

# Nova Scotia Health Fair



## Messages for All Voices

Integrating Cultural Competence and Health Literacy  
in Health Materials, Forms, and Signage

NOVA SCOTIA  
NOUVELLE-ÉCOSSE

Health  
Santé



**Meeting Cultural Competence Guideline 9:**

Nova Scotia district health authorities, the IWK, and primary health care organizations should reflect Nova Scotia's diverse populations in pictures, written information and advertisements and post signage and provide written material for all literacy levels in the languages commonly spoken in their service areas.

*Cultural Competence Guidelines for the Delivery of Primary Health Care in Nova Scotia (2006)*

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This document is available on the Internet at  
**[www.gov.ns.ca/health/primaryhealthcare/healthliteracy.asp](http://www.gov.ns.ca/health/primaryhealthcare/healthliteracy.asp)**

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# About This Resource

## Who is the audience for this resource?

This resource is intended for health-care and health promotion professionals and community partners who create, assess, and/or adapt health materials, forms, and signage.

## What is our goal?

Our goal in writing this resource is to share key concepts and practical tools needed to create health and health promotion materials, forms, and signage that:

- are clear and understandable;
- are appropriate and responsive; and
- reflect the **culture, language** and **health literacy** levels of the people we serve

**Culture** refers to groups that share common experiences that shape the way group members see and understand the world. Culture is multi-layered and evolving. It includes groups we are born into and those we choose. Culture includes, but is not limited to, race and ethnicity, language, gender and gender identity, sexual orientation, (dis)ability, religion and/or spirituality, age, geographic origin, and socio-economic status (class). People have multiple cultures.

**Health literacy** is the ability to find, understand, and use health information, services and supports that help us make informed choices about how to be healthy.<sup>1</sup> Health literacy requires communication, math and reading skills, and an ability to navigate forms and health systems.

**Cultural competence** is a set of congruent behaviours, attitudes and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations.<sup>2</sup>



**Cultural competence** is not 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 the world around us. Because culture is dynamic, shared and continuous, so is cultural competence. It is a process of becoming, not an end to be reached.<sup>3</sup>

The *Cultural Competence Guidelines for the Delivery of Primary Health Care in Nova Scotia* (2006) originated as a response to needs and barriers identified through a process of engagement with Nova Scotia's diverse minority communities (see Appendix 1). This resource supports the implementation of Guideline 9:

*Nova Scotia DHAs, the IWK and primary health care organizations should reflect Nova Scotia's diverse populations in pictures, written information and advertisements and post signage and provide written material for all literacy levels in the languages commonly spoken in their service areas.*

### **How was this resource developed?**

We chose the format and content of this resource through a series of consultations with cultural competence and health literacy staff, people who create health and health promotion materials, and members of cultural groups working in health care. A list of some of those consulted is included.

We scanned the literature and best practice resources in cultural competence and health literacy to create a working draft. We made changes to the draft based on feedback and further consultations.

### **How should this resource be used?**

- Refer to the assessment guide and highlights in Section 1.
- For more information, refer to the concepts and starting points in Section 2.
- For practical tools on community engagement and minimizing language and health literacy barriers, refer to Section 3.
- For a glossary of terms, see Appendix 2.

## Why integrate culture, language and literacy in health materials, forms, and signage?

Integrating culture, language, and literacy in health materials, forms, and signage means better health for all Nova Scotians.

To be healthy, we need access to health and health promotion information that is in a language and at a literacy level we understand and that values our cultural identities. This is true for our interactions with health-care providers, the patient education materials and health information we receive, the forms we complete, and the tools we use to navigate health facilities and systems of care.

Including culture, language, and literacy in health and health promotion materials means they will be more accessible, accurate and appropriate. They will be written the way people speak, in words and languages people understand, with images and content mirroring culture, income, and education levels. This will enable health literacy. More people will read and understand health education materials. They will see themselves reflected in health promotion materials. Forms will be easier to complete, with the diversity of individuals and families included. People will be better able to navigate health systems and make better-informed decisions about their health.

Providing **culturally competent** programs and care, which includes paying attention to culture, language, literacy, and health literacy, thus builds inclusion and aims to:

- reduce long-standing health inequities;
- improve access, quality of service and health outcomes; and
- decrease liability and improve health system efficiency.



# Section 1: Assessment Guide and Highlights

# 1

## About this section

This section contains an assessment guide, content highlights, and a vision statement.

Use the **assessment guide** to ensure that your health and health promotion materials include culture, language and health literacy. Refer to the appropriate page of the resource if you need more information.

The **how-to highlights** summarize the key concepts.

The **vision statement** inspires us towards a future where culture, language and health literacy are integrated in health materials, forms, and signage.



# Assessment Guide for Culturally Competent Health Materials

When writing, adapting, or choosing health materials, ask yourself, “Have I considered culture, language, and health literacy?”

## QUESTIONS TO ASK

## FOR MORE INFORMATION

1. **Do I understand culture, cultural competence, and health literacy?** **See page 16**

2. **Who is my audience? Did I engage with them? Have they identified their needs? Do my materials meet their needs?** **See page 54**

3. **Have I considered . . .**

**Culture:** What cultural groups do I work with? Did I include these groups in my health materials? What issues do they face? How do I reflect their life experience, culture, and biomedical reality? How will they have access to my information? **See page 22**

**Race/ethnicity:** Did I consider the needs and lived experience of local racially and ethnically diverse individuals, such as Aboriginal people, Acadians and francophones, African Canadians, immigrants and refugees? Did I consider race and ethnicity in content, images and examples? **See page 25**

**Sex/gender:** Did I consider the needs and lived experience of men and women, boys and girls? Did I make sure I have not stereotyped roles and behaviours? Did I consider sex and gender diversity in content, images and examples? **See page 38**

**Gender identity:** Did I consider gender identity—a person’s self-image about being female, male, both, or neither—in content, images and examples? **See page 42**

**Socio-economic status:** Did I consider the effects of low social status and low income on health? Can those on low incomes relate to this? Will they have access to it? **See page 40**

**Sexual orientation:** Did I consider sexual orientation in content, images and examples? For example, did I consider same-sex relationships? Health concerns? Confidentiality? **See page 42**

**Ability:** Did I consider people with differing levels of physical or mental ability? **See page 46**

**Location:** Did I consider where people live, including rural and urban realities (for example, safety, access to services and transportation)? **See page 50**

**Age:** Did I consider different age groups, for example children, youth, seniors, and the middle-aged? **See page 50**

**Spirituality:** Did I consider diverse faiths, spiritual beliefs, and practices? **See page 52**

## QUESTIONS TO ASK

## FOR MORE INFORMATION

### 4. Have I minimized language barriers?

Did I develop or adapt this in partnership with local groups whose home language may not be English (for example, Aboriginal people, francophones and Acadians, recent immigrants, and refugees)? **See page 61**

Did I consider the Deaf and those with hearing loss? The deaf-blind? **See page 46**

Did I make this information available in languages spoken/read/signed in my local community (for example, French, Mi'kmaq, Braille, American Sign Language, and local newcomer languages)?  
Do I need to have it translated? Adapted to a non-print format? **See page 64**

Did I look for other ways to share this information so that my message will be heard and understood? **See page 77**

### 5. Have I minimized literacy and health literacy barriers?

Is my material easy to read and understand? Is it written at a literacy level appropriate to my audience? Will it empower people to take action for better health? **See page 68**

Did I include diverse photographs, images, and diagrams that assist with understanding? **See page 22**

Can I provide this in alternative formats, such as audio, digital, or DVD (described format)? **See page 76**

Do I need to provide a large-print version? **See page 74**

Can I combine this with clear verbal communication? Will my message reach the intended audience? **See page 77**

### 6. Have I assessed culture, language, and health literacy in forms and signage?

Are intake, assessment, and consent forms easy to read, appropriate, and inclusive? **See page 78**

Are signs easy to read and understand and inclusive? **See page 84**

Are maps, signs and other tools designed to help with navigation? Are multilingual staff/volunteers on hand to help? **See page 84**

## How-to Highlights

### How to engage the target audience

- Identify your audience. To whom are you writing? What is their age, their culture, their education, their language and literacy level? What groups most need this information? Where will it have the most impact?
- Engage people in identifying their needs and capacity. When your materials are developed, ask people to read them. Can they understand the material? Does it meet their needs? Can they see themselves reflected there?

### How to consider culture

- Consider all expressions and intersections of culture.
- Learn more about the cultural groups in your local community. Identify needs and develop relationships through a process of meaningful engagement. Use this information to adapt, choose, or develop health information so it is culturally appropriate. Test it with your audience to be sure it meets their needs.
- In images and content, reflect the voice, culture, and lived reality of cultural groups. Consider historical, economic, social, environmental, and political context.
- Ensure that materials consider biomedical and physiological differences, disease burdens, and skin colour of the people you serve.
- Use inclusive language, such as “seniors” instead of “the elderly.” Include male and female voices. Consider using the “singular they” or varying “he” and “she” in the text; do not use forms such as s/he or (s)he. Think of parents, same-sex couples, single parents, and extended families.
- Include diverse individuals in images and diagrams.
- Profile culture in case studies using names and relevant issues. Choose words and images that do not reinforce stereotypes. Use examples that make health concerns of cultural groups more visible.
- Reflect culture by considering complimentary/traditional providers and practices, the role of family, food, birth and death rituals, community supports, spirituality, and traditions in cultural beliefs and health practices.
- Do not assume Internet use.
- Do not assume heterosexuality. Do not assume only male or female gender identity.
- Consider the profound influence of poverty and status on health.
- Do not suggest approaches that are unrealistic for people with limited incomes.

## How to include language

- Provide culturally appropriate health materials in the languages used in your service area. Consider signed and spoken languages.
- Develop written materials in partnership with people whose home language is not English.
- Make sure that translated material is easy to read. Avoid or explain technical terms.
- Find alternative (non-print) ways to communicate and deliver health information.
- Use cultural health interpreters or American Sign Language (ASL) interpreters, supplemented by health materials. If there are no trained interpreters in your area, investigate telephone or video interpretation options.
- Provide information in alternative formats such as large-print, Braille, audio, or digital format/CD/DVD (described format).

## How to create inclusive forms

- Translate forms into key languages. Make them available in large-print, Braille, audio, digital, or DVD (described format).
- Make forms easy to read and navigate. Have someone on hand to answer questions and clarify.
- Use inclusive questions and terms: consider food, spirituality, gender identity, sexual orientation, racial and ethnic identity, same-sex couples, single parents, partners versus husband and wife.
- Keep forms confidential. Train staff to ensure that information is confidential.
- Ask only what you need to know.

## How to create inclusive signs

- Consider large font, contrast, universal symbols, and diverse images and languages.
- Include signage for cultural health and ASL interpretation services where available.
- Encourage, promote, and increase French signage in health-care facilities through the Bonjour program.
- Provide and identify single-stall washrooms for transgender individuals.
- Have multilingual staff/volunteers on hand to help.
- Use maps, signs, colour-coding and other tools to help with navigation.



## How to include literacy and health literacy

- Identify your audience. Assess their needs. Involve them.
- Adapt, choose, or write materials for the literacy level of your audience.
- If possible, hire a plain language writer.
- Write with clarity and understanding in mind. Use shorter and familiar words and clear language. Avoid jargon, acronyms, abbreviations, and technical terms. Explain difficult words and necessary medical terms.
- Use fewer than 20 words per sentence. Use a logical order with one main idea per paragraph. Put the most important information first.
- Write the way people speak. Use a friendly and inviting tone. Use “you” and “we” not “patient,” “consumer,” or “client.”
- Write in the active voice. For example, “Cats eat fish” instead of “Fish are eaten by cats.”
- Include only what is necessary.
- Use bias-free, inclusive language.
- Use lists to summarize key information. Emphasize key words and phrases with bold or in text boxes.
- Use clear layout and design. Make your document look clean and inviting, not overwhelming. Limit the amount of text on each page. Use headings and other tools to help readers navigate the material. If possible, hire a designer with experience in this area.
- Avoid the use of italics and shadowing. These are hard to read.
- Use at least a 12 point font that is easy to read. The Canadian National Institute for the Blind (CNIB) recommends Verdana (12) and Arial (14). Left align the text and leave the right margin ragged.
- Provide alternative formats, such as large-print, Braille, and audio or digital format/DVD (described format).
- Use images, diagrams, and text descriptions that assist with understanding.
- Use clear verbal communication in tandem with easy-to-read, inclusive health materials.
- Use personal and community channels to share health messages.
- Keep in mind the stigmas facing people with limited literacy and health literacy skills.
- Encourage and empower people to ask questions and learn more through the materials you provide.

## Our Vision of the Future

In the future, all Nova Scotians have full access to culturally and linguistically appropriate health resources in order to reduce health inequities and improve health outcomes.

To achieve this, our vision is to provide health information that:

- is clear and understandable;
- is appropriate and responsive; and
- reflects the **culture, language** and **health literacy** levels of the people we serve.

### Our health promotion and patient education materials are

- accurate and regularly updated
- clearly written and easy to read and use
- culturally competent—inclusive and appropriate for all cultural groups
- available in multiple formats including written, large-print, audio, and audio-visual
- available in local languages

### Our forms are

- clearly written and easy to read and use
- culturally competent—inclusive and appropriate for all cultural groups
- available in local languages and accessible formats

### Signs in our facilities are

- clearly written and easy to read and use
- represent diverse local populations in images and content
- available in local languages and accessible formats

### All staff, including front desk staff,

- use culturally competent approaches
- understand the extent and stigma of health literacy barriers
- use clear verbal and written communication
- know how, when, and where to access health resources for people of diverse cultures and languages
- relay this information respectfully and appropriately to people of all cultural groups and literacy levels

## Case Study: Canada's Food Guide

Canada's Food Guide is a good example of a health information resource that has been adapted to include culture and language. The food guide helps people make healthy and balanced food choices.

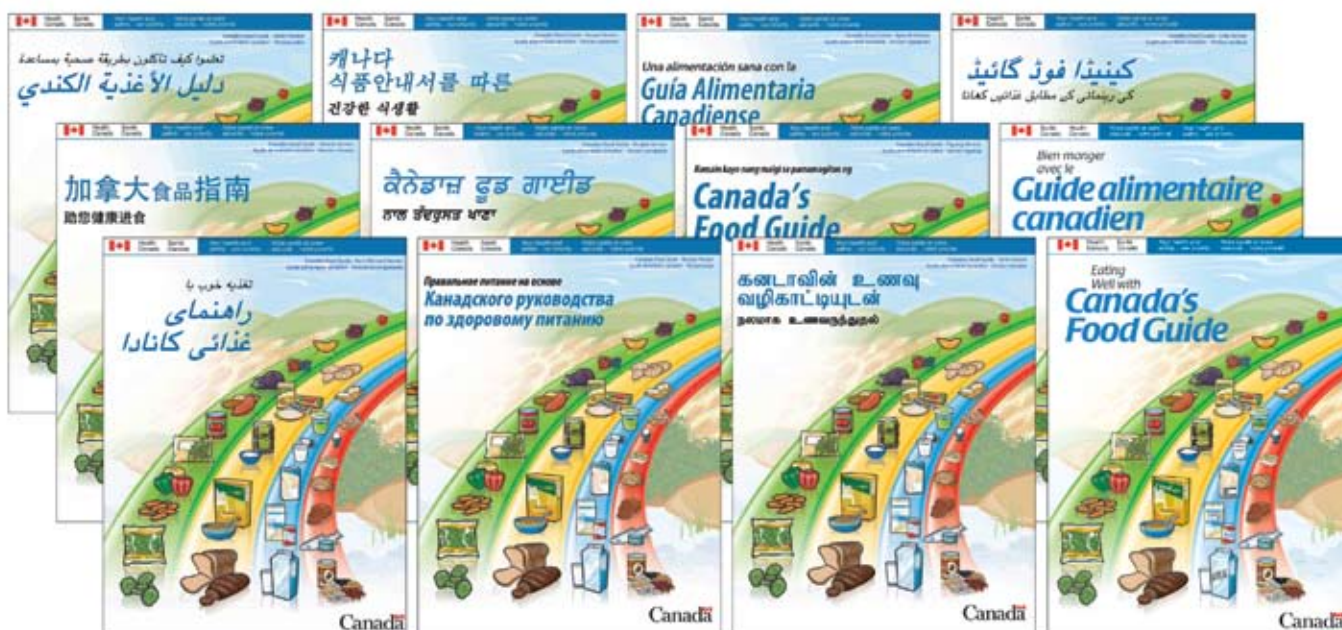
Through public consultations in 2004, staff learned that the guide did not include foods commonly eaten by Canadians from all cultures. As a result, it was revised to include food options that reflect traditional diets and foods.

*The multicultural make-up of Canada is rich and diverse. As such, revisions to Canada's Food Guide will need to embrace the variety and depth of foods available to Canadians. By making sure the new Food Guide is relevant to people of all cultures, we not only ensure its inclusiveness but we also provide all Canadians with a vast array of food selections that broadens and enhances their healthy food choices.<sup>4</sup>*

In addition to English and French, *Eating Well with Canada's Food Guide* was translated into 10 different languages: Arabic, Chinese, Farsi, Korean, Punjabi, Russian, Spanish, Tagalog, Tamil, and Urdu. All are available online.

The guide was written to be easy to read and understand. It includes visual cues and images to enhance understanding for limited-literacy readers.

To see Canada's Food Guide, visit [www.hc-sc.gc.ca/fn-an/food-guide-aliment/index\\_e.html](http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index_e.html).





Health  
Canada

Santé  
Canada

Your health and  
safety... our priority.

Votre santé et votre  
sécurité... notre priorité.

# Eating Well with *Canada's Food Guide*

## First Nations, Inuit and Métis



Canada

Source: *Eating Well with Canada's Food Guide (2007)*, <http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index-eng.php>, Health Canada. Reproduced with the permission of the Minister of Public Works and Government Services Canada, 2009.



# Section 2: Concepts and Starting Points

# 2

## About this section

- **Understanding concepts:**  
Culture, cultural competence, cultural safety, and health literacy
- **Cultural starting points:**  
General health information on cultural groups in Nova Scotia



# Concepts: Cultural Competence and Safety

## Cultural competence

Culture refers to a group or community sharing and creating common experiences that shape the way its members view the world. Culture “applies to any group of people where there are common values and ways of thinking and acting that differ from those of another group.”<sup>5</sup>

Culture is multi-layered and evolving. It includes groups we are born into and those we may choose. Culture includes, but is not limited to, race and ethnicity, language, gender, gender identity, sexual orientation, (dis)ability, religion and/or spirituality, age, geographic origin, socio-economic status (class), and income.

Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients’ social, cultural and linguistic needs.<sup>6</sup>

It is “. . . a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations.”<sup>7</sup>

Cultural competence is not only a concept, a problem-solving approach, or a communication technique. Instead, it requires a fundamental change in the way we think about, understand, and interact with the world around us. Culture is dynamic and is learned throughout a lifetime. As a result, cultural competence is a continuous, dynamic process, not simply an end to be reached.<sup>8</sup>

Cultural competence requires that health-care providers have effective skills, knowledge, and attitudes; that organizations have inclusive procedures and guidelines; and that health systems have adequate funding, sound policies, and supportive leaders and champions.

## Cultural safety

The concept of cultural safety arose in the 1980s in New Zealand as a response to Maori discontent with nursing care.<sup>9</sup> Actions that “diminish, demean, or disempower the cultural identity and well-being of an individual” are said to be unsafe.<sup>10</sup>

Cultural safety gets to the heart of power imbalances, discrimination, and colonization in health-care systems.

Cultural safety is

*... more or less—an environment, which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what, they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening.*<sup>11</sup>

## Cultural competence in Nova Scotia

Nova Scotia’s Diversity and Social Inclusion (DSI) Initiative was a three-year project (2003–2006) with two main goals:

- to lead in raising awareness of diversity and social inclusion issues in primary health care
- to consult with stakeholders, including diverse populations, to develop guidelines and policies

The DSI Initiative resulted in the first provincial guidelines for cultural competence in primary health care in Canada. This resource supports the implementation of Guideline 9:

*Nova Scotia DHAs, the IWK and primary health care organizations should reflect Nova Scotia’s diverse populations in pictures, written information and advertisements and post signage and provide written material for all literacy levels in the languages commonly spoken in their service areas.*

### Want to Know More?

Nova Scotia Department of Health. *A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia*. 2005. Available online at [http://healthteamnovascotia.ca/cultural\\_competence/Cultural\\_Compentence\\_guide\\_for\\_Primary\\_Health\\_Care\\_Professionals.pdf](http://healthteamnovascotia.ca/cultural_competence/Cultural_Compentence_guide_for_Primary_Health_Care_Professionals.pdf).

Cultural Competence Guidelines for Primary Health Care, Nova Scotia, Appendix 1.





# Concepts: Literacy and Health Literacy

## What is literacy?

Literacy is the ability to understand and use reading, writing, speaking, and other forms of communication to fully take part in society and achieve life goals.<sup>12</sup>

Basic or fundamental literacy includes four main areas:

- prose (understanding text)
- document (locating information on maps, forms, etc.)
- numeracy (working with numbers)
- problem solving

Other literacy areas include scientific, computer, media, civic (relating to governance), and cultural (ability to use figures of speech and the informal language of a dominant culture).

## Levels of literacy

**Level 1:** People at this literacy level have difficulty reading and have few basic skills or strategies for working with text. For example, they may be able to read package information well enough to figure out how much medicine to take.

**Level 2:** People at this level can read, but do not read well. They need material that is simple and clearly laid out.

**Level 3:** People at this level can read well but may have problems with more complex tasks. This level is considered by many countries to be the minimum skill level for full participation in society.

