# Board of Health

Thursday, September 20, 2018

1:30 p.m.

Public Health Sudbury & Districts Boardroom

1300 Paris Street

# Board of Health, Public Health Sudbury & Districts, September 20, 2018

Board of Health Meeting #06-18

1.0 CALL TO ORDER

2.0 ROLL CALL

3.0 REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST



4.0 DELEGATION / PRESENTATION

i) Public Health Update on Cannabis
Anik Proulx, Manager, Health Promotion Division

5.0 CONSENT AGENDA

i) Minutes of Previous Meeting



ii) Business Arising From Minutes

iii) Report of Standing Committees



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



v) Correspondence

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



b. Cannabis Sales Taxation Revenue

Public Health
Santé publique
SUDBURY & DISTRICTS

# AGENDA – SIXTH MEETING
# BOARD OF HEALTH
# PUBLIC HEALTH SUDBURY & DISTRICTS
# BOARDROOM, SECOND FLOOR
# THURSDAY, SEPTEMBER 20, 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) Public Health Update on Cannabis**

- Anik Proulx, Manager, Health Promotion Division

**5. CONSENT AGENDA**

**i) Minutes of Previous Meeting**

a. Fifth Meeting – June 21, 2018

**ii) Business Arising From Minutes**

**iii) Report of Standing Committees**

a. Board of Health Executive Committee Unapproved Minutes, July 11, 2018

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

a. MOH/CEO Report, September 2018

**v) Correspondence**

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

- Letter from the Perth Board of Health to the Minister of Justice dated June 14, 2018

b. Cannabis Sales Taxation Revenue

- Letter from the Grey Bruce Health Unit Acting Medical Officer of Health to the Premier-Elect dated June 18, 2018

c. Recommendation/Resolution Report – Oral Health Report Update 2018

- Letter from the Grey Bruce Health Unit Acting Medical Officer of Health to the Windsor-Essex County Health Unit dated June 18, 2018

d. Youth Exposure to Smoking in Movies

- Letter from the Grey Bruce Health Unit Acting Medical Officer of Health to the Ontario Film Review Board dated June 18, 2018

e. Cancellation of the Basic Income Research Project

- Letter from the Public Health Sudbury & Districts Board Chair to the Premier of Ontario dated August 3, 2018
- Email from the Premier of Ontario to the Public Health Sudbury & Districts Board Chair dated August 7, 2018
- Letter from the Association of Local Public Health Agencies to the Minister of Children, Community and Social Services dated August 2, 2018
- Letter from the Simcoe Muskoka Board of Health to the Minister of Children, Community and Social Services dated August 1, 2018
- Letter from the Peterborough Public Health Board of Health to the Minister of Children, Community and Social Services dated August 3, 2018
- Letter from the North Bay Parry Sound District Board of Health to the Premier of Ontario and the Minister of Children, Community and Social Services dated August 16, 2018
- Letter from the Haliburton, Kawartha, Pine Ridge District Board of Health to the Minister of Children, Community and Social Services dated August 17, 2018
- Letter from the Timiskaming Board of Health to the Premier of Ontario dated August 8, 2018
- Letter from the Leeds, Grenville and Lanark District Board of Health to the Premier of Ontario dated August 30, 2018
- Letter from the Huron County Board of Health to the Premier of Ontario dated September 6, 2018

f. Drug Policy Reform

- Letter from the Simcoe Muskoka District Board of Health to the Minister of Health and the Minister of Justice and Attorney General of Canada dated July 10, 2018
- Letters from the Toronto Board of Health to interested parties dated August 1, and August 3, 2018

g. Smoke-Free Ontario Act, 2017

- Letter from the President of the Association of Local Public Health Agencies to the Minister of Health and Long-Term Care dated July 4, 2018
- Letter from the Timiskaming Board of Health to the Minister of Health and Long-Term Care dated July 12, 2018
- Letter from the Kingston, Frontenac and Lennox & Addington Board of Health to the Deputy Premier and Minister of Health and Long-Term Care dated July 16, 2018
- Letter from the Premier of Ontario to the Public Health Sudbury & Districts' Board Chair dated July 17, 2018
- Letter from the Windsor-Essex County Board of Health to the Premier of Ontario dated July 19, 2018

- Letter from the Middlesex-London Board of Health to the Minister of Health and Long-Term Care dated July 20, 2018
- Letter from the Chatham-Kent Board of Health to the Premier of Ontario dated July 23, 2018
- Letter from the Association of Local Public Health Agencies President to the Minister of Health and Long-Term Care dated July 24, 2018
- Letter from the Board of Health for the Grey Bruce Health Unit to the Premier of Ontario dated July 27, 2018

h. Supervised Consumption Facilities

- Letter from the Association of Local Public Health Agencies to the Minister of Health and Long-Term Care dated July 27, 2018

i. Health and Physical Education Curriculum

- Letter from the Ontario Physical and Health Education Association President and the Executive Director & CEO to Dr. Sutcliffe dated August 1, 2018

j. Literacy in Ontario Curriculum

- Letter from the Kingston, Frontenac and Lennox & Addington Board of Health to the Provincial Minister of Education/Minister Responsible for Early Years and Child Care dated April 26, 2018
- Letter from the Grey Bruce Health Unit Acting Medical Officer of Health to the Provincial Minister of Education/Minister Responsible for Early Years and Child Care dated June 18, 2018
- Letter from the Peterborough Public Health Board of Health to the Deputy Premier and Minister of Health and Long-Term Care and the Minister of Education dated July 16, 2018

**vi) Items of Information**

| | |
|---|---|
| a. Public Health Sudbury & Districts Workplace Health Newsletter, English and French | 2018 Spring/Summer |
| b. alPHa Information Break Newsletter | July 24, 2018<br>August 31, 2018 |
| c. 2018 alPHa Conference Proceedings, *The Changing Face of Public Health* | June 10 to 12, 2018 |
| d. The Globe and Mail Article *Delving into the health Data shows that Canadian kids aren't all right* By André Picard | September 4, 2018 |
| e. *Public Health must become a priority* by Trevor Hancock and Sen. Art Eggleton | September 12, 2018 |

**APPROVAL OF CONSENT AGENDA**

**MOTION:**

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

## 6. NEW BUSINESS

**i) Annual Board of Health Self-Evaluation**

- 2018 Board Self-Evaluation Questionnaire
  (electronic survey is available to Board members in BoardEffect app)

**ii) 2018 Annual Service Plan and Budget Submission**

- Ministry of Health and Long-Term Care (MOHLTC) Overview and Feedback Slide Deck, August 2018

## 7. ADDENDUM

**ADDENDUM**

**MOTION:**

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

## 8. ANNOUNCEMENTS / ENQUIRIES

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

## 9. ADJOURNMENT

**ADJOURNMENT**

**MOTION:**

**THAT we do now adjourn. Time: ____**

# MINUTES – FIFTH MEETING
# BOARD OF HEALTH
# PUBLIC HEALTH SUDBURY & DISTRICTS
# THURSDAY, JUNE 21, 2018 – 1:30 P.M.
# RAINBOW LODGE, BIRCH ISLAND

**BOARD MEMBERS PRESENT**

Janet Bradley
James Crispo
Jeffery Huska
René Lapierre
Monica Loftus
Thoma Miedema
Ken Noland
Rita Pilon
Nicole Sykes
Carolyn Thain (via teleconference)

**BOARD MEMBERS REGRETS**

Maigan Bailey
Robert Kirwan
Paul Myre
Mark Signoretti

**STAFF MEMBERS PRESENT**

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

**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**

There were no declarations of conflict of interest.

**4. DELEGATION/PRESENTATION**

**i) Accountability Monitoring Plan**

– Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer

Dr. Sutcliffe recapped that in January 2018, when the 2018 – 2022 Strategic Plan and Visual Identity were endorsed, the Board also directed the Medical Officer of Health to operationalize the Strategic Plan and develop a monitoring process for the Board's approval. This presentation today provides an update on the work to develop an Accountability Monitoring Plan (AMP). A motion will be further discussed under today's agenda item 6. iv)

Drivers of our work include the Board's strategic plan and the Ontario Public Health Standards. The Ministry of Health and Long-Term Care (MOHTLC) has stipulated certain indicators and the proposed accountability monitoring framework incorporate these, locally developed indicators, and the Board's strategic priorities. It is intended that the AMP will be a key accountability tool for ourselves and for the public.

The MOHLTC's reporting requirements, including the quarterly financial reports, were outlined, and it was noted that some of these newly established provincial reporting requirements are still in evolution; however, are taken into account in the proposed accountability monitoring framework. The following MOHLTC Organizational Requirements, as it relates to monitoring and reporting, will be reported to the Board using a visual depiction of the compliance status for each of the 45 requirements categorized within four domains:

1. Delivery of programs and services;
2. Fiduciary requirements;
3. Good governance and management practices; and
4. Public health practice.

It was pointed out that there are six additional requirements common to all domains and health units will be required to report on compliance status through attestations.

In addition to the provincial requirements, locally-determined program indicators deemed important to measure, year-over-year, are also included in the proposed AMP to monitor progress and measure success. These include a mix of quantitative and quality measures.

The draft AMP being presented today for approval proposes twice yearly narrative reports (spring and fall) that will help monitor the integration of our strategic priorities within programs and services.

Reporting timelines include an annual accountability monitoring report that would come forward for approval each February. A mid-year accountability monitoring report would be reviewed by the senior management team.

A Joint Board of Health/Staff Accountability Working Group will be established, similar to the sunsetted Joint Board of Health/Staff Performance Monitoring Working Group. The role of the working group will be to review monitoring reports and strategic narratives, provide interpretive comments, and present to the full Board for final approval.

Three Board members are being sought for participation in the Working Group. The Board's endorsement of the 2018–2022 Accountability Monitoring Plan will be sought under 6) iv. R. St Onge and the Knowledge and Strategic Services team were thanked for their work in the development of the AMP.

## 5. CONSENT AGENDA

**i) Minutes of Previous Meeting**

a. Fourth Meeting – May 17, 2018

**ii) Business Arising From Minutes**

**iii) Report of Standing Committees**

a. Board of Health Executive Committee Unapproved Minutes dates May 17, 2018

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

a. MOH/CEO Report, June 2018

**v) Correspondence**

a. Provincial Public Health Funding Approvals

- Letter from the President of the Association of Local Public Health Agencies to the Minister of Health and Long-Term Care dated May 14, 2018

b. Canada's Tobacco Strategy

- Letter from the President of the Association of Local Public Health Agencies to the Federal Minister of Health dated June 5, 2018

**vi) Items of Information**

| | |
|---|---|
| a. Public Health Agency of Canada, Sport, Physical Activity and Recreation Minister Release re Pan-Canadian Policy to Increase Physical Activity and Reduce Sedentary Living | May 31, 2018 |
| b. Health Canada News Release re New Tobacco and Vaping Products Legislation Receives Royal Assent | May 28, 2018 |
| c. Health Canada News Release re Government of Canada Marks World No Tobacco Day with Launch Of Canada's Tobacco Strategy | May 31, 2018 |

d. Perth District Health Unit News Release re Huron, Perth Health Units to Proceed with Amalgamation — May 10, 2018
e. Globe and Mail Article Will we be prepared for 'Disease X' – the next pandemic? — May 28, 2018

In response to a question relating to the MOH/CEO report, it was clarified that the tender for facilities will result in additional expertise in this area.

**22-18 APPROVAL OF CONSENT AGENDA**

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

**CARRIED**

## 6. NEW BUSINESS

### i) Addressing Anti-Racism for Improved Health Equity

- Briefing Note from the Medical Officer of Health and Chief Executive Officer dated June 14, 2018

The briefing note outlines the issues of systemic racism which is a significant, modifiable, and unjust barrier to health opportunities.

At the provincial level, the Ontario government introduced a 3-year anti-racism plan in 2017. The National Collaborating Centre for Determinants of Health further identifies racism as a root cause of health and social inequities experienced by racialized and discriminated peoples in Canada.

This Board of Health has prioritized and advocated for equitable opportunities in various aspects. It has been supportive of the health equity work and given systemic racism and discrimination creates barriers for equitable opportunities for health, it is recommended that the Board endorse the proposed motion.

Questions were entertained and it was recognized that it was not necessary to single out indigenous peoples as this is inherent in our work.

**23-18 ADDRESSING ANTI-RACISM FOR IMPROVED HEALTH EQUITY**

***MOVED BY MIEDEMA – PILON: WHEREAS the Board of Health is committed to ensuring all people in Sudbury and districts~~, including Indigenous people,~~ have equal opportunities for health; and***

***WHEREAS systemic racism is a significant, modifiable and unjust barrier to health opportunities; and***

***WHEREAS in 2017 Ontario established the Anti-Racism Directorate and launched a 3-Year Anti-Racism Strategic Plan, A Better Way Forward, that describes important pillars for comprehensive action on racism;***

***THEREFORE BE IT RESOLVED THAT the Board of Health declare its commitment to anti-racism and direct the Medical Officer of Health to engage in a collaborative process to develop an Anti-Racism Action Plan informed by the provincial strategic plan; and***

***FURTHER THAT the Public Health Sudbury & Districts Anti-Racism Action Plan be presented to the Board of Health for approval within one year of this date.***

**CARRIED WITH FRIENDLY AMENDMENT**

**ii) Board of Health Manual Review**

- Briefing Note from the Medical Officer of Health and Chief Executive Officer dated June 14, 2018

The process that was undertaken for the 2018 review of the Board of Health Manual is outlined in the briefing note. There are a number of housekeeping items, including updates to reflect our name change, which have not been included in today's agenda package. Substantive changes include a new Conflict of Interest Policy, Procedure and Declaration Form, updates to reflect the Ministry of Health and Long-Term Care's Ontario Public Health Standards, Accountability Framework, and Annual Service Plan as well as to reflect the Ministry's Policy Guide for Medical Officer of Health, Associate Medical Officer of Health, and Acting Medical Officer of Health appointments.

Questions were entertained. In addition to being available to all staff, the Board of Health manual is available to Board members electronically on through their electronic devices and will shortly be available to the public through the Public Health Sudbury & Districts website.

Consideration will be given to adding cultural competency training to the Board orientation requirements through the Indigenous Engagement strategy.

**24-18 BOARD OF HEALTH MANUAL**

***MOVED BY PILON – LOFTUS: THAT the Board of Health, having reviewed the proposed revisions within the Board of Health Manual, rescind Board motion 02-17, and approve the Manual as presented on this date.***

**CARRIED**

**iii) 2018 Association of Local Public Health Agencies (alPHa) Conference / Annual General Meeting (AGM)**

- alPHa Conference Program-at-a-Glance
- alPHa Board of Health Section Agenda, June 12, 2018

- Summary of Resolutions Considered at the June 2018 alPHa AGM

J. Crispo, Board member, provided highlights of the 2018 alPHa Conference and Annual General Meeting, resolution session, and Board of Health Section meeting which had representation from all 35 Boards of Health. He provided an overview of the conference plenary sessions that were held on local Public Health system sustainability and Indigenous Engagement.

He announced that one of the four recipients of the alPHa Distinguished Service Awards was our Director of Health Promotion, Sandra Laclé. The Board congratulated and applauded Sandra for her award and dedication to Public Health.

On behalf of Public Health Sudbury & Districts, J. Crispo received the alPHa fitness challenge for which there was 100% staff participation.

Dr. Sutcliffe noted that she chaired her last Council of Ontario Medical Officers of Health (COMOH) meeting concluding four years as COMOH Chair and handing over the Chair role to another MOH.

**iv) Accountability Monitoring Plan**

- Public Health Sudbury & District's Accountability Monitoring Plan

Further to today's delegation, the motion seeks endorsement of the proposed accountability monitoring plan for Public Health Sudbury & Districts. A call for interest will be emailed to the Board seeking three Board members to participate on the Joint Board/Staff Accountability Working Group.

It was recognized that municipal elections this fall may result in changes in municipal representation on our Board; however, Board representation can be looked at post-election if the working group membership is affected at that time.

**25-18 2018–2022 ACCOUNTABILITY MONITORING PLAN**

***MOVED BY LOFTUS – PILON: WHEREAS Board of Health motion #02-18 endorsed the 2018–2022 Strategic Plan and Visual Identity and directed the Medical Officer of Health to operationalize the Strategic Plan and develop a monitoring process for the Board's approval; and***

***WHEREAS an accountability monitoring plan has been developed that integrates provincially required measures and local performance indicators all important to achieving the Board's strategic priorities and vision of healthier communities for all;***

***THEREFORE BE IT RESOLVED THAT the Board of Health approve the Public Health Sudbury & Districts Accountability Monitoring Plan 2018–2022; and***

***FURTHER THAT the Board of Health endorse the establishment of a Joint Board of Health/Staff Accountability Working Group for 2018–2022 for the purpose of guiding the reporting of the Accountability Monitoring Plan to the full Board of Health.***

**CARRIED**

## 7. ADDENDUM

No addendum.

## 8. ANNOUNCEMENTS / ENQUIRIES

Dr. Sutcliffe shared that the delegation/presentation for the September Board of Health meeting is cannabis. The topic is timely given the federal government's announcement yesterday that the Federal Cannabis Act was passed in the Senate and will be proclaimed into law on October 17, 2018, making cannabis legal for recreational use on that date. Meanwhile, we are engaging with the province to ensure we are aware of our Public Health role, particularly our role with the Ontario Cannabis Act. Public Health has the role of health promotion and health protection and will also be looking at its policies and new developments as it relates to being a responsible employer. Locally, we have met with the City of Greater Sudbury, Greater Sudbury Police Services and others to work through implementation to understand issues related to the siting of an Ontario Cannabis Store in Sudbury, as well as enforcement, and education.

The Public Health Sudbury & Districts' 2017 annual report is now available on the www.phsd.ca website. The report will be shared through social media and emailed to partner agencies. Short bilingual videos are also available on our website from the Board Chair and the Medical Officer of Health.

## 9. ADJOURNMENT

**26-18 ADJOURNMENT**

***MOVED BY HUSKA – SYKES: THAT we do now adjourn. Time: 2:24 p.m.***

**CARRIED**

_____ _____

(Chair) (Secretary)

# MEETING NOTES
# BOARD OF HEALTH EXECUTIVE COMMITTEE
# PUBLIC HEALTH SUDBURY & DISTRICTS, BOARDROOM, SECOND FLOOR
# THURSDAY, JULY 11, 2018 – 2 P.M.

**BOARD MEMBERS PRESENT**

René Lapierre
Paul Myre
Ken Noland
Nicole Sykes

**BOARD MEMBERS REGRETS**

Jeffery Huska

**STAFF MEMBERS PRESENT**

Rachel Quesnel
France Quirion
Dr. Penny Sutcliffe

In the absence J. Huska, Chair of the Board Executive Committee, consensus was reached for the Board Chair to act as Board Executive Committee Chair for today's meeting.

**R. LAPIERRE PRESIDING**

**1. CALL TO ORDER**

The meeting was called to order at 2:05 p.m. followed by a territorial acknowledgement.

**2. ROLL CALL**

**3. REVIEW OF AGENDA / DECLARATION OF CONFLICT OF INTEREST**

There were no declarations of conflict of interest.

**4. APPROVAL OF BOARD EXECUTIVE COMMITTEE MEETING NOTES**

4.1 Board Executive Committee Meeting Notes dated May 17, 2018

**06-18 APPROVAL OF BOARD OF HEALTH EXECUTIVE COMMITTEE MEETING NOTES**

***MOVED BY SYKES – MYRE: THAT the meeting notes of the Board of Health Executive Committee meeting of May 17, 2018, be approved as distributed.***

**CARRIED**

## 5. NEW BUSINESS

**IN CAMERA**

- Labour relations or employee negotiations

**07-18 IN CAMERA**

***MOVED BY NOLAND – MYRE: That this Board of Health Executive Committee goes in camera. Time: 2:09 p.m.***

**CARRIED**

**RISE AND REPORT**

**08-18 IN CAMERA**

***MOVED BY MYRE – NOLAND: That this Board of Health Executive Committee rises and reports. Time: 2:38 p.m.***

**CARRIED**

It was reported that one agenda item relating to *labour relations/employee negotiations* was discussed for which the following motions emanated:

**09-18 APPROVAL OF MEETING NOTES**

***MOVED BY MYRE – NOLAND: THAT this Board of Health Executive Committee approve the meeting notes of the May 17, 2018, 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**

**10-18 CUPE MEMORANDUM OF SETTLEMENT RATIFICATION**

***MOVED BY SYKES – MYRE: THAT the Board of Health Executive Committee ratify the June 27, 2018, Memorandum of Settlement setting terms for a 3-year renewal collective agreement from April 1, 2018, to March 31, 2021, between the Sudbury and District Health Unit, operating as Public Health Sudbury & Districts and the Canadian Union of Public Employees.***

**CARRIED**

The bargaining unit will be advised of the ratification.

## 6. ADJOURNMENT

**11-18 ADJOURNMENT**

***MOVED BY MYRE – SYKES: THAT we do now adjourn. Time: 2:42 p.m.***

**CARRIED**

_____ _____

(Chair) (Secretary)

# Medical Officer of Health/Chief Executive Officer
# Board of Health Report, September 2018

## Words for thought

### Delving into the health data shows that Canadian kids aren't all right

ANDRÉ PICARD >
PUBLISHED SEPTEMBER 4, 2018

As the school year begins, it makes for some fairly grim reading.

