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Paramedic education and training on cultural diversity: conventions underpinning practice

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Abstract

Clinical skills form the basis of paramedic education and training, but the broader cultural context presents an even greater challenge to the quality of paramedic and health professional practice. Since the United Nations adopted the *Universal Declaration of Human Rights* in 1948, the development of initiatives at international, national, state and professional levels have progressively responded to the growing demand for culturally responsive health care within the rising cultural milieu.

In the paramedic context, these initiatives provide strong support for paramedics to take action and champion this advance in an increasingly multicultural society. Wide-ranging initiatives represent a hierarchy of knowledge which not only underpin the importance of teaching cultural diversity in paramedic education, but offer a sound rationale for advancing culturally responsive care to incorporate 'best practice principles' in paramedic practice. More importantly, acceptance of these initiatives pays heed to and respects culturally diverse patients.

The lack of a readily accessible single compendium in the area of culturally responsive health care in paramedic education or practice validates the need for this paper, which extracts information from relevant and significant declarations, conventions and guidelines at international, national and state levels and thus, serves as a resource for paramedics and other health professionals. The objectives of this compendium are to present the range of initiatives which underpin cultural diversity education and practice for paramedics, and to highlight the need of an awareness of these for all health professionals.

Keywords

cultural diversity; education; emergency health; health professional education; paramedic education and training

Introduction

As members of a multi-disciplinary research team, the authors are currently investigating the research question, 'Do cultural factors influence optimal paramedic care in out-of-hospital acute health events?'

The lead author developed and taught a program to undergraduate paramedic students to cultivate an awareness of the way culture impacts on health and health care. During the course of these lectures, it became increasingly evident that an explicit rationale was needed to demonstrate the relevance of culture to health care. Many paramedic students, particularly those in the early stage of training, expressed scepticism and portrayed a dismissive attitude about cultural influences in acute health settings. Other health professions also document this student sentiment.¹⁻⁴ For some paramedic students, an acute health event was associated with an emergency life-threatening situation, in which cultural diversity was perceived as unimportant and 'not worth worrying about'. By casting aside cultural diversity, these students perceived the patient as a 'universal body' rather than an 'individual person', illustrating how health care could become protocol driven with a disregard for the inherent cultural ambiguities in all patients. Some students perceived cultural diversity as 'soft' and irrelevant, which was supported by the fact that the topic is not examinable, and hence contributes little to their perception of the more important clinical protocols and clinical skills. However, students could be encouraged to see the emergency setting as a culturally laden arena with all emergency services contributing to the many complex meanings operating at the scene.

The difficulty in locating the 'hard-to-find hierarchy' of knowledge affects the careers of all health professionals, which now are also influenced by the recent National Health and Medical Research Council's (NHMRC) publication on *Cultural Competency in Health: A guide for policy, partnership and participation*.⁵ This hierarchy of knowledge and recent publication underpin the need for cultural diversity in training and ongoing professional development. The purpose of this paper is to extract the new and not so new policy directions at the international, national, state and professional level to illustrate how these initiatives inform and provide an awareness of cultural diversity for educators and all health professional students.

Methods

To explore policy directions at the international, national, state and professional level, a literature search was undertaken to identify specific conventions and noteworthy initiatives which offer a foundation for the inclusion of cultural diversity in paramedic and other student health professional education, training and practice. The search identified an array of policy documents which demonstrates to all health professionals the importance of having an interest in the cultural aspects of health care.

Multi-cultural health issues in a new global demography

Migration in the new global demography raises cultural health issues in most countries as a priority, and innovative health care delivery models are needed to cope with an increasing range of complex forces that now exist. The *World Health Report 2006* notes that health care professionals need to respond to demographic and epidemiological transitions.⁶ The importance of this statement for health professionals is that the process of change will alter the way health services deliver care to patients. In the Australian context, consumer preferences will impact on the provision of health services as

'consumer participation is increasingly linked to improvements in the quality of health care and improved health outcomes'.⁷ The Consumers' Health Forum (CHF) promotes consumers' views in all areas of health care.⁸ The NHMRC funded the CHF's proposal to develop a statement on consumer and community participation in health and medical research.⁹ Consumers, rather than providers, will increasingly influence the way health services function, while health care professionals will gain new insights into how patients perceive different aspects of health care. In this setting, traditional medicine could become the alternative choice.¹⁰ These changes are supported by a range of policy initiatives which are described in the next four sections of this paper.

