# Needs Assessment Winnipeg, Manitoba

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Doctors of the World (DoW) needs assessment to identify gaps in access to health care services for marginalized people in Winnipeg

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## Abstract

Doctors of the World (DoW) conducted a needs assessment to identify gaps in access to health care services for marginalized people in Winnipeg (Manitoba). The aim was to better understand the health care needs of people with vulnerability factors (i.e. experiencing or at risk of experiencing homelessness, using substances, sex workers and Indigenous living in an urban setting). After a thorough literature review, we conducted interviews in Manitoba's capital with local service providers, beneficiaries as well as decision and policy makers.

Our findings suggest that Winnipeg has a worrying situation of crystal meth use, causing an increase in violence and positive test results for syphilis infection. Indigenous urban populations face complex social realities due to, among other things, strong disparities and injustices. Moreover, the current government is restructuring the health care system and the future promises many more changes for Manitoba's overall health services.

Although community-based organizations have particularly well-coordinated services and continue to work hard to improve service delivery, as do regional health authorities developing innovative programs to reach the most vulnerable; several gaps have been identified. Until financial and human resources needs can be met, there is a considerable gap between the expectations and needs of marginalized populations and the offer of safe services that are culturally and ethnically sensitive in Winnipeg.

The results suggest that there is a need to develop a mobile health clinic providing a wide variety of primary care on board. The participants also expressed their interest and willingness to co-construct such a clinic with DoW, tailoring it to the uniqueness of their city.

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## List of abbreviations and acronyms

AHWC Aboriginal Health and Wellness Centre of Winnipeg, Inc.

AFM Addiction Foundation of Manitoba

CFS Child and Family Services

DoW Doctors of the World

MHRN Manitoba Harm Reduction Network

HIV Human Immunodeficiency Virus

HCV Hepatitis C Virus

MACH Manitoba Association of Community Health

MHSAL Ministry of Health, Seniors and Active Living

RAY Resource Assistance for Youth

STBBIs Sexually Transmitted Blood-Borne Infections

SUA/MH Substance Use/Addiction and Mental Health problems and illnesses

WRHA Winnipeg Regional Health Authority

## Acknowledgements

Doctors of the World Canada acknowledges that the city of Winnipeg and the services visited are located on the original lands of Treaty 1 and on the homelands of the Metis Nation. Doctors of the World respects that the First Nation treaties were made on these territories and acknowledges the harms and mistakes of the past, and we dedicate ourselves to collaborate in partnership with First Nation, Metis and Inuit people in the spirit of reconciliation.

Doctors of the World would like to thank all of those who, kindly and generously, agreed to meet with us, regardless of the time and resources required, and shared their expertise and knowledge without counting. You have allowed us to discover a warm city and a strong community, a great example for all initiatives that help the most vulnerable across Canada.

Doctors of the world would like to thank all the partners who took time to review this need assessment.

Doctors of the World would like to take this opportunity to thank all focus group participants for their generosity, honesty and humility. Without embarrassment, with enthusiasm and energy, all readily shared their opinions, experiences, perceptions and needs and above all, their dream and vision for a better working system.

Doctors of the World would also like to thank TELUS for supporting this needs assessment and our clinics across the country.

OUR VISION

A world where healthcare is truly a right

OUR MISSION

To offer and promote access to healthcare for excluded and vulnerable people, in Canada and abroad

OUR VALUES

Commitment – Empowerment – Humanity – Independence – Balance – Equity

# 1. INTRODUCTION AND BACKGROUND

## 1.1 Doctors of the World: an international network

Doctors of the World (DoW) is an independent humanitarian movement that works locally and internationally to promote access to health care and defend social justice. With 400 programs in more than 70 countries managed with the contribution of thousands of volunteers, DoW provides medical care, strengthens local health care systems and addresses underlying barriers to access to healthcare. By empowering excluded people to access health care through medical programs and evidence-based advocacy, while fighting for universal medical coverage, DoW encourages capacity building and knowledge sharing. Development projects are built to ensure their sustainability, encouraging local governments to take over once they have the capacity to do so. DoW strives to overcome unfair situations and unmet health needs. Our vision is a world without barriers to health, where health care is recognized as a fundamental right.

## 1.2 The Canadian delegation

By the early 1990s, the rates of Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV) infection had increased in Canada, as had rates of injection drug use and the number of street youth, a population at risk of blood-borne sexually transmitted infections (STBBIs). Public institutions were unable to control transmission, which was fast growing especially among marginalized populations. It is in this context that DoW was founded by Dr. Réjean Thomas, a family physician specializing in HIV. DoW decided to implement medical interventions directly on the streets and to focus on providing accessible, non-nominal screening for STBBIs especially for populations at risk. Since then, appropriate treatment for a positive result is provided directly on the streets by outreach nurses, and for more complex infections, such as HIV or HCV, service links are established with teams in the public health care system to facilitate access to care and adherence to treatment.

## 1.3: Approaches and intervention framework

Since its creation, DoW's national operations have grown into five different programs in two Canadian cities to fulfill its core mission: offering and promoting access to health care for excluded and vulnerable people. To do so, DoW follows five guiding principles of intervention: i) harm reduction; ii) co-construction with local organizations; iii) reconnection of marginalized and excluded populations to the public health care system; iv) empowerment and capacity building; and v) outreach work.

## 1.4 Guiding principles of intervention

### i) Harm reduction: the heart of DoW's approach

DoW Canada's harm reduction approach is a pragmatic and humanistic approach promoting health, social justice, self-determination, respect and dignity for people in their life and health journey. We aim to mitigate the health risks and negative consequences associated with individual behaviours and/or structural barriers to access to care, for individuals, their families, friends and communities. We place and support people at the very heart of their own approach, as actors of the changes they want and are able to achieve. This involves, among other things, reaching out to people both physically and psychologically by fostering a trusting and welcoming relationship; nurturing and ensuring cultural safety; and respecting their identity, choices, lifestyle and pace.

### ii) Co-construction with local partners

Co-construction is fundamental to us: the mobile health clinic can only exist if partnerships are established with local organizations. In fact, without the involvement of all key stakeholders, the mobile health clinic cannot function. We draw on the expertise, knowledge and relationships of local organizations within the community to ensure that the mobile health clinic provides care in the most effective way. Our expertise focuses on providing primary health care in a motor vehicle that is equipped with the necessary equipment and technology (i.e. EMR) to improve the quality and continuity of care. However, we also need the expertise of partners who can inform us about the reality on the ground, for example about

issues pertaining to certain neighborhoods, specific problems and/or psychosocial challenges. In order to collaborate effectively, all partners must participate equally and agree on the principles and values that govern our activities. For example, it would be difficult to work with groups against the distribution of harm reduction supplies. All partners, together with DoW, create a single model that represents the community's wishes and needs.

### iii) Reconnection to the public health care system

Wherever we implement a project, we ensure that it does not duplicate, substitute or replace the existing public health care system. Each encounter with a person in need is an opportunity to support them and encourage them to seek a stable and long-term follow-up for their global health. Moreover, we believe that through a positive experience while seeking health care and the creation of a trust-based relationship between a person in need and a health care worker, a marginal person is more likely to return to the health care system and use other state resources. Thus, we try to work as a bridge between marginalized populations and the existing health system.

### iv) Empowerment and capacity building

DoW believes that an empowering approach is the key to the emancipation of individuals. Empowerment is defined as a positive approach encouraging a person to regain control over their health. We recognize the skills of people in vulnerable situations and believe that they can take care of themselves if appropriate support is provided. Also, we promote a relationship based on the exchange of complementary professional and experiential skills between two individuals. This is done through an equal partnership of care based on capacity building and a dynamic process of interaction and learning, promoting optimal patient self-determination, free and informed decision-making and concrete and realistic health outcomes. This philosophy requiring equal investment from each, and valuing shared decision-making. Individuals are thus at the centre of their plan of care and can make health decisions to the best of their ability.

### v) Outreach work

The structure of our mobile health clinic is based on the proximity model that has been at the heart of our practice since the beginning: going where people are to provide health care. Outreach work has proved its worth when it comes to reaching someone – especially if marginalized or disaffiliated – who will not seek care in a fixed and more conventional structure. Providing care directly in the environment that a person describes as their home, or where they feel comfortable seems to encourage them to access care, by reducing barriers to care and changing the dynamics with the health care worker. Indeed, it is no longer the person who comes to a health care facility, but the care that comes to the person.

## 1.5 TELUS: an ally

Since 2014, we have been working in partnership with TELUS Health to implement an electronic medical records (EMR) system for our Montreal mobile clinic, and to develop one in our clinic for migrants with precarious status. Since April 2018, TELUS has also equipped our Victoria mobile health clinic with the EMR. With funding from TELUS through its *Health for Good* program, we conducted this needs assessment over the span of three months. It is imperative to mention that the needs assessment was conducted independently of any influence from TELUS. Their involvement was limited to providing financial means and to offer support through their local community board, connecting us to key stakeholders.

## 2. THE NEEDS ASSESSMENT

The Winnipeg analysis is the fourth of its kind after Montreal (Quebec), Victoria (British Columbia) and Edmonton (Alberta). In this context, we assess whether there are gaps in access to health care for marginalized populations in a city and whether we can be useful in the overall effort to address these gaps. In addition, we evaluate the health care needs of marginalized and disaffiliated people. Winnipeg was chosen based on socio-economic aspects made public by the media and research reports.

The provision of primary health care services to marginalized populations has been the subject of greater scrutiny over the past several decades. Research on primary health care delivery for marginalized populations highlights several persistent problems: (i) inverse care (i.e., those who are most marginalized and have the greatest health problems have the least access to care); (ii) fragmentation and under-resourcing of care for marginalized populations; (iii) significant gaps in knowledge concerning how to make services responsive to marginalized populations; and (iv) policy and funding environments inadequate to address these problems (Browne et al., 2012).

### 2.1 Objectives

The purpose of this needs assessment was to document existing primary health care services and the health care needs of marginalized populations. Special attention was given to gaps in the existing system and to barriers to access health care services. Finally, our goal was to meet with different stakeholders and determine with them if a mobile health clinic could add value to the overall local initiatives in place.

As explained above (i.e. co-construction principle), we rely on community partnerships to ensure that our services are complementary and that they use a holistic, rights-based approach while advocating for social change. For this reason, this needs assessment considers the views of a range of stakeholders, decision makers, policy makers, champions and public health professionals, local service

providers and beneficiaries, all in Winnipeg. One of the reasons for including such a large group of experts was to avoid duplication and to obtain all the information necessary to develop a tailored service. In addition, our intention was to establish alliances and partnerships with community groups and local service providers. We do not want to replace services that should be provided by government agencies; we would rather complement existing initiatives to support and strengthen local service providers and improve access to health care.

## 2.2 Methodology

This needs assessment did not involve a research protocol or a team of researchers. It was a voluntary and confidential process, based on a set of qualitative questions for participants. We were seeking to understand the local population's perspective. This includes culturally specific information, enabling us to embrace the values, opinions, behaviours and social contexts of the target population. Data were collected through key informant interviews and focus groups, and participants gave their consent verbally before answering any of the questions. The questionnaires collected qualitative data on gaps in access to health care for vulnerable populations. Three distinct questionnaires[1] were developed for the following groups: decision makers and policy makers; local service providers; and beneficiaries.[2] It should be noted that beneficiaries presenting unique health care needs were presented with specific questions. As a result, it was possible to collect, on a voluntary basis, information from the following subgroups: individuals who are or have experienced homelessness (adults and youth); those who may use drugs; those who may be involved in the sex trade; those who may have a mental health issue and those who identify as Indigenous. In addition to these methods and tools, a literature review of key organizational documents and other academic research was conducted to further explore issues specific to the Winnipeg context. Overall, we met with 9 local community

[1] See Annex 1 to 4.
[2] By beneficiaries, we mean people experiencing homelessness and/or people who have experienced homelessness (and/or that are part of any of the subgroups mentioned, i.e. with a substance use disorder, sex workers, etc.).

organizations, 4 public health champions, 2 policy maker groups, 6 teams from the health authorities, and organized 4 focus groups with a total of 46 beneficiaries.

### 2.3 Limitations of the Needs Assessment

This evaluation has some limitations. While there is an important amount of recent research on marginalized populations in Winnipeg, a detailed picture of some of the city's vulnerable groups is still needed. Although data are available on individuals who are experiencing homelessness, youth and Indigenous people, data on sex workers and people who use drugs are still incomplete. Moreover, the needs assessment took place over a period of less than three months and while great care was taken to understand Winnipeg's unique perspective and culture, this short period of analysis limits the strength of the results. Fortunately, the stakeholders who met with us, possessed and generously shared their rich and extremely precise knowledge, expertise and experience.

Finally, there was not enough time to cover all the questions during the interviews, and not all participants answered the same questions since the interviews were guided by the respondents' preferred topics. Nevertheless, several pieces of information either overlapped or provided different points of view based on each respondent's unique expertise or experience.

## 3. Findings and Analysis

Doctors of the World collected information and insights through key informant interviews and focus groups on the health care issues of the most marginalized, between November 5th and 15th 2018. All information collected is confidential and participants gave their consent verbally before answering any of the questions. We conducted 19 meetings with various stakeholders[3] and professionals from different agencies. The insights collected on health care issues, needs, gaps in services and challenges faced were not only shared by decision and policy makers but also by community-based organizations and professionals. Furthermore, we organized focus groups with participants from the following target populations to capture and integrate their unique perspectives and experiences:

- 19 adults who are experiencing or have experienced homelessness. They were met at a Housing First drop-in centre led by an Indigenous organization;
- 19 adults who are experiencing homelessness and using the services of one of the emergency shelters in Winnipeg;
- 7 youth (12 to 25 years old) who are part of an employment program within a youth organization;
- 8 adults who have experienced chronic homelessness and who are now advocating on experienced homelessness.

The next section presents our main findings, based on individual interviews and group discussions.

### 3.1 Challenges pertaining to marginalized populations

The following challenges were repeatedly reported as the greatest barriers to accessing health care for Winnipeg's marginalized population:

- **Access to transportation** remains one of the most frequently mentioned barriers. Indeed, the city is widespread, and several neighbourhoods are located 20 minutes away by car or ambulance from an emergency

[3] See Annex 6: Schedule of DoW Winnipeg's Visit.

department. This is an obstacle for emergencies as well as for medical appointments;

- **Waiting times** to be seen by a doctor or nurse also remain one of the major obstacles to care. About 50% of the people interviewed did not have an assigned family doctor and used the local walk-in clinics. They reported a wait of 4 to 8 hours in a regular clinic (open Monday to Friday, 9am to 5pm), and between 8 and 12 hours (or more) in an emergency department;

- Another obstacle arising from the focus groups was the **lack of written information or channel** to share pertinent information on the services and resources available for people experiencing homelessness, especially about how to access these services (for example, how to open an account to obtain Employment and Income Assistance (EIA), how to obtain a health insurance card, etc.). Without access to the Internet, the only way this information can be accessed is through "word of mouth";

- The **feeling of being unable to explain their situation properly, to express their needs or defend their rights** when in a state institution, and as a result **feeling denigrated and treated unfairly** was a recurring theme among respondents. Thus, they repeatedly mentioned the need to have access to a person who could defend them, support them, accompany them through institutional services (such as clinics, employment assistance, etc.). This "advocate" could be a worker, a peer, a volunteer, a citizen; someone with thorough knowledge of the system who could explain it to them;

- According to the beneficiaries we met, the **prospects of a long-term follow-up with a general practitioner or medical specialist are slim**. Half of them did not have one at the time of our meeting. More so, there is no single, centralized waiting list to see a doctor. One must contact each clinic or doctor's office to inquire about the availability of a specific physician. It is up to each clinic to decide whether they will offer a follow-up. Some

participants mentioned discrimination in this regard or reported being kicked out after two missed appointments – forcing them to start searching for a doctor again. However, projects such as Doorways are trying to address these waiting list issues;

- **Access to mental health services**, whether it is a first assessment with a psychiatrist or a long-term follow-up with other health professionals, also seems to be a major challenge for most of the participants interviewed. They reported waiting lists of more than 12 months, causing those who moved or did not have a phone number to fall through the cracks. Even when they did manage to be seen, very often the assessment was no longer accurate because the symptoms had occurred a year beforehand. This was also noted of crisis centres or detoxification services, which are designed to facilitate access but have a 30-day waiting list;

- Several participants also reported that a **high number of walk-in clinics** offer punctual help and brief health assessments. However, many complained about the lack of rigor they felt during their clinical examination and reported an over-prescription of drugs (especially opiates), even when not needed, and without any support or follow-up. Many shared recent experiences of discrimination and stigmatization on a daily basis in the healthcare system, feeling that they have not been fully examined, thoroughly evaluated, mostly presumed drunk or stoned, which completely biases the evaluating professional's viewpoint. They all shared several stories in this regard.

