et al., 2019; Malatzky et al., 2018a; Moreton-Robinson, 2014; Popay et al., 2008).

**Exclusion needs to be identified and challenged before a service can increase inclusion.** Current structures, policies and practices (both clinical and non-clinical) within a health service warrant reviewing, questioning and challenging in order to prepare a foundation for change and inclusion.

3. As addressing exclusion means changing the ways people work, the language used and the understandings held, *relationships* will alter. As common practices and approaches in the health service are questioned, not everyone will agree with each other or the changes being made. This requires leaders of change to make changes, justify those changes and sometimes challenge others. For example, it requires everyone to act on behaviours that lead to exclusion, it requires peers to not ‘go along with’ sentiments that may lead to exclusion and it can also require teams to redesign some approaches to their work, including changing menus, clinical processes and service user input. Challenging staff to re-think inclusion is usually more effective in a safe environment that allows questioning rather than shaming.

Relationships are key to inclusion work. Strong engagement and relationships with service users improve communication and enable service users to speak up about disrespectful and exclusive practices. Strong relationships between staff and service users assist when diverse perspectives are encountered. During the process of addressing exclusion, relationships between staff and service users and between staff will be changed, however relationships can also buffer some resistance to change and encourage reflection about current structures, practices and policies.

4. **CQI processes** are used to enable gradual change in ways that are effective in health services. CQI enables small actions to be completed. Using and repeating the cycle of Plan, Do, Study and Act can ensure small actions to address exclusion are planned, implemented, reviewed and then adapted (Gardner et al., 2010; Renzaho, 2008). This keeps change manageable, actionable and consistent with other change processes in health services (Mitchell et al., 2018).

5. **Voices of health service users:** It is only those experiencing exclusion, disengagement or lacking access who can identify reasons for exclusion (Gatwiri et al., 2021; Paradies, 2016). Ways to hear, empower and give voice to those excluded identify the practices of exclusion. Therefore, the voices of health service users and local residents must be sought so that change is undertaken in ways that reflect the needs and wants of the local community.

There are many ways to seek out these voices, including through consultation, activities, groupwork, feedback avenues and so forth. It does take time to engage with these groups as they may be uncomfortable expressing their views or discussing their experiences. Including these voices ensures that others are not ‘speaking for’ but asking how health services can better meet their needs.
Phase 2—Tenets of the Framework

There are six tenets that a rural health service needs to adopt to make sure the framework is workable. Health services need to agree on these, ensure that leadership is committed to them and embed these into their strategic plans and other directives.

The six tenets required at the outset are:

1. **Commit to a long-term journey**—as cultural change and addressing exclusion is not easy, a long-term approach is required. The commitment needs to endure over time and remain firm through difficult times along the way. The journey is not a linear pathway but will oscillate between times of change, stagnation and resistance, sometimes achieving change in one way and resistance to other types of change.

2. **Expect resistance**—as challenging exclusion questions long held understandings and cultural positions, there will be resistance to change encountered. Leaders and drivers of change can expect and be ready to encounter resistance; being prepared, they can be clear and firm about the organisation’s commitment to the change effort when resistance arises.

3. **Whole of service approach**—the change in the health service must be across the entire service. If one area of a service is not part of the change, it allows exclusion to continue and undermines change efforts in other areas of the service.

4. **Make clear the reasons for change**—not everyone who works in a health service will see exclusion or understand that it exists. Not only do the changes need to be made clear across the health service, the reasons for the change and how particular practices are exclusionary need to be clearly articulated.

5. **All health service staff and patients/clients bring their culture**—the framework is premised on ideas of cultural humility that argues all people are cultural beings and therefore we all bring cultural perspectives to health care. Acknowledging this is a key step to understanding difference and being open to other perspectives and ways of working.

6. **People centred care**—the framework is premised on the patient/client and their significant networks being at the centre of their care. This includes patients and their significant persons being informed of choices, enabling patient choice, respecting patient choice and involving family, friends and significant people in these decisions and the care of this person (Goodwin, 2014).
Phase 3—Actions to Address Exclusion

The framework outlined in this document proposes six steps to develop actions to address exclusion. These steps are outlined here and discussed in more detail in the next few pages. Although each step is described, each is not necessarily undertaken independently, in the order presented, or as one action. Rather, each step is key to the process of change but may be re-visited as issues arise, changes are made, and as resistance to change emerges. In this way, these steps can be merged with other activities in the plans and processes of the health service. Resources for each step are included in the toolkit presented later in this document.

Figure 3: Six steps to develop actions to challenge cultural exclusion

The actions will be presented through two case studies, Shanaya and Raj, to provide specific examples.

Shanaya
Shanaya is a 17 year old Muslim who is questioning their gender identity. Shanaya is seeking health care to have confidential discussions about sexual health, mental health and asthma.

Raj
Raj is a 40 year old nurse who migrated to Australia seven years ago. He is currently working as a nurse in a small rural health service. Raj is hearing impaired and has been since a young boy.
Step 1: Organisational commitment to inclusion

Principles:
1. Commit to the value of inclusion for all.
2. Becoming more inclusive is a journey, a long-term process of change.
3. Leadership of the service must be committed to drive and maintain the process of change.
4. Expect resistance to change. This process will create discomfort as it challenges existing ways of thinking and doing. Persistence, and working through resistance to change, is critical to achieving inclusion.

This approach calls for the health service to make a commitment to change that is organisation-wide, publicly asserted and embedded in the service’s statement of priorities, strategic and operational plans. There are some key principles that the health service would find useful: the importance of adopting a long term process; the need for leadership to drive and maintain change; and anticipating that resistance to change (by staff and others) will happen.

Shanaya
Shanaya sees a story in the local newspaper that a local health service has celebrated their inclusion work. Shanaya thinks this could be an appropriate service to contact.

Raj
Raj welcomes the recent announcement by the CEO that the service he works in is committed to inclusion. He volunteers to sit on a working group to embed inclusion in the strategic plan of the service. He is motivated to do this as he is tired of his colleagues commenting on his understanding of English when he struggles due to his hearing impairment, not his comprehension of English.

Resources:
Health services need to engage with service users and potential service users in order to embed their voices, experiences and perspectives in the process of change. Such perspectives cannot be assumed. Engagement may begin by developing relationships between the health service leadership team and culturally specific organisations, groups or respected Elders. Or it may start with development of reference groups or increased communication between the health service and the community through various media platforms. Health services may have committees, events or activities to ensure diverse service users have a voice in the governance and operation of the health service. Of course, it is imperative to respond to the concerns, preferences and choices of local residents to sustain these relationships.

