

IFMSA Policy Proposal

Equity, Diversity and Inclusion

Proposed by Team of Officials

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Policy Commission

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Policy Statement

Introduction:

Diversity is the essence of humanity. However, it can create inequality and oppression when the difference in identities causes prejudice, power imbalances and differential treatment. This, in turn, leads to marginalisation and exclusion of individuals and groups, impacting people's livelihood, well-being, development and contributions, and aggravating the existing inequities in communities— perpetuating the vicious cycle of oppression and injustice. As equality, participation, inclusion, and non-discriminatory are core principles of human rights including the right to health, these systems of oppression and injustice not only violate human rights principles but also undermine the health of individuals and communities by directly impacting access to, acceptability and quality of healthcare services as well as through weakening the social determinants of health. As such, we, as members of the community, current medical students and future health workforce, have an important role to promote equity, diversity and inclusion in our spheres.

IFMSA position:

The International Federation of Medical Students' Associations (IFMSA) reaffirms universality, participation, inclusion, equality and non-discrimination as core human rights principles and further recognizes the right to personal identity as a basic human right. The IFMSA acknowledges inequity, discrimination, and exclusion in response to diverse backgrounds, and social categorizations, and their intersectionalities as detrimental determinants of individual and community health and violation of human rights. Furthermore, the IFMSA acknowledges that oppression, exclusion and marginalisation vary with individual, social, political and geographic contexts. Hence, the IFMSA believes that healthcare workers have a crucial role in promoting and advocating for equity, diversity and inclusion (EDI) in the health sector as well as in the different aspects of life. The IFMSA is further committed to:

- Promote inclusive working conditions where all our members feel safe, respected and valued.
- Cherishing and promoting respect for diversity and fostering a safe space for all members to express themselves and engage meaningfully.
- Regularly surveying and assessing the experience of our members of equity, diversity and inclusion in IFMSA and acting upon findings.

Call to Action:

Therefore, IFMSA calls on:

Governments to:

- Respect, protect and fulfil the human rights of all individuals from different backgrounds in a universal, equal and non-discriminatory manner, respecting the core principles of human rights;
- Assess and examine the diverse needs, barriers, and opportunities of all people and groups of the community through an intersectional approach, emphasising the needs of the disadvantaged and marginalised groups, to inform more accessible and inclusive decision-making, planning and design in all sectors;
- Assess and examine existing laws, regulations, policies, programs and services to identify aspects of systemic oppression and discrimination and to take measures to eliminate these structures to be more inclusive and equitable for the different members of the community;
- Develop anti-discrimination and anti-harassment laws and regulate accountability measures to protect vulnerable groups and minorities against all forms of discrimination;
- Integrate diversity education into primary and secondary education frameworks as a core component to foster a culture of respect, dialogues, diversity and, subsequently, inclusion;
- Develop and employ equity and inclusion programs to guide the health systems and health policies, ensuring accessible, equitable, non-discriminatory and inclusive healthcare provision.

International organisations and non-governmental organisations (NGOs) to:

- Develop anti-oppression policies and training for their staff to ensure that their operations and activities are diversity-sensitive, equality-promoting and do not end up perpetuating the systems of oppression;
- Develop workplace regulations and policies combatting discrimination and barrier to inclusion;
- Create comprehensive mechanisms for staff and members to speak up about and report bias, oppression, discrimination and harassment, and develop concrete accountability measures to tackle such reports.

The health sector, educational and training institutions and research institutions to:

- Create the conditions for a diverse, inclusive, and equal working climate where everyone – especially traditionally marginalized groups – has the same opportunities and support to achieve growth and development;
- Mainstream EDI in institutional strategy, policies and programs as well as ensure meaningful participation of various groups in the planning, execution, monitoring and evaluation process.
- Ensure that the recruitment and selection process of both staff and students are equitable, non-discriminative, and inclusive, as well as actively recruit and include groups that have been traditionally marginalised;
- Ensure that people with diverse backgrounds can fully participate in all aspects of an organisation's work, especially leadership positions and decision-making processes;
- Develop the competencies of students and workers on equity, diversity and inclusion (including intercultural competence, bias awareness and essential communication skills among others);
- Systematically and regularly examine educational and training curriculum development, curriculum delivery, and their learning environment to eliminate components that underpin exclusion and oppression;
- Increase the collection, stratification and use of disaggregated data (sexual orientation, gender identity, ethnicities, disability status, social status, etc) among diverse populations in order to identify disparities and gaps within these populations.
- Actively work on ensuring equity, diversity and inclusion in the research workforce, including research teams as well as editorial and management boards. This should be supplemented with the systematic provision of guidance and mentorship opportunities for students and junior researchers from marginalised and underrepresented groups to conduct research studies.

