Manitoba Poverty Reduction Strategy Submission

Population & Public Health

Winnipeg Regional Health Authority

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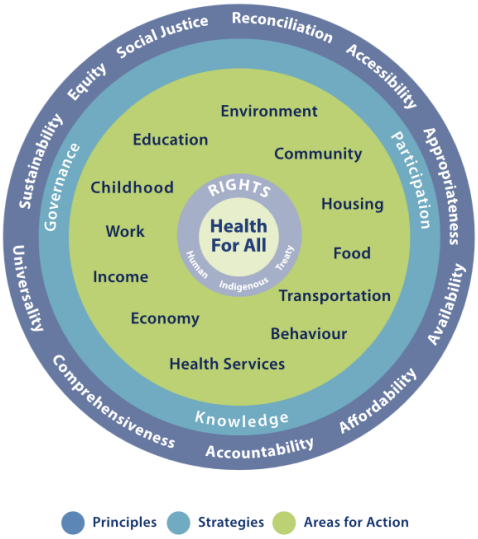
INTRODUCTION AND CONTEXT

This submission is from the Population and Public Health program of the Winnipeg Regional Health Authority (WRHA). As such, its focus is on the **health impacts of poverty** and the health gaps and gradients that result between those privileged with social and economic advantages and those blocked by disadvantages. Health gaps that arise from social and economic conditions are preventable and unjust, and are referred to as health inequities. For the purpose of this submission, *we consider actions to **reduce health inequities** and actions to **reduce poverty** as essentially synonymous.*

As such, we are using the WRHA framework for understanding and addressing health equity[1] to organize this poverty reduction and community involvement submission. An earlier version of this framework was first published in the document Health for All: Building Winnipeg's Health Equity Action Plan (2013).

Figure 1: Framework for Understanding and Addressing Health Equity



This submission will be organized around the five themes that were solicited for comment, but intersected with the pertinent health equity Areas for Action as per the outline below:

A: Health and Wellbeing	1. Health care services including mental health services 2. Childhood
B: Everyday Living	3. Income 4. Housing 5. Food 6. Transportation 7. Environment
C: Employment	8. Work
D: Education and training	9. Education
E: Sense of Belonging	10. Community

[1] Health Equity means that all people can reach their full health potential and should not be disadvantaged from attaining it because of social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance.

POVERTY AND HEALTH: THE CONCEPTS AND EVIDENCE

Poverty affects health in very real and direct ways. Poverty is complex and multifaceted, and creates social and economic exclusion. Social and economic circumstances either facilitate or block access to the social determinants of health, which are those elements fundamentally required for health, such as food; housing; positive early childhood experiences; education; health services; income; and transportation. The inequitable distribution of social determinants of health in Winnipeg contributes to significant gaps in health. For example:

- Life expectancy of babies born to the wealthiest 20% of Winnipeggers is 8 to 10 years longer than those born to the 20% with the lowest income (Centre for Healthcare Innovation [CHI] & WRHA, 2015).
- There is nearly a 17-year difference in female life expectancy and a 15-year difference in male life expectancy between the lowest income neighborhood (Point Douglas South) and the highest income neighborhood (River East North) (CHI & WRHA, 2015).
- Rates of mood and anxiety disorders are 24.4% in the lowest income neighbourhood vs. 18.7% in the highest, while suicide rates are 4.3% compared to 0.8%, and substance use prevalence is 9.8% vs. 2.8% (CHI & WRHA, 2015).

See more health outcome indicators under *Income* section.

Approaches to address this inequitable distribution would have a positive impact on improving health equity and reducing poverty. The WRHA's Population and Public Health program recommends that a poverty reduction strategy broadly consider and act on the determinants of health, and in particular, inequities in their distribution.

It is important to recognize that health equity/poverty reduction work is grounded in rights. Everyone is entitled to a standard of living that supports their highest attainable mental and physical health status, as health is a fundamental human right. Additionally,

- Poverty relates to other human rights such as the right to food, housing, work, education, human dignity, non-discrimination, and equality (United Nations, 1948).
- The right to non-discrimination means that everyone possesses the same rights regardless of who they are, where they are from, and other life circumstances (United Nations, 2008a).
- In particular, Indigenous Peoples have individual and collective rights, the right of existence, the right to live free of discrimination, and rights entitling them as peoples to self-determination (United Nations, 2008b).

People who live in poverty experience worse health outcomes because of differences in historic and current access to money, power and resources.

- Urban inner-city neighborhoods of Winnipeg have some of the highest poverty rates in the province. The lowest income communities in Winnipeg have the highest proportion of Indigenous residents.
- Ethnic groups and others who experience current or historical marginalization or oppression are disproportionately affected by economic and social disadvantage.
- The social, economic and health inequities of the First Nations, Metis and Inuit people living in Manitoba are the results of colonization, including the policies of the residential and day school system. Historic and current multilevel racism has had ongoing negative and tragic impacts on all aspects of Indigenous people's health and wellbeing.

Women, Indigenous peoples, persons with disabilities, and racialized communities are over represented among those who live in poverty and therefore at greater risk of poor health.

- Poverty disproportionately impacts the Indigenous population in Winnipeg. Aboriginal households in Winnipeg experience poverty at a rate of 2.5 times that of non-Aboriginal families. 1/3 of Aboriginal households in Winnipeg have incomes below the low-income measures (LIM) (Silver, 2015).
- 4 in 10 recent immigrants to Winnipeg live in poverty, whereas 2 in 10 of Canadian-born people in Winnipeg live in poverty (Canadian Council on Social Development, 2007).
- People with mental illness often live in chronic poverty. Poverty can be a significant risk factor for poor mental health. People with mental illness face many barriers, including stigma and discrimination, which may prevent them from securing adequate education and employment. In Winnipeg, there is a strong tie between mental illness and income levels; where low-income areas have the highest treatment prevalence (Currie, 2004).
- People with disabilities face barriers to adequate income assistance, training, and employment. Poverty can lead to disability and disability can lead to poverty. People with disabilities face barriers to adequate income assistance, training, and employment.

"Poverty is an independent risk factor for poorer health, not just a marker of poor health behaviours. Health is often thought of as an individual matter and an outcome of the choices or willpower of individuals. However, limited access to the conditions, circumstances and determinants of health imposes barriers and limits individual action. Racism and discrimination influence access to the conditions that support health." (WRHA, 2013b)

A. Health & Well-being

Health services

Health services are noted to be one of the determinants of health, and one area for action to address gaps in health related to poverty. According to the Canadian Medical Association, access to health care is estimated to account for 25% of what makes Canadians healthy.[2] While this underscores the much larger impact of such factors as income, early childhood, education and employment, the role of the health care system in poverty reduction and health equity promotion cannot be ignored.

The WRHA is committed to and undertakes efforts to promote health equity.[3] In 2013, the WRHA committed to increase the health equity focus of our services and the way we conduct our planning and operations. The WRHA seeks to work in partnership and share knowledge and decision-making support to others outside the health care sector (WRHA, 2013a).

The Health for All: Building Winnipeg's Health Equity Action Plan (2013b, pg. 59) identifies common approaches required for effective action in health care and across all sectors:

1. Reaching out: provide services that reach out to those with unmet needs.
2. Dignity, respect and cultural safety: those working with structurally disadvantaged people must exemplify an inclusive, respectful, reflective, culturally proficient and participatory approach.
3. Integrated services: teams of providers offer various services.

[2] For more information visit: https://www.cma.ca/En/Pages/health-equity.aspx
[3] For more information visit: http://www.wrha.mb.ca/about/healthequity/

4. Locally based services: provide services in local neighborhoods and foster development of local areas.
5. Equity impact assessment: all major WRHA, City and Provincial policies should be based on equity impact assessments.[4]

Health equity promotion and poverty reduction should be considered at all levels of health care including:

- Health system leadership
- Direct care
- Community partnerships/community participation

Everyone working in the health care system has a role to play.[5] At all levels, health care should be planned and delivered based on respect, dignity, cultural safety, anti-racism, rights-based, person-centered and empowerment approaches. Ensuring the health care workforce is reflective of our population is a critical step. Supporting and adequately funding Indigenous healing opportunities is also essential.

