



health for all

Building Winnipeg's Health Equity Action Plan



Winnipeg Regional
Health Authority
Caring for Health

Office régional de la
santé de Winnipeg
À l'écoute de notre santé

Health for All

WE'RE **ALL** IN THIS **TOGETHER**

The Winnipeg Regional Health Authority's vision is "Healthy People, Vibrant Communities, Care for All." Influenced by this vision, the health region has embraced the principles and values of Health Equity, and has embarked on an initiative titled "Health for All."

This report outlines the problem and the strategies we intend to use, as well as identifying opportunities for action, offered for consideration to our community partners and other sectors.

"We're all in this together" to close Winnipeg's unnecessary health gaps and establish an equitable and sustainable health system and civil society that reaches towards "Health for all."

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Preface

– By Louis Sorin
Community Area Director, Point Douglas

Equity work calls us to see our world with different eyes. This enables us to appreciate the truth that is found within our lived experience. An Elder shared the following wisdom about the search for truth and the courage needed to take action:

There are two very different ways to understand truth. From a Western, Euro-centric perspective, truth is like a single “pearl of wisdom” to which all stories and perspectives are linked. This fundamental or essential truth will guide our decision making and judgment of the situation. In science-based medicine, we use evidence as our pearl to help us quantify truth and reduce complex problems into solutions. There is much evidence about the need for health equity action.

In Indigenous world views, truth is like a crystal. In every situation, there are multiple perspectives and experiences, each carrying a piece of the truth. Each is valid, equal, and interconnected. All facets of the crystal are important and it is the responsibility of the searcher to shift their stance in order to validate and incorporate an alternative perspective. The work is not to look for truth, but rather, to have the courage to engage in a learning journey that will transform our relationships and create new opportunities. It is within this space that equity work can thrive.

Our goal is to bring together the best elements of different perspectives and to harness the tools that have emerged from these traditions. Together, seeing with both eyes¹, we can build a more equitable Winnipeg.

1. “seeing with both eyes” alludes to the concept of “Two-Eyed Seeing” which is the Guiding Principle brought into the Integrative Science co-learning journey by Mi’kmaw Elder Albert Marshall, Fall 2004. <http://www.integrativescience.ca/Principles/TwoEyedSeeing/>

Acknowledgments

This document represents the work and consensus of a number of working groups under the direction of the Winnipeg Health Region Promoting Health Equity Oversight Committee. At least 80 people were involved in shaping this document. We thank each and every person for their engagement and thoughtful contributions.

Data used in this report mostly comes from existing reports referenced in the document, but we acknowledge the Manitoba Center for Health Policy, Healthy Child Manitoba and Manitoba Health in particular for the resources they have produced that call attention to health equity.

We also acknowledge with appreciation the many organizations and individuals who are already working on creating more equitable conditions for health in many sectors, many of whom have been dedicated to this important work for years.

Finally, and most importantly, we acknowledge many individual Winnipeggers who, despite significant barriers, strive every day to make a better life for themselves, their families and their communities. They have our respect and deserve our support.

WHY THIS REPORT?

Large gaps exist in Winnipeg between those experiencing the best and poorest health. People living in some areas of Winnipeg have nearly 19 years lower life expectancy than people living in other parts of the city. Many of the gaps arise from unfair, unjust and modifiable social circumstances. It doesn't have to be this way. We can do something about it. *Health equity asserts that all people can reach their full health potential and should not be disadvantaged from attaining it because of their social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance.* The notion of 'health' is being used here in its broadest context based on the World Health Organization's definition: "Health is a state of complete *physical, mental and social well-being*, and not merely the absence of disease."²

This report is not an answer book or a prescription. It is not yet even an action plan. Rather, it lays a foundation upon which **we can collectively build Winnipeg's health equity action plan.** Health equity is dependent on a complex web of interrelated factors and there are no quick, easy, linear solutions.

2. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

But when large numbers of people fall short of their full health potential, we all share the consequences one way or another. Health care providers see people every day with illnesses and injuries that didn't need to happen. Both the human suffering and the costs could have been avoided. The health care system could run more smoothly, waitlists could be shorter, taxpayers' dollars used more effectively. More people could flourish, reach their full potential and contribute to the community and the economy. Since we are all affected, and since the actions needed to achieve health for all do not lie solely, or even primarily, within the health care sector, we are all in this together.

Health equity has increasingly become a topic of dialogue across the world. High profile international, national and local reports are recognizing that improved health and quality of life cannot be achieved through more health care or economic growth alone. Wide gaps in social advantage result in wide health gaps. The seminal 2008 World Health Organization (WHO) report threw down the gauntlet by stating, "**Achieving health equity within a generation is achievable, it is the right thing to do and now is the right time to do it.**"³ Now is the right time to take up that challenge in Winnipeg.

3. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health, Geneva, World Health Organization, 2008.

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we are all in this together.*

Health gap data for Winnipeg can be found in various reports produced by the Manitoba Centre for Health Policy and others. However, one easy-to-read description that paints an overall picture of health equity for Winnipeg by drawing on these many sources did not previously exist. Also, suggested actions by many sectors to improve health equity in Winnipeg have not previously been summarized for consideration. This report aims to do both of these things.

This report focuses on the Winnipeg Health Region (WHR) which includes the City of Winnipeg and East and West St. Paul. Churchill, which recently joined with the WHR, has not been included at this time. “Winnipeg” will be used throughout the report to mean the WHR population. We recognize that many health services are provided in Winnipeg to people who live in other parts of Manitoba as well as northwestern Ontario, Nunavut and beyond, and that people frequently move back and forth between Winnipeg and neighbouring and northern communities. And while equity needs, connections and influences beyond Winnipeg are also recognized, and collaboration with other equity efforts welcomed, the scope of this report is Winnipeg (WHR).

This report is intended to facilitate collaborative conversations so that together, we can move towards achieving greater health equity in Winnipeg. We need to set Health for All “stretch

goals”⁴ and boldly reach towards them. This conversation needs many voices. Please join in.

Health for All – A Vision

In a ‘perfect world’, what would an ideal, vibrant, healthy Winnipeg look like? Even though ideal circumstances are not fully attainable, creating a shared vision to reach towards helps move us closer. Imagine a Winnipeg where:

- diversity is celebrated and everyone belongs;
- people are safe, share a strong sense of community, and neighbours know and help one another;
- most adults are employed and feel their work is meaningful;
- children flourish in loving families, caring communities and stimulating schools where they develop strong friendships;
- incomes span a narrower range and even the lowest wages are sufficient to provide for healthy living;
- the city is predominantly of a mixed use urban design with little neighbourhood polarization, plentiful green spaces, architecture and built

4. Goals that cannot be achieved by incremental or small improvements but require extending oneself to the limit to be actualized. Hamel, G., & Prahalad, C. K. 1993. Strategy as stretch and leverage. Harvard Business Review, 71(2): 75–84.

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environment that encourages positive social interactions;

- communities are walkable with excellent public transportation and cycling infrastructure;
- people of all ages are usually active going about their daily lives with less car trips needed;
- the air and water are clean, and sustainability and environmental protection are part of all development and city planning decisions;
- most people describe themselves as happy and enjoying life;
- people look forward to living full and healthy lives as they age;
- nearly everyone reaches their full physical and mental health potential, and;
- excellent physical and mental health care services are readily available and accessible when needed.

A Winnipeg like this would realize the OurWinnipeg vision “living and caring because we plan on staying.”⁵ Residents overall would be in better health and there would be a narrower

gap between the experiences of those with the best and poorest health. Less money may be needed for health care treatment, leaving more money for other priorities such as education, infrastructure, childcare or the arts.

Right now, even though we have some of the highest quality universal health care in the world, our health experience is far from this ideal.

Health for All Health equity and inequity – ideas and definitions

Individual and community health are determined by many things in addition to health care services. Income, education, where you live, the opportunities you had or did not have in childhood, especially in early childhood, are among the key factors that shape your chances of good health throughout life. Health is not equally experienced by all and some differences in health – particularly those that are socially determined and largely preventable – are troubling and unjust. This sense of unfairness, preventability and ‘fixability’ is why some differences in health are viewed as ‘health inequities’. On the other hand, health “equity” (see glossary) is like the flip side of the same coin.

Health equity (“health for all”) occurs when all people reach their full health potential and are not held back by the socially determined yet modifiable barriers associated with poverty

Health equity (“health for all”) occurs when all people reach their full health potential and are not held back by the socially determined yet modifiable barriers associated with poverty.

5. City of Winnipeg. OurWinnipeg. It's Our City, It's Our Plan, It's Our Time; 2011. Available at http://speakupwinnipeg.com/wp-content/uploads/2011/07/OurWinnipeg.Jul13_2011.WEB_RGB_.pdf

(e. g., lack of quality learning or recreational opportunities in childhood, food insecurity, poor housing) or prejudice or policies that perpetuate social inequities. The multiple adverse social, economic and environmental conditions associated with poverty determine a person's quality of health and longevity. These determinants of health are not found in health care settings but rather in the communities where we live, learn, grow, work and play every day.

When there are large gaps in health and social circumstances between those most and least advantaged, everyone is affected, not just those at the bottom.

Social disadvantage matters...

to all of us.

- It affects the cost and availability of health care for everyone
- It affects crime and everyone's sense of community safety
- It affects whether communities thrive socially and economically
- It affects tourism and our ability to attract economic investments
- It leaves less funds for other social development initiatives and public priorities

It fundamentally affects quality of life for everyone. Our individual and collective health and well-being is on the line. Social disadvantage matters... to all of us.

A Look at Health Equity in Winnipeg

In a city such as Winnipeg, in the heart of an affluent country with well trained health professionals providing medical care that is available to everyone, one would expect that everyone lives as long and in as good health as their genetics may permit. Sadly, this isn't the case. Whether we look at health inequities by where people live (knowing that different areas of Winnipeg have different levels of income and social advantage) or by income quintiles where income is measured more directly, we can see a clear link between wealth and health. Although income is not the only aspect of disadvantage, it aligns well with other markers of material and social deprivation and is the main one used in this report.

Some health information can also be drawn from reports that compare the health of First Nations or Métis people living in Winnipeg to all other residents. Indicators by other ethnicities or cultural identification are not currently available.

While culture is an important determinant of health and is related to factors such as health behaviours, perceptions of illness, social supports and the extent to which people use health care services, culture or ethnicity alone do not cause health inequalities. Rather, ethnic groups and others who experience current or historical deprivation, marginalization or oppression are disproportionately affected by economic and social disadvantage which leads to health gaps.

...those who experience current or historical deprivation, marginalization or oppression are disproportionately affected by economic and social disadvantage which leads to health gaps.

The pattern of income distribution in Winnipeg can be seen in the maps showing Winnipeg's urban income quintiles. Reference information on the median household incomes in Winnipeg's 12 Community Areas (CAs) and 25 Neighbourhood Clusters (NCs) is available in the Health Equity Indicator Resource document. There is nearly a \$75,000 gap in median household income (2006) between the highest and lowest income NCs in Winnipeg, which represents more than a four-fold difference.

THE HEALTH GAPS PICTURE

...not only is there a huge divide between the highest and lowest health status, every step down the economic ladder is associated with poorer health.

There is a growing body of literature around the world and a long list of local indicators that point to differences in health related to social and economic differences (see the Winnipeg Health Region Health Equity Indicators Resource companion document). The gaps are staggering. And not only is there a huge divide between the highest and lowest health status, every step down the economic ladder is associated with poorer health. This means social and economic advantage matters throughout the spectrum, with the biggest impact felt by those most disadvantaged.

