## Case study discussion exercise: Success Factors for Equity-Integrated Environmental Health Practice

Goal: Identify actions individuals can take in their day to day work.

These case studies are from the action-oriented [document](http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/EH/Equity%20in%20EPH%20success%20factors%20discussion%20guide.pdf) summarizes the key facilitators to integrating an equity lens and uses three case studies to illustrate different ways these facilitators have been implemented. It can be used individually or as a tool for strategic planning or in workshops and meetings to support staff training and development.

This exercise is best for groups that have some basic knowledge about health equity and environmental health practice and are considering how to build capacity for action within their department or organization (Senior EPHP staff, managers, directors).

<http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/EH/Equity%20in%20EPH%20success%20factors%20discussion%20guide.pdf>

**Small group exercise – 15-20 minutes:**

1. Get into groups of 3-6 people.
2. Each group is given one of three case studies to review.
3. All groups can consider the questions on the slide.
4. Each scenario has specific discussion questions that the groups can consider.

Have each small group summarize their discussion and share some highlights or key learnings with the larger group.

***Facilitators may wish to provide the critical success factors listed after each case study, or remove them to avoid influencing the discussion and ideas generated by the small groups.***

Case study 1: Decision trees for rabies and mould control (Niagara Region Public Health)

In 2013, two public health inspectors (PHIs) began a project to review a policy on rabies vouchers, with a focus on equity and social determinants of health. Existing policy provided vouchers to people who could not afford veterinarians to access cost-reduced rabies vaccination. Using the Ontario Public Health Standards as a guide, they began assessing why vouchers were being provided, reviewing past rabies investigations, and interviewing PHIs. They analyzed this data using the Ontario Marginalization (ON-Marg) Index to consider differences in measures of socio-economics, population groups, and geographical areas. There was a clear match between areas of deprivation and areas where rabies vouchers were being distributed.

The research results were used to create a decision tree for PHIs, helping to formalize the process of determining the need for the vouchers. The decision was then made to create a similar algorithm for mould complaints by examining indicators of income, education, employment, safe and affordable housing, and personal health practices. The finding that mould complaints were coming from higher areas of deprivation has changed the process of service delivery to respond to the needs of priority populations.

Some of the **critical success factors** that supported this initiative are:

* Support from the public health unit to address social determinants of health and equity concerns, backed by a mandate from the Ontario Public Health Standards
* Intra-agency support and collaboration—the project team included public health inspectors (acting as mentors to environmental health summer students), health promoters, an epidemiologist, and a GIS analyst.
* Available equity tools and strategies, e.g., an existing voucher policy, data from the Ontario Marginalization Index

**Discussion Questions:**

1. Health status and socio-demographic data were key in identifying and responding to existing inequities. What is known about health inequities in your community or region?

2. Are there existing programs (such as vouchers) to support vulnerable populations? Could these decision trees be adapted for any programs in your region?

3. How can more be learned about vulnerable populations and the role of various determinants of health in creating barriers to compliance in your context (e.g., income, geographical location)?

Case study 2: Healthy Communities (Northern Health)

The concept of an equity lens recognizes that, although the root causes of health inequities may be outside the mandate of environmental public health practice, external partnerships and collaboration with other sectors may be required. Based on the belief that the environment and culture can be nurtured to support people to make healthier choices, Northern Health works in partnership with local governments on a Healthy Communities Approach. Local committees are usually co-chaired by the mayor and a senior Northern Health Leader, and include community members from various sectors, environmental health officers (EHOs), and other public health staff. The local communities determine health priorities and the committee works to address upstream risk factors and collaboratively develop local action strategies to make real and sustained improvements in the health of residents.

When first introduced, the approach challenged EPHPs/EHOs with a new way of working and a steep learning curve in terms of identifying community and health resources they could call upon. According to one EHO, the approach has gone far to break down barriers between sectors and even within the health unit. There are still challenges in finding relevant, local health data, but looking for the underlying healthy equity issues has now become an integral part of how they work.

