Health Equity Framework

July 2023

Message from Minister

All Nova Scotians deserve to be treated with respect and be free from racism or discrimination while seeking and receiving healthcare. A Nova Scotian's race, gender, ethnicity, language, religion, and ability should not affect how they are treated by providers or other staff.

That is why we developed the Health Equity Framework. We acknowledge racism and discrimination in our healthcare system, and the framework is our commitment to a more equitable present and future. The framework will guide our health providers and partners in identifying, reducing, and eliminating all forms of racism and discrimination within the health system.

In the pages that follow, the framework sets out the actions we will take to help us reduce and eliminate racism and discrimination. The framework has three key themes: Patient Experience, Health Human Resources, and Health System Policies and Practices. Each theme has actions.

The framework flows from extensive consultation sessions over the past nine months with Indigenous and equity communities, healthcare providers and partners across the province. The conversations will not stop with the publishing of the framework. We will continue to engage and listen to patients, health practitioners, and various lived experiences to address health system inequalities and report progress.

We know this is not a simple task, but we are committed to the actions that will get us to our goal. It will take government, health partners, patients, and the community working together to make our health system more responsive, safe, and inclusive for all Nova Scotians.

Michelle Thompson

Minister of Health and Wellness

Health Equity Framework Executive Summary

Part of the Equity and Anti-Racism Strategy

The Nova Scotia Health Equity Framework is a guide the Nova Scotia Government, health practitioners, and health system partners will use to identify, reduce, or eliminate the reasons—such as racism and discrimination—why people from some communities do not receive the same level of health care as others. This framework sets out the actions we will take to help us transform our health system and achieve the goals in Nova Scotia's Action for Health plan.

The framework is based on two principles: 1) EDIRA, which stands for equity, diversity, inclusion, reconciliation, and accessibility, and 2) anti-racism/anti-oppression (ARAO). Together, these two principles emphasize a person's or community's history and lived experiences—that means they ask us to find out when, where, and why the racism and/or discrimination started. They also call for everyone to receive the same level of respect and dignity whenever and wherever they access health services. A person's race, gender, ethnicity, language, religion, and ability should not affect the treatment they receive.

The Department of Health and Wellness, along with our health system partners, led the development of this framework. As part of the process to develop it, we met with underrepresented and underserved communities, held public online surveys, and reviewed existing health inclusion strategies and best practices research from other provinces.

The framework has three key themes: 1) Patient Experience, 2) Health Human Resources, and 3) Health System Policies and Practices. It includes actions under each of these themes.

Some of the actions under those key areas include

- **improving reporting systems for racism and discrimination.** We will create a safe, effective system so we can identify, report, and address racism and discrimination incidents when they happen at hospitals and health-care locations.
- **conducting a health system policy audit.** We will review health policies, procedures, and operations to identify and remove inherent racist and discriminatory practices.
- **implementing trauma-informed and person-centred care.** We will get regular input and feedback from underrepresented and underserved patients and families, and apply it to system designs, staff training, and programs.
- **increasing focus on equity-based data.** We will use evidence, statistics, and data to support key initiatives that improve health equity outcomes.

- **removing red tape and barriers that affect various equity communities**. For example, we will make it easier for
    - internationally trained health workers to get their credentials recognized
    - patients who speak other languages to access interpretive services
    - people who need gender-affirming care to receive it
- **increasing equity representation in health leadership and frontlines.** We will build a health-care workforce that reflects the increasing diversity of all the people who live in this province.
- **establishing a health equity framework partnership charter.** All core health system partners, health institutions, and community partners, will commit to this charter and to the actions in this framework.

The Department of Health and Wellness is accountable for ensuring the actions and priorities identified in this Health Equity Framework are implemented. We will do this by tracking actions with our partners, measuring the progress of these actions, and engaging with the communities. We will also publicly report on progress on a regular basis.

Introduction

Nova Scotia is home to over 100 cultures and ethnicities from around the globe and is encouraging more people to immigrate here so we can reach a population goal of two million people by 2060.

Currently, many newcomers to the province are coming from South and South-East Asia. Nova Scotia also has the highest rates of gender diversity per capita in the country, and nearly one in three Nova Scotians identifies as having a disability.