**Level 4/5:** People at this level have strong literacy skills and many strategies for dealing with complex materials. They can handle new reading challenges and meet most reading demands.

## Consider literacy levels when identifying your audience

According to a 2003 International Adult Literacy Survey (IALS), 42 per cent of Canadian adults (age 16 to 65) have limited fundamental literacy skills. Thirty-eight per cent of Nova Scotian adults (240,000 people, or approximately 4 out of 10 adults) are reading below Level 3. This is below the level at which they can use and understand information to fully take part in daily life (limited prose skills). Fifty per cent of Nova Scotian adults have limited ability to work with numbers (numeracy skills).<sup>13</sup> A majority of Nova Scotian seniors have limited basic literacy skills.

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42% of Canadian adults have limited fundamental literacy skills.

## What is health literacy?

**Health literacy** is the ability to find, understand, use, and share information, services, and supports that promote, maintain, and improve health throughout life.

Health literacy is more complex than basic literacy. To be health literate, we need to use more than one literacy skill, often at the same time. We need to be able to read and understand but also advocate for our own health, seek out health information, and use social skills to communicate effectively with care providers. We may also need to be able to use math skills.

Technically, there are at least four areas of health literacy:<sup>14</sup>

- fundamental (or basic) literacy: includes language and numbers
- scientific/technological literacy: includes some understanding of physical and natural sciences, technology, and scientific uncertainty
- civic/community literacy: includes media literacy and knowledge of local, provincial, and federal government processes
- cultural literacy: includes recognition of community beliefs, customs, view of the world, and social identity

People with health literacy challenges may have difficulty navigating health systems, completing forms, or using health information to make decisions. For example, math and readings skills are needed to interpret this dosage chart.

<b>Weight</b>	<b>Drops</b> Acetaminophen 80 mg in each 0.8 ml	<b>Suspension</b> Acetaminophen 160 mg in each 5 ml	<b>Tablets</b> Acetaminophen 80 mg in each tablet
6–11 lbs	0.4 ml	<b>X</b>	<b>X</b>
12–17 lbs	0.8 ml	2.5 ml (½ tsp)	<b>X</b>
18–23 lbs	1.2 ml (0.8 + 0.4 ml)	3.75 ml (¾ tsp)	<b>X</b>
24–35 lbs	1.6 ml (0.8 + 0.8 ml)	5 ml (1 tsp)	2 tablets
36–47 lbs	<b>X</b>	7.5 ml (1 ½ tsp)	3 tablets
48–59 lbs	<b>X</b>	10 ml (2 tsp)	4 tablets
60–71 lbs	<b>X</b>	12.5 ml (2 ½ tsp)	5 tablets

## Consider health literacy levels when identifying your audience

Levels of health literacy vary across the country. Generally, seniors, recent immigrants, those with lower levels of education and with low French or English proficiency, and people on social assistance tend to have lower literacy and health literacy levels.<sup>15</sup>

Many people have health literacy challenges, especially when faced with complex health information. You can't identify health literacy challenges by the way someone looks or if they appear to scan materials. Treat all encounters as if everyone has health literacy limitations. To see health literacy rates in your area, refer to the interactive map Health Literacy in Canada: A Healthy Understanding, [www.ccl-cca.ca/CCL/Reports/HealthLiteracy](http://www.ccl-cca.ca/CCL/Reports/HealthLiteracy).

Low health literacy is linked to poor health outcomes. Canadians with the lowest health literacy skills are 2.5 times more likely to report being in fair or poor health as compared with those at the highest skill levels, even after adjusting for factors like age, education and gender.<sup>16</sup> A recent American study found that seniors with low literacy skills had a 50 per cent higher mortality rate compared to seniors with better literacy skills.<sup>17</sup>

*Informed patients have better outcomes . . . they seek care earlier because they recognize warning signs; they read and comprehend instructions; they understand what their doctors advise them to do; and they are not afraid to ask questions when they do not understand. They are able to seek new information on the internet, read the newspaper critically, and place new health studies in context.*<sup>18</sup>

### Strategies for improving health literacy

- Train all staff on the importance of health literacy and how to remove health literacy barriers.
- Structure care as if everyone has health literacy challenges.
- Write and speak in plain language. Avoid using jargon and technical terms. Define medical terms.
- Ask people to repeat back key information. Encourage questions. Ask, "What questions do you have?"
- Consider language, literacy and culture in health materials.
- Use written materials and clear communication. Provide options for self-learning
- Reach out to diverse groups to minimize communication barriers.
- Use materials, signs, maps and staff or volunteers to help people navigate through buildings and health systems.
- Keep in mind the social stigma attached to limited literacy.

## Linking cultural competence, language, and health literacy

In Nova Scotia, those most vulnerable to health literacy barriers include groups such as seniors, recent immigrants and refugees, people with low levels of education or low incomes, Aboriginal people, francophones, and African Canadians.

Health literacy challenges are even greater for members of these groups whose first language is not that of the majority.<sup>19</sup>

*For health care providers and health systems to demonstrate cultural competence, they must try to understand what their patients believe and where they get their information, two essential elements of health literacy.<sup>20</sup>*

Providing Nova Scotians with health and health promotion materials they can read, with content that reflects culture will improve their health literacy. They will thus be better able to find and understand health information, be able to access health services more effectively, and be more empowered to take action for good health.



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wleyasi

## Considering Culture in Health Materials

This section provides general starting points for developing inclusive health materials, forms, and signage.

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A stereotype leads to the end of any discussion. No attempt is made to learn whether the individual in question fits the statement.

Used selectively, general knowledge of cultural groups can increase your awareness. But beware of the danger of stereotyping. Recognize that all individuals are unique.

For example, although some people have experienced exclusion and barriers, we cannot assume that all people experience the same reality. This will depend on their life circumstances and the influences of the determinants of health. As well, people identify with more than one cultural group at the same time. In some cases, this may result in additional or more complex barriers to good health.

- A **stereotype** leads to the end of any discussion. No attempt is made to learn whether the individual in question fits the statement.
- A **generalization** is a beginning. It lays out information, but more information is needed. The individual is the one who knows if the generalization is appropriate.<sup>21</sup>

The information in this section is intended to be a starting point for developing health materials, forms, and signage. Starting point summaries provided in this section include information on the following:

- race and ethnicity
  - francophone and Acadian Nova Scotians
  - African Canadians
  - First Nations, Inuit and Métis
  - immigrants
  - refugees
- sex and gender
- socio-economic status
- sexual orientation and gender identity
- ability
- location (rural, remote, and urban)
- age
- spirituality

Used with the permission of Women's Health in Women's Hands Community Health Centre, Toronto, Ontario. Graphic design by Frantz Brent-Harris.



# Your Health and HPV:

## The Facts Every Woman Should Know

(HPV - Human Papillomavirus)



## How culture and language are linked to health

Culture and language influence how health professionals, patients, and subpopulations interact with the health-care system and maintain well-being and good health. Culture and language influence the way we interpret health promotion messages and understand health education materials. Culture shapes our models of wellness and illness and ways of healing.

**Impact of life events:** The history and lived experience of discrimination and the “isms” (like racism, colonialism, sexism, heterosexism, ageism, ableism and classism) as well as the impact of homophobia, transphobia, xenophobia, segregation and stereotyping contributes to marginalization, oppression and low social status. These burdens, separately or intersecting, often impact the mental and physical health of individuals within populations, including increasing the risk of stress, depression and high risk behaviours.

Elements of health influenced by culture and diversity also include the following:<sup>22</sup>

- **communication styles:** language, eye contact, greetings, time, names, touch, common phrases
- **rituals, customs, diet, and spirituality:** common foods; meaning of food and food rituals; fertility practices; pregnancy, birthing, and post-birth beliefs and rituals; death rituals and bereavement; beliefs about the afterlife; religious practices; use of prayer; link between spirituality, prayer, and health
- **health-care practices:** traditional practices and beliefs, responsibility for health, perspective on health
- **views towards care and caregivers:** folk practices; gender and care
- **family roles and organization:** gender roles, roles of the aged, extended family
- **biology, physiology, incidence, prevalence, pharmacology, and risk:** biological variation (skin colour, heredity, genetics) and drug metabolism

*“I go through plenty of patient education material every year and the implied default is that people have white skin. What does “redness” look like on the skin of someone who is very dark? What does “jaundice” or “sallow” look like on someone who is of Asian descent?”*

*These are critical questions if we are sending people home and depending on their ability to interpret what we’ve given them—which may be useless. Remind health care providers that, until recently, most research was done on white men—so how does that translate into the information we provide patients? Is it valid?”*

– Project key informant

## Race and Ethnicity

**Race:** a group of persons related by common descent or heredity; any of the traditional divisions of humankind . . . characterized by supposedly distinctive and universal physical characteristics.<sup>23</sup>

**Racism:** The belief that race accounts for differences in human character or ability and that a particular race is superior to others. Discrimination or prejudice based on race.<sup>24</sup>

**Ethnicity:** Identity with or membership in a particular racial, national, or cultural group and observance of that group's customs, beliefs, and language.<sup>25</sup>

### Ethnicity in Nova Scotia

According to Canadian census data (2006),<sup>26</sup> the majority of Nova Scotians claim English, Scottish, Irish, French, and Western Europe (Dutch, German, and others) as their ethnic origin. Other individuals of European origin include those from Eastern Europe (Polish, Ukrainian, and others), Southern Europe (Italian and others), Acadian, and Northern Europe (Finnish, Scandinavian, and others).

Nova Scotians of Aboriginal origin, mostly the Mi'kmaq First Nation, as well as Inuit and Métis, make up 5.3 per cent of the population. The ethnic origins of other Nova Scotian populations include African, 1.1 per cent; Arab (Lebanese and others), 1 per cent; East and Southeast Asian (Chinese and others), 0.9 per cent; Jewish, 0.4 per cent; South Asian (East Indian and others), 0.5 per cent; Caribbean, 0.3 per cent; and West Asian, 0.1 per cent. A complete list of the ethnic origin of Nova Scotians by district health authority area is included in this resource as Appendix 3.

Ethnicity may include sharing a common language. Individuals from ethnic groups whose home language may not be English can include Aboriginal people, francophone and Acadian Nova Scotians, and immigrants and refugees. See **Minimizing Language Barriers**, page 61, for detailed information on languages.

### Race/visible minorities in Nova Scotia

Almost 4 per cent of Nova Scotians identify on the census as belonging to a visible minority.\* Visible minority populations in Nova Scotia include Black†, 2.1 per cent; Chinese, 0.5 per cent; Arab/West Asian, 0.6 per cent; and South Asian (for example, East Indian), 0.4 per cent.

\* Using the term "visible minority" can be controversial. For example, visible minority data used here comes from the census, but for a variety of reasons, many people do not self-identify on census surveys.

† The term "Black" is used by Statistics Canada; elsewhere in this guide the term "African Canadian" is used.



## Francophone and Acadian Nova Scotians

Francophone and Acadian Nova Scotians live in every district health authority in Nova Scotia. The communities of Halifax, Digby, and Yarmouth account for 65.8 per cent of Nova Scotia's francophone population. In some communities, Acadians represent the majority of the population, including Argyle (55 per cent), Clare (68.3 per cent), Isle Madame (51.6 per cent), and Inverness North (44 per cent).

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The Acadian community has a history in Nova Scotia dating back more than 400 years.

The Acadian community has a history in Nova Scotia dating back more than 400 years, with settlement from France beginning in the 17<sup>th</sup> century. Acadia was founded separately from Quebec, which led to two distinct cultures. Between 1755 and 1763, most Acadians were deported from Acadia by the British, a time known as the Expulsion or Grand Dérangement. Some managed to flee to New Brunswick and Quebec. Others—the Acadian diaspora—were dispersed to England, France, and areas of the United States. A large number of Acadians eventually settled in Louisiana. Over time, some returned and settled in rural areas of Nova Scotia.

Acadians and francophones may speak French as their first language. In the 2006 census, 32,540 Nova Scotians (3.6 per cent) identified “French only” as their mother tongue—the first language learned at home in childhood and still understood.<sup>27</sup>

## Health Materials Starting Points

### Impact of life events

The history and lived experience of discrimination, the “isms”, phobias, segregation and stereotyping contributes to marginalization, oppression and low social status. For some, this is exacerbated by loss of language and culture. These burdens, separately or intersecting, often impact the mental and physical health of individuals within populations, including increasing the risk of stress, depression and high risk behaviours.

### Communication

- medical records, prescriptions, forms, and written health materials not provided in both French and English
- signs and posters promoting the availability of services in French not promoted well enough in health-care facilities
- shortage of francophone health-care providers
- available written information in French not always provided in plain language
- interpretation services not always available and not widely available throughout the province

### Rituals, customs and spirituality

- prominent role of spirituality and faith

For more information, see **Minimizing Language Barriers**, page 61.

## Want to Know More?

For a selection of reports on French language health-care services, refer to Réseau Santé Nouvelle-Écosse. [www.reseausantene.ca/Documents.htm](http://www.reseausantene.ca/Documents.htm)

Fédération acadienne de la Nouvelle-Écosse : [www.fane.ns.ca](http://www.fane.ns.ca)

Le Réseau Santé – Nouvelle-Écosse : [www.reseausantene.ca](http://www.reseausantene.ca) (in French) AND [www.reseausantene.ca/English.htm](http://www.reseausantene.ca/English.htm) (in English)

Nova Scotia Department of Health, French Language Services:

<http://gov.ns.ca/health/fls> (in French)

AND [www.gov.ns.ca/health/fls/default\\_en.asp](http://www.gov.ns.ca/health/fls/default_en.asp) (in English)

Nova Scotia Office of Acadian Affairs: [www.gov.ns.ca/acadian/fr](http://www.gov.ns.ca/acadian/fr) (in French)

AND [www.gov.ns.ca/acadian/en](http://www.gov.ns.ca/acadian/en) (in English)

Nova Scotia Bonjour Program: [www.gov.ns.ca/bonjour](http://www.gov.ns.ca/bonjour) (in French)

AND [www.gov.ns.ca/acadian/en/bonjour.htm](http://www.gov.ns.ca/acadian/en/bonjour.htm) (in English)

L'Équipe d'alphabétisation – Nouvelle-Écosse :

[www.bdaa.ca/eane/indexe.htm](http://www.bdaa.ca/eane/indexe.htm)



## African Canadians

African Canadians live in every district health authority of the province. Many African Canadians have a history in the Atlantic provinces dating back 400 years. There are 48 distinct African Canadian communities across Nova Scotia. Sixty-six per cent of the African Canadians living in Nova Scotia live in Halifax. South-western Nova Scotia (Kings, Annapolis, Digby, Yarmouth, Shelburne, Queens and Lunenburg counties) has the largest community of African Canadians outside Halifax.

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There are 48 distinct African Canadian communities across Nova Scotia.

The movement of Africans and their descendants throughout the world—such as to the Americas, the Middle East and Europe—is known as the **African diaspora**. Much of the African diaspora is a result of the Atlantic slave trade. The vast majority of people of African descent who have lived outside of Africa over generations (historic migrants) have a shared history of slavery and segregation.<sup>28</sup>

African Canadian heritage in Nova Scotia is represented by three distinct groups:

- indigenous (have no country of ethnic origin other than Canada)\*
- Caribbean immigrants
- immigrants from the African continent

## Health Materials Starting Points

### Impact of life events

The history and lived experience of discrimination, the “isms”, phobias, segregation and stereotyping contributes to marginalization, oppression and low social status. For some, this is exacerbated by loss of language and culture. These burdens, separately or intersecting, often impact the mental and physical health of individuals within populations, including increasing the risk of stress, depression and high risk behaviours.

### Communication

- difficulties in communicating with health-care providers due to past trauma of racism, discrimination, and language and cultural barriers

### Diet and nutrition

- decreased access to healthy foods and risk of food insecurity if living on a low income

\* Halifax has the highest proportion of Canadian-born African Canadians among major urban areas in Canada; 91 per cent of African Canadians living in Halifax were born in Canada.

## Rituals, customs and spirituality

- health-care providers, health promotion professionals, and health systems may not consider prominent role of spirituality and spiritual practices such as prayer

## Health-care practices and practitioners

- use of traditional and complimentary healing practices

## Family roles and organization

- health-care providers, health promotion professionals, and health systems may not consider the influence and role of family and extended family

## Biology, physiology, incidence, prevalence, and risk

*Note: Much of the information in this section is based on studies and data from the United States. For references, see Appendix 5.*

- the way in which diseases, treatments, and symptoms appear on black skin often not considered
- high prevalence of sarcoidosis—a chronic disease marked by the formation of nodules in the lungs and liver and lymph glands and salivary glands
- higher rates of, and mortality from, hypertension, cardiovascular disease, coronary heart disease, and stroke
- anemia
- high rates of systemic lupus erythematosus—an inflammatory disease of the connective tissues, occurring mainly among middle-aged women, characterized by skin eruptions, joint pain, recurrent pleurisy, and kidney disease
- high incidence of, and mortality from, cancer, especially prostate, breast, and stomach
- high rates of, and mortality from, diabetes and diabetes-related complications such as end-stage renal disease
- high rates of, and mortality from, asthma
- high rates of sickle cell disorders; carriers of sickle cell trait
- lactose intolerance
- bone disorders such as osteoporosis
- fibroids; twice the incidence in African American women



## Want to Know More?

Kisely, Steve, Mikiko Terashima and Don Langille. "A population-based analysis of the health experience of African Nova Scotians." *Canadian Medical Association Journal (CMAJ)* 179, no. 7 (September 23, 2008): 653-658.

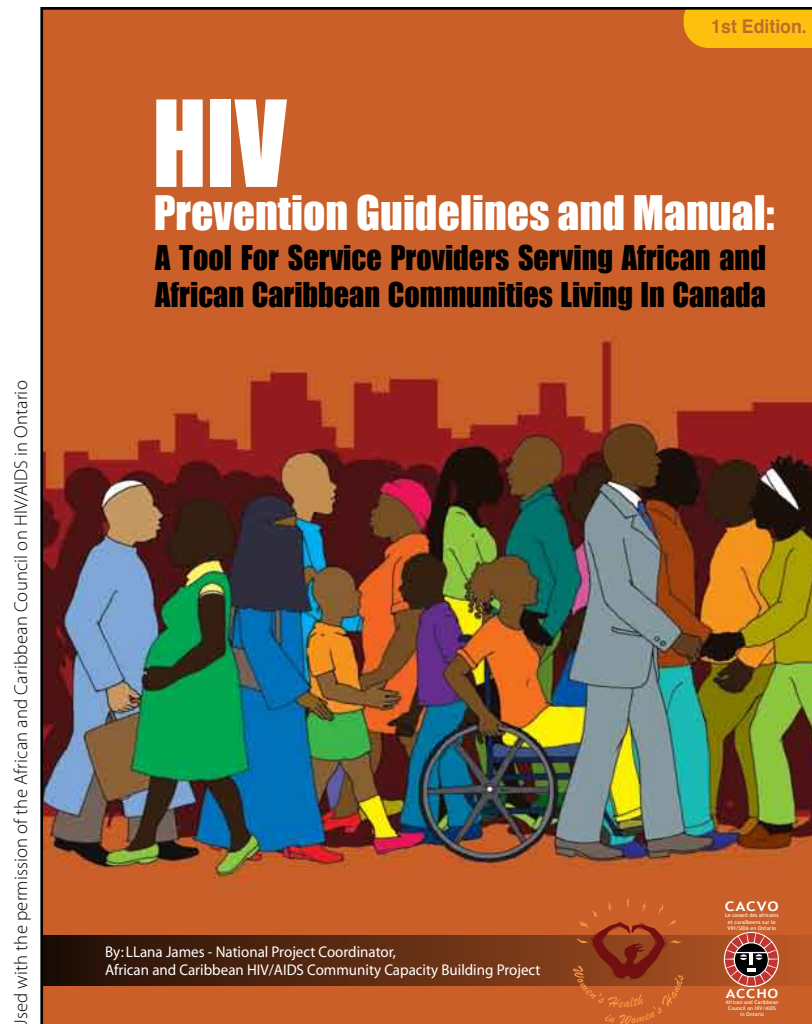
For a range of local publications, refer to the work of Dr. Josephine Etowa and Dr. Wanda Thomas Bernard

Office of African Nova Scotian Affairs: [www.gov.ns.ca/ansa/default.asp](http://www.gov.ns.ca/ansa/default.asp)

Health Association of African Canadians: [www.haac.ca](http://www.haac.ca)

African Diaspora Association of the Maritimes (ADAM): [www.adamns.ca](http://www.adamns.ca)

Black Cultural Centre for Nova Scotia: [www.bccns.com](http://www.bccns.com)



Used with the permission of the African and Caribbean Council on HIV/AIDS in Ontario

## First Nations, Métis, and Inuit

Aboriginal People is a broad term that encompasses a three distinct groups of Indigenous Peoples in Canada: First Nations, Métis, and Inuit People.

The vast majority of Nova Scotia's Aboriginal people are members of the Mi'kmaq First Nation. Inuit, Métis, and members of other First Nations also live in Nova Scotia. There are 13 bands with 34 Mi'kmaw (on reserve) communities across the province. The Union of Nova Scotia Indians and the Confederacy of Mainland Mi'kmaq are tribal organizations that serve as administrative bodies for each of the 13 bands. Many First Nations people also live off reserve.

Most of Nova Scotia's First Nations population lives in Cape Breton. A growing number of Aboriginal people live in Halifax, and significant numbers of people living in the Yarmouth/Shelburne area consider themselves to be Aboriginal.

Many Mi'kmaw people are Roman Catholic but may also follow traditional beliefs, take part in traditional ceremonies, and use traditional medicines to treat common ailments.

