



Board of Health

Meeting #03-18

Thursday, April 19, 2018

1:30 p.m.

Boardroom, Public Health Sudbury & Districts

1300 Paris Street

Board of Health Meeting - April 19, 2018

1.0 CALL TO ORDER

2.0 ROLL CALL

3.0 REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST

Agenda - April 19, 2018

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4.0 DELEGATION / PRESENTATION

i) Oral Health Program Update
Charlene Plexman, Manager, Clinical Services Division and
Jodi Maki, Health Promoter, Clinical Services Division

a. Oral Health Program Update, 2018 Report

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5.0 CONSENT AGENDA

i) Minutes of Previous Meeting

a. Second Meeting – February 15, 2018

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ii) Business Arising From Minutes

iii) Report of Standing Committees

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

a. MOH/CEO Report, April 2018

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Financial Statements

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v) Correspondence

a. Income Security: A Roadmap for Change

Letter from the Association of Local Public Health Agencies and the Ontario Public Health Association to the Minister of Community and Social Services dated January 5, 2018

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b. Repeal of Section 43 of the Criminal Code Refresh 2017

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c. Ontario Public Health Standards – Implementation Work Plan	
Memo from the Assistant Deputy Minister, Population and Public Health Division, Ministry of Health and Long-Term Care dated February 16, 2018	Page 57
d. Chief Medical Officer of Health 2016 Annual Report	
Email from the Chief Medical Officer of Health and 2016 Annual Report, Improving the Odds: Championing Health Equity in Ontario	Page 63
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Letter from the alPHa President to the Chief Medical Officer of Health dated March 13, 2018	Page 91
e. Food Insecurity/Nutritious Food Basket Costing	
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Letter from the Grey Bruce Board of Health to the Premier dated February 15, 2018	Page 93
Letter and Resolution from the Municipality of St-Charles to Dr. Sutcliffe dated March 26, 2018	Page 94
f. Alcohol Retail Sales	
Letter from the Grey Bruce Board of Health dated February 15, 2018	Page 96
g. Smoke-Free Modernization	
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h. Publically Funded Vaccine for Childcare Workers	
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i. 2018 Annual Service Plan	

Letter from the Haliburton, Kawartha, Pine Ridge District Board of Health dated March 13, 2018	Page 99
j. New Minister of Health and Long-Term Care	
Letter from the aPHa President dated February 27, 2018	Page 101
Letter from the COMOH Chair dated February 28, 2018	Page 102
k. Minister's Expert Panel on Public Health	
Letter from Minister Hoskins to aPHa President dated February 23, 2018	Page 104
l. Additional One-Time Funding for 2017-2018	
Letter from the Minister of Health and Long-Term Care to the Board Chair dated March 22, 2018	Page 105
m. Cannabis Sales Taxation Revenue	
Letter from Hastings Prince Edward Board of Health to the Premier dated March 28, 2018	Page 106
n. Amendments to the Health Protection and Promotion Act (HPPA) and the Immunization of School Pupils Act (ISPA) and New Regulations Made Under the HPPA	
Email from the Assistant Deputy Minister, Population and Public Health Division, Ministry of Health and Long-Term Care dated April 5, 2018	Page 108
vi) Items of Information	
a. Health Canada News Release Government Launches Food Consultations to Help Canadians Make Healthy Choices dated February 9, 2018	Page 110
d. aPHa's Response to the 2018 Ontario Budget dated April 3, 2018	Page 114
b. Government of Ontario News Release Premier's Statement on Changes to the Executive Council dated February 26, 2018	Page 118
c. News radio article Northwestern Ontario Municipal Association Against Proposal to Merge Health Units dated February 26, 2018	Page 119

e. MOHLTC News Release Ontario Moving Quickly to Expand Life-Saving Overdose Prevention Programs dated March 7, 2018 Page 120

f. Government of Ontario News Release Throne Speech Announces Major Investments Guided by a Commitment To Care and Creating Opportunity dated March 19, 2018 Page 122

g. Northern Ontario Health Equity Strategy, A plan for achieving health equity in the North, by the North, for the North dated April 13, 2018 Page 125

h. aPHa Information Break Newsletter dated April 12, 2018 Page 185

MOTION: Approval of Consent Agenda Page 188

6.0 NEW BUSINESS

i) BUSINESS NAME REGISTRATION

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MOTION: Business Name Registration Page 191

ii) aPHa Conferences

a. Winter Meetings – February 2018

Boards of Health Section Meeting Page 192

- Verbal Report from Board Member, James Crispo

Council of Ontario Medical Officers of Health (COMOH) Section Meeting

b. Annual General Meeting (AGM) and Conference – June 2018

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Motion: aPHa Conference Page 197

7.0 ADDENDUM

MOTION: Addendum Page 198

8.0 IN CAMERA

MOTION: In Camera

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A proposed or pending acquisition or disposition of land by the municipality or local board;

9.0 RISE AND REPORT

MOTION: Rise and Report

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10.0 ANNOUNCEMENTS / ENQUIRIES

Evaluation for completion

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11.0 ADJOURNMENT

MOTION: Adjournment

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AGENDA – THIRD MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS, BOARDROOM, SECOND FLOOR
THURSDAY, APRIL 19, 2018 – 1:30 P.M.

- 1. CALL TO ORDER**
- 2. ROLL CALL**
- 3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST**
- 4. DELEGATION/PRESENTATION**
 - i) Oral Health Program Update**
 - Charlene Plexman, Manager, Clinical Services Division
 - Jodi Maki, Health Promoter, Clinical Services Division
 - a. Oral Health Program Update, 2018 Report
- 5. CONSENT AGENDA**
 - i) Minutes of Previous Meeting**
 - a. Second Meeting – February 15, 2018
 - ii) Business Arising From Minutes**
 - iii) Report of Standing Committees**
 - iv) Report of the Medical Officer of Health / Chief Executive Officer**
 - a. MOH/CEO Report, April 2018
 - v) Correspondence**
 - a. Income Security: A Roadmap for Change
 - Letter from the Association of Local Public Health Agencies and the Ontario Public Health Association to the Minister of Community and Social Services dated January 5, 2018
 - b. Repeal of Section 43 of the Criminal Code Refresh 2017
 - Resolution from the Board of Health for the Haliburton, Kawartha, Pine Ridge Board of Health dated December 7, 2017
 - c. Ontario Public Health Standards – Implementation Work Plan
 - Memo from the Assistant Deputy Minister, Population and Public Health Division, Ministry of Health and Long-Term Care dated February 16, 2018

- d. Chief Medical Officer of Health 2016 Annual Report
 - Email and 2016 Annual Report, *Improving the Odds: Championing Health Equity in Ontario*
 - Letter from the alPHa President to the Chief Medical Officer of Health dated March 13, 2018
- e. Food Insecurity/Nutritious Food Basket Costing
 - Board of Health motion #48-17*
 - Letter from Carol Hughes, MP Algoma-Manitoulin-Kapuskasing, to Dr. Sutcliffe dated February 5, 2018
 - Letter from the Grey Bruce Board of Health to the Premier dated February 15, 2018
 - Letter and Resolution from the Municipality of St-Charles to Dr. Sutcliffe dated March 26, 2018
- f. Alcohol Retail Sales
 - Letter from the Grey Bruce Board of Health dated February 15, 2018
- g. Smoke-Free Modernization
 - Letter from the Grey Bruce Board of Health dated February 15, 2018
- h. Publically Funded Vaccine for Childcare Workers
 - Letter from the Grey Bruce Board of Health dated February 15, 2018
- i. 2018 Annual Service Plan
 - Letter from the Haliburton, Kawartha, Pine Ridge Board of Health Unit dated March 13, 2018
- j. New Minister of Health and Long-Term Care
 - Letter from the alPHa President dated February 27, 2018
 - Letter from the COMOHC Chair dated February 28, 2018
- k. Minister's Expert Panel on Public Health
 - Letter from Minister Hoskins to alPHa President dated February 23, 2018
- l. Additional One-Time Funding for 2017-2018
 - Letter from the Minister of Health and Long-Term Care to the Board Chair dated March 22, 2018
- m. Cannabis Sales Taxation Revenue
 - Letter from Hastings Prince Edward Board of Health to the Premier dated March 28, 2018
- n. Amendments to the Health Protection and Promotion Act (HPPA) and the Immunization of School Pupils Act (ISPA) and New Regulations Made Under the HPPA
 - Email from the Assistant Deputy Minister, Population and Public Health Division, Ministry of Health and Long-Term Care dated April 5, 2018

vi) Items of Information

- a. Health Canada News Release *Government Launches Food Consultations to Help Canadians Make Healthy Choices* February 9, 2018
- b. Government of Ontario News Release *Premier's Statement on Changes to the Executive Council* February 26, 2018
- c. News radio article *Northwestern Ontario Municipal Association Against Proposal to Merge Health Units* February 26, 2018
- d. alPHa's Response to the 2018 Ontario Budget April 3, 2018
- e. MOHLTC News Release *Ontario Moving Quickly to Expand Life-Saving Overdose Prevention Programs* March 7, 2018
- f. Government of Ontario News Release *Throne Speech Announces Major Investments Guided by a Commitment To Care and Creating Opportunity* March 19, 2018
- g. Northern Ontario Health Equity Strategy, *A plan for achieving health equity in the North, by the North, for the North* April 13, 2018
- h. alPHa Information Break Newsletter April 12, 2018

APPROVAL OF CONSENT AGENDA

MOTION:

THAT the Board of Health approve the consent agenda as distributed.

6. NEW BUSINESS

i) BUSINESS NAME REGISTRATION

- Briefing Note from the Medical Officer of Health and Chief Executive Officer dated April 12, 2018

BUSINESS NAME REGISTRATION

MOTION:

WHEREAS the Sudbury & District Health Unit proposes to identify itself to the public under the business name Public Health Sudbury & Districts; and

WHEREAS the *Business Names Act* (Ontario), provides that no corporation shall carry on business or identify itself to the public under a name other than its corporate name unless the name is registered by that corporation;

THEREFORE BE IT RESOLVED THAT the Board of Health for Sudbury & District Health Unit adopt the business name Public Health Sudbury & Districts and that its solicitors be instructed to take all required steps to register the aforesaid business name pursuant to the *Business Names Act* (Ontario).

ii) aPHa Conferences

- a. Winter Meetings – February 2018
 - Boards of Health Section Meeting
 - Verbal Report from Board Member, James Crispo
 - Council of Ontario Medical Officers of Health (COMOH) Section Meeting
- b. Annual General Meeting (AGM) and Conference – June 2018

ALPHA CONFERENCE

MOTION:

WHEREAS Public Health Sudbury & Districts has a modest travel budget to cover remuneration, registration, travel, meals, and accommodation as per the Board Manual Policy and Procedure I-I-10, permitting Board members to attend official Board of Health functions; and

WHEREAS the Public Health Sudbury & Districts is allocated four votes at the aPHa Annual General Meeting;

THEREFORE, BE IT RESOLVED THAT in addition to the Medical Officer of Health and the Associate Medical Officer of Health, the following Board member(s) attend(s) the 2018 aPHa Annual General Meeting as voting delegates for the Board of Health:

7. ADDENDUM

ADDENDUM

MOTION:

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

8. IN CAMERA

IN CAMERA

MOTION:

THAT this Board of Health goes in camera. Time: _____ p.m.

- A proposed or pending acquisition or disposition of land by the municipality or local board

9. RISE AND REPORT

RISE AND REPORT

MOTION:

THAT this Board of Health rises and reports. Time: _____ p.m.

10. ANNOUNCEMENTS / ENQUIRIES

Please remember to complete the Board evaluation following the Board meeting:

11. ADJOURNMENT

ADJOURNMENT

MOTION:

THAT we do now adjourn. Time: _____



Oral health program update (2018)

Oral health program update (2018)

Introduction

The overall goal of Public Health Sudbury & Districts' oral health program is to enable all children and youth to attain and sustain optimal oral health. Programs and services are delivered in accordance with the Ontario Public Health Standards and aligned with our agency's strategic plan. Programming is evidence-informed and considers local needs. We provide both universal programming for all children and youth, and targeted initiatives for those at higher risk of poor oral health outcomes. This report provides a brief update on the following five key priority areas:

1. School screening and surveillance
2. Healthy Smiles Ontario (HSO)
3. Early Childhood Caries (ECC) Prevention
4. Indigenous oral health
5. Adult oral health inequities

School screening and surveillance

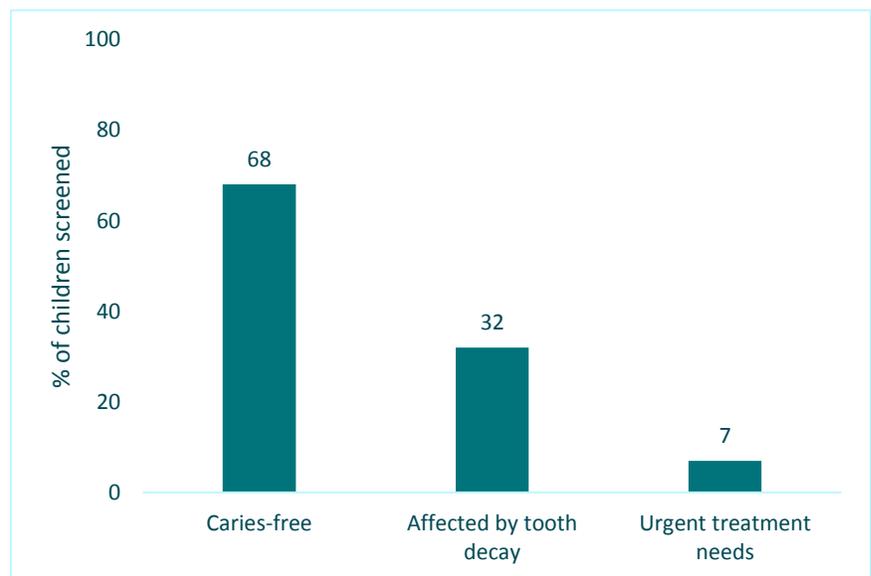


OVERVIEW: Public Health screens children in all elementary schools on an annual basis. The purpose is to identify and refer children in need of dental care, help families access treatment, and follow-up to make sure care has been received. We also collect screening data, to monitor children’s oral health status and identify schools or communities who may be in need of targeted programming. For instance, schools are designated as ‘low-’, ‘medium-’, or ‘high-risk’, depending on the prevalence of tooth decay and unmet treatment needs noted during screening. Children with no active tooth decay (caries) or history of dental treatment at the time of screening are considered ‘caries-free’. Every year, we want to see a high percentage of ‘caries-free’ children, as this is an indicator of good oral health.



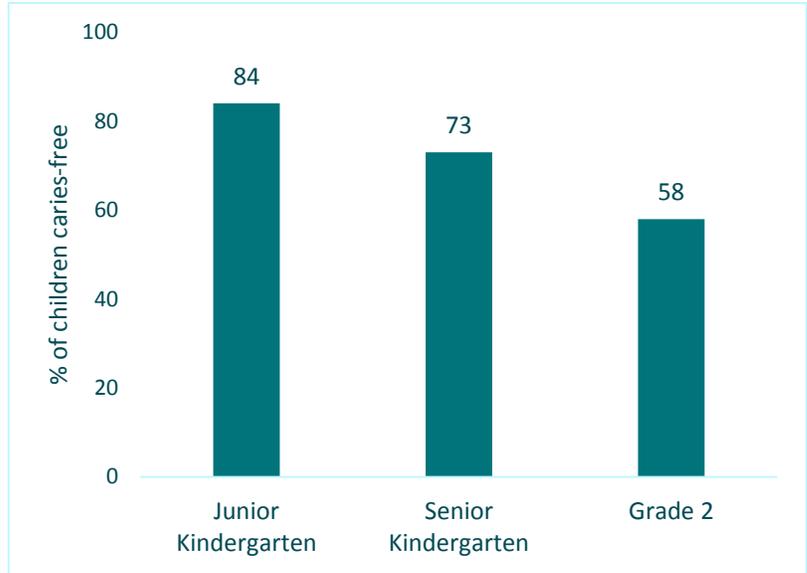
UPDATE: In the 2016-17 school year, we screened 7,973 children in 92 elementary schools¹. Findings were similar to those of previous years. On the upside, a high percentage of children were ‘caries-free’ and the vast majority were receiving dental care (see Figure 1). However, one in three children had been affected by decay, which is preventable, and we continue to find a subset of children with urgent and unmet treatment needs. The proportion of children with unmet treatment needs varies by school, with ‘low-risk’ schools requiring treatment referrals for 2% of children screened compared to 11% for ‘high-risk’ schools. Another troubling trend that we see from year to year is a sharp decrease in the percentage of ‘caries-free’ children from Kindergarten to Grade 2 (see Figure 2).

Figure 1:
School screening results,
Sudbury & Districts,
2016-17



Source: Oral Health Information Support System (OHISS)

Figure 2:
Percentage of children
screened who were
'caries-free', by grade,
Sudbury & Districts,
2016-17



Source: Oral Health Information
Support System (OHIS)



NEXT STEPS: We will continue to provide oral health education and promotion through a variety of channels to help more children obtain optimal oral health. Based on our screening findings, programming in 2018 will include education and skill-building targeting children in Grade 1 from schools found to have higher rates of decay.

Healthy Smiles Ontario (HSO)



OVERVIEW: HSO is a government-funded program that provides free dental services for eligible children and youth from lower-income families. Local public health’s role includes promoting the program, assisting families with enrolment, helping families find a dental provider, and providing preventive treatments through on-site and school-based clinics. We also assist dental offices with HSO program administration.

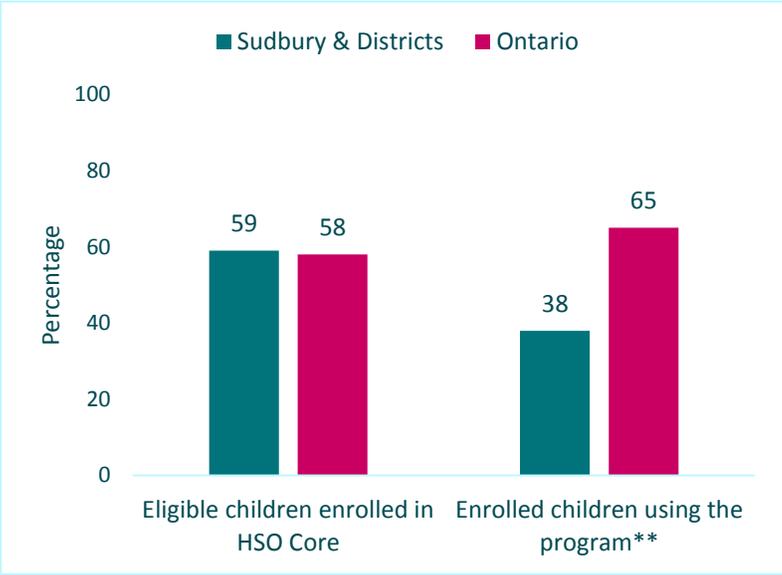


UPDATE: As of March 31, 2017, 4,922 children and youth in Sudbury & Districts were enrolled in HSO². Enrolment has been increasing, but there are still many eligible children across Ontario who are not yet utilizing this program (see Figure 3).

HSO program highlights for 2017:

- 415 calls from parents for information, emergency care, or help finding a dental provider
- 119 drop-ins from parents seeking information and assistance
- 63 calls from dental providers for information and assistance
- 341 new clients enrolled for emergency assistance
- 695 children provided preventive dental treatments on-site or at school clinics

Figure 3:
Enrolment and utilization of HSO*, Sudbury & Districts and Ontario, as of March 31, 2017



*does not include children who received only HSO preventive services from Public Health
 **represents HSO clients who utilized treatment from April 1, 2016 to March 31, 2017
 Source: Oral Health Reporting Solution (OHRS)



NEXT STEPS: We want all eligible children to benefit from the HSO program. We will continue to promote the program through a variety of channels, including connecting with community agencies for help in reaching families, attending community events, and implementing a promotional campaign targeting families who are enrolled but not utilizing services.

Early Childhood Caries (ECC) prevention



OVERVIEW: ECC is a severe type of tooth decay that affects baby teeth. ECC is a significant public health problem that has been considered the most common chronic disease of children³. ECC can cause pain, speech difficulties, altered eating and sleeping patterns, and problems with permanent teeth⁴. In addition, treatment often requires general anesthesia, which increases risks and costs⁵. ECC can be prevented through a number of practices such as good oral hygiene and dental visits beginning by age one. We implement a variety of initiatives to prevent ECC, including education and promotion, and a daily toothbrushing program for daycare centres (Smile Care).

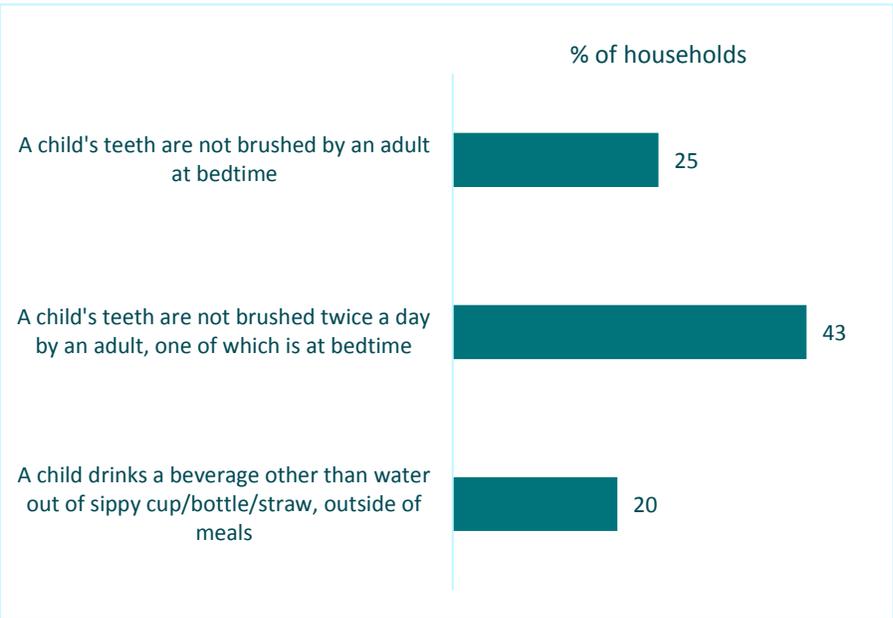


UPDATE: We do not know the local prevalence of ECC, but we do know that many children are at risk, and are developing ECC. For instance, 16% of Junior Kindergarten and 27% of Senior Kindergarten children screened in public schools¹ and 25% of children screened in First Nations daycares have been affected by decay. When exploring risk and protective factors, surveys of local households indicate that many children are not receiving regular oral hygiene and only a very small percentage are receiving the recommended age one dental visit^{6,7} (see Figures 4 & 5). As such, programming in 2017 focused on promoting early dental visits, distributing a pediatric screening tool to help parents and caregivers identify risk factors for ECC, and recruiting daycare centres into Smile Care.

Program highlights for 2017 include:

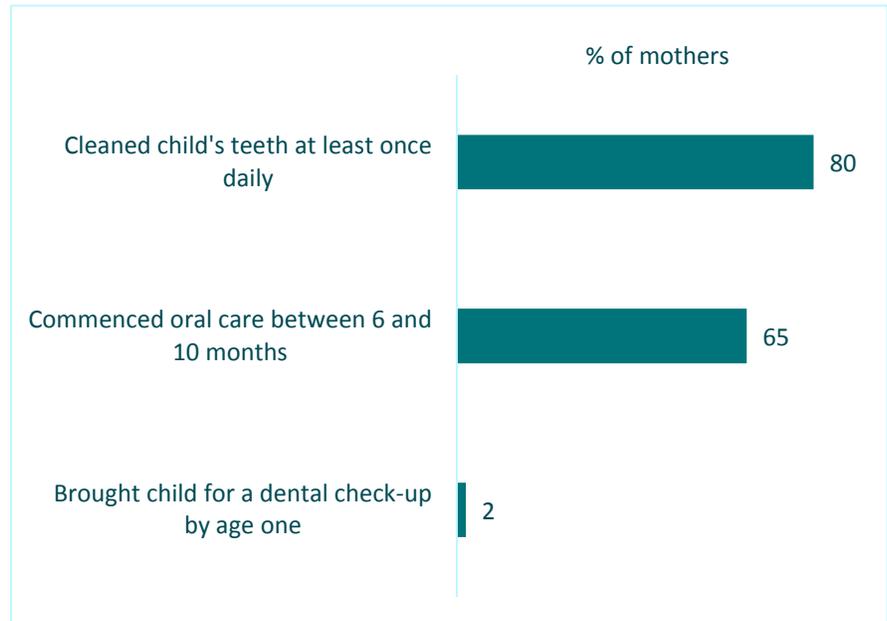
- 10 daycares implemented Smile Care (up from three in 2016), including two First Nations daycares
- 237 children received daily toothbrushing while in daycare through Smile Care
- 175 parents and caregivers received the pediatric screening tool through Smile Care
- 70 pediatric screening tools were provided to First Nations health centres for distribution
- A campaign was implemented during oral health month to promote dental visits by age one

Figure 4:
Oral hygiene practices
of households with
a child aged 0-6,
Sudbury & Districts,
2015



Source: Rapid Risk Factor Surveillance System (RRFSS)

Figure 5:
Oral hygiene practices
of mothers with a
12-month old child,
Sudbury & Districts,
2013



Source: Public Health
Sudbury & Districts⁷



NEXT STEPS: ECC is preventable – we want to see more children remain caries-free in early childhood and beyond. Activities in 2018 include participating in a province-wide social media campaign to promote the importance of oral health for childhood growth and development, providing education and resources to expecting parents during the pre-natal period, and continuing to recruit and support daycares to deliver daily toothbrushing. We will also explore additional preventive treatments that could be provided to reduce caries risk and progression, for higher-risk children from low-income families and First Nations communities.

Indigenous oral health

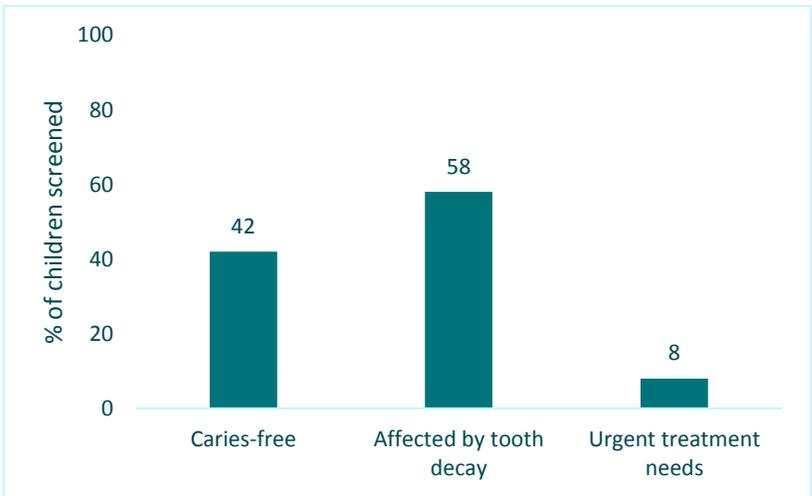


OVERVIEW: Since 2011, Public Health has been partnering with local First Nations communities to deliver oral health programs and services for children. Indigenous people have generally poorer oral health than non-Indigenous Canadians and higher treatment needs^{8,9}. As such, the overall goal of this work is to create equal opportunities for oral health for Indigenous children. Each First Nation community has unique demographics, needs, priorities, and resources, thus a one-size-fits-all approach will not work. Planning must take place at the local level, driven by each community, and must include taking the time to build relationships and trust. In order to facilitate relationship-building over time, the same public health dental hygienist has been leading this work since the program started.



UPDATE: There has been increasing interest among First Nations communities to partner with us, and the number of participating communities has been growing. This has enabled us to reach more children, and in return, we have been able to report back on the oral health status of children in their schools and daycares. In the 2016-17 school year, we screened 606 children in six First Nations elementary schools. More than half of the children screened had been affected by tooth decay, and 8% had urgent treatment needs (see Figure 6). These findings were comparable to what we typically see in the 'high-risk' schools in our public school screening program. We also screened 89 children in First Nations daycares and found that approximately one in four children screened had been affected by decay. Overall, there is wide variation in oral health status and treatment needs from one community to another and from year to year. This variation appears to relate to differences in access to services and other factors such as relationships between communities and local dental providers.

Figure 6:
First Nations elementary
school screening results,
2016-17



NEXT STEPS: We will continue to build relationships and collaborate with our First Nations partners to develop comprehensive oral health strategies within each community. This will include oral health screening and surveillance, education and skill-building, and prevention. We will also be exploring opportunities to increase access to preventive treatments, such as developing a combined toothbrushing and fluoride varnish program for children in daycare centres.

Adult oral health inequities



OVERVIEW: Although the majority of Ontarians have access to high quality dental services and are in good oral health, there are significant income-related inequities in access to services¹⁰. Not surprisingly, groups with reduced access to care also suffer the greatest burden of oral health illness¹⁰. Public Health programs and services strive to reduce oral health inequities by increasing access to services for underserved populations. The public health mandate in Ontario has traditionally focused on children and youth, however there may be opportunities to expand programming to include adults. We are in the very early stages of this work, beginning with a local needs assessment.



UPDATE: Surveys of residents in Sudbury & Districts confirm that income-related inequities exist locally¹¹. Overall, 25% of local respondents reported that they did not have insurance for dental expenses¹¹. Compared to respondents from higher-income households, those from lower-income households were **less likely** to have dental insurance, visit the dentist, and report having 'excellent or very good' oral health; and **more likely** to experience dental pain and seek dental care only in emergencies (see Figures 7 & 8). Ontarians who are unable to access dental care often seek out services from hospital emergency departments¹². Local data indicates that approximately 550 visits per year (one to two visits per day) are made to hospital emergency departments in our catchment area for oral health issues such as dental pain, infection, or trauma to tooth¹³. Unfortunately, there is very little that can be done for these patients and it places increased burden on the healthcare system¹². Although we do not know the specific circumstances around each visit, they are an indication that there are local barriers to accessing dental care.

Figure 7:
Self-reported access
to dental care,
by household income,
Sudbury & Districts,
ages 12+, 2013/14

Source: Canadian Community
Health Survey (CCHS)

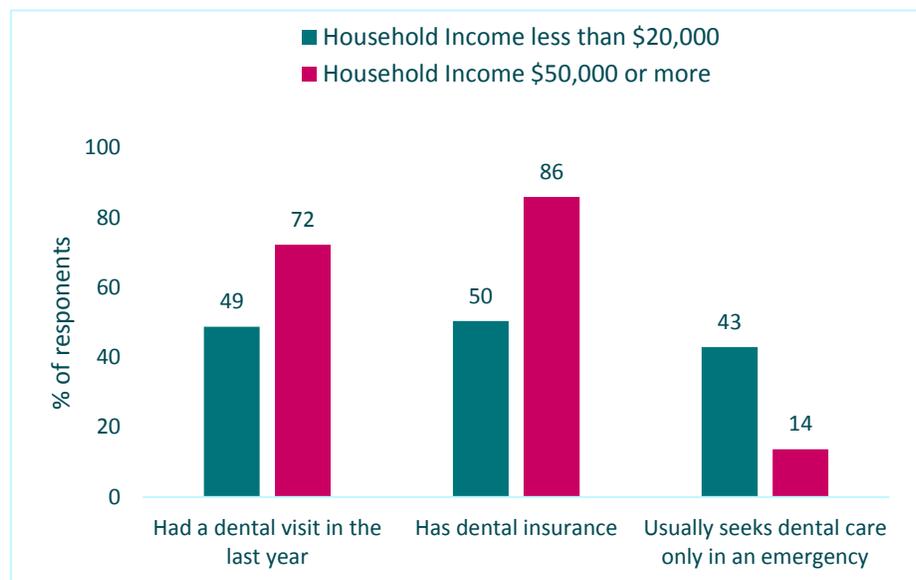
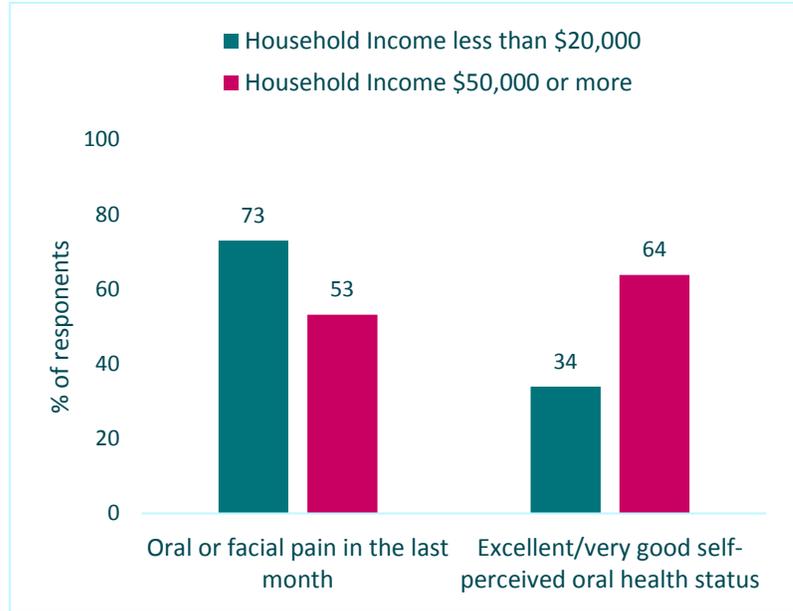


Figure 8:
Self-reported oral health
status, by household income,
Sudbury & Districts,
ages 12+,
2013/14



Source: Canadian Community Health
Survey (CCHS)



NEXT STEPS: We know that inequities exist locally, but we need to explore this in more detail. In 2018, we will be engaging community partners to find out who is facing the greatest barriers accessing oral healthcare and opportunities to address these barriers. The findings will be used to inform the development and implementation of a local adult oral health strategy, in collaboration with community partners.

Summary

Public Health has been making progress in our efforts to provide equitable opportunities and enable more children and youth to attain and sustain optimal oral health. We will continue to focus on the above priority areas, with an emphasis on identifying and addressing inequities in oral health. Collaboration with community partners has been vital to the success of our work, including dental professionals, schools, daycares, and First Nations communities. Going forward, we will continue to work with our communities to promote oral health and create healthier communities for all.

References

1. Oral Health Information Support System (OHISS)
2. Oral Health Reporting Solutions (OHRS)
3. US Department of Health and Human Services. (2000). Oral Health in America: A Report of the Surgeon General. Rockville: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health
4. Irvine JD, Holve S, Drol D, Schroth R; Canadian Paediatric Society, First Nations, Inuit and Metis Health Committee. (2011). Early childhood caries in Indigenous communities: A joint statement with the American Academy of Pediatrics. *Paediatr Child Health*; 16(6):351-7
5. Schroth R, Smith W. (2007). A review of repeat general anesthesia for pediatric dental surgery in Alberta, Canada. *Pediatr Dent* 2007; 29:480-7.
6. Rapid Risk Factor Surveillance System (RRFSS)
7. Sudbury & District Health Unit (2013). The Sudbury & District Infant Feeding Survey: Final Report. Sudbury, ON: Author
8. The First Nations Information Governance Centre. (2012). Report on the Findings of the First Nations Oral Health Survey (FNOHS) 2009-10. Ottawa: The First Nations Information Governance Centre, September 2012. http://fnigc.ca/sites/default/files/docs/fn_oral_health_survey_national_report_2010.pdf
9. Chiefs of Ontario. (2013). Ontario First Nations Oral Health Survey – Summary Report. July 2013. <http://health.chiefs-of-ontario.org/sites/default/files/files/OFNOHS%20Report.pdf>
10. College of Dental Hygienists of Ontario. (2014). Review of Oral Health Services in Ontario. <http://www.cdho.org/docs/default-source/pdfs/news/ohsreview.pdf>
11. Canadian Community Health Survey (CCHS)
12. Singhal, S., McLaren, L., Quinonez, C. (2017). Trends in emergency department visits for non-traumatic dental conditions in Ontario from 2006 to 2014. *Can J Public Health*; 108(3):e246-e250
13. Acute Care Enhanced Surveillance (ACES)

**MINUTES – SECOND MEETING
BOARD OF HEALTH FOR PUBLIC HEALTH SUDBURY & DISTRICTS
PUBLIC HEALTH SUDBURY & DISTRICTS, BOARDROOM, SECOND FLOOR
THURSDAY, FEBRUARY 15, 2018 – 1:30 P.M.**

BOARD MEMBERS PRESENT

Maigan Bailey	James Crispo	Jeffery Huska
Robert Kirwan	René Lapierre	Monica Loftus
Ken Noland	Rita Pilon	Mark Signoretti
Nicole Sykes	Carolyn Thain	

BOARD MEMBERS REGRETS

Janet Bradley	Thoma Miedema	Paul Myre
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STAFF MEMBERS PRESENT

Nicole Frappier	Sandra Laclé	Stacey Laforest
Rachel Quesnel	France Quirion	Dr. Penny Sutcliffe
Renée St Onge	Dr. Ariella Zbar	

Media

R. LAPIERRE PRESIDING

1. CALL TO ORDER

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

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

James Crispo declared a conflict of interest for 6.2.

4. DELEGATION/PRESENTATION

i) 2017 Year-In Review

- Dr. Ariella Zbar, Director, Clinical Services Division
- Stacey Laforest, Director, Environmental Health Division
- Sandra Laclé, Director, Health Promotion Division
- Renée St Onge, Director, Resources, Research, Evaluation and Development Division

Dr. Sutcliffe noted that on an annual basis, program directors present divisional statistical year-in review highlights of program and services activities from the preceding year. The presentation showcases the scope, diversity and volume of divisional work. An annual statistical report containing similar information is shared at the same meeting through the Medical Officer of Health and Chief Executive Officer report to the Board.

The program directors were introduced and each presented an overview of their divisional highlights of program activities undertaken in 2017.

Questions and comments were entertained. Clarification was provided regarding the Needle Exchange Program benchmarks, best practices, and the intent of the program was recapped. Questions were entertained regarding car seat inspections and West Nile Virus. Kudos were extended for the purple cap program.

It was shared that the program statistical information is helpful for newer Board members. Dr. Sutcliffe clarified that the directors select specific statistics that would show uniqueness or volume in any specific area versus displaying year over year comparators for all statistics. Although there are pre-scheduled delegations on specific topics, board members can suggest topics that are of particular interest for future delegations.

5. CONSENT AGENDA

- i) Minutes of Previous Meeting**
 - a. First Meeting – January 18, 2018
- ii) Business Arising From Minutes**
- iii) Report of Standing Committees**
 - a. Joint Board/Staff Performance Monitoring Working Group Unapproved Minutes dated January 23, 2018
- iv) Report of the Medical Officer of Health / Chief Executive Officer**
 - a. MOH/CEO Report, February 2018
- v) Correspondence**
 - a. Nutritious Food Basket (Advocacy for increasing social assistance rates)
Board of Health for Public Health Sudbury & Districts' Motion 48-17
 - Letter from the Township of Nairn and Hyman to the Premier of Ontario dated January 25, 2018,
 - b. Needle Exchange Program Initiative Additional Base Funding and One-Time Funding for 2017-18 Funding Year
 - Letter from the Minister to the Board Chair dated January 24, 2018

- c. Income Security: A Roadmap for Change
 - Letter and Motion from the Northwestern Health Unit Board of Health dated January 5, 2018
- d. Ontario Public Health Standards
 - Memo from the Assistant Deputy Minister dated December 29, 2017
- e. Support for Maintaining Local Surveillance and Monitoring of Food Costing by Public Health Units within the Modernized Standards for Public Health Programs and Services
 - Letter from the Middlesex-London Health Unit to Boards of Health dated February 5, 2018
- vi) **Items of Information**
 - a. Bicycle Friendly Community Award January 10, 2018
 - b. Public Health Agency of Canada News Release: Government of Canada Supports Program that Promotes Smoke-Free Lifestyle January 26, 2018
 - c. Statement from Chief Public Health Officer of Canada January 18, 2018
 - d. The Globe and Mail article: “Canada must rethink health spending strategy” January 22, 2018
 - e. The Globe and Mail article: “Fighting the flu: We need a new kind of intelligence” January 22, 2018
 - f. Canadian Public Health Association, *Erosion of public health capacity should be a matter of concern for all Canadians* Vol. 108, NO. 5-6
 - g. Email from alpha Re: February 23 alpha Board of Health Section Meeting and Updated Agenda February 8, 2018

Feedback regarding the statistical MOH report was that it was easily readable and displays the volume of work undertaken by Public Health Sudbury & Districts. Board members appreciated the details provided and amount of work that goes into preparing the statistical update. Board members were reminded that all Board delegations can be accessed in BoardEffect.

05-18 APPROVAL OF CONSENT AGENDA

MOVED BY HUSKA – BAILEY: *THAT the Board of Health approve the consent agenda as distributed.*

CARRIED

6. NEW BUSINESS

- i) **Northern Network for Health Equity**

- Briefing Note from the Medical Officer of Health/Chief Executive Officer to the Board Chair dated February 8, 2018

Health Quality Ontario (HQO) identified northern challenges in that people living in Northern Ontario experience poorer health outcomes and greater health inequities on many indicators compared with the rest of the province and subpopulations within the North face substantial inequities.

To address health inequities in the north, HQO began an initiative in partnership with Public Health Sudbury & Districts to engage communities across the North to identify northern needs and to develop a strategy to address health inequities. Dr. Sutcliffe indicated it has been a pleasure working with HQO over the past year to develop this strategy which included staff secondment to research, consultation and drafting the final report. Dr. Sutcliffe also co-chaired the Steering Committee with a leader from the northwest LHIN, benefitting from the leadership of HQO's Dr. 4Jeff Turnbull.

Extensive engagement across the North identified that while there is a wide range of organizations, tables, and initiatives aiming to address health equity, gaps exist across sectors and an intersectoral approach is needed to address the upstream causes of poor health. This engagement led to a review of evidence on health equity initiatives and strategies and the steering committee is proposing the development of a Northern Network for Health Equity.

It was pointed out the proposed motion, if passed today, will be shared with HQO to incorporate in their Ministry of Health and Long-Term Care funding proposal along with their report that will be released in March.

06-18 NORTHERN NETWORK FOR HEALTH EQUITY

MOVED BY BAILEY – HUSKA: WHEREAS Public Health Sudbury & Districts supported the development of a Ministry-funded Northern Ontario Health Equity Strategy in partnership with Health Quality Ontario and other northern stakeholders; and

WHEREAS health equity is a longstanding priority of the Board of Health, is a strategic priority in the 2018-2022 Strategic Plan, and is a Foundational Standard within the Ontario Public Health Standards, 2018;

THEREFORE BE IT RESOLVED that the Board of Health for Public Health Sudbury & Districts endorse in principle the establishment of a Northern Network for Health Equity, the Strategy's key recommendation; and

FURTHER THAT the Board directs the Medical Officer of Health to ensure appropriate organizational participation in the Northern Network for Health Equity.

CARRIED

ii) Tobacco and Smoke-Free Campuses

- Briefing Note from the Medical Officer of Health and Chief Executive Officer to the Board Chair dated February 8, 2018

J. Crispo had declared a conflict and was excused from the discussion and voting for this agenda item.

The briefing note and recommendations are to recognize area post-secondary institutions for their establishment of tobacco-related health protective policies surpassing current provincial legislation and strongly urge and support area post-secondary institutions to enhance existing policies to achieve 100 % tobacco and smoke-free campuses within an accelerated timeframe.

It was clarified that smoke-free include all types of smoke, including e-cigarettes, marijuana and this will be clearly articulated when we send out correspondence with today's motion. Also, there is no specific timeline for the recommended accelerated timeframe in the motion as institutions are at different places and would require different target dates for implementation.

07-18 TOBACCO AND SMOKE-FREE CAMPUSES

MOVED BY NOLAND – BAILEY: *WHEREAS on January 1, 2018, McMaster University became the first post-secondary institution in Ontario to establish a 100% tobacco and smoke-free campus; and*

WHEREAS the presence of tobacco use on campus further normalizes tobacco use, undermining provincial and local tobacco prevention and cessation efforts; and

WHEREAS an [Environmental Scan of Ontario College and University Tobacco Control Policies 2016-2017](#), indicates that while the three post-secondary campuses in Sudbury have policies exceeding the current Smoke Free Ontario Act (SFOA), they maintain on-campus Designated Smoking Areas (DSA's);

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts congratulate area post-secondary institutions for their tobacco-related health protective policies surpassing current provincial legislation; and

FURTHER that the Board strongly urge and support area post-secondary institutions to enhance existing policies to achieve 100% tobacco and smoke-free campuses within an accelerated timeframe; and

FURTHERMORE that the Board share this motion with area post-secondary leadership, alpha, the Chief Medical Officer of Health, Minister of Health and Long-Term Care,

Ministry of Advanced Education and Skills Development~~**Ministry of Colleges and Universities and local MPPs.**~~

CARRIED with friendly amendment

iii) Part VIII – Ontario Building Code Fee Increases

- Revised Board Manual G-I-50 By-Law 01-98

Proposed revisions to By-Law 01-98 is the second step of the two year phase for increasing fees. Per the Ontario Building Code, PHSD engaged in consultations regarding the proposed increase through public meetings and letters and nothing has arisen to flag concerns. Changes to the by-law and updated fee schedule are recommended today for the Board's endorsement.

08-18 AMENDMENT TO FEE SCHEDULE "A" TO BY-LAW 01-98

MOVED BY NOLAND – LOFTUS: *WHEREAS the Board of Health is mandated under the Ontario Building Code (O. Reg. 332/12), under the Building Code Act to enforce the provisions of this Act and the Building Code related to sewage systems; and*

WHEREAS program related costs are funded through user fees on a cost-recovery basis; and

WHEREAS the fee increases approved by the Board of Health in 2017 were phase 1 of a proposed 2 phase increase, where the second phase was scheduled to be implemented in 2018; and

WHEREAS the proposed fees are necessary to address increased program associated operational and delivery costs;

THEREFORE BE IT RESOLVED THAT the Board of Health approve the amended fees within Schedule "A" and that the appendix of Board of Health By-law 01-98 be correspondingly updated; and

FURTHERMORE THAT this fee schedule shall immediately come into effect.