But even as Nova Scotia is becoming more multicultural and diverse, our health system is still founded on old colonial practices and public-sector policies. These practices and policies have caused historical and current damage to those who do not share that colonial heritage, such as Mi'kmaw and African Nova Scotian communities. This damage includes trauma that spans many generations, poorer health status for people from these communities, and distrust in the health system.

When the Office of Equity and Anti-Racism held engagement sessions to develop the Dismantling Racism and Hate Act, they learned the health care system had a serious issue with racism and discrimination and needed to address those issues. In particular, they learned people from underrepresented and underserved communities often do not achieve the same health outcomes as others because they do not get the same treatment, the same level of care, or have the same access to care.

Health-care staff and physicians from these communities also experience racism and discrimination from patients seeking care, as well as from their co-workers and workplaces. On top of that, they face unique barriers and obstacles to being recruited for jobs in the health-care profession and advancing in those jobs once they get them.

As a result, a system that is supposed to benefit the health of the people in these communities is often doing the opposite. That's why the Dismantling Racism and Hate Act required government, in collaboration with all health partners and in consultation with underrepresented and underserved communities, to develop this **Health Equity Framework**.

The experiences we heard during our engagement sessions to develop this framework are challenging and upsetting. They prove that exclusion, marginalization, and mistreatment happen in Nova Scotia – and that is a heavy weight to read and acknowledge. But it's even heavier for those who have experienced them first-hand.

We encourage readers to understand that this document contains many examples of experiences that may be triggering for those who have experienced similar trauma.

However, our journey toward eliminating racism and oppression in our health system starts by acknowledging these truths. Together, we can then begin to shoulder some of the weight that our First Peoples, historic communities, neighbours, care givers, and colleagues have been carrying for generations, while improving the health-care experience for all Nova Scotians.

What Is the Health Equity Framework?

Nova Scotia's Health Equity Framework is a guide that will help make the health system as beneficial and effective as possible for all Nova Scotians. It will help us identify, reduce, or eliminate the reasons why some communities do not receive the same level of health care as others.

There are many factors that influence a person's health outcomes, such as where they live, their level of education, their level of income, and more. However, the initial scope of our work will focus on the health-care system itself. Over time, we will collaborate with the Office of Equity and Anti-Racism and other government departments to expand this scope so it includes a greater focus on the social and structural determinants of health.

This framework

- considers all EDIRA and ARAO elements when making improvements to the health system
- guides us to incorporate ARAO principles across the health system
- focuses on addressing how the health system creates health inequities, anchored by the social and structural determinants of health
- provides clear, measurable outcomes with indicators/metrics so we can assess progress

This Health Equity Framework is also an important initiative under Solution Six of government's Action for Health plan, which says government must address the factors affecting health and well-being. The priority actions in this framework are at the core of the work laid out in Action for Health and are absolutely necessary for us to transform the health system in our province. The approach detailed in this framework is in line with government's Equity and Anti-Racism Strategy, which calls for coordinated action, community engagement, and accountability to Nova Scotians.

Nova Scotia's health system works well for many – but not for all. Right now, many people in this province will never reach their full health potential. Our goal is to break down the barriers related to race, culture, gender, sexual orientation, religious association, disability, language, geography, or any other characteristic that stands in the way of Nova Scotians achieving health.

EDIRA stands for Equity, Diversity, Inclusion, Reconciliation, and Accessibility. These core concepts and principles are at the heart of an equity-based approach.

- ***Equity*** – refers to an approach that ensures everyone has access to the same opportunities.
- ***Diversity*** – is defined as the many ways we are unique and different from one another while distinguishing ourselves as individuals and identifying ourselves as belonging to a group or groups.
- ***Inclusion*** – refers to the intentional, ongoing efforts and actions to ensure that people with different identities actively participate in all aspects of the work of an organization and/or society.
- ***Reconciliation*** – is a process of healing relationships that requires public truth sharing, apology, and commemoration that acknowledges and redresses past harm.
- ***Accessibility*** – when our environments, services and products and policies are proactively designed and constructed so that people with a disability can fully and equally participate without experiencing barriers.