A pan-Aboriginal approach to cultural competence is not appropriate. Although First Nations may share some cultural traits each Nation has its own laws, customs, and traditions, complete with local variations. Inuit and Métis cultures are also distinct and unique, with variations in laws, customs and traditions.<sup>29</sup>

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**A pan-Aboriginal approach to cultural competence is not appropriate.**

## Health Materials Starting Points<sup>30</sup>

### Impact of life events

The history and lived experience of discrimination, the "isms", phobias, segregation and stereotyping contributes to marginalization, oppression and low social status. For some, this is exacerbated by loss of language and culture. These burdens, separately or intersecting, often impact the mental and physical health of individuals within populations, including increasing the risk of stress, depression and high risk behaviours.

### Communication

- barriers resulting from language, culture, and traditions
- interactions with primary health-care providers who appear disrespectful
- misconceptions around adherence issues
- cultural differences in the use of body language, eye contact, and touch

## Diet and nutrition

- health-care providers, health promotion professionals, and health systems may not consider and value traditional diet
- decreased access to healthy foods and risk of food insecurity if living on a low income with limited access to country foods

## Rituals and customs and spirituality

- health-care providers, health promotion professionals, and health systems may not include and value rituals, customs and spirituality

## Health-care practices and practitioners

- Traditional/complimentary healing practices may not be considered and valued by health-care providers, health promotion professionals, and health systems

## Family roles and organization

- health-care providers, health promotion professionals, and health systems may not include and value roles of elders and extended family

## Biology, physiology, incidence, prevalence, and risk

For full references, see Appendix 5.

- more likely to have high blood pressure
- higher incidence of diabetes, insulin resistance (women)
- greater risk of heart disease and stroke
- high rates of chronic obstructive pulmonary disease (COPD)
- higher rates of infectious diseases
- **infants and toddlers:** otitis media, sudden infant death syndrome (SIDS), accidental injury, asthma and respiratory tract infections, dental caries, fetal alcohol spectrum disorder, hip dysplasia, rickets
- **children and youth:** complications from otitis media, accidental injuries, diabetes, dental caries
- **young adults and parents:** diabetes, injuries and poisonings, HIV/AIDS, sexually transmitted diseases (STDs), hepatitis A and C, gallbladder disease, rheumatic heart disease, cervical cancer, rheumatoid arthritis, tuberculosis, disability
- **grandparents and elders:** diabetes, disability, dental care needs

*“The paradigm shift that we have witnessed in the area of health care confirms what Aboriginals have always thought about health and healing. [ . . . ] The principles behind primary health care are similar to those that inspire the circle of life and the Spirit wheel, which guided generations of Aboriginals in terms of their health needs.”*

– Penny Ericson, Canadian Association of University Nursing Schools<sup>31</sup>

## Want to Know More?

Atlantic Policy Congress of First Nation Chiefs Secretariat. *Orientation Guide: Atlantic First Nations*. 2007. Available online at **209.162.178.242/documents/Orientation%20Guide%20Atlantic%20First%20Nations.pdf**.

Confederacy of Mainland Mi’kmaq. *Kekina’muek: Learning about the Mi’kmaq of Nova Scotia*. Truro: Eastern Woodland Publishing, 2006. Available online at **www.cmmns.com/Kekinamuek.php**.

Cook, Sarah Jane. “Use of Traditional Mi’kmaq Medicine among Patients at a First Nations Community Health Centre.” *Canadian Journal of Rural Medicine* 10, no. 2 (Spring 2005): 95–99.

National Aboriginal Health Organization (NAHO). *Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators*. 2008. Available online at **www.naho.ca/publicationsculturalcompetency.pdf**.

Nova Scotia Office of Aboriginal Affairs: **www.gov.ns.ca/abor/office**

Confederacy of Mainland Mi’kmaq: **www.cmmns.com**

Union of Nova Scotia Indians: **www.unsi.ns.ca**

Atlantic Policy Congress of First Nations Chiefs (see Health): **www.apcfn.ca**





# Immigrants and Refugees

## Immigrants

Most recent immigrants live in Halifax, although immigrants are present in every district health authority in the province. The proportion of recent immigrants coming to Nova Scotia from Europe is on the decline, while the number of immigrants from Asia, Central America, Africa, and the Middle East is on the rise.

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Stress related to getting credentials recognized and/or finding employment strongly affects immigrant health.

Given broad ethnic origins, it is difficult to generalize about this group. Recent immigrants may be unemployed or underemployed. Stress related to difficulty in getting credentials recognized and/or finding employment strongly affects immigrant health. Most recent immigrants are healthy upon entry into Canada, but many experience poorer health over time. Culture shock, loneliness, homesickness, and inability to find rewarding employment lead to stress and may lead to mental health issues.<sup>32</sup> Racism has been known to profoundly affect the health of racially visible immigrants and their descendants.

## Refugees

Refugees come from areas of the world where there is war, violence, trauma, or political and cultural oppression. As a result, refugees may often experience post-traumatic stress—an anxiety disorder that can occur following a traumatic event. They may also arrive in Canada in poor mental or physical health, having lacked access to food, water, and health services.

Refugees may also have lived in several countries before arriving in Canada, including refugee camps. Some refugees may be unemployed or underemployed. Stress related to difficulty in getting education and credentials recognized and/or finding employment strongly affects refugee health. As with the recent immigrant community, culture shock, loneliness, homesickness, and inability to find rewarding employment lead to stress and may lead to mental health issues.<sup>33</sup>

## Health Materials Starting Points: Immigrants

### Impact of life events

The history and lived experience of discrimination, the “isms”, phobias, segregation and stereotyping contributes to marginalization, oppression and low social status. For some, this is exacerbated by loss of language and culture. These burdens, separately or intersecting, often impact the mental and physical health of individuals within populations, including increasing the risk of stress, depression and high risk behaviours.

### Communications

- barriers resulting from language, culture, and traditions
- cultural differences in the use of body language, eye contact, and touch

## **Diet and nutrition**

- health-care providers, health promotion professionals, and health systems may not include and value traditional diet
- health impacts of changing diet

## **Rituals, customs and spirituality**

- beliefs in pregnancy, birth, death, and health rituals that may not be understood, considered, and valued by health-care providers, health promotion professionals, and health systems
- traditional/complimentary healing practices may not be considered and valued by health-care providers, health promotion professionals, and health systems

## **Health-care practices and practitioners**

- traditional health-care practices that may not be considered and valued by health-care providers, health promotion professionals, and health systems

## **Family roles and organization**

- health-care providers, health promotion professionals, and health systems may not consider the influence and role of family and extended family

## **Biology, physiology, incidence, prevalence, and risk**

- variations in drug metabolism
- other, depending on race and ethnicity (see Appendix 5 for information on some individual ethnic groups)

# **Health Materials Starting Points: Refugees**

## **Impact of life events**

The history and lived experience of discrimination, the “isms”, phobias, segregation and stereotyping contributes to marginalization, oppression and low social status. For some, this is exacerbated by loss of language and culture. These burdens, separately or intersecting, often impact the mental and physical health of individuals within populations, including increasing the risk of stress, depression and high risk behaviours.

## **Communications**

- barriers from language, culture, and traditions
- cultural differences in the use of body language, touch, and eye contact

### **Diet and nutrition**

- health-care providers, health promotion professionals, and health systems may not include and value traditional diet
- health impacts of changing diet and potential food insecurity
- decreased access to healthy foods and risk of food insecurity if living on a low income

### **Rituals, customs and spirituality**

- beliefs about pregnancy, birth, and death that may not be understood, considered, and valued
- rituals, customs and spirituality may not be considered and valued

### **Health-care practices and practitioners**

- traditional/complimentary healing practices may not be considered and valued by health-care providers, health promotion professionals, and health systems

### **Family roles and organization**

- health-care providers, health promotion professionals, and health systems may not consider the influence and role of family and extended family

### **Biology, physiology, incidence, prevalence, and risk**

- variation in drug metabolism
- other, depending on race and ethnicity (see Appendix 5 for information on some individual ethnic groups)

## Want to Know More?

Akbari, Ather H., Scott Lynch, James Ted McDonald, and Wimal Rankaduwa. *Socioeconomic and Demographic Profiles of Immigrants in Nova Scotia*. Atlantic Metropolis Centre, 2007.

Available online at <http://atlantic.metropolis.net> (see Research and Policy).

McDonald, James. *The Health Behaviours of Immigrants and Native-Born People in Canada*. Working Paper No. 01-06. Atlantic Metropolis Centre, 2006.

Available online at <http://atlantic.metropolis.net> (see Working Papers).

For a range of local publications, refer to the work of Dr Swarna Weerasinghe.

Multicultural Association of Nova Scotia: [www.mans.ns.ca](http://www.mans.ns.ca)

Immigrant Settlement and Integration Services (ISIS): [www.isisns.ca](http://www.isisns.ca)

Metropolis (network for research and public policy development on migration, diversity, and immigrant integration in cities in Canada and around the world):

[http://atlantic.metropolis.net/index\\_e.html](http://atlantic.metropolis.net/index_e.html)



## Sex and Gender

**Sex** is the way we label the males and females of a species, usually by reproductive function. **Gender** refers to the roles, attributes, opportunities, and relationships constructed by society for men and boys and women and girls.

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Gender determines what is expected, allowed, and valued in females or males in a given context.

Gender determines what is expected, allowed, and valued in females or males in a given context. Society defines different expectations for men's and women's work (paid and unpaid), roles and responsibilities, access to and control over resources, and decision making. Gender inequalities result in women being unable to fully take part in society and realize all of their economic, political, and social potential. As a result, they are not fully able to contribute to national, political, economic, social, and cultural development and to benefit from the results. Gender inequalities are also linked to widespread global human rights abuses of women and girls. Gender inequities often lead to health inequities.

It is also important to keep in mind that the intersection of multiple forms of oppression and gender, such as race, homophobia, or transgender, further excludes and marginalizes groups of women and girls.

Gender roles and stereotypes lead to women and men working in different occupational groups. This results in different exposure to risk and illness.

Women's health is much more than "what most people view as women's health concerns: birth control, breast cancer and menopause."<sup>34</sup> Women's unequal social and economic status affects their health. For example, women bear a higher burden of unpaid caregiving and domestic work. They account for the majority of the paid health-care and social services workforce, which leads to higher stress and poor health. Women are much more likely to be victims of violence and abuse. Women also make up the majority of users of the health system because they have babies, care for others, live longer than men, and so on.

Women form the majority of the poor in Canada and around the globe. Women's poverty affects their health in many ways, including

- increased rates of acute and chronic ill health
- increased susceptibility to infectious and other diseases
- increased risk of heart disease, arthritis, stomach ulcers, and migraines
- increased risk of clinical depression, stress, breakdown, vulnerability to mental illness, and self-destructive coping behaviours
- increased risk of violence and abuse

# Health Materials Starting Points: Women

## Impact of life events

The history and lived experience of sexism, discrimination and stereotyping contributes to marginalization, oppression and low social status.

## Communications

- need to include women's biomedical and lived reality in information, symptoms, treatments, research, images and approaches

## Diet and nutrition

- decreased access to healthy foods and risk of food insecurity if living on a low income

## Health care practices and practitioners

- low-income women unable to afford complimentary health-care providers, medications, and healthy living activities
- women form the majority of health-care providers and health-care support workers

## Family roles and caregiving

- women are primary caregivers across all groups. Burden of caring role, paid, unpaid and community work leads to stress and illness.

## Biology, physiology, incidence, prevalence, and risk

- incidence and prevalence of many diseases and health concerns differ for women and men. For example, women are twice as likely as men to require hip replacement surgery. Specific groups of women are also more likely to experience certain illnesses. For example, First Nation and Inuit women have diabetes rates nearly five times higher than those of other women and higher rates than First Nations and Inuit men<sup>35</sup>
- Consider the effects of poverty and low social status on women's health and well-being

### Want to Know More?

Canadian Research Institute for the Advancement of Women:  
[www.criaw-icref.ca](http://www.criaw-icref.ca)

Centres of Excellence for Women's Health: [www.cewh-cesf.ca](http://www.cewh-cesf.ca)

Canadian Women's Health Network: [www.cwhn.ca](http://www.cwhn.ca)



## Socio-Economic Status

**Socio-economic status (SES)** relates to a person's position in society—the social class to which they belong. Income and education are often used as indicators of SES, although they alone do not determine status.

SES is linked to both culture and health literacy. For example, low income rates are higher among diverse groups such as seniors, single parents, women, First Nations, the disabled, recent immigrants, and African Canadians. The health effects of low income and low status are often greater in minority groups who have faced a long history of racism, exclusion and marginalization.

Income and social status are often cited as the most important determinants of health. For those of us living in the developed world, autonomy (greater control over our lives) and our ability to participate fully in society are even more important than material well-being for good health, well-being, and longevity.

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Where people are on the social hierarchy affects the conditions in which they grow, learn, live, work and age, their vulnerability to ill-health, and the consequences of ill-health.

— World Health Organization<sup>37</sup>

The social determinants of health are the economic and social conditions that influence the health and well-being of individuals and communities. They include, for example, income, availability of food, housing, employment and working conditions, gender, health care services and various forms of social exclusion, including racism. The influence of income and social conditions during childhood years is also important to health. Individuals who lived in low-income circumstances during childhood tend to have poorer health status even if later in life their income and social status improve.

The lower our socio-economic status, the less autonomy we typically have and the fewer opportunities we have to enjoy life and engage in all that society has to offer. Research shows that higher socio-economic status leads to better health. This has been referred to as the status syndrome.<sup>36</sup>

The way income and status is distributed is also important. Populations with a more equitable distribution of income and status tend to be healthier. Inequity—through poverty and exclusion—has more impact on health than the choices people make in their daily lives. The provinces of Atlantic Canada have more social, economic, and health inequities than the other Canadian provinces. They also have higher rates of chronic disease.

According to the Public Health Agency of Canada (2004):<sup>38</sup>

- Only 47 per cent of Canadians in the lowest income bracket rate their health as very good or excellent, compared with 73 per cent of Canadians in the highest income group.
- Low-income Canadians are more likely to die earlier and to suffer more illnesses than Canadians with higher incomes, regardless of age, sex, race, and place of residence.
- At each rung up the income ladder, Canadians have less sickness, longer life expectancies, and improved health.

In 2005, 81,000 Nova Scotians (8.9 per cent) lived in low-income circumstances.<sup>39</sup>

## Health Materials Starting Points: SES

### Communications

- barriers from low literacy and education levels

### Diet and nutrition

- decreased access to healthy foods and risk of food insecurity

### Health care practices and practitioners

- lack of health and dental insurance
- unable to afford complimentary providers

### Family roles and caregiving

- single parents: caregiver stress and burnout, lack of family support

### Biology, physiology, incidence, prevalence and risk

- consider the effects of poverty and low social status on health and well-being

#### Want to Know More?

*What Makes Canadians Healthy or Unhealthy* (2003). Available online at [www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php#income](http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php#income).

*Turning the Tides: Why Acting on Inequity Can Help Reduce Chronic Disease*. Available online at [www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/Tides\\_of\\_change/index-eng.php](http://www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/Tides_of_change/index-eng.php).

For information on the Social Determinants of Health, refer to the World Health Organization (WHO) [www.who.int/social\\_determinants/en](http://www.who.int/social_determinants/en) or the work of D. Raphael (Canada)

Nova Scotia Department of Community Services, *Poverty Backgrounder*, 2007: [www.gov.ns.ca/coms/departement/backgrounders/poverty/index.html](http://www.gov.ns.ca/coms/departement/backgrounders/poverty/index.html)





## Sexual Orientation and Gender Identity

**Sexual orientation** relates to the development of intimate emotional and sexual relationships with people of the same, opposite, or both sexes. Sexual orientation is not a choice—it cannot be changed voluntarily. People are born with their sexual orientation.

**Gender identity** is a person's self-image or belief about being female or male. For some, biological sex does not fit with who they feel they are. Gender identity is a continuum ranging from male to female. Using male or female labels alone does not include people who are transgender, transsexual, intersex, and others (see definitions below).

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This community is sometimes referred to as the LGBTTIQQA, Rainbow, or Pride community.

This community is sometimes referred to as the LGBTTIQQA (see below), Rainbow, or Pride community. Studies show that from 3 per cent to 10 per cent of the population (27,000 to 90,000 Nova Scotians) belong to this community. It is very difficult to accurately assess the size of this community as it is an invisible culture—individuals are in different stages of their own “coming-out” process.

### Key definitions

Because these terms are often not well understood, they are defined in this section. Some of the definitions are open to debate within the Rainbow community. This reflects the changing nature of sexual orientation and gender identity. It is also related to how important identity is to this marginalized group.\*

#### Gay

A male or male-gendered person who is emotionally, physically, and/or romantically attracted to other males/male-gendered people and is capable of forming loving relations with them.

#### Lesbian

A woman or female-gendered person who is physically, emotionally, and/or romantically attracted to other females/female-gendered people and is capable of forming loving relations with them. Because issues facing gay men and lesbians differ, many women prefer the term lesbian to “gay woman.”

#### Bisexual

A person who is emotionally, physically, and/or romantically attracted to either male or female people and can form a loving relationship with either. A bisexual could be more attracted to men or more attracted to women, but feel they can have relationships with either.

#### Transgender

An umbrella term for people whose behaviour, manner of dress, or identity does not strictly conform fit how society defines “male” and “female.” The term transgender can thus include a transsexual, a cross dresser, or a drag queen.

**Transsexual**

An individual who is committed to altering his or her sex (their body)—through cosmetics, hormones, and, in some cases, surgery—to be more in line with their gender (how they feel).

**Two-spirited**

A term within many First Nations cultures for a person with close ties to the spirit world and who may or may not identify as being lesbian, gay, bisexual, or transgender (two spirits in one person).

**Intersex**

This is a relatively new term to describe someone who is born with ambiguous genitalia or chromosomal anomalies. Often gender is assigned at birth by parents and physicians. The child may or may not grow up to identify with that assigned gender.

**Queer**

Although historically used as a negative term, queer is more commonly being used by the Rainbow community, by the academic world, and by the media as an inclusive term to refer to people who are lesbian, gay, bisexual, and transgender. However, in our society, it is often still used in a negative way.

**Questioning**

A person who may be in the process of assessing their sexual orientation/identity.

**Asexual**

A person who does not experience sexual attraction.

\* *Definitions and health information have been adapted from Halifax Rainbow Health Project Inclusion Program: Assessment Tool Guidelines, Nova Scotia Rainbow Action Project, 2006.*

# Health Materials Starting Points: Sexual Orientation

## Impact of life events

The history and lived experience of discrimination, the “isms”, phobias, segregation and stereotyping contributes to marginalization, oppression and low social status. For some, this is exacerbated by loss of language and culture. These burdens, separately or intersecting, often impact the mental and physical health of individuals within populations, including increasing the risk of stress, depression and high risk behaviours.

## Communications

- barriers due to lack of understanding and intolerance
- difficult and at times unsafe to disclose sexual orientation in health settings

## Health-care practices and practitioners

- delayed use of health services
- reduced use of preventative screening
- few health services meeting the needs of this group
- certain subpopulations, such as seniors, may be removed from life partners or forced back into hiding their identity when interacting with health or long-term care system

## Family roles and caregiving

- same-sex couples and parenting are not reflected in materials
- heterosexuality is often assumed

## Biology, physiology, incidence, prevalence and risk

- Gay men: more likely to experience eating disorders and may be at increased risk of hepatitis and cancer (anal, prostate, testicular or colon).
- Lesbians: may be at increased risk of cancer (breast, gynecologic). Lesbians also have specific fertility treatment needs.
- For more detailed information, see page 115.

# Health Materials Starting Points: Gender Identity

## Impact of life events

The history and lived experience of discrimination, the “isms”, phobias, segregation and stereotyping contributes to marginalization, oppression and low social status. For some, this is exacerbated by loss of language and culture. These burdens, separately or intersecting, often impact the mental and physical health of individuals within populations, including increasing the risk of stress, depression and high risk behaviours.

## Communications

- barriers due to lack of understanding and intolerance
- difficult and at times unsafe to disclose gender identity in health settings

## Health-care practices and practitioners

- delayed use of health services
- reduced use of preventative screening
- few health services meeting the needs of this group
- certain subpopulations, such as seniors, may be removed from life partners or forced back into hiding their identity when interacting with health or long-term care system

## Family roles and caregiving

- transgender parenting not always considered

## Biology, physiology, incidence, prevalence and risk

- hormone and sex reassignment therapy needs
- For more transgender health, see page 116.

### Want to Know More?

Nova Scotia Rainbow Action Project. *The Halifax Rainbow Health Project: Improving Access to Primary Health Care for the Rainbow Community*. 2005. Available online at [www.nsrp.ca/hrhproject/docs/report.pdf](http://www.nsrp.ca/hrhproject/docs/report.pdf)

Nova Scotia Rainbow Action Project: [www.nsrp.ca](http://www.nsrp.ca)

Canadian Rainbow Health Coalition: [www.rainbowhealth.ca/english/index.html](http://www.rainbowhealth.ca/english/index.html)



## Ability

Twenty per cent of Nova Scotians over the age of 15 (146,000 people) are affected by some form of mental or physical disability, as compared with 14.6 per cent of Canadians. Mobility (23.4 per cent), agility (21.3 per cent), and pain (22.8 per cent) are the most common types of disability in the province, followed by hearing (10.9 per cent, 49,290 people) and seeing (5.5 per cent, 24,860 people).<sup>40</sup> Disability statistics for the province are included as Appendix 4.

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**20 % of Nova Scotians over the age of 15 are affected by some form of mental or physical disability.**

All forms of disability have an impact on health and access to health and wellness services. This section will focus on people with visual and hearing (dis)abilities as they are linked to health materials, forms, and signage.

