Sudbury & District Board of Health

Thursday, January 19, 2017

SDHU Boardroom

1300 Paris Street

Sudbury & District Board of Health Meeting - January 19, 2017

Sudbury & District Board of Health Meeting #01-17

1.0 CALL TO ORDER

2.0 ROLL CALL

3.0 REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST

4.0 ELECTION OF OFFICERS

5.0 DELEGATION / PRESENTATION

i) No Time to Wait: Healthy Kids in the Sudbury and Manitoulin Districts Report Card Progress Update
- Paula Ross, Public Health Nutritionist, Nutrition Physical Activity Action Team, Health Promotion Division

6.0 CONSENT AGENDA

i) Minutes of Previous Meeting

ii) Business Arising From Minutes

ii) Report of Standing Committees

iv) Report of the Medical Officer of Health / Chief Executive Officer

v) Correspondence

a. Association of Municipalities of Ontario (AMO) and Alcohol Policy

b. 2016 Ontario Public Health Standards Modernization Review

c. Bill 5 – Greater Access to Hepatitis C Treatment Act, 2016

d. Oral Health Programs for Low-Income Adults and Seniors

e. Nutritious Food Basket

f. Student Nutrition Programs

Sudbury & District

Health Unit

Service de santé publique

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December 21, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Minister's Office
Hepburn Block, 10th floor
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Hoskins:

Re: Sudbury & District Board of Health Public Re-Appointment, Janet Bradley

The purpose of the letter is to convey the Sudbury & District Board of Health's full support for Ms. Janet Bradley's request for a reappointment to the Board of Health.

Ms. Janet Bradley has served a six-year term as public appointee to the Sudbury & District Board of Health which will be ending on February 21, 2017, and she has confirmed her interest in seeking reappointment.

The Public Appointment Secretariat (PAS) Reappointment Information Form (RIF) is attached.

The Board recognizes the valuable contributions that Ms. Bradley makes as a public appointee to the Sudbury & District Board of Health over the course of her six-year term. The Board of Health is hopeful that Ms. Bradley will have the opportunity to continue in this important role.

Sincerely,

René Lapierre
Chair
Sudbury & District Board of Health

Encl.

c.: Tom Boyd, Manager, Agency Liaison and Public Appointments, Ministry of Health and Long-Term Care
Jelena Rakovac, Special Assistant, Operations, Minister's Office
Dr. Penny Sutcliffe, Medical Officer of Health, Sudbury & District Health Unit

The Chair will ask Board members whether there are any conflicts of interest.

This is an opportunity for Board members to announce a conflict which would then eliminate the individual(s) from any discussion on that topic.

Sudbury & District Health Unit
Service de santé publique

AGENDA – FIRST MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
BOARDROOM, SECOND FLOOR, SUDBURY & DISTRICT HEALTH UNIT
THURSDAY, JANUARY 19, 2017 – 1:30 P.M.

1. CALL TO ORDER

i) Letter from the Sudbury & District Board of Health Chair to the Minister of Health and Long-Term Care dated December 21, 2016, Recommending Reappointment for Sudbury & District Board of Health member, J. Bradley

2. ROLL CALL

3. REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST

4. ELECTION OF OFFICERS

APPOINTMENT OF CHAIR OF THE BOARD

(2016 Chair: René Lapierre – 2 terms)

THAT the Sudbury & District Board of Health appoints _____ as Chair for the year 2017.

APPOINTMENT OF VICE-CHAIR OF THE BOARD

(2016 Vice-Chair: Claude Belcourt – 2 terms; Jeffery Huska (effective June 2016)

THAT the Sudbury & District Board of Health appoints _____ as Vice-Chair for the year 2017.

APPOINTMENT TO BOARD EXECUTIVE COMMITTEE

(2016 Board Executive: Janet Bradley – 4 terms; Jeffery Huska – 2 terms; Stewart Meikleham – 2 terms; René Lapierre – 2 terms; Claude Belcourt – 3 terms / Mark Signoretti – 1 term (effective June 2016)

THAT the Board of Health appoints the following individuals to the Board Executive Committee for the year 2017:

1. **_____, Board Member at Large**
2. **_____, Board Member at Large**
3. **_____, Board Member at Large**
4. **_____, Chair**
5. **_____, Vice-chair**
6. **Medical Officer of Health/Chief Executive Officer**
7. **Director, Corporate Services**
8. **Secretary Board of Health (ex-officio)**

APPOINTMENT TO FINANCE STANDING COMMITTEE OF THE BOARD

(2016 Finance Committee: Carolyn Thain – 2 terms; René Lapierre – 2 terms; Stewart Meikleham – 1 term; Claude Belcourt – 1 term

THAT the Board of Health appoints the following individuals to the Finance Standing Committee of the Board of Health for the year 2017:

1. **_____, Board Member at Large**
2. **_____, Board Member at Large**
3. **_____, Board Member at Large**
4. **Medical Officer of Health/Chief Executive Officer**
5. **Director, Corporate Services**
6. **Manager, Accounting Services**
7. **Board Secretary**

5. DELEGATION / PRESENTATION

i) No Time to Wait: Healthy Kids in the Sudbury and Manitoulin Districts Report Card Progress Update

- Paula Ross, Public Health Nutritionist, Nutrition Physical Activity Action Team, Health Promotion Division

6. CONSENT AGENDA

i) Minutes of Previous Meeting

a. Eighth Meeting – November 24, 2016

ii) Business Arising From Minutes

None

iii) Report of Standing Committees

iv) Report of the Medical Officer of Health / Chief Executive Officer

a. MOH/CEO Report, January 2017

v) Correspondence

a. Association of Municipalities of Ontario (AMO) and Alcohol Policy

- Correspondence from the Northwestern Health Unit to alPHa dated November 1, 2016

b. 2016 Ontario Public Health Standards Modernization Review

- Letter from the Board of Health for Grey Bruce Health Unit to the Ontario Public Health Standards Modernization Committee and Executive Steering Committee dated November 25, 2016

c. Bill 5 – Greater Access to Hepatitis C Treatment Act, 2016

- Letter from the Board of Health for Peterborough Public Health to the Minister of Health and Long-Term Care dated November 28, 2016

d. Oral Health Programs for Low-Income Adults and Seniors

- Letter from the County of Lambton Board of Health to the Minister of Health and Long-Term Care dated December 8, 2016

e. Nutritious Food Basket

- Email from the Premier of Ontario to Dr. Sutcliffe dated November 22, 2016
- Letter from the North Bay Parry Sound District Board of Health to the Ministers of Health and Long-Term Care, Community and Social Services as well as Housing, Poverty Reduction Strategy dated November 25, 2016
- Letter from the Durham Region Health Unit to the Premier of Ontario dated December 14, 2016
- Letter from the Township of Nairn and Hyman to the Premier of Ontario dated December 16, 2016, supporting the Sudbury & District Board of Health motion 50-16

f. Student Nutrition Programs

- Letter from the Durham Region Health Unit to the Prime Minister dated December 14, 2016

g. Marketing of Food and Beverages to Children, Support for Bill S-228 and Bill C-313

- Letter from the Durham Region Health Unit to the Prime Minister dated December 14, 2016
- Letter from Huron County Board of Health to the Federal Health Minister dated December 8, 2016
- Letter from Middlesex-London Board of Health to the Federal Minister of Health dated December 13, 2016

h. alPHa Update for 2017

- Email and 2017 alPHa Update from the North East regional representative on the Board of Health Executive/alPHa Board of Directors

i. Manitoulin Drug Strategy

- Letter from the Municipality of Central Manitoulin to the Sudbury & District Health Unit dated November 29, 2016

j. Health Hazards of Gambling

- Letter from the Board of Health for the North Bay Parry Sound District Board of Health to the Minister of Health and Long-Term Care dated December 5, 2016

k. Immunization Program Funding

- Letter from the Huron County Board of Health to the Minister of Health and Long-Term Care dated January 5, 2017

vi) Items of Information

a.	alPHa Information Break	December 8, 2016 January 10, 2017
b.	2016 Financial Controls Checklist	
c.	Report: *Board Learning and Information Session, Strengthening Indigenous Relationships*	November 9, 2016

APPROVAL OF CONSENT AGENDA

MOTION: THAT the Board of Health approves the consent agenda as distributed.

7. NEW BUSINESS

i) Sudbury & District Board of Health Meeting Attendance

- Summary – 2016

ii) Board Survey Results from Monthly Board Meeting Evaluations

- 2016 Evaluation Summary Results

iii) 2016 Board Annual Self-Survey Results

- 2016 Board Self-Evaluation Summary Results

iv) Electronic Cigarettes Act

INCLUSION OF ELECTRONIC CIGARETTES ACT VENDOR CONVICTIONS WITHIN EXPANSION OF PROACTIVE DISCLOSURE SYSTEM

MOTION: WHEREAS the Minister of Health and Long-Term Care has requested that all boards of health make transparency a priority objective in business plans and develop reporting practices to make information readily available to the public; and

WHEREAS the Sudbury & District Board of Health is committed to public transparency; and

WHEREAS the Sudbury & District Board of Health endorsed motion 36-15 (Expansion of Proactive Disclosure System) at its September 17, 2015, meeting; and

WHEREAS, inclusion of enforcement-related activities pertaining to the Electronic Cigarettes Act (2015), would further improve transparency by enhancing public access to inspection findings;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the inclusion of enforcement-related activities pertaining to electronic cigarette vendors within the expanded proactive disclosure system; and

THAT the following be the Board policy on the release of enforcement and inspection information pertaining to the Electronic Cigarettes Act:

1. **Charges: Statistical information on charges (i.e. no identifying information) is released to the Sudbury & District Board of Health at its regularly scheduled meetings.**
2. **Convictions: Convictions related to electronic cigarette vendor infractions are posted on the Sudbury & District Health Unit website as soon as possible following the conviction and for a period of 12 months from the date on which the conviction was rendered.**
5. **Requests for information not posted on website: Requests for information not posted on the website are considered on an individual basis in accordance with Health Unit policy and the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and the Personal Health Information Protection Act (PHIPA); and**

FURTHER THAT Board of Health Disclosure Information Sheet F-IV-10 be correspondingly updated.

v) Anti-Contraband Tobacco Campaign

- Slide Deck by the Physicians for Smoke-Free Canada
- Algoma Board of Health Anti-Contraband Tobacco Campaign Resolution 2016-109 dated November 23, 2016

ANTI-CONTRABAND TOBACCO CAMPAIGN

MOTION: WHEREAS the Sudbury & District Board of Health has reviewed information indicating that recent anti-tobacco contraband campaigns from the National Coalition Against Contraband Tobacco and the Ontario Convenience Store Association were supported by the tobacco industry with the intention of blocking

tobacco excise tax increases and regulation of tobacco products generally; and

WHEREAS Ontario municipalities including the City of Greater Sudbury have endorsed such campaigns without being informed of tobacco industry support; and

WHEREAS municipalities within the SDHU service area are longstanding advocates for measures to protect the public from exposure to environmental tobacco smoke;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health advise area municipalities of this information and urge municipalities to not endorse tobacco industry supported campaigns; and

THAT the Sudbury & District Board of Health request municipalities to call on the Ontario Ministry of Finance to raise tobacco excise taxes and enhance enforcement activities designed to reduce the presence of contraband tobacco in Ontario communities; and

FURTHERMORE THAT this resolution be shared with municipal councils, local MPPs, the Ontario Ministry of Finance, the Association of Local Public Health Agencies, Ontario public health units, and the Ontario Campaign for Action on Tobacco.

vi) Cannabis Regulation and Control

- Letter from the Simcoe Muskoka District Health Unit to the Minister of Health and Long-Term Care dated December 15, 2016

CANNABIS REGULATION AND CONTROL

MOTION: **WHEREAS the Final Report of the Task Force on Cannabis Legalization and Regulation, *A Framework for the Legalization and Regulation of Cannabis*, recommended to the federal government that current restrictions on public smoking of tobacco products be extended to the smoking of cannabis products and to cannabis vaping products; and**

WHEREAS the recently amended Smoke Free Ontario Act permits certain products and substances to be prohibited under the regulatory framework of the Act; and

WHEREAS Sudbury & District Board of Health motion #54-15 called for a public health approach to the forthcoming cannabis legalization framework, including strict health-focused regulations to reduce the health and societal harms associated with cannabis use; and

WHEREAS a public health approach focuses on high-risk users and includes strategies such as controlled availability, age limits, low risk use guidelines, pricing, advertising restrictions, and general and targeted prevention initiatives and allows for more control over the risk factors associated with cannabis-related health and societal harms; and

WHEREAS by prohibiting the smoking of all cannabis in all places where the smoking of tobacco is prohibited, children, youth and adults in our communities will result in reduced public and second-hand exposure to cannabis;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health call for the inclusion of marijuana (medicinal and recreational) as a prescribed product or substance under the Smoke Free Ontario Act; and

FURTHER THAT this resolution be shared with the Honourable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-Term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

vii) Sugar Sweetened Beverages and Menu Labelling

- Position of Dietitians of Canada – Taxation and Sugar-Sweetened Beverages, February 2016

SUPPORT FOR THE POSITION OF DIETITIANS OF CANADA ON TAXATION AND SUGAR-SWEETENED BEVERAGES AS PART OF A COMPREHENSIVE HEALTHY EATING APPROACH

MOTION: WHEREAS obesity results from a complex interaction of many factors including genetic, social and environmental; and

WHEREAS 32% of Canadian children and youth have excess weight or obesity; and

WHEREAS intake of sugar-sweetened beverages is one of the dietary factors leading to increased rates of overweight and obesity; and

WHEREAS children with high intakes of sugar sweetened beverages are 55% more likely to have obesity or excess weight in comparison to those with low intakes; and

WHEREAS available evidence suggests that policy efforts which decrease the consumption of sugar sweetened beverages have the potential to positively impact the health of Canadians; and

WHEREAS the Dietitians of Canada position statement on Taxation and Sugar-Sweetened Beverages identifies sugar-sweetened beverage taxation as a public health intervention with potential positive health impact, especially when combined with further policy efforts; and

WHEREAS Dietitians of Canada recommends that an excise tax of at least 10-20% be applied to sugar sweetened beverages sold in Canada; and

WHEREAS a number of influential Canadian national organizations support a tax on sugar sweetened beverages including the Association of Local Public Health Agencies, the Childhood Obesity Foundation, Heart and Stroke Foundation of Canada, Chronic Disease Prevention Alliance of Canada, and the Canadian Diabetes Association;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the Position of Dietitians of Canada on Taxation and Sugar-Sweetened Beverages, and urge the federal government to implement an excise tax on sugar-sweetened beverages; and

FURTHER THAT copies of this motion be shared with key provincial and national stakeholders.

8. ADDENDUM

ADDENDUM
MOTION: THAT this Board of Health deals with the items on the Addendum.

9. IN CAMERA

IN CAMERA
MOTION: That this Board of Health goes in camera. Time: _____ p.m.

- Labour Relations or Employee Negotiations

10. RISE AND REPORT

RISE AND REPORT
MOTION: That this Board of Health rises and reports. Time: _____ p.m.

11. ANNOUNCEMENTS / ENQUIRIES

12. ADJOURNMENT

ADJOURNMENT
MOTION: THAT we do now adjourn. Time: _____ p.m.

APPOINTMENT OF CHAIR OF THE BOARD

(2016 Chair: René Lapierre – 2 terms)

THAT the Sudbury & District Board of Health appoints _____ as Chair for the year 2017.

APPOINTMENT OF VICE-CHAIR OF THE BOARD

(2016 Vice-Chair: Claude Belcourt – 2 terms; Jeffery Huska (effective June 2016)

THAT the Sudbury & District Board of Health appoints _____ as Vice-Chair for the year 2017.

APPOINTMENT TO EXECUTIVE COMMITTEE

(2016 Board Executive: Janet Bradley- 4 terms; Jeffery Huska – 2 terms; Stewart Meikleham – 2 terms; René Lapierre – 2 terms; Claude Belcourt – 3 terms / Mark Signoretti – 1 term (effective June 2016)

THAT the Board of Health appoints the following individuals to the Board Executive Committee for the year 2017:

1. **_____, Board Member at Large**
2. **_____, Board Member at Large**
3. **_____, Board Member at Large**
4. **_____, Chair**
5. **_____, Vice-chair**
6. **Medical Officer of Health/Chief Executive Officer**
7. **Director, Corporate Services**
8. **Secretary Board of Health (ex-officio)**

APPOINTMENT TO FINANCE STANDING COMMITTEE OF THE BOARD OF HEALTH

(2016 Finance Committee: Carolyn Thain – 2 terms; René Lapierre – 2 terms; Stewart Meikleham – 1 term; Claude Belcourt – 1 term

THAT the Board of Health appoint the following individuals to the Board Finance Standing Committee for the year 2017:

1. **_____, Board member at large**
2. **_____, Board member at large**
3. **_____, Board member at large**
4. **Medical Officer of Health/Chief Executive Officer**
5. **Director, Corporate Services**
6. **Manager, Accounting Services**
7. **Board Secretary**

Sudbury & District Health Unit
Service de santé publique

MINUTES – EIGHT MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
SUDBURY & DISTRICT HEALTH UNIT, BOARDROOM
THURSDAY, NOVEMBER 24, 2016, AT 1:30 P.M.

BOARD MEMBERS PRESENT

Maigan Bailey	Janet Bradley	Jeffery Huska
René Lapierre	Stewart Meikleham	Paul Myre
Ken Noland	Rita Pilon	Carolyn Thain

BOARD MEMBERS REGRETS

Robert Kirwan	Mark Signoretti

BOARD MEMBERS ABSENT

Richard Lemieux

STAFF MEMBERS PRESENT

Megan Dumais	Stacey Laforest	Rachel Quesnel
France Quirion	Dr. Ariella Zbar	Dr. P. Sutcliffe

R. LAPIERRE PRESIDING

1.0 CALL TO ORDER

The meeting was called to order at 1:30 p.m.

The Board Chair recognized that the Board is gathered together today on the territorial lands of the Robinson-Huron Treaty, traditionally shared by the people of the Atikameksheng Anishnawbek and Wahnapitae First Nations.

2.0 ROLL CALL

3.0 REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST

There were no declarations of conflict of interest.

4.0 DELEGATION / PRESENTATION

i) Tobacco: Respecting Tradition and Protecting Public Health

- K.C. Rautiainen, Public Health Nurse, School Health Promotion, Health Promotion Division
- Page Chartrand, Student, This is My Tobacco Youth Group
- Chuck Beauparlant, Tobacco Enforcement Officer, Environmental Health Division

Dr. Sutcliffe introduced the three presenters who were invited to outline inspection and enforcement activities, which reduce the negative effects of tobacco and describe an Indigenous youth engagement project promoting the traditional use of tobacco.

C. Beauparlant indicated that the SDHU has a comprehensive tobacco control strategy to comply with the Ontario Public Health Standards (OPHS). The goal of the Smoke-Free Ontario (SFO) Strategy is to eliminate tobacco-related illness and death by preventing children and youth from starting to smoke, by supporting those who choose to quit smoking, and by protecting everyone from involuntary second-hand smoke. Two examples of SDHU's work under the SFO strategy were provided as well as an overview of the Smoke-Free Ontario Act's enforcement activities, which are part of the protection component of the overall strategy.

K.C. Rautiainen and P. Chartrand described a community-led youth engagement project aimed at increasing knowledge about the traditional use of tobacco and that may influence youth make better choices around commercial tobacco. A collaboration between the SDHU and the Shkagamik-Kwe Health Centre, *This is my Tobacco,* aims to educate youth and community about the traditional uses of sacred tobacco.

While the two concepts, tobacco control and traditional use of tobacco, appear to be contradictory to one another, an effective tobacco control strategy includes traditional use of tobacco by Indigenous people. SFOA enforcement and promotion of traditional tobacco use both reduce the likelihood that youth will begin to smoke commercial tobacco. While fulfilling our health protection duties under the SFOA, the SDHU respects traditional use of tobacco. The SDHU will continue its collaborative work to effectively balance these two components within a broader tobacco control framework and will navigate challenges through open collaboration and communication.

Questions were entertained and clarification was provided regarding enforcement of smoking on school properties and who the public should contact for enforcement calls. Presenters were thanked and the Board was grateful for this information noting the importance of respecting various cultures.

5.0 CONSENT AGENDA

There were no consent agenda items identified for discussion.

i) Minutes of Previous Meeting

a. Seventh Meeting – October 20, 2016

ii) Business Arising From Minutes

None

iii) Standing Committees

a. Board of Health Finance Standing Committee Meeting Notes, November 2, 2016

iv) Report of the Medical Officer of Health / Chief Executive Officer

a. MOH/CEO Report, November 2016

v) Correspondence

a. Cannabis

- Letter from Algoma Public Health to Prime Minister dated November 4, 2016

b. Food Security

- Letter from the Chatham-Kent Board of Health to the Premier of Ontario and Minister Responsible for the Poverty Reduction Strategy dated September 27, 2016

c. Nutritious Food Basket

- Letter from the Peterborough Board of Health to the Minister Responsible for the Poverty Reduction Strategy, Minister of Health and Long-Term Care and Minister of Community and Social Services dated November 4, 2016

d. HPV/Immunization Program Funding

- Letter from the Grey Bruce Board of Health to the Minister of Health and Long-Term Care dated November 8, 2016

e. Basic Income Pilot

- MOHLTC News Release dated November 3, 2016
- Letter from the Sudbury & District Board of Health Chair to the Minister of Community and Social Services dated November 17, 2016

f. 2016 Program-Based Budget

- Letter from Michael Mantha, MPP, to the Sudbury & District Board of Health Chair dated October 12, 2016

vi) Items of Information

a.	alPHa Information Break	October 13, 2016
b.	Public Health Agency of Canada News Release *Statement from the Chief Public Health Officer of Canada*	October 21, 2016
c.	MOHLTC Population and Public Health Division Organizational Chart	October 24, 2016
d.	Algoma Public Health News Release *Board of Health Announced new Medical officer of Health for Algoma*	October 26, 2016

53-16 APPROVAL OF CONSENT AGENDA

Moved by Thain – Noland: THAT the Board of Health approves the consent agenda as distributed.

CARRIED

6.0 NEW BUSINESS

i) Engagement with Indigenous Peoples

- Briefing note from the Medical Officer of Health and Chief Executive Officer dated November 17, 2016

Dr. Sutcliffe thanked the Board members for attending the November 9, 2016, educational session on Indigenous engagement and communities in the health unit catchment area. Those who could not attend were asked to review the educational session materials of the

day if they have not already done so. The agenda for that session is attached to today's agenda package for ease of reference.

It is timely that the Board strengthen its governance commitment to ensuring all people in the Sudbury & District Health Unit service area, including Indigenous people and communities, have equal opportunities health.

The motion presented today for the Board's consideration builds next steps to action motion 20-12.

At this point of the meeting, the Board Chair invited Board member, M. Bailey, to share her key take-aways from the November 17 full-day alPHa Symposium session she attended in Toronto, *Cultural Competencies to Support Indigenous Truth and Reconciliation*". The day included an update from the Deputy Minister, Deborah Richardson on the province's investments over the next three years and a panel discussion about priorities, principles and future directions. Dr. Sutcliffe was one of these panellists who spoke about the SDHU's work on Indigenous engagement in support of public health. N. Logan from the National Centre for Truth and Reconciliation also spoke prior to the cultural competency training offered by the Ontario Federation of Indigenous Friendship Centres.

Questions and comments were entertained and concerns were voiced regarding potential additional costs. Dr. Sutcliffe noted that the impacts of the modernization of the OPHS are not yet known, however, expected to include requirements of boards of health to engage with Indigenous communities. It is expected that the SDHU's proposed strategy will be implemented similarly to the health equity model with an initial investment to ensure we are on an effective path in building and maintaining relationships, determining what can be done differently, and building in-house capacity and sustainability.

54-16 ENGAGEMENT WITH INDIGENOUS PEOPLES

Moved by Noland – Thain: WHEREAS the Board of Health is committed to ensuring all people in the Sudbury & District Health Unit service area, including Indigenous people and communities, have equal opportunities for health; and

WHEREAS the Board of Health identified the need to better define relationships with Indigenous communities as part of its risk management strategy;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health reaffirm its commitment to motion #20-12; and

FURTHER THAT the Board direct the Medical Officer of Health to develop a comprehensive strategy for the organization's engagement with Indigenous people and communities in its service area for the purpose of collaboratively strengthening public health programs and services for all; and

FURTHER THAT this strategy include, among others, strategic, governance, risk management and operational components; and

THAT the Board of Health direct the Medical Officer of Health to regularly report on the progress of this strategy.

CARRIED

ii) Staff Appreciation Day

- Briefing note from the Medical Officer of Health and Chief Executive Officer dated November 17, 2016

The proposed Staff Appreciation Day, previously called the Board Float, was established as a symbol of appreciation from the Board of Health to all Health Unit staff in the form of a gift of one day with pay and is subject to annual approval by the Board of Health.

The SDHU collective agreements with ONA and CUPE reference the Staff Appreciation Day noting that scheduling will be subject to a "mutually agreeable time" and recognize that the Staff Appreciation Day is contingent upon Board of Health approval.

Dr. Sutcliffe shared that staff do appreciate and numerous thank you notes have been received in the past for the Board from staff.

Questions and comments were entertained and it was clarified that employees do not take the day within the designated timeframe, the day off is lost and cannot be carried forward.

55-16 STAFF APPRECIATION DAY

Moved by Myre – Thain: THAT this Board of Health approve a Staff Appreciation Day for the staff of the Sudbury & District Health Unit during the upcoming holiday season. The Staff Appreciation Day may be taken between the dates of December 1, 2016, to February 28, 2017. Essential services will be available and provided at all times during the holiday period except for statutory holidays when on-call staff will be available.

CARRIED

iii) 2017 Cost-Shared Budget

- Briefing Note and Appendices from the Medical Officer of Health and Chief Executive Officer dated November 17, 2016

C. Thain, Chair of the Finance Standing Committee of the Board, noted that the Finance Committee reviewed the proposed 2017 cost-shared budget at its November 2, 2016, meeting. The Finance Committee also reviewed the 2017 budget principles, reviewed all relevant documents that are tabled with today's proposed 2017 budget, and reviewed relevant developments in the public health and fiscal environments.

The Finance Committee also reviewed the 2017 budget assumptions and staff reviewed the variances year over year and how these items are to be funded.

We also discussed the impact of the 2016 cost reduction initiatives and reviewed their impact on this year's budget. The organization has benefited from the very difficult decisions last fall for implementation in the 2016 budget as the incremental savings are rolled in for the complete year in the 2017 cost-shared budget. The management team remains vigilant in

identifying opportunities for future savings and focused on innovations that will protect programs and services to the fullest extent possible.

The Finance Committee also supported a modest increase to Part VIII fees which are based on a cost recovery model.

The Finance Committee is recommending the 2017 cost-shared budget to the full Board for approval. There has been great benefit for the 2017 budget from the work that was done last year for the 2016 budget as all indications point to 0% growth in our Provincial funding levels and we will face continued pressure in the future.

Dr. Sutcliffe noted that she has been invited to present the 2017 Board-approved budget to the City of Greater Sudbury Council on December 6.

IN CAMERA

56-16 IN CAMERA

Moved by Bailey – Huska: That this Board of Health goes in camera.
Time: 2:11 p.m.

CARRIED

- Labour relations or employee negotiations

RISE AND REPORT

57-16 RISE AND REPORT

Moved by Meikleham – Pilon: That this Board of Health rises and reports.
Time: 2:24 p.m.

CARRIED

58-16 APPROVAL OF BOARD IN-CAMERA MEETING NOTES

Moved by Pilon – Meikleham: THAT this Board of Health approve the meeting notes of the May 19, 2016, Board in-camera meeting and that these remain confidential and restricted from public disclosure in accordance with exemptions provided in the Municipal Freedom of Information and Protection of Privacy Act.

CARRIED

59-16 2017 COST-SHARED BUDGET

Moved by Huska – Pilon: THAT the Sudbury & District Board of Health approve the 2017 operating budget for cost shared programs and services in the amount of $22,774,566.