International Initiatives – World Health Organisation

Most governments are signatories to the *Declaration of Alma-Ata*,¹¹ which was developed in 1978 as a major twentieth century milestone in the field of public health care. This Declaration reaffirmed health as a fundamental human right and identified primary health care as the key to the attainment of 'Health for All'. Australia became a signatory¹² to the *WHO Global Strategy for Health for All by the Year 2000*¹³ in 1981. In 1986, at the first International Conference on Health Promotion, the *Ottawa Charter for Health Promotion*¹⁴ was developed to provide a clear statement for 'enabling people to increase control over, and to improve, their health'.¹⁵ The *Charter* established core principles significant to health by advocating that cultural factors either help or hinder health, and that health promotion strategies take into account differing social and cultural systems to suit the local needs and expectations of individual countries and regions. Similarly, health services needed to reorient and move beyond the responsibility of providing clinical and curative services to embrace a larger mandate, sensitive and respectful of cultural needs. Such an approach requires the organisation of health services, and the attitudes of health care professionals to focus on the total needs of the individual person as a whole.

Almost thirty years after the *Alma-Ata Declaration*, and twenty years after the adoption of the *Ottawa Charter*, participants convened in 2005 at the 6th Global Conference on Health Promotion to discuss health challenges in the 21st Century and adopted the *Bangkok Charter for Health Promotion in a Globalized World*.¹⁶ Despite criticisms over failure to achieve the goals of the initial *Alma Ata Declaration*, with gross health inequalities scarring the world's health landscape¹⁷ and many people in resource-poor settings remaining without equitable access to basic services,¹⁸ this most recent *Charter* builds upon the values, principles and action strategies that were established in the *Ottawa Charter*, and highlights the changing context of global health, including the impact of globalization and the need for a sound evidence-based approach to better exploit health promotion opportunities.

International Initiatives – United Nations

As in other perspectives of emergency health, "9/11" also shaped future cultural perspectives of health care. Most notably, and as a direct consequence of the 11 September 2001 World Trade Centre disaster, the United Nations Educational, Scientific and Cultural Organisation (UNESCO) promoted cultural diversity as a new universal ethic. The General Conference unanimously adopted the 2001 *UNESCO Universal Declaration on Cultural Diversity*. Member States wished:

to define a standard-setting instrument, in the context of Globalization, for the elaboration of their national cultural policies, while respecting international rules and fundamental rights. It was the first time the International community has

possessed a legal instrument which raises cultural diversity to the rank of 'common heritage of humanity'.¹⁹

The Declaration responded to two concerns. The first ensured respect for cultural identities with the participation of all peoples in a democratic framework. The second contributed to the emergence of a favourable climate for the creativity of all, within which culture features as a factor of development. From this we interpret development to embrace culturally appropriate health care which includes the preservation of alternative health beliefs.

As a relatively new initiative, the *UNESCO Universal Declaration on Cultural Diversity*¹⁹ needs to be understood in the context of seven other core international human rights treatiesⁱ which in their broadest sense impact on the care of patients. The most relevant to health issues are discussed here. The *Universal Declaration of Human Rights*²⁰, adopted in 1948 by the United Nations, was a major achievement which detailed human rights and fundamental freedoms for the first time. Article 25 declares that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family', including medical care, necessary social services and the right to security in the event of sickness or disability. This first Declaration remains a powerful tool and continues to exert enormous effect on people's lives around the world. Similarly, Article 12 of the 1966 *International Covenant on Economic, Social and Cultural Rights*²¹ requires governments to recognise the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. Supporting these declarations is the 1981 *Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief*²² which promotes and encourages a universal respect for and observance of human rights and fundamental freedoms for all without distinction as to race, sex, language or religion as a basic principle. Underpinning each of these declarations is the statute of the 1945 *United Nations Charter*.²³

Fifty-five years hence, the UN General Assembly adopted the 2000 *Millennium Declaration*²⁴ which reaffirmed its faith in the Organization and its *Charter* as 'indispensable foundations of a more peaceful, prosperous and just world'. This millennium reaffirmation occurred one year before "9/11" and at a time when the General Assembly articulated the need for a more positive force for the world's people. Broad and sustained efforts were needed to create a shared future based upon a common humanity in all its diversity, and the challenge was for globalisation to be fully inclusive and equitable.ⁱⁱ

