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Chapter Title: Culture and Allied Health Professions Service Delivery

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Introduction

There is yet another wind of culture change. I write this in August 2020, looking out my window there is a summer thunderstorm after a 37^0C heatwave. What a year it has been, the year of COVID19, the murder of George Floyd in America March 2020, the re-emphasis of the Black Lives Matter movement, the professional organisations globally sending out lukewarm statements of solidarity and their stance against racism. My own struggles with my professional body the Royal College of Occupational Therapists, with regards to encouraging them to change, by firstly looking inward towards their colonial stance and institutional racism, before even considering any meaningful change actions. Also, at this time Health and Care Professions Council (HCPC) is reviewing its equality, diversity and inclusion content in its standards of proficiency (SOP). Yes, the situation is real, the struggle continues for Black Asian and Minority Ethnicity (BAME) individuals, groups and communities. So, yeah, this is a necessary chapter for all allied health professions (AHPs), and any health and social care practitioner. The focus of the chapter is on culture of service users/patients and service delivery.

In this chapter I will discuss the topic through answering a series of questions, in relation to: the meaning of culture, culture and AHP service delivery, brief discussion of legislation and policy, the regulator of the AHP the HCPC; a case study with critical questions to consolidate learning from the chapter; and include a checklist of questions to promote and deliver equality, diversity, equity and anti-racist culture in AHP service delivery.

What is culture?

There is no definitive description of culture, because it is subjectively formed from multiple factors, and hence open to interpretation, resulting in different outcomes of

behaviours and practices of groups and individuals. These multiple factors include: “ethnicity, religions, faith, beliefs, [values], taboos, diet, language, history” (Bartoli 2013, p.48), “origins, physical appearance, family structure, politics, art, music, literature, attitudes towards body, gender roles, clothing and education” (Storkey 1991, cited in Thompson 1993, p.58), and more. Culture is a construct of shared values, beliefs, rules and laws at: i) macro level – wider society, e.g. government and laws, ii) meso level –local community, such as groups people join or belong to, e.g. in school or workplaces, and iii) micro level – family and friendships groups (Bonder and Martin 2013, Tufano and Cole 2007). There are dynamic interrelationships between the levels, essentially, culture is a factor of influence for your behaviour, attitudes, decision making and life journey (Bonder and Martin 2013). Hence, a catch all definition of culture is hard to pin down.

For me, as an individual, a cis gender woman of Bangladeshi ethnicity in an euro-western country, currently where I am in my life, culture is defined by the humanitarian rules of conduct identified by my ethnic and local community, my work and work ethic, religion, my religious and national festivities, my biracial intersectional family, being bilingual, my ethnic language and the food. This is dynamically influenced by, and influencing my viewpoint of the world and how I engage with it, and my thoughts, behaviours and actions.

Hall (1976) identified that for individuals there are parts of their culture that are visible to the world and parts of their culture that are hidden (see Figure 1). Hall likened an individual’s cultural context to an iceberg. What you see of the iceberg, that which is visible above the water is only 10-15% of the whole ice boulder, the largest part of the iceberg is hidden under water. What you see ‘above the water’ is a manifestation of the outcomes from the influences of culture ‘under the water’. Sandercock (2000) said, cultural diversity is organised under broad categories of dimension such as: race, class, gender, education, finances/wealth, and more.