Anti-Racism Anti-Oppression (ARAO) Principles are guides to identifying, understanding, and taking systemic action against racist and oppressive practices. These principles call for us to take a deep examination of the colonial influences in our system and put robust structures and leadership in place to raise up and support diverse communities. ARAO requires honest, real community engagement, examination of bias and power imbalances, and true valuing of diversity so we can eliminate racism and oppression.

A Community-led Approach to Health Equity

This framework was developed in partnership with the communities identified in the Dismantling Racism and Hate Act, which include

- Mi'kmaq and people of Indigenous descent
- African Nova Scotians and people of African descent

- 2SLGBTQIA+ communities
- Newcomers (immigrants, refugees)
- Faith-based communities
- Persons with disabilities

This framework also includes Acadian and Francophonie communities in recognition of their concerns that health services, supports, and resources have not been available in French.

Project Leadership and Guidance

Under the Health Authorities Act, the Department of Health and Wellness oversees and is accountable for Nova Scotia's health system. Our core health system partners include Nova Scotia Health, IWK Health, the Department of Seniors and Long-term Care, the Office of Addictions and Mental Health, and the Office of Healthcare Professionals Recruitment.

The Department of Health and Wellness led the development of this framework along with our core health system partners, health leaders from across the province, and experts in evaluation and measurement. We also worked in close collaboration with underrepresented and underserved communities.

Background Research

Before developing this framework, we reviewed existing research on health equity work that is being done in Nova Scotia and in other parts of Canada. We reviewed many documents, including important reports such as *The Health & Wellness of People of African Descent in Nova Scotia* (2019) (commonly referred to as the "Waldron Report") and *The Provincial Diversity and Inclusion Framework* (2017–20), which was developed jointly by Nova Scotia Health and IWK Health.

The information we gathered from these sources provided guidance on how we should develop the framework and emphasized the importance of including community voice and lived experience. Thanks to this information, we were able to start our discussions with the communities by first reflecting on what we had already learned from those who had taken the time and effort to raise their voices to government. As a result, we did not need to ask communities to repeat what they have said before.

Engaging with Communities

We held 58 initial engagement conversations with partners at the health system and community partner level. These partners included equity-focused community-based organizations, post-secondary institutions, community health boards, Nova Scotia Health's staff from

underrepresented and underserved communities, and others. We added to this the learning we had collected from health-care workers while developing government's Action for Health plan. See Appendix A for details.

These engagements also brought attention to important intersectional characteristics, such as people from more than one underrepresented and underserved community who also live in rural areas, are across the age spectrum, and who live in all regions of the province.

Public Engagement

For our general public engagement, we hosted English and French surveys on the Engage4Health online platform and received over 1,100 responses. We also put up displays at 80+ community libraries across the province so people could participate in person.

Three Key Themes

The feedback we received from participants revealed three overarching themes for the areas that require priority action:

- **Patient Experience**
- **Health Human Resources**
- **Health System Policies and Practices**

Although this document is organized according to these three themes, this in no way suggests that we did not hear the specific experiences of individual communities. We will work with individual communities to ensure the unique concerns we heard regarding racism and discrimination are addressed.

Community Validation of Themes

We wanted to make sure the communities agreed with the themes and actions we were proposing for the framework, so we held a series of 17 additional reflection engagement sessions with underrepresented and underserved community leaders and health system partners. We also re-engaged the public through the Engage4Health platform. We shared the key themes as well as the initial set of priority actions, and asked if they were accurate and represented the communities' and public's views.

There was general support for the themes and actions, and community members provided additional feedback, context, and experience, which was incorporated into the framework.

We appreciate each and every person who came to an engagement session or shared their experience and feedback with us online. This framework is the result of your input and partnership.

Patient Experience

"A nurse wouldn't draw blood from a darker-skinned man because she 'couldn't see a vein,' but yet they are taught to palpate for a vein. Providing culturally safe care should be tied to performance reviews." Participant

What We Heard from the Communities

Participants across all communities told us they did not feel safe in the health-care system.

This experience ranged from being the target of verbal abuse to being concerned about the level of treatment they were receiving. Some said they were not able to access safe treatment.

For example, many participants from the Mi'kmaw, African Nova Scotian, and newcomer communities said health-care professionals often used bias, racist, derogatory language when speaking to them and also dismissed or misdiagnosed their concerns. They also said they had longer wait times for treatment compared to people who are not from underrepresented or underserved communities, and had been denied medication or treatment based on stereotypical thinking.

