

EVIDENCE TO ASSESS THE IMPACT OF COVID-19 ON COMMUNITY-BASED DEMENTIA CARE IN NOVA SCOTIA (DEMENTIA CARE UNDER COVID-19)

DEMENTIA RELEVANT COMMUNITY SERVICES:
A SGBA+ POLICY SCAN

JUNE 2023

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EXECUTIVE SUMMARY

For the policy scan and analysis we developed a new methodology which involved an intersectional Sex and Gender Based Analysis Plus (SGBA+) analytical approach and adaptation of the Health Equity Impact Assessment (HEIA) tool, which we shared with an international audience as part of a special COVID-19 plenary at the Gerontological Society of America online conference in Fall 2020.

The first objective of the scan was to create a baseline slate of legislative and regulatory policy instruments that influence the design, eligibility, and administration of community-based dementia-related programs and services for people living with dementia and their caregivers in Nova Scotia. To our knowledge, this has not been done before. A total of 66 policies were identified and subsequently analyzed. A key finding of the policy scan was that it revealed a complex web of legislative acts and policies exert influence over the care of persons with dementia; it was not simple or easy to navigate the programs and services available for support before the pandemic. COVID-19 further exacerbated these challenges. Only one policy, the Supportive Care Program in the Department of Health and Wellness, is specific to persons with dementia.

The unique SGBA+ and intersectional analytic approach adopted by the policy group provided a nuanced understanding and analyses of the layered impacts of COVID-19 policies on community dementia care from the perspective of marginalized communities. It is fair to say that these populations living with dementia have experienced further isolation and barriers to access of community services and negative health inequities because of the layered impacts of COVID-19 on individuals (i.e., gathering restrictions, fewer translation services, reduced access to informal supports) and businesses/organizations (reduced access to formal supports including home care and respite). The federal government is committed to using GBA+ analysis, however uptake is questionable. At the provincial level, policy analysis indicates that policy makers and other stakeholders pay scant attention to the diverse needs of Nova Scotians. Most dementia related policies have no inclusion or mention of marginalized populations. Only one policy mentioned Nova Scotians who are Black and/or of African descent. Program policies explicitly exclude immigrants and refugees with the requirement that applicants must have a Nova Scotia Health card.

Mitigation strategies that could potentially reduce unintended negative effects of the layered impact of COVID-19 on dementia care policies include: consulting with representative/advocacy organizations to ensure that different perspectives are included in policy development, communicating public health information in different languages, and distribution via channels other than the internet. As well, it is critical to engage with marginalized populations to learn about their experiences of living with dementia or as caregivers during the pandemic so that these perspectives can be included in future policy design. Scarce resources need to be allocated appropriately to reduce and prevent further health inequities from developing during future public health crises.

INTRODUCTION

Dementia is a public health priority (World Health Organization, 2012). In Nova Scotia, there are 17,000 people living with dementia (Alzheimer Society Canada, 2022). Dementia does not discriminate; Black, Asian, and minority ethnic individuals as well as those with disabilities, immigrants and refugees, and people in the LGBTQ2S+ and linguistic minority populations are diagnosed with dementia. People with dementia experience stigma, social isolation, challenges associated with disability, human rights violations and difficulties accessing health programs and services (World Health Organization, 2017).

The World Health Organization announced COVID-19 as a global health crisis on March 11, 2020. Consequently, the government of Nova Scotia declared a provincial state of emergency (subsection of the Emergency Management Act) on March 22, 2020, to help contain the spread of COVID-19 and implemented public health measures under the Health Protection Act. The 'Dementia-related Care under COVID-19' project addresses the pressing need for information that can be used to assess the impact and health equity implications of COVID-19 on community supports for vulnerable older adults living with dementia and their family/friend caregivers in Nova Scotia. Within the current context of physical distancing and social isolation, evidence about the resources, services and supports that make it possible for dementia care to continue at home in the community is lacking. The goal is to strengthen supports for vulnerable people living with dementia and their family/friend caregivers and communities in Nova Scotia under COVID-19.

The project included a Sex and Gender Based Analysis Plus (SGBA+) policy scan. The purpose of the policy scan was to provide current baseline information on legislative and regulatory policies related to dementia care in the community within the Nova Scotia context (primary search), and orders and legislation enacted in response to COVID-19 that potentially impacted these policies (secondary search). As well, a specific aim of the scan was to generate knowledge about the impact of these layered policies in the context of a public health crisis from the perspective of local socially and geographically marginalized communities (LGBTQ2S+, African Nova Scotian communities, immigrants/refugees, persons with disabilities, and linguistic minorities). A SGBA+ analytical approach was used to assess potential health equity impacts of COVID-19 policies on dementia care in the community. Information was organized and analyzed using an adapted Health Equity Impact Assessment (HEIA) tool and a Systems Health Equity Lens (SHEL).

This report discusses the methods, tools, results and findings of the policy scan and analysis.

POLICY ANALYSIS DESIGN AND METHODS

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STAGE 1: POLICY SCAN (CRITERIA)

The policy scan was conducted between June and August 2020, using an adapted ten-step process from the Connecticut Department of Public Health. Dementia care was defined as *health, social and community/cultural resources, services and supports* for this project. The scope of the scan for the primary search included six provincial policy domains: Health and Wellness; Community Services; Justice; Seniors; Business; and Communities, Culture and Heritage. Policies enacted due to COVID-19 were collected using publicly available information on federal and provincial government websites. Policies relating to human rights and diversity were also searched during this phase. A data collection tool collated the policies found in the primary and secondary searches.

The policies included consisted of regulatory documents that have compliance attached (legislative acts and regulations); federal and provincial policies that legislate/regulate dementia-relevant community care resources, services and supports (e.g., dementia, caregiving, continuing care for older adults, age or caregiving related benefit program policies; seniors/aging; income; safety; museums, libraries, galleries and community spaces; shopping); and provincial policies relating to the vulnerable populations of interest (LGBTQ2S+, African Nova Scotian communities, immigrants/refugees, persons with disabilities, linguistic minorities). Exclusions were strategies and guidelines that are not enforceable by law, regulatory documents or policies pertaining to transportation, young-onset dementia, and childcare.

After the initial collection phase, the next steps included refining the inclusion criteria and determining which of the legislative acts and policies were relevant to the research. A clear rationale was needed beyond the initial inclusion criteria to further understand why particular legislative acts and policies were included in the policy scan. In other words, how do we answer the question: *Why is this policy included?* To help assess the relevance and appropriateness of each policy, the mandate and stakeholders of each domain were documented and the data collection tool was adapted to include this information. As well, to further facilitate the development of inclusion criteria five questions were created including: *Does this policy impact health, social or community/cultural resources, services or supports? Is there an obvious or clear connection to dementia relevant community care? Is the Act specific to older adults over the age of 65? Does the legislative act or policy pertain specifically to employees/people in professional occupations either in terms of occupational health and safety or regulations for licensed professions for code of conduct? (If yes, exclude). Does the policy address a topic that could potentially inform, or promote the goals and strategies of the research project?* The data collection tool was amended to capture the rationale for inclusion of each policy.