CARRIED

iv) Bill S-228 – Food and Beverage Marketing

- Letter from the Peterborough Board of Health to the Federal Minister of Health dated November 4, 2016
- Senator Nancy Greene Raine News Release dated September 28, 2016

There is no briefing note accompanying this motion, however, the motion is self-explanatory and there is correspondence from the Peterborough Board of Health and a news release. The proposed legislation is consistent with the Sudbury & District Board of Health's endorsement of the Healthy Kids Panel recommendations.

Dr. Sutcliffe noted that she has responded to one media interview request for which the reporter took interest on the topic from today's Board agenda package. The reporter will also be speaking with the Senator who proposed the bill and we look forward for this important topic being highlighted in the local media.

60-16 RESTRICTING THE MARKETING OF UNHEALTHY FOODS AND BEVERAGES TO CHILDREN

Moved by Huska – Pilon: WHEREAS children are particularly susceptible to commercial marketing and need to be protected from marketing influences on their food and beverages choices; and

WHEREAS Health Canada, through the newly introduced multi-year Healthy Eating Strategy, is committed, following a review of the evidence and consultation with experts in the field, to introducing restrictions on the commercial marketing of unhealthy food and beverages to children; and

WHEREAS the Stop Marketing to Kids Coalition's Ottawa Principles outline the components required for effective policies and regulations on any form of commercial advertisement or otherwise promotion of food and beverages to children age 16 years and younger; and

WHEREAS the Association of Local Public Health Agencies endorsed The Ottawa Principles, and has written a letter of support for Senator Nancy Green-Raine's Bill S-228, Child Health Protection Act, which if passed would ban food and beverage marketing to children under 13 years of age; and

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health encourage Members of Parliament to endorse Bill S-228, and commend the Honourable Jane Philpott, Minister of Health, for introducing the multi-year Healthy Eating Strategy; and

FURTHER THAT this motion be forwarded to local, provincial and federal health and non-health sector partners as appropriate.

CARRIED

7.0 ADDENDUM

No addendum

8.0 ANNOUNCEMENTS / ENQUIRIES

Board member, M. Bailey summarized discussions from the half-day Board of Health section meeting that was held the morning November 18, 2016, as part of the aIPHa Symposium. Speakers also informed Board members of Ontario's involvement, federal

interest and what implementation of basic income guarantee could look like. Updates were provided on alPHa's strategies and advocacy work, Patients First and the OPHS review.

Questions were entertained and clarification was provided regarding the purpose of the sub-LHINs. Meeting proceedings will be shared with the Board once they are received from alPHa.

Board members were encouraged to complete the Board evaluation regarding today's Board meeting

Board members were also asked to complete the annual board self-evaluation survey as the deadline date to complete the annual survey has been extended. Results of the annual survey which were to be tabled at today's meeting will now be presented at the January Board meeting in the hopes of improving the response rate.

9.0 ADJOURNMENT

61-16 ADJOURNMENT

Moved by Myre –Bailey : THAT we do now adjourn. Time: 2:43 p.m.

CARRIED

_____ _____

(Chair) (Secretary

Sudbury & District Health Unit
Service de santé publique

Medical Officer of Health/Chief Executive Officer
Board of Health Report, January 2017

Words for thought…

Calorie Amounts Coming to Ontario Menus Beginning January 1st
Ontario Helping People Make Informed, Healthy Food Choices

As the new year begins, Ontario is making it easier for people to make informed and healthy choices about what to eat when dining out or purchasing ready-to-eat meals to take home.

Starting January 1, Ontario will be the first province in Canada to require food service providers with 20 or more locations in the province -- such as restaurants, coffee shops, convenience stores, grocery stores and movie theatres -- to include the number of calories for each food and beverage item on their menus, labels or tags.

Including information about calories on menus is part of Ontario's plan to create jobs, grow our economy and help people in their everyday lives.

Quick Facts

- Food service providers are also required to post an educational statement for customers about average daily caloric needs.
- Calories are a measure of how much energy is in the food we eat. Knowing how many calories are in our food can help us get the right amount of energy for our needs.
- Individual calorie needs vary depending on a number of factors, including activity level, age and gender.
- For more information, please refer to Health Canada's Estimated Energy Requirements.

Source: Ministry of Health and Long-Term Care Website
Date: December 30, 2016

Chair and Members of the Board,

Starting the New Year off with information to help us keep our resolutions, Ontario's Healthy Menu Choices Act came into force on January 1, 2017. Over the last number of months, Health Unit staff have actively prepared for the Act's implementation. The legislation requires all food service premises with 20 or more locations in Ontario to post calories and contextual statements on menus. We are supporting comprehensive enforcement, public education and evaluation to ensure that the legislation effectively helps Ontarians make informed food choices when eating out. The recommendation requiring restaurants to post calories on menus was included in the 2012 *No Time to Wait: The Healthy Kids Strategy* as a means to create more supportive food environments for families. The Sudbury & District Board of Health motion calling for restrictions in marketing of foods and beverages to children is another important strategy in support of healthy kids.

Best wishes for a productive and healthy 2017.

I am very pleased to share with you new developments and highlights from Sudbury & District Health Unit (SDHU) activities since the November 2016 Board of Health meeting.

GENERAL REPORT

1. Sudbury & District Board of Health

The Public Appointment Secretariat is the body that appoints provincial appointees to the Board of Health. The Secretariat is aware of the Board vacancy with the resignation of C. Belcourt in May 2016. They have been informed of J. Bradley's interest in a reappointment as her term expires February 21, 2017. A letter of support for this reappointment has been sent by the Board Chair.

2. Electronic Board Meetings

January 2017 marks two-year post-implementation of transitioning to paperless meetings for the Board and the Senior Management Executive Committee. Board members' feedback and suggestions are always welcome through either the monthly Board evaluation surveys or by contacting the Board Secretary.

3. Human Resources

As previously communicated, Dr. Marlene Spruyt, former Timiskaming MOH/CEO has begun as the Algoma Public Health MOH/CEO. I am pleased to have been able to serve as the APH MOH for our northern neighbour for approximately two years and recognize the Sudbury & District Board's support during this time. The Ministry of Health and Long-Term Care, the Chief Medical Officer of Health, the Algoma Board and staff have shared their thanks to our Board, myself and S. Laclé for our assistance.

4. Engagement with Indigenous Peoples

At the November meeting, the Board of Health resolved (54-16) to reaffirm their commitment to ensuring all people in the Sudbury & District Health Unit service area, including Indigenous people and communities, have equal opportunities for health and identified the need to better define relationships with Indigenous communities as part of its risk management strategy. In follow up a Manager, Indigenous Engagement has been hired until March 31, 2017. This position will assist with the development of a comprehensive strategy for the Sudbury & District Health Unit's engagement with Indigenous people and communities in our service area for the purpose of collaboratively strengthening public health programs and services for all.

5. Quarterly Compliance Report

The SDHU is compliant with the terms and conditions of our Public Health Accountability Agreement. The SDHU has procedures in place to uphold the Ontario Public Health Organization Standards, to provide for the effective management of our funding and to enable the timely identification and management of risks.

The SDHU has paid all payable remittances for employee income tax deductions and Canada Pension Plan and Employment Insurance premiums, as required by law to December 30, 2016, on December 30, 2016. The Employer Health Tax has been paid as required by law, to December 30, 2016, with a cheque dated January 15, 2017. Workplace

Safety and Insurance Board premiums have also been paid, as required by law, to December 30, 2016, with a cheque dated January 31, 2017. There are no outstanding issues regarding compliance with the Occupational Health & Safety Act, Ontario Human rights Code, or Employment Standards Act.

6. Local and Provincial Meetings

On November 29, 2016, the SDHU hosted a meeting between NE LHIN / NE Public Health MOHs/CEOs and Board Chairs. R. Lapierre Chaired the meeting. The purpose of the meeting was to strengthen the engagement between the NE LHIN and NE Boards of Health to improve health and health equity in northeastern Ontario. The meeting served to:

- Further mutual understanding of respective mandates
- Explore the current context of change including Patients First proposals
- Discuss relationships, roles and respective expectations
- Identify next steps

A number of regularly scheduled meetings including those with the NE LHIN, COMOH, alPHa, the Public Health Work Stream and the Chief Medical Officer of Health have occurred since the last Board of Health meeting.

7. SDHU Performance Targets for the Accountability Agreement Indicators

We continue to track well with respect to our accountability agreement indicators. Any anticipated or known deviations are reported to the Board in a timely manner.

It is expected that we will be required to submit a variance report for our performance indicator related to investigation of salmonella cases. Two salmonellosis case investigations which were closed in December did not identify potential risk factors for exposure as required in the indicator. Multiple attempts were made to contact these two cases including telephone call during and after-hours, site visits and letters, none of which the cases responded to. The MOHLTC acknowledges within the indicator technical document that some cases may be lost to follow-up or may have recall bias, which would account for behavioural risk factors not being identified. Our 2016 target of 100% was based on having achieved 100% compliance with this indicator in 2015 and despite us expressing concern to MOHLTC regarding ability to consistently meet this target due to limitations listed above within the technical document. Environmental Health Division staff will continue to ensure thorough investigation of all reported cases.

I am very pleased to share with you new developments and highlights from each of the SDHU divisions over the last two months since the November 2016 Board of Health meeting.

CLINICAL & FAMILY SERVICES DIVISION

1. Control of Infectious Diseases

Influenza: There were 9 community cases of influenza A identified during the month of December 2016.

The 2016-17 Universal Influenza Immunization Program (UIIP) immunized 2,288 individuals with this year's trivalent or quadravalent influenza vaccine at the SDHU and community based clinics. This number represents a decrease of 1,645 individuals as compared to numbers of community individuals who received the vaccine through SDHU community clinics in 2015-16. Influenza vaccine continues to be available to those wishing to receive.

The SDHU has distributed 56,473 doses of influenza vaccine to all area health care practitioners and pharmacies beginning October 2016. This is a decrease of 5,175 doses compared to this time last year. 52 pharmacies took part in this year's UIIP compared to 49 pharmacies that took part in the program last year.

Respiratory Outbreaks: There was one identified respiratory outbreak in a long-term care home during the month of December. Espanola Nursing Home was declared in a respiratory outbreak on December 30, 2016.

The Control of Infectious Diseases team continues to monitor all reports of respiratory illness.

Vaccine Preventable Disease: The CID team started the planning for the upcoming Immunization of School Pupils Act (ISPA) implementation in November 2016. This involves reviewing student immunization records for all school-aged children up to 18 years of age to ensure compliance. Suspension packages have been created for school boards detailing upcoming suspension dates for each of the schools in our district. We are expecting their continued support in accordance with provincial requirements.

The CID team has begun preparations around scheduling the Adacel (diphtheria, tetanus acellular, and pertussis adult vaccine - also called Tdap) clinics in support of the ISPA which will commence in early January 2017. There have been 1,231 letters sent advising parents of the upcoming Adacel clinics offered in each of the high schools in our Health Unit catchment area.

2. Family Health

Breastfeeding: The Baby Café (Breastfeeding Support Group) continues to run twice a month with four to six participants on average in attendance. The A Breastfeeding Companion (ABC) Program continues to provide over the phone support for breastfeeding families. The team continues to develop the Academic Detailing topic of "Low Milk Supply".

Positive Parenting Program (Triple P): The Triple P Network has signed the new partnership agreement for 2017.

The new Triple P website www.parenting4me.com will be launched in early 2017. A new campaign will be launched with the website that highlights positive parenting messaging with the new tagline "Helping Families Build Strong and Healthy Relationships".

A new Transitions Group session for parents that are divorced or separated will begin in January 2017.

A new collaboration with School Health Promotion program will offer Triple P and parenting support to Rainbow District School Board Barrydowne Campus School. A consultation meeting with teachers resulted in further discussions in January 2017 to develop a TipSheet connecting the school with Our Children Our Future (OCOF) and other community agencies to explore supporting the student parents at the school.

Child Health Community Events: The Learning Tools working group created in partnership with the Best Start Hubs continues to meet monthly at the SDHU to discuss and create learning tools to be used by 9 hubs in the city.

Baby Friendly Initiative (BFI): The SDHU received notice of its successful BFI Designation. Two members of the BFI team met with a Sudbury city councillor to discuss incorporating Baby-Friendly practices at the City level.

PEERS (Program for the Evaluation and Enrichment of Relational Skills): The PEERS program trial is in session 10 with the final session scheduled for February 4. There are currently 3 families attending the program. The facilitators are holding weekly debrief meetings with HSN to offer a comprehensive overview for the evaluation of each session.

3. Oral Health

The Oral health programming for children residing on First Nations communities is well underway. Plans for elementary school screening for the winter or early spring months are being finalized. Sagamaok and Birch Island elementary schools will host the school screening program in January. Oral health programming for First Nations communities includes screening sessions for childcare and school age children. Parents of children requiring urgent dental care are contacted by the SDHU dental hygienist and support is provided to assist with financial assistance and with locating a dentist near their community. Classroom education sessions are offered to those grades where tooth decay is high. These sessions also include instruction on proper oral hygiene.

4. Sexual Health\Sexually Transmitted Infections including HIV and Blood Borne Infections

The sexual health clinic responded to three community requests for presentations during the month of December reaching 32 participants.

A Facebook ad to promote “MyTest” (an on-line testing initiative for chlamydia and gonorrhea) was posted from December 19 to December 25. During December, 12 individuals accessed “MyTest” with 5 positive cases reported.

In support of World AIDS Day awareness on December 1, the sexual health program developed and ran a radio ad on the 93.5 radio station. The ad was played 3x/day for 2 weeks from November 28 to December 9 encouraging people to get tested for HIV.
Needle Exchange Program (NEP): The Needle Exchange Program continued to experience a high volume of clients and distribution. For the month of November, 72,459 needles were distributed through The Point locations. We continue to work with partners of The Point to address any common challenges experienced while working with this clientele.

Substance Misuse- Community Drug Strategy: A Steering Committee meeting for the Sudbury Community Drug Strategy was held on December 6. A presentation was provided on the current opioid crisis and the plan under the Federal and Provincial governments to address the crisis. The legislation for the legalization of marijuana proposed by the federal government was also presented. The Community Drug Strategy responded to five media requests in November and December related to safe injection sites, naloxone, community needle pick-up/kiosks and supply distribution for the Needle Exchange Program.

5. Healthy Babies Healthy Children

The Healthy Babies Healthy Children team often sees families struggling on a daily basis to make ends meet; whether that is making their rental payments, buying groceries to feed the family or simply finding the money for their child to participate in a school field trip. This time of year is especially challenging. The SDHU was pleased to receive community donations of baby supplies, clothing items, something for the parents, gift cards for groceries, etc. for distribution through the HBHC program.

ENVIRONMENTAL HEALTH DIVISION

1. Control of Infectious Diseases

During the months of November and December, six outbreaks were declared, and 18 sporadic enteric cases, as well as four infection control complaints were investigated.

A public service announcement was issued on December 6, 2016, reminding the public that the SDHU typically sees increased gastrointestinal illness, likely due to Norovirus, in long-term care facilities, daycares and in the community at this time of year. The PSA also provided information on how to prevent becoming infected with, or spreading the virus.

An expanded norovirus media release was issued on December 30, 2016, informing the public that the health unit has been seeing an increase in gastrointestinal illness in the community, child care centres and long-term care homes.

In December the Environmental Health Division investigated a foodborne outbreak upon receipt of a report of an ill individual who had attended a family gathering and who reported that additional attendees were also ill with similar enteric symptoms.

2. Food Safety

In December, calendars were distributed to approximately 1,200 food premises. The calendar provides year-round food safety messages and promotes the Food Handler Training and Certification Program. Funding to design, print, and distribute the calendar was provided through 100% Ministry of Health and Long-Term Care Haines Enhanced Food Safety funding.

As noted earlier in this report, effective January 1, 2017, public health inspectors are responsible for enforcing the *Healthy Menu Choices Act (HMCA)* and *General Regulation.* The legislation requires food service premises with 20 or more locations in Ontario to display calories on menus for standard food items.

Requiring the display of calories on menus will provide customers with information to help them make well-informed choices about what to eat and feed their children when dining out. Specifically, the law will require food service premises to:

1. Display the number of calories for every standard food item and self-serve item, on menus (including menu boards), labels and display tags; and
2. Display contextual information to help educate customers about their daily caloric requirements.

In support of Sudbury & District Board of Health Motion 33-14 (Food Premises Inspection), an enhanced promotion of the "*Check Before You Eat!*" website was carried-out in the months of November and December.

During the months of November and December, four food product recalls prompted public health inspectors to conduct checks of 1,017 local premises. All affected establishments had been notified, and subsequently had removed the recalled products from sale. The recalled food products included Compliments brand Broccoli Slaw due to possible contamination with Listeria, certain Sabra brand Hummus due to possible contamination with Listeria, Duncan Hines brand Apple Caramel Cake Mix due to possible contamination with Salmonella, and Old Dutch Cheddar & Sour Cream Potato Chips due to potential contamination with Salmonella.

In November, public health inspectors issued one charge to a food premises for an infraction identified under the *Food Premises Regulation*.

In November and December, staff issued 28 Special Event Food Service Permits to various organizations for events serving approximately 12,650 attendees.

Through Food Handler Training and Certification Program sessions offered in November and December, 223 individuals were certified as food handlers.

3. Health Hazard

In November and December, 45 health hazard complaints were received and investigated. Two of these complaints involved marginalized populations. Additionally one PSA was issued in November in support of Radon Action Month and one press release was issued in December regarding frostbite and hypothermia prevention.

4. Ontario Building Code

During the months of November and December, 29 sewage system permits, 10 renovation applications, and seven consent applications were received.

5. Rabies Prevention and Control

Forty-one rabies-related investigations were carried out in the months of November and December. One specimen was submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis, and was subsequently reported as negative.

One individual received rabies post-exposure prophylaxis due to exposure to a stray dog.

6. Safe Water

During November and December public health inspectors investigated six blue-green algae complaints in four lakes. All of these lakes were subsequently identified as containing blue-green algae blooms capable of producing toxin.

During November and December, 90 residents were contacted regarding adverse private drinking water samples. Public health inspectors investigated five regulated adverse water sample results.

Additionally during the months of November and December, three boil water orders and one drinking water advisory were issued. Furthermore three boil water orders, and one drinking water advisory were rescinded.

7. Tobacco Enforcement

In November and December, tobacco enforcement officers charged one individual for smoking on school property, one individual for smoking in an enclosed workplace vehicle, three individuals for smoking in enclosed workplaces, and five individuals for smoking in enclosed public places. A television and movie theatre campaign promoting the Smoke-Free Ontario Act requirement for smoke-free workplaces was run during the month of December.

HEALTH PROMOTION DIVISION

1. Healthy Eating

In December, nutrition staff submitted a collective response to Health Canada's online consultation process to contribute to the revision of *Canada's Food Guide*. The submission included local evidence and professional input on ways to effectively communicate nutrition information to Canadian audiences, and to develop healthy eating recommendations and policies. The consultation is part of Health Canada's newly launched *Healthy Eating Strategy*.

Discussions have started in December with the Recreation Director in Chapleau around the potential to offer healthier choices in the arena canteen. SDHU staff are discussing potential perishable and non-perishable ideas that could be included on the menu.

2. Healthy Weights

In November, staff from Health Sciences North's *NEO Kids BALANCE Program* delivered an in-service on their program for SDHU staff who work with children and/or families. At the end of the in-service, SDHU staff reciprocated and provided the audience, including *NEO Kids BALANCE Program* staff, with an update on SDHU healthy weights programming. This exchange helped to facilitate enhanced communication and relationship building between key service providers who work to provide comprehensive healthy weights programming in our community.

In late November, a Health Promotion staff member presented to approximately 40 parents and staff at Holy Cross Public School regarding the importance of healthy sleep.

Health Promotion Division staff are pleased to offer our continued support to our Healthy Kids Community Challenge partner Shkagamik-Kwe as their new Program Coordinator begins her position.

The Ministry of Health and Long-Term Care approved long-term funding for the Diabetes Prevention Program (DPP). In November (for Diabetes Awareness Month) and December, DPP staff supported four Diabetes and wellness-themed conferences in collaboration with First Nation communities and partners throughout the SDHU catchment area. The conferences provided the opportunity to promote healthy lifestyle activities in the communities which are at-risk of developing diabetes. The DPP has also been providing supports, resources and incentives for partnering First Nation health organizations to run health promotion and disease prevention programs and activities.

3. Injury Prevention

On November 1, a public health nurse supported the Ontario Ministry of Transportation launch of the Pedestrian Safety campaign and provided two radio interviews.

On November 15, a public health nurse attended the City of Greater Sudbury (CGS) pedestrian safety /pedestrian cross over launch. As part of this campaign SDHU and partners created a billboard, eight bus backs and 25 bus interiors. As well, the SDHU Communication team, along with Health Sciences North, created a pedestrian safety sign, which is located at the intersection of Paris and Centennial. The SDHU and the Sudbury East Road Safety Coalition created a similar message for their mobile signs in Hagar and Noëlville.

4. Physical Activity

In mid-December, Health Promotion staff, along with local community leaders, provided opening remarks at the official unveiling of Science North's new Object Theatre, *Ready Set Move!* The innovative and interactive exhibit will encourage families to be active together, which has the potential to improve health and reduce the risk of chronic disease.

5. Prevention of Alcohol Misuse

Along with 28 health units in Ontario, the SDHU has joined a coordinated province-wide campaign, entitled *Rethink Your Drinking*, to promote and increase awareness of the Canadian Low-Risk Alcohol Drinking Guidelines (LRADG) and standard drink sizes among men and women age 25-44 years in Ontario. The campaign is being implemented over a three month period from mid-December until mid-March at a number of community venues and through our ongoing *Alcohol, Let's Get Real* social media pages.

6. Tobacco Control

SDHU and the Center for Addiction and Mental Health (CAMH) held *a Smoking Treatment for Ontario Patients (STOP) on the Road* smoking cessation workshop at our Paris Street location. There were 5 participants, all of whom received free nicotine patches from CAMH. Group cessation information sessions were also held at Maison Vale Hospice (now known as the Maison McCulloch Hospice) and the Northern Initiative for Social Action (NISA) for a total of 9 workers and clients.

SDHU had several media campaigns related to tobacco in December. We supported the NE TCAN with the creation and development of a regional public education media campaign on Smoke Free Housing. Dissemination was through CTV North, social media banner ads, and print media ads. The SDHU partnered with CTV North to create a public education television ad related to the Smoke-Free Ontario Act with specific targeting to workplaces and workplace vehicles. The Leave the Pack Behind's *Would You Rather* quit campaign targeting youth 18 to 29 continued to be disseminated in the district via Cineplex ads, posters, and social media ads.

SDHU staff continued to provide services to the community through the Quit Smoking Clinic and Telephone Information Line, having received 88 calls and 31 visits to the clinic in November and December.

RESOURCES, RESEARCH, EVALUATION AND DEVELOPMENT (RRED) DIVISION

1. Health Equity

The SDHU is collaborating with Health Quality Ontario (HQO) and a number of partners across the North, including Local Health Integration Networks, on the development of a Northern Health Equity Strategy. The SDHU has entered into an agreement with HQO to second one full-time equivalent to support this work, which includes community engagement across the North. Dr. Sutcliffe is a member of the Northern Health Equity Strategy Steering Committee, and the SDHU will contribute to the Strategy as a leader in health equity.

Five representatives from the SDHU participated in the local public consultation session hosted by the province that was held in Sudbury in December. As a follow up to the consultation, the SDHU will be encouraging staff and teams to complete the survey (individual or expert version) prior to the deadline of January 31, 2017. In order to magnify support for the basic income pilot, members of the Board of Health are also invited to complete the individual survey (https://www.ontario.ca/page/basic-income-pilot-consultation).

SDHU staff is also collaborating with alPHa-OPHA's Health Equity Work Group on two submissions (general and technical) to submit to the province in support of the proposed basic income pilot.

2. Population Health Assessment and Surveillance (PHAS)

The Population Health Assessment and Surveillance (PHAS) team produced one new internal report on *Cell Phone Use While Driving* using data from the 2015 Rapid Risk Factor Surveillance System (RRFSS).

3. Research and Evaluation

The SDHU is involved in two Public Health Ontario (PHO) Special Edition Locally Driven Collaborative Projects. The SDHU will lead a project on the development of an engagement model for use by local board of public health and Indigenous communities in Northeastern Ontario. The project team includes other northern health units as well as Indigenous and academic partners. The SDHU is also a participant on a project being led by Ottawa Public Health that addresses the Patients First legislation. This project will work towards the development of tools and methods to learn from collaborations for population health assessment evolving between public health units and Local Health Integration Ne. Project planning is currently underway, and the project is to be completed by March 2018.

SDHU is now receiving library resource services from the Public Health Ontario Shared Library Services Partnership via the Thunder Bay District Health Unit. Services include requests for articles, literature searches, and staff training.

4. Staff Development

Training on positive psychology was provided to SDHU management over two half days on November 25 and December 16. Concepts that were introduced included health and safety culture change, organizational and personal values, signature character strengths, learned optimism, positive relationships, gratitude, and resiliency. The sessions were designed to align with and build upon the new leadership core competencies developed by the SDHU management team.

5. Student Placement Program

Student placement policies were recently revised to support those learners who may have a disabilities.

The SDHU is working with Western University to develop an affiliation agreement that will allow the SDHU to accommodate students from their Master of Public Health Program beginning in 2017.

6. Presentations

A RRED epidemiologist presented two technical workshops, entitled "*Doing More With Less – Strategies for Systematized Reporting*" and "*An Introduction to Loops in Stata*", at the Association of Public Health Epidemiologists in Ontario (APHEO) workshop on November 7 and 8, 2016.

Respectfully submitted,

Original signed by

Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health and Chief Executive Officer

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT
BRIEFING NOTE

Date: November 1, 2016

Prepared by: Dr. Kit Young Hoon, Medical Officer of Health, Northwestern Health Unit

Prepared for: Association of Local Public Health Agencies (alPHa) Board Meeting

Title: Association of Municipalities of Ontario and Alcohol Policy

Background

The Burden of Disease on Ontario

In Ontario, alcohol consumption is the second leading cause of death, disease and disability. Alcohol consumption results in substantial health and social costs to individuals, families, communities, and society as a whole. Long-term or excessive consumption increases the risk of health harms including cancer, hypertension, stroke, and disease of the liver, pancreas, stomach, heart, and nervous system. According to Cancer Care Ontario, an estimated 1,000 to 3,000 new cancer cases in Ontario in 2010 were attributed to alcohol consumption (2016 Prevention System Quality Index).

Provincial Policy

Government decisions on alcohol should take into the account health and safety of a population. Provincial policy changes that move towards more access to alcohol, while maintaining a lower price, do not take into account the harms associated with increased consumption of alcohol. There is strong evidence to support that an increase in availability of alcohol in a community leads to increased consumption and increased alcohol-related harms Two of the most effective policy options for reducing alcohol-related harms are pricing (as alcohol prices increase, demand declines, even for heavy drinkers), and restrictions on physical availability (government monopoly of retail sales, restrictions on retail outlet density, and limits on hours and days of sale are all associated with reductions in alcohol consumption and alcohol-related harm). Ontario has moved recently toward wider and more liberal access to alcohol. Changes to the way alcohol is distributed, sold and available in Ontario have been made to increase revenue through alcohol taxation, and to increase consumer convenience and choice (Ontario Public Health Association, 2015). These changes are counter to what we know about reducing alcohol-related harms.

Costs of alcohol misuse

Government decisions are informed by the net costs of alcohol to society. This can be defined as alcohol revenues minus the economic and social costs to individuals, families, communities, and society. According to the Canadian Centre on Substance Abuse, the economic cost of alcohol related harm across Canada is $14.6 billion per year. These costs include $7.1 billion for lost productivity owing to illness and premature death, $3.3 billion for direct health care costs and $3.1 billion for enforcement costs (Canadian Centre on Substance Abuse, 2016). Currently, the province receives $3 billion in dividends and taxation from alcohol sales, but the cost to taxpayers is estimated to be $5.3 billion. This is a significant yearly loss due to a single substance. These costs are incurred at every level, including direct health care, law enforcement, our judiciary system, our social system, lost productivity, and premature deaths. In Canada this amounts to an estimated $473 per year in cost to each and every Canadian due to alcohol (OPHA, 2015).