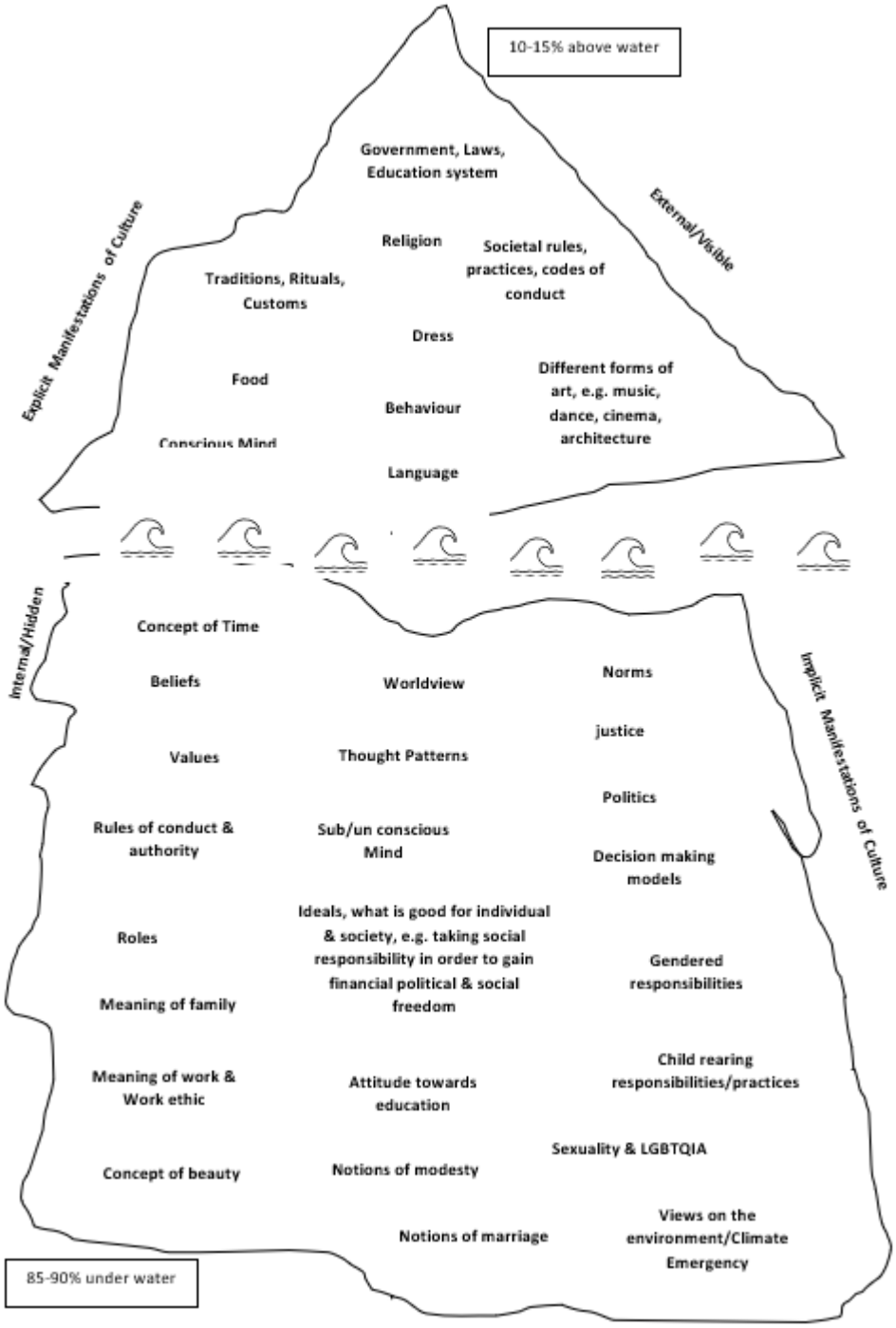

Figure 1: An illustration of Hall's iceberg analogy regards culture (the content is not exhaustive)

Why do you need to know about culture as allied health professionals?

A core tenet of health and social care is that effective public service delivery is built around person-centred care (Care & Support Planning Working Group and Coalition for Collaborative Care 2016). The principles of person-centred care are defined as:

“1. Affording people dignity, compassion and respect;
2. Offering coordinated care, support or treatment;
3. Offering personalised care, support or treatment;
4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life”.