Australian Initiatives – National

As a part of the *Universal Declaration on Cultural Diversity*, UNESCO sponsors an 'Annual World Day for Cultural Diversity Dialogue and Development'²⁵ to provide an opportunity to deepen understanding about the values of cultural diversity. As noted

ⁱThis particular Declaration is underpinned by three other instruments: the 1972 Convention concerning the Protection of the World Cultural, and Natural Heritage, the 2003 Convention for the Safeguarding of the Intangible Cultural Heritage and the 2005 Convention on the Protection and Promotion of the Diversity of Cultural Expressions. Each of these reinforce the notion enshrined in the UNESCO that cultural diversity be recognized as "the common heritage of humanity" and that its defence "is an ethical imperative, inseparable from respect for human dignity".

ⁱⁱ A non-exhaustive selection of universal instruments relating to human rights is available at <http://www.ohchr.org/english/law/index.htm>. While these instruments underpin professional practice their legal status varies: declarations, principles, guidelines, standard rules and recommendations have no binding legal effect, but such instruments have an undeniable moral force and provide practical guidance to states in their conduct; covenants, statutes, protocols and conventions are legally-binding for those states that ratify or accede to them.

earlier, these sentiments are documented in the *World Health Report 2006*, promoting the belief that health care professionals respond to not only the demographic and epidemiological transformations of the community they serve, but also that service delivery be transformed by consumer preferences, thus impacting on the type of care they want.

Australia's response to the WHO Global Strategy for Health for All by the Year 2000¹³ included the creation of the National Better Health Commission in 1985. The 1988 Health for all Australians²⁶ report represented Australia's first national attempt to improve health and reduce inequities in health outcomes. In 1993, a revised set of broad targets were published in the Goals and Targets for Australia's Health in the Years 2000 and Beyond²⁷ and were refined in 1994.²⁸ However, like in a number of other countries, shortcomings in this model were recognised and, in 1996, Australia also developed a more selective approach to this international initiative with the establishment of the National Health Priority Areasⁱⁱⁱ which have subsequently been refined but remain the current model.²⁹ In parallel, in an effort to improve Australia's coordination of public health activity, the National Public Health Partnership³⁰ was created in 1997 and continues to demonstrate leadership through involvement with a large range of key players in Australian public health.

The UN International initiatives are reflected in the Australian legislative context, for example human rights³¹ and antidiscrimination,^{32,33} which support Australia's culturally and linguistically diverse society. Some states also reflect this legislation, for example Victoria's Racial and Religious Tolerance Act Vic 2001³⁴ and the Multicultural Victoria Act 2004.³⁵ Complementing such legislation is the Australian Government's key statement on cultural diversity policy, *Multicultural Australia: United in Diversity* (May 2003), which reaffirms fundamental principles and sets strategic directions.^{iv}

Most recently, the Australian Government, through the NHMRC, released a major publication entitled Cultural Competency in Health: A Guide for Policy, Partnerships and Participation.^v The NHMRC Health Advisory Committee established a working committee on 'Increasing Cultural Competency' to develop and produce this Guide. Led by a multi-disciplinary committee with personal and professional experience in cultural diversity, and with clinical and population health expertise, this group prepared a discussion paper and called for submissions from the professional and lay community. The resulting document provides background material to support the need for cultural competency in health care and outlines a model for 'increasing cultural competencies for healthier living and environments' comprising the following key components: systemic specifications; organisational specifications; professional specifications, and, individual specifications. The Guide provides examples for applying the model to health care, together with a range of scenarios and outlines steps to implement a culturally competent health care model in a diverse society. The Guide also provides keystone strategies for policy makers, researchers, educators, and practitioners in Australian health care.

Equally key initiatives preceded this NHMRC publication. The Federation of Ethnic Communities Councils of Australia (FECCA) was established in 1979 as a non-political community-based organisation and peak, national body representing Australians from culturally and linguistically diverse backgrounds.

ⁱⁱⁱ National Health Priority Areas are Asthma, Cancer, Cardiovascular Health, Diabetes, Injury Prevention, Mental Health, and Arthritis and Musculoskeletal Conditions

^{iv} A revised policy statement is due for release later in 2006.