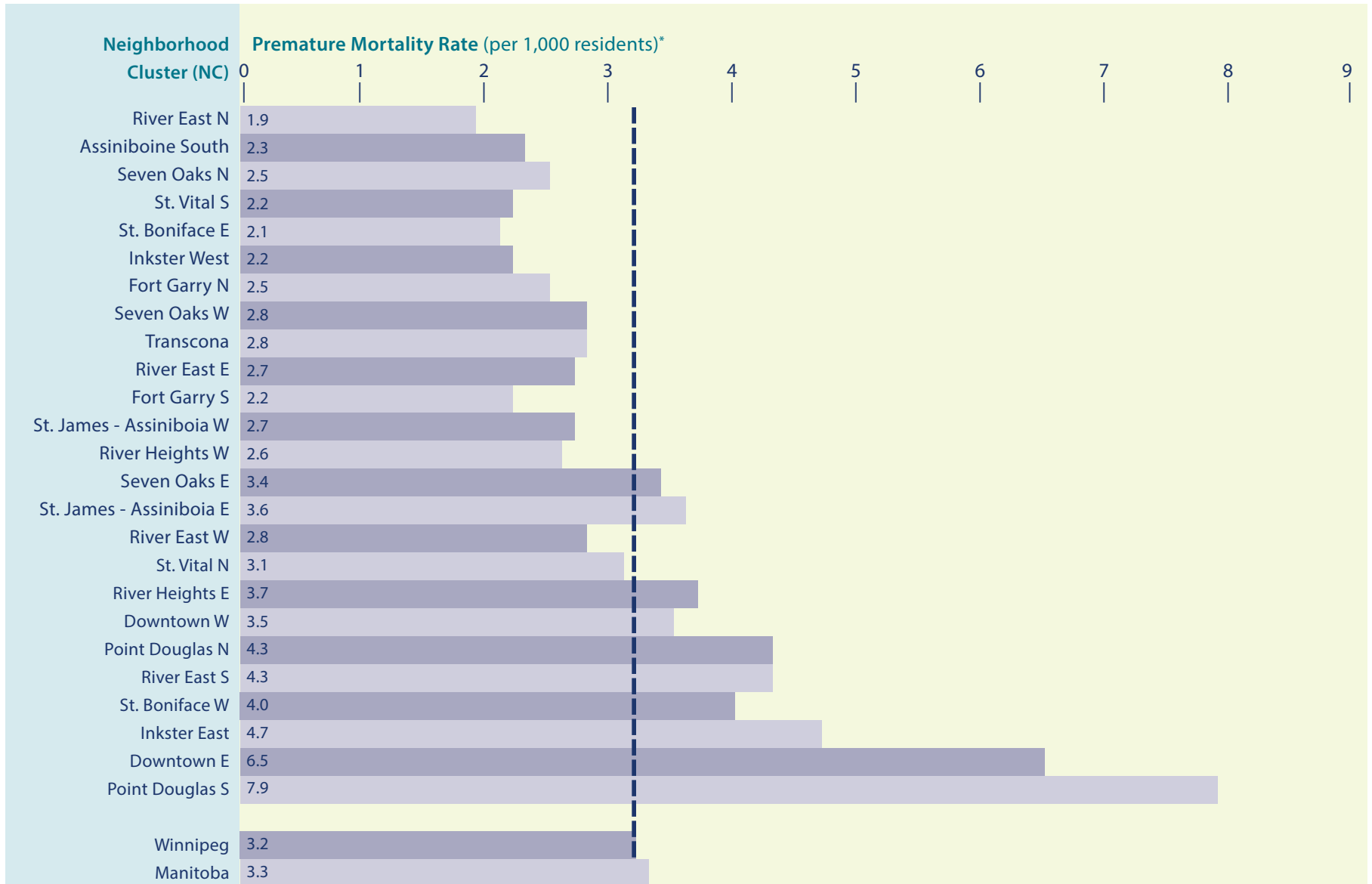
Over 50 indicators from various sources have been compiled for easy access in the Health Equity Indicator Resource. Some of the most

telling indicators are highlighted below to provide a series of snapshots that illustrate the alarming pattern found.

Death and length of life

- Imagine two babies born on the same day in Winnipeg – one from an affluent neighbourhood, and the other from a neighbourhood with low average income. Based on where their families live, the latter baby can expect nearly two fewer decades of life. There is a shocking 18.6 years difference between the highest and lowest life expectancy (by neighbourhood cluster) for a baby girl (70.5 years vs. 89.1) and 18.8 years difference for a baby boy (67.2 years vs. 86.0). Higher life expectancies are found in higher income areas and the lowest life expectancies where incomes are lowest. All of Winnipeg's new parents should be able to hold the same hope that the infant in their arms can live well into old age.
- For every funeral for a person who died before 75 in an advantaged area of Winnipeg, more than four similar funerals would occur in a disadvantaged area. The gap between the highest and lowest Premature Mortality Rate (PMR), defined as dying before the age of 75, is a 4.3 fold difference. See Figure 1.
- The 'potential years of life lost' (PYLL) – a measure of how many years before age 75

Figure 1: Premature Mortality Rate by Neighbourhood Cluster in Winnipeg from Highest to Lowest Income Area (Household Income 2006).



*Source: Manitoba Centre for Health Policy, 2009

someone dies – is between five and seven times higher in the lowest income NC than several of the highest. Picture 75 years of expected life being like everyone getting \$75 dollars to spend (one for each year). If you die at age five, you have been 'robbed' of \$70. If you die at age 70 you have been robbed of \$5. If you add up all the dollars 'robbed' from everyone, up to seven times as much has been taken from people living in lower income areas. In other words, people living in disadvantaged areas are dying much younger.

How can this occur in a city in Canada that has universal, publically funded health care? Because many common causes of death occur more frequently in lower income groups or lower income areas of Winnipeg. Some we hear about on the news and others are quieter killers. For example:

- Six families in lower income areas face the devastating news that a loved one they hugged hours earlier is not ever coming home again due to an injury for every one family from a higher income area facing the same news. Injury deaths are six times higher in lower income areas of Winnipeg compared to higher income areas and over three times more frequent in Winnipeg's lowest income quintile compared to the highest.

This same pattern is seen to varying degrees across many causes of death, and it tells us a hard truth: that multiple adverse social, economic and

environmental conditions related to poverty rob Winnipeggers of years and quality of life.

Kevin had traumatic experiences in his childhood that led to difficulties coping as a youth and adult, and because of this he struggled with depression. He left school before graduating and decided to move from his home community to Winnipeg to try and find a job and hoped that the change of setting would improve his depression. With little education or support, he had difficulty finding a job and began to feel more lonely and isolated. Despite the difficulties in his life, he was always a kind and caring person who tried to do the best for his community and help anyone in need. He wanted a better life for himself and his many friends and he spoke up on issues that were impacting their ability to enjoy the lives many take for granted. He often mentioned feeling like a prisoner with limited options and opportunities. He was aware of how he and others in his public housing block with similar life situations were perceived. Eventually, he was not able to pay even his modest rent and ended up on the street. One evening he fell, scraping his shoulder, hip and knee on the concrete pavement not far from the apartment block where he had lived. A few days later he was discovered unconscious in an alley. His wounds had become infected and the infection spread throughout his body very quickly. Kevin died after three days in the ICU at the age of 52.⁶

...multiple adverse social, economic and environmental conditions related to poverty rob Winnipeggers of years and quality of life.

6. Stories presented are based on the real experiences of Winnipeggers, but are composites of many life stories to protect individual identities. Names used are not those of any individual client or patient whose experiences contributed to the vignettes. Also, the vignettes are not meant to judge the commitments of individuals, organizations, and programs who are engaged in the lives of vulnerable individuals, families, and communities.

But it didn't have to be this way. What if conditions and supports had been different at many points along the way?

We could spend a long time examining Kevin's story to determine the interconnection of the personal, social, economic, and environmental conditions that are exacerbated by poverty. Rather, it is important from an equity framework that the systems, organizations, and programs that were connected to Kevin throughout his life examine how they may not have best served his needs. What part of this trajectory could have been prevented if early investment had been made to protect him from experiencing childhood traumas? What could have been done during his youth to heal his emotional trauma and give him the tools to move forward? How did the health system interpret his struggle with depression and serve him when he was in crisis? What if housing with supports had been available or job training opportunities? Did he feel welcome when he reached out for help? What if...?

These are some of the questions that need to be explored if our system and its institutions want to demonstrate their commitment to equity work.

Illness, injury and wellness

It follows that if people are dying earlier and at higher rates from illnesses and injuries in lower income areas of Winnipeg, then they are also living with poorer health and more illnesses, chronic conditions and injuries throughout their lives. And this is precisely what we find. For example:

- The highest prevalence of diabetes⁷ (14%) in the lowest income area is nearly three times higher than the lowest rate of diabetes (5%) in a more affluent area. If we were able to include people who have diabetes but don't yet know it, the difference could be even higher.
- Ischemic heart disease (the kind associated with narrowed or blocked arteries to the heart) is 1.6 times higher in the lowest income area of Winnipeg (11%) compared to the highest income area (7%).
- Suicide attempts are eight times higher in the lowest income area (3.6 per 1000) compared to attempts in the highest income area (0.4 per 1000).

This pattern repeats itself for many illnesses, injuries and chronic conditions, showing us that Winnipeggers living in the lowest income areas tend to become further disadvantaged by experiencing more than their fair share of health problems.

...Winnipeggers living in the lowest income areas tend to become further disadvantaged by experiencing more than their fair share of health problems.

7. The prevalence of diabetes and some other chronic conditions are estimated from their prevalence of treatment. For further explanation, see the Health Equity Indicator Resource.

People's perceived health correlates very strongly with their physical and mental health.

Ana fled to Canada from Central America with her three children after her husband was kidnapped and presumed dead. She came to Canada as a refugee looking for a better life for her children. Ana did not speak English and her university degree was not recognized so she was unable to find a good job in Winnipeg. With everything unfamiliar, Ana struggled to find a safe place to live, provide healthy food for her family, figure out transportation and send her children to school. She finally found a job as a housekeeper, working 16 hours a day for minimum wage. This was barely enough to pay for a small apartment in a low income neighbourhood. Ana had little time to spend with her children and they were not involved in any after-school activities. She worried about what was going to happen to them. Her work was difficult and she developed knee and low back pain and was diagnosed with asthma thought to be triggered by the mould in her apartment or the chemicals that she worked with. Because she couldn't afford her prescribed medications and, with language challenges, couldn't figure out if there were any benefits she was eligible to apply for, she ended up in the emergency department frequently.

But it didn't have to be this way.... What if conditions and supports had been different at many points along the way?

What if conflict and corruption had not traumatized the family and caused them to flee? Could there have been support for her to upgrade her credentials to get a job in her field in Canada? What if afterschool programs had been available and easy to access for her children?

Better affordable housing could have been available and what if she was protected from exposures at work and not required to work such long hours. Could benefits for medication have been available and easy to understand? What if...?

When you are frequently sick or injured or living with chronic conditions and chronic stress, it follows that you don't tend to feel well. People's perceived health correlates very strongly with their physical and mental health.⁸

- About seven out of 10 people you walk past on some of the wealthiest streets in Winnipeg are feeling healthy and ready for their day, while only about half of the people you walk by on some of the lowest income streets are likely feeling the same way. Seventy per cent of people in the most affluent CA in Winnipeg report excellent or very good health compared to 56% in a low income CA. Over twice as many people rate their health as fair or poor in the lowest income areas compared to the highest, and in the lowest income quintile compared to the highest.
- Similarly, people in middle to higher income areas report higher perceived mental health than those in the lowest income areas or income quintile.

8. Results here and for some health risks are from the Canadian Community Health Survey (CCHS) which is designed to collect health data at provincial and health region levels. While the results for the whole Winnipeg Health Region are reliable, we need to use some caution to interpret comparisons among community areas and neighborhood clusters due to small sample size.

Rising above difficult life circumstances and making positive changes for health often takes extra energy and determination at a time when energy reserves are low due to symptoms such as pain or fatigue from a chronic condition, recovery from an illness or injury, or mental health challenges. Thus, poor health can become a vicious cycle. Also, the health effects of chronic stress from social and psychological circumstances should not be underestimated. Living with high or compounding stress from things such as money worries, food insecurity, the experience or fear of violence, overcrowded or run down housing, racism, stigmatization or prejudice, social isolation, the feeling of having less than other people, the pain of past trauma, including generational trauma, neglect, abandonment or complicated grief profoundly affect health (i.e., physical, mental and social well-being), particularly when high stress has been a part of life since infancy.

Health risks and behaviours

Too often, health differences are attributed solely to behavioural factors seen as being within the control or 'will power' of individuals to change. In truth, all sorts of life conditions affect the degree of control people have over health behaviours, and these behaviours are only one of many factors, often not the most important factor, that determine health. When living in lower income environments with lower education levels and many social and economic challenges, healthier

choices are frequently not the easier choices, and often they are not even possible. Poverty is an independent risk factor for poorer health, not just a marker of poor health behaviours. Factors such as the stressors mentioned above directly affect health through a number of pathways, in addition to affecting the resiliency needed to adopt and sustain healthy behaviors.

The day-to-day decisions people make are markedly affected by their physical, social and economic environment. Health behaviors must be seen in the context of these environments considering such things as housing circumstances, safety, access to affordable food, level of family supports, meaningful employment and level of control. These are all needed, along with motivation towards healthy behaviours, for people to create a positive future for themselves, their families and communities.

Health behaviour is always more complex than a simple path from intention to action. Let's have a look at some health behaviours.

- The picture for physical activity may not be what many people expect. When activity at work, during transportation and from exercise are all added up, the highest rate of physical activity is found in the lowest income quintiles, with the highest income quintile being the least active. Inactivity is a problem throughout Winnipeg, where a concerning 40% of all Winnipeg adults are inactive, but some of the most inactive areas are not the

Rising above difficult life circumstances and making positive changes for health often takes extra energy and determination at a time when energy reserves are low...

lowest income areas. So poorer health in lower income areas cannot be readily explained by lower levels of overall physical activity. Nevertheless, more recreation opportunities are still needed for a variety of benefits in low income areas, where physical activity tends to come from more active labour at work and reliance on walking or cycling for transportation than in higher income areas.