Current situation

A number of municipalities under the Association of Municipalities of Ontario (AMO) are working towards an advocacy effort to request that a proportion of the provincial tax revenues from alcohol sales be reallocated to municipalities. Within Northwestern Ontario, a significant percentage of municipal budgets are dedicated to policing and emergency service costs. Billing practices for police services for some municipalities are partially based on the number of times that the police are required to respond to a call (Ministry of Community Safety and Correctional Services, 2014). The OPP servicing Northwestern Ontario have identified alcohol misuse as a contributor to most of the calls for service.

Discussion

There are some potential opportunities and risks from a public health perspective from this municipal advocacy effort.

The social and health harms from alcohol is a common message that can be supported by both municipalities and local public health agencies and an important message to be highlighted for the provincial government. For the provincial government there may be a disconnect in their understanding of the health harms of alcohol sales as they receive the tax revenues of alcohol sales but do not pay all the social costs associated with alcohol consumption i.e. enforcement costs and emergency services.

If municipalities are successful in their advocacy effort to receive funding, they will benefit financially from the tax revenues and, like the provincial government, may support efforts to increase alcohol sales through increased convenience and availability of alcohol.

Possible next steps to utilize this opportunity and reduce the potential risks could include:

- Working with AMO in the development of their argument for the request for funding. Ensure that the argument highlights the health and social harms and costs of alcohol, the health and social harms of provincial policies, and the benefits of alcohol policies that reduce availability.
- Educate municipalities on public health considerations with respect to alcohol policy.
- Request that alcohol sales tax revenues to the province be used to fund public health efforts to prevent the misuse of alcohol, social costs of alcohol, treatment of alcohol addiction and health protection and injury prevention activities related to alcohol.

- Request that alcohol sales tax revenues to municipalities be used to fund prevention programming, in addition to police and emergency services.

References

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Ontario Public Health Association (OPHA), 2015. *Alcohol Availability Advocacy Package.* Retrieved from email June 15, 2015.

Ministry of Community Safety and Correctional Services, 2014. *Backgrounder. New OPP Billing Model.* Accessible at https://news.ontario.ca/mcscs/en/2014/08/new-opp-billing-model.html

November 25, 2016

The Ontario Public Health Standards Modernization Committee
Executive Steering Committee
c/o Jackie Wood
Director, Planning and Performance Branch
College Park, 19th Floor
777 Bay Street, Suite 1903
Toronto ON M7A 1S5

Dear Jackie Wood:

Re: 2016 Ontario Public Health Standards Modernization/Review

The Board of Health for the Grey Bruce Health Unit strongly recommends that the Ministry of Health and Long-Term Care, Population Health and Public Health Division adopt a "Health in all Policy" approach when reviewing the current Ontario Public Health Standards. This evidence-based approach will assist public health leaders to work across sectors to integrate considerations of health, well-being and equity during the development, implementation and evaluation of policies and services (Adelaide 2000).

Modernizing the Ontario Public Health Standards using a population health and Health in all Policy framework will optimize public health resources by supporting a cross-sectoral approach to program and service delivery. As an example, we recommend that the Standards for Child Health, Chronic Disease and Injury Prevention be prepared together in order to facilitate a lifespan approach to these important issues. The Grey Bruce Health Unit have had success moving in this direction at the local level and would welcome the opportunity to share our experiences.

Complex issues such as childhood obesity, substance misuse and falls across the lifespan require unique and strategic partnerships to support system development within our communities. The modernization of the Ontario Public Health Standards allows the opportunity to place Public Health in a leadership role for this important work.

Sincerely,

Kevin Eccles

Kevin Eccles
Chair, Board of Health

Cc: Paulina Salamo, MOHLTC
Ontario Boards of Health
Association of Local Public Health Agencies

Peterborough Public Health

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

November 28, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4
ehoskins.mpp@liberal.ola.org

Dear Minister Hoskins,

RE: Bill 5 – *the Greater Access to Hepatitis C Treatment Act, 2016*

As you are no doubt aware, approximately 110,000 Ontarians are living with hepatitis C. Individuals can live with hepatitis C for many years without experiencing any symptoms, even though the disease slowly damages their liver. If left untreated, hepatitis C can lead to cirrhosis, liver cancer, and ultimately premature death.

Fortunately there is a cure for hepatitis C, with new treatments having demonstrated a 95 percent effectiveness rate in restoring individuals to health. While new treatments have shown great promise in curing individuals with hepatitis C, many individuals cannot access these highly effective treatments until they meet restrictive clinical criteria that require that an individual's liver be substantially damaged.

The Board of Health for Peterborough Public Health was pleased to hear about and supports MPP Sylvia Jones' private Member's bill, Bill 5 – *the Greater Access to Hepatitis C Treatment Act, 2016.* If adopted, MPP Jones' private Member's bill would ensure every individual in Ontario with hepatitis C will receive treatment upon the recommendation from their physician, no matter what stage their disease is in. If Bill 5 is adopted, an individual will no longer have to wait and let their liver further deteriorate before receiving lifesaving treatment.

The board of health hopes that your government will support the principle of treating at risk individuals before evidence of harm exists. A universal program, where physicians are able to access curative treatment for their patients based on their own assessments of readiness and suitability, would be far better than the current limited access that exists. Thank you for considering this policy change.

Yours in health,

Original signed by

Mayor Mary Smith
Acting Chair, Board of Health

/ag

cc: MPP Sylvia Jones, Dufferin-Caledon
MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes-Brock
Dr. David Williams, Chief Medical Officer of Health
Association of Local Public Health Agencies
Ontario Boards of Health

Office of the County Warden
789 Broadway Street, Box 3000
Wyoming, ON N0N 1T0

Telephone: 519-845-0801
Toll-free: 1-866-324-6912
Fax: 519-845-3160

December 8, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, ON M7A 2C4
ehoskins.mpp.co@liberal.ola.org

Dear Minister Hoskins:

Re: Access to Publicly Funded
Oral Health Programs for Low-Income Adults and Seniors

During its meeting on November 2, 2016, Lambton County Council (which serves as the County of Lambton Board of Health) accepted a report from Lambton Public Health regarding Access to Publicly Funded Oral Health Programs for Low-Income Adults and Seniors.

In January 2016, the Healthy Smiles Ontario public oral health program for children was expanded to help all low-income children, regardless of any coverage under employer-sponsored dental insurance. However, the expansion did not address the barriers to accessing dental care experienced by working poor adults and seniors. These cohorts are often ineligible for Ontario Works or the Ontario Disability Support Program and are without employer-sponsored dental benefits. These marginalized adults and seniors find they cannot afford to access dental care at the best of times. Often they must choose between paying for living expenses such as rent, utilities, or groceries, and paying for their oral health.

Lambton County Council recognizes the effects of poor oral health on general health as well as the impacts that extend beyond medical concerns. Unchecked, oral disease may lead to pain and infection which can spread throughout the body. Poor oral health can affect employability, work attendance and performance, self-esteem, and social relationships.

Oral health issues are not covered under universal healthcare through the Ontario Health Insurance Program. For low-income adults or seniors who are less likely to have employer-sponsored dental benefits and are more likely to report poor oral health, the cost of dental care is prohibitive. Typically when an adult or senior cannot afford to visit a dentist for pain and infection in their mouth they often end up visiting the emergency

room, or their family doctor instead. At these visits they will receive a course of antibiotics and pain medications which do not address the true cause of the problem. This only provides a temporary solution often resulting in repeat emergency room visits to defer the pain. In 2016, the Association of Ontario Health Centres reported over 60,000 visits to emergency rooms resulting in an estimated $31 million for costs directly related to oral health issues. In 2014, the Erie St. Clair Local Health Integration Network region had 3,160 emergency room visits due to oral health issues.

The Provincial Government has promised to extend oral health programs starting in 2025. However, nine years is too long to wait to address the current demand in low-income adults and seniors. In response to this delayed action, Lambton County Council calls on the Province to accelerate its promise to expand oral health programming for low-income adults and seniors starting within the next two years.

Sincerely,

Warden Bill Weber
County of Lambton (Board of Health)

cc: Bob Bailey, MPP, Sarnia-Lambton
Monte McNaughton, MPP, Lambton-Kent-Middlesex
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health
Dr. Sudit Ranade, Medical Officer of Health
Andrew Taylor, General Manager, Public Health Services Division

-----Original Message-----
From: Kathleen Wynne [mailto:premier@premier.gov.on.ca]
Sent: Tuesday, November 22, 2016 11:36 AM
To: Rachel Quesnel <quesnelr@sdhu.com>
Subject: An email from the Premier of Ontario

Dear Dr. Sutcliffe:

Thank you for your letter informing me of the Sudbury and District Board of Health's resolution regarding the Nutritious Food Basket 2016. I appreciate your keeping me updated on the board's activities.

I note that you have sent a copy of the board's resolution to my colleague the Honourable Helena Jaczek, Minister of Community and Social Services. I have also forwarded a copy of the board's resolution to my colleague the Honourable Chris Ballard, Minister Responsible for the Poverty Reduction Strategy. I trust that the ministers will also take the board's views into consideration.

Once again, thank you for the information.

Kathleen Wynne
Premier of Ontario

c: The Honourable Helena Jaczek
The Honourable Chris Ballard

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound

681 Commercial Street, North Bay, ON P1B 4E7 TEL: 705 474 1400
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL: 705 746 5801

myhealthunit.ca
TOLL FREE: 1 800 563 2808

November 25, 2016

Hon. Dr. Eric Hoskins, MPP
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Hon. Helena Jaczek, MPP
Minister of Community and Social Services
6th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 1E9

Hon. Christopher Ballard, MPP
Minister of Housing, Poverty Reduction Strategy
17th Floor
777 Bay Street
Toronto, ON M5G 2E5

Dear Ministers:

Subject: The Cost of Healthy Eating 2016 – BOH Resolution #BOH/2016/11/06

I am writing to inform you of the resolutions passed on November 23, 2016 at the North Bay Parry Sound District Health Unit (NBPSDHU) Board of Health meeting. These resolutions focus on increasing household incomes in order to reduce food insecurity in Ontario.

According to the 2016 Nutritious Food Basket data, the cost of healthy eating for a family of four in the North Bay Parry Sound District is approximately $885 per month. When this cost along with local rent costs are considered in several income scenarios, it is clear that many households relying on social assistance or earning minimum wage do not have enough money to pay for the basic costs of living, including nutritious food. Our 2016 Cost of Healthy Eating Report and associated infographic include more information on these income scenarios and are included in this package for your reference.

Household food insecurity is defined as inadequate or insecure access to food because of financial constraints. Food insecurity is a serious public health problem that affected 11.9% of Ontario households in 2014. Adults who experience food insecurity have poorer self-rated health and are more likely to suffer from chronic conditions such as diabetes, heart disease and depression. Children who live in food insecure households have an increased risk of developing asthma and depression in adolescence and early adulthood.

The NBPSDHU Board of Health commended the Ontario government's efforts to implement a Basic Income Pilot, as a way to investigate whether a Basic Income can reduce poverty and have positive outcomes on health, housing and employment in Ontario.

The NBPSDHU Board of Health also supported Bill 6 (An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission). This bill would help ensure social assistance rates reflect regional costs of living including the cost of a Nutritious Food Basket and other basic necessities. The NBPSDHU Board of Health recognizes the importance of increasing social assistance rates, as 64% of Ontario households who rely on social assistance experienced food insecurity in 2014.

The NBPSDHU Board of Health understands the importance of the Nutritious Food Basket Protocol and supported keeping it in the modernized Ontario Public Health Standards.

Thank you in advance for taking the time to review this information and please consider the resolutions passed by the NBPSDHU Board of Health.

***Whereas**, the Nutritious Food Basket Survey results show that many low income individuals and families do not have enough money for nutritious food after paying for housing and other basic living expenses,*

***Whereas**, the Board of Health for the North Bay Parry Sound District Health Unit recognizes the impact of adequate income on food security and other social determinants of health,*

***Whereas**, the provincial government announced a Basic Income Pilot in the 2016 budget and are hosting a public Basic Income Pilot consultation until January 31, 2017,*

***Whereas**, Bill 6 (An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission) would help ensure social assistance rates reflect regional costs of living including the cost of a Nutritious Food Basket and other basic necessities, are indexed to inflation and reviewed on an annual basis,*

***Whereas**, the Ontario Public Health Standards are currently undergoing a modernization and public health stakeholders are invited to provide feedback,*

***Now Therefore Be It Resolved,** that the Board of Health for the North Bay Parry Sound District Health Unit commend the provincial government on taking steps to investigate the basic income guarantee as a policy option for reducing poverty and food insecurity,*

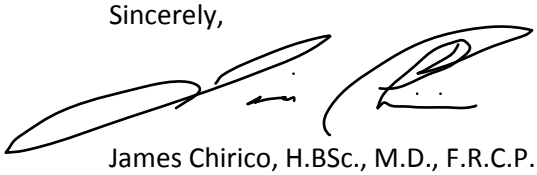
***Furthermore Be It Resolved,** that the Board of Health for the North Bay Parry Sound District Health Unit support Bill 6 (An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission),*

***Furthermore Be It Resolved,** that the Board of Health for the North Bay Parry Sound District Health Unit support keeping the Nutritious Food Basket Protocol in the modernized Ontario Public Health Standards,*

***Furthermore Be It Resolved,** that the Board of Health for the North Bay Parry Sound District Health Unit continue to support the efforts of employees and community stakeholders that play a role in addressing food insecurity through social determinants of health work,*

***Furthermore Be It Resolved,** That the Board of Health for the North Bay Parry Sound District Health Unit provide correspondence of these resolutions to member municipalities, the Honourable Anthony Rota (Nipissing-Timiskaming), the Honourable Tony Clement (Parry Sound-Muskoka), Victor Fedeli, MPP (Nipissing), Norm Miller, MPP (Parry Sound-Muskoka), the Honourable Kathleen Wynne (Premier), the Honourable Deborah Matthews (Deputy Premier), the Honourable Helena Jaczek (Minister of Community and Social Services), the Honourable Dr. Eric Hoskins (Minister of Health and Long-Term Care) and the Honourable Christopher Ballard (Minister of Housing, Poverty Reduction Strategy), Ontario Boards of Health and the Association of Local Public Health Agencies (alPHa).*

Sincerely,



James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

Attachments (2)

C: Hon. Anthony Rota, MP, Nipissing-Timiskaming
Hon. Tony Clement, MP, Parry Sound-Muskoka
Victor Fedeli, MPP, Nipissing
Norm Miller, MPP, Parry Sound-Muskoka
Hon. Kathleen Wynne, Premier of Ontario
Hon. Deb Matthews, Deputy Premier of Ontario
Ontario Boards of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Member Municipalities (31)

The 2016 Cost of Healthy Eating: North Bay Parry Sound District

What is the Nutritious Food Basket?

The Nutritious Food Basket is a provincial survey tool that is used to calculate the cost of a basic nutritious diet (Ministry of Health Promotion, 2010). Each year, the North Bay Parry Sound District Health Unit conducts the survey in 12 grocery stores across the district to price food items that represent a basic healthy diet according to Canada's Food Guide and Canadian purchasing patterns. The results of the Nutritious Food Basket survey are then compiled into the annual Cost of Healthy Eating Report.

The list of 67 food items in the Nutritious Food Basket does not include processed and convenience foods, snack foods, foods that are purchased for religious or cultural reasons, or household non-food items such as cleaning products, toothpaste and toilet paper. The survey does not consider the additional costs of eating out or special occasions such as holiday or birthday celebrations. The survey also assumes that people have the skills and ability to access, prepare and store food.

Year after year, the results of the survey show that for many low income households in our district, it may not be possible to pay rent, bills, and buy nutritious food.

What is the cost of healthy eating in the North Bay Parry Sound District?

In 2016, the cost for a family of four to eat a basic healthy diet for one week was $204.36 or $884.88 a month.

What is left after monthly rent and food costs?

- A 40 year old single man on Ontario Works with a total monthly income of $780.00 paying $550.00 per month in rent (which may or may not include heat and hydro) would need $297.42 to maintain the cost of a nutritious diet. This person would have no remaining income and would be in debt by $67.42 per month.
- A single man on Ontario disability support program with a total monthly income of $1,218.00 paying $720.00 per month in rent (which may or may not include heat and hydro) would need $297.42 to maintain the cost of a nutritious diet. This person would have $200.58 remaining per month.
- A family of four on Ontario Works with a total monthly income of $2,245.00 paying $1,131.00 per month in rent (which may or may not include heat and hydro) would need $884.88 to maintain the cost of a nutritious diet. This family would have $229.12 remaining per month.
- A single mother with a son and daughter on Ontario Works with a total monthly income of $2,034.00 paying $896.00 per month in rent (which may or may not include heat and hydro) would need $668.88 to maintain the cost of a nutritious diet. This family would have $469.12 remaining per month.
- A 75 year old single woman on an old age security/guaranteed annual income with a total monthly income of $1,574.00 paying $720.00 per month in rent (which may or may not include heat and hydro) would need $216.10 to maintain the cost of a nutritious diet. This person would have $637.90 remaining per month.

- A family of four with a full-time minimum wage earner with a total monthly income of $2,958.00 paying $1,131.00 per month in rent (which may or may not include heat and hydro) would need $884.88 to maintain the cost of a nutritious diet. This family would have $942.12 remaining per month.
- A family of four with the Ontario average income of $7,448.00 paying $1,131.00 per month in rent (which may or may not include heat and hydro) would need $884.88 to maintain the cost of a nutritious diet. This family would have $5,432.12 remaining per month.

Note: Monthly income includes additional benefits and credits. A family of four consists of a man and a woman, both age 35, a boy age 14, and a girl age 8. The Health Unit can provide references for income calculations. Please contact Kendra Patrick, RD at 705-474-1400 ext. 2532 for further information.

The scenarios above only account for monthly rent and a basic healthy diet. Other monthly expenses may include heat, hydro, child care, transportation, telephone, insurance, out of pocket health costs such as prescriptions and dental care, costs associated with school, and other unexpected costs.

Many costs including heat and hydro are much higher in Northern, rural communities. For instance, a recent report showed that Northern Ontario households spend 25% more on home energy costs than other regions of Ontario (Financial Accountability Office of Ontario, 2016). The burden is highest on rural households, who pay steep delivery charges (Hydro One, 2016).

Even with careful planning and budgeting, many low income families are unable to cover all of their necessary expenses and afford a basic healthy diet. When forced to decide, people pay for their fixed expenses like rent first and food becomes a 'flexible' part of the household budget and is compromised. People may worry about running out of food, fill up on less nutritious foods, or skip meals, resulting in poor diets (Tarasuk et al., 2016).

How does income impact health?

Household food insecurity is defined as inadequate or insecure access to food because of financial constraints (Tarasuk et al., 2016). Poverty is the root cause of food insecurity (OSNPPH, 2015).

Food insecurity greatly impacts health and wellbeing. Adults who are food insecure have poorer self-rated health and are more likely to suffer from chronic conditions such as diabetes, high blood pressure, heart disease, and depression. Children who experience food insecurity have an increased risk of developing asthma and depression in adolescence and early adulthood. In addition, being food insecure is strongly associated with being a high-cost health care user (Tarasuk et al., 2016).

Food insecurity in Ontario

In 2014, 11.9% of Ontario households were food insecure and 1 out of 6 children in Ontario experienced food insecurity (Tarasuk et al., 2016). Some households were at greater risk for food insecurity than the general population. These household characteristics include: having a low income, having children under the age of 18 (especially those headed by a lone parent), being an unattached individual, being Indigenous, being Black, being a newcomer to Canada, and renting rather than owning one's home (Dietitians of Canada, 2016).

The source of household income is also important. 58.9% of food insecure households in Ontario had income from employment. 64% of households reliant on social assistance experienced food insecurity (Tarasuk et al., 2016). These numbers show that current social assistance and minimum wage rates do not reflect the true costs of living.

What is the solution?

Community responses to food insecurity such as food banks and meal programs provide some low income individuals and families temporary hunger relief. However, they do not to address the root problem, which is poverty. These programs will never be enough to truly address food insecurity. The only long term solution to food insecurity is to reduce poverty rates.

Advocacy efforts to provincial and federal governments are needed to support policy change to improve the social safety net, and in turn, promote health and wellbeing for all, including:

- The implementation of a basic income guarantee for all;
- Immediate increased social assistance and minimum wage rates to reflect the actual cost of living and indexed annually to inflation; and
- More stable employment opportunities (e.g. full-time employment opportunities with medical benefits)

Encouraging News

In February 2016, the Ontario government announced their plan to implement a pilot of the basic income guarantee (Ministry of Finance, 2016). A basic income guarantee would ensure adequate income for all, regardless of work status (Basic Income Canada Network, 2016). In Canada, a successful example of a basic income guarantee is the Guaranteed Income Supplement for adults aged 65 years and older. Research shows that food insecurity rates drop by fifty per cent among low income people aged 65 to 69 compared to those 60 to 64 (OSNPPH Food Security Workgroup, 2015). In November 2016, the Honourable Hugh Segal submitted a discussion paper, *Finding a Better Way: A Basic Income Pilot for Ontario,* and the government announced a public Basic Income Pilot consultation (Ministry of Community and Social Services, 2016).

Bill 6, An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission, was reintroduced in the Ontario legislature in September 2016 (Legislative Assembly of Ontario, 2016). This bill would establish an advisory group that would recommend social assistance rates each year for different regions of the province. The group's recommendation would be based on the actual costs of living including nutritious food, housing, utilities, transportation, telephone, internet access, and other basic necessities.

What can you do?

- Share these messages
    - Poverty is the root cause of food insecurity
    - Implement a basic income guarantee for all
    - Increase social assistance and minimum wage rates
    - Ensure health benefits for all
    - Strengthen employment standards to reduce unstable employment and improve working conditions
- Talk or write to your local MP and MPP
    - Share your support for the basic income guarantee and Bill 6
- Endorse your local food charter
    - Nipissing & Area Food Charter: www.nipissingareafood.ca
    - Parry Sound & Area Food Charter: https://parrysoundareafood.com

Additional Resources

- PROOF, Research to Identify Policy Options to Reduce Food Insecurity: http://proof.utoronto.ca/
- Basic Income Canada Network: http://www.basicincomecanada.org/about_basic_income
- Basic Income Pilot Consultation: https://www.ontario.ca/page/basic-income-pilot-consultation
- Ontario Society of Nutrition Professionals in Public Health – Position Statement on Responses to Food Insecurity: http://www.osnpph.on.ca/news/membership/news/osnpph-releases-position-statement-on-responses-to-food-insecurity
- Dietitians of Canada – www.dietitians.ca/foodinsecurity
- Call 705-474-1400 or 1-800-563-2808 and ask to speak with a Public Health Dietitian

References

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Dietitians of Canada. (2016). Executive summary addressing household food insecurity in Canada: Position statement and recommendations. Retrieved from http://www.dietitians.ca/Downloads/Public/HFI-Executive-Summary-Dietitians-of-Canada-FINAL.aspx

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Ministry of Health Promotion. (2010). Nutritious food basket guidance document. Retrieved from http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guidance/nutritiousfoodbasket_gr.pdf

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Tarasuk, V, Mitchell, A, Dachner, N. (2016). Household food insecurity in Canada, 2014. Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved from http://proof.utoronto.ca

The Cost of Healthy Eating

North Bay Parry Sound 2016

$885 Local monthly cost to feed a family of 4.

12% of Ontario households are food insecure

59% of food insecure households in Ontario have income from employment

Household food insecurity = Not enough money to buy healthy food

Higher rates of:

- Diabetes
- Heart disease
- Depression
- High blood pressure

In children, higher rates of:

- Asthma
- Depression later in life

What can you do?

Share these messages

- Poverty is the root cause of food insecurity
- Implement a basic income guarantee for all
- Increase social assistance and minimum wage rates
- Ensure health benefits for all
- Strengthen employment standards to reduce unstable employment and improve working conditions

Talk or write to your local MP and MPP

Sign your local food charter at:

www.nipissingareafood.ca
www.parrysoundareafood.com

What is left

after monthly rent and food costs?

Family of Four on Ontario Works	Individual on Ontario Works
$2,245 INCOME	$780 INCOME
- $1,131 RENT	- $550 RENT
- $885 FOOD	- $297 FOOD
+ $229 REMAINING	- $67 MINUS BALANCE

For heat, hydro, telephone, child care, transportation, clothing, out of pocket health costs etc.

Social assistance rates are inadequate

All people should have access to a nutritious, adequate and culturally appropriate diet

Learn more

www.myhealthunit.ca @NBPSDHealthUnit facebook.com/NorthBayParrySoundDistrictHealthUnit

North Bay Parry Sound District Health Unit

DURHAM REGION

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

605 ROSSLAND ROAD EAST
PO BOX 623
WHITBY, ON L1N 6A3
CANADA

905-668-7711
1-800-372-1102
Fax: 905-668-9963

www.durham.ca

Matthew L. Gaskell
Commissioner of
Corporate Services

December 14, 2016

The Honourable Kathleen Wynne
Premier
Minister of Intergovernmental Affairs
Room 281
Main Legislative Building
Queen's Park
Toronto ON M7A 1A1

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, re: Nutritious Food Basket
Our File: P00

Honourable Premier, please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on December 14, 2016, Council adopted the following recommendations of the Committee:

"A) That the correspondence from Peterborough Public Health urging the Government of Ontario to continue provincial monitoring of food insecurity rates, to participate in a pan-Canadian food security strategy as proposed by the Dietitians of Canada, and to use the costs of nutritious food basket (NFB) in setting social assistance rates be endorsed; and

B) That the Premier of Ontario, Ministers of Community and Social Services, Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health be so advised."

Please find enclosed a copy of the Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, for your information.

Debi A. Wilcox, MPA, CMO, CMM III
Regional Clerk/Director of Legislative Services

DW/np

Attach.

If this information is required in an accessible format, please contact 1-800-372-1102 ext. 2009.

*"Service Excellence for our **Communities**"*

c: The Honourable Helena Jaczek, Minister of Community and Social Services
The Honourable Charles Sousa, Minister of Finance
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
Lorne Coe, MPP (Whitby/Oshawa)
The Honourable Tracy MacCharles, MPP (Pickering/Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R. Kyle, Commissioner and Medical Officer of Health

TOWNSHIP OF NAIRN AND HYMAN

64 McIntyre Street • Nairn Centre, Ontario • P0M 2L0 ☎ 705-869-4232 🖷 705-869-5248
Established: March 7, 1896 Office of the Clerk Treasurer, CAO E-mail: nairncentre@personainternet.com

December 16, 2016

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto ON M7A 1A1

RE: Nutritious Food Basket 2016

Dear Honourable Premier:

Please be advised that our Council adopted the following resolution at their meeting of December 12, 2016:

SUPPORT OF RESOLUTION REGARDING BASIC INCOME GUARANTEE
RESOLUTION #2016-16-289
MOVED BY: Charlene Y. Martel
SECONDED BY: Riet Wigzell

RESOLVED: that Council supports resolution #50-16 adopted by the Sudbury and District Health Unit, dated October 20, 2016 commending the provincial government on taking steps to investigate basic income guarantee as a policy option for reducing poverty and that social assistance rates be increased to reflect the actual cost of nutritious food and adequate housing as informed by the current results of the Ministry of Health and Long-Term Care's Nutritious Food Basket and the Canada Mortgage and Housing Corporation Rental Income (Ontario) reports

CARRIED

Sincerely Yours,

Robert Deschene
CAO
LF/lc
cc: Sudbury and District Health Unit
The Honourable Eric Hoskins, Minister of Health and Long Term Care
The Honourable Helen Jaczek, Minister of Community & Social Services
Michael Mantha, MPP, Algoma-Manitoulin

DURHAM REGION

December 14, 2016

The Right Honourable Justin Trudeau
Prime Minister
House of Commons
Ottawa ON K1A 0A6

COPY

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

605 ROSSLAND ROAD EAST
PO BOX 623
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1-800-372-1102
Fax: 905-668-9963

www.durham.ca

Matthew L. Gaskell
Commissioner of
Corporate Services

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, re: Student Nutrition Programs
Our File: P00

Honourable Sir, please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on December 14, 2016, Council adopted the following recommendations of the Committee:

"A) That the correspondence from Peterborough Public Health dated September 30, 2016 urging the Governments of Canada and Ontario to provide student nutrition programs with enhanced and stable funding to meet the needs of all elementary and secondary students in Ontario be endorsed; and

B) That the Prime Minister of Canada, Ministers of Families, Children and Social Development, Health and Finance, Durham's MPs, Premier of Ontario, Ministers of Children and Youth Services, Education, Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health be so advised."