Many participants living with disabilities told us they faced physical and attitudinal barriers: these ranged from feeling unwelcome, misunderstood, stigmatized, and not having accessibility services (such as ASL), to not being able to physically access buildings and offices. People from this community told us they frequently asked for accommodations (again, such as ASL) but that those accommodations were not provided.

Some 2SLGBTQIA+ participants told us that health-care providers have refused to treat them, and there were no repercussions for that. They also described the system as being outdated and still operating with a rigid view of gender identity, expression, and sexuality (e.g., only two options available on patient charts: male or female). Women told us they also experience discrimination and misogyny when seeking care. Persons with an intersectional identity – meaning they belong to more than one underrepresented/underserved community—have distinct negative experiences that combine sexism, misogyny, and racism.

Language was another major issue. Participants from Acadian and Francophonie communities said health care is not readily available in French either for in-person service or through other communications, such as websites. Newcomers also said they had challenges getting health-care service in their first language. Some participants told us they had not followed through with treatment, such as medication, because they had not understood what the health-care provider had told them. Both communities suggested that interpreters needed to be made available, but were also concerned that having an interpreter present impacts their privacy in health care.

Participants said health-care providers do not understand the cultural needs of their communities. For example, newcomers told us that the system needs to do a better job of providing culturally sensitive mental health- and trauma-informed care, especially for refugees.

Participants from several communities, including the Mi'kmaw and African Nova Scotia communities, said mental health supports were not readily available in their communities.

Many participants told us they often travel great distances to access health care either because it is not available in their community or is not available in a way that respects their culture or community. We heard this from members of the Mi'kmaw, African Nova Scotian, and 2SLGBTQIA+ communities. Some told us they do not seek care at all because of this.

Participants from all communities told us they are frustrated that they do not have a way to complain about mistreatment in the health-care system that will actually bring about a solution.

Finally, they said they are tired and stressed out by the need to constantly advocate for proper care and to have to educate the people around them about what it's like to be from an underrepresented, underserved community.

What are we doing now to address some of these concerns?

- Government has provided increased funding for Indigenous patient and family navigators who can support Mi'kmaw and Indigenous community members through their care journey.
- We have taken several steps to improve access to gender-affirming care. The application process for gender-affirming surgeries has been significantly streamlined in recent years. Fewer referrals are now required and can be provided by a broader range of providers than ever before.
- The Nova Scotia Brotherhood, which helps African Nova Scotian men access and navigate the health-care system, has been expanded, and the Nova Scotia Sisterhood was established to provide similar supports to women of African descent.
- A range of primary care options are now available for Nova Scotians who do not have a dedicated primary care provider. These include the increased availability of virtual care and walk-in clinics for those on the Need a Family Practice Registry, as well as more primary care services being available at community pharmacies across the province.
- Government has provided increased funding to support Pride Health to deliver important navigational support to 2SLGBTQIA+ communities across the province.

We will take the following system-level priority actions to address the patient experience:

- Implement a safe, effective system for identifying, reporting, and addressing incidents of racism and discrimination against patients. This includes the (re)development and enforcement of associated policies.
- Work with communities and sectors to address stigma and bias in health service provision. The initial focus will be on substance use, addictions, mental illness, weight bias/size-ism, and ageism.
- Engage Mi'kmaw communities and Indigenous peoples to identify and address anti-Indigenous racism in specific health system facilities.
- Collaborate with community partners to improve the availability of health system navigators and advocates among Mi'kmaw and Indigenous communities.
- Engage Black and African Nova Scotian communities to identify and address anti-Black racism in specific health system facilities.
- Engage historic African Nova Scotian communities to improve access to mental health and addictions supports in their communities.
- Work with Black and African Nova Scotian communities to improve access to primary care.
- Collaborate with the trans community to further improve access to gender-affirming care.
- Work with physicians and other care providers to improve access to safe, effective primary care services for the 2SLGBTQIA+ community.
- Collaborate with Acadian and Francophonie communities to develop greater access to health system services in French.
- Collaborate with disability communities to ensure people with disabilities have equitable access to health services, and to address barriers related to technology, transportation, and the physical environment.
- Improve the availability and continuity of interpretation services throughout the health system and explore how health system information could be delivered in various languages that reflect the increasing provincial diversity.