Increasingly, healthcare providers recognize the negative health impacts of poverty, and work to support clients living on a low income who may struggle to access their entitled government income support benefits. Resources such as the "Get Your Benefits" booklet, available on the Manitoba Health, Seniors and Active Living website, increase awareness about eligible benefits and programs. System integrators, such as the Income Security Promoter in the Downtown/Point Douglas My Health Team, work in partnership with government and community programs that deliver income services to develop and deliver interventions to identify and address income insecurity. The physicians and community area clinic partners who identified this as a gap in service for their clients developed this position through a collaborative process at the Downtown/Point Douglas My Health Team local table.

While supporting client access to government benefits, a number of system barriers within and beyond the health care system have been identified. For example:

- Some benefits require completion of a form by a medical professional. The completion of medical forms is not a service included in the claims for compensation by fee-for-service physicians. The current system does not incentivize medical professionals to complete critical forms, which can result in prohibitive costs being passed along to low income patients. For example, clients describe fees of $150 for completion of the lengthy form required for the Disability Tax Credit.
- In Manitoba, birth certificates are still issued on a cost recovery basis, despite identification being recognized by the United Nations as a basic human right. The minimum fee is $30 but additional fees can be added to correct an error on the birth certificate application ($30), correct an error on the permanent birth registration record ($120) or to rush processing and delivery time ($65). The cost of a birth certificate can be prohibitory for low-income families.
- The Manitoba Public Insurance (MPI) sets out specific requirements for guarantors, which include people who hold professional positions who have known the applicant for two years.

[4] Equity impact assessments analyze the potential impact of service, program or policy changes on health inequities and/or the health of structurally disadvantaged populations. Using structured procedures and methods policies, programs or projects are assessed for their potential, and often unanticipated, effects on the health of the population and differential health impacts among population groups.
[5] See http://www.wrha.mb.ca/about/healthequity/files/RoleToPlay.pdf

> While corrections officers, social workers, teachers, and military or police officers (for example) can be guarantors, registered nurses cannot. Registered nurses work regularly with those who experience poverty including those who experience homelessness, chronic mental health conditions and substance use disorders.

People with mental illness often experience chronic poverty. Additionally, poverty can be a significant risk factor for poor mental health. Almost one third of Point Douglas South residents have a mood and anxiety disorder (32.0%), a prevalence rate of mood and anxiety disorders that is 67% higher than rates in the highest income community areas and a rate of suicide that is over four times higher (CHI & WRHA, 2015). A comprehensive poverty reduction strategy and health system ensures access to community mental health services and expands the types of mental health services available.

Stepped Care service delivery model is an evidence-based service delivery model that shifts mental health services from a series of independent services to a collaborative system of care that is responsive to population based needs. The single practitioner models of service that exist today lead to significant wait times, high caseloads, access to only one provider and corresponding reluctance to close files on the part of both the individual and providers due to lengthy waits to reopen if relapse occurs. Further, primary care providers are sometimes reluctant to accept new patients who experience episodic or ongoing mental illness in case of being unable to access mental health services and supports when needed. Through the reorganization of existing resources and small amounts of additional funding, mental health services and interventions can be based on a foundation of recovery-oriented practice and Stepped Care approaches (e.g., systems navigation, transition services, consultation, assessment and treatment and case management) (Joint Commissioning Panel for Mental Health, 2013; Raphael, 2000). Mental Health Teams, based on the Stepped Care service delivery model, have been demonstrated locally in Winnipeg West and South Winnipeg.

While there are successful models demonstrating tangible ways to optimize efficient access to mental health services, mental health funding falls short of the population based need. The World Health Organization (WHO, 2013) observes that "there is a substantial gap between the burden caused by mental disorders and the resources available to treat and prevent them," noting that mental disorders account for 33% of all years living with disability and 13% of global burden of disease. Additionally, WHO (2013) notes that suicide is the second most common cause of death globally among young people, under age 24.

Canada's spending on mental health care lags behind other similar countries, such as Britain, which spend an average of 10% of its healthcare budget on mental health, or New Zealand and Sweden (11%) compared to Canada's average of 7% (Jacobs et al., 2010). According to the Mental Health Economics European Network (MHEEN, 2002), the ratio of 5% is a danger point and anything below this is considered to be too low (Jacobs et al., 2010). Manitoba's average spending is below the national average (Health Intelligence & Associates, 2017).

Similarly, public health is an underfunded part of the health care system in Manitoba. Its role in prevention, promotion, health assessment, partnerships and healthy public policy is critical in health equity and poverty reduction leadership. The report Provincial Clinical and Preventive Services Planning for Manitoba- Doing Things Differently and Better ('Peachey Report'), accepted by government in 2016, emphasized the benefit and value of adequately resourcing the public health part of the health care system.

> *"Manitoba lags much of the country in public health funding. It is fair to conclude increasing the funding to public health initiatives will likely yield the greatest return on investment in healthcare in the province, over any other initiative. This will be particularly true in the north and remote communities and the inner city of Winnipeg; however, it is equally true that there is no part of the healthcare system not touched by public health. Yet, it remains poorly understood."* [6]

Considerations for action:

- Build upon the existing resources and activities of health systems to promote health equity by supporting and funding action that enables clients living in poverty to access the social determinants of health, including, but not limited to health care.
    - For example, health care providers promote tax filing to enable people living in poverty to access eligible benefits such as the Canada Child Benefit.
- Increase the pace of training all health care professionals in cultural competency, anti-racism and health equity approaches.
- Address system barriers encountered while providing patient care such as:
    - Reduce barriers for accessing medical benefits by including the completion of forms in the fee-for-service physician compensation claims or widening the professionals who may complete forms (e.g., occupational therapists).
    - Reduce the frequency that such reports need to be submitted for those with chronic conditions.
    - Create a fee waiver system that enables low-income Manitobans to obtain or replace a birth certificate for free (Canadian Centre for Policy Alternatives – Manitoba [CCPA], 2017a).
    - Support access for individuals leaving prison, youth exiting Child and Family Services, and patients leaving long stay hospitalizations to obtain government issued ID prior to leaving (CCPA, 2017a).
    - Expand the MPI guarantor list (used to issue photo-ID) to include professionals that low-income and/or marginalized populations are more likely to have contact with (CCPA, 2017a).
- Increase access to community mental health services and expand the types of mental health services available. Adequately fund sufficient teams of mental health practitioners to be responsive to population based needs across the province (e.g., evidence-based interventions including Program of Assertive Community Treatment, Early Psychosis Prevention and Intervention Service, psychological interventions, integrated mental health and addictions services, and Mental Health Teams based on the Stepped Care service delivery model) (CCPA-MB & Canadian Community Economic Development Network – Manitoba [CCEDNet], 2015).
- Appropriately resource and position public health to fully play its role in prevention, health equity leadership and healthy public policy to close health gaps and contribute to health care sustainability.

Suggested indicators to track progress in this area:

- Increased number of Manitobans who have the identification they need.
- Case management support is available to low-income Manitobans to enable access to benefits.

[6] See https://www.gov.mb.ca/health/documents/pcpsp.pdf pg. 189

- Increased number of low-income Manitobans filing income taxes through Community Volunteer Income Tax Program clinics.
- Increased percentage of low-income Manitobans receiving eligible benefits.
    - Increased number of Manitoba children receiving Canada Learning Bond.
- Mental health funding is increased to established national benchmarks.
- Significant increase in low-income Manitobans accessing community mental health and addictions services.
- Public health funding is increased to national benchmarks.
- Increased frequency of public health engagement in healthy equity public policy issues.

Childhood

Early childhood experiences set the course for lifelong health, learning and development. Everything in a person's future is affected; well-being, obesity/stunting, mental health, heart disease, competence in literacy and numeracy, graduation rates, criminality, and economic participation throughout life. Experiences of poverty, particularly in early childhood, have long lasting effects on health outcomes, access to education, training and employment. The health impact of adverse childhood experiences can persist throughout life even if a person experiences higher economic circumstances in adulthood.

- The child poverty rate in Winnipeg was 14% in 2010, 6% higher than the national average (World Vision Canada, 2013).
- Half of Aboriginal children under six in Winnipeg live in families with income below the Low Income Measure (LIM) (Silver, 2015).
- Parents in households with low incomes are more than twice as likely to be chronically stressed as middle to high-income parents. Chronic stress in the family impedes children's ability to learn and build relationships with others (Bernas & MacKinnon, 2015).