### 3.2 Challenges pertaining to local service providers

We also engaged with local service providers who greatly impact, directly or indirectly, the health care of marginalized populations in Winnipeg. The mapping[4]

[4] See WON's map https://spcw.mb.ca/wp-content/uploads/2018/04/WON-guide-high-res-print-version.pdf

developed by the Winnipeg Outreach Network, allowed us to identify the broad range of local organizations providing services in the Central, North End, West End and Broadway areas. We tried to meet with as many different organizations as possible to get an objective understanding of the reality of local service providers throughout the city. Meetings were held with ten different local community organizations. Despite their different agendas, priorities and target populations, they all mentioned without exception, the same two challenges in providing services to marginal populations.

First, there is a significant **lack of coordination and leadership**. Indeed, all providers expressed their willingness to work together, to agree on urgent needs and to better coordinate their services given the precariousness of their funding. All mentioned the goodwill of everyone but the inability to get together at the same table. Specifically, the lack of consensus and decision-making at the executive level, especially between health authorities and community organizations, is said to make the whole process uncoordinated. In addition, most of the people we met showed spontaneous enthusiasm for the project but immediately mentioned their concerns about the logistics of the mobile health clinic and especially the co-construction approach. They asked: "will we be able to bring everyone together at the same table? Who will have the last word? Will there be conflicts of interest or power when it comes to making a decision?" etc. It is also worth mentioning that according to some participants, it can be difficult to reconcile non-Indigenous and Indigenous resources for a common agenda, which can hamper the coordination of services.

Second, there is an obvious **lack of sustainable human and financial resources**. Many mentioned the lack of continuity in funding, which has a direct impact on their strategic planning and vision. For example, one broad initiative was launched in 2016; the team was completed in 2017; their programs were showing some success by the fall of 2018, but their funding might be reduced in March 2019. This has major consequences on their ability to develop social programs

with real long-term impacts. Moreover, according to our respondents the current political and economic situation is not favourable to funding in the health care and social services system. This leads to significant funding cuts and increased competition for funding between community organizations who are trying to keep their projects going. Furthermore, most organizations are facing a crystal meth crisis which has a huge impact on their services. The demand for harm reduction supplies has become so significant (it quadrupled over 4 years) that only two months before the end of the budget year, the main distributing organization had already exceeded their budget and now faces critical material shortages. According to the respondents outreach medical workers must prioritize the distribution of materials over nursing interventions, because from a cost-benefit perspective it makes more sense to address the risk of infection than mitigating its effects. This situation also has an impact on human resources: there is significant turnover because community organizations cannot provide the same conditions to their employees as the health care system, so that most social workers get their first year of experience in the community and then move away; this represents an additional cost for an organization and its beneficiaries. Also, the stress, pressure and lack of resources are felt by the beneficiaries themselves in their interactions with workers. In fact, several recipients mentioned that workers were exhausted and that the quality of their interventions suffered as a result. In fact, they even asked if we could provide psychosocial support for the community workers, so they would be less disillusioned, and be more respectful and appropriate with them.

### 3.3 Challenges pertaining to the publicly funded health care system

At the institutional and governmental level, several major changes are expected to take place in the coming years, following decisions of the provincial government elected in 2016. With health care being the single largest item on its budget, and to curb rising costs and expenses while guaranteeing access to quality care for all, the Ministry of Health, Seniors and Active Living (MHSAL) is currently undergoing significant changes throughout its system and organizations, in the hope of better coordination and efficiency, and eventually, provision of better care.

In Manitoba, there are "eight independent health delivery organizations - the five regional health authorities, as well as Diagnostic Services Manitoba (DSM), CancerCare Manitoba (CCMB) and Addictions Foundation of Manitoba (AFM). Each of these organizations plans health services in relative isolation from one another, leading to duplicate services and inefficient service delivery while acting as an impediment to the development and implementation of a clinical services plan for all Manitobans" (Government of Manitoba, 2018). The MHSAL "Transformation Program has been established to guide the thoughtful planning and phased implementation of broad health-system changes aimed at improving the quality, accessibility and efficiency of health care services across Manitoba" (*Ibid*).

This includes among other things the creation of a new provincial health organization, *Shared Health Manitoba*, "being created from within existing resources to provide centralized clinical and business services for the regional health authorities", mainly "supporting effective health human resource planning, capital equipment investments, construction planning and other initiatives that should be coordinated province-wide" (*Ibid*). While there is not a common understanding of what the changes will exactly look like, many stakeholders mentioned the closing of several emergency departments in Winnipeg, centralizing all acute care to the Health Science Center (HSC) or St. Boniface Hospital, and closing for example all Seven Oaks Hospital acute care departments (while this hospital is serving most of North East Winnipeg), as well as many other changes at the executive level, in terms of governance thus affecting the allocation of human and financial resources.

Several respondents mentioned an important report published in March 2018 entitled *"Improving Access and Coordination of Mental Health and Addiction Services: A Provincial Strategy for all Manitobans",* reviewing Manitoba's health care services. This research started from the premise that "despite Manitoba having one of the highest provincial per capita health expenditure rates in Canada,

and the highest percentage of the overall budget spent on health services, Manitobans actually experience poorer health outcomes" (Virgo, 2018: 31). The report looked at ways "to improve access and coordination of services for individuals with substance use/addiction and mental health problems and illnesses (SUA/MH)" (*Ibid*: vi). DoW found this provincial analysis extremely relevant as it looked at access to care for one of DoW's target populations, the obstacles and barriers, and ways to overcome them.

One of the most striking sections of the report is and illustration of the barriers to access to care and coordination, which is linked to the very structure of the system (see *Figure 3*). Thus, researchers describe the trajectories of people propelled into the health care system by multiple "engines". These drivers can be rooted in colonization and residential schools, deinstitutionalization, the placement of thousands of children in homes, the increasing availability and diversification of psychoactive substances and the increasing social complexity of people's lives. On the positive side, researchers also name the reduction of stigma and discrimination as well as the Truth and Reconciliation Commission as means to seeking help. However, despite the increase and complexity of these 'drivers,' the situation is managed with roughly the same resources as decades ago. So, with the few resources available, there has been an increase in services to meet demand, but these have not necessarily been well coordinated. This has also contributed to the protectionist behaviour of many organizations seeking to provide their communities with the services they need, using the resources they have. As already mentioned, despite the many excellent examples of collaboration and partnership, from the perspective of beneficiaries, the rules around integrating the system can be summed up as "keep you out" rather than "welcome you" (for example, because of the waiting time or the appointment system) thus reflecting the system's inability to meet current needs. Moreover, even when a person manages to access the system through one of the few ports of entry, it is another matter to have full access to concrete and comprehensive therapeutic care. Finally, from this diagram it becomes clear that it is difficult for the system in place to

provide services in a continuum of care (*Ibid*: xvii) because of all the obstacles encountered.

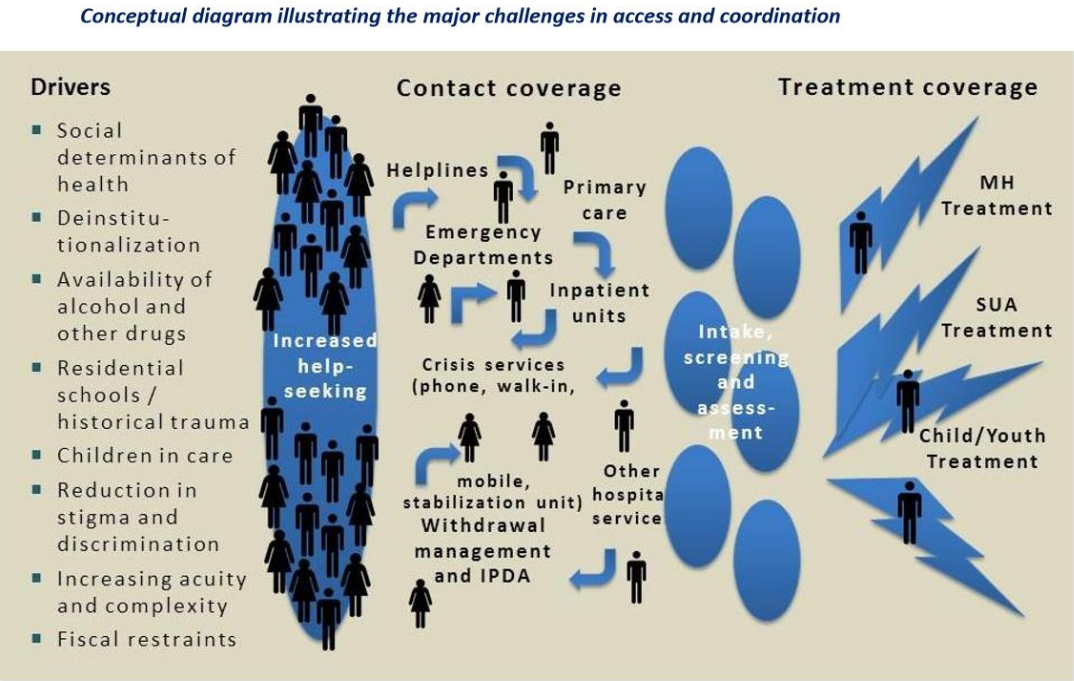



*Figure 3. "Conceptual diagram illustrating the major challenges in access and coordination" (diagram reproduced from the Virgo report, 2018: xvii)*

Researchers also report significant overlapping between services, resulting in a poor use of the few resources available for high users of the health care system. Because a person with both mental and physical health conditions, defined as "medical complexity," falls in two different categories, he or she might be seen by two different teams at the same time. That being said, a significant number of high users of health services also fall into the category of "social complexity", defined with indicators of income assistance, education, justice, social housing, and CFS involvement" (*Ibid:* 33*)*. Finally, researchers conclude that "a well-organized and functioning system should emphasize collaboration and partnership so as to increase system capacity for access as well as service provision; improve navigation either through centralizing one-stop shops or well-articulated pathways; and expand the overall reach of the system response" (*Ibid:* 207).

With the mobile health clinic, we integrate into the existing health system on two levels. First, since DoW works in proximity to local partners, it has exposure to the community and their needs, thus increasing contact coverage. Second, by working together with local actors, we aim to create a bridge to the health system by overcoming obstacles related to intake, screening and assessment while supporting beneficiaries in the process.

To illustrate this idea, we used the same illustration as above and added an image representing the clinic at the two levels we are working on (see Figure 4).

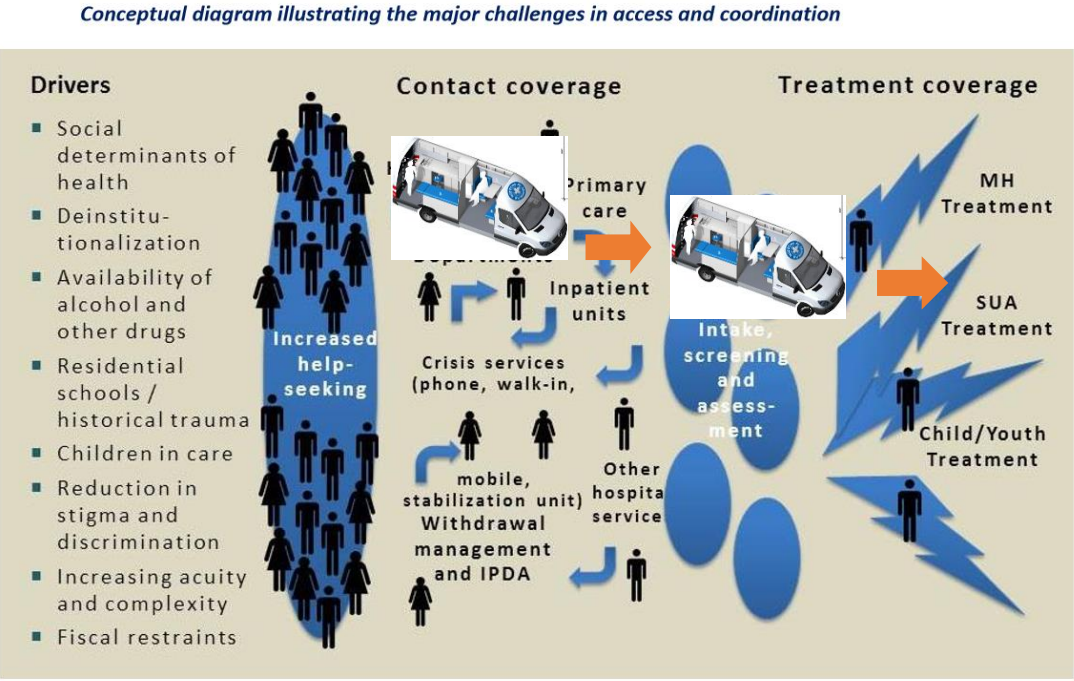



*Figure 4. Representation of where DoW's approach can fill some of the gaps in access to care. (Adapted from Virgo, 2018)*

## 3.4 Gaps in the existing health care system

After completing a literature review and interviewing multiple stakeholders as well as directly concerned individuals in Winnipeg, we may stress the following major gaps:

- Difficulties in accessing the health care system due to challenges in appointment taking, difficulties accessing contact information and health care card;

- Referral systems and waiting lists which make it almost impossible to get through in time;
- Absence of services that are patient centered and adapted to people living on the streets: duplication, lack of communication between health facilities and organizations;
- Lack of appropriate services and insufficient human and financial resources.

As a result, most respondents found it difficult to navigate the health care system and to find information about where and how to access services.

Now that barriers to care have been assessed from different perspectives, several gaps in the system itself are becoming apparent, particularly in its operating structure. For example, the **system of care based on making appointments and giving full responsibility to the patient for following up** is definitely doomed to failure with a clientele who is not reachable and who does not have the comfort of taking such responsibility (for example, keeping their referral papers in a clean and dry place, without losing them; arriving in time for their appointment, at an hour and a day that they have not decided…might represent many challenges). In short, from an organizational point of view their psychosocial and life situation should not have a direct impact on the quality of the care they receive.

As noted by one of the participants, the proliferation of walk-ins and the "9-minute care" mentality is creating even more silos, as it becomes impossible to offer any continuity or follow up. It is assumed that the care is based on a single-time encounter and the health care professional behaves accordingly. This system of care does not allow connection and offers no long-term perspectives. Above all, since not all issues can be addressed in such a short period of time, referrals to an appropriate service, specialist or organization are encouraged. The referral system gives hope to the person met and protects the practitioner who requests it. However, as logical as the approach may seem, the waiting times for referrals or

to be seen by a general practitioner or specialist and receive a service are so long that many people fall through the cracks. They cannot be reached later, the needs are no longer accurate at the time of referral, their immediate needs have never been met and they no longer have faith in the system. There does not appear to be a fast-track system between services or any way to coordinate care in a person-centred approach that would not generate additional wait times.