### Hearing

Recent literature shows that Canadians with hearing problems (deaf or hearing loss) are more likely to report adverse health conditions, lower levels of physical activity, and increased depression as compared with other Canadians.<sup>41</sup>

### Deaf (capital “D”)

The use of a capital “D” signifies people who are deaf or hard of hearing and who identify with and participate in the culture, society, and language of Deaf people. The primary language and preferred mode of communication of the Deaf community is Sign Language. The official working languages of the Canadian Association of the Deaf are American Sign Language (ASL) and la Langue des Sourds du Québec (LSQ).

In Nova Scotia, in addition ASL, a number of Deaf people, particularly older Deaf people, use what is known as Maritime Sign Language (MSL). MSL is often used in conjunction with ASL.

As with other languages, ASL is a distinct form of communication. It is not a direct translation of English. For some Deaf individuals, reading and writing in English involves functioning in their second language. Some, not all, members of the Deaf community may have low English literacy levels.

Health issues facing the Deaf community include<sup>42</sup>

- lack of access to ASL interpreters for medical appointments and treatment
- misdiagnosis of other disabilities
- failure of health-care services and facilities to be accessible
- lack of support workers in hospice and palliative care settings
- difficulty paying for hearing aids and replacement parts and other assistive devices
- lack of specialized mental health services for Deaf people
- lack of health-care professionals knowledgeable and trained in ASL
- too few mental health services
- services concentrated in large cities
- few hospitals with assistive devices such as TeleTYpewriter (TTY) and caption TV sets

In Nova Scotia ASL interpreting is available free of charge 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). For contact information, see page 62.

## **Persons who are deaf and/or hard of hearing**

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. The Society of Deaf and Hard of Hearing Nova Scotians also provides a range of programs and services.

## **The deaf-blind**

The deaf-blind are people who are unable to both hear and see. They are often part of the larger Deaf community and will use Sign Language as a primary mode of communication, using either the “two-hand” or the “hand-over-hand” system. Both of these are tactile systems in which the deaf-blind person touches the hands of the person who is signing to them.

To facilitate access and communication in everyday life, deaf-blind people may use the services of intervenors who act as their eyes. To ensure access to health-care services deaf-blind people may require the services of both a Sign Language (ASL) interpreter and an intervenor.

## Vision

Most people with vision problems have a form of visual impairment but are not totally blind. Seniors make up 70 per cent of the visually impaired in Nova Scotia due to conditions such as macular degeneration and glaucoma.

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). 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 per cent of library clients read Braille—most use CDs or the Internet. The library posts material (books, newspapers, and other materials) online using large-print screens, voice, and refreshable Braille (an electro-mechanical device for displaying Braille characters).

## Health Materials Starting Points

### Impact of life events

The history and lived experience of discrimination, the “isms”, phobias, segregation and stereotyping contributes to marginalization, oppression and low social status. For some, this is exacerbated by loss of language and culture. These burdens, separately or intersecting, often impact the mental and physical health of individuals within populations, including increasing the risk of stress, depression and high risk behaviours.

### Communications

- language and literacy barriers

### Diet and nutrition

- decreased access to healthy foods and risk of food insecurity if living on a low income

### Health care practices and practitioners

- may be unable to afford complimentary health-care providers if living on a low income
- may be unable to afford healthy living activities if living on a low income or to take part in such activities due to (dis)ability

### Biology, physiology, incidence, prevalence, and risk

- biological conditions such as macular degeneration, glaucoma and hearing loss/deafness
- identify as having adverse health conditions (deaf and hearing loss)

## Want to Know More?

Canadian Association of the Deaf "Health Care." *Deaf Issues*, 2007. Available online at [www.cad.ca/en/issues/health\\_care.asp](http://www.cad.ca/en/issues/health_care.asp).

Nova Scotia, Disabled Persons Commission. *Persons with Disability in Nova Scotia: A Statistical Report*, 2004, page 9. Available online at [www.gov.ns.ca/disa/PDF-files/Statistical%20Manual%202004%20bc.pdf](http://www.gov.ns.ca/disa/PDF-files/Statistical%20Manual%202004%20bc.pdf).

CNIB: [www.cnib.ca](http://www.cnib.ca)

CNIB, Nova Scotia and PEI: [www.cnib.ca/en/ns-pei](http://www.cnib.ca/en/ns-pei)

Society of Deaf and Hard of Hearing Nova Scotians (SDHHNS): [www.sdhhs.org](http://www.sdhhs.org)

Nova Scotia Disabled Persons Commission: [www.gov.ns.ca/disa](http://www.gov.ns.ca/disa)

Nova Scotia Hearing and Speech Centres: [www.nshsc.ns.ca](http://www.nshsc.ns.ca)

## Good Example: Accessible Websites

See the CNIB website ([www.cnib.ca](http://www.cnib.ca)) for an example of an accessible website. The menu across the top of the page allows you to choose font size, contrast, and text alternative formats.





## Location

Where people live has a strong influence on their health. Healthy housing, neighbourhood safety and exposure to toxins and pollution are all linked to location. Income inequalities within neighbourhoods and communities influence health, as does access to jobs, health services, recreation options and other supports. According to Statistics Canada, approximately 56 per cent of Nova Scotians live in urban areas, and 44 per cent live in rural areas. Health and wellness accessibility challenges facing rural Nova Scotians may include isolation, lack of transportation, and inadequate health services and social supports.

Keep this in mind when creating and distributing health materials. For example, do not assume that your target clients will be able to pick up an important brochure at their local health centre. In addition, consider the reality that many rural areas of the province do not have access to Internet, or high-speed Internet services.

## Age

It is important to consider all age categories when creating health materials. Always start by identifying your target audience and clarifying need. Given the continued growth of Nova Scotia's senior population and their health system requirements, this section will focus on seniors.

Here are some statistics you should know about seniors in order to develop materials that meet their needs.<sup>43</sup>

- Most Canadian seniors live on their own in private households (58 per cent with a partner/spouse and 29 per cent on their own).
- The majority of Canadian seniors are women (57 per cent of seniors over 65 and 70 per cent over 85 are women).
- Many seniors have low levels of education. Sixty per cent did not finish high school, and only about 20 per cent have a university degree. As many as 80 per cent of Canadian seniors may have reading problems that interfere with completing forms or reading instructions on medicine containers, understanding information, or doing basic math (versus 48 per cent of the general population). This creates literacy and health literacy challenges.
- Seniors are at high risk of becoming hard of hearing and/or visually impaired, which interferes with communication.
- Seniors are culturally diverse. About 20 per cent of Canadian seniors are immigrants or children of immigrants.
- Only about 20 per cent of seniors (65 and over) have home Internet use.

## Want to Know More?

Public Health Agency of Canada. *The Senior Audience: Large, Growing, Diverse—Communicating with Seniors*. 2006. Available online at [www.phac-aspc.gc.ca/seniors-aines/pubs/communicating/audience\\_e.htm](http://www.phac-aspc.gc.ca/seniors-aines/pubs/communicating/audience_e.htm).

Nova Scotia Seniors' Secretariat. *Seniors' Statistical Profile 2009*. Available online at [www.gov.ns.ca/seniors/pubs/Seniors'StatisticalProfile2009\\_Final.pdf](http://www.gov.ns.ca/seniors/pubs/Seniors'StatisticalProfile2009_Final.pdf).

Nova Scotia Senior Citizens' Secretariat. *Enhancing the Basic Learning Skills of Older Nova Scotians: Context and Strategies*. 2003. Available online at [www.gov.ns.ca/scs/pubs/enhancing\\_skills.pdf](http://www.gov.ns.ca/scs/pubs/enhancing_skills.pdf).

Nova Scotia Department of Seniors: [www.gov.ns.ca/scs](http://www.gov.ns.ca/scs)



## Spirituality

Religion implies a specific set of beliefs or practices agreed upon by a group. Spirituality is a way by which people find meaning, hope, comfort, and peace.

The spirituality of a people ... is part of what makes up their culture – something that defines who they are. The spirituality of a people is wrapped up in their language and their songs, in their stories and dances, in how they live and interact with each other and who or what they honor.<sup>44</sup>

Spirituality a core component of culture and language and thus influences the way people look at and interact with the world. There are deep links between mind, body and spirit. Spirituality thus influences health. For some people, the comfort and strength gained from meditation and prayer lead to feelings of well-being. Spirituality helps people cope with illness, loss, and stress and, as a result, may prevent additional health problems.

Spirituality affects health beliefs and practices. Diverse beliefs and practices are visible during times of celebration, stress and illness, and death and dying and in birthing and postpartum rituals. They can also determine foods and food rituals for some populations during religious holidays and celebrations.

Religion is one path to spirituality. Organized religions in Nova Scotia include, but are not limited to, Buddhist, Islamic, Hindu, Jewish, Protestant (Anglican, Baptist, United Church), and Roman Catholic.

### Major Religious Denominations in Nova Scotia (2001)

	Number	Percentage
Roman Catholic	327,940	36.5%
Protestant	438,150	48.8%
Christian Orthodox	3,585	0.4%
Christian (not included elsewhere)	10,105	1.1%
Muslim	3,550	0.4%
Jewish	2,120	0.2%
Buddhist	1,735	0.2%
Hindu	1,235	0.1%
Sikh	270	0%
No religion	104,280	11.6%

Source: Statistics Canada (2001) Census of Canada. Available online at: [www12.statcan.ca/english/census01/Products/Analytic/companion/rel/tables/provs/nsmajor.cfm](http://www12.statcan.ca/english/census01/Products/Analytic/companion/rel/tables/provs/nsmajor.cfm). (accessed March 2008). Note: There is no category for "other."

# Section 3: Practical Tools for Minimizing Barriers

# 3

## About this section

- **Engaging a diverse audience**  
Suggestions and tools for appropriate and respectful community engagement
- **Minimizing language barriers**  
Suggestions and helpful resources
- **Minimizing literacy and health literacy barriers**  
Suggestions and helpful resources
- **Creating inclusive forms and signage**  
Specific options and strategies for inclusive signage and forms



# Tool 1: Engaging a Diverse Audience

## 1. Identify your audience.

To whom are you writing this material? Why is this material or message needed? Will this target health disparities? Who will most benefit from the material?

## 2. Learn more before you begin.

Consider life experience, status, culture and biomedical realities. Build on information and needs that have already been identified. Identify potential language, literacy and health literacy needs.

## 3. Involve your audience.

This will help you identify what people know already and most want to know. Do not assume you know what is best.

### **Respect and value people's time.**

Although it may be your job to develop or adapt materials, your readers have paid and unpaid work responsibilities. Value this by scheduling sessions at times that work best in local, easily-to-access locations. If possible, provide honoraria and supports such as food, transportation, and/or childcare subsidies.

### **Learn about and support community needs.**

For example, ask people if they would like to learn about the subject of your materials during an information session. Use your review session as an opportunity to share information in a culturally appropriate manner. This means that both you and your target audience will gain from the encounter.

Work with/hire a community leader to bridge culture, language, and/or literacy gaps.

Work with/hire a translator for written material.

See: *Writing health information for patients and families: A guide to creating patient education materials that are easy to read, understand and use*. Hamilton Health Sciences, 2008, [www.hamiltonhealthsciences.ca](http://www.hamiltonhealthsciences.ca). This provides a more detailed materials development process, from which *Tool 2: Sample Feedback Form* (page 60) was adapted.

Ask users to review a draft of your material. Make changes as required. If you have followed steps 1 and 2 you'll need to make fewer changes.

Ask for feedback through interviews, surveys, or small focus groups. Develop questions to make sure your material

- is easy to read and understand
- uses clear layout
- is helpful
- contains what people want to know
- includes life experience, culture and biomedical realities
- incorporates language, literacy and health literacy

A sample feedback form for draft materials is included as Tool 2, page 60.

#### **4. Evaluate the results.**

Evaluate your materials over time. Keep them up to date and relevant.

*"I think it would help if the policy makers and those who create services had the fore-thought to be inclusive. Maybe consulting our Community before creating policies would help. I would love to get involved with something like that."*

– Rainbow Community member

## **Case Study: Cervical Cancer Brochure for Arabic-Speaking Women**

### **An example of giving back through consultation**

Staff of the Cervical Cancer Prevention Program at Cancer Care Nova Scotia identified a need for a brochure and fact sheets on cervical cancer written specifically for Arabic-speaking women.

They began this process by working directly with a community leader who was also a health interpreter and licensed translator. The leader met with local Arabic-speaking women to identify what they already knew about cervical cancer and to learn about additional needs.

The women said that they needed more information about cervical cancer, presented in a language they could understand and a format that was culturally acceptable. A supporting committee of staff from Cancer Care Nova Scotia, Capital District Health Authority, and the IWK Health Centre had the cervical cancer brochure translated with identified cultural needs and language in mind.

Staff and the interpreter then held a focus group where the translated brochure was pilot-tested with a group of Arabic-speaking women.

Out of respect for their time and travel needs, participants received an honorarium for child care and transportation. To value their request for more information, the pilot test was combined with a physician presentation on cervical cancer. This process built trust and encouraged shared understanding of cervical cancer issues within the group.

In addition to assessing whether the translated brochure was appropriate and effective, the support committee learned the cultural perspective on health and cervical health among Arabic-speaking women, as well as new strategies for disseminating health information within the Arabic-speaking community.

The supporting committee has identified the next step as evaluating the brochure within the community for effectiveness.



## اعتن بنفسك

هائلتك و أهدافك سوف يسكروك على ذلك

**المعلومات في هذا الكتيب هي لكل النساء**

سواء كن شابات أو مسنات ، مساجفات أو مسنعات ، مهاجرات أو كنديات مسجرات أو مسجات أو من ألقاه الأصلية ، فإذا كان لديك حتى رحم فهذه المعلومات تصبلك.



### هام لكل من بدان حياتها الجنسية

**إذهبي لإجراء اختبار (باب):**

قد يعني هذا الفرق بين الحياة والموت

إن إجراء اختبارات (باب) و بصحة منتظمة قد يحمي 9٠% من أسباب الإصابة بسرطان عنق الرحم

إن أي امرأة حملت وأن مارست الجنس (الجماع) فكوني مبررة لخطر سرطان عنق الرحم

المزيد من المعلومات  
اتصلي بـ ١-٨٨٨-٤٨٠-٤٨٨٨

**كوفي على قدر المسئولية من أجل صحتك**

اكتشفي المزيد حول أهمية إجراء اختبار (باب) بشكل منتظم

**اتصلي بـ:**

- طبيبك / مقدم الرعاية الصحية
- وحدة المرأة السليمة في منطقتك Well Women's Clinic
- ممرضة صحة عامة - أنطوي في القسم أقرب
- في دليل الهاتف تحت:
- خدمات الصحة بواشنطن Health NS ( Health NS)
- الصيدلي الخاص بك
- جمعية السرطان لكندية
- ( Canadian Cancer society )
- برنامج التوعية من سرطان عنق الرحم
- هاتف ٩٠٢٤٧٦٧٢٨ أو ٩٠٢٤٧٦٧٢٨
- أو ١ ٨٨٨ ٤٨٠ ٤٨٨٨
- [www.cancer.ca/en](http://www.cancer.ca/en)

**من الممكن التوعية من سرطان عنق الرحم**

إجراء اختبار (باب) بانتظام من شأنه أن يقيّد حياتك

**إتصلي اليوم لتحمي نفسك**








**كيف يتم عمل اختبار (باب) PpP ؟**

عندما نذهب لإجراء اختبار (باب) PpP ، سوف يطلب منك أرفوق على سرير الفحص بالأنثى بمؤخرتك أسفل ، ووضوح ساواك على مسافة للأعلى ، وسطلب منك الاسترخاء والسماح لركبتك بالتسقوط على الجانب.

لرأسك يوضع أداة تسمى "سبيكولوم" في مهكك ، و يرفق بحيث تستدعي على فتح المهول قليلا حتى يتسدى به عنق الرحم بوضوح أكبر ، وتذكر أنه كلما تكلمت من الاسترخاء أثناء إجراء الاختبار سكونك مرتبطا أكثر بالنسبة لك.

لم تأخذ بعض الحلايا يرفق من عنق الرحم باستخدام فرشاة وعود معينين تم إرسال هذه الحلايا بعد ذلك إلى المختبر على شريحة زجاجية.

**هذه ستحصلين على نتائج؟**

سوف يتسلم طبيبك نتائج الاختبار الخاص بك من المختبر في خلال فترة تتراوح بين ٢ - ٤ أسابيع وإن كان في نتائجك أي شيء غير عادي، سوف يتم استدعاؤك فوراً وتأتي من أن تستفسري عن الموجد الذي ستحصلين فيه على نتائجك.

**حافظي على صحتك وتذكرتي**

إذهبي لزيارة طبيبك إن كان لديك أي من الأياض التالية:

- عدم انتظام أو وجود زيادة غير معادة في الحيض
- ظهور بؤبؤ أو تريف في الفترات الفاصلة بين نزول الحيض ، أو بعد ممارسة النشاط الجنسي أو بعد القيام بالعسل أو بعد إبطاع الفتك

**هنا نحتاجين لإجراء اختبار (باب) PpP ؟**

بعد عليك البدء في إجراء اختبار (باب) PpP في خلال ثلاث سنوات من ذلك ٤٨٤٤ جنسية أو عندما تكونين ٢١ سنة

إن كنت نتائج الاختبار الخاصة بك ضمنية (سلبية) أو صالحة أو عندما ثلاث سنوات متوالية عليك الاستمرار في عمل اختبارات (باب) PpP كل عامين حتى تبلغ سن ٧٥ سنة ، وبعدها إن تستعري في عمل اختبار (باب) PpP حتى وإن توقف نشاطك الجنسي أو بعد إبطاع الفورة (من الجاسر) ، وإذا كان عمرك يتولى الـ ٧٥ سنة استشيرين طبيبك إن كنت بحاجة للاستمرار في إجراء الاختبار.

إن كنت قد تعرضت لعملية استئصال رحم (أزيل رحمك) ، فقد تكونين متواجبات إن عمل اختبار (باب) PpP بشكل منتظم ، يجب أيضا على المرأة التي لم تتم إزالة عنق رحمها بالكامل أو المرأة التي سبق لها تلقي العلاج ضد أعراض ما قبل الإصابة بالسرطان أو سرطان عنق الرحم فحوص عليها باستمرار في عمل اختبارات (باب) PpP بصحة جيدة بعد عملية استئصال الرحم و إن كانت قد أن استشارتك حول اختبار الاختبار (باب) PpP فحدثني مع طبيبك.

**أين يمكنك عمل اختبار (باب) PpP ؟**

يمكن عمل اختبار (باب) PpP في عيادة طبيبك أو في أي عيادة صحية في منطقتك.

**كيف تستعدين لإجراء اختبار (باب) PpP ؟**

للمصالح على عتبة حيدة للاختبار (باب) PpP ، يجب أن تكوني المهول و الرحم في حالة عادية و طبيعية ، ولهذا يجرى لك قبل الذهاب إلى الاختبار:

- عدم القيام بالعسل أو استعمال كبريتات أو حبل مع الحمل وذلك لمدة ٤٨ ساعة
- عدم ممارسة الجنس لمدة ٢٤ ساعة
- في وقت غير وقت نزول الحيض

إن كان يوصيك إنتاج هذه النتائج، سوف يتلقى المختبر أفضل عينة حلايا ممكنة

**ما هو اختبار (باب) PpP ؟**

اختبار (باب) PpP هو اختبار بسيط من الممكن أن يساعد على منع الإصابة بسرطان عنق الرحم و قد سمي بهذا الاسم نسبة إلى اكتشافه جورج (بابسكولاو) إز و ما زال هو الطريقة الوحيدة للتحقق على أنه ضمرات في خلايا عنق الرحم و التي قد تظهر إلى سرطان ، إن اكتشافها و علاجها مبكرا سوف يحمي جود تحول اختبارات إلى سرطان.

على الرغم من أنه اختبار غير مريح و صعب إلى حد ما بالنسبة للتحقق إلا أن الفايض الفعالة التي تستعري في إجرائه قد تنقذ حياتك.



أنيب قانيو  
أسيبي  
الرحم  
عنق الرحم  
المهول

**لماذا إجراء اختبار (باب) PpP بشكل منتظم؟**

إن إجراء اختبار (باب) PpP بشكل منتظم سوف يساعد على التأكد من أن العنق الذي نقرأ على الحلايا الموجودة في عنق الرحم - التي قد تستعري بالسرطان - أن عمل و كذلك أن تظهر على سرطان. فقد وجدت الدراسات أنه عندما نتجمع النساء لإجراء اختبارات عنق الرحم بشكل أقل، فإن نسبة الإصابة بسرطان عنق الرحم تزداد.

كما أن إجراء اختبار (باب) PpP بشكل منتظم من شأنه اكتشاف سرطان عنق الرحم في مرحلة مبكر مما جدي في أن تظهر على المرأة أي علامات أو أعراض بوضوح بالألمة بالظهر، وتكون فرحة النساء في اكتشاف أفضل عندما يكتشف السرطان في مرحلة مبكر.



## Case Study: Loving Care A Population Health Approach

In 2003, staff of the Nova Scotia Department of Health, Public Health Division (now the Department of Health Promotion and Protection), and Public Health Services identified the need to replace the publications *Year One: Food for Baby* and *After Year One: Food for Children*. They felt the new books should be more comprehensive and use a capacity-building approach with parents.

A working group of health professionals, social support staff, and family resource centre staff hired consultants to carry out background research. This included a scan of parent resources, key informant interviews with health and health promotion professionals who work with parents, a literature review, parent focus groups, and a stakeholder workshop. Parent focus groups were representative of culture and included rural and urban mothers and fathers, francophones and Acadians, newcomers, African Canadians, and Aboriginal people.