Children First Canada and the O'Brien Institute for Public Health have just published a new report examining the mental and physical health of the 7.9 million young people under the age of 19. "Many Canadians think this is one of the best countries in the world to raise a child, but the statistics prove otherwise," says Sara Austin, founder and lead director of Children First Canada.

She notes that Canada ranks a middling 25th out of 41 countries in UNICEF ranking of well-being of children and youth.

Canada is a safe country for kids – free of the ravages of war, largely free of deadly childhood diseases and prosperous. But the data from comparable countries remind us we can do better. Very few children and youth die in developed countries – just over 3,000 a year in Canada, and half of those are in the first year of life. Our infant mortality rate, 4.5 per 1,000 live births, is one of the worst in the developed world. Iceland, by comparison, has 0.7 deaths per 1,000 live births.

Worse yet, Canada's poor showing overall masks the disparities within the country, ranging from 3.4 per 1,000 in B.C. to 17.7 per 1,000 in Nunavut.

Source: Excerpted from André Picard, The Globe and Mail
Date: September 4, 2018

***Chair and Members of the Board,***

Welcome back from a warm northern summer. As we return from our holidays and family vacations and return to work and school, the above quoted statistics from author, A. Picard remind us that not all kids in Canada have equal opportunities for health. At Public Health Sudbury & Districts, our staff work hard with kids, families, communities and partner agencies to even the odds for all kids. We are excited about the school year ahead!

# General Report

## 1. Local and Provincial Meetings

With the change in provincial government, we have had relatively little interaction with our provincial colleagues over the summer months. A number of initiatives are on hold as provincial policy is reviewed and programming implications are understood and communicated. We continue to plan for and work with the new Ontario Public Health Standards and related

reporting requirements. From a leadership perspective, pressing public health issues continue to include partnership development, health equity, substance use, Indigenous engagement, mental health and collaboration with northeastern health units.

Earlier this month, the Ministry of Health and Long-Term Care (MOHLTC) held teleconferences for all public health units to review updates on the Ontario Public Health Standards and on public health accountability and reporting, including risk management reporting and the 2019 Annual Service Plan and Budget Submission Templates.

I continue on the Council of Ontario Medical Officers of Health (COMOH) Executive and participated in the Executive Committee teleconference on September 12.

As part of its development of a three-year strategic plan, the North East LHIN will be meeting with Public Health Sudbury & Districts senior managers on September 17 to engage on its 2019–2022 Integrated Health Services Plan.

## 2. Annual Board Self-Evaluation Survey

As part of the Board of Health's commitment to good governance and continuous quality improvement, and in accordance with Board of Health Manual policy C-I-12 and C-I-14, the Board of Health conducts an annual self-evaluation of its governance practices and outcomes.

The completion rate for the annual Board of Health member self-evaluation is included as one of the indicators in the 2018–2022 Accountability Monitoring Plan. This indicator, which also measures the completion rate for the monthly Board of Health meeting evaluations, measures the level of commitment and engagement of the members of the Board of Health and shows accountability to good governance practices.

Board of Health members are asked to complete the 2018 self-evaluation questionnaire in BoardEffect (under the Board of Health workroom – Collaborate – Surveys) by Tuesday, October 23, 2018. The questionnaire will be used to obtain valuable and comparative data and identify possible areas for improvement in Board effectiveness and engagement.

Results of the annual Board of Health member self-evaluation of performance evaluation will be presented at the November Board meeting.

## 3. Health Matters: Municipal election

Similar to our approach for the provincial election, Public Health Sudbury & Districts is developing a municipal election primer. This primer – along with related communication materials – presents information on priority public health issues such as tobacco, cannabis, opioids, income security and the build environment. It targets candidates in the municipal election as well as members of the public. The primer will be shared with candidates and posted on our website. In addition, related social media posts will be promoted in the coming weeks.

## 4. Board of Health Manual

The Board of Health manual has been updated with the revisions approved at the June 21, 2018, Board of Health meeting. The manual is available to all staff through SharePoint and available to Board of Health members in BoardEffect.

We are pleased to share that the manual is now available to the public, in an accessible format, on the Public Health Sudbury & Districts website, under About, Board of Health.

## 5. Financial Report

The July year-to-date mandatory cost-shared financial statements report a positive variance of $820,693 for the period ending July 31, 2018. Gapped salaries and benefits account for $636,939 or 76%. This year, a significant portion of the gapped salaries is the result of the additional $440,700 in base funding that was announced in May. Decisions relating to this funding have been operationalized over the summer with most of the expenses being realized from September to December. Operating expenses and other revenue account for $183,754 or 22% of the variance. Monthly reviews of the financial statements ensure that shifting demands are adjusted in order to mitigate the variances caused by the timing of activities.

In the month of July, a total of $86,114 in available gapped funding was reallocated towards one-time operational priorities including staffing – program support; cultural humility training ; and infrastructure – workstation renovations .

## 6. Accountability Monitoring Plan

At the June 21, 2018, Board of Health meeting, the Board endorsed the establishment of a Joint Board of Health/Staff Accountability Working Group for 2018–2022 for the purpose of guiding the reporting of the Accountability Monitoring Plan to the full Board of Health. The role of the Working Group is to review reports, provide interpretive comments, and present reports to the full Board for final approval. I am grateful to the three Board of Health members who have volunteered to participate in the Working Group: James Crispo, Nicole Sykes, and Carolyn Thain. The Working Group's first meeting will be held in early October, during which they will approve the Terms of Reference and review the first Strategic Priority Narrative Report, which is scheduled to be shared with the full Board at its October meeting.

## 7. Quarterly Compliance Report

The Agency is compliant with the terms and conditions of our Public Health Funding and Accountability Agreement. Procedures are in place to uphold the Ontario Public Health Accountability Framework and Organizational Requirements, to provide for the effective management of our funding and to enable the timely identification and management of risks.

Public Health Sudbury & Districts has paid all payable remittances for employee income tax deductions and Canada Pension Plan and Employment Insurance premiums, as required by law to August 24, 2018 on August 24, 2018. The Employer Health Tax has been paid as required by law, to August 31, 2018, with a cheque dated September 15, 2018. Workplace Safety and Insurance Board premiums have also been paid, as required by law, to August 31, 2018, with a cheque dated September 30, 2018. There are no outstanding issues regarding compliance with the Occupational Health & Safety Act, Ontario Human rights Code, or Employment Standards Act.

## 8. Ministry of Labour Report

On July 31, 2018, the Ministry of Labour (MOL) visited the 1300 Paris Street building as part of their Safe at Work strategy related to the Internal Responsibility System Health Care initiative, which is running from July 1, 2018 to March 31, 2019. During their physical inspection, the MOL looked for tripping hazards, cluttered work spaces, proper storage of boxes, chemicals and sharps, availability of hand washing facilities and sand sanitizer, etc. Public Health Sudbury & Districts received one order from the MOL as a result of boxes being stacked in front of an electrical panel in the maintenance room. In response to the order, the boxes were moved from the electrical panel within the two-day time frame that was provided. Overall, the MOL was very pleased with the condition of our workplace. Over the next several months, the MOL may visit our district office sites. Human Resources has been working with the district office staff to ensure they are prepared.

Following are the divisional program highlights.

# Clinical Services

## 1. Control of Infectious Diseases

### *Influenza*

There have been no cases of influenza A or B identified in the area. This was expected as Public Health Sudbury & Districts is currently between influenza seasons.

### *Respiratory Outbreaks*

There are currently no reported respiratory outbreaks.

### *Preparation for Universal Influenza Immunization Program (UIIP)*

Preparation for the 2018/2019 influenza season is underway. Fifty five pharmacies are currently preparing to receive influenza vaccine as part of the UIIP.

Influenza vaccine clinics are currently being planned for our main and district offices for this season. Since the UIIP has increased access to the influenza vaccine in the community, the agency has been able to decrease community clinics in an effort to avoid duplication of services. Our Paris Street location organizes flu vaccine delivery to all district offices, health care

providers, walk in clinics, long-term care and retirement homes, hospitals as well as providing flu vaccines at all Public Health locations. Clinics will also be held upon request for remote areas with limited-to-no access to vaccinations.

## *Cold Chain Inspections*

During July and August 2018, public health nurses (PHNs) conducted "cold chain" inspection visits at all health care provider clinics and offices that administer publicly-funded vaccines in our service area. "Cold chain" refers to maintaining vaccines within the required range of 2–8°C at all times during handling, storage and transport. Breaks in the cold chain can result in reduced vaccine effectiveness, diminishing the protection for the person receiving the vaccine. As of August 29, 2018, 180 of the 199 vaccine fridges in the area have been inspected with plans to have remaining inspections completed by mid-September.

## *Vaccine Preventable Disease*

There are 66 child care centres with 2335 total registrants this 2018 season in our catchment area. Public Health Sudbury & Districts PHNs have reviewed all registrants' vaccine history.

In September, PHNs will be providing vaccines in schools for the following infectious diseases: meningococcus, human papillomavirus (HPV 4 and 9) and hepatitis B. This is the second year where HPV 9 is publicly funded and provided to both girls and boys in Grade 7. HPV is a virus associated with several anogenital and oropharyngeal cancers. HPV 9 protects against the four strains covered by the HPV 4 vaccine plus five additional strains of the virus.

As of September 1, 2017, Bill 87 (Protecting Patients Act) under the Immunization of School Pupils Act (ISPA) required parents or legal guardians of school age students to complete an immunization education session prior to filing a Statement of Conscience or Religious Belief exempting their children from mandatory school immunizations. There were a total of 61 parents who were provided immunization education at the agency to complete their request to have their child(ren) exempt from school based vaccine(s) based on conscientious or religious beliefs. Despite these exemptions, Public Health Sudbury & Districts immunization rates of vaccination against mandatory vaccines remain at a high level as per the recent Public Health Ontario report on immunization coverage in Ontario.

## *Panorama*

The provincial online immunization reporting system, Immunization Connect Ontario (ICON), has been made available on our agency website since September, 2017. Through ICON, individuals can view, print and or update their own immunization records. As of June 14, 2018, 2197 immunizations have been submitted through our ICON site by 459 clients. As of June 13, 2018, 1092 digital yellow cards were retrieved.

## 2. Sexual Health/Sexually Transmitted Infections including HIV and Blood Borne Infections

The Sexual Health Clinic responded to 12 community referrals between June and August. The presentations provided education on healthy relationships, birth control and prevention of sexually transmitted infections.

In June, as part of their program, a group of Northern Ontario School of Medicine (NOSM) students took part in a scavenger hunt activity in the downtown and visited the sexual health clinic. Information related to Public Health services such as the sexual health clinic, Growing Family Health program, Healthy Babies Healthy Children program and breastfeeding clinic were provided to the students.

Information related to sexually transmitted infection testing and prevention was provided in an interview on CTV local news in June.

As part of pride/sexual health orientation campaign, our “We are not defined by one thing” poster was displayed inside 30 city transit buses in the month of July.

### *Needle Exchange Program (NEP)*

On July 30, 2018, Wiikiwemkoong Unseeded Territory signed a Memorandum of Understanding (MOU) for the NEP. NEP services will be provided by Naandwechige Gaming. An MOU for NEP is currently in development for St. Charles Pharmacy.

## 3. Oral Health

The Oral Health team provided preventive care during the summer break for children who were enrolled in the preventive services program. The team has been preparing for the 2018–2019 school year and has promoted the Health Smiles program to a variety of community partners who work with children and families. Team members participated in the Back to School event held in Val Caron in August.

## 4. Child Vision Health and Vision Screening

The vision screening program is a new requirement under the Ontario Public Health Standards. Vision screening will be conducted in the 2018–2019 school year, with an anticipated start date of January 2019 for all students enrolled in senior kindergarten. In August, the MOHLTC hosted several webinar training sessions for this new service.

# Environmental Health

## 1. Control of Infectious Diseases

During the months of June, July and August, 46 sporadic enteric cases and 2 infection control complaints were investigated. Three enteric outbreaks were declared in institutions.

## 2. Food Safety

During the summer months, 6 food product recalls prompted public health inspectors to conduct checks of 262 local premises. All affected establishments had been notified and subsequently had removed the recalled products from sale.

Public health inspectors issued 3 closure orders to food premises due to an increase in reported enteric illnesses, a lack potable water and a lack of hot water. The closure orders have since been rescinded following corrective action, and the premises allowed to reopen.

Public health inspectors issued 3 charges to food premises for infractions identified under the *Food Premises Regulation* during the months of July and August.

Staff issued 227 special event food service permits to various organizations during the summer months.

Through Food Handler Training and Certification Program sessions offered in June, July and August, 279 individuals were certified as food handlers.

## 3. Health Hazard

In June, July and August, 113 health hazard complaints were received and investigated. Ten of these complaints involved marginalized populations.

In the month of June, a media release was issued to provide the public with tips to prevent heat-related illness. Subsequently, 9 heat warnings and extended heat warnings were issued during the summer months.

## 4. Part VIII - Ontario Building Code

During the months of June, July and August, 128 sewage system permits, 56 renovation applications, and 7 consent applications were received.

The number of Part VIII applications received from January 1 to August 27, 2018, were slightly fewer than the number submitted for the same time period in 2017. Staff will continue to track the number of applications during the remainder of the Part VIII season.

## 5. Rabies Prevention and Control

One hundred and fifty-one rabies-related investigations were carried out in the months of June, July and August. Two animals were submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis, and were subsequently reported as negative.

Seven individuals received rabies post-exposure prophylaxis following exposure to wild or stray animals.

## 6. Safe Water

During the months of June, July and August, 35 public beaches were sampled with a total of 2158 samples collected during 404 visits. Re-sampling was conducted in response to 18 sampling results that exceeded the recreational water quality standard of 200 *E. coli* per 100 mL of water. In June, July and August, 3 beaches were posted as unsafe for swimming due to elevated levels of *E.coli*. Media releases were issued to inform the public both when the beach water quality was not suitable for recreational use and when it was suitable again. Advisory signs have since been removed from the 3 posted beaches as sample results have returned to levels that are deemed to be acceptable for recreational use.

Public health inspectors investigated 17 blue-green algae complaints in the months of June, July and August, 5 of which were subsequently identified as blue-green algae capable of producing toxin. Media releases were issued to inform the public of the importance of taking precautions and being on the lookout for algal blooms. Two public beaches were posted due to blue-green algae.

During June, July and August, 296 residents were contacted regarding adverse private drinking water samples. Public health inspectors investigated 41 regulated adverse water sample results, as well as drinking water lead exceedances at 21 local schools.

Twenty boil water orders, and 3 drinking water orders were issued. Furthermore, 16 boil water orders, and 2 drinking water orders were rescinded. One closure order was issued to a premises due to adverse water and 2 closure orders were issued to two pools for adverse water chemistry and clarity.

## 7. Tobacco Enforcement

In June, July and August, tobacco enforcement officers charged 7 individuals for smoking in an enclosed workplace, with 11 additional charges as a result of smoking in a workplace vehicle. One individual was charged for smoking on school property, 2 charges were laid for smoking on hospital property, and 4 retail employees were charged for selling tobacco to a person who is less than 19 years of age.

## 8. Vector Borne Diseases

During the summer months, a total of 18 763 mosquitoes were trapped and sent for analysis. During this time, a total of 240 mosquito pools were tested for Eastern Equine Encephalitis virus and for West Nile virus. All pools tested negative.

On July 30, 2018, a media release was issued informing the public that even though the risk of contracting Lyme disease in our area is low, there is still a need to take precautions to prevent tick bites. Information on how to remove and submit a tick for testing was provided, as well as the signs and symptoms of Lyme disease. On August 29, 2018, an interview with CTV was aired which reinforced the messages provided in the previous media release. The Public Health Sudbury & Districts service area is not considered to be an endemic area for the tick that can cause Lyme disease. Staff continue to monitor the local risk and provide residents and health care providers with valuable information to protect the public.

## 9. Emergency Preparedness

On July 10, 2018, Public Health attended the City of Greater Sudbury Emergency Operations Centre and worked collaboratively with agency partners to address the public impacts of a severe storm. Staff followed-up with affected food premises, and provided information to the public, via traditional and social media, regarding cleaning up after the storm as well as food safety tips during the associated power outage.

In response to active wildfires in our region, staff provided support to affected municipalities and information to the public regarding health effects of exposure to wildfire smoke and personal protective measures.

# Health Promotion

## 1. Chronic Disease Prevention and Well-Being

### *Mental health promotion*

Four weight bias education sessions were delivered to 170 City of Greater Sudbury municipal summer camp staff and Greater Sudbury Healthy Kids Community Challenge partners.

### *Physical activity and sedentary behavior*

Active Sudbury, of which the Nutrition and Physical Activity team is a member, hosted a Physical Literacy Movement Preparation workshop for 25 sport and recreation leaders to train on incorporating and improving fundamental movement and sport into activity. Active Sudbury also hosted a demonstration night for local coaches and leaders on fundamental movement.

## *Substance use*

### *Cannabis*

In August, PHNs team presented on the topic of cannabis, providing sample policies, to senior leadership and resident assistants at Cambrian College, and faculty and student leaders at Laurentian University. The Lower-Risk Cannabis Use Guidelines (LRCUGs), Cannabis Talk Kits and parent resources were provided for distribution.

### *Alcohol*

Between June and September, PHNs facilitated a discussion on "Alcohol Use and the Health of our Communities" with eight community partners. Staff also presented on the topics of resiliency and character strengths at the "Taking Care of my Spirit" conference at the Atikameksheng Anishnawbek community.

### *Tobacco*

Staff participated in a CTV interview on Health Canada's warnings and labels on new tobacco packaging. Supported community champions to establish a no-smoking zone at the downtown Tim Horton's and LCBO locations. Three monthly STOP on the Road (SOR) quit smoking workshops were held between June and August where 31 community participants received a free 5-week supply of nicotine patches and nicotine replacement therapy (NRT) voucher support. Additionally, 35 clients were seen at Public Health Sudbury & Districts Quit Smoking Clinic (QSC). A total of 156 calls were received through the tobacco information line and 136 NRT vouchers were distributed through SOR the QSC.

The Northeast Tobacco Control Area Network (NE TCAN) along with the Leave the Pack Behind (LTPB), implemented a media buy across our region related to "Make Quit Memorable", a campaign that focuses on supporting young adults to make successful quit attempts with free nicotine patches and gum. Campaign specific holidays included National Indigenous Peoples Day (June 7 – 21), Pride (June 10 – 24), Canada Day (June 18 – July 1), Civic Holiday (June 23 – August 6), and Labour Day (August 20 – September 3).

## *Workplace health*

On June 11, 2018, a PHN hosted a Workplace Network meeting where coping with stress and mental health were identified by the participants as areas of future focus. The September Workplace Wellness newsletter, focused on alcohol and the connection to chronic diseases including cancer.

# 2. Healthy Growth and Development:

## *Breastfeeding*

The Family Health team hosted two breastfeeding support groups.

## *Growth and development*

The nutritionist and dietitian on the Family Health team met with the kitchen manager at a daycare to discuss menu planning, infant feeding and supportive nutrition environments.

### *Healthy pregnancies*
The Family Health team hosted prenatal class with 24 people in attendance.

### *Preparation for parenting*
In response to community need and addition of Preparation for Parenting to the list of topics under the Healthy Growth and Development standard, the Family Health Team is piloting a new Preparation for Parenting class. In total, in two successful classes, 16 clients have taken the class and provided positive feedback.

The Louise Picard Health Research Grant funded project 'The Profile and Story of Fatherhood as a Factor of Evidence Informed Public Health' has received ethics' approval from both Public Health Sudbury & Districts and Laurentian University, and will now commence recruitment from the Preparation for Parenting class.

### *Positive parenting*
Development of a new Triple P website is underway with construction of the site (Parenting4me.com). Staff are taking into consideration registration methods, usability, screening needs and ongoing surveillance and data collection.

## 3. School Health

### *Healthy eating behaviours*
Registered dietitians from the School Health Promotion team completed a monthly food literacy series to twelve students in Grades 3 to 8 at a local school. A total of eight sessions focused on the different aspects of food literacy; namely, food preparation skills, food and nutrition knowledge, food attitudes and self-confidence with food. The themes were created to address the components of the curriculum and to allow students the opportunity to work together in food preparation and recipe tasting. The last session had students leading the preparation of their own chosen recipes and teaching their peers about the fun facts of the ingredients. Our public health dietitians addressed Equitable Opportunities by supporting this school community with levelling up their health potential with stronger food literacy.

### *Mental health promotion*
The School Health Promotion team supported school communities' preparation for this school year by promoting healthy approaches for families to alleviate back to school anxiety. A PHN conducted a media interview on preparation for this school year by promoting healthy approaches for families to alleviate back to school anxiety.

Staff facilitated a session with Health Sciences North's communications team at their full-day team-building workshop. The session focused on building awareness about the importance of incorporating a growth mindset and building resiliency for strengthening team building, team success and improving health and well-being.

### *Road safety / Off-road safety - Substance use and harm reduction*

Public health nurses on the School Health Promotion team addressed a local school board's need for capacity building for the administration of naloxone and harm reduction strategies in schools. Thirty school board representatives, including the Director of Education, superintendents, and other administrators, were advised of the population trends on the emerging opioid issue, discussed naloxone policies and management of substance misuse. Public Health staff continue to strive for practicing excellence through the use of local data to adapt innovative public health approaches to support our school communities in addressing this emerging health issue.