Colonialism, racism and social exclusion have contributed to a disproportionate number of Indigenous children in the child welfare system and unequal outcomes for children, families and communities.

- There is an over-representation of Indigenous children in care (First Nations, Metis, and Inuit); they compose approximately 26% of the child population in Manitoba, yet they accounted for close to 90% of children in care on March 31, 2014 (Brownell et al., 2015).
- Aboriginal children are in care at a rate 17 times higher compared to non-Aboriginal children (84.3 compared to 5 per 1000 children) (McKenzie & Shangreaux, 2010).
- Indigenous children are more often taken into care as a result of neglect due to poverty and poor housing, rather than abuse (Brownell et al., 2015).
- A report focused on the educational outcomes of children in care found that children in care have fewer successes in school than children who have not been in care. Further, for most of the outcomes examined, non-Indigenous children in care tended to have better educational outcomes than Indigenous children in care. These inequities in educational outcomes are a reflection of the social inequities confronting Indigenous groups, including inequities in income, housing, social services, and education services (Brownell et al., 2015).

Allowing large cohorts of children to continue growing up with disadvantage and toxic stress not only limits possibilities in their individual lives, but also has huge societal impacts for everyone. Without conditions for optimal physical, emotional, social development from prenatal to youth for all children,

poverty is perpetuated and amplified, increasing costs to all systems (healthcare, mental health, judicial, education, etc.).

- Children born to teen moms, in families on income assistance, or in Child and Family Services are four times more likely to have poor outcomes in early development (physical health and well–being, social competence, emotional maturity, language and cognitive development (including literacy and numeracy), and communication skills and general knowledge) (Santos et al., 2012).
- The odds of poor outcomes grow rapidly from poor early development - less credits in Grade 9, to less likely to complete high school, to more likely to receive income assistance in early adulthood (Santos et al., 2012).
- Mental health problems in childhood and adolescence have a significant impact on child development and have been identified by many as today's leading pediatric problem (Jakovljevic et al, 2016). A large and growing body of research, including studies in Canada, the US, and the UK, demonstrates that children living in poverty are significantly more likely to have psychiatric conditions and inferior mental health when compared with peers from families with higher socioeconomic status (Jakovljevic et al., 2016).

Considerations for action:

- Ensure early learning and child care programs are culturally appropriate and reflect Indigenous peoples to fully participate in the care and education of their children (Truth and Reconciliation Commission of Canada, 2015).
- Provide multiple avenues for families to access support for positive parenting of all children with emphasis on reaching out to support parenting in families with the most challenges (WRHA, 2013b).
- Increase the availability of deliberate interventions to increase school readiness among the children who need most help to be ready for school (WRHA, 2013b).
- Enhance early identification and create supportive interventions where children experience vulnerabilities or developmental delays (WRHA, 2013b).
- Increase funding for more child care spaces and to ensure quality (CCPA & CCEDNet, 2015).
    - Ensure that early learning and child care is accessible for all, especially for families facing additional barriers (e.g., low income, single parents) (WRHA, 2013b).
    - Remove barriers associated with the Manitoba Child Care Subsidy (e.g,. address requirement for child to attend daily to maintain subsidy and child care space, reduce or eliminate parent fee for low income families).
- Ensure that inclusive early learning and child care opportunities are available and accessible for children with disabilities or complex medical needs (WRHA, 2013b).
- Invest in programs to promote family welfare and alleviate the conditions that currently result in taking children into care — programs such as those that provide adequate housing, adequate income and employment opportunities, addictions prevention and treatment, mental health services, parent skill training, and parent support (Brownell et al., 2015).
    - Increase funding for interventions such as Families First Home Visiting, Towards Flourishing and Partners in Inner City Integrated Prenatal Care that have demonstrated positive impacts. Current funding does not meet population needs.
- Increase Manitoba Prenatal Benefit (MPB) amount and index it to the cost of living. Address barriers to accessing the MPB.

For more information on these approaches, please see Health for All: Building Winnipeg's Health Equity Action Plan pgs. 39-40.

Suggested indicators to track progress in this area:

- Indigenous peoples early learning and child care programs are decolonized as defined by the community.
- Those who need the most help to be ready for school access supportive interventions and the interventions meet their identified needs.
- The numbers of early learning and child care spaces are increased.
- Early learning and child care opportunities are financially accessible, especially for families on a low-income.
- Decrease in the number of children in care.
- Closed poverty-related gaps in established early learning and developmental markers (e.g. EDI scores).

B. Everyday Living

Income

Income is one of the strongest predictors of health status. In Winnipeg:

- Lower household income is associated with higher infant mortality rates. There is a 4 times higher infant death rate in children in low-income community areas compared to the highest income areas of Winnipeg (CHI & WRHA, 2015).
- Lower income community residents are more likely to have chronic diseases such as hypertension, diabetes, and ischemic heart disease (CHI & WRHA, 2015).
- Lower income communities tended to have higher mental disorder and substance abuse prevalence (CHI & WRHA, 2015).
- Intentional and unintentional injuries hospitalization rates for residents living in the lowest income quintile are more than double than that for those living in the highest income quintile (CHI & WRHA, 2015).

Income is structurally imposed and socially produced rather than a reflection of an individual's hard work.

- Income determines the conditions that shape the chances of good health throughout life. The quality of early childhood, education, food security, employment and housing are all in part determined by income (Raphael, 2015). People with less income than others experience material and social exclusion.
- There is a significant association between higher income inequality (unequal distribution of income) and worse outcomes (Pickett & Wilkinson, 2015).
- There is a correlation between income inequality and several measures of health. Measures include mental illness, teenage birth rates, drug use, child wellbeing, life expectancy, infant mortality, obesity, and homicides (Pickett & Wilkinson, 2015).

Low income is associated with higher use of the healthcare system.

- Canadian healthcare costs increase as income decrease[7] (Public Health Agency of Canada [PHAC], 2017).

[7] based on Canadian data on the costs of acute care in-patient hospitalizations, prescription medications (non-hospital) and physician consultations (general practitioner and specialist, PHAC, 2017).

- Health inequalities cost the Canadian health care system an estimated $6.2 billion annually. This represents over 14% of total annual expenditures on acute care in-patient hospitalizations, prescription medications and physician consultations (PHAC, 2017).

Approaches to address adequate income must consider income more broadly than wages from paid work. The racialization of employment rates among Indigenous people results in a much higher proportion of Indigenous people gaining most of their income through government transfers than non-Indigenous people. Focusing income approaches only on wages would contribute to increased economic exclusion among people who are already most disadvantaged.

- 1 in 5 Indigenous men ages 15-64 gain most of their income through government transfers compared to 1 in 10 of non-Indigenous men.
- For Indigenous women ages 15-64 years, the proportion is 1 in 3 compared to 1 in 5 for non-Indigenous women.
- For those 65 years and older, the proportion is 73% for Indigenous men compared to 54.1% of non-Indigenous men.
- For Indigenous women 65 years and older the proportion is 83.38% and 72.9% for non-Indigenous women (Canadian Human Rights Commission, 2013).

Many community members living in poverty face barriers to tax filing and applying for government benefits.

- Individuals living in poverty who are unbanked or underbanked are particularly vulnerable to high cost alternative financial services such as cheque cashing, rent-to-own arrangements, pay day loans and pawn loans. The high fees and interest charges associated with these services result in greater financial stress for families who rely on these predatory financial services. Financial institutions also require identification in order to open bank accounts and may have additional charges (e.g. minimal balances, debit charges etc.).
- Indigenous people may experience additional challenges due to having inadequate information about families of origin, and no formal participation in banking institutions, and therefore require enhanced supports.

For more information on income and health see Income, Income Inequality & Health: Background Document.