Some of the **critical success factors** for incorporating equity into environmental health practice in this context includes:

* Executive support and championship at the senior leadership level for an upstream approach to environmental health services
* Recognition that the most powerful interventions come from empowerment (i.e., public health doesn’t have all the answers)
* Effective strategies to engage the community solving problems collaboratively

**Discussion Questions:**

1. Do you see tensions between ”upstream” approaches that focus on equity and social determinants of health and a traditional focus on inspections and enforcement in the field of environmental health? Does recognizing operators/clients as members of the same public you are working to protect and serve help to re-frame the discussion?

2. What barriers and opportunities exist for the participation of environmental health officers on cross-sectoral committees? Are there other ways that EPHPs can build stronger community relationships? How can managers and senior leadership support relationship-building and collaboration?

3. What existing partnerships could be strengthened or what opportunities are available for EPHPs to work with other health professionals or agencies outside the health system to take a more upstream approach to health protection and promotion?

Case study 3: Health Equity Impact Assessment for food safety training and certification (Ontario)

Ontario’s Health Equity Impact Assessment (HEIA) tool helps users make program or policy decisions with a clear understanding of how it will impact population groups in different ways. For example, “universal” programs are actually taken up far less often by people in low socioeconomic status neighbourhoods, risking that they may fall further behind the rest of the population. Applying the strategy of “targeted universalism”, many public health authorities are offering food safety certification at a reduced cost or in revised formats to overcome a range of learning barriers. For example:

* Ontario’s North Bay Parry Sound District Health Unit will waive the course fee and reduce the class size, even providing individual support, for those with mental, emotional, or academic needs.
* In the Regional Municipality of York, PHIs worked with nurses in the Health Equity Program, using the HEIA tool to identify changes needed in its Food Handler Certification Program to accommodate people with intellectual disabilities. The full-day, 6-hour course was broken down into smaller time segments, using oral and pictoral formats rather than the usual lecture and presentation-based approach.
* In the Sudbury and District Health Unit, A Guide to Accommodating People with Disabilities was developed in 2015 to help program instructors in food handler training to be aware of and accommodate physical or learning disabilities. The Guide is now being used in training programs across the health unit and the training program is being delivered twice monthly.

**Critical success factors** influencing the success of these initiatives varied across regions, but included:

* Partnerships and collaboration were central to the development and delivery of the programs (e.g., involvement of health equity nurses and health educators).
* Provincial (reportable) standards raised the profile of equity as part of health unit mandates. As equity was already defined as an organizational goal, getting support and buy-in for the initiative was not as difficult.
* An active Health Equity Committee provided support and consultation. In addition to the manager of the health protection division being on the committee, members also provided training on how to use the HEIA tool and how to find data and information about vulnerable populations.
* Policy support in the form of new provincial guidelines on food handler training programs (requiring programs to address culture, gender, and disability) led to a program evaluation.
* A new by-law requiring all high and moderate-risk food premises in the region to have a certified food handler on site during operations created the opportunity to apply the HEIA tool.
* Outcomes-based regulations provided EPHPs/EHOs with discretionary powers in meeting their mandates, i.e., EHOs had flexibility to decide how to deliver food safety training.

**Discussion questions:**

1. Other regions, such as Fraser Health in British Columbia, are developing a Health Equity Assessment Tool (HEAT) to assess the needs of vulnerable populations in their communities. Are there similar tools in use or in development in your area of work? Are there other tools that could be adapted to your area of practice to address equity concerns?

2. In the area of food safety training, are there current initiatives to meet the needs of specific populations? How might health equity assessment improve those initiatives?

3. Are EPHPs in your area using other less formal strategies to address equity concerns, e.g., reading exam questions aloud to students with literacy challenges? How could these ad hoc strategies be implemented more systematically to help break down inequitable structural barriers?