- Looking at fruit and vegetable consumption as a marker of good nutrition, again the pattern may be surprising. This health behaviour is remarkably low throughout Winnipeg so differences are small and hard to discern. Only just over a third of Winnipeggers report eating fruit or vegetables five or more times a day. Some of the lower income areas have rates approaching the higher income areas. The income quintile pattern does suggest some relationship with income, but the pattern is not entirely linear. While access to affordable, healthy food is an important and concerning issue in lower income neighbourhoods, more information than just fruit and vegetable consumption is needed to understand the link between poverty and nutrition.
- Smoking is one of the most important modifiable risk factors for common killers such as cancer and cardiovascular disease. Currently, just under one in five Winnipeggers

smoke,⁹ but smoking is not evenly distributed across all income groups. People in low income areas are nearly four times more likely to smoke than Winnipeggers living in higher income areas.¹⁰ Suggested explanations for higher continued smoking in lower income groups include coping with high chronic stress, feelings of relative deprivation, the role of addiction, and social network norms.

- Similarly, being exposed to second hand smoke at home is over four times higher for Winnipeggers 12 and older in lower income areas (48%) compared to the lowest rate of exposure in a high income area (11%). Smoking (addiction to nicotine) and exposure to second hand smoke is currently strongly associated with poverty in Winnipeg, as it is in most high and middle income countries.
- Binge alcohol consumption also appears to have some relationship with income. The highest rate (29%) is found in a lower income area where it is nearly four times higher than the area where binge drinking is lowest (8%) and nearly double most higher income areas. However, a simple linear pattern does not appear to exist.
- Safety-related behaviours are also associated with income. For example, bicycle helmet

Poverty is an independent risk factor for poorer health, not just a marker of poor health behaviours.

9. Based on Manitoba estimates. Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS) 2011, available at http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/ctums-esutc_2011-eng.php

10. These rates are based on old data 2001-2005 since that is the most recent data available by NCS in Winnipeg. We believe that the actual smoking rates are now lower, but the relative gap is similar or perhaps larger.

use was nearly 16 times higher in the highest helmet wearing community areas compared to the lowest. Policy and promotion measures have the potential to close this equity gap.¹¹

So the picture regarding health behavior is complex and requires a more detailed examination in Winnipeg. Sometimes poverty is associated with higher risk health behaviours and sometimes it isn't.

What is clear is that the impact of poverty on health cannot be assumed to simply be due to poor health choices by individuals. It is related to many more societal and environmental influences than that. Collaborative action to better understand and address the connections between the physical, social and economic environments and health behavior is urgently needed.

Early beginnings and education

Good beginnings early in life have profound effects on health and wellness throughout the life course. Looking at rates of teen pregnancy and birth, dramatic differences are seen across Winnipeg.

- Picture 32 babies in strollers pushed by teen mothers on some streets of Winnipeg for

every one similar stroller in another area. The highest teen birth rate is astoundingly nearly 32 times higher compared to the lowest teen birth rate in a more affluent area. Similarly, there is an 18-fold difference between the birth rate in the lowest versus highest income quintile. The rate in the lowest income quintile is more than double that of even the second lowest income quintile.

- Having good prenatal care that begins early (within the first trimester) and continues throughout pregnancy is an important part of a baby's best start. Three Winnipeg CAs have significantly more delayed initiation of prenatal care than the provincial average. Over twice the rate of delayed prenatal care occurs in lower income CAs compared to the least delay in a higher income CA.¹² Delayed prenatal care is associated with income across the gradient.
- Pregnant women living in the lowest income CA are nearly five times as likely to have inadequate prenatal care (19%) compared to pregnant women living in the highest income area (4%).

Adolescents who are mature and prepared for parenthood can provide excellent nurturing, healthy environments for their babies. A pregnancy may present an opportunity for

...the impact of poverty on health

cannot be assumed to simply be due to poor health choices by individuals.

11. IMPACT, the injury prevention program WRHA. Bicycle Helmet Use Among Winnipeg Cyclists. Winnipeg, MB: WRHA. January 2012 <http://www.wrha.mb.ca/healthinfo/prev entinj/index.php>

12. Manitoba Centre for Health Policy. Perinatal Services and Outcomes in Manitoba. November 2012. Available at http://mchp-appserv.cpe.umanitoba.ca/reference/perinatal_report_WEB.pdf

an adolescent to improve her quality of life by making sound life changes. If we value adolescents and support them as new parents, this can represent a positive life turning point. However, without adequate support, adolescents facing the responsibilities of parenthood may have difficulty taking care of themselves and providing their children with the good foundation for life they need, and health inequity is perpetuated.

Kayla's mom was a single parent who struggled to make enough money to support Kayla and her siblings. She worked two jobs at minimum wage just to earn enough money to pay for a crowded apartment. They moved frequently. There never seemed enough money to buy food, let alone school supplies or clothing. Playing sports or an instrument was out of the question. Kayla worked hard at school and took care of her younger sisters. She hoped to be a teacher. Like many teenagers, she went to parties on the weekends where she and her friends would drink. When she was 16, Kayla got pregnant. She continued to drink until she realized she was pregnant at four months. Kayla had to drop out of high school and find a place to stay. She didn't have a family doctor and prenatal care wasn't a top priority as she was struggling to find a place to live. Finally, with some social assistance support she found a small place of her own by the time her baby arrived. Her son was a difficult baby and she worried he might have Fetal Alcohol Spectrum Disorder.

But it didn't have to be this way..... What if conditions and supports had been different at many points along the way?

What if Kayla's mom had been supported to finish her education and find a better job? Might Kayla have been able to play sports and join a music program? What if Kayla had gotten early prenatal care and support for parenting while also continuing her education? What if...?

Not only is a healthy pregnancy important, but the early years (prenatal to five) are essential in setting a sturdy foundation for good health throughout life. Readiness for school data collected with the Early Development Instrument (EDI) demonstrate that large inequities in children's development can be detected as early as kindergarten.

- Children who come from families who self report low socio-economic status (a mix of parental income and education) can be upwards of four times more vulnerable in the areas of physical development and literacy skills than those children who come from middle to high socio-economic status families.¹³
- 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.

Not only is a healthy pregnancy important, but the early years are essential in setting a sturdy foundation for good health throughout life.

13. Healthy Child Manitoba. 2008/09 Provincial Report Are Our Children Ready for School? 2012. Available at <http://www.gov.mb.ca/healthychild/edi/edi2008.pdf>

- Positive school experiences and level of education attained are also important for health throughout life. Overall, 79% of Winnipeg students complete high school with high graduation rates of 88-90% in high income CAs 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.

Employment

Employment is linked to health and unemployment is associated with poorer health.

- Overall, just over 5% of Winnipeggers aged 15 and over who are available to work do not have a job. However unemployment rates in areas of Winnipeg with the highest unemployment (8.7% for men and 7.9% for women) are about double areas with the lowest rates (4.0% for men and 3.9% for women).

Dennis had a good job in construction since leaving high school part way through grade 11. He owned his own house and was proud of his work. One day a beam he was helping secure slipped out of place and landed on his leg fracturing it badly. His company kept him on, but when they went out of business, Dennis couldn't find work due to his age, injury and lack of training. Bored and lonely, he found himself drinking most days and taking more and more pain killers. Soon the bills piled up and eventually the bank took over his house. Life on the street was hard on Dennis and his pain got worse. He had smoked for years and now was humiliated to look for discarded butts to reroll to ease his cravings. He didn't want to see family or friends until he was back on his feet again. His health declined, and his smokers cough turned into pneumonia. Lying in the hospital he wondered how he had ended up where he was, and where he would go when they wanted to send him home.

But it didn't have to be this way... What if conditions and supports had been different at many points along the way?

What if Dennis had stayed in school and went on to get training in a trade? Perhaps better understanding of and compliance with workplace safety practices could have prevented his injury? What if he had never smoked and his fracture healed completely? What if he accessed retraining and entered another line of work? What if there had been supports for him to keep his home until he could get his finances on track? What if...?

***Employment is linked to health
and unemployment is associated
with poorer health.***

WHAT DOES IT ALL MEAN?

This report connects some of the dots between social and economic circumstances and health, and challenges us to see the people and communities affected rather than numbers. A comprehensive picture of health equity in Winnipeg has not been provided, rather the nature and magnitude of local health gaps has been sketched. To view more health equity indicators, please go to the Winnipeg Health Region's Health Equity Indicator Resource.

This report connects some of the dots between social and economic circumstances and health, and challenges us to see the people and communities affected rather than numbers.

We must look to the lived experience of those who face inequity and who continue to be resilient despite the weight of poverty, historical marginalization, and lack of access to opportunity. They carry and share the hope that is needed to inspire, mobilize, and sustain the health and social change that is possible within our city. Collaborative and sustained action is urgently needed.

Towards Health Equity Action

Imagine if everyone in Winnipeg could experience the level of good health that the most advantaged Winnipeggers currently enjoy. Clearly the right and socially just thing to do is to 'level up' those individuals who are experiencing more than their fair share of preventable health problems. It also makes good business sense. The Manitoba Centre for Health Policy in 2004 estimated that 15% of hospital and physician costs could be eliminated if the whole population experienced the level of health that the 20% most affluent Winnipeggers do.¹⁴ Recently, the President of the Canadian Medical Association, Dr. Anna Reid, was quoted as saying that an

estimated 20% of the \$200 billion Canada spends on health care each year can be attributed to socioeconomic disparities.¹⁵ Reducing disparities and leveling up in Winnipeg would help protect a sustainable, high quality health care system, contribute to a healthy workforce and improve Winnipeg's reputation as a desirable place to live, invest and visit. While it may not be feasible to ever completely eliminate health gaps, considerably narrowing the gap is well within reach. There are many examples of effective action here in Winnipeg and around the globe. So what should we do?

*... 15% of hospital and physician costs
could be eliminated.*

14. Roos NP, Sullivan K, Walld R, MacWilliam L. Potential savings from reducing inequalities in health. *Can J Public Health* 2004;95(6):460-464.

15. Canadian Medical Association. Being poorer, dying faster: it's time to end Canada's "national disgrace," CMA says. CMA website Feb. 5, 2013 available at <http://www.cma.ca/being-poorer-dying-faster-national-disgrace>.

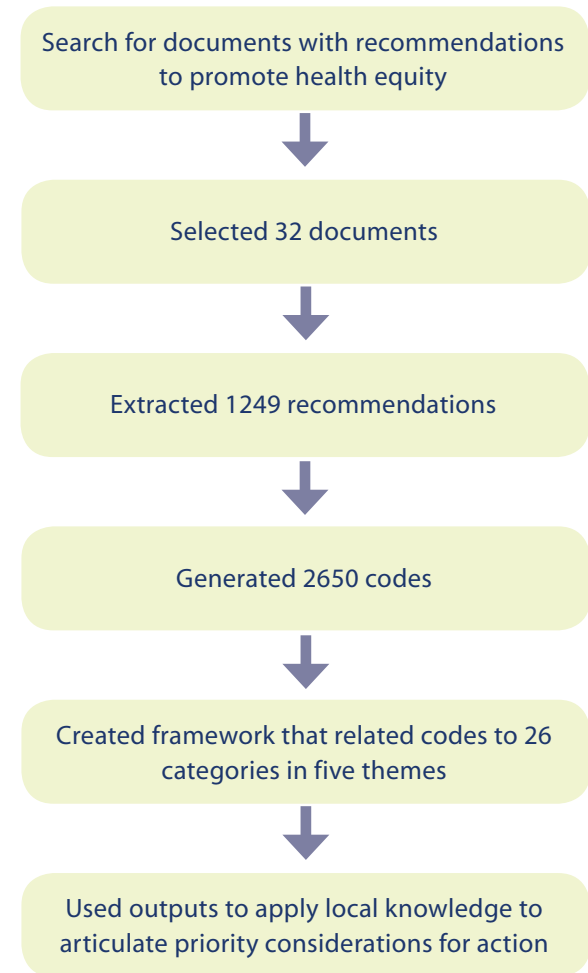
GETTING STARTED

Health equity action in Winnipeg needs to be based on the best possible evidence on what works. Unfortunately, the published health literature currently contains more on describing health equity gaps than on proven interventions to close them. Some of the likely reasons for this include the need for research methods that can study complex, interrelated factors over time, as well, health equity as a specific topic of research is fairly new. Nevertheless, there are more and more reports coming out with recommendations drawing on available evidence, promising practices and expert opinion.