When engagement with a particular group is difficult, the health service has the responsibility to develop communication with these local residents and adopt a new approach of engagement. It is important not to place marginalised health service users in uncomfortable situations. Therefore, key staff from the health service may meet local residents outside the service, listen to their particular issues and complaints, and take a few key actions to address initial concerns and build trust. This process may take considerable time, commitment, resources and persistence. Being genuine, listening and responding are crucial.
Based upon the voices of local residents, the health service will honestly assess its inclusiveness and identify where exclusion can be challenged. Each health service is different and will have varying strengths and barriers. The assessment includes staff attitudes, common practices, service user feedback, policy and documentation reviews, and patient data reviews. The service can systematically consider which groups do not have access to or do not use the service, which groups need more attention, and who is less comfortable using the service. It also includes identifying the barriers and what changes are required. Sometimes the barriers are at the individual level, such as interpersonal interactions, the use of language, or particular judgements being made. Sometimes barriers can be common practices or policies (i.e., rigid protocols, menus and inappropriate forms), and in other situations barriers are structural issues across the organisation (i.e., the building structure, the lack of culturally identified positions, etc.). Assessment of the service may be undertaken by an external organisation or internal group, but must comprehensively assess inclusiveness.

**Shanaya**

As Shanaya entered the health service, they were pleased to see options for payment assistance, translators and private rooms to discuss sensitive issues rather than an open reception.

**Raj**

On the working group, Raj was asked to review the complaints process for the health service as one way to identify issues of inclusion and exclusion.
Step 4: Action plan for the whole organisation

Principles

1. The Action Plan is for the whole organisation.
2. Assigning responsibility and accountability to improve inclusion across the organisation is key.
3. Undertaking change through specific CQI approaches can be helpful.
4. Integrating cultural inclusion within People-Centred Care (PCC) approaches allows adoption of inclusive practices to be more easily facilitated.
5. Developing multiple, flexible, innovative and different actions enables diverse approaches to care.

An Action Plan should embrace values of inclusion, people-centred care, cultural humility and community engagement. The plan can include existing targets and projects already underway within the service. The Action Plan also includes actions challenging barriers to inclusion identified in the assessment, which may require changes for staff, structural changes, and/or long-term strategies. Including staff from across all clinical and non-clinical areas ensures the plan is comprehensive and designed for implementation across the whole organisation. The plan also needs to delegate responsibility for undertaking specific actions within identified timeframes. Progress is ideally reported at a governance level.

CQI processes can be used to make specific changes across the organisation. It is valuable to include some short-term, less resource intensive actions that can be completed quickly so that change is observed by both staff and service users. This might include displaying Aboriginal and Torres flags at the service entrance, including acknowledgement of country and/or preferred gender pronouns where appropriate, and/or the translation of key signs, menus and health information into various languages.

Shanaya
Shanaya was first asked to complete a set of forms which asked gender identity as either male or female. Leaving this question blank, the first health professional commented that Shanaya missed a question so the staff member said “I will tick female for you.”

Raj
Raj reviewed the previous six months of complaints and identified three key areas for change: (1) not assuming things about patients, (2) ensuring patients understood the care being provided, and (3) the need for menu options for a range of diets. He engaged with a clinical group developing a plan for care with diverse clients and engaged the kitchen staff about broadening the menu.
To challenge exclusion, some of the changes required are structural, relating to the systems, structures and processes of the organisation that discourage flexibility and inclusion. These could include governance structures (including Board sub-committees), reporting and accountability structures, workplace cultures and roles across the organisation. The implementation or broadening of culturally identified positions and who they report to may be considered. Changing documentation, such as job descriptions and performance indicators, to include inclusion related targets, can embed the expectation of inclusive practice across the organisation. Reviewing staffing ratios in relation to the available time for staff to interact with patients/clients can be an important consideration. Similarly, reviewing messages from leadership, targets and listings of mandatory training can aid in building the organisation’s capacity and expectations. Reviewing the physical layout, such as the entrance, waiting areas and how people move throughout the organisation, can relate to barriers and enablers of inclusion. Structural changes can take time but will highlight to staff and service users the importance of inclusion.

**Principles**

1. Becoming more inclusive is a continuous process that requires persistence to build into the organisational structure.
2. A safe environment is needed to improve inclusion that allows for questions, discussion and innovation.
3. The strengths of the health service and its staff are useful in change processes.
4. Partnerships assist to achieve change.

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**Shanaya**

Shanaya was asked for feedback as they left the service. Shanaya commented on the gender options on the form. Shanaya was delighted that the form was changed before their next visit.

**Raj**

Raj has called for structural changes in the reception area, as there is a lack of privacy and it is hard to hear patients/clients in the busy space. Changes to this space have been identified as too expensive.
There are often common assumptions and understandings in health care that are barriers to implementing inclusive practice. Questioning, re-thinking and developing alternative understandings of these assumptions is useful. While some are specific to particular groups of service users, some are voiced by many from diverse backgrounds (Mohamed Sharburdin et al., 2020a). A common assumption is “I treat everyone the same” which assumes everyone is the same and has similar needs. Another is making assumptions about what people want or need based on stereotypes of a group (e.g., all Aboriginal people want to see the Aboriginal Liaison Officer).

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**Common assumptions in health that can be challenged include:**

- **Inclusion is not important and my focus is clinical care:** consider the importance of how patients view sickness, health care and their bodies as well as the role of these in determining clinical outcomes.

- **I treat all patients the same:** we are all different with diverse needs and concerns; we want to be treated as individuals and not provided with the same options and processes for all, or treated as ‘just another patient.’

- **That Western health care is the only way to approach health care:** there are other approaches that could compliment, support and be included.

- **Assumptions about what patients/clients prefer** (e.g., ‘all Aboriginal patients prefer...’ or ‘my last Aboriginal patient wanted... so this Aboriginal patient will too’); avoid assumptions and remember it is ok to ask patients what they would prefer!

- **Respect is just about being nice to people:** rather respect is about hearing, accepting and supporting patient choices you may or may not agree with.

- **Access is about having a health service:** access is much more than being available—quality, appropriate and respectful care are key to people accessing services.

- **The patient is solely responsible for accessing health care or following treatment plans:** health professionals have a role in enabling access and choice.
Therefore, being reflective and tailoring care to the requests of individual patients and their support networks becomes important. This charges health care professionals with the task of asking service users about their preferences and choices. Clinicians are encouraged to be humble and not assume knowledge about what a patient/client may want or know. A safe environment for open discussion and learning as well as individual reflection will assist this process.

**To challenge these assumptions, consider:**

- It’s ok to ask; we can’t be expected to know what is important to every patient, client or carer.
- Building rapport and relationships with patients/clients is essential.
- We are all different in many ways, some of which are not obvious.
- The health service is responsible for access and inclusion.
- Think about ‘what other ways are there to....?’ Flexibility in approach to health care is important.
- Communication is key; build a positive relationship that will benefit patients beyond the immediate care.
- Reflect on what went well and what did not go so well—there is always room for improvement.
- Respect that the patient is an expert on their own life and makes their health decisions for particular reasons.
- Teams are responsible for inclusive practice; regular discussion and reflection among teams is important to improve inclusion.
- Ask service users what would help them to feel included within the health service and in their care?