Considerations for action:

- Prioritize policies that support adequate income (upstream intervention) over addressing downstream interventions such as health care, corrections and child welfare.
- Ensure that all people in Manitoba have access to sufficient income to meet the actual costs of conditions required for health (WRHA, 2013b).
- Income assistance levels are based on and indexed to real costs of living (CCPA & CCEDNet, 2015).
- Policies should support adequate income without means test or work requirement. Build on and learn from Ontario's pilot of guaranteed annual income and the success of previous effective basic income interventions (e.g. Mincome in Dauphin, Manitoba).
- Provide sufficient resources for the employment and income assistance workforce to provide optimum case management support to the most disadvantaged people (WRHA, 2013b).
- Consolidate income and disability services while ensuring recognition that persons with disabilities may have unique funding, service and support needs (WRHA, 2013b).

- Increase incentives and support for people on disability to work by continuing to provide benefits not available through employment, such as vision, dental and Pharmacare, in recognition that some disabilities, like mental illness, are relapsing conditions and ability to work will vary over time.
- Remove barriers to identification required to access provincial, federal and other benefits (as above in health care section).
    - Waive administrative costs for a period of five years for the name-change process and the revision of official identity documents, such as birth certificates, passports, driver's licenses, health cards, status cards, and social insurance numbers to enable residential school Survivors and their families to reclaim names changed by the residential school system (Truth and Reconciliation Calls to Action #17).
- Develop Indigenous-specific strategies to examine the processes for rural and isolated individuals, as they face unique barriers, and mainstream systemic interventions may not adequately consider their needs.
- Develop, strengthen and advertise education and retirement saving incentives for socially and financially disadvantaged populations.
- Reduce barriers in order to gain timely access to income support services i.e. offer alternative formats for Employment and Income Assistance (EIA) pre-intake orientations.

For more information on some of these approaches, please see Health for All: Building Winnipeg's Health Equity Action Plan pgs. 33-34.

Suggested indicators to track progress in this area:

- Income assistance levels are sufficient and indexed to real costs.
- Income support approaches provide sufficient income to support all people to access the conditions for health regardless of work attachment.
- Reliance on food banks is reduced (see more in Food section).
- Increased proportion of low income people receiving all their eligible benefits.
- Indigenous-specific strategies are developed by Indigenous people and implemented to reduce barriers to income.

Housing

Good housing is essential for health and safety. Housing is a key determinant of health.

- At its most basic, having shelter provides protection from the elements. It is a place to sleep, store food and eat food, and attend to personal hygiene.
- Housing should provide stability, privacy, dignity and a sense of safety. Stable housing allows individuals and families to participate more fully in society, which contributes to health.
- Housing that is conducive to health is of good quality, not overcrowded, cold, damp, and poorly ventilated or in disrepair. For example, damp, mouldy housing conditions are associated with chronic respiratory conditions such as asthma. Overcrowding is associated with spread of infectious diseases and high stress. Disrepair is associated with greater injury risks.
- People without access to stable housing have a higher risk of acquiring illnesses or becoming injured, and the likelihood of recovering well from a health problem is greatly diminished. Stable housing provides a platform for health care delivery for individuals with chronic health conditions.

- Children who experience housing instability or homelessness have a 25% greater risk of poor health in adulthood and higher mortality rates in adulthood (Weitzman et al., 2013).

Currently Manitoba has a lack of housing that is affordable for low-income individuals and families. This means that many people in poverty are either living in housing beyond their means, settling for housing that is unsafe or unsuitable, or are homeless. When there are fewer affordable housing options, tenure is often unstable meaning that individuals and families may have to move frequently. All these factors have negative health consequences.

Many people in Winnipeg live in core housing need.[8]

- The majority of low-income households live in rental housing. In Manitoba, well over one third of rental households (35%) live in core housing need as compared to less than one seventh (13%) of home owners.
    - 44,315 of renter households spend more than 30% on housing.
    - 19,340 renter households spend more than 50% on housing (15% of all renters).
- Core housing need (both owned and rented) is higher in Aboriginal households (35%) than non-Aboriginal households (20%).
- There are 2620 couples with children in rental housing in Winnipeg who are in core housing need (25% of couples with children).
- There are 4687 households with a female lone parent in rental housing in Winnipeg in core housing need (47.6% of female lone parents) (Statistics Canada, 2011).

Though housed, living in a state of core-housing need, creates health issues related to not having enough household funds for other essential needs and stress due to finances and having to move frequently. Households in core housing need are at imminent risk of becoming homeless.

Homelessness remains high in Manitoba and can be in all forms whether provisionally accommodated, staying in emergency shelter or being unsheltered. Without affordable housing options, temporary states of homelessness turn into chronic homelessness.

- Maes et al. (2016) found through the Winnipeg Street Census, (and almost certainly an underestimate) 1400 people were homeless people, and 121 children were homeless with their parents/guardians. Marginalized groups are over-represented in the homeless population:
    - 71.1% of all respondents identified as Indigenous.
    - 49.2% of all respondents had spent time in foster care or group homes.
    - 23% of respondents age 29 years or younger identified as part of the LGBTQ community (Maes et al., 2016).
- The Winnipeg Street Census identified that the top 2 barriers and challenges people who were homeless faced in finding housing:
    - Low income, no income, lack of employment: 50.9% of respondents;
    - Lack of appropriate affordable housing: 36.7% of respondents.
- Family breakdown, conflict or violence was the most common reason for first experience of homelessness for 39.4% of respondents of the Winnipeg Street Census 2015.

[8] Core housing need is any combination of 3 situations: (1) households may be forced to spend a larger proportion of their income on housing than they can comfortably afford, defined as >30% of before-tax income, (2) having to live in housing that is in need of major repair, and/or (3) living in overcrowded situations.

- 24.6% identified a need for mental health services, and 31.7% identified a need for addiction services.

People who experience homelessness are at higher risk of premature death and poor health in all aspects. The longer people are homeless the worse their health becomes. 40% of respondents in the Winnipeg Street Health Report reported having been physically assaulted in the past year with an average of three times per year (Gessler & Maes, 2011).

Considerations for action:

- Increase and sustain the overall supply of diverse types of affordable housing.
- Incentivize the housing market to create affordable units in multi-unit dwellings.
- Increase government funding for new social housing and maintain current social housing with rent geared to income (Brandon, 2016).
- Encourage diverse forms of housing including social housing and co-op housing.
- Support zoning that requires affordable units in new builds of multi-unit dwellings, which promotes mixed income neighbourhoods and prevents large concentrations of poverty (Direction régionale de santé publique, 2015).
- Continue and expand programs that assist households with affordability such as through rental allowances.
- Expand housing tax benefits for low income renters and homeowners (CCPA & CCEDNet, 2015).
- Expand Housing First (a model that supports people who are homeless and living with mental illness by combining the immediate provision of permanent housing with wrap around supports).[9]
- Provide sponsored Mental Health First Aid and Safe Talk training sessions annually to staff and volunteers of community based organizations working with the homeless and those at risk of homelessness.

Suggested indicators to track progress in this area:

- Decrease in numbers of households in core housing need.
- Increased number of new social housing units per year.
- Increased proportion of affordable units available for rent.
- Decrease in average time people spend homeless before they are rehoused.

Food

Access to healthy food is a requirement for health. Food insecurity is the inadequate or insecure access to food due to financial constraints. The most recent Manitoba data (2012) shows that 12.1% of households experience food insecurity (Tarasuk, Mitchell, & Dachner, 2014). The greatest predictors of household food insecurity status in Canada are being of Indigenous descent, households on a low-income, reliance on income assistance, households using rental accommodations, households with children under 18 years of age, and lone-parent female-led households (Tarasuk, Mitchell, & Dachner, 2016).

- In Canada, 28.2% Indigenous households are food insecure (excluding people living on First Nations communities and in some northern/remote regions).

[9] See https://www.mentalhealthcommission.ca/English/document/32946/winnipeg-final-report-homechez-soi-project

- 17.5% of households with children experience food insecurity in Manitoba (Tarasuk, Mitchell, & Dachner, 2014).
- 24.5% of households renting their accommodations experienced food insecurity versus 6.2% of homeowners (Tarasuk, Mitchell, & Dachner, 2014).
- Households in Manitoba with incomes less than the low-income measure (LIM) make up 69% of food insecure households. The proportion is most pronounced among households with incomes less than half of LIM – at 45.3% (Tarasuk, Mitchell, & Dachner, 2014).
- 70% of people who access food banks in Manitoba live in rented or social housing (Hunger Count, 2016).