WHAT WE DID

A review team scanned published health equity literature, including 'grey' literature to find local, provincial, national or international reports with relevance to Winnipeg. Thirty-two applicable reports up to March 2012 were located and all the recommendations from those reports were extracted. Over 1000 (1249) recommendations were then broken down into their essential ideas and coded, then reconstituted into recommendation themes (see Figure 2). A more detailed description of the methods is available in the Winnipeg Health Region's Health Equity Recommendation Synthesis companion document.

Figure 2: Health Equity Recommendations Report Synthesis Methods



A framework was developed based on the pooled, reconstituted recommendations that arose. (Figure 3) Then, the main areas for action in the framework were reviewed by a committee using the synthesis analysis outputs to prioritize areas for action to consider for Winnipeg. The committee applied their local knowledge of Winnipeg to the summary outputs of the data analysis to generate locally relevant recommendations. The committee also looked for gaps and added to the considerations for action if relevant local issues were not highlighted within the summarized outputs from existing reports. Full outputs from the recommendations synthesis including original recommendations and sources are available in the Winnipeg Health Region's Health Equity Recommendation Synthesis companion document.

It should be emphasized that this is not a "best practice" guide based on well established evidence of effectiveness. Health equity action is methodologically complex to study and health equity intervention research is still in early days so that a fully "evidence-based" approach is not yet possible. However, reports from elsewhere have reviewed and evaluated currently available knowledge; with arising consensus that there is enough to warrant beginning to act while more evidence is being produced. We have used the pooled recommendations of others as a reasonable starting point.

What follows then, are the compiled considerations for action resulting from this

process offered up to serve as a starting place for conversations among key stakeholders in Winnipeg.

A FRAMEWORK FOR UNDERSTANDING AND ADDRESSING HEALTH EQUITY

The main themes from the above work have been developed into the framework for understanding and addressing health equity (see Figure 3). The diagram shows the key themes organized into principles, strategies, and areas for action. These are shown as layers around the desired outcome of health equity or "health for all" with a reminder that health, and most of the factors identified, are internationally recognized human rights.

Principles of health equity make up the outer contextual layer of the framework. Eleven principles represent a basic set of intentions to facilitate planning and action to improve health equity.

The second layer shows three strategies:

1. Knowledge: the information (e.g., research evidence, indicators/data, lived experience) and tools (e.g., health equity assessment,

...considerations are offered up to serve as a starting place for conversations among key stakeholders in Winnipeg.

The WRHA respectfully recognizes it lacks expertise and authority in areas outside of health services to 'prescribe' action...

...areas outside health services hold the greatest potential to improve health equity. More action and collaboration is urgently needed.

- surveillance) that are necessary to inform effective health equity action
2. Governance: the authority, power and resource deployment necessary to make effective 'game changing' health equity decisions and system changes
 3. Participation: the relationships, partnerships and participatory citizen engagement required for effective and lasting health equity results

The third layer represents the areas of opportunity for action recommended. Action in each of the respective 12 areas has potential to improve health equity, and the combined effect of addressing all the inter-related factors promises the greatest impact. The 12 'areas for action' identified are very similar to the established 'social determinants of health' However, the frame of reference here is geared towards motivating enhanced action going forward rather than explaining causation looking backwards.

This framework is offered as a tool to help understand health equity, and at the same time, to envision how to collaborate on actions towards the health equity target of "health for all."

The remainder of this report will expand on the 12 areas for action identified in the model. More detailed considerations for action within each of those areas informed by

the recommendations synthesis work will be presented. Throughout the report, the three strategies and the underlying principles provide a backdrop to the considerations identified.

SUGGESTED CONSIDERATIONS FOR ACTION

Through the review and synthesis of recommendations from many health equity reports, and reflection on the local context of Winnipeg, key considerations for action are suggested below. This is intended as a starting place for conversation and action planning in all the areas involved. The WRHA respectfully recognizes it lacks expertise and authority in areas outside of health services to 'prescribe' action, and appreciates that related and contributory efforts in many sectors are already underway. However, the health sector has a responsibility to act as a 'steward' of health equity and recognizes that areas outside health services hold the greatest potential to improve health equity. More action and collaboration is urgently needed. The work done here to summarize and share potential health equity action is offered to encourage dialogue, collaboration and expanded efforts within and across many sectors.



Figure 3. Framework for Understanding and Addressing Health Equity

- Principles
- Strategies
- Areas for Action

Given that the source of the recommendations and the review process largely came from a health perspective, more detail will be noted regarding health services and some of the sector areas more familiar to health care. This is not a reflection on the relative importance of various factors, only uneven familiarity. There was no attempt to level out the amount of detail available, trusting that additional detail can be added by the relevant sectors. While some lists are lengthy, no attempt was made to further categorize or subtheme any of the listed considerations for action other than the health sector considerations. Since these are potential starting points, any sorting or prioritizing would be the purview of the applicable sectors.

Additionally it should be noted that while the specific intention of action is to improve the health of those most vulnerable, some considerations are also applicable to improving the health of the whole population (e.g., urban planning for better health, increased active transportation). In fact, the ultimate goal in health gains is captured in the notion of 'proportionate universality' (see glossary). This means that we want everyone to reach their full health potential 'universally' while at the same time recognizing that greater flexibility, adaptation, reaching out or effort may be required to ensure that inequity-affected populations benefit in 'proportion' to their need. While not all population-wide 'one size fits all' initiatives benefit those most marginalized, virtually all equity-focused initiatives benefit everyone, either directly or indirectly.

What follows is a summary of suggested considerations for each of the 12 areas for health equity action in the framework, starting first in our own health services 'back yard.'

While not all actions may be feasible or appropriate to tackle at this time, and other ideas may be missing, starting a conversation around these considerations, and adding to efforts underway, can build momentum and move equity forward in Winnipeg. Small actions in many areas building over time can make a difference if we all ask "what more could we do?"

1. Health Services Considerations for Action



The WRHA is committed to changing health equity outcomes by promoting health equity in leadership and governance decisions, ensuring equity in health care services, producing and translating health equity knowledge and facilitating participation to amplify health equity action in and beyond the health sector.

Health equity considerations need to be embedded throughout all aspects of the WRHA's planning and operational decision-making—vertically and horizontally. An equity 'lens' should not only be used for new program considerations, but also the ways in which we seek to improve existing services. This means not just doing the right things, but also doing the things that we do in the right way. Many improvement approaches can help address health equity; however, we need more explicit focus around this value to better contribute (e.g., process improvement, integration, quality and safety, innovation).

Health services recommendations have been sub-categorized, using the health equity framework, to consider action in the three strategic areas of **governance/leadership**, **participation/partnerships**, and **knowledge**, as well as our own 'core business' of **health care** service delivery. It should be recognized that existing and newly developed programs and initiatives, such as Aboriginal Health Services and Cultural Proficiency and Diversity, are foundational to ensure health equity in all health care services and to demonstrate the WRHA's commitment to align service provision with client need.

Presented below are the compiled considerations for action resulting from the recommendations review process, offered as a conversation starting place among key stakeholders regarding health services. In most areas below potential actions are for consideration by the WRHA. Considerations for broader health sector action as well as sectors outside health are included in Section 3.

1. Promote health equity in leadership and decision making (governance) in the WRHA:

a. Leadership

- i. Health equity must be a central value that drives all aspects of health care; internalized, championed and acted upon from the highest levels of WRHA leadership through to every interaction with every person.
- ii. The WRHA Board recognizes equity as a core value. It systematically and regularly reviews the status of, and progress toward, health equity.
- iii. The WRHA ensures health equity consideration and actions are built into all operational aspects of WRHA business such as planning, finance, human resources, procurement, logistics, volunteerism, corporate citizenship.
- iv. The WRHA more completely ensures a health care culture that places the person, their context and their experiences at the centre of health care, particularly for inequity-affected populations.
- v. The WRHA recognizes that the following

initiatives and approaches are all interrelated and are the foundation of health equity action in health care: Cultural Proficiency, Aboriginal Health Services, Language Access, French Language Services, professionalism, interprofessional and intraprofessional practice and education, Collaborative Care, Person-centred Care, Dignity in Care, Patient and Public Engagement, Respectful Workplace, and Ethics.

b. Planning

- i. Use health inequity data as the base from which to design and evaluate all current and future health initiatives. Ensure maximum transparency about use of health service and health outcome inequities.
- ii. The WRHA, in collaboration with others within and outside of the health sector, sets targets for health equity action and monitors and reports on progress towards the targets.
- iii. WRHA routinely uses equity focused organizational planning, management and evaluation tools including equity assessments.

c. Human Resources

- i. Each WRHA program allocates resources to carry out equity planning and assessment activities and central support for regional health equity coordination is resourced.
- ii. WRHA models activities to ensure workforce diversity in recruitment,

retention, mentorship, succession planning, training and education, while supporting existing programs such as the Aboriginal Health Programs Workforce Development.

- iii. All WRHA human resource functions and activities are reviewed and modified to meet regional health equity objectives.
- iv. WRHA strives to hire in full-time regular positions using equitable recruitment processes and provides wages and benefits that are fair.
- v. The WRHA models participatory decision making and a fair, trusting, respectful, supportive and caring work environment minimizing power imbalances.

d. Finance

- i. The WRHA allocates sustained core funding for:
 - 1. Human resources required for coordination of the health equity initiative
 - 2. Specific interventions and supports for inequity-affected populations
 - 3. Contribution towards social actions to change systemic origins of health inequities such as poverty
- ii. The WRHA demonstrates flexibility to allocate funds to equity-focused programs.
- iii. WRHA procurement policies are developed and implemented that includes criteria that support health equity through improved determinants of health locally, nationally and internationally.
- iv. Equity considerations are included as an

integral and routine component of WRHA risk management.

- e. Continue to support universal publicly funded health care services and increase equitable access to services as needed. Continue to develop working partnerships with fee-for-service providers and private services to enhance access and equity (e.g., Primary care home partnership development).

2. Ensure health equity considerations and actions are embedded in all health care services provided in the WHR:

- a. Ensure inclusive, comprehensive programs and services proportionate to need.
 - i. Increase acceptability and accessibility of services for inequity-affected populations based on listening to and respecting the preferences, views and self determination rights of those served and increasing cultural safety by providing culturally proficient services for all inequity-affected people.
 - ii. Programs/services are planned and delivered for populations that experience profound health inequity so that services are proportionate to need and that universal outcomes are achieved (proportionate universalism).
 - iii. The WRHA expands its efforts to reach out to those with the highest health care and health promotion and protection needs,

- meeting people where they are, and in ways that are relevant and acceptable to them.
- iv. WRHA adapts services for marginalized populations who may not fit into traditional community service operating hours. Flexible or extended hours and/or location of services must be considered to better reach out to those who have highest levels of health inequity.
 - v. Advocate for services such as vision, dental care and coverage for pharmaceuticals to be equitably accessible according to need.
- b. Address the priorities of communities where people experience health inequities (e.g., low income neighbourhoods, recent immigrants, homeless persons) on the community's terms through models of interprofessional and intersectoral practice.
 - c. Resource public health and promotion activities to focus on inequity-affected populations and on upstream investments in health (e.g., immunization, health behaviour change, prenatal care, intensive parenting support during early childhood, school health, tobacco reduction, harm reduction).
 - d. Ensure equity is a key component as primary care networks develop through key elements of access, quality and safety, patient-centred, seamless transitions in care, efficiency and sustainability.
- 3. Facilitate participation and partnerships with other parts of the health care system and beyond the health sector to amplify health equity action:**
- a. Each program develops formal, transparent, and public mechanisms to engage citizens, and civil society organizations that have an interest in the work of that program.
 - i. Build capacity with inequity-affected communities (community development) – using a collaborative and strength-based approach consistent with the WRHA's Community Development Framework where community development is recognized as a process that includes organizational capacity building, intersectoral networking and local area development.
 - b. Advocate with or on behalf of inequity-affected populations in the community.
 - c. Resource and develop strong relationships with the City of Winnipeg to support planning and work on many factors in its control and within its influence that can address health inequity, fully supporting opportunities as identified in *"OurWinnipeg"*¹⁶.