Changing these common ways of thinking in health care and replacing them with more flexible, responsive, people-centred approaches will take time. Formal training can enable this as well as peer learning where colleagues listen, learn and question peers. These discussions have more impact when occurring regularly and embedded within ongoing staff development. The voices of service users must underpin these discussions in a safe space for both service users and staff.

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**Shanaya**
Shanaya was delighted that a counsellor at the service asked about Shanaya’s cultural approaches to mental health and self-care. The counsellor then integrated new techniques with practices from Shanaya’s culture.

**Raj**
Raj had witnessed a strange interaction between a colleague and a patient. He asked his team leader if the team could have a safe discussion about patient relationships they struggled with. At the discussion, his colleague raised issues and talked about their struggle with cultural humility at times.
The Framework as a Whole

Implementation of this framework is a long-term process that will require commitment, dedication and the identification and planning of small steps. The six actions in the process of change do not need to occur independently, and may often occur simultaneously. Moreover, health services are likely to undertake actions in all steps repeatedly. There is no one clear process for all health services but a process of committing to the change, reflecting on what change is needed, including the voices of service users, planning the change, implementing the change across all areas and levels of the service, and evaluating the change will enable inclusion to increase over time. A CQI approach can assist to translate a major plan into specific activities.

A few points to remember:

- **The voices of local residents are key:** Gaining feedback from local residents must inform and underpin change. Responding to their experiences of inclusion, exclusion, what makes them feel comfortable and what offends them is critical and cannot be assumed. This step will be revisited so that more perspectives can be heard and included over time throughout the change process.

- **The small steps are important.** The little initiatives do make a difference and many small actions contribute to organisational change. It will take time but continual progress, both among staff and at the organisational level, is key to improving inclusion.

- **It requires change and action by all health service staff.** Having staff who are generally considered ‘the norm’ (usually White, heterosexual, middle class, etc.) champion and lead processes/actions of change, advocate for others and genuinely consult with service users is very powerful. This demonstrates that the whole health service is changing and does not burden staff or service users of particular identities with progressing the change process.

- **Language is important;** the use of language and challenging inappropriate language is important. At the heart of most exclusionary practices is communication and interaction. What health professionals say, ask and hear is at the centre of such interactions. This change takes time and all health service staff need to be regularly involved in communication training and reflection on their interpersonal interactions.

- **Reflective practice is necessary.** Being a health professional who can effectively integrate their training, current evidence and patient/client beliefs and values is an important skill required for inclusion. Being open to asking questions, to adapting clinical approaches and to not having answers are important skills, although they may be uncomfortable. Reflecting and learning from experience is key to cultural humility.

- **Problem solving is required.** Cultural humility requires change in us all and will be done at different rates of change. Addressing these problems and working through solutions is important in the development of cultural humility. This is not an easy change process so expect to confront challenges.

This framework outlines a process to challenge exclusion in many forms across a rural health service and replace exclusionary approaches with inclusive practices. Existing forms of exclusion are identified by service users and, by embedding cultural humility, alternative practices are developed. The specific forms of exclusion are not the same for every health service, therefore each service will have to apply the framework in relevant ways. The following toolkit provides examples, activities and resources to assist with implementation of this framework.
Part B — The Toolkit

A toolkit to assist in implementing this framework to challenge exclusion in rural health services

Welcome to the Toolkit
This section provides a toolkit of activities, links and resources to assist you in implementing the framework. The framework and toolkit together provide a process and resources to examine the core structures, policies, processes and practices that currently exclude some local residents from health services. The resources in the toolkit can assist the process of making a commitment to inclusion, identifying areas where exclusion exists, breaking down exclusionary processes and, in so doing, make the implementation of specific inclusion approaches possible and sustainable. This toolkit has been designed as a resource that can be adapted to suit the needs of rural health services as they move along the journey to improving inclusion for everyone in their community. We hope you find the materials and activities useful.

How to use the Toolkit
Challenging exclusion requires action to bring about change. We hope this toolkit will provide you with some practical ideas and ways to challenge exclusion in your health service. Use this toolkit as an opportunity to apply a critically reflective eye to your health service and how it delivers services and care to a wide range of diverse members of the community. Use the resources to reflect carefully upon the objectives of the health service and what might be the intended and/or unintended consequences of current or future practices.

When using this toolkit to identify and challenge exclusion, please keep an open mind and a consciousness of the positions of others. In particular, the discussion activities, tools and resources are offered to help guide conversations on the different elements that contribute to inclusion or exclusion of certain groups. These discussions will likely challenge some long held beliefs, values and ideas held by health service staff. As a result, the discussions can at times be uncomfortable. When this is the situation, try to persist and work through the uncomfortable-ness; shying away from these discussions will not address the underlying divergent views or values. Consider engaging an external professional facilitator to help guide these discussions. Staff require open and safe discussions in order to be able effectively identify areas of exclusion. All of us are sometimes blind to the experiences of others—gentle encouragement is often more effective than public identification or shaming.

This toolkit is an open resource and we would value your feedback and contributions. Please share with us your feedback, suggestions and questions so that the toolkit can continue to evolve and improve (send to Olivia Mitchell at olivia.mitchell@unimelb.edu.au).
Phase 1—Readings on the Foundational Concepts

**Foundational concepts:**

1. Cultural humility underpins inclusive practice
2. Exclusion needs to be challenged to become inclusive
3. Change involves challenging relationships
4. Continuous Quality Improvement (CQI) is useful in health service change
5. Voices of health service users drive change

Readings below provide more detailed discussion of the framework and the foundational concepts to assist in clarifying their meanings and how they can be used within a health service.

**Background to the Framework**


**Exclusion**


**Cultural Humility**

Chavez, V. (2012). Cultural Humility. [https://www.youtube.com/watch?v=SaSHLbS1V4w&feature=youtu.be](https://www.youtube.com/watch?v=SaSHLbS1V4w&feature=youtu.be) (This is a 30-minute documentary that explains what cultural humility is and why it is needed.)


Challenging relationships


Continuous Quality Improvement


Voices of health service users


Phase 2—Readings on the Tenets of the Framework

Tenets at the outset:
1. Commit to a long-term journey
2. Expect resistance to change
3. Whole of service approach
4. Make clear the reasons for change
5. Health professionals and clients bring their culture
6. People centred care

It is important that the tenets of the framework above are understood, adopted and embraced as they shape expectations for the process. In particular, these tenets need to be adopted and portrayed by leadership. While these may be clearly understood, some readings are suggested below that explain further why each is important.