CARRIED

iv) 2013 – 2017 Performance Monitoring Plan and Annual Performance Monitoring Report

- 2017 Performance Monitoring Report, February 2018

On behalf of the Joint Board of Health/Staff Performance Monitoring Working Group, Rita Pilon was pleased to share the final Annual Performance Monitoring Report for the 2013-2017 period. The Joint Board of Health/Staff Performance Monitoring Working Group has been responsible for reviewing and providing our

comments on the performance monitoring reports and strives to make sure that the reports resonate and are clear, easily understood, and accurate.

The 2017 Performance Monitoring Report compiles information about Public Health Sudbury & Districts' performance based on various accountability measures, all of which are grounded within the 2013–2017 Strategy Map.

Overall, the summary provides evidence of commitment to excellence and accountability, detailing performance as follows:

- 15 Strategic Priorities Narratives highlight descriptive stories of Public Health Sudbury & Districts' programs and/ or services that demonstrate the 2013–2017 Strategic Priorities “in action”.
- We have monitored the 13 Public Health Sudbury & Districts' Organization-Specific Performance Monitoring Indicators and additional notes have been provided in the report to highlight areas of strength.
- We are compliant with, or have exceed expectations for, all 44 Ontario Public Health Organizational Standards which help to establish consistent organizational processes, and facilitate desired program outcomes.
- As per the June 2017 Accountability Agreement, the Ministry has discontinued measuring accountability agreement indicators pending the review of the Ontario Public Health Standards (OPHS) thus, we have only presented data up to and including 2016.

This report marks the completion of the 2013–2017 Performance Monitoring Plan reporting requirements. The Medical Officer of Health will operationalize the Strategic Plan and lead the development of a monitoring process for 2018–2022. Once prepared, this monitoring process will be reviewed with and recommended to the Board of Health.

Dr. Sutcliffe thanked the three Board members who provided constructive and valuable contributions on the Working Group: Rita Pilon, Carolyn Thain and Janet Bradley.

7. ADDENDUM

None.

8. IN CAMERA

09-18 IN CAMERA

MOVED BY THAIN – KIRWAN: *THAT this Board of Health goes in camera.*

Time: 2:33 p.m.

CARRIED

9. RISE AND REPORT

10-18 RISE AND REPORT

MOVED BY KIRWAN – PILON: *THAT this Board of Health rises and reports.*

Time: 2:47 p.m.

CARRIED

It was reported that one agenda item relating to *Labour relations or employee negotiations* was discussed for which the following motion emanated:

11-18 APPROVAL OF MEETING NOTES

MOVED BY PILON – KIRWAN: *THAT this Board of Health approve the meeting notes of the November 23, 2017, 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

10. ANNOUNCEMENTS / ENQUIRIES

Board members were advised that there is one additional question in this month's meeting evaluation to capture feedback regarding the year-in review statistical report and delegation.

There is no regular Board meetings in March; therefore, the next regularly scheduled Board meeting is April 19, 2018, at 1:30 p.m.

11. ADJOURNMENT

12-18 ADJOURNMENT

MOVED BY KIRWAN – THAIN: *THAT we do now adjourn. Time: 2:52 pm*

CARRIED

(Chair)

(Secretary)



Medical Officer of Health/Chief Executive Officer Board of Health Report, Month Year

Words for thought

Northern Ontario Health Equity Strategy



Some 800,000 people living in Northern Ontario are more likely to have worse health, poorer access to health care and die earlier than people in other parts of Ontario. On top of this overall disadvantage for the North, many populations in the North face greater inequities than others.

The Northern Ontario Health Equity Strategy has been developed to identify the greatest health disparities and help remove barriers. Informed and inspired by an in-depth multi-faceted engagement process with individuals representing nearly 150 organizations and more than 300 participants in the North, the Strategy sets out key actions for change. These actions will develop planning at the regional level to help support locally-appropriate approaches to improving health equity for communities across Northern Ontario.

Developed in the North, by the North, for the North, the Strategy gathers the passion and determination of diverse and resilient people.

From the Steering Committee Co-chairs

Northern Ontario covers a vast expanse of rugged and breathtaking land – a land so large it covers roughly the same area as all of France. Northern Ontario's population is diverse and resilient. We live in urban centres, rural villages and remote communities. We are Indigenous and Francophone, long-term settlers and new arrivals. We work in health care and education, resource extraction and retail, and we have deep connections to the land, our communities, and our families. As Northerners, we know we have huge health potential as well as huge health challenges. Compared to the rest of Ontario, the North has higher levels of poverty and poor health, elevated rates of many health-harming behaviours and poorer access to high-quality health care and social services.

Addressing these pressing challenges and leveraging our many strengths requires us to come together. It is only by working together across many different sectors that we will be able to achieve common health goals and ensure everyone has equal opportunities for health. We see great promise in joint leadership bringing perspectives from across the North – East and West, urban, rural and remote – and also across health care, public health, other public sectors and communities. We see this Strategy as a critical step toward achieving joint action on health equity.

We want to thank the many people who took the time to speak with the Northern Ontario Health Equity Strategy team to share their stories and have their voices heard. Hundreds of people from across the North told us of their and their communities' challenges. They shared their vision for the future and their successes and lessons from the past. The Northern Ontario Health Equity Strategy is inspired by these stories and our future actions must be founded in the wisdom of all of these contributions.

Health equity will be achieved when all Northerners have equal opportunities for health and no one is unfairly disadvantaged. Health equity will also be achieved when health outcomes across the North are leveled up to meet those in the rest of Ontario. Our broad consultations confirmed that we are up to the challenge of improving health equity in the North, by the North, for the North!



Penny Sutcliffe
Medical Officer of Health and Chief
Executive Officer, Sudbury & District
Health Unit
Co-chair, Northern Ontario Health Equity
Strategy Steering Committee



Alex Vistorino
Director, Health System Planning and
Integration, North West Local Health
Integration Network
Co-chair, Northern Ontario Health Equity
Strategy Steering Committee



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Source: Health Quality Ontario (2018). *Northern Ontario Health Equity Strategy: A plan for achieving health equity in the North, by the North, for the North.*

Date: Retrieved April 10, 2018

From: <http://www.hqontario.ca/Portals/0/documents/health-quality/health-equity-strategy-report-en.pdf>

As Co-Chair of the Northern Ontario Health Equity Strategy Steering Committee and MOH/CEO of Public Health Sudbury & Districts, it has been my privilege to be a part of the development and April 6, 2018, launch of the *Northern Ontario Health Equity Strategy*.

Health Quality Ontario, the provincial advisor on the quality of health care, supported stakeholders in Northern Ontario as we all engaged to develop a strategy to improve health equity in the region. For Health Quality Ontario, health equity is one of the foundational pillars upon which a high-quality health system is built.

The engagement identified four areas of focus including the social determinants of health, equitable access to high quality and appropriate health care services, Indigenous healing and well-being, and evidence availability for equity decision-making.

The main recommendation from the newly released *Northern Ontario Health Equity Strategy* calls for the creation of a Northern Network for Health Equity. A network which would aspire to connect and align diverse leaders and communities from across the North's large geographical area and its many sectors to tackle big issues in health equity together. I am anxious to hear of the government's response to this key recommendation.

General Report

1. Performance Monitoring Plan

The Performance Monitoring Plan is a framework that monitors the organization's performance relating to provincially mandated indicators and requirements, strategic priorities, and organization-specific indicators. The development of the 2018–2022 Performance Monitoring Plan is currently underway, and, per Board motion #02-18, is expected to be presented to the Board of Health for approval in the coming months.

2. Local and Provincial Meetings

Dr. Zbar and I attended the COMOH Section meetings on February 23 and Board of Health member, James Crispo attended the Board of Health Section meeting that same day. Brief verbal updates will be provided at the April 19 Board meeting.

alPHa will be holding its 2018 Annual General Meeting (AGM) and Conference from June 10 to 12 in Toronto, Ontario. Board members interested in attending are asked to pencil these dates in their calendars. A motion is included in the meeting agenda relating to Board member attendance for the AGM.

R. Quesnel chaired the 2018 alPHa Public Health Executive & Administrative Assistants Conference Planning Committee. Both she and H. Leroux attended the very successful conference on February 22, 2018. One of the speakers at the conference was Stacey Gilbeau, Program Manager, Health Promotion Division, Public Health Sudbury & Districts, who presented on strength-based approaches to change.

I, along with other Public Health Sudbury & Districts staff, attended the Chiefs of Ontario 12th annual health forum on February 27 in Toronto. The agenda include sessions on health policy, naloxone, and cannabis as well as other important topics.

On March 1, I was invited to attend a pan-Canadian forum on public health roles in population mental health and wellness promotion. This was an initiative of the National Collaborating Centres for public health and was hosted in partnership with the Public Health Agency of Canada, the Centre for Addiction and Mental Health, the Mental Health Commission of Canada, and the Canadian Mental Health Association. The Forum was an occasion to bring together stakeholders and practitioners across Canada to collectively address and support public health's role in population mental health and wellness promotion.

A First Nations, Inuit and Métis engagement session was hosted at and by the Public Health Sudbury & Districts in partnership with Public Health Ontario on March 5.

I continue to participate on the Mental Health and Addictions System Transformation Steering Committee Chaired by Health Sciences North. Meetings were held on March 6 and April 10.

Public Health Sudbury & Districts was well represented at The Ontario Public Health Convention (TOPHC) held from March 21 to 23 as participants, panelists, and presenters.

The Medical Officers of Health from the Northern public health units continue to meet regularly. Meetings were held on February 23, March 20, and April 17.

I attended the alPHA Board Strategic Planning Session in Toronto on April 12 and the alPHA Board face-to-face meeting on April 13.

The Ministry of Health and Long-Term Care will be hosting a session focused on the Implementation Work Plan for the Ontario Public Health Standards (OPHS). The day session in Toronto will focus on recent legislative and regulatory changes as well as key streams of implementation work underway to support implementation of the modernized OPHS and related initiatives

3. Northern Leadership Program

May 2, 2018, will mark the completion of our fellows' one-year participation in the Northern Leadership Program (NLP). The goal of the NLP is to develop and accelerate leadership skills and capabilities, strengthen networks, and build leadership capacity within the north. The NLP program has been a valuable opportunity for our organization and our fellows have benefited from the experience. However, in light of new and increasing expectations under the updated Ontario Public Health Standards, and ongoing fiscal constraints, Public Health Sudbury & Districts will be pausing our participation in the NLP program and reassessing what staff development programs and opportunities would best meet the needs of our organization looking forward.

4. Sage and Time Artwork Unveiling

On April 6, 2018, Public Health Sudbury & Districts received a piece of art created via L'Arche Sudbury's Sage & Time Art Project. The first piece of art was developed with the theme *Health for All* in celebration of World Health Day. It was created by members of L'Arche Sudbury, local seniors and advocacy groups, athletes from the Sudbury Chapter of Special Olympics Ontario, representatives from the Sudbury Wolves, and members from the Northern Initiative for Social Action. The artwork will be displayed at our 1300 Paris St. location for one year.

5. Annual Medical Officer of Health and Chief Executive Officer Performance Appraisal

Feedback regarding the MOH/CEO's annual performance appraisal, as per Board of Health Policy and Procedure I-VI-10, will be sought shortly from the Board of Health and Senior Management members through an electronic survey in BoardEffect on your iPad. The deadline to complete the survey will be Thursday, May 3, 2018. Please stay tuned for more details.

6. North East Public Health Unit Collaborative Project

Discussions on the Shared Services Collaborative project with the all five Northeast Public Health Units have continued. The MOHLTC approved a 2017 one time funding request to support phase 1 of this project and we await the Ministry's decision on the 2018 funding request. The Collaborative agreed that the work should be facilitated by an external consultant. With this in mind, an RFP was drafted and proposals were received. The successful proponent has been selected and work is being done to finalize the contract. Building on a shared vision, values, and guiding principles, the consultants will prepare a best practices report and assist in the identification and development of shared services opportunities. Evidentiary support, baseline data, and risk benefit analysis will also form part of the work. This phase of the project is exploratory and expected to be completed in late fall.

7. Disclosure

Staff have continued to work with Hedgerow Software Limited to resolve software issues in an effort to launch the enhanced *Check Before You Go!* disclosure website. Previously reported issues that significantly affected the functionality of the *Check Before You Go!* disclosure website have now been addressed. Remaining minor functionality issues are expected to be addressed by Hedgerow as part of an upcoming software update. The expanded proactive disclosure system will be soft-launched in April 2018 and meet the direction provided in Board of Health Motions 36-15 and 02-17 (Expansion of Proactive Disclosure System). Promotion of the *Check Before You Go!* disclosure website will begin in May 2018. As a next step, staff will begin work toward meeting new disclosure requirements outlined within the 2018 *Ontario Public Health Standards*.

8. Louise Picard Public Health Research Grant

Public Health staff actively participated in Laurentian University's Research Week held March 19 to the 23. Highlights included the announcement of the 2018 Louise Picard Public Health Research Grant funded projects, a presentation at the Hidden Homelessness and Reconciliation Symposium, and participation in two community-university research exchange events. In addition, the Social Science and Humanities Research Council Partnership Award, of which Public Health Sudbury & Districts is a co-recipient, was voted one of the top 10 Research and Innovation Achievements at Laurentian University for 2017.

This year, a total of six research projects were funded by the Louise Picard Public Health Research Grant and these were announced at the March 19 event where I had the honour of introducing Louise Picard, retired director of the Resources, Research, Evaluation and Development Division and PHRED Program with Public Health Sudbury & Districts, formerly known as Sudbury & District Health Unit. This Grant, which is a partnership between Laurentian University and Public Health Sudbury & Districts, aims to fund research that will inform public health practice. The topics of this year's funded research projects include managing food allergies, understanding the experiences of parents raising children on plant based diets, building nursing core competencies, understanding the experiences of fatherhood, identifying

infection prevention and control needs in oral health practice, and utilizing community based evidence to inform the development of a Fetal Alcohol Spectrum Disorder communication campaign.

9. Financial Report

The February 2018 year-to-date mandatory cost-shared financial statements report a positive variance of \$342,607 for the period ending February 28, 2018. Gapped salaries and benefits account for \$130,390 or 38.1%, with operating expenses and other revenue accounting for \$212,217 or 61.9% of the variance. Monthly reviews of the financial statement ensure that shifting demand are adjusted to account in order to mitigate the variances caused by timing of activities.

The majority of the gapping to the operating and other revenues is related to the timing of the program activities and the need to refine the calendarization of the budget to actual expenses and projected needs in future periods.

Please note the February financial statements reflects the 2018 Board of Health mandatory cost-shared budget, which was approved November 2017. No adjustments related to one-time Ministry funding and/or in-year approved one-time requests have been incorporated.

10. Quarterly Compliance Report

Public Health Sudbury & Districts is compliant with the terms and conditions of our Public Health Funding and Accountability Agreement. The agency 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 agency has paid all payable remittances for employee income tax deductions and Canada Pension Plan and Employment Insurance premiums, as required by law to March 23, 2018, on March 23, 2018. The Employer Health Tax has been paid as required by law, to March 31, 2018, with a cheque dated April 15, 2018. Workplace Safety and Insurance Board premiums have also been paid, as required by law, to March 31, 2018, with a cheque dated April 30, 2018. There are no outstanding issues regarding compliance with the *Occupational Health & Safety Act*, *Ontario Human rights Code*, or *Employment Standards Act*.

11. Division Name Change

The Resources Research, Evaluation and Development (RRED) Division has been renamed *Knowledge and Strategic Services (Services stratégiques et du savoir)*. Over the course of the last several years, the Division has grown to include a number of new or refreshed portfolios; the new name is more reflective of both the Division's full scope of work and the current context.

Following are the divisional program highlights.

Clinical Services

1. Control of Infectious Diseases

Influenza: As of March 31, 2018, a total of 245 confirmed cases of influenza have been reported within the Public Health Sudbury & Districts catchment area this flu season. Of this, 143 cases were influenza A, 98 influenza B, and 4 with both influenza A and B.

Respiratory Outbreaks: Since January 2018, the Control of Infectious Diseases (CID) team has managed 30 respiratory outbreaks in institutions including long-term care homes, hospitals, daycares and retirement homes. Causative organisms included influenza A in 13 facilities, influenza B in 7 facilities and influenza A and B in 3 facilities. Causative organisms were not identified in 7 facilities. There is currently one active respiratory outbreak.

Vaccine Preventable Disease: Public health nurses on the Control of Infectious Diseases (CID) and Vaccine Preventable Diseases teams are in the process of reviewing approximately 26 000 immunization records for all local school-aged children up to 18 years of age for compliance with the *Immunization of School Pupils Act*. This is in addition to preparing for the review of immunization records of registrants from over 55 daycares under the *Childcare and Early Years Act*.

Tuberculosis: World TB day was March 24, 2018, and was commemorated by tweets and posts, as well as posters and information displayed on the lobby TV's in our various office locations. The date marks the day in 1882 when Dr. Robert Koch discovered the bacterium that causes TB, which opened the way toward diagnosing and curing the disease. Despite significant progress over the last decades, TB continues to be the top infectious killer worldwide, claiming over 4 500 lives a day. The emergence of multidrug-resistant TB poses a major health security threat and could risk gains made in the fight against TB.

CID staff follow-up daily with suspect and confirmed active and latent tuberculosis clients, which may include contact tracing, providing education, ensuring compliance with treatment requirements, as well as follow-up chest x-rays and referrals to an infectious diseases physician. There are currently no active TB cases in the Public Health Sudbury & Districts catchment area.

National Immunization Awareness Week (NIAW): This year NIAW is April 21 to 28, 2018. Public Health Sudbury & Districts will be sharing Facebook posts and tweets sent out by Immunize Canada, in addition to displaying posters, adding a colouring and reading print out for children in the lobby at the main office and poster displays at local libraries. Each year we celebrate NIAW to highlight the success and impact that immunization has had in protecting and saving lives. Public Health Sudbury & Districts promotes an online immunization tool and continues to advertise this vaccine reporting option for our community. Staff have received a total of 1394 online submissions via this tool from our community since the launch on September 1, 2017. This tool is available on the website and also provides the ability to print out one's own immunization record.

2. Oral Health

The Oral Health team has initiated a social media campaign for Oral Health Month (April), which promotes the importance of good oral health and that oral health is integral to a child's growth and development. This is provincial wide campaign with 35 public health units participating in the social media messaging.

3. Sexual Health \ Sexually Transmitted Infections Including HIV and Blood Borne Infections

The Sexual Health program responded to ten community requests for the months of January to March. Three of the 10 requests were displays at community events. These displays promoted the services of the sexual health program and yielded 967 attendees in total. The remaining seven requests were presentations to community groups to promote healthy relationships, birth control, and prevention of sexually transmitted infections. These presentations yielded 109 participants.

February's mass media campaign consisted of healthy relationship messaging displayed at Silver City during the pre-show of adult only rated movies from February 9 to the 22. Sexual consent messaging promotional items were also distributed to Cambrian College for their sexual assault/violence event and Laurentian University's student association office for distribution throughout campus.

Environmental Health

1. Control of Infectious Diseases

During the months of February and March, nine sporadic enteric cases, and four infection control complaints were investigated. Seventeen enteric outbreaks were declared in institutions. The causative organism for two of these outbreaks was confirmed to be norovirus.

2. Food Safety

In March, the recall of Harvest Creek brand Chicken Nuggets from Erie Meat Products Ltd., due to possible contamination with Salmonella, prompted public health inspectors to conduct checks of 81 local daycares. No recalled product was found.

A media release was issued on March 3, 2018, to alert the public that certain smoked rainbow trout products sold from a local meat and fish market had been recalled due to the potential presence of *Clostridium botulinum*. The Canadian Food Inspection Agency issued the food recall warning based on recent inspection activities.

During the months of February and March, public health inspectors issued four closure orders to food premises due to adverse water sample results and lack of hot water. The closure orders

have since been rescinded following corrective action, and the premises allowed to reopen. Additionally, one order to comply was issued due to a water main break that caused flooding. This order has also been rescinded following corrective action.

Public health inspectors issued two charges to two food premises for infractions identified under the *Food Premises Regulation*.

Staff issued 57 special event food service permits to various organizations in the months of February and March.

Through Food Handler Training and Certification Program sessions offered in February and March, 204 individuals were certified as food handlers.

3. Health Hazard

In February and March, 47 health hazard complaints were received and investigated. Two of these complaints involved marginalized populations.

One order to comply was issued to an owner of a rental property for faulty plumbing and ponding of sewage in the basement. This order has since rescinded following corrective action.

4. Ontario Building Code

During the months of February and March seven sewage system permits, 17 renovation applications, and six consent applications were received.

5. Rabies Prevention and Control

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

6. Safe Water

During February and March, 33 residents were contacted regarding adverse private drinking water samples and public health inspectors investigated five regulated adverse water sample results.

During February and March, one pool and one spa were ordered closed due to adverse water sample results. These orders have since been rescinded following corrective action, and the premises allowed to reopen.

One drinking water order was issued. Furthermore, two boil water orders and one drinking water order were rescinded. In addition, two health information notices were issued due to adverse sodium results.

7. Tobacco Enforcement

In February and March, tobacco enforcement officers charged one individual for smoking in an enclosed workplace, one individual for smoking on school property, and two retail employee for selling tobacco to a person who is less than 19 years of age.

8. Emergency Preparedness

On March 28, 2018, more than 40 community agencies from Sudbury and Manitoulin districts came together to test and practise their emergency preparedness for scenarios involving opioid overdoses. Jointly hosted by Public Health Sudbury & Districts and Public Health Ontario, the workshop involved many groups, including representatives from municipalities, first responders, public health, enforcement, community-based organizations, health care, schools, academia, and First Nations communities. Throughout the session, those in attendance were able to learn about opioids, test emergency response plans, clarify roles and responsibilities, and identify strengths and areas for improvement within existing emergency response plans. The findings of the workshop will be used to inform the development of a local interagency emergency response plan for opioid poisonings that will support an effective and timely multi-agency response to, and community recovery from, a mass casualty event secondary to opioids.

Health Promotion

1. Family Health

On February 28, Public Health Sudbury & Districts hosted an Informed Decision-Making workshop on infant feeding. The Workshop was delivered by the Baby-Friendly Initiative Strategy of Ontario. Ten community members and partners were in attendance.

In partnership with Laurentian University staff, a preconception health video was released entitled “Your Life Plan?”. The video was posted to a [YouTube account](#) and sent to 100 Laurentian University students for feedback and review.

Two prenatal classes were provided to 41 expectant parents. Resources were provided on resilience and brain development at two Early Years hubs, including an Aboriginal hub.

2. Healthy Eating

On March 8, Sudbury East office staff participated in the St.-Charles International Women’s Day event organized by the Sudbury East Community Health Centre with over 240 participants in attendance. Information was provided on healthy eating and alcohol misuse prevention with a focus on *Re-think Your Drink* messaging.

A public health nutritionist presented at TOPHC on March 22. This participatory action study aimed to examine perceptions of food environments experienced by community members residing in neighbourhoods with limited access to grocery stores.

Staff worked with the Greater Sudbury Food Policy Council members to plan and host the annual Four Minute Foodies event. The lunch hour event profiles food initiatives occurring across Greater Sudbury and this year highlighted the themes of the Greater Sudbury Food Strategy.

3. Indigenous Engagement

Continual progress has been made on the development of the Indigenous Engagement strategy. Notably:

- (a) A joint session involving the Indigenous Engagement Steering Committee (internal) and Indigenous Engagement Strategy Advisory Committee (external) was held on February 6 to identify shared relationship principles and values and begin to describe a vision.
- (b) The external Advisory Committee also held its second meeting to receive an update, the staff survey results and to provide feedback on the draft Territorial Acknowledgement Protocol, as well as the proposed Community Engagement Plan for gathering community input to further develop the strategy.
- (c) The first of four Public Health Planning Roundtables was held on March 26 in Timmins to engage with Timmins/Chapleau area First Nations and health service partners. This session was well attended with participation by almost all invited and generated insightful dialogue to further refine the eventual strategy.
- (d) A “What Is Public Health?” brochure was developed for use at each of these planning roundtables. The purpose is to help inform participants about the role Public Health undertakes in relation to other system partners.

A Board of Health education session on Indigenous Engagement is being planned for the morning of June 21, 2018. Please stay tuned for further details.

4. Injury Prevention

Falls Prevention/Stay on Your Feet (SOYF): Two videos were created, one related to medication management and another on nutrition. In addition, five testimonials were created on the importance of physical activity. These videos were created as part of the SOYF strategy across the North East and are being shared on social media and CTV to increase awareness and educate the older adult community on prevention of falls.

Road Safety: In January, February, and March, a public health nurse, in partnership with community partners, held car seat inspection clinics. A total of 39 inspections were completed. Public Health Sudbury & Districts provides support to agencies to build community capacity to host car seat safety inspection clinics.

5. Prevention of Substance Misuse

In February, Public Health Sudbury & Districts participated in the *Rethink Your Drinking, Cancer Matters* provincial working group campaign. A public health nurse participated in a media interview on CBC radio and the campaign was shared on social media. Staff also participated in the Cambrian College "Possibilities Day" by providing resources on harms of alcohol and resources for adult influencers on how to prevent underage drinking. A "Pour Challenge" was held at a Laurentian University event to raise awareness on Canada's Low Risk Alcohol Drinking Guidelines.

6. Built Environment

The Municipality of St.-Charles and the City of Greater Sudbury were selected to receive the 2018 Ontario Age-Friendly Community Recognition Award. The Award has been established to celebrate the work of Ontario communities that demonstrate a strong commitment to key principles for creating age-friendly communities and to showcase promising practices across the province. A public health nurse from the Sudbury office is an active member of the City of Greater Sudbury Age-Friendly Community Steering Committee, and a public health nurse from the Sudbury East office is the co-chair of the St.-Charles Age-Friendly Advisory Committee.

7. Physical Activity, Sedentary Behaviour, and Sleep

An internal sleep awareness campaign, including a sleep health lunch-and-learn, for staff ran throughout the month of March to coincide with daylight savings time and World Sleep Day. Sixty-four staff completed a survey that asked about sleep quantity, quality, and how their sleep may be impacting their work. Feedback gathered from the pre- and post- campaign surveys will be used to inform future sleep health messaging and initiatives.

On February 28, Active Sudbury officially launched its Physical Literacy for Communities (PL4C) initiative. The initiative will engage stakeholders from the community in the delivery of sustainable physical literacy programming aimed at improving the health and physical activity levels of its citizens. This is a three-year project funded by an Ontario Trillium Foundation Grow Grant. The goal of the project is to develop and support Physical Literacy and You (PLAY) Groups in four areas: Education, Sport and Recreation, Health, and Early Years. Each PLAY Group will aim to increase physical activity and participation in sport through "developing physical literacy approach" within the Greater Sudbury. The focus will be on building the capacity of over 1600 staff and volunteers to assess and deliver evidence informed, high quality physical activity programs in these sectors. Active Sudbury partners include SportLink – Greater Sudbury Sport Council, City of Greater Sudbury, Cambrian College Physical Fitness Management Program, Laurentian University School of Education, Public Health Sudbury & Districts, and Sport for Life.

Our staff facilitated a two-day physical literacy training to 16 early childhood professionals. The early childhood staff are in the process of becoming Physical Literacy Leaders in their respective agencies as part of the Active Sudbury project.

8. School Health

Public health nurses facilitated a professional development session to 25 elementary school principals on stress, mental health promotion, and resiliency.

Staff facilitated a professional learning workshop to 75 fifth year School of Education students. The students who are future educators explored the concept of a growth mindset and its relationship to overall health and well-being.

In partnership with the Shkagamik-Kwe Health Centre, we celebrated the launch of the *This Is My Tobacco* storybook. The storybook is part of a three-year collaborative project aimed at gifting our community with cultural teachings and traditions around sacred tobacco. This project has empowered local Indigenous youth to educate young children across the province about sacred tobacco while recognizing the difference between traditional and commercial tobacco use. This project adopted a strength-based approach to tobacco cessation by empowering youth to make healthful choices to protect their health and well-being.

On March 9, a public health dietitian facilitated a session on food literacy to 13 students at S. Geiger Public School.

9. Tobacco Control

On January 10, February 7, and March 7, Public Health Sudbury & Districts staff, in partnership with the Centre for Addiction and Mental Health (CAMH), held *Smoking Treatment for Ontario Patients on the Road* smoking cessation workshops. There was a total of 51 participants in attendance who received nicotine replacement therapy (NRT) vouchers at the workshop and all were eligible for receiving five weeks of free nicotine patches in the mail from CAMH.

Public Health Sudbury & Districts continues to provide services to the community through its Quit Smoking Clinic and telephone information line. In January and February, there were three initial visits and six return visits to the Quit Smoking Clinic, seven return telephone visits, and 14 drop-ins. A total of 25 NRT vouchers were distributed.

Consultation was provided to Laurentian University about proposed amendments to the *Smoke-Free Ontario Act 2017* and the proposed *Cannabis Act*.

10. Workplace Health

A public health nurse facilitated two sessions related to drugs and alcohol in a workplace to a total of 28 supervisors.

Pedometers were loaned to support efforts by three workplaces to increase employee levels of physical activity.

11. Healthy Weights

Three professional development sessions were delivered by Health Promotion staff to community partners in Espanola, Sudbury East, and Greater Sudbury in relation to weight bias and the importance of protecting and promoting mental health as we continue to address healthy weights.

In early March, a public health dietitian met with the new Community Health Representative for the Sagamok Anishnawbek Community Wellness Department to discuss diabetes prevention programming and Public Health support.

Knowledge and Strategic Services

1. Health Equity

Public Health Sudbury & Districts is leading a Local Poverty Reduction Fund grant in partnership with 10 other community agencies to introduce three linked programs into the community: Bridges Out of Poverty, Leader Training, and Circles. A third installment of a six-week Leader Training program was recently delivered by members from the Health Equity Team in partnership with St. Albert Adult Learning Centre. A total of 17 participants (leaders) living on low income graduated from the program in March. The Circles program launched in February in partnership with the N'Swakamok Native Friendship Centre. Circles brings together participants who previously completed the Leader Training program and volunteers (allies) committed to supporting participants while they work on their plans to exit poverty.

Public Health Sudbury & Districts is the third-party evaluator for the City of Greater Sudbury's (CGS) Local Poverty Reduction Fund project, which is aimed at increasing educational outcomes among elementary school students living in low income through participation in free afterschool recreational programs. Evening information sessions co-facilitated by the CGS and Public Health were held with parents and students in February at each of the eight participating schools with the intent of the program commencing in the spring.

Public Health Sudbury & Districts supported the development of a multi-agency meeting hosted by the City of Lakes Family Health Team on February 16 to discuss their piloting of the poverty screening tool developed for primary care providers by the Centre for Effective Practice. Following the meeting, Public Health staff facilitated a Bridges Out of Poverty workshop with members from the Family Health Team.

Members from the Health Equity Team facilitated a workshop with graduate students from Laurentian University's Science Communication program in February focusing on the challenge of communicating information about the social determinants of health and health equity with the goal of increasing actions in support of health equity.

2. Population Health Assessment and Surveillance (PHAS)

In consideration of the Ontario Public Health Mental Health Promotion Guideline, a Population Health Assessment and Surveillance team Internal Report (PHAS-IR) was produced using the Positive Mental Health Module of the Canadian Community Health Survey (CCHS). Fifteen indicators were analyzed and the report includes regional comparisons for Sudbury and districts, Northeastern Ontario, and Ontario. The percent of people in Sudbury and districts who were classified as “flourishing” using the CCHS Positive Mental Health Scale was not statistically different than Ontario. However, locally there were differences in age groups. Young adults aged 18 to 29 had the lowest prevalence of individuals who were “flourishing” while youth (12 to 17) had the highest prevalence.

3. Research and Evaluation

Beyond BMI is a Locally Driven Collaborative Project (LDCP) funded by Public Health Ontario and co-led by an epidemiologist from Public Health Sudbury & Districts. The vision of the of the Beyond BMI research team is to develop an electronic medical record (EMR)-based healthy growth surveillance system that includes risk and protective factors for overweight and obesity in Ontario children. In phase three of the project, the research team worked with five primary care practices to test the feasibility of using an electronic version of NutriSTEP® screen in their EMR as a step toward a surveillance system for childhood healthy weights including risk and protective factors. The final report is now available on Public Health Ontario’s website at the following link:

<https://www.publichealthontario.ca/en/ServicesAndTools/Documents/LDCP/Beyond%20BMI%20Phase%203%20Final%20Report%2017%20Jan%202018.pdf>. The research team presented their findings at TOPHC in March, 2018.

The Manager, Population Health Assessment and Surveillance, is a contributor on a Locally Driven Collaborative Project that explores the key elements for a successful Public Health Unit-LHIN collaboration, as required by the *Patients First Act*. Key informant interviews, focus groups, and an online survey were used to explore definitions, processes, structures, and the use of population health measures to determine the scope and key elements of a successful collaboration. Various knowledge exchange activities are currently underway, including a presentation at The Ontario Public Health Convention in March.

4. Staff Development

The spring Knowledge Exchange Symposium was hosted on April 10. The focus of this event, which is geared to Public Health staff members, was strategy development. Presenters spoke about their experiences developing key strategy documents, including, for example, the Community Drug Strategy, the Northern Ontario Health Equity Strategy, the agency’s Strategic Plan, and the Indigenous Engagement Strategy. This event builds internal capacity to carry out the work of Public Health Sudbury & Districts and supports inter-professional and team development.

5. Student Placement Program

We are collaborating with Schools of Nursing at both Laurentian University and Cambrian College to improve processes for student placements. Most recently, an interview component has been added for selection of 4th year Nursing student placements, which allows assessment for fit with the placement opportunity. This process has been successful in supporting positive student placement experiences.

This year, there has been an increase in requests for spring student placements from local Schools of Nursing and Masters of Public Health students from across the province. Our preceptors are able to accommodate a large number of these placement requests, thus further contributing to public health workforce development.

6. Presentations

Staff were well represented at TOPHC, which was held in Toronto from March 21–23. Presentations by Knowledge and Strategic Services staff included the following:

- The process for culturally adapting Bridges out of Poverty, Leaders, and Circles to ensure their relevance to local Indigenous communities (presented by the Chair of the Indigenous advisory for this project and a member of the Health Equity Team).
- The social determinants of health lesson plan pilot study project underway in partnership with Laurentian University's Faculty of Education (presented by two members of the Health Equity Team).
- Findings from the Locally Driven Collaborative Project which is exploring the development of principles and practices of engagement with First Nations communities (presented by the Director, Knowledge and Strategic Services, and the Manager, Indigenous Engagement).
- Findings from the Beyond BMI Locally Driven Collaborative project.

In addition to the various presentations, staff contributed to the development of workshops on topics such as meeting the new Ontario Public Health Standards Health Equity Standard, Indigenous Cultural Safety, and Informing Public Health practice through Population Health Assessment.”

7. Strategic Engagement Unit / Communications

The Strategic Engagement Unit is developing the agency's comprehensive agency-wide social media strategy, which seeks to increase community engagement, knowledge, reach, and awareness of the role of public health. To inform the content of the strategy, the Strategic Engagement Unit led a session with management staff to gather their input and raise

Medical Officer of Health/Chief Executive Officer
Board Report – April 2018
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awareness about opportunities to leverage social media engagement and the importance of establishing a strong, positive agency brand presence and brand promise.

Respectfully submitted,

Original signed by

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

Public Health Sudbury & Districts
STATEMENT OF REVENUE & EXPENDITURES
For The 2 Periods Ending February 28, 2018

Cost Shared Programs

	Annual Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over)/under	Balance Available
Revenue:					
MOHLTC - General Program	14,687,000	2,447,833	2,447,833	0	12,239,167
MOHLTC - Unorganized Territory	819,400	136,567	136,567	(0)	682,833
MOHLTC - VBD Education & Surveillance	65,000	10,833	10,833	0	54,167
MOHLTC - SDWS	106,000	17,667	17,667	(0)	88,333
Municipal Levies	7,064,806	1,177,465	1,177,465	(0)	5,887,341
Municipal Levies - Small Drinking Water Syst	47,222	7,870	7,870	0	39,352
Municipal Levies - VBD Education & Surveill	21,646	3,608	3,608	(0)	18,038
Interest Earned	85,000	23,565	23,565	0	61,435
Total Revenues:	\$22,896,074	\$3,825,408	\$3,825,408	\$0	\$19,070,666
Expenditures:					
Corporate Services:					
Corporate Services	4,445,047	722,427	669,005	53,422	3,776,042
Print Shop	120,816	20,136	12,302	7,834	108,514
Espanola	119,921	19,133	18,970	163	100,950
Manitoulin	128,909	20,524	19,318	1,206	109,591
Chapleau	101,289	15,987	14,567	1,420	86,722
Sudbury East	16,508	2,751	2,816	(65)	13,692
Intake	325,506	50,078	47,148	2,930	278,358
Volunteer Services	5,711	952	62	890	5,649
Total Corporate Services:	\$5,263,706	\$851,987	\$784,188	\$67,799	\$4,479,518
Clinical Services:					
General	919,342	146,801	141,819	4,982	777,523
Clinical Services	1,315,349	201,564	160,327	41,237	1,155,022
Branches	270,828	41,766	34,998	6,769	235,830
Family	618,225	95,132	82,197	12,935	536,028
Risk Reduction	98,842	24,579	23,253	1,326	75,589
Clinical Preventative Services - Outreach	144,218	22,356	20,816	1,540	123,402
Sexual Health	947,285	147,432	132,813	14,619	814,472
Influenza	0	0	(0)	0	0
Meningitis	0	0	1	(1)	(1)
Dental - Clinic	520,983	80,607	76,638	3,969	444,345
Total Clinical Services:	\$4,835,072	\$760,238	\$672,861	\$87,376	\$4,162,211
Environmental Health:					
General	804,254	125,878	105,675	20,204	698,579
Environmental	2,425,197	401,300	390,472	10,828	2,034,725
Vector Borne Disease (VBD)	86,667	11,442	3,476	7,966	83,190
Small Drinking Water System	153,222	23,420	21,606	1,814	131,616
Total Environmental Health:	\$3,469,339	\$562,040	\$521,229	\$40,811	\$2,948,110
Health Promotion:					
General	1,223,354	189,226	177,018	12,208	1,046,337
School	1,402,553	215,979	192,837	23,142	1,209,716
Healthy Communities & Workplaces	145,513	22,560	21,769	791	123,744
Branches - Espanola / Manitoulin	334,250	51,501	55,833	(4,332)	278,417
Nutrition & Physical Activity	1,050,154	163,857	141,854	22,003	908,301
Branches - Chapleau / Sudbury East	389,609	60,018	56,263	3,755	333,346
Injury Prevention	375,956	58,023	38,885	19,138	337,071
Tobacco By-Law	269,249	41,688	42,525	(836)	226,724
Healthy Growth and Development	1,225,068	189,034	122,748	66,286	1,102,320
Substance Misuse Prevention	105,651	16,254	17,197	(943)	88,454
Mental Health and Addictions	260,749	40,243	42,697	(2,454)	218,052
Alcohol Misuse	234,480	36,472	17,471	19,001	217,009
Total Health Promotion:	\$7,016,587	\$1,084,856	\$927,097	\$157,759	\$6,089,490
Knowledge and Strategic Services:					
General	1,692,207	279,361	277,669	1,692	1,414,538
Workplace Capacity Development	23,507	3,918	892	3,026	22,615
Health Equity Office	14,440	2,407	21,224	(18,817)	(6,784)
Strategic Engagement	581,215	89,578	86,618	2,961	494,598
Total Knowledge and Strategic Services:	\$2,311,369	\$375,263	\$386,402	\$(11,139)	\$1,924,967
Total Expenditures:	\$22,896,074	\$3,634,384	\$3,291,777	\$342,607	\$19,604,297
Net Surplus/(Deficit)	\$0	\$191,024	\$533,631	\$342,607	

Public Health Sudbury & Districts

Cost Shared Programs

STATEMENT OF REVENUE & EXPENDITURES

Summary By Expenditure Category

For The 2 Periods Ending February 28, 2018

	BOH Annual Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over) /under	Budget Available
Revenues & Expenditure Recoveries:					
Funding	22,983,374	3,839,958	3,886,794	(46,836)	19,096,580
Other Revenue/Transfers	760,740	83,253	167,891	(84,638)	592,849
Total Revenues & Expenditure Recover	23,744,114	3,923,211	4,054,685	(131,474)	19,689,429
Expenditures:					
Salaries	15,662,685	2,410,357	2,268,640	141,717	13,394,045
Benefits	4,446,538	684,102	695,429	(11,327)	3,751,109
Travel	258,121	42,853	9,173	33,681	248,948
Program Expenses	824,434	163,841	147,912	15,929	676,522
Office Supplies	247,896	11,373	5,964	5,409	241,932
Postage & Courier Services	70,536	11,756	7,529	4,227	63,007
Photocopy Expenses	32,207	5,368	3,663	1,705	28,544
Telephone Expenses	62,306	10,218	9,243	974	53,063
Building Maintenance	365,069	58,877	43,603	15,274	321,466
Utilities	208,937	34,823	36,039	(1,216)	172,898
Rent	256,105	42,684	41,658	1,026	214,447
Insurance	103,774	88,274	87,441	834	16,333
Employee Assistance Program (EAP)	34,969	7,800	7,873	(73)	27,096
Memberships	32,289	5,923	4,331	1,592	27,958
Staff Development	111,025	17,435	24,916	(7,482)	86,109
Books & Subscriptions	11,315	1,886	329	1,556	10,986
Media & Advertising	106,201	17,700	4,825	12,875	101,376
Professional Fees	147,376	25,563	31,069	(5,506)	116,307
Translation	46,000	7,667	4,922	2,744	41,078
Furniture & Equipment	14,770	6,628	7,457	(829)	7,313
Information Technology	701,560	77,060	79,037	(1,977)	622,523
Total Expenditures	23,744,114	3,732,187	3,521,054	211,133	20,223,059
Net Surplus (Deficit)	0	191,024	533,631	342,607	

Sudbury & District Health Unit

SUMMARY OF REVENUE & EXPENDITURES

For the Period Ended February 28, 2017

100% Funded Programs

Program	FTE	Annual Budget	Current YTD	Balance Available	% YTD	Program Year End	Expected % YTD
INFOWAY - Immunization Ontario	702	-	23,471	(23,471)	#DIV/0!	Mar 31/18	91.7%
MOHLTC Local Model for Indigenous Engagement	703	227,718	155,614	72,104	68.3%	Mar 31/18	91.7%
Pre/Postnatal Nurse Practitioner	704	139,000	6,978	132,022	5.0%	Dec 31	16.7%
OTF - Getting Ahead and Circles	706	216,800	47,361	169,439	21.8%	Mar 31/2020	33.3%
CGS - Local Poverty Reduction Evaluation	707	44,897	7,608	37,289	16.9%	Nov 30/2019	50.0%
SFO - Electronic Cigarette Act - New Nov./15 - Base Fndg	722	36,700	3,084	33,616	8.4%	Dec 31	16.7%
SFO -TCAN - Prevention	724	97,200	(3,756)	100,956	-3.9%	Dec 31	16.7%
SFO - Tobacco Control Area Network - TCAN	725	285,800	34,428	251,372	12.0%	Dec 31	16.7%
SFO - Local Capacity Building: Prevention & Protection	726	259,800	24,374	235,426	9.4%	Dec 31	16.7%
SFO - Tobacco Control Coordination	730	100,000	16,407	83,593	16.4%	Dec 31	16.7%
SFO - Youth Engagement	732	80,000	11,112	68,888	13.9%	Dec 31	16.7%
Infectious Disease Control	735	479,100	73,686	405,414	15.4%	Dec 31	16.7%
LHIN - Falls Prevention Project & LHIN Screen	736	100,000	70,228	29,772	70.2%	Mar 31/18	91.7%
MOHLTC - Special Nursing Initiative	738	180,500	32,793	147,707	18.2%	Dec 31	16.7%
MOHLTC - Northern Fruit and Vegetable Funding	743	156,600	20,305	136,295	13.0%	Dec 31	16.7%
Beyond BMI - LDCP	747	150,000	109,807	40,193	73.2%	"May/16 to May/18	54.2%
Food Safety - Haines Funding	750	36,500	-	36,500	0.0%	Dec 31	16.7%
Triple P Co-Ordination	766	4,451	4,451	-	100.0%	Dec 31	16.7%
CGS - Healthy Kids Bright Bites Project	772	1,644	1,644	-	100.0%	Dec 31	16.7%
Healthy Babies Healthy Children	778	1,476,897	217,146	1,259,751	14.7%	Dec 31	16.7%
Healthy Smiles Ontario (HSO)	787	612,200	73,580	538,620	12.0%	Dec 31	16.7%
Anonymous Testing	788	59,393	53,650	5,743	90.3%	Mar 31/18	91.7%
PHO/LDCP First Nations Engagement	790	108,713	26,927	81,786	24.8%	May/17 to May/18	16.7%
MHPS- Diabetes Prevention Program	792	175,000	8,634	166,366	4.9%	Dec 31	16.7%
Total		5,028,913	996,061	4,032,852			

January 5, 2018

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

Dear Minister Jaczek,

On behalf of the Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA), we are writing to provide feedback on the recently released “Income Security: A Roadmap for Change” report.

Our associations, representing the public health sector, are member-based and not-for-profit. OPHA represents the public health workforce and is comprised of a diverse membership of 10 public health and community health associations and individuals from the public health, health care, academic, voluntary and private sector. alPHa provides leadership to the boards of health and public health units in Ontario. Membership is open to the 36 public health units in Ontario. alPHa works closely with board of health members, medical and associate medical officers of health, and senior public health managers in each of the public health disciplines – nursing, inspections, nutrition, dentistry, health promotion, epidemiology and business administration.