## 4. Substance Use and Injury Prevention

### *Concussions*

A concussion awareness and helmet information session was delivered to City of Greater Sudbury municipal summer camp counsellors during their orientation week.

### *Falls – Stay On Your Feet*

On June 25, 2018, PHNs from the Falls Prevention team in partnership with North East Local Integration Network (NE LHIN), 4 northeastern health units, our local SOYF Falls Prevention Coalition and the Registered Nurses' Association of Ontario (RNAO) hosted via Ontario Telemedicicne Network (OTN) a Best Practice Champions workshop highlighting the new falls prevention guideline. Public Health Sudbury & Districts hosted the workshop and in attendance, were 34 health care providers from local community agencies, including long-term care, retirement homes, paramedicine, Health Sciences North and Laurentian University.

On June 7, 2018, Stay on Your Feet (SOYF) coordinated and organized a *STAND UP!* facilitator training. A total of 23 facilitators were trained from diverse local agencies to further promote physical activity for older adults in our catchment area. Stay on Your Feet also supported a *STAND UP!* facilitator training on August 15, 2018, in our Sudbury-East area and a total of 4 facilitators were trained. 16 *STAND UP!* exercise programs will be implemented by our community partners starting this fall in Sudbury, Sudbury-East, Espanola and Manitoulin Island.

### *Life promotion, suicide risk and prevention*

Two youth engagement sessions were held in both Greater Sudbury and Atikameksheng Anishinawbek First Nation. These two sessions hosted 24 youth, who discussed various ways in which feelings of belonging, adult influences, community services and positive peer relationships contribute to life promotion. These sessions will be used as a springboard to discuss the larger life promotion and youth suicide prevention strategy at a summit in September.

### *Off-road safety*

On June 2, 2018, a PHN participated in the annual bike rodeo event hosted by the Rayside Balfour neighbourhood. Over 100 participants attended and approximately 55 children were fitted for a bike helmet. In addition, 8 helmets were exchanged for ill-fitting or broken helmets.

Staff also delivered a concussion and helmet safety presentation to 130 summer camp counselors requested by the City of Greater Sudbury.

## *Road safety*

In June, a PHN hosted a car seat technician training and 11 community technicians were trained. On August 1, 2018, staff in partnership with the Children's Aid Society hosted a car seat inspection clinic in Azilda and a total of 18 child restraint systems were inspected and installed. On August 21, 2018, PHNs in partnership with OPP hosted a "Baby ride blitz" in Markstay and Warren. On June 13, 2018, Public Health Sudbury & Districts in partnership with the Sudbury Road Safety Committee hosted and led a media launch related to distracted driving. A PHN completed 3 interviews that appeared on CBC Radio and CBC Morning North. Regular updates on distracted driving were posted to social media with Facebook postings reaching 10 689 people and engaging 856 people. Five tweets were promoted during the campaign and received a total of 62 689 impressions. In partnership with the Sudbury Road Safety Committee, the vulnerable road user signs "Slow down watch for us" sign out program was re-created to increase accessibility for the public to sign out signs more easily.

## *Substance Use - Drug Strategy*

Work on the Supervised Injection Service Needs and Feasibility Study (SIS/NAFS) continues. A community stakeholder meeting was facilitated by the Associate Medical Officer of Health to begin stakeholder engagement with the NAFS. Twenty partners attended the first meeting. Two grants requesting federal funds have been submitted, with a third being prepared by the Réseau ACCESS Network for submission in early September.

Two billboards, in high density locations, were used to promote the "Fentanyl is getting into street drugs" campaign.

The Community Drug Strategy supported Réseau ACCESS Network's Overdose Awareness Week event on August 27.

## *Harm reduction – Naloxone*

The naloxone program has 18 memorandums of understanding with local agencies. Overall, 16 agencies have been trained, with a total of 79 individuals receiving the "train the trainer" model for the distribution of naloxone. Also, Public Health Sudbury & District staff have been trained both in distribution and administration. This includes PHNs on the Sexual Health team, as well as our first aid delegates (all office assistants across our offices). In total, over 100 people have been trained across Sudbury and districts.

Up to now, 935 kits have been ordered from the Ministry pharmacy. A total of 415 kits have been sent out to local agencies for distribution and the rest have been available through Public Health Sudbury & Districts for distribution.

# Knowledge and Strategic Services

## 1. Health Equity

Public Health Sudbury & Districts continues to lead a Local Poverty Reduction Fund project in partnership with community agencies to introduce three linked programs into the community: Bridges Out of Poverty, Leader Training, and Circles. Over the summer, three additional partners, the Sudbury Vocational Resource Centre, Monarch Recovery and Jubilee Heritage Family Resources joined the project's steering committee to support this initiative, bringing the total number of partnering agencies to 14. Upcoming Leader Training sessions are scheduled to start this fall in partnership with the Sudbury Vocational Resource Centre and St. Albert's Adult Learning Centre. Circles programming will commence in September at the new host site of Jubilee Heritage Family Resources. Two Bridges out of Poverty workshops were held in July and August including one in English and one in French.

A letter was submitted by Public Health Sudbury & Districts' Board of Health Chair to the Premier and the Ministers of Health and Long-Term Care and Children, Community and Social Services expressing concern in response to the provincial government's decision to prematurely end the Ontario Basic Income Pilot and reduce the previously promised increase in social assistance rates. Similar letters were also submitted by both alPHa and OPHA with support from the alPHa-OPHA Health Equity Work group.

## 2. Population Health Assessment and Surveillance (PHAS)

The Demographic Profile for our service area, which includes information from Statistics Canada's 2016 short-form Census, has recently been posted to our website. Topics presented include population distribution, official languages, marital status and family and household structure for Greater Sudbury, Manitoulin District and Sudbury District.

## 3. Staff Development

On June 28 and 29, Public Health Sudbury & Districts, in partnership with a research team from the NOSM, hosted the "Noojamadaa: Let's Heal!" art and photovoice exhibit. The exhibit features art and photography by First Nations women and men from Mantioulin Island exploring the essence of healthy relationships in families, communities and with the land.

This experiential learning opportunity aims to help foster and promote healing and reconciliation within families, communities and the nation. Facilitated tours were animated by presenters Randy and Lorelai Trudeau from Wiikwemkoong, who also shared a number of key reflections. Approximately 40 individuals participated in guided tours.

## 4. Student Placement Program

Over the  summer, the Student Placement Program hosted a total of 11 students, totaling 2850 preceptor hours. This included four Masters of Public Health (MPH) students who contributed to research, evaluation, Indigenous engagement, and health equity, two medical students and three nursing students hosted by Clinical Services and Health Promotion divisions, a Northern Ontario Dietetic Internship Program (NODIP) student, and a human resources student. Heading into the 2018 school year, our agency will host 16 students on placement, totaling 2076 preceptor hours. Students scheduled for this fall are also from various disciplines including nursing, medicine and Masters of Social Work. In addition, over 40 second-year nursing students will participate in full-day observations throughout the semester.

Respectfully submitted,

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

## Public Health Sudbury & Districts

**STATEMENT OF REVENUE & EXPENDITURES**

**For The 7 Periods Ending July 31, 2018**

## Cost Shared Programs

| | Annual Budget | Budget YTD | Current Expenditures YTD | Variance YTD (over)/under | Balance Available |
|---|---|---|---|---|---|
| **Revenue:** | | | | | |
| MOHLTC - General Program | 15,127,700 | 8,567,417 | 8,567,417 | (0) | 6,560,283 |
| MOHLTC - Unorganized Territory | 819,400 | 477,983 | 477,983 | 0 | 341,417 |
| MOHLTC - VBD Education & Surveillance | 65,000 | 37,917 | 37,917 | (0) | 27,083 |
| MOHLTC - SDWS | 106,000 | 61,833 | 61,833 | 0 | 44,167 |
| Municipal Levies | 7,064,806 | 4,121,129 | 4,121,129 | (0) | 2,943,677 |
| Municipal Levies - Small Drinking Water Syst | 47,222 | 27,546 | 27,546 | 0 | 19,676 |
| Municipal Levies - VBD Education & Surveill | 21,646 | 12,627 | 12,627 | (0) | 9,019 |
| Interest Earned | 85,000 | 85,000 | 91,241 | (6,241) | (6,241) |
| **Total Revenues:** | $23,336,774 | $13,391,452 | $13,397,693 | $(6,240) | $9,939,082 |
| **Expenditures:** | | | | | |
| **Corporate Services:** | | | | | |
| Corporate Services | 4,401,791 | 2,656,879 | 2,590,779 | 66,100 | 1,811,012 |
| Print Shop | 120,816 | 64,476 | 52,700 | 11,776 | 68,116 |
| Espanola | 119,921 | 69,557 | 64,156 | 5,401 | 55,765 |
| Manitoulin | 128,909 | 75,642 | 69,309 | 6,332 | 59,600 |
| Chapleau | 101,289 | 58,637 | 54,956 | 3,681 | 46,332 |
| Sudbury East | 16,508 | 9,630 | 9,833 | (203) | 6,675 |
| Intake | 323,006 | 182,772 | 180,542 | 2,230 | 142,464 |
| Volunteer Services | 5,711 | 3,331 | 650 | 2,682 | 5,062 |
| **Total Corporate Services:** | $5,217,950 | $3,120,923 | $3,022,924 | $97,999 | $2,195,026 |
| **Clinical Services:** | | | | | |
| General | 1,062,370 | 559,692 | 503,997 | 55,695 | 558,373 |
| Clinical Services | 1,308,822 | 773,192 | 775,462 | (2,271) | 533,360 |
| Branches | 221,693 | 129,511 | 123,180 | 6,331 | 98,513 |
| Family | 603,725 | 332,942 | 324,881 | 8,061 | 278,844 |
| Risk Reduction | 98,842 | 27,312 | 25,549 | 1,762 | 73,293 |
| Clinical Preventative Services - Outreach | 135,218 | 73,520 | 68,995 | 4,525 | 66,223 |
| Sexual Health | 945,014 | 533,344 | 525,483 | 7,861 | 419,531 |
| Influenza | 0 | 0 | 855 | (855) | (855) |
| HPV | 0 | 0 | 1 | (1) | (1) |
| Dental - Clinic | 520,983 | 299,203 | 270,796 | 28,406 | 250,187 |
| **Total Clinical Services:** | $4,896,667 | $2,728,715 | $2,619,200 | $109,515 | $2,277,467 |
| **Environmental Health:** | | | | | |
| General | 846,353 | 470,738 | 435,736 | 35,002 | 410,616 |
| Enviromental | 2,478,704 | 1,415,420 | 1,326,311 | 89,109 | 1,152,393 |
| Vector Borne Disease (VBD) | 86,667 | 35,300 | 29,631 | 5,669 | 57,036 |
| Small Drinking Water System | 153,222 | 89,202 | 86,441 | 2,762 | 66,781 |
| **Total Environmental Health:** | $3,564,945 | $2,010,661 | $1,878,119 | $132,542 | $1,686,826 |
| **Health Promotion:** | | | | | |
| General | 1,298,822 | 721,289 | 695,178 | 26,112 | 603,645 |
| School | 1,335,915 | 737,550 | 688,950 | 48,600 | 646,965 |
| Healthy Communities & Workplaces | 145,513 | 84,087 | 80,528 | 3,559 | 64,985 |
| Branches - Espanola / Manitoulin | 334,250 | 200,431 | 182,605 | 17,826 | 151,645 |
| Nutrition & Physical Activity | 998,641 | 560,448 | 496,587 | 63,861 | 502,055 |
| Branches - Chapleau / Sudbury East | 386,609 | 223,753 | 219,070 | 4,683 | 167,539 |
| Injury Prevention | 356,869 | 196,416 | 117,572 | 78,844 | 239,298 |
| Tobacco By-Law | 275,085 | 162,855 | 136,013 | 26,842 | 139,072 |
| Healthy Growth and Development | 1,145,879 | 628,273 | 520,252 | 108,021 | 625,627 |
| Substance Misuse Prevention | 113,172 | 69,493 | 69,466 | 27 | 43,706 |
| Mental Health and Addictions | 384,066 | 182,296 | 162,854 | 19,442 | 221,212 |
| Alcohol Misuse | 203,980 | 92,438 | 82,110 | 10,328 | 121,870 |
| **Total Health Promotion:** | $6,978,803 | $3,859,331 | $3,451,186 | $408,145 | $3,527,617 |
| **Knowledge and Strategic Services:** | | | | | |
| General | 1,759,696 | 1,035,422 | 1,004,986 | 30,435 | 754,709 |
| Workplace Capacity Development | 29,001 | 12,777 | 12,869 | (92) | 16,133 |
| Health Equity Office | 223,182 | 111,026 | 104,524 | 6,503 | 118,658 |
| Strategic Engagement | 666,530 | 387,281 | 357,876 | 29,405 | 308,654 |
| **Total Knowledge and Strategic Services::** | $2,678,409 | $1,546,506 | $1,480,254 | $66,252 | $1,198,155 |

## Public Health Sudbury & Districts

**STATEMENT OF REVENUE & EXPENDITURES**

**For The 7 Periods Ending July 31, 2018**

## Cost Shared Programs

| | Annual Budget | Budget YTD | Current Expenditures | Variance YTD | Balance Available |
|---|---|---|---|---|---|
| **Total Expenditures:** | $23,336,774 | $13,266,136 | $12,451,683 | $814,453 | $10,885,091 |
| **Net Surplus/(Deficit)** | $0 | $125,316 | $946,009 | $820,693 | |

## Public Health Sudbury & Districts

## Cost Shared Programs

STATEMENT OF REVENUE & EXPENDITURES
Summary By Expenditure Category
For The 7 Periods Ending July 31, 2018

| | BOH Annual Budget | Budget YTD | Current Expenditures YTD | Variance YTD (over) /under | Budget Available |
|---|---|---|---|---|---|
| **Revenues & Expenditure Recoveries:** | | | | | |
| Funding | 23,631,064 | 13,644,845 | 13,653,486 | (8,641) | 9,977,578 |
| Other Revenue/Transfers | 853,229 | 436,429 | 480,070 | (43,642) | 373,159 |
| **Total Revenues & Expenditure Recoveries:** | 24,484,292 | 14,081,273 | 14,133,556 | (52,282) | 10,350,737 |
| **Expenditures:** | | | | | |
| Salaries | 16,079,036 | 8,951,673 | 8,461,550 | 490,123 | 7,617,487 |
| Benefits | 4,537,347 | 2,646,807 | 2,499,991 | 146,816 | 2,037,356 |
| Travel | 258,194 | 120,655 | 100,959 | 19,696 | 157,235 |
| Program Expenses | 999,502 | 520,772 | 465,288 | 55,484 | 534,214 |
| Office Supplies | 101,799 | 40,232 | 24,113 | 16,119 | 77,686 |
| Postage & Courier Services | 70,536 | 40,101 | 34,245 | 5,856 | 36,291 |
| Photocopy Expenses | 32,207 | 18,787 | 14,792 | 3,995 | 17,415 |
| Telephone Expenses | 62,306 | 36,261 | 31,680 | 4,582 | 30,626 |
| Building Maintenance | 370,710 | 262,646 | 261,736 | 910 | 108,974 |
| Utilities | 208,937 | 121,880 | 112,944 | 8,936 | 95,993 |
| Rent | 263,153 | 153,806 | 156,323 | (2,517) | 106,830 |
| Insurance | 103,774 | 98,774 | 98,756 | 18 | 5,018 |
| Employee Assistance Program ( EAP) | 34,969 | 23,740 | 22,799 | 941 | 12,170 |
| Memberships | 32,289 | 27,643 | 32,365 | (4,722) | (76) |
| Staff Development | 228,217 | 140,710 | 149,746 | (9,036) | 78,471 |
| Books & Subscriptions | 11,377 | 6,867 | 2,105 | 4,762 | 9,272 |
| Media & Advertising | 139,886 | 44,496 | 21,658 | 22,838 | 118,228 |
| Professional Fees | 163,822 | 92,468 | 96,382 | (3,914) | 67,440 |
| Translation | 44,927 | 26,889 | 26,060 | 829 | 18,867 |
| Furniture & Equipment | 27,224 | 13,030 | 18,925 | (5,895) | 8,298 |
| Information Technology | 714,080 | 567,721 | 555,130 | 12,591 | 158,950 |
| **Total Expenditures** | 24,484,292 | 13,955,957 | 13,187,546 | 768,411 | 11,296,746 |
| **Net Surplus ( Deficit )** | 0 | 125,316 | 946,009 | 820,693 | |

**Sudbury & District Health Unit**
SUMMARY OF REVENUE & EXPENDITURES
For the Period Ended July 31, 2018

## 100% Funded Programs

| Program | FTE | Annual Budget | Current YTD | Balance Available | % YTD | Program Year End | Expected % YTD | |
|---|---|---|---|---|---|---|---|---|
| INFOWAY - Immunization Ontario | 702 | - | 16,358 | (16,358) | #DIV/0! | *Dec./19* | 33.3% | **E |
| MOHLTC Local Model for Indigenous Engagement | 703 | 103,302 | 46,159 | 57,143 | 44.7% | *Mar 31/19* | 33.3% | **B |
| Pre/Postnatal Nurse Practitioner | 704 | 139,000 | 80,623 | 58,377 | 58.0% | *Dec 31* | 58.3% | |
| OTF - Getting Ahead and Cirlcles | 706 | 216,800 | 81,357 | 135,443 | 37.5% | *Mar 31/2020* | 36.7% | |
| CGS - Local Poverty Reduction Evaluation | 707 | 46,592 | 18,579 | 28,013 | 39.9% | *Nov 30/2019* | 50.0% | **C |
| SFO - Electronic Cigarette Act | 722 | 36,700 | 10,877 | 25,823 | 29.6% | *Dec 31* | 58.3% | |
| SFO -TCAN - Prevention | 724 | 97,200 | 21,634 | 75,566 | 22.3% | *Dec 31* | 58.3% | |
| SFO - Tobacco Control Area Network - TCAN | 725 | 285,800 | 147,588 | 138,212 | 51.6% | *Dec 31* | 58.3% | |
| SFO - Local Capacity Building: Prevention & Protection | 726 | 259,800 | 96,176 | 163,624 | 37.0% | *Dec 31* | 58.3% | |
| SFO - Tobacco Control Coordination | 730 | 100,000 | 58,202 | 41,798 | 58.2% | *Dec 31* | 58.3% | |
| SFO - Youth Engagement | 732 | 80,000 | 45,103 | 34,897 | 56.4% | *Dec 31* | 58.3% | |
| Infectious Disease Control | 735 | 479,100 | 276,723 | 202,377 | 57.8% | *Dec 31* | 58.3% | |
| LHIN - Falls Prevention Project & LHIN Screen | 736 | 100,000 | 24,510 | 75,490 | 24.5% | *Mar 31/19* | 33.3% | |
| MOHLTC - Special Nursing Initiative | 738 | 180,500 | 106,647 | 73,853 | 59.1% | *Dec 31* | 58.3% | |
| MOHLTC - Northern Fruit and Vegetable Funding | 743 | 156,600 | 94,776 | 61,824 | 60.5% | *Dec 31* | 58.3% | |
| Food Safety - Haines Funding | 750 | 36,500 | 7,653 | 28,847 | 21.0% | *Dec 31* | 58.3% | |
| Triple P Co-Ordination | 766 | 20,392 | 20,392 | - | 100.0% | *Dec 31* | 58.3% | **A |
| MOHTLC - Harm Reduction Program | 771 | 150,000 | 86,888 | 63,112 | 57.9% | *Dec 31* | 58.3% | |
| Healthy Babies Healthy Children | 778 | 1,476,897 | 752,350 | 724,547 | 50.9% | *Dec 31* | 58.3% | |
| Healthy Smiles Ontario (HSO) | 787 | 612,200 | 313,713 | 298,487 | 51.2% | *Dec 31* | 58.3% | |
| Anonymous Testing | 788 | 61,193 | 20,511 | 40,682 | 33.5% | *Mar 31/19* | 33.3% | |
| PHO/LDCP First Nations Engagement | 790 | 108,713 | 43,851 | 64,862 | 40.3% | *May/17 to May/19* | 45.8% | **D |
| MHPS- Diabetes Prevention Program | 792 | 175,000 | 67,344 | 107,656 | 38.5% | *Dec 31* | 58.3% | |
| MOHLTC- Built Envir.-Climate Chg. - Disclosure & Healthy Menu | 793 | 131,100 | 3,159 | 127,941 | 2.4% | *Mar 31/19* | 33.3% | **F |
| **Total** | | 5,053,389 | 2,424,815 | 2,628,574 | | | | |

**A Div. 766 -- Set up July/13 (funding by school board in Sudbury and other partners)
**B Div. 703 - set up Apr. 1/17 as orig. (Jan.-Mar./17) in cost shared but Mar. Y/E didn't work there
**C Div. 707 - set up June/17 - May/17 to Nov./19 program (2.5 yr. prog.)
**D Div. 790 - New May/17 - May 2017 to May 2019 program
**E Div. 702 - New Sept./17 to Dec./19 - Kim Presta Mgr.
**F Div. 793 -- New June/18 for 1-time Funding approved for Environmental Health Apr./18 to Mar./19

Perth District Health Unit
653 West Gore Street
Stratford, Ontario N5A 1L4
(519) 271-7600 • www.pdhu.on.ca

June 14, 2018

Honourable Jody Wilson-Raybould
Minister of Justice
House of Commons
Ottawa, ON K1A 0A6

Dear Minister Wilson-Raybould;

**RE: Repeal of Section 43 of the Criminal Code**

The Board of Health of the Perth District Health Unit considered the attached resolution from the Haliburton, Kawartha, Pine Ridge District Health Unit at its regular meeting on March 21, 2018. The following motion was passed:

> **That the Board support the Haliburton, Kawartha, Pine Ridge District Health Unit letter re Repeal of Section 43 of the Criminal Code.**

This is not the first time the Board of Health considered the repeal of Section 43 of the Criminal Code of Canada. In September 2005, the Board of Health for the Perth District Health Unit first adopted a resolution to support the repeal of Section 43 of the Criminal Code of Canada and affirmed its position on potential harm and ineffectiveness of the physical punishment of children by endorsing the Joint Statement on Physical Punishment of Children and Youth. The Perth District Health Unit works in collaboration with other local community agencies to further our goal of ensuring optimal preconception, pregnancy, newborn, child, youth and parental and family health. Our work includes comprehensive public health interventions related to preparation for parenting and positive parenting. The repeal of Section 43 of the Criminal Code of Canada which would afford children the same protection from physical assault as adults is a long overdue policy change that supports this community work.