STAGE 1: POLICY SCAN (CRITERIA)

Additional exclusions were legislative acts that pertain to occupational health and safety or licensing of individuals in regulated professions; acts that pertain to nursing homes or residential care facilities; and aboriginal policies. It was also decided that the analysis would focus only on provincial acts/policies and not federal acts/policies. The following statements provide rationale for each exclusion:

- 1) Acts pertaining to occupational health and safety or licensing of individuals in regulated professions were excluded due to the sheer volume of these acts that exist for the professionals that provide care to persons with dementia in the community (e.g., physicians, registered nurses, licensed practical nurses, continuing care assistants, dentists, dental hygienists, lawyers, etc.). Although considered relevant, these were deemed not directly related to dementia care in the community.
- 2) Acts pertaining to nursing homes and residential care facilities were excluded because although there may be a connection between them and dementia care in the community (e.g., on-site adult day programs), the acts do not address these community programs.
- 3) Federal policies for both primary and secondary searches were excluded from the analysis phase.
- 4) Policies focusing on Indigenous issues were excluded because they fall under federal jurisdiction.

The data collection tool was adapted with a section added to collate excluded policies within each domain. As well, it was noted where a policy may have been included in more than one domain in the initial collection phase. In the final scan each policy was only counted in the domain/government department that had ownership and responsibility for its' enforcement.

STAGE 2: POLICY LENSES

Our policy analysis used a novel approach with SGBA+ tools, an intersectional lens, and a SHEL.

The SGBA+ lens is an analytical tool to assess how different groups of people may experience policies and programs (Government of Canada, 2022). It acknowledges that an individual has many intersecting identity factors including gender, race, ethnicity, religion, age, and mental or physical disabilities. It offers questions to consider for policy analysis such as: *Is the issue important to a particular group? Whose voice is most important? Have the experiences of women, men, and non-binary people been considered in defining the issue from their perspective? Are there groups of people that might experience the issue differently?* These questions were considered in the context of the policy scan analysis for how dementia care and COVID-19 policies (both separately and in a layered approach) have negatively (or positively) impacted health equity for marginalized populations of people living with dementia and their caregivers. SGBA+ training was undertaken by members of the research team.

Intersectionality is one of the theoretical underpinnings of this policy analysis research. It was developed by Kimberly Crenshaw in 1989 to “describe how race, class, gender and other individual characteristics intersected with one another and overlap” and to conceptualize that “individuals have individual identities that intersect in ways that impact how they are viewed, understood, and treated” (Coaston, 2019). While we intended to use an existing intersectional policy lens, it became evident as the research progressed, that such a lens to suit our research didn’t exist. Thus, it was decided that we would create our own intersectional lens. This was done by reviewing and drawing upon SGBA+ tools and other policy lenses and writing questions targeted to what we wanted to learn from the policies. Our lens was comprised of seven sections including: *Background Questions, Health Equity Scoping Questions, Health Equity Impacts, Social Justice, Language and Representation, Mitigation Strategies, Dissemination, and Closing Questions*. The categories included 25 questions and sub-questions.

The SHEL (based on socio-ecological theory) was developed by the University of Victoria as part of their work in health equity and to support health equity across health systems, moving the focus from vulnerable populations to a focus on *systems, structures and processes* that create disadvantage and vulnerability (Pauly et al., 2018). Intersectionality is one of the theoretical foundations of SHEL making it very suitable and relevant to our policy analysis. SHEL is also underpinned by complexity theory which considers how institutional structures, arrangements and political agendas impact people’s social positions and access to resources and can be used to address the challenge of intersectionality analysis. SHEL and intersectionality can be used in tandem to explore multiple intersecting social inequalities. The SHEL framework was used to map the policies within systemic levels and to consider how the *systems, structures and processes* have contributed to the layered impact of COVID-19 policies on dementia care in the community (intrapersonal, interpersonal, organization, community, public policy). “As we develop a critical consciousness and work to help address and dismantle racism, sexism and other forms of oppression, it is important that we apply a systems approach to our work and begin to analyze, uncover and change the ways that oppression is operating at the personal, interpersonal, institutional and cultural levels.” (Pizaña, 2017).

STAGE 3: ADAPATING THE HEALTH EQUITY IMPACT ASSESSMENT TOOL

A HEIA template and workbooks (a Guide to the HEIA template, French Language Services Supplement, the LGBTQ2S Populations Supplement and the Immigrant Populations Supplement) developed by the Ontario Ministry of Health and Long-Term Care (MOHLTC) to advance health equity and reduce avoidable health disparities between population groups were used in this research (Ontario Ministry of Health and Long-Term Care, 2012). The tool provides a method of asking questions about specific populations to identify inequities, helps to facilitate an in-depth examination of policies and provides a way to organize the information.

The HEIA workbook outlines a five-step process that corresponds with the HEIA template tool. Briefly, the five steps are:

- 1) Scoping - Identify affected populations or groups of interest and the social determinants of health that will be used in the template.
- 2) Potential Impacts - Assess the potential impacts of the policy, program or initiative of interest including common knowledge, working experiences, literature review, analysis of existing data, environmental scan, grey literature, online resources, stakeholder consultations, interviews with local experts or staff from organizations, client surveys, field evidence and tacit information. The quality of the evidence inputted by the user of the HEIA determines the quality of the analysis.
- 3) Mitigation - Develop ideas for mitigation and evidence-based recommendations to minimize or eliminate negative impacts on vulnerable groups (and maximize positive impacts).
- 4) Monitoring - Determine how you will monitor your initiative and impacts on vulnerable populations.
- 5) Dissemination - Share results and recommendations for addressing equity.

Steps one and two were helpful to our work and completed in the Fall of 2020, using the HEIA template as developed by the Ministry of Health. Steps three, four and five of the HEIA tool were less relevant to our research and policy analysis. However, mitigation strategies will be mentioned briefly in the recommendation section of this report and dissemination will be addressed by a knowledge translation plan as part of the larger project plan.

The HEIA was adapted to focus more on potential impacts and to answer questions posed by our intersectional lens including: *Is there anything in the policies that speak to (each population)? What are the ways in which policies manage identities? Do some people have different access to the programs or services? Do the policies have negative effects that contribute to, maintain, or strengthen health disparities? Is there anything in the policy that speaks to access, agency, advocacy, or action? What is the layered impact of COVID-19 policies on the dementia policies and each of the populations?*

STAGE 4: POLICY ANALYSIS USING THE ADAPTED HEIA TOOL AND SHEL

The final stage of the methodology was to complete the SGBA+ policy analysis using the intersectionality lens and adapted HEIA template. In this phase, each legislative act or policy was reviewed for the desired information and entered in the template. Where some policy manuals were lengthy, it was not possible to read them in their entirety, so a search strategy using key words (gender, sex, sexuality, race, culture, ethnicity, immigrants, refugees, Nova Scotians who are Black and/or of African descent, disabilities, language, linguistics) was employed to find references within the manuals applicable to our analyses. One HEIA template for each was completed for Health and Wellness, Community Services, and Communities, Culture and Heritage. The analysis findings for the Justice, Seniors, and Business domains were included on one template. Lastly, policies were mapped using the SHEL.