Together, our associations have established a joint Work Group on Health Equity. The Work Group focuses on advocating for policies at all levels that reduce inequities in health and on promoting activities that address the social and economic determinants of health within the mandate of public health units in Ontario. The interest of our members in seeing improvements made to the provincial social security system arises from our understanding of current research linking lower incomes with poorer health status and outcomes. This link is also well outlined in the Roadmap Report. Our Health Equity Work Group reviewed the Report and prepared this response.

Previously, one or both of our associations have made submissions on related issues such as Basic Income (in 2015), the Ontario Poverty Reduction Strategy (in 2013 and 2008), the minimum wage (in 2013), and the 2012 report from the Commission for the Review of Social Assistance in Ontario. In 2017, alPHa and OPHA passed Resolutions on the Public Health sector’s Response to the Truth and Reconciliation Commission Calls to Action.

First, we want to commend your government for commissioning this broad review of the Ontario income security system. The three working groups represented a wide range of perspectives layering expertise with lived experience and Indigenous representation to focus on low income and income security issues.

The Roadmap promotes taking a fundamentally different approach, putting people – and their needs and rights – at the centre of the income security system. We believe the major directions and recommendations of this report are insightful and far-reaching. If implemented, we believe that the proposed changes would have a significant impact on income and health.

We are particularly supportive of the following areas:

- Adoption of the six guiding principles as a basis for change is a crucial step needed to move away from the current ‘punitive’ system. The six guiding principles: adequacy, human rights, reconciliation, access to services, economic and social inclusion, and equity and fairness follow from the recommended new vision for Ontario’s income security system, in which:

“All individuals are treated with respect and dignity and are inspired and equipped to reach their full potential. People have equitable access to a comprehensive and accountable system of income and in-kind support that provides an adequate level of financial assistance and promotes economic and social inclusion, with particular attention to the needs and experience of Indigenous peoples” (p.69).
- Making a commitment to moving towards income adequacy
 - Establishing an adequate Minimum Income Standard that sets a goal for income assistance programs as per the recommendations made in the Report about first using the Low Income Measure (LIM) - with 30% more for people with disabilities - and eventually moving towards developing a transparent Ontario Market Basket Measure.
- Providing immediate help to those in deepest poverty and continuing to raise income assistance rates to meet the goal of the Minimum Income Standard
 - It is imperative to move on making regular and sustained increases in income support levels - the steps as outlined in the Report provide a solid plan to follow to progress toward income adequacy. We strongly urge the government to provide immediate increases in assistance levels to those in greatest need.
- Improving the broader income security system
 - Ensuring that all low-income adults receive Pharmacare, dental, vision, hearing, and medical transportation benefits, phased in over the next ten years starting with prescription drug coverage for all low-income adults.
 - Creating a portable housing benefit is critically needed now in Ontario.
- Transforming the social assistance system, including a First Nations-based approach
 - Transforming social assistance including legislative reform and establishing a culture of collaboration and problem solving, trauma-informed, equity-informed and anti-racist practices.

- Taking an ‘assured income’ approach for disability, that is, establishing a basic income for those with a disability.
- Creating a flat rate structure in Ontario Works and modernizing Ontario Works income and asset rules
- Respecting First Nations jurisdiction and ensuring adequate funding
 - It is reassuring to see a substantial focus on Indigenous populations as having considerable need and a very unique context, including the recommendation for self governance of social assistance.
- In order to increase accountability, we support the Roadmap’s recommendation to ensure government reporting take place, with follow-up by a third party, concerning the changes that are planned. A performance measurement framework should be put in place on both an individual and system level to assess how these policy changes are affecting our communities and health.

We would like to see reform of the income security system go further than proposed in the Report in certain areas, as follows:

- In terms of Recommendation #5 about making essential health benefits available to all low-income people starting with those in the deepest poverty, we believe dental coverage should be extended to low income Ontarians beyond the age of 65 as many low income seniors do not have insurance coverage.
- We also recommend that access to mental health counselling services be extended to all low income individuals.
- In addition to the portable housing benefit recommended in the Report, which we strongly support, we believe the provincial government needs to take more measures to increase the supply of affordable, livable housing. As part of this, we urge the government to explore provincial participation in the recently announced National Housing Strategy.
- We believe a basic income approach should be taken to Ontario Works and the entire low income population - working or not.

In summary, we are very supportive of the recommendations and general direction of the Roadmap, and hope that it receives positive and swift action by your government. The Report sets out a progressive, phased ten-year plan for how change should happen, and the investments that government should make in the first three years. As a first priority, we emphasize the need for your government to act immediately to increase social security rates. This government must take action now to make life better for low-income people in Ontario.

We understand the Ministry will release its own report taking into consideration the strategies presented in this document. With this in mind, please accept our appreciation for the opportunity to share our thoughts with you.

We would value an opportunity to engage further with the government on this issue. Should you wish to discuss our feedback in greater detail, please contact Pegeen Walsh, Executive Director, OPHA at pwalsh@opha.on.ca or Loretta Ryan, Executive Director, aPHa at loretta@alphaweb.org.

Sincerely,



President
Association of Local Public Health Agencies



President
Ontario Public Health Association

cc:

Hon. Kathleen Wynne, Premier of Ontario
Hon. Charles Sousa, Minister of Finance
Hon. Peter Milczyn, Minister of Housing and Minister Responsible for the Poverty Reduction Strategy



RESOLUTION #2017-03

Board of Health, Haliburton, Kawartha, Pine Ridge District Health Unit

December 7, 2017

Repeal of Section 43 of the Criminal Code Refresh 2017

WHEREAS, research indicates that physical punishment is harmful to children and youth and is ineffective as discipline; and

WHEREAS, the goal of the Ontario Public Health Standards (OPHS) Child Health Program (2008) is to enable all children to attain and sustain optimal health and developmental potential and of the draft Ontario Standards for Public Health Programs and Services (2017) Healthy Growth and Development Standard is to achieve optimal maternal, newborn, child, youth, and family health; and

WHEREAS, Section 43 of the Criminal Code of Canada justifies the use of physical punishment of children between the ages of 2 and 12; and

WHEREAS, the Ontario Public Health Association (OPHA) supports the repeal of Section 43 of the Criminal Code of Canada, as repeal would provide children the same protection from physical assault as that given to adults; and

WHEREAS, over 550 organizations in Canada, including the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit (in 2006) and the City of Kawartha Lakes, have endorsed the *Joint Statement on Physical Punishment of Children and Youth*; and

WHEREAS, calls for the repeal of Section 43 of the Criminal Code of Canada have been made repeatedly for almost 40 years; and

WHEREAS, Prime Minister Justin Trudeau stated the Calls to Action of the Truth and Reconciliation Commission, which includes the repeal of Section 43, would be fully implemented;

THEREFORE BE IT RESOLVED that the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit support the repeal of Section 43 of the Criminal Code of Canada and write to the Minister of Justice indicating the Board's position and urging swift action on this matter;

BE IT FURTHER RESOLVED that copies of this resolution be sent to the Prime Minister, all local Members of Parliament, all local Members of Provincial Parliament, all Member Municipalities, all local Boards of Education, all Ontario Boards of Health, and all local children's planning tables for support.

**Ministry of Health
and Long-Term Care**

Assistant Deputy Minister's Office

Population and Public Health Division
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Toronto ON M7A 1S5

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**Ministère de la Santé
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Bureau du sous-ministre adjoint

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February 16, 2018

MEMORANDUM

**TO: Medical Officers of Health, Chief Executive Officers, and
Board of Health Chairs**

RE: Ontario Public Health Standards – Implementation Work Plan Updates

Dear Colleagues,

As you know, January 1, 2018 marked the effective date of the new Ontario Public Health Standards: Requirements for Programs, Services and Accountability, and implementation will take place over the year. The ministry is working on a comprehensive work plan which includes engagement, participation and involvement with all of you, and we will provide details, in the ensuing weeks. In the meantime, please see below for some key status updates.

Protocols and Guidelines

- The first batch of protocols and guidelines were shared with you on December 29, 2017, and the second batch were released on February 5, 2018. Over the next few weeks, the Standards Implementation Task Force will review the outstanding protocols and guidelines. Please see **Appendix 1** for the complete list of protocols and guidelines and anticipated release dates for those outstanding.

Indicators

- In my December 29 memo, I announced that an Indicators Implementation Task Force will be established to support the implementation of the Ontario Public Health Standards Indicators Framework.

I will be reaching out to individuals to participate in this critical indicators work, and I will update you on that membership and the Task Force's terms of reference shortly thereafter.

Reporting

- As we continue to work with you and your staff to complete your 2018 Annual Service Plan and Budget Submissions, we are also in the process of developing the other accountability reporting tools required under the new Public Health Accountability Framework, including the Standards Activity Reports (i.e., in year financial/programmatic reports, annual report and attestation). The content and timing for these accountability reports will be shared with Boards of Health shortly.
- The ministry will continue to consult with the field on the development of the accountability reporting tools and we are committed to provide ongoing training and support to throughout this process.

Continuous Quality Improvement

- Ten years passed between the last major update of the Ontario Public Health Standards (in 2008) and this 2018 update. I think we can agree that this is too long a time period. We need to strike a balance between ensuring that the Standards reflect critical new inputs i.e.: new evidence, research findings, learnings from monitoring and surveillance, evaluation results, and providing operational certainty for Boards of Health and staff working in local public health. The ministry is currently considering how best to keep the Standards, protocols and guidelines up-to-date, and we will seek your input into this in the coming months.

Coordinated Research Agenda

- High quality, relevant and coordinated research is needed on an ongoing basis to inform the development of policies and programs, both locally and provincially. While a significant amount of research is conducted within the sector, a coordinated approach would maximize impact by reducing duplication, leveraging capacity within the system, and ensuring that our needs and priorities are being met. As a first step in the development of a coordinated research agenda, we will embark on a consultative process to identify provincial research priorities across the range of programs and services reflected in the modernized standards.

Public Health Workforce

- Another next step with the release of the new Standards will be a process to assess how the current public health workforce is aligned to deliver these programs and services within current resources and to develop various strategies to begin addressing the gaps. We want to engage various disciplines in the field to participate in this work, so please stay tuned for further communication.

Surveillance and Monitoring Strategy and Central Repository (coordinated data backbone, centralized data collection)

- The purpose of the Surveillance and Monitoring Strategy is to provide a framework for what information will be collected and monitored, how it will be organized, captured, and made available through a central repository to support the implementation of Board of Health requirements under the Standards, as well as program reporting and population health assessment.
- The ministry is currently developing the proposed policy approach and will be engaging local public health and other key partners shortly.

Education & Training

- With the significant changes that have been made to the Standards, the *Health Protection and Promotion Act* and the new Public Health Accountability Framework, the ministry recognizes that the sector will require knowledge and awareness of all components of these changes, as well as specific training for components within certain areas. To this end, we will be developing a Coordinated Education and Training Plan, which will organize and prioritize this content over the coming year. The ministry intends to use various training modalities to make this as efficient as possible and a training calendar will be developed so that Boards of Health can plan accordingly.

Evaluation

- The ministry is committed to the systematic evaluation of all aspects of our work, including the new Standards. As we work to develop a comprehensive evaluation plan for the new standards over the next year, we will be seeking feedback and advice from the field not only on the overall plan, but also on how to specifically include local evaluation results as local public health staff also work to evaluate the programs and services they offer in accordance with the Standards.

Evidence and Best Practices

- In recognition of the important role that evidence and best practices play in policy/strategy/program development and implementation, we will consult with our public health and other key partners to explore how best to incorporate and support this critical public sector activity.

Thank you for your continued support and collaboration. If you have any questions, please do not hesitate to contact the ministry by e-mail at PHTransformation@ontario.ca.

Sincerely,

Original signed by

Roselle Martino
Assistant Deputy Minister, Population and Public Health Division

Copy: Dr. David Williams, Chief Medical Officer of Health
Jackie Wood, Director, Planning and Performance Branch
Nina Arron, Director, Disease Prevention Policy and Programs Branch
Liz Walker, Director, Accountability and Liaison Branch
Laura Pisko, Director, Health Protection Policy and Programs Branch
Dianne Alexander, Director, Healthy Living Policy and Programs Branch
Clint Shingler, Director, Health System Emergency Management Branch

Appendix 1: Summary of Protocols and Guidelines with Release Dates

Document	Release Date or Anticipated Release Date
Child Visual Health and Vision Screening Protocol	February/March 2018
Electronic Cigarettes Protocol	December 29, 2017
Food Safety Protocol	February 5, 2018
Health Hazard Response Protocol	February 5, 2018
Healthy Babies, Healthy Children Protocol	January 3, 2018
Immunization for Children in Schools and Licensed Child Care Settings Protocol	February 5, 2018
Infection Prevention and Control Complaints Protocol	February 5, 2018
Infection Prevention and Control Disclosure Protocol	February 5, 2018
Infection Prevention and Control Protocol	February 5, 2018
Infectious Diseases Protocol	February 5, 2018
Institutional/Facility Outbreak Management Protocol	February/March 2018
Menu Labelling Protocol	December 29, 2017
Oral Health Protocol	February/March 2018
Population Health Assessment and Surveillance Protocol	December 29, 2017
Qualifications for Public Health Professionals Protocol	February 5, 2018
Rabies Prevention and Control Protocol	February 5, 2018
Recreational Water Protocol	February 5, 2018
Safe Drinking Water and Fluoride Monitoring Protocol	February 5, 2018
Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol	December 29, 2017
Tanning Beds Protocol	December 29, 2017
Tobacco Protocol	December 29, 2017
Tuberculosis Prevention and Control Protocol	February 5, 2018
Vaccine Storage and Handling Protocol	December 29, 2017
Board of Health and Local Health Integration Network Engagement Guideline	December 29, 2017
Chronic Disease Prevention Guideline	February 2018
Guidelines for Emergency Management	February/March 2018

Document	Release Date or Anticipated Release Date
Health Equity Guideline	February 2018
Healthy Environments and Climate Change Guideline	February 2018
Healthy Growth and Development Guideline	February 2018
Injury Prevention Guideline	February 2018
Management of Avian Chlamydiosis in Birds Guideline	February 2018
Management of Avian Influenza or Novel Influenza in Birds or Animals Guideline	February 2018
Management of Echinococcus Multilocularis Infections in Animals Guideline	February 2018
Management of Potential Rabies Exposures Guideline	February 2018
Mental Health Promotion Guideline	February 2018
Operational Approaches for Food Safety Guideline	February 2018
Operational Approaches for Recreational Water Guideline	February 5, 2018
Relationship with Indigenous Communities Guideline	February 2018
School Health Guideline	February/March 2018
Small Drinking Water Systems Risk Assessment Guideline	February 5, 2018
Substance Use Prevention and Harm Reduction Guideline	December 29, 2017
Tuberculosis Program Guideline	February 2018

From: MacDonald, Gillian (MOHLTC) <Gillian.MacDonald2@ontario.ca> on behalf of Williams, Dr. David (MOHLTC) <Dr.David.Williams@ontario.ca>
Sent: February 28, 2018 3:58 PM
To: CMOH
Subject: CMOH Annual Report
Attachments: MOH_CMOH Annual Report_v1_English_2018_Feb_27.pdf

Follow Up Flag: Follow up
Flag Status: Completed

Dear Colleagues,

I am pleased to provide you with a copy of my 2016 Annual Report, *Improving the Odds: Championing Health Equity in Ontario*.

Organizations across Ontario have released reports on improving health equity, acknowledging that this is both an important and timely issue. However, despite conversations and efforts to address health equity, there is growing inequity in parts of the population.

Improving the Odds calls for urgent, intersectoral action to improve health equity championed by public health, using a community development approach and collecting good, local data.

It makes the case that public health units have the expertise, interconnectivity and experience to lead community development which can reduce inequities through its mitigating effects on poor health outcomes. The report also calls on system-wide and government-wide action, forging new relationships at all levels to address the complexity of health equity issues. As in my previous 2015 Annual Report, *Mapping Wellness*, this report continues to advocate for the long-term collection of good local data in order to identify priority populations that need health equity interventions the most.

Thank you for your ongoing support. I am hopeful this report's recommendations will inspire urgent action for improving health equity in Ontario.



David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health



Improving the Odds Championing Health Equity in Ontario

**Ministry of Health
and Long-Term Care**

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**Ministère de la Santé et
des Soins de longue durée**

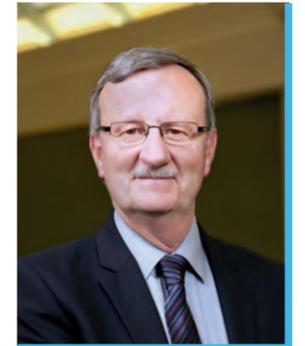
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February 2018

The Honourable Speaker
Speaker of the Legislative Assembly of Ontario

Room 104, Legislative Building
111 Wellesley St. W
Toronto, Ontario M7A 1A2



Dear Speaker,

I am pleased to provide the 2016 Annual Report of the Chief Medical Officer of Health of Ontario for submission to the Assembly in accordance with the provision of section 81.(4) of the Health Protection and Promotion Act.

Yours truly,

A handwritten signature in black ink that reads "D Williams".

David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health



Executive Summary

All Ontarians should have the opportunity to be as healthy as possible, regardless of race, ethnicity, religion, gender, age, social class, geography, socioeconomic status or other social circumstances.

Yet many struggle with health inequities: systematic and unfair disadvantages that threaten their health, such as low incomes, lack of education and employment opportunities, lack of access to stable housing and healthy food, violence and social isolation.

As a society, there are many things we can do together to improve the odds of good health for everyone. To create healthy communities, it's time for the public health sector in Ontario to champion health equity: to bring a wide range of partners together to develop policies and programs that reduce or eliminate social, economic and environmental barriers to good health.

Public health units are well placed to facilitate partnerships at the local level and promote collective action. They can leverage their strong relationships with many organizations in their communities – municipalities, LHINs, Indigenous communities and other intersectoral partners, including social services, housing programs and shelters, and police services – to improve health equity.

We have the tools to make a difference:

- With Patients First, Ontario laid the groundwork for a system-wide approach to health equity. Health equity is now part of the mandate of Local Health Integration Networks (LHINs). As part of public health transformation, public health units will now be working much more closely with their LHINs and LHIN sub-regions to improve health equity.
- The updated Ontario Public Health Standards Requirements for Programs, Services and Accountability, which came into effect in January 2018, include a new Health Equity Standard and Guideline¹ that requires public health units to embed strategies to improve health equity in their everyday work.
- Different data sources and novel analytical approaches are now available to map health inequities, identify the complex factors that put people at risk and target interventions.

- The public health sector can apply and adapt its effective approach to managing outbreaks of infectious diseases to reducing or eliminating social inequities. That approach, which brings a greater sense of urgency and focus to solving health problems, can help public health units look beyond income inequality to other social, economic and environmental factors that may be easier to address in the short-term.
- Community development interventions can bring community members together to take collective action and solve common problems. They can also help build social cohesion, which, in turn, improves health.
- Strong partnerships with a wide range of local organizations – both within and outside the health system – can make health equity initiatives more powerful and effective. Different players and levels of government have unique levers and opportunities to improve health. Working together as a system, they can reduce or eliminate health disparities.

Because the responsibility for achieving health equity reaches far beyond the public health sector and even the health sector, other sectors whose policies affect health, such as education, the environment and economic development, must be actively engaged.

To support the public health sector in championing health equity, the Chief Medical Officer of Health for Ontario recommends that government:

- 1 **Support public health to identify “outbreaks” of health inequities and plan effective, sustainable interventions through community development**
- 2 **Work system-wide and government-wide to improve health equity**
- 3 **Provide data to understand health inequities and inform community development efforts**

Strategic investments in health equity research, partnerships and data will help improve the odds for good health for all Ontarians. They will pay off in better health outcomes for individuals, healthier, happier, fairer communities, and lower health care and social costs.



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I. Health Equity: Improving the Odds of Good Health

All Ontarians should have the opportunity to be as healthy as possible.

But health is influenced by many factors, including genetics, lifestyle choices and social determinants of health, such as income, education, access to health services, and the social and physical environments where we live, learn, work and play.

Some of these factors are out of our individual control. In fact, for many Ontarians, the chances of living a long and healthy life can seem like a rigged lottery or a stacked deck.

If you are fortunate enough to be born into a family that has a high steady income and lives in a good neighbourhood and you have easy access to education, health care and other services, you are more likely to win the health lottery.

But if not, then what? Can Ontarians still aspire to be as healthy as possible?

Yes. As a society, community or neighbourhood, there are many things we can do together to improve the odds: to ensure everyone has a fair chance to lead a long, healthy life.

To achieve health equity, we must tackle health inequities that are systematic, unfair and avoidable: the ones caused by social, economic or environmental conditions (i.e., social determinants of health). We have to give all Ontarians the opportunity to live in social and economic conditions that support good health, regardless of race, ethnicity, gender, age, socioeconomic status, geography or other circumstances.

DEFINITIONS

Health is the physical, spiritual, mental, emotional, environmental, social, cultural and economic wellness of the individual, family and community.²

Health equity means all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance.²

Health inequality: refers to measurable differences in health between individuals, groups or communities. It is sometimes used interchangeably with the term “health disparities.”²

Health inequity: refers to differences in health associated with social disadvantages that are modifiable and considered unfair.²

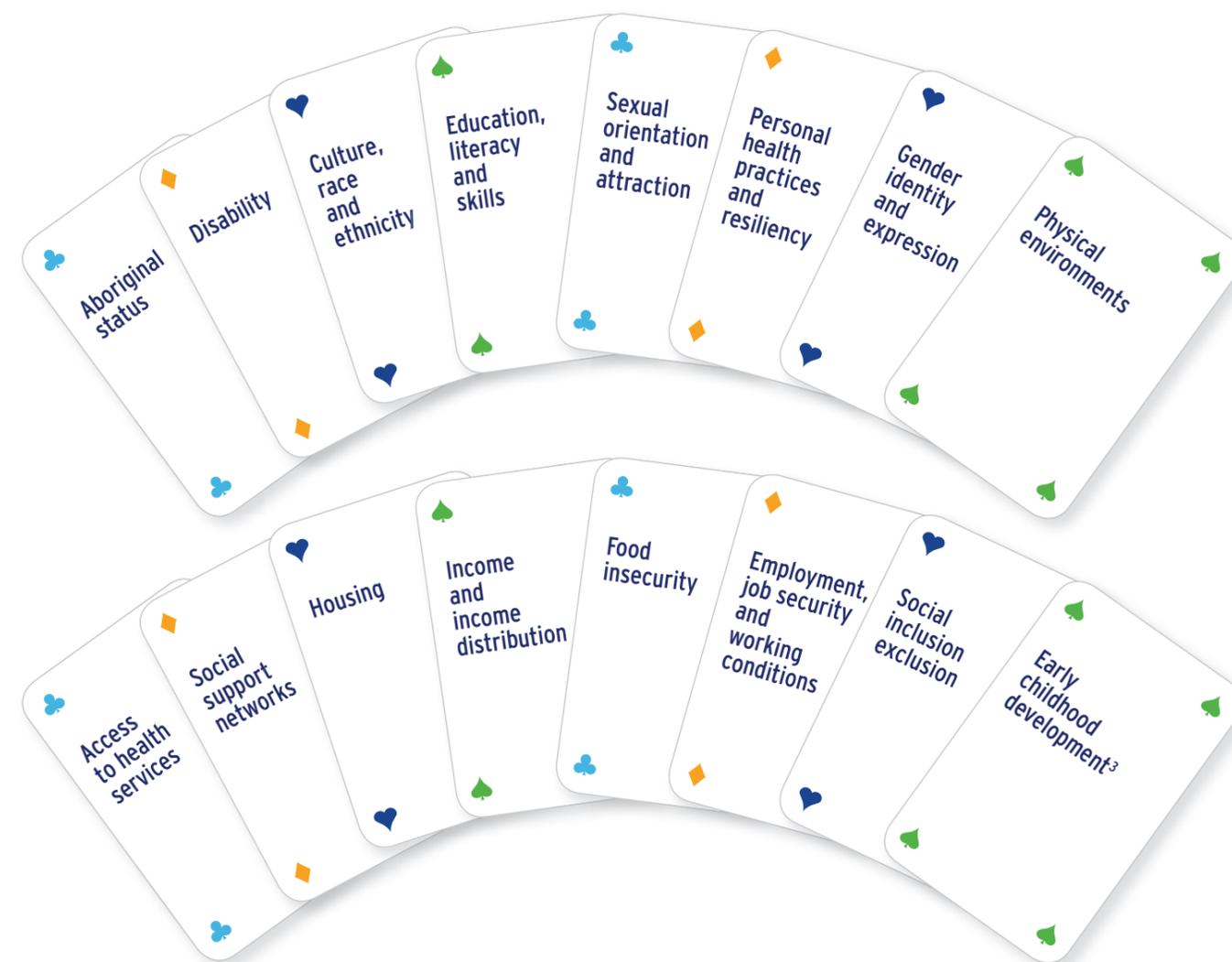
Priority populations are individuals or groups of people who are experiencing and/or at higher risk of poor health outcomes due to the burden of disease and/or factors for disease; the determinants of health, including the social determinants of health and/or the intersection between them. Priority populations are those who are more likely to benefit from public health interventions.³

Social Determinants of Health

Social determinants of health are the interrelated social, political and economic factors that create the conditions in which people live, learn, work and play. The intersection of the social determinants of health causes these conditions to shift and change over time and across the life span, impacting the health of individuals, groups and communities in different ways.²

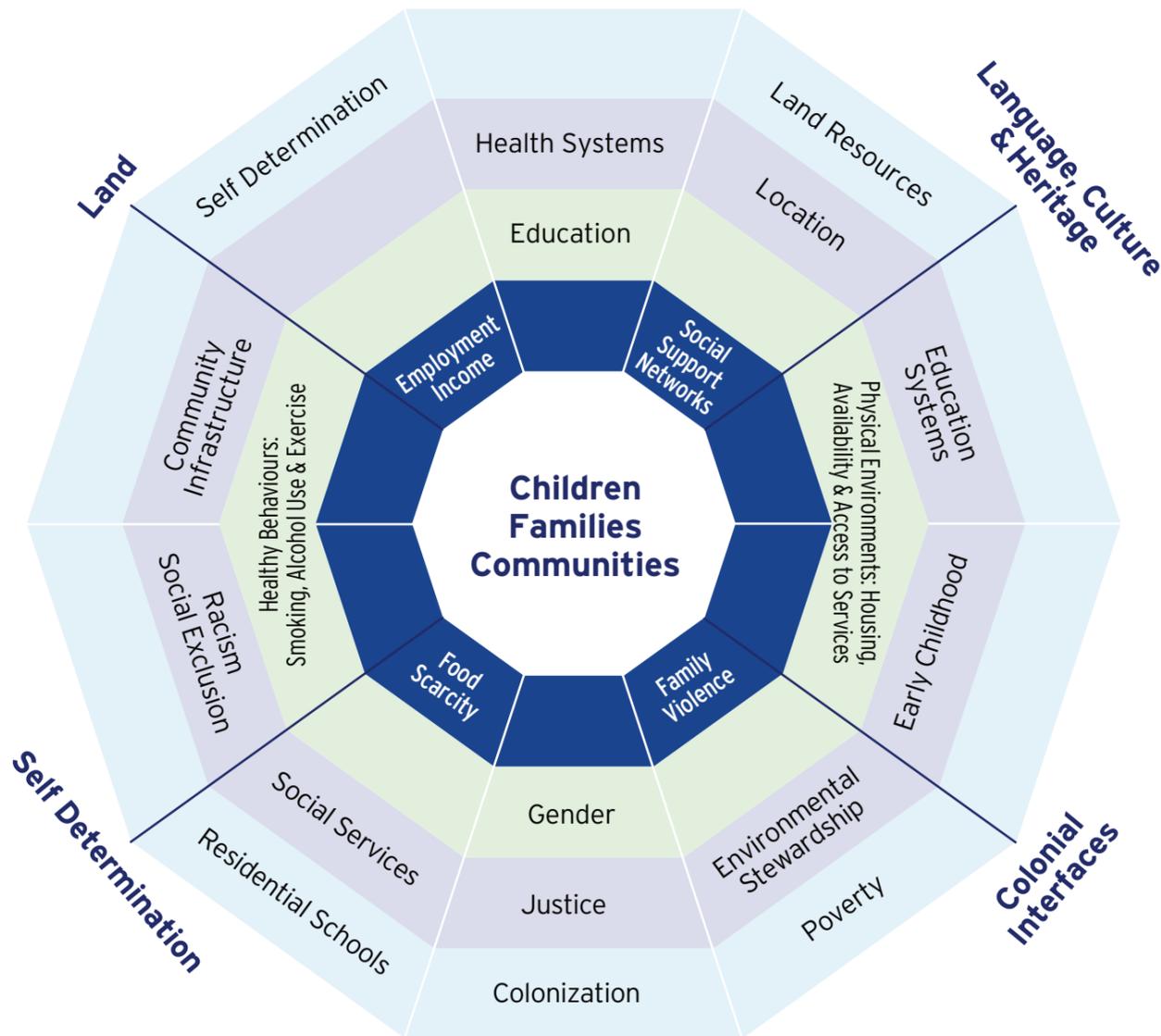
“I have come to learn that the dream that everyone in Ontario will have the same opportunity for health, no matter who they are, where they live and what they have, is at this time, still just a dream. ... However, despite the challenges, I remain convinced that health equity is possible for all. There are many things the health system can do to mitigate inequity ...”

Dr. Jeffrey Turnbull, Health Quality Ontario's Health Equity Plan



Web of Being

First Nations, Inuit and Métis take a holistic approach to addressing risk factors, including determinants of health, based on the Indigenous view of wellness as a balance of the four dimensions of health – physical, mental, emotional and spiritual – throughout the stages of life.⁴ While traditional concepts of the social determinants of health seem to identify them as separate and sometimes cumulative forces, the Indigenous way of knowing sees them as more of an interconnected and interdependent web.



The National Collaborating Centre on Aboriginal Health has developed a Web of Being, which illustrates the determinants of health for First Nations, Inuit and Métis and shows how these factors form an interconnected web that affects Indigenous people’s health and well-being. Indigenous health cannot be understood outside of the context of factors such as colonialism, racism and social exclusion, which act as barriers to accessing health care for Indigenous communities, families and individuals.⁵ Given the wide range of unique cultural, historical, geographical and socioeconomic challenges facing Indigenous communities, it is important to consider that each community is unique and may require different approaches. A bottom-up, community-centred approach to public health that reflects the Web of Being is most likely to provide meaningful, positive change.⁶

Public Health’s Role in Improving the Odds

The public health sector has a long history of sustained initiatives that “powerfully and assuredly bolster life expectancy”⁷ including sanitation, water safety, food safety, immunization programs, efforts to control outbreaks of infectious diseases, smoking cessation programs, seatbelt laws and efforts to promote healthy eating and physical activity.

We know that the kind of lifestyle changes advocated by public health units – not smoking, maintaining a healthy weight, being physically active and eating more fresh fruits and vegetables – can dramatically reduce the risk of heart disease, a leading cause of premature deaths in Ontario. We know that policies that restrict smoking in public and tax tobacco have helped reduce deaths from lung cancer.⁸ However, not everyone benefits equally. Even with the best knowledge and intentions, it is not easy for people who face systematic and unfair disparities – such as having a low income, living far from services or being socially isolated – to stop smoking or eat healthfully.

Public health units can play a key role in creating healthier communities by working with partners to develop policies that reduce or eliminate those systematic social, economic and environmental barriers to good health.

Goal: Public health practice results in decreased health inequities such that everyone has equal opportunities for optimal health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances.¹



The updated Ontario Public Health Standards: Requirements for Programs, Services and Accountability (Ontario Public Health Standards),³ which came into effect in January 2018, include a new Health Equity Standard and Guideline that require public health units across the province to focus on health equity to help Ontarians reach their full health potential. They must work to:

- 1 Understand the Problem.** Public health units will gather data to continually assess the health of local populations and identify:
 - health inequities
 - priority populations - those at risk of poor health outcomes who would benefit most from public health interventions
- 2 Develop Targeted Universal Programs.** Public health units will implement universal strategies designed to improve the health of the entire community while targeting those strategies to priority populations within that community experiencing health disparities.
- 3 Pursue Partnerships.** Public health units cannot eliminate health inequities on their own. They must work closely with other local partners, such as municipal programs (e.g., housing, recreation, social services), LHINs, Indigenous communities, other federal and provincial government programs and services, civic society and the private sector. They must continue to build relationships with partners inside and outside the health system who can help reduce health disparities and improve health for those at risk.

The new Guideline also requires public health units to foster meaningful relationships with Indigenous communities and organizations, starting by engaging with those communities and then working to develop collaborative partnerships to reduce health disparities and improve health equity.

- 4 Champion Health Equity.** Public health units, in collaboration with other partners, will provide data and health policy analyses and advocate for public policies that reduce or eliminate health inequities. They are a trusted voice in their communities and can champion the importance and benefit of health equity for the entire population.

II. Measuring and Understanding Health Inequity

The public health sector's ability to fulfill its role in improving health equity depends on its capacity to measure and understand health disparities. *Mapping Wellness*, the 2015 report of the Chief Medical Officer of Health, describes how local-level population health data can be used to make evidence-informed decisions to improve the health of communities. That report made a series of recommendations for collecting and using local data to map wellness community by community, neighbourhood by neighbourhood, and population by population. It also recognized the importance of connecting data from different sources to avoid unnecessary costly duplication.

Reducing premature mortality is one of the United Nations Sustainable Development Goals. Health care interventions can significantly reduce premature mortality. Many deaths can be prevented through effective public health and preventive care.

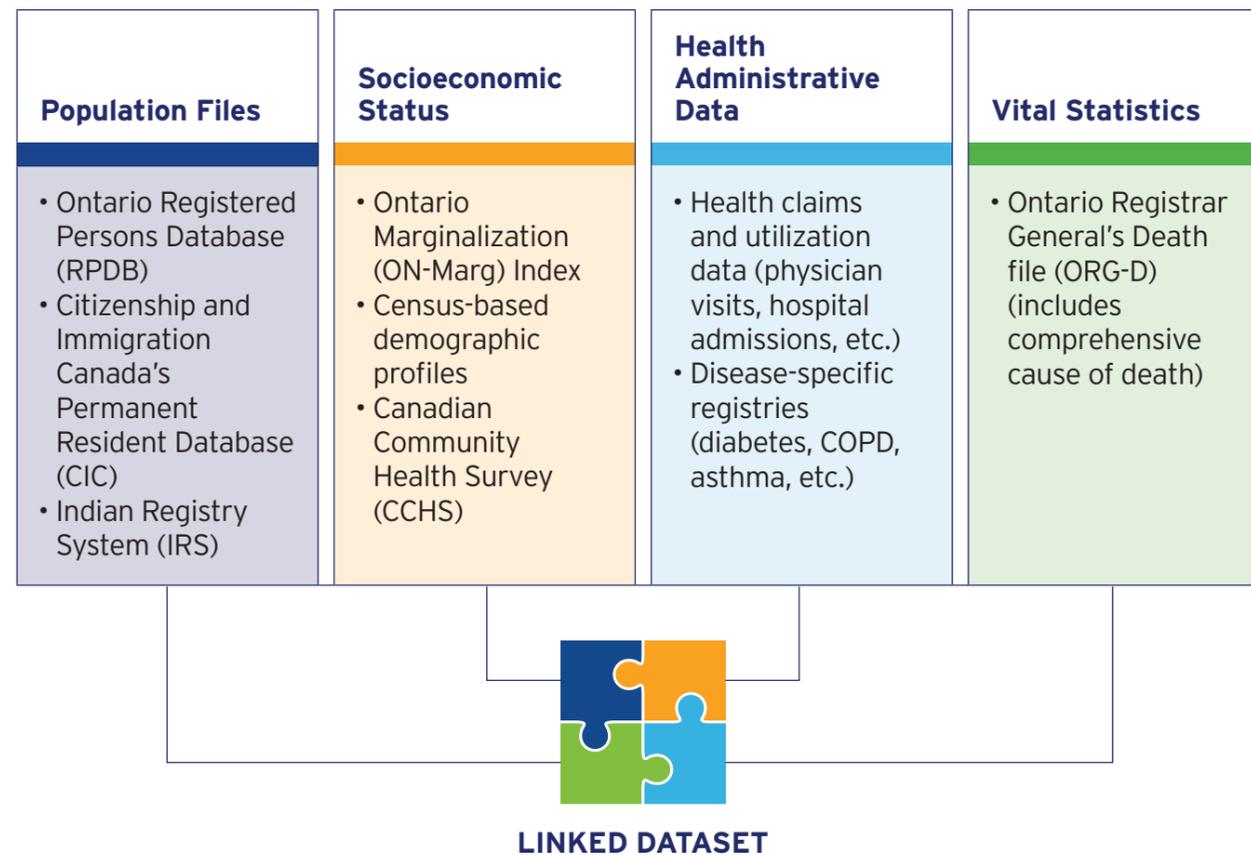
Understanding Factors that Contribute to Premature Deaths

One indicator of health equity is mortality and particularly premature mortality, which is the measure of unfulfilled life expectancy (i.e., the number of deaths that occur before the average age of death in a certain population).

The Population Health Analytics Laboratory, based at the University of Toronto's Dalla Lana School of Public Health, is developing innovative ways to link existing data to understand public health and improve health services. The OPTIMISE Project (Ontario Population Trends in Improved Mortality: Informing Sustainability and Equity of the health care system) uses comprehensive multi-linked mortality files to help guide health system planning. OPTIMISE can help answer questions such as: Is our health system reaching who it needs to? Who is being left behind?



OPTIMISE LINKS DATA FROM FOUR TYPES OF SOURCES:



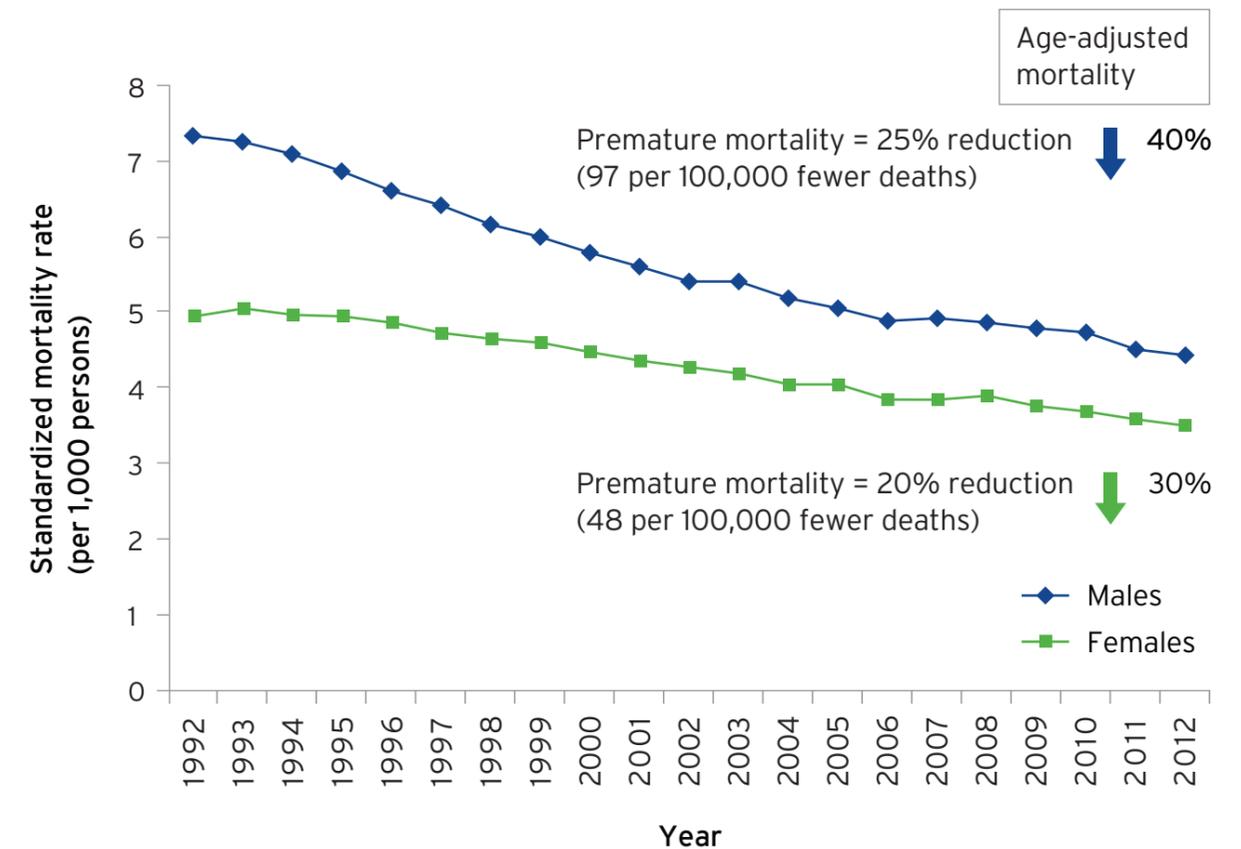
The OPTIMISE analyses⁹ reveal that, in general, Ontarians are living longer. Over the past two decades, mortality rates have steadily declined for both women and men, and the gap in life expectancy between women and men has narrowed.

However, trends for the overall population hide the fact that not everyone is benefitting equally. Some clusters of people are still dying young. For example, when we look at the impact of neighbourhood-level income on mortality (see Figure 2), the graph tells a different story. Just 25 years ago, sex was the key driver of deaths from all causes. Women, regardless of income, lived longer than men: in fact, low-income women lived longer than high-income men.

To achieve health equity, we must identify the priority populations most at risk and develop targeted interventions that work to reduce or eliminate health disparities.

FIGURE 1. NARROWING SEX DIFFERENCES IN MORTALITY

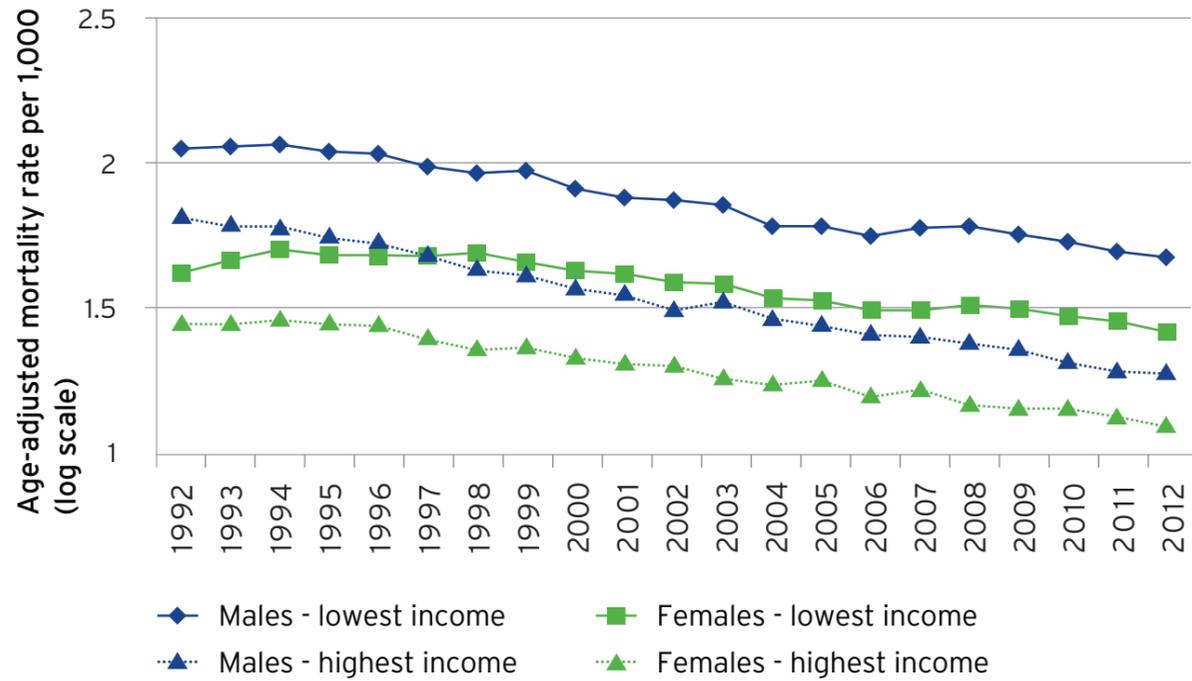
All-cause age-standardized* mortality rates for males and females



*Standardized to the 1991 Canadian population *Rosella LC, Calzavara A, Frank JW, Fitzpatrick T, Donnelly PD, Henry D. (2016). Narrowing mortality gap between men and women over two decades: a registry-based study in Ontario, Canada. *BMJ Open*, 6(11): e012564¹⁰



FIGURE 2.
DIFFERENTIAL SOCIOECONOMIC STATUS-SEX TRENDS OVER TIME



Rosella LC, Calzavara A, Frank JW, Fitzpatrick T, Donnelly PD, Henry D. (2016). Narrowing mortality gap between men and women over two decades: a registry-based study in Ontario, Canada. *BMJ Open*, 6(11): e012564¹⁰

Today, low-income women have a higher mortality rate than high-income men and a much higher mortality rate than high-income women: in fact the gap between poorer and wealthier women has grown considerably – as has the gap between poorer and wealthier men. Socio-economic status is a key determinant of health inequity. When it comes to living longer in good health, many people with lower incomes are being left behind.