(The Health Foundation 2017, p:7)

Hence to fully implement the principles of person-centred care, individualising the treatment/care, a person’s culture must be considered. Understanding the person’s culture enables you to collaborate with services users/patients to individualise the service, to adjust the treatment or care pathway, to enable fair, just and equitable access and opportunities. Gaining insight into and adjusting services and individualising treatment/care pathways to a person’s culture, or cultural needs, will only aid in effective and efficient service delivery (Care & Support Planning Working Group and Coalition for Collaborative Care 2016). For example, it has potential in reducing DNAs, and reduce delays in discharge through improving engagement in collaborating in treatment/care pathways and discharge planning, which could lead to cost savings.

What is the outcome if culture is not incorporated into health and social care service. practice and delivery?

The importance of cultural contexts is evidenced in research, articles and reports repeatedly. For example:

Anekwe, L., (2020), Ethnic disparities in maternal care – Between 2014-2016, deaths per 100000 women in pregnancy in the UK were recorded as 8 for white women, 15 for Asian women and 40 for Black women. The data indicates that there appears to be an institutionally racial bias in the deaths of women in pregnancy in the UK.

Bray et al., (2018), Socioeconomic disparities in first stroke incidence, quality of care, and survival: a nationwide registry-based cohort study of 44 million adults in England - Patients from the lowest socioeconomic groups had their first stroke 7 years earlier and had a 26% higher rate of death 1 years post stroke. This indicates that there are socioeconomic determinants that influence outcomes in stroke. The race disparity

audit (cabinet office 2017) identified that BAME populations were more likely to be in persistent poverty compared to the white ethnic backgrounds.

Care Quality Commission, (2019), New research for the Care Quality Commission shows racial disparity in people raising concerns about their care - People from Black Asian and Minority Ethnic (BAME) backgrounds are less likely to complain about their standard of care received compared to individuals not from BAME backgrounds. This indicates that there are structural or institutionally systemic barriers preventing BAME populations speaking out about poor health and social care service experiences.

Goyal et al., (2015), Racial Disparities in Pain Management of Children With Appendicitis in Emergency Departments - Racial disparities in analgesia administration exist for Black children, suggesting a different threshold for treatment. This is an example of a consequence of institutional racism in healthcare.

Public Health England, (2020), Disparities in the risk and outcomes of Covid 19 - Regarding the Covid 19 virus, it identified that people from Black Asian and Minority Ethnicity (BAME) backgrounds were between 10% and 50% likely to die from the virus. This indicates that there are systemic issues in healthcare institutions and continuing influence of social determinants in mortality outcomes.

Public Health England, (2017), Public Health Outcomes Framework: Health Equity Report Focus on ethnicity – Health inequalities continue to exist, and there has been little improvements, wide inequalities in health by ethnicity and by country of birth. Where there is improvement there is indication that the wider determinants of health are mixed. This again indicates that there are ongoing unchanged systemic issues in healthcare institutions and social determinants continuing to influence health outcomes and service experiences of the public from ethnic backgrounds.

Salway et al., (2016), Obstacles to "race equality" in the English National Health Service: Insights from the healthcare commissioning arena - Inequitable healthcare access, experiences and outcomes continue across ethnic groups, with limited progress in England given the apparent strength of legal and policy framework.

Another example of institutional racism and the services not tailoring their delivery for people from different cultures.

There is a repeating theme in the articles, in that services are not adequately and justly organising themselves to meet the needs of the individuals from different cultures and ethnicities. This is the continuing inequity of health and social care service delivery and accessibility for individuals from BAME backgrounds, with real consequences, e.g. shortening life expectancy or, inadequate care, continuing the suffering with the persistence of their condition. The reasons for this inequity in health and social care are complex, and due to the existing inequalities and inequity already experienced by BAME populations (Public Health England 2020).

