SCENARIOS for discussion and reflection

GOAL: Illustrate the kinds of health equity issues that arise in environmental public health. Encourage self-reflection and provoke new ways of thinking about these issues.

These scenarios are designed to illustrate the kinds of health equity issues that arise in environmental public health, as well as to encourage self-reflection and provoke new ways of thinking about these issues. They are presented as examples of how EPH and health equity have come together, as well as to introduce some promising practices and ways that EPH staff can be involved with the social determinants of health and health equity.

You may use the scenarios included in this document or develop your own. It is helpful to copy and paste the text for each scenario onto a separate page that can be printed in a larger font for reading at the tables or posting on the walls.

Format A: Small group discussion. Each group/table is provided with the collection of scenarios and are given time to read the scenarios and discuss at their tables (10–20 minutes). Follow with the Q&A segment.

Format B: Individual reflection/collective discussion. Participants will be asked to walk around and independently review short scenarios posted around the room (approximately 10 minutes). Option to follow with the Q&A segment or simply ask people to consider these scenarios and their own individual reflections during the rest of the workshop.

Q&A segment. The facilitator leads a Q&A session with the full group to explore how the concepts discussed so far in the presentation apply to scenarios. Discussion questions are provided with each scenario – feel free to draw from these, develop your own, or facilitate conversations that arise organically among participants. Invite people to share other practice examples or suggest ways to respond to these scenarios.

This exercise was developed for a joint NCCEH/NCCDH/BCCDC workshop at the 2017 Canadian Public Health Association Conference: *Shifting Space – Facilitating Organizational Capacity for Health Equity in Environmental Public Health* (Hosted by Karen Rideout and Dianne Oickle)

Scenarios and discussion questions **Policy advocacy**

Three EPHPs at a regional health authority are responsible for following up on housing complaints. Beyond inspections of housing conditions and supporting individual clients, their work has developed an advocacy perspective. They consulted with public health staff in other programs and discovered that there were health equity nurses who actually sat in the same office area they did. As they developed a relationship and found out more about each other’s work, the EPHPs found opportunities to contribute to housing affordability and poverty reduction strategies. They also began to advocate for policies that address issues beyond health protection, including social exclusion, food insecurity, access to public transportation, and age-friendly environments.

* Who are some possible partners for collaboration in your organization? How could you find out about roles such as health equity nurses that you may not be aware of?
* What are some issues that might benefit from this sort of collaboration?

**Health equity committee & designated staff**

A public health organization has designated staff to take the lead on social determinants of health and health equity. These staff give presentations on health equity and the role of public health in general, and environmental health staff are interested in getting involved. The organization has instilled the concept of health equity into the mission, values, and strategic direction of their agency, and has created an agency-wide health equity committee. This committee includes representation from all public health departments and professions, including environmental health/health protection. In addition to the agency-wide committee, the environmental health department formed its own health equity committee to consider how to address the social determinants of health within their programs specifically.

* What might a health equity committee look like in your organization? Who should be invited to contribute?
* How is health equity reflected in the mission, vision, or service plans in your organization?

**Communicable disease & foodservice workers**

An EPHP doing restaurant inspections is involved with a case where a low-wage restaurant worker is diagnosed with a communicable disease and must be absent from work for a specified period of time according to regulations that exclude people with certain infectious diseases from handling food for the public. The employee expresses great distress—as a single parent of two young children who works part time with no sick leave benefits, he can’t pay the rent or buy groceries if he misses paid work shifts.

The EPHP works with the restaurant owner and employee to negotiate an agreement whereby the worker is absent from work but continues to get paid, agreeing to make up the shifts when he is no longer infectious. In addition, the manager of the Communicable Disease team reviewed the impact of “exclusion periods” on low-wage staff. A communication strategy was developed to explain to employers and staff the importance of exclusion periods. The team then worked with food industry and foodservice worker groups to identify solutions, such as medication funding and negotiated work schedules, which protect public health while minimizing financial risks for low-income workers.

* What other examples of unintended consequences might arise from enforcing public health regulations? How could they be avoided or mitigated?
* How could strategies such as this be formalized into regular procedures?

**Working with First Nations communities**

There is a disparity in tobacco use between First Nations and non-First Nations communities in Canada. The Health Protection Department is tasked with developing a strategy to work with local First Nations communities to address the contributing factors. Public health staff, elders, and Indigenous community leaders worked together to identify the mitigating factors. An agreement was developed to facilitate working together despite the Health Protection Department’s lack of regulatory authority in First Nations communities. A Tobacco Enforcement Program was implemented to address illegal sales of tobacco products, increase monitoring of tobacco retailers, create culturally appropriate education materials, introduce consequences for policy violations, and build collaboration between Indigenous communities and public health. Illegal sales to minors and overall smoking rates declined significantly in the first year after implementation and youth from the participating communities were being trained to take over program implementation.

* How might the ceremonial use of tobacco in indigenous communities impact recreational tobacco use, and how should awareness of this historical context influence the public health response?
* How do you think relationships influenced the success of this collaborative effort?

**Targeting programs to marginalized populations**

A public health agency was undergoing program planning to meet new provincial standards, which included attention to the social determinants of health in all programs. EPHPs began by considering rabies guidelines, knowing that many low-income families could not afford a veterinarian to access cost-reduced rabies vaccinations for their pets. A voucher program was developed whereby vouchers were distributed based on income, condition of the home environment, and education level of clients. The EPHPs developed a decision tree to formalize the process for allocating vouchers. The process used to create this decision tree was then adapted to formalize consideration of mold complaints based on geographical areas of deprivation in the community. In both of these cases, service delivery was altered to more effectively respond to the needs of the most vulnerable populations.

* What processes or tools might help identify opportunities to increase access to programs in your area? (Hint: Health equity impact assessments are one example)
* What programs in your area might benefit from targeting to improve access or uptake by vulnerable or at-risk populations? Are there specific sub-regions in your community that are at risk?

**Healthy Communities framework**

A regional health authority with above-average rates of chronic disease decided to focus on the intersection of physical, social, and cultural environments to help people make healthier choices. A Healthy Communities committee is developed that includes representatives from municipal offices, community organizations, local leaders, members of the public, as well as public health and acute care staff. Environmental health staff are trained to take on various roles, including identifying community needs, collaborating with other agencies, determining priorities, providing health data, identifying community resources, delivering education sessions, advocating for policy change, and bridging communication between public health and the community.

* How does the Healthy Communities approach differ from traditional health protection approaches? What are the pros and cons of each, with respect to health equity and program efficacy?
* Do EPHPs have the skills needed to work in this way? How could collaborative capacity be increased now or in the future?