Sincerely,

Teresa Barresi
Chair, Board of Health

/cp

Encl.



c. The Right Honourable Justin Trudeau, Prime Minister of Canada
John Nater MP
Randy Pettapiece, MPP
Kids First Steering Committee
Association of Local Public Health Agencies
All Ontario Public Health Units

June 18, 2018

Premier-Elect Doug Ford
Legislative Building
Queen's Park
Toronto ON M7A 1A1

Dear Premier-Elect:

**Re: Dedicated Funding For Local Public Health Agencies From Cannabis Sales Taxation Revenue**

On April 27, 2018 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Hastings Prince Edward Public Health regarding dedicated funding for local Public Health agencies from cannabis sales taxation revenue. The following motion was passed:

GBHU BOH Motion 2018-39

Moved by: David Inglis Seconded by: Mitch Twolan

"THAT, the Board of Health support the resolution from Hastings Prince Edward Public Health urging the provincial government to dedicate a portion of the cannabis excise tax revenue from the federal government to local Public Health agencies in Ontario."

Carried

Sincerely,

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

Cc: All Ontario Boards of Health

Encl.

June 18, 2018

Windsor-Essex County Health Unit
1005 Ouellette Avenue
Windsor ON N9A 4J8

To Whom It May Concern:

**Re: Recommendation/Resolution Report – Oral Health Report Update 2018**

On May 25, 2018 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached recommendation/resolution report and Oral Health Report Update from Windsor-Essex County Board Of Health. The following motion was passed:

GBHU BOH Motion 2018-50

Moved by: Arlene Wright Seconded by: David Shearman

"THAT, the Board of Health for the Grey Bruce Health Unit support the resolution from Windsor-Essex County Health Unit regarding municipal water fluoridation; and FURTHER THAT this report and resolution be shared with local media."

Carried

Sincerely,

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

Cc: Local Media

Encl.

June 18, 2018

Ontario Film Review Board
c/o Ontario Film Authority
4950 Yonge Street, Suite 101B
OFRBinfo@ontariofilmauthority.ca

Dear Ontario Film Review Board:

**Re: Youth Exposure to Smoking in Movies**

On May 25, 2018 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Peterborough Public Health regarding increased regulations to protect kids and teens from smoking in movies. The following motion was passed:

GBHU BOH Motion 2018-52

Moved by: Paul Eagleson Seconded by: Laurie Laporte

"THAT, the Board of Health for the Grey Bruce Health Unit support the recommendations from Peterborough Public Health regarding youth exposure to smoking in movies."

Carried

Sincerely,

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

Cc: Ontario Boards of Health

Encl.

Public Health
Santé publique
SUDBURY & DISTRICTS

August 3, 2018

VIA EMAIL

The Honourable Doug Ford
Premier of Ontario
premier@ontario.ca

The Honourable Lisa MacLeod
Minister of Children, Community and Social Services
mcssinfo.css@ontario.ca

The Honourable Christine Elliott
Minister of Health and Long-Term Care
ccu.moh@ontario.ca

Dear Premier Ford and Ministers MacLeod and Elliott:

**Re: Ontario Basic Income Research Project and the Reduction in the Scheduled Social Assistance Rate Increase**

I am writing on behalf of the Board of Health for Public Health Sudbury & Districts to express deep concern regarding the recent announcements to reduce important supports to Ontario's most vulnerable citizens. These announcements include the termination of the Basic Income Research Project and the reduction in the scheduled social assistance rate Increase.

The Board of Health for Public Health Sudbury & Districts cares deeply about vulnerable Ontarians and supports measures to support health equity through critical financial policies. The Board has previously called for provincial and federal levels of government to pursue a basic income guarantee policy and to increase social assistance rates to reflect the actual cost of nutritious food and adequate housing (Board motions #43-15 and #50-16).

**Sudbury**
1300 rue Paris Street
Sudbury ON P3E 3A3
t: 705.522.9200
f: 705.522.5182

**Rainbow Centre**
10 rue Elm Street
Unit / Unité 130
Sudbury ON P3C 5N3
t: 705.522.9200
f: 705.677.9611

**Sudbury East / Sudbury-Est**
1 rue King Street
Box / Boîte 58
St.-Charles ON P0M 2W0
t: 705.222.9201
f: 705.867.0474

**Espanola**
800 rue Centre Street
Unit / Unité 100 C
Espanola ON P5E 1J3
t: 705.222.9202
f: 705.869.5583

**Île Manitoulin Island**
6163 Highway / Route 542
Box / Boîte 87
Mindemoya ON P0P 1S0
t: 705.370.9200
f: 705.377.5580

**Chapleau**
101 rue Pine Street E
Box / Boîte 485
Chapleau ON P0M 1K0
t: 705.860.9200
f: 705.864.0820

**Toll-free / Sans frais**
1.866.522.9200

**phsd.ca**

There is considerable research that clearly shows that people with lower incomes experience higher burdens of adverse health and social outcomes compared with people of higher incomes. This includes morbidity and/or mortality from chronic and infectious disease, mental illness, and infant mortality, amongst others.[i]. There is a corresponding financial burden to the health care system. A recent report from the Public Health Agency of Canada estimates that socio-economic inequalities cost the health care system $6.2 billion annually, with Canadians in the lowest income bracket accounting for 60% (or $3.7 billion) of those costs.[i]

It is with deep regret that we learned of your government's recent announcements and we respectfully urge you to reconsider these important supports to vulnerable Ontarians. In line with our own strategic priority of decreasing health inequities and striving for equitable opportunities for health, we would very much welcome the opportunity to engage in dialogue with you on this important health matter.

Yours sincerely,

René Lapierre
Chair
Board of Health for Public Health Sudbury & Districts

Cc: Jamie West, Member of Provincial Parliament, Sudbury
France Gélinas, Member of Provincial Parliament Nickel Belt
Michael Mantha, Member of Provincial Parliament, Algoma- Manitoulin
Dr. David Williams, Chief Medical Officer of Health
Helen Angus, Deputy Minister, Ministry of Health and Long-term Care
All Ontario Boards of Health

---

[i] Auger, N and Alix, C. (2016). Income, Income Distribution, and Health in Canada. In Raphael, D. (Eds), Social Determinants of Health (p. 90-109), 3rd edition. Toronto: Canadian Scholars Press Inc.

[i] Public Health Agency of Canada. The direct economic burden of socioeconomic health inequalities in Canada: an analysis of health care costs by income level. Ottawa: Public Health Agency of Canada; 2016 [Accessed 2016 Dec 28]. Retrieved from http://vibrantcanada.ca/files/the_direct_economic_burden_-_feb_2016_16_0.pdf.

## Helene Leroux

**From:** Doug Ford <premier@premier.gov.on.ca>
**Sent:** August 7, 2018 4:24 PM
**To:** Helene Leroux
**Subject:** An email from the Premier of Ontario

Dear Mr. Lapierre:

Thanks for getting in touch with me, on behalf of the Board of Health for Public Health Sudbury and Districts, to share your views about our plan to reform social assistance in Ontario. I appreciate hearing from you.

Our social assistance programs are an important part of the safety net designed to assist our most vulnerable people. This is an important responsibility, and one we take seriously. Upon assuming government and reviewing the system we inherited, it quickly became apparent that the status quo was not working for people in need. Instead of helping people get their lives back on track, the old system left too many people trapped in a cycle they could not break out of.

Social assistance will always be about compassion for people in need, but it must also be about lifting people up and helping them get their lives back on track through more jobs, more opportunities and more hope. Tackling the serious issues facing our social assistance system isn't an easy thing to do. But it's the right thing to do, and we'll get this right.

Thanks again for contacting me.

Doug Ford
Premier of Ontario

C: The Honourable Lisa MacLeod
Minister of Children, Community and Social Services

The Honourable Christine Elliott
Minister of Health and Long-Term Care

alPHa
Association of Local PUBLIC HEALTH Agencies

2 Carlton Street, Suite 1306
Toronto, Ontario M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

**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

Hon. Lisa MacLeod
Minister of Children, Community and Social Services
14th Floor, 56 Wellesley St W
Toronto, ON M7A 1E9
lisa.macleod@pc.ola.org

August 2, 2018

Dear Minister MacLeod,

**Re: alPHa Resolution A15-4, Public Health Support for a Basic Income Guarantee**

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 disappointment with the decision to cancel Ontario's Basic Income Pilot (OBIP).

This project was carefully designed, limited in time and scope and not significantly costlier than the payments that Ontario Works (OW) or the Ontario Disability Support Program (ODSP) would have transferred to those enrolled. It was based on a detailed and well-researched proposal authored by Senator Hugh Segal, which was in turn subject to a broad consultation that received input from over 35,000 Ontarians as well as support from each of the province's major political parties.

Its aim was to investigate the potential for a basic income to improve the income security of vulnerable Ontarians and increase their chances of breaking the cycle of poverty. It was also designed to permit the evaluation of the potential of such an initiative as a simpler and more economically effective form of social assistance than the current OW and ODSP model.

In addition to this, the pilot was intended to measure outcomes in areas such as food insecurity, stress and anxiety, mental health, health and healthcare usage, housing stability, education and training and employment and labour market participation. These are all key determinants of health and are therefore at the root of public health's interest in and strong support of the OBIP.

There is consistent evidence that health outcomes improve as income rises. Lower income people are at far greater risk from a range of preventable medical conditions, including cancer, diabetes, heart disease, and mental illness. We therefore believe that improving incomes is an exceptionally effective public health intervention that also contributes to reducing the burden on Ontario's health care system.

The OBIP is an innovative approach to income security that should be allowed to reach its conclusion so that the evidence can be gathered, analyzed and interpreted to evaluate it against its stated objectives. We ask that you reconsider the decision to cancel the program.

alPHa's 2015 resolution in support of the concept of basic income is attached, and I would welcome the opportunity to discuss this with you and to inform any review of social assistance that your government might undertake. Please contact Loretta Ryan (loretta@alphaweb.org or 647-325-9594), should you be receptive to such a meeting.

Sincerely,

Dr. Robert Kyle
alPHa President

**COPY**: Hon. Christine Elliott, Minister of Health and Long-Term Care
Helen Angus, Deputy Minister, Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Branch (Health and Long-Term Care)
Dr. Christopher Mackie, Chair, Council of Ontario Medical Officers of Health
Trudy Sachowski, Chair, Boards of Health

**ENCL.**

**alPHa RESOLUTION A15-4**

**TITLE:** **Public Health Support for a Basic Income Guarantee**

**SPONSOR:** **Simcoe Muskoka District Health Unit**

WHEREAS low income, and high-income inequality, have well-established, strong relationships with a range of adverse health outcomes; and

WHEREAS 1,745,900 Ontarians, or 13.9% of the population, live in low income according to the 2011 National Household Survey after-tax low-income measure; and

WHEREAS income inequality continues to increase in Ontario and Canada; and

WHEREAS current income security programs by provincial and federal governments have not proved sufficient to ensure adequate, secure income for all; and

WHEREAS a basic income guarantee – a cash transfer from government to citizens not tied to labour market participation - ensures everyone an income sufficient to meet basic needs and live with dignity, regardless of work status; and

WHEREAS basic income resembles income guarantees currently provided in Canada for seniors and children, which have contributed to health improvements in those age groups; and

WHEREAS there was an encouraging pilot project of basic income for working age adults conducted jointly by the Government of Manitoba and the Government of Canada in Dauphin, Manitoba in the 1970s, which demonstrated several improved health and educational outcomes; and

WHEREAS a basic income guarantee can reduce poverty and income insecurity, and enable people to pursue educational, occupational, social and health opportunities relevant to them and their family; and

WHEREAS the idea of a basic income guarantee has garnered expressions of support from the Canadian Medical Association and the Alberta Public Health Association as a means of improving health and food security for low income Canadians; and

WHEREAS there is momentum growing across Canada from various sectors and political backgrounds for a basic income guarantee;

**NOW THEREFORE BE IT RESOLVED THAT** the Association of Local Public Health Agencies (alPHa) endorse the concept of a basic income guarantee**;**

**AND FURTHER** that alPHa request that the federal Ministers of Employment and Social Development, Labour, and Health, as well as the Ontario Ministers Responsible for the Poverty Reduction Strategy, Seniors, Labour, Children and Youth Services, and Health and Long-Term Care, prioritize joint federal-provincial consideration and investigation into a basic income guarantee, as a policy option for reducing poverty and income insecurity and for providing opportunities for those in low income;

**AND FURTHER** that the Prime Minister, the Premier of Ontario, the Chief Public Health Officer, the Chief Medical Officer of Health for Ontario, the Canadian Public Health Association, the Ontario Public Health Association, the Federation of Canadian Municipalities, and the Association of Municipalities of Ontario be so advised.

*Sent via email:* lisa.macleodco@pc.ola.org

August 1, 2018

Honourable Minister Lisa MacLeod
Minister of Children, Community and Social Services
80 Grosvenor Street, 6th Floor, Hepburn Block
Ministry of Community and Social Services
Toronto, ON M7A 1E9

Dear Minister MacLeod:

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I am writing to convey our profound disappointment at your recent announcement of your intentions to cancel the Ontario Basic Income Pilot, and to urge you to reconsider this decision. Your government's change in direction from your pre-election indications of continuing the pilot will leave the more than 4000 pilot participants facing extremely challenging circumstances, which is an unethical approach to a scientific endeavor. This pilot is recognized throughout our province and internationally as a pivotal opportunity to study the impact of basic income on a range of economic, social, and health outcomes in modern day Ontario. With the extent of the societal impact of poverty, income inequality, and growing precarious employment, basic income is widely recognized as a key policy avenue for exploration to help address these issues. A great deal of time and resources have already been invested in effectively planning and beginning to implement this pilot; we feel it would be a substantial waste to terminate it so prematurely, without the opportunity to first learn from it.

SMDHU has been a vocal proponent of the basic income concept since 2015. Among other actions, we sponsored a resolution at the Association of Local Public Health Agencies (alPHa) general meeting in May 2015, endorsing the concept of basic income and requesting that the provincial and federal governments jointly consider and investigate a basic income guarantee as a policy option for reducing poverty and income insecurity, available at this link. The full backgrounder informing this resolution, and a related resolution for the Ontario Public Health Association, is available at this link. In June 2016, SMDHU's Board of Health endorsed the Responses to Food Insecurity Position Statement of the Ontario Society of Nutrition Professionals in Public Health. This statement recognizes the strong link between poverty and food insecurity and urges the investigation of a basic income for reducing these phenomena. SMDHU's Board of Health has also written on several occasions to the previous provincial government, including to provide input into the design of the basic income pilot and to acknowledge the scientifically and socially sound approach to the design decisions.

Our support of basic income is informed by evidence of the powerful link between income and health. Twelve per cent of the population of Simcoe Muskoka live in low income. Those living with a lower income in our region are at far greater risk of experiencing a lower life expectancy -- two and a half years less for females and five years less for males, compared to those with the highest income. Moreover, the prevalence of self-reported chronic diseases, such as diabetes and heart disease, are one and a half to two times higher for those living in low income compared to their higher income counterparts in our region.

In the immediate future, we also strongly urge the Province to maintain the planned increase to social assistance rates. Current rates are highly insufficient to afford basic needs, including rent and nutritious food. The need for increased social assistance rates, as well as continuing the basic income pilot and creating policies that encourage good jobs with regular hours and benefits, is highlighted in SMDHU's campaign on food insecurity: No Money for Food is Cent$less.

Ontario has the opportunity to continue its basic income pilot and to learn if, in fact, this policy option will help to provide people in poverty and precarious employment with greater opportunity - to live with dignity, to experience improved physical and mental health, and to fully participate in and contribute to society. We urge your government to maintain this pilot and its planned evaluation, so that future generations may benefit from this learning.

Sincerely,

**ORIGINAL Signed By:**

Scott Warnock
Board of Health Chair
Simcoe Muskoka District Health Unit

SW:LS:cm

cc: Honourable Doug Ford, Premier of Ontario
Honourable Christine Elliott, Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
MPPs Simcoe and Muskoka
Mayors and Councils of Simcoe and Muskoka
North Simcoe Muskoka and Central Local Health Integration Network

Peterborough Public Health

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

August 3, 2018

The Honourable Lisa MacLeod
Minister of Children, Community and Social Services
80 Grosvenor Street, 6th Floor, Hepburn Block
Ministry of Community and Social Services
Toronto, ON M7A 1E9
**Sent via email: lisa.macleodco@pc.ola.org**

Dear Minister MacLeod:

I am writing on behalf of the Board of Health for Peterborough Public Health to urge you to reconsider the recent decision to cancel the Ontario Basic Income Pilot Project. We feel strongly that the Pilot Project offers a well-designed, cost-effective and unique opportunity to determine the contribution of a Basic Income to improving a range of economic, social and health outcomes in Ontario. The 4,000 pilot participants, including 2,000 participants in our neighbouring community of Lindsay, have entered into significant future commitments since the launch of the project, and in good faith have agreed to provide important data on the impact of this poverty reduction approach. We feel it is ethically essential to honour the promise of a full pilot program to them.

Peterborough Public Health has actively supported the concept of the basic income guarantee for many years. In September, 2015, our Board urged the provincial government to undertake a Basic Income initiative in order to address extensive health inequities in our province. Dr. Salvaterra, the Medical Officer of Health, has provided public information and support for the concept in local media. Public health staff also participate in the local Basic Income Peterborough Network. The Network has hosted a number of public education events, including an event featuring Dr. Evelyn Forget to share her analysis of the basic income project in Dauphin Manitoba, which predated the Ontario pilot.

There is an abundance of evidence on the powerful link between income and health, which is supported by data from our local community. Fifteen per cent of the population of Peterborough City and County live in low income. Those living with a lower income in our community are more likely to die earlier than people who are better off financially – females in the highest income group live eight years longer than those in the lowest income group, while males in the highest income group live fourteen years longer than males in the lowest income group. Similarly, individuals living with the lowest incomes have higher rates of chronic disease. Self-reported diabetes in Peterborough among adults aged 50+ in the lowest income group (18%) is more than double that of the highest income group (8%).

It has also been well documented that food insecurity is closely related to poorer health outcomes and higher health care costs. The most recent edition of the Peterborough Limited Incomes/Nutritious Food Basket Report reported that 16.5% of people in Peterborough City and County experience food insecurity. The Report clearly demonstrates that incomes from current social assistance programs and minimum wages from often precarious employment, are insufficient to meet people's basic needs. A Basic Income Guarantee has the potential to dramatically reduce food insecurity in our communities.

Previous research has shown that improved health outcomes are obtained when people receive a liveable basic income. Residents of Dauphin, Manitoba, for instance, saw an 8.5% reduction in hospitalization rates (primarily due to fewer accident and injury hospitalizations and fewer hospitalizations due to mental health issues). These improvements are direly needed in our current situation of significant health inequities.

We firmly believe that the Ontario Basic Income Pilot Project has enormous potential to inform the development of an effective income support system which will directly impact a wide range of key determinants of health and health outcomes. We ask that you allow the pilot and its planned evaluation to proceed as planned and fulfill its considerable potential.

Sincerely,

***Original signed by***

Councillor Henry Clarke,
Chair, Board of Health

/ag

cc: Honourable Doug Ford, Premier of Ontario
Honourable Christine Elliott, Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
MPP David Piccini
MPP Laurie Scott
MPP Dave Smith
Central-East Local Health Integration Network
Ontario Boards of Health

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound
*Your lifetime partner in healthy living.*
345 Oak Street West, North Bay, ON P1B 2T2 TEL 705-474-1400 FAX 705-474-8252 | myhealthunit.ca
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL 705-746-5801 FAX 705-746-2711 | 1-800-563-2808

August 16, 2018 **SENT ELECTRONICALLY**

The Honorable Doug Ford
Premier of Ontario
doug.ford@pc.ola.org

The Honourable Lisa McLeod
Minister of Children, Community and Social Services
lisa.macleodco@pc.ola.org

Dear Premier Ford and Minister McLeod,

The North Bay Parry Sound District Health Unit (Health Unit) staff and Board of Health are deeply concerned about the Ontario government's recent decision to cancel the Ontario Basic Income Pilot (OBIP), and to reduce the scheduled increase to Ontario Works and the Ontario Disability Support Program rates from 3% to 1.5%.