If this makes you feel uncomfortable, then you are reading this through a critical lens and understanding the real fact that some parts of the population in the UK are being disadvantaged due to their ethnicity, and or being from different cultural backgrounds from the majority population. Hence you, as a qualified allied health professional to be, or you are currently one, you have potential to be an agent of change, to collaborate with service users//patients, and join with others, to chip away strategically to create meaningful and sustainable change. That is delivering effectively culturally responsive services designed for the local ethnic populations, to deliver equitable provision of health and social care. That is the socially just thing to do.

What are the legal and policy frameworks to support and enable cultural responsiveness in health and social care service delivery?

i) Acts of Law

The Equality Act 2010 was activated October 2010, it absorbed 116 separate pieces of legislation.

The nine main acts that have been merged are:

- “the Equal Pay Act 1970
- the Sex Discrimination Act 1975
- the Race Relations Act 1976
- the Disability Discrimination Act 1995

- the Employment Equality (Religion or Belief) Regulations 2003
- the Employment Equality (Sexual Orientation) Regulations 2003
- the Employment Equality (Age) Regulations 2006
- the Equality Act 2006, Part 2
- the Equality Act (Sexual Orientation) Regulations 2007”

(Equality and Human Rights Commission 2019).

The purpose of the Equality Act 2010 is to prohibit unlawful, direct discrimination, indirect discrimination, harassment or victimisation in relation to nine protected characteristics, two of which are related to culture:

- “race including colour, nationality, ethnic or national origin
- religion or belief”

(GOV.UK 2015).

The Equality Act applies to everyone who provides a service to the public (Social Care Institute for Excellence 2011).

The recognition of health and social care services to employ the Equality Act 2010 was enforced through the Health and Social Care Act 2012 and the Social Value Act 2012 (GOV.UK 2015, 2016). They introduce legal duties about health inequalities, and to consider economic, social, and environmental wellbeing when commissioning services or contracts. Additionally, there is requirement that local authorities engage in public health. Specific duties for health bodies are assigned, including that the Department of Health, Public Health England, Clinical Commissioning Groups, and NHS England require organisations to make decisions in reducing health inequalities when delivering services (GOV.UK 2015, 2016).

Following these Acts of law, the Care Act 2014 came into play. This law stated that local authorities had to demonstrate that their care pathways are co-produced with service users, and or their carers, from assessment to treatment/goal plans, and reviews/evaluations (Local Government Association 2020). Additionally, local authorities have to play a clear part in prevention of deterioration or developing of care needs for individuals, be involved in the maintenance of function for people with long term illness, and prevent delays in the public receiving the required services (Department of Health and Social Care 2016).

ii) Equality Diversity and Inclusion policy for service delivery

Equality diversity and inclusion (EDI) is embedded in the person-centred service delivery principles, and commitment from health and social care under the existing acts. Equality is about all the service users/patients having the same access and provision from services, diversity means that individuals are different hence will have different requirements from services, and inclusion is about the aspect of co-production of treatment/care pathways. These descriptions are representative of the 4 principles of person-centred care as denoted by The Health Foundation (2016). These concepts are imperative to embed in health and social care because they show authenticity of actions by staff to deliver services that are service user/patient focussed to meet the service user/patient needs, in the way they want it, so that they are empowered to engage in their treatment/care pathway in context of their cultural background.

That is why equality diversity and inclusion have to be part of the policy and practices of the premises of contemporary health and social care. As, then it is genuinely demonstrating that staff are meaningfully actioning service delivery that is culturally responsive, inclusive and anti-discriminatory (Tilmouth and Quallington, 2012).

So, laws and policy exist to enable enforcement of integrating cultural context, to individualise treatment, and service delivery, as part of person-centred care. Yet, we continue to see inequity of provision and outcomes for people of ethnic cultures in contemporary practice. Equity is the way forward for AHP practice/service delivery. This is because person-centred care is about individualisation of health and social care, and that does not mean the same for all. It is, after all, about effective service delivery by adapting treatment/care to meet the different needs of the individuals in the diverse populations. Equity is the answer (see Figure 2 for an illustration of equity).

