



Equity in EPH Practice

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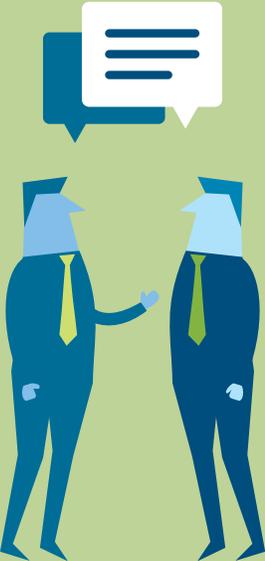
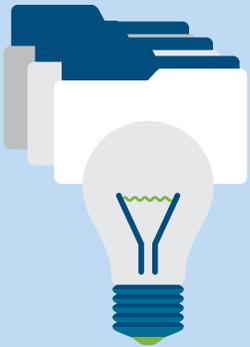
This is the third of three **Primers on Health Equity and Environmental Public Health** produced as part of a consultation with field staff by BCCDC's *Through an Equity Lens* project. The first primer, **Five Things to Know About Equity in EPH**, provides background about the concept of health equity and how it relates to environmental public health (EPH) practice. The second Primer, **Areas of EPH Practice Impacted by the Social Determinants of Health**, illustrates how equity issues impact different areas of EPH practice. This document highlights emerging approaches for responding to inequities through EPH practice, and identifies options to support further integration of an equity lens for EHOs.

This information was gathered through a series of focus groups with environmental health officers (EHOs) held in March 2015 in each of BC's regional health authorities and the First Nations Health Authority, and through subsequent consultations with EHOs and public health inspectors at conferences and online.



1 Emerging practices

Equity strategies for EHOs have not been formalized in policy or guidelines, but individual practitioners report using a variety of ad hoc approaches to support people perceived to be facing barriers.

ONE-ON-ONE Supportive relationships Adaptive communication 	RISK MANAGEMENT Prioritize critical risks Contextualize 	COLLABORATION Borrow tools and resources Mutual Support Networking and referral 	DOCUMENTATION Acknowledge and educate Flag system gaps 
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ONE-ON-ONE APPROACH

In many cases, EHOs described adjusting their approach to working with individuals in an inspection or consultation scenario. They often tried to find ways to work around people's barriers, applying an equity lens in order to help mitigate the inequities created by people's circumstances.

Supportive relationships

One commonly reported tool to apply an equity lens at the individual level is a focus on **relationships**. When people come to know and trust their EHO, they become more open about their challenges and barriers and allow the EHO to support them. EHOs have pointed out that this takes time and openness. They are careful to lay out all the relevant information and try to discuss it in that person's terms. One focus group participant described a situation in which a restaurant owner needed to do a lot of upgrade and repair work to be in compliance. This EHO decided to prioritize that work so it would be more manageable for the cash-strapped operator, rather than overwhelming him with more than he was able to do at one time. In such scenarios, the EHO recommends to "give them a list and let them know... I'm not going to throw you under the bus ... I will work with you to get it done."

Relationships are particularly important when working in First Nations communities, where EHOs offer guidance but do not have regulatory authority. In these communities, EHOs rely heavily on building trust and relationships, a process that can take years to develop.

Adaptive communication

A frequently used strategy for working with individuals that have language or literacy barriers is to adapt the communication style to the individual's abilities.

When language barriers are present, **demonstrations and visual aids** are used to explain procedures (but are not useful for communicating complex public health rationales). Family or employees, or even online tools such as Google Translate, are used in lieu of official interpreters.

To work around literacy barriers, some EHOs **verbally** walk through education materials or exams to help people who have difficulty understanding written material.

When recent immigrants used to more authoritarian inspectors try to hide challenges because they are fearful of immediate shutdown, EHOs have found that explaining the education role of inspectors in Canada, **building trust**, and letting the operator know that they will support them through the upgrade process can improve the working relationship with many food premise or personal services operators.



RISK MANAGEMENT APPROACH

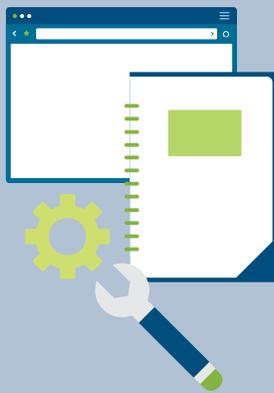
Risk prioritization, a common tool in EPH practice, is also used to respond to equity-related barriers. It is particularly common when multiple hazards or barriers are present, making it difficult for an operator to address everything at once. It is also used in cases where addressing one public health hazard or regulatory infraction might lead to the creation of another hazard (e.g., requiring system upgrades that would bankrupt a small water system and leave residents with no potable water, or destroying carefully handled meat from an unapproved source in a community with limited access to fresh food).