POLICY SCAN

The policy scan achieved the first two objectives of the policy research:

- 1) What are the policies (legislative acts and regulations) related to dementia care in the community within the Nova Scotia context?
- 2) What are the COVID-19 policies (legislative acts and regulations) that potentially impact policies related to dementia care in the community within the Nova Scotia context?

In the initial collection phase, 135 acts were collated in the data collection tool. This included acts pertaining to dementia care in the community within the six domains at the provincial and federal levels, as well as federal and provincial COVID-19 enacted policies. With duplications removed, the final number of policies collected was 125.

Following the refinement of the inclusion criteria, 66 legislative acts and policies related to the project's definition of dementia care were included for analysis. The Health and Wellness Domain yielded the most results with 26 legislative acts/policies, followed by Community Services (12), Communities, Culture and Heritage (8), Justice (6), Seniors (2) and Business (1).

There were two COVID-19 legislative acts enacted in Nova Scotia which were the Emergency Management Act and the Health Protection Act. The Emergency Management Act was enacted by the government of Nova Scotia declaring a provincial state of emergency on March 22, 2020 which was still in effect at the time of writing this report. The Health Protection Act is the legal framework that enables public health officials to protect the public and contain health threats. It laid out the public health directives during the pandemic including social distancing guidelines, requirements for wearing a mask in most indoor public places, self-isolation requirements, the need for businesses or organizations to reduce operations if required and guidance around gathering limits, as well as Schedule A, COVID-19 Management in Long Term Care facilities.

POLICY ANALYSES

The first step to the analysis was to research the populations of interest (LGBTQ2S+, African Nova Scotian communities, immigrants/refugees, persons with disabilities, and linguistic minorities) to better understand their experiences with dementia, social determinants of health and specific COVID-19 issues. A brief discussion of the populations follows here:

LGBTQ2S+

While exact numbers are not entirely known, the LGBTQ2S+ community is estimated at approximately 3-4% of the population, with the trans community accounting for 0.5% (Government of Canada, 2021). It is important to note that the LGBTQ2S+ community is not a homogenous group; different inequities are experienced by bisexual/trans individuals compared to those that identify as gay. Regardless of identity, stigma and social discrimination are common. LGBTQ2S+ seniors face unique housing challenges; are more likely to become homeless, live on their own and be single; are less likely to have family and children to support them; family of choice and peers are often older adults with their own health problems; social support between urban and rural locations varies; and partners are denied recognition during end of life and care planning. Trans individuals have higher rates of inter partner violence, unemployment, and poverty (Employment and Social Development Canada, 2018).

In terms of healthcare, several issues existed for the LGBTQ2S+ community prior to COVID-19 including an increased risk of poorer health and isolation; underuse of health services; barriers to accessing healthcare; stigma in care practices; difficulty finding a doctor; resistance from service providers in engaging with sexuality/identity issues; higher substance abuse rates; increased likelihood of living with chronic health conditions and physical disability; and poorer mental health for persons who identify as bisexual (Employment and Social Development Canada, 2018).

Nova Scotians who are Black and/or of African Descent

Nova Scotians who are Black and/or of African descent are the largest racially visible population in Nova Scotia and experience higher rates of unemployment and poverty compared to other Nova Scotians (Statistics Canada, 2016). "Black workers, (particularly Black women), are over-represented in front facing service provider roles, including among PSW and RPN's. Many are providing essential services, yet unable to access support for their families. These factors will exacerbate precarity, food insecurity, isolation and mental health concerns" (Statement from Black Health Leaders). They are more likely to live in densely populated areas and multi-generational households and have differential access to health care (CBC, 2021). Systemic racism in healthcare is a long-standing issue and many African Nova Scotian communities are without a health care center. The culture also has close greetings and faith plays an important role.

POLICY ANALYSES

Immigrants/Refugees

Dementia is not always recognized or discussed in different ethno-racial communities. It is common for immigrants/refugees to be confronted with discrimination, stigma, and racism; to live in crowded or suboptimal environments; and to experience challenges with participating in society. Cultural-linguistic barriers may also exist for immigrants/refugees requiring them to rely on others for translation services and depending on their immigrant status, they may not be eligible for social services (Ontario Ministry of Health and Long-Term Care, 2014).

Persons with Disabilities

Many persons with disabilities live in poverty; one in five do not use the internet; many live alone and are housebound; have limited social networks; rely on public transportation; are more likely to have underlying health conditions; and 74% receive help with activities of daily living (ADLs). Nova Scotia has the highest percentage of persons with disabilities in Canada. Thirty percent or 229,430 of Nova Scotians 15 years and older have at least one disability; by age group, 29% of working adults (often the caregivers of persons with dementia) and 41% of adults over the age of 65 have at least one disability. Memory represents 5.3% of disability types with pain related disability being the most prevalent at 19.8% (Government of Nova Scotia, 2020; Statistics Canada, 2020).

Linguistic Minorities

The Acadian and Francophone community in Nova Scotia includes 34,000 people with French as a mother tongue (Government of Nova Scotia, 2011). Traditionally based in rural areas in Nova Scotia, rural internet access is an issue for this population, as is access to healthcare. Some linguistic minorities may rely on English speaking friends/family to translate information.

This research, conducted with an intersectionality lens, considered health equity impacts on individuals within marginalized populations who have multiple intersecting characteristics: i.e., LGBTQ2S+ people who are newcomers, Francophone immigrants, minority women, and Nova Scotians who are Black and/or of African descent with disabilities.

HEIA OF DEMENTIA CARE POLICIES (PRIMARY SEARCH RESULTS)

This section highlights some of the key findings of the analyses performed on policies within each of the domains using the adapted HEIA tool.

1

HEALTH AND WELLNESS

2

COMMUNITY SERVICES

3

COMMUNITY, CULTURE AND
HERITAGE

4

SENIORS, JUSTICE AND BUSINESS

HEALTH AND WELLNESS

Twenty-six policies related to dementia care in the community were found within Health and Wellness, the greatest amount found within any of the domains, highlighting the appreciable impact this domain exerts on the care of people with dementia living in the community. Policies were dated from 1986 to 2019.