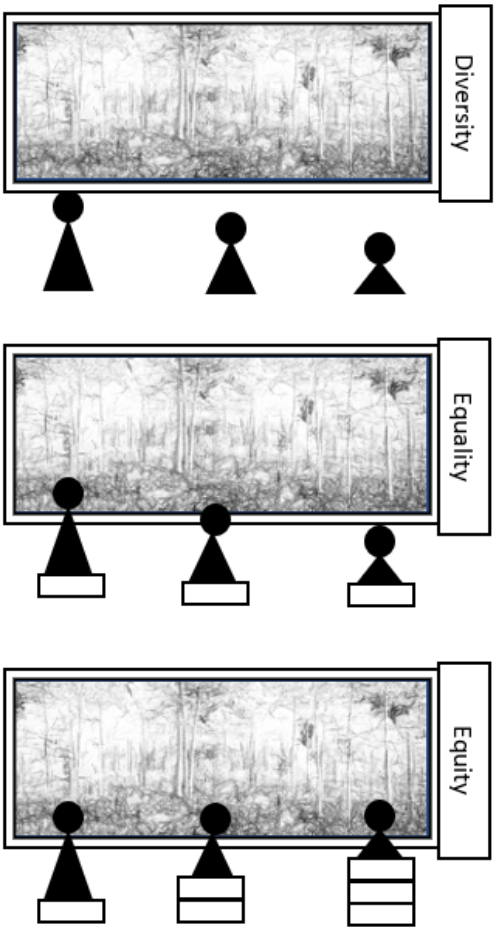

Figure 2: An illustration to demonstrate an act of equity

Why is the Health and Care Professions Council making changes to the standards of proficiency?

The Health and Care Professions Council (HCPC) regulate fifteen health and care professions in the UK, buy setting the standards for education training and practice (HCPC 2018a). In August 2020, the HCPC (HCPC 2020) sent a consultation statement out to paying registrants, regarding changes to generic and profession specific standards of proficiency (SOP). Like all public sector or related organisations, this was in response to the issues raised regarding race and health inequalities, with the resurgence of the Black Lives Matter movement; and the Public Health England (2020) report, on how the COVID19 virus has unequally killed a higher percentage of individuals from BAME populations from the public and health and care staff. The SOPs, for each registrant profession, are the minimum thresholds of practice for individuals to meet and maintain, to deliver practice that is

safe, equal, and inclusive to service users/patients, whilst maintaining their dignity (HCPC 2018b). HCPC want registrants to feedback as to whether the generic standards make it clear that registrants must ensure their practice is equal, fair, and inclusive in their approach to all service users. Also, HCPC asked registrants to review the profession specific standards to check its precision and clarity. Standard 5. and 6. are related to EDI in the generic SOP, and hence related to culture.

Standard 5.- be aware of the impact of culture, equality, and diversity on practice.

Standard 6. - be able to practise in a non-discriminatory manner.

Evaluating these standards' statements, I am reminded of Walker's (1994) Valuing Difference Model. This model is based on 4 key principles:

"1. People work best when they feel valued.
2. People feel most valued when they believe that their individual and group difference have been taken into account.
3. The ability to learn from people regarded as different is key to becoming fully empowered.
4. When people feel valued and empowered, they are able to build relationships in which they work together interdependently and synergistically"

(Walker 1994, p:212).