The 2011 cost of healthy eating for a family of 4 in Winnipeg ranged from $778.90 to $860.80/month (Winnipeg Regional Health Authority, 2012). The strongest predictor of food insecurity is income. Both households with and without employment struggle to have enough income to access food.

- 4.8% of people in Manitoba access food banks. 43% of Manitoba children use a food bank, the second highest percentage among the provinces and territories. Since 2008, there has been a 53% increase in food bank use (Food Banks Canada, 2016).
- 72.4% of food insecure households in Manitoba rely on wages and salaries (Tarasuk, Mitchell, & Dachner, 2014). 14.9% of people who access food banks have employment wages as their primary source of income (Food Banks Canada, 2016).
- 47.3% of people who access food banks in Manitoba rely on social assistance as their primary source of income. 14% rely on disability related income support (Food Banks Canada, 2016).

In a recent study, food insecurity surfaced as the single strongest predictor of high-cost health care use. People who are food insecure have 46% greater odds of high-cost health care use in next 5 years, after taking into account baseline morbidity and other socio-demographic risk factors (Fitzpatrick et al., 2015).

While often cited, there is no evidence of association between food skills, use of home or community gardening for food, or proximity to food retail and household food insecurity status (Tarasuk, Mitchell, & Dachner, 2016).

Considerations for action:

- Participate annually in the Household Food Security Survey Module of the Canadian Community Healthy Survey (CCHS) to measure household food insecurity to enable evidence-based decisions.
- Ensure sufficient funding of other basic needs (e.g. rent, transportation) to avoid diversion of funds for food to these other needs.
- Base income and social assistance rates on the real costs of a healthy food basket and keep it tied to these costs.
- Adequately fund schools and childcare centers to provide nutritious meals for those in need (CCPA & CCEDNet, 2015).

Suggested indicators to track progress in this area:

- Decreased prevalence and severity of food insecurity as measured by the Household Food Security Survey Module of the CCHS.
- Social assistance rates allow for the current cost of a healthy food basket.
- Reduced reliance on food banks and meal programs.

Transportation

A healthy transportation network incorporates a diversity of transportation modes and places priority on active transportation (i.e. cycling, walking and transit) to be used by the whole community, accruing health benefits across the whole population. Safe and accessible transportation systems reduce inequities and are good for public health.

- Prioritizing active transportation and encouraging mobility for all can help achieve an increase in physical activity, which can lead to better mental and physical health (Provincial Health Services Authority [PHSA], 2014).
- Accessible and affordable public transit increases access to recreation, stores, healthy affordable food, childcare settings, and spiritual space. Increasing access to affordable public transit can help reduce barriers experienced by people living in poverty because it is a means to reach employment and educational opportunities (Titheridge et al., 2014).
- Those disadvantaged by low-income in Winnipeg face greater health burdens and have more transportation barriers to access the health care services that they need. Transportation barriers can cause delays or prevent access to health care services or medication. These missed opportunities for timely treatment can lead to worse health outcomes that require more extensive and expensive health care services such as hospitalizations (Syed et. al., 2013). Public transit is a fundamental way that people living in households without access to cars routinely reach health services for preventative and early treatment.

Considerations for action:

- Promote and invest in safe active transportation, including walking, cycling and other modes of human powered transportation (WRHA, 2013b).
- Promote and invest in convenient, affordable public transportation infrastructure and services including no or low cost non-stigmatized bus transportation especially for people on a low income (WRHA, 2013b).
- Include a monthly bus pass as part of EIA benefits.
- Improve Handi Transit to match service level of Winnipeg Transit.
- Develop and implement a sustainable transportation plan that promotes active and public transportation systems (WRHA, 2013b).
- Ensure affordable access to transportation related safety equipment such as bicycle helmets, cycling safety equipment (lights/reflectors), appropriate motor vehicle child restraint equipment (e.g., car seats, booster seats) considering a variety of mechanisms such as loan, low cost purchase, tax-free, tax-rebate, redistribution or free programs (WRHA, 2013b).

For more information on these approaches, please see Health for All: Building Winnipeg's Health Equity Action Plan pg. 56.

Suggested indicators to track progress in this area:

- Transportation mode share demonstrates more walking and cycling.
- Non-stigmatized low-income public transit fares and passes are available.
- Increased public transit use especially on routes connecting low income areas to destinations.
- Increased active transportation infrastructure, especially those connecting low income areas to destinations.

Environment

Healthy built and natural environments can improve health and mitigate negative impacts associated with poverty through healthy neighbourhood design, and protecting and incorporating natural environments accessible and experienced by all.

- Neighbourhood design through land use decisions is vitally important to health through influencing the distances people have to travel to work, school and amenities, and parks and public spaces (PHSA, 2014). A variety of amenities within close proximity of home supports access to opportunities and services required for good health such as employment, education, and healthy food. This is particularly important for people living in poverty who may face transportation barriers.
- There are physical and mental health benefits of being in and viewing nature. Exposure to nature reduces stress, chronic disease, depression, anxiety, improves concentration and cognitive functioning (PHSA, 2014).
- Expanding natural elements across the built environment increases human access to and interaction with green space, which is particularly important in low income neighbourhoods (PHSA, 2014).
- Vegetation in the urban environment has the potential to clean the air of significant pollution and mitigate the formation of heat islands (PHSA, 2014). Heat events have a greater negative impact on low-income people in urban environments.

The United Nations Declaration of the Rights of Indigenous Peoples recognizes that respect of Indigenous knowledge, cultures, and traditional practices contributes to sustainable and equitable development and proper management of the environment. For example:

- Indigenous peoples have the right to maintain and strengthen their distinctive spiritual relationship with their traditionally owned or otherwise occupied and used lands, territories, water and coastal seas and other resources and to uphold their responsibilities to future generations in this regard (United Nations, 2008b, Article 25).
- Indigenous peoples have the right to the conservation and protection of the environment and the productive capacity of their lands or territories and resources (United Nations, 2008b, Article 29).

Although the relationships between ecosystem services (e.g., air, water and soil quality, biodiversity) and human health are indirect and difficult to study, the importance of the relationship should not be overlooked as the ecosystem makes human life possible (PHSA, 2014).

Considerations for action:

- Engage in built environment and urban planning discussions with municipalities and other stakeholders to promote health and health equity through urban design, including the use of health equity impact assessments to ensure day-to-day urban planning decisions consider health and well-being impacts on population groups, particularly on people living in poverty.
- Work in partnership to promote the protection and maintenance of natural ecosystems to support clean air, water and soil.
- Prioritize access to healthy natural environments in low income neighborhoods.
- Fully adopt and implement the *United Nations Declaration on the Rights of Indigenous Peoples* as the framework for reconciliation.

Suggested indicators to track progress in this area:

- Increased land use mix (i.e., variety of amenities) in low-income neighbourhoods.
- Increased green space access in low-income neighbourhoods.
- Increased accessibility of grocery stores across low-income neighbourhoods.
- Indigenous leaders perceive that they can exercise their right to conserve and protect the environment.

C. Employment

Work

Employment and working conditions are linked to health, and unemployment is associated with poorer health. As mentioned in the Income section, approaches to address adequate income must consider income more broadly than wages from paid work. The component of a poverty reduction strategy focusing on work should address fair and equitable employment, safe and healthy working conditions, and wages that support access to the conditions required for health. Particular focus should be given to the racialization of employment rates in Manitoba:

- Indigenous people have lower rates of labour force participation and employment than non-Indigenous people (Moyser, 2017).
- Table 1 shows that the employment rate is 17% lower among Indigenous adults in Manitoba, and the participation rate is 13% lower than non-Indigenous adults. The unemployment rate is 6% higher.