Commitment to a long-term journey:


Expecting Resistance:


Whole of Service approach

Make clear the reasons for change:


Health professionals and clients bring their culture


People centred care:


Phase 3—Actions to Address Exclusion

Step 1: Organisational commitment to inclusion

As described within the framework, this step calls for the health service to make a commitment to change that is organisational-wide, publicly asserted and embedded in the service’s statement of priorities and strategic goals. Careful consideration about how the organisation’s commitment to inclusion will be effectively captured and communicated is required by health service leadership (Executive, senior management and/or Board of Directors).

Activity: Demonstrating the value the organisation places inclusion

Discussion among the Board and executive/senior managers is important if this framework is to be adopted across the health service. Include in these discussions an overview of the foundational concepts and key tenets of the framework. The Quality team may be charged with leading discussions about the approach of the framework, how the framework will be implemented in health service structures, and when, where and how progress will be reported. In the discussions, consider the following.

**Principle: Commit to the value of inclusion for all**

The commitment needs to planned, including how the principles of inclusion align with the values of the organisation. Are they congruent and, if not, how can this be overcome?

Then consider, where will the health service communicate the commitment to improving inclusion, both internally and externally to the organisation (for example, internally to the organisation in Strategic Plan(s) and Statement of Priorities, and externally to the public on the health service website, through social media platforms, health service newsletters and community advisory group forums). Leadership and strategic planning ensures the commitment is embedded across the organisation.

**Principle: Becoming more inclusive is a journey, a long-term process of change**

The service may consider:

- Over what timeframe will the health service invest in improving inclusion?
- How much will the organisation invest in implementing projects and actions to improve inclusion, in relation to budget, staff and other resources, over the short, medium and long-term?
- Will this investment become a permanent budgetary item for the health service, now and in the future?

**Principle: Leadership of the service must be committed to drive and maintain the process of change.**

The service may consider:

- How will individuals at executive, senior or mid-management levels be assigned responsibility for co-ordinating or progressing the programs to improve inclusion?
• What will leadership commitment look like and how can it be re-affirmed over time? How will this commitment be structured, reported upon and reviewed? For example, it may include a public launch of the action plan, a sign at reception, reporting in the annual report, re-affirmation at events such as NAIDOC events, and so forth.
• How will the health service develop a whole of organisation approach to accountability for improving inclusion? Examples can include a regular agenda item at board, manager and team meetings, accountability measures written into position descriptions and an action item from each area of the health service.
• How will the commitment be sustained with staff and manager turnover? Ensuring the commitment is not reliant on one or two individuals is important.

**Principle: Expect resistance to change.**

This process will create discomfort as it challenges existing ways of thinking and doing. Persistence, and working through resistance to change is critical to achieving inclusion. Sometimes those resistant can become champions for change if the reasons for inclusion are explained clearly. The service may consider:

• How will staff across the organisation be made aware of the commitment to inclusion and how will this commitment be implemented in their day-to-day work?
• How will the reasons for improving inclusion be articulated to all staff?
• What mechanisms will be in place to support, encourage and recognise staff adoption of inclusive practice change?

**Resources**

A range of resources to help further guide such discussions can be found at The Centre for Culture Ethnicity, and Health website resource hub: [https://www.ceh.org.au/resource-hub/](https://www.ceh.org.au/resource-hub/).

Other resources include the following.

- Cultural Competence Learning Institute. Downloadable resource Creating Common Language. [https://higherlogicdownload.s3.amazonaws.com/ASTC/a6c0f3de-e0b1-4198-8ab7-01cee4a55b00/UploadedImages/Creating_Common_Language_2020.pdf](https://higherlogicdownload.s3.amazonaws.com/ASTC/a6c0f3de-e0b1-4198-8ab7-01cee4a55b00/UploadedImages/Creating_Common_Language_2020.pdf)
It is vital that the health service and its staff do not assume to know who experiences exclusion, how they experience exclusion and what needs to change. The voices of the local residents, particularly those who have been identified as hardly reached (see Wallace et al., 2020) by the service, must underpin change. Therefore, community consultation will be critical for the development and refinement of the Action Plan.

**Principles:**

- Service user voices inform changes to improve inclusion.
- Patients’ family, carers and support networks are embraced as partners in healthcare.
- Relationships underpin the change (between staff and patients, among staff, and between leadership and staff).
- Health services are encouraged to adopt principles of community engagement by seeking input from specific groups.

Community consultation can be undertaken in a variety of ways and conducted in ways that are contextually appropriate for the community and the health service. The various states and territories across Australia have different guidelines and rules relating to engagement with local residents by health service organisations. The location of the health service and the context of the local community will determine how, when and with which members of the community the health service engages.

This engagement can also be informed and directed by regular analysis of community profiles and health service data to ensure that the voices of those groups who tend to under-utilise services are heard. Planning how the health service will genuinely engage and reviewing this plan regularly to ensure it remains relevant and effective is important. The health service may already have structures in place to consult, engage and enable feedback. If this is the case, then consider how these structures could be expanded or improved to develop community consultation.

**Activity: Planning for engagement**

Discussion of the following can assist in directing conversations about how to engage with local residents in different ways.

- How does the health service currently engage with local residents? What avenues exist, such as The Board of Directors, Board sub-committees, Consumer Advisory Committee(s)/group(s), through partner organisations, at health service or community events, the health service website, through social media, print media or word of mouth?
- Currently, are all social and cultural groups within the local community being engaged through these strategies?
- Which groups are not being engaged effectively?
- How could these groups be reached and engaged with? What partnerships with local agencies, sporting clubs, social clubs or networks could assist?
- Would/should local residents be reimbursed for their time or provided with an incentive? (This depends on State or Territory guidelines.)
Tips for engagement

Both formal and informal engagement with local residents, groups and organisations can be considered in order to provide opportunities for local residents and service users to give voice to their health care needs. Some health services establish reference groups, some employ consumer advocates, some engage with particular Elders or community members, some host events and others engage in different and creative ways. This begins with relationship building, going to the community and engaging in ways the community groups want to engage. Across many cultures, the sharing of a meal or light refreshment is often considered an appropriate way to build a relationship and facilitate discussion. Providing a community morning tea, lunch or BBQ can be an effective way to engage community members. We also strongly support employment of staff from diverse backgrounds.

The Moore et al. (2016) reference below is a good starting point if you are unsure where to begin (see: https://aifs.gov.au/cfca/publications/community-engagement).

Resources:
A number of resources are provided in relation to the engagement by health services across different states and territories.


Step 3: Honest assessment of place in the cultural inclusion journey

Principles

- Acknowledge honestly where the health service is on the journey of inclusion. What does the service do well? What can be improved?
- It is important to identify how well staff understand inclusion and why inclusion is important to the health and wellbeing of diverse residents.
- Change needs to occur at the pace of the health service and in response to feedback from service users in the local region.
- Understanding that change is a complex process and may not be linear is also relevant. The process will adapt to the context and demands of each health service.