IFMSA National Member Organisations (NMOs) and medical students to:

- Recognize their individual and social role in creating inclusive communities and working environments, those that support and embrace diversity and equity.
- Develop strategies that ensure equitable, diverse and inclusive access to the diverse training, educational and leadership opportunities at IFMSA, on the local, national and international levels, for all medical students, ensuring the representation of the diversity of medical students they represent.
- Raise awareness and develop the competencies of their members on equity, diversity and inclusion in health and care settings as well as in the community, through campaigns, targeted training and capacity development activities.
- Engage in examining discrimination and exclusion patterns and structure in their education, training and health systems. Furthermore, engage in providing feedback and advocating for equity, diversity and inclusions elements and strategies in their education, training and health systems;

Position Paper

Background information:

Equity, diversity and inclusion are complex and often contested terms, in both meaning and enactment [1]. Diversity is at the core of the human social fabric. Human beings around the world, and within regions and even communities, belong to different social groups and categories. This is often naturally reflected in the different human activities we carry on a day-to-day basis. However, with increased misinformation, disinformation, polarization and lack of bias and prejudice awareness, this diversity is subject to discrimination, exclusion and inequitable systems of power and privilege [2]. This can be reflected in working and learning settings as well. Through this position paper, we aim to examine the importance of actively working to ensure that learning and working environments respect and promote diversity and inclusion.

Discussion:

1. Definitions:

According to the *Oxford Bibliographies*, **Diversity** is defined as “real and perceived differences among individuals or groups and the ways in which these differences affect interactions and relationships as well as the status of different groups in organizations” [3]. It is the state of heterogeneity in a group of people, as members of the group belong to various backgrounds and identities including, but are not limited to, gender, age, race, ethnicity, sexual orientation as well as individual differences such as personality and physical ability [4][5][6][7].

Equity is often used synonymously for justice and fairness [8]. It could be defined as fairness and justice in opportunities, process and results rather than sameness of treatment and outcomes [5][9]. Achieving equity, hence, entails a continuous process of identifying and removing the conditions that produce disparities in the distribution of resources, access to opportunities and design of processes to ensure fair outcomes [5][10]. Equity is, as such, concerned with the fairness of ‘conditions’.

Inclusion is defined as the process of ensuring that the diversity of people in a group are accepted for their identities and ideas, are valued as members of the community and have their voices and opinions welcomed and appreciated [5][7]. It is an ongoing and intentional process of integrating the different members of a group in a community to be able to fully participate in all aspects of life, including in working opportunities, leadership positions and decision-making processes [7][11]. Inclusion, hence, entails dismantling social and cultural barriers and the different forms of discrimination that lead to exclusion and marginalisation of groups. As such, Inclusion is concerned with ‘attitudes’ and ‘behaviours’ and is seen as a practice of “cultural review and social construction” [11].

2. EDI in Workplace

EDI is good for business. EDI is an essential component for organisations to thrive [12]. It is imperative to reap the benefits of diverse backgrounds and unique skills, especially in an increasingly globalized world and diverse workforces. Research shows that workplace EDI strategies are linked to higher productivity, innovation, and employee well-being [13]. Promoting EDI in the workplace has been shown to lower turnover rates and sick absence amongst employees by 50% and 75% respectively, which results in increased productivity and decreased losses for an organization [14]. The extensive and emerging body of research is loud and clear – EDI is good for business. Looking at different perspectives, one might ask what are the costs of exclusion. According to the Organisation of Economic Co-operation and Development (OECD), the current levels of gender discrimination cost the global economy up to US\$12 trillion, or 16% of global revenue, and eliminating gender discrimination by 2030 could boost annual global income growth by 0.03 to 0.6 per cent [15]. These economic losses also are

associated with the exclusion of people with disabilities and the LGBTQI+ community from the workplace as it linked with losses ranging from 3-10% of global GDP [16][17]. Nevertheless, these harmful effects can be mitigated or even reversed [14].

Equity, diversity, and inclusion in workspaces have been approached from various aspects over the years due to the growing interest in creating safer spaces for everyone. Starting with equity, it is an approach that ensures that everyone has access to the same opportunities. Contrary to diversity, inclusion and equality, equity is more of a state than a step – It is harder to specify and quantify. In the workplace, equity takes into account not only access to fair remuneration but also other situations, such as access to resources, promotions, and contribution to their personal development [7]. Although the definition of equity varied amongst organizations, in general, when all members of an organization have the same opportunities and support to achieve growth and development, equity is achieved in a workspace [18].