Annually, the Health Unit monitors food affordability through the Nutritious Food Basket food costing project. In 2017, the monthly cost of healthy eating for a family of four was $879. When this number is paired with local rent rates and compared to low income scenarios, our data shows that a nutritious diet is out of reach for those living with low incomes, whether they are receiving social assistance, or working for minimum wage.[1]

Food insecurity is defined as inadequate or insecure access to food due to financial constraints, which points to low income as the root of the problem. It can range from worrying about running out of food, to diet quality being compromised, to skipping meals altogether, due to not having enough money. While 1 in 8 Ontario households report experiencing food insecurity, social assistance recipients are at increased risk, with 64% of households receiving social assistance reporting food insecurity.[2] However, food insecurity numbers likely underrepresent the problem given that data is not collected from First Nation reserves, within the homeless population, and other vulnerable population groups that are difficult to reach.

Food insecurity is a significant public health problem because there is a direct link between food insecurity and negative health outcomes.[3] Adults experiencing food insecurity are more likely to develop chronic conditions such as diabetes, high blood pressure, heart disease, and mental health problems. Children and adolescents who experience food insecurity are more likely to develop asthma and mental

[1] North Bay Parry Sound District Health Unit. (2017). The cost of healthy eating report. Retrieved August 9, 2018, from http://www.myhealthunit.ca/en/resources/The-2017-Cost-of-Healthy-Eating-Report.pdf
[2] PROOF: Food Insecurity Policy Research. Household food insecurity is a serious public health problem that affects 1 in 8 Canadian households. Retrieved August 9, 2018, from http://proof.utoronto.ca/
[3] PROOF: Food Insecurity Policy Research. The Impact of Food Insecurity on Health. Retrieved August 9, 2018, from http://proof.utoronto.ca/wp-content/uploads/2016/06/health-impact-factsheet.pdf

health problems later in life. As a result, food insecurity costs the province in health care spending; individuals experiencing food insecurity have significantly higher health care usage than those who are food secure.[4]

For all of these reasons, our health unit has advocated to the provincial government for the past several years about the importance of adequate incomes to reduce food insecurity and improve health and social outcomes. In particular, our health unit has endorsed the idea of a basic income, which has gained popularity in recent years among many sectors as a viable, universal solution to increasing income security in Ontario.[5]

We urge you to consider the following recommendations in order to benefit the health of many low income Ontarians:

- Reinstate the Ontario Basic Income Pilot and follow through with the evaluation plan. This will fulfill the promise made to the 4000 people enrolled in the pilot project who were relying on the extra monthly funds for the next two years. Reports are being made in the media about how lives will be significantly affected by this, including not being able to pursue higher education and being stuck in a housing lease that is now unaffordable.[6] It is imperative that the results of the pilot project are evaluated to determine whether the basic income model is an effective policy intervention to improve health and social outcomes in low income populations.
- Proceed with the 3% scheduled increase as planned for Ontario Works and the Ontario Disability Support Program. Focusing efforts on reducing hydro and gasoline prices will not benefit many of the lowest income citizens of Ontario, many of whom do not own a car, and/or have their utility costs included in their monthly rent. Increasing social assistance rates however, will directly benefit many of Ontario's lowest income households.
- Refer to the report *Income Security: a Roadmap for Change* when formulating your plan for social assistance reform over the next 100 days. This report was prepared in collaboration with many experts, including Indigenous representatives, and has already undergone a public consultation process. Our health unit provided a response as part of the consultation and reviewed the report in detail. Please consider the time and associated public dollars that went into the development and subsequent consultation process related to this report.

In the spirit of the new foundational standard of Health Equity outlined in the 2018 Ontario Public Health Standards, public health now has an explicit role in reducing health inequities. Part of this requirement includes raising awareness about health inequities, from which income security cannot be excluded. Much of the responsibility related to income security lies on the shoulders of provincial policy makers such as yourselves. We recognize the importance of being fiscally accountable to the taxpayers

[4] Tarasuk V, Cheng J, de Oliveira C, Dachner N, Gundersen C, & Kurdyak P. (2015). Association between household food insecurity and annual health care costs. *Canadian Medical Association Journal*, 187(14), E429-E436.
[5] Tarasuk V. (2017). Implications of a basic income guarantee for household food insecurity. Research Paper 24. Northern Policy Institute. Retrieved August 9, 2018, from http://proof.utoronto.ca/resources/proof-annual-reports/implications-of-a-basic-income-guarantee-for-household-food-insecurity/
[6] CBC News. Hamilton woman can't afford rent, stuck in lease after province scraps basic income. Retrieved August 9, 2018, from https://www.cbc.ca/news/canada/hamilton/hamilton-woman-basic-income-1.4777326

of Ontario, but it is unjust to do so at the expense of our most vulnerable citizens. The repercussions of these actions will ultimately cost the province in health care and social service dollars.[7]

Thank you for taking the time to review this information and we look forward to hearing a response.

Sincerely,

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

Nancy Jacko
Chairperson, Board of Health

ER/er

Copied to: Hon. Victor Fedeli, MPP Nipissing
Norm Miller MPP Parry Sound-Muskoka
John Vanthrof, MPP Timiskaming-Cochrane
Ontario Boards of Health
Association of Local Public Health Agencies

[7] Dutton D, Forest P.G., Kneebone R, & Zwicker J. (2018). Effect of provincial spending on social services and health care on health outcomes in Canada: An observational longitudinal study. *Canadian Medical Association Journal*, 190(3), E66-71.

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

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1-866-888-4577

Hon. Lisa MacLeod
Minister of Children, Community and Social Services
14th Floor, 56 Wellesley St. W
Toronto, ON M7A 1E9
Sent via email to: lisa.macleod@pc.ola.org

August 17, 2018

Dear Minister MacLeod,

**Re: Cancellation of the Basic Income Pilot Project**

On behalf of the Board of the Health for the Haliburton, Kawartha, Pine Ridge District Health Unit, I am writing to urge you to reconsider the decision to cancel the Ontario Basic Income Pilot Project. This very important initiative would have provided the Province with valuable information regarding the impact of basic income on health, social, and economic well-being.

In a position statement released in June of 2016 (attached), the Haliburton, Kawartha, Pine Ridge District Health Unit (Health Unit) cited research and evidence in its support of Basic Income Guarantee as an essential component of a strategy to effectively eliminate poverty, ensure all Canadians have a sufficient income to meet their basic needs, and live with dignity and to eliminate health inequities.

The Health Unit believes that eliminating poverty is an urgent public health and health equity issue, as well as a human rights and social justice issue. Research clearly indicates that people living in poverty are more likely to experience poorer health, have chronic health conditions, more injuries, and have a disability. Those living with low-income have a greater use of a variety of health care and social services and are more likely to live shorter lives.

The recent cancellation of the 3-year Basic Income Pilot Project will impact more than the 4,000 Ontarians who are currently committed to the Project. The research to be gleaned from this Project had the potential to impact the 1.7 million Ontarians who are living in poverty. In addition to the cancellation of the research project, the proposed cuts to the previously planned increase in social services rates (from 3% to 1.5%) and the 50% reduction in the amount of allowable earned income for those on social assistance are extremely concerning. These cuts directly contradict the significant volume of available evidence indicating that it is costlier, and socially unjust to keep people in the province living with inadequate income to meet their basic needs. As the Association of Local Public Health Agencies (alPHa), expressed in its August 2, 2018 letter to you, the Basic Income Pilot Project was based on a well thought out, researched proposal, which had received valuable input from over 35,000 Ontarians. To so abruptly cancel this Project undermines the investments made both financially and personally by many Ontario citizens. The unethical and unjust treatment of the participants from Lindsay, Hamilton-Brant, and Thunder Bay is unconscionable.

.../2

Previous research on Basic Income Guarantee programs demonstrates substantial benefits such as decreased hospitalization rates, work-related injuries, emergency department visits and mental illness consultations. The Basic Income Guarantee (BIG) is considered by many economists and researchers as an economically sound and an effective policy option to reduce the number of programs and their associated costs, and to streamline the effort to tackle poverty. It is predicted that BIG will cost less than the current amounts spent on social programs, housing, justice and health care needs.

The Health Unit's position statement also acknowledges the success of existing guaranteed income supplement programs (Old Age Security and Guaranteed Income Supplements for seniors), which provide evidence of improved health status and quality of life for recipients.

Although the causes of poverty are complex, and a multipronged approach is required to improve health, the Basic Income Guarantee is one policy approach that could reduce the economic barriers to good health and ensure low-income individuals and families in Ontario have a sufficient income to meet their basic needs and live with dignity.

Continuation of the Basic Income Pilot Project would allow researchers to fully assess the impact of the Basic Income Guarantee on labour participation, health, social engagement, food security, housing stability and educational activities. We know through anecdotal reports from our staff, that participants in the Lindsay Pilot Project located in our Health Unit area, have already experienced benefits of BIG in terms of improved housing, ability to further education to improve employment opportunities, ability to purchase more nutritious food and reduced reliance on food banks.

The Health Unit therefore respectfully requests that the Basic Income Pilot Project be reinstated and allowed to be completed as originally planned. By completing the Project, the evidence obtained would then serve to guide further action for policies and programs to reduce poverty, thereby improving the health and well-being for all people in the Province of Ontario.

Yours truly

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

A. Lynn Noseworthy, MD, MHSc, FRCPC
Medical Officer of Health

ALN:kn

Attachment: Haliburton, Kawartha, Pine Ridge District Health Unit Position Statement-Basic Income Guarantee

Copy to: Hon. Doug Ford, Premier of Ontario
(via email) Hon. Christine Elliott, Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Branch
MPP Laurie Scott
MPP David Piccini
City of Kawartha Lakes
Haliburton County
Northumberland County
Central-East Local Health Integration Network
Loretta Ryan, Executive Director, Association of Local Public Health Agencies

…/3

Pegeen Walsh, Executive Director, Ontario Public Health Association
Ontario Boards of Health
Association of Municipalities of Ontario

Services de santé du TIMISKAMING Health Unit
*Enhancing your health in so many ways.*

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**www.timiskaminghu.com**

August 8, 2018

VIA EMAIL

Honourable Doug Ford
Premier of Ontario
Premier@ontario.ca

Honourable Lisa MacLeod
Minister of Children, Community and Social Services
lisa.macleodco@pc.ola.org

Honourable Christine Elliott
Minister of Health and Long-Term Care
christine.elliott@pc.ola.org

Dear Premier Ford and Minsters MacLeod and Elliott:

**Re: Basic Income Research Project and Social Assistance Rate Reduction and Reform**

On behalf of the Timiskaming Health Unit (THU), I am writing to express our concerns with the recent announcements to reduce income supports to Ontario's most vulnerable citizens. These announcements include stopping the Basic Income Research Project and the reduction in the scheduled social assistance rate increase.

There is substantial evidence that demonstrates the powerful relationship between income and health and social outcomes. Those with lower incomes experience higher burden of adverse outcomes compared to those with higher income. The effects of low income and of income inequality perpetuated by the current system may be felt more severely in northern areas of the province such as Timiskaming, where the median income is lower than the provincial average, a greater proportion of the population lives in low income, and access to health and social services may be more limited.[1]

Reducing the negative impact of income and income inequalities is fundamental to the work of public health. The Board of Health for the Timiskaming Health Unit has previously called for and expressed support for a basic income guarantee policy and social assistance rates that reflect the actual cost of basic needs.

As such, we request that you:

- **Reconsider the decision to cancel the basic income pilot**. The basic income pilot was based on sound research, considerable public consultation, and expressed support from all provincial political parties. The basic income pilot should be maintained and evaluated at the end of its three-year duration as planned before decisions are made as to its effectiveness and viability.

- **Maintain the planned increase to social assistance rates and consider social assistance reform as an investment in society rather than a cost to society**. Current social assistance rates are insufficient as highlighted by a public health campaign on food insecurity – No Money for Food is Cent$less.[2] Studies have shown that investing to eliminate poverty costs less than allowing it to persist.[3] Investing to eliminate poverty saves money spent on treating the consequences of poverty in all sectors of government.

- **Act on the recommendations from the "Income Security: A Roadmap for Change" report**. The Roadmap promotes taking a fundamentally different approach to income security—putting people's dignity, their needs, and their rights at the centre of the system.[4] The changes proposed in this report would have a significant impact on income and health.

It is with grave concern that we learned of your governments recent announcements and we urge you to reconsider these important supports. Furthermore, as your government undertakes an accelerated plan to reform Social Assistance we ask you to consider the points above to make the most of the opportunity for the people of Ontario.

Sincerely,

Carman Kidd, Chair
Board of Health for Timiskaming Health Unit

cc: John Vanthof, Member of Provincial Parliament, Timiskaming-Cochrane
Dr. David Williams, Chief Medical Officer of Health
Helen Angus, Deputy Minister, Ministry of Health and Long-Term Care
All Ontario Boards of Health

References


1. Statistics Canada. 2017. Timiskaming Health Unit, [Health region, December 2017], Ontario and Ontario [Province] (table). Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29, 2017. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E (accessed July 24, 2018).
2. Ontario Dietitians in Public Health. *No Money fo Food is Cent$less.* Accessed August 8 2018: https://www.odph.ca/centsless
3. National Council of Welfare. *The Dollars and Sense of Solving Poverty*. Ottawa, Ontario: Her Majesty the Queen in Right of Canada; 2011.
4. Income Security Reform Working Group, First Nations Income Security Reform Working Group, Urban Indigenous Table on Income Security Reform. *Income Security: A Roadmap for Change*. Toronto, Ontario; 2017.

Leeds, Grenville & Lanark District
HEALTH UNIT
Your Partner in Public Health

August 30, 2018

VIA EMAIL

The Honourable Doug Ford
Premier of Ontario
premier@ontario.ca

The Honourable Lisa MacLeod
Minister of Children, Community and Social Services
mcssinfo.css@ontario.ca

The Honourable Christine Elliott
Minister of Health and Long-Term Care
ccu.moh@ontario.ca

Dear Premier Ford and Ministers MacLeod and Elliott:

**Re: Ontario Basic Income Research Project**

I am writing today to express our concern about the discontinuation of the Ontario Basic Income Research Project.

Several reports in recent years have described the extent of poverty and growing income inequality in Ontario and Canada.[1,2] The relationship between income and health has also been well established; countless analyses have consistently and clearly shown that as income rises, health outcomes improve. In doing so, they also demonstrate that lower income people are at far greater risk from a range of preventable medical conditions, including cancer, diabetes, heart disease and mental illness. [3] From a public health perspective, there is a strong literature base demonstrating the relationship between both low absolute income, the extent of income inequality in a society, and a range of adverse health and social outcomes. It is, therefore, reasonable to conclude that improving incomes would be an effective public health intervention.

Given that 16.5% of people in Leeds, Grenville and Lanark live in low income situations based on the after-tax low-income (2011 National Household Survey, Statistics Canada), the avoidable burden of disease from low income and income inequalities is substantial.

In response to these key social and public health challenges, a growing number of individuals and organizations in the health, economics, social, and political sectors have proposed the introduction of a basic income guarantee for all Canadians, also known as guaranteed annual income. A basic income guarantee ensures everyone has sufficient income to meet basic needs and live with dignity, regardless of work status. It can be achieved through a range of policy approaches.

Basic income is a concept that has been examined and debated for decades, including through pilot projects in the United States, Canada, and other countries more recently.[4,5] Mincome, in particular, a pilot project of basic income for working age adults conducted jointly by the Government of Manitoba and the Government of Canada in the 1970s, demonstrated several improved health and educational outcomes.[4] Basic income concepts which are already present in our current system of progressive taxation, credits and benefits for families with children and income guarantee for seniors have contributed to health and social improvements in those age groups. [6,7] While these measures are undoubtedly important and valuable to those who benefit from them, we are convinced that there would be great merit in a serious exploration of the arguments that favour a basic income guarantee as a simpler solution that would benefit more people.

There has been recent support for a basic income guarantee from several health and social sector groups, including the Canadian Medical Association, the Canadian Public Health Association, the Ontario Public Health Association, and the Canadian Association of Social Workers, among others. Beyond the health and social sectors, a non-governmental organization, Basic Income Canada Network, is now dedicated to achieving a basic income guarantee in Canada, and several citizen groups are forming across Ontario and Canada in support of this issue.

Advocating for improved income security policies is supportive of the Leeds, Grenville and Lanark District Health Unit's strategic direction on Health Equity, which states that the health unit 'strives to address the challenges that prevent all residents from having the opportunity to reach their optimal health.'

We hope that you will respond favourably to our request, along with that of many health units and others, to reinstate the Ontario Basic Income Research Project.

Sincerely,

Anne Warren

Anne Warren, Chair
Leeds, Grenville and Lanark District Health Unit

cc: Dr. David Williams, Ontario Chief Medical Officer of Health
Loretta Ryan, Association of Local Public Health Agencies
Pegeen Walsh, Ontario Public Health Association
Ontario Boards of Health
Leeds, Grenville and Lanark Members of Provincial Parliament
Champlain and South East Local Health Integration Network
Jamie McGarvey, President, Association of Municipalities Ontario
Brock Carlton, Chief Executive Officer, Federation of Canadian Municipalities
Leeds, Grenville and Lanark Municipalities

**References**


1. Canadian Index of Wellbeing. How are Ontarians Really Doing?: A Provincial Report on Ontario Wellbeing. Waterloo, ON: Canadian Index of Wellbeing and University of Waterloo, 2014

2. Conference Board of Canada. How Canada Performs: A Report Card on Canada. 2013. Accessed April 27, 2015. http://www.conferenceboard.ca/hcp/details/society/incomeinequality.Aspx

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4. Forget, E. The Town with No Poverty: The Health Effects of a Canadian Guaranteed Annual Income Field Experiment. Canadian Public Policy xxxvii(3) 283-306, 2011. http://utpjournals.metapress.com/content/xj02804571g71382/fulltext.pdf

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7. Milligan, K., and Stabile, M. “Do Child Tax Benefits Affect the Well-Being of Children? Evidence from Canadian Child Benefit Expansions”. American Economic Journal: Economic Policy 3(3): 175-205, 2011.

HURON
COUNTY

September 6, 2018

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto ON M7A 1A1
Email: premier@ontario.ca

Dear Premier Ford,

We are writing to urge you to reconsider your recent decision to cancel the Ontario Basic Income Pilot.

As you know, the aim of the pilot is to investigate the potential for a basic income to improve the income security of vulnerable Ontarians and increase their chances of breaking the cycle of poverty. It is also designed to permit the evaluation of an initiative that is potentially a simpler and more economically effective form of social assistance than current social assistance programs: Ontario Works (OW) and Ontario Disability Support Program (ODSP) – systems that to date have kept people mired in poverty.

This pilot is recognized throughout our province and internationally as a pivotal opportunity to study the impact of basic income on a range of economic, social, and health outcomes in modern day Ontario.

With the extent of the societal impact of poverty, income inequality, and growing precarious employment, basic income is widely recognized as a key policy area to explore to help address these issues. In addition, the pilot was intended to measure outcomes in areas such as food security, mental health, health and healthcare usage, housing stability, education and training and employment and labour market participation. These are all key determinants of health.

In fact, there is consistent and ample evidence that health outcomes improve as income rises. People living with low income are at far greater risk of a range of preventable medical conditions, including cancer, diabetes, heart disease, and mental illness. Improving incomes is an exceptionally effective public health intervention that reduces poverty and its impact, and also contributes to reducing the burden on Ontario's health care system. The pilot has the potential to tell us to what degree increased income provides people with the stability they need to break the cycle of poverty, get back on track and succeed.

The pilot was based on a detailed and well-researched proposal authored by Senator Hugh Segal, which was in turn subject to a broad consultation that received input from over 35,000 Ontarians and support from each of the province's major political parties. Moreover, the pilot has been carefully designed, is limited in time and scope and is not significantly costlier than the payments that OW or ODSP would have transferred to those who are participating.

**Huron County Health Unit**
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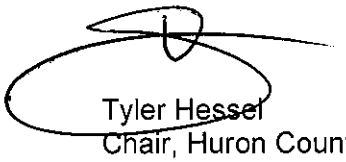
A great deal of time and resources have already been invested in effectively planning and implementing this pilot. We feel that it would be a substantial waste to terminate it so prematurely, without the opportunity to first learn from it. As such, we encourage you to reconsider your decision to cancel this very important initiative.