# 4. Discussion

The mobile health unit can provide onboard outreach health care, including primary health care, public health and mental health care. This type of model heavily relies on the involvement of each community key player and a desire to work collaboratively towards the same goal. The Winnipeg community expressed its willingness and motivation to embrace this approach and considers the implementation of such a project as an opportunity to coordinate and support all efforts to provide access to health care for marginal populations. This is consistent with one of the 2018 Street Census's recommendation that given "that health, mental health and addictions are inextricably linked to homelessness, an increase to services both governmental and community-based, which adhere to harm reduction approaches and address the variety of unique needs of those struggling (…) is essential" (Winnipeg Street Census, 2018: 31).

## 4.1 Target populations

Based on the findings of the needs assessment, the following communities would need support accessing health care services:

- Urban Indigenous experiencing homelessness
- Youth experiencing homelessness
- Adults experiencing homelessness (or at imminent risk)
- People who uses addictive drugs
- People involved in sex work and/or people experiencing sexual exploitation

## 4.2 Priority neighbourhoods

As previously mentioned, the Winnipeg Outreach Network developed a resource guide that has both visual and written information on all resources available in terms of housing, shelters, food banks, drop-in centres, outreach groups, youth organizations, health services, etc. across the city. The map is colour-coded and illustrates the four main neighborhoods with the most resources: North End, West End, Broadway and Central. It has tremendously helped us understand and identify areas and neighbourhoods where people experiencing homelessness may be more concentrated and what resources are available. Caution must be

exercised when using this visual representation, as there may be other neighbourhoods with concentrations of people experiencing homelessness outside of the illustrated perimeter. Because the WON map is only accessible online, below is a smaller (and much simpler) representation of some of the resources available across the city. We strongly encourage the reader to access the online, more detailed version developed by WON[5].

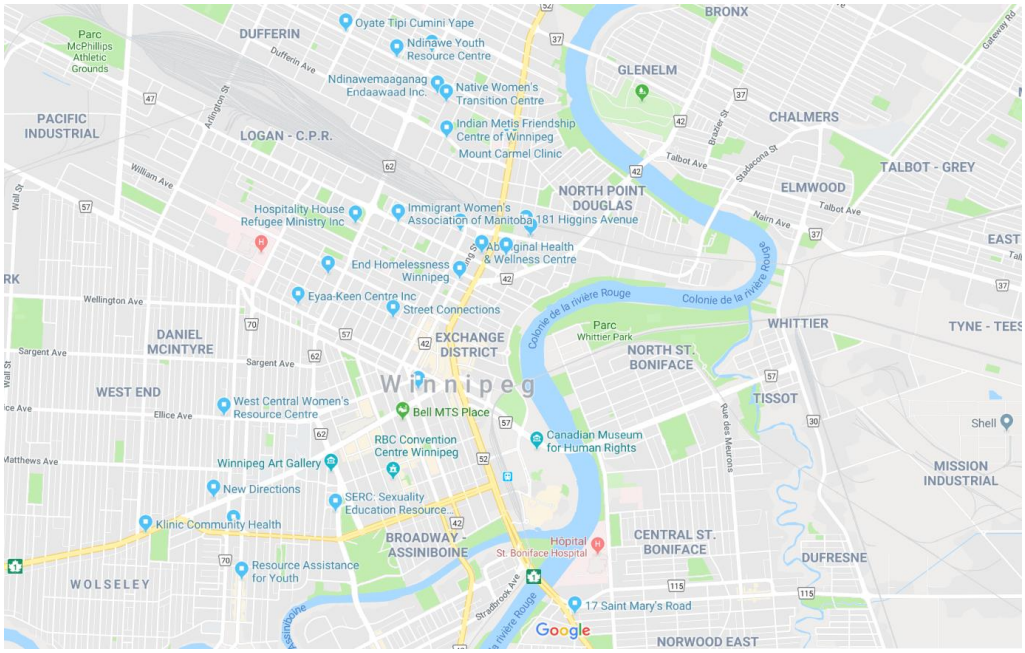



*Figure 5. Location of main resources (drop in centres, shelters, etc.) available in Winnipeg*

It should also be noted that the three emergency shelters are located within a 500 square meters (Figure 6). If a person cannot access this area for any reason, their access to emergency resources is significantly limited. However, based on the assumption that shelters are in neighbourhoods with higher concentrations of people experiencing homelessness, it can be hypothesized that it serves the greatest number of people in need due to proximity.

[5] See WON's map https://spcw.mb.ca/wp-content/uploads/2018/04/WON-guide-high-res-print-version.pdf.

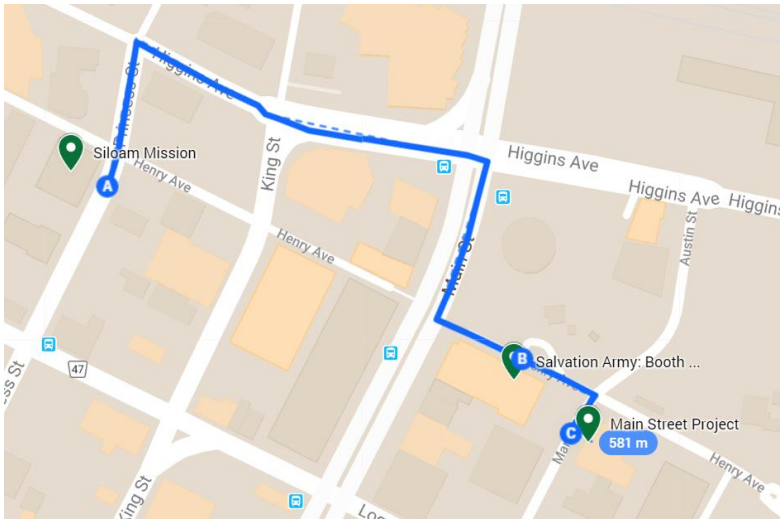



*Figure 6. Location of shelters available in Winnipeg in Point Douglas.*

Even though we do not yet have a set route as it will be developed with local partners, it would potentially cover North End, West End, Point Douglas and the inner city, and Broadway. We will also consider expanding the route more broadly into the city areas identified here – to serve those experiencing hidden homelessness.

### 4.3 Potential

During our visit to Winnipeg, local service providers were very receptive to the idea and need of a mobile health clinic to be implemented in their city. Nine different local organizations, already providing services to the most marginalized groups in Winnipeg, agreed to co-construct and actively engage in the creation of this project with us. Their letters of engagement are attached in Annex 8. It is important to note that most of the local service providers are functionally highly collaborative with each other, and already have existing networks and discussion groups.

### 4.4 Ensuring cultural safety

Cultural safety is defined by the Health Council of Canada as follows. It: " i) is an outcome, defined and experienced by those who receive a service - they feel safe; ii) is based on respectful participation that can help patients find their way to wellness; iii) is based on an understanding of the power imbalance inherent in the delivery of health services, institutional discrimination and the need to correct these

inequities by making changes in the education system and field; iv) requires us to recognize that we are all carriers of culture; there is a personal reflection on our own attitudes, beliefs, prejudices and values." (Health Council of Canada, 2012: 5). Moreover, culturally safe care: "i) requires building trust with Indigenous patients and recognizing the effects of socio-economic conditions, history and policies on health; ii) calls for respectful communication of patients' beliefs, behaviours and values; and iii) allows clients or patients to be partners in the decision-making process throughout their plan of care" (*Ibid*).

In that respect, we will in many ways do our best possible to ensure cultural safety throughout this project. Above all, it will be essential to involve First Nations, Metis and Inuit groups from the beginning. We do not want to fall into the trap of a top-down approach or take advantage of a method that would bypass others. Our experience with Indigenous populations is based on our outreach work over the past 15 years with community members living on the streets of Montreal. This presence in the field in close collaboration with Indigenous organizations has allowed us to develop a certain need awareness. Obviously, our expertise is medical, and our findings are influenced by our non-Indigenous origin. It is therefore essential for us to work in partnership with community members who can help us adapt our approach and target (and meet) the needs of the community. We do not know the Winnipeg community; its strengths, values, customs, culture, medical approaches, etc. We will, in a good way, try our best to engage and integrate key players from the Indigenous community from the beginning and to respond to community demand.

It is too early to say what shape this partnership will take, but, as suggested by participants in the interviews, we could try to provide, promote and encourage the use of both Western and Traditional Medicine on board of the mobile health clinic. To do so, we will do our best to have clinical tools and traditional treatments developed and supported by traditional caregivers, encouraging and welcoming knowledge sharing. The use of tea and smudging ceremony could be available

and accessible in the clinic and supervised by knowledgeable members of the community. Perhaps an advisory committee with members from the community and focus groups with peers could be set up (or consulted if they already exist) so that our service offer remains connected to the needs of the community and improves over time. Moreover, we could try to coordinate with many different key players to integrate different aspects and perspectives from Indigenous groups. For example, we could consult with the Assembly of Manitoba Chiefs, work with Indigenous peer support groups and collaborate with researchers at the University of Manitoba's Ongomiizwin, Indigenous Institute of Health and Healing.

## 4.5 Challenges

### i) Non-nominative testing

Some considerations need to be noted and validated before progress can be made towards the implementation of this project. Indeed, in order to respect our mission, it must be possible and certain that non-nominal laboratory tests can be carried out for the screening of STBBIs free of charge. When asking regional public health authorities, it was noted that tests without identifiers are possible with a service, by simply providing a name and date of birth. However, the nurses performing the test must then write the health insurance card number on the sample and the requisition. Thus, it is possible for a person to be tested without having a physical Manitoba Health card, but they must have access to the card number through their systems to send the specimens to the lab (the HCW gets it from their database, either eChart or the EMR). All sampling tests in the region are performed by a private laboratory, Cadham, which has an agreement with the WRHA. Thus, no one residing in Manitoba has to pay for their test, because it is covered by health authorities through a health insurance number. Without this number or without the possibility of obtaining it, it remains to be assessed whether Cadham would still agree to carry out the analysis, at no cost.

### ii) Volunteer general practitioner

As explained earlier, the proper functioning of the clinic also depends on the implication of general practitioners. All doctors involved in our activities are

volunteers. Their commitment and dedication are voluntary. The role of the Care Committee (composed of 2 to 6 doctors) and others physicians involves, among other things, the following actions:

- Ensure medical monitoring, verify laboratory and other tests as needed, support nurses in certain medical follow-ups and provide daily clinical support on medical matters (on-call doctors);
- Inform the health care team of significant changes related to "best practices"';
- With all the members of the Care Committee, they must ensure the accuracy of the nursing protocols in place, create others if necessary and sign them as responsible physicians.

As far as we have learned through our interviews with doctors, the remuneration system for physicians in Manitoba provides them with a self-employed status and they can therefore invoice independently with a prescriber number. They may be employed in the public or private system, and many have multiple jobs. It would be possible for them to volunteer with DoW as long as they meet their obligations to their other employers. The physicians with whom we spoke about the project were enthusiastic about working in the mobile health clinic or helping to develop our Care Committee and medical community in Winnipeg.

### iii) Nurses' scope of practice

It should also be noted that nurses' scope of practice, which was extended to include certain procedures and allowed them to decide on wound care, prescribe a contraceptive method, or give treatment for a positive chlamydia result; will be changed by April 2020. To access nursing prescriptions and other related procedures, a clinical nurse will now have to take a one-year university course and pass an exam to become a certified registered nurse with authorized prescriptions (RNAP). It has not yet been said how the transition will be made and who will follow up on all the affected clients. However, it is of value to know that primary care nurse practitioners are widely recognized in Manitoba and can be self-employed,

so hiring a NP (with a free spectrum of practice allowing to meet the needs of a large population) is strongly considered by our team.

### iv) Safety and security

Although safety was not identified as an issue by the outreach community services we met (there were no reports of acts of violence or dangerous situations directed at their organizations), Winnipeg was repeatedly identified as unsafe by different stakeholders, including beneficiaries. Given the impulsive, unpredictable and long-lasting behaviour that crystal meth use can cause (especially when injected), this is an important element to consider in the development of this project, especially because the staff on board will most likely work outside regular hours and in remote neighborhoods. As we do not believe in working with security guards and we do not support this method at DoW in general, because of the threat it represents to the trust-based relationship established with people on board, we could ensure and encourage safety in other ways. For example, by establishing a security protocol, or by providing crisis management training to new employees, or by developing support and educational activities with and for other community groups (who have themselves requested support and knowledge sharing on drug-induced crisis management). The presence of working peer support groups who are respected by the community and understand their needs, would also be an important element of this safety net.

### v) Space and outlets

In anticipation of moving to Winnipeg, we will need to find a space for parking (with access to an electrical outlet to connect the truck when it is not in service), a workspace, a meeting space and a locker to store harm reduction and care equipment, medications, and other products related to the proper functioning of the mobile health clinic. To date, several locations have been proposed by local community organizations, but none has been confirmed.

### vi) Team composition

The proposed clinic will be based on the same model as the two other mobile health clinics but will be organized differently to meet the needs mentioned in our

assessment. Thus, at each outing, the team will be composed of a trio, as judged necessary for the proper functioning of the clinic. The composition of this trio will be determined by a community partner from a local organization and our clinic's coordinator; but most importantly, we will need the full-time presence of a peer support group member. The involvement of volunteer citizens in the team will also be encouraged, whether they are persons from civil society or doctors. Last, in order to implement this project, we will work with our partners in a cultural safety perspective. All staff on board will need to be able to respect the principles and be comfortable with the concept of cultural safety. As mentioned above, Indigenous and non-Indigenous organizations will work together to ensure this is reflected in the multiple stages of project development.

### vii) Communication

There has been appropriate emphasis on the current lack of coordination and communication amongst programs, services and agencies serving the vulnerable population and how this weakness significantly contributes to health care inequity. As one partner specifically mentioned, it is vital to develop a strong plan of communication between DoW care providers and any other programs, services and agencies that are connected to the individuals receiving services. This communication needs to occur electronically and be integrated into the community electronic record and eChart. Telephone communication is also valuable but time consuming and may discourage community-based teams from engaging with DoW.

## 4.6 Next steps

To complete this assessment, we heavily relied on the support and knowledge of our partners. We shared our needs assessment report with all the stakeholders with whom we met in November and December 2018. All were encouraged to comment, reflect about and modify any section of the Needs Assessment by January 16, 2019. We also received engagement letters from stakeholders who will be actively involved in the project.

We are now to:

- Organize a second visit with all stakeholders to share our results and decide on the next steps;
- If the mobile health clinic is to be implemented, meet with the organizations that will be actively involved in the project and develop a detailed action plan together (logistics, schedule, principles of action charts, etc.);
- Collaborate with local organizations who will be actively involved towards the implementation of the mobile health clinic (Spring 2019).

## 5. PERSPECTIVES

In the current context of care in Manitoba and following the findings established previously, setting up a mobile health clinic promoting and offering primary health care onboard could help reduce the obstacles and difficulties encountered in access to care by marginalized populations. In addition, through close collaboration with local partners, it is hoped that this project will help bridge the gap between these populations and the public health care system.

The community's enthusiasm for this project, although new, and different has exceeded our expectations and only increased our desire to work with such dedicated, sincere and knowledgeable people. We would like to thank all Winnipeg's stakeholders who are ready to host this initiative and offered their support and expertise to make the mobile clinic a successful model of care. If all goes well and all the collaborative partners agree to build this project together, the mobile health clinic could be on the road in Winnipeg as early as the summer of 2019.