On the other hand, in an increasingly globalised world, diversity in the workplace has become a necessity. In a work environment, diversity is concerned with the representation of the different groups of a community; races, ethnicities, languages, nationalities, religions, genders, and sexual orientations. Diversity requires and demands that those who compose that group are examined to ensure that multiple perspectives and realities are represented [7][19]. Contemporary literature has a fixed conclusion: diversity in the workplace has a broad positive impact. Research shows that diversity within executive teams is linked with higher levels of employee productivity as well as higher profit and innovation revenue [13][20]. However, if no clear and concrete diversity management and inclusion strategies are in place, cohesion and safe spaces in the workplace end up being exposed and undermined, as differences of opinions and other variables manifest and may hinder the development of unity, creating barriers in communication and understanding between peers, and resulting in an increased incidence of interpersonal conflict [21].

Several research bodies show that inclusive organisational cultures and policies are powerful drivers of job satisfaction, organizational commitment, creativity, innovation and overall job performance and these were found to be more effective than pay rise in driving innovation [2].

Diversity management entails all organizational policies and practices focused on recruiting, retaining, and managing members of diverse backgrounds and identities [22]. While inclusion, as a practice, is focused on the experience of individuals and groups in the workplace, promoting a work environment that values and respects the similarities and differences of individuals [6][13]. Inclusion requires intentional and ongoing effort to ensure that diverse people with different identities can fully participate in all aspects of an organisation's work, including leadership positions and decision-making processes [7].

In light of the points mentioned earlier, it's evident that equity, diversity and inclusion must be addressed together within all organisational spaces, not only as a matter of human rights but also for improved working outcomes. Despite increased efforts to initiate changes in policies, practises and programs to address discrimination and exclusion in the workplace, research is still limited on what skills or competencies are required to promote equity and inclusion [2].

3. EDI in Medical Education, Health Education and Training

As patients are a diverse population with a wide array of health needs and determinants, it is critical that the educational and health institutions be held socially accountable for such needs [23]. Furthermore, a diverse and inclusive health workforce is pivotal for health equity. It has proven to result in an improved relationship with the patients, enhance communication and better adherence to care plans while also improving access to and quality of services and, hence, health equity [24][25].

3.1. The case for EDI in Health Education and Training

The notion of social and EDI accountability calls for institutions to be 1) diverse through an equitable and inclusive admission process and 2) equip their students and staff with EDI knowledge, attitude, and skills – one of which is through its curriculum [26]. Having strong EDI policies – that not only foster inclusion but also challenge exclusion – is imperative to create an environment and workforce that are better equipped to serve a diverse set of patients and close the health inequities [27]. Including an EDI approach also helps, not only to have greater acceptance and tolerance in learning or work environments but also a better dynamic with patients [28][29]. Moreover, EDI in curriculum and training can potentially mitigate microaggression and unconscious bias, as well as set the standard of behaviour for positive and respectful interaction among health workers [30]. This is as important due to the fact that the exclusion and inequity of students faced by minority groups in education tend to persist throughout their careers [26]. This evidence is not exhaustive, but it highlights the fact that integrating EDI into education policy brings many benefits to not just institutions, but students and communities.

3.2. Gaps and Challenges

On the other hand, the current body of evidence also identifies several gaps and challenges in including EDI in medical and health education and training, as well as underrepresentation in the institutions. There are several instances that identify barriers to the active inclusion of marginalized student groups in higher education [26]. Many researches also bring underrepresentation [31] [32] [33] [34], discrimination [35] [36] [37] [38], and inequality [39][40][41] issues in higher education to fore. Furthermore, many curriculums in our time still lack EDI of educational components, as well as experience of professionals delivering those components to deliver them in an inclusive cultural sensitive non-discriminatory method [43] [44]. Some countries also identify a lack of reliable and up-to-date data on the diversity of medical trainees, physicians, and senior management [43]. Even more, the research also shows that the current healthcare professionals' diversity doesn't reflect its population diversity. The research conducted by The Canadian Federation of Medical Students (CFMS) also identified some financial and social barriers in the admission process, as well as highlighted that for diverse students, medical schools are not always safe and welcoming [43]. To sums up, four gaps can be identified: 1) Lack of social accountability to respond to deeply rooted underrepresentation, exclusion, and discrimination in our educational institutions; 2) The current solutions focused on the individual with the problem instead of addressing the problem systematically and synergistically; 3) Lack of EDI curriculum and teaching staff, as well as an environment where EDI can thrive; and 4) Lack or even absence of data, as well as rigorous monitoring and evaluation mechanism.

3.3. Recommendations

Accordingly, we provide the following recommendations for educational institutions as well as medical education and training to be held accountable for challenging exclusions and to progress EDI in their institutions.

First, institutions need to ensure that the recruitment and selection process of both staff and students are equitable, non-discriminative, and inclusive. This can be done by taking into account people with diverse backgrounds during 1) the recruitment process through demographic research, outreach and empowerment strategies– and the selection process through auditing the process. Moreover, education institutions' strategies, policies, and programs should explicitly state and clearly reflect the importance and how much the institutions value EDI [26]. A working group mandated to ensure EDI implementation, monitoring, and evaluation is recommended if not in place. This working group can also be mandated to train and ensure all staff have an understanding of EDI and value it [26].