Sincerely,



Tyler Hessel
Chair, Huron County Board of Health

cc: Christine Elliott, Minister of Health and Long-Term Care
Lisa Thompson, Member of Provincial Parliament, Huron-Bruce
All Ontario Boards of Health
Loretta Ryan, Association of Local Public Health Agencies
Dr. David Williams, Chief Medical Officer of Health

simcoe muskoka
DISTRICT HEALTH UNIT

By email at: Ginette.PetitpasTaylor@parl.gc.ca and Jody.Wilson-Raybould@parl.gc.ca

July 10, 2018

The Honourable Ginette Petitpas Taylor
Minister of Health
House of Commons
Ottawa, Ontario
Canada
K1A 0A6

The Honourable Jody Wilson-Raybould
Minister of Justice and Attorney General of Canada
House of Commons
Ottawa, Ontario
Canada
K1A 0A6

Dear Ministers Petitpas Taylor and Wilson-Raybould,

**Re: A Public Health Approach to Drug Policy Reform**

On June 20, 2018, the Simcoe Muskoka District Health Unit Board of Health (SMDHU BOH) endorsed the recommendations of the Canadian Public Health Association (CPHA) from their 2017 Position Statement, in regards to decriminalization of illicit psychoactive substances (IPS). These recommendations call for a shift from addressing IPS as a criminal issue to that of a pressing public health issue, through implementing the following recommendations:

a) Decriminalize the possession of small quantities of currently illegal psychoactive substances for personal use and provide summary conviction sentencing alternatives, including the use of absolute and conditional discharges;
b) Decriminalize the sales and trafficking of small quantities of IPS by young offenders using legal provisions similar to those noted above;
c) Develop probationary procedures and provide a range of enforcement alternatives including a broader range of treatment options, for those in contravention of the revised drug law;
d) Develop the available harm reduction and health promotion infrastructure such that all those who wish to seek treatment can have ready access;
e) Provide amnesty for those previously convicted of possession of small quantities of IPS; and

f) Provide expanded evidence-informed harm reduction options that include, for example, improved access to supervised consumption facilities and drug purity testing services.

In light of the opioid crisis facing Simcoe and Muskoka, and Canada as a whole, the SMDHU BOH has endorsed this position based on research and evidence that Canada's historical approach to drug policy based on criminalization has created a three-fold problem. The first is the financial burden on our enforcement, justice and corrections infrastructure, estimated at multi-billions of dollars per year[i].

The second is that criminalization has created and perpetuated stigma that alienates those who choose to use drugs, who are often seeking to escape mental or physical pain. This same stigma disproportionately affects marginalized populations such as those living in poverty, those living with mental health issues, and Indigenous communities[ii]. Research identifies how stigma in fact perpetuates drug use by reducing empathy, and drives persons away from supports such as treatment and counselling[iii].

The third aspect of the problem is that exposure to the criminal justice system is harmful to those who use drugs. This approach exposes the person to a wider criminal element, disassociates them from their family or other supports, and creates immense stress[iv]. Additionally, a criminal record impairs a person's ability to find and maintain employment, housing or education. Further, the nature of arrests, penal penalties and court processes further disrupts Opioid Agonist (Replacement) Therapy, exacerbates the incidence of HIV and Hepatitis and worsens management of these conditions, and creates significantly heightened risk for overdose upon release[v].

In light of extensive evidence that criminalization perpetuates problematic drug-use and compounds its associated harms, we strongly urge you to consider decriminalization of illicit psychoactive substances with a concomitant investment in health services. We call upon your government to reform the necessary policies to more effectively and humanely address drug use and addiction as major societal priorities.

Decriminalization of IPS, in order to be most effective, must be accompanied with commensurate investments in harm reduction, treatment and mental health infrastructure. Where this multi-tiered approach has been implemented in other countries, such as in Portugal, measurably positive outcomes have resulted, including pronounced reductions in overdose deaths and substantial increases in entry to drug treatment[vi]. Funds for these health investments would be made available from reduced costs within justice, enforcement and corrections services that are anticipated to result from this shift from a criminalized system to a public health approach.

Please see attached a copy of the 2017 CPHA Position Statement for your reference.

Sincerely,

**ORIGINAL Signed By:**

Scott Warnock
Board of Health Chair
Simcoe Muskoka District Health Unit

SW:LS:mk

Encl.

c. Honourable Christine Elliott, Minister of Health and Long-Term Care for Ontario
Honourable Caroline Mulroney, Attorney General of Ontario
Dr. David Williams, CMOH
Ms. Roselle Martino, ADM
Ontario Boards of Health
Association of Local Public Health Agencies
Ontario Public Health Association
Canadian Public Health Association
MPs and MPPs in Simcoe Muskoka
Mayors and Councils in Simcoe Muskoka
North Simcoe Muskoka and Central Local Health Integration Network

[i] Department of Justice Canada (2008) *Cost of Crime in Canada*
[ii] Csete J. et. al (2016) The Lancet Commissions. *Public Health and international drug policy*. The Lancet Vol 387, April2, 2016
[iii] Global Commission on Drug Policy (2017). *The World Drug Perception Problem*. 2017 Report. Executive Summary. P.7
[iv] Canadian Mental Health Association (2018). *Care Not Corrections: Relieving the Opioid Crisis in Canada*. April 2018
[v] Csete J. et. al (2016) The Lancet Commissions. *Public Health and international drug policy*. The Lancet Vol 387, April2, 2016
[vi] Hughes, C. and Stevens, A. (2011). Harm Reduction Digest [44] *A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalization of Illicit Drugs*. Drug And Alcohol Review (January 2012) 31, 101-113

TORONTO

City Clerk's Office

Ulli S. Watkiss
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Julie Lavertu, Secretary
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Web: www.toronto.ca/council

August 1, 2018

SENT VIA E-MAIL

**To:** Interested Parties

**Subject:** Toronto Overdose Action Plan: Status Report 2018 (Item HL27.1)

---

**The Toronto Board of Health, during its meeting on June 18, 2018, adopted Item HL27.1, as amended, and:**

1. Directed that the Board of Health's decision and the report (June 4, 2018) from the Medical Officer of Health be forwarded to all Boards of Health in Ontario for information.

2. Reinforced with provincial and federal governments the urgency of the opioid poisoning emergency, and the critical need to scale up actions in response.

3. Urged the Ministry of Health and Long-Term Care to extend approval of the maximum term for overdose prevention sites from the current 6 months to a 12-month period.

4. Urged the Ministry of Health and Long-Term Care to support urgent implementation of managed opioid programs (i.e., pharmaceutical heroin/diacetylmorphine and/or hydromorphone), including low-barrier options, across Ontario.

5. Reaffirmed its support for a comprehensive, evidence-based response to the opioid overdose crisis that includes prevention, harm reduction, and treatment and, in particular, the critical role that harm reduction measures such as naloxone distribution, peer support, supervised consumption services, and overdose prevention sites, play in saving lives and improving health.

6. Requested that the Medical Officer of Health review the communications and public presentations received at the Board of Health meeting on June 18, 2018 for consideration as to the next steps in developing the Toronto Drug Strategy.

**Toronto City Council, during its meeting on June 26-29, 2018, also:**

1. Reaffirmed its support for a comprehensive, evidence-based response to the opioid overdose crisis that includes prevention, harm reduction, and treatment and, in particular, the critical role that harm reduction measures, such as naloxone distribution, peer support, supervised consumption services, and overdose

prevention sites, play in saving lives and improving health.

2. Called on the Province of Ontario to continue its response to the opioid overdose crisis by supporting and expanding existing provincially-funded prevention, harm reduction, and treatment measures in the City of Toronto.

3. Requested the Medical Officer of Health to work with the Toronto Community Housing Corporation to train their staff on the safe disposal of drug use equipment and actively participate in the safe disposal of this equipment.

4. Requested the Toronto Community Housing Corporation to require their staff to receive overdose training from Toronto Public Health staff.

5. Requested the Toronto Community Housing Corporation to urgently review their current policies that discriminate against people who use drugs and implement a moratorium on evicting tenants based on drug use during the opioid poisoning crisis.

To view this item and background information online, please visit: http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2018.HL27.1.

Sincerely,

*Julie Lavertu*

Julie Lavertu/ar
Secretary
Board of Health

Sent to the following Boards of Health in Ontario (via e-mails to the Public Health Units):
- Algoma Public Health Unit
- Brant County Health Unit
- Chatham-Kent Health Unit
- Durham Region Health Department
- Eastern Ontario Health Unit
- Grey Bruce Health Unit
- Haldimand-Norfolk Health Unit
- Haliburton, Kawartha, Pine Ridge District Health Unit
- Halton Region Health Department
- City of Hamilton Public Health Services
- Hastings Prince Edward Public Health Unit
- Huron County Health Unit
- Kingston, Frontenac, Lennox & Addington Public Health
- Lambton Public Health
- Leeds, Grenville and Lanark District Health Unit
- Middlesex-London Health Unit
- Niagara Region Public Health Department
- North Bay Parry Sound District Health Unit
- Northwestern Health Unit

- Ottawa Public Health
- Oxford-Elgin-St. Thomas Public Health Unit
- Peel Public Health
- Perth District Health Unit
- Peterborough Public Health
- Porcupine Health Unit
- Public Health Sudbury & Districts
- Renfrew County and District Health Unit
- Simcoe Muskoka District Health Unit
- Thunder Bay District Health Unit
- Timiskaming Health Unit
- Region of Waterloo, Public Health
- Wellington-Dufferin-Guelph Public Health
- Windsor-Essex County Health Unit
- York Region Public Health

cc (via e-mail):

- Dr. Eileen de Villa, Medical Officer of Health, Toronto Public Health
- Elena Zeppieri, Administrative Assistant to the Medical Officer of Health, Toronto Public Health

TORONTO

Ulli S. Watkiss
City Clerk

City Clerk's Office

Secretariat
Julie Lavertu, Secretary
Board of Health
Toronto City Hall, 10th Floor, West Tower
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Toronto, Ontario M5H 2N2

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E-mail: boh@toronto.ca
Web: www.toronto.ca/council

August 3, 2018

SENT VIA E-MAIL

**To:** Interested Parties

**Subject:** A Public Health Approach to Drug Policy (Item HL28.2)

---

**The Toronto Board of Health, during its meeting on July 16, 2018, adopted Item HL28.2, as amended, and:**

1. Directed that the report (June 28, 2018) from the Medical Officer of Health be forwarded to the following for their information and endorsement:

    a. Ontario-based public health boards, the Boards of Health in the 10 largest Canadian cities, the Ontario Public Health Association, the Association of Local Public Health Agencies, and other appropriate public health bodies; and

    b. key organizations of families of drug users and users of drugs.

2. Called on the federal government to decriminalize the possession of all drugs for personal use and scale up prevention, harm reduction, and treatment services.

3. Called on the federal government to convene a task force, comprised of people who use drugs and their families and policy, research, and program experts in the areas of public health, human rights, substance use, mental health, education, and criminal justice, to explore options, including best practices and equitable measures, for the legal regulation of all drugs in Canada, based on a public health approach.

To view this item and background information online, please visit:
http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2018.HL28.2.

Sincerely,

*Julie Lavertu*

Julie Lavertu/ar
Secretary
Board of Health

Sent (via e-mail) to the following Boards of Health in Ontario (via e-mails to the Public Health Units), organizations, and individuals:

- Algoma Public Health Unit
- Brant County Health Unit
- Chatham-Kent Health Unit
- Durham Region Health Department
- Eastern Ontario Health Unit
- Grey Bruce Health Unit
- Haldimand-Norfolk Health Unit
- Haliburton, Kawartha, Pine Ridge District Health Unit
- Halton Region Health Department
- City of Hamilton Public Health Services
- Hastings Prince Edward Public Health Unit
- Huron County Health Unit
- Kingston, Frontenac, Lennox & Addington Public Health
- Lambton Public Health
- Leeds, Grenville and Lanark District Health Unit
- Middlesex-London Health Unit
- Niagara Region Public Health Department
- North Bay Parry Sound District Health Unit
- Northwestern Health Unit
- Ottawa Public Health
- Oxford-Elgin-St. Thomas Public Health Unit
- Peel Public Health
- Perth District Health Unit
- Peterborough Public Health
- Porcupine Health Unit
- Public Health Sudbury & Districts
- Renfrew County and District Health Unit
- Simcoe Muskoka District Health Unit
- Thunder Bay District Health Unit
- Timiskaming Health Unit
- Region of Waterloo, Public Health
- Wellington-Dufferin-Guelph Public Health
- Windsor-Essex County Health Unit
- York Region Public Health
- Dr. Mylène Drouin, Directrice régionale de santé publique, Direction régionale de santé publique du CIUSSS du Centre-Sud-de-l'Île-de-Montréal
- Dr. Patricia Daly, Chief Medical Health Officer and Vice President, Public Health, Vancouver Coastal Health
- Dr. David Strong, Zone Lead Medical Officer of Health, Alberta Health Services
- Dr. Vera Etches, Medical Officer of Health, City of Ottawa
- Dr. Chris Sikora, Medical Officer of Health, Edmonton Zone
- Dr. Lawrence Elliott, Regional Medical Officer of Health, City of Winnipeg
- Dr. Elizabeth Richardson, Medical Officer of Health, City of Hamilton
- Dr. Chris Mackie, Medical Officer of Health and CEO, Middlesex-London Health Unit
- Dr. Liana Nolan, Commissioner and Medical Officer of Health, Region of Waterloo
- Dr. Jessica Hopkins, Medical Officer of Health, Regional Municipality of Peel

- Pageen Walsh, Executive Director, Ontario Public Health Association
- Loretta Ryan, Executive Director, Association of Local Public Health Agencies
- Lana McDonald, Administrative Assistant, Urban Public Health Network
- Sheila Jennings, Ontario Leader, Moms Stop the Harm
- Sean O'Leary, Founder, Executive Director, and Outreach and Partnerships Chair, We the Parents
- Steve Cody, Say No for Nick
- Jennifer Johnston, Niagara Area Moms Ending Stigma
- Heather Alce-Steffler, Co-Founder, Tanner Steffler Foundation
- Donna May, Director, Canadian and International Focus, mumsDU
- Andrea Kusters, Grief Recovery After Substance Abuse Passing
- Frank Crichlow, Representative, Toronto Drug Users Union
- Jordan Westfall, President, Canadian Association for People Who Use Drugs

cc (via e-mail):
- Dr. Eileen de Villa, Medical Officer of Health, Toronto Public Health
- Elena Zeppieri, Administrative Assistant to the Medical Officer of Health, Toronto Public Health

alPHa
Association of Local PUBLIC HEALTH Agencies

**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

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E-mail: info@alphaweb.org

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

July 4, 2018

Dear Minister Elliott,

**Re: Smoke-Free Ontario Act (SFOA) 2017**

On behalf of the Association of Local Public Health Agencies (alPHa), in partnership with the Council of Ontario Medical Officers of Health, Boards of Health, and Affiliate organizations, I am writing today to seek reassurance that the Ontario Government remains committed to addressing the health harms of tobacco, the number one cause of death in Ontario, and related health risks.

On top of the tremendous health burden that tobacco and related products cause, the economic harm is severe. In June of this year, the Canadian Centre on Substance Use and Addiction estimated that tobacco costs the Canadian economy $12 billion each year. The bulk of those costs are in lost productivity of employees who are home sick or in the hospital when they should be at work.

We understand that there is an intention to modify the Smoke-Free Ontario Act, 2017 (SFOA), which was to replace the existing SFOA and the Electronic Cigarettes Act on July 1, 2018, specifically the new regulations related to vaping. We have concerns about this possible decision, as we believe that harmonizing the rules about the consumption of tobacco, e-cigarettes and combustible cannabis in public places is sound policy.

Legislated protections from exposure to cannabis smoke in enclosed spaces are reasonable and based on the known health risks of inhaling smoke of any kind, and we are supportive of placing similar restrictions on vaping while the possible negative health impacts of exposure and long-term use are assessed. The new restrictions will reinforce ongoing efforts to reduce the use of tobacco and its associated or analogous products.

We recognize this as an important opportunity to take a close look at how the addition of non-tobacco-related provisions to the 2017 Smoke-Free Ontario legislation can improve the health of the people of Ontario. We are, for example, on record with our disappointment with the failure of the SFOA 2017 amendments to include water pipes (also known as "hookah" or "shisha"), the negative health impacts of which are more clearly demonstrated than those of vaping. Ontario's ongoing permission of the use of these water pipes in enclosed public places is already inconsistent with the aims of the Smoke-Free Ontario Act, 2017, and this inconsistency is only magnified by placing stricter limitations on vaping. Please find attached alPHa Resolution A13-5, which provides more background on this issue.

Public health agencies and associations in Ontario have consistently been unanimous in supporting the regulation of sale, promotion and use of both e-cigarette products and cannabis. At the same time, alPHa members recognize that this is an evolving public health issue and are keen to be involved in discussions about the most appropriate regulatory interventions.

The Smoke-Free Ontario Act, 2017 remains a worldwide standard for effective tobacco control, and we welcome any opportunity to make it even stronger. We look forward to being fully consulted during your government's review of the new legislation. To schedule a meeting, please contact Loretta Ryan, Executive Director, alPHa at 647-325-9594 or loretta@alphaweb.org

Sincerely,

Dr. Robert Kyle
alPHa President

**COPY**: Andrea Horwath, MPP, Hamilton Centre, Leader of the Opposition, Ontario
John Fraser, MPP, Ottawa South, Interim Liberal Leader, Ontario
Helen Angus, Deputy Minister, MOHLTC
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, ADM, Population and Public Health Division (Health and Long-Term Care)
Dr. Peter Donnelly, President and CEO, Public Health Ontario

alPHa
Association of Local PUBLIC HEALTH Agencies

**alPHa RESOLUTION A13-5**

**TITLE:** **Provincial Legislation to Prohibit the Use of Waterpipes in Enclosed Public Places and Enclosed Workplaces**

**SPONSOR:** **Simcoe Muskoka District Health Unit**

WHEREAS the emerging use of waterpipes in enclosed public places and enclosed workplaces has the potential to undermine the success of the Smoke-Free Ontario Act; and

WHEREAS tobacco-free ("herbal") waterpipe smoke has been demonstrated to have concentrations of toxins comparable to tobacco waterpipe smoke[1]; and

WHEREAS the environmental smoke from waterpipe use in indoor public places and workplaces has been demonstrated to contain toxins at harmful concentrations[2]; and

WHEREAS the alleged "herbal" preparations are poorly regulated and often contain tobacco even when they are labelled tobacco free[3]; and

WHEREAS the Tobacco Strategy Advisory Group report recommends an amendment of the Smoke-Free Ontario Act, with "the addition of controls on the indoor use of waterpipes such as hookahs";

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies (alPHa) advocate for provincial legislation to be enacted to prohibit the use of waterpipes (regardless of the substance being smoked) in all enclosed public places and enclosed workplaces.

**ACTION FROM CONFERENCE:** **Resolution CARRIED**

**References**

1 Shidadeh A; Salman R; Jaroud E; Saliba N; Sepetdijian E; Blank M; Does switching to a tobacco-free waterpipe reduce toxicant intake? A crossover study comparing CO, NO, PAH, volatile aldehydes, tar and nicotine yields. Food and Chemical Toxicology Journal Vol. 50, Issue 5, 2012.
2 The Ontario Tobacco Research Unit, OTRU Update, Waterpipe Smoking: A Growing Health Concern, January 31, 2011.
3 The Non-Smokers' Rights Association, Hooked on Hookah: Issue Analysis and Policy Options for Waterpipe Smoking in Ontario, March 2011.

Services de santé du TIMISKAMING Health Unit
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***Branch Offices:***
Englehart Tel.: 705-544-2221 Fax: 705-544-8698
Kirkland Lake Tel.: 705-567-9355 Fax: 705-567-5476

**www.timiskaminghu.com**

July 12, 2018

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

Dear Minister Elliott,

First, congratulations on your appointment to the position of Minister of Health and Long-Term Care. We look forward to working with you in promoting the health of Ontarians.

We are joining other Public Health Units in Ontario such as Public Health Sudbury and Districts and Simcoe Muskoka District Health Unit in expressing our concern over the government's decision to delay implementation of the *Smoke-Free Ontario Act, 2017* (SFOA 2017).

We appreciate your understanding of the scale and complexity of this issue, which accounts for over half of Ontario`s substance use related health care costs—$5.9 billion and over 47,000 deaths (2014).[1] Timiskaming is home to Ontario's highest rate of tobacco use at 30.8%, in contrast to a provincial rate of 17.7% (2013-2014). This burden is felt most among those aged 25-64, men, and in particular "blue collar workers" (those who work in trades, transport and equipment operators, resource industry).[2]

As an organization whose mandate is to improve and protect the health and well-being of the population and reduce health inequities, we appreciate the importance of informing policy with the best available evidence. Similarly, we appreciate the importance of provincial policy that is responsive to the needs of all Ontarians.

It is our understanding that the provincial government wishes to review the potential for e-cigarettes to assist with smoking cessation, and thus is delaying the commencement of the SFOA 2017. While further research is needed to fully understand the impacts of e-cigarettes on tobacco smoking uptake, cessation, and its second-hand exposure effects, the best available evidence is currently represented in the SFOA 2017[3]. By limiting access and exposure to e-cigarettes, we are helping prevent young people from initiating tobacco use and protecting all from second-hand vaping exposure.