Table 1: Participation, employment and unemployment rates of people aged 25 to 54 by Indigenous status in Manitoba, 2015

	Indigenous Population (living off-reserve)	Non-Indigenous Population (includes born in Canada and foreign-born)	Difference (percentage points)
Participation rate	75.9	89.3	-13.4
Employment rate	68.2	85.6	-17.4
Unemployment rate	10.2	4.1	6.1

Adapted from Moyser (2017)

Consideration for action:

- Regulations and incentives are developed to improve full-time and well paid employment prospects for people and populations who are underemployed (e.g., recent immigrants) or those people and populations with high levels of unemployment (e.g., Indigenous, inner Winnipeg populations, transgender, experiencing mental illness) to ensure fair and equitable employment. A focus is placed on:
    - employment readiness (e.g. scholarships for low income populations, employment training, job search)
    - employer readiness (e.g. workplace truth and reconciliation training, anti-racism training, human resources duty to accommodate and workplace culture change)
    - improved hiring practices (e.g., non- discrimination, job placement, life- skills training, work-based learning apprenticeships), and

    - job retention (e.g., addressing racism and discrimination in the workplace, specialty training services for refugees, programs to promote appreciation of diversity, job coaching, work-associated child care, and other job supports) (WRHA, 2013b).
- Employee's rights, respectful workplaces and equitable work environments are assured. The labour movement plays a role contributing towards protecting and promoting these elements, addressing social and economic disparities and developing new opportunities for employment (e.g., encouraging entry level training positions to fill gaps in the workforce) (WRHA, 2013b).
- Governments will use a community economic development lens in its employment initiatives. Development targets would include local hiring of groups under-represented in the workforce. Criteria for creating contracts include payment of a wage sufficient for healthy living (CCPA & CCEDNet, 2015; WRHA, 2013b).
- Psychological well-being is addressed through full implementation of SAFE Work Manitoba's Psychological Health and Safety in the Workplace Strategy (SAFE Work Manitoba, 2017).

The public, business, and community sectors can play an important role as both employers and provider of services for some of the approaches.

Suggested indicators to track progress in this area:

- Closed gaps in employment statistics between Indigenous and non-Indigenous Manitobans.
- Increased number of work-based learning apprenticeships.
- Increased percentage of employers who have anti-racism training opportunities for staff.

Work in Street Economies

Structurally disadvantaged groups living in poverty are often pushed into street economies – including drugs and sex work markets – by marginalization and constrained choices, and their experiences largely do not resemble those of individuals with a range of options available to them. Problematic drug use is often a response to physical, emotional, spiritual and socially inflicted pain. Societal responses to drug use and sex work often inflict harms greater than those they purport to alleviate. Criminalization in particular has led to the de facto regulation of drug and sex work markets by criminal organizations with its associated violence, and the worsening of stigma and discrimination experienced by sex workers and people who use drugs (WRHA, 2016).

Consideration for action:

- Consult regularly with people who use drugs and with sex workers in order to prioritize the most salient harms (WRHA, 2016).
- Support legally-regulated drug markets and the decriminalization of drug use (WRHA, 2016).
- Support policy, legal, environmental and structural interventions that reduce the harms identified by people who use drugs (e.g., "Good Samaritan Immunity" legislation, overdose monitoring and response systems, heroin-assisted treatment programs, safer drug consumption spaces; provision of harm reduction supplies in correctional facilities, managed alcohol programs) (WRHA, 2016).
- Increase accessibility of safer drug use and safer sex supplies, including drug checking opportunities for individuals and groups who need them (WRHA, 2016).
- Support the decriminalization of sex work, and the extension of labour regulations and protections governing workplace safety and health to sex work (WRHA, 2016).

Suggested indicators to track progress in this area:

- Sex work is decriminalized.
- Drug use is decriminalized.
- Increased funding for safer drug use and safer sex supplies.

D. Education and Training

Education

Positive school experiences and level of education attained are important for health throughout life. Education is informed by best practice and is multi-dimensional in its design and learner-centric in its approach. It empowers individuals and communities with knowledge, motivation, skills and confidence (self-efficacy) conducive to positive societal engagement and the benefit of all. Economic circumstances influence education attainment.

- The proportion of kindergarten aged children not ready for school is nearly twice as high in some areas of Winnipeg compared to the most ready areas. About two out of five kindergarten aged children are not ready in lower income areas, compared to one out of four or five children in the most ready areas (WRHA, 2013b). Children who are not ready in kindergarten continue to fall behind their peers, as identified in a study linking school readiness kindergarten to Grade 7 and 8 school outcomes (Fortier, 2017).
- Overall, 79% of Winnipeg students complete high school. High-income community areas in Winnipeg have high graduation rates of 88-90% compared to only a 53% graduation rate in the lowest income area.
- High school graduation is strongly associated with family income with 94% of students from families in the highest income quintile completing high school compared with only 53% high school completion in the lowest income quintile.
- Lower educational attainment of youth in lower income areas means a higher chance of unemployment or a low paying job in the future, which continues the cycle of poverty and health inequity.
- Experiencing a mental illness can seriously interrupt a person's education and result in diminished opportunities for employment, and as a result, people may eventually drift into poverty (Canadian Mental Health Association [CMHA] Ontario, 2007).

Considerations for action:

- Establish well-funded accessible early learning and child care across the income gradient including enhanced pre-school/pre- kindergarten at low or no cost for low income families (WRHA, 2013b).
- Utilize engagement and outreach efforts (such as a "books at home" program) to increase uptake of these programs and services by low income children and families (WRHA, 2013b).
- Improve access to primary and secondary education by identifying and augmenting efforts that improve opportunities for success and narrow the gap in educational attainment for people from disadvantaged backgrounds (e.g., children in care, Indigenous children and youth, immigrant students, sexual and gender minority youth, children living in neighbourhoods with poor graduation rates) (WRHA, 2013b).
- Increase accessibility and inclusion for low income qualified students to participate in post-secondary education and training (WRHA, 2013b).

- Raise the level of awareness and understanding of the entire public on Indigenous issues such as the effects of residential schools and cultural genocide (WRHA, 2013b).
- Implement the Education Calls to Action from the Truth and Reconciliation Commission of Canada.
- Invest in mental health promotion programming in schools (Healthy Child Manitoba, n.d.); fund Sources of Strength Program (trainers in each school division) (Wyman et al., 2010).
- Improve access to adult literacy and learning.

Suggested indicators to track progress in this area:

- Closed income related gaps for children reading at grade 3.
- Closed income related gaps for children still in school at grade 9.
- Closed income related gaps for completing high school.
- Increased number of students from low-income, Indigenous and newcomer groups attending post-secondary education.

E. Sense of Belonging

Community

Community arises from the nature and quality of relationships between people with commonalities such as place, culture, experience, interests, beliefs, values and/or norms. Some aspects of community include sharing, commitment, availability, friendliness, cohesion, safety, connection and participation.

As poverty contributes to social exclusion, people living in poverty may be less connected to their community or the broader community. There is a strong association between sense of belonging to a community and mental health. Social inclusion boosts immune system function, protects from harmful effects of stress and helps to prevent loneliness and depression. Social exclusion, or the limitations to full participation in society, contributes to a reduced sense of belonging, increased stress, and poor mental and physical health (Umberson & Karas Montez, 2010).

Self-identity is an essential component of the sense of belonging to a community. Indigenous self-identity has been disrupted through colonization. Increasing the sense of belonging among Indigenous peoples requires supporting self-determination – the rights for Indigenous peoples to decide what is best for them and their communities (UNICEF, 2013).

Community based organizations (CBO) enhance and protect the health of low-income, disadvantaged citizens through supporting critical elements of basic needs, social stability and access to opportunities.

- CBOs are located within the community and use a community-led model. They are well situated to build trust and work in strength based, culturally safe ways with the communities they serve.
- CBOs have longstanding relationships, familiarity and credibility with people who are disadvantaged and have been impacted by policies and social conditions.
- Governments and health authorities rely on partners such as CBOs to do the work they do because:
    - CBOs have the trusted partnerships established, with community members and each other.
    - CBOs can work in a very cost effective way (responsibly achieving more with funding than government or health authority structures can).

- CBOs can be more flexible and nimble, and thus more responsive to ever changing and diverse community needs.
- CBOs present opportunities for community members to belong and gain skills, capacity, and experience that empowers engagement in further opportunities (e.g., school, work, advocacy).
- CBOs are more likely to reflect the diversity of the communities they are part of and provide culturally safe spaces for those impacted by trauma and structural disadvantage.