Currently, there are very few comprehensive assessment tools for reviewing in/exclusion of local residents in the Australian rural healthcare context. However, there are many audit tools and other assessments that can provide comprehensive assessment for different cultural and social groups that can be adopted and combined to make an overall assessment of your organisation.

The following activities can help guide the assessment of the health services’ current level of inclusion.

Activity 1: Analysis of your local population and community data

After analysis of the population data, look for patterns, correlations and gaps between the population data and your health service data. From analysis of the community and population data, and potentially consulting a local advisory group, the following questions can help make visible members of the community who may be being excluded from the health service:

- What is the profile of the community in which your health service operates?
- Where do people live?
- Were they born locally, nationally or overseas?
- What languages do they speak?
- How many First Nations people are living locally?
- How many older and younger people are there in the community?
- How many people are living with intellectual and/or physical disability?
- How many people are gender and/or sexually diverse?
- Are there groups represented within your community that your health service was unaware of or who do not regularly use the health service as shown in your data?

For further ideas on the types of elements to consider, the following website may be helpful: [https://www.relias.com/blog/how-diversity-equity-inclusion-influence-healthcare](https://www.relias.com/blog/how-diversity-equity-inclusion-influence-healthcare)

The following websites may also be useful:

• ID website www.id.com.au
• Australian Bureau of Statistics (ABS) www.abs.gov.au
• Centre for Culture Ethnicity and Health to find Resources and information on CALD Communities https://disability.ceh.org.au/
• Victorian Department of Health and Human Services, Centrelink Statistics and Data www.humanservices.gov.au/statistical-information

**Activity 2: Consult with local residents, groups and organisations**

All data is imperfect so consultation with local groups, advisory groups or key organisations can identify key issues, groups or relevant information to inclusion. It may not be a group with a social or cultural identity but rather a group experiencing key health determinants, such as homeless people, unemployed people, people with mental health conditions or those on low incomes. Seek out existing groups and organisations and draw on engagement processes in Step 2. Consider:

- Who struggles to attend health services?
- Who in the community does not always receive health care?
- Who is uncomfortable using the service?
- What other health and non-health related assistance/services are needed?

**Activity 3: Assessment of current inclusion within your health service**

Once potential groups experiencing exclusion have been identified, an audit or gap analysis of inclusion within the health service can be undertaken to help to identify:

- How do current policies, procedures and practices promote access to and use of services by different groups?
- Who might be missing out or excluded from services because of these policies, procedures and practices?
- What assumptions are made about service users in these policies, procedures and practices? For example:
  - Do your policies, procedures and practices assume a person’s ability to read proficiently in English or in a person’s first language?
  - Do they assume all patients/clients can travel to the service?
  - Do they assume a person’s ability to see or hear at a particular level?
  - Is there the ability to effectively identify within health service forms gender, sexual or other forms of diversity?
  - Is there the ability to identify with different social, cultural or religious groups? For Aboriginal and Torres Strait Islander Australians, is there the ability to identify with a particular Nation, language or family group?
  - Is there sufficient explanation contained within such forms for the service user to understand why this information is being collected and how it will be used by the health service?
How do your policies/procedures seek to protect people from harm? This includes clinical harm, cultural and/or social harm or psychological harm?

Further discussion could explore:

- Who in the local community does not attend this health service as often as they probably should?
- Who is uncomfortable using this service?
- Why is inclusion important? (What observations were made about how well staff understand inclusion and why it is important?)
- How do staff adapt to different service users? (Think about their talk in terms of sameness or flexibility, judgement or respect, practitioner-led or people centred.)
- What types of training and professional development could assist to embed inclusion across the organisation?
- What do they find difficult in being inclusive in their daily work?

Use the audit tools, checklists and other resources listed under “General Resources” below to guide this process. Information from all the activities above in combination with information from Step 2 can identify barriers to inclusion and areas for improvement.

**General Resources**


**Resources for assessing health service inclusion of Aboriginal and Torres Strait Islander peoples**


Resources for assessing health service inclusion for members of the CALD community

Resources for assessing health service inclusion for members of the LGBTQIA+ Community

Resources of assessing health service inclusion of people with disability
Step 4: Action plan for the whole organisation

Challenging exclusion needs to be undertaken across the whole organisation to be effective. Avoiding areas of the service that may be assumed to be more difficult or more resistant can lead to undermining change processes. Sometimes those most resistant at the outset can become champions of change.

Principles

- The Action Plan is for the whole organisation.
- Assigning responsibility and accountability to improve inclusion across the organisation is key.
- Undertaking change through specific CQI approaches can be helpful.
- Integrating cultural inclusion within current Person-Centred Care (PCC) approaches allows adoption of inclusive practices to be more easily facilitated.
- Developing multiple, flexible, innovative and different actions enables diverse approaches to care.

Activity 1: Development of a working group

Bring together a leadership group that will develop, action and review progress against both existing and new inclusion Action Plans. This may be a working group or a steering committee but representation from all areas across the organisation is critical. Bringing together representatives from each clinical and non-clinical area of the organisation will provide a diversity of perspectives, ways of thinking and problem solving. The purpose of the Working Group is to champion the change process and to direct progress towards improving inclusion across the whole organisation.

Activity 2: Setting priorities and intended outcomes

Once an assessment of current points of exclusion within the health service has been completed, it is appropriate to set organisational priorities and expected outcomes for improving inclusion. Many health services will already have undertaken audits, assessments and collected data in relation to socially and/or culturally diverse groups and may have priorities or outcomes for the organisation. These priorities and outcomes can be included and/or expanded within this exercise. The process of challenging exclusion and removing barriers often has beneficial outcomes for many socially and culturally diverse people. The incorporation of previously identified priorities and outcomes can assist in making this process more effective and comprehensive. Therefore, setting priorities, including new and existing priorities, can assist in focusing the Action Plan.

Activity 3: Development of an action plan to improve inclusion

An Action Plan is best documented clearly and specifically so everyone is aware of its goals, actions and expected outcomes. There are many templates for Action Plans available and many health services have their own templates. Use or adapt an Action Plan template that will best serve the context of the health service and the community. Actions can include those that promote inclusion as well as those that challenge exclusion.
Resources available include:


A systematic approach to review and implement changes in all areas of the service supports the approach that inclusion is important. One of the most common and effective means of undertaking change processes within healthcare organisations is through CQI. This approach can be used to structure the Action Plan and implement the plan across the health service. Similarly, align changes with the principles, policies and processes that already exist within the health service and focus on people-centred care. Combining these two approaches can structure the Action Plan where outcomes are focussed on improving people-centred care and are planned, undertaken, reviewed and then further developed within the CQI process.

When constructing the plan, consider the following points.

**Responsibility and Accountability**

The responsibility for implementing inclusion actions and/or projects is better shared across the organisation, rather than a few people being responsible for all actions. Accountability for moving actions forward also needs to be specific and measurable for individuals, teams and areas across the health service in order to fully embed the process of inclusion throughout the health service. Plan mechanisms that will be implemented to ensure responsibility and accountability are monitored and reviewed regularly.