Walker's model enables people to note and address beliefs and assumptions about others and their individual and group differences. So that staff can use the principles to build a process for action. These principles can also relate to AHPs delivering services through person-centred care. In essence, Walker's model relates to the concept of personalised treatment/care, in that the professional has to demonstrate to the service users/patients that they are valued as an individual. That by valuing the person, the professional will act to respectfully integrate the cultural needs and adapt the treatment/care pathway. Thus, enabling the person to autonomously engage collaboratively, and therefore making the service effective for the individual. If we evaluate HCPC standards of proficiency 5 and 6 through the lens of Walker's model, certain questions arise. By using the term 'be aware' in standard 5, it is removing the responsibility to take action. Standard 5 is suggesting that overall, the professional just has to be cognisant, but has no responsibility to take action. Yet

personalisation of services that is responsive to cultural needs is not just a thinking activity but a demonstration of the real pragmatic adaptation of the service. Interestingly, out of the 15 main standards, this is the only one that has this term about awareness of concepts attached to a standard's statement. The other standards use the terms 'able to [an action]' or 'understand to [do something]', that is taking a stance of actively doing. Standard 6 uses the term 'non-discriminatory manner'. The United Nations (no date) describes the term non-discrimination as absence of discrimination, again this appears to be a passive stance. There needs to be the addition of 'and deliver anti-discriminatory service/practice' to the end of standard 6. The Equality Act 2010 refers to 'antidiscrimination' and uses the term 'discriminated against' (GOV.UK 2015), because it is taking a position of actively protecting against and 'calling out' any forms of discrimination.

So, the HCPC is attempting to revise and update its requirement for registrants to show that they are meeting and maintaining minimum standards regarding knowledge, understanding and ability regarding culture, equality, diversity, and inclusion. However, it needs to be consistent in its messaging and positioning in that it wants its registrants to be able to demonstrate actively meeting and delivering the SOPs.

I am going to give feedback to HCPC on my thoughts about these standards through their consultancy feedback portal, and I hope a large momentum of other registrants do too.

What are race and health inequalities, and social determinants?

Race, culture and ethnicity, are all separate constructs, race and ethnicity are not replacement terms for culture, and like culture, race and ethnicity are not easy to define (Bonder and Martin 2013). Race denotes groups of individuals with physical attributes, such as skin tone/pigment or facial features (Delgado and Stefancic 2017). Ethnicity relates to country of origin, not always equating to the country one calls home (Bonder and Martin 2013).

Let's talk about institutional racism because this is at the core of race and health inequalities in health and social care. Macpherson (1999) described institutional racism as: "*the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance thoughtlessness and racist stereotyping which disadvantage minority ethnic people*" (paragraph 6.34). The term institutional racism has been around since the 60s, where it represented a collective organisational failure that allowed continuing of anti-Black attitudes and practices to limit the quality of life, life opportunities and life expectancies of Black people (Macpherson 1999).

If inequality is a disruption to dynamic equilibrium, then race inequality is an imbalance of power, outcomes of social determinants, economic resources and opportunities in favour of the majority white ethnic populations, over ethnic minority groups. There have been approximately 60 reviews, maybe more, regarding race inequalities over the last 40 years in the UK. Following decades of legislation, the government launched the Race Disparity Audit Report 2016, which found significant racial injustices in all areas of public life: health, education, employment, housing and the criminal justice system (Cabinet Office, 2017). For example, in the UK, BAME groups were the most likely to be living in "persistent poverty" (Cabinet Office, 2017, p:9). The audit also found that whilst "1 in 25 White British people were unemployed, rates increased to around 1 in 10 for those of a Black, Pakistani, Bangladeshi or Mixed background. Black men were almost three and a half times more likely to be arrested than White men" (Cabinet Office, 2017, p:11). These, name just a few of the many injustices raised in the report regarding race inequality. This illustrates the outcomes of institutional racism, as policies, premises and practices are enabling these injustices to occur. So, even prior to the race disparities in healthcare due to COVID19, raised in the Public Health England (2020) report, there were existing societal hurdles for BAME populations.

So, health inequalities, which are avoidable and correctable, are policies, premises and practises that are enabling the systematic differences of health status. For example:

- “life expectancy and prevalence of health conditions
- access to care, for example, availability of treatments
- quality and experience of care, for example, levels of patient satisfaction
- behavioural risks to health, for example, smoking rates
- wider determinants of health [also known as social determinants of health], for example, quality of housing”

(Williams, Buck, Babalola 2020).