Health Human Resources

"We need people who have different lenses and representations in high levels rather than just people who have read about equity..." Participant

What We Heard from the Communities

Participants across all communities who work in the health-care system told us that the workforce, particularly leadership, does not reflect the diversity of the community it serves and this lack of representation leads to many issues.

They said the system needs to do a better job of recruiting members from underrepresented, underserved communities – including Acadian and Francophonie communities. Health-care spaces also need to remove barriers for members from the disability community. These barriers could be physical or attitudinal. All communities said they need opportunities to advance to leadership roles within the health system.

We were told there is a lack of training in cultural competency, cultural humility, accountability, and EDIRA for health-care workers. Participants from the Black Nova Scotia, African Nova Scotian, and Mi'kmaw communities said racism is prominent in the education and training system and their members are not supported to thrive in these programs. We also heard that more training needs to be provided to IWK Health staff and physicians so they have the tools and resources they need to appropriately treat Indigenous children.

Participants from all communities described themselves as being caught in the middle: they experience bullying, microaggressions, and discrimination based on their race, gender, and/or ability from the public on one side and from their co-workers and managers on the other.

They also have no effective, formal complaint process. Managers also told us they do not have adequate tools and the support they need to identify racism and discrimination, or to address it.

Participants said the Pride Network, which includes and supports 2SLGBTQIA+ employees within Nova Scotia Health and IWK Health, has been under-resourced for years while at the same time facing increasing demand for its support, and that hospitals should also provide advocates for Black and African Nova Scotian patients.

While progress has been made in speeding up the process so internationally trained health-care professionals can get their education and credentials recognized, some newcomer health professionals are still finding the process challenging and are leaving Nova Scotia as a result.

What are we doing now to address these concerns?

- The Department of Health and Wellness, Nova Scotia Health, and IWK Health have created leadership positions in their organizations that focus on EDIRA and have begun building teams with representation from underrepresented and underserved communities.
- In collaboration with government, all health-care licensing bodies are working to increase the speed of their international application process. Some changes have already been implemented and there is an immediate pathway to licensure for nurses applying to Nova Scotia from the Philippines, India, Nigeria, USA, UK, Australia, and New Zealand, and for American Board-certified physicians.
- Government has partnered with the NS College of Physicians and Surgeons on the Welcome Collaborative, a support program for internationally educated doctors coming to Canada to work.
- IWK Health has partnered with Tajikeimɨk and Dalhousie University to develop training for health system staff rooted in the concept of Etuaptmumk, or two-eyed seeing (a worldview that brings together the two perspectives of Indigenous knowledge and Western science), to better serve Indigenous patients. The modules in this training focus on cultural safety, Mi'kmaw culture and language, the harmful legacy of racism and colonialism to the Mi'kmaw people, and trauma-informed clinical care.
- The Department of Health and Wellness has developed the Leadership Equity Action Program, which will support staff from underrepresented and underserved communities to advance to leadership roles in the department.

We will take the following system-level priority actions to address health human resources:

- Work with health system partners to ensure EDIRA and diverse perspectives are represented at each organization's leadership level.
- Implement a safe, effective system to identify, report, and address incidents of workplace racism and discrimination. This includes the (re)development and enforcement of associated policies.
- Further encourage underrepresented and underserved communities to enter health professional training programs by exploring ways to address barriers, increase accessibility of education programs, and engage communities.
- Take an equity-based approach to health workforce recruitment and retention and support successful employment.
- Support staff from underrepresented and underserved communities to move into more senior roles within the health system.

- Advance training in ARAO principles, trauma-informed care, person- and family-centred care, and cultural competency/humility for the existing health workforce and those in professional training programs.
- Collaborate with underrepresented and underserved communities to develop and deliver training materials that reflect specific community needs, histories, and cultural context.
- Create and foster safe spaces where staff and physicians from underrepresented and underserved communities can engage and share their experiences. Ensure employers/organizational leadership take appropriate action as a result.
- Ensure managers are provided with, and effectively use, training, tools, and supports to address racism and discrimination in their units.
- Continue to work with health professional regulators and associations to further reduce barriers and streamline the process for internationally trained physicians and health-care providers to have their credentials recognized.
- Advance a community-based, cross-sectoral approach to help internationally trained health-care providers settle in Nova Scotia.
- Work with community partners to create an environment that promotes efficient and accessible services in French. Increase the number of physicians and other care providers who can deliver health services in French.