16. City of Winnipeg. OurWinnipeg. It's Our City, It's Our Plan, It's Our time. City of Winnipeg 2011: 73–78. Available at <http://winnipeg.ca/interhom/CityHall/OurWinnipeg/pdf/OurWinnipeg.Jul15.2010.pdf>

- d. Develop strong working relationships with major funders and foundations such as the United Way of Winnipeg and Winnipeg Foundation to intensify health equity efforts.
 - e. Collaborate with other sectors to address social determinants of health inequities such as housing, food, education, and income.
 - f. Intensify partnerships and collaboration with Governments and leadership (Federal, Provincial, First Nations, Métis, Inuit) to support investments in:
 - i. Health services for First Nations, Métis, and Inuit populations to bring them to the standards of health care for the general public and support health equity activities.
 - ii. Health services for inmates of correctional facilities to bring them to the standards of health care for general public.
 - iii. Health services for refugee claimants, refugees, and all refugees resettled in Canada.
 - g. Support collaborative planning and evaluation, intensify linkages with Manitoba Health's Health Equity Unit and the Manitoba Centre for Health Policy.
 - h. Intensify partnerships with universities to:
 - i. develop higher numbers of professionals in inequity-affected groups,
 - ii. develop understanding and skill in promoting health equity among professional school graduates,
 - iii. ensure education about health literacy is embedded within the education of future health professionals, and
 - iv. develop skills to communicate effectively with diverse health system users.
 - v. Continue the formal relationship with the Winnipeg Poverty Reduction Council.
- 4. Produce and translate health equity knowledge in the WHR:**
- a. WRHA develops and resources a communication strategy (including online and media) to raise public awareness and motivation to act on health equity.
 - b. WRHA develops and resources a strategy to inform other sectors and to motivate and coordinate action on health equity.
 - c. WRHA develops and resources a strategy to raise awareness about health equity within and among health sector systems, leadership and the workforce.
 - i. WRHA includes as part of its orientation for new staff knowledge and skill building sessions in cultural proficiency and health equity. In addition, ongoing continuing professional development in health equity and cultural proficiency will be considered a mandatory component of professional development.
 - ii. WRHA increases individual and system competencies to address health barriers identified by health care workers. WHR

EQUITY ACTION EXAMPLE – HEALTH SERVICES

BRIDGECARE CLINIC

In late November 2010, BridgeCare Clinic opened its doors to newly arrived government-sponsored refugees referred by Welcome Place and Accueil Francophone. The top five countries of origin are Bhutan, Somalia, Congo, Iraq and Ethiopia. Over the past two years, they have seen almost 900 newcomers. As most do not speak English, they work with our partners at Language Access to arrange interpreter services for each appointment. The community health worker plays a key role in helping refugee patients navigate the health care system and in helping them find a permanent primary care home. Health services are provided for up to a year at BridgeCare before the patient moves on to a permanent primary care provider.

creates effective channels through established routes of organizational communication to inform and influence practice, program or policy changes to address the identified barriers.

e. WRHA establishes a strategy for a range of regional staff to develop competencies (knowledge, skills and attitudes) essential for health equity actions.

d. WRHA develops and implements a process to describe, monitor and promote awareness of health gaps in Winnipeg including involvement by Manitoba Health.

EQUITY ACTION EXAMPLE – HEALTH SERVICES

IMMUNIZATION

The WRHA is increasing equitable access to universal immunization programs, working in schools where there are consistently low numbers of consent forms returned. Improved rates will be achieved by making it easier for families who are not opposed to vaccination but for whom there are barriers to returning consent forms in the context of life stresses. By partnering with schools selected based on historically low consent form return rates (< 70%) and using tools such as reminder messages in multiple languages, more students who missed their routine immunization will be reached. An equity outreach component has become an integral part of the annual public health influenza immunization campaign, where approximately 4000 annual immunizations are provided in accessible community locations, including missions or shelters, to people at risk of serious complications of influenza illness who otherwise would not likely receive a flu shot.

2. Economy Considerations for Action

The economy is all the work that humans perform to produce and distribute the goods and services we need and use in our lives. The work of economies includes formal, informal, paid and voluntary arrangements within families and communities.

Presented below are the compiled considerations for action resulting from the recommendations review process, offered as a conversation starting place among key stakeholders regarding economy.

1. Organizations and businesses practice good corporate citizenship to broadly promote equity opportunities and break barriers to economic inclusion through activities such as: scholarship provision, procurement, recruitment and retention, skill development, mentorship and on the job training.
2. Economic development strategies are designed and include plans to break the cycle of the various levels and types of disadvantage. These plans are broad and inclusive (e.g., greater availability of quality affordable housing and sustainable and affordable food production and distribution). Criteria and tools are developed that imbed equity principles and paradigms into economic development approaches.
3. Local area regeneration creates opportunities for breaking the cycle of disadvantage for people who currently live or want to live

- in these areas. Plans include consideration of affordable, livable neighbourhoods, inclusive urban planning and stimulation of locally relevant business and employment opportunities.
4. Economic strategies and policies include mechanisms to support income sufficient for healthy living (such as redistribution through progressive taxation and transfers, fair wage policies, and universal social protection systems).
 5. Social entrepreneurship redistribution opportunities are created, for example the redistribution of excess usable goods. In addition to getting goods to people who need them, this will also improve job opportunities, skill development, meaningful occupation and environmental sustainability.

EQUITY ACTION EXAMPLE – ECONOMY

DUBLIN DOCKLANDS

The Dublin Docklands Development Authority established in 1997, combined economic investment with neighbourhood and community regeneration. Waterfront property in this formerly downtrodden inner city neighbourhood was purchased for investment in new businesses and residences. Community revitalization was an essential part of the plan including employment initiatives to encourage developers and businesses to hire local people, a policy that 20% of new housing units were to be affordable and social, development of education programs and facilities, and public amenity improvement. The area has been transformed into an attractive urban neighbourhood and continues to grow as residents, workers and visitors continue to benefit from infrastructural delivery, services and other programs created.

3. Income Considerations for Action



Income is the flow or accumulation of money or its equivalents to allow people to purchase or negotiate goods and services.

Presented below are the compiled considerations for action resulting from the recommendations review process, offered as a conversation starting place among key stakeholders regarding income.

1. Progressive tax systems are built or strengthened, enhancing progressive taxation of all real income including investment income and inherited wealth, increasing the lower limit tax exemption, supporting tax benefits for children and dependents, reviewing the system of tax credits, decreasing tax havens, and addressing tax evasion. Additional revenue is directed to breaking the cycle of poverty in children, including education, training, and employment readiness.
2. Policies are created that prioritize adequate income (upstream intervention) over addressing downstream interventions such as health care, corrections and child welfare. The policies incent business to create well-remunerated, full-time, meaningful and permanent jobs that provide a living wage (e.g., large employers could be given the option of contributing to employment in populations who are underemployed or unemployed, or paying additional taxes). Possible policies for review consider a minimum annual income for healthy living.

3. Develop, strengthen and advertise education and retirement saving incentives for socially and financially disadvantaged populations.
4. Consolidate income and disability services but ensure recognition that persons with disabilities may have unique funding, service and support needs. Base social assistance and income supplement rates on, and increases indexed to, the real cost of healthy living including housing, food, laundry/cleaning, clothing, transportation, medication, dental and vision care, health aids, telephone, loans repayment, child care and needs associated with life transitions (e.g., starting school, pregnancy). Treat people who can independently manage their money differently from those who require more support. Persons with disabilities may require different services including support for managing finances and access to health care and having their unique differences and needs addressed. Provide sufficient resources for employment and income assistance workers to provide case management support to the most vulnerable people.
5. Explore the eligibility of the working poor for income supplements and other social protection services to allow for healthy living and voluntary withdrawal from social assistance. This will entail revised income thresholds and benefits reductions as well as addressing the cliff edges faced by people moving between benefits and work and for people moving in and out of work.
6. Waive the travel loan repayment requirement for travel, travel documentation and medical exams for all refugees, resettled refugees, and in particular for large families and those experiencing employment difficulties.

EQUITY ACTION EXAMPLE – INCOME

SEED WINNIPEG

Supporting Employment and Economic Development (SEED) Winnipeg Inc. has a range of services and programs which provide opportunities for people with low incomes to strengthen their financial situations. SEED's Asset Building Programs assist low-income participants to save for productive assets or household necessities through money management training classes, matched savings credits, opportunities for peer support, and one-to-one support from SEED staff. SEED's Business Development Services help low-income individuals and groups develop or expand small business enterprises, social enterprises, and co-ops in Winnipeg through business management training and one-to-one business counselling. 'Recognition Counts' is a new program that provides accessible, low interest loans to assist skilled immigrants in Manitoba with qualification recognition, upgrading and/or training needed for employment in the fields for which they have obtained education and experience outside of Canada.

Remember Ana?....with more supports Ana's story could have unfolded differently. Imagine if....

Ana heard about the SEED (Supporting Employment & Economic Development) program from a friend. At SEED, Ana was provided with English training and financial help towards starting her own business. Through SEED's 'Saving Circle', Ana saved enough money to open her own business where she now makes a reasonable living and only works 10 hours a day. The extra time, money and education has

allowed her to find a safer apartment for her family and because of this, her breathing is improving. She feels really good about herself and is no longer feeling run down. She hasn't had to visit the emergency department in months. Her neighbourhood has a community centre where the children are able to spend a lot of their free time and she is also getting involved with being a SEED Money Management Training Facilitator to help others. Her children are thriving and she sees bright futures for them in Canada.

4. Work Considerations for Action



Work is purposeful human activity that may result in the production of goods or services or other meaningful outcomes. Work can be paid or unpaid. It includes production of goods or services in or outside of formal relationships with employers. It includes care-providers who are paid or unpaid. Formal employment is usually regulated. Exposures to, and vulnerabilities and consequences of, work-related risks may be considered and addressed.

Presented below are the compiled considerations for action resulting from the recommendations review process, offered as a conversation starting place among key stakeholders regarding work.

1. Regulation 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., Aboriginal, inner Winnipeg populations, transgender) to ensure fair and equitable employment. A focus is placed on:
 - a. employment readiness (e.g. scholarships for equity-seeking populations, employment training, job search),
 - b. improved hiring practices (e.g., non-discrimination, job placement, life-skills training, work-based learning apprenticeships), and

- c. 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).

The community sector can play an important part as both as employer and as a provider of services for some of the recommended actions.

2. Planning, zoning, incentives, and other mechanisms are developed for highly intensive mixed use neighbourhoods to benefit job opportunities. Mixed use encourages local employment opportunities and higher job satisfaction due to decreased commuting time and increased opportunities for flexible hours of work due to the proximity of employee's homes and services. The strongest priority for transition to mixed use neighbourhoods with associated jobs are the lowest income communities.
3. 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).
4. Policy is created to include local development targets in contracts managed by governments. 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.
5. Psychological well-being is included as a workplace safety and health standard and it is supported, prioritized and optimally realized in workplaces.

EQUITY ACTION EXAMPLE – WORK

BUILD

Building Urban Industries for Local Development (BUILD) performs two important roles for low income groups, both in employability to its trainees and savings in household expenses to its clients. BUILD hires Aboriginal, newcomer and inner city residents who are at a disadvantage in the job market and provides training in construction trades retrofitting households in low income neighbourhoods for water and energy efficiency. Employee trainees may be those who did not finish high school, have had contact with the criminal justice system, have a history of struggling with addictions, or face other barriers in the labour market. As of March 2012, BUILD estimates its efforts have saved recipients \$1,146,933, by insulating over 875 dwellings and doing 3288 water retrofits

Remember Dennis? ... with more supports Dennis's story could have unfolded differently. Imagine if...

Dennis managed to get connected with BUILD. This organization offered Dennis training in carpentry and hired him to help work on inner-city construction. BUILD allowed him to work shorter days as he built up his stamina and strength. He gained social connections to others who had also been through

hard times. Knowing he had something to get up for in the morning, he stopped drinking every night. He plans to quit smoking to help feel better and get stronger. Dennis is working towards his carpentry journeyman ticket and is now able to afford his own apartment and take better care of himself rather than spend all his energy just surviving. He has reconnected with family. Since his injury, he has not been back in the hospital.

5. Childhood Considerations for Action

Child development, including early childhood development, includes the physical, social/emotional, and language/cognitive domains, each equally important. Early childhood experiences set the course for a child's 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, criminality, and economic participation throughout life.

Presented below are the compiled considerations for action resulting from the recommendations review process, offered as a conversation starting place among key stakeholders regarding childhood.

1. Improve and optimize prenatal environments, access to prenatal care and multiple supports in lower income populations and neighbourhoods.
2. 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.
3. Promote and sustain community environments that have the capacity to enhance resilience and promote protective factors in young children and their families (e.g., child care centers, schools, family resource centres), thereby creating a foundation for positive mental health throughout the lifespan.