Second, national and subnational institutions need to create a systematic and synergistic solution that incorporates systems thinking and needs assessment (especially corporate need assessment) to deal

with EDI challenges [45]. Meaningful involvement of stakeholders, especially students of diverse background, need to be at the heart of solving EDI issues and challenges.

Third, educational institutions need to actively challenge exclusion in their curriculum development, curriculum delivery, and its learning environment. In terms of curriculum development, the curricula and learning materials should consider involving students from diverse backgrounds meaningfully, integrate intersectional approaches during development, as well as identify and decolonise the pre-existing curricula [26]. Apart from the curriculum, it was also described that the faculty's commitment is also important to teach EDI topics such as having a multidisciplinary team of educators to achieve the 'diversity' and bringing the concept of EDI out of the classroom into the hospitals so that students not only have the context, but also the cross-cultural communication skills as future doctors [46]. On top of that, institutions have to make sure that students regardless of their background can feel safe, secure, and included in the school environment, either through inclusive events, EDI student societies, examination of the school physical environment, and decision-making. As discrimination and harassment are prevalent in medical schools, schools should also develop bidirectional communication channels for students, patients and staff to be able to report discrimination, harassment, and microaggressions within their organisation [x]. Moreover, certain actions that were suggested in the study were to provide a safe environment for medical students to be in when having discussions on EDI topics and to have clear learning outcomes so that medical students understand what they are trying to achieve during such discussions [46].

Fourth, educational institutions are recommended to map their current students and staff according to characteristics such as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. This will allow institutions to evaluate how diverse their institutions actually are. Moreover, these institutions can also develop other indicators to assess their EDI achievements. An intersectional approach during data analysing and consulting the research result with diverse stakeholders is also recommended [26].

After all, as we have seen, ensuring EDI in medical and health education and training institutions is a complex topic that needs collective efforts from all parties in the process, missing one aspect of this process creates gaps in the other. On the other hand, it is worth all the efforts and time as the results include a more healthy environment that assures the protection of human rights of workers, students, and the community by eliminating health inequity and improving the health of the marginalized and underprivileged communities.

4. EDI in Research

Having highlighted EDI strategies' importance in many fields, now we assess their impact on Research. In fact, research is a product of organised sciences whose main objective is to systematically analyse various phenomena and increase our understanding of them [47]. However, even research tends to be sometimes biased. Bias can occur either intentionally or unintentionally during data collection, analysis, interpretation, and/or publication, and can lead to false and unethical conclusions [48]. Furthermore, subjectivity in research could also underline structures of discrimination and oppression as seen in previous sections. Therefore, it is where the true importance of EDI in Research lies.

4.1. Research Producers:

a) The gender gap:

The scientific workforce continues to be dominated by men 2 to 1, and men accumulate more impact with a 27% gender gap in total productivity across all countries and in all scientific fields. There is also a large gender gap in total productivity for the highest-ranked affiliations (determined from the 2019 Times Higher Education World University Rankings [49]). This gender gap was also highlighted during the

COVID-19 pandemic. In fact, our understanding of the virus may have been greatly impacted by the under-representation of women in research production, affecting both the availability and interpretation of sex-disaggregated data and thus making our information less accurate [50].

b) Race and educational background gaps:

In the United States, only 9% of STEM workers are Black, compared to 11% of the overall workforce, and only 8% are Hispanic, compared to 17% of the overall workforce [51]. Even more staggeringly, in the United Kingdom, Black workers represent just 0.7% vs 85% of professors who are white [52]. South African studies have even pointed out the fact that career progression for black academics is constantly being set back by biased students' ratings; being same ethnicity students, ironically, the toughest of them all [53]. These constant ethnic barriers have proved to be dissuading and discouraging. In fact, these students are several times less prone to continue their studies and pursue their academic interests.

Furthermore, graduate and postgraduate studies in the United States have clearly identified an incongruity between the undergraduate pool of minority students and the proportion of those that indeed keep climbing on the academic ladder. PhD percentages, for example, are not consistent with nor representative of the wide array of ethnicities present in freshman years [54]. Studies blame not the lack of awareness but the selection criteria many graduate and postgraduate institutions currently apply [54]. Students are often judged on their undergraduate institutions' prestige and the kind of scholarly background they possess, instead of filtering them by aptitude, ability, or drive. On the other hand, though, programs that do take this into account, have proven to be successful in attaining and maintaining graduate and postgraduate talent [55]. By applying a holistic approach to the issue; assigning tutors and mentors, and advocating for tools and guidance for undergraduate preparation and overall companionship along the way; Programs have indeed seen a promising increase in the rates of doctoral conclusion when compared with the national average; they have successfully levelled the field for those with vulnerable backgrounds which would have made them more prone to fail and quit [55].