Health System Policies and Practices

"Anglophones in the health system have the attitude that French-speaking patients 'speak enough English' so they don't feel they need to provide services in French." Participant

What We Heard from the Communities

Participants said the system needs to engage their communities and incorporate their input when planning services and determining how those services will be delivered.

For example, participants from the 2SLGBTQIA+ community said the health system and community partners need to work together to develop a comprehensive approach to gender, sexual, and reproductive health, including gender-affirming care, and have more sexual and gender-based health resources in rural areas.

Participants from Mi'kmaw communities said the health system needs to work with Mi'kmaw and Indigenous communities in a mutually beneficial, nation-to-nation relationship. They further said the system needs to increase access to traditional healing and practices for Mi'kmaq and Indigenous persons and that screening for suicide needs to be more intentional and available.

Members from other communities told us about the power imbalance Nova Scotia's family physician situation is creating. Patients who experience inappropriate care from a health-care provider feel they need to either stay, or leave and go on the Need a Family Practice Registry to find another source of care. Several Mi'kmaw participants told us health directors in their communities have been denied the right to advocate on behalf of their community members when they have a negative experience.

Finally, participants said more support is needed to collect race-based data to hold the system accountable.

What are we doing now to address these concerns?

- We are working with health system partners to develop a more comprehensive, coordinated approach to public engagement so we can use that input when developing health programming and policies.
- In spring 2023, Nova Scotia signed a trilateral memorandum of understanding with Tajikeimɨk and Canada. This is an important step toward ongoing partnership and mutual support in transforming the design and delivery of health services serving the Mi'kmaq in Nova Scotia.
- The Department of Health and Wellness has established a Health Equity Partnership table made up of leadership from all core health system partners. This table oversees and collaboratively guides EDIRA-related work across Nova Scotia's health system.
- Nova Scotia Health (NSH) and IWK Health collaborated to develop an Accessibility Plan through extensive engagement with staff, patients, and families. The plan includes a wide range of recommendations to make NSH and IWK facilities and services more accessible to all Nova Scotians.

We will take the following system-level priority actions to address health system policies and practices:

- Ensure leadership of all health system partner organizations adopt the Health Equity Framework and commit to demonstrating how they will meet their obligations under the framework.
- Meaningfully engage with communities and partners when planning and delivering health system programs, services, and policies and reflect how this input is incorporated.

- Ensure EDIRA-related tools/processes are used when developing new programs, services, and policies.
- Perform reviews or audits of existing programs, services, and policies using EDIRA and ARAO principles and tools, and follow through with required changes.
- Support Mi'kmaw health directors, Elders, and knowledge keepers to advocate within the health system on behalf of their community members.
- Continue working with Tajikeimɨk and the federal government to develop and foster a respectful nation-to-nation working relationship between government and Mi'kmaw communities.
- Advance gender, sexual, and reproductive health.
- Continually review, prioritize, and bring forward recommendations from community- and EDIRA-based reports and submissions.
- Identify opportunities to build or improve internal health system data sources related to EDIRA-related initiatives and equity populations.
- Require all EDIRA-related initiatives to have processes to monitor and report on outcomes.
- Improve health system accessibility and quality of care for underrepresented and underserved communities by collaborating with organizations outside the health system.

Implementation and Accountability

In addition to core health system partners, the Health Equity Framework will be implemented across the health system in partnership with

- extended health systems and Government of Nova Scotia partners, including professional colleges, allied health professionals, unions, and other government departments
- key community institutions, including municipalities, community-based organizations, universities and colleges, community foundations, private companies and other large employers, social services, and other key institutions

Accountability

On an ongoing basis, the Department of Health and Wellness will monitor progress of all initiatives that are related to the framework and will collaborate with our partners to ensure those initiatives are successfully implemented.

We will collect data to make sure the actions are having the desired impact. See Appendix B for more information on some initial metrics that will be used to measure success.