# 6. Literature Review

## 6.1 Winnipeg today


Winnipeg is Canada's seventh most populous city and Manitoba's capital. Today, it is facing several important issues related to precariousness and invisible populations. Described as the "most racist city in Canada" (Macdonald, 2015), Winnipeg has had, in recent years, media coverage that showed all the disparities and injustices experienced by urban First Nations and Metis peoples. "Indigenous Winnipeggers are more likely to face poverty and homelessness, and more likely to interact with correctional or child and family services than their non-Indigenous neighbours" (Levinson-King, 2018). Many researchers have now studied the "linkages from the abuses suffered in the residential schools to the poverty, sickness and violence that disproportionately affects Indigenous people today" (*Ibid*). In addition, in the grip of a national opioid crisis, Winnipeg is facing a significant crystal meth crisis as its "consumption has increased by more than 100% among adults and by nearly 50% among young people since 2014" (Malone, 2018). Crystal meth is becoming more and more popular as it is cheap, long-lasting and has strong stimulant effects. However, this drug can also create unpredictable

and violent behaviour among some users; and there is no safe place for consumers to go in the Manitoban capital. As a result, many consumers find themselves in prison or in the emergency room without a valid reason.

With a dangerous lethal effect, overdose or drug-related adverse effects from crystal meth consumption is responsible for 35 deaths in Winnipeg in the last year (Coubrough, 2018). Moreover, it was recently said by a community organization group working with sex workers that "the spike in methamphetamine use is also leading to more people being exploited as they look for ways to make money or make bad decisions while under the drug's influence. Moreover, the psychosis it causes prompts unpredictable and often violent behaviour" (CBC, 2018). Again, disparities within the population are overrepresented and have disproportionately affected the Indigenous community (Levinson-King, 2018). Furthermore, Winnipeg is facing a public health epidemic with a very rapid increase in syphilis cases. The Winnipeg Regional Health Agency (WRHA) mentioned that over 120 new cases have been reported since January 2018 and it could reach 250 by the end of the year, which represents more than twice the number of cases reported in 2017. The WRHA indicates that about 20 to 30% of those newly infected are crystal meth users and about 20% are experiencing homelessness (Unger, 2018). Last, people experiencing homelessness are at a high risk of contracting tuberculosis due to their living conditions, but their symptoms are often misinterpreted for the flu. In 2011, 2% of people surveyed in the street health census had had tuberculosis during their lifetime (Street Health Census, 2011: 26).

## 6.2 Towards reconciliation


Indigenous-led groups and the community are working with the city of Winnipeg towards reconciliation and collaboration as First Nations, Metis and Inuit living in the city still face an important number of social discrepancies and injustices. In March 22, 2017, the *Indigenous Agreement* was signed aiming at "inspiring Indigenous and non-Indigenous peoples to transform Canadian society so that our children and grandchildren can live together in dignity, peace, and prosperity on these lands we now share" (City of Winnipeg, 2018). "Winnipeg is also a designated Urban Aboriginal Strategy City, which has been guided, since 2004, by the Aboriginal Partnership Committee (APC) working with the Aboriginal community, other levels of government, stakeholders, and Elders" (AAND, 2010b). Now called the Aboriginal Strategic Partnership Circle, the organization focuses on three priority areas related to overall health and well-being: healthy families, education and training, and economic development (Place, 2012: 30).

## 6.3 Overview of marginalized populations in Winnipeg

### i) People experiencing homelessness

Last year, a national research was conducted in several major Canadian cities to count the number of people experiencing homelessness. In Winnipeg, during the night of April 17th to 18th 2018, 1,519[6] people were interviewed and reported experiencing homelessness in the past year. Of these people, 38% reported living in absolute homelessness[7]. It is estimated that "for every person experiencing absolute homelessness, another three people are in hidden homelessness" (Winnipeg Street Census, 2018: 9). It was also reported that a third of individuals encountered were women. It is important to mention, however, that many women experience hidden homelessness (i.e., exchanging sexual favours or staying with a possible abusive partner to have a place to stay) which is not accounted for in these statistics (*Ibid*: 12).

### ii) Indigenous urban populations: First Nations, Metis and Inuit

In 2016, 52,130 people living in Winnipeg identified themselves as Metis, representing an increase of 28% over 10 years. Thus, Manitoba's capital has the largest Metis and First Nation population living in urban centres in Canada, with 92,810 people, or 12.2% of the general population (Statistics Canada, 2016). More recently, the 2018 Street Census revealed that 65.9%[8] of the 1,519 individuals surveyed identify themselves as Indigenous, yet they constitute no more than 8.4% of Winnipeg's total general population (*Ibid*). As a matter of fact, Indigenous people are significantly overrepresented amongst those experiencing homelessness in Winnipeg. The census also identified that 60.6% of First Nation people surveyed grew up in a First Nation community and 58.5% of Indigenous respondents were involved with the Child and Family Services (CFS) (Winnipeg Street Census, 2018:

[6]We can assume that the figure is not completely accurate and that there are many other people experiencing homelessness who were not encountered. The study is interesting not because of the numbers it reports but rather in its portrait of the situation and the reality of homelessness itself.

[7] Absolute homelessness is defined as "staying in an unsheltered circumstance or in an emergency shelter" (Winnipeg Street Census, 2018: 33).

[8]Due to the way data are collected during the census, we believe that this number is actually much higher and people who identify as indigenous represent 75-80% of people experiencing homelessness.

### iii) Youth homelessness

Although the Street Census respondents' median age was 39, 455 people were under 29 years of age and 124 of them were under 18 (Winnipeg Street Census, 2018: 5). Also, 73.8% of these young people were Indigenous. The Street Census also provided some insight to the root causes of homelessness and its societal components. For example, the report indicated that in Winnipeg, those who experienced homelessness in their youth were more likely to experience it throughout their lives. The median age at which people first became homeless was 20 years and the most common age was 18 years. And, "[t]he most common reason people experienced homelessness for the first time was family breakdown, abuse, or conflict. 51.5% of people experiencing homelessness had been in the care of [Child and Family Services] CFS at one point in their lives. 62.4% of them experienced homelessness within one year of leaving care" (Winnipeg Street Census, 2018: 5). Given that family breakdown, issues with addiction, housing, income, health and mental health remain the dominant responses as to why people first became and remain homeless, one recommendation of the researchers was to "create a coordinated intake and assessment system that supports a 'no wrong door policy' to ensure people do not get 'lost' by being directed, redirected and misdirected through our various governmental systems" (Winnipeg Street Census, 2018: 31). Many people had a difficult time summarizing the cause of their homelessness since it often resulted from a combination of factors. For example, almost one third of those who named addiction issues as the cause of their homelessness also experienced abuse by a parent or spouse. Interestingly, while 246 respondents experienced homelessness within the first year of aging out of the care of CFS, only 90 named the transition from CFS care as the cause of their homelessness (Street Census, 2018: 26)

### iv) People involved in sex work and/or people experiencing sexual exploitation

There is insufficient data on certain specific groups, particularly sex workers and /or people experiencing sexual exploitation making it more difficult to count the total number of marginalized people who may benefit from specific services in

Winnipeg. Yet, there is evidence that 70% of sex workers in Winnipeg are of Indigenous origin (Ward, 2014: 2). There is also evidence that the face of the sex trade industry is changing because it is less visible than ever: "Five to ten years ago, there were well over 500 people involved in the street sex trade. This number is now less than 100, but at the same time, the sex trade in the city is booming. There are probably many more people participating now than ever before, but they are invisible" (CBC, 2016). Moreover, recent data from the 2018 Street Census indicated that the first reason for 2% of respondents becoming homeless was sexual exploitation[9] (*Ibid*: 27).

### v) Drug users

Again, the most recent figures are not clear on the number of people using substances in Winnipeg among those who are experiencing homelessness. However, several studies have shown that there is a clear connection between health problems, drug use and street life. The Street Census revealed that 32.5% of surveyed participants first experienced homelessness due to a substance abuse problem, and 27.8% of them named it as the reason for their most recent experience of homelessness (*Ibid,* 2018: 28). In addition, while we may not know the exact number of drug users exhibiting risky behaviour, there is evidence that "poverty, homelessness, relationship breakdown and mental health are correlated, as well as not seeking medical care or feeling judged in the health care system" (Winnipeg Health Street Census, 2011: 30).

### vi) LGBT2SQ+[10]

The Street Census revealed that 13.4% of respondents under 29 identified themselves as part of the LGBT2SQ+ community. Few resources directly target the LGBT2SQ+ community. Sunshine House, a drop-in centre with many different services and the Rainbow Resource Center are the main community-based

[9] Sex workers of Winnipeg Action Coalition (SWWAC) defines sex work as "the exchange of sex or sexualized intimacy for compensation." Sex work is different from, and commonly conflated with, sexual exploitation, which is when "one person is coercing another person into getting money or things for sex, and that first person is benefitting from it." http://uniter.ca/view/sex-workers-are-not-illegal

[10] Defined as Lesbian, Gay, Bisexual Transgender, Two-Spirited, Queer and whoever identifies as part of this community.

organizations serving and advocating for the community. Moreover, the Salvation Army Booth Centre just opened in January 2018, with fifteen beds in their shelter for people who are experiencing homelessness and identifies as part of the LGBT2SQ+ community (Global News, 2018).

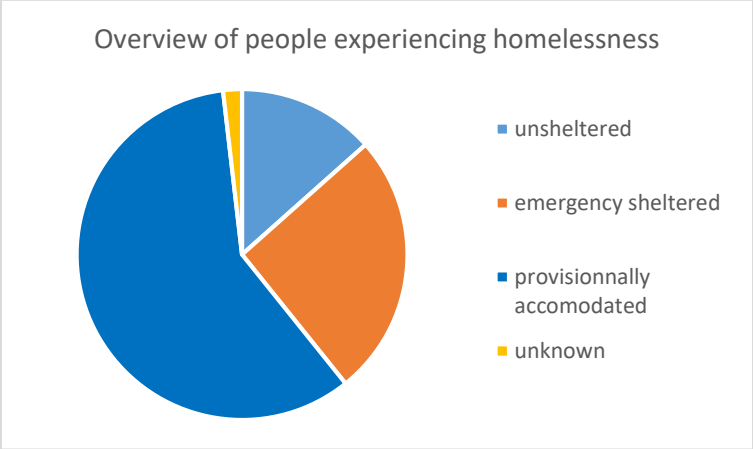



*Figure 1. Overview of people experiencing homelessness (based on data from the 2018 Winnipeg Street Census).*

## 6.4 Overview of the Manitoba health care system

The Ministry of Health, Seniors and Active Living (MHSAL) administers the most complex and publicly funded program of Manitoba's provincial government. It is delivered partially by the department and partially through grant agencies, health authorities, independent physicians, or other service providers paid through fee-for-service or alternate means. It is a complex combination of insured benefits, funded services provided through public institutions ranging from community-based primary care to tertiary teaching hospitals, and publicly regulated but privately provided services such as proprietary personal care homes. The MHSAL also manages the insured benefits claims payments related to the cost of medical, hospital, personal care, Pharmacare and other health services, for the residents of Manitoba. Most direct services are delivered through regional health authorities, and other health care organizations (Government of Manitoba, 2018). The Manitoba Health Care system also has its own challenges. For many years, the province faced longer wait times and a shortage of family physicians, two significant challenges that continue to affect the current system. Providing care to an isolated and inaccessible community also has its own challenges and significant costs (*Ibid*).

The MHSAL plans and coordinates the delivery of programs and specialized services, with five regional health authorities. The mandate of the five regional health authorities is to govern, plan, and deliver health care services within their geographic areas. Three regional health authorities have developed a regional mobile clinic, where through nurse practitioners and clinical nurses, 13 isolated communities have access to primary health care consultations (Interlake Eastern Regional Health Authority, 2018). These three regional mobile clinics do not provide services in the Winnipeg region and do not work with the population of this region.

Manitoba has a publicly funded health care system that provides access to medical health care services through the Medical Services Plan (MSP), and to prescription

medications, medical supplies and pharmacy services via the Manitoba PharmaCare Program. These are available to all eligible Manitoba residents. "The eligible population includes people who are Canadian citizens, permanent residents, refugee/asylum claimants, temporary foreign workers on work permits, and students on study permits. Tourists and visitors are not covered under this system" (Government of Manitoba, 2018). It should be noted that several requirements in Manitoba can have an impact on the provision of health care for a marginalized person. For example, without a permanent address, one cannot obtain a Manitoba Health Card; and without a Manitoba Health Card, access to health services is limited (*Ibid*). In the 2011 Street Health Survey, "24% of respondents did not have their Manitoba Health Card. The main reasons were that it was lost (56%) or stolen (21%), and 22% of respondents had been refused health care in the past year because they did not have a Manitoba Health Card" (Winnipeg Health Street Census, 2011: 30).

### i) Winnipeg Regional Health Authority

The Winnipeg Regional Health Authority (WRHA) is responsible for the governance, planning and delivery of health care services in Winnipeg. It has put in place several strategies, for example the Strategy for Equity and the Harm Reduction Strategy, to orient the programming and coordination of care, which directly affect access to health care for the marginalized population. Moreover, specific programs have been developed by the WRHA to offer health care to vulnerable populations, through outreach programs. Several such programs are proving their effectiveness in reaching populations in need. DoW has drawn up a non-exhaustive list of the programs with which they would coordinate their efforts as they have similar values and mandates.

- **Street Connection** is a public health outreach program with the mandate to decrease the spread of Sexually Transmitted and Blood-borne Infections (STBBIs). Using a van, they provide safer drugs and safer sex material, nursing services, and other activities on board, reaching people where they are. They follow a fixed schedule to reach out where there are no services

and the most needs and respond to on-call demands for material. While they focus mainly on harm reduction distribution and safe disposal, they also provide first aid and basic primary health care on board as needed. The clinic operates all week, every evening from Monday to Friday, and during the daytime on weekends. The nursing services on board include STBBI screening and treatment. Beneficiaries must provide their name and date of birth in order to receive any sort of care (but not the actual Manitoba Health Card). In addition, there are other public health outreach programs such as the outreach tuberculosis team working to manage supervised medication intake in the community and also coordinating with other services. As well, there are outreach flu clinics and outreach resources which provide support for pregnant women.

- **Health Outreach and Community Support (HOCS)** is "an outreach consultation service that aims to improve the focus populations' access to primary care and behavioural health services and decrease the use of emergency services to meet basic health needs." They are "a direct point of connection for information and referral, problem solving, service linkages, assessment, psychosocial support, service coordination and service delivery" (University of Manitoba, 2018). This program "is about a paradigm shift, it is about seeing a population that has been historically characterized as perhaps problematic as individuals who have had significant trauma and for us in health to work with them through that lens rather than through a risk and safety lens" (Samson, 2017). It is an outreach clinical inter-professional team that provides consultation, capacity building, coordination and direct services to beneficiaries (through regular consultations with other teams, a presence in the community, an engagement focus, and thorough assessment and integrated person-centred plans).

- **The HOCS Network** regroups many different local organizations from the WRHA, the hospitals network (many emergency departments), home care

workers, community workers, etc. They work and identify the trends in the community, the service needs and the needs of the population and possible solutions, etc.

- There is a variety of **Crisis Response Services** such as the Crisis Response Center (providing a safe place); a mobile unit and a Crisis Stable Unit (CSU) that are providing support and treatment during times of crisis for people living with a mental health diagnosis.

- A **Complex Situation Committee** providing clinical supervision once a month for outreach case workers. They bring together agencies and WRHA resources to provide input from experiential and clinical perspectives to assist in situations.

- In the same idea, the WRHA offer **Capacity Building Sessions** (i.e. workshops, training, etc.) to community agencies that provide new clinical information, knowledge sharing and address clinical decisions to manage complex situations.