In addressing these issues, awareness has been identified as a major tool in the fight against implicit and structural (systemic) academic biases [56]. However, bringing awareness to EDI knowledge alone has not proven to be enough. For research to be truly Equitable, Diverse, and Inclusive, the very core of research institutions must change, for they account for one of the most influential agents on the matter [54].

c) Countries and institutional gaps:

This same responsibility that lies within institutions lies as well within the Journals and publication means; they too should be held accountable for their internal and external policies since they will affect research's reach and impact. For scientific journals, externally, publication output seems to mimic that of global health research funds; a big majority of them are concentrated in High (and Upper-Middle) Income Countries (HIC) [57], whereas Low-Middle Income Countries (LMIC) are "awarded" with what is left; scientific papers follow a staggering 90 vs 9% distribution [58]. Internal structure, on the other hand, happens to obey a rather resemblant trend: their Editorial Board and advisors, Editor in chief or other leading positions and editor team (senior, deputy, or associate editors), all are dominated by males who come from HIC, which typically have a Caucasian majority [59].

Furthermore, it has been observed that global health-related issues tend to strike LMIC disproportionately; see COVID-19 Pandemic, its effect on them, and the extent to which they can respond. Input from this LMIC then is extremely valuable to address and eventually tackle global health issues; they can masterfully and first-handily account for the problems' roots and repercussions since they deal with them on a regular basis. More so, pretending to tackle these challenges with an exclusive HIC perspective has proven time and time again to be short of absurd; see the failure of the COVID-19

vaccine COVAX delivery strategy because the scheme was allegedly designed to be implemented on LMIC but inherent LMIC realities were not taken into account [60]. This lack of expert representation on editorial boards. When considering that women are underrepresented as well, the credibility of the scarce input and research being produced in the LMIC (previously mentioned 9%) may be compromised to a further extent, for it again messes with representativity [59].

Some solutions scientific Journals may want to assess regarding this matter can be identified by analysing examples of concrete case studies. These may suggest that Journals, for instance, create and develop specially oriented editions in order to highlight the importance of inclusivity amongst its readers and foster multidisciplinary approaches [61]. They may also wish to reconsider their staff recruitment methods and the appointment of their editorial board [61]. Finally, Journals may want to slowly transition out of conventional pay-to-read models and favour open-access ones, even if only to a certain degree [61].

In conclusion, the team's diversity, for starters, is a clear indicator of how inclusive a research model is. It is not feasible then, to expect equitable, diverse, and inclusive research if the team which will be conducting said research does not demonstrate diversity from within. In this context, diversity alludes to the multiple perspectives different individuals (i.e., from different socioeconomic backgrounds, sexual orientations, gender identities, and ethnicities...) can bring to the research team [62]. When campaigning for diverse, equitable, and inclusive compositions, nonetheless, research teams must be careful not to incur the so-called "tokenism"; the practice of acting, in this case selecting or recruiting a researcher from an ethnical minority, just to comply with what is socially acceptable and avoid being called out [63].

4.2. Research Subjects:

In order to be effective, EDI in research must go beyond a diverse team. In fact, the research community should stop judging a scientific paper by its methodological rigour only and start double-crossing it with how accurately it conceives people and communities to be [64]. In other words, research projects might be systematically and thoroughly conducted, but if they fail to acknowledge populations and social phenomena appropriately, the research itself will thus be flawed. Therefore, besides a diverse team composition, EDI in research should focus on diverse research methods and questions [62].

a) Diversity of methods:

Firstly, diversity in research methods aims to advocate for more comprehensive planning and methodology during the strategizing of a research proposal. Following up on the gender example, but applicable to all other marginalised groups, typical clinical and subclinical studies, for instance, have traditionally used male subjects; both in humans and animals. Regardless of this being due to ease of physiological understanding or an indirect result of the patriarchal model scientific academia was first built upon, numerous case examples of this non-randomised screening bias can be mentioned; in vitro / ex vivo use of white individuals' tissues and blood for drug testing [55], osteoporosis-related hip fractures studies [62]. among many others. Unsurprisingly, and very unfortunately as well, these deliberate acts of exclusion have not only contributed to the further ostracising of certain populations in research but have also had a direct impact on human health. Dozens of drugs, 10 of them during the 1997-2000 period in the United States alone, have had to be withdrawn from the market due to their life-threatening health effects [62]. Researchers, however, were many times oblivious to these effects, especially in women, because of the lack of diversity in clinical trials and subject inclusivity [62].