Conclusion

In preparing this framework, partners from across the health system joined together in taking a long, hard, honest look at our system. Thanks to this process, we know where we've been, and where we want to be. Good work is already happening and changes are being made. And we now have a path forward to build on that work and create a system inclusive of all Nova Scotians.

We would like to thank everyone who engaged with us in creating this framework, especially the members of the underrepresented and underserved communities in the health system who work so hard to advocate for your communities. Your input is invaluable. Your voices are heard. This transformation is long overdue, but, thanks to you, it is happening. As we continue this journey we will remain open to and grateful for the guidance and knowledge Nova Scotians share with us.

Contact Us

Department of Health and Wellness
Equity and Engagement Division
1894 Barrington Street, Halifax NS B3J 2A8
Email: ***health.equity@novascotia.ca***

Appendix A – Community Engagement Summary

Engagement period: October 2022 – June 2023

*NOTE – some organizations were engaged on more than one occasion.

Equity Group/ Community/ Sector	Meetings Held	Organizations Engaged/ Notes
Indigenous	3	Tajikeimɨk; Wabanaki Council on Disability; Mi'kmaq/ Indigenous Health Leaders
African NS and People of African Descent	12	Health Association of African Canadians; Association of Black Social Workers; United African Canadian Women's Association/African Diaspora Association of the Maritimes; African NS Community Leaders; Black Nurses Association of NS; Promoting Leadership for African Nova Scotians (PLANS); Whitney Pier ANS Community
2SLGBTQIA+	7	Pride Network; Youth Project (CB and HRM); Sexual Health NS; Gender Affirming Care NS; 2SLGBTQIA+ Community Leaders
People with Disabilities	2	Accessibility Directorate; Accessibility Advisory Board
Newcomers, Racialized, and Faith-Based Groups	5	YMCA Immigrant Settlement Services; CB Centre for Immigration; Halitube; Muslim Community Leaders; Atlantic Jewish Council

Acadian and Francophonie Groups	4	Réseau Santé; Acadian and Francophonie Community Leaders
Other Organizations	8	Antigonish Early Years Committee; Aberdeen Health Foundation; Antigonish Community Leaders; Equity and Indigenous Community Leaders; HEF Open House Community Reflection Meetings; Gov't of NB – Public Health; Ontario Health – IDEA division
Post-secondary/ Academics	4	Dalhousie University; NSCC School of Health and Human Services; Cape Breton University
Health-care Unions	1	NSGEU, NSNU, UNIFOR, CUPE (single meeting)
Health Professional Regulatory Bodies	5	Regulated Health Professionals Network; Doctors Nova Scotia; NS Continuing Care Assistant Advisory Committee; Health Association of NS; NS College of Social Workers
Community Health Boards	11	Eastern Shore/ Musquodoboit; West Hants; Cobequid; Southeastern; Central and East Pictou; Clare; Yarmouth County; Digby and area; Dartmouth; Halifax; Chebucto West
NSH Staff Engagement Sessions	14	All equity groups; Mi'kmaw/ Indigenous health system staff; NSH SSP Public Health
TOTAL	75	

Appendix B – Initial Outcomes and Performance Indicators

Outcomes	Performance Indicators
Greater representation of underrepresented and underserved groups within the health system leadership, including DHW, NSH, IWK, and other health system partners	% of leadership who identify as members of equity groups
	% of frontline staff and physicians who identify as members of equity groups
	% of administrative staff who identify as members of equity groups
	% of equity group candidates who applied for non-designated positions; are interviewed; are successful
Increased system accountability for poor patient experience	% of patient reports that identify racism
	% of patient reports that identify discrimination
Increased use of EDIRA-related tools/ processes in the development of new programs, services, and policies	% audited policies updated to incorporate EDIRA and anti-racism/anti-oppression (ARAO) principles
Community health partners have a greater level of involvement in addressing health disparities in health system	% of new initiatives incorporating EDIRA and ARAO principles that meaningfully engage with equity community-based groups
Improved health system accessibility and quality of care for underrepresented and underserved communities through collaboration and capacity building with organizations outside the health system	% initiatives that address health system accessibility and quality of care through intersectoral collaborations
Developed and/or improved internal health system data sources for EDIRA-related initiatives and equity populations	% incidence of chronic disease in equity groups compared to Nova Scotia general population