The mission of the Federation strives to ensure that the needs and aspirations of Australians from diverse cultural and linguistic backgrounds are given proper recognition in public policy. FECCA monitors a wide range of issues. One that is pertinent to this paper is that of health services.³⁶ FECCA proposed the establishment of the Australian Bicentennial Multicultural Foundation in 1981 and achieved this in 1988 with the formation of Australian Multicultural Foundation (AMF). The AMF aims to: cultivate in all Australians a strong commitment to Australia as one people drawn from many cultures; promote awareness among the people of Australia about the diversity of cultures within Australia; and, spread an understanding of respect between all cultural groups.³⁷ Update³⁸ is the AMF's occasional magazine which reports on important events affecting cultural and linguistically diverse (CALD) communities, including health issues.

Another course of action came from the Department of Immigration and Multicultural Affairs in 1995 when its Council of Ministers agreed that Australian governments needed to increase efforts toward access and equity. In 1998, the Department produced the Charter of Public Service in a Culturally Diverse Society³⁹ to represent a nationally consistent approach to the delivery of government services and to establish a framework for best practice in culturally responsive service delivery. This Charter guides the Access and Equity Strategy and ensures government programmes meet the needs of a CALD society. The Charter integrates a set of service delivery principles pertaining to cultural diversity into all processes of all government service delivery.^v Its companion document A Good Practice Guide for Culturally Responsive Government Services⁴⁰ describes how an agent's management culture might use the Charter's principles to develop more culturally responsive services. The principles are designed to ensure all government service providers have the capacity to deliver culturally appropriate client services which are accessible, consumer oriented and effective. The Access and Equity Annual Report⁴¹ reports the progress of agencies implementing the Charter's principles.^{vi}

The Diversity Health Institute (DHI)⁴² is a collaborative initiative which provides diversity in health care at the national level. The DHI is a coalition of public health organisations^{vii} working together to improve the health and well being of Australia's CALD community. The DHI partners with communities, health service consumers, carers, health professionals, service providers, non-government organisations and academics to promote optimal quality health care based on improved clinical diagnosis and assessment practices, and to ensure that health services and programs are responsive to the social, cultural, linguistic and religious values and practices of Australia's diverse population.

These Australian initiatives and accompanying documents show a twenty-seven year progression of national initiatives guiding both the need for, and ways to develop a respect for a culturally diverse society and provide adequate services for Australia's culturally diverse community.

^v The Charter principles include Access, Equity, Communication, Responsiveness, Effectiveness, Efficiency, and Accountability.

^{vi} In 2005, eighty-four agencies provided separate contributions to this Report which represented a 31 per cent increase on contributions received in 2004.

^{vii} Member Organisations include: Diversity Health Clearinghouse; Diversity Health Institute Research Network; Diversity Health Institute Workforce Development, Education and Training Network; Global Health Institute; Multicultural Mental Health Australia; Multicultural Problem Gambling Service; NSW Education Program on Female Genital Mutilation; Service of Excellence in Diversity Health Care; Transcultural Mental Health Centre and Women's Health at Work.

Australian Initiatives – State

A number of policy documents value and support cultural diversity at the State Government level, some of which include various multicultural health websites.

In Victoria, Valuing Cultural Diversity Policy Statement 2002⁴³ provides a framework for Victoria's multicultural policies and programs, and details the four core principles for the government's whole-of-government approach to cultural diversity.^{viii} The Multicultural Strategy Team promotes culturally and linguistically responsive service delivery to improve access to CALD people and produces the *Cultural Diversity Guide*⁴⁴ to assist and support departmental programs. In addition it produced supporting documents: a Language Service Policy⁴⁵ and a Refugee Health and Wellbeing Action Plan⁴⁶ both of which recognise the special needs of people from CALD and refugee backgrounds .