The Office of Research on Women's Health (OWRH) recently launched a revised NIH Inclusion Outreach Toolkit to help researchers recruit and retain female participants in their clinical studies in order to amplify women's inclusion, which would help reduce gender bias and enhance research strategies and results [65]. This inclusion would lead to a more accurate representation of the population by ensuring adequate

distribution of study participants by sex, gender, race, ethnicity, and age. Thereby, the scientific goals of the clinical study will be achieved.

b) Diversity in Research questions:

On the other hand, diversity in research questions should also be addressed for the entire research process to be truly equitable, diverse and inclusive. Here, it is about stepping back even further in the process and beginning to diversify the initial problems and questions academics wish to solve or cater to with their research proposals [62]. True diversity in research is not about undertaking the same old proposals and having a new team carry them out, but actually coming up with changes to these proposals and adjusting them to the needs and wants of an entirely new context with unprecedented demands. Under this new light diversity poses, traditionally neglected issues can be further explored; there is now a resurfaced will to study previously disavowed subjects; and even more importantly, new queries can develop as a result of a more complex and dynamic set of interactions between orthodox social agents and newly arisen ones. At the end of the day, it is nothing but a logical consequence of introducing diverse-background members into a team and considering the questions/problems they find to be relatable or compelling; they are obviously set to be different as well.

References

1. Tamtik M, Guenter M. Policy Analysis of Equity, Diversity and Inclusion Strategies in Canadian Universities – How Far Have We Come?. Canadian Journal of Higher Education. 2019;49(3):41–56. Available from <https://doi.org/10.7202/1066634ar>
2. Vohra N, Chari V, Mathur P, Sudarshan P, Verma N, Mathur N, et al. Inclusive Workplaces: Lessons from Theory and Practice. Vikalpa: The Journal for Decision Makers. 2015;40(3):324-62. Available from <https://journals.sagepub.com/doi/pdf/10.1177/0256090915601515>
3. Nkomo S. Diversity: Oxford Bibliographies. 2013 DOI: 10.1093/OBO/9780199846740-0031. Available from: <https://www.oxfordbibliographies.com/view/document/obo-9780199846740/obo-9780199846740-0031.xml>
4. Moore KJ, Xiong S, Bhattacharya M, Bustamante G, Calvert C. Beyond Diversity: Focusing on and Enhancing Inclusion in the Society for Epidemiologic Research. Am J Epidemiol. 2020;189(10):1042-6.
5. Lange J. Equity, Diversity, & inclusion. McGill journal. 2022. Available from: <https://libraryguides.mcgill.ca/c.php?g=452153&p=5175488>
6. Inegbedion H, Sunday E, Asaley A, Lawal A, Adebajani A. Managing Diversity for Organizational Efficiency. SAGE Open. 2020;10(1):215824401990017. Available from: <https://journals.sagepub.com/doi/10.1177/2158244019900173>
7. Tan TQ. Principles of Inclusion, Diversity, Access, and Equity. The Journal of Infectious Diseases. 2019;220(Supplement_2):S30-S2. Available from: https://academic.oup.com/jid/article/220/Supplement_2/S30/5552351
8. Arnaud A. Equity. International Encyclopedia of the Social & Behavioral Sciences. 2001;:4729-4734. Available from: <https://www.sciencedirect.com/science/article/pii/B0080430767028540>
9. Espinoza O. Solving the equity–equality conceptual dilemma: a new model for analysis of the educational process. Educational Research. 2007;49(4):343-363. Available from: <https://www.tandfonline.com/doi/abs/10.1080/00131880701717198>
10. Braveman P, Gruskin S. Defining equity in health. J Epidemiol Community Health. 2003 Apr;57(4):254–8. doi: 10.1136/jech.57.4.254. PMID: 12646539; PMCID: PMC1732430. Available from: <https://pubmed.ncbi.nlm.nih.gov/12646539/>
11. McMaster C. Ingredients for Inclusion: Lessons from the Literature. 2012; 13(2):11-23. Available from: <https://files.eric.ed.gov/fulltext/EJ994981.pdf>
12. American Psychological Association. Take a critical look at equity, diversity, and inclusion policies. 2022. Available from: <https://www.apa.org/topics/workplace/mental-health/edi-policies>
13. ILO. Transforming enterprises through diversity and inclusion. 2022. ISBN 978-92-2-036737-7 Available from: https://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---act_emp/documents/publication/wcms_841348.pdf
14. Evan W. C, Andrew R, Kellerman G, Alexi R. The Value of Belonging at Work [Internet]. Harvard Business Review. 2022 [cited 30 June 2022]. Available from: <https://hbr.org/2019/12/the-value-of-belonging-at-work>
15. Ferrant G., Kolev A. The economic cost of gender-based discrimination in social institutions. 2016. Available from: https://www.oecd.org/dev/development-gender/SIGI_cost_final.pdf
16. ILO. The price of excluding people with disabilities from the workplace. 2010. Available from: https://www.ilo.org/skills/pubs/WCMS_149529/lang--en/index.htm