MAP OF ONTARIO'S PUBLIC HEALTH UNITS

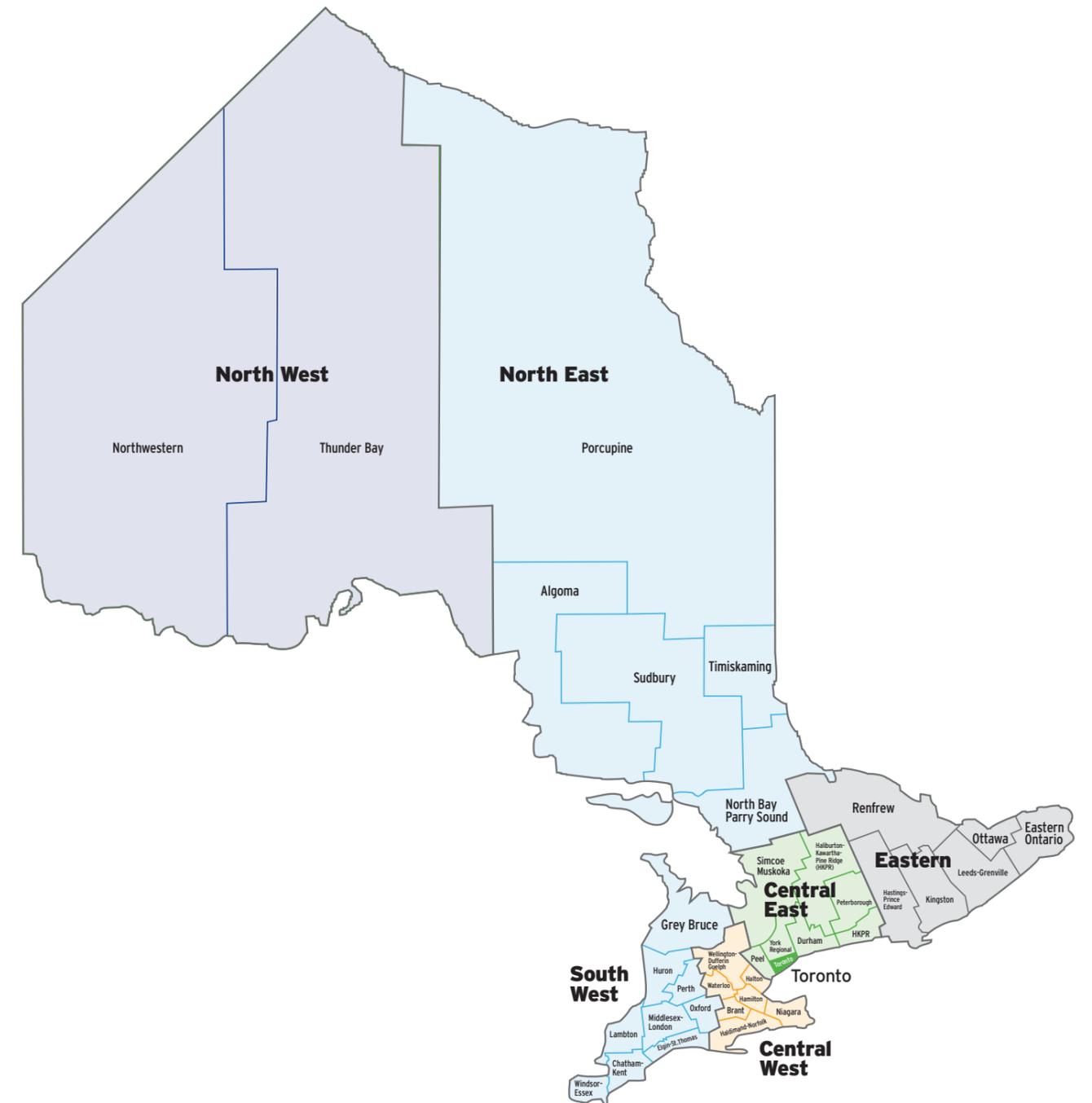
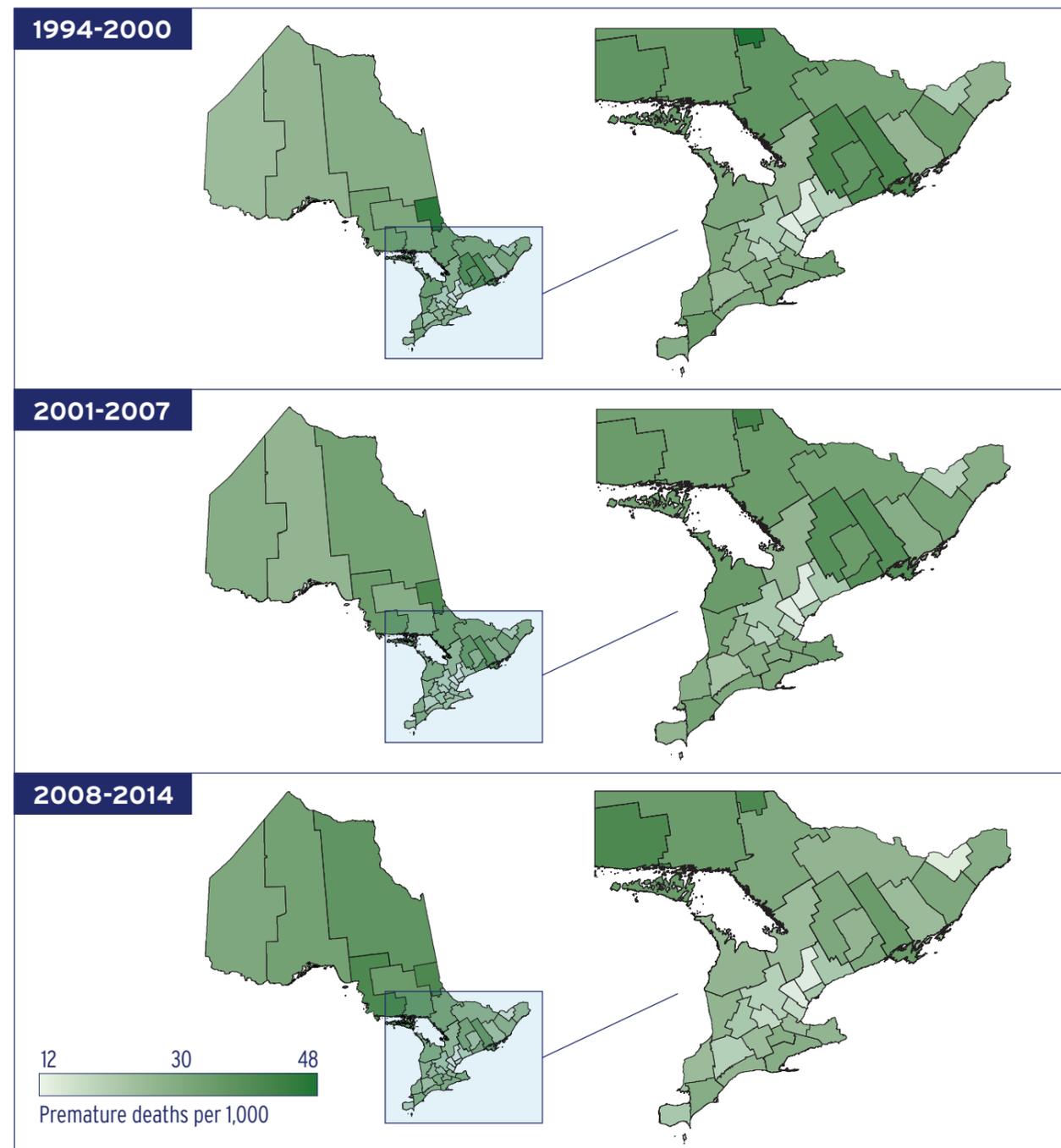


FIGURE 3.
PREMATURE (AGE <75) MORTALITY RATES BY PUBLIC HEALTH UNIT



Dr. Laura Rosella provided the data in figure 3. Dr. Rosella is supported by a Canadian Institutes of Health Research Foundation Scheme Grant [FDN-148456] and by a Canada Research Chair in Population Health Analytics.

While there may be limitations in using premature mortality as a measure of health equity, it may help us to address factors that contribute to health disparities. As Figure 3 illustrates, some parts of the province – particularly those in the south – have seen marked improvements in premature mortality rates over time while many in the north have not. There appear to be systematic unfair barriers to health in the northern parts of the province that must be overcome.

Using Novel Approaches to Measure Health Inequity

Novel predictive data tools, such as the RII, the Ontario Marginalization Index and the High Resource User Population Risk Tool, may help communities measure and understand health inequity.

The Ontario Marginalization Index (ON-Marg) summarizes census data so it can be analyzed to understand how the key dimensions of social determinants play out in neighbourhoods and communities across the province and affect people's health. ON-Marg data and related maps for the 2001, 2006 and 2011 census are available on the PHO website. They can be used to track changes in marginalization and health equity over time. Data is available at the small area level as well as larger geographies such as public health units and LHINs. See:

<https://www.publichealthontario.ca/en/DataAndAnalytics/Pages/ON-Marg.aspx>

Relative Index of Inequality

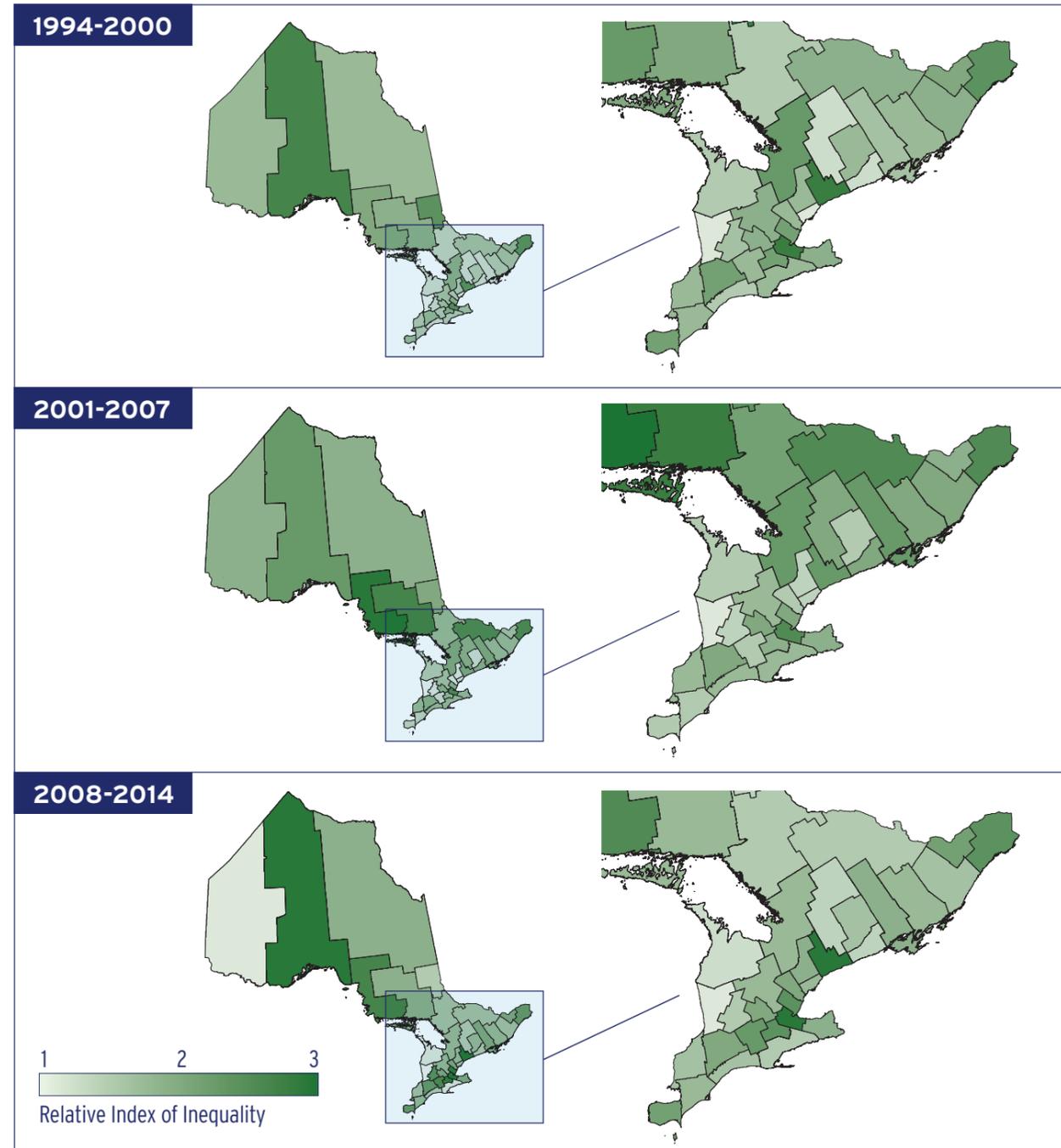
The Relative Index of Inequality (RII) can help identify, within a given population, the impact of social, economic and environmental health disparities, where these disparities are occurring and who is most affected. The index compares the relative risk of inequality of people who are most advantaged socio-economically with those who are least advantaged and measures the equity gap. It can help public health planners understand how inter-related risk factors, such as low income, low level of education and cigarette smoking, affect health. A higher RII means less health equity. The goal is to have a relatively low RII and, when the index is high, understand the factors contributing to inequity and reduce or eliminate them.

To calculate the RII, researchers categorize populations into levels of deprivation using the four material deprivation dimensions from the ON-Marg Index:

- **residential instability** - including living alone, being single, widowed or divorced, not owning a home and moving frequently
- **material deprivation** - including not having graduated from high school, being unemployed, being a single parent household, having a low income and living in a dwelling in need of repair
- **dependency** - including being over 65 and the proportion of the population over age 15 not in the workforce
- **ethnic concentration** - including people who are recent immigrants and the proportion who identify as part of a visible minority.

The result? Population Health and Analytics Laboratory was able to map the relative index of inequality for premature mortality by public health unit over a 20-year period. As these maps illustrate, health inequity shifts over time depending on a number of factors.

FIGURE 4.
RELATIVE INDEX OF INEQUALITY (RII) BY PUBLIC HEALTH UNIT



Dr. Laura Rosella provided the data in figure 4. Dr. Rosella is supported by a Canadian Institutes of Health Research Foundation Scheme Grant [FDN-148456] and by a Canada Research Chair in Population Health Analytics.

The RII tool provides a more nuanced look at the causes of premature mortality. For example, the maps on page 16 that looked only at mortality trends seemed to show that the entire north faced larger disparities, while the RII maps displayed on page 18 indicate that certain northern regions, such as Northwestern and Timiskaming, have seen a decrease in their RII. There is a smaller gap between the most and least disadvantaged in those and other regions. It appears that some measures of equity in those regions are improving.

High Resource User Population Risk Tool

Health inequities are devastating for the people who experience them. Over a lifetime, they reduce opportunities for health, increase health problems such as chronic diseases and shorten lives. In fact, almost one in four premature deaths among people who are most disadvantaged (high RII) could be avoided if we could reduce or eliminate inequities, which would also eliminate about one in six premature deaths among people who are the least disadvantaged.

The impact of health inequities is not limited to the individuals and their families who face them. There are ripple effects throughout society, including lower productivity, more use of health services, and higher health care and other social costs. People who experience high rates of health inequities and poorer health outcomes are more likely to become high users of health services. The top five per cent of service users account for 55 per cent of health care spending.¹¹ If we don't invest in upstream policies, programs and services to improve health equity for everyone, we will pay more downstream for preventable emergency, hospital and other health services.

To help identify populations at high risk of poor health outcomes over the next five years, Ontario researchers have developed the High Resource User Population Risk Tool (HRUPoRT), which takes into account both the clinical and social determinants that contribute to people developing the kind of health problems that make them high users of health services.



To develop the tool, the researchers looked at the clinical, sociodemographic and health behavioural characteristics of the top five per cent of health care service users over a five-year period. The factors most likely to predict high use of services were:

RISK FACTORS FOR HIGH RESOURCE USERS

sex	food security
age	perceived general health
history of a chronic condition	body mass index
ethnicity	smoking status
immigrant status	physical activity quartile
household income quintile	alcohol consumption

Public health units can use the HRUPoRT to help identify priority populations and target interventions. This analysis can complement other information on priority populations.

III. Adapting the Outbreak Approach to Reduce Health Inequities

The new Health Equity Standard sets out an ambitious role for public health units. The challenge will be putting the standard into action.

Are there lessons from other areas of public health practice that we can modify and apply to reduce or eliminate health inequities? We think so. When faced with outbreaks of infectious and communicable diseases, public health immediately uses a well-established outbreak approach and protocol.

That approach is based on the fact that – left unchecked – infectious diseases and water and foodborne illnesses will spread within communities. Can that same approach also be applied to non-communicable health risks? There is evidence that some non-communicable threats to health, such as homicides, suicides, drug and alcohol use, smoking, depression, sleep disorders and even obesity, can also spread or be shared between people in a neighbourhood or community^{12,13,14,15} – as can happiness and healthy behaviours such as self-care, healthy eating and physical activity. The actions of a person's social network, as well as other pressures in the socio-economic environment, can have a significant effect on her or his choices and behaviours.

What would happen if public health units approached clusters of health inequities with the same sense of urgency as infectious diseases and applied the outbreak approach to improve health in neighbourhoods and populations?



THE OUTBREAK APPROACH

1

CONFIRM THE OUTBREAK
Are there more cases than expected in a given area over a given time period among a specific group of people?

2

ASSEMBLE AN OUTBREAK RESPONSE TEAM
Identify experts who can lead, organize and deliver the response.

3

ESTABLISH COMMUNICATIONS
Put in place a system to keep all partners – everyone who has a role to play – informed.

4

DEFINE THE PROBLEM/THREAT
Establish a case definition that includes standard criteria to determine whether someone is part of the outbreak (e.g., signs, symptoms, demographics). Understand the factors contributing to the outbreak.

5

IDENTIFY CASES AND CONTACTS
Who is directly affected (cases)? Who has had contact with those affected?

ADAPTED TO HEALTH INEQUITIES

Are certain neighbourhoods or populations facing health challenges that are systematic, unfair and avoidable? One suicide in a community may be an isolated problem, but a cluster of suicides may be a sign of social, economic and environmental disparities that are threatening mental health.

The causes of health inequity are often complex and inter-related: poverty plus lack of access to housing, services, healthy foods, employment and/or recreation. To respond, a social determinants of health outbreak team must draw experts from the community or population itself as well as city planners, a wide range of health, municipal and social services, and employers/the private sector.

Effective initiatives to end unfair health disparities have formal working groups that bring all partners together as well as other strategies, such as a lead agency and web sites, to keep everyone engaged and informed.

To reduce or eliminate disparities, it is critical to understand the signs, symptoms and risk factors. "Surveillance" for health disparities means understanding not only who is currently part of the outbreak, but who is at risk. For example, a community may identify a serious problem with obesity in children between the ages of eight and 14. However, to address the problem the community must look upstream to also identify younger children exposed to the same environmental factors who – if nothing is done – are at high risk of becoming obese.

With social determinants of health, cases and contacts are likely to include broader social networks. The problem, such as high alcohol use, may affect an entire community or certain groups or populations within that community based on age, gender, income, geography, ethnicity or other factors.

6

ORGANIZE DATA
Map the progress of the outbreak. When did it start? When will it peak? What is the epidemiologic curve?

7

DEFINE THE POPULATION AT RISK
Use the surveillance and other data to identify who you need to engage.

8

DEVELOP AND TEST HYPOTHESES
Determine what factors are driving the outbreak and how to reduce or eliminate them.

9

IMPLEMENT STRATEGIES
Implement strategies that will reduce the risk or enhance health. With an infectious or communicable disease, strategies might be immunization, treatment, isolation, education and/or measures to reduce or eliminate the causes of the outbreak (e.g., a food recall).

10

MONITOR THE RESPONSE
Continually collect data on cases to measure the impact of the strategies used and adjust them as required.

Mapping infectious diseases relies heavily on diagnoses. Mapping social health threats means looking at a wider range of data sources and understanding how social disadvantage will affect the "spread" of the health problem. For example, high rates of depression in a rural community may be associated with a lack of employment opportunities as well as increasing social isolation.

Effective interventions target specific priority groups, neighbourhoods or communities – focusing on those who are most likely to benefit.

Armed with a good understanding of the inter-connected factors that drive health disparities, the outbreak team can develop and test hypotheses. For example, if homicide rates are higher in communities where there is an increased likelihood of violence (e.g., access to guns, places where alcohol and drugs are misused), then reducing those other forms of violence may result in fewer homicides.

With health inequities, strategies might be community engagement/development, education, new services, better housing, recreation programs, social enterprises, economic development and structural/environmental changes.

The right data are key to monitoring the response to health inequities. Public health units will need regular information on both the determinants of health and health outcomes.



Using the Outbreak Approach to Look Beyond the Impact of Income on Health Equity

Low income is a key driver of health disparities – largely because it limits access to things that improve health, such as healthy food and stable housing. We are all aware of the growing gap between rich and poor in Ontario and most of the rest of the world. Work is currently underway at both the federal and provincial levels to try to reduce the income gap (see page 34). However, if we focus only on income as the driver of health equity, we risk missing other opportunities to improve health equity for people with low incomes.

AN OUTBREAK APPROACH TO REDUCING YOUTH ALCOHOL USE

When Iceland faced an outbreak of youth alcohol and drug use and public disorder, the country gathered data that identified the extent of the problem as well as factors that protected youth, including participating in organized activities such as sports and music three or four times a week, spending more time with their parents, feeling cared about at school and not being outdoors in the late evenings.

Working closely with political leaders, schools and the parent organizations required by law in every school, the Youth in Iceland initiative developed a range of interventions that included:

- more funding for organized sport, music, art, dance and other clubs
- banning tobacco and alcohol advertising
- raising the age limit to buy tobacco and alcohol
- an evening curfew for kids between the ages of 13 and 16
- agreements that parents signed saying they would, for example, spend more time with their children, not allow their kids to have unsupervised parties, not buy alcohol for minors and keep an eye on the well-being of other children

The impact? From 1998 to 2016, the percentage of 15- to 16-year-old Icelandic youth who were inebriated in the past 30 days dropped from 42 per cent to five per cent. Among youth, daily cigarette smoking dropped from 23 per cent to three per cent; and having used cannabis one or more times, fell from 17 per cent to five per cent.¹⁶

Health behaviours and outcomes in communities change over time but those changes can be difficult to detect or understand. For example, a neighbourhood survey may reveal that a significant proportion of residents have low incomes and there are high rates of alcohol use. However, a more detailed assessment might reveal that it is people in the neighbourhood with higher incomes who are drinking more¹⁷ and that the increase is associated with a recent

recession, a growing number of wealthy people retiring to the community and zoning changes that led to an increase in the number of restaurants and bars in the neighbourhood.

Using an outbreak approach to understand the problem will encourage us to look at all the inter-related social, economic and environmental factors that drive health inequities as well as the full range of strategies that could reduce or eliminate them. Armed with the right data, public health units can, for example, identify an outbreak of harmful alcohol use, its causes and strategies to reduce it. Using a community development approach to the situation described above, the public health unit would partner with key individuals, groups or organizations to assess the factors driving the increase in alcohol use and identify social network strategies to reduce alcohol consumption while also working with the municipality and community to develop more recreation opportunities for retirees and change zoning by-laws.

While income is a key driver of health inequity, some causes of premature death are not as income-sensitive as others. Figure 5 compares mortality rates for people in the second, third, fourth and fifth (most deprived) quartiles with those in the first (least deprived) quartile. It illustrates that deaths from homicide, suicide, cardiovascular disease and cancer occur across all socio-economic groups – from least deprived to most deprived. Rates of cardiovascular disease and cancer appear to be less affected by income than rates of suicide and homicide – perhaps due to more equitable access to treatment for those conditions.

Even though rates of suicide increase with material deprivation, they are still relatively high among people who are not socio-economically disadvantaged, which indicates that more than income is driving the risk of suicide.

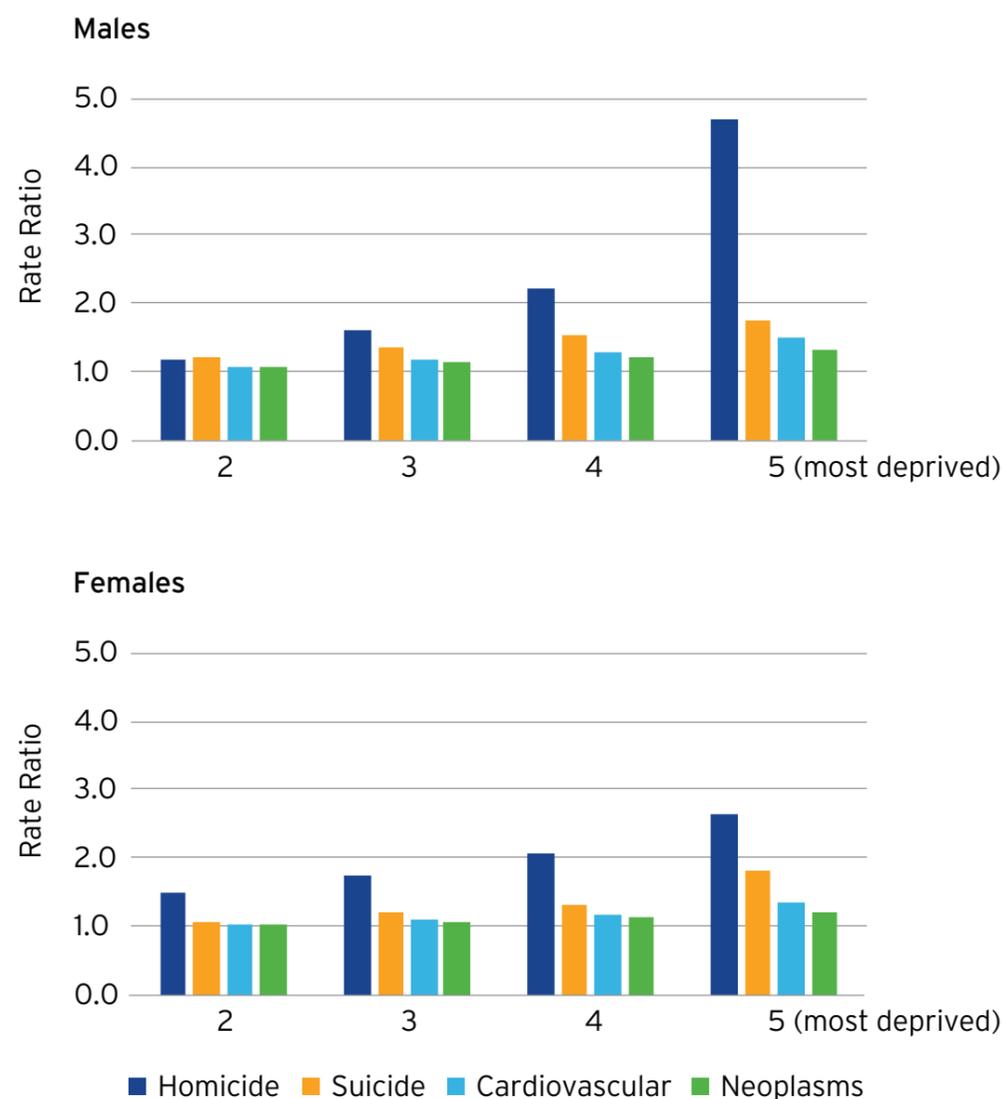
In fact, many of the inequities that put people at risk are outside the health system and involve more than income. A recent study on homicides in Ontario¹⁸ revealed that Canada ranks 5th in homicide rates among developed countries in the world. Between 1999 and 2012, Ontario lost 63,512 person years of life for males and 24,066 for females from homicide. Those most at risk are young males, between the ages of 15 and 29 – particularly those who live in socially disadvantaged neighbourhoods. Public Health Ontario identified a number of different cross-cutting social conditions and factors (in addition to income) that contribute to high rates of homicide, including low levels of education, more socially deprived neighbourhoods (e.g., poor housing, few jobs), exposure to places where alcohol and drugs are used in harmful ways, contact with people who have access to firearms and regular use of violence to solve conflicts. Some of those inequities may be more amenable to public health interventions than income gaps.



FIGURE 5. CAUSE-SPECIFIC MORTALITY & SOCIOECONOMIC STATUS

Homicide, suicide, cardiovascular disease, and cancer mortality rate ratios in Ontario by ON-Marg material deprivation index, 1999-2012.

Material Deprivation



Lachaud J, Donnelly PD, Henry D, Komar K, Calzavara A, Bornbaum C, Rosella L. (2017). A population-based study of homicide deaths in Ontario, Canada using linked death records. *Int J Equity Health*, 16:133.¹⁸
 Lachaud J, Donnelly PD, Henry D, Komar K, Fitzpatrick T, Calzavara A, Bornbaum C, Rosella L. (2017). Characterising violent deaths of undetermined intent: a population-based study, 1999-2012. *Inj Prev*, pii: injuryprev-2017-042376 [epub ahead of print].¹⁹

THE COST OF THE HEALTH DISPARITIES

In the case of homicides, the individual, community and societal costs are high. They include loss of life for the people killed and loss of opportunity – a future – for those who commit homicides. Family members and friends also experience high rates of depression, anxiety and post-traumatic stress among themselves. At the community level, high homicide rates generate fear, which keeps people from participating in social activities and leads to poorer mental health: homicides have a negative effect on sense of community and community cohesion. For society, high numbers of homicides increase costs for medical care, police and legal services and correctional services.

Faced with concerns about high rates of homicides, public health units could work with partners such as family members, community leaders, schools, social services agencies, police and correctional institutions to raise awareness of the problem and develop a mix of strategies to reduce homicides and related forms of personal violence, such as:

- reducing or eliminating environmental factors that may contribute to homicides such as inadequate housing, high social/cultural rates of alcohol or drug use, few places in the community for young men to go for healthy activities, a built environment that encourages or at least turns a blind eye to violence and/or lack of community policing
- offering programs/incentives to keep young men in school and teach them how to manage conflict
- creating more opportunities for young men to work and participate in non-violent social activities
- working with families of youth at risk to enhance parenting skills and develop a community-wide response to the problem
- providing upstream preventive programs, such as support for new moms, early childhood development programs and evidence-informed school-based programs such as “Roots of Empathy”,²⁰ a program offered across Canada for children from kindergarten to grade 8, which has been shown to significantly reduce levels of aggression and bullying among children while building social/emotional competence and increasing empathy



Greater health inequities in some neighbourhoods and populations may be partly explained by factors such as higher crime rates, few community resources, few stores selling affordable healthy foods, high rates of mental health issues and more social isolation – all problems that may be structurally easier and faster to “fix” than income gaps.

IMPROVING MENTAL HEALTH, REDUCING SUICIDES

In the spring of 2015, a local employer contacted the Windsor-Essex County Health Unit for support in addressing suicide. That workplace had lost several workers to suicide and was concerned about the mental health of its employees. The health unit looked at the data; there had been more than 200 deaths by suicide in the region between 2007 and 2011 – or about 40 a year. Most were males between the ages of 45 and 64. Between 2010 and 2015, the region also saw a marked 143 per cent increase in the number of youth (10 to 19 years old) visiting the emergency department to be treated for self-harm.

The health unit partnered with the Canadian Mental Health Association (CMHA) Windsor-Essex to launch a suicide prevention effort. They started with a workplace intervention and quickly expanded to a whole community approach that involved more than 50 partners (public and private). In September, they organized a Suicide Prevention Week to align with World Suicide Prevention Day, which was followed by other awareness events throughout the year. Different strategies were developed to reach populations at high risk, including first responders (police, paramedics, fire services), the LGBTQ community, post-secondary students, school-age kids and those in certain workplaces.

The group continues to meet, discussing ways to bring evidence-informed programs like *zero suicide* to the community and to create a suicide surveillance and response system. In addition, the public health unit, which coordinates the initiative with CMHA, will be monitoring the impact of the initiative and other efforts on suicide rates in the local community.

IV. Using Community Development to Reduce Inequities

Community development interventions that improve social connection and reduce isolation may have the potential to improve health and well-being and reduce health disparities – even in the absence of interventions that address underlying economic disparities. For example:

- People in disadvantaged neighbourhoods who are socially active and have many friends do not experience the same mental health problems or decrease in quality of life as those who are socially isolated.²¹
- The Toronto Neighbourhood Effects on Health and Well-being study found that women who were more socially connected (regardless of age, race, income, household size, education) were less likely to be overweight or obese – even when they lived in neighbourhoods that were less walkable or safe. That sense of belonging may create a sense of safety within the neighbourhood and encourage more outdoor physical activity.²²
- Higher levels of social connection can encourage positive behaviours and health outcomes: people who feel more socially connected are more likely to take steps to protect their health, such as getting their flu shot, having a mammogram and having their lipid levels tested.²³

Community development: The United Nations defines community development as “a process where community members come together to take collective action and generate solutions to common problems.”

The Health Benefits of Social Cohesion

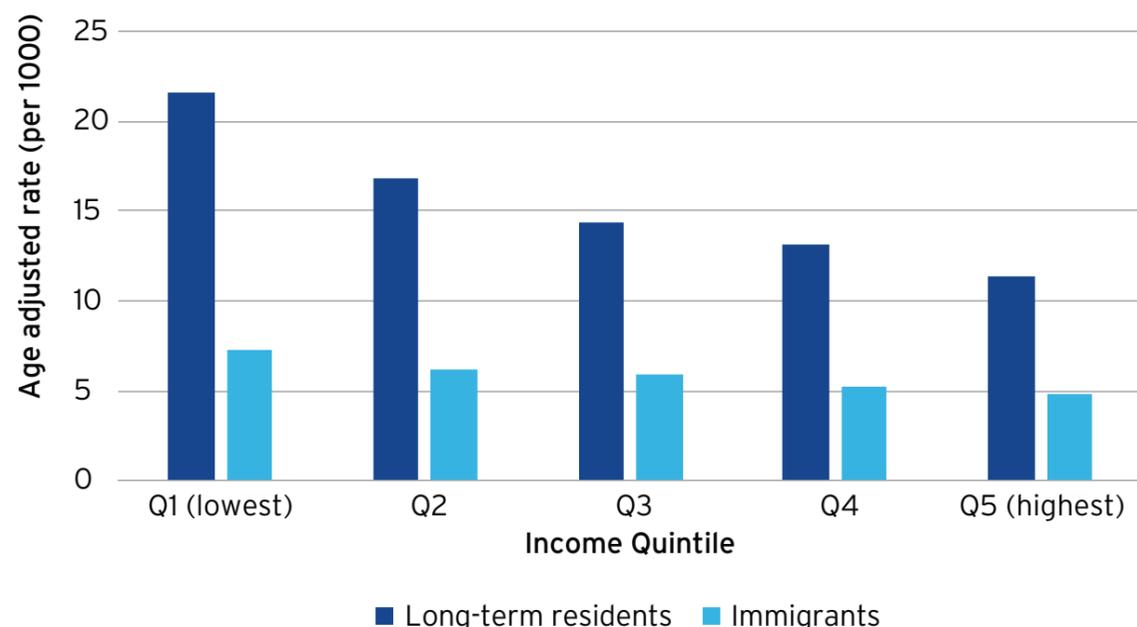
Newcomers are less likely than long-term residents to die prematurely – even though they are more likely to have lower incomes (see Figure 6). While many newcomers benefit from the “healthy immigrant effect”,²⁴ social cohesion may also have a powerful impact on newcomers’ ability to thrive in Ontario.

Neighbourhood cohesion is the perceived degree of connection among neighbours and people’s willingness to intervene for the common good. It is broader than individual social networks because it involves the community as a whole: residents feel they belong and trust their neighbours.²⁵



FIGURE 6. MORTALITY TRENDS BY IMMIGRANT STATUS

Premature mortality (death before age 75) rate (per 1,000 population) in Ontario, according to income quintiles and immigrant status, 2002-2012



Khan AM, Urquia M, Kornas K, Henry D, Cheng SY, Bornbaum C, Rosella LC. (2017). Socioeconomic gradients in all-cause, premature and avoidable mortality among immigrants and long-term residents using linked death records in Ontario, Canada. J Epidemiol Community Health, 71(7):625-632.²⁶

Social cohesion – a sense of belonging – is protective, even in the presence of other threats, such as low incomes.

For example, those who move into a neighbourhood with others who share their language and culture may have the additional advantage of feeling more connected. Their neighbours help them navigate the health and other systems.

On the other hand, newcomers who move into neighbourhoods where they do not feel as though they belong socially or ethnically are often isolated. They don't have as many friends, are less likely to be connected to their community, are more likely to be high users of health care services²⁷ and have poorer health outcomes.

Given the relationship between social cohesion and health, well-designed community development initiatives that improve social cohesion may help reduce the impact of social inequities.

Community Development in Action

Many Ontario public health units already take a community development approach to health equity. Examples are highlighted throughout this report. Here are three initiatives that targeted priority populations experiencing health disparities:

SUPPORTING YOUNG DADS: NIAGARA REGION PUBLIC HEALTH

According to a 2013 literature review, many young men under age 24 who become fathers want to maintain a relationship with the child's mother and be actively involved in their child's life. Fathers play a vital role in supporting their child's health and development, but becoming a father is challenging for young men, particularly those with low incomes: they report feeling alone. An environmental scan revealed a lack of information and services for these young fathers.

The public health unit asked young dads what they would find helpful. They wanted a free program that was flexible, frequent, provided incentives and opportunities to learn from other young dads and was led by a dad facilitator. The health unit worked with Strive Niagara (formerly Adolescent's Family Support Services of Niagara) to develop a 15-week peer-to-peer parenting and life skills program for young dads, which also provided transportation, childcare and food. The organizations reached out to community agencies to recruit participants.

An advisory committee of community partners, Dad Central Niagara, provides guidance.

“Once you are a father a lot of your real friends back off, so it's nice to make some friends that are actually in the same shoes as you and that have a child 'cause they will really understand you, regardless.”

The program, which has been running continuously since 2014, works because it takes a peer-based youth engagement approach and is facilitated by male and female staff who model a healthy relationship and have experience working with the youth population. Flexible and accessible (locations based on community consultation and capacity, later reinforced by mapping analytics), the program tries to reduce the stigma young dads feel by acknowledging their struggles. It also provides referrals to other community services if needed.

According to the evaluation of the pilot program, the young dads made significant gains in terms of knowledge, skills, confidence, stress reduction and support. They reported:

- being able to identify and respond to their children's needs
- knowing age-appropriate activities for their child
- being confident they could respond to situations that might arise
- learning new things and being more connected to community supports
- feeling supported by fellow participants



EMPOWERING ISOLATED WOMEN: HURON COUNTY HEALTH UNIT

The Huron County Health Unit identified isolated rural communities that were experiencing the impact of low income, social isolation, food insecurity, unstable housing and precarious employment. Working with the county's 40+ member anti-poverty coalition, Poverty to Prosperity, the public health unit identified and engaged women, as heads of households and potential community leaders, to identify priorities for themselves, their families and their communities. The public health unit then helped the women build their capacity to address those priorities. By removing barriers such as transportation and the cost of child care, the public health unit was able to engage the women in a range of planning and community development activities that have markedly decreased their sense of social isolation.

The women have formed a working group to realize their community goals. In addition, four of the women are now employed, one is enrolled in an early childhood education program and one has trained to be a Zumba instructor in the community. The women, who are working with community partners to develop a childcare facility, have also:

- developed connections and leadership skills
- formed relationships with municipal leaders
- participated in training and workshops
- developed and delivered a community survey
- felt supported by fellow participants
- helped the community legal clinic host a public meeting on tenant issues
- held a safe food handling course
- developed a plan for recreation activities for children and families
- held fundraisers to support recreation activities
- partnered with local service clubs and firefighters
- found a building to develop for community space

According to the public health unit, when communities are organized (social cohesion) and work in partnership to increase fairness, equity and social justice, it is possible to reduce the impact of the most detrimental social determinants of health. In this case, the women are more socially connected and less isolated, and the work-sharing and bartering that arises from trusting relationships has helped reduce the negative impacts of low incomes.

PROVIDING STIGMA-FREE SERVICES FOR GAY MEN: SUDBURY & DISTRICT HEALTH UNIT

Gay men living in smaller communities often face stigma and do not disclose their sexual orientation to their family physicians, many of whom are not aware of gay men's health needs. To improve access to services for gay men, the Sudbury & District Health Unit offers a range of confidential services, including sexual health counselling, testing for HIV and other sexually transmitted infections, free treatment for chlamydia, gonorrhoea and syphilis, and referrals. The health unit delivers services at the men's clinic offered at Réseau ACCESS Network, the community-based HIV organization. It also collaborates with other organizations that serve gay men, such as PRIDE events and transgender support groups.

To reach gay men, the health unit has a presence on Grindr, a geosocial media app used by gay, bisexual and other men who have sex with men. A public health nurse is available two to three days a week online to chat with the men, answer questions related to sexual health and encourage them to be tested regularly. The online outreach provides a safe, comfortable way for men to get information. Many men who access services at the health unit's sexual health clinic report that they first talked to the nurse on Grindr before going to the clinic.

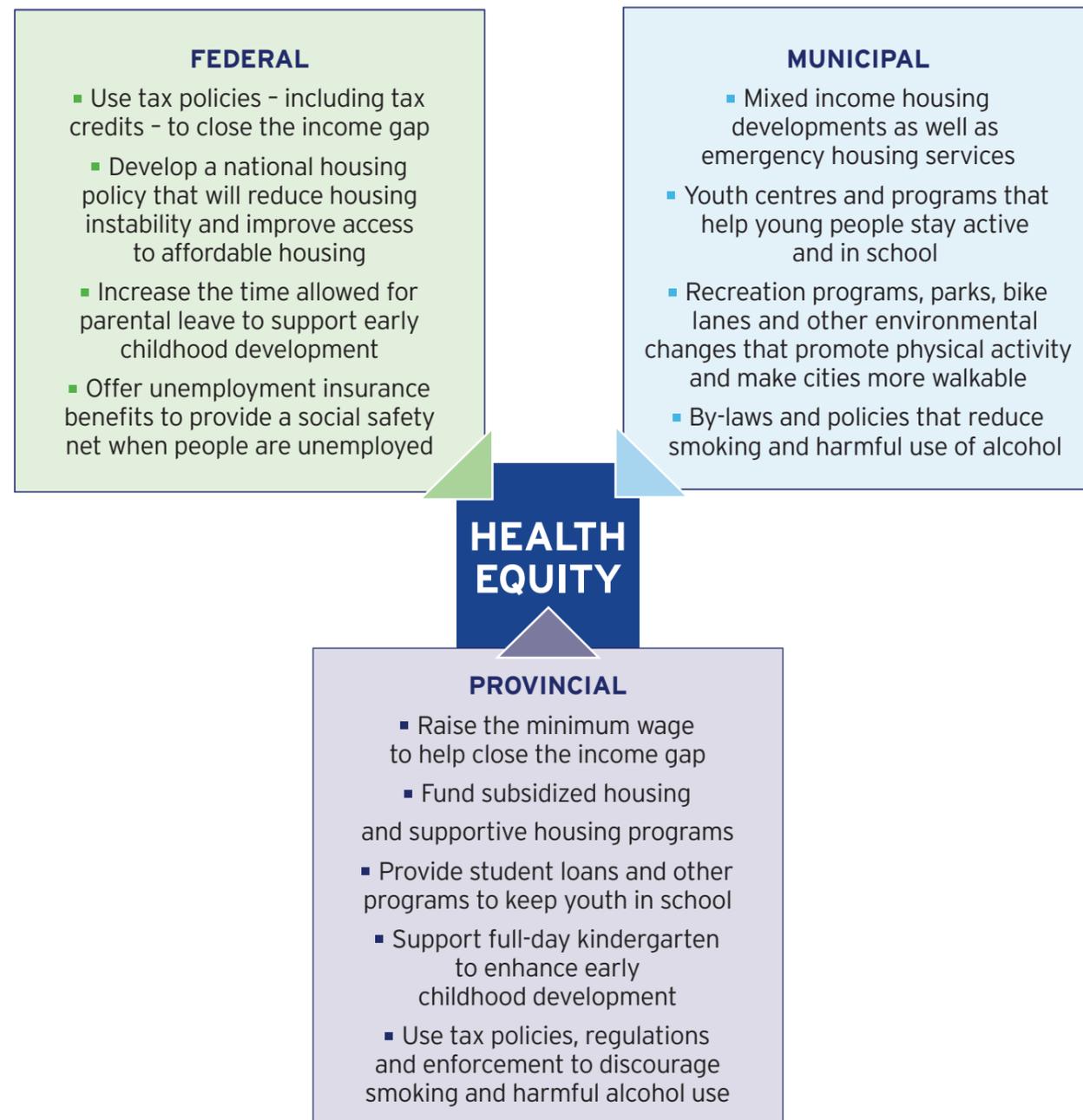
The impact? Services are more accessible. Men who are concerned about stigma can receive services online. Clients are referred to other services and community partners as needed. In the year after the health unit started this initiative, the number of men who have sex with men seeking point-of-care HIV testing increased by 133 per cent.



V. Pursuing Partnerships: A System-Wide Effort to Improve the Odds of Good Health

Public health units have a strong role to play in championing health equity at the local level. However, to achieve province-wide goals of good health for all, public health units must engage a wide range of partners and work together as a system.

The factors that influence health are complex, and each player and level of government has different levers and opportunities to improve health equity. The following are examples of steps that federal, provincial and municipal governments can or have taken to reduce or eliminate health disparities:



Provincial Initiatives

PROMOTING EQUITY IN THE WORKPLACE

Ontario's Fair Workplaces, Better Jobs Act, 2017 takes several steps to enhance health equity, including raising the minimum wage to \$14 on January 1, 2018, and to \$15 an hour on January 1, 2019, and mandating equal pay for part-time, temporary, casual and seasonal employees doing the same work as full-time employees. The legislation also gives workers up to 10 days' personal leave per calendar year and bans employers from requiring a note from employees who take personal emergency leave. It brings Ontario's vacation time in line with the national average and requires employers to pay employees for three hours of work if their shift is cancelled within 48 hours of its start time. These initiatives will reduce many of the structural inequities faced by people who have less education, work part-time and head single parent families.

REDUCING INCOME INEQUITIES

Ontario is pilot testing the impact of a basic income in three communities across Ontario.