Department of Health and Wellness Policies Affecting Dementia Care in the Community	
Title	Year
Legislation	
Adult Protection Act	1986
Co-ordinated Home Care Act	1990
Emergency Health Services Act	2005
Essential Health and Community Services Act	2014
Essential Home-support Services Act	2014
Fair Drug Pricing Act	2011
Health Authorities Act	2014
Health Services and Insurance Act	1989
Homemakers Services Act	1989
Personal Directives Act	2008
Self-managed Support-care Act	2005
Policy Manuals	
Adult Protection Policy Manual	2011
Challenging Behaviour Program Manual	2013
Critical Incident Reporting Policy	2009
Home Care Policy Manual	2011
Home Care Standards for Quality Service Policy	2011
Publicly Funded Vaccine Eligibility for Individuals at High Risk of Acquiring Vaccine Preventable Diseases Policy	2011 (Revised 2019)
Continuing Care Programs	
Bed Loan Program Policy	2008
Caregiver Benefit Program Policy	2009 (Revised 2018)
Facility Based Respite Policy	2012
Home Oxygen Services Policy	2007
Medication Dispenser Assistive Technology Policy	2013
Personal Alert Assistance Program Policy	2011 (Revised 2013)
Self-managed Support-care Services Policy	2013
Seniors Community Wheelchair Loan Program Policy	2013
Supportive Care Program Policy	2011
Total	26

Table 1: Department of health and wellness policies affecting dementia care in the community

HEALTH AND WELLNESS

The legislative acts impact at the individual level (i.e., Self-managed Support-care Act, Personal Directives Act) as well as at the organizational level (i.e., Essential Health and Community Services Act). One policy within Continuing Care, the Supportive Care Program, pertains directly to persons with dementia. It supports clients with long term cognitive impairment and their families to remain within their homes with monthly funding that can be used for home care services delivered by providers of the client's or family's choice (Supportive Care Program Policy, 2020).

The HEIA revealed several items within policies that could create differential access to programs or services, as well as create negative effects that contribute to or strengthen health disparities. The primary concern noted for the LGBTQ2S+ population is language and how the inconsistent use of, or lack of definitions for caregivers and family could potentially exclude members due to subjective interpretation of the policies either by themselves or others. It's important that all individuals see themselves represented within policies with the use of inclusive language and visuals on print materials, websites, etc. As well, the use of he/she was noted in the Medication Dispenser Policy which excludes individuals with other non-conforming gender identities.

Positively, there are some examples of broad definitions inclusive of friends, who are often the primary caregivers of LGBTQ2S+ individuals in the absence of biological family members. For example, the Caregiver Benefit Program and Facility Based Respite Policy define a caregiver as an individual providing unpaid assistance with ADLs/IADLs (instrumental activities of daily living) to a family member or friend, and the Bed Loan Program assigns responsibility for the equipment in the home to the client or their friends/family (Bed Loan Program Policy, 2008; Caregiver Benefit Program Policy, 2021; Facility Based Respite Policy, 2012). In the Home Care Standards Policy Manual, there is a policy and practice that service is provided to clients regardless of their age, gender, race, religion, sexual orientation, or diagnosis (Home Care Policy Manual, 2011). The client's linguistic and cultural needs must also be recognized and respected. The Adult Protection Manual has guiding principles including "recognizing and respecting the intrinsic worth of each person by ensuring that his or her practice is free from discrimination based on race, national or ethnic origin, religion, sex, sexual orientation, age or mental or physical disability or any other characteristic for which someone might be discriminated against in society" (Adult Protection Policy Manual, 2011).

Generally, there was little inclusion of African Nova Scotian communities within policies. Similarly, to the LGBTQ2S+ population, Nova Scotians who are Black and/or of African descent must see themselves represented in policies. A few exceptions include the Home Care Standards Policy Manual and Adult Protection Act which mention race (Adult Protection Act, 2014; Home Care Policy Manual, 2011).

HEALTH AND WELLNESS

The Caregiver Benefit Program has eligibility criteria that the caregiver and care recipient must be 19 or older excluding younger individuals such as grandchildren who may be providing care in a multigenerational household, often the case for this population (Caregiver Benefit Program Policy, 2021). This type of care by family members should be acknowledged and compensated; doing so could even inspire young individuals to pursue a career in caregiving based on their positive home experience. Decreasing the age requirement to 16 or 17 years could be beneficial.

Most policies (within all domains) exclude non-residents (i.e., immigrants and refugees) from being able to access programs and services. Expanding eligibility of programs to immigrants could be beneficial to the provincial strategy to attract more immigrants as younger people who immigrate with older family members may face barriers to staying if there are insufficient social services and access to healthcare for all members of their family.

For people of various ethno-racial and linguistic communities, a few positive examples of inclusion were noted. The Home Care Policy states that home care services should be provided in a manner that respects the client's cultural values and the delivery of home care services should be in keeping with the Department of Health and Wellness's Cultural Competence Guidelines for the Delivery of Primary Health Care in Nova Scotia. The Home Care Standards Policy Manual also highlights the need to consider culture in their definition of accessibility: "the quality of providing the right service at the right time and in the right place. Accessibility includes consideration of physical, cultural and language needs" (Home Care Policy Manual, 2011). The Adult Protection Manual, inclusive of marginalized populations, similarly states that "any known religious and/or cultural values of the client must be considered; unidentified cultural differences may cause us to see a client as incapable in relation to specific risk-related decisions; [and] information relayed must be easily understood by the client and take into account cultural and language challenges" (Adult Protection Policy Manual, 2011). Interestingly, eligibility for publicly funded vaccines requires that individuals must be residents. It is unknown if this applies to COVID-19 vaccines.

With the population of persons living with disabilities, there was a wide range of terms and definitions used within the policies to manage identity including wheelchair user, person who is handicapped, and disabled persons. However, many of the policies do attend to the needs of persons with disabilities with policies aimed at helping this population. The Co-ordinated Home Care Services Act "provide[s] for and ensure[s] the delivery of a Co-ordinated Home Care Program for Nova Scotia's senior citizens, disabled persons, and families at risk; [and] respects the provision of attendant care for disabled persons" (Co-ordinated Home Care Act, 1990). The personal alert, wheelchair loan, and medication dispenser programs specifically mention disability. Many of these policies also attend to agency with the Self-managed Support-care Services stating that it "provides an opportunity for clients to gain increased control over their lives and may enhance their participation in the community" (Self-managed Support-care Act, 2005). The home care policy provides a range of services to maintain client independence, teach skills and improve functional abilities.

COMMUNITY SERVICES

The Disability Services Program (DSP) is a predominant program within this domain. It is unclear how much access people with dementia have to the programs and services within the DSP; nonetheless it was included as being relevant to dementia care in the community. This domain also included legislative acts/policies specific to seniors that are owned by the Department of Community Services (rather than the Department of Seniors). Acts/policies were dated between 1989 and 2020. It is noted that the oldest acts are the ones pertaining to seniors (with no updates). It has also been observed that although there are acts respecting the provision of services for seniors, there are no related policies to operationalize the acts.