The working group identified those most in need of receiving parenting information as families experiencing the challenges of limited literacy and lack of social supports and/or those with limited access to health and parenting resources.

The working group identified social and cultural inclusion as one of four guiding criteria for the development of the new parent health education booklets. They used the results of the research to determine the content, tone, reading level, and distribution method of the *Loving Care* series, the new parent health education booklets.

They hired a plain language writer and a designer who used clear layout and design principles. Given the target audience, the booklets were written for readers with limited literacy, targeting a grade 4 level. However, the information provided and the style and tone of the booklets mean that they can be read and used by people of all literacy and education levels.

Drafts of *Loving Care* were reviewed by Public Health Services staff and individuals from a wide variety of disciplines including literacy. Drafts were focus-tested with the target audience. The French translation was reviewed for language by Acadian and francophone parents. The families used in the photographs are all residents of Nova Scotia.

A review of *Loving Care* will also take place in the context of cultural competence. This includes consideration of the life experience, culture and biomedical realities of Nova Scotia populations as well as the health disparities between them.



# You are your child's most important teacher!

Are you parenting a child from birth to age 3? All parents can use information and support once in a while. Ask Public Health Services staff for your free copy of Loving Care. Whether you're a parent by birth, adoption or fostering, Loving Care has information you can use.

**Loving Care**

NOVA SCOTIA

Health Promotion and Protection

Public Health Services

[www.gov.ns.ca/hpp](http://www.gov.ns.ca/hpp)

Note: This is a sample only. It is not available for public use.

## Tool 2: Sample Feedback Form

Help us improve our materials! Check the box that matches how you feel about the following statements.

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Undecided</b>	<b>Agree</b>	<b>Strongly Agree</b>
I found this easy to read and understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					
I got the information I needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					
I can use this information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					
I see my culture included in this information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					
I see myself included in this information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					
I would recommend this information to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					
I would have liked more information about:					
I would have liked less information about:					
I would have liked this in another language or format. Please describe:					
Other comments and suggestions:					

*Adapted from Hamilton Health Sciences, 2008: 106.*

## Minimizing Language Barriers

Equal access to health-care services, regardless of language, is a right under the Canada Health Act. We must strive to overcome language barriers and cross-cultural miscommunication to achieve accessible, quality health care.

- People not able to speak an official language may have lower health literacy.
- Language barriers negatively affect access, quality of care, satisfaction, and health outcomes.
- Language barriers have ethical, liability, and cost implications for individuals and health systems.
- Language barriers further marginalize cultural groups and vulnerable communities.<sup>45</sup>

*"... I have to sit and listen ... because I'm digesting this ... in my thoughts of my language ... if the doctor or even the nurse doesn't understand, why we are silent, that says a lot when you are silent as First Nations because you're thinking about what's being said and you need to give the right answers back."*

– First Nations patient<sup>46</sup>

Note: For the purposes of this document

- an **interpreter** deals with the spoken word
- a **cultural health interpreter** deals with the spoken word and bridges cultural gaps, including body language, embedded meaning or words and so on
- a **translator** deals with written text

*"I couldn't explain to my mom everything the doctors were telling me."*

– A seven-year-old girl who was asked to interpret for her Spanish-speaking mother to let her know that her unborn child had died (Haffner 1992)<sup>47</sup>

## Tool 3: Cultural Health and American Sign Language (ASL) Interpreters

For face-to-face encounters, use the services of a cultural health interpreter, American Sign Language (ASL) interpreter, or telephone interpretation service. Using family or friends—especially children—risks the health and well-being of the individual and the family. This should only happen if it is the expressed wish of the patient.

The following interpretation services can be accessed by health-care providers and staff on behalf of patients:

- **Mi'kmaq Hospital Interpreter Liaison Program:** Cultural interpreters are available in Halifax and Sydney; call (902) 453-9358 or (902) 567-8000.
- **Deaf:** American Sign Language (ASL) interpreters are available through the Society of Deaf and Hard of Hearing Nova Scotians (see [www.sdhhs.org](http://www.sdhhs.org)). The cost of ASL interpreters is covered by MSI. Interpreters are available for all primary care settings. In Cape Breton, call 1-888-770-8555, and in mainland Nova Scotia call 1-800-516-5551.
- **Deaf-blind:** To ensure access to health-care services, deaf-blind people may require the services of both a Sign Language (ASL) interpreter and an intervenor (enables communication for the deaf-blind).
- **Cultural health interpretation:** Call the answering service of Nova Scotia Interpreting Services (902) 425-5532. Leave your name and department information (mainly based in Metro Halifax). Cost centre is required. For an account, call 425-6604.
- **The IWK Health Centre** has a Coordinator of Bilingual Services who provides interpretive services for patients, families, and care providers throughout the IWK.
- **Telephone health interpretation:** Telephone language services provide over-the-phone interpretation using certified medical interpreters who listen, analyse the message, and accurately convey its original meaning. Service providers frequently used are Access Alliance ([www.aais.ca](http://www.aais.ca)), Language Line ([www.language.com](http://www.language.com)), and Telelanguage ([www.telelanguage.com](http://www.telelanguage.com)). Private companies include Access Alliance ([www.aais.ca](http://www.aais.ca)), Language Line ([www.language.com](http://www.language.com)), Telelanguage ([www.telelanguage.com](http://www.telelanguage.com)) and CanTalk ([www.cantalk.com](http://www.cantalk.com))
- **Video health interpretation:** In Demand Interpreting, and other companies, provide instant access to certified medical interpreters through video technology. Contact: [www.culturallink.net](http://www.culturallink.net)

Do you need an interpreter? (ENGLISH)

Avez-vous besoin d'un(e) interprète? (FRENCH)

Nuta'n nuji nestmalsewet? (MI'KMAQ)

ኣማርኛ ኣስተርጓሚ ያስፈልጎታል? (AMHARIC)

Da li vam je potreban prevodilac? (BOSNIAN/SERBIAN/CROATIAN)

Necesita un(a) intérprete? (SPANISH)

آیا شما به یک مترجم احتیاج دارید؟ (FARSI)

Je unahitaji mtafsiri? (SWAHILI)

Benoetigen sie einen uebersetzer? (GERMAN)

هل تحتاج مترجما؟ (ARABIC)

Ban can mot nguoi thong dich khong? (VIETNAMESE)

Czy potrzebuje pan/pani tlumacza? (POLISH)

您是否需要口譯員？ (CHINESE)

Keni nevoj per perkthyes? (ALBANIAN)

To petvi harikariya ezmani? (KURDISH)

Ti serve un interprete? (ITALIAN)

ትግሪኛ ኣስተርጓሚ የድልየኩምዶ? (TIGRIGNA)

ВАМ НУЖЕН ПЕРЕВОДЧИК? (RUSSIAN)

Nama affaan sii hiiku ni barbaaddaa? (OROMO)

당신은 통역관이 필요 하십니까? (KOREAN)

Ma doonaysaa tarjumaan? (SOMALI)



Capital Health



NOVA SCOTIA

STAFF: please read attached instruction card. PATIENTS: please ask a nurse or call (902) 473-1909

## Tool 4: Translating Health Materials

Develop health materials, signs, and consent forms in the languages read by people in your community. Find out if Aboriginal, French, immigrant and refugee languages, and Braille are required.

### Translated health materials

**Mi'kmaq:** Some health materials have been translated into the Mi'kmaq language, although there is no one central source of information. Not everyone who speaks Mi'kmaq is able to read it.

**French:** Contact the French-Language Services Coordinator in your district or the French-Language Services Coordinator at the Department of Health or the Department of Health Promotion and Protection to access translation services from the Office of Acadian Affairs.

**Braille** materials are available from the CNIB (see [www.cnib.ca/en](http://www.cnib.ca/en)). Keep in mind that many seniors experience vision loss with age. For these individuals, provide text in large font (14-point Arial, 12-point Verdana, and larger). Use sharp contrast when printing health materials.

**Immigrant/refugee:** Use the services of Nova Scotian fee-for-service translators (look in the yellow pages under Translators and Interpreters).

### Online sources of translated health information

The following is a list of online sources of translated health materials. Check the appropriateness and accuracy of US materials for a Canadian setting before using.

- Centre for Addiction and Mental Health:  
[www.camh.net/About\\_Addiction\\_Mental\\_Health/Multilingual\\_Resources/index.html](http://www.camh.net/About_Addiction_Mental_Health/Multilingual_Resources/index.html)
- Canadian Mental Health Association, Edmonton:  
[www.cmha-edmonton.ab.ca/bins/site\\_page.asp?cid=284-1189-1690-1750](http://www.cmha-edmonton.ab.ca/bins/site_page.asp?cid=284-1189-1690-1750)
- British Columbia Department of Health, Health Files:  
[www.healthlinkbc.ca/multicultural.stm](http://www.healthlinkbc.ca/multicultural.stm)
- The 24 Languages Project, Utah, USA:  
<http://library.med.utah.edu/24languages>

## Translating Health Materials: Three Approaches

### 1. Translation: what's good?

Translate materials into the language of the communities you serve. Or locate materials from elsewhere that have been translated. Make sure that you maintain the literacy level of any translated materials. Collaborate with a professional translator who belongs to the Association of Translators and Interpreters of Nova Scotia ([www.atins.org](http://www.atins.org)).

### 2. Translation: what's better?

Translate existing materials with input from the community on content, language, diagrams, and cultural interpretation. Collaborate with a bilingual/bicultural health interpreter on style and content. Make sure that any translated material maintains the literacy level of the original. Collaborate with a professional translator who belongs to the Association of Translators and Interpreters of Nova Scotia ([www.atins.org](http://www.atins.org)).

### 3. Translation: what's best?

Develop health materials from the outset with, by, and for a minority language group. Something is always lost in translation. By starting from the beginning, the materials will not simply be a translation, but will appropriately reflect the language, cultural beliefs, and values of the target group. Collaborate with a professional translator who belongs to the Association of Translators and Interpreters of Nova Scotia ([www.atins.org](http://www.atins.org)). Make sure that any translated material maintains the literacy level of the original.

*Even perfectly exact translations may not make sense to people. Their background or culture may give them a different frame of reference than the one you are using, creating imposing barriers to understanding.<sup>48</sup>*



## Translating health materials: additional suggestions

- Write in plain language (see page 71 for more information). All readers benefit from plain language, less jargon, fewer technical terms, and shorter words and sentences. This is especially true for people facing language barriers and people with low health literacy skills.
- Use appropriate drawings, images, and/or diagrams to enhance and clarify what you want to say. However, too many images or illustrations can make written text confusing and take away from the message.
- Use universal health symbols on signage (see page 87).
- Use a large-point font for seniors (14 or greater) and the visually impaired. Make this an option on websites as well.
- Use picture boards to bridge communication gaps. These are large, double-sided panels where people point to icons showing their problem and the part of the body that is affected.
- Provide a poster with a list of languages to choose from to assess interpretation needs.
- Consider alternatives to the written word such as CDs, MP3 files, and DVD or video. For example, consider putting health and consent information on CDs. These can be played on DASY readers used by the visually impaired.
- Use captioning for the Deaf, hard of hearing, and those with low literacy levels. For more on alternatives to written material see page 77.
- Work with one of the 25 local Nova Scotia Hearing and Speech Clinic staff members to develop strategies for individuals with communication barriers who are not Deaf or blind (see [www.nshsc.ns.ca](http://www.nshsc.ns.ca)).

## Bonjour!

Bonjour! is a visual identification program used by district health authorities and designated departments, offices, agencies of the Government of Nova Scotia. The Bonjour! word found in the program logo is a well-recognized greeting, meaning ‘hello’ in French. When providers and facilities display the logo it indicates that services are available in French and English.

The Bonjour! Visual Identification Program has a dual role. It operates internally, encouraging employees to offer services in French, often referred to as the *offre active* or active offer. Externally, the program encourages members of the public to ask for and use government services in French.

Visit [www.gov.ns.ca/bonjour](http://www.gov.ns.ca/bonjour) for a list of government departments, offices, and agencies and district health authorities that provide information and services in French.



## Minimizing Health Literacy Barriers

Health literacy generally refers to the ability of individuals to access and use health information to make appropriate health decisions and maintain basic health.

Everyone has a role to play in health literacy. To enhance health literacy

- Health-care providers, health promotion professionals, and health systems must share clear, organized, realistic, culturally appropriate health messages in languages and formats that reach consumers. This starts with understanding and respecting diverse communities served.
- Health consumers must feel accepted and empowered: able to read, understand, interpret, and act on messages in order to take control of their health. They must confirm understanding with providers and get help when needed.

### Health Visit Prompt Card

Literacy Nova Scotia suggests that low-level readers bring a Health Visit Prompt Card when they visit a doctor. This reminds patients to identify what they want to know before their visit. It has four questions for the patient to ask during the visit:

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?
- Will I get better? How long will it take?

As a health-care provider, make sure written and verbal information answers these basic questions for people (even if they don't ask).



## Planning your visit to a doctor

1. Think of what you want to talk about before you go. You can take someone with you to help you talk to the doctor.
2. Write 2 or 3 words that will remind you of what you want to ask.
3. Ask the most important things first.
4. Tell the doctor as much as you can about what's bothering you.
5. Know what medicine you are already taking.

## At the end of your visit

*You might say: "Doctor, I just want to make sure I understand."  
Then ask these questions:*

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?
4. Will I get better? How long will it take?

## If you still don't understand . . .

*You might:*

- say: "This is new to me. Will you please explain that to me again?"
- ask: "What does that mean? I don't understand that word."
- ask for a picture of the medical problem
- ask the doctor to write things down

## Questions about medicine

1. What is the name of this medicine? Can you write it down for me?
2. What will it do for me?
3. Are there problems that this medicine might cause?
4. How much does it cost?
5. Are there other medicines or treatments that might help me with this problem?
6. When should I take this medicine?

## Health Visit Prompt Card

Name / Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Birthdate: \_\_\_\_\_

Health Card Number: \_\_\_\_\_

## My rights

*I have the right:*

- to be told what is happening to me
- to have my questions answered in words I can understand
- to know the different treatments, and to say yes or no, and to change my mind
- to be treated with dignity, kindness and respect at all times
- to know that my health information will not be shared with anyone without my consent

## Important Phone Numbers

Doctor: \_\_\_\_\_

Doctor: \_\_\_\_\_

Drug Store: \_\_\_\_\_

Emergency 911 or: \_\_\_\_\_

Contact person and phone number: \_\_\_\_\_

\_\_\_\_\_

## My medicine list

Write down what you need to take. The doctor or pharmacist can help you. Cross the name off when you no longer take the medicine.

Date	Name of drug	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Writing in plain language

Most health materials are written at a grade 12 level or beyond and contain technical terms and jargon that get in the way of understanding. This is a barrier to people with limited literacy and health literacy skills. These barriers are even greater when people are ill or under stress or if their home language is not English.

Plain language or clear language is writing so that material is easy to read, to understand, and to use. It does not mean “dumbing down” information. Plain language puts the reader first. We recommend hiring a plain language consultant to write your materials. If this is not possible, use techniques shared in Tool 5, page 71.

### Practical Tools

*Writing health information for patients and families: A guide to creating patient education materials that are easy to read, understand and use,*  
[www.hamiltonhealthsciences.ca](http://www.hamiltonhealthsciences.ca).

*The Health Literacy Universal Precautions Toolkit,*  
[www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf](http://www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf).

*Opening Doors: A Literacy Audit Tool Kit for Customer Service Excellence,*  
[www.literacyalberta.ca/opendoor.htm](http://www.literacyalberta.ca/opendoor.htm).

### Being Healthy

We all deserve to be healthy, regardless of our age, race, income, sexual orientation or gender identity.

Being healthy means taking care of our physical, emotional, sexual, psychological and spiritual needs.

For transsexual and transgender people, this can be a challenge given the stress of dealing with prejudice and discrimination.

But being trans is a wonderful, positive experience for many people and gender identity can be a source of pride and celebration.

Many people get healthier after coming out and transitioning as they feel more in touch with their bodies and more in control of their lives.

Some things that can help you to be healthy include:

- Accepting and loving yourself for who you are.
- Coming out if you feel safe and comfortable.
- Finding personal strengths, other people, and activities that make you feel good about yourself.
- Connecting with others who support you in the trans and queer communities.
- Figuring out what may be stressful for you and learning the best ways to deal with stress.
- Learning about your body so that you know what to do to take care of yourself.

### Getting Good Health Care

For transsexual and transgender people, getting good health care can be hard. Health care providers may be transphobic or they may not know much about your health concerns. This can make it tough to come out about your gender identity to your health care provider, and some trans people may just avoid seeking health care altogether. But it is important to get regular check-ups and to get professional help when something is wrong. Here are some suggestions to improve the quality of your health care:

- Ask other trans people about their health care providers and who they recommend, or check local queer newspapers and community directories for advice.
- Visit potential providers and ask questions about their training and experience with trans health issues.
- Check out the office space and look for LGBT-friendly posters, brochures, magazines or other signs of a LGBT-positive environment.
- Listen for how the provider talks with you and whether you are encouraged to talk about your concerns in a culturally sensitive and nonjudgmental manner.
- If you feel safe, come out to your provider so that you can be open about discussing the issues that are of concern to you and your provider can better understand how to help you stay healthy or get better.
- If you do not feel comfortable with a provider, shop around to find a place where you can be yourself so that you can get the best health care possible.

### Toronto Resources

**Canadian Cancer Society**  
Cancer Info Service • 1-888-939-3333  
Smokers' Helpline • 1-877-513-5333  
[www.cancer.ca](http://www.cancer.ca)

**519 Trans Programmes**  
Information, support, and resources for TS/TG people.  
416-392-6874  
[www.the519.org/programs/trans/index.shtml](http://www.the519.org/programs/trans/index.shtml)

**Hassle Free Clinic**  
Sexual health medical and counselling services.  
416-922-0566 • [www.hasslefreeclinic.org](http://www.hasslefreeclinic.org)

**Rainbow Services at the Centre for Addiction and Mental Health**  
Counselling for drug and alcohol concerns.  
416-535-8501 ext.6781

**Sherbourne Health Centre**  
LGBT medical and wellness care, counselling, workshops, group support and Supporting Our Youth programs for LGBT youth.  
416-324-4180 • [www.sherbourne.on.ca](http://www.sherbourne.on.ca)

### Internet Resources

**Trans-Health.com**  
[www.trans-health.com](http://www.trans-health.com)

**TransGender Care**  
[www.transgendercare.com/default.asp](http://www.transgendercare.com/default.asp)

**International Journal of Transgenderism**  
[www.symposion.com/ijt](http://www.symposion.com/ijt)

**Canadian Rainbow Health Coalition**  
[www.rainbowhealth.ca](http://www.rainbowhealth.ca)

**LGBT Health Channel**  
[www.gayhealthchannel.com](http://www.gayhealthchannel.com)

Produced by **Sherbourne Health Centre** with support from **The Rotary Club of Toronto**.

# Let's Talk About Trans Health

Health information for transsexual and transgender people



**SHERBOURNE Health Centre**

## Tool 5: Health Literacy How-to

- Identify your audience. Assess their needs. Engage with them.
- Adapt, choose, or write materials for the literacy level of your audience.
- Write with clarity and understanding in mind. Use shorter and familiar words and clear language. Avoid jargon, acronyms, abbreviations, and technical terms. Explain difficult words and necessary medical terms.
- Use shorter sentences—fewer than 20 words per sentence. Organize your thoughts. Include one key concept for each paragraph. Think logically about the order of information. Put the most important information first.
- Pay attention to tone and voice. Write the way people speak. Use a friendly and inviting tone. Use “you” and “we” not “patient,” “consumer,” or “client.”
- Write in the active voice. For example, say “Cats eat fish” instead of “Fish are eaten by cats.”
- Include only what is necessary.
- Use bias-free, inclusive language.
- Use bulleted lists to summarize key information. Emphasize key words and phrases with bold type or in text boxes.
- Provide alternative formats, such as large-print, Braille, and audio or digital format/DVD (described format).
- Use inclusive images, diagrams, and text that help with understanding.
- Use clear verbal communication in tandem with easy-to-read, inclusive health materials. Encourage questions. Suggest resources for learning more.
- Use personal and community channels to share health messages.
- Keep in mind the stigma facing people with limited literacy and health literacy skills. Train staff. Address health literacy for all individuals.

### Determining Reading Level

It is difficult to provide an exact target reading level. It is often recommended that materials for the “general public” should be at a grade 6 level. A better approach is to identify the sex, age, ethnicity, education and literacy level, and economic status of the reader, then adjust the reading level accordingly. This may mean writing your materials at an even lower reading level.

To determine reading level, consider a tool such as the SMOG (Simple Measure of Gobbledygook) test. This looks at the length of sentences, organization of text, number of words with more than three syllables, and so on. For an online version, see [www.eastendliteracy.on.ca/clearlanguageanddesign/readingeffectivenessstool/](http://www.eastendliteracy.on.ca/clearlanguageanddesign/readingeffectivenessstool/).