In New South Wales, the NSW Multicultural Health Communication Service focuses on communication and provides information and services to assist health professionals communicate with people of culturally and linguistically diverse backgrounds throughout the state. The service produces over 450 multilingual health resources, which are accessible to health care providers and to people who speak languages other than English and available in up to forty-five languages.⁴⁷

In Queensland, Queensland Health produces extensive multicultural health resources for hospitals and community health services.⁴⁸ In addition, and similar to Victoria, the Queensland Government's Department of the Premier and Cabinet produced a Multicultural Queensland Policy.⁴⁹ The government expects all agencies to implement its principles and strategies in programs and services, and to adopt the Charter of Public Service in a Culturally Diverse Society. The Queensland Health Multicultural Policy Statement⁵⁰ adapts the Multicultural Queensland Policy to the health portfolio to provide guidance for health services to implement the policy. The Policy identifies the Charter principles to shape state responses to challenges received from cultural and linguistic diversity. In addition, the government has produced the Queensland Government Language Services Policy Statement⁵¹ and Queensland Health produced Queensland Health Language Services Policy.⁵² All of these resources support the Queensland Government's Multicultural website⁵³ which provides health professionals with guides and policies to make available culturally sensitive health care in hospitals and community health services.

In Tasmania, multicultural health is located within the Population and Health Priorities Unit (PHPU),⁵⁴ a subdivision of the Community Population and Rural Health Division within the Department of Health and Human Services. Unit staff develop policy to public, the PHPU undertakes research to develop 'best practice' in service delivery to multicultural communities. The Department of Health and Human Services also provides translation and interpreting services.⁵⁵

^{viii} These are: valuing diversity, reducing inequality, encouraging participation, and promoting the social, cultural and economic benefits of cultural diversity to all Victorians.

Professional Initiatives

Professional agencies, such as Emergency Management Australia (EMA), identify the need for adequate cultural training for the responding workforce, particularly from an emergency perspective where natural and man-made disasters require a national and international response. In an emergency context, many variables make CALD communities particularly vulnerable. Inadequate English may decrease resiliency in an emergency, as CALD people or new arrivals in unfamiliar environments may be unable to access information thus increasing their susceptibility to particular hazards. Additionally, cultural differences and linguistic peculiarities could impede communication and result in people being unaware of possible risks which may reduce their capacity to cope in times of an emergency. To address these needs, the EMA produced publications⁵⁶⁻⁵⁸ that relate to CALD communities, specifically in the context of emergencies and to provide emergency planners and responders with information about multicultural issues in emergency management. An extensive range of professional and discipline specific initiatives are also available which will provide the basis for a subsequent paper to be published in the next issue of the Journal of Emergency and Primary Health Care.

Discussion

In this paper, we provide a compendium that illustrates a hierarchy of knowledge which educators can use as a resource to underpin their teaching of cultural diversity to health professionals. In addition, this comprehensive resource provides both the teacher and sceptical student with an explanation and a *raison d'être* for adopting culturally responsive care and to develop and increase 'best practice principles' in paramedic and health professional education, training and practice. Giving credence to these initiatives makes the patient from a CALD background an 'individual person' imbued with cultural ambiguities, which is so much more than a 'universal body'. In this way, caring for patients from a CALD background becomes a 'priority' rather than a peripheral concern.

The outcome of initiatives developed since the United Nations adopted the Universal Declaration of Human Rights in 1948 might suggest a long-term commitment to caring for culturally diverse patients. However, this relentless production and reproduction of declarations, conventions and guidelines could also suggest that educators and health professionals experience difficulties with linking existing knowledge to the needs of a dynamic cultural environment. Or, as one research paper reports, delivering 'cross-cultural care lags behind preparedness in other clinical and technical areas'.⁵⁹ A lack of communication between organisations that produce guidelines and the health professional could also mean educators and health professionals are unaware of new initiatives; senior staff may avoid or reject such initiatives in favour of other more pressing budgetary priorities and may even discourage some new ideas. Another possibility is that some educators and health professionals may be confident in their ability to incorporate culturally appropriate care. Conversely, perceived confidence may be manifesting itself as unconscious ineptitude or neglect which places patients at great risk.

The idea that health professionals provide inappropriate care was put forward in the 1950s by Brock Chisholm, the first Director General of WHO. He argued that humanity was in 'grave danger' of destroying itself and had to learn to think and act differently.⁶⁰ Advancing globalisation adds to this dilemma and challenges health professionals to provide culturally responsive care that responds to the guidelines described above. In many areas new legislation encourages 'culturally and linguistically diverse communities to retain and express their social identity and cultural inheritance'.³⁵ To ignore contemporary thinking is to adopt antiquated colonial ideas which demonstrate an

ethnocentric philosophy or intolerance to alternative health beliefs. Such a perspective presumes a health care model in which 'one-size fits all' in which educators standardise their teaching and health professionals standardise their practise to a level that prevents them from effectively engaging with a diverse patient population with dissimilar health beliefs.