The differences in treatment and care received, by different groups in the population, will impact on their opportunities to lead healthy lives. The King’s Fund identify that the differences are evaluated against four factors: socioeconomic, “quality and experience of care”, protected characteristics and marginalised groups (Williams, Buck, Babalola 2020). There can be a myriad of different combinations of these factors resulting in unique health inequalities experienced by individuals. In this chapter, the section “What is the outcome if culture is not incorporated into health and social care service practice and delivery?”, has already exampled literature demonstrating some outcomes from health inequalities, please refer to them again. One of the striking outcomes of the Public Health England (2020, p:39) Report, is that, “after accounting for the effect of sex, age, deprivation and region; it still showed that people of Bangladeshi ethnicity had about twice the risk of death when compared to people of White British ethnicities”. This both demonstrates the complexity and interplay of race inequality and health inequalities, resulting in potentially lethal outcomes for a population and an outcome of institutional racism. This should not be happening in a contemporary first world country with the fifth richest economy.

One of the identified health status differences in health inequalities is the unequal distribution of social determinants of health (The Health Foundation 2017). There is consensus that the social determinants of health are the conditional factors for healthy life, for individuals and groups, and health inequalities are a result of disparities across these factors (Marmot et al. 2020). The broad categories for the social determinants for health are: social, economic and environmental (Marmot et al. 2020, Williams, Buck, Babalola 2020). In general, the social determinants of health are: having employment, able to purchase or access nutritious food, having money and resources, access to housing, surroundings being healthy and accessible (includes green space),

access to education and skills, having access to family, friends and communities, and accessible transport (The Health Foundation 2017). Marmot et al. (2020) strongly advocate that a well-funded health and social care service doesn't just deliver and maintain the healthy lives of individuals and groups, it is also transactional and dynamically interrelated to the social determinants of health. That is, the conditions of our birth, the place we live, grow, work and age into our golden years, and health inequity arises when there is an imbalance of sharing and distribution of power, money and resources (Marmot et al. 2020).

Hence, when a society is built on and sustains race and health inequalities, the health of the nation cannot flourish, and this will affect the country's societal stability, and economic wealth and advancement (Marmot et al. 2020). A government and society that is willing to look after its population, backed up with infrastructure and resources, will reduce institutional racism effects and will always be in profit.

How do AHPs improve their ability to attend to cultural aspects of person-centred care? A checklist to take action to change

Hall (1976) said to understand beliefs, values and thought patterns of others, is to actively participate in other's cultures. So that, what is hidden beneath the surface of the iceberg of culture starts to become visible or known. As students and qualified practitioners, you are unable to readily take a long-term action to immerse yourselves in the culture of interest to get a better understanding and experience of the hidden aspects of culture, to then improve practice. So, what can you do that will be effective for service user/patient populations from a diversity of cultures?

The checklist of actions enables you to:

-Be equity focused to ensure you are meeting the requirements of the Acts of law regarding anti-discriminatory and antiracist practice with service delivery

-Be equality and equity focussed, and consciously mindful about cultural diversity and needs, means you will be less likely to be discriminatory or exclusionary, and be adaptable when caring for or treating individuals

-Recognise the importance to engage as part of social justice and effective working relations with service users/patients

-Recognise diversity and cultural inclusivity as part of AHP service delivery as normative.

i) Improving self

ia) Reflect, review and identify, what you proactively do currently, that includes adapting your practice to different cultural backgrounds of service users/patients. List what are the positive outcomes for the service users/patients, you and the service

ib) Reflect, review and identify, what you need to do more and why, or what is missing and list currently how that affects the service users/patients, you and the service

ic) Remember don't expect service users/patients from diverse communities to adapt to you if you want effective working relationships

id) Check if you are able to identify the cultural requirements of service users/patients when they come to seek your service

ie) Reflect, review and identify, what topics would you like to read in relation to culture and AHP, your specialism and service delivery. Make a list.