**Set Definitive Timelines for actions**

Consider the timeline for implementation of the Action Plan. This process will take time. Some actions will be able to be achieved quickly, while others will be larger and require breaking down into small, achievable steps over time. Avoid using the term “on-going” within timelines for completion or for review. Instead, look at how the action can be broken down into smaller actions to be completed by a specific date.

**Allow for flexibility**

The action plan can become an active document that changes and evolves as the organisation grows to become more inclusive. The Action Plan needs to be referred to regularly, flexible enough to allow for adjustments as challenges and opportunities arise, and maintain momentum in the change process by documenting changes that have been completed.

**Language is important**

Wording in the Action Plan is best when consistent with current language conventions in the region. Creating a common and consistent use of inclusive language across the organisation can play an important role in changing perceptions and practices of inclusion.

**Indicators**

- What mechanisms will be used to collect, collate and disseminate information about improvements and projects for inclusion within the health service?
- How, and how often, will community needs be reviewed and actions re-assessed?
After development of the Action Plan, it is important to consider which of the actions relate to structural change and how these changes will be effectively achieved.

**Principles**

- Becoming more inclusive is a continuous process that requires persistence to build into the organisational structure.
- A safe environment is needed to improve inclusion that allows for questions, discussion and innovation.
- The strengths of the health service and its staff are useful in change processes.
- Partnerships assist to achieve change.

Structural changes to challenge exclusion can be important means of communicating commitment to this process. Some structural changes can take time to plan and implement, while others can be undertaken relatively quickly. Leadership need to commit to these structural changes.

Some of these actions will have been identified during the Action Plan development process and may include: the need to review the structure, language and content of health service documentation; the need for staff to undertake further inclusion-related training; the need for a diverse workforce; and reviewing the physical environment of the organisation, such as how spaces are welcoming and private. Some activities to help guide discussions relating to structural change are proposed here.

**Activity: Identifying structural changes**

A committee or a process of staff engagement can identify reforms that need to be undertaken to address exclusion across the organisation to identify where barriers to inclusion exist within:

- Strategies, including the strategic plan
- Reputation
- The organisational structure
- Values of the organisation
- Reporting and accountability
- The physical structure
- The financial structure
- Infrastructure (such as information technology or amenities)
- Engagement with local residents
- Engagement with staff
- Information sharing and dissemination (including information about the service, translation to other languages and information gaps among local residents)
- Policies and procedures
- Workplace culture
- Events and activities (both internal and external)
Consider:

- How long will each of these changes take?
- How can these changes be broken down into achievable, incremental steps?
- Who are the stakeholders that need to be engaged in order to undertake this change?
- How will they be engaged and how long will this engagement process take?

**Resources**


- David Pedulla, Associate Professor of Sociology at Standford University Web article Diversity and Inclusion Efforts that Really Work. [https://hbr.org/2020/05/diversity-and-inclusion-efforts-that-really-work](https://hbr.org/2020/05/diversity-and-inclusion-efforts-that-really-work)

*Artwork: Rebecca Atkinson, Empowering our People, 2019. © Rebecca Atkinson*
To continue the journey over time and embed a cultural humility learning approach, reflection and conversation need to re-occur. The topics below can be used to guide and prompt discussion to challenge exclusion and promote inclusion. These conversations, discussions and reflections take time. They also need to be consistent and re-occurring rather than single sessions. Including short discussions within team meetings is ideal to encourage continued reflection over time and the development of cultural humility.

**Principles**
- Adopt a cultural humility approach, where:
  a) staff cultural perspectives are acknowledged
  b) patients’ perspectives are prioritised, understood to be diverse and not assumed.
- The change process involves learning, negotiation and creativity.

The following activities are designed to be undertaken with staff from all areas and levels across the health service in order to challenge exclusion through discussion, increase peer learning, and promote changes to improve inclusion across the health service. These activities could be facilitated by someone from within the health service, such as a change champion or, depending on the context of the health service, may be facilitated by a professional external facilitator. These activities can be included within the action plan in the context of staff development and training and can be used as a guide for further quality improvement activities and/or training initiatives.

**Activity 1: Why is inclusion important?**

**Purpose of the Activity:** To explore why inclusion is important in our health service.

In health care teams, have multiple discussions about why this health service considers inclusion to be important. In each session, you might discuss one of the following questions:

- Are there any local residents who do not use the health service?
- Are there any service users who appear uncomfortable using the health service?
- Would a person who is [First Nations, LGBTQIA+, with a disability, with a mental illness, young and/or with limited English literacy] feel welcome in this health service?

**A Note of Caution:**

These topics will challenge many people’s beliefs, values and ideas. These discussions should be facilitated carefully, with understanding and humility, in a safe space for people to openly explore these concepts without fear of repercussion.
- How would a person who is [First Nations, LGBTQIA+, with a disability and/or with limited English literacy] be treated if they came to the service after hours and were staggering with slurred speech?
- Have you ever felt intimidated, uncomfortable or unwelcome? Why was this and what helped or hindered you moving past these feelings?
- If a person who is [First Nations, LGBTQIA+, with a disability, with a mental illness, young and/or with limited English literacy] does not use this health service, where would they go? What other health services are available in the local area? How would they get to the service?

**Activity 2: Access to healthcare**

Access means that all persons have opportunities to attend/connect with available Australian government services. Equity is the means that enables this and can include the policies and mechanisms that support those accessing the service. Access for all is important but many do not know how, when or why to access a health service. There are many different reasons why people do not access health care.

**Purpose of the Activity:** To unpack understandings of access to health care and equity of care by exploring how mainstream health services can potentially enable or disable access for different groups of service users. This activity can be undertaken with staff from across all areas and levels of the service in addition to the Board of Directors, consumer advisory groups and/or advocacy groups.

**Pose the following question to the group:** What do you think are the barriers to accessing health services?

<table>
<thead>
<tr>
<th>Potential barriers to local residents accessing healthcare:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial</strong></td>
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<tr>
<td>Not having financial capacity to pay for services</td>
</tr>
<tr>
<td>Not being able to afford the time away from work/family</td>
</tr>
<tr>
<td>Not being able to afford travel to the service</td>
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<tr>
<td><strong>Structural</strong></td>
</tr>
<tr>
<td>Lack of care providers needed for the presenting condition, including waiting lists/times.</td>
</tr>
<tr>
<td>Lack of health care facilities</td>
</tr>
<tr>
<td>Geographical - Having to travel for services</td>
</tr>
<tr>
<td><strong>Personal</strong></td>
</tr>
<tr>
<td>Cultural or Spiritual differences – Individual expectations as service users may not always be congruent with those of health care professionals</td>
</tr>
<tr>
<td>Language differences – is the person able to effectively communicate with their health care provider and to receive information from them?</td>
</tr>
<tr>
<td>Health literacy – not knowing what to do or when to seek care. Access to health services implies that individuals recognise and accept their need for services, consent to a role as a service user and acknowledge socially generated resources that they are willing to utilise. These processes of access are subject to social and cultural influences as well as environmental constraints.</td>
</tr>
<tr>
<td>General literacy – is the person able to read? In their first language or in English?</td>
</tr>
<tr>
<td>Concerns about confidentiality or discrimination</td>
</tr>
<tr>
<td>Previous negative experiences</td>
</tr>
<tr>
<td>Other priorities or needs—the person may have non-health issues that are priority</td>
</tr>
</tbody>
</table>
For readings on access, see:

Activity 3: Understanding diversity within our community

Purpose of Activity: To unpack understandings of the cultural and social diversity within and around the health service area and explore how mainstream health services can provide appropriate healthcare to diverse residents. See https://community.astc.org/ccli/resources-for-action/group-activities/diversity-wheel.

