We all have a role to play

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

*This exercise is adapted from the Winnipeg Regional Health Authority:*

Provide participants with print versions of one or both of these documents.

1. **Role to Play** (<http://www.wrha.mb.ca/about/healthequity/files/RoleToPlay.pdf>)   
   This is the simpler of the two, so you may wish to use only this one if health equity is a new topic for your organization or team. Invite participants to think about their own department (e.g., Public Health, Environmental Health, or Health Protection) if that is a better fit than “Patient Care” in the top blue circle.
2. **What Can I Do?** (<http://www.wrha.mb.ca/about/healthequity/files/WhatCanIDo.pdf>)  
   This diagram is more complex, but useful to guide conversations and thinking about individual actions and organization capacity. You may invite participants to think about their own work (e.g., Inspections, Education, or Health Promotion) if that is a better fit than “Clinical Care” in the inner green bubble. The diagram illustrates places where health equity action might be taken. The second page provides ideas for how services could be made more equitable. Each program or region will differ, so you may add to these in your group discussion.

In small groups or all together, consider the feasibility for EPHPs to use these suggested actions. What could be implemented now? What might be the anticipated outcomes? Which actions have organizational barriers and how could they be overcome?

* Consider using a “dignity” question when interacting with clients who might face barriers e.g., “What do I need to know about you as a person to work with you as effectively as possible?”
* Listen genuinely and provide explanations that are easy to understand considering literacy, language, comprehension, attention, priorities, etc.
* Factor social and economic factors into risk assessment and response plan (cost, accessibility, acceptability, feasibility, barriers).
* Collect and use local population health data and assessments to understand your community and clients as members.
* Build ongoing relationship of trust for continuity of service.
* Refer clients to supportive community programs and services. Use bc211 where appropriate.
* Provide client advocacy such as filling forms, letters for better housing, forms for work, increased funding, support program eligibility.
* Take notes and discuss service gaps and unsolved or recurring problems with your supervisors.