- **Micro-teams** use simplified intake processes for primary care: each time a person walks into a clinic, they do not see a specific health care worker (HCW) but instead they meet with any HCW (RN, SW, etc.). They see a micro-team, as it was proven that 70% of people walking in a clinic do not need to necessarily see a doctor. From our understanding, this approach is only available at the ACCESS downtown clinic but will be expanded to other ACCESS clinics. One of the advantages of working in micro-teams is more than improving access: it is building relationships between the patient and the clinic staff, with the understanding that so many of the clients have gone through complex trauma and have had adverse experiences in the health care system which has led to a loss of trust and subsequent reluctance to seek care. This is often done using a "warm hand off" i.e. a friendly introduction to the other team member by the most trusted clinic team member. It should also be noted that

the micro-team model is based on the principles of NUKA (Nuka being an Alaska Native word meaning strong, giant structures and living things)[11]. As mentioned above, although Access Downtown was the test site for this model, it is currently being implemented in other Access Centres throughout the city.

- Integration of care plans across sectors and programs to support increased access and coordination, for example, by integrating intervention plan for frequent hospital users, throughout the hospital system and EMRs.
- **Step in to Health**: step down clinic to address and see people who do not have an address or do not want to be seen at home as a space to use for home care and post hospitalization follow up.

- **Indigenous navigators** provide health services and support for Indigenous populations by accompanying persons during periods of transition and navigating the system (ex: Eagle Urban Transition Center (EUTC)).

### ii) Harm reduction policies and strategies

The MHSAL does have a public health policy on harm reduction (Government of Manitoba, 2016). There is no supply distribution plan (as highlighted in the Virgo Report- Virgo, 2018: 40 & 226) which is a major issue for many of the local service providers working with at-risk populations.

On the other hand, the WRHA has a harm reduction statement and strategy. Thanks to that, they have also developed (and helped develop) many outreach and harm reduction programs within the region. They are also the core centre for material orders, distribution, exchange and safe disposal. Under the public health branch, the harm reduction and healthy sexuality program are managing and coordinating all harm reduction strategies throughout the region.

[11] https://www.kingsfund.org.uk/publications/population-health-systems/nuka-system-care-alaska accessed January 21 2019.

The Manitoba Harm Reduction Network (MHRN) "works toward equitable access, systemic change, and reducing the transmission of STBBI through advocacy, policy work, education, research and relationships" (MHRN, 2018). This network advocates and coordinates efforts across jurisdictions to support harm reduction (prevention, promotion, education, etc.).

The Addiction Foundation of Manitoba provides, organizes and supports a wide range of services for substance abuse users, and supports harm reduction activities.

### 6.5 Winnipeg's End Homelessness Initiative

End Homelessness Winnipeg (EHW) was founded in 2015 to coordinate and lead efforts among different stakeholders working with people experiencing homelessness, to implement Winnipeg's *10-Year Plan to End Homelessness (2015-2025)*. Furthermore, the Winnipeg Plan to End Youth Homelessness, *Here and Now: The Winnipeg Plan to End Youth Homelessness* was developed and is currently being implemented. The city of Winnipeg is also part of the *Homelessness Partnering Strategy (HPS)* a Canada-wide program with strategies and policies to be developed during the period 2014-2019. HPS is a "community-based program aimed at preventing and reducing homelessness by providing direct support and funding to 61 designated communities and to organizations that address Aboriginal homelessness across Canada" (Government of Canada, 2018).

### 6.6 Local community organizations providing health care services [12]

The below organizations are already offering health services to our focus population. A better understanding of their programmatic reach and approach allowed us to identify possible gaps which may be filled by Doctors of the World actions.

[12] Organizations have been listed in alphabetical order. Only available information is included.

- **Aboriginal Health and Wellness Centre of Winnipeg, Inc. (AHWC)**[13] is a non-profit organization that provides primary health services and social programming for Urban Aboriginal constituents (clients/consumers/participants) who face multiple barriers with opportunities to improve their self-sufficiency and overall quality of life. The philosophy and vision of AHWC is founded on the medicine wheel, a concept which emphasizes the provision of resources that enable individuals to attain a balance in their lifestyle necessary for "holistic health". Their program(s) work from a holistic approach that strives to combine programming, support, services and resources that are innovative and engaging for the constituents and their families. Some of their services are their Primary Care Clinic, Abinotci, Head Start, Insight, IRS, Men's Healthy Living, and Housing and Housing Supports. AHWC provides wrap around supports for children and parents both independently and as part of a family unit to strengthen parenting, promote social networking, reduce isolation, promote primary health and community engagement that meets the needs of each family members.

- **Klinic Community Health** is a charitable, not-for-profit health care centre providing a full range of health-related services from medical care to counselling and education. They are an important centre for mental health programs, one of them being a 24/7 crisis centre for the whole province (Klinic, 2018).

- The **Main Street Project** has many different programs, including one of the three emergency shelters in the city, and tolerates people who are under the influence of drugs or alcohol. They "provide clients with support by in-house nursing staff including primary care, mental health support, assessments and medication management. Nursing staff work across

[13] Ten different community health centres located in Winnipeg represent the Manitoba Association of Community Health (MACH).

programs with clients to assess their primary health care needs and manage any non-urgent issues. They also have a detoxification program where having access to a nurse becomes essential in managing the patient's diagnostic, treatment, and strategic interventions" (Main Street Project, 2018). They also have an agreement with Emergency Medical Services: once the paramedics arrive on a scene and feel that the person's needs are psychosocial, they call the Main Street outreach van and it must arrive on site within 10 minutes.

- **Mount Carmel Clinic** is a non-profit community health centre committed to helping families live healthier lives. They have a wide range of community programs. The ones that are of interest to DoW are the Hepatitis C treatment, the Assertive Community Treatment (ACT) team providing intensive mental health follow-up and the Sage House program, a resource for women who are involved in survival sex work. Moreover, they have access to point of care testing and screening (XR, labs, etc.) and can then see beneficiaries without their Manitoba Health Card (Mount Carmel Clinic, 2018).

- **Ndinawemaaganag Endaawaad Inc.** is a non-profit organization dedicated to helping at-risk youth in Winnipeg. With numerous programs, they aim to connect youth at -risk with appropriate services and to provide a safety net and housing options. While they do not offer direct health services directly, their outreach team delivers information and prevention material on safer sex and safer drug use (Ndinawemaaganag Endaawaad Inc., 2018).

- **Nine Circles Community Health Center** has expertise in the care and treatment of HIV, Hepatitis C and other sexually transmitted infections, delivers comprehensive primary care, social support, education and prevention services. They offer their services free of charge and without a

Manitoba Health Card. They see people who are experiencing homelessness, using drugs and involved in the sex trade (Nine Circles Community Health Centers, 2018).

- **Resource Assistance for Youth** is a non-profit community organization offering a range of programs for the youth (29 years old and younger) with a large scope of resources ranging from a drop-in centre to housing support to employment programs. The Health and Wellness Department offers services related to the mental, emotional, and physical health of youth by providing low-barrier access to a community mental health worker, and an addiction support worker. Their Nurse Practitioner is well-known by the youth after 8 years of being there twice a week and offering many different health care services. All services at RAY follow a holistic and harm-reduction approach to all aspects of physical and mental health (Resource Assistance for Youth, 2018).

- **Saul Sair Health Center** is part of the Siloam Mission, an organization that provides an array of services to people experiencing homelessness and has the largest emergency shelter in Winnipeg. In terms of health centre, their volunteer health care professionals provide primary care, specialized care and urgent needs care for those experiencing homelessness. Services include: primary care (physicians and nurses), dentistry (dentists and hygienists), optometry, podiatry and foot care nursing. All services require a form of identification and are billed by the volunteer professional to Manitoba Health (Siloam Mission, 2018).

- The **Manitoba Association of Community Health** is a group of ten Community Health Centres (CHCs), including some of the CHCs already mentioned above such as AHWC or Klinic, that "envision a society in which all individuals, families and communities have access to comprehensive, coordinated and cohesive primary health care". This association of front-

line health groups work together to, among other things, "facilitate collaboration and coalition building and advocate on issues of common general interest". It also allows for the sharing of knowledge among professionals or the provision of a range of care by addressing several social determinants of health. (MACH, 2018).

## 6.7 Specific outreach services

These include:

- **Outreach teams**: There are many different outreach programs throughout Winnipeg. These teams have a variety of different services and mandates, but what is similar is the individuals they reach out to. Because they work in proximity to their community, they can reach the ones in need, those who do not use resources, those who are usually not seen or followed. This creates a sense of security, as they break barriers to access services, they establish contact, they build relationships, they provide follow-up and support. Spence Neighborhood Association has 3 full-time and 4 part-time outreach workers, all working outside regular hours. The Bear Clan, a group that was created in 2014, by and for the community of the north end, is almost entirely volunteer-run. They have a huge harm reduction impact on the community, working every evening, providing safe material supplies, disposing of sharps and used material found in the street, distributing food and water. The Community Homeless Assistance Team (CHAT) is another key outreach player. They play "a vital role in connecting the homeless community with social agencies that: i) connect to permanent housing options; ii) enhance wellness; iii) provide addictions and educational support and iv) help find employment" (Downtown Winnipeg Biz, 2018).

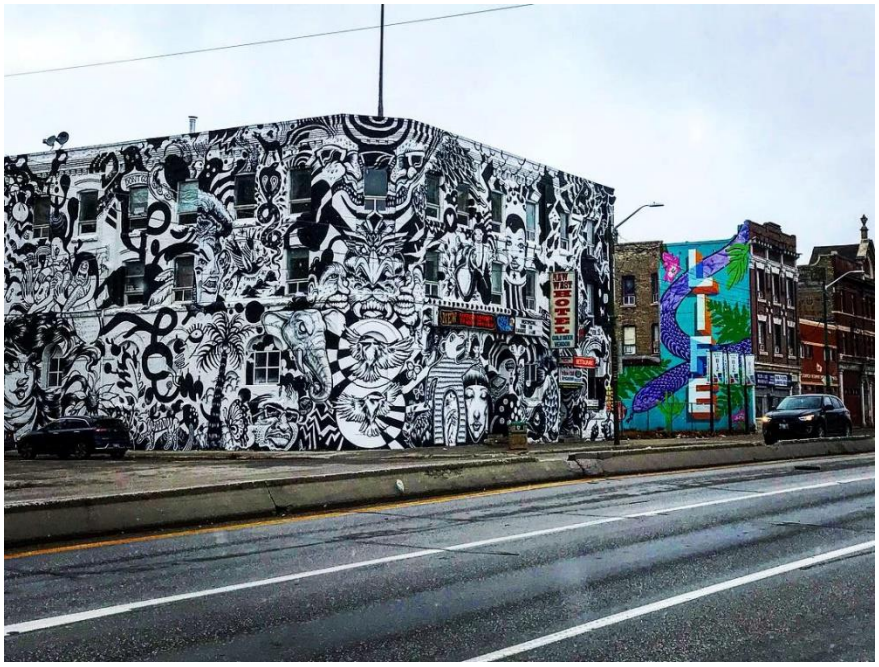
- **Outreach Vans:** Many organizations have outreach vans operating in different neighborhoods. They usually provide transportation, food, warm clothes and support. They have their own routes and schedules. The workers are well-known by the community, they know their needs and they

trust each other. Some of the organizations with outreach vans are Rossbrooke House, Main Street Project, RaY, Inc., Ma Mawi Chi Itata Center Inc. and Salvation Army.

## 6.8 New initiatives


There are new initiatives and programs at both the community and institutional levels, trying to change the way they approach care and offer services. They are about resource sharing; bridging the gaps and creating relationships. They are also about shifting ways of thinking beyond interventions, to also consider the person and their needs. A concrete representation of this change is MyHealth Teams. This new approach is based on a model developed in Alaska called NUKA (meaning strong, giant structures and living things), which is based on customer ownership, so clients have the authority to decide what services and care they want. Inspired by this approach, the WRHA has put into place MyHealth Teams. These teams are made up of different professionals supporting individuals to navigate the system and efficiently use appropriate resources.

## 6.9 Health and the street




The Winnipeg Street Health Report (2011) was conducted by a team of community researchers and brings to light the precariousness of the street and its effects on physical and psychological health. This report concluded that most people experiencing homelessness have significantly poorer health than the general population and that the "health needs of homeless people are often complex, unsatisfied and not effectively addressed by conventional health care services" (Winnipeg Street Health Report, 2011: 7). The report revealed that pain is the most common symptom among those experiencing homelessness: nearly half of the respondents reported generalized suffering, with most describing moderate to severe pain. Chronic and acute conditions are overrepresented in the homeless population compared to the general population. Indeed, people living in the street are more likely to have Hepatitis C, FAS/FAE[14], epilepsy, a heart attack, angina, asthma, arthritis or rheumatism, diabetes and headaches – see Figure 1 for more detail (Winnipeg Street Health Report, 2011: 20).

[14] FAS: Fetal Alcoholic Syndrome & FAE: Fetal Alcoholic Effect.

In addition, although marginalized populations have significantly higher health care needs than the rest of the population, they are much less likely to seek medical attention. The most commonly cited reason for this mistrust is that access to care by marginalized populations is limited by many hurdles: long hours of waiting, not enough general practitioners taking new patients, lack of phone or transportation, lack of knowledge of existing resources, requirements to have a health care card, etc. The obstacles encountered on their health journey are largely related to their lifestyle and economic situation. Moreover, the discrimination and the feeling of being judged increases the lack of trust among beneficiaries and their reluctance to seek care. The respondents also felt that health professionals often did not respond to their needs in an appropriate way, as the advice and treatment were not adapted to their situation (Winnipeg Health Street Report, 2011: 30).

**PHYSICAL HEALTH CONDITIONS**

**Chronic or Ongoing Physical Health Conditions**

| | Street Health Survey % | General Population % |
|---|---|---|
| Diabetes | 11.3 | 3.9 [8] |
| Anemia | 15.3 | N/a |
| High Blood Pressure | 23.3 | 22.0 |
| Heart Disease | 4.3 | 5.0 (in Canada) [9] |
| Angina | 11.7 | 1.9 (in Canada) [10] |
| Congestive Heart Failure | 1.3 | 1.0 (in Canada) [11] |
| Stroke | 7.3 | N/a |
| Heart Attack | 7.3 | 2.1 (in Canada) [12] |
| Epilepsy | 5.0 | 0.6-0.7 (in Canada) [13] |
| Tuberculosis | 2.0 | N/a |
| Chronic Bronchitis | 14.3 | N/a |
| Hepatitis B | 3.0 | 0.7-0.9 (in Canada) [14] |
| Hepatitis C | 16.3 | 0.8 (in Canada) [15] |
| Cirrhosis | 3.7 | N/a |
| Other Liver Disease | 7.0 | 10.0 (in Canada) [16] |
| Cancer | 3.0 | 0.004 (in Manitoba) [17] |
| HIV | 1.7 | N/a |
| AIDS | 0.7 | 0.02 (in Manitoba) [18] |
| Eye Problems (other than needing glasses) | 18.7 | N/a |
| Hearing Problems | 26.0 | N/a |
| Stomach Ulcers | 18.0 | N/a |
| Skin Disease | 12.3 | N/a |
| Migraine Headaches | 39.0 | 7.5 |
| Arthritis | 36.0 | 21.5 |
| Asthma | 24.7 | 16.1 |
| Problems Walking | 32.7 | N/a |
| FAS/FAE | 10.0 | 1.0 (in Canada) [19] |
| Acquired Brain Injury | 12.7 | N/a |

*Figure 2. Chronic or ongoing physical health conditions (Winnipeg Street Health Report, 2011: 20).*

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## ANNEX 1: CONSENT FOR PARTICIPANTS

### CONSENT

Doctors of the World Canada is an independent, international voluntary movement working at home and abroad. Through innovative medical programs and evidenced-based advocacy, we empower excluded people and communities to claim their right to health while fighting for universal access to healthcare.