Using the data websites from Step 2, present statistics about the diversity of the population in which the health service operates to groups of staff. Then discuss the following questions:

1. What does the group think about this data?
2. Is this diversity well known or understood within the service?
3. What does this information mean for delivering health care to local residents?

Activity 4: Exploring our own culture

Purpose of the Activity: To explore what we think of and understand as our own culture and begin to understand the cultural similarities and differences between ourselves and others.

Use the Cultural Competence Learning Institute’s “Cultural Connection Conversation Starters” https://higherlogicdownload.s3.amazonaws.com/ASTC/a6c0f3de-e0b1-4198-8ab7-01cee4a55b00/UploadedImages/Cultural%20Connection%20Conversation%20Starters.pdf

Using the resources, generate discussions with staff to make visible elements of everyone’s own culture, the cultures of others and how these elements can be inclusive or exclusive of people with differing cultures.

Activity 5: Understanding ‘White Privilege’

Purpose of Activity: To unpack understandings of privilege within and around the health service area and explore how mainstream health services can provide appropriate healthcare to people with diverse cultures, social identities and experiences.

Watch the video “Joy Degruy: A trip to the grocery store” available at https://youtu.be/GTvU7uUgjUI with a group of staff and then use the following questions as discussion points about recognising our own culture, privilege and how to be a good ally:

• What does this video suggest about how offending someone can impact them?
• What are the wider implications of the experience of Joy for herself, her sister, her daughter and others who witnessed this scene?
Other discussion points:

- Can the group recognise that White privilege is not about assigning blame, but rather about how privilege blinds us.
- How we can use privilege to be a good ally to empower others?
- What other aspects of our privilege blind us to the experience of local service users?
- What does this mean for access and care in our health service? (How can we all play a role in changing interactions, advocating for clients/patients and making exclusion visible so that it can be addressed?)

Other resources for discussions about white privilege:

- Peggy McIntosh White Privilege: Unpacking the Invisible Knapsack. [https://www.racialequitytools.org/resourcefiles/mcintosh.pdf](https://www.racialequitytools.org/resourcefiles/mcintosh.pdf) (Downloadable resource)
- Dr Robin DiAngelo. Deconstructing White Privilege. [https://www.youtube.com/watch?v=Dwlx3KQer54](https://www.youtube.com/watch?v=Dwlx3KQer54)
- Dr Robin DiAngelo. White Fragility. [https://www.youtube.com/watch?v=cGGI66uK9x4](https://www.youtube.com/watch?v=cGGI66uK9x4)

Activity 6: What is cultural respect and what does inclusive practice look like?

Culturally respectful health care can be especially challenging when you are asked to deliver both “evidence-based” and “people-centred” care. These two approaches are not always consistent. It is easy to be culturally respectful when a person makes a decision we agree with. Where it becomes more challenging to be respectful and inclusive is when we personally or professionally do not agree or understand, or when their preference is particularly difficult to implement.

**Purpose of the Activity:** To discuss and explore understandings of what constitutes culture and cultural respect.

The Cultural Iceberg image is required for this activity (simply type “Cultural Iceberg” into a web browser). Use the cultural iceberg image to explore the parts of ourselves and our organisations that constitute our “culture”.

**Questions to pose to the group:**

1. What parts of our culture are visible and not visible?
2. How does our “culture” shape how we think and feel about other people?
3. What is cultural respect? How does it differ to simply being polite? Does being “polite” differ between cultural and social groups?
4. At what point can you accept and respect a person’s decision without needing to know more or the reason why they are making that decision?
5. Is the “needing to know why” just so that you can try to convince them otherwise?
6. What are some of the ways that you can respectfully hear and act upon the choice of a patient or client, when you do not agree with that choice?
7. How do we monitor our language, our body language and our responses so that our interactions are respectful?
8. What are some ways to discuss options with patients/clients when their particular preferences are not yet available in the health service?
## Toolkit Quick Reference Guide

### Phase 1—Readings on the Foundational Concepts

**Cultural Humility**

<table>
<thead>
<tr>
<th>Author</th>
<th>Resource Type</th>
<th>Title</th>
<th>Available at</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karin Gonzalez and Jennifer Levitas</td>
<td>online</td>
<td>Cultural Humility: Definition and Example</td>
<td><a href="https://study.com/academy/lesson/cultural-humility-definition-example.html">https://study.com/academy/lesson/cultural-humility-definition-example.html</a></td>
</tr>
<tr>
<td>Professor Vivian Chavez</td>
<td>Online documentary</td>
<td>Cultural Humility</td>
<td><a href="https://www.youtube.com/watch?v=SaSHLb51V4w">https://www.youtube.com/watch?v=SaSHLb51V4w</a></td>
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</table>
### Phase 3—Actions to Address Exclusion

#### Step 1: Organisational commitment to inclusion

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<th>Author</th>
<th>Resource Type</th>
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<th>Available at</th>
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<tbody>
<tr>
<td>Cultural Competence Learning Institute</td>
<td>Downloadable resource</td>
<td>Creating Common Language</td>
<td><a href="https://higherlogicdownload.s3.amazonaws.com/ASTC/a6c0f3de-e0b1-4198-8ab7-01cee4a55b00/UploadedImages/Creating_Common_Language_2020.pdf">https://higherlogicdownload.s3.amazonaws.com/ASTC/a6c0f3de-e0b1-4198-8ab7-01cee4a55b00/UploadedImages/Creating_Common_Language_2020.pdf</a></td>
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### Step 2: Engagement with local residents

**Resources to guide engagement with consumers**

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<th>Author</th>
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### Step 3: Honest assessment of place in the cultural inclusion journey