Following a tax credit model, selected low-income families and individuals will receive a basic income (regardless of their employment status) of up to:

- \$16,989 for a single person, less 50 per cent of any earned income
- \$24,027 per year for a couple, less 50 per cent of any earned income
- an additional \$6,000 per year for a person with a disability.

"Engagement will continue with First Nations and Provincial and Territorial Organizations on a First Nations Basic Income Pilot."

In Hamilton, Brantford, Brant County, and Thunder Bay and surrounding area, the Pilot will select two groups of eligible applicants who will be asked to participate in the research study:

- The Basic Income Group** will receive monthly basic income payments for up to a three-year period.
- The Comparison Group** will not receive monthly basic income payments, but will actively participate in the research study.



In Lindsay, all eligible participants will be selected to participate in the Pilot. This will allow the researchers to study community-level impacts.

In all three sites, the Pilot will assess the impact of a basic income on:

- food security
- stress and anxiety
- mental health
- health and health care usage
- housing stability
- education and training
- employment and labour market participation

What we learn from the Ontario Basic Income Pilot will help inform the province's longer-term plans for income security reform.

Municipal governments, local health systems, local public health units and other community partners can implement targeted universal community development initiatives that reduce the impact of low incomes, social isolation and other health disparities, such as:

- Community gardens and farmers' markets that make healthy foods more accessible
- The Healthy Babies, Healthy Children program that helps families at risk develop parenting skills
- Youth centres and programs that help young people stay active and in school
- Mixed income housing developments as well as emergency housing services
- Recreation programs, parks, bike lanes and other environmental changes that promote physical activity and make cities more walkable
- Services for victims of domestic violence
- Community policing and crime prevention programs
- By-laws and policies that reduce smoking and harmful use of alcohol

Local Initiatives

BRINGING SERVICES TO A VULNERABLE NEIGHBOURHOOD: ALGOMA PUBLIC HEALTH

In 2014, the Sault Ste. Marie Police Service received a high volume of calls from people within a 1,000 metre radius of one intersection – mainly to deal with landlord and tenant disputes, domestic violence and child welfare issues. When the public health unit looked at data from local studies, it was clear that many people living in the downtown core had limited incomes, supports and resources. Many lived in substandard housing and had little access to recreational facilities. There was little business activity in the area, which only made the social problems worse. The answer? A long-term, comprehensive, social development approach to crime prevention.

“They treat you like a person when you come in. Have a cup of coffee, sit down, talk to us, what's your problem? Well, we can hook you up with this person or that person. They are actually picking up the phone saying we need someone from your department here now...They're actually working together.”

Eight agencies, including Algoma Public Health, initially agreed to participate with police in the initiative. Now, more than 30 service providers are involved. An existing building has been renovated and is now a Neighbourhood Resource Centre. The goal is to increase well-being in the neighbourhood and reduce/prevent crime by developing stronger relationships among neighbours, between neighbours and service organizations, and between organizations.

On an average day, the centre will respond to a range of individual needs, such as:

- an elderly woman in need of food - workers call the soup kitchen, pick up a box of food and deliver it to her home
- a young man who needs housing - workers give him an updated list of vacant apartments and a referral to the Ontario Works worker, who makes an appointment onsite to complete intake forms with him
- a sex trade worker seeking medical help - workers refer her to the health unit's clinic
- an older gentleman who doesn't have a doctor and needs care – workers refer him to the medical clinic

The impact? Services are more accessible and person-centred. Agencies work better together. Vulnerable residents face fewer barriers and feel more accepted. The community has a more positive perception of the neighbourhood.

In the public health unit's view, the initiative is successful because there is a community champion (Sault Ste. Marie Police Services), the neighbourhood residents have a strong voice, the process is not bureaucratic and the partners have created an environment of trust. Although the initial impetus for resource centre was crime prevention, the project has had a positive impact on access to services, health and well-being, and social cohesion.



PRESCRIPTIONS FOR SOCIAL DETERMINANTS OF HEALTH: NIAGARA REGION PUBLIC HEALTH

Paramedics called to deal with a medical problem often see vulnerable people struggling with social issues but do not have the time or resources to respond. To fill this gap, Niagara Region Public Health collaborated with Niagara Emergency Medical Services and INCommunities, the organizations that handle 211 calls from Niagara and the Central South area of Ontario. Paramedics were surveyed to measure their knowledge and awareness of the social determinants of health and health equity and given education, training and some new tools.

Paramedics now go out with a better understanding of the services in the community that can help people deal with social issues and a referral “prescription pad.” When they see someone with an unmet need, they can quickly write a “prescription” for the person to contact the 211 helpline. Paramedics report that they now regularly make 211 referrals as part of their calls. The process doesn’t add to their workload but it does connect vulnerable people with services. For example:

- A middle-aged woman with respiratory problems frequently called 911 because she was unable to afford her medications and puffers and had transportation issues accessing health care. Although she had refused a referral to the community care access centre (CCAC, now LHIN), she accepted the 211 referral.
- Paramedics saw an elderly man who fell because of physical problems accessing his home. Although the man was already a CCAC client for personal care and mobility issues, he and his family were willing to talk to 211 about other services that could help with the cost of accessibility equipment.
- A young couple that had just moved to Ontario were struggling to afford food because of the cost of over-the-counter insulin for the woman, who has diabetes. The 211 referral helped them find a family physician as well as financial assistance with medications and food stamps.
- Paramedics visited an ill, elderly woman who had become increasingly unable to perform daily tasks and is dependent on her children who had to visit more frequently. Paramedics referred the family to the 211 services and the CCAC for home care visits, respite care, personal care and meals. The family had no idea these services were available. They were grateful to be connected with these services.

This new 211 referral resource reduces health inequities by connecting vulnerable people to local programs and services they might not have known existed. It empowers people and allows them to reach out for confidential help when they are ready. It also helps paramedics recognize and address complex social issues and provide better customer service.

CHALLENGING A COMMUNITY TO IMPROVE CHILD HEALTH: THUNDER BAY DISTRICT HEALTH UNIT

Concerned about the health of children in some parts of the community, the Thunder Bay District Health Unit in partnership with the Thunder Bay HKCC Steering Committee used data from several sources (the Census, the Canadian Community Health Survey, the BORN information system on newborn health and local surveys) to paint a profile of child health by neighbourhood. The public health unit identified one particular neighbourhood that was struggling with high levels of social risk: limited access to healthy food, housing, transportation or recreation services and high rates of mental health problems, addictions and racism. To try to close the health gaps and improve the neighbourhood’s odds of good health, the public health unit brought neighbourhood champions, community organizations, health organizations, the local school board, police and researchers together. The Neighbourhood Community Partnership Program developed a mix of inter-related interventions including:

- working with the local Community Action Group to provide training and support community-driven initiatives
- offering capacity-building programs, such as cooking classes and a community kitchen
- subsidizing the cost of transportation to programs
- building on the local Good Food Box program to distribute locally produced vegetables and fruit to about 100 families in the neighbourhood

The program is currently being evaluated; however, early signs are that it is contributing to well-being. Said one community member:

“ When there’s a community kitchen, many of the people who come are the ones that are involved ... the hope is that it creates a community where everybody is looking out for everyone’s best interest, and they’re all interested in the development of the community both spiritually and materially: that the interactions are positive and the physical hardships are lessening.”



WORKING TOGETHER TO ADDRESS FOOD INSECURITY: PETERBOROUGH PUBLIC HEALTH

Curve Lake First Nation was facing a growing problem with food insecurity and high rates of type 2 diabetes, exacerbated by few good quality job opportunities. The Band Council responded by developing a food bank at its health centre but members recognized that more needed to be done to address the underlying factors. The Band Council also wanted to respond to its residents' desire for increased access to healthy foods including more locally grown vegetables and fruit.

Curve Lake First Nations staff worked with Nourish, a collaborative partnership of the YWCA Peterborough Haliburton, Peterborough Public Health (PPH) and GreenUP, which uses food to build healthy inclusive communities through eating, cooking, growing and advocating. Nourish, which grew out of the Peterborough Food Action Network (a working group of the Peterborough Poverty Reduction Network, chaired by the local medical officer of health), tries to increase access to healthy foods. Peterborough Public Health supports Nourish by co-leading the initiative, helping to develop the programs, establishing food literacy standards and sharing a teaching kitchen facility. Public health unit staff have also offered a five-week food literacy program called Come Cook With Us and food handler training/certification at Curve Lake First Nation.

The Nourish program at Curve Lake First Nation, developed with the community, included:

- community dinners to bring people together to discuss ideas for interventions and encourage a sense of belonging
- monthly Just Food boxes, which are now coordinated by Band staff
- a pop-up farmers' market that featured less commonly known local produce as well as how to use those products to make healthy, easy-to-make meals
- incentives such as Nourish Market Dollars given to people who participate in food literacy activities, which encourage them to try activities at home and nudge them to join other food programs
- growing, cooking and canning activities/workshops including collective kitchens
- programs for youth on healthier eating
- Nibi Giinwiindawan - We Are Water, an Indigenous Youth and Water Curriculum for children in grades 4 to 6 developed by Curve Lake Elders and other partners with financial support from Healthy Kids Community Challenge Peterborough

The impact? Services are more accessible and person-centred. Agencies work better together. Vulnerable residents face fewer barriers and feel more accepted. The community has a more positive perception of the neighbourhood.

Grounded in the principle of working with and not for communities, the Curve Lake Nourish collaboration ensures that both community members and decision-makers have a say and can shape the activities to meet the community's needs. The activities are also continually modified based on feedback from the community. A report card documenting the impact of Nourish at Curve Lake First Nation, along with three additional sites, will be released in November 2019.



VI. Championing Health Equity: Recommendations

The new Ontario Public Health Standards set out a clear role for the public health sector in health equity. Public health units, in collaboration with other local partners, are expected to champion and facilitate the types of analyses and public policies that reduce health inequities. Medical officers of health – the spokespeople for health in their communities – will actively promote health equity for the entire population. The Ministry of Health and Long-Term Care and Public Health Ontario will champion health equity at the provincial level and provide research, analyses and other supports to public health units.

However, the responsibility for achieving health equity reaches far beyond the public health sector and even the health sector. Other sectors, such as education and the environment, whose policies affect health, must be actively engaged.

With Patients First, Ontario has laid the groundwork for a system-wide approach to health equity. Health equity is now part of the mandate of LHINs. As part of public health transformation, public health units will now be working much more closely with LHINs and the LHIN sub-regions, providing data on the health of local communities and integrating population health initiatives into the health care system. To build on that foundation and enable the public health sector – in collaboration with other partners – to improve the odds of good health for everyone, the Chief Medical Officer of Health for Ontario recommends that the Government of Ontario take the following steps:

1 Support public health to identify “outbreaks” of health inequities and plan effective, sustainable interventions through community development

The goals are to understand the complex, inter-related factors that drive health disparities and find, adapt and adopt effective interventions that will improve health for the entire population/community while targeting those at highest risk. The public health sector should explore a wide range and mix of community development interventions that can influence the behavioural, economic, social and structural drivers of health and well-being. The impact of these interventions should be monitored and measured over time for their individual and combined impact.

2 Work system-wide and government-wide to improve health equity

We must work across the health system, across governments and across other sectors – break down silos – to achieve health equity. We need effective collaborative partnerships across all ministries and organizations that can help reduce or eliminate health disparities. This will mean reaching out and establishing new relationships: different parts of the health system must be able to talk to one another and to other sectors whose actions can influence health. As one of the case studies in this report noted, success depends on avoiding bureaucratic processes that, themselves, contribute to health inequity.



Ministries and organizations must be willing to reach beyond narrow mandates to create healthy communities. Community development solutions require engagement, first and foremost, of priority populations: those clusters of people most vulnerable to health disparities. They also require the active involvement of all other partners, and a willingness to look at all policies, programs and services through a health equity lens. The public health sector can champion a system-wide and government-wide approach by working with partners to identify the factors that influence health and engaging them in implementing effective interventions.

The goal of these partnerships is to implement effective community development interventions that reduce health disparities and even the odds for health for everyone.

Public health units are uniquely positioned to facilitate partnerships at the local level and promote collective action. They already have strong relationships with many organizations in their communities and can leverage these – building closer ties with their municipalities, LHINs, Indigenous communities and other intersectoral partners, including social services, housing programs and shelters, and police services – to improve health equity.

3 Provide data to understand health inequities and inform community development efforts

As part of their new relationship with LHINs and the LHIN sub-regions, public health units will be responsible for bringing information about community health to LHIN planning tables and advocating for the health care system to look beyond traditional health measures to the socio-economic factors that influence health.

To fulfill this role, public health units will need strong local data. In the 2015 report, the Chief Medical Officer of Health recommended that Ontario establish an ongoing health survey that will give all public health units, regardless of size or resources, access to timely high-quality information. Survey data will help public health units understand the complexity of health equity issues, identify priority issues and populations, and plan and evaluate public health programs and interventions.

In addition, the public health sector should make more effective use of other data to understand and improve health equity. Public health units will also need the capacity to apply new tools, such as the Relative Inequality Index (RII) and High Resource User Population Risk Tool (HRUPoRT), so they can develop health profiles for their communities that identify clusters of health disparities.

Armed with this information, public health units can work with their partners to reduce health disparities and improve health equity.

Strategic investments in health equity research, partnerships and data will help improve the odds for good health for all Ontarians. They will pay off in better health outcomes for individuals, healthier, happier, fairer communities and lower health care and social costs.

Every effort should be made to ensure the public health sector has the data, knowledge, skills and resources to champion health equity within the health system, with other ministries and levels of government and within communities.



References

- ¹ Ontario Ministry of Health and Long-Term Care. (2018). Health Equity Guideline. Queen's Printer for Ontario. Toronto, ON.
- ² National Collaborating Centre for Determinants of Health. (2014). Glossary of essential health equity terms. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.
- ³ Ontario Ministry of Health and Long-Term Care. (2018). Ontario Public Health Standards: Requirements for Programs, Services and Accountability. Queen's Printer for Ontario. Toronto, ON.
- ⁴ Ontario Ministry of Health. (1994). New Directions - Aboriginal Health Policy for Ontario. Queen's Printer for Ontario. Toronto, ON.
- ⁵ Allan B, & Smylie J. (2015). First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada. The Wellesley Institute. Toronto, ON.
- ⁶ Lavoie J, Gervais L, Toner J, Bergeron O, Thomas G. (2011). The Aboriginal health legislation and policy framework in Canada. National Collaborating Centre for Aboriginal Health. Prince George, BC.
- ⁷ Epstein D and Propublica. (2017). When Evidence Says No, but Doctors Say Yes. The Atlantic.
- ⁸ Smoke-Free Ontario Scientific Advisory Committee, Ontario Agency for Health Protection and Promotion (Public Health Ontario). (2017). Evidence to guide action: Comprehensive tobacco control in Ontario (2016). Queen's Printer for Ontario. Toronto, ON.
- ⁹ Population Health Analytics Laboratory. (2017). Ontario Atlas of Adult Mortality 1992-2014. Trends in Local Health Integration Networks. University of Toronto.
- ¹⁰ Rosella LC, Calzavara A, Frank JW, Fitzpatrick T, Donnelly PD, Henry D. (2016). Narrowing mortality gap between men and women over two decades: a registry-based study in Ontario, Canada. *BMJ Open*, 6(11): e012564
- ¹¹ T, Wodchis WP, Calzavara A, Manson H, Goel V. (2014). High-cost health care users in Ontario, Canada: demographic, socio-economic and health status characteristics. *BMC Health Serv Res*, 14:532.
- ¹² Rosenquist JN, Murabito J, Fowler JH, Christakis NA. (2010). The spread of alcohol consumption behavior in a large social network. *Ann Intern Med*, 152(7):426-33.
- ¹³ Christakis NA, Fowler JH. (2008). The collective dynamics of smoking in a large social network. *N Eng J Med*, 358(21):2249-58.
- ¹⁴ Mednick SC, Christakis NA, Fowler JH. (2010). The Spread of Sleep Loss Influences Drug Use in Adolescent Social Networks. *PLoS ONE*, 5(3):e9775.
- ¹⁵ Christakis NA, Fowler JH. (2007). The Spread of Obesity in a Large Social Network over 32 Years. *N Engl J Med*, 357:370-379.
- ¹⁶ Young E. (2017). How Iceland Got Teens to Say No to Drugs: Curfews, sports and understanding kids brain chemistry have all helped dramatically curb substance abuse in the country. The Atlantic.
- ¹⁷ Cancer Care Ontario, Ontario Agency for Health Protection and Promotion (Public Health Ontario). (2012). Taking action to prevent chronic disease: recommendations for a healthier Ontario. Queen's Printer for Ontario. Toronto, ON.
- ¹⁸ Lachaud J, Donnelly PD, Henry D, Komar K, Calzavara A, Bornbaum C, Rosella L. (2017). A population-based study of homicide deaths in Ontario, Canada using linked death records. *Int J Equity Health*, 16:133.
- ¹⁹ Lachaud J, Donnelly PD, Henry D, Kornas K, Fitzpatrick T, Calzavara A, Bornbaum C, Rosella L. (2017). Characterising violent deaths of undetermined intent: a population-based study, 1999-2012. *Inj Prev*, pii: injuryprev-2017-042376 [epub ahead of print].
- ²⁰ Roots of Empathy. (2017). Accessed 2017 from: <http://www.rootsofempathy.org>
- ²¹ Klijs B, Mendes de Leon CF, Kibele EU, Smidt N. (2017). Do social relations buffer the effect of neighborhood deprivation on health related quality of life? Results from the LifeLines Cohort Study. *Health Place*, 44: 43-51.
- ²² Guilcher SJ, Kaufman-Shriqui V, Hwang J, O'Campo P, Matheson FI, Glazier RH, Booth GL. (2017). The association between social cohesion in the neighborhood and body mass index (BMI): An examination of gendered differences among urban-dwelling Canadians. *Prev Med*, 99:293-298.
- ²³ Kim ES, Kawachi I. (2017). Perceived Neighborhood Social Cohesion and Preventive Healthcare Use. *Am J Prev Med*, 53(2):e35-e40.
- ²⁴ Vang ZM, Sigouin S, Flenon A, Gagnon, A. (2017). Are immigrants healthier than native-born Canadians? A systematic review of the healthy immigrant effect in Canada. *Ethn Health*, 22(3):209-241.
- ²⁵ Kawachi I, Berkman L. (2000). Social cohesion, social capital and health. In *Social Epidemiology*. (pp. 174-190). Oxford University Press. New York, NY.
- ²⁶ Khan AM, Urquia M, Kornas K, Henry D, Cheng SY, Bornbaum C, Rosella LC. (2017). Socioeconomic gradients in all-cause, premature and avoidable mortality among immigrants and long-term residents using linked death records in Ontario, Canada. *J Epidemiol Community Health*, 71(7):625-632.
- ²⁷ Fitzpatrick T, Rosella L, Calzavara A, Petch J, Pinto A, Manson H, Goel C, Wodchis WP. (2015). Looking beyond income and education - Socioeconomic status gradients among future high cost users of health care. *Am J Prev Med*, 49(2):161-71.



Acknowledgements

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Other: Ministry of Community and Social Services, Ministry of Health and Long-Term Care

Appendix

Ontario Health Units with Vacant Medical Officer of Health (MOH) Positions* Filled By Acting MOHs as of January 9, 2018

- Grey Bruce Health Unit
- Haldimand-Norfolk Health Unit
- Hastings & Prince Edward Counties Health Unit
- Huron County Health Unit
- City of Ottawa Health Unit
- Oxford County Health Unit
- Porcupine Health Unit
- Renfrew County & District Health Unit
- Timiskaming Health Unit
- Windsor-Essex County Health Unit

Total = 10 Health Units with MOH Vacancies

**Under 62. (1)(a) of the Health Protection and Promotion Act, every board of health shall appoint a full-time medical officer of health. **Vacancies may include positions filled by qualified physicians awaiting appointment by boards of health and ministerial approval.*

Ontario Public Health Units with vacant AMOH positions* as of January 9, 2018

- Durham Region Health Department
- Grey Bruce Health Unit
- City of Hamilton Health Unit
- City of Toronto Health Unit
- York Region Health Unit

Total = 5 Health Units with AMOH Vacancies**

**Under 62. (1)(b) of the Health Protection and Promotion Act, every board of health may appoint one or more associate medical officers of health. **Vacancies may include less than or more than one FTE position per health unit and include positions filled by qualified physicians awaiting appointment by boards of health and ministerial approval.*



Notes



alPHa's members are
the public health units
in Ontario.

alPHa Sections:

Boards of Health
Section

Council of Ontario
Medical Officers of
Health (COMOH)

**Affiliate
Organizations:**

Association of Ontario
Public Health Business
Administrators

Association of
Public Health
Epidemiologists
in Ontario

Association of
Supervisors of Public
Health Inspectors of
Ontario

Health Promotion
Ontario

Ontario Association of
Public Health Dentistry

Ontario Association of
Public Health Nursing
Leaders

Ontario Dietitians in
Public Health

March 13, 2018

Dr. David Williams
Chief Medical Officer of Health
393 University Ave,
21st Floor
Toronto, ON M5G 2M2

Dear Dr. Williams,

Re: 2016 Annual Report of the Chief Medical Officer of Health

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health and Affiliate organizations, I am writing to express our appreciation and congratulations for your 2016 Annual Report to the Legislative Assembly, *Improving the Odds: Championing Health Equity in Ontario*.

We agree that all Ontarians should have the same opportunity to achieve optimal health irrespective of circumstance, and we agree that the public health sector has a crucial role to play in generating the conditions that will make this so.

As you observe throughout this report, there are many challenges to truly achieving health equity, and it will require a dedicated, multi-sectoral effort to meet them. Public health is indeed well-situated to lead such an effort, as health equity has long been recognized by our sector as the upstream solution to a multitude of downstream problems.

With the addition of the Health Equity Standard to the 2018 Ontario Public Health Standards and the related mandate to bring the population health perspective to the broader health system, we believe that there is an important opportunity before us to make far more substantial strides in the near term.

We therefore fully support your recommendations, which call on the government to support and invest in a system-wide approach to assessing the impact of health inequities, developing partnerships, and implementing interventions that will improve the odds of good health for all Ontarians.

Taking an "outbreak approach" to reducing inequities is an apt and creative framing of our activities, and we look forward to applying and sharing our expertise as we continue to champion health equity in Ontario.

Yours sincerely,



Carmen McGregor
alPHa President

COPY: Hon. Kathleen Wynne, Premier of Ontario; Hon. Helena Jaczek, Minister of Health and Long-Term Care; Dr. Bob Bell, Deputy Minister, Health and Long-Term Care; Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care, Population and Public Health Division.

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HOUSE OF COMMONS
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February 5, 2018

Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health and Chief Executive Officer
Sudbury & District Health Unit
1300 Paris St.
Sudbury, ON P3E 3A3

SUDBURY & DISTRICT HEALTH UNIT	
Medical Officer of Health and CEO	
FEB 20 2018	
Environ Health _____	RRED _____
CFS _____	SEU _____
Corporate Services _____	Board _____
Health Promotion _____	Committee _____
File () Circulate () Return () F.Y.I ()	

Dear Dr. Sutcliffe,

Thank you very much for including me in your letter of December 5th to Premier Wynne concerning resolution #48-17.

I agree that more needs to be done to ensure those receiving social assistance have access to healthy, nutritious food. I appreciate you taking the time to keep me apprised of the recommendations and opinions of the Board of Health for the Sudbury & District Health Unit.

Thank you again for including me in your correspondence.

Sincerely,

Carol Hughes, MP
Algoma-Manitoulin-Kapusksing



carol.hughes@parl.gc.ca
<http://carolhughes.ndp.ca>



February 15, 2018

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

Dear Premier Wynne:

Re: Food Insecurity/Nutritious Food Basket Costing

On December 15, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Sudbury and District Health Unit regarding food insecurity and nutritious food basket costing. The following motion was passed:

Moved by: Stewart Halliday

Seconded by: David Shearman

“THAT, the Board of Health support item 8.3, Sudbury and District Board of Health resolution regarding food insecurity and nutritious food basket costing.”

Carried

Sincerely,

A handwritten signature in black ink, appearing to read "H. Lynn".

Hazel Lynn, MD, FCFP, MHSc
Acting Medical Officer of Health
Grey Bruce Health Unit

Cc: All Ontario Boards of Health

Encl.

Page 93 of 202

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*La Corporation de la Municipalité de / The Corporation of the Municipality of
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SENT ELECTRONICALLY BY E-MAIL TO sutcliffep@phsd.ca

Monday, March 26th, 2018

Public Health Sudbury & Districts
c/o Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health and Chief Executive Officer
1300 Paris Street
Sudbury, Ontario
P3E 3A3

RE: SUPPORT RESOLUTION FOR NUTRITIOUS FOOD BASKET

Dear Mrs. Sutcliffe,

At its Regular Meeting of Council held on March 21st, 2018, Council for the Municipality of St.-Charles passed the enclosed resolution, which is self-explanatory.

Please feel free to communicate with our office should you require anything further.

Respectfully,



Jérôme Courchesne
Clerk
Municipality of St.-Charles

Encl.

THE MUNICIPALITY OF ST.-CHARLES RESOLUTION

Date: 21 Mar 2018

No: 2018-80

Moved By: Moved by: Councillor *Loftus*
Seconded by: Councillor *Lafleur*

RESOLUTION: *Public Health Sudbury + Districts*

WHEREAS ~~the Sudbury & District Board of Health~~ has monitored the cost of healthy eating on an annual basis in accordance with the Nutritious Food Basket Protocol and the Population Health Assessment and Surveillance Protocol per the Ontario Public Health Standards 2008; and

WHEREAS the draft Standards for Public Health Programs and Services 2017 do not include the Nutritious Food Basket Protocol which is a concern because food costing data gathered by public health units each year is important for policy and program development; and

WHEREAS the Canadian Community Health Survey's Household Food Security Survey Module (HFSSM) is a measure of food security but is not always a mandatory core module; and

WHEREAS regular and consistent monitoring of household food insecurity is essential for evidence-informed policy decision making; and

Public Health Sudbury + Districts
 WHEREAS ~~the Sudbury & District Board of Health~~ requests that social assistance rates be increased immediately to reflect the cost of the Nutritious Food Basket and local housing costs; and

Public Health Sudbury + Districts
 WHEREAS ~~the Sudbury & District Board of Health~~ advocate to the Province to ensure continued consistent local surveillance and monitoring of food costing by public health units through the continuation of a Nutritious Food Basket Protocol and Guidance document.

THEREFORE BE IT RESOLVED THAT the Municipality of St.-Charles agrees with regular and consistent monitoring of the Nutritious Food Basket and local housing costs in order to make evidence-based policy decisions at a provincial and local level; and

Public Health Sudbury + Districts
 FURTHER THAT a copy of this resolution be forwarded to ~~the Sudbury & District Board of Health~~.

Recorded Vote Requested by:		
	Yea	Nay
Lemieux	_____	_____
Lafleur	_____	_____
Loftus	_____	_____
Belanger	_____	_____
Schoppmann	_____	_____

Paul Schoppmann

MAYOR

Deferred ___ Tabled ___ Lost ___ Carried

Declaration of Pecuniary Interest:

 Disclosed his/her/their interest(s), vacated he/her/their seat(s), abstained from discussion and did not vote



February 15, 2018

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:

Re: Alcohol Retail Sales

On November 24, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence items from Northwestern Health Unit, Algoma Public Health and Thunder Bay District Health Unit regarding alcohol retail sales. The following motion was passed:

Moved by: Mitch Twolan

Seconded by: Mike Smith

“THAT the Board of Health endorse correspondence items 8.5, 8.6 and 8.11 from Northwestern Health Unit, Algoma Public Health and Thunder Bay District Health Unit regarding provincial action to address the potential health harms from the modernization of alcohol retail sales.”

Carried

Sincerely,

A handwritten signature in black ink, appearing to read "Hazel Lynn". The signature is fluid and cursive, with a large initial "H" and "L".

Hazel Lynn, MD, FCFP, MHSc
Acting Medical Officer of Health
Grey Bruce Health Unit

Cc: All Ontario Boards of Health

Encl.

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February 15, 2018

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:

Re: Smoke-Free Modernization

On November 24, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Simcoe Muskoka District Health Unit regarding Smoke-Free Ontario Modernization. The following motion was passed:

Moved by: Mitch Twolan

Seconded by: Mike Smith

“THAT the Board of Health endorse Simcoe Muskoka District Health Unit’s recommendation’s to the province regarding the Smoke-Free Ontario Modernization strategy and commitment to the Tobacco Endgame for Canada.”

Carried

Sincerely,

A handwritten signature in black ink, appearing to read "Hazel Lynn". The signature is fluid and cursive, with a large initial "H" and "L".

Hazel Lynn, MD, FCFP, MHSc
Acting Medical Officer of Health
Grey Bruce Health Unit

Cc: All Ontario Boards of Health

Encl.

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February 15, 2018

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

Dear Premier Wynne:

Re: Vaccine Recommendations for Childcare Workers

On October 27, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Durham Region Public Health and the Council of Ontario Medical Officers of Health regarding vaccine recommendations for childcare workers. The following motion was passed:

Moved by: Alan Barfoot

Seconded by: Arlene Wright

“WHEREAS, it is the position of the Grey Bruce Health Unit to support vaccines for high risk groups and those working with high risk groups, which would include child care workers, and

WHEREAS, it is the position of the Health Unit that access to services should not be restricted due to financial hardship,

THEREFORE BE IT RESOLVED THAT, the Board of Health supports the recommendations of the Council of Ontario Medical Officers of Health with respect to providing publically funded vaccines for child care workers.”

Carried

Sincerely,

A handwritten signature in black ink, appearing to read "Hazel Lynn".

Hazel Lynn, MD, FCFP, MHSc
Acting Medical Officer of Health
Grey Bruce Health Unit

Cc: All Ontario Boards of Health

Encl.

Working together for a healthier future for all.

March 13, 2018

Honourable Helena Jaczek
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Jaczek:

Re: 2018 Annual Service Plan including the 2018 Budget for the Haliburton, Kawartha, Pine Ridge District Health Unit

At its meeting on February 15, 2018, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit approved its 2018 Annual Service Plan (Plan) including the 2018 Budget. As the Board discussed the Plan and Budget, it expressed its concerns that the Ministry of Health and Long-Term Care (MOHLTC) had frozen base funding at 2014 levels for our Health Unit and others. Of course, the Board recognizes that there have been additions to base funding for targeted purposes such as the recent Harm Reduction Program Enhancement funding. Boards of health continue to face significant financial pressures as costs increase with no corresponding increase in base funding going into this fourth-year post-budget freeze. Locally, our obligated municipalities have increased their share of the Board's base funding every year to the point that now the ratio of cost-shared base funding is 29% municipal to the MOHLTC's 71%. We understand that the majority of Ontario boards of health are in a similar position.

As you know, the past couple of years have been a period of significant transformation for Ontario boards of health with the release of the new Ontario Public Health Standards (OPHS), amended and new protocols and guidelines to support the new OPHS and amendments to the *Health Protection and Promotion Act, 1990* and many of its Regulations. The Board is most appreciative of the Harm Reduction Program Enhancement funding, and other minor adjustments to base funding. However, the Board is concerned about the MOHLTC's increasing expectations regarding the new/amended OPHS, protocols and guidelines including those pertaining to Infection Prevention and Control Lapse investigations, engagement with the Local Health Integration Networks, the new School Health Program Standard, the Healthy Environments Program Standard requirement for health impact assessment related to climate change, and follow-up of hepatitis C cases to name a few, as well as the role of public health regarding opioids and the new cannabis legislation. Doing more with less is causing strain on staff and the Board is concerned about the psychological and physical well-being of Health Unit employees in light of ever-increasing requirements and our ability to deliver programs and services.

The Board has implemented many initiatives over the past four years to address the provincial funding shortfall including closing branch offices and renegotiating leases as well as utilizing technological solutions where feasible to address telephone and fax as well as organizational meetings. The Board recognizes its important role in community-based health promotion, disease prevention and health protection over a large geographic area with a low population density. The Board values its relationships with the broader health sector as well as its many community partners and stakeholders including local municipalities, school boards, children's aid societies, law enforcement, non-governmental

.../2

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Honourable Helena Jaczek
March 13, 2018
Page 2

agencies and community coalitions and wishes to build on these relationships to implement the new OPHS. The Board is concerned that if the provincial share of the base budget remains frozen, decisions will need to be made regarding delivery of essential programs and services and the remaining programs may erode making them harder to re-build when not maintained at optimal levels.

The Board has again approved a 2% municipal increase for the Health Unit this year and has requested a 2% increase in its base funding from the MOHLTC in addition to some one-time requests to facilitate addressing new program requirements. Municipalities are also facing increasing cost pressures and may be challenged to continue to offset provincial funding with enhanced municipal support in the future. The Board respectfully requests that the MOHLTC approve its 2018 Annual Service Plan including the 2018 Budget. Lastly, with this request to approve the proposed budget, the Board would greatly appreciate earlier budget approval than the historic September to November timeline so that the Health Unit can effectively plan and implement one-time funding approvals.

Sincerely

BOARD OF HEALTH FOR THE HALIBURTON,
KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT



Mark Lovshin
Chair, Board of Health

ML/ALN/MCM:ed

Copy: Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Lou Rinaldi, MPP, Northumberland-Quinte West
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
City of Kawartha Lakes
Haliburton County
Northumberland County
Association of Municipalities of Ontario
Association of Local Public Health Agencies
Ontario Boards of Health
Eastern Ontario Wardens' Caucus

alPHa's members are
the public health units
in Ontario.

alPHa Sections:

Boards of Health
Section

Council of Ontario
Medical Officers of
Health (COMOH)

**Affiliate
Organizations:**

ANDSOOHA - Public
Health Nursing
Management

Association of Ontario
Public Health Business
Administrators

Association of
Public Health
Epidemiologists
in Ontario

Association of
Supervisors of Public
Health Inspectors of
Ontario

Health Promotion
Ontario

Ontario Association of
Public Health Dentistry

Ontario Dietitians in
Public Health

February 27, 2018

Hon. Helena Jaczek
Minister of Health and Long-Term Care
80 Grosvenor Street
5th Floor, Hepburn Block
Toronto, ON M7A 1R3

Dear Minister Jaczek,

Re: Welcome from the Association of Local Public Health Agencies (alPHa)

On behalf of the Association of Local Public Health Agencies (alPHa) and its Council of Ontario Medical Officers of Health, Boards of Health Section and Affiliate Organizations, we are writing to congratulate you on your appointment as Ontario's Minister of Health and Long-Term Care, and to re-introduce you to our Association.

alPHa, as you are aware, is a non-profit organization that provides leadership to the boards of health and public health units in Ontario. Membership in alPHa is open to the 36 public health units in Ontario and we work closely with board of health members, medical and associate medical officers of health, and senior public health managers in each of the public health disciplines – nursing, inspections, nutrition, dentistry, health promotion, epidemiology and business administration.

The Association also collaborates with governments and other health organizations, advocating for a strong, effective and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention, and surveillance services in all of Ontario's communities.

A short while ago, alPHa sent Ontario's political party leaders, health critics, and the previous Minister of Health and Long-Term Care a set of policy priorities and key messages in anticipation of the 2018 provincial election on Tobacco Endgame, Oral Health for Adults, Universal Pharmacare, Cannabis Legalization, and Opioids Strategy. I would like to share these with you and copies are attached.

We look forward to discussing the transformation of Ontario's health system with you. We are pleased to extend an invitation to you to meet with our Board of Directors during its next meeting that is taking place in Toronto on April 13th 2018. We would also be pleased to have members of our Executive meet you and your staff at another time. To confirm your availability for our Board of Directors' meeting or to schedule a meeting, please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 647-325-9594.

Sincerely,



Carmen McGregor
President

Copy: Dr. Bob Bell, Deputy Minister, Health and Long-Term Care; Dr. David Williams, Chief Medical Officer of Health; Roselle Martino, Assistant Deputy Minister, Population and Public Health Division; Dr. Penny Sutcliffe, Chair, Council of Ontario Medical Officers of Health (COMOH); Trudy Sachowski, Chair, alPHa Boards of Health Section.

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Ontario

Health Promotion
Ontario

Ontario Association of
Public Health Dentistry

Ontario Association of
Public Health Nursing
Leaders

Ontario Dietitians in
Public Health

February 28, 2018

Hon. Helena Jaczek
Minister of Health and Long-Term Care
10th Flr, 80 Grosvenor St,
Toronto, ON M7A 2C4

Dear Minister Jaczek,

Re: Engagement with the Council of Ontario Medical Officers of Health

On behalf of the Council of Ontario Medical Officers of Health (COMOH), a section of the Association of Local Public Health Agencies (alPHa), please accept my congratulations on your appointment as Minister of Health and Long-Term Care for Ontario. Ontario's Medical and Associate Medical Officers of Health very much look forward to working with you and supporting you in this new role.

Although we are aware that you have great familiarity with COMOH and with local public health, we would like to follow up on the alPHa letter that you would have received recently to request a meeting to review with you the specific COMOH perspectives on a number of key public health issues.

Investing upstream in public health arguably has never been more important. Our communities are facing mounting pressures related to opioids and other drugs, mental health, climate change, infection prevention and control issues, aging populations and more. Further, the need to address growing health inequities (including working with Indigenous populations) is critical and the public health role in championing this work was highlighted in the just-released 2016 Annual Report of the Chief Medical Officer of Health and is now embedded in the revised Ontario Public Health Standards.

In this dynamic context, we highlight with some urgency the fact that local boards of health are facing significant financial pressures. These pressures are particularly acute and relate to the now three-year funding freeze experienced by most boards of health combined with the new and increased expectations on us and the growing needs of our local communities as referenced above.

In response to these pressures, I am pleased to share that COMOH recently gathered to explore issues related to the sustainability of Ontario's public health system. Our desire is to be solution-oriented and pursue local and regional innovative solutions to preserve and reinforce the important contributions we make to Ontarians' health. We are keen to pursue our collective interest in this continuous quality improvement work and to share our thinking with you.

In closing, Minister, please accept our congratulations to you on your new appointment and our desire to support your work for Ontarians' health. Your prior leadership in public health and in Ontario's poverty reduction strategies provide an important broad perspective on health and its determinants that will serve our province well.

We look forward to hearing from you and to scheduling a meeting. Gordon Fleming can be reached at gordon@alphaweb.org to coordinate calendars.

Sincerely,

A handwritten signature in black ink, appearing to be 'Penny Sutcliffe', with a long horizontal line extending to the right.

Dr. Penny Sutcliffe,
Chair, Council of Ontario Medical Officers of Health

COPY: Hon. Kathleen Wynne, Premier of Ontario
Dr. Bob Bell, Deputy Minister, Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care, Population and Public Health Division
Carmen McGregor, alPHa President
Loretta Ryan, Executive Director, Association of Local Public Health Agencies



FEB 23 2018

HLTC2966MC-2017-8814

Ms. Carmen McGregor
President
Association of Local Public Health Agencies
1306 – 2 Carlton Street
Toronto ON M5B 1J3

Dear Ms. McGregor:

Thank you for your interest in the report of the Minister's Expert Panel on Public Health. I regret that my schedule does not permit me to meet with you. However, I would like to respond to your concerns.

First, I would like to assure you that we have not made any decisions about the recommendations outlined in the panel's report. The report captures the independent views and recommendations of the expert panel, and my ministry is currently reviewing the panel's advice and the feedback we have received from stakeholders. We will carefully consider all input prior to making any decisions.

We established the Expert Panel on Public Health in January 2017 to strengthen and increase the integration of the public health sector within the rest of the health care system. The panel was asked to provide advice on structural, organizational and governance changes for public health to support greater integration with other health system partners.

The expert panel's report recommends strengthening public health's relationships with primary care, community care and other partners, so that all health care services are more responsive to community needs. It states that stronger relationships between public health and other partners will make it easier to integrate health protection and promotion into all health care services. The recommendations also focus on preserving the independent public health voice and core public health functions.

I appreciate your interest, and I will keep your concerns in mind as we work to strengthen the public health sector and improve public health capacity and delivery in Ontario.

Yours sincerely,

Dr. Eric Hoskins
Minister

Ministry of Health
and Long-Term Care

Office of the Minister

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Ministère de la Santé
et des Soins de longue durée

Bureau du ministre

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iApprove-2017-01730

MAR 22 2018

Mr. René Lapiere
Chair, Board of Health
Sudbury and District Health Unit
1300 Paris Street
Sudbury ON P3E 3A3

Dear Mr. Lapiere:

I am pleased to advise you that the Ministry of Health and Long-Term Care will provide the Board of Health for the Sudbury and District Health Unit up to \$39,400 in additional one-time funding for the 2017-18 funding year to support the provision of public health programs and services in your community.

The Assistant Deputy Minister of the Population and Public Health Division will write to the Sudbury and District Health Unit shortly concerning the terms and conditions governing this funding.

Thank you for your dedication and commitment to Ontario's public health system.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Jaczek".

Dr. Helena Jaczek
Minister

c: Dr. Penny Sutcliffe, Medical Officer of Health, Sudbury and District Health Unit

March 28, 2018

Premier Kathleen Wynne
Legislative Building
Queen's Park
Toronto, ON M7A 1A1

Re: Dedicated funding for local Public Health agencies from cannabis sales taxation revenue

Dear Premier Wynne,

At its meeting on March 06, 2018, the Hastings Prince Edward (HPEPH) Board of Health passed the following motion:

THAT the HPEPH Board of Health urge the provincial government to dedicate a portion of the cannabis excise tax revenue from the federal government to local Public Health agencies in Ontario.

On December 12, 2017, the Federal Government announced that the revenue generated from the taxation of cannabis sales will be split with provinces and territories according to the following principals:

- Provinces and territories will receive 75% of this revenue while the federal government will retain 25%.
- The federal portion of cannabis excise tax revenue will be capped at \$100 million annually and any revenue above this limit would be provided to provinces and territories.
- With respect to this revenue, provinces and territories will work with municipalities according to shared responsibilities towards legalization.

Subsequently, on March 09, 2018 the Ontario Government sent a press release titled, **“Ontario Supporting Municipalities to Ensure Safe Transition to Federal Cannabis Legalization”**. In the release it was noted that it would: “Provide public health units with support and resources to help address local needs related to cannabis legalization.” While this release made no specific reference to how much, or how resources would be invested within the Public Health system, it is reassuring that the Ontario Government recognizes the importance of investment in the comprehensive cannabis control strategy delivered by local public health agencies. To help meet the Government of Ontario’s twin goals of creating a safe and sensible framework to

Page 106 of 202

manage legalized cannabis, and of having the lowest provincial/territorial smoking rate in Canada, it is essential to invest in the prevention pillar of the comprehensive cannabis control strategy and to provide adequate resources for the implementation and enforcement of the revised smoke-free legislation that now includes cannabis.

Local Public Health agencies are uniquely placed to increase public awareness of the health risks of cannabis use and driving under the influence of cannabis. Local Public Health agencies are also primed to prevent the renormalization of smoking through the legalization of cannabis. This Public Health work is foundational to helping keep our communities healthy and safe – a goal that we share with the Government of Ontario.

Although local Public Health agencies are partially funded by municipalities, we recognize that their ability to share funding from cannabis excise tax revenue with local Public Health agencies may be limited due to other conflicting priorities. With dedicated funding from this revenue, local Public Health agencies will be better resourced to provide the essential public awareness work, education and enforcement that is required with the legalization of cannabis. It is important that prevention be a pillar of cannabis legalization from the outset and dedicated funding to local Public Health agencies is an important component of supporting and strengthening this pillar.

We urge the Ontario Government to dedicate sufficient resources to local Public Health agencies to ensure that both education and enforcement are a priority.

Thank you for your consideration of this request. Please do not hesitate to contact me if you have any questions or concerns.

Sincerely,



Maureen Piercy
Chair
Hastings Prince Edward Public Health Board of Health

Copy

Honourable Charles Sousa, Provincial Minister of Finance
Honourable Dr. Helena Jaczek, Provincial Minister of Health and Long-Term Care
Mr. Todd Smith, MPP, Prince Edward-Hastings
Mr. Lou Rinaldi, MPP, Northumberland-Quinte West
Association of Local Public Health Agencies
Boards of Health in Ontario
Dr. Ian Gemmill, MOH HPEPH

Page 107 of 202

From: Hope, Amy (MOHLTC) [mailto: Amy.J.Hope@ontario.ca] **On Behalf Of** Martino, Roselle (MOHLTC)
Sent: April 5, 2018 1:12 PM
To: Ontario Medical Officers of Health
Subject: Update: Changes to the HPPA, ISPA and Related Regulations

Dear Colleagues,

As part of the government's continued efforts to better reflect current evidence and practice for public health programs and services, I am pleased to advise you that the government has recently approved amendments to a number of regulations under the *Health Protection and Promotion Act* (HPPA) and the *Immunization of School Pupils Act* (ISPA), and new regulations made under the HPPA.

These amendments are **in addition** to HPPA legislative and regulatory changes previously communicated in late 2017.

A summary of the legislative and regulatory amendments follows below:

Immunization of School Pupils Act (ISPA):

On May 30, 2017, the *Protecting Patients Act, 2017* received Royal Assent, including provisions in Schedule 2 that would amend the ISPA to:

- Require mandatory education sessions for parents who request a non-medical exemption – this requirement was effective as of September 1st, 2017.
- Require health care providers to report to their local medical officer of health the record(s) of immunizations administered to children that protect against the nine designated diseases in the ISPA.
- Recently, changes were approved to the regulation under the ISPA to specify the requirements for health care providers to report immunizations for diseases specified under the ISPA directly to local medical officers of health. These amendments will come into force on **July 1st, 2018**.