4. Enhance early identification and create supportive interventions where children experience vulnerabilities or developmental delays.
5. Ensure that family incomes, including social assistance, are sufficient to support healthy living for children. Particularly where children are concerned, income gaps associated with transition in income of the parents are bridged.
6. Ensure that early learning and child care is accessible for all, especially for families facing additional barriers (e.g., low income, single parents): particularly those who do not have standard working hours (e.g., service sector), are entering or reentering the workforce, are between jobs, are continuing their education to allow for employment at a wage for healthy living, or are in transition. Financial and program supports are timely and appropriate to the family and child's needs.
7. Increase the availability of deliberate interventions to increase school readiness among the children who need most help to be ready for school. Enhance support to promote positive parenting during early childhood and the provision of quality child care. Services to families include evidence-based developmental, educational and nutritional support in a culturally safe manner.
8. Ensure that inclusive early learning and child care opportunities are available and accessible for children with disabilities or complex medical needs. Families are provided support to navigate the health care, education and family services sectors to maximize potential and minimize systemic barriers, including financial barriers. All children have equal access to the supplies and equipment they need regardless of their family or caregiver circumstances. Confusion and uncertainty about how to obtain required services and supports is eliminated by effective management and system partnership.

EQUITY ACTION EXAMPLE – CHILDHOOD

MANIDOO GI MIINI GONAAN

Manidoo Gi Miini Gonaan was established in 1991. Manidoo has four locations in the Lord Selkirk Park Community: R.B. Russell Infant Centre, David Livingstone School Age Program, Lord Selkirk Park Resource Centre and most recently opened Lord Selkirk Park Child Care Centre which is a new early childhood education and care (ECEC) program which partners with Healthy Child MB to pilot the Abecedarian Project in the Lord Selkirk Park Community. Participants will benefit from the enhanced early childhood curriculum and efforts to ease accessibility and connect with the families. High quality ECEC is known to create strong foundations for those who receive it. The Lord Selkirk Park Child Care Centre program is based on the Abecedarian Project of the 1970s in which a group of pre-school aged children living in a high risk neighbourhood in the US received high quality curriculum and learning games until they were aged five. This group was found to have higher school performance in childhood and adolescence and greater professional achievements as adults compared to their peers as well as lower teen parenthood and drug use.

Remember Kayla?... with more supports Kayla's story could have unfolded differently. Imagine if...

One of her friends told her about a public health nurse who had visited their school. Kayla borrowed money for a bus ticket and went to the public health office. The nurse there helped her apply for several government benefits such as the Canada Child Tax Benefit and the Manitoba Prenatal Benefit. More importantly, she helped connect her with a variety of different programs and services such as prenatal classes and the Families First program and a family

doctor for prenatal care. The Families First Home Visitor met with her once a week to help prepare for the birth of her baby focusing on the strengths that Kayla already showed as a future parent and building up her confidence. Kayla had a healthy baby she brought home to the apartment her social worker helped her find. There was a good child care centre near her building that Kayla was able to get subsidies for so she could return to school and get her high school diploma. Today, Kayla is applying for a university education, and her daughter is thriving in kindergarten.

6. Education Considerations for Action



Education is a learning process that plays a crucial role in the development of healthy, inclusive and equitable social, psychological and physical environments. It 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.

Presented below are the compiled considerations for action resulting from the recommendations review process, offered as a conversation starting place among key stakeholders regarding education.

1. Commit to 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.
2. 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.
3. 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 equity-affected backgrounds (e.g., children in care, Aboriginal children and youth, immigrant students, sexual and

gender minority youth, children living in neighbourhoods with poor graduation rates). Current efforts should also:

- a. Identify and implement 'pull versus push' motivators to improve relevance, engagement and attendance;
 - b. Improve targeting with clear and measurable goals for school readiness, attendance, children retained in school, academic achievement and graduation;
 - c. Ensure social and emotional learning opportunities are maximized through whole school, classroom and targeted approaches;
 - d. Use culturally relevant and acceptable curricula that facilitates cultural awareness and a positive attitude towards diversity;
 - e. Ensure that the teaching of Canadian history accurately portrays First Nations, Inuit and Métis history including the impact of residential schools, the Indian Act and the effect of colonization;
 - f. Implement demonstrated best practices appropriate for educational success with vulnerable learners;
 - g. Explicitly address active and passive prejudice in curriculum and educational environments (e.g., racism, homophobia, sexism);
 - h. Provide education on drugs, alcohol, tobacco, sex, sexuality and relationships, culturally based beliefs and values, physical activity, cooking, money and household management, and parenting.
4. Develop community schools in low income areas where schools could be the hub of the community. These schools:
 - a. Foster strong collaborative relationships with health and social services including health and social services that may be available on weekends and evenings;
 - b. Provide health promotion, prevention and primary care related services as needed such as immunizations and teen clinics;
 - c. Provide nutritious food and limit non-nutritious foods and beverages i.e. 'junk' food and soft-drinks;
 - d. Extend the role of schools in supporting families and communities while taking a 'whole child' approach to education. Using a community development approach, create a 'hub' model which integrates the following key services: public health and primary care services, early learning and child care services, family resource centres, parent-child programming, school based programming and parent education. Pay particular attention to the needs of vulnerable children and provide outreach for low income

EQUITY ACTION EXAMPLE – EDUCATION

PATHWAYS TO EDUCATION

Pathways to Education was started in 2001 in the economically disadvantaged Regent Park area of Toronto where there had been no high school and a 56% drop-out rate (twice the Toronto average). Today the program operates in twelve communities in four provinces. Pathways provides youth in low-income communities with tutoring, mentoring, student-parent support workers, as well as short-term financial supports such as free transit tickets and longer-term financial support in the form of bursaries for college or university. Pathways is known for closely measuring the results of its program. Since 2001, dropout rates have declined by 70% and the rate of youth going on to college and university has grown by 300%. Since 2010, Winnipeg's Community Education Development Association (CEDA) has run the Winnipeg division of 'Pathways' in the north-end of the city where currently 226 students are enrolled.

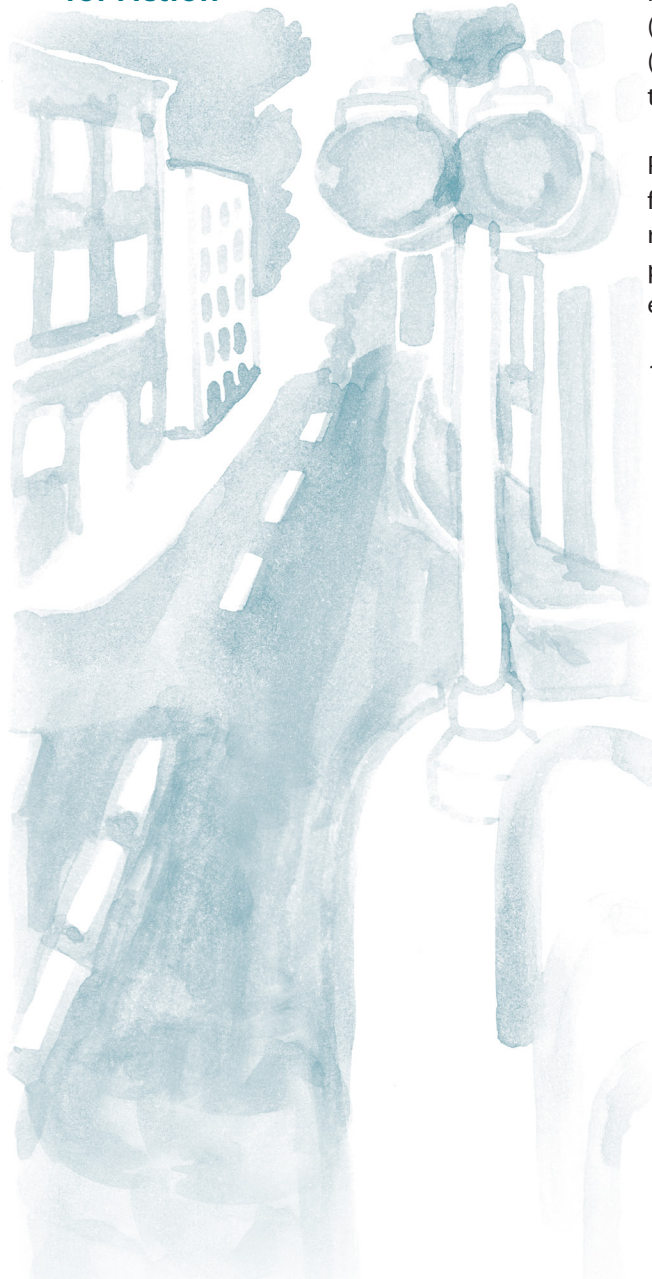
- families with infants and preschoolers so as to optimize a child's readiness for school;
 - e. Facilitate business/education partnerships to help bridge gaps, provide extracurricular resources, counter stereotypes and facilitate role modeling and networking;
 - f. Provide vocational, skills-based training, adult literacy and other educational opportunities for the local community;
 - g. Schools are adequately resourced to develop partnerships (employed positions) between schools and other organizations, systems, and service delivery agencies including child welfare and justice. These partnerships foster intersectoral collaboration and achieve whole child approaches for those children and families not fully engaged in education.
5. Increase accessibility and inclusion for low income qualified students to participate in post-secondary education and training by:
 - a. Controlling tuition fees;
 - b. Increasing awareness of possible financial supports for low income children from infancy through to adulthood;
 - c. Foster open (free web-based) learning;
 - d. Develop and maximize on the job training, apprenticeship and mentorship for underrepresented youth and young adults.
 6. Professional education in many disciplines are reviewed and augmented. For example, ensure that the education of all future health professionals includes curriculum about improving social determinants of health, health literacy, cultural proficiency, an understanding of equity and health, and interprofessional practice and partnerships within and outside of the health sector. Ensure that the training of all professionals involved in urban design and planning (e.g., engineers, architects) includes curriculum about the health and equity impacts of planning and design.
 7. Raise the level of awareness and understanding of the entire public on Aboriginal issues such as the effects of residential schools and cultural genocide.

7. Environment Considerations for Action

The physical environment consists of two main components - the natural environment (air, water and soil) and the built environment (housing, indoor air quality, community design, transportation, and food systems).

Presented below are the compiled considerations for action resulting from the recommendations review process, offered as a conversation starting place among key stakeholders regarding environment.

1. Engage in built environment and urban planning discussions with the City of Winnipeg and other stakeholders to support planning, design, resource allocation and collaboration to promote health equity through urban environmental design.
 - a. Recognize and support the health equity promoting aspects of the longer term Our Winnipeg plan such as complete communities that focus on a diverse range of household types, easily accessible amenities (inclusive of all the venues for daily life such as child care and schools, recreation, restaurants, grocery stores, retail stores, spiritual settings, etc.), a range of sustainable transportation options, and opportunities for local employment. Prioritize zoning, development, redevelopment, and maintenance of mixed use, sustainable, highly dense communities that minimize residential/industrial conflict. Priority spaces for planning and redevelopment are low income neighbourhoods.



EQUITY ACTION EXAMPLE – BUILT ENVIRONMENT

PEEL HEALTH REGION

Public Health is building a relationship with planners and engineers with the aim of including consideration of health impacts into new development. Recognizing that rising chronic disease has a link with decreased physical activity due to city design that makes walking and cycling too difficult especially for the disadvantaged, Peel Public Health is working towards urban design where all residents can use active transport easily to access daily needs. Their work has already led to some policy changes in local planning, influencing transportation studies and integrating health promoting elements into urban design guidelines.

- b. Consider the impact on health equity in day-to-day urban planning decisions in all areas through local area development plans, variance allowances, rezoning, and design of infrastructure. With health equity in mind, these decisions have the ability to foster social interaction, enhance inclusiveness and diversity, address environmental sustainability, provide public and active transportation options, and expand affordable housing. Conduct health equity impact assessments where applicable.
 - c. Create safer neighborhoods throughout Winnipeg through combined approaches of environmental design, maintenance, policy and community engagement. Support the directions identified in "OurWinnipeg" to collaborate to make safe communities.¹⁷
 - d. Authentic engagement of local community groups by the WRHA, the City of Winnipeg, and the government of Manitoba is integral to addressing health equity through urban planning. Adequately allocating financial and human resources is key in supporting these relationships and the directions they recommend.
 - e. Planners, decision-makers and local community members experiment with, learn and share successful community based projects originating in Winnipeg and other jurisdictions. A major focus is to create a sense of neighborhood ownership where people live, play and work.
2. Ensure that available environmental services include:
 - Effective routine and bulk waste garbage pickup in all neighbourhoods, especially lower income where more frequent or extra (bulk pick up) may be needed
 - Boulevard and green space maintenance
 - Maintaining clean and pleasant surroundings (street cleaning, graffiti prevention and clean up)
 - Public health inspection and by-law enforcement
 3. Recognize that the maintenance of natural ecosystems plays a role in sustaining air, water and soil quality throughout the city and that this is a contributor to good health. Local environment issues, such as air quality and offensive odours, are minimized by addressing residential/industrial conflict.

17. City of Winnipeg. OurWinnipeg. It's Our City, It's Our Plan, It's Our time. City of Winnipeg 2011: 42–45. Available at <http://winnipeg.ca/interhom/CityHall/OurWinnipeg/pdf/OurWinnipeg.Jul15.2010.pdf>

8. Community Considerations for Action

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. People can belong to many communities. Within communities there may be considerable diversity.