Prioritize critical risks

EHOs who participated in these consultations expressed a clear preference for education over enforcement. In the presence of inequities, progressive enforcement techniques are used, with a particular focus on **prioritizing critical risks** to avoid overwhelming vulnerable operators with too many seemingly insurmountable problems. This requires a delicate balance between protecting public health while continuing to build the kind of trusting relationship with a struggling operator that could have long term benefits. This might be interpreted as prioritizing the intent over the letter of written guidelines. Such a balance requires a significant level of confidence—as well as managerial support—in an EHO's ability to exercise appropriate discretion.

Contextualize

Similarly, EHOs often take the **local context** into account when prioritizing risks. They may focus on maximizing available resources (human, financial, or technical) for the biggest public health impact. For example, providing guidance on how to safely source and prepare wild game might be seen as preferable to prohibiting uninspected meat in a community with limited access to outside food sources or that prefers traditional foods. Context may also be taken into account (e.g., by accepting verbal test results from labs) when working with small water system operators in remote locations that are unable to meet standardized testing protocols due to their location.



COLLABORATION APPROACH

Informal collaboration occurs between health protection/ environmental health colleagues, between different professions within public health, and across sectors outside the health system. Many EHOs rely on colleagues to share approaches and resources to support their work with clients and operators that experience barriers.



Borrow tools and resources

Communication **tools may be borrowed** or adapted from other areas when not available within a particular health authority. EHOs reported searching for multilingual documents and visual aids online or asking colleagues in other regions and using them in their own work as needed.

Mutual support

EHOs rely on their **colleagues** for support and information when they encounter complex or unfamiliar issues for which there may be no standardized response. Those new to the field in particular use their senior colleagues for information about how to help people who are marginalized or who face social, economic, or geographic barriers.

Networking and referral

EHOs engage in **networking** and refer to other professionals or sectors when they encounter situations that are outside their expertise or scope of practice. This is generally *ad hoc* or informal and depends on personal contacts. Some people make a point to get to know who else is working in related support roles, and to let those people know who they are, so that they can refer people elsewhere to support them through their challenges. Junior staff rely on senior staff to extend their networks, as EHOs consistently report that formal opportunities for referral are limited at best.

Despite the lack of official channels, **informal referrals** are frequently used in the context of housing, though they also occur to help people access funding or education opportunities, and may involve mental health services, literacy services, grant opportunities, nursing or social work, police and fire department, landlord tenancy services, or physicians. In some cases, privacy legislation can make informal referrals difficult due to restrictions on sharing personal information.



DOCUMENTATION APPROACH

Documentation fills an important gap in the absence of formal structures to respond to inequities.

Acknowledge and educate

At an individual level, documenting hazards or infractions—and the reasons for them (including equity-related barriers)—in inspection reports can be a valuable tool for working with operators. These reports can be referenced for educational purposes, but also serve as **acknowledgement that barriers exist** and show that the EHO recognizes that the individual operator is doing everything he or she can within the confines of their circumstances.

Flag system gaps

Most health authority inspection reports do not require a narrative documentation of hazards, EHO response, and barriers. However, such reporting can benefit the EHO and the public health system. EHOs may feel it is important to document processes to show they are doing the best job possible in the face of unmitigated barriers, and can **flag issues** that may warrant additional attention or resources. As one EHO noted:

The first thing I try to do is document as much as we can. So we can show that we have been doing our due diligence to get things to a certain way, and there are reasons why it hasn't happened. I think that's a really important thing to express... "Well, these are the reasons why we're at where we're at. Yes, they're not in compliance, but we've had these issues and it's really not been the fault of either party why things have happened the way they have." And [show] what we've done to try and alleviate or correct that, and show that we've been doing our part and they've been doing their part as much as they can.

Such documentation could be an early step toward transformative health system change (see next section).