Please find enclosed a copy of the Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, for your information.

Debi A. Wilcox, MPA, CMO, CMM III
Regional Clerk/Director of Legislative Services

DW/np

Attach.

If this information is required in an accessible format, please contact 1-800-372-1102 ext. 2009.

"Service Excellence for our Communities"

100% Post Consumer

c: The Honourable Jean-Yves Duclos, Minister of Families, Children and Social Development
The Honourable Jane Philpott, Minister of Health
The Honourable William Francis Morneau, Minister of Finance
Mark Holland, MP (Ajax)
Erin O'Toole, MP (Durham)
Jamie Schmale MP
Kim Rudd, MP
Dr. Colin Carrie MP (Oshawa)
Jennifer O'Connell, MP (Pickering/Uxbridge)
Celina Caesar-Chavannes MP (Whitby)
The Honourable Kathleen Wynne, Premier
The Honourable Michael Coteau, Minister of Children and Youth Services
The Honourable Mitzie Hunter, Minister of Education
The Honourable Charles Sousa, Minister of Finance
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
Lorne Coe, MPP (Whitby/Oshawa)
The Honourable Tracy MacCharles, MPP (Pickering/Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R. Kyle, Commissioner and Medical Officer of Health

DURHAM REGION

December 14, 2016

The Right Honourable Justin Trudeau
Prime Minister
House of Commons
Ottawa ON K1A 0A6

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

605 ROSSLAND ROAD EAST
PO BOX 623
WHITBY, ON L1N 6A3
CANADA

905-668-7711
1-800-372-1102
Fax: 905-668-9963

www.durham.ca

Matthew L. Gaskell
Commissioner of
Corporate Services

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, re: Marketing of Food and Beverages to Children
Our File: P00

Honourable Sir, please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on December 14, 2016, Council adopted the following recommendations of the Committee:

"A) That the correspondence from Peterborough Public Health dated November 4, 2016 supporting the Government of Canada's intent to restrict the marketing of food and beverages to children be endorsed, and to consider Bill S-228; and

B) That the Prime Minister of Canada, Minister of Health, Durham's MPs, Chief Public Health Officer and all Ontario boards of health be so advised."

Please find enclosed a copy of the Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, for your information.

Debi A. Wilcox, MPA, CMO, CMM III
Regional Clerk/Director of Legislative Services

DW/np

Attach.

c: The Honourable Jane Philpott, Minister of Health
Mark Holland, MP (Ajax)
Erin O'Toole, MP (Durham)

If this information is required in an accessible format, please contact 1-800-372-1102 ext. 2009.

"Service Excellence for our Communities"

Jamie Schmale MP
Kim Rudd, MP
Dr. Colin Carrie MP (Oshawa)
Jennifer O'Connell, MP (Pickering/Uxbridge)
Celina Caesar-Chavannes MP (Whitby)
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R. Kyle, Commissioner and Medical Officer of Health

HURON
COUNTY

COPY

December 8, 2016
The Honourable Dr. Jane Philpott
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON K1A 0K9
Jane.Philpott@parl.gc.ca

Dear Minister Philpott:

Re: Children's marketing restrictions, federal Healthy Eating Strategy, and support for Bill S-228 and Bill C-313

Our Board of Health writes this letter expressing support for the federal government's plan to consider marketing restrictions as part of their recently announced Healthy Eating Strategy. This issue requires prompt attention to support the health and well-being of our population. We applaud and offer our express support for the two current private member bills seeking to address this issue: Senator Green-Raine's private member bill, Bill S-228, which if passed, would prohibit the advertisement of food and beverages to children under the age of 13 years; and Peter Julian's private member bill C-313, National Strategy on Advertising to Children Act, which focuses on strategy about advertising to children and amending the Broadcasting Act.

Over the last 5 years, it has become clear that restrictions on marketing to children are warranted. Protecting children from exposure to commercial marketing empowers parents to instill healthy habits in their children. Research in this intervention has shown that effective marketing restrictions help prevent chronic health conditions and allow children to grow up without the negative influences that powerfully shape food and beverage choices. National polling has revealed broad population support for such interventions.

Peterborough Public Health said it well:
Young children cannot distinguish between truth and the claims of advertisement. Young children are still developing their palate and food preferences. Parents often complain that they feel powerless to fend off the food industry's well-funded and well positioned campaign to create a demand for their products. Ontario's schools have policies promoting healthy choices in foods and beverages, but leaving the nutritional protection of children up to schools is too little and too late. Clearly we need to do more to protect vulnerable children from the onslaught of marketing to allow families, schools and community agencies like public health to support these children in making healthy choices.

Huron County Health Unit
77722B London Road, RR 5, Clinton, ON N0M 1L0 CANADA
Tel: 519.482.3416 Confidential Fax: 519.482.9014 www.huronhealthunit.ca

We know:

- Canada has one of the highest rates of advertising to children compared to many other developed countries. There are many different types of advertising to children including television, product packaging, branding, social media and digital technology.
- Advertisers actively target children and youth.
- Children are particularly vulnerable to advertising due to their underdeveloped cognitive and critical thinking skills. It influences preferences, perceptions, purchase requests and consumption patterns. Even adults are highly susceptible to advertising power, though we'd like to believe we're not.
- Advertising to children is essentially misleading. In 1989, the Supreme Court of Canada concluded that "advertising directed at young children is per se manipulative."
- Food and beverage advertising is a known contributor to poor food environments, purchasing and eating behaviours, and the development of chronic disease.
- Canadians diets are not meeting recommendations for nutrition and health.
- There is significant evidence that Canada's current approach to marketing to kids (voluntary regulation) is not working.
- It should be our highest priority to create an environment that supports children to grow up healthy.
- Most major health promotion and public health bodies agree that addressing advertising to children is a top priority.

The Huron County Health Unit is committed to protecting the health and well-being of our residents. We strongly believe that the implementation of federal marketing restrictions, similar to those imposed in Quebec, as part of your recently announced Healthy Eating Strategy, will help to do so.

The Huron County Health Unit can add its voice to the growing concern about the impact of advertising for children with a letter of support for Bill S-228 and Bill C-313.

Sincerely,

Tyler Hessel
Chair, Huron County Board of Health

cc:

Ben Lobb, MP, Huron-Bruce
Lisa Thompson, MPP, Huron-Bruce
Association of Local Public Health Agencies
Ontario Boards of Health

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December 13, 2016

The Honourable Dr. Jane Philpott
Health Canada
70 Colombine Driveway, Tunney's Pasture
Ottawa, ON N1A 0K9

Dear Minister Philpott,

Re: Bill S-228, *An Act to amend the Food and Drugs Act (prohibiting food and beverage marketing directed at children)*

At its December 8, 2016 meeting, under Correspondence item b), the Middlesex-London Board of Health voted to endorse the following:

b) Date: 2016 November 04 (Received 2016 November 07)
Topic: Bill S-228, *An Act to amend the Food and Drugs Act (prohibiting food and beverage marketing directed at children)*
From: Rosana Salvaterra, Medical Officer of Health, Peterborough Public Health
To: Dr. Jane Philpott, Health Canada

Background:
Creating supportive environments for healthy food choices makes the healthier choice the easier choice. Many public health advocacy groups have recommended limitations on marketing that is targeted at children. Peterborough Public Health echoes the recommendations identified by the Healthy Kids Panel and wrote the Federal Minister of Health to support their plan to consider marketing restrictions.

The Board of Health received a report in March 2016 regarding the Impact of Sugar Sweetened Beverage and Creating Supportive Environments. At this meeting the Board of Health endorsed the Heart and Stroke Foundation's position statement that includes a wide range of recommendations one of which is a reduction in marketing to children.

It was moved by Mr. Meyer, seconded by Ms. Vanderheyden *that the Board of Health endorse correspondence item b)* Bill S-228, *An Act to amend the Food and Drugs Act (prohibiting food and beverage marketing directed at children)*

Carried

The Middlesex-London Board of Health is pleased to support plans to consider marketing restrictions as part of a comprehensive Healthy Eating Strategy.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc: Bev Shipley, MP, Lambton-Kent-Middlesex
Irene Mathyssen, MP, London-Fanshawe
Karen Vecchio, MP, Elgin-Middlesex-London
Kate Young, MP, London West
Peter Fragiskatos, MP, London North Centre
Association of Local Public Health Agencies, Ontario Boards of Health

From:	Helene Leroux
To:	Helene Leroux
Subject:	FW: Jan Board: January 2017 Update for North East Board of Health Chairs
Date:	January 6, 2017 10:06:47 AM

From: Maria Cook [mailto:Maria.Cook@porcupinehu.on.ca]
Sent: Thursday, January 5, 2017 5:08 PM
To: Carmen Kidd (Temiskaming) <ckidd@temiskamingshores.ca>; Lee Mason (Algoma) <cluukkonen@algomapublichealth.com>; Rachel Quesnel <quesnelr@sdhu.com>; Nancy Jacko (nhjacko@icloud.com) <nhjacko@icloud.com>
Cc: Don West <Don.West@porcupinehu.on.ca>; Gilles Chartrand <girard_chartrand@hotmail.com>
Subject: January 2017 Update for North East Board of Health Chairs

Dear Board of Health Chairs,

Happy New year to all! Please find attached, from Mr. Gilles Chartrand, your North East regional representative on the Board of Health Executive/alPHa Board of Directors, an alPHa Update, for your information. The next meeting of the alPHa BOH Executive will take place on Tuesday, January 24th and the next alPHa Board meeting will take place on Friday, February 3rd. If you have any items for discussion at either of these meetings, please forward to Gilles Chartrand at girard_chartrand@hotmail.com with a copy to me maria.cook@porcupinehu.on.ca.

Thank you.

Maria Cook

for

Gilles Chartrand

Board of Health Chair, Porcupine Health Unit

girard_chartrand@hotmail.com

Maria Cook
Executive Assistant to the Chief Administrative Officer, and
Secretary to the Board of Health

Porcupine Health Unit
Postal Bag 2012, 169 Pine St. So.
Timmins, ON P4N 8B7
Phone: 705-267-1181, Ext. 2361
Fax: 705-264-3980
maria.cook@porcupinehu.on.ca

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Providing leadership in public health management

UPDATE FOR BOH CHAIRS – January 2017

Patients First Activities

On December 7, 2016 The Ontario Legislature yesterday passed Bill 41 - *The Patients First Act*. In the Ministry's news release (click here) announcing the passage, the Act will, among other things, "formally connect Local Health Integration Networks (LHINs) and local boards of health to leverage their community expertise and to ensure local public health units are involved in community health planning." alPHa president Valerie Jaeger provided a quote for the ministry's news release.

On December 1, 2016 the bill was ordered to Third Reading in the Ontario Legislature with a number of amendments. alPHa updated its summary of the bill when it was first introduced, including changes that had been made since Second Reading. Prior to Third Reading, consultations on Bill 41 were held in November with the Standing Committee on the Legislative Assembly. On November 16, alPHa president Valerie Jaeger presented to the Committee on behalf of the Association, which also provided a written submission.

As one of 16 work streams that have been created to work on different aspects of Patients First, a Public Health Work Stream, co-chaired by Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, and Michael Barrett, CEO, South West LHIN, has been established. The Public Health Work Stream will focus on formal linkages between LHINs and boards of health to support alignment and improved population health. alPHa's Executive Director, Linda Stewart, and the Boards of Health Section Chair, Mary Johnson are members of the Work Stream along with representatives from COMOH, AMO, the LHINs and the Ministry of Health and Long-Term Care.

The Public Health Expert Panel, first recommended in the Patients First discussion paper released in December 2015, has now been established and will have its first meeting in early January 2017.

alPHa and its board will be monitoring developments closely as Patients First activities continue to roll out and plan next steps.

Ontario Public Health Standards Review

alPHa continues to coordinate opportunities for the 19 alPHa members who are participants on the committees involved in the review of the Ontario Public Health Standards (OPHS) and Organizational Standards to discuss activities by teleconference. Recommendations regarding the OPHS are expected to be released for consultation in the coming weeks.

Skills Based Boards

A small group of alPHa's BOH Section Executive met at the end of November to provide initial feedback on a draft set of tools to support skills-based boards of health that have been developed by the Institute of Governance for the Ministry of Health and Long-Term Care. The feedback will be collated to form an official alPHa response.

alPHa Strategic Plan

An update of activities related to alPHa's 2014-2016 Strategic Plan, *Building on Our Strengths*, is available on alPHa's website by clicking here. This plan was distributed at the Boards of Health Section Meeting held on November 18 in Toronto. For the past several years alPHa has been focusing on the following five key strategic areas: promoting members, representing members, supporting members, connecting members and enriching members.

Wrap Up: 2016 Fall Symposium

alPHa successfully concluded its Fall Symposium, *Cultural Competencies to Support Indigenous Truth and Reconciliation*, on November 17 in Toronto. Thanks go to the guest speakers and attendees who participated in this informative and timely event. For the full proceedings and presentations, please visit alPHa's website by clicking here.

Recap: November 2016 Boards of Health Section Meeting

On November 18, 2016 the BOH Section held a meeting at which board of health members received an update on alPHa's activities related to member support, promotion and enrichment. Monika Turner from the Association of Municipalities of Ontario (AMO) presented an update on AMO's activities regarding public health, including the renewal of its Health Task Force. A main focus of the presentation was the impact of the provincial government's transformation agenda on the municipal sector and health.

AMO's update was followed by guest presenters who spoke to the Basic Income Guarantee issue and Ontario's pilot project in this area. Associate Medical Officer of Health, Dr. Lisa Simon from Simcoe Muskoka District Health Unit and Sheila Regehr, who co-founded the Basic Income Network, also provided updates on public health advocacy and the political landscape surrounding this issue. Several suggestions were made on how best to increase support for this issue across municipalities, including the provision of tools and talking points to assist municipalities to further understand and promote Basic Income.

Upcoming Meetings for All Board of Health Members

February 23, 2017 – alPHa Winter Symposium, DoubleTree by Hilton Toronto Downtown Hotel, Toronto. Further program and registration details to come.

February 24, 2017 – alPHa Boards of Health Section Meeting at the DoubleTree by Hilton Toronto Downtown Hotel.

Next alPHa Board of Directors Meeting

The alPHa Board of Directors will meet next on February 3, 2017. If your board of health has any issues it would like raised at the alPHa Board meeting, please contact your regional representative on the alPHa Boards of Health Section Executive Committee.

This update was brought to you by your regional representative on the Boards of Health Section Executive Committee of the alPHa Board of Directors. alPHa provides a forum for member boards of health and public health units in Ontario to work together to improve the health of all Ontarians. Any individual who sits on a board of health that is a member organization of alPHa is entitled to attend alPHa events and sit on its various committees.

Municipality of CENTRAL MANITOULIN

6020 Highway 542, P.O. Box 187
Mindemoya, ON P0P 1S0
Tel: 705-377-5726
Fax: 705-377-5585
Email: centralm@amtelecom.net

November 29, 2016

Sudbury & District Health Unit
1300 Paris Street
Sudbury, ON P3E 3A3

Please be advised of the following motion passed during open Council on November 24th, 2016:

431-16 MOTION: MacDonald and Taylor

That Council support the Manitoulin Municipal Association request to support **Resolution 16-16: RESOLVED to support the Manitoulin Drug Strategy "to work in collaboration to promote health and prevent substance misuse, restore and maintain community safety and advocate for services and support for people living with addictions".....carried.**

If you require any further information please do not hesitate to contact us.

Yours truly,

S. Bowerman

Sarah Bowerman
Administrative Assistant

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound
in your community . . . here for your health
681 Commercial Street, North Bay, ON P1B 4E7 TEL 705.474.1400 FAX 705.474.8252
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL 705.746.5801 FAX 705.746.2711
myhealthunit.ca TOLL FREE 1 800 563 2808

December 5, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear: Minister Hoskins

Subject: Health Hazards of Gambling – BOH Resolution #BOH/2016/11/10

On November 30, 2016, at a meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board approved the following motion #BOH/2016/11/10:

Whereas, *a casino development is likely to occur within the Nipissing region due to provincial gambling expansion, and*

Whereas, *gambling expansion has been identified as a significant public health issue in Ontario and internationally due to its links to the prevalence of problem gambling, and*

Whereas, *increased availability and accessibility of gambling, including new casinos or slot machines, is strongly associated with increases in the prevalence of problem gambling, and*

Whereas, *problem gambling has serious adverse health impacts on individuals, families and communities, and*

Whereas, *the impacts of problem gambling are not evenly distributed in the community - males, youth, older adults, Aboriginal peoples, individuals and families with low income are disproportionately affected, and*

Whereas, *an estimated 35 percent of Ontario gambling revenue is derived from people with moderate and severe gambling problems, and*

Whereas, *a broad range of policies and strategies that focus on prevention are needed to minimize the probability of problem gambling occurring and to reduce health and social impacts for problem gamblers and their families, and*

Whereas, *healthy gambling builds on the World Health Organization (WHO) definition of health and involves informed choice on the probability of winning, a pleasurable gambling experience in low-risk situations, and wagering in sensible amounts of money for sensible amounts of time.*

Now Therefore Be It Resolved, *the Board of Health endorse a North Bay Parry Sound District Health Unit Position Statement that:*

- *gambling expansion has adverse health impacts on individuals, families and communities, and*

- *a public health strategy of prevention and harm reduction be recommended, and*

Furthermore Be It Resolved, *the Board of Health recommend to municipalities within our district implementing gambling expansion initiatives that municipalities:*

- *collaborate with the Health Unit to develop and employ strategies as outlined herein that prevent or mitigate gambling-related harm and protect vulnerable populations at risk of gambling addiction, those least able to recover from the consequences of problem gambling, and*
- *to set aside an adequate portion of gambling revenues to:*
    - *undertake a baseline study to determine the prevalence of problem gambling within our community, and*
    - *undertake a future study to determine the impact of a local casino on problem gambling, and*
    - *establish a responsible and problem gambling program to help prevent and reduce the harmful impacts of excessive or uncontrolled gambling and which provides education, free support and treatment services.*

Furthermore Be It Resolved*, that the Board of Health for the North Bay Parry Sound District Health Unit provide correspondence of this resolution to member municipalities, Premier Kathleen Wynne, Deputy Premier Deb Matthews, the Honourable Dr. Eric Hoskins (Minister of Health and Long-Term Care), the Association of Local Public Health Agencies (alPHa) and Ontario Boards of Health.*

Sincerely,

James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

C: Hon. Kathleen Wynne, Premier of Ontario
Hon. Deb Matthews, Deputy Premier of Ontario
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

HURON COUNTY

January 5, 2017

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Hoskins:

Re: HPV/Immunizations Program Funding

On December 8, 2016 at a regular meeting of the Board of Health for the Huron County Health Unit, the board considered the attached correspondence from the Boards of Health for Grey Bruce, Peterborough and Algoma Health Units regarding the annual funding for the Vaccine Preventable Disease Program and the following motion was passed:

MOTION:
Moved by: Member Rognvaldson and Seconded by: Member Gowing
THAT:
The Huron County Board of Health endorses correspondence from the Peterborough Public Health Board of Health and Algoma Public Health Board of Health regarding the HPV/Immunization Program Funding.

CARRIED

Sincerely,

Tyler Hessel
Chair, Huron County Board of Health

cc:
Hon. Dr. Bob Bell, Deputy Minister, MOHLTC
Roselle Martino, Executive Director, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Ben Lobb, MP, Huron-Bruce
Lisa Thompson, MPP, Huron-Bruce
Association of Local Public Health Agencies
Ontario Boards of Health

Encl.

Huron County Health Unit
77722B London Road, RR 5, Clinton, ON N0M 1L0 CANADA
Tel: 519.482.3416 Confidential Fax: 519.482.9014 www.huronhealthunit.ca

Information Break

December 8, 2016

This semi-monthly update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

2016 Fall Symposium - Indigenous Cultural Competencies

alPHa concluded another successful Fall Symposium last month on *Cultural Competencies to Support Indigenous Truth and Reconciliation*. The November 17 workshop featured presentations by the Ministry of Indigenous Relations and Reconciliation and the National Centre for Truth and Reconciliation as well as a panel discussion focusing on public health support of and engagement with Indigenous populations. A highlight for many was the afternoon training workshop with facilitators from the Ontario Federation of Indigenous Friendship Centres. Thank you to members and speakers who joined us in Toronto for this informative and educational event. For those who could not attend, alPHa is pleased to have summarized the Fall Symposium proceedings that include all slide presentations and which now have been uploaded to the alPHa website.
View the 2016 Fall Symposium Proceedings of November 17 here

Patients First Update

The Ontario Legislature yesterday passed Bill 41 - *The Patients First Act*. In the Ministry's news release announcing the passage, the Act will, among other things, "formally connect Local Health Integration Networks (LHINs) and local boards of health to leverage their community expertise and to ensure local public health units are involved in community health planning." alPHa president Valerie Jaeger is quoted in the December 7 news release: "*By mandating a relationship between Local Public Health and LHINs, the Patients First Act creates an important avenue for incorporating population health and health equity principles into health system planning. As public health professionals, we applaud the measures proposed in the Patients First Act that aim to bring disease-prevention and health promotion principles to local health system planning in Ontario. We strongly believe that the best way to guarantee improvements in the quality of patient-centred care and truly put patients first is to prevent Ontarians from becoming patients for as long as possible*."
Read the Ministry news release announcing passage of The Patients First Act

On December 1, the bill was ordered to Third Reading in the Ontario Legislature with a number of amendments. alPHa has updated its summary of the bill when it was first introduced, including changes that have been made since Second Reading (see below). In the coming weeks, alPHa will be working with the Ministry of Health and Long-Term Care and other colleagues to better understand next steps.
Read the latest version of Bill 41 - The Patients First Act (including tracked changes since 2nd reading)
View alPHa's Summary of Bill 41 here

Prior to Third Reading, consultations on Bill 41 were held in November with the Standing Committee on the Legislative Assembly. On November 16 alPHa president Valerie Jaeger presented to the Committee on behalf of the Association, which also provided a written submission.
Read alPHa's Nov. 16 deputation to the Standing Committee and written submission to Committee hearings (submission follows deputation beginning on page 5)

On Our Radar

Local Public Health Funding - The alPHa board of directors is monitoring the issue of health unit budgets closely. The board is drafting a letter to the Minister of Health and Long-Term Care to express concerns over the budgeting for Ontario's health units and their boards and the means through which it is being determined. The letter will be circulated for the membership's information when finalized. alPHa is also currently gathering data on provincial/ municipal funding ratios for further study.

Basic Income Pilot - The Ontario government recently launched a consultation process to get public input that will inform the design of a basic income pilot. Basic income refers to a government payment to eligible people to ensure they meet a minimum income level. The consultation will be based on a discussion paper produced for the province, which is now asking members of the public to complete an online survey on the development of the pilot project. The consultation period runs from November 2016 to January 2017. alPHa is on the books for supporting a basic income guarantee through its 2015 resolution which endorses the basic income concept. The resolution also calls on federal and provincial ministers to jointly explore this policy option to reduce poverty and income insecurity.
Read the news release on the Basic Income consultation here
Download the discussion paper on an Ontario Basic Income Pilot
View 2015 alPHa resolution on Basic Income Guarantee

Through their joint Health Equity Work Group, alPHa and the Ontario Public Health Association (OPHA) will be submitting a written response during the consultation period and plan to attend the in-person consultation sessions. Once finalized, the written submission will be shared with the alPHa membership.

Public Health Items of Interest

Continuous Quality Improvement in Ontario Public Health Units (from Public Health Ontario)
Final Report on the Winnable Battles Program, an effort to make the biggest health impact in America in the shortest time (from the Centers for Disease Control & Prevention)
Increasing Ontarians' Availability to Travel Vaccines (from MOHLTC)
Annual Report of Ontario's Chief Drinking Water Inspector (from MOHLTC)
Ontario Proposes Amendments to Municipal Act (from Ministry of Municipal Affairs)
Federal Health Minister Unveils Healthy Eating Strategy (from Health Canada)

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alPHaWeb Feature: Current Consultations

Health units and members of the public are often invited by government to provide their input on legislation and initiatives of interest. alPHa has compiled a list of consultation opportunities for members on its website. Click below to view.
Go to alPHa's list of Current Consultations

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alPHa Group Insurance Offer

alPHa members and all health unit staff are eligible to receive an exclusive group discount of 12.5% on home and auto insurance from Aviva Insurance. Request a quote today by visiting www.alphagroupinsurance.ca or by calling 1-877-787-7021. Other benefits include: additional savings available through other discounts, free access to personal legal, home and health information service (included with home insurance policies), and professional claims handling backed by Claims Service Satisfaction Guarantee.

Upcoming Events - Mark your calendars!

February 23 & 24, 2017 - alPHa Winter Symposium, Doubletree Hilton Hotel, Toronto, Ontario.

March 29-31, 2017 - TOPHC 2017: Global challenges. Local Solutions. Allstream Centre, Toronto.

June 11, 12 & 13, 2017 - 2017 alPHa Annual General Meeting and Conference: *Driving the Future of Public Health*, Chatham-Kent John D. Bradley Convention Centre, Chatham, Ontario.

alPHa is the provincial association for Ontario's public health units. You are receiving this update because you are a member of a board of health or an employee of a health unit.

alPHa
Association of Local
PUBLIC HEALTH
Agencies

Information Break

January 10, 2017

This semi-monthly update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

Save the Date: Feb. 23 & 24 alPHa Winter Symposium

Even though it seems alPHa's fall membership event just wrapped up yesterday, planning is underway for the **2017 Winter Symposium**, which will take place on February 23 at the DoubleTree by Hilton in downtown Toronto. On the following day, February 24, alPHa will be holding concurrent Section meetings for board of health members and medical officers of health at the same venue. Details on registration and program coming soon.

TOPHC 2017: Global challenges. Local solutions.

The 7th annual The Ontario Public Health Convention (TOPHC) will be held March 29-31, 2017 at the Allstream Centre in Toronto. A collaboration of Public Health Ontario, alPHa and the Ontario Public Health Association, TOPHC is an opportunity for public health professionals to learn from each other, provoke thought, and get motivated to make a difference in the practice of public health. This year's theme, ***Global challenges. Local solutions.*** will highlight solutions to the global challenges facing public health every day. Emerging infectious diseases, the effects of the social determinants of health, the impacts of climate change, and rising chronic diseases will all be a focus. Come and learn about solutions to these pressing challenges and how to apply them to your work. Registration is now open; early bird deadline is **February 12**.
Register here for TOPHC 2017
Learn more about TOPHC 2017

Updated alPHa Records Retention Guidelines

alPHa has updated its *Guidelines on Minimum Retentions for Health Unit Records*. While retention periods have not changed, citations of legislation have been updated, where applicable, in the appendix, and links to legislation have also been added. Many thanks to the working group members from the following health units who assisted with the review: Haliburton, Kawartha Pine Ridge District; Leeds, Grenville & Lanark District; Niagara Region; and Wellington-Dufferin-Guelph. For a copy of the Guidelines, please send an email to alPHa.

Public Health Reports of Interest

Health Status of Canadians 2016: Report of the Chief Public Health Officer (released Dec. 15, 2016)

A Framework for the Legalization and Regulation of Cannabis in Canada -- The Final Report of the Task Force on Cannabis Legalization and Regulation (released Dec. 13, 2016)

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alPHaWeb Feature: Current Consultations

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Upcoming Events - Mark your calendars!