In total within the Community Services domain, twelve legislative acts/policies were related to dementia care in the community. The Disability Support Program (including five policies) was also included in the analysis. These acts and policies lacked inclusion or mention of the needs of marginalized populations of interest other than persons with disabilities who are the primary clients of the suite of programs within the Disability Support Program (e.g., Flex, Alternative Family Support Program, Independent Living Support).

Department of Community Services Policies Affecting Dementia Care in the Community	
Title	Year
Legislation	
Disabled Persons Commission Act	1989
Employment Support and Income Assistance Act	2000
NS Freedom of Information and Protection of Privacy Act	1993
Senior Citizens' Financial Aid Act	1989
Senior Citizens' Secretariat Act	1989
Senior Citizens' Social Services Act	1989
Social Assistance Act	1989
Policy Manuals	
Alternative Family Support Program Policy (AFS)	2006
Disability Support Program (DSP) Policy	2016 (Revised 2020)
End of Life Care Policy	2014
The Flex Individualized Funding Program (Flex) Policy	2016 (Revised 2020)
The Full Independent Living Support Policy (ILS)	2006 (Revised 2020)
Total	12

Table 2: Department of community services policies affecting dementia care in the community

COMMUNITY SERVICES

The Senior Citizens' Social Services Act and Senior Citizens' Secretariat Act play a role in the provision of services to seniors. The mandate of the Senior Citizens' Social Services Act is to: “seek out and encourage persons interested in providing voluntary services to citizen groups concerned with aging; promote new activities and social services for senior citizens through voluntary agencies and through all levels of Government as may be deemed appropriate; [and] review existing legislation and Government programs and make recommendations as to how these may be improved to provide more adequate services for senior citizens” (Senior Citizens' Social Services Act, 1989). The Senior Citizens' Secretariat Act states that the purpose of the Secretariat is “to facilitate the planning and development of services and programs for senior citizens by (a) coordinating plans, policies and programs presented by the departments of the Government, and (b) developing plans, policies and programs for and with senior citizens in partnership with the Departments of Community Services, Health and Fitness and Municipal Affairs, the Minister of Housing, any other Government departments, the Nova Scotia Senior Citizens' Commission and voluntary senior citizens groups” (Senior Citizens' Secretariat Act, 1989).

Both Acts are examples of legislation that existed prior to the pandemic that explicitly state that their role is to work with government to make recommendations and inform programs and policies within government, so it begs the question as to what role these two representative bodies have played in supporting and advocating for the interests of older adults during the pandemic and how older adults have been considered by all levels of government during the COVID-19 pandemic response?

COMMUNITY SERVICES

The Seniors Advisory Council, (formerly called the Group of IX), an independent body of elected officials representing nine seniors' organizations, is also dedicated to improving the inclusion, well-being, and independence of older adults living in Nova Scotia. In email correspondence requesting if a public report was available on the Council's work during the last year, a response from the chair stated: "I cannot provide any reports or information as the Council has been fully involved with the COVID-19 vaccine rollout and its impact on seniors. We are hoping that once we have our members over 65 vaccinated that we will then turn our attention to long term care, the Nova Scotia Blueprint on Continuing Care, a National Pharmacare Plan, a National Seniors Strategy and dementia" (B. Berryman, personal communication, March 17, 2021). In the Council meeting minutes from September 24, 2020, it was noted that a meeting was held with Dr. Strang to provide the Council's perspective on reopening the economy (no information provided on what their perspective is) and that Dr. Orrell, Deputy Minister, Department of Health and Wellness shared that there is currently no Continuing Care strategy document due to staff changes at the DHW. He stated that, "Based on the review and recommendations seniors should be kept out of nursing homes and provided support services and homecare supports to keep seniors in their home as long as possible." It is unclear which review or recommendations are being referred to. Interestingly, the minutes also include a discussion that the Council had regarding COVID-19 recovery measures for seniors and seniors' clubs reopening. It stated that, "Deputy MacLellan advised members that seniors clubs and councils do not need to submit plans to the Department of Health and Wellness for approval. It is strongly recommended that there be some documented guidelines about operational cleanliness and hygiene practices following the Public Health Guidelines. Department of Seniors staff... [should] share sample plans/guidelines to members to consider when re-opening."

COMMUNITY, CULTURE AND HERITAGE

This domain includes eight legislative acts/policies pertaining to culture, volunteers, the French language, and multiculturalism.

Department of Communities, Culture and Heritage Policies Affecting Dementia Care in the Community	
Title	Year
Legislation	
Art Gallery of Nova Scotia Act	1989
Arts Nova Scotia Act	2012
French Services Language Act	2004
Gaelic College Foundation Act	1980
Libraries Act	1989
Multiculturalism Act	1989
Nova Scotia Museum Act	1989
Volunteer Protection Act	2002
Total	8

Table 3: Department of communities, culture and heritage policies affecting dementia care in the community

These acts, dated between 1980 and 2012, were deemed relevant to dementia care because of the well documented role that these community/sociocultural institutions have on person-centered care of people with dementia and their positive effects on quality of life. Programs provided by these organizations often rely on volunteers (Community Sector Council of Nova Scotia, 2020). The French Services Language Act, the Gaelic College Foundation Act, and the Multiculturalism Act are directly related to populations of interest (immigrants, linguistic minorities).

There were no references to the LGBTQ2S+ population or persons with disabilities within these legislative acts. There was one mention of African Nova Scotian communities within the Arts Nova Scotia Act that stated: “where possible, include representation from differing art disciplines, generations and the Province's cultural mosaic including, but not limited to, representation from the African Nova Scotian, Mi'kmaq and Acadian communities (in the composition of the board)” (Arts Nova Scotia Act, 2011). This statement was also inclusive of immigrants/refugees and linguistic minorities as it referenced the ‘cultural mosaic’ of the province.

COMMUNITY, CULTURE AND HERITAGE

Within the Libraries Act, it states that the duties of the provincial librarian include “co-operation with any cultural or educational organization, library association, library board or librarian in matters pertaining to the organization, maintenance and administration of the Provincial Library or any library established under any Act” (Libraries Act, 1989) The Multiculturalism Act exists to “encourage recognition and acceptance of multicultural society as a mosaic of different ethnic groups and cultures [to] encourage a climate between harmonious relations among people of diverse cultural and ethnic backgrounds without sacrificing their distinctive cultural and ethnic identities” (Multiculturalism Act, 1989). The purpose of the French Languages Act is to contribute to the preservation and growth of the Acadian and francophone community, and provide for the delivery of French-language services by designated departments, offices, agencies of Government, Crown corporations and public institutions (French-language Services Act, 2004).