[1] Canadian Substance Use Costs and Harms Scientific Working Group. (2018). *Canadian substance use costs and harms (2007–2014)*. (Prepared by the Canadian Institute for Substance Use Research and the Canadian Centre on Substance Use and Addiction.) Ottawa, Ont.: Canadian Centre on Substance Use and Addiction.
[2] Statistics Canada. Canadian Community Health Survey 2013/14. CANSIM table 105-0502. Date Accessed June 25, 2015.
[3] Smoke-Free Ontario Scientific Advisory Committee, Ontario Agency for Health Protection and Promotion (Public Health Ontario). Evidence to guide action: Comprehensive tobacco control in Ontario (2016). Toronto, ON: Queen's Printer for Ontario; 2017.

The modernized SFOA 2017 also includes new smoke-free public spaces that would help to enhance protection of the public from second-hand smoke, to provide additional assistance for smoking cessation, and to prohibit medical cannabis smoking and vaping in the same public locations as tobacco smoking.

We urge the Government of Ontario to consider the children and the hard working adults of Ontario who deserve to lead their best life and implement the *Smoke-Free Ontario Act, 2017* without delay. Reducing the risks of illness and death associated with tobacco, vapour, and cannabis use are essential components of the modernized Smoke-Free Ontario Strategy that aims to drastically reduce tobacco use and associated costs by 2035. Given the importance of tobacco control for Timiskaming we are eager to take on our responsibilities under the act.

Sincerely,

Carman Kidd
Board of Health Chair, Timiskaming Health Unit

cc:
Hon. Doug Ford, Premier of Ontario
John Vanthof, Member of Provincial Parliament, Temiskaming-Cochrane
Association of Local Public Health Agencies
All Ontario Boards of Health
Dr. David Williams, Chief Medical Officer of Health
Dr. Glenn Corneil, Medical Officer of Health (Acting), Timiskaming Health Unit

July 16, 2018

Minister Christine Elliott
Minister of Health and Long-Term Care and Deputy Premier
Hepburn Block 10th Floor
80 Grosvenor St.
Toronto, Ontario
M7A 2C4

Dear Minister Elliott:

**RE: Implementation of the *Smoke-Free Ontario Act, 2017***

On behalf of the Kingston, Frontenac, Lennox & Addington Board of Health, I would like to congratulate you on your appointment to the position of Minister of Health and Long-Term Care. We look forward to working with you to promote and protect the health of Ontarians.

We are joining other local public health agencies across the province to express our grave concern over the delay in the implementation of the *Smoke-Free Ontario Act*, 2017 (SFOA, 2017). Tobacco remains the leading cause of death and disability in Ontario. In addition to this tragic and unnecessary illness and loss of life, tobacco exacts a burden on the Canadian economy[1]. Tobacco use costs the Canadian economy $12 billion per year.

We understand that there is an intention to modify the SFOA, 2017 with respect to the new regulations for e-cigarettes. Not only is harmonizing the rules about consumption of tobacco, e-cigarettes and combustible cannabis in public places sound policy, but delaying the implementation of the SFOA, 2017 will continue to expose youth and young adults to e-cigarettes and fail to further protect Ontarians from the harms of second-hand smoke and vapour in public spaces.

… 2

[1] Canadian Substance Use Costs and Harms Scientific Working Group (2018). *Canadian substance use costs and harms (2007-2014).* (Prepared by the Canadian Institute for Substance Use Research and the Canadian Centre on Substance Use and Addiction.) Ottawa, Ont: Canadian Centre on Substance Use and Addiction.

Kingston, Frontenac and Lennox & Addington Public Health
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Napanee 613-354-3357 Fax: 613-354-6267
Sharbot Lake 613-279-2151 Fax: 613-279-3997

The SFOA, 2017 is based on the best available evidence to date and is a global standard of excellence for effective tobacco control. We urge the Government of Ontario to implement the SFOA, 2017 without delay.

Yours truly,

Denis Doyle, Chair
KFL&A Board of Health

Copy to: Board of Health members
Hon. D. Ford, Premier of Ontario
I. Arthur, MPP, Kingston and the Islands
R. Hillier, MPP, Lanark-Frontenac-Kingston
Ontario Boards of Health

Premier of Ontario
Le premier ministre de l'Ontario

Legislative Building
Queen's Park
Toronto, Ontario
M7A 1A1

Édifice de l'Assemblée législative
Queen's Park
Toronto (Ontario)
M7A 1A1



July 17, 2018

Mr. René Lapierre
Board of Health Chair
Public Health Sudbury and Districts
1300 Paris Street
Sudbury, Ontario
P3E 3A3

Dear Mr. Lapierre:

Thanks for your letter on behalf of Public Health Sudbury and Districts about the *Smoke-Free Ontario Act*. I appreciate hearing your concerns.

I note that you've sent a copy of your letter to the Honourable Christine Elliott, Minister of Health and Long-Term Care. I trust that the minister will also take your views into consideration.

Thanks again for contacting me.

Sincerely,

Doug Ford
Premier

c: The Honourable Christine Elliott

WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

519-258-2146 | www.wechu.org

Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

July 19, 2018

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

Sent via Email: premier@ontario.ca

**Pause in Implementation of Smoke-free Ontario Act, 2017**

Dear Premier Ford:

Windsor and Essex County has always been on the forefront of progressive measures which protect residents from the dangers of tobacco and tobacco related harms. Recognizing the importance of provincial regulations under the *Smoke-free Ontario Act* and *Electronic Cigarettes Act,* municipalities in our region have further enhanced these protections by passing bylaws which include additional prohibited products (e.g., electronic cigarettes, medicinal cannabis) and spaces.

As such, it is with great disappointment that we learned of the pause in implementation of the progressive and health protecting measures put forward in the *Smoke-free Ontario Act, 2017* (SFOA 2017) and we encourage the provincial government to move forward with all aspects of this Act as soon as possible. In doing so, the provincial government would better protect residents of Windsor-Essex and all Ontarians from the known cancer-causing agents in tobacco and cannabis smoke, as well as the potential harms of electronic cigarette vapour.

The measures proposed in the SFOA 2017 are in line with the modernized *Smoke-free Ontario Strategy* and the recommendations of the Smoke-free Ontario Scientific Advisory Council in their 2016 report *Evidence to Guide Action: Comprehensive Tobacco Control in Ontario*. In addition, they will be important steps toward reaching the federal goal of achieving a smoking rate which is under 5% of Canadians by the year 2035, and with that, a tobacco endgame. By delaying the implementation of some measures and reconsidering others, the provincial government may unintentionally be promoting the exposure of harmful products to vulnerable populations such as children, youth, those who are trying to quit, and others which are already disproportionately at risk for negative health outcomes.

As Chair of the Board of Health I support the measures proposed in SFOA 2017, and the Windsor-Essex County Health Unit is prepared to move forward with implementation of the regulations as they stand. These are important measures which will positively impact the health of residents of Windsor-Essex and Ontarians as a whole and, in this regard, I welcome the opportunity to discuss this matter further.

Sincerely,

Gary McNamara, Chair
Windsor-Essex County Board of Health

c: Christine Elliott, Minister of Health and Long-term Care

Percy Hatfield, Member of Provincial Parliament, Windsor-Tecumseh

Lisa Gretzky, Member of Provincial Parliament, Windsor-West

Taras Natyshak, Member of Provincial Parliament, Essex

Rick Nicholls, Member of Provincial Parliament, Chatham-Kent – Leamington

All Ontario Boards of Health

Loretta Ryan, Association of Local Public Health Agencies

Dr. David Williams, Chief Medical Officer of Health

Theresa Marentette, Acting Chief Executive Officer, Windsor Essex County Health Unit

Dr. Wajid Ahmed, Acting Medical Officer of Health, Windsor-Essex County Health Unit

July 20, 2018

The Honourable Christine Elliott
Minister of Health and Long-Term Care
Deputy Premier
80 Grosvenor Street, 10th Floor, Hepburn Block
Toronto, Ontario M7A 1E9

Dear Minister Elliott,

On behalf of the Board of Health of the Middlesex-London Health Unit, congratulations on your appointment as the Minister of Health and Long-Term Care. We look forward to our continued partnership with the Ontario Government as we work together to tackle complex issues of public health concern.

Even though great gains have been made in tobacco control and the rate of smoking is declining, tobacco remains the leading cause of preventable disease and death in the province of Ontario. According to the *Canadian Substance Use Costs and Harms Study* released in June 2018, substance use costs the Canadian economy $38.4 billion, or almost $1,100 for every person in Canada, with tobacco use alone contributing to 31.2% ($12.0 billion) of these costs, second only to alcohol ($14.6 billion or 38.1%).

The healthcare burden associated with tobacco remains high; in 2014, substance use-related healthcare costs amounted to $11.1 billion in Canada, with tobacco use contributing to 53.1% ($5.9 billion) of these costs. The Middlesex-London Health Unit and its Board of Health looks forward to working under the leadership of the Ontario Government to address the harms from tobacco use and the growing use, availability and promotion of other inhaled products and other emerging nicotine products, like cannabis, heat-not-burn tobacco, shisha and electronic cigarettes (e-cigarettes or vapour products).

At its July 19th meeting, the Board of Health reconfirmed its commitment to tobacco control as a top public health priority. The Board of Health understands that the provincial government wishes to re-examine the evidence related to vaping as a cessation tool, and that the enactment of the *Smoke-Free Ontario Act 2017 (SFOA 2017)* has been suspended. Further research is needed to fully understand the impacts of e-cigarettes on tobacco use initiation and smoking cessation, and the health impacts from second-hand exposure. It is critical that any policy framework that allows vaping as a cessation tool include safeguards to prevent youth uptake.

Research has confirmed that that use among youth of products such as e-cigarettes increases the likelihood of youth smoking tobacco, potentially leading to a lifetime of smoking cigarettes, with all of the risk that this entails. Legislation that prohibits the use of vaping products in the same public locations where smoking tobacco is already restricted can help reduce this risk.

Regardless of any changes to vaping provisions, other aspects of *SFOA 2017* are important and worthy of note. The consolidation of the Electronic Cigarettes Act with the Smoke-Free Ontario Act creates the legislative framework that will be a crucial tool for any tobacco control strategy. The prohibition of displays included in the legislation is also important, with research evidence indicating that such measures help reduce youth initiation.

The Board of Health of the Middlesex-London Health Unit remains committed to working in partnership with the Ontario Government to tackle the burden of tobacco and nicotine addiction. The public health community and its institutions and agencies, including local public health agencies, the seven Tobacco Control Area Networks, Public Health Ontario, the Ontario Tobacco Research Unit, and the non-governmental organizations, have expertise and institutional history that will be crucial during current and future reviews of tobacco control strategy development.

The public health community looks forward to the opportunity to share their expertise and experience, working together under the leadership of the Ministry of Health and Long-Term Care, to create a healthier, more productive population with enhanced quality of life and reduced health care costs.

Sincerely,

Joanne Vanderheyden, Chair
Middlesex-London Board of Health

Attachment: Report No. 048-18 "*Provincial Government Suspends the Enactment of the Smoke-Free Ontario Act 2017"*

cc by email: The Honourable Doug Ford, Premier of Ontario
The Honourable Monte McNaughton, Minister of Infrastructure, MPP Lambton-Kent-Middlesex
The Honourable Jeff Yurek, Minister of Natural Resources and Forestry, MPP Elgin-Middlesex-London
Teresa Armstrong, MPP London-Fanshawe
Terence Kernaghan, MPP London North Centre
Peggy Sattler, MPP London West
Helen Angus, Deputy Minister, Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Dr. David Williams, Chief Medical Officer of Health
The Association of Local Public Health Agencies
Ontario Boards of Health

**Municipality of Chatham-Kent**
*Public Health Unit*
PO Box 1136, 435 Grand Avenue West, Chatham, ON N7M 5L8
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Email ckhealth@chatham-kent.ca

July 23, 2018

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

*Delivered via email*

Dear Premier Ford,

**RE: Pause in Implementation of the Smoke-Free Ontario Act, 2017**

At a special meeting of the Chatham-Kent Board of Health on July 16, 2018, the Board received a staff presentation (attached) regarding the pause of the implementation of the *Smoke-Free Ontario Act, 2017* (SFOA, 2017). The Board felt there was significant evidence presented to raise concerns over the provincial government's pause of this important legislation.

While gains have been made in tobacco control, and the rate of smoking is declining, tobacco remains the leading cause of preventable disease and death in Ontario. According to the **Canadian Substance Use Costs and Harms Study** released in June 2018, substance use costs the Canadian economy $38.4 billion, or almost $1,100 for every person in Canada, with tobacco use alone contributing to 31.2% ($12.0 billion) of these costs, second only to alcohol ($14.6 billion or 38.1%).

The healthcare burden associated with tobacco remains high; in 2014, substance use-related healthcare costs amounted to $11.1 billion in Canada, with tobacco use contributing to 53.1% ($5.9 billion) of these costs.

It is understood that the delayed implementation of the SFOA, 2017 is because the government wishes to review the new regulations related to vaping and how e-cigarettes could be used as a cessation tool. Although more research needs to be done to understand the long-term effects of e-cigarette use, a recently published (2018) comprehensive evidence review by the National Academies of Science, Engineering and Medicine concluded the following:

…/2

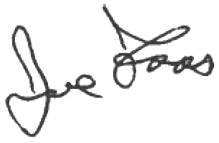
- The effectiveness of e-cigarettes as a cessation aid for smokers is unclear.
- E-cigarette use is associated with subsequent cigarette smoking among youth.
- While chemical levels of second-hand exposure from e-cigarettes are lower than that of combustible tobacco cigarettes, this exposure could have the potential to lead to adverse health effects.

From these findings, it cannot be assumed that e-cigarettes are harmless. The modernized legislation would protect Ontarians from second hand smoke and vapour, and regulate not only the sale, supply, use, display, and promotion of tobacco and vapour products, but also the smoking of medicinal cannabis. These are important policy measures to reduce tobacco use to 5% by 2035 and protect the health of Ontarians, especially vulnerable populations, including youth. It is critical that any policy framework that allows vaping as a cessation tool include safeguards to prevent youth uptake.

The Chatham-Kent Public Health Unit and the Chatham-Kent Board of Health look forward to continuing to work collaboratively with the Ontario government to protect Ontarians from the effects of tobacco, vapour, and cannabis. We urge the government to reconsider implementing the *Smoke-Free Ontario Act, 2017* as intended and without delay so that all Ontarians are able to live, learn, work, and play in the healthiest environment possible.

The public health community looks forward to the opportunity to share their expertise and experience, working together under the leadership of the Ministry of Health and Long-Term Care, to create a healthier, more productive population with enhanced quality of life and reduced health care costs.

Sincerely,



Joe Faas
Chair,
Chatham-Kent Board of Health

Attachment

c: Hon. Christine Elliott, Minister of Health and Long-Term Care
Hon. Monte McNaughton, MPP, Lambton-Kent-Middlesex
Rick Nicholls, MPP, Chatham-Kent – Leamington
Ontario Boards of Health

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Association of Local PUBLIC HEALTH Agencies

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**Affiliate Organizations:**

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Ontario Association of Public Health Dentistry

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July 24, 2018

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

Dear Minister Elliott,

**Re: Smoke-Free Ontario Strategy**

On behalf of members of the Association of Local Public Health Agencies (alPHa) and its Council of Ontario Medical Officers of Health, Boards of Health and Affiliate organizations, I am writing to ask for your commitment to the Smoke-Free Ontario (SFO) Strategy, which was released on May 1st of this year.

Ontario is a world leader in implementing policies that have significantly reduced tobacco use and its associated burdens of mortality and disease. The release of a long-term strategy with specific actionable commitments and outcome targets is a first for the province, and we cannot understate the importance of a clear commitment from your Government to build on past success and make further strides towards the elimination of Ontario's leading cause of preventable disease and premature death.

alPHa has passed several tobacco-related resolutions over the years, including a call on the Province in 2011 to develop a comprehensive tobacco control strategy for Ontario and another in 2017 calling for a commitment to a Tobacco Endgame in Canada (both attached). We were delighted that the former call was answered this past May, and that the innovative, comprehensive and evidence-based recommendations of the Executive Steering Committee for the Modernization of Smoke-Free Ontario that were supported in the latter are reflected in the SFO Strategy.

We would also like to remind you that the Strategy includes specific references to targeting priority populations and acknowledges the related challenges posed by legal cannabis and vaping. It also makes statements of willingness to explore innovative measures and opportunities to support the Strategy's goals in the future.

Our members are eager to continue to play their key roles in achieving a Smoke-Free Ontario and look forward to congratulating your Government for an unequivocal commitment to the provincial policies and strategic initiatives that are required to make this a reality.

Yours sincerely,

Robert Kyle,
alPHa President

**COPY**: Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care, Population and Public Health Division

**ENCL.**

alPHa
Association of Local PUBLIC HEALTH Agencies

**alPHa RESOLUTION A11-3**

**TITLE:** **Call for Immediate Release of a Comprehensive Tobacco Control Strategy for Ontario**

**SPONSOR:** **Peterborough County-City Health Unit**

WHEREAS smoking and other forms of tobacco use still remain the single largest cause of preventable disease and contributes to the premature death of Ontarians annually; and

WHEREAS alPHa has, following a 2009 resolution, urged government to commit to the goal of preserving and enhancing reductions in tobacco use, and to this end to reinstate funding to 2008-2009 levels and in addition, enhance funding for comprehensive tobacco control efforts in Ontario; and

WHEREAS the Smoke-Free Ontario Scientific Advisory Committee (SAC) submitted its report "Evidence to Guide Action: Comprehensive Tobacco Control in Ontario" to the Ontario Agency for Health Protection and Promotion (OAHPP) in the Fall of 2010. The report presents a case for continued comprehensive tobacco control in Ontario; and

WHEREAS the SAC report was closely followed by a report from the Tobacco Strategy Advisory Group (TSAG) with the objective to advise the Ministry of Health Promotion & Sport in the development of a five-year plan to renew the Smoke-Free Ontario Strategy. The TSAG report concluded that "The government must invest in a sustained and sufficiently intensive comprehensive tobacco control strategy in Ontario at levels required to eliminate the burden of tobacco use rapidly, equitably and cost-effectively"; and

WHEREAS Ontario has an opportunity to build on and expand its achievements obtained since the introduction of the Ontario Tobacco Strategy;

**NOW THEREFORE BE IT RESOLVED** that alPHa urgently request the Premier of Ontario (Dalton McGuinty), the Minister of Health Promotion & Sport (Margarett Best), the Minister of Health and Long-Term Care (Deb Matthews), the Office of the Attorney General (Chris Bentley), the Minister of Finance (Dwight Duncan), the Minister of Revenue (Sophia Aggelonitis) and the Chief Medical Officer of Health (Arlene King), to demonstrate the entire set of recommendations within the Tobacco Strategy Advisory Group report and announce a renewed, long-term commitment to a comprehensive tobacco control strategy to reduce use and exposure to tobacco products and the illnesses and deaths they cause to Ontario's populations.

alPHa Association of Local PUBLIC HEALTH Agencies

## alPHa RESOLUTION A17-5

**TITLE:** **Committing to a Tobacco Endgame in Canada**

**SPONSOR:** **Simcoe Muskoka District Health Unit**

WHEREAS tobacco use remains the leading cause of preventable death and disease in Canada; and

WHEREAS the direct and indirect financial costs of tobacco smoking are substantial and were estimated as $18.7 billion in 2013; and

WHEREAS 18.1% of adolescents and adults, or 5.4 million Canadians, were still smokers in 2014; and

WHEREAS under the status quo, and even with the implementation of all MPOWER measures under the World Health Organization Framework Convention on Tobacco Control, Ontario research has estimated that smoking-related deaths will continue to increase beyond 2030, while smoking rates will decline by less than half in the same period; and

WHEREAS a tobacco endgame shifts the focus from tobacco "control" to envision a future that is free from commercial tobacco, and is a strategic process to implement measures that gradually decrease smoking prevalence, demand and supply to extremely low levels; and

WHEREAS there is growing support in Canada and globally for a tobacco endgame, with the adoption of Endgame targets by Ireland, Scotland, Finland, and New Zealand; and

WHEREAS a Steering Committee for Canada's Tobacco Endgame was convened in 2015 and identified an endgame goal of less than 5% tobacco prevalence by 2035; and

WHEREAS a summit on A Tobacco Endgame for Canada in 2016 brought together experts from broad sectors and published a Background Paper with evidence-based and innovative recommendations for tobacco endgame measures in Canada; and

WHEREAS the Federal Tobacco Control Strategy is scheduled for renewal after March 31, 2017;

WHEREAS the federal government's consultation paper Seizing the Opportunity: the Future of Tobacco Control in Canada proposed a number of endgame strategies including being committed to a target of less than 5% tobacco use by 2035;

WHEREAS the provincial Smoke Free Ontario Strategy is also presently under review; and

WHEREAS it is the position of alPHa that Governments of Canada, Ontario and Canadian municipalities must act immediately to minimize the use of tobacco products and their related health impacts;

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies write to the federal Minister of Health supporting the federal government's proposal to commit to a target of less than 5% tobacco use by 2035;

**AND FURTHER** that the Association of Local Public Health Agencies recommend that the federal government's approaches include those identified at the 2016 summit, A Tobacco Endgame for Canada;

**AND FURTHER** that the Association of Local Public Health Agencies write to the Ontario Minister of Health to recommend that the Smoke Free Ontario Strategy be aligned with the proposed tobacco endgame in Canada;

**AND FURTHER** that copies be sent to the Chief Public Health Officer of Canada, and the Chief Medical Officer of Health of Ontario.