Considerations for action:

- All organizations and civil society develop community inclusion policies or approaches that ensure community voice and authentic engagement in decisions that affect community members and in delivering and evaluating services. This will enhance community ownership, democratic and transparent decision making, accountability, collective action, relationships and inclusion (WRHA, 2013b).
- Fully adopt and implement the *United Nations Declaration on the Rights of Indigenous Peoples* as the framework for reconciliation (Truth and Reconciliation Commission of Canada, 2015).
- Fully adopt and implement the *United Nations Convention on the Rights of Persons with Disabilities*.
- Invest in policing and justice systems that engage the community and build trust (e.g., restorative justice) (WRHA, 2013b).
- Protect funds for community based organizations recognizing their significant value for money and their role in being the community safety net for those who fall through systems cracks or for whom current system supports are insufficient (CCPA & CCEDNet, 2015).
- Establish appropriate mechanisms to better assess the actual value and contributions of CBOs. Typical cost effectiveness measures were not designed for this task and therefore are an inappropriate instrument to measure cost effectiveness.
- Evaluation frameworks used to evaluate Indigenous programming should be decolonized (CCPA, 2017b).

Suggested indicators to track progress in this area:

- Funding for Community Based Organizations is maintained and increased.
- Increased neighbourliness as measured by the percentage of people that report knowing many or most of their neighbours (Peg, n.d.).
- Increased sense of belonging as measured by the percentage of people who report that they have a very strong or somewhat strong sense of belonging to their community (Peg, n.d.).
- Increased perceptions of safety measured by the percentage of people that report feeling safe walking in their neighbourhood alone at night (Peg, n.d.).

INDICATORS

A poverty reduction plan should incorporate a holistic understanding of the nature of complex socio-economic issues. Setting an aspirational goal to end poverty in Manitoba should be kept on the horizon and actively sought. In addition to topic-specific indicators, a poverty reduction plan requires measurable overarching goals, objectives, and targets. Poverty reduction and social inclusion targets should be set involving people with a variety of expertise such as lived experience, academic, administrative, service provision and traditional knowledge.

Given the complexity of poverty reduction, both process and outcomes of the strategy should be measured.

- Process indicators are needed to inform ongoing implementation improvements, and to help guide and redirect poverty reduction efforts.
- Outcome indicators should be disaggregated by income quintiles and local geographies whenever possible. It is also important to collect indicator data ethnicity whenever possible to better understand and track the racialization of poverty.

CONCLUSION

The WRHA's Population and Public Health program strongly supports a comprehensive, multi-dimensional provincial poverty reduction strategy. We appreciate the recognition that meaningful consultation to capture diverse experiences is essential. This consultation can utilize and build upon significant historic and ongoing community and stakeholder knowledge.

From a public health perspective, promoting health equity is strongly aligned with poverty reduction. Eliminating poverty in Manitoba would effectively close gaps in health status that arise from social and economic exclusion. These preventable health gaps represent an immeasurable burden of avoidable suffering for individuals, families and communities affected, as well as high costs that threaten the sustainability of our health care system.

The WRHA used the framing of our Health Equity Promotion work throughout this document. Other frameworks exist in Manitoba with striking commonalities, such as articulated in the View from Here 2015 and The Winnipeg Poverty Reduction Council's Framework for Action.

With pooled wisdom across all sectors and the inclusion of diverse viewpoints in Manitoba, we know enough to strategize for the end of poverty and the achievement of health equity in our province. As public health in the Winnipeg Health Region, we are pleased to offer this contribution to the strategy development from a public health perspective. As we continue to promote health equity, we will continue to be supportive of provincial poverty reduction efforts.

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Appendix 1: Summary of Considerations for Action

A: Health and Wellbeing

➢ Health care services

1. Build upon the existing resources and activities of health systems to promote health equity by supporting and funding action that enables clients living in poverty to access the social determinants of health, including, but not limited to health care.
    a. For example, health care providers promote tax filing to enable people living in poverty to access eligible benefits such as the Canada Child Benefit.
2. Increase the pace of training all health care professionals in cultural competency, anti-racism and health equity approaches.
3. Address system barriers encountered while providing patient care such as:
    a. Reduce barriers for accessing medical benefits by including the completion of forms in the fee-for-service physician compensation claims or widening the professionals who may complete forms (e.g., occupational therapists).
    b. Reduce the frequency that such reports need to be submitted for those with chronic conditions.
    c. Create a fee waiver system that enables low-income Manitobans to obtain or replace a birth certificate for free (Canadian Centre for Policy Alternatives – Manitoba [CCPA], 2017a).
    d. Support access for individuals leaving prison, and youth exiting Child and Family Services, and patients leaving long stay hospitalizations to obtain government issued ID prior to leaving (CCPA, 2017a).
    e. Expand the MPI guarantor list (used to issue photo-ID) to include professionals that low-income and/or marginalized populations are more likely to have contact with (CCPA, 2017a).
4. Increase access to community mental health services and expand the types of mental health services available. Adequately fund sufficient teams of mental health practitioners to be responsive to population based needs across the province (e.g., evidence-based interventions including Program of Assertive Community Treatment , Early Psychosis Prevention and Intervention Service, psychological interventions, integrated mental health and addictions services, and Mental Health Teams based on the Stepped Care service delivery model) (CCPA-MB & Canadian Community Economic Development Network – Manitoba [CCEDNet], 2015).
5. Appropriately resource and position public health to fully play its role in prevention, health equity leadership and healthy public policy to close health gaps and contribute to health care sustainability.

➢ Childhood

6. Ensure early learning and child care programs are culturally appropriate and reflect Indigenous peoples' to fully participate in the care and education of their children (Truth and Reconciliation Commission of Canada, 2015).
7. Provide multiple avenues for families to access support for positive parenting of all children with emphasis on reaching out to support parenting in families with the most challenges (WRHA, 2013b).

8. Increase the availability of deliberate interventions to increase school readiness among the children who need most help to be ready for school (WRHA, 2013b).
9. Enhance early identification and create supportive interventions where children experience vulnerabilities or developmental delays (WRHA, 2013b).
10. Increase funding for more child care spaces and to ensure quality (CCPA & CCEDNet, 2015).
    a. Ensure that early learning and child care is accessible for all, especially for families facing additional barriers (e.g., low income, single parents) (WRHA, 2013b).
    b. Remove barriers associated with the Manitoba Child Care Subsidy (e.g. address requirement for child to attend daily to maintain subsidy and child care space, reduce or eliminate parent fee for low income families).
11. Ensure that inclusive early learning and child care opportunities are available and accessible for children with disabilities or complex medical needs (WRHA, 2013b).
12. Invest in programs to promote family welfare and alleviate the conditions that currently result in taking children into care — programs such as those that provide adequate housing, adequate income and employment opportunities, addictions prevention and treatment, mental health services, parent skill training, and parent support (Brownell et al., 2015).
    a. Increase funding for interventions such as Families First Home Visiting, Towards Flourishing and Partners in Inner City Integrated Prenatal Care that have demonstrated positive impacts. Current funding does not meet population needs.
13. Increase Manitoba Prenatal Benefit (MPB) amount and index it to the cost of living. Address barriers to accessing the MPB.

B: Everyday Living

- **Income**

14. Prioritize policies that support adequate income (upstream intervention) over addressing downstream interventions such as health care, corrections and child welfare.
15. Ensure that all people in Manitoba have access to sufficient income to meet the actual costs of conditions required for health (WRHA, 2013b).
16. Income assistance levels are based on and indexed to real costs of living (CCPA & CCEDNet, 2015).
17. Policies should support adequate income without means test or work requirement. Build on and learn from Ontario's pilot of guaranteed annual income and the success of previous effective basic income interventions (e.g. Mincome in Dauphin, Manitoba).
18. Provide sufficient resources for the employment and income assistance workforce to provide optimum case management support to the most disadvantaged people (WRHA, 2013b).
19. Consolidate income and disability services while ensuring recognition that persons with disabilities may have unique funding, service and support needs (WRHA, 2013b).
20. Increase incentives and support for people on disability to work by continuing to provide benefits not available through employment, such as vision, dental and Pharmacare, in recognition that some disabilities, like mental illness, are relapsing conditions and ability to work will vary over time.
21. Remove barriers to identification required to access provincial, federal and other benefits (as above in health care section).
    a. Waive administrative costs for a period of five years for the name-change process and the revision of official identity documents, such as birth certificates, passports, driver's licenses, health cards, status cards, and social insurance numbers to enable residential

school Survivors and their families to reclaim names changed by the residential school system (Truth and Reconciliation Calls to Action #17).