17. Badgett M, Waaldijk K, Rodgers Y. The relationship between LGBT inclusion and economic development: Macro-level evidence. *World Development*. 2019;120:1-14. Available from:
18. Link J. Council Post: The Difference Between Workplace Equity And Equality, And Why It Matters [Internet]. *Forbes*. 2022 [cited 30 June 2022]. Available from: <https://www.forbes.com/sites/forbeshumanresourcescouncil/2019/08/15/the-difference-between-workplace-equity-and-equality-and-why-it-matters/?sh=33eec4513d31>
19. Roberson, Q. M. (2018). Diversity and Inclusion in the Workplace: A Review, Synthesis, and Future Research Agenda. *Annual Review of Organizational Psychology and Organizational Behavior*, 6(1). doi:10.1146/annurev-orgpsych-012218-015243
20. Leone, Margaret. "Diversity and Inclusion in the Workplace; Benefits, Challenges and Strategies for Success". School of Professional Studies. 2020. Available from: https://commons.clarku.edu/sps_masters_papers/42
21. Coote, G. The Effects Of Cultural Diversity In The Workplace. *Journal of Diversity Management*. 2014; 9(2). Available from: <https://clutejournals.com/index.php/JDM/article/view/8974>
22. Syed J, Tariq M. *Global Diversity Management*. Oxford Research Encyclopedia of Business and Management. 2017; Available from: https://www.researchgate.net/publication/323004237_Global_Diversity_Management#:~:text=Abstract.achieve%20organizational%20and%20personal%20objectives
23. Dijk S, Glasner J. Social Accountability in Medical Schools: Students' Toolkit. International Federation of Medical Students' Associations (IFMSA). 2017. Available from: https://ifmsa.org/wp-content/uploads/2017/09/Toolkit-on-Social-Accountability_Final-v.32.pdf
24. Rosenkranz K, Arora T, Termuhlen P, Stain S, Misra S, Dent D et al. Diversity, Equity and Inclusion in Medicine: Why It Matters and How do We Achieve It?. *Journal of Surgical Education*. 2021;78(4):1058-1065. Available from: <https://gme.dartmouth-hitchcock.org/sites/default/files/2021-10/diversity-equity-inclusion-in-medicine.pdf>
25. Pittman P, Chen C, Erikson C, Salsberg E, Luo Q, Vichare A, Batra S, Burke G. Health Workforce for Health Equity. *Med Care*. 2021; 1;59(Suppl 5):S405-S408. doi: 10.1097/MLR.0000000000001609. PMID: 34524235; PMCID: PMC8428843. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8428843/>
26. Medical Schools Council. Active inclusion: Challenging exclusions in medical education. 2021. Available from: <https://www.medschools.ac.uk/media/2918/active-inclusion-challenging-exclusions-in-medical-education.pdf>
27. Saha S, Guiton G, et al. Student body racial and ethnic composition and diversity-related outcomes in US medical schools. *JAMA* 2008; 300 (10): 1135-45 . Available from: <https://pubmed.ncbi.nlm.nih.gov/18780842/>
28. Antonio AL, Chang MJ, et al. Effects of racial diversity on complex thinking in college students. *Psychol Sci* 2004; 15;507-510. Available from: <https://journals.sagepub.com/doi/abs/10.1111/j.0956-7976.2004.00710.x?journalCode=pssa>
29. Whitla DK, Orfield G, et al. Educational benefits of diversity in medical school: A survey of students. *Academic Medicine* 2003; 78:460-466. Available from: <https://pubmed.ncbi.nlm.nih.gov/12742780/>
30. Cavallo, J. Addressing Discrimination and Bias in Medical Education. 2020. Available from: <https://ascopost.com/issues/july-10-2020/addressing-discrimination-and-bias-in-medical-education/>
31. Erik M. Hines, Renae D. Mayes, Paul C. Harris, Desireé Vega. Using a Culturally Responsive MTSS Approach to Prepare Black Males for Postsecondary Opportunities. *School Psychology*