There are a few points of interest to the analysis in how policies manage identities in the following statement: “where possible, include representation from differing art disciplines, generations and the Province's cultural mosaic including, but not limited to, representation from the African Nova Scotian, Mi'kmaq and Acadian communities” (Arts Nova Scotia Act, 2011). Prefacing the statement with ‘where possible’ as a suggestion rather than a mandate, immediately weakens expectations as to whether cultural representation on the board does in fact exist. If efforts are not made to ensure inclusion of immigrants and ethno-racial communities in the arts, they may not receive benefits that representation may confer. Likewise, within the Multiculturalism Act, there is a statement that says: “The Governor in Council may appoint a Multiculturalism Advisory Committee consisting of such number of persons and representing such cultural and ethnic groups as the Governor in Council considers advisable to review policies, programs and activities that relate to multiculturalism and to make recommendations to the Cabinet Committee as to what policy initiatives should be taken” (Multiculturalism Act, 1989). This Act could contribute to health inequities of cultural and ethnic groups as it appears to be at the discretion of the Governor to appoint whomever they decide for policy initiatives, leaving groups not represented at risk of being left out of policy decisions. Lastly, do all people within marginalized populations see themselves represented in library services? How easy or difficult is it given cultural, linguistic, and other barriers for every individual to get a library card?

Although there are no policies pertaining to religious or faith communities, the role that these institutions play in the care of people living with dementia and the impact of COVID-19 is noteworthy. For people with dementia, attendance at a weekly church service contributes to a sense of purpose and routine. For many individuals it may be one of few social opportunities providing substantial benefit, both physically and mentally. For people of racialized communities and linguistic minorities, other members of the church may be the only people who they interact with that are of the same culture and language. Nova Scotians who are Black and/or of African descent also have closely knit religious communities that play a significant role in their lives. Although many services went online, people of marginalized communities may not have had internet access and online services do not allow for the same degree of interpersonal interaction.

SENIORS, JUSTICE AND BUSINESS

These three domains were included together due to the small number of policies they each contain. Surprisingly, the Seniors' domain only included two policies (see Table 4). There was nothing to note from these two acts on the HEIA template for their inclusion of any of the populations of interest.

Department of Seniors Policies Affecting Dementia Care in the Community	
Title	Year
Legislation	
Senior Citizens' Property Tax Rebate Act	2018
Senior Citizens' Week Act	1989
Total	2

Table 4: Department of seniors policies affecting dementia care in the community

In the Business domain, there was only one policy deemed relevant to dementia care (see Table 5) and that is because its' primary initiative is to expand internet technology throughout the province, critical to the access of services for all persons, including persons with dementia and their caregivers (Develop Nova Scotia Act, 2018).

Department of Business Policies Affecting Dementia Care in the Community	
Title	Year
Legislation	
Develop Nova Scotia Act	2018
Total	1

Table 5: Department of business policies affecting dementia care in the community

The website for Develop NS states: "Connection matters. We all know that reliable high-speed Internet is critical—for access to health and education services, for business, and for people to connect with the world and one another. COVID-19 has only underlined the urgency of making these connections and improving this service as soon as possible" (Build Nova Scotia, 2021). The Act also discusses the importance of place-making – attracting and retaining people with diverse perspectives to the province to promote economic growth and social enterprises. To promote place making, it states they will communicate and collaborate with communities, municipalities, private sectors, and others.

SENIORS, JUSTICE AND BUSINESS

The Justice domain had six acts dated from 1989 to 2020.

Department of Justice Policies Affecting Dementia Care in the Community	
Title	Year
Legislation	
Accessibility Act	2017
Adult Capacity and Decision-making Act	2017
Legal Aid Act	1989 (Revised 2020)
Powers of Attorney Act	1989
Public Trustee Act	1989
Wills Act	1989
Total	6

Table 6: Department of justice policies affecting dementia care in the community

Perhaps most significant for its' impact on dementia care in the community is the Accessibility Act, the purpose of which is to achieve accessibility by preventing and removing barriers that disable people with respect to:

- the delivery and receipt of goods and services,
- information and communication,
- public transportation and transportation infrastructure,
- employment,
- the built environment,
- education, and
- a prescribed activity or undertaking (Accessibility Act, 2017).

SENIORS, JUSTICE AND BUSINESS

Access to information and communication is of concern during the pandemic as it has been reported that 20% of people with disabilities do not use the internet (Abdelaal, 2021). Where information, programs and services have migrated online, it begs the question: *How do people with disabilities receive information on programs and services and to what degree has digital exclusion played a role in limiting their access and possibly contributing further to health inequities?* This Act also created the Accessibility Directorate to address broader disability-related initiatives by acting as a central government mechanism to ensure that the concerns of persons with disabilities respecting policy, program development and delivery are advanced and considered by the Government (Accessibility Act, 2017).

The 2019-2020 Accessibility Advisory Board Annual Report summarized the work that was done to champion accessibility initiatives and an awareness campaign that will: “highlight the barriers that exist for persons with disabilities, Deaf, and/or neurodivergent persons; create awareness that accessibility is a human right; [and] provide information about the Accessibility Act, government’s commitment to accessibility, and the progress toward it.” The 2019-2020 Minister’s report on accessibility references following efforts to remove barriers and improve accessibility in response to the COVID-19 pandemic including engaging with 60 community organizations to share issues related to COVID-19 that were arising for persons with disabilities and efforts by Communications NS to create accessible ways to reach Nova Scotians with critical information about the COVID-19 briefings (Government of Nova Scotia, 2020; Minister’s Annual Report on Accessibility, 2021).

HEIA OF COVID-19 POLICIES (SECONDARY SEARCH RESULTS)

The Health Protection Act provided the legal framework for public health directives throughout the pandemic. It was amended 52 times from March 2020 to March 2021. Copies of the amendments were attained by request from the Government of Nova Scotia.

The orders within the Health Protection Act were directed to the general population and there was little to no mention of vulnerable or marginalized populations other than residents in long term care (Health Protection Act, 2004). On February 19, 2021, it was noted that an amendment was included to stipulate that the maximum number of persons allowed to gather applied to several settings including mental health and addictions support group meetings but did not apply to Department of Community Services funded organizations, long term care facilities, or persons providing care under the Self-managed Support-care Program, Supportive Care Program, Caregiver Benefit Program, or Independent Living Support.

POLICY ANALYSES USING A SYSTEMS HEALTH EQUITY LENS

The last component of the policy analysis was to shift the focus from marginalized populations to the *systems, structures and processes* that create disadvantage and vulnerability using the SHEL tool. A system includes people; agencies, groups and institutions that serve and support them; research and training that affects the provision of services; laws, policies and programs under which services are provided; and services provided by families, friends, and neighbors. There are multiple levels of oppression within systems, which are represented in the SHEL tool as intrapersonal, interpersonal, organizational, community, and public policy with the healthcare institution being at the core (Pauly et al., 2018). Root causes of health inequities (history, policies, individuals' social positioning and how geography impacts access to resources) is represented by: *Social determinants of health x 'isms' x Geography*. Isms include ageism, racism, sexism, heterosexism, classism, ableism, gender binarism, and colonialism.