These emerging practices were identified from focus group discussions with approximately 45 EHOs in British Columbia, and supplemented with conversations and input from EHOs and public health inspectors from across Canada. Although this was not a representative sample, their professional experience and focus varied widely. Similar approaches and strategies were reported across regions, but there were some differences between health authorities. Relationship building was particularly important in the First Nations Health Authority due to the advisory, rather than legislated, role of EHOs. EHOs in rural regions appear to have a greater degree of flexibility to take creative approach to “use the tools you’ve got” to get the job done. The health authorities also varied in terms of perceived managerial support for the integration of an equity lens to EPH practice, although this is an emerging area of practice and further investigation is needed to examine how the different health authorities are introducing health equity into environmental public health.

Despite the variety of EHO responses to equity-related barriers, it is important to recognize that these are emerging practices that still need to be evaluated for their impact on both inequities and public health. All of them rely on individual EHO time, discretion, motivation, knowledge, and personal networks. In many cases, they were described simply as strategies to do the job and not as equity tools per se. In others, individual EHOs reported extending their involvement beyond the requirements of their role and sometimes using personal time to support individuals facing barriers.

Moving toward an equity-oriented EPH practice

These emerging practices suggest that some EHOs are beginning to bring an equity lens to typical inspection activities. (It should be noted that the strategies described here in the context of health equity are viewed by many practitioners as simply the way they serve the public, and they may not conceptualize what they do as applying an “equity lens.”) Others are taking a broad population health view of health protection and environmental public health (Figure 1). The one-on-one tactics, i.e., changing the way they work in typical inspection scenarios, could be described as transactional change (Quadrants A and B). These strategies are valuable to help individuals overcome or work around their barriers (Figure 2). Broader, systemic strategies will be needed to better serve individuals with multiple or complex barriers, and to help remove some of the larger barriers (or hurdles) that result from in the way health services are structured. Risk management strategies begin to move in this direction by considering population-wide outcomes within a traditional inspection model (Figure 1: Quadrants A and D). Collaboration strategies take a health promotion approach while still working with individual practitioners or situations (Figure 1: Quadrants B and C). The practice of documentation, as well as formalized structures for collaboration and referral, could help move toward system change to support wider population health impacts (Figure 1: Quadrants C and D).

Equity in EPH practice



	PERSON-CENTRED APPROACH TO EPH	SYSTEMS APPROACH TO EPH
Practice model	A. Traditional Focus on regulation and health protection, using education as a tool.	C. Emergent Focus on health promotion and creating supportive environments.
Response to health inequities	B. Individual Respond to socioeconomic barriers when they arise. Incorporate equity into practice by providing tools for practitioners to help them work with individuals who face socioeconomic barriers.	D. Population Remove barriers to health in society. Integrate equity into the EPH mandate with policy and collaborative mechanisms across all areas of practice.

Figure 1. The Equity Quad: Moving toward an equity-oriented EPH practice. The top row describes typical EPH practice, which has been gradually shifting from a regulatory compliance approach to one that incorporates health promotion and healthy environments as tools to both improve health and improve compliance. The bottom row indicates how an equity lens could be applied to either the Traditional or Emerging approaches to EPH practice.