Health Protection and Promotion Act (HPPA):

- In December, 2017, the government approved regulatory amendments to: improve the provision of safe food and ensure public health and safety at Ontario's recreational camps, pools and spas; to enhance prevention measures for infectious diseases; and a number of housekeeping changes to address inconsistencies and reflect updated terminology and practice in the delivery of public health services. Some of these changes came into force on **January 1st, 2018** with the remaining changes to come into effect on **July 1st, 2018**.
- On December 12, 2017, Bill 160, the *Strengthening Quality and Accountability for Patients Act, 2017* (SQAPA) received Royal Assent. Bill 160 included, in Schedule 3, amendments to the HPPA. These amendments included a new authority to permit the regulation of certain recreational water facilities (such as splash pads and wading pools), and personal services settings as well as to permit the voluntary merger of specified public health units.

- o Recently, the government approved the regulatory amendments associated with SQAPA, plus unrelated HPPA regulation amendments permitting parents to opt-out of antibiotic treatment in the eyes of their new born, and other technical amendments.
- A consolidated Designation of Diseases regulation, which is a Minister's regulation, will come into force on May 1st, 2018.
- Finally, amendments have been made to Regulation 950 under the *Provincial Offences Act* (POA). These amendments update existing offences associated with food premises, camps and rabies immunization regulations as well as establishing new offences in relation to the Public Pools regulation and the new Personal Service Settings regulation.

The above noted regulations were filed on March 29th, 2018 and changes are available on e-laws:

- *Health Protection and Promotion Act*: <https://www.ontario.ca/laws/statute/90h07>
- *Immunization of School Pupils Act*: <https://www.ontario.ca/laws/statute/90i01>

In addition, proclamations for the *Health Protection and Promotion Act* and the *Immunization of School Pupils Act* will be published in the Ontario Gazette issue no. 15 as of April 14, 2018.

A more detailed summary of all the recent public health legislative and regulatory changes is being developed and will be shared soon.

To support continued implementation of the Ontario Public Health Standards and associated legislation and regulation changes, the ministry is also developing a Coordinated Education and Training Plan. Further details on this plan will also be shared shortly.

These legislative and regulatory changes are in response to feedback received from stakeholders over the past several years and represent our collective vision for a safe and strong public health environment.

If you have any questions, please do not hesitate to contact the ministry by e-mail at PHTransformation@ontario.ca.

Sincerely,
~Roselle

Roselle Martino
Assistant Deputy Minister
Population and Public Health Division

From: my CNW subscription [<mailto:noreply@newswire.ca>]

Sent: Friday, February 9, 2018 1:50 PM

To: Portfolio E-Mail <noreply@newswire.ca>

Subject: Government Launches Food Consultations to Help Canadians Make Healthy Choices

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CISION



News by Health Canada

Transmitted by Cision on February 9, 2018 13:32 ET

Government Launches Food Consultations to Help Canadians Make Healthy Choices

Front-of-package symbol will identify foods high in sodium, sugars, or saturated fat

OTTAWA, Feb. 9, 2018 /CNW/ - Canadians are struggling with high rates of chronic diseases. Two in five Canadian adults report having one of the most common chronic diseases, which include heart disease, stroke, diabetes and cancer. Even more worrisome, some of these chronic conditions are starting to show up in our children.

The Government of Canada is taking action to make it easier for Canadians to make healthier food choices. Poor diets – including those that are high in sodium, sugars, or saturated fat – are a primary risk factor for diseases such as cancer, stroke, type 2 diabetes, and heart disease.

The Minister of Health, the Honourable Ginette Petitpas Taylor, today announced that Health Canada will launch consultations on regulations for a new front-of-package nutrition symbol on food. This is part of Health Canada's Healthy Eating Strategy.

Every day, Canadians make hundreds of food choices, often in a matter of seconds, and the front of a food package is the first place they look for information. A front-of-package symbol will provide a clear visual cue that a food is high in nutrients of public health concern, such as sodium, sugars, or saturated fat. This symbol will complement the Nutrition Facts table on the back or side of the food package.

In order to receive feedback from Canadians before making a final decision on the symbol that will appear on foods high in nutrients of public concern, Health Canada launched [consultations](#) on the proposed front-of-package symbol earlier today.

A front-of-package symbol represents significant and important progress towards achieving the goals of Health Canada's Healthy Eating Strategy, which takes a reasonable and responsible approach to addressing chronic disease in Canada.

Quotes

"The consultations launched today are geared towards helping Canadians make healthier food choices. Identifying foods that are high in sodium, sugars, or saturated fat is not always easy, and this front-of-package symbol will make it clearer while shopping for groceries. I invite all Canadians to participate in the process by giving us feedback on the proposed symbols."

*The Honourable Ginette Petitpas Taylor
Minister of Health*

"Maintaining a healthy lifestyle, including regular physical activity and healthy eating helps prevent chronic diseases like type 2 diabetes, heart disease, and some cancers. Healthy living is about choosing healthy options like reducing our intake of foods that are high in sodium, sugars and saturated fat. It's the small, daily choices we make that can set the foundation for ourselves and for our children to lead healthier lives."

*Dr. Theresa Tam
Chief Public Health Officer*

"The Heart and Stroke Foundation of Canada fully supports the proposal to require a front-of-package nutrition symbol on food and beverage products as one important way to improve the health of Canadians. Adding labels that are clearly visible and easy to understand will help steer consumers away from unhealthy products high in sugars, sodium and saturated fat and support them to make healthy choices."

*Yves Savoie
CEO, Heart and Stroke Foundation of Canada*

"This front-of-package labelling will help Canadians to more quickly compare products and make healthier food choices for their households. A regulated requirement will also encourage product innovation, providing more food products that are lower in sodium, sugars and saturated fat. Dietitians of Canada will draw on the collective expertise of our members, with their diverse roles across the food and health systems, to contribute to the finalization of this new regulation."

*Nathalie Savoie
CEO, Dietitians of Canada*

"The overconsumption of foods high in sugars, saturated fat and sodium has had terrible effects on the health of Canadians, increasing the burden of diet-related chronic disease in this country. Diabetes Canada supports Health Canada's actions

to better inform Canadians about the content of their food and beverages. The proposed front-of-package labelling regulations will offer simple, clear messaging to consumers about nutrients of concern and make the healthier choice the easier choice."

*Dr. Jan Hux
President, Diabetes Canada*

"Educating the public on healthy eating is no longer sufficient and must be supported by policies and regulatory action. For the Coalition québécoise sur la problématique du poids, the front-of-package labelling initiative will help to provide consumers with the facts, and encourage the industry to improve the quality of certain products."

*Corinne Voyer
Director, Coalition Poids*

Quick Facts

- Processed foods are a major source of sodium, sugars and saturated fat in our diets.
- Research indicates that Canadians consume too much of these nutrients. For example, approximately 8 in 10 Canadians consume too much sodium. This number is even higher in children. Almost 1 in 2 Canadians eat too much saturated fat.
- Health Canada brought in regulations last year to update the Nutrition Facts table and list of ingredients to make it easier for Canadians to use and understand them.

Associated Links

[Healthy Eating Strategy](#)

[Vision for a Healthy Canada](#)

[Food Front-of-Package Nutrition Symbol Consumer Consultation](#)

[Consultation on proposed front-of-package labelling](#)

SOURCE Health Canada

For further information: Thierry Bélair, Office of Ginette Petitpas Taylor, Minister of Health, 613-957-0200; Media Relations, Health Canada, 613-957-2983; Public Inquiries, 613-957-2991, 1-866 225-0709

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Leaders

Ontario Dietitians in
Public Health

April 3, 2018

Hon. Charles Sousa
Minister of Finance
10th Flr, 80 Grosvenor St,
Toronto, ON M7A 2C4

Dear Minister Sousa,

Re: Ontario Budget 2018

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health and Affiliate organizations, I am writing today to congratulate you on the release of this year's Ontario Budget, "*A Plan for Care and Opportunity*" and to provide some initial feedback on its content.

We agree with the observation in your speech that a balanced budget is a means to an end, and that it has provided an important opportunity to build on the investments that have been made to improve economic growth and to ensure fair distribution of its benefits. Health Equity is the foundation of the programs and services that local public health agencies deliver, and its strength depends on an equitable society.

We therefore appreciate the strong focus on priority and vulnerable populations (seniors, Indigenous, homeless, children with developmental disabilities etc.) that appears throughout this year's budget papers.

We also appreciate the actions that are being taken in areas that are not part of local public health's direct mandate, but have demonstrable impacts on population health, such as climate change, public transit, community hubs, and access to quality education. Our members have a keen interest in all of these as determinants of health and will have important contributions to make.

Although this year's budget does not specifically mention Ontario's unique and valuable public health system, we welcome the opportunity to comment on several items that are well-aligned with our interests if not directly related to public health's mandate. Several alPHa Resolutions that are related to this year's Budget announcements are referred to by number and attached for your further consideration.

Better Health Care for Everyone in Ontario

As part of the additional investment of \$5 Billion over three years into health care, we are very supportive of the expansions to OHIP+ to include seniors starting in August 2019. This is well-aligned with alPHa's call upon the Government of Canada and the Province of Ontario to move forward with the development and implementation of a national, universal pharmacare program (*Resolution A15-2*). We recognize Ontario's leadership and hope that the tangible steps being taken here will be replicated across Canada in the near future.

We also support the principles of a new Ontario Drug and Dental Program for the 1 in 4 working-age Ontarians (and 60% of seniors) who do not have access to extended health benefits through employers or government programs. This is aligned with our previously-stated support for universal pharmacare as well as our call for a provincially funded oral health program for low-income adults and seniors in Ontario. To be clear, we also view the latter as but one step in the right direction, as alPHA has also called upon the federal government to develop a National Oral Health Strategy that includes universal access of both preventative and treatment services to all Canadians (*Resolutions A17-1 and A05-5*).

The three-year, \$5M investment in the implementation of Rowan's Law, which will establish requirements for concussion management for amateur competitive athletes, was also most welcome by our members. alPHA expressed its strong support for this initiative to the Minister of Culture, Tourism and Sport via correspondence in October 2017 (*letter attached*).

Expanding Access to Mental Health and Addictions Services

We agree completely that there is “no health without mental health” and applaud the Province's commitment to ensuring access to care and supports for people living with mental illness and / or substance abuse disorders. As you are aware, Mental Health Promotion is now a required consideration for local public health under the revised Ontario Public Health Standards in the areas of Chronic Disease Prevention, Healthy Growth and Development, Substance Use and School Health. We therefore look forward to being directly involved in the development of the integrated, high quality mental health and addictions system that has been promised, as well as facilitating the implementation of the “Budget Talks” pilot, which will provide up to five Public Health Units with funding for “initiatives that promote mental health, including assistance for those who are underhoused and living in rural and remote regions” (Budget Papers, p.20).

We will of course also continue to play our roles in supporting the provincial Strategy to Prevent Opioid Addiction and Overdose, with thanks for the additional staff resources already assigned to us to support local responses including naloxone distribution.

Making Child Care More Accessible and Affordable

Although affordable and accessible child care is not directly associated with the core mandate of public health, the importance of a “best start” in life cannot be overstated. There are many facets to promoting the health, development and wellbeing of all families with young children, and this initiative will address many of them (early learning opportunities and income security to name but two). We are therefore extremely pleased with this announcement.

alPHA has been vocal in its support for healthy public policy aimed at early childhood development and has been equally vocal about its members' commitment to doing the work that supports it (*Resolution A11-8*). Beyond the obligations set out under the Healthy Growth and Development Ontario Public Health Standard, we are ardent advocates of measures that support its goals.

Growing the Economy and Creating Good Jobs

This chapter's focus is on job creation and skills development to service a strong economy. We appreciate the mention of a focus on well-being, equity and new approaches to learning (Budget Papers, p. 77), which promises to strengthen programs that improve students' cognitive, emotional, social and physical development. This is an important continuation of healthy growth and development, and

measures to improve the quality of and access to education – a key determinant of health – are always welcome.

This section however also contains a pledge that we find extremely worrisome. There is a brief reference to the “development of a new multi-year strategy for beverage alcohol industry growth” (budget papers, p. 95), and we remind you that such growth is in fact in direct conflict with public health’s obligations to prevent substance use (including alcohol) and reduce associated harms.

The negative social and health consequences of increasing access to beverage alcohol are well documented, and as your Government continues to actively support the growth of this industry we are becoming increasingly discouraged and disappointed in its failure to produce the Ontario Alcohol Strategy that was announced in December of 2016. I have attached a recent letter that outlines our concerns in more detail.

Fairness and Opportunity through Partnerships

As public health practitioners, we understand the value of partnerships and collaboration, and we are pleased to see that this understanding is reflected in this year’s budget.

Working with Indigenous partners is a priority for us, and we are pleased that the new Health Equity Public Health Standard includes direction on engaging with Indigenous communities, as our desire to address their severe health inequities has now been formalized. We look forward to opportunities to work together on this and appreciate the commitment to engagement that is demonstrated throughout the budget document.

Reference is also made in this chapter to the implementation of cannabis legalization, which includes a pledge to “provide public health units with support and resources to help address local needs related to cannabis legalization” (Budget Papers, p. 270). We of course welcome further discussions on this as the health protection, health promotion and enforcement implications for our members become clearer.

Taxation

We are supportive of the immediate tax increase on tobacco amounting to \$4 per carton of cigarettes. Taxation has been clearly demonstrated as one of the most effective means of reducing tobacco initiation and use, and we applaud your Government’s ongoing commitment to Smoke-Free Ontario.

In closing, aPHa’s members are supportive of many of the initiatives that are introduced or reinforced in the 2018 Budget, and we hope that the foregoing is an effective reminder that the programs and services that are delivered through Ontario’s Boards of Health are well-aligned with government priorities. We hope that you will give the various positions that we have shared with you careful consideration as the work begins on implementing your Plan for Care and Opportunity.

Yours sincerely,

A handwritten signature in blue ink that reads "Carmen McGregor". The signature is written in a cursive, flowing style.

Carmen McGregor,
aPHa President

COPY: Hon. Kathleen Wynne, Premier of Ontario
Hon Helena Jaczek, Minister of Health and Long-Term Care
Dr. Bob Bell, Deputy Minister, Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care, Population and Public Health Division

Statement

Premier's Statement on Changes to the Executive Council

February 26, 2018

Premier Kathleen Wynne released the following statement today:

Today I accepted Minister Eric Hoskins' resignation as Ontario's Minister of Health and Long-Term Care, as well as MPP for St. Paul's.

"I am so grateful for the work Eric has done to continue improving Ontario's world-class health care system to better support patients and their families. Eric has always been one of the most vocal advocates for our universal health care system and has played an active role in lowering surgical wait times across Ontario, increasing access to primary care providers, including family doctors, expanding the availability of services for people with mental illnesses and building new hospitals in communities across the province. He has also been instrumental in making sure Ontario is leading the effort to expand our system with historic initiatives like OHIP+, which has made prescription drugs free for everyone under the age of 25. There is much more work to do, and I know Eric will look forward to telling you about how he will be involved.

In the meantime, I am pleased that Dr. Helena Jaczek has agreed to take over as Minister of Health and Long-Term Care, effective immediately. The experience she brings to this role as a former physician with Women's College Hospital in Toronto and former Chief Medical Officer of Health for York Region will ensure that our government can seamlessly move forward with the important investments we are making and the work we are doing in health care right across the province. Minister Jaczek will continue in her role as Chair of Cabinet.

Also effective immediately, Michael Coteau will become Minister of Community and Social Services, while maintaining his role as Minister of Children and Youth Services and Minister Responsible for Anti-Racism. I thank both Ministers Jaczek and Coteau for stepping into these new roles, and I am confident they will continue to serve the people of Ontario with care, intelligence and compassion."

News Radio Article from CKDR Radio

NOMA Against Proposal To Merge Health Units

Posted on Monday, February 26, 2018 08:16 AM

The President of the Northwestern Ontario Municipal Association is throwing cold water on a proposal to amalgamate Health Units in the districts of Kenora-Rainy River and Thunder Bay.

Wendy Landry says the merger talk is being done without consultations with municipalities, health officials and the public.

Landry is asking the government to abandon the panel recommendations.

She stresses that the size of the land mass would be far too cumbersome to properly manage all of northwestern Ontario.

Landry says she will be raising possible merger concerns when she meets with Premier Kathleen Wynne at the Ontario Good Roads Conference this week in Toronto.

Ontario Moving Quickly to Expand Life-Saving Overdose Prevention Programs

Latest Data Shows Opioid-Related Deaths Continue to Increase

NEWS

March 7, 2018

Ontario is expanding access to addiction and harm reduction services across the province, as the latest data shows that opioid-related deaths continue to rise.

There were 1,053 opioid-related deaths in Ontario from January to October 2017, compared with 694 during the same time period in 2016 — this represents a 52 per cent increase. From January to December 2017, there were 7,658 emergency department visits related to opioid overdoses, compared with 4,453 during the same time period in 2016 — this represents a 72 per cent increase.

To help combat the crisis, more than 85 mental health and addiction providers across the province are enhancing treatment services and supports for opioid use disorder. Twelve of these providers are supporting targeted supports for youth. Over 20 providers are investing in withdrawal management services in Ontario. More than 30 communities will also benefit from new or expanded Rapid Access Addiction Medicine (RAAM) clinics. In addition, up to 40 providers are hiring new front-line health and social service workers to provide counselling, case management and other supports.

Since the new overdose prevention site program began in January, four sites have been approved, with the first site now open in London, Ontario. Supervised injection services, which offer referrals and access to primary care, social services and addiction and mental health treatment, also continue to be expanded. Both services provide easy-to-access lifesaving supports in a stigma-free environment as well as harm reduction supports.

Other initiatives rolling out as part of Ontario's Strategy to Prevent Opioid Addiction and Overdose include:

- Releasing, in collaboration with Health Quality Ontario, three new opioid-related quality standards that are based on evidence and developed with clinical experts and people with lived experience. These standards outline the improved prescribing of opioids for [short-term acute](#) and [long-term chronic pain](#), and how to identify and provide the best care for people with an [opioid use disorder](#).
- Making easy-to-use nasal spray naloxone kits available for free at participating pharmacies, giving people the choice between nasal spray or the injectable kits that have already been available.
- Expanding public education to ensure people have information on how to access free naloxone and how it can be used to temporarily reverse an opioid overdose, including providing pharmacies with [posters](#) and [brochures](#) with information about prescription opioids, how to use them safely and potential risks.

QUOTES

“These numbers are a stark reminder of why we are putting so much effort into addressing the opioid crisis on all fronts. We are working to save lives, both now and in the long-term, and to help all people in Ontario affected by this tragedy.”

— Dr. Helena Jaczek, Minister of Health and Long-Term Care

“As we learn more about the opioid crisis, we continue to enhance our response. By monitoring the data, we are able to modify our strategy and put our resources where they will help the most people across the province.”

— Dr. David Williams, Chief Medical Officer of Health

“By improving data collection methods, we have a clearer picture of the reality of the opioid problem in Ontario. It is our hope that the new information will inform evidence-based decisions, resulting in better and more targeted programs to help all people affected by the dangerous use of opioids.”

— Dr. Dirk Huyer, Chief Coroner for Ontario

QUICK FACTS

- Ontario has approved nearly \$7 million in funding for seven supervised injection services. Five of these sites (three in Toronto and two in Ottawa) opened between August 2017 and February 2018. The province continues to accept applications.
- Overdose prevention sites provide core harm reduction supports and services such as supervised injection and access to harm reduction supplies and naloxone.
- On February 12, 2018, the first Overdose Prevention Site (OPS) opened in London, Ontario. The province continues to [accept applications](#).
- Health Quality Ontario and the Council of Academic Hospitals are helping to support the provincial rollout of the Rapid Access Addiction Medicine model, with funding from the province.
- Over the next three years, Ontario is investing more than \$222 million to combat the opioid crisis in Ontario, including expanding harm reduction services, hiring more front-line staff and improving access to addictions supports across the province.

LEARN MORE

- [Where to Get Naloxone Kits and How to Use Them](#)
- [Ontario's Strategy to Prevent Opioid Addiction and Overdose](#)
- [How to Apply for an Overdose Prevention Site](#)
- [Interactive Opioid Tool](#)

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416-314-6197

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*News Release***Throne Speech Announces Major Investments Guided by a Commitment to Care and Creating Opportunity**

March 19, 2018

Ontario's Plan Will Take Bold Action to Enhance Health Care, Home Care, Mental Health and Child Care

The Ontario government is investing more in the care and services that people across the province rely on, easing the mounting pressures families are facing and giving them every opportunity to care for their loved ones and get ahead.

The government's upcoming Budget will focus on doing more for people in health care, home care, mental health care and child care services. It will also expand a number of other programs that support people to care for their loved ones and help them to succeed in a changing economy.

Ontario's economy remains strong, with the unemployment rate at its lowest in almost two decades. Yet between the rising cost of living and stable, long-term jobs becoming harder to find, many people are struggling to take care of themselves and their families. As the changing economy widens the gaps within our society, the government has a plan to build a fairer, better Ontario by supporting everyone in the province with the care and opportunity they need to get ahead.

The government's priorities were outlined in the Speech from the Throne delivered today by the Honourable Elizabeth Dowdeswell, Ontario's Lieutenant Governor. The speech opened the third Session of the province's 41st Parliament.

Priorities include:

- Reducing wait times for health care by significantly increasing hospital operating budgets
- Expanding home care to provide more services for seniors choosing to stay at home, and to provide financial relief for families who are caring for aging loved ones
- Making historic investments in mental health and addictions services so people of all ages across the province can get the care they need

- Ensuring more people without a drug and dental benefits plan will have access to more affordable prescription drugs and dental care
- Providing more college and university students with free tuition through the new OSAP
- Making investments to train more apprentices for the workforce, including in emerging fields
- Focusing on regions that are struggling to achieve economic growth by investing in workers and businesses
- Continuing to make record-breaking investments across Ontario in public infrastructure such as schools, hospitals, roads, bridges and transit systems.

The Throne Speech outlines the next steps to build on the government's plan for fairness, and providing care and opportunity during this period of rapid economic change. The plan includes a higher minimum wage and better working conditions, free tuition for hundreds of thousands of students, easier access to affordable child care, and free prescription drugs for everyone under 25 through the biggest expansion of medicare in a generation.

QUICK FACTS

- In February, the unemployment rate in Ontario was 5.5 per cent, the lowest since 2000.
- The Throne Speech builds on [measures the government](#) brought forward during the first two sessions of the 41st Parliament as part of its plan for fairness, and providing care and opportunity in a time of rapid economic change.

ADDITIONAL RESOURCES

- [Read the Speech from the Throne](#)

QUOTES

"I hear from people every day who put caring first — whether it's at home, caring for their families, or at work, caring for patients, students or society's most vulnerable people. The people of Ontario are our greatest strength, and our government doesn't accept that anyone should be left to fend for themselves, particularly in this turbulent, changing economy. We're taking bold steps to ensure the best care for our children, our seniors and our friends and

family members. Our plan will relieve pressure on families by making it easier for people to care for themselves and for each other."

— *Kathleen Wynne, Premier of Ontario*

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Northern Ontario Health Equity Strategy

A plan for achieving health equity
in the North, by the North, for the North

Health Quality
Ontario

Let's make our health system healthier



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Forewords

From Health Quality Ontario's CEO

You can't truly have a quality health care system without having equitable opportunities for health. Equity is one of the six core dimensions of quality care, along with safety, effectiveness, patient-centeredness, efficiency, and timeliness, and it is a dimension to which Health Quality Ontario has paid special attention recently.

Northern Ontario is one region of the province where health equity is often lacking and needs to be addressed with some urgency. *Health in the North: A report on geography and the health of people in Ontario's two northern regions* is a health system performance report we released last year. It documented how the 800,000 people living in Northern Ontario have a life expectancy more than two years lower than the provincial overall and are more likely to die (before age 75) due to suicide, circulatory disease and respiratory disease.

Earlier in my career, I worked in the North as a doctor. I saw first-hand the unique challenges facing those with long distances to travel, poor weather conditions and a shortage of medical resources (including healthcare providers). Those working in our two Northernmost Local Health Integration Networks (LHINs) know these are just some of the reasons those living there do not have the same standard of health and health care seen in other parts of the province. Other inequities associated with the social determinants of health – income, and access to proper housing, clean water and adequate nutrition – also play a big role.

Our quest with others to develop a strategy to address health equity in the North was built on a principle now embedded in the patient advocacy movement – “Nothing about us without us.” Or as Dr. Jennifer Walker, Canada Research Chair in Indigenous Health at Laurentian University, eloquently put it, “Solutions cannot simply be imported from the southern part of the province. The landscape – social and cultural as well as geographic – is totally different.”

Guided by leaders in the North, Health Quality Ontario helped facilitate an in-depth multi-faceted engagement process with hundreds of people living in the North that has led to a northern strategy to address health equity in the North, focusing on those important barriers and opportunities for building health equity.

The Northern Ontario Health Equity Strategy is guided by a vision that all Northerners will have equitable access to social and economic resources, as well as to high-quality health care, regardless of where they live, what they have or who they are.

For too long those living in Northern Ontario have lived and worked on an unbalanced playing field. I am hopeful that this clear vision and goal, and the recommendations outlined as part of this strategy, will provide the impetus to address the challenges facing the North in a manner that will have a significant impact.



Joshua Tepper

President and CEO, Health Quality Ontario

From the Steering Committee Co-chairs

Northern Ontario covers a vast expanse of rugged and breathtaking land – a land so large it covers roughly the same area as all of France. Northern Ontario’s population is diverse and resilient. We live in urban centres, rural villages and remote communities. We are Indigenous and Francophone, long-term settlers and new arrivals. We work in health care and education, resource extraction and retail, and we have deep connections to the land, our communities, and our families. As Northerners, we know we have huge health potential as well as huge health challenges. Compared to the rest of Ontario, the North has higher levels of poverty and poor health, elevated rates of many health-harming behaviours and poorer access to high-quality health care and social services.

Addressing these pressing challenges and leveraging our many strengths requires us to come together. It is only by working together across many different sectors that we will be able to achieve common health goals and ensure everyone has equal opportunities for health. We see great promise in joint leadership bringing perspectives from across the North – East and West, urban, rural and remote – and also across health care, public health, other public sectors and communities. We see this Strategy as a critical step toward achieving joint action on health equity.

We want to thank the many people who took the time to speak with the Northern Ontario Health Equity Strategy team to share their stories and have their voices heard. Hundreds of people from across the North told us of their and their communities’ challenges. They shared their vision for the future and their successes and lessons from the past. The Northern Ontario Health Equity Strategy is inspired by these stories and our future actions must be founded in the wisdom of all of these contributions.

Health equity will be achieved when all Northerners have equal opportunities for health and no one is unfairly disadvantaged. Health equity will also be achieved when health outcomes across the North are leveled up to meet those in the rest of Ontario. Our broad consultations confirmed that we are up to the challenge of improving health equity in the North, by the North, for the North!



Penny Sutcliffe

Medical Officer of Health and Chief
Executive Officer, Sudbury & District
Health Unit

Co-chair, Northern Ontario Health Equity
Strategy Steering Committee



Alex Vistorino

Director, Health System Planning and
Integration, North West Local Health
Integration Network

Co-chair, Northern Ontario Health Equity
Strategy Steering Committee





Executive Summary

People living in Northern Ontario experience poorer health and greater health inequities on many indicators compared with the rest of the province. This Strategy and its recommendations come directly from extensive engagement in 2016 and 2017 with those living in the North. It is concerned with the health of those living in Northern Ontario, and is guided by a vision that all Northerners will have equitable opportunities for health, including access to social and economic resources, as well as to high-quality health care, regardless of where they live, what they have or who they are.

The Northern Ontario Health Equity Strategy, developed in the *North, by the North, for the North*, is based on four foundations for action considered most important by stakeholders in the North:

- Addressing the social determinants of health
- Equitable access to high-quality and appropriate health care services
- Indigenous healing, health and well-being
- Evidence availability for equity decision-making

A health equity strategy for those living in Northern Ontario requires that we identify the greatest health disparities and remove barriers for people facing inequities. It also requires that we address opportunities for health in the North as a whole, and identify ways to bring health outcomes across the North up to meet those in the rest of Ontario.

Health Equity is a Shared Responsibility

Our society generally strives toward equity, inclusiveness and creating a sense of belonging, and this is certainly the case in health care. Despite these sentiments, barriers to equity continue to exist and be experienced by Northerners. Throughout extensive engagement, we heard from Northerners that collaborative, intersectoral action is needed to address health inequities in Northern Ontario. The message was clear:

“We are working in silos. To make change we have to get out of those silos. Meaningful change will result from partners working together in a coordinated way across sectors, rather than working in isolation.”

– Northern Health Care Provider

Recommendation: A Northern Network for Health Equity

Although the following Strategy outlines concerns and proposes a variety of solutions, the driving recommendation is to establish a Northern Network for Health Equity (“the Network”) that will support intersectoral action, with a goal to improve health and health equity outcomes for people living in Northern Ontario. The Network itself will neither deliver care nor do the work of any one sector. The Network will focus on health equity broadly, and will bring together network partners and key stakeholders to work on key health priorities which have disproportionate impacts on more vulnerable populations and have been identified by Northerners as priorities for the North, such as mental health and addictions, diabetes prevention and management, and parental and child health.

There is strong evidence in other jurisdictions that this kind of coordinated approach is essential to reducing enduring health and social inequities. Once established, the Network will facilitate intersectoral collaboration that will drive policy and service-delivery change to bridge the inequitable gaps in health outcomes currently experienced in Northern Ontario.

Network Partners and Structure

The Network will be comprised of individuals and organizations from many sectors, including partners from public health, municipalities, Local Health Integration Networks (LHINs), Indigenous organizations and authorities, educational and research institutes, Francophone organizations, provincial and federal ministries, agencies, the business community and community organizations and members. This work is aligned with the LHIN mandate to convene cross-sectoral tables, and supports the current movement towards greater collaboration between public health units and the LHINs.

The Network will be directed by a steering committee that will provide direction and establish priorities for achieving the objectives of this Strategy. The steering committee will be supported by working groups focused on specific issue areas, with representation from the Northeast and the Northwest. The working group members will be individuals with expertise relevant to their group domain, with representation from partnering agencies and sectors, including sectors outside of health. To be effective in driving policy change and developing health equity initiatives, the Network will be resourced with dedicated staff who will provide leadership and coordination to the collaborative efforts of the Steering Committee and its working groups.

Through these collaborations, the combined strength of all partners will have the potential to improve the health of all those residing in Northern Ontario through education, policy

development, and evidence-informed action.

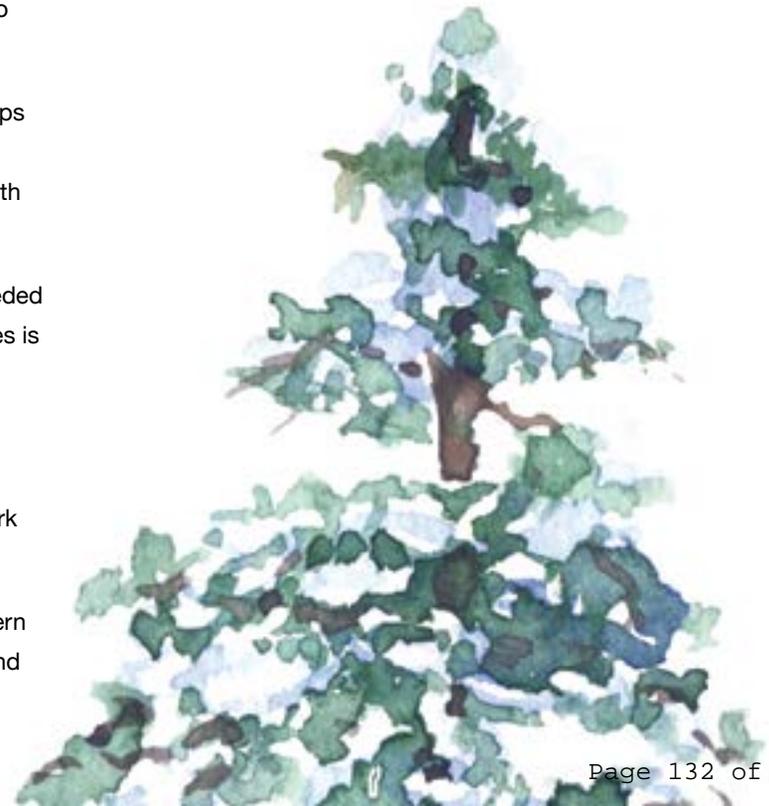
With strong intersectoral enthusiasm and support, the Network will be well-positioned to build on existing work. Because distances in the North are substantial, much of the work of the Network will be done virtually; the Network will not require its own facility but dedicated staff will locate with one of its partnering agencies.

Functions of the Northern Network for Health Equity

- Supporting Northern partners to develop deeper health equity commitments within their own organizational goals
- Engaging stakeholders, partners, government at all levels to collaborate intersectorally and to develop and advance policy solutions to improve health equity
- Collaborating with Northern research groups and agencies to conduct research and surveillance in priority areas to inform health equity action
- Supporting Indigenous researchers as needed to ensure research with Indigenous peoples is Indigenous-led
- Providing guidance, training, technical assistance and leadership to strengthen capacity for intersectoral health equity work in the North
- Facilitating knowledge exchange in Northern Ontario related to evidence, information and best practices

Network Objectives

Preliminary objectives within each foundation for action of the proposed Network were developed through consultation with Northern stakeholders and solidified through an environmental scan. The objectives are far-reaching and ambitious; however, advances in health equity rely on taking bold action and moving forward together for meaningful change. These proposed objectives and options are presented here not as a final mandate, but to reflect the important contributions of participants in the development of this Strategy and to give tangible meaning to the potential for a Northern-led Network. The Network will implement a planning process to further consider these objectives and options for action.



Foundation 1:

Addressing the Social Determinants of Health

1.1

Improve awareness of the social determinants of health and Indigenous determinants of health in the general public and among health care and social service providers

1.2

Engage partners across sectors to develop poverty reduction strategies

1.3

Work with partners to identify opportunities to improve accessibility to safe, affordable, and culturally appropriate foods across the North

1.4

Work collaboratively across the North to improve access to post-secondary education

1.5

Engage partners across sectors to improve access to safe and affordable housing

1.6

Work with partners to improve access to early childhood education and care

1.7

Work intersectorally to promote social inclusion

Foundation 2:

Equitable Access to High-Quality and Appropriate Health Care Services

2.1

Work with relevant providers to promote timely access to and coordination of health care where people live

2.2

Work across jurisdictions to improve health care provider recruitment and retention rates

2.3

Improve ability of all people, regardless of where they live, to access services

2.4

Improve access to French language health care services

2.5

Improve access to appropriate and inclusive health care services

2.6

Improve access to culturally safe health care services for all Indigenous peoples

Foundation 3:

Indigenous Healing, Health and Well-being

3.1

Work collaboratively across jurisdictions to provide equitable health care services to all Indigenous people

3.2

Move forward the Truth and Reconciliation Commission of Canada's Calls to Action, and support the efforts of Indigenous people in achieving self-determination

3.3

Work with providers and leverage opportunities to facilitate the provision of safe living conditions that allow residents to thrive in all First Nation communities

3.4

Support Indigenous culture as a determinant of Indigenous health

Foundation 4:

Evidence Availability for Equity Decision-making

4.1

Develop a Northern Ontario Data Strategy to streamline collection, analysis, and interpretation of data for equity decision-making

4.2

Support local engagement in research and use of evidence

Looking Forward: Anticipated Impact

Taken together, the actions of a coordinated Network would create opportunities for advancing health equity, with resulting impact in critical areas including mental health and addictions, diabetes prevention and management, and parental and child health. These, and other health issues that are strongly influenced by social and economic conditions, would benefit from an equity-focused intersectoral approach that addresses multiple factors related to health and well-being. The Network's deliverables will include:

In the first two years

- Establish the Network Steering Committee, with geographic and sectoral representation
- Hire core Network staff
- Develop the foundations for collaboration as a basis for action to achieve health equity, such as processes for engagement, inclusion and consultation, development of a Network Charter, and work with Network member organizations on integration of equity priorities into strategic plans
- Undertake process of evidence-informed priority setting, using the potential objectives and actions the Network can take to meet the goal of achieving health equity in the North as a starting point
- Undertake coordinated actions to address determinants of health, building on and strengthening capacity through work already under way within sectors
- Regularly inform government about the priorities of Network partners and the Network work plan



In five years

- Continue to undertake coordinated actions to address determinants of health, building on work already under way within sectors
- The development, measurement and reporting of Northern-relevant equity and health indicators

In ten years

- Improvements in indicators of equity and health among Northern populations
- Progress in equity priority areas identified by Network partners

Next Steps

The formation of the Northern Network for Health Equity is the first step in moving forward the objectives of this strategy. The development of the network would require commitments of stakeholders across Northern Ontario, and staff support to bring Network partners together.

The Strategy is an expression of the ambition, the passion, and the dedication of health and social sectors to work together for a more equitable, healthier Northern Ontario. Through developing this Strategy, we have heard that across the North, and across sectors, there is recognition of a societal obligation to address the pressing inequities facing Northerners. This Strategy is intended to create the foundation to move toward achieving health equity in the North, and will develop capacity to address pressing health equity challenges in the future.

This Network is an ambitious undertaking. It aspires to connect and align diverse leaders and communities from across a large geographical area. If successful, it will achieve the Strategy's vision of equitable opportunities for health for all Northern Ontarians.



Introduction: Health Equity in Northern Ontario

People living in Northern Ontario experience poorer health and greater health inequities compared with the rest of the province. Overall life expectancy is lower in the North¹, and mental health and addictions, diabetes, and parental and child health are of particular concern.² Poor health outcomes in the North are influenced by limitations to social and economic opportunities – income, housing, food security, education, childhood development, social supports, access to services in general, and access to services that are linguistically and culturally appropriate. These health disparities between the North and the rest of the province have prompted the development of this Strategy. This Strategy is concerned with all Northern Ontario populations. Among them, it highlights greater inequities faced by Indigenous populations due to the effects of colonization, historical and current trauma, racism, and the lack of self-determination.

The social and economic opportunities that determine people's health go beyond individual biology and behaviours. They are the living conditions that people are born into and that they grow, live, and work in.³ Although these factors affect everyone, some environments either amplify or diminish health and impact individuals' and communities' opportunities to attain their full health potential. Any differences or variations in health status between groups are known as health inequalities. When health inequalities have the potential to be changed or decreased by changes in policies or social action, they are known as health inequities.⁴ When members of the population experience equal opportunities to reach their full health potential, this is known as health equity.⁵

We are focusing attention on a specific geographic area that is referred to in this Strategy as Northern Ontario. However, we wish to acknowledge the original inhabitants of the treaty areas of Robinson-Huron, Robinson-Superior, Manitoulin Island, Treaty 3, Treaty 5, Treaty 9 and Wikwemikong Unceded Indian Reserve as the traditional owners and custodians of these lands. We honour and respect their ongoing cultural and spiritual connections to this place.

We recognize First Nations, Métis and Inuit as three distinct cultural identity groups, each of which has a unique history, set of traditions and cultural practices, and governance structures. For the purpose of this document the term Indigenous will be used to encompass these populations. However, the term First Nations communities will be used when referring to communities located on reserve.

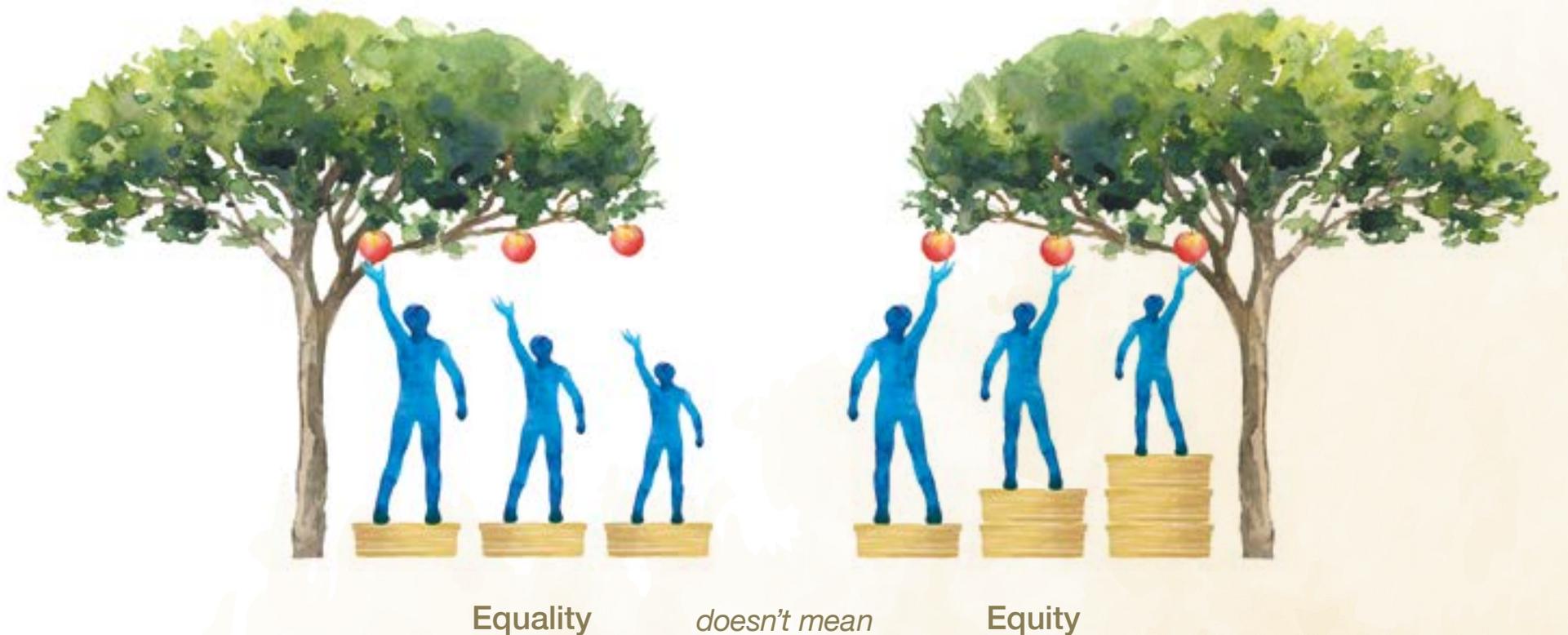
Central to the concept of health equity is the idea of fairness. Whereas *health equality* refers to the division of health-supporting resources into equal parts so that everyone gets the same, *health equity* involves fairness in resource allocation and opportunity so that people have the supports necessary to be healthy (see Figure 1).

Achieving health equity is about creating viable opportunities for the attainment of the “highest level of health for all people.”⁶

A health equity strategy for those living in Northern Ontario requires that we identify the greatest health disparities and tailor our approaches to remove

barriers for people facing inequities. It also requires addressing opportunities for health in the North as a whole, and identifying ways to bring health outcomes across the North up to meet those in the rest of Ontario.

Figure 1: Health equity requires an approach that acknowledges the varying needs of different people and populations⁷



Despite the barriers that Northerners face, the strength of the North and its potential to achieve health equity is clear from actions that have already been taken, programs that have been created, and policies that have improved health equity:

- The Northern Ontario School of Medicine is focused on meeting the needs of Northern, rural, and remote communities through intentional learning opportunities for its students with vulnerable populations, including Indigenous and Francophone communities
- Public health is leading the charge on creating awareness in the general population about the social determinants of health
- Community paramedicine is bringing supportive care to the people that need it the most
- The North West and North East LHINs are moving planning to the sub-region level to help support locally-appropriate approaches to improving health equity for their populations
- Many organizations, both Francophone and Anglophone, are working with the Francophone population to find innovative ways to ensure access to care in French, by use of technology or other solutions when direct patient care in French is unavailable
- Indigenous organizations are advocating for, and providing, care for their population in ways that are more culturally appropriate than ways used in the past
- Research is being conducted in Northern Ontario that focuses on transforming health policy, systems and practice to improve health equity in the North

We are ready to build on the momentum of the great work that is already under way. This strategy leverages the Northern spirit of self-reliance and determination to improve opportunities for health for all with a powerful vision for the future

VISION

All Northerners have equitable opportunities for health, including access to social and economic resources, as well as to high-quality health care services, regardless of where they live, what they have or who they are.

The Northern Ontario Health Equity Strategy builds on what we've heard across the North about what is working, what is not working and what is needed to ensure that *all Northerners have equitable opportunities for health, including access to social and economic resources and high-quality health care services, regardless of where they live, what they have or who they are.*

The content and direction of this Strategy have come from a review of existing documents and extensive multi-sector engagement with individuals, communities, and leaders from across the North, drawing from their experiences living and working in Northern Ontario. Those engaged represent health care, health promotion, education and research institutions, social services (governmental and non-governmental),

enforcement, municipalities, Indigenous communities and organizations, Francophone organizations, LGBTQ² organizations, early childhood development, elder care and many more. A vision, goal, guiding principles, and objectives have been created with significant input from people living in Northern Ontario.

Through this engagement process, Northerners identified four foundations for action for a Northern Ontario health equity strategy:

- Addressing the social determinants of health⁹
- Equitable access to high-quality and appropriate health care services
- Indigenous healing, health and well-being
- Evidence availability for equity decision-making

Northerners felt strongly that an intersectoral approach is critical to tackle the complex problems associated with health equity. They shared that the current work under way by a variety of sectors to improve health equity across the North needs to be meaningfully connected. This means aligning work within the health system and with research institutions, education, social services, economic development, municipal affairs, justice, and non-governmental community organizations.



The Strategy's primary recommendation is to establish a Northern Network for Health Equity. The Network will drive action within the four foundations for action previously listed with the goal of improving health equity for those living in Northern Ontario. The Network will focus on health equity broadly, and will begin with three key health priorities that were identified through the engagement process, each of which has disproportionate impacts on more vulnerable populations: mental health and addictions, diabetes prevention and management, and parental and child health.

The following sections provide an overview of how this strategy was developed, the context in Northern Ontario, the health status of people living in Northern Ontario, and challenges that Northerners face when trying to achieve their full health potential.

“Acute care is important but if we don’t deal with the issues that are making people sick, we will never get ahead.”