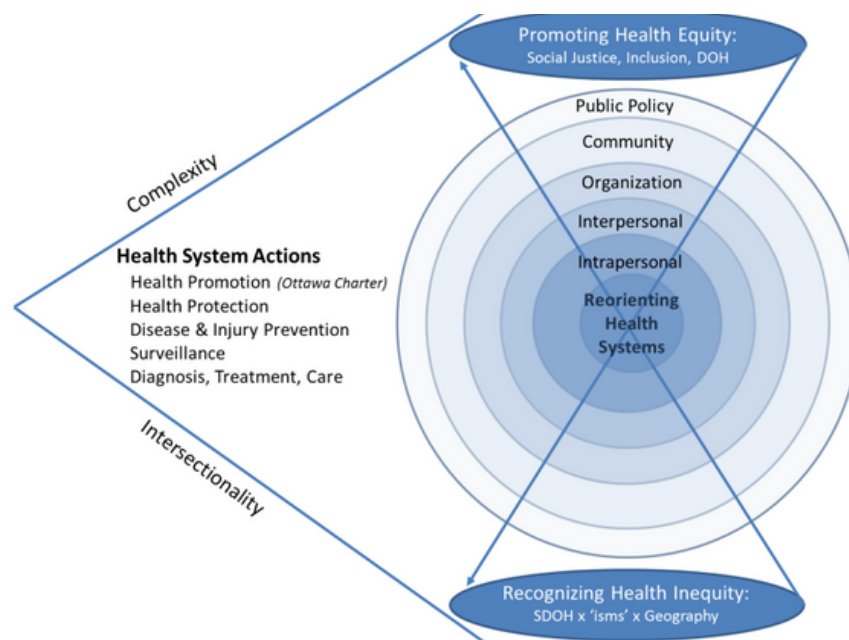
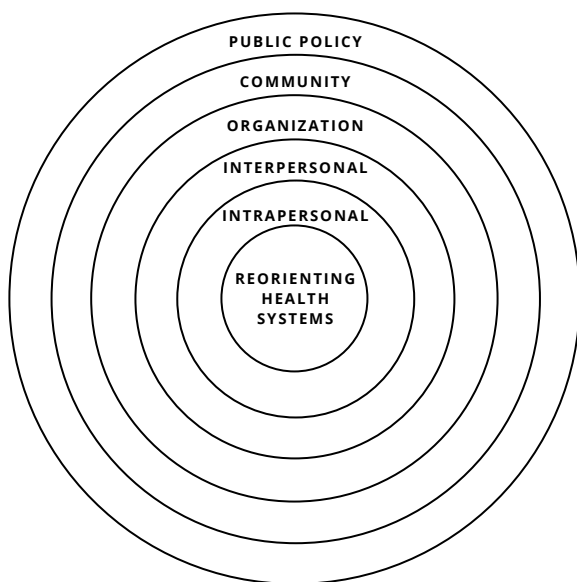


Figure 1: Reorienting health systems toward health equity using the SHEL model (Figure by Pauly et al., 2018).

POLICY ANALYSES USING A SYSTEMS HEALTH EQUITY LENS

Policies were mapped onto the SHEL model according to their areas of impact. The five areas of impact within the SHEL model and their definitions are:

- Intrapersonal: Policy is associated with health equity or structural competencies
- Interpersonal: Policy is associated with social support networks
- Organizational: Policy is associated with the implementation of health equity strategies by organizations
- Community: Policy is associated with community involvement in identifying/reducing health inequities
- Public Policy: Policy is associated with health policies in ministries or sectors



TOTAL POLICIES REVIEWED = 66
PUBLIC POLICY IMPACT = 20
COMMUNITY IMPACT = 15
ORGANIZATIONAL IMPACT = 40
INTERPERSONAL IMPACT = 17
INTRAPERSONAL IMPACT = 12

Figure 2: Systems Health Equity Lens (SHEL) model by Pauly et al., 2018.

POLICY ANALYSES USING A SYSTEMS HEALTH EQUITY LENS

Act/Policy/Program Name	Year	Impact – SHEL Model				
		Intrapersonal	Interpersonal	Organizational	Community	Public Policy
Business						
Develop Nova Scotia Act	2018				X	X
Seniors						
Senior Citizens' Property Tax Rebate Act	2018			X		
Senior Citizens' Week Act	1989		X		X	
Justice						
Accessibility Act	2017	X	X	X	X	X
Adult Capacity and Decision-making Act	2017	X	X	X		X
Legal Aid Act	1989 (Revised 2020)					X
Powers of Attorney Act	1989			X		
Public Trustee Act	1989			X		
Wills Act	1989			X		
Communities, Culture and Heritage						
Art Gallery of Nova Scotia Act	1989			X	X	
Arts Nova Scotia Act	2012			X	X	
French Services Language Act	2004	X	X	X	X	X
Gaelic College Foundation Act	1980			X	X	
Libraries Act	1989	X		X	X	
Multiculturalism Act	1989	X	X	X	X	X
Nova Scotia Museum Act	1989			X	X	
Volunteer Protection Act	2002			X		
Department of Community Services						
Alternative Family Support Program Policy (AFS)	2006	X	X			
Disability Support Program (DSP) Policy	2016 (Revised 2020)		X			
Disabled Persons Commission Act	1989 (Repealed in Accessibility Act 2017, c. 2, s. 72)		X		X	X
Employment Support and Income Assistance Act	2000			X		X
End of Life Care Policy	2014	X	X			
NS Freedom of Information and Protection of Privacy Act	1993			X		X
Senior Citizens' Financial Aid Act	1989			X		X
Senior Citizens' Secretariat Act	1989				X	X
Senior Citizens' Social Services Act	1989			X		X
Social Assistance Act	1989					X
The Flex Individualized Funding Program (Flex) Policy	2016 (Revised 2020)			X		
The Full Independent Living Support Policy (ILS)	2006 (Revised 2020)				X	X

POLICY ANALYSES USING A SYSTEMS HEALTH EQUITY LENS

Department of Health and Wellness						
Adult Protection Act	1986		X	X		X
Adult Protection Policy Manual	2011	X	X	X		
Bed Loan Program Policy	2008			X		
Caregiver Benefit Program Policy	2009 (Revised 2018)		X	X		
Challenging Behaviour Program Manual	2013	X		X		
Co-ordinated Home Care Act	1990			X		
Critical Incident Reporting Policy	2009			X		
Emergency Health Services Act	2005			X		X
Essential Health and Community Services Act	2014		X			
Essential Home-support Services Act	2014		X			
Facility Based Respite Policy	2012			X		
Fair Drug Pricing Act	2011					X
Health Authorities Act	2014			X	X	X
Health Services and Insurance Act	1989	X	X	X		X
Home Care Policy Manual	2011	X		X		
Home Care Standards for Quality Service Policy	2011	X	X	X		
Home Oxygen Services Policy	2007			X		
Homemakers Services Act	1989		X		X	
Medication Dispenser Assistive Technology Policy	2013			X		
Personal Alert Assistance Program Policy	2011 (Revised 2013)			X		
Personal Directives Act	2008			X		
Publicly Funded Vaccine Eligibility for Individuals at High Risk of Acquiring Vaccine Preventable Diseases Policy	2011 (Revised 2019)			X		
Self-managed Support-care Act	2005					X
Self-managed Support-care Services Policy	2013			X		
Seniors Community Wheelchair Loan Program Policy	2013			X		
Supportive Care Program Policy	2011			X		

Table 7: Policies mapped onto the SHEL model's areas of impact.