## Plain language: words to lose, words to chose

Replace complex words with easier words for clarity.<sup>49</sup>

<b>Lose</b>		<b>Choose</b>
additional		more
adequate		enough
advise		tell
ailment		sickness, illness
assistance		help
avoid		stay away from
benign		is not cancer
beverage		drink
demonstrate		show
determine		decide
discontinue		stop
dysfunction		problem
encounter		meet
excessive		too much
factor		other thing
hazardous		not safe
hemorrhage		heavy, unstoppable bleeding
hypertension		high blood pressure
if at all possible		if possible
incision		cut
increase gradually		add ( <i>example: add 5 minutes a week</i> )
indicates		says
inform		tell
intermittent		on and off
larynx		voice box
lesion		wound, sore
lethal		deadly
masticate		chew
moderately		not too much
oral		by mouth
pharmaceuticals		drugs
physician		doctor
poultry		chicken, turkey
prior to		before
proceed		go
referral		see another doctor (service)
render		give
request		ask
significantly		enough to make a difference
soiled		dirty

## Plain language: before and after

The following writing samples show text that has been made easier to read and understand.<sup>50</sup>

Initially, the writing is in an intimidating, unfriendly tone. The font is small and hard to read. The sentences and terms are complicated. They may also be all one block of text.

The revised text is larger, simpler and uses a friendly tone. Shorter sentences and less complicated language and jargon are used. When possible, sections are divided to make them easier to read and understand.

### Before

*Eligible patients are required to apply for this pharmaceutical program but will only be accepted if they meet the required criteria. Once approval for criteria have been met, eligibility benefits include a 35 per cent co-payment on some pharmaceutical costs. Additional coverage may be obtained. If additional coverage is required, complete this report and mail it or take it to the office shown in the box below. In addition, contact staff by telephone about additional coverage. If this report does not provide enough room, write the additional information on a separate sheet.*

### After

You may be able to take part in this program if you meet our criteria. If approved, we will pay for 65% of your drug costs. You will need to pay the other 35%.

Let us know if you need more help. You can:

- call our office
- or
- fill out this form and send it to us. If you need more room, use another sheet of paper.



## Tool 6: Using Clear Layout and Design

Clear design makes materials easier to read and understand. Although artistic designs look interesting, some styles and formats make text harder to read

Think of layout and design as a way to help people feel optimistic about reading. Make it easy for them find their way through your text. If possible, hire a designer who specializes in clear layout and design. If that is not possible, here are some suggestions.<sup>51</sup>

- **Left-align the text and use a ragged right margin.**

Leaving the right margin ragged (align left) helps readers follow the text. Straight lines (justified) are harder to read as they create broken words and uneven spaces.

- **Choose fonts that are large enough and easy to read.**

Some clear language resources recommend serif fonts (ones with hooks, like Bookman or Garamond) for the main text and sans serif (without hooks, such as Arial) for headings and captions. A minimum of 12-point font size is also often recommended.

The CNIB recommends using Verdana (12) and Arial (14) as fonts. If seniors are your target audience, use an even larger font size.

Do not use italics or shadowed fonts as they are hard to read.

- **Consider no more than two different fonts—one for headings and one for text. Choose larger font sizes for headings to guide the reader through the text.**

- **Look for ways to highlight key information.**

Use text boxes or other design elements to summarize and highlight the most important information. Use bulleted lists instead of dense written text.

- **Include a lot of white space on each page.**

Text looks too crowded without white space and is overwhelming to readers. Aim for a clean, uncluttered look.

- **Use inclusive pictures and images.**

Choose pictures and illustrations that help the reader understand the text. Make sure that those chosen reflect the culture of readers. Diagrams with captions are useful for educational materials.

- **Use dark ink and non-glare paper.**

Choose dark ink (dark blue, brown, or black) on light paper. Shiny paper, coloured paper, and shading make text more difficult to read, especially for older readers.

## Tool 7: Canadian National Institute for the Blind (CNIB) Clear Print Accessibility Guidelines

Keep these guidelines in mind to reach a wider audience, especially those with vision challenges.

- **Use high-contrast colours for text and background:** Good examples are black or dark blue text on a white or yellow background.
- **Type colour:** Printed material is most readable in black and white. If using coloured text, restrict it to things like titles, headings, or highlighted material.
- **Point size:** Bigger is better. Keep your text large, preferably between 12 and 18 points, depending on the font (point size varies among fonts). Consider your audience when choosing point size.
- **Leading:** Space between lines of text should be 25 to 30 per cent of the point size. This lets readers move more easily to the next line of text. Heavier typefaces require slightly more leading.
- **Font family and font style:** Avoid complicated or decorative fonts. Choose standard fonts with easily recognizable upper and lower-case characters. Arial and Verdana are good choices.
- **Font weight:** Opt for fonts with medium heaviness, and avoid light type with thin strokes. When emphasizing a word or passage, use a bold or heavy font. Italics or all upper-case letters are not recommended.
- **Letter spacing:** Don't crowd your text: keep a wide space between letters. Choose a monospaced font rather than one that is proportionally spaced.
- **Margins and columns:** Separate text into columns to make it easier to read, as they require less eye movement and less peripheral vision. Use wide binding margins or spiral bindings if possible. Flat pages work best for vision aids such as magnifiers.
- **Paper finish:** Use a matte or non-glossy finish to cut down on glare. Reduce distractions by not using watermarks or complicated background designs.
- **Clean design and simplicity:** Use distinctive colours, sizes, and shapes on the covers of materials to make them easier to tell apart.

CNIB is a nationwide, community-based, registered charity, committed to public education, research, and the vision health of all Canadians. CNIB provides the services and support necessary to enjoy a good quality of life regardless of vision loss. For more information, call 1-800-563-2642 or visit [www.cnib.ca/accessibility](http://www.cnib.ca/accessibility).

## Tool 8: Alternative Formats

Cultural and health literacy barriers make using traditional formats like pamphlets and information sheets less successful. Such barriers also limit the validity of consent forms.

Consider the following alternatives to communicate with diverse groups, people with limited literacy skills or those whose home language is not English.

**Audio** options can include audio or digital CD. Having materials in audio format is helpful for blind and visually impaired people such as seniors. CDs can be played on DAISY (Digital Accessible Information SYstem) readers used by CNIB Library users.

**Audio/visual** formats include television programming, movies, videotapes/DVDs, and webcasts. Ensure that captions are used for the Deaf/hard of hearing (see below). Described DVDs help people with vision loss understand silent/action-oriented scenes.

**Braille** is a tactile system of raised dots representing letters of the alphabet. It allows people who are blind to read and provides essential access to information.

**Captions** are superimposed titles that print out the dialogue and sound effects of video programming. They are almost always closed (not visible on the screen without the assistance of a decoder machine or chip) rather than open (visible on the screen to all viewers). Use captions to ensure that audio-visual material is accessible to the Deaf and hard of hearing. Captions also may assist second-language speakers and those with limited literacy levels. Seeing the written text provides additional clues for understanding.

**Large-print:** seniors and others who are visually impaired benefit from large-print documents—font size 14 points or greater. Also consider providing a clickable large-print/low-contrast option on websites.

**TTY** (derived from TeleTYpewriter) describes special devices used by Deaf and deaf, hard of hearing, and hearing people to communicate with each other through the telephone system.

For more on audio options, large print and braille, see the CNIB ([www.cnib.ca](http://www.cnib.ca)).

For more on captioning and TTY devices, see the Canadian Association of the Deaf ([www.cad.ca](http://www.cad.ca)) or the Society of Deaf and Hard of Hearing Nova Scotians ([www.sdhhs.org](http://www.sdhhs.org)).

## Tool 9: Sharing Health Messages

Sometimes bridging communication barriers across cultures involves considering where and how health messages are distributed. Also keep in mind that health messages are best understood when materials are combined with clear verbal communication.

Learn about communication options from your target audience. Consider the following:

- ethnic media in local languages such as radio, newsletters, television shows
- networks and communication options through the Deaf and blind community
- providing information in familiar community locations, such as community centres, libraries, and grocery stores
- providing in-person information sessions followed up with written materials

The Canadian Public Health Agency, National Literacy and Health Program suggests these tips for clear verbal health communication:<sup>52</sup>

- Organize your information.
- Use common words, not technical jargon.
- Give your clients a chance to express how they feel and to tell the story of their illness.
- Make direct eye contact.
- Use written information as a back-up.
- Plan with your clients what they can do.
- Let your client know what you are thinking.
- Explain procedures and ask permission during examinations.
- Focus on your client, not on notes, X-rays or the computer screen.
- Check that your clients have understood what you have said.

For example, ask people to repeat back what you have said in their own words. Negotiate and clarify as needed.

## Tool 10: Creating Inclusive Forms

Don't overlook forms when considering culture, language, and literacy. Intake, assessment, and consent forms are often the earliest points of contact with the health system. They set the stage for building safe and inclusive relationships with people.

The information collected on forms is critical to quality care, safety and reducing risk. If a person cannot read or understand the form, the information collected may not be accurate.

### 1. Ask only what is needed

Don't ask for too much information. Make sure that the information you collect is necessary.

- Is everything needed? Does it have a purpose? If not, take it out.

### 2. Ensure confidentiality

People must be sure that the information you collect is confidential and will not be read or used except for medical purposes.

- Ensure that your staff are trained and aware of confidentiality rules.
- Check where records and forms are stored. Who can access them? Are they secure?

### 3. Train staff

Giving people the impression that health-care providers and health systems are inclusive simply because they use inclusive forms can jeopardize patient confidentiality and safety.

- Provide cultural competence training to staff who collect, store, and use form information.

### 4. Consider literacy levels

Many forms are too complicated or crowded to be well understood by people with limited health literacy skills. This is especially true of consent forms and legal documents.

- Simplify forms so they are easier to read. Use easier words and avoid complicated terms.
- Include more white space. Look for ways to help readers navigate through form sections.
- Ask only what is necessary.
- Test forms with users.

## 5. Consider language

Not everyone can read and understand forms they are given.

- Have important forms translated into local languages
- Include a question on preferred languages.

## 6. Ask about interpretation

Include an interpreter option when one is available.

- Have people identify directly on the form whether they need an interpreter.
- Train intake staff to assess for language barriers.
- Ensure that staff know how to access interpreters.

## 7. Include people who are blind

- Create Braille versions of forms.
- Create a CD of informed consent forms so they are accessible to the blind and those with low vision.

## 8. Include seniors and people with low vision

Seniors and people with low vision have difficulty reading and navigating forms.

- Create large-print forms or use standard 14-point Arial font.
- Make forms easy to navigate.

## 9. Include race and ethnicity

There are several elements of forms that can exclude cultural groups. These include languages, parent/guardian arrangements, spouse/partner identification, foods and diet, complimentary/traditional healing, religion and spirituality, and so on.

- **Languages:** See languages and interpreters section, above.
- **Parent/guardian options:** Some forms provide a place to identify parents. Including only “mother” and “father” as the options for parents ignores the reality of many households, such as those where the grandmother provides the majority of child care.

Replace “mother” and “father” with a numbered “parent/guardian” option. If you need information about legal guardians or birth parents, ask specifically for that information as well in a separate question.

- **Spouse/partner:** Asking to identify as husband and wife can be insulting, depending on religion and/or culture.  
Change forms with spaces for “husband” or “wife” to the gender-neutral “spouse/domestic partner.”  
Don’t ask this question unless it is necessary.
- **Foods/diets:** When food information is required, be sure to include culturally diverse options or an open-ended “other” line.
- **Providers:** Include information on traditional or complimentary providers and practices

## 10. Include the Rainbow community

Forms may exclude those of diverse sexual orientation or gender identity. This makes explaining these issues difficult or traumatic. It makes people reluctant to disclose information and makes the information collected less accurate, potentially affecting health.<sup>53</sup>

- **Sexual orientation:** There are few circumstances where knowing sexual orientation is medically necessary. However, if you need to collect this information, consider the following question. This format also provides respondents with a sense it may be safe to “come out” in the health setting.

### How would you identify your sexual orientation?<sup>54</sup>

- straight/heterosexual
- lesbian
- gay
- WSW (woman who has sex with women)
- bisexual
- MSM (man who has sex with men)
- queer
- transsexual (person attracted to transsexual or transgender individuals)
- polysexual
- two-spirit
- questioning
- asexual/autosexual/unsure
- other \_\_\_\_\_
- prefer not to answer

- Sex/gender identity is a person’s self-image or belief about being female or male. For some, biological sex does not fit with who they feel they are. Gender identity is a continuum ranging from male to female. Using male or female alone does not include people who are transgender, transsexual, intersex and others. Consider using the following question:

**Sex (confidential information, for medical purposes only)**

- female
- male
- intersex
- transsexual
- other \_\_\_\_\_

**If you need more information for medical reasons, consider:** <sup>55</sup>

- female
- male
- transsexual
- transgender
- genderqueer
- two-spirit
- FTM (female-to-male)
- MTF (male-to-female)
- intersex
- unsure
- questioning
- other \_\_\_\_\_
- prefer not to answer

Note: Some individuals may prefer *your description* to *other*.

*“... you don’t want to have to explain yourself every single time. You don’t want to have to ... try and educate every single person out there who should be the one answering questions. They need training.”* <sup>56</sup>

– Rainbow Community member



## 11. Include non-traditional families

- Title options: Many people do not feel comfortable with titles, so it is important to include the option to not be addressed by any of them. If you need to collect information on titles, include all of the following options.

Choose all that apply

Mrs.

Miss

Mr.

Ms.

Prefer not to be addressed by title

- Parents/Guardians: Some forms provide a place to identify parents. Including only “mother” and “father” as the options for parents ignores the reality of many households.

Replace “mother” and “father” with a numbered “parent/guardian” option. If you need information about legal guardians or birth parents, ask specifically for that information as well in a separate question.

- Spouse/partner: Change forms with spaces for “husband” or “wife” to the gender-neutral “spouse/domestic partner.”

Specify whether this information is for a legal purpose or not.

*Too often, gay, genderqueer, lesbian, bisexual, transgender, transsexual, questioning, queer, intersex, asexual, and ally-identified people are forced to make difficult choices on the forms they fill out—choices that put them in boxes, make them uncomfortable, and don't accurately describe their lives. In addition to alienating a segment of the population, ignoring these issues can decrease the accuracy of the data collected.<sup>57</sup>*

# Ottawa Personal Decision Guide For People Facing Tough Health or Social Decisions





You will be guided through four steps:

- 1 Clarify the decision.
- 2 Identify your decision making needs.
- 3 Explore your needs.
- 4 Plan the next steps.

## 1 Clarify the decision.


What decision do you face?		
What is your reason for making this decision?		
When do you need to make a choice?		
How far along are you with making a choice?	<input type="checkbox"/> I have not yet thought about options <input type="checkbox"/> I am thinking about the options	<input type="checkbox"/> I am close to making a choice <input type="checkbox"/> I have already made a choice
Are you leaning toward one option?	<input type="checkbox"/> Yes If yes, which one?	<input type="checkbox"/> No

## 2 Identify your decision making needs.

 <b>Support</b>	Do you have enough support and advice from others to make a choice?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you choosing without pressure from others?	<input type="checkbox"/> Yes <input type="checkbox"/> No
 <b>Knowledge</b>	Do you know which options are available to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you know <u>both</u> the benefits and risks of each option?	<input type="checkbox"/> Yes <input type="checkbox"/> No
 <b>Values</b>	Are you clear about which benefits and risks <u>matter most</u> to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
 <b>Certainty</b>	Do you feel sure about the best choice for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No

People who answer "No" to one or several questions are more likely to delay their decision, change their mind, feel regret about their choice or blame others for bad outcomes. Therefore, it is important to work through steps **three** and **four** that focus on your needs.

## 3 Explore your needs.

 <b>Support</b>			
Who else is involved?	Name:	Name:	Name:
Which option does this person prefer?			
Is this person pressuring you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
How can this person support you?			
What role do you prefer in making your choice?	<input type="checkbox"/> I prefer to share the decision with _____ <input type="checkbox"/> I prefer to decide myself after hearing the views of _____ <input type="checkbox"/> I prefer that someone else decides. Who? _____		

Decisional Conflict Scale © 2006 O'Connor



In this example of an inclusive form:

- ✓ Colour and layout help guide the reader.
- ✓ The text is easy to read.
- ✓ It speaks to the reader personally (using "you").
- ✓ It includes a band of diverse images and examples and illustrations (holidays, names, life contexts, etc.).
- ✓ Open-ended questions mean that no one is left out

## Tool 11: Creating Inclusive Signs

Good signs are important. Signs bridge health systems and users. Signs and other visual systems help people find their way around, keep them safe, give them information, and ensure that they feel comfortable and welcome. Poor signage can increase the stress of what may already be a stressful health encounter.

### Groups to consider

- **Low vision, including seniors:** This community will have difficulty navigating health systems when they can't read the signs. Use the suggestions outlined here—such as including using large font sizes, universal symbols, and sharp contrast—so signs can be read easily.
- **Blind:** Include Braille and tactile cues on signs.
- **Deaf, deaf, and hard of hearing:** This community experiences barriers when asking for help. Make sure signs are easy to read.
- **Limited health literacy levels:** This community has difficulty navigating health systems and may have reading challenges. Use the suggestions here to ensure that signs are clear and easy to read and understand.
- **Language:** People whose home language is not English may have difficulty understanding complex signs. Use easy-to-read text and large font sizes. Translate signs for your local communities. Investigate universal symbols. Ensure that front desk staff can assist with navigation.
- **Race, ethnicity, and gender:** Ensure that images and text are racial, ethnic, and sex/gender-inclusive.
- **Transgender:** Many Rainbow and/or transgender people face discrimination when they use gender-segregated washrooms. One solution is to create, sign and map the location of gender-neutral washrooms. These are single stall, accessible washrooms available to everyone, no matter what their gender or biological sex. Choose signs through an inclusive, consultative process. Some sample signs are included below.



# Taking in pride health...

**We support**  
lesbian, gay, bisexual,  
transsexual & transgender  
**health & wellness!**



SHERBOURNE  
Health Centre

[www.sherbourne.on.ca](http://www.sherbourne.on.ca)

Used with the permission of Sherbourne Health Centre.

## Suggestions for creating inclusive signs

- Use upper- and lower-case fonts. Do not use all capital letters as they are harder to read.
- Use large font sizes.
- Keep text simple and short.
- Use uncomplicated fonts (sans serif, such as Arial).
- Avoid the use of italics. It is hard to read.
- Place signs at eye level.
- Avoid placing signs under lights and in high-glare areas.
- Include Braille on signs when possible. Locate it below the text.
- Ensure that images and text are racially, ethnically, and sex/gender-inclusive.
- If you have an inclusive anti-discrimination policy and staff are trained, monitored and supported in its use, display this on signage.
- If your staff are trained, monitored and supported in creating LGBTI-safe spaces, display this on signage.
- Use signs, maps and colour-coding to enhance patient navigation through health facilities.
- Signs alone are not enough. Ensure multilingual staff or volunteers are on hand to help patients navigate health spaces and systems.

### **Can people see themselves reflected on the walls around them?**

Signs, posters, pictures, and images on the walls of health facilities play an important role in making people from diverse cultures feel included and welcome. Include diversity on your walls by

- displaying pictures, posters, artwork, and other decorative items that reflect the diverse cultures and racial/ethnic backgrounds of local communities
- ensuring that brochures, magazines, and other printed materials in reception areas are of interest to and reflect the diversity of local communities

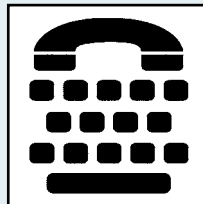
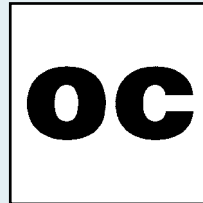
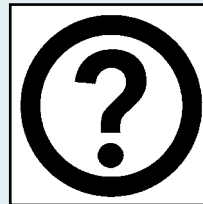
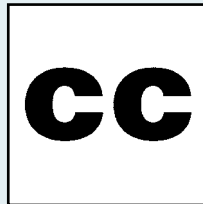
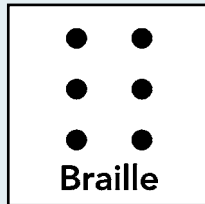
## Universal Symbols for Health Signage

The Robert Wood Johnson Foundation (US) has developed 28 universal symbols for health facility wayfinding. These are an effective way to make health signage easier to use and understand. The Canadian Public Health Association's Report of the Expert Panel on Health Literacy<sup>58</sup> recommends policies for the use of visual symbols on health signage.

You can find these symbols in the Universal Symbols in Health Care Workbook, available online at [www.hablamosjuntos.org/signage/PDF/Best%20Practices-FINALDec05.pdf](http://www.hablamosjuntos.org/signage/PDF/Best%20Practices-FINALDec05.pdf).

### Universal symbols

- are easy to implement and maintain
- are more noticeable and easier to understand than written signs
- are helpful for second language speakers—one symbol can replace a sign written in multiple languages
- are user-friendly for people with vision problems
- can be combined with numbers and letters
- can be used in simple signs or complex wayfinding systems
- are helpful because users see the same symbol in all health settings





# Appendices

## Appendix 1: Cultural Competence Guidelines for the Delivery of Primary Health Care in Nova Scotia

Cultural competence refers to the attitudes, knowledge, skills, behaviours and policies required to better meet the needs of all the people we serve.

Culture in these guidelines refers to a group or community that share common experiences that shape the way its members understand the world. It is multi-layered, evolving and includes groups that we are born into or become such as; national origin, levels of ability, gender, sexual orientation and identity, race/ethnicity, socio-economic class or religion. People have multiple cultures.

Cultural competence can work to reduce disparities in health services, address inequitable access to primary health care and respectfully respond to the diversity of Nova Scotians (race, ethnicity, language, sex, sexual orientation, gender identity, (dis)ability, spirituality, age, geography, literacy, education and income, etc.)