February 23 & 24, 2017 - alPHa Winter Symposium, DoubleTree Hilton Hotel, Toronto, Ontario. Registration and program details coming soon!

March 29-31, 2017 - TOPHC 2017: Global challenges. Local solutions. Allstream Centre, Toronto.

June 11, 12 & 13, 2017 - 2017 alPHa Annual General Meeting and Conference: *Driving the Future of Public Health*, Chatham-Kent John D. Bradley Convention Centre, Chatham, Ontario.

alPHa is the provincial association for Ontario's public health units. You are receiving this update because you are a member of a board of health or an employee of a health unit.

Financial Controls Checklist

Board of Health:	Board of Health for the Sudbury and District Health Unit	**Period ended:**	Dec. 31/16

Objective:

- The objective of the Financial Controls Checklist is to provide the Board of Health and the Public Health Unit with a tool for evaluating financial controls while also promoting effective and efficient business practices.

Responsibilities:

- This checklist is for the management of the public health unit to document that controls have been implemented. The controls listed in the checklist are not meant to be exhaustive. Management of the public health unit should outline other key controls in place for achieving the control objectives. One must note that no effective financial control is achieved by signing the checklist. The control is achieved through carrying out the key controls themselves.
- The following table outlines the responsibilities for completing and using this Financial Controls Checklist.

Description of Responsibilities	Board of Health	Management of the Public Health Unit
• Completion of Financial Controls Checklist		✓
• Review and assessment of the completed Financial Controls Checklist	✓	✓
• Ongoing design of financial controls		✓
• Ongoing preparation of policies related to financial controls		✓
• Ongoing testing of financial controls		✓
• Ongoing monitoring of financial controls testing results	✓	✓
• Approval of key financial controls and related policies	✓	✓
• Implementation of financial controls		✓

Financial controls support the integrity of the Board of Health's financial statements, support the safeguarding of assets, and assist with the prevention and/or detection of significant errors including fraud. Effective financial controls provide reasonable assurance that financial transactions will include the following attributes:

- **Completeness** – all financial records are captured and included in the board of health's financial reports;
- **Accuracy** – the correct amounts are posted in the correct accounts;
- **Authorization** – the correct levels of authority (i.e. delegation of authority) are in place to approve payments and corrections including data entry and computer access;
- **Validity** – invoices received and paid are for work performed or products received and the transactions properly recorded;
- **Existence** –assets and liabilities and adequate documentation exists to support the item;
- **Error Handling** – errors are identified and corrected by appropriate individuals;
- **Segregation of Duties** –certain functions are kept separate to support the integrity of transactions and the financial statements; and,
- **Presentation and Disclosure** – timely preparation of financial reports in line with the approved accounting method (e.g., Generally Accepted Accounting Principles (GAAP)).

Control Objective	Controls / Description	Control Deficiency (If Any) And Potential Impact
1. Controls are in place to ensure that financial information is accurately and completely collected, recorded and reported.	**Please select (☒) any following controls that are relevant to your board of health:** ☒ Documented policies and procedures to provide a sense of the organization's direction and address its objectives. ☒ Define approval limits to authorize appropriate individuals to perform appropriate activities. ☒ Segregation of duties (e.g., ensure the same person is not responsible for ordering, recording and paying for purchases). ☒ An authorized chart of accounts. ☒ All accounts reconciled on a regular and timely basis. ☒ Access to accounts is appropriately restricted. ☒ Regular comparison of budgeted versus actual dollar spending and variance analysis. ☒ Exception reports and the timeliness to clear transactions. ☒ Electronic system controls, such as access authorization, valid date range test, dollar value limits and batch totals, are in place to ensure data integrity. ☒ Use of a capital asset ledger. ☒ Delegate appropriate staff with authority to approve journal entries and credits. ☒ Trial balances including all asset accounts that are prepared and reviewed by supervisors on a monthly basis. ☐ Other – (*Please specify*)	*List control deficiencies and their potential impact.* **The SDHU is compliant with all items listed. No deficiencies to note.** *What is the action plan to correct the identified control deficiencies? Who is responsible to action the items? When will they be actioned?*

Control Objective	Controls / Description	Control Deficiency (If Any) And Potential Impact
2. Controls are in place to ensure that revenue receipts are collected and recorded on a timely basis.	**Please select (☒) any following controls that are relevant to your board of health:** ☒ Independent review of an aging accounts receivable report to ensure timely clearance of accounts receivable balances. ☒ Separate accounts receivable function from the cash receipts function. ☒ Accounts receivable sub-ledger is reconciled to the general ledger control account on a regular and timely basis. ☒ Original source documents are maintained and secured to support all receipts and expenditures. ☐ Other – (*Please specify*)	*List control deficiencies and their potential impact.* **The SDHU is compliant with all items listed. No deficiencies to note.** *What is the action plan to correct the identified control deficiencies? Who is responsible to action the items? When will they be actioned?*

Control Objective	Controls / Description	Control Deficiency (If Any) And Potential Impact
3. Controls are in place to ensure that goods and services procurement, payroll and employee expenses are processed correctly and in accordance with applicable policies and directives.	**Please select (☒) any following controls that are relevant to your board of health:** ☒ Policies are implemented to govern procurement of goods and services and expense reimbursement for employees and board members. ☒ Use appropriate procurement method to acquire goods and services in accordance with applicable policies and directives. ☒ Segregation of duties is used to apply the three way matching process (i.e. matching 1) purchase orders, with 2) packing slips, and with 3) invoices). ☒ Separate roles for setting up a vendor, approving payment and receiving goods. ☒ Separate roles for approving purchases and approving payment for purchases. ☒ Processes in place to take advantage of offered discounts. ☒ Monitoring of breaking down large dollar purchases into smaller invoices in an attempt to bypass approval limits. ☒ Accounts payable sub-ledger is reconciled to the general ledger control account on a regular and timely basis. ☒ Employee and Board member expenses are approved by appropriate individuals for reimbursement and are supported by itemized receipts. ☒ Original source documents are maintained and secured to support all receipts and expenditures. ☒ Regular monitoring to ensure compliance with applicable directives. ☒ Establish controls to prevent and detect duplicate payments. ☒ Policies are in place to govern the issue and use of credit cards, such as corporate, purchasing or travel cards, to employees and board members. . ☒ All credit card expenses are supported by original receipts, reviewed and approved by appropriate individuals in a timely manner.. ☒ Separate payroll preparation, disbursement and distribution functions. ☐ Other – (*Please specify*)	*List control deficiencies and their potential impact.* **The SDHU is compliant with all items listed. No deficiencies to note.** *What is the action plan to correct the identified control deficiencies? Who is responsible to action the items? When will they be actioned?*

Control Objective	Controls / Description	Control Deficiency (If Any) And Potential Impact
4. Controls are place in the fund disbursement process to prevent and detect errors, omissions or fraud.	**Please select (☒) any following controls that are relevant to your board of health:** ☒ Policy in place to define dollar limit for paying cash versus cheque. ☒ Cheques are sequentially numbered and access is restricted to those with authorization to issue payments. ☒ All cancelled or void cheques are accounted for along with explanation for cancellation. ☒ Process is in place for accruing liabilities. ☒ Stale-dated cheques are followed up on and cleared on a timely basis. ☒ Bank statements and cancelled cheques are reviewed on a regular and timely basis by a person other than the person processing the cheques / payments. ☒ Bank reconciliations occur monthly for all accounts and are independently reviewed by someone other than the person authorized to sign cheques. ☐ Other – (*Please specify*)	*List control deficiencies and their potential impact.* **The SDHU is compliant with all items listed. No deficiencies to note.** *What is the action plan to correct the identified control deficiencies? Who is responsible to action the items? When will they be actioned?*

Prepared by : *Manager, Accounting Services* **Date:** *January 5, 2017*

Position Title

Approved by : **Date:**

Medical Officer of Health/
Chief Executive Officer

Received by the Board of Health at the board meeting held on: **Date:**

Sudbury & District Health Unit

Service de santé publique

BOARD LEARNING AND INFORMATION SESSION
STRENGTHENING INDIGENOUS RELATIONSHIPS

NOVEMBER 9, 2016
SUDBURY, ON

Draft Prepared by:

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Birch Island, ON
P0P 1A0
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November 30, 2016

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Background

The Sudbury & District Health Unit has over the past five years, formally recognized the need to strengthen its relationships with First Nations and indigenous groups in order to ensure equitable access, the provision of responsive services and improved coordination in the delivery of public health services.

A November 2011 Board Motion expresses this interest and commitment as follows:

> *"That the board recognizing the worse overall health status and socioeconomic status challenges facing First Nations people in Canada and the historic separation between provincial public health systems and federally funded public health systems, direct the MOH to convene a workshop for the board for the purposes of orienting itself to these issues and determining board direction in this matter."*

A March 2012 workshop involving the Board of Health and SDHU staff considered and framed discussion around a number of important questions including:

1. What do we know about area First Nations and issues affecting health?
2. What public health / health care services already exist on reserve?
3. How does SDHU already interact with area First Nations?
4. What is the legal context of working with First Nations?
5. What about funding?
6. What are other boards of health doing?
7. What are possible next steps?

Based on the information and dialogue at this workshop, the SDHU Board provided direction and leadership to the organization in a follow up Board motion:

> *"That the Sudbury and District Board of Health, having carefully considered issues of health status, health services, historical relationships, and applicable legislation concerning area First Nations on-reserve; and having given thoughtful consideration to its strategic priorities of championing equitable opportunities for health, strengthening relationships with priority communities, and partners and supporting community voices to speak about issues that impact health equity; hereby direct the Medical Officer of Health to engage in dialogue with area First Nations' leaders to explore needs and strategies for strengthening public health programs and services with area First Nations."*

In the fall of 2016, the Board gave direction to the the Medical Officer of Health to renew the organization's commitment and efforts expressed in this board motion.

Towards that end, an Executive Retreat was held with senior managers of the SDHU on September 26, 2016 at Whitefish River First Nation. The purpose of the meeting was to explore pathways to strengthening relationships with First Nations and indigenous partners.

A follow up board information and learning session was convened to bring board members up to speed as to these activities and to allow board members to give direction to these efforts going forward. This session was held on November 9th, 2016 at the SDHU offices.

This report documents the key outcomes from discussion at this session.

Introduction

An information and education session was held on November 9th, 2016 for 18 members of the SDHU's Board of Health and Senior Management Executive Committee to consider and explore pathways to deepen and strengthen relationships with First Nations and indigenous groups in SDHU's service area.

The objective of the meeting was:

"To explore pathways for the SDHU to meaningfully and respectfully engage with Indigenous peoples in the SDHU service area."

Participants

Eighteen members of the SDHU Board of Health and senior managers who are members of the Executive Committee took part in this session. A local facilitator Mariette Sutherland and community elder Marion McGregor were also on hand to guide and support the process. Participants included:

Board of Health Members:

Maigan Bailey
Janet Bradley
Jeffery Huska
Robert Kirwan
René Lapierre
Stewart Meikleham
Ken Noland
Rita Pilon
Mark Signoretti (till approx. 11 am)
Carolyn Thain

Senior Management Executive Committee Members:

Megan Dumais, Director Health Promotion
Sandra Laclé, Director Clinical and Family Services
Stacey Laforest, Director Environmental Health
Rachel Quesnel, Executive Assistant to MOH, Secretary to Board of Health
France Quirion, Director Corporate Services (October 3, 2016)
Renée St Onge, Director Resources, Research, Evaluation and Development Division
Dr. Penny Sutcliffe, Medical Officer of Health
Dr. Ariella Zbar, Associate Medical Officer of Health

Format

The agenda for the strategic planning session was developed in collaboration with the Medical Officer of Health and the Director for Resources, Research, Evaluation and Development in two brief planning calls (see attachment in Appendix A). A comprehensive package of background information was prepared and provided to all participants (see attachment in Appendix B).

With a focus on learning and exploration, a number of key presentations and interactive discussions were structured for the morning. The afternoon was an opportunity for small group discussion about the vision, hopes, fears, risks and benefits of engaging more closely with First Nations and indigenous groups.

Topics for the morning portion of the information and learning session were framed around four principle areas:

- A discussion about "the journey – past and current" activities underway in working with First Nations health centres or other Aboriginal/indigenous health service organizations. A summary of the current collaborations and the types of activities that SDHU has thus far engaged in, in their work with First Nations and Aboriginal/indigenous organizations was presented.

- Presentation materials were also shared concerning the socio-demographic profile of First Nations and indigenous groups in the SDHU catchment area.

- A more open ended discussion was held concerning Indigenous engagement in support of public health including a brief environmental scan of recent public health policy directions, in particular, the work of Public Health Working Group, one of four sub-committees of the Tri Lateral First Nations Health Senior Officials Committee (TFNHSOC) ; the provincial review of the Ontario Public Health Standards and its implications for First Nations as well as a brief overview of the legal context for partnership agreements and engagement around the HPPA.

- Other presentations described the current situation within the organization vis a vis the recent cultural competency training, staff sharing circles and an analysis of supports described by the Executive Committee at its September retreat.

In the afternoon small group activities were used to animate discussion of the vision that SDHU has as an organization in deepening or strengthening its relationships with First Nations or Aboriginal/indigenous groups. Other activities explored the board's hopes, fears, risks and benefits as well as particular processes or supports that will be necessary to enable this approach and advance the organization toward its vision.

The day began with a morning prayer and ceremonial observance involving a smudge at Health Sciences North's Medicine Lodge lead by Elder Marion McGregor and supported by Lisa Pitawanakwat, HSN's Medicine Lodge Keeper. After reconvening at the Ramsey Room at SDHU's offices, Dr. Sutcliffe provided brief welcoming remarks and shared background as to the organization's vision and intention in this direction.

A brief roundtable of introductions took place and the goals for the day's retreat were reviewed. As an ice breaker, Board and EC members were asked to share a particular SDHU achievement they are proud of or value that guides their work. These values and accomplishments included such things as:

- Professionalism
- Equity
- Alignment with mission and vision
- Strong community ties
- Respect, humility and courage and being open minded
- How we empower individuals and communities to take ownership and agency over their own health
- Staff accomplishments, for example, a recent presentation at the OPHA annual conference
- Team work how staff are able to cover for one another, multitask and do whatever is needed to get the job done
- The fact that our services come to the people, where they are….
- Proud of the fact that SDHU is a leader and takes on things that even the province or federal departments do not tackle
- That we have strong focus on children's health in our organization

The full agenda including discussion activities is included in Appendix A.

Current collaborations with First Nations & indigenous groups

A comprehensive summary of the recent and current activities that Sudbury & District Health Unit (SDHU) divisions have engaged in with First Nations and indigenous groups was shared.

Board questions and commentary included:

- How are these activities being received – are we doing the right things?
- How about the governance – why don't we have a board representative or some indigenous representative? What has been the bottleneck in pursuing this direction more proactively?
- Why are we still talking about it? What do we need to do to make further progress?

Following this presentation, a socio demographic profile containing area First Nations population figures and other statistics within the SDHU catchment was prepared and presented as well to better situate everyone.

Some clarifications and limitations with respect to the statistics were shared. A Board member asked "how do the First Nations or indigenous people wish to refer to themselves".

Overview and discussion of legal context and provincial policy directions

Several important provincial policy directions were discussed including:

- Public Health Working Group of the Trilateral First Nations Health Senior Officials Committee (TFNHSOC)
- Truth and Reconciliation Commission – Ontario's Commitment
- Modernization of Ontario Public Health Standards

The legal context of working with First Nations and Section 50 of Ontario's Health Protection and Promotion Act was also briefly discussed. Section 50 provides for agreement between a Board of Health and a Band Council on the following terms:

- The Board of Health provides public health programs and services to band members.
- The Band agrees to accept the responsibilities of an obligated municipality (share in municipal levy).
- The Band has the right to appoint a member of the Band to a Board of Health.

In general, legal opinion of whether the HPPA applies on reserve varies in interpretation.

A frank discussion about the legal ambiguities associated with Section 50 agreements and applicability of the Health Promotion and Protection Act ensued.

A board member raised the question about risk and appropriateness of pursuing more formal relationships such as Section 50 agreements especially as enforceability of the HPPA on reserve settings is a matter of interpretation.

It was agreed that this would require ongoing advice and discussion moving forward but would not detract from the overall goal of seeking strengthened relationships with First Nations and indigenous groups.

In the afternoon, the board turned its attention to their overall vision in this regard, their hopes, fears, anticipated benefits and pragmatic risks.

Board Vision

What is the vision that the Board is driving towards in closer engagement with Indigenous peoples?

Two small groups discussed this question and formulated the following key elements of the vision SDHU has for itself in working more closely with indigenous community partners.

- SDHU has established relationships with indigenous partners that are founded on trust and respectful dialogue. The organization is respectful of cultural differences and the people in the organization have cultural competencies and confidence in working with indigenous partners.

- These relationships emphasize collaborative, two way engagement and participation as equals and are reciprocal, in that they generate benefits for all involved.

- The work that SDHU engages in, in partnership with indigenous groups is informed by First Nation and indigenous community perspectives and needs and their vision or model for public health.

- Access to equitable services, equitable opportunities for health and improved quality of life are key underpinnings of this vision. Principles of equity, a strengths-based approach and consideration of social determinants of health are foundational.

- In carrying out work towards this vision, SDHU is adaptable and tailors it approach to respond to community needs, priorities and aspirations.

- SDHU seeks to work collaboratively with all agencies, partners and government departments implicated in this work and exercises leadership to ensure all are coordinating and integrating efforts towards the same goal or vision expressed by First Nation and indigenous communities.

- Key learnings or lessons which may result in greater clarity concerning federal and provincial jurisdiction are shared so that others can benefit.

- Within the organization, a cohesive team approach mobilized around a unified vision of relationships with SDHU indigenous partners is in place.

- Representation by indigenous or First Nation representation is part of the vision as is measurable progress and accountability.

- Striving towards this vision is premised on the the understanding that this is an evolutionary process; that the organization and its people will evolve on this learning journey and that key insights may come from failures and mistakes. In this regard, SDHU has committed to long term, proactive partnership with First Nations and indigenous partners.

Hopes, Fears, Benefits and risks as part of the vision

Two groups were formed to discuss hopes, fears, benefits and risks involved in pursuing this approach.

Fears and Risks

Fears and risks described by board members can be categorized as follows:

Resources / Funding – In any organization, pursuing any new strategic direction or new focus of activities will require additional funds. It is difficult to assess what this new approach will require in terms of organizational resources. A lack of funding to appropriately pursue this work is a concern as is staffing capacity to deliver upon expectations which the organization may not be able to respond to. "Lack of time to see this through" is a related fear linked with appropriate resources and staff capacity.

Breakdown in relationship – Damaging sensitive or nascent relationships or of "closing the door" through relationship breakdown is a very real fear on the part of the board and organization. "Lack of participation" on the part of the First Nations or indigenous partners or within the organizations is a fear and may result from poor engagement and relationship building.

Lack of progress – Lack of any tangible results or measurable improvements or progress is a concern, best illustrated by the following participant quote: "Being in the same place two years from now". Even worse is the fear of "being unsuccessful" and / or "giving up" owing to the challenges and difficulties the organization may face.

Larger issues – A fear expressed by the board is around the regulatory and jurisdictional uncertainties and the legal ambiguities. A further fear is that despite SDHU's earnest efforts, fragmentation will still exist.

Representation – A worrisome fear is the fear of having "token" representation on the Board as well as the instability represented by First Nation political turnover every two years which may affect the continuity in relationships developed.

These same two groups also discussed the hopes they held for this endeavour and the anticipated or intended benefits they perceive from pursuing this approach. These are summarized in the next two sections.

Hopes

Board members expressed the following as hopes they have for the organization and for the First Nations and indigenous partners SDHU may engage with:

- They hope that this work will be informed by a better understanding of the needs of First Nations and indigenous communities and that appropriate responses will be created or tailored to reflect local context and need.

- They hope that this endeavour will make progress and that it will result in improvements in health indicators and issues like housing and social determinants of health

- They hope that there will be indigenous representation on the board (even if non-voting at the outset) and that the board will continue to be proactive and that these actions will be sustainable.

- They hope that this approach and its learnings will become embedded in the SDHU culture and infused across the whole organization.

Benefits

Benefits expressed by the board fall into three important groupings. Benefits for the First Nations and indigenous partners; benefits for SDHU as an organization and a third category comprised of benefits to *both* SDHU and its First Nations and indigenous partners.

First Nations and Indigenous partners:

- Benefits anticipated for First Nations and indigenous partners are clearly, better health for all, beginning with equitable opportunities for health and indigenous representation on the board.

Sudbury District Health Unit

- Benefits anticipated for SDHU include key learnings both accrued from and shared with other public health units such as via existing Section 50 agreements. Having representation from First Nation or indigenous communities can also strengthen understanding and knowledge within SDHU and allow for greater movement forward in this area.

- Pursuing this approach can also bring the organization in closer alignment with its values of equity and improved health for all as well as more broadly, with provincial policies and directions.

- This will put the SDHU in a better position as well to capitalize on health opportunities in this area.

Both SDHU and First Nations and indigenous partners:

- Benefits for both partners include the possibility of achieving better outcomes due to synergies and maximizing efforts and resources through closer collaborative efforts.

- Reciprocal benefits may accrue to both SDHU and First Nations and indigenous partners as they learn more about their respective cultures. This will assist in reducing stereotypes and breaking down barriers. Learning about each other's views on health will also support better holistic health for all.

- An ancillary benefit anticipated is greater clarity around roles and statutory responsibilities and the development of a model for engagement that can be shared broadly to help others.

- Equal opportunities for health for everyone is the stated goal and the key benefit of this endeavour.

Supports needed

A final discussion activity of the day focused on the types of supports and resources that Board members might need to fulfill their roles in supporting this organizational strategy. A large group discussion was framed around the following key question:

> ***What supports do Board members need to fulfill their roles in moving this approach forward?***

Important supports which were described as needed included:

- Board resolutions – Update and strengthen the 2012 board motion to include specifics around governance, risk management, and accountability.

- Indigenous Representation - Explore ways to have SDHU governance structure include space for indigenous representation i.e. have indigenous representation on the Board or alternatively, seek approval from municipalities to use board vacancies to include indigenous representation.

- Accountability mechanisms – A way to embed and formalize this approach in the overall organization's strategy and performance management plan. Direction was given to the organization to set goals, and develop, implement and monitor a plan for moving this forward.

- Guiding Principles - Ensure that guiding principles are co-created with First Nations indigenous partners.

- Ongoing information and education including updates concerning:

- Existing public health services landscape in First Nations and indigenous organizations (both on reserve and off reserve) i.e. What do they have in terms of funding/staffing/funding, etc.?
- Regular updates concerning current collaborations with First Nations and indigenous partners
- Greater clarity on federal /provincial roles, authority, jurisdiction.
- First Nations perspectives on the same questions and concerns shared with the Board.

Meeting outcomes

Board members shared the following as key outcomes they perceived as ensuing from this one-day information and education session:

1. Board members gained new background and insights concerning public health in First Nations. This increased knowledge helped inform productive discussions and deliberation.
2. The board embraced a shared understanding as to what SDHU is driving toward or should be aiming towards in working more closely with First Nations and indigenous groups. There is a sense that “Everyone on the same page”.
3. The board has reaffirmed its commitment to ensuring progress and accountability to move this forward.
4. The board has recognized the need for and agreed to explore indigenous representation on the Board.
5. The Board acknowledged the significant work of the organization to achieve a state of readiness to mobilize more effectively in response to First Nation/indigenous communities’ needs and aspirations in public health.
6. The education session has allowed an opportunity for discussion of risks.
7. There is a shared understanding that developing this approach and carrying out the work to strengthen these relationships will be ongoing. This educational session is an important step in an ongoing journey.
8. Most importantly, there is shared understanding and agreement that the approach must be co-created with First Nations and indigenous groups who are implicated.

Implications

The work the organization is undertaking in strengthening its relationships with First Nations and indigenous groups will have implications for:

- Indigenous representation in the organization’s board and committee structures
- Overall organizational strategic priorities
- Organizational structures to allow for effective implementation and action in this direction

As a starting point, one of the key initial steps will entail the development of a set of guiding principles for this engagement co-created in partnership with First Nations and indigenous groups affected. Longer term, the results of this session will inform the next cycle of strategic planning for the organization.

Next steps

It was agreed that the meeting fulfilled its objective of information sharing, learning and initial dialogue around the way forward for strengthening and deepening relationships with area First Nations and indigenous groups.

A meeting summary report will be prepared by November 30th, 2016 and submitted to meeting participants for review and finalization.

Appendix A: Meeting Agenda

Sudbury & District Health Unit
Service de santé publique

Sudbury & District Board of Health
INDIGENOUS ENGAGEMENT EDUCATIONAL SESSION
8:30 am to 4 pm Wednesday, November 9, 2016
Ramsey Room, SDHU, 1300 Paris Street

Purpose:
To explore pathways for the SDHU to meaningfully and respectfully engage with Indigenous peoples in the SDHU service area.

***NOTE**

The educational session will begin with an opening ceremony held at the Medicine Lodge of Health Sciences North. Members participating in the opening ceremony are asked to ***meet in the Ramsey Room of the SDHU at 8:30 am*** *and the group will walk the short distance to the Medicine Lodge. Those unable to participate in the opening ceremony are asked to meet in the Ramsey Room for a 9:30 am start.*

Attendees:

Guests
Marion McGregor – Elder
Mariette Sutherland – Facilitator

Senior Management
Executive Committee Members
Megan Dumais
Sandra Laclé
Stacey Laforest
Rachel Quesnel
France Quirion
Renée St Onge
Dr. Penny Sutcliffe
Dr. Ariella Zbar

Board of Health Members
Maigan Bailey
Janet Bradley
Jeffery Huska
Robert Kirwan
René Lapierre
Richard Lemieux
Stewart Meikleham
Paul Myre
Ken Noland
Rita Pilon
Mark Signoretti
Carolyn Thain

Topic and Resources	***Lead***	***Time*** *(approx.)*
1. Opening ceremony held at the Health Sciences North Medicine Lodge *(please meet in the SDHU Ramsey Room at 8:30)* *a.* Medicine Lodge presentation, L. Pitawanakwat, HSN	Elder/Lisa Pitawanakwat Medicine Lodge Keeper	8:30-9:30

2. Welcome and introductions Meeting purpose and participants' goals	P. Sutcliffe M. Sutherland	9:30-9:50
3. Journey - past and current a. Indigenous Engagement in Support of Public Health presentation b. Current Collaborations – SDHU and Indigenous Peoples, October 2016 c. Snapshots of Indigenous People in the SDHU Service Area, November 2016 d. Truth and Reconciliation Commission: Ontario's Commitment Summary (further information : https://www.ontario.ca/page/journey-together-ontarios-commitment-reconciliation-indigenous-peoples) e. Indigenous Determinants of Health	P. Sutcliffe S. Laclé R. St Onge P. Sutcliffe P. Sutcliffe	9:50-11:15
4. Discussion	M. Sutherland	11:15-11:30
5. Journey – future a. Indigenous Engagement at the SDHU: Staff Circles Executive Summary b. Analysis of SDHU Supports Needed - Extract from Strengthening Indigenous Relationships Planning Session, Senior Management Executive Committee Retreat, September 26, 2016	R. St Onge P. Sutcliffe	11:30-12:10
6. Discussion	M. Sutherland	12:10-12:30
LUNCH		12:30-1:30
7. Board Member dialogue a. What is the vision that Board is driving towards in closer engagement with Indigenous peoples? b. What are the Board's greatest hopes; greatest fears; what are the benefits and risks? c. What supports to Board members need to fulfill their roles? d. Reaffirmation of Board direction (future motion)	M. Sutherland	1:30-3:00
8. Next steps and key messages from the day	M. Sutherland	3:00-3:30
9. Closing Prayer	Elder	3:30-3:45

APPROVAL OF CONSENT AGENDA

MOTION: THAT the Board of Health approves the consent agenda as distributed.