The Needs Assessment: The needs assessment will seek to answer this question: *Are there gaps in access to healthcare for marginalized populations and if so, can DoW be useful in the overall effort to address them?* Through meetings and discussions with different stakeholders, we would like to understand if DoW can **add value to existing health care and if there is a potential to co-construct a project with local partners.** It is noteworthy to mention that DoW's target population must meet all three attributes i.e. vulnerable, marginalized, and lack access to healthcare services.

The Questionnaire: This comprehensive questionnaire will help investigate gaps in access to healthcare for vulnerable populations. Since there are multiple stakeholders involved in this needs assessment, separate sets of questions were prepared for each group. All of the questions are tied to the same purpose i.e. to identify gaps in access to healthcare services.

Your Participation: You will be asked a series of predetermined questions and your response will be used to support the needs assessment objectives. Your participation is completely voluntary and you have the option to withdraw from this survey at any point in time.

Associated Risks: There are no known risks associated with participating in the survey.

Associated Benefits: There are no direct benefits associated with participating in this survey. However, your contribution will help better understand gaps in healthcare access and may help in improving related issues in the future.

Consent: Do you give consent to participate in this survey? Do you give consent to quote you only on the significant information that you mention during this survey?

## ANNEX 2: NEEDS ASSESSMENT QUESTIONNAIRE FOR BENEFICIARIES

Personal and Demographic Information:

1. Age:

2. Gender

3. City

4. Ethnicity

5. To which group would you identify most to: Homeless, Substance Abuse, Sex Worker, Immigrant, Aboriginal

*Access to Health Care:*

1. By show of hands, if you agree to share this as a group....do you have your own Government issued Health Card?

2. Do you have a safe and easily accessible place to secure your health card/ID?

3. Do you have health coverage from government or any insurance provider?

4. Do you have a family doctor or routine health care provider?

a) If the answer is 'no' then which of the following reasons apply?

i. Never needed a doctor
ii. No providers in my area
iii. No preferred providers in my area
iv. No insurance
v. Don't like primary care physician assigned
vi. Negative past experience
vii. Other:

5. Where do you go when you need to see a health care professional about a non-emergency health problem or illness?

a) Family Doctor

b) Regular physician

c) Emergency Room

d) Urgent Care Clinic

e) Community Health Clinic

f) Pharmacists

g) Aboriginal Health Centers

h) Health Bus

i) Call telephone health-line (e.g. Info-Santé, TeleCare)

j) Other:

6. Have you been to hospital emergency in the last six months?

a) If 'yes' then what was the reason of your visit to hospital emergency?

*Additional Questions[15] for Sex Workers Only:*

8. If you wanted to take a screening test (for STBBIs):

a) Where could you go?

b) Is it easily accessible? Free of charge?

c) Do you need to show an identifier? Or do you need your heath care card?

10. When you need to consult a health care professional, what do you do (i.e. where do you go, what's the schedule, what is needed beforehand, what are obstacles you encounter? etc.)?

11. Have you experienced difficulties in any of the following?

a) Getting a referral

b) Getting an appointment

c) Waited too long between appointment scheduling and actual test

d) Once arrived at the facility, had to wait too long to get the test

e) Service not available at time required

f) Service not available in the area

g) Transportation problems

h) Language problems

i) Did not know where to go (i.e. information problems)

j) Other - Specify

12. What kind of ideal heath care services will help you "continue your life" in safer

conditions?

*Additional Questions for Substance Abuse Only:*

13. If you need sterile equipment (needle, pipe, etc.), what distribution services are easily accessible? (hours of operation, locations, etc.)

14. Do you think harm reduction services are adapted to your needs and living situation? If yes or no, please explain your point of view.

[15] All additional questions were asked depending on the openness of the group and its composition.

15. If you could change these services, what would you do? (hours, location, type of setting, intervention worker, etc.)

*Additional Questions for First Nations and the Inuit Population*

16. Is there a difference between First Nations and non-First Nations populations in terms of access to care? If so, which ones?

17. Do you have access to health care services that is free of charge when you need it (medications and equipment as well)?

a) If not, what are the reasons?

b) What challenges do you face regarding access to health care?

18. Do you have any health care follow-up in the health care system?

a) If yes, what type of follow-up is it (doctor, nurses, specialist, etc.)? Are they easily accessible to see you?

b) If not, what are difficulties you encounter that prevent you from having any follow-up?

c) How often have you been to the emergency department in the last year to receive care?

19. What type of health care needs do you have that are not met in the actual health care system?

*Additional Questions for Immigrants with Precarious Status Only:*

19. What challenges have you faced in accessing healthcare services with a precarious immigration status?

20. Where do you go when you need to see a doctor about a health problem or illness?

21. What are your fears associated with accessing and using healthcare resources?

*Additional Questions regarding Access to Non-nominal testing:*

28. Do you have access to public, non-nominative laboratory testing for STBBIs here in Winnipeg?

a) If yes, with whom (name of the organization)?

b) How are they accessible for you (location and schedule)?

c) Have you ever had to give your name in order to get it?

d) How do you get your results?

29. How could we make this process and collaboration easy, safe and realistic

for you?

a) What are some of the obstacles someone can face while trying to get a test done?

b) If tests were available non-nominally, would that be an incentive to get checked more often?

30. What other interventions would you like to propose to solve these issues? Why do you think it has not been tried yet?

31. What specific elements and considerations would you like to share with Doctors of the World?

## ANNEX 3: NEEDS ASSESSMENT QUESTIONNAIRE FOR LOCAL SERVICE PROVIDERS

*Personal and Demographic Information:*

1. Name of Institution:

2. Name of Person:

3. Role/Position:

4. Category (Health Service Provider, Coalition, Peer Support Program):

5. City:

6. Address of the Organization:

6.1 For outreach service providers, what are the neighbourhoods or streets covered?

*Access to Health Care:*

1. What is the mandate/scope of action of your organization?

2. Who is your organization's target population?

3. Who are the beneficiaries that use your services? (i.e. Homeless, youth, drug users, sex workers, migrants, etc.)

4. Do you feel like you are reaching the most vulnerable of your targeted population?

If not, what could explain this situation?

5. How do you overcome obstacles when bridging the gap between services and your client's needs, and accessing healthcare?

5.1 And how, in this difficult process, are you able to reach out to the most vulnerable (i.e. the ones that are the most disaffiliate?)

6. If you have any intake process, what is your screening process to determine if an individual is eligible to your services?

7. Do you have a high acceptance threshold (i.e. Identifier, intoxication, etc.)

8. How many vulnerable individuals does your institution reach on average in a month/week?

9. Do you have any harm reduction services? Which ones?

10. How do you empower your beneficiaries to use available public healthcare services?

a) And does it work? if not, what are the barriers you encounter to access to care?

11. Do you have partnerships with other agencies, service providers, community organizations or else?

12. Are there any service needs from your targeted population that your

organization cannot fulfill? What are some challenges in addressing them or offering such services? How could Doctors of the World help you fulfill such needs?

14. Do you have any specific comment or advice for Doctors of the World?

*Additional questions for local service providers of health care services (i.e. Street Connections, Siloam Mission, Klinic, Nine Circles, Aboriginal Health and Wellness, Main Street Project, Ma Mawi, RAY, etc.)*

15. Are any public laboratory testing done non-nominative in Winnipeg?

16. What laboratory tests are available non-nominative and free of charge for the population you serve?

17. How are they accessible (location and schedule)?

18. Do you know if the person needs to provide a name or date of birth to be identified and tested?

19. Do you know if a person who tests positive on a STBBI screening can access free and easily accessible treatment?

20. What are the cost - associated if they don't have a health care card?

21. As a local service provider for the marginalized, what are the difficulties or challenges your clientele face in getting tested?

6. How could we make this process and collaboration easy, safe and realistic for you?

7. What other interventions would you like to propose to solve these issues?

a) Are there any reasons we should know why this has not been put in place (political will, lack of funding for groups, etc.)

8. What specific elements and consideration you would like to suggest for Doctors of the World?

## ANNEX 4: NEEDS ASSESSMENT QUESTIONNAIRE FOR DECISION AND POLICY MAKERS

*SECTION A: Personal and Demographic Information:*

1. Name:

2. Role/Position:

4. Number of years in this position:

5. Institution:

6. City/Province:

*SECTION B: Access to Health Care for marginalized population*[16]

1. How would you describe the health and social status of (ask for each: drug users- homeless- sex workers- urban Indigenous population) in Winnipeg?

2. What are the health and social services already in place for these vulnerable subgroups?

2.1 Moreover, are there are any plans/programs/strategies also in place for this matter (i.e. End Homelessness Winnipeg, Here and Now, etc.)?

3. Who are the main stakeholders/main organizations involved in the healthcare and social services for these vulnerable subgroups?

3.1. Who should we meet absolutely and involve in this process? (for example, it could be to help us understand better the situation or if interested, to develop a partnership)

4. Where are the gaps between the demand and supply of services for the vulnerable population? What could be some of the reasons behind these gaps?

4.1 What are the main challenges/obstacles that vulnerable subgroups face when they seek healthcare or social services? Why are there such challenges?

5. What are the strengths of the system in place in your city to reach the population that are most vulnerable?

5.1. What is currently being done in [city/ministry/taskforce] to improve

[16] In this needs assessment, we mean by marginalized population: people experiencing homelessness, people using drugs, sex workers and urban indigenous people.

healthcare access?

6. As far as we know, the Public Health program of the Winnipeg Regional Health Authority has a service area named: healthy sexuality and harm reduction, and are responsible, among other things, for STBBIs testing and other harm reduction strategies (outreach and delivery of sterile material for example). Other than that, local organization, like Sunshine House or RAY, also have harm reduction policies and work towards the same goal. Are there joint strategies between the WRHA and local service providers in this area? (for example, to address the difficulty of access to care, are there strategies in place to overcome the difficulties of access to health and social services?)

Are you satisfied with the current efforts from the government (at the local and provincial level) to collaborate with local service providers in order to overcome healthcare and social services access challenges?

7. What other interventions would you like to propose? Is there any reason why is has not happened yet?

8. What specific elements and consideration you would like to suggest for Doctors of the World?

8.1 What could be the additional value of Doctors of the World to the actual panorama of service providers in your city?

8.2 What are the challenges we may face? How could they be overcome?

*Additional Questions for health instances stakeholders regarding access to non-nominative testing*

1. To your knowledge, are any public laboratory testing done non-nominatively and free of charge in Winnipeg?
2. What laboratory tests are available non-nominatively and free of charge?
3. What settings (hospitals, clinics, walk-ins, etc.) offer those tests for free?
4. Where are they located? What is their schedule?
5. If those tests are available but aren't free of charge, what are the cost-associated if the patient does not have a health care card and/or if tests are done non-nominatively?
6. Is there any referral process for patients that test positive? Could they have access to a free treatment without a health care card?
7. To your knowledge, do at-risk populations of an STBBI have easy access to tests?
   7.1. If so, are there any difficulties the patient's encounter to get tested for STBBIs non-nominatively?
8. How could we make this process and collaboration easy, safe and realistic for the city of Winnipeg?

*Additional questions for decision-makers in a laboratory setting:*

9. What are the non-nominative tests already offered? If so, what is considered to be "non-nominative" (i.e. does the patient still need to give an identifier or a health card? Or is it done with a number)?
10. What's the delay to respect for handling lab samples (blood, urine and swabs) from their collection to the deposit in-site?
11. Does the health care worker need a biohazard safe handling certificate in order to do the testing outside a clinical ward?
12. What are the associated costs if the patient does not have a health care card and/or if tests are done non-nominative?
13. What requisitions should we use if we want to process samples (blood, urine and swabs) through a health centre working with you?
14. If done outside a designated setting, what needs to be done to fit in the "criteria(s)" and be accepted by the lab quality control?
15. At which medical facility (hospital, clinic, laboratory, etc.) do outreach workers deposit their samples? Is this service available 24/7?
16. Our doctors signing off the requisitions are volunteers. How could they access their results? Could they use their number of practice on a MdM requisition and still be recognized in the system (i.e. EMR)?
17. To your knowledge, do you know if the nurse clinician can sign the STBBI screening requisition herself? Or should it be a nurse practitioner or a doctor?
18. Last but not least, how could we make this process and collaboration easy, safe and realistic for the WRHA and respecting the legal infrastructure of the laboratory in province of Manitoba?

## ANNEX 5: LIST OF CONTACTS

| Contact | Organisation | Contact Information |
|---|---|---|
| Public health champions and professionals | | |
| NYD | Street Connections – Winnipeg Regional Health Authority | 496 Rue Hargrave Street<br>Wpg, MB, R3A 0X7<br>(204) 981-0742 |
| Shannon Watson | Health Outreach and Community Services (HOCS) - Winnipeg Regional Health Authority | swatson5@wrha.mb.ca<br>Dr. Mark Etkin<br>Phone: 204-794-3804 |
| Sharon Kuropatwa | Winnipeg Regional Health Authority<br>Housing Support and Service Integration | 204-223-6795 Skuropatwa@wrha.mb.ca |
| Dr. Sheldon Permack | Primary Health Care<br>Winnipeg Regional Health Authority | SPermack1@wrha.mb.ca |
| Maria Cotroneo | Director of Primary Health Care – Integrated Palliative, Primary & Home Health Services<br>Winnipeg Regional Health Authority | 5-496 Rue Hargrave Street<br>Wpg, MB, R3A 0X7<br>Téléc./Fax: (204) 940-8575<br>Cell: (204) 791-2159<br>mcotroneo@wrha.mb.ca |

| | | |
|---|---|---|
| Carolyn Perchuk | RN, MN, IBCLC<br>Program Director<br>Public Health<br>Winnipeg Regional Health Authority | 239-490 Hargrave St.<br>Winnipeg Manitoba R3A 0X7<br>Ph. (204) 918-2124<br>Fax (204) 956-4494<br>eMail cperchuk@wrha.mb.ca |
| Dr. Pierre Plourde | Medical Officer<br>Public Health<br>Winnipeg Regional Health Authority | pplourde@wrha.mb.ca |
| JoAnne Warkentin | Program Director<br>Mental Health<br>Winnipeg Regional Health Authority | jwarkentin@wrha.mb.ca |
| Dr. Jitender Sareen | Medical Director<br>Mental Health<br>Winnipeg Regional Health Authority | JSareen@hsc.mb.ca . |
| Dr. Kaufert | Medical Anthropologist<br>Professor in the Department of Community Health Sciences | College of Medicine, Faculty of Health Sciences at the University of Manitoba |
| Ian Jones | Physician Assistant Program Director - University of Manitoba | mpas@umanitoba.ca |
| Network and Working Group | | |
| Lucille Bruce | CEO<br>End Homelessness Winnipeg<br>(2009-2019) | lbruce@endhomelessnesswinnipeg.ca<br>204-223-0868 |
| Denisa Gavan-Koop | Coordinator<br>Here and Now: Winnipeg Plan to end Youth Homelessness | 650 Burrows Avenue<br>204-470-3541<br>denisa@hereandnowwpg.ca |

| | | |
|---|---|---|
| Melissa Stone | Co-chair<br>Winnipeg Outreach Network: 18 service providers + local agencies | info@mamawi.com |
| Speakers – involved in their community[17]: Lukas Maitland (Social Worker)<br>Margaret Bryans (Nurse) | Manitoba Harm Reduction Network | info@mhrn.ca<br>204- 782-2184<br>705 Broadway, Winnipeg MB<br>PH: 204.783.6184<br>FAX: 204.783.6343 |
| Local service providers | | |
| Brent Retzlaff | Research and Evaluation Coordinator<br>Health Center Saul Sair Siloam Mission | Siloam Mission<br>300 Princess Street<br>Winnipeg, MB R3B 1M3<br>Phone: 204.956.4344 ext. 2111<br>Fax: 204.956.0956<br>Email: brent.retzlaff@siloam.ca<br>Web: www.siloam.ca |
| Nicole Chammartin | Executive Director<br>Klinic Community Health Center | 870 Portage Avenue<br>Winnipeg, MB, R3G 0P1<br>Clinic: (204) 784-4090<br>Director: (204) 784-4075<br>nchammartin@klinic.mb.ca |
| Tammy Christensen | Executive Director<br>Ndinawemaaganag Endaawaad Inc. | tchristensen@ndinawe.ca<br>204.586.2588 |
| Della Herrera | Executive Director<br>Aboriginal Health and Wellness Centre of Winnipeg, Inc. | 215-181 Higgins Avenue<br>Winnipeg, MB, R3B 3G1<br>Telephone: 204-925-3700 |