Presented below are the compiled considerations for action resulting from the recommendations review process, offered as a conversation starting place among key stakeholders regarding community.

1. Multiple approaches are explored to facilitate socially cohesive local communities that are vibrant, inclusive, safe, friendly, co-operative and where people can rely on each other. Safe communities should be free from hazards, violence, or fear of violence.
2. Foster multiple dimensions of social well-being including social integration, social acceptance, social contribution, social coherence and social actualization.
3. Build capacity with inequity-affected communities using a collaborative, strength-based community development approach consistent with the WRHA's Community Development Framework where community development is recognized as a process that includes organizational capacity building, intersectoral networking and local area development.



4. Enhance or create social situations that draw people together around things that are meaningful, affordable, accessible and welcoming (e.g., coffee drop-ins, after school programming, community gardens, walking groups).
5. Encourage participation in physical and social activities that facilitate social integration.
6. 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.
7. Invest in policing and justice systems that engage the community and build trust (e.g., restorative justice).
8. Organizations actively reach out to people in vulnerable situations proportionate to their need. Ways to reach out should be appropriate and acceptable to the population (e.g., use of peers, local or mobile services, home visiting and social media).
9. Organizations accept and celebrate diversity and multiculturalism. Provide settlement services for those coming to Winnipeg from reserves, rural and northern areas, and from foreign countries. A sufficient quantity and range of settlement services including immediate access to long term, full-time language training should be available.
10. Increase the number and range of opportunities for people to interact with each other in a positive way that fosters a sense of belonging and connection to their local community and the larger society.
11. Recognize the integral role urban design and built environment play in fostering inclusive, engaging, safe and complete communities.
12. Intentional collaboration, partnerships, and alignment with Indigenous people and groups should occur, building on the strengths that exist in Indigenous communities.
13. More media stories intentionally focus on positive public engagement in community activities, supporting and celebrating diversity. Organizations proactively encourage media to become aware of stories that support these goals.
14. Enhance access and remove barriers to free internet connectivity to facilitate social inclusion and access to online communities. (e.g., more public or city-wide access to Wi-Fi).
15. Neighbourhood improvement plans go beyond beautification and avoid the displacement of residents.

EQUITY ACTION EXAMPLE – COMMUNITY

MEET ME AT THE BELL TOWER (MM@BT)

Meet Me at the Bell Tower (MM@BT) is a grassroots, youth-led anti-violence movement that brings together many facets of the community in Winnipeg's North End. It was started by Aboriginal Youth Opportunities (AYO) in November 2011 as a positive stand in response to a violent incident in the community. Everyone is invited to meet at the Bell Tower on Friday nights at 6:00 to ring the bell, march and have their voices heard. They have met every Friday night now for over a year. In between meetings, MM@BT uses facebook, twitter and blogs to stay connected and spread messages of hope, change and community activism. The media has picked up on this positive story. Beyond the initial goal of anti-violence, this group provides role modeling opportunities for children and youth where confidence is built as they take on responsibility through meaningful participation. The movement not only empowers people to stand together against violence but offers a supportive and safe environment to deal with the grief and suffering brought by violence and despair. MM@BT is a dependable constant for community members of all ages, where gifts and strengths are celebrated and fear is overcome.

NEW BRUNSWICK ECONOMIC & SOCIAL INCLUSION PLAN

Recognizing that poverty reduction needed broad cooperation across the population, the Overcoming Poverty Together: The New Brunswick Economic and Social Inclusion Plan was developed after a thorough consultation process with all sectors of society while carried out at the community level. The funding is centralized, and the Community Inclusion Networks (CINs), submit to ESIC funding requests based upon their regional plan. Funds are then distributed to the CINs for the approved projects for the regions. This process emphasizes social inclusion, consultation and that local needs are best understood by local government, community and private sector working together.

9. Housing Considerations for Action



Housing is any permanent or temporary building or other structure in which people live. Housing structures will have varying qualities; may be self-contained or shared; may be permanent or transient; and may or may not be owned, rented, or occupied without legal rights. Housing is a subset of environment, but warrants specific considerations given the magnitude of impact on health and equity.

Presented below are the compiled considerations for action resulting from the recommendations review process, offered as a conversation starting place among key stakeholders regarding housing.

1. Resource strategies and policy levers to ensure that a full spectrum of affordable housing and social housing options are available (e.g., rental, cooperative, owner-occupied) with a focus on supporting those in core housing need (families or individuals who spend more than 30% of their income on housing). Consideration is given to: single room occupancy hotel strategies, subsidized housing, investing a portion of all development funds in inner-city housing, designating surplus land for affordable housing projects, inclusionary zoning, improving the speed of approval for affordable housing, tax abatements for affordable housing projects or units, stopping rental unit conversion to condominiums until there is a sufficient supply of new affordable rental units, encouraging cooperative housing, transition from renting to home ownership

- e.g. 'rent to own', micro-financing and land trusts.
2. Create policies and programs for households on low incomes and increase incentives and subsidies to:
 - a. Reclaim and retrofit older housing stock for low income residents and reduce energy loss costs;
 - b. Create affordable adaptations so that low income people can age in place, including those in rental units;
 - c. Promote adaptable construction (e.g., modular multinunit dwellings) to allow for flexibility and sustainability and to facilitate both 'aging in place' and mixed demographics neighbourhoods;
 3. Increase shelter allowance of social assistance to 75% of median market rent to allow for better access to the housing market of those on social assistance, tying annual increases to the cost of living. Other basic needs (food, transportation) should also be sufficiently funded to avoid diversion of funds from housing to other needs.
 4. Increase the capacity of support programs and targeted supportive housing options to help people who are homeless (particularly those experiencing longstanding homelessness) and people who are marginally housed to find and maintain stable tenancies. Support plans to end homelessness.
 5. Increase the accessibility of stable housing options across the lifespan. Develop and implement innovative models of community-based quality, affordable housing with integrated support services for individuals with complex needs to maximize independence and support personal choice, while reducing reliance on hospital or other institutional settings.
 6. Develop a process to deal with difficult public health housing situations that are not clearly addressed by any one program or agency, empowering people to address issues with landlords, or solve owner occupied housing issues.
 7. Enhance connections and partnerships between housing providers (landlords and developers) and housing and health support service providers recognizing that community-based housing with supports requires collaborative inter-sectoral approaches.

EQUITY ACTION EXAMPLE – HOUSING

VANCOUVER'S SECURED MARKET RENTAL HOUSING POLICY

Vancouver's incentive based initiative supports the development of affordable rental units. The Rental 100: Secured Market Rental Housing Policy supports projects where 100% of the residential units are rental and are secured as such for 60 years, or for the life of the building. Affordability is achieved primarily through the tenure (renting is less expensive than owning), through reduced parking, modest size, limited on-site common amenities, level of finishing, and other design considerations. Vancouver's affordable rental market includes a one-for-one rental unit replacement policy for any new rental builds. Manitoba has announced legislative amendments that would give municipalities the authority to encourage or require new residential developments to include homes that are affordable to low- and moderate-income households. This includes zoning by-law provisions, incentive-based affordable housing, and development agreements that protect affordable housing.

BELL HOTEL SUPPORTIVE HOUSING PROJECT

The Bell Hotel Supportive Housing Project provides permanent housing with supports for 42 individuals who have experienced homelessness. The project is led by Main Street Project and The Bell Steering Committee including community, business and government partners. The goal is to provide affordable housing with supports to maintain tenancy and address a range of needs. The project utilizes a housing first approach, harm reduction practices and tenant-centred planning. Tenants are assisted to address the underlying causes of their homelessness, which may include mental health and addictions, from the security of a home. Early findings are encouraging. Health experts note an initial 70-80% reduction in tenants' utilization of emergency health services. Tenants have been supported to gain improved access to community health and social service resources, education, employment and recreational services. Permanent funding has been allocated in support of continued success.

10. Food Considerations for Action



Food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life.

Presented below are the compiled considerations for action resulting from the recommendations review process, offered as a conversation starting place among key stakeholders regarding food.

1. Schools and child care centres are adequately funded and required to:
 - a. Ensure all school age children who may otherwise not be provided with nutritious meals are provided with the option of at least two nutritious meals a day in schools, year round.
 - b. Educate children in budgeting and cooking skills (e.g., recipe reading).
 - c. Offer opportunities for families and adults to gain skills in budgeting and cooking (e.g., menu planning, label reading, recipe use).
 - d. Encourage families with young children to accept and choose nutritious food starting at a very early age.
2. Base the food portion of social assistance rates on the real costs of a healthy food basket and keep it tied to these costs. Ensure adequate funding of a healthy diet, including support

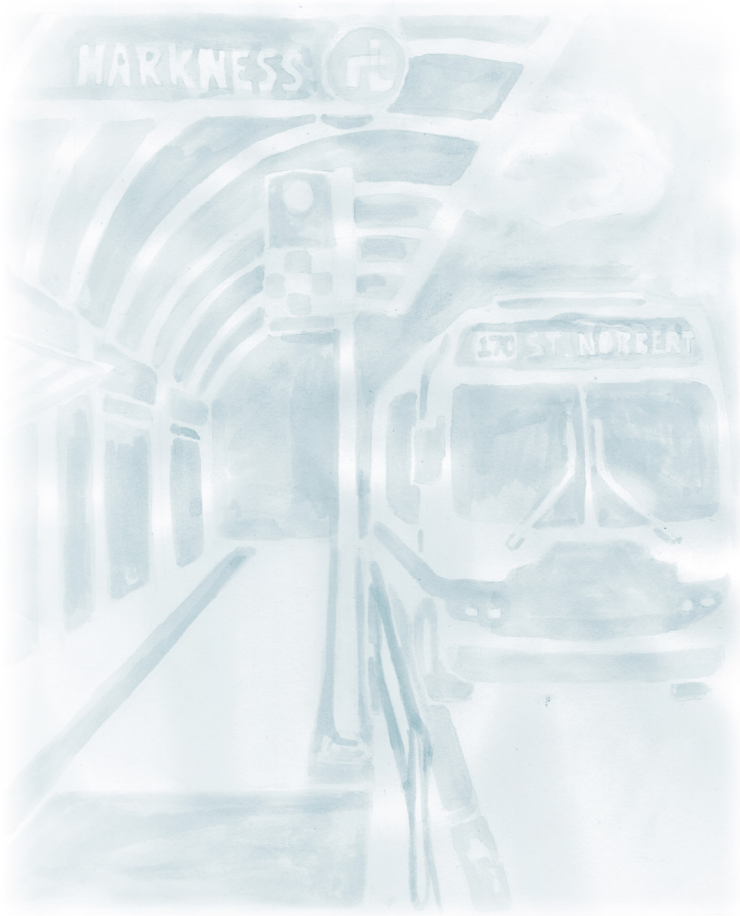
- for access to a full-service grocery store, to increase availability of nutritious and better quality perishable foods, as well as availability of basic cooking equipment (e.g., knives). Ensure sufficient funding of other basic needs (rent, transportation) to avoid diversion of funds from food to other needs.
3. Require simpler and more understandable labeling on all packaged foods, ban trans-fats, reduce sodium and fat, restrict advertisements and sales of junk foods, implement subsidy programs and regulate the cost of nutritional foods (e.g., fruits and vegetables) and determine the need for additional nutrient fortification.
 4. Develop non-stigmatized ways of redeploying nutritious and safe surplus food, including related entrepreneurship opportunities.
 5. Ensure zoning, bylaws and incentives are in place to:
 - Locate quality affordable retail food outlets within easy walking distance in all neighbourhoods but particularly in low income neighbourhoods.
 - Create edible landscapes, gardens, boulevards, urban agriculture, farmers' markets, community kitchens, and community storage options.

EQUITY ACTION EXAMPLE – FOOD

NEECHI FOODS CO-OP LTD

Since 1990, Neechi Foods Co-op Ltd has filled a neighbourhood void in Winnipeg's North End by selling healthy, locally harvested or made food including traditional foods and providing a range of economical food services. Their diabetes prevention work has been recognized by the Canadian Diabetes Association and Reh-Fit Centre. An expansion to the new Neechi Commons Community Business Complex opened in March 2013. It is a community hub that includes a neighbourhood supermarket, cafeteria-style restaurant, farmer's market that features local fruits and vegetables, a bakery, speciality boutiques and an Aboriginal arts centre. The worker owned and operated cooperative will give neighbourhood residents a chance to be entrepreneurs; 60 new jobs are expected to be created and they will also be coordinating employment and training opportunities with local high schools.

11. Transportation Considerations for Action



Transportation is the movement of people or goods. Transportation may be accomplished through human power, motor vehicles or other methods. Transportation-related risks such as injury, noise and pollution can be mitigated. Concerns include affordability and accessibility.