ATTENDANCE REGISTER
2016 BOARD MEETINGS

Date of Meeting	01/21/16	02/18/16	04/20/16	05/19/16	06/16/16	09/15/16	10/20/16	11/24/16	Total	%
Type of Meeting	**Board**	**Board**	**Board**	**Board**	**Board**	**Board**	**Board**	**Board**		
Bailey, Maigan						√	√	√	3/3	100%
Belcourt, Claude	√	Regrets	√	√ resigned May 19/16					3/4	75 %
Bradley, Janet	√	√	regrets	√	√	√	regrets	√	6/8	75%
Huska, Jeffery	√	√	√	√	√	regrets	√	√	7/8	88%
Kirwan, Robert	√	√	√	√	√	√	√	regrets	7/8	88%
Lapierre, René	√	regrets	√	√	√	√	√	√	7/8	88%
Lemieux, Richard	√	√	√	√	regrets	√	regrets	regrets	5/8	63%
Meikleham, Stewart	√	√	√	regrets	√	regrets	√	√	6/8	75%
Myre. Paul	√	regrets	√	√	√	√	regrets	√	6/8	75%
Noland, Ken	√	√	√	√	√	√	√	√	8/8	100%
Pilon, Rita	√	√	√	√	√	√	√	√	8/8	100%
Sauvé, Ursula	regrets	regrets	√	√	√ resigned June 16/16				3/5	60 %
Signoretti, Mark	√	√	regrets	absent	√	√	√	regrets	5/8	63%
Thain, Carolyn	√	√	√	√	√	√	√	√	8/8	100%

Board of Health Manual Policy G-I-30 - By-law 04-88

Board members who are elected or appointed representatives of their municipalities shall be bound by the rules of attendance that apply to the councils of their respective municipalities. Failure to attend without prior notice at three consecutive Board meetings, or failure to attend a minimum of 50% of Board meetings in any one calendar year will result in notification of the appointing municipal council by the Board chair and may result in a request by the Board
for the member to resign and/or a replacement be named.

Board members appointed by the Lieutenant Governor-in Council are answerable to the Board of Health for their attendance. Failure to provide sufficient notice of non-attendance at three consecutive meetings or failure to attend a minimum of 50% of Board meetings without just cause may result in a request by the Board for the member to resign.

Board of Health Post-Meeting Evaluations
Roll up of 2016 Evaluation Results

After ever Board of Health meeting, Board of Health members are asked to complete a post meeting evaluation. Overall, most of the board members (78%-100%) who attended the Board of Health meetings in 2016 completed a post meeting evaluations in 2016.

Table 1: Board of Health Response Rate by Month, 2016

Month	Completed Evaluations	Attendance	Response Rate%
January	10	12	83%
February	7	9	78%
April	9	11	82%
May	9	11	82%
June	9	11	82%
September	8	10	80%
October	8	9	89%
November	9	9	100%

In these post-meeting evaluations, Board of Health members are asked to reflect on various aspects of the meeting and to state their level of agreement or disagreement with the following statements:

1. The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.

2. The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject.

3. The MOH/CEO report was informative, timely and relevant to my governance role.

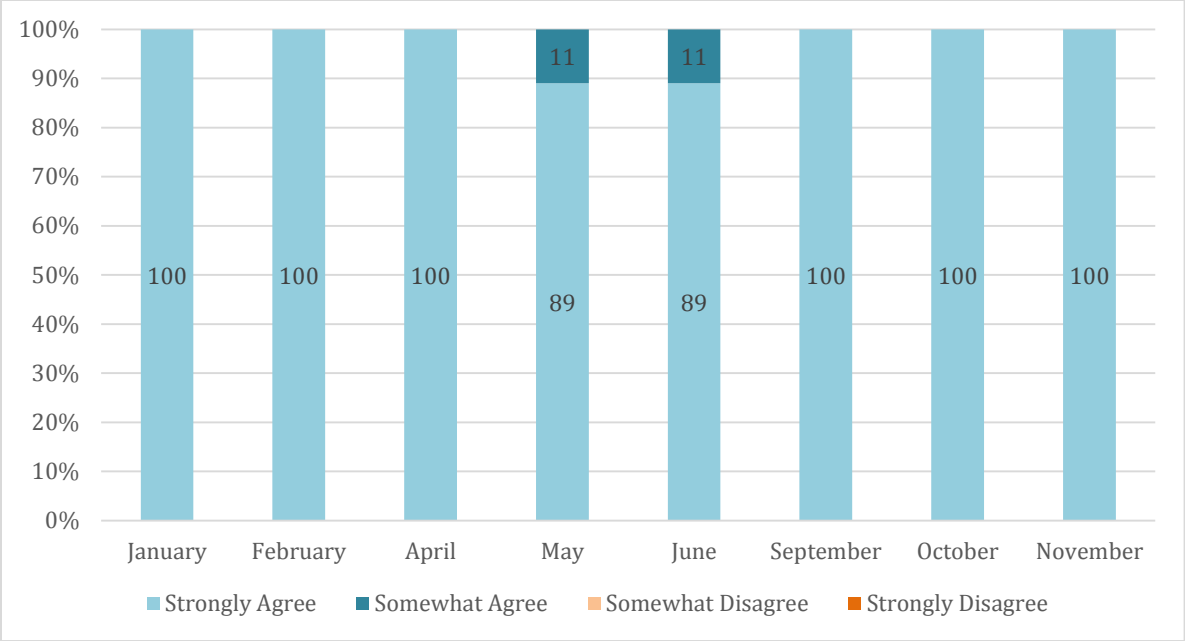
4. Overall, Board members participated in a responsible way and made decisions that further the SDHU vision and mission.

5. There is alignment with items that were included in the Board agenda package and the SDHU's 2013-2017 Strategic Plan.

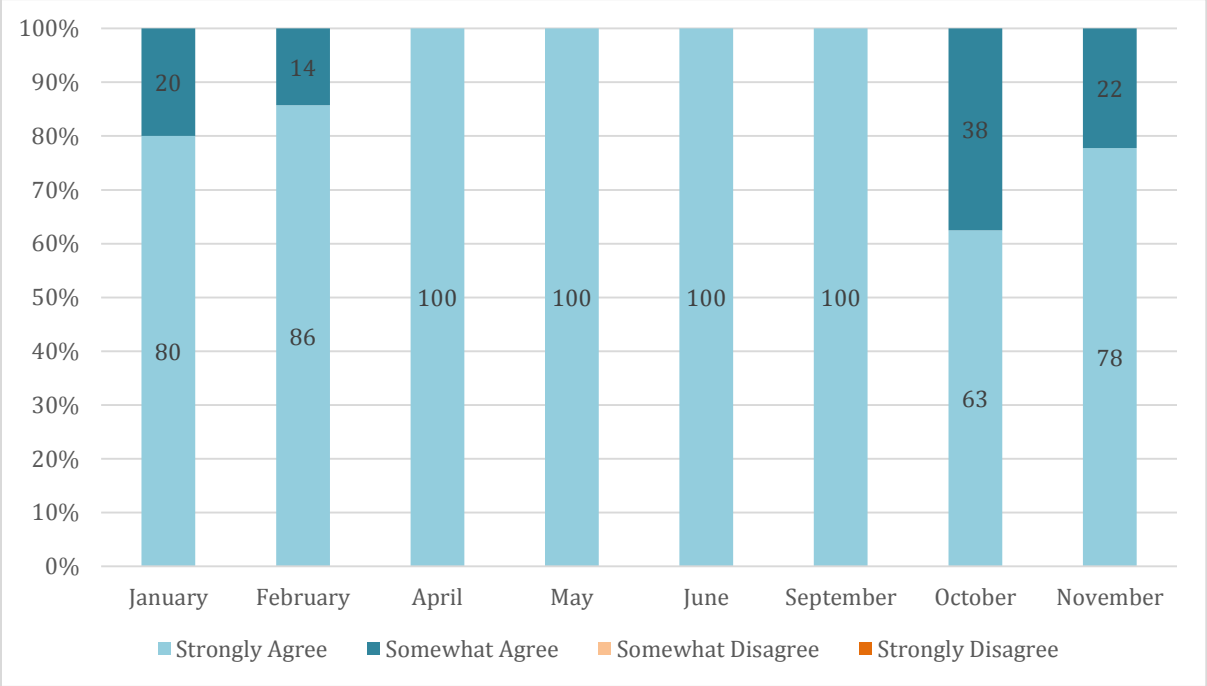
6. Board members' conduct was professional, cordial and respectful.

Overall, there was negligible disagreement reported by Board Members relative to these six statements. Figures 1-6 below provide a breakdown for each question by month.

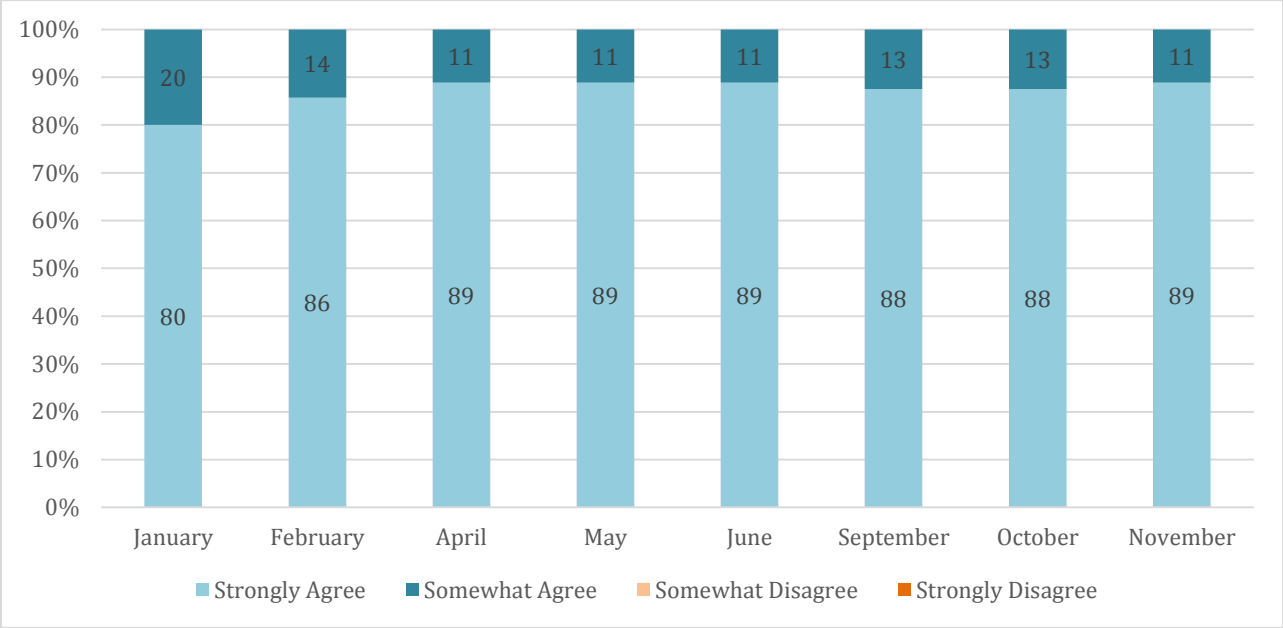
Statement #1: The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role



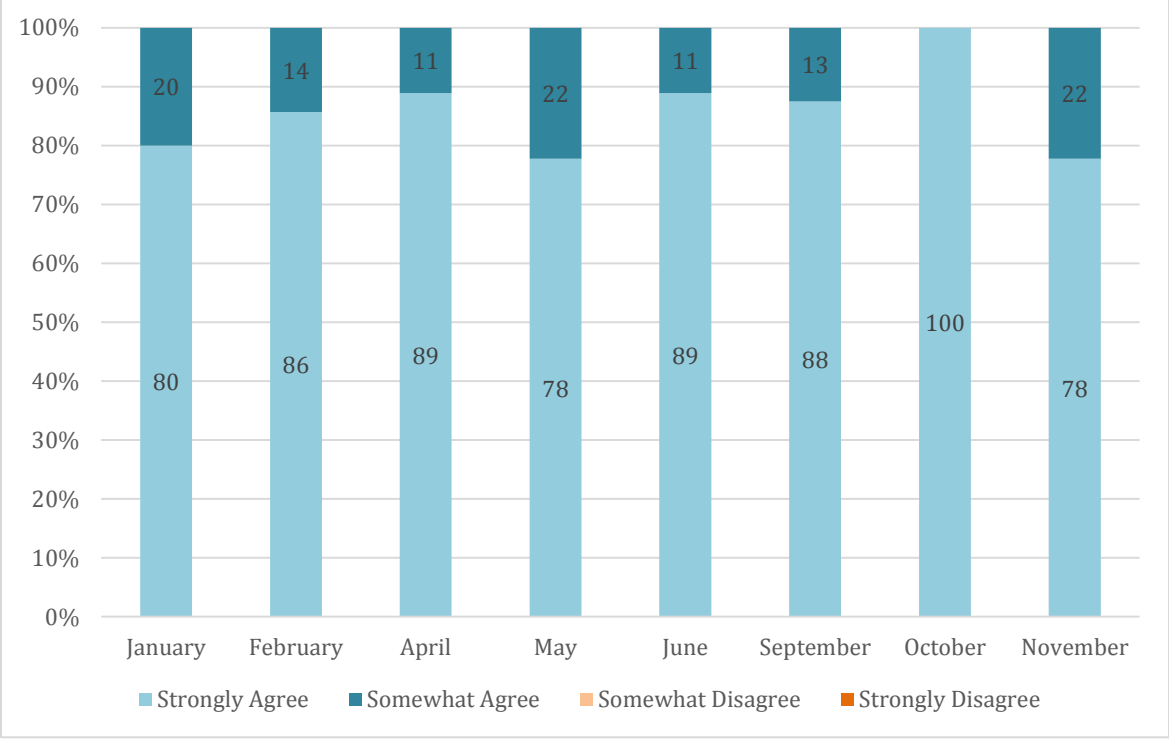
Statement #2: The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject



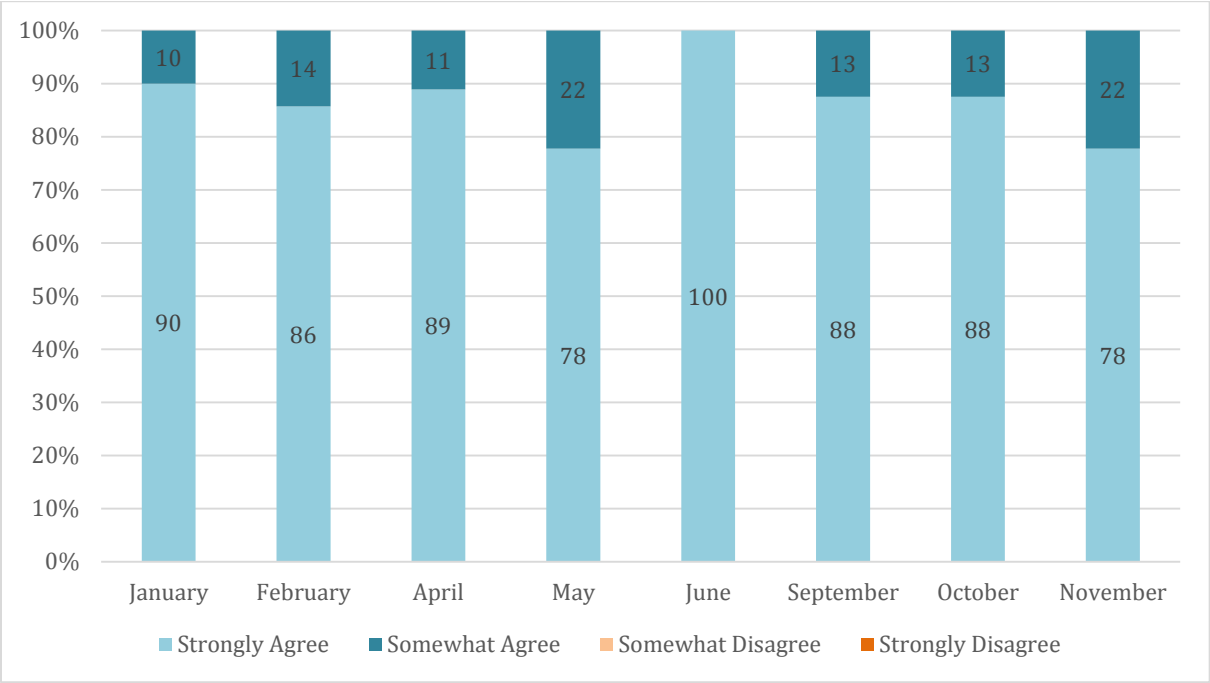
Statement #3: The MOH/CEO report was informative, timely and relevant to my governance role



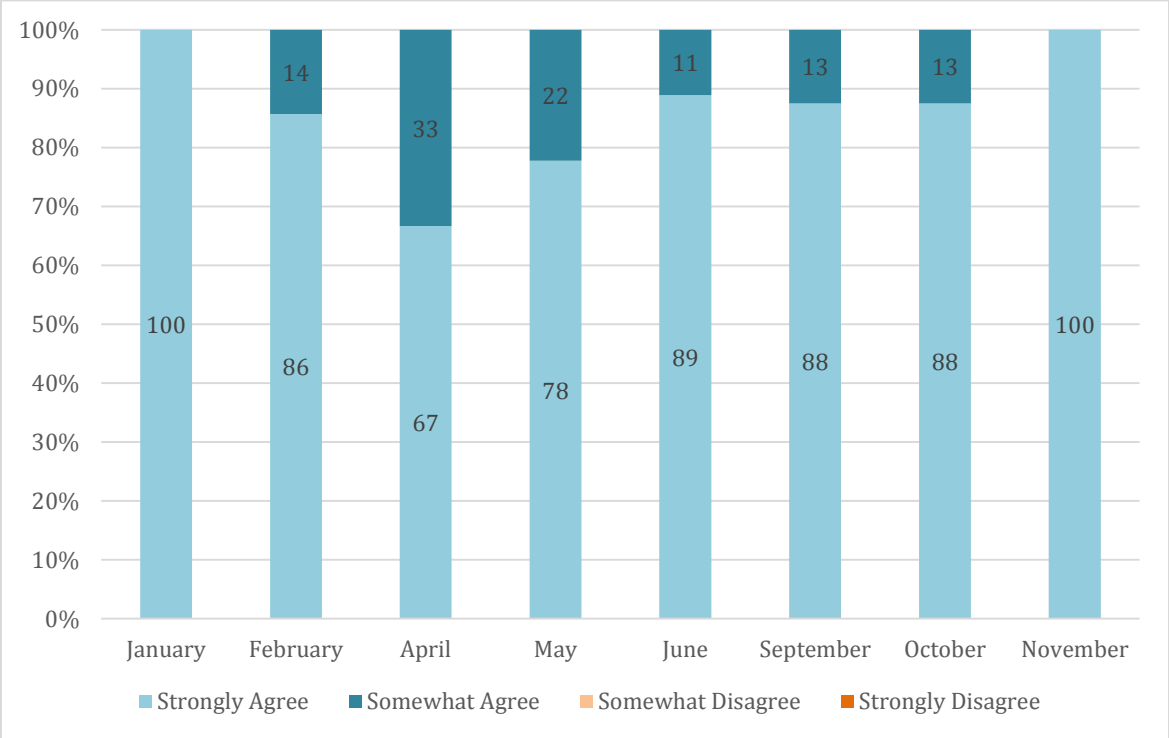
Statement #4: Overall, Board members participated in a responsible way and made decisions that further the SDHU vision and mission



Statement #5: There is alignment with items that were included in the Board agenda package and the SDHU's 2013-2017 Strategic Plan



Statement #6: Board members' conduct was professional, cordial and respectful



Overall responses for all seven monthly Board of Health meetings are found in the table below.

Table 2: Overall Response to Statements

Statement	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Total Responses
1. The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.	67 (97.1%)	2 (2.9%)	0 (0.0%)	0 (0.0%)	69
2. The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject.	61 (88.4%)	8 (11.6%)	0 (0.0%)	0 (0.0%)	69
3. The MOH/CEO report was informative, timely and relevant to my governance role.	60 (87.0%)	9 (13.0%)	0 (0.0%)	0 (0.0%)	69
4. Overall, Board members participated in a responsible way and made decisions that further the SDHU vision and mission [1].	59 (85.5%)	10 (14.5%)	0 (0.0%)	0 (0.0%)	69
5. There is alignment with items that were included in the Board agenda package and the SDHU's 2013-2017 Strategic Plan [2].	60 (87.0%)	9 (13.0%)	0 (0.0%)	0 (0.0%)	69
6. Board members' conduct was professional, cordial and respectful.	60 (87.0%)	9 (13.0%)	0 (0.0%)	0 (0.0%)	69

Comments and suggestions

In each meeting evaluation, Board of Health members are given the opportunity to provide feedback on the things they liked/disliked about the meeting as well as provide suggestions on how to improve future meetings.

Many of the respondents took the opportunity to praise and show appreciation for how great and organized the meetings have been while being conducted in a timely, respectful and professional fashion. It was also mentioned that the candor and professionalism of Dr. Sutcliffe "who contributed to the greater understanding of new possible method of operation" was greatly appreciated.

The Board of Health members also commented on the great discussions they had in the meetings, and about there being lots of relevant questions and good detail and clarification at those meetings.

Respondents also felt positive about making informed decisions and feeling a part of a progressive health care project.

Other positive aspects noted by respondents included the “incredible” presentations on key topics such as the Baby Friendly Initiative, texting and driving, and traditional tobacco, as well as the summary of the alPHa meeting and the report on conference attendance. Some respondents also mentioned excellent resource materials in the agenda, making preparation easier and meetings more efficient. Another comment made was that the Board of Health members seem more willing to question, comment, or confront when required.

One comment was made after one meeting about ensuring meeting timeliness.

Overall, all comments received for the monthly meeting evaluations were positive.

Sudbury & District Health Unit
Service de santé publique

BRIEFING NOTE

To: Chair, Sudbury & District Board of Health

From: Rachel Quesnel, Secretary to the Board of Health
Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer

Re: 2016 Board Member Self-Evaluation of Performance Results

Date: January 12, 2017

☐ For Information ☒ For Discussion ☐ For a Decision

Issue:

At its meeting of September 15, 2016, a confidential self-evaluation using a 23-question survey tool was distributed to Board of Health members.

One new question relating to the consent agenda was added under Part 2: Board of Health Processes in the 2016 self-evaluation survey.

The evaluation is part of the Board's ongoing commitment to good governance and continuous quality improvement and is consistent with C-I-12 and C-I-14 of the Board of Health Manual.

Board members were informed that the results would be confidentially compiled by the Secretary to the Board and reported at its regularly scheduled November 2016 meeting. This briefing note constitutes the evaluation report.

Recommended Action:

That Board of Health members review and discuss the results of the 2016 self-evaluation and ensure continued reflection and improvement.

Board Member Self-Evaluation of Performance:

Methods

- The Board of Health Member Self-Evaluation of Performance survey consists of 23 items on performance and processes. Board members of Health members are asked to rate each of the items as either "Strongly Agree", "Agree", "Disagree", "Strongly Disagree" or "Not Applicable". The survey also contains three open-ended questions.
- The online self-evaluation questionnaire was distributed to all Board of Health members in the September 15, 2016, Board of Health meeting agenda package via hyperlink in the MOH report.

- Board of Health members were sent an email reminder to complete the survey by the Secretary to the Board of Health on September 29, 2016. It was incorrectly reported at that time that the response rate was 92%.
- At the October 20, 2016, Board meeting, Dr. Sutcliffe noted a correction from the October MOH report that the response rate for the annual self-evaluation was 33% (versus 92%). Board members were asked to complete the evaluation by October 24.
- In an email dated November 7, 2016, Board members were reminded to complete the online self-evaluation questionnaire by November 15, 2016 Board meeting as the results of the Board of Health member self-evaluation of performance were slated to be presented at the November 24, 2016, Board meeting. It was noted that, as mentioned at the October Board meeting, the response rate was currently 4/12 for a 33% response rate.
- In the November 2016, Board report, it was reported that results from the annual Board of Health self-evaluation survey were to be tabled at the November Board meeting; however, in consultation with the Board Chair, it was decided that an extension be provided for Board members to complete the annual Board of Health self-evaluation survey to December 16, 2016. The Board member response rate as of November 16 was below 60% and that the evaluation survey would remain open for those who had not had a chance to complete it.
- Time was designated following the November Board meeting for the completion of the annual survey.
- On December 1, 2016, the November 24, 2016, unapproved Board minutes were emailed and a reminder was included to complete the annual survey. Current response rate was reported as 9/12 or 75%.
- On December 15, 2016, a final reminder was emailed to complete the survey by December 16. It was shared that the current response was 10/12 or 83%.
- The annual Board survey results are being tabled at the January 2017 Board meeting as the performance monitoring plan will be tabled at the January 24, 2017, Joint Board/Staff Performance Monitoring Working Group Meeting before being tabled at the February 16, 2017, Board meeting.
- The Secretary of the Board of Health collaborated with the Resources, Research, Evaluation and Development (RRED) Division to anonymously tabulate and summarize the survey results. The Medical Officer of Health was consulted once the results had been compiled in order to maintain anonymity.

Results

- 10 out of 12 Board members completed the annual Board of Health self-evaluation survey for 2016, for a response rate of 83.3%(compared to the 2015 response rate of 69% and 84.6 % response rate in 2014)
- The following table summarizes the responses to each of the 23 rated questions. Non-responses were excluded from the analysis.

Part 1: Individual Performance Compliance with Individual Roles and Responsibilities as a Board of Health member	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable	Total Responses
1. As a BOH member, I am satisfied with my attendance at meetings.	8 (80.0%)	2 (20.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10
2. As a BOH member, I am satisfied with my preparation for meetings.	8 (80.0%)	2 (20.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10
3. As a BOH member, I am satisfied with my participation in meetings.	9 (90.0%)	1 (10.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10
4. As a BOH member, I understand my roles and responsibilities.	8 (80.0%)	2 (20.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10
5. As a BOH member, I understand current public health issues.	3 (30.0%)	7 (70.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10
6. As a BOH member, I have input into the vision, mission and strategic direction of the organization.	5 (50.0%)	3 (30.0%)	1 (10.0%)	0 (0.0%)	1 (10.0%)	10
7. As a BOH member, I am aware and represent community perspective during board meeting.	8 (80.0%)	2 (20.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10
8. As a BOH member, I provide input into policy development and decision-making.	4 (40.0%)	4 (40.0%)	1 (10.0%)	1 (10.0%)	0 (0.0%)	10
9. As a BOH member, I represent the interests of the organization at all times.	10 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10

Other comments or suggestions pertaining to your role as a Board of Health member:

- Comments on this item included comments about looking forward to Strategic Planning in the new year, and comments about the Board always being well prepared, with excellent dynamics, good respectful conversation, and a good variety of guest presenters. One comment touched on the importance of ensuring everyone's voice is heard and respected, including dissenting opinions.

Part 2: Board of Health Processes Effectiveness of Policy and Process	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable	Total Responses
1. The BOH is compliant with all applicable legislation and regulations.	8 (80.0%)	2 (20.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10
2. The BOH ensures members are aware of their roles and responsibilities through orientation of new members	8 (80.0%)	2 (20.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10
3. The BOH is appropriately informed about financial management, procurement policies and practice, risk management and human resources issues.	7 (70.0%)	3 (30.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10
4. The BOH holds meetings frequently enough to ensure timely decision-making.	8 (80.0%)	1 (10.0%)	1 (10.0%)	0 (0.0%)	0 (0.0%)	10
5. The BOH bases decision making on access to appropriate information with sufficient time for deliberations.	7 (70.0%)	1 (10.0%)	1 (10.0%)	0 (0.0%)	1 (10.0%)	10
6. The BOH is kept apprised of public health issues in a timely and effective manner.	8 (80.0%)	2 (20.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10
7. The BOH sets bylaws and governance policies.	7 (70.0%)	3 (30.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10
8. The BOH remains informed with issues pertaining to organizational effectiveness through performance monitoring and strategic planning.	7 (70.0%)	2 (20.0%)	1 (10.0%)	0 (0.0%)	0 (0.0%)	10

9. The consent agenda is helpful in enabling the Board to engage in detailed discussion of important items.	**7 (70.0%)**	**2 (20.0%)**	**1 (10.0%)**	**0 (0.0%)**	**0 (0.0%)**	**10**

Other comments or suggestions pertaining to Board of Health policy and process

- A number of respondents made positive comments about the consent agenda, including that it helps separate routine correspondence from the main agenda, and that it allows for good discussion when needed while at the same time preventing the Board from delving into details if not necessary. One respondent indicated that some items within the MOH report could, however, have a higher profile. The risk management work was also identified as being very positive in that it allows the SDHU to look forward to the development of new policies and approaches to manage these risks.