1. Nova Scotia DHAs, CHBs, the IWK and primary health care organizations should ensure that their staff provide to Nova Scotia patients/consumers, primary health care that is respectfully delivered and responsive to cultural health beliefs, practices, lived experiences and linguistic differences in Nova Scotia.
2. The Nova Scotia Departments of Health and Health Promotion and Protection, DHAs, CHBs, the IWK and primary health care organizations should work collaboratively with culturally diverse populations, including but not limited to First Nations, African Canadians, Acadians, francophones, and immigrant communities, to design targeted, accessible and effective health initiatives in all aspects of primary health care.
3. The Nova Scotia Departments of Health and Health Promotion and Protection, DHAs, CHBs, IWK and academic institutions should collaborate to devise and implement strategies for the recruitment, retention and promotion of diverse health staff, providers and leaders at all levels.
4. The Nova Scotia Departments of Health and Health Promotion and Protection, DHAs, CHBs the IWK, primary health care organizations and health related, academic institutions should make cultural competence training available on an ongoing basis to all primary health care students, staff and providers at all levels and across all disciplines, and facilitate the development of cultural competence across the primary health care system.



5. The Nova Scotia Departments of Health and Health Promotion and Protection, DHAs, the IWK and primary health care organizations should offer and provide services in Canada's official languages with the phased in recruitment of French-speaking, bilingual staff and the use of cultural health interpreters.
6. Nova Scotia DHAs, the IWK and primary health care organizations should offer and provide cultural health interpretation services in languages provided by Nova Scotia's Community Health Information and Interpreting Service for any primary health care patient/consumer with English or French as a second language at no cost to the patient/consumer.
7. Nova Scotia DHAs, the IWK, and primary health care organizations should provide written notice of the availability of cultural health interpretation services in all of the languages provided by Nova Scotia's Community Health Information and Interpreting Service and when possible, cultural health interpretation in the Mi'kmaq language.
8. Nova Scotia DHAs, the IWK and primary health care organizations should ensure that patient/consumer family and friends not be used to provide interpretation services except at the direct request of the patient/consumer.
9. Nova Scotia DHAs, the IWK and primary health care organizations should reflect Nova Scotia's diverse populations in pictures, written information and advertisements and post signage and provide written material for all literacy levels in the languages commonly spoken in their service areas.
10. The Nova Scotia Departments of Health and Health Promotion and Protection, DHAs, CHBs the IWK and primary health care organizations should ensure that their vision, mission, strategic plans, job performance expectations and accreditation processes incorporate accountability for cultural competence and culturally appropriate services at the highest level of the organization.
11. The Nova Scotia Departments of Health and Health Promotion and Protection, DHAs, CHBs, the IWK and primary health care organizations should work collaboratively and independently to develop public information and communication plans to explain the importance of race, ethnic and linguistic identifiers in epidemiological and health utilization data for the purposes of effective planning, program delivery and the development of a culturally competent, primary health care system.
12. DHAs, CHBs, the IWK and primary health care organizations should maintain up-to-date demographic, cultural and epidemiological profiles of their communities in order to effectively plan and provide services that respond to the racial, ethnic, cultural, spiritual and linguistic needs of the populations they serve.

13. The Nova Scotia Departments of Health and Health Promotion and Protection, DHAs, CHBs, the IWK and primary health care organizations should ensure that data collected and updated through the MSI database, and other data collected by organizations incorporates, with patient/consumer agreement, information that specifies race, ethnicity and language of patients/consumers without individual patient identification.
14. The Nova Scotia Departments of Health and Health Promotion and Protection, DHAs, CHBs, the IWK and primary health care organizations should ensure that data collected and research resulting from the data, facilitate best practice in culturally competent care, movement toward the elimination of health disparities among populations, and the improvement of health status of those populations most at risk for poor health.
15. The Nova Scotia Departments of Health and Health Promotion and Protection, DHAs, CHBs, the IWK, provincial programs and primary health care organizations should inform, increase and facilitate culturally appropriate screening among Nova Scotia's culturally diverse populations for chronic diseases including but not limited to; diabetes, cancers, cardiovascular disease, hypertension and sickle cell anemia.

July 2008

## Appendix 2: Glossary of Terms

This glossary develops a common understanding of the many terms involved in this work.

**Aboriginal people:** people who are native to a country; in Canada, this term includes Inuit, First Nations, and Métis people, without regard to their separate origins and identities.

**Acadians:** descendants of 17<sup>th</sup>-century French colonists who settled in Acadie (now parts of Nova Scotia, New Brunswick, Prince Edward Island, and Maine), who have a distinct culture separate from that of francophones within Quebec.

**Accessibility:** the state or quality of whether services and opportunities are available to diverse groups. Often used when referring to people with disabilities, but can include other forms of diversity.

**African Nova Scotian or African Canadian:** a person who identifies as of African descent. African Canadian heritage in Nova Scotia is represented by three distinct groups: indigenous (have no country of ethnic origin other than Canada); Caribbean immigrants; and immigrants from the African continent.

**Antisemitism:** opposition or hostility towards individual Jews or the Jewish people, leading to social, economic, institutional, religious, cultural, or political discrimination. Antisemitism has also been expressed through acts of physical violence, vandalism, and the organized destruction of entire communities.

**Asexual:** a person who does not experience sexual attraction.

**Bisexual:** a person who is emotionally, physically, romantically attracted to either male or female people and can form a loving relationship with either.

**Braille:** a tactile system of raised dots representing letters of the alphabet. The reader moves their fingers over dots that have been embossed onto paper or refreshed line by line on an electronic Braille display. Invented by Frenchman Louis Braille in 1829, Braille allows people who are blind to read and provides essential access to information.

**Class:** division within society based mainly on economic status but can include power and privilege.

**Clear design:** this addresses issues such as layout, font, and use of pictures to communicate effectively. A brochure written plainly that is poorly formatted will still be difficult to read.

**CNIB:** Canadian National Institute for the Blind

**Consumer Health Information (CHI):** health information materials directed at a general lay audience rather than at an individual patient. Unlike patient education materials, generally used without the mediation of a health-care provider.

**Cultural health interpreter:** an oral interpreter working across language and/or culture to improve health communication.

**Culture:** the integrated patterns of human behaviour that include thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups.

**Cultural blindness:** situation where cultural differences are ignored and one proceeds as though differences do not exist.

**Cultural competence:** a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations.

**Cultural competence:** having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviours, and needs presented by consumers and their communities.

**Cultural safety:** a concept developed by a group of Maori nurses in New Zealand in order to reflect on nursing practice from their point of view as the indigenous minority. Culturally unsafe practice is defined as “any actions which diminish, demean or disempower the cultural identity and well-being of an individual.” Culturally safe nursing practice includes “actions which recognize, respect and nurture the unique cultural identity of the *Tengata Whenua* [‘people of the land’], and safely meet their needs, expectations and rights.” Cultural safety was brought to the national media’s attention by Irihapeti Ramsden and, in the spirit of the Maori renaissance in New Zealand, adopted by the Nursing Council of New Zealand as part of the basic curriculum for nursing training.

**Cultural sensitivity:** the ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups of people that share a common and distinctive racial, national, religious, linguistic, or cultural heritage.

**deaf:** a medical/audiological term referring to those people who have little or no functional hearing (deaf, Deaf, and deafened). The term may also be used as a collective noun (“the deaf”) to refer to people who are medically deaf but who do not necessarily identify with the Deaf community.

**Deaf:** a sociological term referring to those individuals who are medically deaf or hard of hearing and who identify with and participate in the culture, society, and language of Deaf people, which is based on Sign Language. Their preferred mode of communication is sign.

**Deafened:** people who become deaf later in life.

**Determinants of health:** the economic and social conditions under which people live that influence their health. These include income and social status; social support networks; education and literacy; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture.

**Disability:** a natural or acquired characteristic that may prevent someone from fully taking part in educational, social, economic, political, religious, institutional, or formal activities of a group or that may require accommodation to enable full participation.

**Discrimination:** denial of equal treatment, civil liberties, and opportunity—the unequal treatment of people or groups resulting in subordination and deprivation of political, social, and economic rights with respect to education, accommodation, health care, employment, and access to goods, services, and facilities. Discrimination may occur on the basis of race, nationality, ethnicity, gender, sexual orientation, age, religious or political affiliation, marital or family status, or disability. Discrimination is often invisible to those who are not its targets. Discrimination can be

- **overt:** granting or denying of certain rights to certain groups or individuals.
- **unequal treatment:** differential treatment of one group in comparison with another because of certain characteristics
- **systemic:** policies and practices in established institutions that result in the exclusion or promotion of designated groups. No individual intent is necessary.

**Diversity:** the broad variety of ways in which people can be similar and different. These can include, but are not limited to, race, age, place of origin, religion, ancestry, colour, citizenship, sex, sexual orientation, ethnic origin, disability, marital, parental or family status, educational background, literacy, geographical location, income, cultural tradition, and work experience.

**Equity:** the quality of being fair or impartial. Equity acknowledges the different life experiences, needs, resources, and access to and control of power and authority of diverse groups. Equity recognizes the need for different approaches to achieve equal outcomes. Equal treatment does not necessarily lead to equal results. See also health equity and health inequity.

**Equality:** the state of being equal; the absence of discrimination (on the basis of gender, race, ethnicity, culture, language, ability, sexual orientation, and so on) in opportunities, allocation of resources, benefits, and/or access to services.

**Ethnicity:** identity with or membership in a particular racial, national, or cultural group and observance of that group’s customs, beliefs, and language.

**Ethnocentrism:** inability to accept another culture’s world view; the tendency to look at the world primarily from the perspective of one’s own culture. This often includes believing that one’s own race or ethnic group is superior or more important than another.

**Exclusion:** the state of being left out.

**First Nations:** The term First Nations came into common usage in the 1970s to replace band or Indian, which some people found offensive. Despite its widespread use, there is no legal definition for this term in Canada. Many people prefer to be called First Nations or First Nations People instead of Indians. The term is not a synonym for Aboriginal Peoples because it doesn’t include Inuit or Métis. The term First Nations People generally applies to both Status and Non-Status Indians.

**Francophone:** any person, regardless of ethnic origin, who speaks French as their primary language. It can also refer to people whose cultural background is associated with the French language, regardless of ethnic and geographic differences.

**Gay:** a male/male-gendered person who is emotionally, physically, and/or romantically attracted to other males/male-gendered people and is capable of forming loving relations with them.

**Gender:** the socially constructed roles, behaviours, and attributes considered appropriate for men and women and girls and boys in a given society at a particular point in time.

**Gender identity:** a person's self-image or belief about being female or male. Gender identity is a continuum ranging from male to female. Using male or female alone excludes people who are transgender, transsexual, intersex, and others.

**Hard of hearing:** a person whose hearing loss ranges from mild to profound and whose usual means of communication is speech. It is both a medical and a sociological term.

**Health disparity:** differences in health status that occur among population groups defined by specific characteristics. For policy purposes, the most useful categorizations are those consistently associated with the largest variations in health status. The most prominent factors in Canada are socio-economic status (SES), Aboriginal identity, gender and geographic location.

Disparities in health status among different population groups are unjust and inequitable because, they result from preventable, avoidable, systemic conditions and policies based on imbalances in political power. The most important consequences of health disparities are avoidable death, disease, disability, distress and discomfort. Disparities are also costly for the health system and Canadian society as a whole.

**Health equity:** 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. Equity supports the right to the highest attainable standard of health, as indicated by the health status of the most socially advantaged group.

**Health inequality:** designates differences, variations and disparities in the health achievements and risk factors of individuals and groups . . . that need not imply moral judgment . . . [and may result from] a personal choice that would not necessarily evoke moral concern.

**Health inequity:** differences in health experience and thus outcomes between different population groups. These are due to unfair and/or unjustifiable differences in cause, service and other opportunities. Health inequity is often associated with how fairly resources are distributed in relation to the needs of different groups. The term inequity has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust.

**Health literacy:** the ability to access, understand, evaluate, and communicate information as a way to promote, maintain, and improve health in a variety of settings across the life course. This definition is broadening as the understanding of health literacy increases. The ability to read, understand, and act on printed materials is one of the significant determinants of health. Patients with poor health literacy tend to have poorer health outcomes.

**Health promotion materials:** print, web, or audio-visual formats that deliver health promotion messages. Health promotion messages are those designed to have an impact awareness, values, beliefs, and attitudes—and thus behaviours—to promote good health.

**Heterosexism:** the belief that heterosexuality is the only “natural” sexuality and that it is inherently healthier or superior to other types of sexuality.

**Home language:** a term widely used for a language spoken in the home that is different from the main language spoken in the society. See also mother tongue.

**Homophobia:** an irrational fear and/or hatred of homosexuality and homosexuals. Homophobia results in prejudice, discrimination, harassment, and sometimes acts of violence. Homophobia also harms gay people who live with this discrimination, including increased risks of suicide and alcohol and drug abuse.

**Immigrant:** a person who moves from their place of origin to another country. Recent immigrants are people who have arrived in Canada in the past two to five years. People who are born in Canada to immigrant parents are sometimes referred to as second-generation immigrants.

**Inclusion:** the act or state of including someone. Inclusion is the opposite of exclusion—being left out. Inclusion is characterized by a society’s widely shared social experience and active participation, by a broad equality of opportunities and life chances for individuals, and by the achievement of a basic level of well-being for all citizens.

**Interpreter:** a person who translates orally from one language to another.

**Intersex:** someone who is born with ambiguous genitalia or chromosomal anomalies.

**Inuit:** the Aboriginal People of Arctic Canada. Inuit live primarily in the Northwest Territories, Nunavut and northern parts of Quebec and throughout most of Labrador. They have traditionally lived north of the tree line in the area bordered by the Mackenzie Delta in the west, the Labrador coast in the east, the southern point of Hudson Bay in the south, and the High Arctic islands in the north. The word Inuit means “the people” in Inuktitut and is the term by which Inuit refer to themselves.

**Lesbian:** a woman or female-gendered person who is physically, emotionally, and/or romantically attracted to other females/female-gendered people and is capable of forming loving relations with them.

**Limited English Proficiency (LEP):** a term used to identify individuals whose home language is not English and who have difficulty reading, writing, or speaking English; term often used in the United States.

**Linguistic competence:** the capacity of an organization and its personnel to effectively communicate with people of limited English proficiency (LEP), those who are illiterate or have limited literacy skills, and individuals with disabilities. This may include, but is not limited to, the use of bilingual/bicultural staff; cultural brokers; multilingual telecommunication systems; ethnic media in languages other than English (e.g., television, radio, newspapers, periodicals); print materials in easy-to-read, low-literacy, picture, and symbol formats; and materials in alternative formats (e.g., CD, Braille, enlarged print).

**Literacy:** the state of being literate—able to read and write and to understand and use printed information in daily activities. Literacy can also refer to Sign Language and other forms of communication.

**Marginalization:** the experience of certain groups of being without full and equal access due to being excluded, ignored, or put at the outer edge. Individuals and communities can be socially, politically, and/or economically pushed to the sidelines of society or a dominant group.

**Métis:** French for “mixed blood.” The Constitution Act of 1982 recognizes Métis as one of the three Aboriginal Peoples. Historically, the term Métis applied to the children of French fur traders and Cree women in the Prairies, of English and Scottish traders and Dene women in the north, and Inuit and British in Newfoundland and Labrador. Today, the term is used broadly to describe people with mixed First Nations and European ancestry who identify themselves as Métis. Note that Métis organizations in Canada have differing criteria about who qualifies as a Métis person.

**Mother tongue:** the first language learned at home in childhood and still understood by the individual.

**Non-Status Indians:** people who consider themselves Indians or members of a First Nation but whom the Government of Canada does not recognize as Indians under the Indian Act, either because they are unable to prove their Indian status or have lost their status rights. Non-Status Indians are not entitled to the same rights and benefits available to Status Indians.

**Numeracy:** ability to recognize numbers and perform simple math skills.

**Oppression:** the use of power by one group of people to control or exploit another.

**Patient education materials:** print materials, video, or other multi-media materials used to help an individual learn about their illness and/or condition. Education materials focus on the needs of a particular individual. Health-care providers often use them along with other ways of teaching.

**Person of colour:** see Visible minority.

**Plain language:** organizing, expressing, and formatting information so it can be easily read and understood the first time. Plain language does not mean “dumbed down.” Plain language and clear writing are terms that are often used interchangeably.

**Population health:** an approach that focuses on improving the health status of a population or sub-population, rather than an individual. This also includes reducing inequalities in health status between population groups.

**Power:** capacity to bring about change. It can include “power over,” “power with,” and “power to.” To have power over an individual or group means setting and enforcing parameters and rules.

**Institutional power** is parameters and rules defined and enforced by states and institutions such as schools and judicial systems.

**Prejudice:** to pre-judge. It is a state of mind in one person or group about another, tending to cast the other in an inferior light, despite the absence of legitimate evidence.



**Privilege:** unearned power that gives certain groups economic, social, and political advantages; the unequal distribution of resources and status. It also means the ability to access resources, receive, acquire or assume benefits on the basis of this status.

**Queer:** although historically used as a negative term, queer is more commonly being used by the Rainbow Community, by the academic world and by the media as an inclusive term to refer to people who are lesbian, gay, bisexual and transgender. However, in our society, it is often still used in a negative way.

**Questioning:** a person who may be in the process of assessing their sexual orientation/identity.

**Race:** a group of persons related by common descent or heredity; any of the traditional divisions of humankind . . . characterized by supposedly distinctive and universal physical characteristics.

**Racism:** hatred or intolerance of another race or other races. Racism is a form of discrimination. Racism can be individual and/or systemic. Racism is based on the false belief that one group is superior to another as determined by hereditary factors. Systemic or institutional racism is racism supported by social, political, and economic systems and institutions.

**Refugee:** a person who flees their country of origin for fear of persecution or death or for economic reasons. **Government-assisted refugees (GARs)** are people whose initial resettlement in Canada is entirely supported by the Government of Canada or Quebec through non-governmental agencies for up to one year from the date of arrival. Support may include accommodation, clothing, food, help in finding employment and becoming self-supporting, and other resettlement assistance.

**Sex:** the biological and physiological characteristics that define humans as female or male. These characteristics are not mutually exclusive, however, as there are individuals who possess both. See also **gender**.

**Sexism:** a form of discrimination based on a person's sex; the oppression of women, discrimination combined with power that subordinates women. It is supported by social, political, and economic systems and institutions.

**Sexual orientation:** the capacity to develop intimate emotional and sexual relationships with people of the same, opposite, or both sexes.

**Sign Language:** the official language of the Deaf community. It should always be capitalized, just as English and French are capitalized, because all three are legitimate languages.

**Singular they:** the use of they or their as a non-gender-specific singular pronoun.

**Social determinants of health (SDOH):** the economic and social conditions that influence the health of individuals and communities. These conditions determine whether people stay healthy or become ill and the extent to which people possesses the resources to achieve personal aspirations, satisfy needs, and cope with the environment. Societal resources within the SDOH include conditions of childhood, income, availability of food, housing, employment and working conditions, and health and social services. Also included are issues of gender, class, racism and other forms of social exclusion.

**Socio-economic status (SES):** position within the social structure that depends on occupation, education, income, wealth, and place of residence.

**Status Indians:** people who are entitled to have their names included on the Indian Register, an official list maintained by the federal government. Certain criteria determine who can be registered as a Status Indian. Only Status Indians are recognized as Indians under the Indian Act and are entitled to certain rights and benefits under the law.

**Stereotype:** having an instant or fixed picture of a group of people. Stereotyping is having an oversimplified image of a group that ignores the individual differences and diversity that exist within any group of people. The word comes from the process of making metal plates for printing and means “set image.” Stereotyping means imposing preconceived assumptions and observations about behaviours, beliefs and actions to people without evaluating individual unique values and experiences.

**Transsexual:** a individual who is committed to altering his or her sex (their body)— through cosmetics, hormones, and, in some cases, surgery—to be more in line with their gender (how they feel).

**Transgender:** an umbrella term for people whose behaviour, manner of dress, or identity does not strictly fit how society defines “male” and “female.”

**Two-spirited:** a term used within many First Nations cultures for a person with close ties to the spirit world and who may or may not identify as being lesbian, gay, bisexual, or transgender (two spirits in one person).

**TTY:** the proper acronym for the special devices used by Deaf, deaf, hard of hearing, and hearing people to communicate with each other through the telephone system; derived from TeleTYpewriter.

**Visible minority:** Members of a visible minority are defined by the *Canadian Employment Equity Act* as “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour.” Categories in the 2006 Census visible minority population variable include Chinese, South Asian, Black, Filipino, Latin American, Southeast Asian, Arab, West Asian, Korean, Japanese, Visible minority, n.i.e. (“n.i.e.” means “not included elsewhere”), Multiple visible minority, and Not a visible minority.