if) Write a personal development plan of SMART actions to develop, and change your practice in terms of cultural inclusivity, that are monitored and reviewed annually.

ii) Your service

iia) Reflect, review and identify, with your team what are the local policies and practices that supports person-centred care that explicitly enables adapting your practice to different cultural backgrounds of service users/patients. List what are the positive outcomes for the service users/patients and the service

iib) Reflect, review and identify, what the service is not doing or not doing well, or what is missing, and why. List currently how that affects the service users/patients, and the service

iic) Reflect, review and identify, what to do as a team to change the service to meet and adapt to the diverse needs of service user/patient population. Make a list.

iid) Write a timeframe plan of SMART actions to strategically develop, and change the service in terms of cultural inclusivity, that are monitored and reviewed annually.

iii) Your organisation

iiia) Reflect, review and identify, as to whether the mission statement of the organisation is explicit about cultural inclusivity and person-centred care
iiib) Reflect, review and identify, what data is collected in terms of race equality and health equalities
iiic) Reflect, review and identify, if there are action plans for antidiscrimination and antiracism and the monitoring frameworks and measuring outcomes.

iv) Training
Terms such as cultural competence, cultural intelligence and cultural sensitivity all indicate that it will lead to improved understanding. Each offer different ways to improve individuals and groups, in relation to cultural knowledge and understanding to deliver anti-oppressive, anti-discriminatory and antiracist services.
iva) Be clear of the difference and your rationale for your choice and how it relates to your personal development plan
ivb) Be prepared for the training, be ready to be open, be ready to be challenged about your assumptions, beliefs, and values
ivc) Be ready to change yourself, your practice and the service, and identify how you intend to measure change in relation to yourself and your service.

A case study – reflect, review and critically think
Inci Bayrak (pronounced injee), is 67 years old, of Turkish origin. She is a widow and lives with her eldest son, his wife and their two children.
She arrived for her first appointment in the physiotherapy department. Referred by the rheumatology consultant, due to growing mobility problems and frequent falls.

As the physiotherapist approached, he heard Ms Bayrak and her son speaking their ethnic language. He greeted them both and asked the son if his mother spoke English. Ms Bayrak answered that she speaks English very well.

After the initial assessment paperwork was completed, the physiotherapist asked if Ms Bayrak had brought some shorts and a sports top to change into. She had but said she did not feel comfortable with the male physiotherapist, and her son being present, seeing her in shorts and a sports top.

There wasn't a female physiotherapist available to take over, so the appointment ended early. Ms Bayrak was advised to make another appointment, and make sure that she asks for a female therapist and makes clear that she does not need a translator.

Critical questions

-What are your initial thoughts after reading the case story and why?

-Did any aspects of your initial reflection of the case relate to culture, ethnicity, equality, equal opportunity, fair access, racism, discrimination, intersectionality, civility, and professionalism?

-Is it Inci Bayrak's job to be preparing the physio team and service to be ready for her? Provide reasoning for your answer

-Are there any laws or policies that come to mind for this case story and why?

-How would you have approached this case scenario differently and why?

-What changes need to be made to the physiotherapy service to be effective in delivering a culturally responsive service?

Overall conclusion

While writing this chapter around culture, all the way through I am reminded of a word from the African continent, the word 'UBUNTU', a Zulu Nguni Bantu word, which means 'humanity', more commonly translated as 'I am because we are'. Or in Xhosa, 'umntu ngumntu ngabantu', translated as 'humanity towards others'. Meaning government, institutions and society should vitally work collectively. To deliver polices, develop infrastructures and make resources available, to enable premises and practices to be equitable and work for social justice for the betterment of individuals and groups.

(word count 2057)

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