22. Develop Indigenous-specific strategies to examine the processes for rural and isolated individuals, as they face unique barriers, and mainstream systemic interventions may not adequately consider their needs.
23. Develop, strengthen and advertise education and retirement saving incentives for socially and financially disadvantaged populations.
24. Reduce barriers in order to gain timely access to income support services i.e. offer alternative formats for Employment and Income Assistance (EIA) pre-intake orientations.

- **Housing**

25. Increase and sustain the overall supply of diverse types of affordable housing.
26. Incentivize the housing market to create affordable units in multi-unit dwellings.
27. Increase government funding for new social housing and maintain current social housing with rent geared to income (Brandon, 2016).
28. Encourage diverse forms of housing including social housing and co-op housing.
29. Support zoning that requires affordable units in new builds of multi-unit dwellings which promotes mixed income neighbourhoods and prevents large concentrations of poverty (Direction régionale de santé publique, 2015).
30. Continue and expand programs that assist households with affordability such as through rental allowances.
31. Expand housing tax benefits for low income renters and homeowners (CCPA & CCEDNet, 2015).
32. Expand Housing First (a model that supports people who are homeless and living with mental illness by combining the immediate provision of permanent housing with wrap around supports).
33. Provide sponsored Mental Health First Aid and Safe Talk training sessions annually to staff and volunteers of community based organizations working with the homeless and those at risk of homelessness.

- **Food**

34. Participate annually in the Household Food Security Survey Module of the Canadian Community Healthy Survey (CCHS) to measure household food insecurity to enable evidence-based decisions.
35. Ensure sufficient funding of other basic needs (e.g. rent, transportation) to avoid diversion of funds for food to these other needs.
36. Base income and social assistance rates on the real costs of a healthy food basket and keep it tied to these costs.
37. Adequately fund schools and childcare centers to provide nutritious meals for those in need (CCPA & CCEDNet, 2015).

- **Transportation**

38. Promote and invest in safe active transportation, including walking, cycling and other modes of human powered transportation (WRHA, 2013b).
39. Promote and invest in convenient, affordable public transportation infrastructure and services including no or low cost non-stigmatized bus transportation especially for people on a low income (WRHA, 2013b).
40. Include a monthly bus pass as part of EIA benefits.

41. Improve Handi Transit to match service level of Winnipeg Transit.
42. Develop and implement a sustainable transportation plan that promotes active and public transportation systems (WRHA, 2013b).
43. Ensure affordable access to transportation related safety equipment such as bicycle helmets, cycling safety equipment (lights/reflectors), appropriate motor vehicle child restraint equipment (e.g., car seats, booster seats) considering a variety of mechanisms such as loan, low cost purchase, tax-free, tax-rebate, redistribution or free programs (WRHA, 2013b).

- **Environment**

44. Engage in built environment and urban planning discussions with municipalities and other stakeholders to promote health and health equity through urban design, including the use of health equity impact assessments to ensure day-to-day urban planning decisions consider health and well-being impacts on population groups, particularly on people living in poverty.
45. Work in partnership to promote the protection and maintenance of natural ecosystems to support clean air, water and soil.
46. Prioritize access to healthy natural environments in low income neighborhoods.
47. Fully adopt and implement the *United Nations Declaration on the Rights of Indigenous Peoples* as the framework for reconciliation.

C: Employment

- **Work**

48. Regulations and incentives are developed to improve full-time and well paid employment prospects for people and populations who are underemployed (e.g., recent immigrants) or those people and populations with high levels of unemployment (e.g., Indigenous, inner Winnipeg populations, transgender, experiencing mental illness) to ensure fair and equitable employment. A focus is placed on:
    a. employment readiness (e.g. scholarships for low income populations, employment training, job search)
    b. employer readiness (e.g. workplace truth and reconciliation training, anti-racism training, human resources duty to accommodate and workplace culture change)
    c. improved hiring practices (e.g., non- discrimination, job placement, life- skills training, work-based learning apprenticeships), and
    d. job retention (e.g., addressing racism and discrimination in the workplace, specialty training services for refugees, programs to promote appreciation of diversity, job coaching, work-associated child care, and other job supports) (WRHA, 2013b).
49. Employee's rights, respectful workplaces and equitable work environments are assured. The labour movement plays a role contributing towards protecting and promoting these elements, addressing social and economic disparities and developing new opportunities for employment (e.g., encouraging entry level training positions to fill gaps in the workforce) (WRHA, 2013b).
50. Governments will use a community economic development lens in its employment initiatives. Development targets would include local hiring of groups under-represented in the workforce. Criteria for creating contracts include payment of a wage sufficient for healthy living (CCPA & CCEDNet, 2015; WRHA, 2013b).
51. Psychological well-being is addressed through full implementation of SAFE Work Manitoba's Psychological Health and Safety in the Workplace Strategy (SAFE Work Manitoba, 2017).
52. Consult regularly with people who use drugs and with sex workers in order to prioritize the most salient harms (WRHA, 2016).

53. Support legally-regulated drug markets and the decriminalization of drug use (WRHA, 2016).
54. Support policy, legal, environmental and structural interventions that reduce the harms identified by people who use drugs (e.g., "Good Samaritan Immunity" legislation, overdose monitoring and response systems, heroin-assisted treatment programs, safer drug consumption spaces; provision of harm reduction supplies in correctional facilities, managed alcohol programs) (WRHA, 2016).
55. Increase accessibility of safer drug use and safer sex supplies, including drug checking opportunities for individuals and groups who need them (WRHA, 2016).
56. Support the decriminalization of sex work, and the extension of labour regulations and protections governing workplace safety and health to sex work (WRHA, 2016).

D: Education and training

- **Education**

57. Establish well-funded accessible early learning and child care across the income gradient including enhanced pre-school/pre- kindergarten at low or no cost for low income families (WRHA, 2013b).
58. Utilize engagement and outreach efforts (such as a "books at home" program) to increase uptake of these programs and services by low income children and families (WRHA, 2013b).
59. Improve access to primary and secondary education by identifying and augmenting efforts that improve opportunities for success and narrow the gap in educational attainment for people from disadvantaged backgrounds (e.g., children in care, Indigenous children and youth, immigrant students, sexual and gender minority youth, children living in neighbourhoods with poor graduation rates) (WRHA, 2013b).
60. Increase accessibility and inclusion for low income qualified students to participate in post-secondary education and training (WRHA, 2013b).
61. Raise the level of awareness and understanding of the entire public on Indigenous issues such as the effects of residential schools and cultural genocide (WRHA, 2013b).
62. Implement the Education Calls to Action from the Truth and Reconciliation Commission of Canada.
63. Invest in mental health promotion programming in schools (Healthy Child Manitoba, n.d.); fund Sources of Strength Program (trainers in each school division) (Wyman et al., 2010).
64. Improve access to adult literacy and learning

E: Sense of Belonging

- **Community**

65. All organizations and civil society develop community inclusion policies or approaches that ensure community voice and authentic engagement in decisions that affect community members and in delivering and evaluating services. This will enhance community ownership, democratic and transparent decision making, accountability, collective action, relationships and inclusion (WRHA, 2013b).
66. Fully adopt and implement the *United Nations Declaration on the Rights of Indigenous Peoples* as the framework for reconciliation (Truth and Reconciliation Commission of Canada, 2015).
67. Fully adopt and implement the United Nations Convention on the Rights of Persons with Disabilities.
68. Invest in policing and justice systems that engage the community and build trust (e.g., restorative justice) (WRHA, 2013b).

69. Protect funds for community based organizations recognizing their significant value for money and their role in being the community safety net for those who fall through systems cracks or for whom current system supports are insufficient (CCPA & CCEDNet, 2015).
70. Establish appropriate mechanisms to better assess the actual value and contributions of CBOs. Typical cost effectiveness measures were not designed for this task and therefore are an inappropriate instrument to measure cost effectiveness.
71. Evaluation frameworks used to evaluate Indigenous programming should be decolonized (CCPA, 2017b).