Part 3: Overall Performance of the Board of Health	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Not Applicable**	**Total Responses**
1. The BOH contributes to high governance and leadership performance.	**6 (60.0%)**	**4 (40.0%)**	**0 (0.0%)**	**0 (0.0%)**	**0 (0.0%)**	**10**
2. The BOH oversees the development of the strategic plan.	**6 (60.0%)**	**3 (30.0%)**	**0 (0.0%)**	**0 (0.0%)**	**1 (10.0%)**	**10**
3. The BOH ensures planning processes consider stakeholder and community needs.	**6 (60.0%)**	**3 (30.0%)**	**1 (10.0%)**	**0 (0.0%)**	**0 (0.0%)**	**10**
4. The BOH ensures a climate of mutual trust and respect between themselves and the Medical Officer of Health (MOH).	**8 (80.0%)**	**2 (20.0%)**	**0 (0.0%)**	**0 (0.0%)**	**0 (0.0%)**	**10**
5. The BOH as a governing body is achieving its strategic outcomes.	**6 (60.0%)**	**4 (40.0%)**	**0 (0.0%)**	**0 (0.0%)**	**0 (0.0%)**	**10**

Other comments or suggestions pertaining to overall performance of the Board of Health

- Comments included ensuring that questions and discussions be limited after presentations, and reference to the governance training that was held in 2016 as being very useful.

Summary

The 2016 Sudbury & District Board of Health Member Self-Evaluation of Performance questionnaire gives Board members a chance to reflect on their individual performance, the effectiveness of Board policy and processes, and the Board's overall performance as a governing body. Board of Health self-evaluation of performance is an internal SDHU tool to ensure compliance with the Ontario Public Health Organizational Standards. In addition, the Board self-evaluation survey is part of the SDHU's Performance Monitoring Plan. Results should be interpreted with caution due to the small number of respondents.

Overall results from the self-evaluation questionnaire indicate that the Board of Health members have a positive perception of their governance process and effectiveness. In all sections of the survey (individual performance, Board of Health processes, and overall performance of the Board of Health), respondents either strongly agreed or agreed with most statements. Additional comments that were provided by the Board of Health members in each section are for the Board's consideration and deliberation. Overall, the members have a positive perception of their governance process and effectiveness.

INCLUSION OF ELECTRONIC CIGARETTES ACT VENDOR CONVICTIONS WITHIN EXPANSION OF PROACTIVE DISCLOSURE SYSTEM

MOTION: **WHEREAS the Minister of Health and Long-Term Care has requested that all boards of health make transparency a priority objective in business plans and develop reporting practices to make information readily available to the public; and**

WHEREAS the Sudbury & District Board of Health is committed to public transparency; and

WHEREAS the Sudbury & District Board of Health endorsed motion 36-15 (Expansion of Proactive Disclosure System) at its September 17, 2015, meeting; and

WHEREAS, inclusion of enforcement-related activities pertaining to the Electronic Cigarettes Act (2015), would further improve transparency by enhancing public access to inspection findings;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the inclusion of enforcement-related activities pertaining to electronic cigarette vendors within the expanded proactive disclosure system; and

THAT the following be the Board policy on the release of enforcement and inspection information pertaining to the Electronic Cigarettes Act:

1. **Charges: Statistical information on charges (i.e. no identifying information) is released to the Sudbury & District Board of Health at its regularly scheduled meetings.**
2. **Convictions: Convictions related to electronic cigarette vendor infractions are posted on the Sudbury & District Health Unit website as soon as possible following the conviction and for a period of 12 months from the date on which the conviction was rendered.**
5. **Requests for information not posted on website: Requests for information not posted on the website are considered on an individual basis in accordance with Health Unit policy and the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and the Personal Health Information Protection Act (PHIPA); and**

FURTHER THAT Board of Health Disclosure Information Sheet F-IV-10 be correspondingly updated.

IN THEIR OWN WORDS….

HOW IMPERIAL TOBACCO RAN A FEAR CAMPAIGN ABOUT CONTRABAND CIGARETTES TO BLOCK TAXES AND PREVENT HEALTH REGULATIONS.

In October 2016 an internal tobacco industry document was leaked to a public health researcher from an anonymous whistleblower from within British American Tobacco (BAT). BAT competes to be the world's largest tobacco multinational, and is the complete owner of the largest tobacco manufacturer in Canada, Imperial Tobacco Canada Ltd. (ITL).

The document in question is a presentation made in 2012 by ITL to BAT's Corporate and Regulatory Affairs (CORA) committee. It is through its CORA officials that BAT coordinates its efforts at the national and international level to prevent government measures to reduce tobacco use. [2]

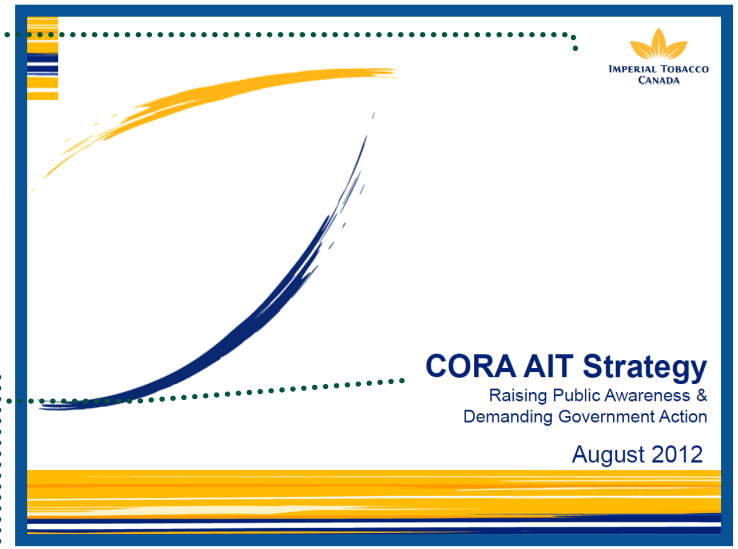
The presentation describes Imperial Tobacco's Anti Illicit Trade campaign from 2009 to 2012. It provides an overview of the evolution of the campaign, and the recruitment of third-parties to execute the campaigns activities. It outlines the strategies and tactics used by the company to achieve its twin goals of "No Regulation" and "No Taxation".

Millions of tobacco industry documents became public as a result of U.S. Court actions. Very few of these, however, involve activities since 2000, or are focused on Canada. The release of this document provides fresh evidence of tobacco industry use of front groups to interfere with public health.

Imperial Tobacco (ITL) is the largest tobacco manufacturer operating in Canada.

The brands it makes include du Maurier, Player's, Matinée, Pall Mall, Peter Jackson, Viceroy, Vogue

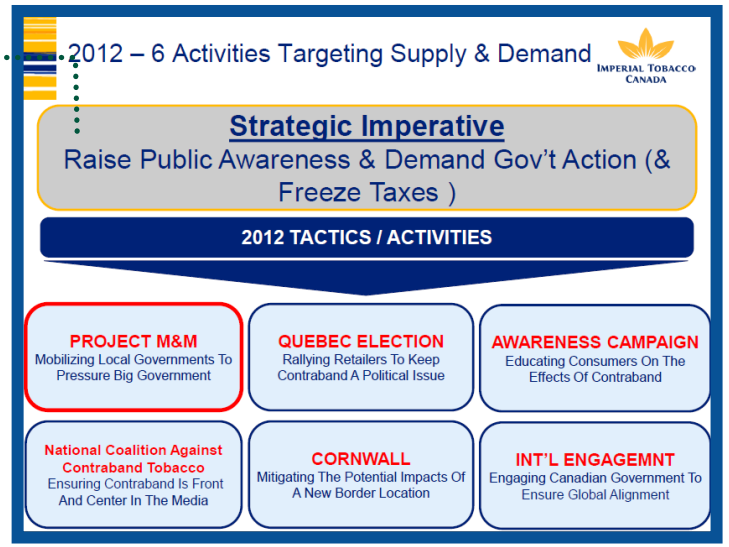
Imperial Tobacco is 100% owned and controlled by British American Tobacco (BAT).



This presentation was made to BAT's Corporate and Regulatory Affairs (CORA) department. The subject of the presentation is its public relations campaign on contraband (Anti Illicit Trade, AIT)

Imperial Tobacco's 6-prong strategy aimed to get governments to "Freeze Taxes"

The World Health Organization says "*the most potent and cost-effective option for governments everywhere is the simple elevation of tobacco prices by use of consumption taxes.*" [1]



[A1] World Health Organization. Web-site. Tobacco Free Initiative. Taxation.
[A2] BAT CORA. Legacy Document lxbp0042 .

This summary was prepared by la Coalition Québécoise pour le contrôle du tabac (The Quebec Coalition for Tobacco Control), the Non-Smokers' Rights Association and Physicians for a Smoke-Free Canada. The full BAT slide deck can be viewed at **www.smoke-free.ca/eng_home/2016/ITL-CORA-AIT.pdf**

A

THE FRONT GROUPS….

Sponsorship promotions were phased out in 2003, smoking in indoor public and work places was eliminated in most of Canada by 2006, and most cigarette displays were banned as of 2008. These changes resulted in Imperial Tobacco defunding former allies (like the Alliance for Sponsorship Freedom, MyChoice.ca and Team Players) and turning its attention to retailers as new advocates.

In 2006 the Canadian Convenience Stores Association (CCSA) was set up, soon followed by regional branches (including L'Association québécoise des dépanneurs en alimentation, AQDA and the Atlantic Convenience Stores Association, ACSA).[2]

Imperial Tobacco helped recruit retailers as members for AQDA and was reported to have provided "hundreds of thousands of dollars" to put the organization in place. [3] Much of the leadership of the CCSA and its regional affiliates, as shown later, were recruited from tobacco industry ranks.

A second layer of separation was created in 2008 when the CCSA recruited non-tobacco-retailers to join a National Coalition Against Contraband Tobacco (NCACT). The invitation was extended broadly, including to health organizations, but few accepted who were not already aligned with corporate interests.

The NCACT is an unincorporated "advocacy group" which functions as a project activity of the CCSA and is managed by a PR firm (Impact Public Affairs) whose clients are not disclosed.[4]

Tobacco industry financing of the CCSA and L'AQDA and its coalition project has remained veiled. In 2015, the head of L'AQDA and the official NCACT spokesperson were grilled about industry financing in a Quebec legislative committee. Both denied knowing the details of their organizations funding. [4]

ITL gradually expanded its relationships with front-line retailers, then business and law-and-order communities, then municipal governments.

The evidence strongly suggests that the Canadian Convenience Store Association and its Quebec wing were set up and remain financed by Imperial Tobacco.

The Quebec Convenience Stores Association is "at the beck and call of the tobacco industry", according to the head of AMDEQ, one of the members of the NCACT. [5]

The National Coalition Against Contraband Tobacco is a project activity with veiled financing and management

Municipalities in Quebec and Ontario were recruited through L'AQDA and the OCSA.

[B1]. Rembiszewski P. "From Great to Gone: Why FMCG Companies are losing the race for customers."
[B2] CCSA was registered as is federal corporation 439863-7 on December 7, 2006; AQDA was registered as a Quebec enterprise (NEQ 1168943232) in 2011, although it was active in 2008.
[B3] Association des détaillants en alimentation du Québec. RADAR. April-May 2008.
[B4] Coalition Québécoise pour le contrôle du tabac. Qui finance L'ACDA ?
[B5] Isabelle Hachey . L'association des dépanneurs financée par les cigarettiers? La Presse. Novvember 5, 2015

B

THE PUBLIC FACES …

Dave Bryans led the Canadian Convenience Stores Association since its establishment in 2006 to 2010, before returning to the Ontario Convenience Store Association which he continued to lead since 2003.

His relations with the tobacco industry were and are strong. In the 1990s he was Director of National Sales for RJR-Macdonald (now JTI-Macdonald).[1] This was during the height of the companies' sales to the contraband market.

Testimony (under oath) made in 2012 by the CTMC's only employee indicates that Mr. Bryans is still an official with JTI-Macdonald. He was identified as the "corporate affairs" person at JTI-Macdonald to whom she reported.[2]

He does not make public his relationship to the tobacco industry.[3]

Michel Gadbois was named vice-president of the CCSA and president of its Quebec wing (L'AQDA) in 2007.

He came to the retail sector after a public relations career with two tobacco interests. In the 1980s, he was manager of public relations for Benson & Hedges (a company which merged with Rothmans in 1985), and represented the company at the Canadian Tobacco Manufacturers' Council political action committee in opposing smoke-free laws. [4] He subsequently became spokesperson for Imperial Tobacco's holding company, IMASCO.[5]

In January 1994, at the culmination of the 1990s contraband crisis, Michel Gadbois led retailers in a tax revolt. This was later revealed by La Presse to have been planned in concert with the CTMC. [6] Imperial Tobacco described this as "the straw that broke the camel's back" and led to the February 1994 tax roll-back. [7]

The current NCACT spokespeople are **Gary Grant** and **Michel Rouillard**. They were recruited from the ranks of retired police officers. Michel Rouillard testified that he has no organizational role, and is hired by Impact Public Affairs and "paid by the act" for each time he speaks. [B5] **Jacqueline Bradley** is no longer identified on the NCACT web-site as a spokesperson, although she was still active on the file in 2015. She also maintains a very colourful alternate career as "the Bombshell Coach." [8]

[C1]. RJR-Macdonald Organization Charts. Blais-Létourneau trial exhibits 591 and 40397.
[C2] Testimony of Diane Tacaks. Blais-Létourneau trial, September 4, 2012.
[C3] For example, Dave Bryans Linked In Profile.
[C4] CTMC Minutes. Blais-Létourneau trial exhibits , i.e. 479M, 479KK.
[C5] Ottawa Citizen. Imperial bruised but victorious after cigarette price war. June 4, 1987.
[C6] André Noel. Les épiciers ont créé de toutes pièces le mouvement des «dépanneurs généreux» . La Presse. January 27, 1994.
[C7] Michel Descoteaux. Lobbying for a Tobacco Tax Rollback in Canada. ITL. 1994.
[B5] Isabelle Hachey . L'association des dépanneurs financée par les cigarettiers? La Presse. Novvember 5, 2015.
[C8] YouTube . https://www.youtube.com/watch?v=fMpRXLhg2LE

Not just "big tobacco"!

The credible voice for contraband tobacco

C

THE EXAGGERATED CLAIMS …

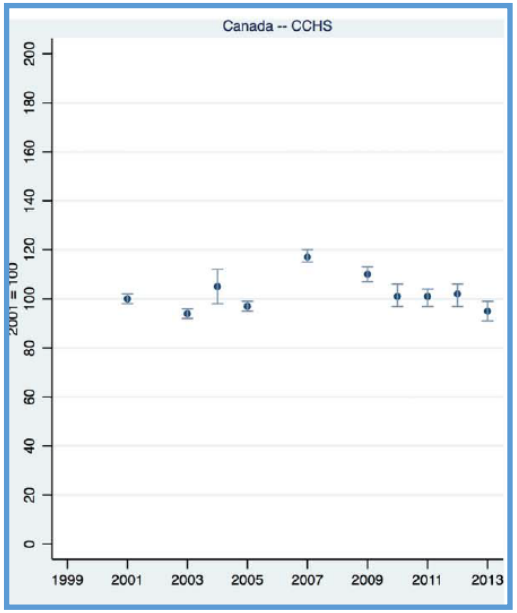
The message delivered by Imperial Tobacco and its allied groups was that there was a dangerously high and growing level of contraband tobacco sales in Canada. They claimed that this was expanding criminal gang activity, increasing youth smoking, closing small businesses, and robbing governments of billions in tobacco taxes.

Their claims exaggerated the evidence, distorted legitimate concerns and drowned out the voices of those who had more reliable data on the scope and nature of illicit tobacco sales.

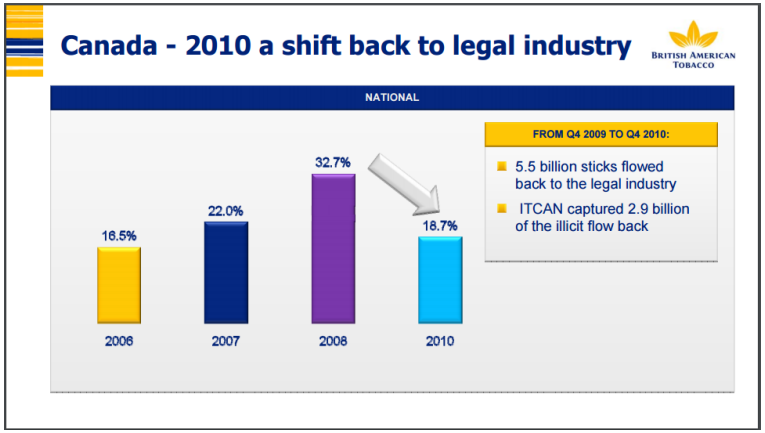
Imperial Tobacco and the other tobacco companies gave more truthful information to their shareholders.

- In 2012, Philip Morris International reported to investors that illicit sales in Canada were 8% of total market (down from 14% in 2007). They noted that contraband sales in Quebec had fallen by more than 50% (from 40% to 15% of total market). [1]
- In 2011, BAT reported to investors that the market share of contraband tobacco fell from 33% to 19% between 2009 and 2010. [2]

A recent independent and peer-reviewed study compared legal sales with surveys of smoking behaviour and concluded that "none of the data … provide support to the tobacco industry narrative that cigarette contraband has been increasing in recent years." Contrary to the media messaging of Imperial Tobacco, the CCSA and the NCACT, Quebec has experienced "relatively low levels of cigarette contraband since 2010, at levels no higher than in the early 2000s." [3]



Philip Morris Int'l[1] **Guindon et al. [3]**



British American Tobacco [2]

[D1]. PMI Investor Day Presentation. LA&C Reigon. June 21, 2012.
[D2] Anti illicit trade: scale and opportunities. BAT investor presentation. 2012
[D3] E. Guindon et al. Levels and trends in cigarette contraband in Canada. Tobacco Control. 2016.

D

THE OBJECTIVE: LESS TAX, FEWER LAWS.

In 2004, the RCMP raided the offices of Imperial Tobacco to gather evidence about the companies' contraband activities in the 1990s. In July 2008, Imperial Tobacco entered a guilty plea and was fined $400 million.

At the same time it launched a campaign to fuel fears of a new contraband crisis. This, it claimed, was a the "real tobacco problem" – and a reason that governments should not adopt new tobacco regulations.[1]

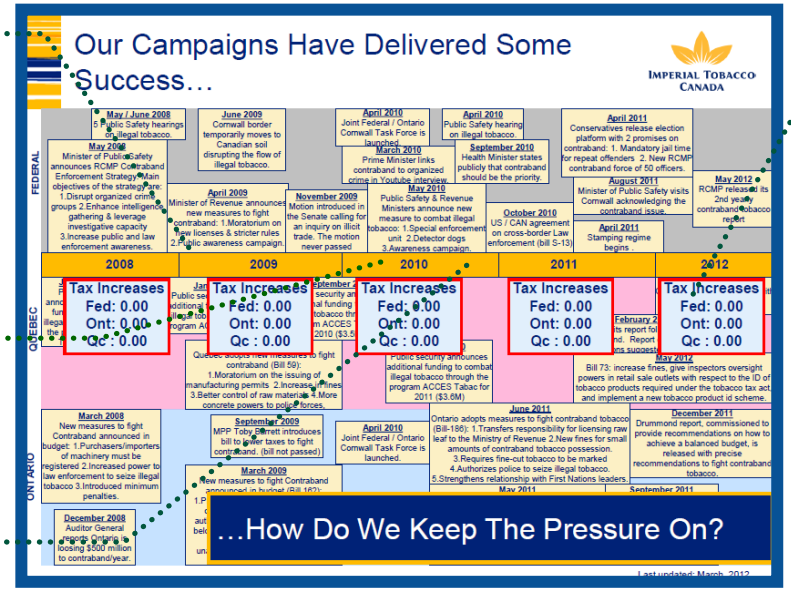
During the 2008 federal election campaign, Imperial Tobacco began to increase the frequency of its contraband messages, and to oppose regulations which affected its products. It did not oppose the C-32 ban on flavourings in cigarettes and cigars manufactured by its rivals. [2]

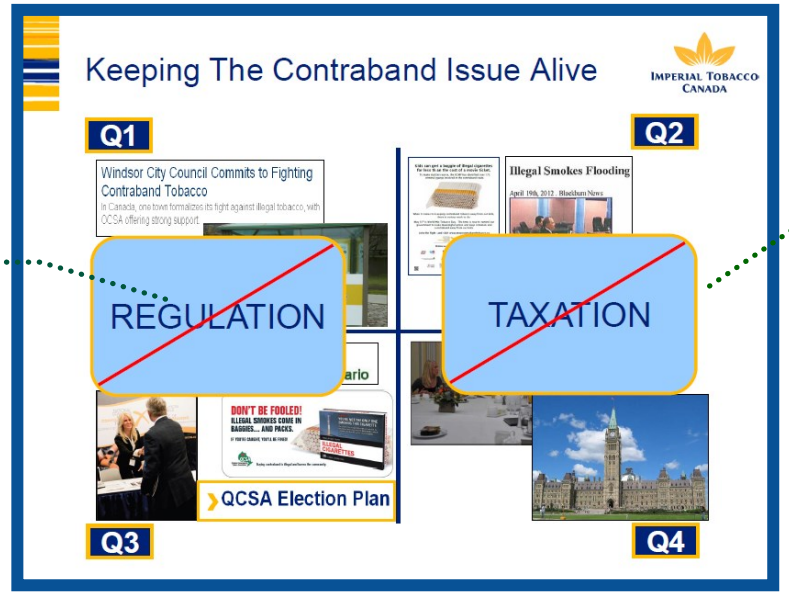
In September 2010, the federal Minister of Health, Leona Aglukkaq, announced that the government was abandoning its commitment to renew cigarette warnings in order to focus its efforts on fighting contraband.[3]

Between 2008 and 2010, more than a dozen federal government departments had been lobbied by tobacco companies about the threat of contraband sales.[4] Only after media exposure and parliamentary review, did the government re-instated the warnings renewal.

The federal government also backed away from banning menthol, although this was eventually adopted by some provincial governments.

Between 2010 and 2016, the federal government announced no new health regulations on tobacco, although it implemented new laws and measures on contraband. It also terminated most programmatic elements directed at reducing smoking. Mass media was wound down in 2006, support to community groups ended after 2012, as did support for international assistance.





Tax Increases
Fed: 0.00
Ont: 0.00
Qc : 0.00

Imperial Tobacco measured success in the decisions of governments not to raise taxes.

Unambiguous messages:

"C-stores Demand a Freeze on New Regulation and Taxation on Legal Tobacco"
CCSA Press Release. 21 October 2010.

"Ontario Budget's Tobacco Tax Increase Will Lead to More Illegal Cigarettes"
CCSA press release May 1, 2014

"[Tax increases in] New Brunswick Budget Makes Contraband Tobacco Worse".
NCACT press release, Feb 2, 2016.

The federal, Ontario and Quebec governments implemented no substantial tobacco tax increases between 2004 and the end of 2012.

Because of inflation, the real value of the tax declined over this 8 year period.

[E1]. B. Kemball. What's stopping cigarette crackdown? Op-Ed. National Post. February 25, 2009.
[E2] Megan Fitzpatrick. Feds move to ban most tobacco print advertising. Canwest News. May 2009.
[E3] G. Galloway. Plans for scarier cigarette labels snuffed. Globe and Mail. September 28, 2010
[E4] Tobacco Lobbying preceded label retreat. CBC News, December 10, 2010.

E

Algoma PUBLIC HEALTH
Santé publique Algoma

Board of Health

DATE: NOVEMBER 23, 2016	RESOLUTION NO.: 2016 – 109
MOVED: Heather	SECONDED: Lucas
SUBJECT: ANTI-CONTRABAND TOBACCO CAMPAIGN	

Resolution:

WHEREAS information referenced from a 2012 slide deck by Imperial Tobacco Canada Ltd. (ITCL) demonstrates that the National Coalition Against Contraband Tobacco (NCACT) and the Ontario Convenience Store Association (OCSA) have worked on behalf of ITCL to convince Ontario municipalities of the importance of the contraband tobacco problem; and

WHEREAS this referenced information makes clear that the anti-contraband campaign pursued by the NCACT and the OCSA in Ontario is designed in part to block tobacco excise tax increases and regulation of tobacco products generally; and

WHEREAS contrary to tobacco industry messaging, impartial research by the Ontario Tobacco Research Unit at the University of Toronto has shown that tobacco excise tax increases do not lead to large increases in contraband; and

WHEREAS municipalities within the District of Algoma have previously passed smoke-free bylaws and support protection of the public from second-hand tobacco smoke.

THEREFORE BE IT RESOLVED THAT Algoma Public Health requests all municipalities within the District of Algoma to explicitly reject motions from tobacco industry and/or its front groups and to call on the Ontario Ministry of Finance to; (a) raise tobacco excise taxes and (b) enhance enforcement activities designed to reduce the presence of contraband tobacco in Ontario communities.

FURTHERMORE THAT this resolution be shared with the Ministry of Finance, Federal Members of Parliament, the Association of Local Public Health Units, Ontario Public Health Units, the Federal Minister of Health and the Ontario Campaign for Action on Tobacco.

CARRIED: Chair's Signature Lee Mason

☐ Lee Mason - Chair	☐ Ian Frazier – Vice Chair	☐ Patti Avery
☐ Lucas Castellani	☐ Debbie Graystone	☐ Sue Jensen
☐ Candace Martin	☐ Heather O'Brien	☐ Dennis Thompson

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Fax: 705-856-1752

ANTI-CONTRABAND TOBACCO CAMPAIGN

MOTION: **WHEREAS the Sudbury & District Board of Health has reviewed information indicating that recent anti-tobacco contraband campaigns from the National Coalition Against Contraband Tobacco and the Ontario Convenience Store Association were supported by the tobacco industry with the intention of blocking tobacco excise tax increases and regulation of tobacco products generally; and**

WHEREAS Ontario municipalities including the City of Greater Sudbury have endorsed such campaigns without being informed of tobacco industry support; and

WHEREAS municipalities within the SDHU service area are longstanding advocates for measures to protect the public from exposure to environmental tobacco smoke;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health advise area municipalities of this information and urge municipalities to not endorse tobacco industry supported campaigns; and

THAT the Sudbury & District Board of Health request municipalities to call on the Ontario Ministry of Finance to raise tobacco excise taxes and enhance enforcement activities designed to reduce the presence of contraband tobacco in Ontario communities; and

FURTHERMORE THAT this resolution be shared with municipal councils, local MPPs, the Ontario Ministry of Finance, the Association of Local Public Health Agencies, Ontario public health units, and the Ontario Campaign for Action on Tobacco.

simcoe muskoka
DISTRICT HEALTH UNIT

December 15, 2016

The Honourable Dr. Eric Hoskins
Minister – Minister's Office
Ministry of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor St
Toronto, Ontario
M7A 2C4

Dear Minister Hoskins:

Re: Marijuana controls under Bill 178, Smoke-Free Ontario Amendment Act, 2016

On behalf of the Board of Health at the Simcoe Muskoka District Health Unit, I am writing to recommend the inclusion of marijuana (medicinal and recreational) as a prescribed product or substance under the auspices of Bill 178, Smoke-Free Ontario Amendment Act, 2016.