These might seem harsh criticisms. A plethora of research, however, demonstrates how health outcomes deteriorate when health professionals do not provide care that is culturally appropriate. Australian and overseas research suggests that racial and ethnic minority groups have a high risk of experiencing disparities in health and health care compared to the average population.⁶¹ Similarly, cultural misunderstandings may occur through failing to recognise the link between language and culture which could compromise patient safety.⁶² Medical mismanagement may lead to negative health outcomes,⁶³ as does racism for minority populations living in western countries⁶⁴ A clear example of such failings is the health status of minority groups in Australia such as Aboriginal and Torres Strait Islander People who live about 20 years less than non-indigenous people,⁶⁵ and who experience inadequate health care and a lack of trained professionals to care for them.⁶⁶ Such health inequalities are unacceptable and tackling this problem is a top priority for all levels of the health professions. Improving the overall 'health for all' means educators and health professionals make a concerted effort to narrow the gap between disadvantaged and advantaged groups. One contemporary example is that of the London Health Commission which has published *Culture and Health: Making the Link*⁶⁷ to stimulate further consideration to how aspects of culture make a difference to people's health and how cultural policy can contribute to improving the health of the population.

At an international level, both the WHO and the UN have responded to extensive criticism that highlighted the failure of their previous initiatives to achieve health improvements. The UN adopted the United Nations Millennium Declaration²⁴ following the United Nations Millennium Summit in 2000. This Declaration recognised the interdependence between health and social conditions. These ambitious goals^{ix} set the context in which the WHO Commission on Social Determinants of Health was launched in March 2005 and whose initial work is to provide evidence on policies that improve health by addressing the social conditions in which people live and work.⁶⁸ The first discussion paper prepared for this Commission explored why past efforts to promote health policies on social determinants failed to achieve health improvements.⁶⁸ The Commission's second discussion paper *Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health*⁶⁹ attempted to provide clarity on basic conceptual issues and reviewed four key models developed to show how the social determinants of health affected health outcomes. Each of these four influential models identified culture as an overarching condition that has a bearing on every other layer. Although culture cannot be portrayed as a sole determinant, one approach might be to frame this issue under the umbrella of the 'social determinants of health' which tries to make explicit 'a broad set of structural, cultural and functional aspects of the social system which impacts on individuals'.^{70 p4}

ix The Millennium Development Goals set ambitious targets in poverty and hunger reduction; education; women's empowerment; child health; maternal health; control of epidemic diseases; environment protection; and the development of a fair global trading system, to be reached by 2015.

Transforming academic evidence into policy for community practice is a complicated task, particularly within public health. In this context, public-health interventions and policies are typically more complex, context-dependent and play a greater mediating role than clinical interventions.⁷¹ Integral to this perspective is the argument that health services contribute to people's health while 'social determinants are the factors that help people stay healthy, rather than the service that help people when they are ill'.^{72 p6}

Working with people and communities to understand culturally-determined approaches to improving health provides an opportunity for action in improving health.⁷³ Developing policy for community practice requires an evidence base of the social determinants of health to support a public health perspective.⁷⁰ As contemporary models of health service delivery continue to evolve by integrating community-based emergency health services and the expertise of paramedics—the cultural and social perspectives in health are becoming 'core business'.

Conclusion

While this paper coincides with the publication of *Cultural Competency in Health: A guide for policy, partnership and participation*, it also sufficiently evinces the many directions and activities at international, national and state levels over the past seventy years. This hierarchy of knowledge cannot be ignored if health professionals are to operate on 'best practice principles'. Similarly, the continued production of principles and initiatives juxtaposed against health outcomes for CALD patients demonstrates both a long-term commitment to caring for culturally diverse patients and the enduring difficulty of implementing new ideas. Indeed, as globalisation progresses, so does the complex challenge of sustaining efforts to create a shared future that is based on a common but diverse humanity, especially if it is to become fully inclusive and equitable. To ignore this challenge is to ignore basic human rights principles.

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