45. Edmondson A. Wicked-Problem Solvers [Internet]. Harvard Business Review. 2022 [cited 30 June 2022]. Available from: <https://hbr.org/2016/06/wicked-problem-solvers>
46. Dogra N, Reitmanova S, Carter-Pokras O. Twelve tips for teaching diversity and embedding it in the medical curriculum. Medical Teacher. 2009 Jan 1;31(11):990-3. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2967223/>
47. OECD (2015), Frascati Manual 2015: Guidelines for Collecting and Reporting Data on Research and Experimental Development, The Measurement of Scientific, Technological and Innovation Activities, OECD Publishing, Paris, <https://doi.org/10.1787/9789264239012-en>
48. Smith J, Noble H. Bias in research. Evidence-based nursing. 2014 Oct 1;17(4):100-1. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3900086/>
49. Huang J, Gates AJ, Sinatra R, Barabási AL. Historical comparison of gender inequality in scientific careers across countries and disciplines. Proceedings of the National Academy of Sciences. 2020 Mar 3;117(9):4609-16. Available from: <https://www.pnas.org/doi/10.1073/pnas.1914221117#:~:text=There%20is%20extensive%2C%20yet%20fragmented%2C%20evidence%20of%20gender,a%20career%2C%20and%20their%20work%20acquires%20fewer%20citations>
50. Pinho-Gomes AC, Peters S, Thompson K, Hockham C, Ripullone K, Woodward M, Carcel C. Where are the women? Gender inequalities in COVID-19 research authorship. BMJ Global Health. 2020 Jul 1;5(7):e002922. Available from: <https://gh.bmj.com/content/5/7/e002922>
51. Temming M. STEM's racial, ethnic and gender gaps are still strikingly large. The Science News 2021. Available from: <https://www.sciencenews.org/article/science-technology-math-race-ethnicity-gender-diversity-gap>
52. Adams R. Fewer than 1% of UK university professors are black, figures show. The Guardian. 2020. Available from: <https://www.theguardian.com/education/2020/feb/27/fewer-than-1-of-uk-university-professors-are-black-figures-show>
53. Balde R. Black Voices Matter: Does Systemic or Implicit Bias Freeze the Careers of Black Academics?. 2021. Available from: www.ourworld.unu.edu/en/black-voices-matter-3-does-systemic-or-implicit-bias-freeze-the-career-s-of-black-academics
54. Hodapp T., Brown E. Making physics more inclusive. Nature. 2018; 557(7707), 629–632. <https://doi.org/10.1038/d41586-018-05260-4>
55. Nature. Science benefits from diversity. Nature. 2018; 558(7708), 5. <https://doi.org/10.1038/d41586-018-05326-3>
56. Balde R. 'Black Voices Matter' #3: Does systemic or implicit bias freeze the careers of black academics?. UNU. 2021. Available from: <https://www.merit.unu.edu/black-voices-matter-3-does-systemic-or-implicit-bias-freeze-the-career-s-of-black-academics/>
57. Abimbola S, Negin J, Martiniuk A. Charity begins at home in global health research funding. Lancet Glob Health. 2017 Jan;5(1):e25-e27. doi: 10.1016/S2214-109X(16)30302-3. PMID: 27955774. Available from: [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(16\)30302-3/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(16)30302-3/fulltext)
58. 10. White K. Publications Output: U.S. Trends and International Comparisons | NSF - National Science Foundation [Internet]. Ncses.nsf.gov. 2022. Available from: <https://nces.nsf.gov/pubs/nsb20206/publication-output-by-region-country-or-economy>
59. Nafade V, Sen P, Pai M. Global health journals need to address equity, diversity and inclusion. BMJ global health. 2019 Oct 1;4(5):e002018. Available from: <https://gh.bmj.com/content/bmjgh/4/5/e002018.full.pdf>

60. Guarascio F. EXCLUSIVE WHO vaccine scheme risks failure, leaving poor countries no COVID shots until 2024. Reuters. 2020. Available from: <https://www.reuters.com/business/healthcare-pharmaceuticals/exclusive-who-vaccine-scheme-risks-failure-leaving-poor-countries-no-covid-shots-2020-12-16/>
61. Reel JJ. Is JCSP diverse enough? Culturally humble strategies for addressing diversity, equity, and inclusion. Journal of Clinical Sport Psychology. 2021 Feb 8;15(1):1-3. Available from: <https://journals.humankinetics.com/view/journals/jcsp/15/1/article-p1.xml>
62. Nielsen, M.W., Bloch, C.W. & Schiebinger, L. Making gender diversity work for scientific discovery and innovation. Nat Hum Behav 2. 2018; 726–734
<https://doi.org/10.1038/s41562-018-0433-1>
63. Government of Canada. Best Practices in Equity, Diversity and Inclusion in Research. 2021. Available from: <https://www.sshrc-crsh.gc.ca/funding-financement/nfrf-fnfr/edi-eng.aspx>
64. Morrell E. Toward equity and diversity in literacy research, policy, and practice: A critical, global approach. Journal of Literacy Research. 2017 Sep;49(3):454-63. Available from: <https://journals.sagepub.com/doi/full/10.1177/1086296X17720963>
65. NIH. NIH Inclusion Outreach Toolkit: How to Engage, Recruit, and Retain Women in Clinical Research. NIH. n.d. Available from: <https://orwh.od.nih.gov/toolkit>