SUMMARY OF ANALYSES

This section summarizes the key findings of the policy analyses, health equity issues and limitations of the research.

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> Supportive Care Program policy in the Department of Health and Wellness specific to persons with dementia; program increased monthly funding from \$500 to \$1000 to allow people more flexibility in purchasing home care or community services One policy mentioned Nova Scotians who are Black and/or of African descent Policies within several government departments and domains govern dementia care services and supports in the community Under the Health Protection Act, persons providing service or repair of medical equipment such as wheelchairs, Red Cross beds/equipment and home oxygen equipment not affected by physical distancing and person limit rules Senior Citizen's Week Act acknowledged Senior Citizen's Week and increased funding to community groups to address increased needs due to COVID-19 Key initiative of Develop Nova Scotia to expand internet access across the province accelerated because of COVID-19 	<ul style="list-style-type: none"> Complex web of legislative acts and policies that exert influence over the care of persons with dementia; programs and services available for support not easy to navigate prior to the pandemic Only one policy specific to persons with dementia; only one policy mentioned Nova Scotians who are Black and/or of African descent Policies enacted to contain the spread of COVID-19 created additional circumstances and difficulties where community supports and services were substantially reduced, temporarily closed, or shut down completely Most dementia related policies have no inclusion or mention of marginalized populations Policies explicitly exclude immigrants and refugees with the requirement that applicants must have a Nova Scotia Health Card
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> Consulting with representative/advocacy organizations can ensure that different perspectives are included in policy development Public health information can be communicated in different languages Information can be distributed via channels other than the internet Marginalized populations can be engaged to learn about their experiences of living with dementia or as caregivers during the pandemic so that their perspectives can be included in future policy design Scarce resources can be allocated appropriately to reduce and prevent further health inequities from developing during future public health crises Government needs to recognize older adults in the community and enact policies that address the different needs of marginalized populations during future health crises 	<ul style="list-style-type: none"> Federal government uptake of GBA+ analysis is questionable Policy analysis at the provincial level indicates that policy makers and other stakeholders pay scant attention to the diverse needs of Nova Scotians Existing policies may unintentionally create health inequities for marginalized populations The state and institutional response to the pandemic operationalized through policies resulted in marginalized populations experiencing disproportionate negative effects of the pandemic

Table 8: Summary of the strengths, weaknesses, opportunities, and threats associated with Nova Scotia's COVID-19 policy response as it relates to dementia care in the community from an intersectional health equity perspective.

SUMMARY OF ANALYSES

The aim of the policy scan was to assess the impacts and health equity implications of COVID-19 on community supports for vulnerable older adults living with dementia and their family/friend caregivers in Nova Scotia. As such, the first objective of the study was to create a baseline slate of legislative and regulatory policy instruments that influence the design, eligibility, and administration of community-based dementia-related programs and services for people living with dementia and their caregivers in Nova Scotia. To our knowledge, this has not been done before. A total of 66 policies were identified and subsequently analyzed.

Our definition of community-based dementia care was: Dementia care in the community includes health, social and community/cultural resources, services and supports (e.g., dementia, caregiving, continuing care for older adults, age, or caregiving related benefit program policies; seniors/aging; income; safety; museums, libraries, galleries, and community spaces; shopping). The broad definition was beneficial as it included policies from several domains rather than just Health and Wellness. A key finding of the policy scan is that it has confirmed that a complex web of several legislative acts and policies exert influence over the care of persons with dementia; it is not simple or easy to navigate the programs and services available for support. Only one policy, developed by the Department of Health and Wellness, is specific to persons with dementia (Supportive Care Program).

The unique SGBA+ and intersectional analytic approach adopted by the policy group supports that no two persons with dementia are the same and that a person consists of several intersecting characteristics. It also supports the mantra adopted by persons with dementia working to improve human rights and access to services around the world: *Nothing about us without us*. The adapted HEIA template provided a nuanced understanding and analyses of dementia care and COVID-19 policies from the perspective of marginalized communities, as well as the layered impacts COVID-19 has on dementia care. It also facilitated the view that people are unique and have different needs during a pandemic. Scarce resources need to reach marginalized populations accordingly to prevent health inequities from being further impacted.

As noted by members of the Policy Working Group, the federal government has committed to using GBA+ analysis, however uptake is questionable. At the provincial level, policy analysis indicates that policy makers and other stakeholders pay scant attention to the diverse needs of Nova Scotians. The majority of policies had no inclusion or mention of marginalized populations. Only one policy mentioned Nova Scotians who are Black and/or of African descent. Program policies explicitly excluded immigrants and refugees with the requirement that applicants must have a Nova Scotia Health card.

Due to the large number of policies, the analyses focused on key policies within each domain. Not every policy underwent rigorous review. As such, limitations of this research include the fact that it is possible that points of interest were missed.

MITIGATION STRATEGIES TO MINIMIZE LAYERED IMPACT OF COVID-19 POLICIES ON DEMENTIA CARE POLICIES

Marginalized populations experienced disproportionate negative effects of the pandemic due to the pandemic itself, as well as from the state and institutional response to the pandemic operationalized through policies. In identifying mitigation strategies that could potentially reduce these negative effects, several ideas are provided. Consulting with representative/advocacy organizations could help ensure that different perspectives are included in policy development. As the HEIA proposes, it is important to assume that different people will be impacted differently by policies and hearing from diverse individuals is a mechanism to learn what people need during a public health crisis and to allocate resources accordingly (e.g., social benefit programs, financial benefits etc.). Communicating public health information in different languages is key and distribution through channels other than the internet is vital so as not to create digital exclusion as not everyone has access to the internet (e.g., rural residents, persons with disability).

CONCLUSION

Policies within several government departments and domains govern dementia care services and supports in the community. The SGBA+, intersectional approach using an adapted health equity impact assessment tool in this research revealed how these policies may unintentionally create health inequities for marginalized populations. Policies enacted to contain the spread of COVID-19 have created additional circumstances and difficulties by which community supports and services have been substantially reduced, temporarily closed, or shut down completely. It is likely that these reduced community supports have negatively impacted the physical and mental health of people with dementia and their family/friend caregivers and worsened health equity. There is a need for government to recognize older adults in the community, and to enact policies that address the different needs of marginalized populations during future health crises.

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