If not regulated appropriately, the likely legalization of marijuana and its use in Canada will be accompanied by significant population health risks particularly as it relates to early and frequent use with a focus on high risk groups such as youth, drivers, those at risk for addiction and mental health disorders, and pregnant and lactating women. There are many lessons that have been learned from successful implementation of comprehensive tobacco control in Ontario which can be transferred to the emerging issue of legal marijuana. This includes the coordination of prevention, cessation and protection policies which are designed to support each other, leading consistently to minimized risk and improved population health outcomes.

Bill 178, Smoke-Free Ontario Amendment Act, 2016 has received Royal Assent but has yet to come into force. It will allow for the Ontario legislature to prohibit the use of certain products and substances under the regulatory framework of the Smoke-Free Ontario Act. In particular, it will allow the legislature to prohibit the smoking of prescribed products or substances in all places where smoking tobacco is prohibited, in addition to certain other protections and requirements.

This legislation as enacted presents an opportunity to manage the emerging issue of legal marijuana use both medicinal and recreational, in our communities. The legislature has an opportunity to act expediently in the interest of public health to list marijuana as a prescribed product or substance under this act. In doing so, Ontario will be better positioned to reduce the harm that may accompany the legalization of marijuana including exposure to second-hand marijuana smoke or vapor whether medicinal or recreational and the significant problem of increased youth uptake if marijuana use is normalized by public use. Research has confirmed the presence of known carcinogens and other chemicals implicated in respiratory and cardiovascular diseases in the second-hand smoke of marijuana cigarettes. [1, 2] By prohibiting the smoking of all marijuana in all places where the smoking of tobacco is prohibited, children, youth and adults in our communities will have a much lower public and second-hand exposure to the use of marijuana.

❑ **Barrie:** 15 Sperling Drive, Barrie, ON, L4M 6K9, 705-721-7520, FAX: 705-721-1495
❑ **Collingwood:** 280 Pretty River Pkwy., Collingwood, ON, L9Y 4J5, 705-445-0804, FAX: 705-445-6498
❑ **Cookstown:** 2-25 King Street S., Cookstown, ON, L0L 1L0, 705-458-1103, FAX: 705-458-0105
❑ **Gravenhurst:** 2-5 Pineridge Gate, Gravenhurst, ON, P1P 1Z3, 705-684-9090, FAX: 705-684-9887
❑ **Huntsville**: 34 Chaffey St., Huntsville, ON, P1H 1K1, 705-789-8813, FAX: 705-789-7245
❑ **Midland:** B-865 Hugel Ave., Midland, ON, L4R 1X8, 705-526-9324, FAX: 705-526-1513
❑ **Orillia:** 120-169 Front St. S., Orillia, ON, L3V 4S8, 705-325-9565, FAX: 705-325-2091

The Board of Health commends the provincial government on amending the Smoke-Free Ontario Act to allow for wider protections. Time is of the essence in positioning the protections available under this amendment.

The inclusion of all marijuana under the act will demonstrate the province's forward thinking on this emerging issue and will put in place one piece of the regulatory framework necessary to prevent population health harms from legalized marijuana in Ontario. Should enforcement of the amendment fall in part to health units, it is critical that long-term funding accompany the initiative to support comprehensive harm reduction, cessation, protection and prevention measures to give health units the opportunity to succeed.

In addition, the Board of Health strongly urges the commencement of workplace and public protections as enacted under the Electronic Cigarettes Act for all the above reasons. The vaping of marijuana will be effectively prohibited in all places where smoking of tobacco is prohibited once all provisions of the Electronic Cigarettes Act come into force.

Thank you for the opportunity to voice our support for the changes outlined and we look to your continued strong leadership to protect and promote the health of Ontario residents.

Sincerely,

ORIGINAL SIGNED BY

Barry Ward
Chair, Board of Health

BW:HM:mk

c. Chief Medical Officer of Health of Ontario
Ontario Boards of Health
Association of Local Public Health Agency
Ontario Public Health Association
Local Members of Provincial Parliament in Simcoe Muskoka
Municipal Councils in Simcoe Muskoka

1. Moir D, Rickert WS, Levasseur G, Larose Y, Maertens R, White P, Desjardins S. A Comparison of Mainstream and Sidestream Marijuana and Tobacco Cigarette Smoke Produced under Two Machine Smoking Conditions. Chem Res Toxicol [serial online]. 2008; 21: 494–502 [Last accessed 2016 Dec 6]. Available from: http://pubs.acs.org/doi/pdfplus/10.1021/tx700275p

2. Wang X, Derakhshandeh R, Liu J, Nabavizadeh P, Le S, Danforth OM, Pinnamaneni K, Rodriguex HJ, Luu E, Sievers RE, Schick SF, Glantz SA, Springer ML. One Minute of Marijua Secondhand Smoke Exposure Substantially Impairs Vascular Endothelial Function. J Am Heart Assoc [serial online]. 2016; Jul 27: 5(8) [Last accessed 2016 Dec 7]. Available from: https://www.ncbi.nlm.nih.gov/pubmed/27464788

CANNABIS REGULATION AND CONTROL

MOTION: **WHEREAS the Final Report of the Task Force on Cannabis Legalization and Regulation, *A Framework for the Legalization and Regulation of Cannabis*, recommended to the federal government that current restrictions on public smoking of tobacco products be extended to the smoking of cannabis products and to cannabis vaping products; and**

WHEREAS the recently amended Smoke Free Ontario Act permits certain products and substances to be prohibited under the regulatory framework of the Act; and

WHEREAS Sudbury & District Board of Health motion #54-15 called for a public health approach to the forthcoming cannabis legalization framework, including strict health-focused regulations to reduce the health and societal harms associated with cannabis use; and

WHEREAS a public health approach focuses on high-risk users and includes strategies such as controlled availability, age limits, low risk use guidelines, pricing, advertising restrictions, and general and targeted prevention initiatives and allows for more control over the risk factors associated with cannabis-related health and societal harms; and

WHEREAS by prohibiting the smoking of all cannabis in all places where the smoking of tobacco is prohibited, children, youth and adults in our communities will result in reduced public and second-hand exposure to cannabis;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health call for the inclusion of marijuana (medicinal and recreational) as a prescribed product or substance under the Smoke Free Ontario Act; and

FURTHER THAT this resolution be shared with the Honourable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-Term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

Dietitians of Canada
Les diététistes du Canada

Taxation and Sugar-Sweetened Beverages

Position of Dietitians of Canada

FEBRUARY 2016

www.dietitians.ca | www.dietetistes.ca

Taxation and Sugar-Sweetened Beverages

Position of Dietitians of Canada

ABSTRACT

Dietitians of Canada recommends that an excise tax of at least 10-20% be applied to sugar-sweetened beverages sold in Canada given the negative impact of these products on the health of the population and the viability of taxation as a means to reduce consumption. For the greatest impact, taxation measures should be combined with other policy interventions such as increasing access to healthy foods while decreasing access to unhealthy foods in schools, daycares, and recreation facilities; restrictions on the marketing of foods and beverages to children; and effective, long-term educational initiatives.

This position is based on a comprehensive review of the literature. The Canadian population is experiencing high rates of obesity and excess weight. There is moderate quality evidence linking consumption of sugar-sweetened beverages to excess weight, obesity, and chronic disease onset in children and adults. Taxation of sugar-sweetened beverages holds substantiated potential for decreasing its consumption. Based on economic models and results from recent taxation efforts, an excise tax can lead to a decline in sugar-sweetened beverage purchase and consumption. Taxation of up to 20% can lead to a consumption decrease by approximately 10% in the first year of its implementation, with a postulated 2.6% decrease in weight per person on average. Revenue generated from taxation can be used to fund other obesity reduction initiatives. A number of influential national organizations support a tax on sugar-sweetened beverages.

Taxation des boissons avec sucre ajouté

Prise de position des Diététistes du Canada

RÉSUMÉ

Les diététistes du Canada recommandent qu'une taxe d'accise d'au moins 10 à 20 % soit appliquée sur les boissons avec sucre ajouté vendues au Canada en raison de l'impact négatif qu'ont ces produits sur la santé de la population et de la praticabilité de la taxation comme moyen de réduire la consommation. Pour obtenir un impact maximal, les mesures de taxation devraient être combinées à d'autres politiques, par exemple une augmentation de l'accès aux aliments sains et une diminution de l'accès aux aliments malsains dans les écoles, les services de garde et les installations de loisirs; des restrictions sur le marketing d'aliments et de boissons auprès des enfants; et des initiatives éducatives efficaces visant le long terme.

Cette prise de position se fonde sur une revue exhaustive de la littérature. La population canadienne présente des taux élevés d'obésité et de surpoids. Il existe des données probantes de qualité modérée associant la consommation de boissons avec sucre ajouté à l'apparition du surplus de poids, de l'obésité et de maladies chroniques chez les enfants et les adultes. Par ailleurs, une taxe sur les boissons sucrées a un impact sur la consommation. Selon certains modèles économiques et les résultats issus de récents efforts de taxation, une taxe d'accise peut mener à une diminution de l'achat et de la consommation de boissons avec sucre ajouté. En effet, une taxation allant jusqu' à 20 % peut entraîner une réduction de la consommation d'environ 10 % au cours de l'année suivant la mise en oeuvre, ainsi qu'une diminution du poids de 2,6 % par personne, en moyenne. De plus, les recettes générées par la taxation peuvent être employées pour financer d'autres initiatives de réduction de l'obésité. D'autres organismes nationaux d'influence soutiennent également la taxation des boissons avec sucre ajouté.

POSITION STATEMENT

Dietitians of Canada recommends that an excise tax of at least 10-20% be applied to sugar-sweetened beverages sold in Canada given the negative impact of these products on the health of the population and the viability of taxation as a means to reduce consumption. For the greatest impact, taxation measures should be combined with other policy interventions such as increasing access to healthy foods while decreasing access to unhealthy foods in schools, daycares, and recreation facilities; restrictions on the marketing of foods and beverages to children; and effective, long-term educational initiatives.

INTRODUCTION

Obesity and excess weight in all age groups continue to be at high levels in Canada with 62% of Canadian adults and 32% of children and youth (6-17 years) having excess weight or obesity (1,2). In 2004, Canada endorsed the World Health Organization (WHO) *Global Strategy on Diet, Physical Activity and Health* and in 2010, the Public Health Agency of Canada released *Curbing Childhood Obesity* (3,4) calling for government leadership and joint and complementary actions by other sectors of society. Recommended measures included coordinating efforts to provide supportive environments for healthy eating, increasing access and availability of healthy foods, and decreasing access, availability, and advertising of foods high in fat, sugar, and sodium.

Definitions of sugar-sweetened beverages (SSBs) vary. For the purposes of this position paper, the definition of the Centre for Disease Control and Prevention is applied which is, SSBs include "soft drinks (soda or pop), fruit drinks, sports drinks, tea and coffee drinks, energy drinks, sweetened milks or milk alternatives, and any other beverages to which sugar … has been added" (5). It is recognized that sweetened milks and milk alternatives contain important nutrients and are nutritionally superior to soft drinks yet adding sugar to milk and milk alternatives adds calories without improving the nutritional quality of the beverage (5). Intake of SSBs is one of the dietary factors leading to the increase in obesity and overweight rates (6,7). As jurisdictions around the world implement taxes on sugar-sweetened beverages, evidence is accumulating to support taxation as a promising measure for decreasing their consumption and potential impact on the health of the population (8).

In 2010, DC released a position paper calling for restrictions on the advertising of unhealthy foods and beverages to children (9) and now DC is working with other Canadian organizations concerned about marketing to children (10). Dietitians of Canada has also called for and supported school nutrition and daycare policies and programs that increase access to healthier foods and decrease access to foods high in fat, sugar, and sodium such as SSBs. This position paper focuses on taxation as a policy instrument to limit consumption of SSBs.

HOW MUCH SUGAR IS CONSUMED BY CANADIAN ADULTS AND CHILDREN AND WHAT IS IDEAL?

In Canada, approximately 13% of the total daily calorie intake comes from added sugars (11,12). Add to this the consumption of foods high in free sugars (e.g., fruit juice, honey, syrups etc.), and the intake of sugars increases to 15% of total daily caloric intake of Canadians (11,12). This level of consumption exceeds the 2015 WHO recommendation to limit free sugar[1] consumption to 10% of total energy intake to reduce the risk of overweight, obesity, and tooth decay (13). Based on the average dietary needs of 2000 calories for an adult, 10% of total energy intake equates to approximately 50 grams of free sugar or 12-13 teaspoons of sugar a day, including sugar from fruit

[1] **Free sugar** is defined by the World Health Organization and the US Food and Agriculture Organization in multiple reports as "all monosaccharides and disaccharides added to foods by the manufacturer, cook, or consumer, plus sugars naturally present in honey, syrups, and fruit juices".

juice, honey, and syrups (14,15). A single can of sugar-sweetened soda can contain up to 40 grams or 10 teaspoons of sugar. Consumption of SSBs has a large impact on the total sugar consumption of Canadians, specifically adolescents as 7-8% of their daily energy intake is from SSBs (16) and one in three report daily consumption of sugary drinks (11). Although intakes and sales of carbonated SSBs have been stabilizing or modestly declining over the past three decades, sales of other sugary drinks (energy drinks, sports drinks, sugar-sweetened waters) have increased significantly around the world (16). In Canada, intake of these other sugary drinks has increased, specifically among adolescents (16).

WHY LIMIT CONSUMPTION OF SUGAR-SWEETENED BEVERAGES?

There is moderate quality evidence supporting the relationship between body weight and intake of SSBs in both children and adults (17–21). Children with high intakes[2] of SSBs are 55% more likely to have obesity or excess weight in comparison to those with low intakes[2] (13). Children who consume SSBs during infancy are more likely to have obesity within six years (22). Having obesity or excess weight increases one's risk for several chronic and/or serious diseases including hypertension, coronary heart disease, insulin resistance, type 2 diabetes, joint problems and esophageal, pancreatic, colorectal, breast, endometrial, prostate and kidney cancers (4,23,24). There may also be a direct link (independent of body weight) between the consumption of SSBs and several chronic diseases including type 2 diabetes, cardiovascular disease, dyslipidemia, and metabolic syndrome (25–30). An increased incidence of dental caries, specifically in adolescents, is also associated with high intakes of free sugars (12,13).

The consumption of SSBs has been shown to displace other nutritionally superior beverages such as milk (31). Canadian food intake data indicates that as sweetened beverage (soft drinks and fruit drinks) consumption increases, there is an associated decrease in plain milk consumption (32). Diets high in sugar are lower in some micronutrients and may lead to nutritional inadequacy (33). Nutrient intake is displaced with each 5% increment of added sugars over the 10% recommendation (34). Finally, there is evidence that individuals do not compensate for calories consumed in liquid form by consuming fewer calories from solid food. This lack of compensation applies to calories consumed from SSBs and it may be one of the mechanisms linking SSBs consumption to weight gain (35–37).

TAXATION OF SUGAR SWEETENED BEVERAGES – A VIABLE POLICY OPTION

Evidence of moderate quality from recent systematic reviews demonstrates that taxation on SSBs can lead to modest decreases in consumption and improvements in body mass index, specifically in high-income countries (38–40). Although, taxes can be applied at different points in the food production, distribution, and retail continuum, numerous reviews and many public health experts have suggested the implementation of an excise tax on SSBs (8,41). An excise tax, unlike a sales tax paid by the consumer at the point of purchase, is levied before the point of purchase. Higher shelf-prices are more of a deterrent for purchase, than sales taxes added at the cash register (42). A recent review and micro-simulation model by The Childhood Obesity Intervention Cost-Effectiveness Study's (CHOICES) research team reported that of all the commonly proposed approaches and policies, the implementation of an excise tax on SSBs was one of three cost-effective interventions

[2] Intakes classified as servings of SSBs: One serving of SSBs was equivalent to 240 mL and contained 26g of sucrose, equaling ~5% of total daily energy intake for adults. Daily serving of SSBs at >1 or 2 were classified as **high intakes**. None or 'very low' consumption of SSBs per day was classified as **low intake**.

that would result in substantial prevention of childhood obesity (43). Taxation was on par with policies for elimination of tax deduction for advertising of nutritionally poor foods to children and the creation of nutrition standards for foods and beverages sold in schools (43). Such a policy could also save more in health care costs over the next decade (2015-2025) than it would cost to implement, and could generate substantial revenue to fund other obesity prevention interventions (43,44). According to Canadian research, a tax of 5 cents/100mL is capable of generating up to $1.8 billion per annum (45). When the idea of targeting this revenue to health-related activities and support of various obesity reduction programs is presented as an option, the general public appears to be more willing to support taxation measures (46). According to a 2011 poll, 40% of Canadians strongly support a tax on sugary drinks if the proceeds are used to fund the fight against obesity (47).

A number of influential Canadian national organizations support a tax on SSBs or sugary drinks including the Childhood Obesity Foundation (48), Heart and Stroke Foundation of Canada (14), Chronic Disease Prevention Alliance of Canada (49), and the Canadian Diabetes Association (50) and in the United States, the American Public Health Association (51) and Oral Health America (52). Public Health England has suggested that a tax of 10 – 20% would have a significant impact on the purchase and consumption patterns of SSBs and other high-sugar products and ultimately population health (53).

Price is one of the major factors that influences food choices (54). Consumption patterns are modulated by price elasticity of demand, a measure of the quantity of responsiveness in demand with a change in price (55,56). The demand for SSBs is elastic (57). High product elasticity, such as that of SSBs, makes substitutions to similar products less likely and allows for price changes to create greater and easier transitions in purchase and consumption patterns (57,58). Economic models have suggested that a 10% tax would reduce consumption by 8 to 13% (59) and that the greater the increase in the price of SSBs, the greater the decrease in their consumption (46). A study done in Norway found that those who consume the largest quantities of SSBs are most sensitive to price and that an increase of 11% in the cost of SSBs would reduce consumption in the lowest consuming group by 7% and in the highest consuming group by 17%. This effect would be magnified with larger tax increases (60). For instance, in a report for the USDA (61), modeling was used to determine the effect of a 20% increase in the cost of SSBs. The results suggested that consumers would adjust their choices to alternatives such as water, juice, coffee/tea, milk and/or diet drinks. A 20% price increase on SSBs may equate to an average 2.6% weight decrease during the first year of implementation of the tax (56). This would occur due to a theorized 8 – 10% reduction in consumption based on the estimates of price elasticity of demand (55,56). Although these caloric changes are small, there is a benefit to changing consumption patterns in light of evidence that SSBs intake is correlated to chronic disease risk, irrespective of caloric intake or body weight.

Several countries and regions such as France, Hungary, Mexico, and Berkeley (California) have implemented a tax on SSBs or foods high in sugar, however evaluation data is only available on the policies implemented in Mexico and Berkeley (11,42,54,62). A 10% excise tax on SSBs (non-dairy and non-alcoholic beverages) has been implemented in Mexico where caloric soda is currently one of the top beverage choices (63). Results from an observational study on the Mexico experience demonstrated a 6-12% decline in purchases in 2014, when compared to pre-tax trends (64). These results were observed across socioeconomic groups and occurred in conjunction with an increase in water consumption (64). A 17% reduction in purchase of SSBs, was observed in the lowest socioeconomic groups (64). The City of Berkeley levied a tax of one cent ($0.01)

per fluid ounce on SSBs (65). Post-tax data showed significant pass-through rates (extent of tax passed through to consumers via higher retail prices) of the excise tax and increased retail prices, marking an important step towards reducing SSBs consumption (42).

CRITICISMS OF USING TAXATION AS A POLICY TOOL?

The most common objections to taxation of SSBs are that it will be (a) regressive, (b) intrusive, (c) ineffective, and (d) detrimental to jobs and the economy.

a. The most prevalent criticism is that it is a regressive tax – that is, it has a disproportionate effect on people at the lowest income levels (66). Despite the theorization of the regressive burden of such a tax, data from studies conducted around the world show inconsistencies. Some show that taxation of SSBs may be equally effective for all socioeconomic groups, others show that tax burden on low-income groups will likely be small, and one reports it to be progressive, thereby imposing a greater burden on those in the higher socioeconomic strata (67,68). Conversely, if the tax is indeed regressive, it is important to note that lower income families are also more price-sensitive in comparison to higher income families. Hence, there is a greater chance for this population to decrease consumption of SSBs (67,69). Currently, SSBs are considerably cheaper than healthier beverages. For example, although prices vary across the country, the average price of a one-litre container of milk in Canada in 2015 was $2.47 compared to $1.94 for a two-litre bottle of cola beverage (70). Increasing the price of SSBs through taxation would lessen the relative price difference between the two products, which might make healthier beverages more desirable. A recent review reported that an increase in the price of SSBs would lead to an increase in the consumption of substitutes such as fruit juice and milk and a decrease in consumption of complements such as diet-drinks (46). Although the consumption of these alternative beverages may not lead to a substantial effect on decreasing caloric intake (71), they are of greater nutritional value which contributes to satiety, and some (i.e., dairy products) are associated with better weight status (46,72). Overall, since many SSBs offer little or no nutritional benefits and are linked to obesity, overweight, and numerous chronic diseases, there would be a benefit for the population as a whole to reduce the intake of these beverages.

b. Another criticism offered is that governments and policy makers have no business interfering in food choices of the population (66). This assumes that government policies do not already affect food choices – which is untrue. Governments set policies and enact regulations that affect all facets of the food supply system. There are sound political and economic arguments that support government intervention when external costs to third parties are high (73,74). This is the case in countries such as Canada and the United Kingdom where health care is publicly funded. As well, recent surveys have shown that the public is willing to pay increased taxes if generated funds are used for the creation of programs that minimize childhood obesity (57). Research on message framing studies shows that policies need to be continually reinforced in order to generate awareness, news coverage, and discussion, which may eventually lead to increased support of the cause (75). Support of SSBs taxation is bound to increase with clear identification of potential health benefits (76).

c. Others have argued that taxation is not a viable solution given obesity is the result of multiple factors (75,76). As recommended by the WHO and others, this points to the importance of taking a comprehensive and integrated approach to address obesity, with the inclusion of education and policy initiatives (13,77,78). Long-term educational interventions in schools, workplaces, retail stores, and via media communications show promise in encouraging the population to make healthier beverage choices but education alone is not sufficient

(53). Obesity prevention warrants broader and multifaceted actions from all relevant commercial and noncommercial sectors to replace the 'obesogenic' food environments with a healthy one (79,80).

d. A common concern of the food and beverage industry is that taxation will have a negative economic impact led by the loss of profits and jobs (76). These arguments may be overstated because they do not account for (i) the increased or substituted consumption of non-SSB products usually produced by the same companies, (ii) the effects of consumer re-allocation to non-beverage goods and services, and (iii) the economic activity generated by higher tax revenue (81). Based on a comprehensive economic model that takes into account the full economic impact of taxation, taxation on SSBs (20% increase) has the potential to create a slight increase or a zero net change in employment (81).

CONCLUSIONS

There is moderate quality evidence linking the consumption of SSBs to having excess weight, obesity, and chronic diseases in children and adults. Approximately 15% of Canadians' total daily caloric intake comes from free sugars. The World Health Organization recommends a limit of 10% of energy intake from free sugars. Sugar-sweetened beverages make a substantial contribution to the total sugar intake of Canadians, especially for adolescents, with 7-8% of their total energy intake being from SSBs.

There is moderate quality evidence that taxation of SSBs is an effective measure in improving dietary behaviours of populations. Economic models and results of taxation of SSBs in Mexico indicate that an excise tax of 10-20% leads to a decline in purchases. Although some argue against taxation as a viable policy measure, many Canadians support taxation especially if the revenue is used to fund public health programs.

Taxation of SSBs in conjunction with other policy efforts, including restrictions on the marketing of foods and beverages to children, limiting access in schools, daycares, and recreation facilities, and effective long-term educational initiatives will have more impact than any one effort on its own. Taxation of SSBs is one step, of the many required, to address the obesity epidemic.

KEY MESSAGES

- There is moderate quality evidence linking the consumption of sugar-sweetened beverages to having excess weight, obesity, and chronic diseases.
- Sugar-sweetened beverages include sweetened carbonated and non-carbonated beverages such as sodas, fruit drinks, energy drinks, sports drinks, and any other beverages to which sugar has been added.
- It would be prudent to follow the World Health Organization recommendations, and limit intake of free sugars to less than 10% of total daily calorie (energy) intake. This is approximately 50 g (12-13 teaspoons) of free sugars consumption per day based on a 2000-calorie diet. Current intakes are at about 15% of total energy intake.
- Canadian children and adults should limit their intake of sugar-sweetened beverages. To quench thirst, consume water instead.
- Sweetened milks and milk alternatives contain added sugar but also contain important nutrients and are nutritionally superior to soft drinks. The primary concern is the volume of soft drinks, fruit drinks, energy drinks, sports drinks and sugar-sweetened waters consumed by children, teens and adults.
- Based on available evidence, policy efforts that decrease the consumption of sugar-sweetened beverages have the potential to positively impact the health of Canadians.
- Taxation has emerged as one viable policy option to reduce the consumption of sugar-sweetened beverages. An excise tax of at least 10-20% is expected to have a considerable impact on the consumption of sugar-sweetened beverages.

- The impact of taxation on sugar-sweetened beverages should be monitored and evaluated to determine the impact on consumption patterns, dietary behaviours, and health outcomes.
- Taxation of sugar-sweetened beverages in conjunction with other policy efforts, including restrictions on the marketing of foods and beverages to children, limiting access in schools, daycares, and recreation facilities, and effective long-term educational initiatives will have more impact than any one effort on its own.

This position paper was adapted by Noor Naqvi, MSc, RD from a 2010 ***Current Issues*** *originally written by Susan Buhler PhD, RD and Dr. Kim Raine, PhD, RD. It was reviewed by Susan Buhler, Kate Comeau, Lynda Corby, Paul Fieldhouse, Janice Macdonald, Kim Raine, Mary Ann Smith, Jayne Thirsk, Pat Vanderkooy, Tom Warshawski, Jacqueline Wassef, and Leslie Whittington-Carter.*

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SUPPORT FOR THE POSITION OF DIETITIANS OF CANADA ON TAXATION AND SUGAR-SWEETENED BEVERAGES AS PART OF A COMPREHENSIVE HEALTHY EATING APPROACH

MOTION: **WHEREAS obesity results from a complex interaction of many factors including genetic, social and environmental; and**

WHEREAS 32% of Canadian children and youth have excess weight or obesity; and

WHEREAS intake of sugar-sweetened beverages is one of the dietary factors leading to increased rates of overweight and obesity; and

WHEREAS children with high intakes of sugar sweetened beverages are 55% more likely to have obesity or excess weight in comparison to those with low intakes; and

WHEREAS available evidence suggests that policy efforts which decrease the consumption of sugar sweetened beverages have the potential to positively impact the health of Canadians; and

WHEREAS the Dietitians of Canada position statement on Taxation and Sugar-Sweetened Beverages identifies sugar-sweetened beverage taxation as a public health intervention with potential positive health impact, especially when combined with further policy efforts; and

WHEREAS Dietitians of Canada recommends that an excise tax of at least 10-20% be applied to sugar sweetened beverages sold in Canada; and

WHEREAS a number of influential Canadian national organizations support a tax on sugar sweetened beverages including the Association of Local Public Health Agencies, the Childhood Obesity Foundation, Heart and Stroke Foundation of Canada, Chronic Disease Prevention Alliance of Canada, and the Canadian Diabetes Association;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the Position of Dietitians of Canada on Taxation and Sugar-Sweetened Beverages, and urge the federal government to implement an excise tax on sugar-sweetened beverages; and

FURTHER THAT copies of this motion be shared with key provincial and national stakeholders.

ADDENDUM

MOTION: THAT this Board of Health deals with the items on the Addendum.

IN CAMERA

MOTION: THAT this Board of Health goes in camera. Time:_____p.m.

RISE AND REPORT

MOTION: THAT this Board of Health rises and reports. Time: _____p.m.

The Board Chair will inquire whether there are any announcements and or enquiries.

Please remember to complete the Board Evaluation following the Board meeting:
https://fluidsurveys.com/s/sdhuBOHmeeting/

ADJOURNMENT
MOTION: THAT we do now adjourn. Time: _____ p.m.