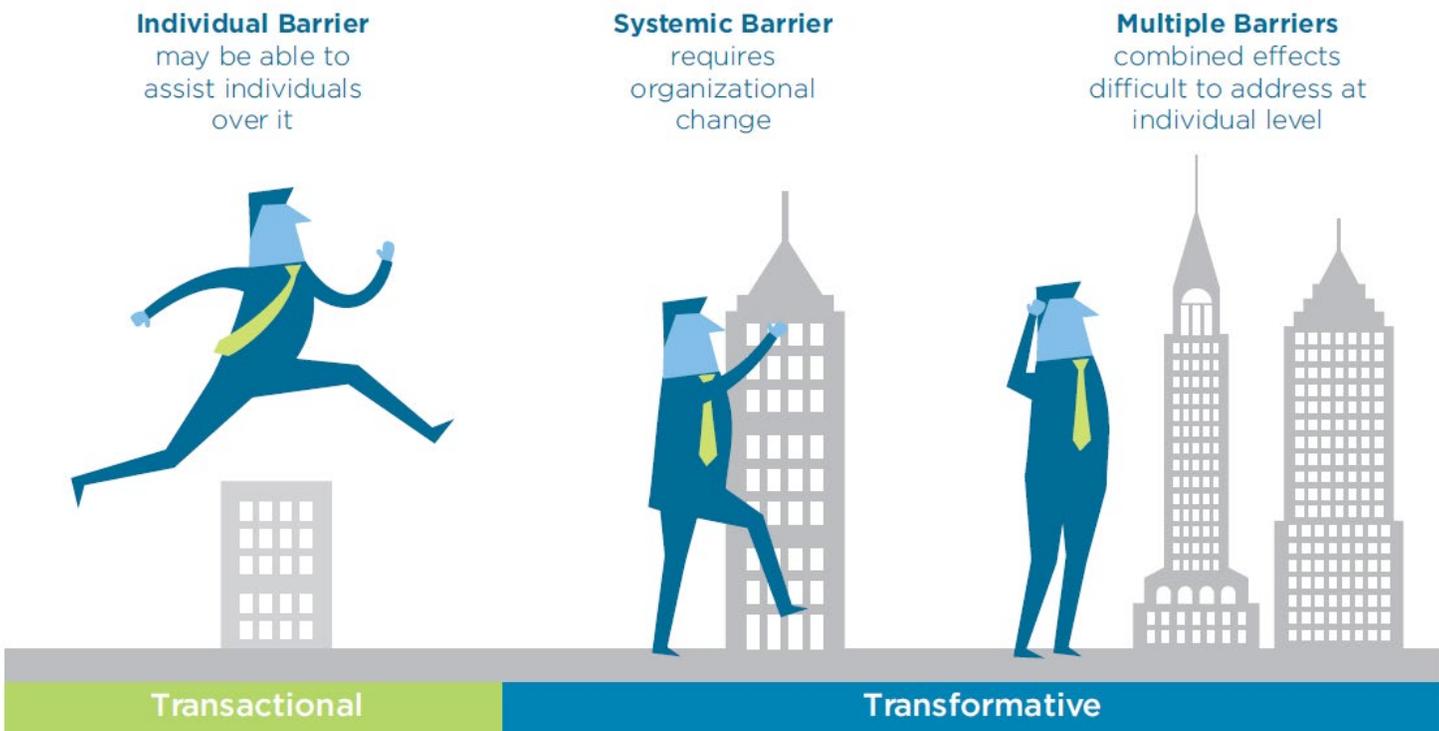
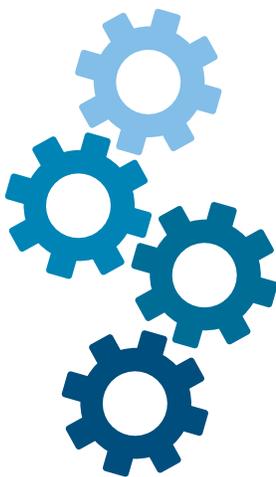


Figure 2. Addressing barriers with an equity lens. Individual barriers may be manageable, particularly if they exist in isolation, while systemic barriers tend to create challenges that are more difficult to surmount. However, when multiple barriers of any kind are present, their combined challenges are complex and more difficult to address. (Adapted from Dr. B. Nummer.)



2 Supporting further action

The intersection of the social determinants of health and health inequities with EPH practice described in the first and second Primers in this series, along with the emerging practices described above, indicate opportunities to integrate an equity lens into EPH practice.



Tools and training

Language, literacy, cultural, and mental health barriers are common challenges in British Columbia.

Where tools exist, e.g., multilingual signage, visual aids, or translated documents, they could be **shared and adapted** for use across regions. There may be value in creating additional tools to fill remaining gaps at the provincial level.

Training in cross-cultural communication, cultural sensitivity, and mental health literacy could support practitioners who interact with individuals facing such barriers. Even if practitioners cannot remove the barrier, they could become better equipped to recognize and respond in a more effective manner.

In-service **professional development** opportunities such as webinars, workshops, or focused staff meetings would raise overall knowledge and awareness with respect to health equity, its relationship to EPH practice, and a role for practitioners.

Collaboration

The concept of an equity lens recognizes that although the root causes of health inequities may be outside the mandate of EPH, all sectors can play a role in minimizing inequities. **Referrals and consultations** with other sectors inside and outside the health system could be a way to respond to equity-related issues that are witnessed by EHOs as frontline public health professionals but that may be beyond their scope of practice.

Networking with colleagues both inside and outside the public health system requires **time and opportunity**. More face to face interactions with a wider range of practitioners could facilitate networks of professional support.