[17] https://mhrn.ca/speakers/

| | | |
|---|---|---|
| | | Fax: 204-925-1206<br>e-mail: dherrera@ahwc.ca |
| Kelly Holmes | Executive Director<br>Resource Assistance for Youth (RAY) | kelly@rayinc.ca<br>204-783-5617 ext. 200<br>204-799-799-5657 (cell) |
| Rick Lees | Executive Director<br>Main Street Project | Phone: 204-982-8244<br>Email: rlees@mainstreetproject.ca |
| Christy Loudon | Outreach Coordinator<br>Community Homeless Assistance Team (C.H.A.T.) program | 426 Portage Ave R3C 0C9<br>Christy@downtownwinnipegbiz.com 204-806-5095 |
| Diane Redsky | Executive director<br>Ma Mawi Wi Chi Itata Centre | Phone: 204-925-0300<br>Email: info@mamawi.com |
| Mike Payne | Nine Circles Community Health Center | 705 Broadway, 204-940-6000<br>ninecircles@ninecircles.ca<br>mpayne@ninecircles.ca |
| Mark Stewart | Salvation Army – Shelter | 180 Henry Ave., 204-946-9400 |
| Rebecca Blaikie | Manager - Mount Carmel Clinic<br>Sage House (drop-in for women in the sex trade) & Hep C program | 204-589-9421 rblaikie@mountcarmel.ca |
| Margaret Ormond | Sunshine House | 646 Logan Ave., 204-783-8565<br>contact@sunshinehousewpg.org |
| Sean Sousa | Coordinator<br>West End 24°7<br>Spence Neighborhood | 430 Langside St.<br>204-333-9681<br>204 783 5000 ext 113<br>sean@spenceneighbourhood.org |

| | | |
|---|---|---|
| Lorie English | Executive Director<br>West Central Women's Resource Centre | executivedirector@wcwrc.ca<br>204-774-8975 |
| Jesse Gair | Executive director<br>Daniel McIntyre/St. Matthews Community Association | 823 Ellice Ave., 204-774-7005<br>director@dmsmca.ca |
| Mike Tuthill | Executive Director<br>Rainbow Resource Centre | 170 Scott St.,<br>204-474-0212<br>info@rainbowresourcecentre.org |
| Ashley Davidson | Donor Relation Officer<br>Faculty of Medicine<br>University of Manitoba | ashley.davidson@umanitoba.ca |
| Phil Chiapetta | Excutive Director<br>Rossbrooke House | ----- |
| Beneficiaries[18] | | |
| Al Wiebe | Chair and coordinator at Chez Soi and The Lived Experience Circle | albelieve@hotmail.ca<br>phone number 204-451-0779. |
| Decision and policy makers[19] | | |
| Christina Maes Nino | Executive director<br>Manitoba Non Profit Housing Association | execdir@mnpha.com |
| Brian Bowman | Winnipeg Mayor (2014 to now). | Email the Mayor's Office |

[18] Focus group organized with: RAY, LEC, Ma Mawi and Siloam Mission.

19 No contact with most policy makers as the municipal elections were on Oct. 24th. Will connect with them once we know if we are going forward and coming back (Feb. 2019).

| | | |
|---|---|---|
| | | Phone: 204-986-5665<br>Fax: 204-949-0566<br>Mailing Address: Mayor's Office<br>510 Main Street<br>Winnipeg, Manitoba<br>R3B 1B9 |
| Robert Falcon Ouellette | Deputy for Winnipeg - Centre<br>LPC<br>Federal Government | 600, avenue Ellice (bureau principal) Winnipeg (Manitoba) R3G 0A3<br>Téléphone : 204-984-1675<br>Fax : 204-984-1676 |
| Cameron Friesen | Ministry of Health, Seniors and Active Living (of Manitoba) | Minister's Office<br>Phone: 204-945-3731<br>Fax: 204-945-0441<br>Email: minhsal@leg.gov.mb.ca |
| Karen Herd | Ministry of Health, Seniors and Active Living (of Manitoba) | Deputy Minister's Office<br>Phone: 204-945-3771<br>Fax: 204-948-2703<br>Email dmhsal@leg.gov.mb.ca |
| NYD | Chief of police Department in Winnipeg-District 1 | 245 Smith Street<br>(Enter at Smith & Graham)<br>204-986-6246 |

## ANNEX 6: SCHEDULE OF DOW WINNIPEG'S VISIT (NOVEMBER 5TH TO 15TH 2018)

| | Monday, Nov. 5th | Tuesday, Nov. 6th | Wednesday, Nov. 7th | Thursday, Nov. 8th | Friday, Nov. 9th |
|---|---|---|---|---|---|
| 8h à 9h | Travel time | | | | |
| 9h à 10h | | | | | |
| 10h à 11h | | **10h:** Christina Maes<br>Nino A-470 River Av. | | **10h-11h30: EHW**<br>Lucille and Corinne<br>C 216 Pacific Ave | ***Siloam Mission***<br><br>**10-12h:** Focus Group<br><br>**12-13h:** Lunch and Visit<br><br>**13-14h:** Meeting with Brent and Julianne |
| 11h à 12h | | | | | |
| 12h à 13h | | | ***Ma MaWi Chi Itata ***<br><br>**12h-14h:** Focus Group with Melissa<br>800 Selkirk Av.<br><br>**14h30-15h30:** Meeting with Diane Redsky<br>445 King Street | | |
| 13h à 14h | | **13h: WRHA**<br>Sharon Kuropatwa and Shannon Watson<br>80 Sutherland | | | |
| 14h à 15h | | | | **14h: Dr Kaufert**[20]<br>Faculty of Medicine | |
| 15h à 16h | | **15h30-16h30: Spence Neighborhood*** Jamil M.- 615 Elice Av. | | **15h30: Rossbrooke House**<br>Phil Chiapetta<br>658 Ross Avenue | **15h: Main Street Project**<br>Rick Lees<br>2-661 Main |
| 16h à 17h | | | | | |
| 17h à 18h | | | **17h: Sunshine House**<br>Margaret Ormond<br>646 Logan Av. | | |
| 18h à 19h | **18h: HRNA**<br>Bryce Koch, RN<br>2300 McPhilipsSt | | | | **18h: Addiction Foundation of Manitoba**<br>Ginette Poulin MD |
| 19h à 20h | | | | | |

20 Court yard at Starbucks at the Rady Faculty of Medicine at 2:00. Phone is 204-488-2510. 750 Bannatyne Ave, Winnipeg, MB R3E 0W2.

| | Monday, Nov. 12th<br><br>**REMEMBRANCE DAY** | Tuesday, Nov. 13th | Wednesday, Nov. 14th | Thursday, Nov. 15th |
|---|---|---|---|---|
| 8h à 9h | | | **RAY, Inc.**<br><br>**8h:** Meeting with Kelly Holmes and Breda Vosters<br><br>**9-11h:** Focus Group | Travel time |
| 9h à 10h | **9h- 10h30: TELUS**<br>Jackie Wild<br>Bronuts Coffee | **9h-11h: MACH**[21]<br>Klinic, Mount Carmel and Youville<br>At 870 Portage Ave | | |
| 10h à 11h | | | | |
| 11h à 12h | | | | |
| 12h à 13h | | | **12-14h: Lived circle experience** (Al Wiebe)<br>599 Portage av 3rd fl. | |
| 13h à 14h | | **13h-15h: WHRA** Public Health, Primary Health Care and Mental Health[22]: Room 518- 496 Hargrave | | |
| 14h à 15h | | | **14h30-16h30: Aboriginal Health and Wellness Centre**<br>Della Herrera and Camisha Mayes | |
| 15h à 16h | | Quick meeting : Darlene Girard and Shelley Marshall – PH, WRHA | | |
| 16h à 17h | | **16h30: Here and Now**<br>Denisa and Cheryl<br>Thom Bargen Kennedy | | |
| 17h à 18h | | | | |
| 18h à 19h | | | **18h -21h: Bear Clan**<br>James Farvel<br>North End Patrol<br>584 Selkirk ave | |
| 19h à 20h | | | | |
| 20h à 21h | | | | |

[21] Nicole Chammartin, Bobette Shoffner, Toni Tilston- Jones (other groups not present that day: Nine Circles, ABHWC, Women's health, Main Street Project).

[22] Dr. S. Permack; Maria Cotroneo; Carolyn Perchuck ; Joanne Warentin ; (Dr. Plourde and Dr. Jitender Sareen not present).

## ANNEX 7: ENGAGEMENT LETTERS

December 5, 2018

Médecins du Monde (MdM)
Att: Ms. Véronique Houle
Director of National Operations
560 Boulevard Cremazie, East
Montreal, QC
H2P 1E8

RaY
Resource Assistance for Youth

**RE: Engagement Letter for the implementation of a Mobile Clinic in Winnipeg**

Dear Ms. Houle,

Resource Assistance for Youth, Inc. (RaY) is an organization which seeks to serve marginalized and street-entrenched youth between the ages of 0 and 29. Our mission is to provide youth with what they need, on their terms, to better their lives. RaY provides evidence informed, harm reduction based wrap-around services to address the social determinants of health. We offer housing, employment and education opportunities, basic needs, cultural supports, advocacy, intensive case management and street outreach to provide services to the most hard to reach and vulnerable populations in Winnipeg.

I write on behalf of RaY in support of the Doctors of the World (DoW) project's proposal to establish a Mobile clinic in Winnipeg, providing community-based health care services to street-entrenched folks in the inner-city.

We strongly support Doctors of the World's community-based and collaborative approach. Indeed, a mobile clinic with an interdisciplinary team from different organizations on board working with street-entrenched folks would facilitate and increase the quality of services offered. The establishment of a mobile clinic in Winnipeg would be an important addition to existing services, especially for the provision of care in remote areas of the city, and would allow for increased evening and weekend services.

We believe that the inclusion of volunteers on board the Mobile clinic will also encourage citizen involvement, promote change towards social equity and reduce social stigmas about the most vulnerable people in our society. The values of commitment, fairness and humanity, foundations of DoW's work, are also values dear to our organization.

In this letter, we acknowledge the specific roles and responsibilities we will assume as part of this partnership. In the event that the project is implemented, we would be an active member of the Mobile health clinic services and would like to contribute part-time human resources, parking lot space and support to these efforts. As a long standing, highly reputable community agency, we are well connected to many other agencies and sit on several committees including the Here & Now Executive Committee and the Winnipeg Outreach Network (WON).

125 Sherbrook Street, Winnipeg MB R3C 2B5 T: 204 783 5617 F: 204 775 4988

www.RaYinc.ca

We look forward to the eventual arrival of the DoW Mobile health clinic and to a strong, transparent and constructive partnership with your organization.

We will stay available at your convenience to participate in the next steps of this project.

Sincerely,

Kelly Holmes

*Executive Director*
Resource Assistance for Youth, Inc.

125 Sherbrook Street, Winnipeg MB R3C 2B5 T: 204 783 5617 F: 204 775 4988

www.RaYinc.ca

The Lived Experience Circle

Monday, December 3rd 2018

Médecins du Monde (MdM)
Att: Ms. Véronique Houle
Director of National Operations
560 Boulevard Cremazie, East
Montreal, QC
H2P 1E8

**RE: Engagement Letter for the implementation of a Mobile Clinic in Winnipeg**

Dear Ms. Houle,

As an organization which supports, people with lived experience and acts as a lived experience advisory council to the community working in and around the homeless issue in Winnipeg, we feel we would be a great asset to this team. We do outreach in the community to those experiencing homelessness and are relationship builders. As an individual, I Al Wiebe have spoken to every department head at the Winnipeg Regional Health Authority, as well as to every single Emergency and Triage personnel in the city. I have been included in the curriculum of the Brandon school of psychiatric nursing, to change their perspective and treatment of the homeless. I have also spoken directly to several other nursing departments. We advocate for and build relationships with the homeless on an ongoing basis.

I write on behalf of Lived Experience Circle in support of the Doctor's of the World (DoW) project's proposal to establish a mobile health clinic in Winnipeg, providing community-based health care services in Winnipeg.

We strongly support Doctor's of the World's community-based and collaborative approach. Indeed, a mobile health clinic with an interdisciplinary team from different organizations on board working with the homeless and indigent in Winnipeg would facilitate and increase the quality of services offered. The establishment of a mobile health clinic in Winnipeg would be an important addition to existing services, especially for the provision of care in remote areas of the city, and would allow for increased evening and weekend services.

We also believe that the inclusion of volunteers on board of the Mobile clinic will also encourage citizen involvement, promote change towards social equity and reduce social stigmas about the most vulnerable in our society. The values of commitment, fairness and humanity, foundations of DoW's work, are also values dear to our organization.

In this letter, we acknowledge the specific roles and responsibilities we will assume as part of this partnership. In the event that the project is implemented, we would be an active member of the Mobile health clinic services and would like to provide assistance through our Lived Experience in an advisory role, as well as work closely wit the team on the vehicle as relationship builders. We look forward to the eventual arrival of the DoW Mobile health clinic and to a strong, transparent and constructive partnership with your organization.

We will stay available at your convenience to participate in the next steps of this project.

Sincerely,

Al Wiebe
Chair Lived Experience Circle
Apt 603 –360 Cumberland Ave
Winnipeg, Manitoba
R3B 1T4

Manitoba Non-Profit Housing Association
PO Box 70003 RPO Kenaston
Winnipeg, Manitoba R3P 0X6
204-797-6746
execdir@MNPHA.com
www.MNPHA.com

November 28, 2018

Médecins du Monde (MdM)
Att: Ms. Véronique Houle
Director of National Operations
560 Boulevard Cremazie, East
Montreal, QC
H2P 1E8

**RE: Engagement Letter for the implementation of a Mobile Clinic in Winnipeg**

Dear Ms. Houle,

I write on behalf of The Manitoba Non-Profit Housing Association (MNPHA) in support of the Doctor's of the World (DoW) project's proposal to establish a Mobile clinic in Winnipeg, providing community-based health care services in Winnipeg.

MNPHA is an association of almost 150 non-profit housing providers and organizations/private-sector partners, representing over 24,000 units of affordable and social housing. It supports its members to build a thriving, sustainable non-profit housing sector in Manitoba. The three pillars of this support are advocacy with government, funders and other stakeholders; provision of professional development opportunities and services; and building partnerships in the sector through networking and opportunities to collaborate. With housing provider members across Winnipeg who serve people who have experienced, or are at risk of, homelessness, we value and support partnerships that increase the accessibility of health services to marginalized populations. Access to health care increases people's ability to find and maintain housing, which in-turn, promotes long-term health and wellbeing.