– Northern Ontario physician





A Health Equity Strategy for Northern Ontario

How This Strategy Was Developed

This Strategy was developed *in the North, by the North, for the North*. It aims to leverage the North's strengths to tackle the challenge of achieving health equity.

In the spring of 2016, Health Quality Ontario developed a Health and Health Care Equity Plan. One of the priorities of this Plan was to work in partnership with those living in the North to develop a Northern Ontario Health Equity Strategy. In October 2016, the Northern Ontario Health Equity Steering Committee was formed. It is comprised of health care, public health, academic and research groups, Francophone organizations, Indigenous organizations, and community leaders and residents from across Northern Ontario.¹⁰ The Steering Committee's task was to direct the development of a strategy that reflects the unique needs and abilities of Northerners and outlines a set of recommended actions necessary to improve overall health and well-being by supporting health equity in Northern Ontario. This Committee provides ongoing direction for the development of the Strategy and was supported by a Northern Ontario Health Equity Strategy team from Health Quality Ontario, in partnership with the Public Health Sudbury & Districts. This work was undertaken with financial support from Ontario's Ministry of Health and Long-

Term Care, demonstrating the Ministry's recognition of the importance of Northern health equity.

In November 2016, a Planning Meeting was held with over 60 people from across Northern Ontario to define the strategy's scope, vision, goal and foundations for action. From January 2017 to November 2017, the Northern Ontario Health Equity Strategy team undertook substantial engagement across Northern Ontario. The engagement process consisted of key stakeholder discussions with individuals representing almost 150 organizations and more than 300 participants, including community members, front-line workers, and decision-makers in rural, remote, urban, Francophone and Indigenous settings. Participant organizations are listed in Appendix A.

In developing the Strategy, the team reviewed existing health equity strategies and programs, research on the health status of people living in Northern Ontario and on health inequities in the North, and other complementary information to support findings from community engagement.

In sum, tremendous commitment and passion from Northerners enabled this work to move efficiently toward a Strategy. For more information about the methodology used to develop this Strategy, please refer to Appendix B.

The Northern Ontario Health Equity Strategy's Guiding Principles:

1. Work collaboratively across sectors to address the fundamental causes of social inequity and ill health
2. Promote inclusion and equity as societal values
3. Support the delivery of programs and services applying principles of health equity
4. Engage, actively involve, and support the North's diverse communities
5. Respect the principles of Indigenous self-determination and the traditions and languages of Indigenous people
6. Respect the French Language Services Act and recognize both official languages
7. Address the North's unique context and challenges by applying the knowledge and skills of northerners to create innovative solutions that are locally responsive
8. Apply principles of evidence-based decision-making

The Northern Context

Northern Ontario encompasses 80% of Ontario's land mass, but it represents only 5.8% of the province's population.¹¹ This creates variation in population density across the North – ranging from high density urban centres to sparsely populated communities accessible only by plane. This variation in population density creates challenges including those related to economic growth and program delivery.¹² As compared with Ontario overall, in Northern Ontario there are

large proportions of Indigenous, Francophone, rural and remote populations. This geographic and population profile presents unique strengths as well as challenges for health, such as access to high-quality health care services, achieving economies of scale for diverse sectors, opportunities for basic determinants of health such as clean water, nutritious foods, adequate and affordable housing, and accessible public transportation.

Figure 2: Northern Ontario¹³

- 80% of Ontario's land mass
- 5.8% of Ontario's population
- 106 First Nations communities



NORTHWEST

3.4% Francophone people
22% Indigenous people

NORTHEAST

23% Francophone people
11% Indigenous people





Why Does Northern Ontario Need a Health Equity Strategy?

Health Outcomes Are Worse in the North

- People in the Northeast and Northwest have life expectancies of 79 and 78.6 years respectively, compared to 81.5 years in Ontario as a whole
- The premature death rates in the Northeast and Northwest are 235 and 258/100,000 people, compared to only 163/100,000 in Ontario as a whole¹⁴
- Only 24% in the Northwest and 28% in the Northeast report being able to see their primary care provider the same or next day when they're sick, compared to 43% in Ontario¹⁵
- 45% of Northern Ontario Francophones feel they are in very good or excellent health, compared to 62% of the province's general Francophone population

Social Outcomes Are Worse in the North

- The unemployment rate in Northern Ontario was 6.5% in September 2017, compared to 5.6% for the province as a whole¹⁶
- Fewer people in Northern Ontario have secondary and postsecondary education than in the province as a whole¹⁷

Overall, this paints a clear picture: Northerners face health inequities relative to the rest of the Ontario population. But beyond this, there are significant inequities within the North itself. Indigenous populations experience some of the worst health outcomes of any population in Canada,¹⁸ and Northern Ontario is no exception. Francophones face challenges accessing healthcare in their own language, which can impede access to quality care and good health. These disparities are socially produced, unfair and unjust.

Specific Health Priorities Emerge for the North

People living in Northern Ontario face many inequities in health, but three health concerns were identified as priorities for the Strategy: mental health and addictions, diabetes, and parental and child health. These priorities will benefit from an intersectoral approach targeting each of the Strategy's four foundations for action: addressing the social determinants of health; improving access to high-quality and appropriate health care services; supporting Indigenous healing, health and well-being; and improving the quality and availability of evidence for equity-based decision-making.

Mental Health and Addictions

People living in Northern Ontario face significant challenges to their mental health. A variety of factors are understood to contribute to this, including economic barriers, geographic isolation, cultural and language barriers for Francophones, and for Indigenous people, intergenerational and current trauma due to discrimination and discriminatory policies.¹⁹

Suicide is the leading cause of death due to injury in Northern Ontario. In the Northwest, the potential years of life lost due to suicide are approximately 300% greater than that of Ontario. In the Northeast, the potential years of life lost due to suicide are 50% greater for men and more than 80% greater for women than in the general Ontario population.²⁰ Suicide rates, especially among youth, are much higher in Indigenous populations. Across Canada, the suicide rate among First Nations youth is five to seven times higher than among youth in the Canadian population as a whole.²¹ There is currently a state of crisis that continues in remote First Nations communities across the North, and communities are experiencing trauma from losing their youth to suicide. In the past 10 years, 42% of suicides among Aboriginal youth in the North have occurred in just seven remote, Northern Ontario Indigenous communities.²² Although these communities are identifying the specific types of supports they require, clearly, it is necessary to address the root causes of suicide on an ongoing basis (including intergenerational trauma due to colonial history, residential schools and land seizures, current discriminatory policies, endemic

poverty, and limited access to mental health counselling and psychiatric services).

Currently, patients who are hospitalized for mental illness or addiction in the North do not receive the support they need after being discharged: In 2014-2015, only 17% of patients in the Northwest and 21% in the Northeast saw a family doctor or psychiatrist within seven days of being discharged, compared to 30% in Ontario as a whole, and 40% in Toronto.²³ For the Francophone population, access to mental health care services is a challenge due to the limited resources available in French. Appropriate language is essential for treatment in mental health and addiction, and because there are limited services available in French, many Francophones are unable to receive the help and treatment they need.

Similarly, misuse of alcohol, opioids, and other substances is a function of a variety of social and economic factors, and disproportionately affects the most disadvantaged members of society. Public health, Local Health Integration Networks (LHINs), and Health Canada can fund preventive and/or treatment services to those living with addiction, but these services do not address the root causes of addictions. Intersectoral approaches to addressing these mental health and addictions challenges include: supporting economic development in disadvantaged communities to improve employment rates and income security; improving educational outcomes in both official languages in all communities; and ensuring individuals and families have stable, safe living environments and housing.

Providers worry that some populations may be falling through the cracks: Community members reported that addiction concerns of patients arriving at the emergency department under the influence of alcohol or drugs often go unreported if addiction is not the presenting complaint. This underreporting minimizes the magnitude of the problem.

Diabetes Prevention and Management

Diabetes is closely linked to income: In Canada, individuals living in lower socioeconomic status neighbourhoods are at a 13% higher risk for diabetes than those in neighbourhoods of higher socioeconomic status.²⁴

The Northeast and Northwest have the highest prevalence of diabetes in Ontario: 12.8% and 12.5% respectively, compared to an average of 10.2% across all of Ontario.²⁵ Diabetes is particularly high among adults living in First Nations communities, with up to 21% reportedly having been diagnosed with diabetes.²⁶

The causes of diabetes and other chronic diseases are often found in social and economic conditions. Although an individual may be genetically susceptible to certain diseases, poverty, combined with the high cost of living in the North, makes it hard for individuals and families to purchase healthy and adequate food, engage in routine physical activity, lead low-stress lives, and participate in other health-promoting behaviours. Remote communities also face a variety of barriers to physical activity. In many remote First Nations communities, unpaved roads, stray dogs, and wildlife impede activities like walking and running on the roads, limiting options for physical activity and increasing the risk of being overweight and developing diabetes.

Diabetes prevention and management at a population level requires coordinated efforts across sectors. Prevention starts with improving living conditions: income, access

to healthy foods, employment opportunities, communities where people can be and stay active. Management requires coordinated efforts across the health system including medical care access, appropriate education and counseling and available home care. For Francophones, the provision of education in French is essential, and translation and interpretation are needed when services are only available in English.

Parental and Child Health

For expectant parents with complex chronic conditions living in low-income neighbourhoods in Ontario, the risk of infant mortality is 25% higher than it is for those in high-income neighbourhoods.²⁷ Further, there are health and health care service challenges for parents, children and youth that are particular to the Northern setting. For example, having a high-risk pregnancy, particularly in remote Northern communities, can lead to challenges like having to relocate to larger centres to give birth, where family and supports are unable to be present. This situation places stress on new parents and families. There are also many communities without birthing services, thereby requiring residents to travel to larger centres to give birth.

Data show that for Indigenous populations, high infant mortality rates compared to the general Canadian population are evidence of health disparities.²⁸ Exposures during pregnancy such as smoking, high levels of stress, and environmental hazards such as poor air quality in substandard housing are more likely to be experienced by

expectant Indigenous mothers than expectant mothers across Canada as a whole.²⁹ Post-neonatal deaths (the deaths of children aged 29 days to one year) are likely to reflect social and environmental factors (e.g., malnutrition, infectious diseases, and unsafe housing conditions). In First Nations populations, infant mortality rates have been found to be almost twice as high (190%) as in non-First Nations populations.³⁰

Prescription opioid use in pregnant women is a concern, with 28.6% of women in a rural clinic in the Northwest found to be using opioids in 2013.³¹ Providing expectant mothers with narcotic weaning and tapering with long-acting morphine precipitated a decrease in the number of babies born with neonatal abstinence syndrome (withdrawal after birth) from 29.5% in 2010 to 18.0% in 2013.³²



“There is little support given to individuals that must relocate for health reasons. There is often an extensive wait for housing in the city where service can be provided and the housing available may not be suitable for families.”

– Northern community service provider

To maintain the good health of infants, children and parents, it's essential that an intersectoral approach be developed to ensure adequate living conditions and health care for expectant parents, and access to public health services and health care for infants and young children.

What we've learned about health equity in the North

Our society generally strives toward equity, inclusiveness and creating a sense of belonging, and this is certainly the case in health care. Despite these sentiments, barriers to equity continue to exist and be experienced by Northerners. Throughout the process of engagement in 2016-2017, individuals from across the North shared their perspectives on barriers to achieving health equity. Additional evidence was collected to bring further depth to these issues. Seven themes emerged from this work:

1. Basic physical needs: inadequate nutrition, housing, and safe drinking water

Participants consistently raised the unaffordability of healthy foods in Northern Ontario as a major concern, especially given the extremely high costs in the far North. For instance, a monthly food basket for a family of four is more than double in Northern First Nations communities such as Attawapiskat than in southern communities like Toronto.³³ In Canada, according to a 2011-2012 survey, 22.3% of off-reserve Indigenous

households were food insecure, with 8.4% being severely food insecure. These rates are three times higher than in non-Indigenous households.³⁴

Many were concerned about insufficient affordable housing, shelters, and supportive housing in Northern communities. In addition, substandard housing issues are highly prevalent in Northern communities.³⁵ The inter-relationship between experiencing homelessness or being under-housed and substance abuse was also raised.

Although by law Ontarians are entitled to expect safe drinking water, there were 37 First Nations communities in Northern Ontario under long-term boil water advisories between 1995 and 2017.³⁶

“It's hard to think about health and well-being without a roof over your head.”

– Community member

2. Safety, security and social inclusion – stigma, colonization, historical and current trauma, racism

Participants identified social exclusion as a pressing issue for several populations, including but not limited to Francophone populations, populations living with low-income, LGBTQ2 populations, racialized populations, newcomers, those living with disabilities, and those who experience poor mental health and addictions. Stigma related to sexual orientation, gender identity and mental health and addictions was cited as a health-related problem in smaller communities, where it's harder to maintain anonymity in health care interactions.

For Indigenous people, stigma and exclusion exist in a context of colonization, historical and current trauma, and systemic racism, and are particular barriers to equity. Indigenous participants shared stories of discrimination in health care settings, in their workplaces, and in their communities. They also shared the impacts that the residential school system had on themselves, their parents and grandparents, and how these experiences continued to affect their mental and physical well-being.

Community members spoke about the importance of social inclusion. One community member told us:

“Over the last several decades, those of us queer people who are older have lived through and survived being declared illegal, mental health diagnoses and the HIV/AIDS crisis. Rejections from family, friends, church groups, and work environments haunt queers daily. Even if direct harassment and rejection isn’t occurring, the constant anxiety about its potential is emotionally damaging. Mental health and social acceptance and security are social determinants of health that affect the physical health of LGBTQ populations across the North regardless of age, ethnicity, language or Indigenous status.”

3. Adequate income and sustainable economies

Participants consistently identified poverty as the strongest determinant of poor health, both at an individual and at a community level. Economic insecurity and underemployment were cited as drivers of poverty in Northern communities. Discrimination and stigma due to language, sexual and gender orientation, and race were also cited as drivers of both unemployment and underemployment. Participants noted that increased income supports are needed to afford adequate and healthy food, housing, health-related benefits and other essential determinants of good health. Some participants noted that current initiatives like the provincial basic income pilot and income security reform, if expanded, could have the potential to decrease poverty in the North.

One school teacher noticed that near the end of the month, some students were missing school because their parents didn't have enough money for food and were ashamed to send their children to school without lunches.

4. Indigenous self-determination and jurisdiction

Participants noted that non-Indigenous approaches to health programs and services for Indigenous people are not well-received in Indigenous communities as they often fail to reflect Indigenous values, beliefs and traditions. This failure inhibits the uptake and effectiveness of these programs in dealing with the significant challenges in health and the social determinants of health with which Indigenous people contend.

Participants pointed to a lack of structures to ensure that First Nations communities and Indigenous organizations have autonomy and decision-making power regarding the health and social services they require. It was felt that structural barriers, such as federal/provincial jurisdictional funding arrangements and status legislation, negatively impact health care services and health care systems for Indigenous populations and communities. Health care in

Canada is generally the responsibility of the provinces, but the federal government provides much of the funding for health care programs on First Nation reserves. Health care providers blamed this jurisdictional split for many problems for service delivery in First Nations communities and for organizations providing services for Indigenous people living and/or seeking services off-reserve. Engagement participants felt that there was only limited collaboration and cooperation between the federal and provincial governments and that resources were not being optimized. Health care providers in First Nations communities reported that these multiple sources of funding all required substantial reporting from First Nations communities, taking time and money away from providing direct patient care.

“The stories of the Sixties Scoop and residential schools are our stories and it is our responsibility to address them. We have credible agencies that are able to take control, but we need resources to do this.”

– Indigenous service provider



5. Strong families and healthy child development

Many participants identified that the overwhelming costs of child care can limit parents, predominantly mothers, from maintaining continuity in the workforce while raising their children. Participants also shared that some communities have no formal child care options available. Participants also pointed out that while publicly-funded and community programs are available for some, after school programs are expensive and out of reach for many working parents in their communities.

6. Education and learning opportunities

For many participants, pursuing postsecondary education was reported to be a challenge due to the costs of tuition, the lost wages from not working while in school and, in most cases, relocating. It was reported that programs for skill enhancement for adults in Northern Ontario are difficult to access because of lack of financial support, location, child care needs, or because prerequisite diplomas or courses are not available.

7. Access to health care services

Access to health care services was cited as a major concern for several groups including, but not limited to, Indigenous people, Francophone people, people living in poverty, people identifying as LGBTQ2, people living with disabilities, newcomers and rural and remote residents in general. Overall, these populations face

challenges accessing culturally competent, linguistically competent and/or inclusive care in Northern Ontario, which can result in stress and poorer health outcomes.

Long distance travel is required to access many services, and health and social services are scattered across municipalities. Extreme weather and the risk of animal collisions make travel in the North dangerous for both patients and service providers. For special access communities, such as fly-in communities or those accessible by ice roads, the geographical challenges are even more pronounced. Participants noted that recent withdrawal of financial support for train and bus transportation in the North has resulted in a sparse inter-city transportation system. Limited agency transportation budgets, compounded over many years, have seriously compromised service delivery. Northern Health Travel Grants do not pay for all of the costs of long-distance transportation. As a result, participants reported that individuals living in poverty have difficulty accessing health care services.

Overall, participants from rural and remote communities noted a lack of access to services such as dialysis, rehabilitation services, and addiction services, and reported that many forego treatment due to this lack of access. Lack of pregnancy and birthing services is a gap in rural and remote communities, and particular challenges exist for at-risk pregnancies in remote communities. Participants also reported that seniors' housing, long-term care, assisted living and palliative care beds as well as

rehabilitation beds are insufficient to meet the needs of Northern communities.

Among Indigenous populations, participants noted both a lack of services in Indigenous languages and a lack of services using traditional healing practices. For those facing addictions, Indigenous participants noted a lack of timely, local and culturally appropriate treatment services.



Service providers and community members shared that in terms of health, the right of Francophones to have access to services in French is not respected.

Other marginalized populations such as newcomers, older adults, and LGBTQ2 populations were noted as having specific gaps in care. Many newcomers face challenges finding linguistically competent care and services. LGBTQ2 community members cited challenges transgender patients face finding health care providers who provide adequate care and treatment, and there is a lack of training available for healthcare providers on LGBTQ2-sensitive care.

Participants reported significant gaps in mental health and addiction services. For example: Detox and residential addiction treatment facilities are sparse; there is inadequate access to services focusing on harm reduction for drug and alcohol use in many areas; and there are challenges to accessing emergency psychiatric beds.

In the North broadly, and specifically in more rural and remote areas, recruitment and retention of health care providers is an ongoing challenge. This challenge is greatly accentuated when trying to retain and recruit health care providers with the capacity to offer services in French.

Community members and service providers repeatedly shared concerns about mental health and addictions throughout engagement. Needs include:

- Culturally and linguistically appropriate treatment facilities for Indigenous people living with addictions
- Social assistance programs to support those living with mental health and addictions challenges.



Access to French-language health care services

For Francophone populations, there are difficulties accessing health care services in French in many communities because of limited capacity of services, a lack of agencies with Francophone designation or a lack of will from agencies to provide services in French. In some cases, services may be available but are not actively offered so people are not aware of them. Recently, the Ministry of Health and Long-Term Care of Ontario recognized this situation in its *Patients First* discussion paper: “Franco-Ontarians face

challenges obtaining health care services in French. To meet their needs, and improve their patient experience and health outcomes, we must ensure that the health care system is culturally sensitive and readily accessible in French.”³⁷ Throughout engagement, participants emphasized that patients must feel confident in their ability to communicate their medical concerns to health care providers. In addition, there are concerns regarding the quality of care for Francophones, including having to seek service in English with the concomitant risk of misdiagnosis.



What Can Be Done to Improve Health Equity in Northern Ontario?

Health Equity Is a Shared Responsibility

Throughout engagement, we heard from Northerners that collaborative, intersectoral action is needed to address health inequities in Northern Ontario. The message was clear:

“We are working in silos. To make change we have to get out of those silos. Meaningful change will result from partners working together in a coordinated way across sectors, rather than working in isolation.”

– Northern Health Care Provider

The World Health Organization’s Commission on the Social Determinants of Health recommended that comprehensive intersectoral strategies on improving and “leveling up” the health of individuals, groups, and communities with the greatest needs would have a substantial impact on individual and population health.³⁸ Intersectoral models to address the complex challenges associated with achieving health equity have been undertaken in places such as

England, Australia, and United States, and we can learn from these approaches.³⁹

Key Recommendation: The Northern Network for Health Equity

Many stakeholders are currently working to improve health and health equity in Northern Ontario. It remains an uphill battle; meaningful strides toward health equity require coordinated efforts.

The primary recommendation of the Strategy is to establish a **Northern Network for Health Equity (the Network)** that would drive intersectoral action to address health inequities in the North. The Network would foster partnership development and facilitate work toward shared goals. The Network itself would neither deliver care nor do the work of any one sector. It would bring together partners and key stakeholders to work on common key priorities identified by Northerners, such as diabetes prevention and management,

mental health and addictions, and parental and child health. Enduring health challenges like these require a coordinated, intersectoral approach to develop long-term solutions.

The Network would be comprised of individuals and organizations from many sectors, including partners from public health, municipalities, LHINs, Indigenous organizations and authorities, community health centres, Aboriginal Health Access Centres, educational and research institutes, Francophone organizations, provincial and federal ministries, municipalities, agencies, and community organizations and members. This work is aligned with the LHIN mandate to convene cross-sectoral tables, and supports the current movement towards greater collaboration between public health units and the LHINs.

The Network would support appropriate partnership development, governance and accountability, coordination, capacity building, and monitoring and evaluation to advance health equity in Northern Ontario.

Network Structure and Partners

The Network would be governed by a steering committee that would provide direction and establish priorities for achieving the objectives of this Strategy. The steering committee would be supported by working groups, with representation from the Northeast and the Northwest. The working group members would be individuals with expertise and responsibilities relevant to their group domain, with representation from partnering agencies and sectors including sectors outside of health. To be effective in driving policy change and developing health equity initiatives, the Network would be resourced with dedicated staff who will provide leadership and coordination to the collaborative efforts of the steering committee and its working groups.

Through these collaborations, the combined strength of all partners will have the potential to improve the health of all those residing in Northern Ontario through education, policy development, and evidence-informed action. With strong intersectoral enthusiasm and support, the Network will be well-positioned to build on existing work. Because distances in the North are substantial, much of the work of the Network will be undertaken virtually; the Network will not require its own facility but dedicated staff will locate with one of its partnering agencies. All partners will sign on to a Network Charter, which will outline Network goals and responsibilities and deliverables of each Network member. Figure 3 conceptualizes this Network.

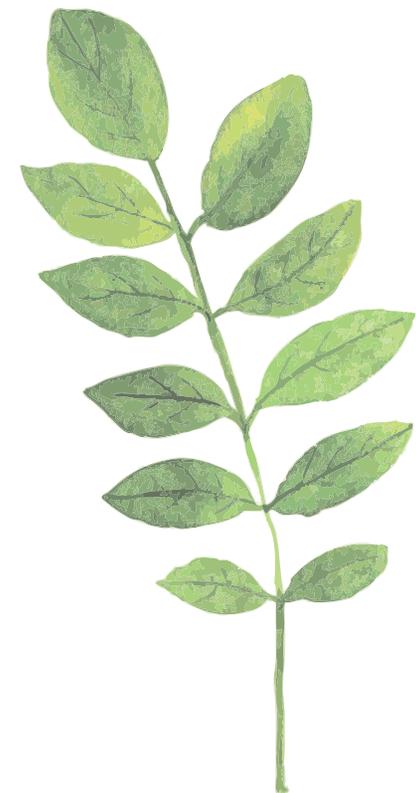
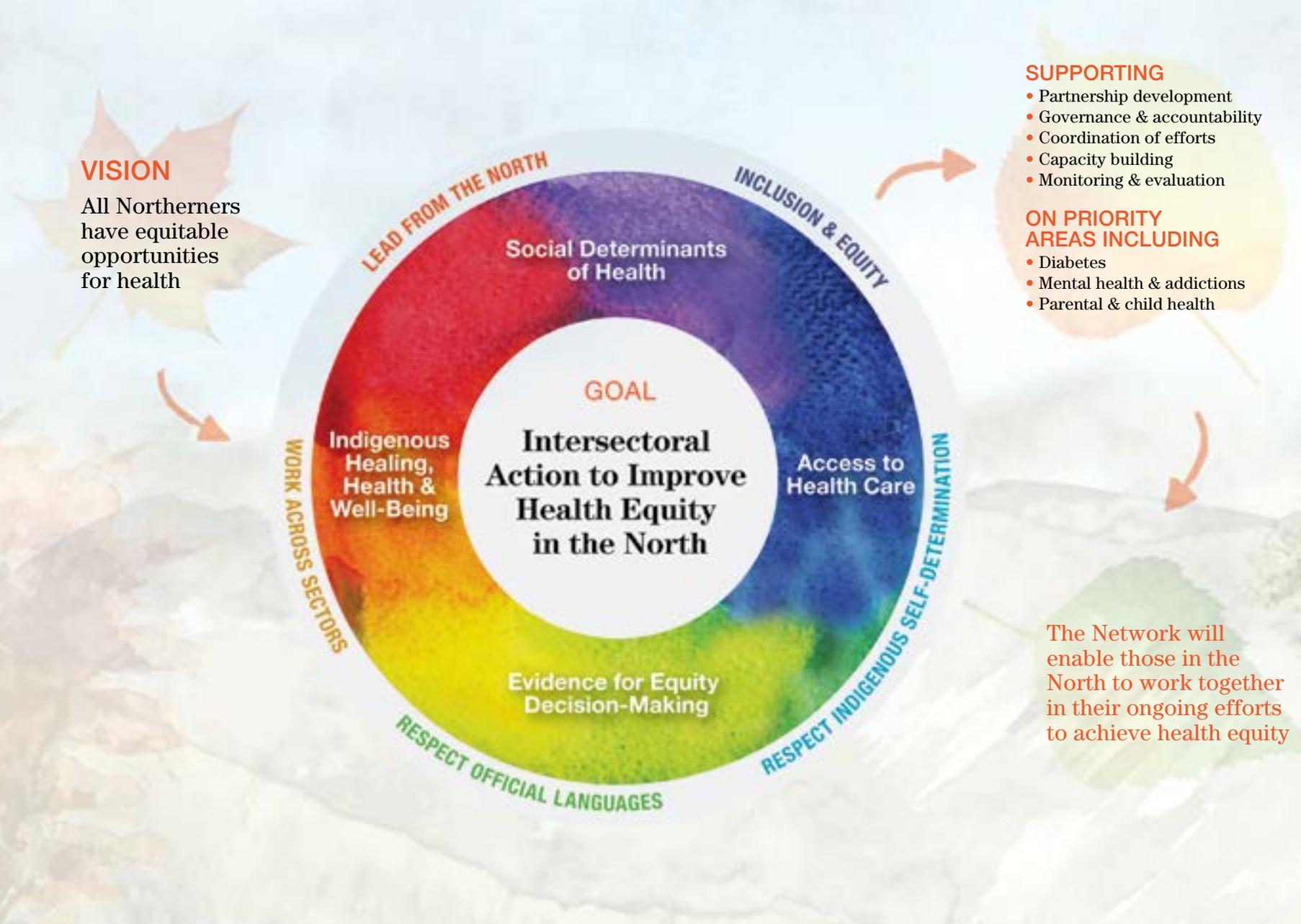


Figure 3: Northern Network for Health Equity



VISION
All Northerners have equitable opportunities for health

- SUPPORTING**
- Partnership development
 - Governance & accountability
 - Coordination of efforts
 - Capacity building
 - Monitoring & evaluation
- ON PRIORITY AREAS INCLUDING**
- Diabetes
 - Mental health & addictions
 - Parental & child health

The Network will enable those in the North to work together in their ongoing efforts to achieve health equity

Functions of the Northern Network for Health Equity:

- Supporting Northern partners to develop deeper health equity commitments within their own organizational goals
- Engaging stakeholders, partners, government at all levels to collaborate and to develop and advance policy solutions to improve health equity
- Collaborating with Northern research groups and agencies to conduct research and surveillance in priority areas to inform health equity action
- Supporting Indigenous researchers as needed to ensure research with Indigenous peoples is Indigenous-led
- Providing guidance, training, technical assistance and leadership to strengthen capacity for health equity work in the North
- Facilitating knowledge exchange in Northern Ontario related to evidence, information and best practices

Four Foundations for Action

Stakeholders from across the North identified four foundations for action which must be addressed to achieve health equity in the North. Advances in health equity in the North will rely on progress in each of these areas.

Foundation 1:

Addressing the social determinants of health

Foundation 2:

Equitable access to high-quality and appropriate health care services

Foundation 3:

Indigenous healing, health and well-being

Foundation 4:

Evidence availability for equity decision-making

Network Objectives

Preliminary objectives within each foundation for action of the proposed Network were developed through consultation with Northern stakeholders and solidified through an environmental scan. The objectives are far-reaching and ambitious; however, advances in health equity rely on taking bold action and moving forward for meaningful change. These proposed objectives and options are presented here not as a final mandate, but to reflect the important contributions of participants in the development of this Strategy and to give tangible meaning to the potential for a Northern-led Network. The Network will implement a planning process to further consider these objectives and options for action.

Preliminary objectives within each foundation for action arose from engagement.

Foundation 1: Addressing the Social Determinants of Health

1.1

Improve awareness of the social determinants of health and Indigenous determinants of health in the general public and among health care and social service providers

Awareness of the importance of social determinants of health is a first step in driving policy and program change. This requires working intersectorally to improve awareness about these determinants as well as drivers of health inequity including racism, colonialism, sexism, homophobia, transphobia, ableism and classism.



1.2

Engage partners across sectors to develop poverty reduction strategies

Throughout the engagement process, participants identified poverty as the most important determinant of poor health. Participants emphasized that increased income supports are needed to ensure adequate income to afford food, housing, child care, health-related expenses and other costs of living. Individuals also spoke to initiatives needed to bring communities out of poverty, such as improving housing conditions and supporting educational opportunities for all.

“We need more programs for children and drop-in centres for teens. There are after school programs but they are not affordable for many people. Day care is very expensive. Parents sometimes have to quit their jobs because they can’t afford day care.”

– Parent in a Northern Ontario city

1.3

Work with partners to identify opportunities to improve accessibility to safe, affordable, and culturally appropriate foods across the North

Food security is achieved when people have access to sufficient, safe, nutritious and culturally appropriate food that meets their dietary needs.⁴⁰ Participants noted that food insecurity in Northern Ontario is consistently a problem, both because of poverty and also because of high food prices created by long shipping distances. The loss of traditional food systems has had an additionally devastating impact on food security for Indigenous populations.

1.4

Work collaboratively across the North to improve access to post-secondary education

Access to post-secondary education is an essential driver to ensure income security and long-term health for individuals and their families. More educational opportunities are needed in the North, and solutions are needed to address access issues for those who cannot afford to attend school.

1.5

Engage partners across sectors to improve access to safe and affordable housing

Affordable housing is necessary to prevent people from becoming homeless and to avoid the negative physical and mental health impacts of living in sub-standard housing and/or being precariously housed.

1.6

Work with partners to improve access to early childhood education and care

Children’s health is determined by the health of their families; supports for high quality child care is one way to improve families’ health. High-quality child care supports the growth and development of children and gives every child the best possible start in life and reduces stresses on parents. Many communities in Northern Ontario currently lack high-quality or any child care options at all.

1.7

Work intersectorally to promote social inclusion

Inclusion and a sense of belonging are important contributors to good health. Individuals from marginalized groups are particularly vulnerable to social exclusion, and efforts are needed to improve the sense of belonging for these individuals and groups.

“Promoting cultural identity among children and youth and a strong sense of the community’s history and resilience is critically important to overall community wellness.”

– Community members in a remote First Nations community

How Could the Network Address the Social Determinants of Health?

- Build upon and share social marketing strategies and messaging currently underway in the North to educate the population about the determinants of health, like Public Health Sudbury & Districts' "You can create change!" and "Let's Start a Conversation about health...and not Talk about Health Care at All" campaigns.
- Support community and economic development in the North by identifying stakeholders who will create a shared vision, identify data for proposals, support policy development and advocacy work, and engage in a unified way with government at all levels.
- Develop partnerships with Northern businesses and entrepreneurs and explore social entrepreneurship opportunities.
- Work across sectors to explore options to develop adequate income supports for people living in poverty such as basic income guarantee, increases in social assistance rates, and universal pharmacare.
- Build upon work such as Food Secure Canada's 2016 Report, *Paying for Nutrition: A Report on Food*

Costing in the North in order to increase income supports and food subsidies to ensure access to healthy, affordable food for all. Consider options for partnering with agricultural organizations (i.e., Ontario Federation of Agriculture) and academic institutions (University of Guelph) to further research opportunities for rural and remote communities.

- Support the development of supportive housing, residential managed alcohol programs, and transitional housing. This can build upon the North East LHIN's *Innovative Housing with Health supports in Northeastern Ontario Strategic Plan 2016-2019* and the work in progress in the North West LHIN based upon their 2016 forum, "A Healthy Foundation: Bridging the Gap Between Health and Housing".
- Support the creation of new subsidized day care spaces across the north by working with *Ontario's Renewed Early Years and Child Care Policy Framework* (2017).
- Collaborate with school boards to assist in the implementation of Ontario's Education Equity Action Plan, which aims to make the education system fairer and more inclusive for all students by identifying and eliminating systemic barriers.

Foundation 2: Equitable Access to High-Quality and Appropriate Health Care Services

2.1

Work with relevant providers to promote timely access to and coordination of health care where people live

Access to high quality, coordinated health care leads to better patient experiences and improved health outcomes. Timely access to primary health care allows patients to better manage chronic diseases like diabetes and provides opportunities for them to remain up-to-date with preventive care like immunizations and early detection like cancer screenings. It helps to avoid emergency rooms visits for conditions that can be more appropriately treated by a primary care provider and decreases the worry that patients experience when they don't know when or where they will receive care.⁴¹

One physician working in a Northern hospital described why it is currently being used for emergency housing:

“So much affordable housing has been taken away. It’s particularly challenging when it’s cold, when there’s no family to take them in, they have disabilities. There are currently no units, no adequate shelters, and no options. You can’t kick people out of hospital with nowhere to go.”

Timely access, and access as close to home as possible, to services like obstetrical care, rehabilitation services, palliative care, emergency department and inpatient services are also important for the health of both individuals and communities.

“Health care professionals in the North don’t have access to technology or diagnostics that are common elsewhere. This becomes a recruitment issue as professionals are not willing to work without the diagnostics that they are accustomed to. This speaks to the quality of diagnosis available in small communities in the North and to the resulting treatment. Wages are not the only reason for difficulty in recruitment.”

– CEO of small Northern Ontario hospital



2.2

Work across jurisdictions to improve health care provider recruitment and retention rates

Recruiting and retaining health care providers and staff who have experience in and respect for Northern contexts and who are linguistically and culturally competent, ensures continued opportunities to provide high quality care. In small communities in Northern Ontario, recruitment and retention of physicians and other hospital-based health care providers ensures access as close to home as possible to services beyond primary care.

The Chief and Council of a First Nations community shared their overall frustration with the ever-changing range of providers and transient workers arriving to the community.

2.3

Improve ability of all people, regardless of where they live, to access health care services

Improving access means ensuring inclusive, culturally and linguistically appropriate services are available and barrier-free. It also means providing a means of transportation to assist people in accessing services, both within their own communities and in major health hubs.⁴² It is also important that transportation be available for physicians to move patients to more intensive care and back home again⁴³ and for service providers to provide outreach where people live.⁴⁴

2.4

Improve access to French language health care services

Language and culture play an essential role in the provision of safe, high-quality health care services.⁴⁵ French language services must be supported and enhanced so that Francophones can receive care in their own language and provide informed consent for treatments and procedures.

2.5

Improve access to appropriate and inclusive health care services

Across the North, diverse populations — including, but not limited to those recently arrived in Canada, those living with disabilities, those identifying as LGBTQ2S and those living with low-income — face barriers to care due to a shortage of inclusive and appropriate care from health care providers. Health care providers need training and resources to support diverse populations. This

includes inclusivity training, training for health providers to deliver care to transgender and queer patients, and cultural competency training.

2.6

Improve access to culturally safe health care services for all Indigenous peoples

In alignment with the Truth and Reconciliation Commission's (TRC) Calls to Action regarding education and training, the Government of Ontario announced mandatory Indigenous Cultural Sensitivity and anti-racism training for all public service employees. The intent of this training is for organizations to contribute to the development of necessary skills, knowledge, attitudes and values that support the development of meaningful and informed relationships with Indigenous communities.

In a series of focus groups conducted in Northern Ontario, Francophones whose physicians did not speak French in their appointments found that language affected their patient experience. As one participant shared:

“Conversing in English is a challenge. It is more difficult to feel at ease, and it is an obstacle in the communication process.”⁴⁶

How Could the Network Address Equitable Access to High-Quality and Appropriate Health Care Services?

- Support initiatives aimed to recruit and retain health care professionals, particularly in rural and remote communities.
- Work with the LHIN sub-regions to understand local context, and support them in the development and delivery of region-appropriate approaches to improving health equity in the populations they serve.
- Engage with the North East and North West LHINs' clinical leadership to promote and support population health approaches to care with the goal of achieving health equity.
- Support the LHINs with expansion of eConsult to provide primary care providers with better electronic access to specialists for treatment decision support.
- Assess utilization of Ontario Telemedicine Network (OTN) in Indigenous, Francophone, rural and remote communities to work alongside the LHINs to promote and expand the Ontario Telemedicine Network to identify ways to better serve the health care needs of these populations.
- Collaborate with municipalities across Northern Ontario to work with hospitals and the Ministry of Health and Long-Term Care to provide subsidies to transportation providers and to return Ontario Northland to previous levels to increase the number and frequency of trips, especially to major health hubs from outlying areas.

This would build upon the Northwestern Ontario Municipal Association's report, *The future of inter-community bus service in northwestern Ontario*.

- Support the creation and/or expansion of coordinating systems such as Community Health Centres, Aboriginal Health Access Centres, Health Links, rural health hubs, and patient navigator and care coordination programs with partners such as the North East LHIN, North West LHIN, Ontario Hospital Association, and Cancer Care Ontario.
- Support Indigenous Cultural Safety Training and anti-racism training for all health system staff.
- Collaborate with partners like Rainbow Health Ontario to provide LGBTQ2 training for health care providers, and develop a Northern registry of health care providers who are allies and have received this training.
- Collaborate with partners to collect evidence to support policy changes to the Northern Health Travel Grant to meet the needs of people living with low-income who incur costs for both travel and accommodation when receiving care far from home.
- Collaborate with the North East LHIN, North West LHIN and Réseau du mieux-être francophone du Nord de l'Ontario in support of their Joint Action Plan on French Language Services 2016-2019 to improve access and coordination of French language health care services.
- Support the training of all health human resources and providers in the Active Offer of French Language Health Services.

Jordan's Principle

Jordan's Principle is a child-first principle designed to ensure that First Nations children do not experience denials, delays, or disruptions of services ordinarily available to other children due to jurisdictional disputes. Jordan's Principle was named in memory of Jordan River Anderson, an Indigenous child from Norway House Cree Nation, Manitoba, born with a rare neuromuscular disease. Because his medical needs could not be treated on reserve, he was transferred to a hospital in Winnipeg where a team decided Jordan's needs would best be met in specialized foster home closer to his home community. However, federal and provincial governments disagreed regarding financial responsibility for the proposed in-house services, and so Jordan remained in hospital for over two years, though it was medically unnecessary for him to be there. He died in hospital in 2005 at age five, having never spent a day in his family home.

According to Jordan's Principle, when jurisdictional disputes arise between two government parties regarding payment for services for a Status Indian child which are otherwise available to other Canadian children, the government or ministry/department of ***first contact must pay for the services without delay or disruption***. The paying government party can then refer the matter to jurisdictional dispute mechanisms. In this way, the needs of the child get met first while still allowing for the jurisdictional dispute to be resolved.⁴⁷

Jordan's Principle was unanimously adopted by the Canadian House of Commons in 2007. However, in 2017 the Canadian Human Rights Tribunal found the Government of Canada has continued "its pattern of conduct and narrow focus with respect to Jordan's Principle," resulting in unnecessary bureaucratic delays, gaps and denial of essential public services to First Nations Children, and the Tribunal issued its third set of non-compliance orders.

Health Inequities in Northern Indigenous Communities

Colonization and settlement of and around Indigenous communities in Northern Ontario and across Canada have resulted in significant health inequities for Indigenous people.⁴⁸ The 1876 *Indian Act* was enacted to oppress Indigenous people and culture in order to de-populate traditional land and transfer it to settlers and to assimilate Indigenous people into colonial culture and society. It also aimed to undermine treaties and take land.

From the 1880s through to the closure of the last residential school in 1996, children were removed from their families and communities, often separated from their siblings and placed in residential schools where they were victims of widespread abuse. The trauma inflicted on these children continues to impact communities and new generations today. Indigenous communities still experience deep inequities in child welfare and continue to feel the effects of colonial policies designed to suppress culture and cultural practices and erode traditional governments. These colonial policies are built on racist and discriminatory mentalities that are embedded in health and social systems and institutions. Systemic racism and discrimination has resulted in marginalization in all areas of public life including, but not limited to, inadequate access to health care.⁴⁹

Overall, Indigenous people are more likely to experience poverty than non-Indigenous people in Canada.⁵⁰ These high rates of poverty are

directly related to systemic racism which results in unequal distribution of resources, including income, education, employment, housing and health care. In 2011, 29% of Indigenous peoples living off-reserve had less than a high school education, compared to 12% of the non-Indigenous population.⁵¹ Among adults, only 38% of off-reserve Indigenous respondents reported being currently employed, compared to 53% of the general Canadian population.⁵² First Nations people living on reserve are seven times more likely to live in crowded homes, and six times more likely to live in homes in need of major repairs than the non-Indigenous population.

There is progress being made to reduce these inequities. Across Ontario, Indigenous leadership is driving change and improving the health and well-being of Indigenous people, through creating opportunities for community ownership and self-determination with respect to the underlying determinants of health, such as education, economic development and health. Additionally, the growing understanding among the general public about the importance of reconciliation is a promising step toward eliminating the health inequities faced by Indigenous people in Northern Ontario.

Foundation 3: Indigenous Healing, Health and Well-being

3.1

Work collaboratively across jurisdictions to provide equitable health care services to all Indigenous people

Providing equitable opportunities for physical and mental health for Indigenous populations may mean that services are provided in different locations, in different ways, and that are community-determined, trauma-informed and culturally safe. Old system patterns can not be changed unless underlying assumptions, policies, and services, together with attitudes and behaviours, are challenged. New delivery systems must be developed with an Indigenous worldview and within the control of an Indigenous framework. For equity to be achieved, Jordan's Principle (see page 42) must be upheld for children and expanded to all First Nations people. Urban Indigenous people require culturally-specific health care services for improved health service access and equity and overall improved health outcomes.⁵³

Indigenous healing and wellness must be guided by Indigenous beliefs, values, customs, languages and traditions that complement those of the current and future health systems. The health system in large part operates from a curative perspective while Indigenous culture-based approaches, which are holistic in nature, emphasize health promotion and prevention as an ongoing component of health. Indigenous communities recognize healers, medicine people, Elders, midwives, community health workers, and community support systems, along with providers represented in the *Ontario's Regulated Health Professions Act*, as health care providers.

“How many organizations do HR right? How many have looked at the tool they use in hiring to make sure it is appropriate for Indigenous culture and hiring? There needs to be personal accountability in leadership to ensure that Indigenous people are not excluded within the hiring process. This DSSAB is revisiting how we recruit new hires. If we have to repost three times, we are doing something wrong.”

– CEO of a Northern Ontario DSSAB (District Social Services Administration Board)

3.2

Move forward the Truth and Reconciliation Commission of Canada's Calls to Action,⁵⁴ and support the efforts of Indigenous people in achieving self-determination

The Truth and Reconciliation Commission (TRC) of Canada's Calls to Action call upon all levels of government to acknowledge that the current state of Indigenous health in Canada is a direct result of discriminatory policies and practices. To move forward, it is necessary to resolve jurisdictional disputes, develop indicators to close health gaps, provide sustainable funding for Indigenous healing centres and to support the use of Indigenous healers alongside the Canadian health care system. In addition, the TRC calls upon the health system to increase the number of Indigenous health care providers, ensure their retention in Indigenous communities, and to ensure Indigenous cultural safety training for all health care providers. Beyond health, the 94 Calls to Action seek to address child welfare, education, language and culture, justice, and outline steps toward reconciliation.

Non-Indigenous approaches to health programs and services for Indigenous people are not well-received in Indigenous communities as they often fail to reflect Indigenous values, beliefs and traditions. This failure inhibits their uptake and effectiveness in dealing with the significant challenges in health and the social determinants of health with which Indigenous people contend. Ongoing prescriptive solutions by government on Indigenous health issues have entrenched fear and mistrust in the intent and form of health care

services, institutions and systems. A change in approach to Indigenous health issues, supporting Indigenous self-determination, is essential to achieve health equity for Indigenous populations.

3.3

Work with providers and leverage opportunities to facilitate the provision of safe living conditions that allow residents to thrive in all First Nation communities

Assistance is required to ensure safe living conditions, such as in the provision of appropriate, mould-free housing, clean water and sanitation infrastructure. Other infrastructure investments, including paved roads and keeping stray dog populations under control, will also improve living conditions.



“We know that we will have less visits to the emergency department for asthma treatment if people are not living in substandard housing. There are also less visits to the emergency department when people can afford to buy the medications that they have been prescribed. Acute care is important but if we don’t deal with the issues that are making people sick, we will never get ahead.”

– Health care provider in remote First Nations communities

3.4

Support Indigenous culture as a determinant of Indigenous health

Over centuries, Indigenous people have been subject to a cultural genocide through colonial and Canadian laws and policies (both past and current) to eliminate or negate their cultural identity, which has had devastating impacts on their health and well-being. When Indigenous culture is able to flourish in the lives of Indigenous people, it can positively transform all aspects of life, including health. Various components of culture, including spirituality, sport, food, craft, and connection to the land are all integral to Indigenous identities. Understanding and supporting of culture as a key driver of creating healthy, self-sufficient and vibrant individuals and communities is essential to ensuring Indigenous healing, health and well-being.