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## Appendix 3: Ethnic Origin by District Health Authority Area (2006)

DHA	Ethnic Origin (2006)									
	Aboriginal	British	Acadian	Francophone	W. Europe (Dutch, German, Scandinavian, other)	N. Europe (Finnish, Scandinavian)	E. Europe (Polish, Ukrainian, other)	S. Europe (Italian, other)	American	
AVDHA	4,495	70,575	730	10,620	18,215	1,105	2,010	1,295	645	
CBDHA	7,810	113,100	1,555	23,460	7,490	1,125	5,590	4,305	390	
CDHA	16,607	360,443	5,470	68,701	66,379	7,396	14,264	13,986	3,044	
CEHHA	4,058	64,833	535	8,329	9,886	1,083	1,371	1,005	426	
CHA	1,100	29,810	220	4,730	3,790	325	500	645	200	
GASHA	2,320	40,760	1,355	12,995	4,550	335	820	760	150	
PCHA	1,835	45,980	275	7,480	5,140	440	820	850	285	
SSH	3,095	37,025	205	7,570	24,170	920	595	1,080	370	
SWH	7,740	36,830	4,020	18,105	6,205	675	590	870	415	
<b>Nova Scotia</b>	<b>49,060</b>	<b>799,356</b>	<b>14,365</b>	<b>161,990</b>	<b>145,825</b>	<b>13,404</b>	<b>26,560</b>	<b>24,796</b>	<b>5,925</b>	
	Jewish	West Asian	Arab (Lebanese, other)	African	South Asian (East Indian, other)	E/SE Asian (Chinese, other)	Central/ S. America	Caribbean	Canadian	
AVDHA	285	50	245	560	135	590	0	90	36,175	
CBDHA	250	45	1,140	530	315	365	10	335	47,330	
CDHA	2,169	795	6,118	6,833	3,442	6,031	105	1,610	149,157	
CEHHA	131	10	402	387	223	189	50	25	29,318	
CHA	15	0	170	200	70	90	0	20	14,580	
GASHA	60	0	170	275	95	130	0	30	18,170	
PCHA	95	0	150	265	75	195	0	85	17,800	
SSH	200	20	270	190	185	85	0	50	24,520	
SWH	125	10	190	585	180	220	0	70	31,865	
<b>Nova Scotia</b>	<b>3,330</b>	<b>930</b>	<b>8,855</b>	<b>9,825</b>	<b>4,720</b>	<b>7,895</b>	<b>135</b>	<b>2,355</b>	<b>368,915</b>	

Source: Statistics Canada (2006 Census) in Nova Scotia, Department of Finance, Nova Scotia Community Counts, [www.gov.ns.ca/finance/communitycounts](http://www.gov.ns.ca/finance/communitycounts) (accessed March 2008).

AVDHA: Annapolis Valley District Health Authority  
 CBDHA: Cape Breton District Health Authority  
 CDHA: Capital District Health Authority  
 CEHHA: Colchester East Hants Health Authority  
 CHA: Cumberland Health Authority  
 PCHA: Pictou County Health Authority  
 SSH: South Shore Health  
 SWH: South West Health

## Appendix 4: Disability Rate and Type of Disability

### Disability Rate and Population Size for Canada and Nova Scotia (2001)

Disability Rate (%)	Number of Persons with Disabilities		
	15 and over	15 and over	Total
Canada	14.6%	3,420,340	3,601,270
Nova Scotia	20.1%	146,000	152,210 (17.1%)

### Rates by Type of Disability in Nova Scotia (2001)

Disability	%	Total
Hearing	10.9%	49,290
Seeing	5.5%	24,860
Speech	3.2%	14,650
Mobility	23.4%	105,970
Agility	21.3%	96,580
Pain	22.8%	103,150
Learning	3.7%	16,700
Memory	3.3%	14,910
Developmental	0.6%	2,600
Psychological	4.5%	20,250
Unknown	0.9%	4,070

*Note: all data nearly 50/50 male/female.*

*Source: Nova Scotia, Disabled Persons Commission. Persons with Disability in Nova Scotia: A Statistical Report. 2004. [www.gov.ns.ca/disa/PDF-files/Statistical%20Manual%202004%20bc.pdf](http://www.gov.ns.ca/disa/PDF-files/Statistical%20Manual%202004%20bc.pdf) (accessed March 2008), pp. 6, 9.*

## Appendix 5: Biology, Physiology, Incidence, and Prevalence Among Select Groups

The table below summarizes literature on biology, physiology and disease incidence and prevalence for select groups. We did not assess the accuracy of these studies, nor the research methods used. Most are not based on cultural groups living within Canada and/or Nova Scotia. This information is provided only as a starting point for considering the topic of biomedical differences across cultural groups.

### Aboriginal/First Nations Populations

#### Cardiac and Vascular Health

- First Nations people are more likely to have high blood pressure and diabetes and, therefore, are at greater risk of heart disease and stroke than the general population.<sup>a1</sup>

#### Diabetes

- First Nations women are more insulin resistant than white women.<sup>a2</sup>

#### Lung Health

- Off-reserve Aboriginal people have a COPD rate of 7.9 per cent compared to the rate of 4.4 per cent in the general Canadian population.<sup>a3</sup>

#### Infectious Disease

- The general infection rate among Aboriginal people is about 2.8 times higher than among non-Aboriginal people.<sup>a4</sup>

#### General Health/Disease Risk

- BMI cut points for obesity in relation to the distribution of glucose, lipid-, and blood pressure-related risk factors for cardio-vascular disease are much lower for Aboriginal people than the conventional value used for Europeans.<sup>a5</sup>

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## African American/African Canadian

### Cardiac and Vascular Health

- African Americans have higher mortality rates from cardiovascular disease, coronary heart disease, stroke, hypertension, and diabetes when compared to overall mortality rates.<sup>b1</sup>
- Cardiovascular disease affects 44.6 per cent of African American men and 49 per cent of African American women (compared to rates of 37.2 per cent and 35 per cent among whites).<sup>b1</sup>
- Stroke incidence among African Americans is almost twice the rate among whites.<sup>b1, b2</sup>
- Hypertension affects 42.6 per cent and 46.6 per cent of African American men and women respectively (compared to rates of 32.5 per cent and 31.9 per cent among whites); the 2004 US mortality rate for deaths attributed to hypertension was 2.8 times greater among African American men and 2.3 times greater among African American women than the general population.<sup>b1</sup>
- African Americans have much higher rates of end-stage renal disease than do whites and Asians. Blacks represent 29 per cent of treated end-stage renal disease patients in the US<sup>b1</sup>
- African American women have the highest death rate from cardiovascular disease and have strokes almost twice as frequently as all other women, irrespective of age.<sup>b3</sup>

### Diabetes

- African Americans are twice as likely to be diagnosed with diabetes as whites. In addition, they are more likely to suffer complications from diabetes, such as end-stage renal disease and lower-extremity amputations.<sup>b1, b2, b4</sup>
- In 2004, African Americans were 2.2 times as likely as whites to die from diabetes.<sup>b2</sup>
- One in 4 Black women develop diabetes compared with 1 in 10 white women.<sup>b5</sup>
- Hemoglobin variants, such as sickle cell trait, more common in people of African American descent can affect the hemoglobin A1C test giving false high or low results.<sup>b6</sup>

### Lung Health

- African Americans have the highest asthma prevalence of any racial/ethnic group. The current asthma prevalence rate among this population was 36 per cent higher than that for whites.<sup>b7</sup>
- Twenty-five per cent of the deaths attributed to asthma in 2003 in the US were among African Americans.<sup>b8</sup>
- The prevalence rates of sarcoidosis among African Americans is one of the highest in the world and is 3 times that of whites.<sup>b9</sup>

### Infectious Disease

- Although African Americans make up only 13 per cent of the total US population, they accounted for 47 per cent of HIV/AIDS cases in 2005.<sup>b2</sup>
- In Ontario, people of African and Caribbean descent make up 4 per cent of the population but accounted for 20 per cent of AIDS diagnoses in 2001 and 2002.<sup>b10</sup>

## Cancer

- African American men are 1.6 times more likely to be diagnosed with and 2.4 times more likely to die from prostate cancer than white men.<sup>b11</sup>
- African American women have a lower incidence of breast cancer, however, they have a lower 5-year survival rate and are 1.4 times more likely to die from breast cancer, compared to white women.<sup>b11, b12</sup>
- The risk for less treatable, more deadly basal-type breast cancer was found to be 2.1 times greater in African Americans than others, with the highest prevalence of this cancer type being among pre-menopausal African American women.<sup>b13, b14</sup>
- African American women are twice as likely to have been diagnosed with stomach cancer, and 2.2 times as likely to die from stomach cancer, compared to white women.<sup>b11</sup>
- African Americans have higher incidence rates for most cancers and the highest mortality rate of any racial and ethnic group for all cancers combined.<sup>b2, b11</sup>

## Autoimmune Disease

- Systemic lupus erythematosus is 3 times more common in Black people than whites.<sup>b15</sup>
- African-Canadians had a higher prevalence of renal disease and damage in systemic lupus.<sup>b16</sup>
- One in 1,000 white women and 1 in 250 Black women in Canada have the disease.<sup>b17</sup>

## Blood Disorders

- Sickle cell disorders are one of the most prevalent genetic disorders in the United States, affecting 1 in 12 African Americans<sup>18</sup>
- In Canada, it has been estimated that over 2 million people are carriers of the sickle cell trait, and about 50,000 have sickle cell disease. There are a growing number of children who are affected by the disease, and it is believed that 80 per cent of couples are at risk of not being diagnosed.<sup>b17</sup>

## Bone Disorders

- African American women tend to have a higher bone density than white women but are still at significant risk for developing osteoporosis.<sup>b19</sup>
- Diseases common in this population such as sickle cell anemia and lupus can increase the risk of developing osteoporosis.<sup>b19</sup>
- As many as 75 per cent of African Americans are lactose intolerant, which can hinder calcium intake and increase risk of osteoporosis.<sup>b19</sup>

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## Asian Populations

### Cardiac and Vascular Health

- Overall, Asian American/Pacific Islander adults are less likely than white adults to have or die from heart disease.<sup>c1, c2</sup>
- Asian sub-populations have been noted to have variable disease rates; Filipino Americans have higher rates of hypertension than whites, and Cambodians have 4 times the rate of stroke as the white population.<sup>c3, c4</sup>
- Among Asians, 6.7 per cent have heart disease, 3.8 per cent have coronary heart disease, 19.4 per cent have hypertension, and 2.0 per cent have had a stroke.<sup>c5</sup>
- Kawasaki disease is most common among Americans of Asian descent.<sup>c6</sup>

### Diabetes

- Overall, Asian Americans/Pacific Islanders have lower prevalence of diabetes than the general population and are 20 per cent less likely than whites to die from diabetes.<sup>c1, c2</sup>
- Asian subgroups have been found to have variable rates of diabetes; one study found South Asian populations to be 7 times more likely to have diabetes than the general population; others found higher prevalence among Filipino Americans and Japanese Americans.<sup>c7–c10</sup>
- Cambodian and Filipino women have higher rates of gestational diabetes.<sup>c11, c12</sup>
- Hemoglobin variants are more common in people of Southeast Asian descent; these variants can affect the hemoglobin A1C test, giving false high or low result, and subsequently affect diabetes management.<sup>c13</sup>

### Lung Health

- Asians were significantly less likely to have been diagnosed with asthma than all racial/ethnic groups except Hispanics.<sup>c14</sup>
- Asians may have a genetic predisposition that lessens their risk of chronic obstructive pulmonary disease, regardless of their smoking habits.<sup>c15</sup>

### Infectious Disease

- Asian Americans/Pacific Islanders have lower AIDS rates than whites, and they are less likely to die from HIV/AIDS.<sup>c1</sup>
- Although Asian/Pacific Islanders have the lowest rates of AIDS diagnosis in the US, AIDS prevalence in this group has increased 54 per cent between 2001 and 2004, compared to a 21 per cent increase among African Americans and an 18 per cent increase among whites.<sup>c16</sup>
- Asians in the US have the highest tuberculosis (TB) case rates among all racial/ethnic groups and accounted for 23 per cent of all new TB cases in 2005.<sup>c17</sup>
- It is estimated that of the 1.4 million Americans who are chronically infected with Hepatitis B (HBV), over half are Asian American/Pacific Islanders, with chronic infection rates among Asian Americans standing at approximately 7 per cent. Infection rate among Vietnamese Americans is over 10 per cent, compared to the rate of less than 1 per cent for the general population.<sup>c18, c19</sup>

## Cancer

- South Asians experience higher rates of cancer in the US than in their native countries. The 2005 California Cancer Registry indicates that the 3 leading cancer sites for South Asian men are prostate, colorectal, and lung.<sup>c20, c21</sup>
- In 2003, Asian Americans/Pacific Islander men were 40 per cent less likely to have prostate cancer and women 30 per cent less likely to have breast cancer than white men and women.<sup>c1</sup>
- Asian American/Pacific Islander men and women have higher incidence and mortality rates for stomach and liver cancer.<sup>c1, c19–c25</sup>
- Asian American/Pacific Islander women have higher incidence of cervical cancer compared to white women; Vietnamese women have incidence rates 5 times those in the white population.<sup>c1, c20, c21, c26</sup>
- Filipino women born in the Philippines had 3.2 times the rate of thyroid cancer of US-born white women, while US-born Filipino women were not at any increased risk than white women; Filipino men born in the Philippines had 2.6 times the rate of thyroid cancer of US-born white men, while US-born Filipino men had 1.5 times the risk of white men.<sup>c27, c28</sup>
- Studies have found that South Asian immigrants are also at high risk for oral cancer due to high rates of chewing paan (tobacco) and sucking/chewing areca (a nut common in South Asia), in conjunction with religious/cultural practices associated with oral cancer.<sup>c29, c30</sup>

## Bone Disorders

- Asian American women are at high risk for developing osteoporosis.
- Up to 90 per cent of Asian Americans are lactose intolerant, which could affect their daily calcium intake and place them at higher risk of developing osteoporosis.<sup>c31</sup>
- Foreign born Chinese women have lower bone density than white women or American-born Asian women and are at higher risk for developing osteoporosis.<sup>c32</sup>

## General Health/Disease Risk

- South Asian, Chinese, and Filipino individuals were found to have increased amounts of abdominal adipose tissue at a given body weight when compared with Canadians of European descent; this supports the benefit of using ethnic specific anthropometric targets.<sup>c33, c34</sup>
- Cut points for obesity (BMI) in relation to the distribution of glucose, lipid, and blood pressure–related risk factors for cardiovascular disease are much lower for South Asians and Chinese than the conventional value used for Europeans.<sup>c35</sup>

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## Hispanic and Latino Populations

### Cardiac and Vascular Health

- US data show there is a lower prevalence and mortality rate related to cardiovascular disease among Hispanic men and women, as compared to white men and women.<sup>d1, d2</sup>
- 2004 U.S. data show that Hispanic men had a 14 per cent lower mortality rate and Hispanic women a 30 per cent lower mortality rate from stroke than white men and women.<sup>d1</sup>

### Diabetes

- Mexican American adults were 2 times more likely than white adults to be diagnosed with diabetes.<sup>d1</sup>
- 2002 US data show Hispanics were 1.5 times as likely to start treatment for end-stage renal disease related to diabetes, as compared to white men and women.<sup>d1</sup>
- Hispanics are more likely to have diabetes and in 2004 were 1.5 times more likely than whites to die from diabetes in the US<sup>d1, d2</sup>

### Lung Health

- Among Hispanic subgroups, Puerto Ricans, and Mexicans are more likely than other Hispanic subgroups to report sarcoidosis.<sup>d3</sup>
- Hispanics have lower rates of asthma than both African American populations and whites.<sup>d4</sup>

### Infectious Disease

- The TB case rate in Hispanics was about 7 times higher than in whites in 2005 in the US<sup>d5</sup>
- Hispanics accounted for 18 per cent of the HIV/AIDS cases in 2005.<sup>d1</sup>
- Hispanic males had over 3 times the rate of reported AIDS cases than white males and were 2.6 times as likely to die from HIV/AIDS in 2004.<sup>d1</sup>
- Hispanic females had over 5 times the rate of reported AIDS cases than white females and were 4 times as likely to die from HIV/AIDS.<sup>d1</sup>

### Cancer

- Overall, Hispanics have lower incidence and mortality rates for all cancers combined, as compared to whites.<sup>d6</sup>
- Hispanic men and women have lower incidence rates for prostate cancer and breast cancer than white men and women, but these sites remain the top cancers in this population, followed by colon and lung.<sup>d6</sup>
- Hispanic men and women have higher incidence and mortality rates for cancers of the stomach, liver, and gallbladder.<sup>d6</sup>
- The incidence and mortality rate of cervical cancer among Hispanic women is almost double that of white women.<sup>d6</sup>
- Breast cancer has been found to present differently in Hispanic women, with diagnosis at younger age, at a later stage of disease, with larger and higher-grade tumours, and with less treatable estrogen and progesterone negative tumours.<sup>d7</sup>

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## Immigrant and Refugee Populations

### Infectious Disease

- Immigrants are at greater risk of tuberculosis than those born in Canada, because of greater likelihood of exposure in their countries of origin.<sup>e1</sup>
- 64 per cent of new and relapsed cases of TB in Canada between 2000 and 2004 were among foreign-born Canadians.<sup>e2, e3</sup>
- Refugees arriving in Canada have a relatively high incidence of hepatitis B infection.<sup>e4</sup>
- The estimated HIV infection rate among individuals from HIV-endemic countries living in Canada is at least 12.6 times higher than among other Canadians.<sup>e5</sup>

### Mental Health

- Depression, post-traumatic stress disorder, and difficulty adapting to the new culture are common among refugees.<sup>e4</sup>
- Overall, immigrants were found to have lower incidence of depression and alcohol dependence than Canadian-born populations.<sup>e6</sup>

### General Health/Disease Risk

- Newly arrived immigrants tend to be in better overall health than the general population.<sup>e7-e9</sup>
- Overall, immigrants—especially those from non-European countries—have a longer life expectancy and more years of life free from disability and dependency compared to the Canadian-born population.<sup>e10</sup>
- The prevalence of chronic illness increases in the immigrant population with increase in years since immigration.<sup>e11</sup>
- The health status of refugees is poorer than that of immigrants in general because of their experiences prior to arrival in Canada and the less-stringent selection process.<sup>e12</sup>
- Refugees have higher incidence and mortality rates for cardiovascular, infectious, and respiratory diseases and cancer than other immigrants.<sup>e13</sup>

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## Middle Eastern Areas

### Diabetes

- Metabolic syndrome (a combination of medical disorders that increases the risk of developing cardiovascular disease and diabetes) is common among Arab Americans and is related to modifiable risk factors.<sup>f1</sup>
- The prevalence of diabetes and glucose intolerance is extremely high among adult Arab Americans in Michigan.<sup>f2</sup>

### Blood Disorders

- In contrast to Northern American populations, and similar to some Mediterranean populations, Lebanese people with sickle cell disorders have a higher prevalence of persistent splenomegaly.<sup>f3</sup>

### Genetic Disorders

- Glucose-6-phosphate dehydrogenase deficiency most commonly affects people of African, Asian, Mediterranean, or Middle-Eastern descent. G6PD deficiency causes a spectrum of diseases including neonatal hyperbilirubinemia, acute hemolysis, and chronic hemolysis; people with this condition also may be asymptomatic.<sup>f4</sup>
- G6PD deficiency is a common genetic problem in Lebanon.<sup>f5</sup>

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## Sexual Orientation

### Gay men

- Depression and anxiety appear to affect gay men at a higher rate than in the general population. The likelihood of depression or anxiety may be greater and the problem may be more severe for men who remain in the closet or who do not have adequate social supports. Adolescents and young adults may be at particularly high risk of suicide because of these concerns.
- Gay men use substances at a higher rate than the general population.
- Gay men are much more likely to experience an eating disorder such as bulimia or anorexia nervosa. Overweight and obesity are problems that also affect a large subset of the gay community. This can cause a number of health problems, including diabetes, high blood pressure, and heart disease.
- Men who have sex with men are at an increased risk of sexually transmitted infection with the viruses that cause hepatitis.
- Sexually transmitted diseases (STDs) occur in sexually active gay men at a high rate. Of all the sexually transmitted infections gay men are at risk for, human papilloma virus—which causes anal and genital warts—may play a role in the increased rates of anal cancers in gay men.
- Gay men may be at risk for death by prostate, testicular, or colon cancer.
- It is still thought that gay men have higher rates of alcohol dependence and abuse than straight men.
- Recent studies support the notion that gay men use tobacco at much higher rates than straight men, reaching nearly 50 per cent in several studies. Tobacco-related health problems include lung disease and lung cancer, heart disease, high blood pressure, and a whole host of other serious problems.

### Lesbians

- Lesbians have the greatest concentration of risk factors for breast cancer than any subset of women in the world, and many do not have routine mammograms or do self-exams.
- Lesbians have been shown to experience chronic stress from homophobic discrimination. This stress is compounded by the need that some still have to hide their orientation from family and colleagues at work.
- Lesbians have higher risks for many of the gynecologic cancers.
- Research confirms that lesbians have higher body mass than heterosexual women. Obesity is associated with higher rates of heart disease, cancers, and premature death.
- Alcohol use and abuse may be higher among lesbians.
- Research indicates that lesbians may use illicit drugs more often than heterosexual women. This may be due to added stressors in lesbian lives from discrimination.
- Although domestic violence occurs at perhaps half the rate of that reported by heterosexual women, there may be no lesbian-friendly shelters and support services available.

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## Gender Identity

### Transgender people

- Transgender people are often reluctant to seek medical care through a traditional provider-patient relationship. Some are even turned away by providers.
- Trans people may hide important details of their health history from their doctors.
- Cross-gender hormone therapy gives desired feminizing or masculinizing effects, but carries risks that include blood clotting, high blood pressure, elevated blood sugar, water retention, liver damage, dehydration, and so on.
- Trans people may be at increased risk for heart attack or stroke, not only from hormone use but from cigarette smoking, obesity, hypertension, and failure to monitor cardiovascular risks.
- Trans people, especially youth, may be rejected by their families and find themselves homeless. They may be forced into sex work to make a living, and therefore be at high risk for STDs including HIV.
- Alcohol abuse is common in transgender people who experience family and social rejection and the depression that accompanies such rejection.
- For many reasons, trans people are particularly prone to depression and anxiety.
- Some trans women use injectable silicon unsafely, which increases risk of disfigurement and/or hepatitis.
- Many trans people are sedentary and overweight. This may be because they are working extra hours to support their transitions.

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**The development of cultural competence can work to reduce disparities in health status and health services. It can support the increased detection of population-specific diseases and conditions. It can also improve equitable access to primary health care and respectfully respond to the diversity of Nova Scotians.**



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