We strongly support Doctor's of the World's community-based and collaborative approach. Indeed, a mobile clinic with an interdisciplinary team from different organizations on board working with people experiencing homelessness and housing need would facilitate and increase the quality of services offered. The establishment of a mobile clinic in Winnipeg would be an important addition to existing services, especially for the provision of care in remote areas of the city, and would allow for increased evening and weekend services.

We also believe that the inclusion of volunteers on board of the Mobile clinic will encourage citizen involvement, promote change towards social equity and reduce social stigmas about the most vulnerable in our society. The values of commitment, fairness and humanity, foundations of DoW's work, are also values dear to our organization.

In this letter, we acknowledge the specific roles and responsibilities we will assume as part of this partnership. In the event that the project is implemented, we would be an active member of the Mobile health clinic services and would promote the services and further partnership development with our members and other community partners. We will also provide advice and support on committees as is needed by the implementation team.

We look forward to the eventual arrival of the DoW Mobile health clinic and to a strong, transparent and constructive partnership with your organization.

We will stay available at your convenience to participate in the next steps of this project.

Sincerely,

Christina Maes Nino
Executive Director
Manitoba Non-Profit Housing Association

**Aboriginal Health & Wellness Centre of Winnipeg, Inc.**
181 Higgins Avenue, Suite 215 Winnipeg, Manitoba R3B 3G1
Telephone: (204) 925-3700 Fax (204) 925-3709

December 6, 2018

Médecins du Monde (MdM)
Att: Ms. Véronique Houle
Director of National Operations
560 Boulevard Cremazie, East
Montreal, QC
H2P 1E8

**RE: Engagement Letter for the implementation of a Mobile Clinic in Winnipeg**

Dear Ms. Houle,

Aboriginal Health and Wellness Centre of Winnipeg, Inc.is a non-profit organization that provides social programming and primary health services that supports Urban Aboriginal constituents (clients/consumers/participants) who face multiple barriers with opportunities to improve their self-sufficiency and overall quality of life. The philosophy and vision of AHWC is founded on the concepts within the medicine wheel, which emphasizes provision of resources that enable individuals to attain a balance in their lifestyle necessary for "holistic health" Our program(s) work from a holistic approach that strives to provide a collaboration of programming, supports, services and resources that are innovative and engaging for the constituents and their families.

Aboriginal Health and Wellness Centre of Winnipeg, Inc. supports the Doctor's of the World (DoW) project's proposal to establish a Mobile clinic in Winnipeg, providing community-based health care services in for Urban Aboriginal population of Winnipeg.

We strongly support Doctor's of the World's community-based and collaborative approach. Indeed, a mobile clinic with an interdisciplinary team from different organizations on board working with the Indigenous community to facilitate and increase the quality of services offered. The establishment of a mobile clinic in Winnipeg would be an important addition to existing services, especially for the provision of care in remote areas of the city, and would allow for increased evening and weekend services.

We also believe that the inclusion of volunteers on board of the Mobile clinic will also encourage citizen involvement, promote change towards social equity and reduce social stigmas about the most vulnerable in our society. The values of commitment, fairness and humanity, foundations of DoW's work, are also values dear to our organization.

In the event that the project is implemented, we would be an active member of the Mobile health clinic services and would like to support this initiative.

We look forward to the eventual arrival of the DoW Mobile health clinic and to a strong, transparent and constructive partnership with your organization.

We will stay available at your convenience to participate in the next steps of this project.

Sincerely,

Della Herrera
Executive Director

MACH | MANITOBA ASSOCIATION OF COMMUNITY HEALTH

**Manitoba Association of Community Health**
c/o Nine Circles Community Health Centre
705 Broadway
Winnipeg, Manitoba, R3G 0X2

November 26, 2018

Médecins du Monde (MdM)
Att: Ms. Véronique Houle
Director of National Operations
560 Boulevard Cremazie, East
Montreal, QC
H2P 1E8

**RE: Engagement Letter for the implementation of a Mobile Clinic in Winnipeg**

Dear Ms. Houle,

We are writing on behalf of Manitoba's Association for Community Health in support of the Doctor's of the World (DoW) project's proposal to establish a mobile clinic in Winnipeg, providing community-based health care services in the different neighborhoods we operate in the city.

As an organization and group of ten independent community health centres, we believe in a society in which all individuals, families and communities have access to complete, coordinated and cohesive primary health care. We work to promote the values and objectives of Community Health Centres, to demonstrate the value and innovation that Community Health Centres bring to the primary health care system, to facilitate collaboration and coalition building and advocate on issues of broad common concern and to provide a regional forum for support and information sharing.

We strongly support Doctor's of the World's community-based and collaborative approach. Indeed, a mobile clinic with an interdisciplinary team from different organizations on board working with marginalised and excluded people would facilitate the access to health care services and increase the quality of services offered. The establishment of a mobile clinic in Winnipeg would be an important addition to existing services, especially for the provision of care in remote areas of the city, and would allow for increased evening and weekend services.

We also believe that the inclusion of volunteers on board of the Mobile clinic will also encourage citizen involvement, promote change towards social equity and reduce social

**WWW.MACHMB.CA**
Phone: **204.940.6000**/ Email: **MACH@ninecircles.ca**
Twitter: **@MACHmanitoba**

MACH | MANITOBA ASSOCIATION OF COMMUNITY HEALTH

**Manitoba Association of Community Health**
c/o Nine Circles Community Health Centre
705 Broadway
Winnipeg, Manitoba, R3G 0X2

stigmas about the most vulnerable in our society. The values of commitment, fairness and humanity, foundations of DoW's work, are also values dear to our organization.

In this letter, we acknowledge the specific roles and responsibilities we will assume as part of this partnership. In the event that the project is implemented, we would be an active member of the Mobile health clinic services and would like to be involved in implementation by; supplying staff from our organizations in a rotation of support to the mobile clinic, assisting with supplies, space for DOW staff and meetings, access to our sites and parking lots as required, and facilitate partnerships with the larger communities that we work with and represent.

We look forward to the eventual arrival of the DOW Mobile health clinic and to a strong, transparent and constructive partnership with your organization.

We will stay available at your convenience to participate in the next steps of this project.

Sincerely,

Michael Payne
Executive Director at Nine Circles Community Health Center
Chairperson, MACH

**MACH Member Agencies**
Aboriginal Health and Wellness Centre
Centre de santé
Klinic
Main Street Project
MFL Occupational Health Centre
Mount Carmel Clinic
Nine Circles
NorWest Co-op Community Health
SERC
Women's Health Clinic
Youville Health Centre

**WWW.MACHMB.CA**
Phone: **204.940.6000**/ Email: **MACH@ninecircles.ca**
Twitter: **@MACHmanitoba**

Siloam Mission

December 6, 2018

Médecins du Monde (MdM)
Att: Ms. Véronique Houle
Director of National Operations
560 Boulevard Cremazie, East
Montreal, QC
H2P 1E8

**RE: Engagement Letter for the implementation of a Mobile Clinic in Winnipeg**

Dear Ms. Houle,

I write on behalf of Siloam Mission in support of the Doctor's of the World (DoW) project's proposal to establish a Mobile clinic in Winnipeg, providing community-based health care services in Winnipeg.

Siloam Mission is a social services agency based in downtown Winnipeg. We provide onside supports to meet the basic needs of people experiencing or at risk of homelessness as well as providing opportunities for transition. We know that access to healthcare can be more difficult (and for some services such as dental and eye care, impossible), for this reason we offer the physical health services at no cost to the user through our Saul Sair Health Centre. In the health centre we offer the services of volunteer medical professionals including Physicians, Nurses, Optometrists, Dentists, Podiatrists, Chiropractors, Physiotherapist and Massage Therapists.

We strongly support Doctor's of the World's community-based and collaborative approach. Indeed, a mobile clinic with an interdisciplinary team from different organizations on board working with the homeless population would facilitate and increase the quality of services offered. The establishment of a mobile clinic in Winnipeg would be an important addition to existing services, especially for the provision of care in remote areas of the city, and would allow for increased evening and weekend services.

We also believe that the inclusion of volunteers on board of the Mobile clinic will also encourage citizen involvement, promote change towards social equity and reduce social stigmas about the most vulnerable in our society. The values of commitment, fairness and humanity, foundations of DoW's work, are also values dear to our organization.

In this letter, we acknowledge the specific roles and responsibilities we will assume as part of this partnership. In the event that the project is implemented, we would be an active member of the Mobile health clinic services and would like to offer physical space for the

300 Princess Street Winnipeg, MB R3B 1M3 | ph 204.956.4344 | toll-free 1.866.648.HOPE (4673) | www.siloam.ca | info@siloam.ca

Siloam Mission

storage of supplies as well as the option to park the mobile health clinic in our parking lot. We are also interested in providing advice on the operations of the mobile health clinic through the governance structure created through Doctors of the World. The clinic at Siloam is regularly in the position of not having enough medical professionals to meet patient needs and we see immense value in more street level health care services. However, we would like to note an exclusion to our involvement: due to the overwhelming demand for our services we will not accept referrals from the mobile health clinic.

We look forward to the eventual arrival of the DoW Mobile health clinic and to a strong, transparent and constructive partnership with your organization.

We will stay available at your convenience to participate in the next steps of this project.

Sincerely,

Julianne Aitken
Director of Services
Siloam Mission

300 Princess Street Winnipeg, MB R3B 1M3 | ph 204.956.4344 | toll-free 1.866.648.HOPE (4673) | www.siloam.ca | info@siloam.ca


December 10, 2018

Médecins du Monde (MdM)

Att: Ms. Véronique Houle

Director of National Operations

560 Boulevard Cremazie, East

Montreal, QC

H2P 1E8

**RE: Engagement Letter for the implementation of a Mobile Clinic in Winnipeg**

Dear Ms. Houle,

As an organization which works to create lasting solutions within our community that prevent and end homelessness, End Homelessness Winnipeg provides leadership for the implementation of Winnipeg's 10-Year Plan to End Homelessness. we work from a collaborative, collective impact approach to address gaps that lead to and exacerbate homelessness, while also working to mobilize solutions to end homelessness versus managing homelessness.

I write on behalf of End Homelessness Winnipeg in support of the Doctor's of the World (DoW) project's proposal to establish a Mobile clinic in Winnipeg, providing community-based health care services in Winnipeg.

We strongly support Doctor's of the World's community-based and collaborative approach. Indeed, a mobile clinic with an interdisciplinary team from different organizations on board working with individuals who are experiencing homelessness would facilitate and increase the quality of services offered. The establishment of a mobile clinic in Winnipeg would be an important addition to existing services, especially for the provision of care in remote areas of the city and would allow for increased evening and weekend services.

We also believe that the inclusion of volunteers on board of the Mobile clinic will also encourage citizen involvement, promote change towards social equity and reduce social stigmas about the most vulnerable in our society. The values of commitment, fairness and humanity, foundations of DoW's work, are also values dear to our organization.

Unit C – 216 Pacific Avenue Winnipeg, Manitoba R3B 0M4
T: 204-942-8677/204-942-8960 F: 204-942-8451

END HOMELESSNESS WINNIPEG

In this letter, we acknowledge the specific roles and responsibilities we will assume as part of this partnership. If the project is implemented, we would be an active member of the Mobile health clinic services and would provide support by participating in a steering committee and potential working groups including evaluation of the project, and by creating connections between organizations in the Winnipeg homeless-serving sector and DoW.

We look forward to the eventual arrival of the DoW Mobile health clinic and to a strong, transparent and constructive partnership with your organization.

We will stay available at your convenience to participate in the next steps of this project.

Sincerely,

Lucille Bruce

CEO, End Homelessness Winnipeg

Unit C – 216 Pacific Avenue Winnipeg, Manitoba R3B 0M4
T: 204-942-8677/204-942-8960 F: 204-942-8451

Spence Neighbourhood Association

January 16th, 2019

Letter of Engagement Doctors of the World in Winnipeg

To Whom it May Concern,

We are pleased to write this letter of engagement in support of Doctors of the World coming to Winnipeg to set up mobile health services for those in our City who need it the most. The Spence Neighbourhood Association works with the people of Spence to revitalize and renew their community in the areas of Holistic Housing, Community Connecting, Community Economic Development, Environment and Open Spaces and Youth and Families. We also take the lead on developing community led 5 year plans. In this work we spend a lot of time consulting, talking to residents, and gather the needs, wants and direction the neighbourhood looks to head in. This initiative is something we have been hoping for, for some time.

Our community, while it is organized and motivated, we don't have the resources needed to support those who need them most. We work on helping folks get housed who are homeless, run a overnight safe space for youth and while we can do a lot to support and resource the community, we cannot provide the access to health supports that are needed.

Our community members have a number of barriers they face, and interacting with the traditional medical or health system can often trigger past experience or directly traumatizes them. So the creation of a community led health service that was mobile and could provide in roads into the health system and support those most vulnerable is a major need.

The Spence Neighbourhood Association is excited to partner and engage in this exciting project, we would also offer outreach staff to support in the Van's operation and to ensure there are people from the community working to make this amazing initiative work for Winnipeg.

Sincerely,

Jamil Mahmood
Executive Director
Spence Neighbourhood Association
615 Ellice Ave, Winnipeg, Mb R3G 0A4
Ph 204-783-5000 ext 103 Fax 775-1802 Cell 204-803-7808
e-mail: jamil@spenceneighbourhood.org
www.spenceneighbourhood.org

main street project

2nd Floor, 661 Main Street
Winnipeg, MB, R3B 1E2
**Phone**: (204) 982-8229
**Fax**: (204) 943-9474
**mainstreetproject.ca**

December 28, 2018

Médecins du Monde (MdM)
Att: Ms. Véronique Houle
Director of National Operations
560 Boulevard Cremazie, East
Montreal, QC
H2P 1E8

**RE: Engagement Letter for the implementation of a Mobile Clinic in Winnipeg**

Dear Ms. Houle,

I write on behalf of Main Street Project in support of the Doctor's of the World (DoW) project's proposal to establish a Mobile clinic in Winnipeg, providing community-based health care services in Winnipeg, Manitoba.

Main Street Project (MSP) is a non-profit community health centre with a mandate to address social determinants of health which give rise to issues of addiction, mental and chronic health conditions and homelessness. MSP uses housing-first and harm reduction principles in the provision of a safe, respectful and accessible place for individuals who are homeless or at risk of homelessness in the community.

We strongly support Doctor's of the World's community-based and collaborative approach. Indeed, a mobile clinic with an interdisciplinary team from different organizations on board working with those experiencing homelessness, addiction and mental and physical health issues would facilitate and increase the quality of services offered. The establishment of a mobile clinic in Winnipeg would be an important addition to existing services, especially for the provision of care in remote areas of the city, and would allow for increased evening and weekend services.

We also believe that the inclusion of volunteers on board of the Mobile clinic will also encourage citizen involvement, promote change towards social equity and reduce social stigmas about the most vulnerable in our society. The values of commitment, fairness and humanity, foundations of DoW's work, are also values dear to our organization.

In this letter, we acknowledge the specific roles and responsibilities we will assume as part of this partnership. In the event that the project is implemented, we would be an active member of the Mobile health clinic services and would like to provide human resources, material, physical space, parking lot, support, and partnership, etc.

MSP will happily work with all parties who may have interest in the project including but not limited to the Winnipeg Regional Health Authority and the Manitoba Association of Community Health Centres.

*Doctor's of the World (DoW)*

We look forward to the eventual arrival of the DoW Mobile health clinic and to a strong, transparent and constructive partnership with your organization.

We will stay available at your convenience to participate in the next steps of this project.

Sincerely,

Rick Lees
Executive Director
Main Street Project