Processes

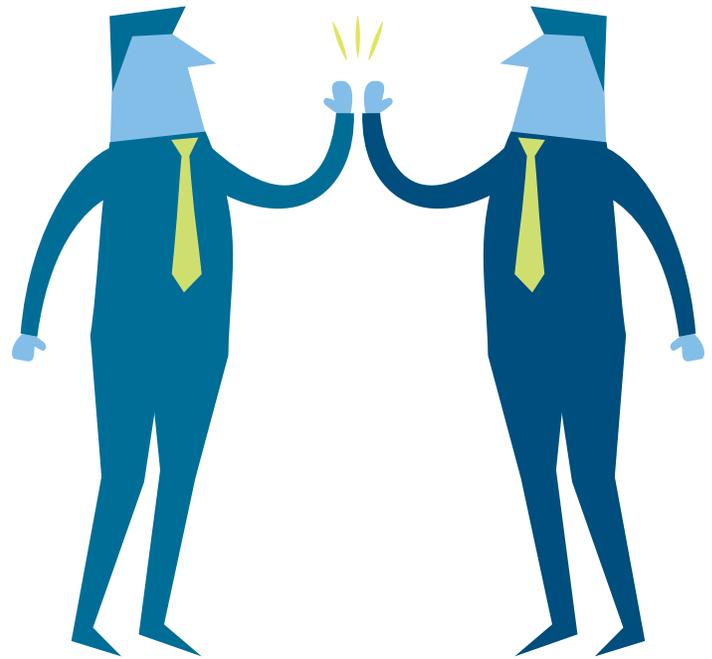
Referrals are currently done primarily through personal or opportunistic networks. More **formal structures for referrals**—including clear guidance about the roles and responsibilities of different professions, agencies, and departments as well as specific contacts within those agencies and departments—could lead to a more efficient and effective referral process.

Where direct action by EPH practitioners is not possible, there is value in **documenting** the challenges faced and efforts made by both EHOs and their clients in order to inform future decision-making. Such documentation can validate those efforts and highlight gaps in the system where actions can be taken to improve health equity.

Leadership support

Many of the strategies described in this report are time-consuming. EHOs are often restricted by daily or weekly inspection quotas that make it difficult to give attention to or build trusting relationships with individuals with barriers. If an equity lens is to be applied at the organizational level, **performance evaluation may need to be restructured** to incorporate the time spent supporting vulnerable or marginalized people.

Discretion is frequently used in response to inequities, but some practitioners report a lack of clarity about where or how to apply discretion. Clarification of the EHO role in such circumstances, leadership support for those who exercise discretion, and clarification of others' roles could increase consistency and support practitioners to apply an



equity lens.

Evaluation to assess outcomes associated with different strategies would be helpful to measure long terms outcomes with respect to compliance, health hazards, and inequities.

An equity-integrated EPH practice will require **clear support from all levels** (e.g., local managers, regional directors, and health authority leadership).

Equity in EPH practice

Conversations about equity in the context of EPH practice have begun in health authorities across Canada. An equity lens is an approach to practice rather than a specific skill or set of actions, and as such will take time to integrate into current processes. There will be opportunities for sharing knowledge, experiences, and lessons learned as different regions explore what equity means in the context of what they do. Early adopters and health equity champions—those practitioners who have already started exploring equity in the context of their role—should be celebrated and supported for helping define what it means to practice environmental health with an equity lens.

The role of EHOs in BC is shifting to incorporate broad population health approaches such as health promotion and healthy built environments. Such approaches provide opportunities for the kind of inter-sectoral collaboration that can also support the integration of equity into practice. Joint efforts between EHOs in health protection and dietitians in health promotion to support food safety and food security are one example of how a collaborative approach can support equity and wider population health goals. Though systemic change can be slow, much can be learned through the process.

It is integral to your growth as an organization, as a field, because otherwise we constantly would be stagnating, whereas other people are constantly evolving and changing. I don't see how that's any different for what an inspector would do, to what a doctor would do, to what a chef would do, for example. They are constantly finding new information. So, that should be part of this job, this growth and this understanding, and this learning throughout.

These three Primers have begun to frame the concept of health equity within the context of environmental public health practice in BC. Tools and resources to support practitioners who apply and equity lens will be valuable. However, strong leadership from health authorities and established processes for inter-sectoral collaboration are essential for transformation toward a more equitable health system.

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