Presented below are the compiled considerations for action resulting from the recommendations review process, offered as a conversation starting place among key stakeholders regarding transportation.

1. Promote and invest in safe active transportation including walking, cycling and other modes of human powered transportation. Escalate the development of active transportation options including: cycling infrastructure, sidewalks, crosswalks and related lighting, well-engineered and enforced traffic calming (40km on residential streets, and 30km near schools and playgrounds). Private business and schools encourage walking school buses and safe bicycle storage. Snow clearing is prioritized for sidewalks, bus shelters and cycling infrastructure to allow immediate and safe human-powered access (including wheeled mobility devices) to destinations.
2. Promote and invest in convenient, affordable public transportation infrastructure and services including no or low cost non-stigmatized bus transportation especially for low income large families. Employment and

EQUITY ACTION EXAMPLE – TRANSPORTATION

VICTORIA BC AND CALGARY AB

Community Social Planning Council of Victoria BC and Fair Fares Calgary are examples of two groups that have made access to public transit easier and affordable for people with low-income. In Victoria an arrangement has come to exist between the transit authority, the Community Social Planning Council and its 65 local agency community partners whereby ticket or passes are purchased by the community local agencies then matched 1:1 by the transit authority and this is facilitated by the Council. In Calgary, the advocacy work of 'Fair Fares Calgary' is largely behind the existence of the city's low income transit passes since 2005. A survey by Calgary Transit and Vibrant Communities Calgary of 401 recipients of the passes found that the passes were important for finding and maintaining employment (55% and 49% respondent respectively), attending education/training (55%), volunteering (49%) and that overall their lives were positively affected (97%).

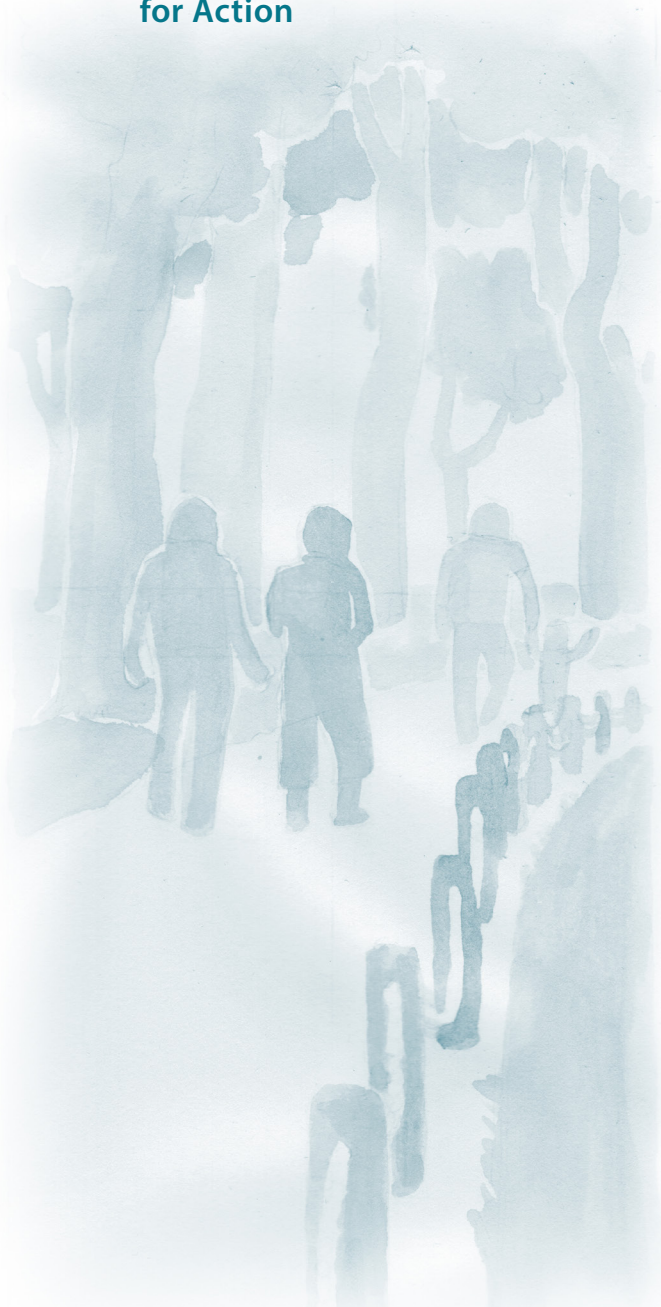
- income assistance adequately supports all transportation needs. Other basic needs (food, housing) are also sufficiently funded to avoid diversion of funds from transportation to other needs.
3. Bus design and transit policy allows for capacity to transport luggage, bicycles and strollers at all times of the day. Affordable, flexible Handi-Transit includes reaching out to high need users, particularly those who have social or mental health challenges and may require higher levels of assistance. Special lenience is needed in winter months. Engage bus and taxi services in mitigation strategies to address the transfer of nuisance pests and/or infection control strategies.
 4. Develop and implement a sustainable transportation plan that considers not only active and public transportation systems, but also the location and density of venues of daily life such as child care centres and schools, work, recreation, residential, restaurants, grocery stores, retail stores, spiritual settings, creating neighbourhoods and social norms that do not require reliance on vehicles.
 5. Consider disincentives for automobile use concurrent with promoting active and public transportation to make them the preferred alternative over automobiles for everyone, normalizing and de-stigmatizing public and active transportation use.
 6. Explore the development of car cooperatives to make vehicles accessible and affordable in low income neighbourhoods.
 7. 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.

12. Behaviour Considerations for Action

The social and physical environment is essential to support and encourage healthy behaviour. Behaviour is any personal action that influences health. Behaviour includes but is not limited to substance use including tobacco, sexual risk-taking and physical activity. Behaviour also includes personal actions associated with other factors that influence health (i.e., food, transportation, housing, environment, community, childhood, education, work, income, economy, health services).

Presented below are the compiled considerations for action resulting from the recommendations review process, offered as a conversation starting place among key stakeholders regarding behaviour.

1. Make healthy choices the easier choices through environmental and social mechanisms such as incentives, disincentives, and supportive social and physical environments.
2. Maximize use of health behaviour change skills in all health care professionals and other support systems where fostering self-efficacy, resiliency and emotional well-being is seen as foundational for behaviour change.
3. Increase opportunities for children to learn effective problem solving, self-control and emotional regulation skills and for adults to further develop those skills throughout life.



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| <p>4. Make active transportation the easy choice. Invest in safe infrastructure for active transportation ensuring connectivity to work and key services and destinations.</p> <p>5. Many people face barriers to participation in physical activity, sport or recreation. Make physical activity, sports and recreation opportunities available for everyone.</p> <p>6. Make a full range of harm reduction, behaviour change, and treatment services and programs widely available.</p> <p>7. Ensure a full range of appropriate tobacco reduction activities are available to specifically</p> | <p>address psychological, social and economic issues underlying tobacco use in low income areas.</p> <p>8. Promote and empower people of all sexual orientations and gender identities to live a healthy sexual life.</p> <p>9. Create and support peer-based promotion of healthy living, particularly in low income and disadvantaged areas.</p> <p>10. Promote the availability, accessibility and requirement for the use of safety items such as smoke alarms or home safety equipment for children.</p> |
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EQUITY ACTION EXAMPLE – BEHAVIOUR

**COMMIT TO QUIT (C2Q)
SMOKING CESSATION**

Commit to Quit (C2Q), delivered out of Mt. Carmel Clinic, is a free group smoking cessation program that also provides no-cost nicotine replacement therapy (NRT) to persons who may not be able to easily afford it. Participants attend group counseling for six weeks and set quit dates to occur between the 4th and 5th week of the program. Weekly follow up for up to 12 weeks occurs with a pharmacist or nurse to assess progress, receive support and adjust NRT dose. Follow up is flexible with walk-in accommodated to make participation easier. People living on lower incomes generally have more difficulty quitting smoking, but the success rate for C2Q at Mt. Carmel Clinic is about equivalent to group programs overall.

Core components for equity action

A number of recommendations were identified that are not stand alone, separate areas for equity action, but rather common approaches that need to be part of effective action throughout all equity promotion work. The following considerations apply to most equity action areas.

1. **Reaching out:** all sectors need to provide services that reach out to those with unmet needs. Vulnerable people frequently do not seek or engage with services that may be helpful. Outreach is the process of finding vulnerable people not already connected to services who would benefit most from them, creating trusting relationships and providing services meaningful to them in their own environments.
2. **Dignity, respect and cultural proficiency:** those working with vulnerable people must exemplify an inclusive, respectful, reflective, culturally proficient and participatory approach.
3. **Integrated services:** develop teams that include providers of various services (e.g., recreation, libraries, arts and culture, education, police, health) delivering services to families and local communities.
4. **Locally-based services:** integrated service teams should foster development of local relationships, local leadership, resident

identification of local strengths and needs, resident participation in decision making and evaluation of local services. Provide services in local neighbourhood venues (e.g., schools) to the extent possible. Neighbourhood teams will also support and coordinate resolution of disputes and cultural conflicts, community building (e.g., neighbourhood watch) and other types of volunteerism. Service providers should to the extent possible reflect the population served. Prioritize implementation in low income neighbourhoods.

5. **Equity impact assessment:** all major WRHA, City and Provincial policies should be based on equity impact assessments.

Remember Kevin?... with more supports Kevin's story could have unfolded differently. Perhaps he did not have to die at the age of 52. Imagine if...

Kevin heard about the Bell Hotel and applied to live there. The Bell Hotel provides housing to people whose histories include homelessness, mental health and/or addiction using a housing first approach. Kevin moved into the Bell while he worked on therapy for his depression, allowing him to focus on his mental health while knowing he was safe and cared for. He also reached out to others and organized social events for all the residents. The staff at the Bell Hotel connected Kevin with the Urban Circle Training Centre, which not only provided him with essential employment skills but also helped him identify with his First Nations roots where he sought healing and embraced his background with pride. Kevin's natural compassion and leadership eventually led to him being recognized as an elder, and he is still mentoring youth and young adults with addictions or mental health concerns.

CONCLUSION

“**Health for All**,” closing the health equity gap in Winnipeg, is a bold stretch goal, but one we must reach. Creating conditions for the highest attainable health is not optional: it is a basic human right. And it is possible through the accumulation of small but sustained efforts by many people acting in diverse sectors. It is unlikely to happen to the required scale spontaneously without deliberate planning, and a concerted, collaborative effort to turn the tide. Hope is essential, but hope alone is not enough. It will take bold, innovative, pragmatic action as we mobilize efforts across the domains of knowledge, governance and participation to develop action plans in the multiple areas where action is urgently needed.

It will also take a willingness to look at Winnipeg through new eyes. Through both eyes. Through loving eyes. We need to see each person in Winnipeg with the compassion that comes from knowing that we are more the same than we are different: we all want our parents, our grandparents, our siblings, our children and our grandchildren to be healthy and thrive, to have the opportunity to dream and realize.

We will need courage to recognize how some of our old thinking, views and systems may unintentionally perpetuate limited opportunity. It will take honesty to acknowledge where we can do better. We will need humility and respect

to genuinely listen to each other, to be willing to shift our frames of reference and points of view to include the perspectives and truths of many. We will need pearls of wisdom and multiple views through facets of the crystal to inform our way forward.

Let's set our sights on a vibrant, healthy Winnipeg where diversity is celebrated and everyone is valued and feels that they belong. Where most people are resilient and describe themselves as happy and everyone reaches their full physical and mental health potential. Let's transform our relationships and create new opportunities. Let's “...dream of a fairer world, but take the pragmatic steps necessary to achieve it”¹⁸ Let's start a conversation. Let's work together.

Because **we're all in this together.**

¹⁸ Preface to Social Determinants of Health- What Doctors Can Do. Sir Michael Marmot. British Medical Association, October 2011. Available at bma.org.uk/-/.../Improving%20health/socialdeterminantshealth.pdf

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- Manidoo Gi Miini Gonaan Early Childhood Education and Care programs
- Pathways to Education
- Peel Heath Region Built Environment
- Meet me at the Bell Tower (MM@BT)
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- Bell Hotel Supportive Housing Project
- Victoria Community Social Planning Council
- Fair Fares Calgary
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- Commit to Quit (C2Q) Smoking Cessation at Mount Carmel Clinic

Abbreviations used in this report

BUILD	Building Urban Industries for Local Development
CA	Community Area(s)
ECEC	Early Childhood Education and Care
EDI	Early Development Instrument
NC	Neighbourhood Cluster
PMR	Premature Mortality Rate
PYLL	potential years of life lost
SEED	Supporting Employment and Economic Development
WHO	World Health Organization
WHR	Winnipeg Health Region
WRHA	Winnipeg Regional Health Authority