#### Resources for Activity 1: Analysis of the local population and community data

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<tr>
<th>Author</th>
<th>Resource Type</th>
<th>Title</th>
<th>Available at</th>
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<tbody>
<tr>
<td>Id.</td>
<td>website</td>
<td>Id.</td>
<td><a href="www.id.com.au">www.id.com.au</a></td>
</tr>
<tr>
<td>Centre for Culture Ethnicity and Health</td>
<td>Website</td>
<td>Find Resources and information on CALD Communities</td>
<td><a href="https://disability.ceh.org.au/">https://disability.ceh.org.au/</a></td>
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#### Resources for Activity 3: Assessment of current inclusion within your health service

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## Resources for assessing health service inclusion of Aboriginal and Torres Strait Islander peoples

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<th>Author</th>
<th>Type</th>
<th>Title</th>
<th>Available at</th>
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<tbody>
<tr>
<td>Victorian Department of Health</td>
<td>Audit Tool</td>
<td>Continuous Quality Improvement Tool: Aboriginal health in acute health services and area mental health services</td>
<td><a href="https://www2.health.vic.gov.au/about/publications/researchandreports/CQI-tool---Aboriginal-health-in-acute-health-services-and-area-mental-health-services">https://www2.health.vic.gov.au/about/publications/researchandreports/CQI-tool---Aboriginal-health-in-acute-health-services-and-area-mental-health-services</a></td>
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### Resources for assessing health service inclusion for members of the CALD community

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<th>Type</th>
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<th>Available at</th>
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<tbody>
<tr>
<td>Centre for Culture, Ethnicity and Health</td>
<td>Tip Sheet</td>
<td>Cultural Considerations in Health Assessment Tip Sheet</td>
<td></td>
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</tbody>
</table>

### Resources for assessing health service inclusion of members of the LGBTIA+ Community

<table>
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<tr>
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### Resources for assessing health service inclusion of people with disability

<table>
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</table>
Step 4: Action Plan for the whole organisation

Resources for Action Plan Templates and Checklists

<table>
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<tr>
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</table>

Step 5: Structural change

Resources for and examples of structural change within health services to improve inclusion

<table>
<thead>
<tr>
<th>Author</th>
<th>Type</th>
<th>Title</th>
<th>Available at</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Pedulla, Associate Professor of Sociology at Standford University</td>
<td>Web article</td>
<td>Diversity and Inclusion Efforts that Really Work</td>
<td><a href="https://hbr.org/2020/05/diversity-and-inclusion-efforts-that-really-work">https://hbr.org/2020/05/diversity-and-inclusion-efforts-that-really-work</a></td>
</tr>
</tbody>
</table>
Step 6: Reflection and conversation

Resources for Activity 2: The Five A’s of Healthcare Access. (Adapted from Penchansky & Thomas, 1981; Saurman, 2016. To assist guide discussions on consumer access.)

<table>
<thead>
<tr>
<th>Dimension of Access</th>
<th>Definition</th>
<th>Dimension components and examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility</td>
<td>Location</td>
<td>An accessible service is within reasonable proximity to the consumer in terms of time and distance.</td>
</tr>
<tr>
<td>Availability</td>
<td>Supply and Demand</td>
<td>An available service has sufficient services and resources to meet the volume and needs of the consumers and communities served.</td>
</tr>
<tr>
<td>Acceptability</td>
<td>Consumer Perception</td>
<td>An acceptable service responds to the attitude of the provider and consumer regarding characteristics of the service and social/cultural concerns. For instance, a patient’s willingness to see a male doctor may determine whether a service is acceptable or not. Or the appearances of the doctors offices, the neighbourhood/town the offices are in.</td>
</tr>
<tr>
<td>Affordability</td>
<td>Financial and Incidental costs</td>
<td>Affordable services examine the direct costs for both the service provider and the consumer.</td>
</tr>
<tr>
<td>Adequacy/Accommodation</td>
<td>Organisation</td>
<td>An adequate service is well organized to accept clients, and clients are able to use the services. Considerations of adequacy include hours of operation (after-hour services), referral or appointment systems, and facility structures (wheelchair access), how long you have to wait for an appointment, how easy it is to get in touch with the physician.</td>
</tr>
<tr>
<td>Awareness</td>
<td>Communication and information</td>
<td>A service maintains awareness through effective communication and information strategies with relevant users (clinicians, patients, the broader community), including consideration of context and health literacy.</td>
</tr>
</tbody>
</table>

Author

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</table>
### Resources for Activity 3. Understanding Diversity within our community

<table>
<thead>
<tr>
<th>Author</th>
<th>Type</th>
<th>Title</th>
<th>Available at</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adapted by Cultural Competence Learning Institute</td>
<td>Downloadable resource</td>
<td>Dimensions of Diversity</td>
<td><a href="https://community.astc.org/ccli/resources-for-action/group-activities/diversity-wheel">https://community.astc.org/ccli/resources-for-action/group-activities/diversity-wheel</a></td>
</tr>
</tbody>
</table>

### Resources for Activity 4. Exploring our own culture

<table>
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<tr>
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<tbody>
<tr>
<td>Cultural Competence Learning Institute</td>
<td>Downloadable resource</td>
<td>Cultural Connection Conversation Starters</td>
<td><a href="https://higherlogicdownload.s3.amazonaws.com/ASTC/a6c0f3de-e0b1-4198-8ab7-01cee4a55b00/UploadedImages/Cultural%20Connection%20Conversation%20Starters.pdf">https://higherlogicdownload.s3.amazonaws.com/ASTC/a6c0f3de-e0b1-4198-8ab7-01cee4a55b00/UploadedImages/Cultural%20Connection%20Conversation%20Starters.pdf</a></td>
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</table>

### Resources for Activity 5: Understanding White Privilege.

<table>
<thead>
<tr>
<th>Author</th>
<th>Type</th>
<th>Title</th>
<th>Available at</th>
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</thead>
<tbody>
<tr>
<td>Peggy McIntosh</td>
<td>Downloadable resource</td>
<td>White Privilege: Unpacking the Invisible Knapsack</td>
<td><a href="https://www.racialequitytools.org/resourcefiles/mcintosh.pdf">https://www.racialequitytools.org/resourcefiles/mcintosh.pdf</a></td>
</tr>
<tr>
<td>Dr Robin DiAngelo</td>
<td>Video clip</td>
<td>Deconstructing White Privilege</td>
<td><a href="https://www.youtube.com/watch?v=Dwlx3KQer54">https://www.youtube.com/watch?v=Dwlx3KQer54</a></td>
</tr>
<tr>
<td>Dr Robin DiAngelo</td>
<td>YouTube clip</td>
<td>White Fragility</td>
<td><a href="https://www.youtube.com/watch?v=cGGi66uK9x4">https://www.youtube.com/watch?v=cGGi66uK9x4</a></td>
</tr>
</tbody>
</table>
References


For more information, please contact:

Dr Olivia Mitchell
The University of Melbourne,
Department of Rural Health
49 Graham St, Shepparton, VIC 3630
Ph: 03 5823 4500
olivia.mitchell@unimelb.edu.au