Foundation 4: Evidence Availability for Equity Decision-Making

4.1

Develop a Northern Ontario Data Strategy to streamline collection, analysis, and interpretation of data for equity decision-making.

Practice, program and service decisions to improve health equity must be based on the best available evidence. A data strategy would provide a systematic approach to guide, support and synchronize the work of multiple organizations that are collecting population-based data. The development and refinement of indicators

and metrics from a Northern perspective would bring increased relevance and value to Northern health and health equity work.

4.2

Support local engagement in research and use of evidence

Community direction and involvement in data collection, evidence use and research contributes to increased relevance of the processes, and better, more grounded decisions.

“Accurate statistics are required to provide a complete picture of the population we serve so that we can better serve these populations and advocate for them.”

– Public Health leader in Northern Ontario

How Could the Network Address Indigenous Healing, Health and Well-Being?

- Develop accountability structures to ensure implementation of the *Truth and Reconciliation Commission Calls to Action* (2015) among all Network partners.
- Work toward the availability of Indigenous language translation services in hospitals. For example, the Meno Ya Win Health Centre in Sioux Lookout has devised a translation guide; similar guides can be developed for other communities.
- Secure funding for Indigenous organizations to develop programs to support Indigenous cultural practice, including hunting, fishing and harvesting traditional foods, learning history, language, craft, and sports.
- Coordinate provincial, federal and First Nations governing bodies on funding for infrastructure projects such as roads, hospitals, schools, and housing in First Nations communities to ensure safe and healthy living conditions.
- Create an opportunity for Indigenous communities and the health and public health sectors to collaborate with post-secondary research and educational institutions to promote the Truth and Reconciliation Calls to Action by building on the *Northern Ontario School of Medicine's Response to the Truth and Reconciliation Commission's Calls to Action* (2017).
- Encourage all health and social service providers to take Indigenous cultural competency training that is delivered by Indigenous organizations, such as Ontario's Indigenous Cultural Safety Training Program.
- Support public health programs within Indigenous communities and learn from existing models. Weeneebayko Area Health Authority and Sioux Lookout First Nation Health Authority, for example, have undergone extensive community engagement to move forward expanded public health service in the communities they serve.

How Could the Network Address Evidence Availability for Equity Decision-Making?

- Support the development of service agreements that encourage data sharing among organizations to facilitate program planning.
- Ensure the application of OCAP® (Ownership, Control, Access and Possession)⁵⁵ or similar data governance principles for those collecting data from First Nations, Inuit and Métis communities.
- Support the application of principles for ethical, culturally appropriate and community-led research in Indigenous communities, which can be informed by the USAI (Utility, Self-Voicing, Access, Inter-Relationality) Research Framework as developed by the Ontario Federation of Indigenous Friendship Centres.
- Systematically collect data related to the Francophone population through the Linguistic Variable in health records and share this information with system planners in order to plan for French language services.
- Provide a forum for collaboration for partners such as the Institute for Clinical Evaluative Sciences North (ICES North), the Centre for Rural and Northern Health Research (CRaNHR), Canadian Institute for Health Information (CIHI), and the Northern Policy Institute (NPI) to identify Northern Ontario health equity indicators that could be used to measure progress in achieving health equity.
- Support collaboration with key institutions and agencies working in and supporting the North, such as ICES North, CRaNHR, Our Health Counts Ontario, and the NPI to support local research, evaluation, and analysis that is suitable for the unique northern context, geography, and populations.
- Assist health and social service agencies with the adoption of the Health Equity Impact Assessment and other tools to be used for program planning and decision making.
- Partner with communities to develop local research capacity including support for research design, data collection, analysis and data sharing to improve local programming and health equity across the North.



Moving Forward: Impacts

Taken together, the actions of a coordinated Network will create opportunities for advancing health equity, with resulting impact in critical areas including mental health and addictions, diabetes prevention and management, and parental and child health. These, and other health issues that are strongly influenced by social and economic conditions, will benefit from an equity-focused intersectoral approach that addresses multiple factors related to health and well-being.

Specific goals of the strategy will be determined by the Network Steering Committee and working group members. The roadmap below outlines the Network's short- and long-term deliverables:

In the first two years

- Establish the Network Steering Committee, with geographic and sectoral representation
- Hire core Network staff
- Develop the foundations for collaboration as a basis for action to achieve health equity, such as processes for engagement, inclusion and consultation, development of a Network Charter, and work with Network member organizations on integration of equity priorities into strategic plans
- Undertake process of evidence-informed priority setting, using the potential objectives and actions the Network can take to meet the goal of achieving health equity in the North as a starting point
- Undertake coordinated actions to address determinants of health, building on and strengthening capacity through work already underway within sectors
- Regularly inform government about the priorities of Network partners and the Network work plan.

In five years

- Continue to undertake coordinated actions to address determinants of health, building on work already underway within sectors
- The development, measurement and reporting of Northern-relevant equity and health indicators

In ten years

- Improvements in indicators of equity and health among Northern populations
- Progress in equity priority areas identified by Network partners

Next Steps

The formation of the Northern Network for Health Equity is the first step in moving forward the objectives of this strategy. The development of the Network would require commitments of stakeholders across Northern Ontario, and staff support to bring Network partners together.

The Strategy is an expression of the ambition, the passion, and the dedication of health and social sectors to work together for a more equitable, healthier Northern Ontario. Through developing this Strategy, we have heard that across the North, and across sectors, there is recognition of a societal obligation to address the pressing inequities facing Northerners. This Strategy is intended to create the foundation to move toward achieving health equity in the North, and will develop capacity to address pressing health equity challenges in the future.

This Network is an ambitious undertaking. It aspires to connect and align diverse leaders and communities from across a large geographical area. If successful, it will achieve the Strategy's vision of equitable opportunities for health for all Northern Ontarians.



Appendix A: Methodological Approach

Described below is the process used for the creation of the Northern Ontario Health Equity Strategy. Direction for the strategy and this report was provided by Health Quality Ontario in conjunction with the Northern Ontario Health Equity Strategy Steering Committee. Engagement was conducted by the team from the Public Health Sudbury & Districts with support from Health Quality Ontario and environmental scans were conducted by both the Health Quality Ontario and Public Health Sudbury & Districts teams.

Formative Phase

Health Quality Ontario developed a Health and Health Care Equity plan for the organization. One of its priorities of this plan is to work in partnership to develop a Northern Ontario Health Equity Strategy. To keep this strategy *in the North, by the North, for the North*, a partnership was forged between Health Quality Ontario and the Public Health Sudbury & Districts which provided a Northern Ontario team. To oversee the Northern Ontario Health Equity Strategy and champion the strategy's recommendations, a steering committee was struck which included

individuals with experience of health inequities in the North which represented the following areas: Indigenous, Francophone, public health, health care, mental health, research, and education. Groups participating in the steering committee included Health Quality Ontario, Public Health Sudbury & Districts, Northwestern Health Unit, North West Local Health Integration Network, North East Local Health Integration Network, Canadian Mental Health Association, Centre for Rural and Northern Health Research, Ministry of Health and Long Term Care, Northern Ontario School of Medicine, Sioux Lookout First Nation Health Authority, Réseau du mieux-être francophone du Nord de l'Ontario, as well as community representation.

Planning Meeting Preparation

Names of those interested in health equity work were gathered by Health Quality Ontario and others who had been involved in initial discussions with Health Quality Ontario and Public Health Sudbury & Districts about the creation of a Northern Ontario Health Equity Strategy. Invitations to the planning meeting were sent to people on this list. Anyone that

approached the planning committee with interest in attending was also included in the meeting.

In preparation for the meeting, an environmental scan was conducted to find existing health equity strategies (mainly from Ontario but a few were included from Canada and beyond). Selected strategies were used to help define a potential scope for the Northern Ontario strategy.

Planning Meeting

Sixty Northern Ontario leaders, academics, health and social service providers, policy makers, funders and individuals with lived experience gathered for a one day meeting at the Northern Ontario School of Medicine simultaneously in Sudbury and Thunder Bay, the traditional territories of the Atikameksheng Anishnawbek and Fort William First Nations, while others participated remotely.

The purpose of the planning meeting was to identify health equity initiatives, scope for future health equity work, and a process for developing a Northern Ontario health equity strategy.

An exercise was completed by participants to help define the scope of the strategy. Twenty-six statements were presented to the groups, as collated from the environmental scan, and participants ranked their top ten choices and added some of their own. These were discussed in small groups and the top five picks of the groups were collated to inform the scope. Five areas of focus rose to the top: addressing the determinants of health, equitable access to health care services, Indigenous health, data availability for decision making, and partnership and collaboration. It was decided that the first four would become areas of focus with awareness that partnership and collaboration would be foundational for all areas of focus.

Participants were asked about who should be engaged and how they should be engaged. There was a very clear indication that discussions needed to occur at the community level, in English and French, with individuals, caregivers, service providers, and municipal and Indigenous leadership. It was also thought that discussion should include provincial and federal government representatives to further understand jurisdictional and ministerial barriers. It was thought best to consult with communities on how best to reach participants. It was considered important for consultations with decision makers, front line workers and those with lived experience be face-to-face where possible. These needed to be coordinated to fairly represent the Northwest and Northeast, rural, urban and remote settings, and Indigenous and non-Indigenous communities.

Engagement Process

The engagement process was twofold:

Engagement discussions through the Steering Committee members' existing committees:

Steering Committee members identified appropriate meetings to discuss the Northern Ontario Health Equity Strategy and solicit feedback from meeting participants; and

Key stakeholder discussions with individuals and groups:

The steering committee and planning meeting participants identified additional key stakeholders that must be engaged to assist in providing a complete picture of the health equity landscape in Northern Ontario and recommended future actions. Invitees included people from urban, rural, remote, and First Nation communities. Front-line providers, decision makers and people facing inequities were invited to participate.

Engagement Questions

How do we create awareness of and act upon the social determinants of health?

What needs to be done to improve access to high quality health care that is timely, available, and appropriate?

What needs to be done to improve Indigenous healing, health and well-being?

What is the best approach to collecting and accessing data for health equity planning and service delivery?

Engagement sessions

In order to answer the above questions 32 group discussions were held (with more than 300 participants in total, representing 125 agencies) and five key informants throughout the Northeast and Northwest were engaged. These participants represent community members, front line workers, and decision makers and individuals living in rural, urban and Indigenous settings. A list of agencies represented during engagement sessions can be found in Appendix B. Groups were engaged through focus groups.

The engagement sessions and key stakeholders interviews were conducted by the Northern Ontario Health Equity Strategy Project Officer and the Project Lead in both French and English.

Analysis

Information from the engagement sessions and interviews were analyzed using themes generated from the engagement questions. Statements were broken down into health inequities and proposed solutions for achieving health equity. Subthemes were identified for most areas of focus. From here, overarching principles, objectives, actions, and a single recommendation for the strategy were created.

Validation

The results of the engagement sessions were validated by the Steering Committee and at the Northern Ontario Health Equity Strategy Summit on May 25, 2017. The purpose of the Summit was to clarify and validate the findings and proposed solutions and to work through ideas for implementing the proposed solutions. Further validation of principles and objectives and a single recommendation which were derived from engagement and summit occurred through an online French and English survey sent to all steering committee, planning meeting, engagement, and summit participants. Principles and objectives were modified as per survey responses.

build upon. Given that the recommendation of the strategy was to create a Northern Network for Health Equity in Northern Ontario, a search was conducted to find potential models for a collaborative network and for existing collaborative networks upon which a Network could be based.

Additional and Ongoing Engagement

Additional engagement was conducted post summit based on identified gaps as well as to engage groups that were unavailable during the initial phase of engagement. These engagement sessions used more targeted questioning to fill in identified gaps.

Secondary literature searches

A secondary literature search was completed to fact check the information collected during engagement. A provincial scan was conducted to locate existing government programs that the Northern Ontario Health Equity Strategy could

Appendix B: List of Engagement Participants and Partners

Members of the following organizations contributed to the development of this document.
We are grateful for their wisdom and interest in the advancement of health for those living in Northern Ontario.

L'Accueil Francophone, Thunder Bay

AEFO, Thunder Bay

Algoma Family Services

Algoma Public Health

Alzheimer's Society, Manitoulin

AIDS Committee of North Bay and Area

Anishnawbe Mushkiki, Thunder Bay

Assiginack Family Health Team

Assisted Living, Manitoulin

Atikameksheng Anishnawbek

Atikokan General Hospital

Attawapiskat First Nation

Brain Injury Service of Ontario

CMHA, Cochrane/Temiskaming

CMHA, Fort Frances

CMHA, Kenora

CMHA, Sault Ste. Marie

CMHA, Sudbury/Manitoulin

Canadian Red Cross, Timmins

Cancer Care Ontario

Carrefour Santé de Kapuskasing

Carrefour Santé de Kirkland Lake

Carrefour Santé de Timmins

Centre de santé communautaire
du Grand Sudbury

Centre de santé communautaire du Temiskaming

Centre for Rural and Northern Health Research

Centr'Elles, Thunder Bay

City of Greater Sudbury

City of Kenora

City of Sault Ste. Marie

Cochrane District EMS

Cochrane District Social Planning Council

Cochrane DSSAB

Cochrane Temiskaming Resource Centre

Community Care Access Centre, Little Current

Community Care Access Centre, Kirkland Lake

Community Living, Fort Frances & District

Community Living Manitoulin

Conseil scolaire catholique de district des Grandes-Rivières	Health Sciences North	Monarch Recovery Services
Conseil scolaire de district catholique des Aurores boréales, Thunder Bay	Health Sciences North, Mental Health and Addiction, Manitoulin	Neighbourhood Resource Centre, Sault Ste. Marie
Conseil scolaire de district du Nord-Est de l'Ontario, Timmins	Huron School Board	Nipissing University
Consortium National de Formation en Santé, Université Laurentienne, Sudbury	Institute of Clinical Evaluative Sciences (ICES) North	Nokiiwin Tribal Council
Constance Lake First Nation	Independent First Nations Alliance, Sioux Lookout	Noojmowin Teg Health Centre
Crane Institute for Sustainability, Sault Ste. Marie	Jubilee Centre, Timmins	North Bay and District Multicultural Centre
Dilico Anishinabek Family Care, Fort William First Nation	Kapuskasung community members	North Bay Parry Sound District Health Unit
Elder Abuse Ontario	Kenora Association for Community Living	North Eastern Ontario Family and Children's Services, Timmins
Elevate NWO	Kenora Chiefs	North East Local Health Integration Network
Elliot Lake Family Health Team	Lakehead University	Northeastern Manitoulin Family Health Team
Elliot Lake Pride	Laurentian University	Northern Ontario School of Medicine
Emo & Area Assisted Living	M'Chigeeng Health Centre	Northern Ontario Service Deliverers Association
Englehart & District Hospital	Maamwesying North Shore Community Health, Cutler	Northwestern Health Unit
Espanola Rural Health Hub	Maison McCulloch Hospice, Sudbury	North Shore Health Centre
Firefly Best Start Hub, Kenora	La Maison Verte, Hearst	North West Local Health Integration Network
Fort Frances Tribal Health Services	Manitoulin Central Family Health Team	NorthWest LHIN Regional Palliative Care Program
Fort William First Nation	Manitoulin Health Centre	NorWest Community Health Centres
Foyer des Pionniers, Hearst	Manitoulin Sudbury DSB Paramedic Services, Little Current	Notre-Dame Hospital, Hearst
Gizhewaadiziwin Health Access Centre, Fort Frances	Marathon Family Health Team	Ontario Hospital Association
Group Health Centre, Sault Ste. Marie	Ministry of Health and Long-Term Care	Ontario Native Women's Association
	Misiway Milopemahtesewin Community Health Centre, Timmins	Ontario Federation of Indigenous Friendship Centres
		Ontario Provincial Police, Fort Frances

Ornge	Sioux Lookout Meno Ya Win Health Centre
Porcupine Health Unit, Timmins	Smooth Rock Falls Health Centre
Pratique de Sage-femme de Hearst	South Cochrane Addiction Service
Pride Manitoulin	Sudbury Action Centre for Youth
Project Love, Timmins	Public Health Sudbury & Districts
Rainbow Health Ontario	Superior Family Health Team
Rainy River District School Board	Temiskaming Health Unit
Rainy River DSSAB	Temiskaming Hospital
Regional Rehabilitative Care Programs	TG Innerselves
Réseau du mieux-être francophone du Nord de l'Ontario Sudbury	Thunder Bay District Health Unit
Réseau du mieux-être francophone du Nord de l'Ontario, Timmins	Thunder Bay Pride
Réseau du mieux-être francophone du Nord de l'Ontario, Thunder Bay	Thunder Bay Regional Health Sciences Centre
Riverside Health Care, Fort Frances	Thunder Bay Regional Palliative Care Program
Sagamok Anishnawbek First Nation	Timmins Family Health Team
St. Joseph's Care Group	Grand Council Treaty #3
St. Joseph's General Hospital, Elliot Lake	United Native Friendship Centre, Fort Frances
Sault Area Hospital	Victoria Order of Nurses, Little Current
Sault College	Weeneebayko Area Health Authority
Sensenbrenner Hospital, Kapuskasing	West Nipissing General Hospital
Serpent River First Nation	Wikwemikong Health Centre
Shelter House, Thunder Bay	West Parry Sound Health Centre
Sioux Lookout First Nation Health Authority	

Appendix C: Northern Ontario Health Equity Steering Committee

Dr. Penny Sutcliffe (Co-chair)

Medical Officer of Health & CEO, Public Health Sudbury & Districts

Alex Vistorino (Co-chair)

Acting Co-Director Health System Design & Development,
North West LHIN

Marion Quigley

Executive Director, CMHA Sudbury/Manitoulin

Dr. Jeffrey Turnbull

Chief, Clinical Quality, Health Quality Ontario

George Stephen

Indigenous Lived Experience Advisor

Alain Gauthier

Associate Professor, Laurentian University

Sharon Lee Smith

Associate Deputy Minister, Policy and Transformation,
Ministry of Health and Long-Term Care

Kate Fyfe

Interim Chief Executive Officer and VP, Performance and Accountability,
North East LHIN

Terry Tilleczek

Vice President, Strategy and System Planning, North East LHIN

Laura Kokocinski

Chief Executive Officer, North West LHIN

Robert Barnett

Administrative Director, Community Engagement and Integrated
Clinical Learning (CEICL)
Northern Ontario School of Medicine (NOSM)

Dr. Kit Young-Hoon

Medical Officer of Health, Northwestern Health Unit

Diane Quintas

Directrice générale/Executive Director Réseau du mieux-être
francophone du Nord de l'Ontario

Janet Gordon

Chief Operating Officer, Sioux Lookout First Nations Health Authority

Endnotes

- ¹ Statistics Canada, Canadian Vital Statistics, Death Database and Demographic Division, CANSIM table 102-4315. CANSIM table 102-4307.
- ² Booth, G.L., Lipscombe, L.L., Bhattacharyya, O., Feig, D.S., Shah, B.R., Johns, A., Degani, N., Ko, B. & Bierman, A.S. (2012). Diabetes. In A.S. Bierman (Ed.), Project for an Ontario Women's Health Evidence-Based Report, vol. 2, Toronto. Retrieved from <http://www.powerstudy.ca/power-report/volume2/diabetes/>; Institute of Clinical Evaluative Sciences (2015) The Mental Health of Children and Youth in Ontario: A Baseline Scorecard. Retrieved from <https://www.ices.on.ca/Publications/Atlases-and-Reports/2015/Mental-Health-of-Children-and-Youth>; Ward M.S., Sahai, V.S., Tilleczek, K.C., Fearn, J.L., Barnett, R.C., & Zmijowskyj, T... (2005) Child and Adolescent Health in Northern Ontario: a quantitative profile for public health planning. *Canadian Journal of Public Health* 96(4): 287-290;
- ³ World Health Organization. (2008). Social determinants of health. Key concepts. Retrieved 24 October 2017 from: http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html
- ⁴ Kawachi, I., Subramanian, S.V., & Almeida-Filho, N. (2002). A glossary for health inequalities. *Journal of Epidemiology and Community Health*, 56, 647–652.
- ⁵ National Collaborating Centre for Determinants of Health. (n.d). Glossary: Health inequity/health equity. Retrieved 13 December 2017 from <http://nccdh.ca/resources/glossary>
- ⁶ Ontario Public Health Association. (2015). Position statement on applying a health equity lens. Retrieved 24 October 2017 from: <http://www.opha.on.ca/Position-Papers/Applying-a-Health-Equity-Lens.aspx>
- ⁷ Saskatoon Health Region. (2014). Better Health for All: Health Status Reporting Series 3 Advancing Health Equity in Health Care. Saskatoon, SK: Author. Retrieved on 24 October 2017 from: https://www.saskatoonhealthregion.ca/locations_services/Services/Health-Observatory/Pages/ReportsPublications.aspx
- ⁸ Refers collectively to Lesbian, Gay, Bisexual, Transgender, Queer, 2-Spirited and any other individuals that so identify
- ⁹ The general term of determinants of health is used throughout this document to encompass both the social determinants of health and the Indigenous determinants of health (Greenwood, M., de Leeuw, S., Lindsay, N.M., Reading, C. (Eds.) (2015) *Determinants of Indigenous Peoples' Health in Canada: Beyond the Social*. Canadian Scholars Press.) Specific terms will be used when appropriate.
- ¹⁰ Partnering agencies include: Canadian Mental Health Association, Centre for Rural and Northern Health Research, Health Quality Ontario, Laurentian University, Ministry of Health & Long-Term Care, North East Local Health Integration Network, North West Local Health Integration Network, Northern Ontario School of Medicine, Northwestern Health Unit, Réseau du mieux-être francophone du Nord de l'Ontario, Sioux Lookout First Nation Health Authority and Public Health Sudbury & Districts. The committee also includes a community member advisor.
- ¹¹ Calculated from statistics from the North East LHIN and North West LHIN (2015). Retrieved from: <http://www.nelhin.on.ca/> and <http://www.nwlhin.on.ca>
- ¹² Government of Canada. (2016). Northern Ontario Development Program: Final Evaluation report. Retrieved 24 October 2017 from: https://www.ic.gc.ca/eic/site/ae-ve.nsf/eng/h_03832.html#p1.1
- ¹³ Figure 2 Sources: Population and land mass calculated from the information provided on the NE LHIN and NW LHIN websites and compared to Statistics Canada, CANSIM, table 051-0001. Retrieved from: <http://www.nelhin.on.ca/aboutus.aspx>; <http://www.northwesthin.on.ca>
First Nations communities data retrieved from: <http://firstnation.ca>
Francophone and Indigenous populations calculated from LHIN data. The number of Indigenous people is likely to be significantly underestimated due to data limitations.
- ¹⁴ Based on 2007-2009 data. Statistics Canada, Canadian Vital Statistics, Death Database and Demographic Division, CANSIM table 102-4315. CANSIM table 102-4307.
- ¹⁵ Based on in 2015 data. Ministry of Health and Long-Term Care. (2015). Health Care Experience Survey. (2015).
- ¹⁶ <https://www.fin.gov.on.ca/en/economy/employment>
- ¹⁷ Northern Policy Institute (2015). Making the Grade? *Education Trends in Northern Ontario*. <http://www.northernpolicy.ca/upload/documents/publications/commentaries/commentary-making-the-grade-education-tr.pdf>
- ¹⁸ Royal College of Physicians and Surgeons of Canada. (2014). Indigenous health values and principles statement. *The Indigenous Health Advisory Committee and the Office of Health Policy and Communications*.
- ¹⁹ Northern Policy Institute. (2015). Access to culturally appropriate care for physical and mental health. <http://www.northernpolicy.ca/healthpolicypriorities2>
- ²⁰ Health Quality Ontario. (2017). Health in the North. <http://healthinthenorth.hqontario.ca>
- ²¹ Health Canada. Acting on what we know: Preventing youth suicide in First Nations. (2010). Retrieved 24 October 2017 from: <https://www.canada.ca/en/health-canada/services/first-nations-inuit-health/reports-publications/health-promotion/acting-what-we-know-preventing-youth-suicide-first-nations-health-canada-2003.html>
- ²² Eggertson, E. (2015). Aboriginal youth suicide rises in northern Ontario. *Canadian Medical Association Journal*, 187(11), E335-336.
- ²³ Health Quality Ontario. (2016). Measuring Up. Retrieved 24 October 2017 from: <http://www.hqontario.ca/portals/0/Documents/pr/measuring-up-2016-en.pdf>
- ²⁴ Rabi et al. (2006). Association of socio-economic status with diabetes prevalence and utilization of diabetes care services. *BMC Health Services Research*, 6:124. Retrieved 24 October 2017 from: <https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-6-124>

- ²⁵ Health Analytics Branch (2013). Key performance measures for the Ontario diabetes strategy. Final Report. Ministry of Health and Long-Term Care. Retrieved 24 October 2017 from: http://www.champlandrcc.ca/downloads/toolbox_providers/Key%20Performance%20Measures_Ontario%20Diabetes%20Strategy_Final%20Report%202013.pdf
- ²⁶ First Nations Information Governance Centre (FNIGC) (2012). First Nations Regional Health Survey (RHS) 2008/10: National report on adults, youth and children living in First Nations communities. Ottawa: FNIGC. Retrieved 24 October 2017 from: <http://fnigc.ca/our-work/regional-health-survey/rhs-phase-2.html>
- ²⁷ Wang, Guttman and To (2009). Neighborhood Income and Health Outcomes in Infants. *Arch Pediatr Adolesc Med.* 2009;163(7):608-615. doi:10.1001/archpediatrics.2009.36
- ²⁸ Smylie, J et al (2010). A Review of Aboriginal Infant Mortality Rates in Canada: Striking and Persistent Aboriginal/Non-Aboriginal Inequities. *Canadian Journal of Public Health*, (101), 143-48.
- ²⁹ First Nations Information Governance Centre (FNIGC) (2012). First Nations Regional Health Survey (RHS) 2008/10: National report on adults, youth and children living in First Nations communities. Ottawa: FNIGC. Retrieved 24 October 2017 from: <http://fnigc.ca/our-work/regional-health-survey/rhs-phase-2.html>
- ³⁰ Lo et al. on behalf of Knowledge Synthesis Group on Determinants of Preterm/LBW Births. (2011). Pregnancy and neonatal outcomes of aboriginal women: A systematic review and meta-analysis. *Women's Health Issues* 21: 28-39.
- ³¹ Kelly, L., Guilfoyle, J., Dooley, J., Antone, I., Gerber-Finn, L., Dooley, R.,...Maki, J. (2014). Incidence of narcotic abuse during pregnancy in northwestern Ontario: Three year prospective cohort study. *Canadian Family Physician.* 60(10), e493-e498.
- ³² Kelly, L., Guilfoyle, J., Dooley, J., Antone, I., Gerber-Finn, L., Dooley, R.,...Maki, J. (2014). Incidence of narcotic abuse during pregnancy in northwestern Ontario: Three year prospective cohort study. *Canadian Family Physician.* 60(10), e493-e498.
- ³³ Food Secure Canada. (2016). Paying for Nutrition: A Report on Food Costing in the North. Retrieved 24 October 2017 from: https://foodsecurecanada.org/sites/foodsecurecanada.org/files/201609_paying_for_nutrition_fsc_report_final.pdf
- ³⁴ Government of Canada. (2017). Household food insecurity in Canada statistics and graphics (2011 to 2012). Retrieved from: <https://www.canada.ca/en/health-canada/services/nutrition-science-research/food-security/household-food-security-statistics-2011-2012.html>
- ³⁵ Canadian Mental Health Association. (2017). Rural and Northern Community Issues in Mental Health. Retrieved from: <https://ontario.cmha.ca/documents/rural-and-northern-community-issues-in-mental-health>
- ³⁶ Government of Canada. (2017). Drinking water advisories: First Nations south of 60. Retrieved 24 October 2017 from: <https://www.canada.ca/en/health-canada/topics/health-environment/water-quality-health/drinking-water/advisories-first-nations-south-60.html#ont>
- ³⁷ Ministry of Health and Long-Term Care. (2015). Patients First: A proposal to strengthen patient-centred health care in Ontario. Discussion Paper, December 17, 2015. http://www.health.gov.on.ca/en/news/bulletin/2015/docs/discussion_paper_20151217.pdf
- ³⁸ Ontario Public Health Association. (2015). Position statement on applying a health equity lens. Retrieved 24 October 2017 from: <http://www.opha.on.ca/Position-Papers/Applying-a-Health-Equity-Lens.aspx>
- ³⁹ Anderson L and Um S. (2015). International Review of Health Equity Strategies. Toronto: Wellesley Institute. <http://www.wellesleyinstitute.com/wp-content/uploads/2016/07/International-Review-of-Health-Equity-Strategies.pdf>
- ⁴⁰ Government of Ontario. (2017). Building Ontario's First Food Security Strategy. Retrieved 24 October 2017 from: <https://www.ontario.ca/page/building-ontarios-first-food-security-strategy>
- ⁴¹ Government of Ontario. (2014). Excellent Care for All. Retrieved 24 October 2017 from: http://www.health.gov.on.ca/en/pro/programs/ecfa/action/primary/pri_access.aspx
- ⁴² Ontario Ministry of Health and Long-Term Care. Rural and Northern health care framework/plan. Stage 1 report. Retrieved 24 October 2017 from: http://www.health.gov.on.ca/en/public/programs/ruralNorthern/docs/report_rural_Northern_EN.pdf
- ⁴³ Ontario Ministry of Health and Long-Term Care. Rural and Northern health care framework/plan. Stage 1 report. Retrieved 24 October 2017 from: http://www.health.gov.on.ca/en/public/programs/ruralNorthern/docs/report_rural_Northern_EN.pdf
- ⁴⁴ Canadian Mental Health Association. (2009). Rural and Northern Community Issues in Mental Health. Retrieved 24 October 2017 from: <https://ontario.cmha.ca/documents/rural-and-northern-community-issues-in-mental-health>
- ⁴⁵ Joint Action Plan on French Language Services. (2015). Retrieved 24 October 2017 from: http://www.reseaudumieuxetre.ca/wp-content/uploads/2016/06/Joint-Action-Plan_NE-LHIN-NW-LHIN-RMEFNO-2016-2019.pdf
- ⁴⁶ CRaNHR (2017). Linguistic Concordance and Discordance: Understanding the Francophone Patient Experience during a visit to their Family Physicians' Office in Northern Ontario. Research in focus on research. Retrieved 24 October 2017 from: http://docs.wixstatic.com/ugd/bca2bf_7518bbe5d7ea403aa269f7aa1c0d1f18.pdf
- ⁴⁷ First Nations Child and Family Caring Society of Canada(2011). Jordan's Principle. <https://fncaringsociety.com/jordans-principle>
- ⁴⁸ Frideres and Gadacz (2011). *Aboriginal Peoples in Canada* (9th ed.). Toronto: Pearson Canada
- ⁴⁹ Waldram, J.B. Herring, A., Young, T. K. (2006). *Aboriginal health in Canada. Historical, cultural, and epidemiological perspectives.* 2nd edition. University of Toronto Press.
- ⁵⁰ Wien, F. (2017). Tackling poverty in Indigenous communities in Canada. NCCA: Retrieved 24 October 2017 from https://www.ccsa-nccah.ca/495/Tackling_Poverty_in_Indigenous_Communities_in_Canada.nccah?id=196
- ⁵¹ Statistics Canada (2011) National Household Survey
- ⁵² Statistics Canada (2011) National Household Survey
- ⁵³ British Columbia. Provincial Health Officer. (2009). *Pathways to Health and Healing – 2nd Report on the Health and Well-being of Aboriginal People in British Columbia.* Provincial Health Officer's Annual Report 2007. Victoria, BC: Ministry of Healthy Living and Sport.
- ⁵⁴ Truth and Reconciliation Commission of Canada. (2015). Calls to Action. Retrieved 24 October 2017 from: http://nctr.ca/assets/reports/Calls_to_Action_English2.pdf.
- ⁵⁵ OCAP® is a registered trademark of the First Nations Information Governance Centre (FNIGC) (www.FNIGC.ca/OCAP)

Health Quality Ontario

Let's make our health system healthier

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Association of Local
PUBLIC HEALTH
Agencies

Information Break

April 12, 2018

This 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.

ALPHA Election Policy Priorities Update

In the winter, ALPHA developed a set of election policy priorities in anticipation of the June 2018 provincial election. The priorities focused on a tobacco endgame, adult oral health, universal pharmacare, cannabis legalization and opioids strategy, and were sent to provincial party leaders, health critics, the Minister of Health & Long-Term Care, and Attorney General. As part of this campaign, health units were also asked to reach out to their local MPPs and electoral candidates on these important issues in the leadup to the election. ALPHA is pleased to report that yesterday it met with various key MPPs to raise awareness about the policy priorities.

[View ALPHA's 2018 election policy priorities here](#)

ALPHA 2018 Winter Meetings

ALPHA successfully held business meetings for its board of health (see below) and COMOH members as well as a one-day workshop for public health executive and administrative assistants in February. The assistants' learning event, which takes place every two years, focused on change management from organizational and personal approaches. Thank you to all the attendees who participated at the February events.

[Read about the Executive/Administrative Assistants' workshop here](#)

Wrap Up: Boards of Health Section Meeting

The alPHA Boards of Health Section convened on February 23rd in Toronto. Representatives from 23 boards of health were welcomed by Toronto board of health chair Joe Mihevc who spoke about the important role played by public health in municipal decision-making. Participants also heard guest presentations on the five election policy priorities by members of alPHA's Election Task Force as well as on the administration of the new Ontario Public Health Standards and provisions for electronic meetings by alPHA counsel James LeNoury. Chief Medical Officer of Health Dr. David Williams also provided members with an update on his [annual report that focuses on health equity](#). A special lunch and learn session on "the power of healthy tensions" by Tim Arnold was a particular highlight. The next scheduled BOH Section meeting will take place during the upcoming annual conference on June 12, 2018 in Toronto.

[View presentations from the Feb. 23 BOH Section meeting](#) (login and password required)

2018 alPHA Annual Conference

Join us from June 10 to 12 at the association's 2018 Annual Conference at the Novotel Toronto Centre hotel in downtown Toronto. Under the theme *The Changing Face of Public Health*, attendees will explore ways to deliver on health units' new and current responsibilities in light of recent changes to the Ontario Public Health Standards and other government initiatives. The conference will also feature an Annual General Meeting and resolutions session as well as Section business meetings and a perennial highlight, an awards dinner honouring those who have made outstanding contributions to the field of public health. Online registration is now available. Accommodations may also be booked. [Register here](#)
[Book a questroom here](#)
[Learn more about the 2018 alPHA Annual Conference here](#)

TOPHC 2018

Congratulations to TOPHC 2018 for achieving their biggest event to date with over 1,000 attendees and sold out workshops on day three. The Ontario Public Health Convention (TOPHC) was held March 21-23, and identified ways for public health professionals to be leaders of change as well as explored strategies for leadership, innovation and action across all levels within the public health. As a TOPHC partner, alPHA is proud to support knowledge exchange and skills building for public health staff.

[Read about TOPHC 2018 here](#)

alPHa Website Feature: Correspondences

Stay current with alPHa's advocacy efforts by visiting the Correspondences page on our website.

[View alPHa's recent correspondences](#)

Upcoming Events - Mark your calendars!

June 10, 11 & 12, 2018 - [alPHa Annual General Meeting & Conference](#), Novotel Toronto Centre, 45 The Esplanade, Toronto. Register [here](#).

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.

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Please note that if you unsubscribe, you will no longer receive notices, important announcements, and correspondence from alPHa.

APPROVAL OF CONSENT AGENDA

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

To: René Lapierre, Chair, Board of Health
From: Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer
Date: April 12, 2018
Re: Business Name Registration

For Information

For Discussion

For a Decision

Issue:

Board of Health motion #02-18 endorsed the 2018-2022 strategic plan and visual identity as presented, including the new operating name, Public Health Sudbury & Districts. The Board is now required under the *Business Names Act (Ontario)* to register the new operating name

Recommended Action:

That the Board of Health for Sudbury & District Health Unit adopt the business name Public Health Sudbury & Districts and that its solicitors be instructed to take all required steps to register the aforesaid business name pursuant to the *Business Names Act (Ontario)*.

Background:

At the January 18, 2018 meeting, the Board of Health for the Sudbury & District Health Unit (the "Corporation") approved the 2018-2022 Strategic plan which included a refresh of our visual identity and an endorsement to identify itself publicly using the business name Public Health Sudbury & Districts.

The Health Protection and Promotion Act (HPPA) provides that we are a corporation without share capital and specifies that our name shall be the "Board of Health for the Sudbury & District". As a Corporation, the Health Unit is subject to the provisions of the *Business Names Act of Ontario (BNA)* which stipulates that "no corporation shall carry on business or identify itself to the public under a name other than its corporate name unless the name is registered by that corporation". (BNA, ss2(1)).

As a corporation, should we carry on business in violation of the BNA, we would be unable to maintain a court proceeding in Ontario in connection with our business, except with the permission of the court. Considering that the Health Unit undertakes proceedings in Provincial Offences Court, we do not wish to be faced with a situation where we are not able to proceed until we register our business name or

2018–2022 Strategic Priorities:

1. Equitable Opportunities
2. Meaningful Relationships
3. Practice Excellence
4. Organizational Commitment

O: October 19, 2001
R: January 2017

even, have our proceedings terminated as a result of not having properly registered our business name.

Note that any registration filed under the BNA is valid for a period of five years only and can be renewed at any time during the five-year period of registration.

Financial Implications:

Registration and legal fees will cost approximately \$1400 plus HST.

Ontario Public Health Standard:

Accountability Framework – Good Governance and Management Practices

Strategic Priority:

Organizational Commitment

1. Equitable Opportunities
2. Meaningful Relationships
3. Practice Excellence
4. Organizational Commitment

BUSINESS NAME REGISTRATION

MOTION:

WHEREAS the Sudbury & District Health Unit proposes to identify itself to the public under the business name Public Health Sudbury & Districts;
and

WHEREAS the *Business Names Act* (Ontario), provides that no corporation shall carry on business or identify itself to the public under a name other than its corporate name unless the name is registered by that corporation;

THEREFORE BE IT RESOLVED THAT the Board of Health for Sudbury & District Health Unit adopt the business name Public Health Sudbury & Districts and that its solicitors be instructed to take all required steps to register the aforesaid business name pursuant to the *Business Names Act* (Ontario).

To All Members of Ontario Boards of Health

AGENDA

Boards of Health Section Meeting Friday, February 23, 2018 • 8:30 AM – 3 PM Hotel Novotel Toronto - Champagne Ballroom, 2nd Floor 45 The Esplanade, Toronto, ON M5E 1W2

CHAIR: Trudy Sachowski, North West Region

7:30 **Registration and Continental Breakfast**
Located in foyer of Champagne Ballroom, 2nd Floor

8:30 **Welcome, Introductions and Welcoming Remarks**

Councillor Joe Mihevc, Chair, Board of Health, City of Toronto, will bring welcoming remarks and speak about the importance of municipally-based board governance.

Attendee's Draw (must be present)
Generously donated by Board of Health for the Northwestern Health Unit

9:00 **Cannabis, Opioids, Oral Health, Universal Pharmacare and Tobacco Endgame - Provincial Election and Local Public Health Issues (see attached)**

alPHa's Election Task Force developed areas of policy focus to influence party platforms for the 2018 Provincial Election. alPHa is asking candidates to endorse these priority actions and to work towards their implementation during the new provincial term and to invest in the health of the population, while also reducing the significant costs associated with the burden of illness. Come and learn more about why these local public health issues are important to you, what alPHa is doing, and join in on the discussion!

Moderator:
Trudy Sachowski, Member of alPHa Executive, Chair, BOH Section and BOH Representative for the North West, alPHa Executive Member

Panelists:
Maureen Cava, Past OPHNL Representative, past alPHa Board Member
Dr. Howard Shapiro, COMOH Representative, Toronto, alPHa Board Member
Paul Sharma, OAPHD President, alPHa Executive Member

10:00 **BREAK**

10:30 **Section Business**

Approval of Minutes from November 3, 2017 BOH Section Meeting (see *attached*)

Faster, Higher, Stronger – It Isn't Just an Olympic Motto!

Glen Paskiw, Managing Director, Enterprise Inc.

A quick look at alPHA's upcoming series of Change Management Webinars that will focus on delivering better, faster and less-expensive change. Building on previous alPHA presentations highlighting change/transformation theory and evidence, the Webinars will feature practical information, tools and techniques to create and support better on-the-ground change in your organization whether it's delivering on your strategic plan or moving forward with other new and better ways of doing business, the primary objective of the alPHA Change Management Webinars is to enhance your organization's potential for change success.

Other alPHA activities, including the new Risk Management e-Learning Module and the upcoming alPHA Conference June 10th-12th

Loretta Ryan, alPHA Executive Director

MOHLTC Update

Update on Ministry activities by the Ministry staff (invited)

11:15 **Dr. David Williams, Ontario Chief Medical Officer of Health, Update**

11:45 **LUNCH and Learn – with a Buffet**
The Power of Healthy Tension – Tim Arnold

Tim Arnold is a leadership and teambuilding expert who helps leaders get unstuck by providing steps to allow them to unite their team, spark change and live their values in both their professional and personal lives. Why is Healthy Tension important? It helps you and your team to be relevant and timely. His keynote will address how to unite your team, spark change, and get unstuck, relevant and timely, practical and actionable, and let's not forget, that healthy tension can also help to make things interactive and, maybe even fun.

1:00 **Strategic Directions**

Glen Paskiw, Managing Director, Enterprise Inc.

alPHA wants your input on Strategic Directions for the association. alPHA is working for you! Join in on this interactive consultation session.

2:00

Boards of Health Constitution

James LeNoury

Join us as we discuss the topics of:

- Implications from the amendments to the *Municipal Act* regarding “Electronic Meetings”
- Changes required to incorporate the new Ontario Public Health Standards to meet your legal and administration obligations.

These topics are important ones that you can take back, share and implement with your Board.

3:00

Adjournment

Attendee's Draw (must be present)

Generously donated by Board of Health for the Northwestern Health Unit

THE CHANGING FACE OF PUBLIC HEALTH

2018 alPHa Annual General Meeting & Conference

June 10, 11 & 12

Novotel Toronto Centre Hotel

45 The Esplanade, Toronto, ON



Recent changes in the Ontario public health system have resulted in public health units taking on new responsibilities in addition to their current mandate. The conference will explore these new commitments and provide perspectives on how to best deliver on them.

REGISTRATION NOW OPEN

Take advantage of the Early Bird rate (ends May 9) - Click [HERE](#) to register!

Learn more about registration [here](#)

BOOK YOUR ACCOMMODATIONS by MAY 22

A limited block of hotel guestrooms has been reserved; book early to avoid disappointment

Click [HERE](#) to book a room

Learn more about the hotel [here](#)



- | | | | |
|---|--|-----------------|----------|
| ✓ | Earlier time for final 2017-18 alPHa Board of Directors meeting. | Sunday, June 10 | 2 – 4 PM |
| ✓ | Special pre-conference activity: A free guided walking tour of downtown Toronto’s St. Lawrence neighbourhood led by a former chief planner for the city, Robert Millward, focusing on the built form and public health. Participation is optional. If attending, please pre-register by indicating as such in the online registration. | Sunday, June 10 | 4 – 6 PM |
| ✓ | Sunday’s registration desk will open earlier this year. Pick up your nametag and folder to avoid next day lineups. | Sunday, June 10 | 2 – 6 PM |

SEE NEXT PAGE FOR A DRAFT PROGRAM OUTLINE

LOOK FOR FURTHER PROGRAM DETAILS IN THE COMING WEEKS at www.alphaweb.org

THE CHANGING FACE OF PUBLIC HEALTH

2018 Annual General Meeting & Conference

June 10, 11 & 12

Novotel Toronto Centre Hotel
 45 The Esplanade, Toronto

DRAFT PROGRAM OUTLINE *

*content subject to change; all sessions take place at conference hotel unless otherwise indicated

SUNDAY, JUNE 10

2 – 4 PM (new time!)	Final meeting of 2017-18 alPHa Board of Directors
2 – 6 PM	Registration
4 – 6 PM	Free guided walking tour; outdoors (rain or shine)
6 – 7 PM	Welcome Reception

MONDAY, JUNE 11

7 – 8 AM	Registration (incl. resolutions voting registration) & Breakfast
8 – 10 AM	AGM & Resolutions Session
10 AM – 4 PM	Plenary/Breakouts
6 – 8:30 PM	President's Reception & Awards Dinner

TUESDAY, JUNE 12

7:30 – 8:30 AM	Registration & Breakfast
8:30 AM – 12 PM	Section Meetings for Board of Health Members, MOHs/AMOHs
12:30 – 1 PM	Inaugural meeting of 2018-19 alPHa Board of Directors
1 PM	Conference Ends (following lunch)

SPECIAL THANKS TO THE FOLLOWING:

Platinum Supporter:



Bronze Supporter:



ALPHA CONFERENCE

MOTION:

WHEREAS Public Health Sudbury & Districts has a modest travel budget to cover remuneration, registration, travel, meals, and accommodation as per the Board Manual Policy and Procedure I-I-10, permitting Board members to attend official Board of Health functions; and

WHEREAS the Public Health Sudbury & Districts is allocated four votes at the alpha Annual General Meeting;

THEREFORE, BE IT RESOLVED THAT in addition to the Medical Officer of Health and the Associate Medical Officer of Health, the following Board member(s) attend(s) the 2018 alpha Annual General Meeting as voting delegates for the Board of Health:

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: _____

RISE AND REPORT

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

All Board members are encouraged to complete the Board of Health Meeting Evaluation following each regular Board meeting.

ADJOURNMENT

MOTION: THAT we do now adjourn. Time: _____