**ACTION FROM CONFERENCE:** **Resolution CARRIED**

July 27, 2018

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

Dear Premier Ford;

Re: Implementation of Smoke-Free Ontario Act 2017

The Board of Health for the Grey Bruce Health Unit urgently requests the provincial government proceed with the immediate implementation of the Smoke-Free Ontario Act 2017.

This legislation is an important component of an over-all strategy that aims to substantially reduce the negative health impacts from tobacco use as it addresses electronic cigarettes (e-cigarettes) and other emerging products.

These new products were not part of the smoking milieu at the time of the development of the existing Smoke-Free Ontario Act, and therefore not adequately recognized in the regulatory framework. The Electronic Cigarettes Act provides some level of mitigation, but does not fully address the use of e-cigarettes in public places and workplaces and the display and promotion of e-cigarettes in retail settings. Also of note, the evidence is unclear as to the value of e-cigarettes to support cessation while there is evidence they can act as a gateway for young people to engage in tobacco smoking (Public Health Ontario, 2016).

Currently, no legislation addresses the use of smoking or vaping of medical cannabis in public places and enclosed places. This normalizes the use of such products to youth and young adults and exposes all Ontarians to the harms of second-hand smoke and vapour.

A consolidated approach, as taken by the Smoke-Free Ontario Act 2017, provides the best means to address many of these outstanding issues.

Grey and Bruce Counties adopted smoke-free bylaws several years before the province introduced the Smoke Free Ontario Act. Our experience has seen a reduction in youth smoking rates. Today, an estimated 98% of 12 to 18 year-olds in Grey Bruce have never smoked a whole cigarette, up from 67% in 2000 (Canadian Community Health Survey, 2015/16).

We also note that support for smoke free outdoor spaces in Grey Bruce is at an all-time high - ranging from 72% - 92% (Grey Bruce Health Unit 2014).

We welcome the enactment of an enhanced and consolidated Smoke Free Ontario Act 2017 and the important benefits it will provide to protect the health of all Ontarians.

Sincerely,

Al Barfoot
Chair, Board of Health for the Grey Bruce Health Unit

Cc: Christine Elliott, Minister of Health and Long-Term Care
Bill Walker, Member of Provincial Parliament, Bruce Grey Owen Sound
Lisa Thompson, Member of Provincial Parliament, Huron Bruce
Jim Wilson, Member of Provincial Parliament, Simcoe Grey
All Ontario Boards of Health
Association of Local Public Health Agencies
Dr. David Williams, Chief Medical Officer of Health

alPHa
Association of Local PUBLIC HEALTH Agencies

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**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

July 27, 2018

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

Dear Minister Elliott,

**Re: Supervised Consumption Facilities (SCF)**

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health and Affiliate organizations, we are writing today to express our support for supervised consumption facilities (SCFs) in Ontario.

Having spent considerable time reviewing the research evidence in this matter, we and many others have found it clear: these sites save lives. What is more, when they are well integrated with other services, they can be a crucial route into the system, connecting people with badly needed supports such as addiction treatment, housing, mental health counselling, and employment.

A comprehensive drug strategy includes investment in addictions treatment, police enforcement, and prevention programing that builds strong individuals, families, and communities to resist drug use. Harm reduction is however a crucial pillar of any such strategy, in part because people cannot enter treatment programs if they die of overdose.

Drug use is a public health issue throughout Ontario for a variety of reasons. In addition to the current overdose crisis, people who inject drugs are at significant risk of acquiring and transmitting infectious blood-borne diseases such as HIV and hepatitis C. Preventive harm reduction interventions such as needle distribution programs, SCFs, and educational outreach not only minimize blood-borne illness in people who are unable or unwilling to stop injecting intravenous drugs, but also form part of a comprehensive continuum of preventive and therapeutic population health and clinical services for individuals with substance use issues.

Peer-reviewed research has clearly demonstrated that SCFs can achieve the following public health, individual health, and public safety outcomes:

- reduction in overdose deaths
- reduction of behaviours that cause HIV and hepatitis C infection, such as the sharing of previously used needles
- reduction of unsafe injection practices
- increased acceptance of detox and addiction treatment services
- reductions in costs to rest of health care system
- reduction of public drug use
- reduction in publicly discarded injection equipmentand
- engagement of injection drug users, including high-risk individuals, with support services.

In addition to the many health organizations that have issued position papers in support of these sites (Canadian Medical Association, Public Health Physicians of Canada,

Canadian Nurses Association, Registered Nurses of Ontario, Centre for Addiction and Mental Health etc.), the Supreme Court of Canada, in a unanimous 2011 ruling, declared that closure of Vancouver's InSite (a SCF now in its 16th year of operation) would constitute a denial of health services as well as deprivation of life and security of the person, and would fit with neither the principles of fundamental justice, nor the maintenance and promotion of public health and safety that is a core purpose of the Controlled Drugs and Substances Act.

In summary, we are committed to a comprehensive, evidence-based approach to preventing the poor health outcomes and premature death associated with substance use disorders. This must include harm reduction initiatives such as SCFs and their acknowledgement as an important part of the continuum of Ontario's health care services.

We would be pleased to meet with you to discuss this issue further and look forward to participating in any consultations that may arise from your review. Please contact alPHa Executive Director Loretta Ryan (loretta@alphaweb.org; 416-595-0006 extension 22).

Yours sincerely,

Dr. Robert Kyle,
alPHa President

Dr. Chris Mackie,
Chair, Council of Ontario Medical Officers of Health (COMOH)

Trudy Sachowski,
Chair, Boards of Health Section

**COPY**: Hon. Doug Ford, Premier of Ontario
Helen Angus, 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 (Health and Long-Term Care)

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ophea
Healthy Schools
Healthy Communities

August 1, 2018

Dear Dr. Sutcliffe,

As you are aware, Ontario's Minister of Education recently announced that the sexual health education ("sex-ed") component of the Health and Physical Education (H&PE) curriculum would revert back to the 1998 version until additional parent consultations have been conducted. Ophea is disappointed with this announcement and believes that Ontario students have a right to learn from an up-to-date, research-based H&PE curriculum that includes human development and sexual health education. Ophea believes that the 20 year old expectations from 1998 will not meet the needs of students in 2018 and does not protect student (and teacher) rights as outlined in the Ontario Human Rights Code and other supportive provincial policies including Ontario's Education Act and Equity and Inclusive Education Strategy.

In response to ongoing questions from teachers, principals, parents and students, some school boards have released statements outlining their commitment to continue addressing current issues facing students including online safety, consent, self-esteem, mental health, healthy relationships, respect for others, diversity and equity. As a provincial subject association for H&PE, we are supportive of these school board statements and would ask that your health unit consider aligning your position with school boards in your region (if you haven't done so already) leading into the 2018 / 2019 school year.

On our end, Ophea will ensure our existing Human Development and Sexual Health teaching supports (made possible through financial and in-kind contributions made by school boards and public health units) remain available through our Teaching Tools website (teachingtools.ophea.net). In addition, Ophea will provide specific documentation that maps our teaching supports to the 1998 Human Growth and Development (or interim) expectations to ensure educators are supported when they return to classrooms in September. These existing teaching supports will continue to include information that addresses current issues facing students including online safety, consent, self-esteem, mental health, healthy relationships, respect for others, diversity and equity.

Ophea will actively engage with government as it relates to the consultation process, including our recommendation that this process is provincially representative of all parents and also engages students, educators, unions, associations, public health and subject-matter experts with lived experience implementing this curriculum. This will ensure that this government has a comprehensive understanding of all perspectives prior to revisiting any curriculum content.

Please feel free to share part, or all, of this information with your colleagues and if you have any questions in the meantime, please contact: chris@ophea.org or 416-426-7126.

Yours sincerely,

**John Dance, President**

**Chris Markham, Executive Director and CEO**

KFL&A Public Health

April 26, 2018

Hon. Indira Naidoo-Harris
Provincial Minister of Education/
Minister Responsible for Early Years and Child Care
22nd Floor, Mowat Block
900 Bay Street
Toronto, ON M7A 1L7

Dear Minister Naidoo-Harris:

**Re: Mandatory Food Literacy Curricula in Ontario Schools**

The Kingston, Frontenac, and Lennox & Addington (KFL&A) Board of Health passed the following motion at its April 25, 2018 meeting:

> **THAT the KFL&A Board of Health endorse provincial policy action found in the 2017 Food EPI Canada Report calling for an examination of current school curricula with regards to food literacy, and introduction of food literacy and food skills as a mandatory component of school curricula, and send correspondence to:**
>
> **1) The Honourable Indira Naidoo-Harris, Provincial Minister of Education**
> **2) The Honourable Dr. Helena Jaczek, Provincial Minister of Health and Long-Term Care**
>
> **And FURTHER that a copy of this endorsement be forwarded to:**
>
> **1) Ms. Sophie Kiwala, MPP Kingston and the Islands**
> **2) Mr. Randy Hillier, MPP Lanark-Frontenac-Lennox & Addington**
> **3) Ontario Dietitians in Public Health Dietitians**
> **4) The Association of Local Public Health Agencies**

Food literacy has been in decline over the past few decades and the resultant food deskilling has affected all segments of society, including children and youth. It has led to an increase of pre-prepared, packaged and convenience foods, eating away from home, and a higher consumption of processed foods that are higher in fat, salt and sugar. These foods are linked to a greater risk of diet-related chronic conditions and diseases such as obesity, heart disease and type II diabetes.



Kingston, Frontenac and Lennox & Addington Public Health www.kflaph.ca

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Branch Offices Cloyne 613-336-8989 Fax: 613-336-0522
Napanee 613-354-3357 Fax: 613-354-6267
Sharbot Lake 613-279-2151 Fax: 613-279-3997

At a time when essential food literacy skills are lacking, there is a lack of opportunity to acquire these skills in the school setting. In Ontario, home economics, including food literacy education and training, was removed several decades ago from the Grade 7 and 8 curricula. Over the same time period, there has been a proliferation in processed and ready to consume foods, and marketing of unhealthy food and beverages. While food literacy curriculum is available to students, it is estimated that only one-third of Ontario students who entered Grade 9 from the 2005/06 to 2009/10 school years earned one or more credits in a course that included a food literacy component during their secondary school education.

Recently, a panel of more that 70 non-governmental experts from 44 universities, non-governmental, and professional organizations from across Canada gathered to comprehensively assess Canadian food environment polices compared to international benchmarks of current best practice. In their report *Creating healthier food environments in Canada, Current policies and priority actions*, this group recommended, among other provincial/territorial recommendations, the following policy action:

> Examine current school curricula with regards to food literacy, and introduce food literacy and food skills training as a mandatory component of school curricula. p. 7

Schools provide an opportunity to support students in making healthy choices and in gaining knowledge and food skills that will lead to developing food literacy, which will guide lifelong healthy eating habits. The KFL&A Board of Health urges the Provincial Government to examine the current school curricula with respect to food literacy, and to introduce mandatory food literacy and food skills training curricula.

Yours truly,

Dennis Doyle, Chair
KFL&A Board of Health

Copy to: The Honourable Dr. Helena Jaczek, Provincial Minister of Health and Long-Term Care
Ms. Sophie Kiwala, MPP Kingston and the Islands
Mr. Randy Hillier, MPP Lanark-Frontenac-Lennox & Addington
Ontario Dietitians in Public Health Dietitians
The Association of Local Public Health Agencies
Board of Health members

June 18, 2018

Honourable Indira Naidoo-Harris
Provincial Minister of Education/
Minister Responsible for Early Years and Child Care
900 Bay Street
Toronto ON M7A 1L7

Dear Minister Naidoo-Harris:

**Re: Mandatory Food Literacy Curricula in Ontario Schools**

On May 25, 2018 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Kingston, Frontenac and Lennox and Addington Board of Health regarding food literacy curricula in Ontario schools. The following motion was passed:

GBHU BOH Motion 2018-51

Moved by: Mitch Twolan Seconded by: Stewart Halliday

"THAT, the Board of Health for the Grey Bruce Health Unit support the motion from Kingston, Frontenac and Lennox & Addington requesting an examination of current school curricula with regards to food literacy, and introduction of food literacy and food skills as a mandatory component of curricula in Ontario Schools."

Carried

Sincerely,

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

Cc: Ontario Boards of Health

Encl.

Peterborough Public Health

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

July 16, 2018

Hon. Christine Elliott
Deputy Premier, Minister of Health and Long-Term Care
christine.elliott@pc.ola.org

Hon. Lisa M. Thompson
Minister of Education
lisa.thompson@pc.ola.org

Dear Ministers Elliott and Thompson:

**Re: Mandatory Food Literacy Curricula in Ontario Schools**

On behalf of our Board of Health, I am writing to you in support of the Kingston, Frontenac, and Lennox & Addington Board of Health's call to examine current school curricula with regards to food literacy, and introduction of food literacy and food skills training as a mandatory component of school curricula.

Our Board is committed to protecting and promoting the health and well-being of our residents. Food literacy has been in decline over the past few decades and the resultant food deskilling has affected all segments of society. It has led to an increase of pre-prepared, packaged and convenience foods, eating outside of the home, and a higher consumption of processed foods that are higher in fat, salt and sugar. These foods are linked to a greater risk of diet-related chronic diseases.

At a time when essential food literacy skills are lacking, it is important to support Ontario students with knowledge and food skills that will lead to developing food literacy and in turn will guide lifelong healthy eating habits. The school setting provides a universal opportunity for students to acquire these skills. While food literacy curriculum is available to students in high school, it is estimated that only one third of Ontarian students who entered grade 9 from the 2005/06 to 2009/10 school years earned one or more credits in a course that included a food literacy component.

We respectfully request that the provincial government examine the current school curricula with regards to food literacy, and introduce mandatory food literacy and food skills training curricula in school.

Yours in health,

***Original signed by***

Councillor Henry Clarke
Chair, Board of Health

/ag
Encl.

cc: Local MPPs
Ontario Dietitians in Public Health
Association of Local Public Health Agencies
Ontario Boards of Health

WORKPLACE HEALTH
*putting health on your agenda*

Spring / Summer 2018

# Healthy sleep

## …and how your workplace can support it

Sleep is essential for a productive lifestyle and overall health and wellness. In fact, we spend about one third of our entire life asleep! In Canada, 32% of adults sleep shorter than the recommended seven to nine hours each night. This sleep deprivation can lead to increased absenteeism, presenteeism, and accidents and injuries in the workplace.

Why do we need sleep?

- Restores functions (e.g. makes proteins, hormones, muscle growth, tissue repair, etc.)
- Helps us learn by creating neuropathways
- Helps with memory
- Enables growth
- Heals previous day's stresses
- Gives physical energy for the next day
- Regulates emotions
- Improves attention and mental health
- Clears toxins from the brain that build up during the day

In this issue, you will be able to assess your own sleep habits, discover ways to deal with shiftwork and learn how your workplace can support optimal sleep habits.

There are many things you do during the day that can affect the quality and quantity of your sleep. The things you do during the day and before bedtime are called sleep hygiene. To complete the table below, think about how each response affects the quality and quantity of your sleep.

| **Circle each response that applies to you** | **Column A** | **Column B** |
|---|---|---|
| | | |
| 1. Do you wake up and go to bed at the same time every day – even on weekends and days off? | Yes | No |
| 2. Do you have a relaxing routine at least one hour before bedtime, e.g. warm bath, reading, listening to calming music, etc.? | Yes | No |
| 3. Is your bedroom dark, quiet, cool, and comfortable? | Yes | No |
| 4. Do you have a phone, computer or TV in your bedroom? | No | Yes |
| 5. Are you physically active during the day? | Yes | No |
| 6. Do you get lots of bright light in the morning? | Yes | No |
| 7. Do you drink caffeine after noon? | No | Yes |
| 8. Do you drink alcohol within two hours of going to bed? | No | Yes |
| 9. Do you watch TV, go on your phone, computer, or tablet within one hour before bedtime? | No | Yes |
| 10. Do you nap during the day? | No | Yes |
| 11. Do you eat a large meal before going to bed? | No | Yes |
| 12. Do you have a small snack before going to bed? | Yes | No |
| 13. Do you set aside time to deal with stress, e.g. to list next day's tasks? | Yes | No |
| 14. Do you go to bed when you are tired? | Yes | No |
| 15. Do you take non-prescription medication to get to sleep? | No | Yes |

Count the number of responses you had in column A:

**13-15 responses:** Wow! You have great sleep habits. Keep it up!

**10-12 responses:** Great work! You have many healthy sleeping habits. For even greater benefits, select 2 or 3 items in column B to work on every day.

**7-9 responses:** You have some healthy sleep habits but may benefit by selecting 2 or 3 items in column B to work on every day.

**Less than 7 responses:** Your sleeping habits may be negatively affecting your sleep. To help improve your sleeping habits, select 2 or 3 items in column B to work on every day.

# Strategies for shift workers

On average, night shift workers sleep for almost one hour and a half less than day shift workers. Night shift workers must sleep during the day when the circadian system is at its strongest and work while the system is at its lowest which often results in poor sleep. This lack of sleep can accumulate over the years and lead to the development of health problems.

**Consequences of lack of sleep**

- Weakened immune system
- Impaired brain activity
- Weight gain
- Heart disease
- Workplace injuries

1. Make sleep a priority.
2. Maintain a regular sleep schedule as best you can – even on your days off.
3. If possible, plan for a fixed sleep period (for example from 9 a.m. to 11 a.m.) which will always be dedicated to your sleep, both during days you work and the days you are off.
4. Control your sleeping environment. A bedroom that is dark, quiet, comfortable, and cool can help promote restful sleep. Consider using blackout curtains to prevent sunlight coming in from your windows. You may also use an air conditioner to keep your bedroom cool as well as cover any noises in or outside your home.
5. Split your sleeping into two parts. Sleep for a few hours when you get home from your night shift then another few hours before your next shift.
6. Keep caffeine use to the beginning of your shift.
7. Limit alcohol and hard-to-digest foods in the few hours before your bedtime. Alcohol may help you relax, however, your sleep will be less deep and you may wake up more frequently. Eat a light snack before going to bed (such as whole grain cereal and milk or fruit and yogurt) and avoid heavy meals.
8. Avoid bright light on the way home from work if you work night shift. Wear dark, wrap-around sunglasses and a large hat to shield yourself from the morning daylight.
9. Keep the same bedtime routine regardless of the time you go to bed. For example, brushing your teeth, changing into pajamas, reading, etc. Following the same routine helps your body and mind recognize it is time for sleep.

For more tips on how to adjust to shift work visit the Canadian Sleep Society at www.css-scs.ca.

Well rested workers are more productive, happy, and are less likely to be absent, and suffer from workplace injuries.

**What can the workplace do?**

- Provide resources/educational sessions about healthy sleep
- Discourage checking and sending emails after work hours
- Recognize that stress is a factor that negatively affects sleep
- Where possible, keep each employee on the same shift
- When shifts must be rotated, rotate them forwards (morning to afternoon to evening to night)
- Avoid scheduling back-to-back shifts
- Provide a quiet space for breaks/naps
- Encourage physical activity during shifts
- Change shifts from 12 hours to 8 hours

Creating healthy workplaces benefits everyone!

# Resources and references:

Public Health Sudbury & Districts www.phsd.ca

Canadian Sleep Society www.css-scs.ca

National Sleep Foundation www.sleepfoundation.org

Chaput, J-P., Wong, S.L., Michaud, I. (2017). Duration and quality of sleep among Canadians aged 18 to 79. Health Reports, 28(9), 28-33.

Lucke, J., & Partridge, B. (2013). Toward a smart population: A public health framework for cognitive enhancement. Neuroethics, 6, 419-427.

Public Health Sudbury & Districts
Workplace Health Team
1300 Paris Street
Sudbury, ON P3E 3A3
705.522.9200, ext. 290
workplacet@phsd.ca

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Chapleau: 705.860.9200
Manitoulin: 705.370.9200
Sudbury East: 705.222.9201
Toll-free: 1.866.522.9200

Public Health
Santé publique
SUDBURY & DISTRICTS

LA SANTÉ AU TRAVAIL

*inscrire la santé à votre agenda*

printemps / été 2018

# Bien dormir

## …et encore mieux en adaptant votre lieu de travail

Le sommeil est essentiel pour avoir un mode de vie productif, être en santé et se sentir bien. En fait, nous passons le tiers de notre vie à dormir! Au Canada, 32 % des adultes dorment moins que les sept à neuf heures de sommeil recommandées chaque nuit. Ce manque de sommeil peut entraîner une hausse de l'absentéisme et du présentéisme ainsi que des accidents et des blessures au travail.

Pourquoi avez-vous besoin de dormir?

- Rétablir les fonctions (p. ex., fabrication des protéines et des hormones, développement musculaire, réparation des tissus)
- Favoriser l'apprentissage en créant de nouvelles voies nerveuses
- Aider à la mémoire
- Favoriser la croissance
- Récupérer des stress de la journée précédente
- Donner de l'énergie pour le lendemain
- Réguler les émotions
- Améliorer l'attention et la santé mentale
- Éliminer les toxines qui s'accumulent dans le cerveau durant la journée

Le présent numéro vous propose d'évaluer vos propres habitudes de sommeil, vous fait découvrir des moyens de composer avec le travail par quarts et vous apprend comment votre lieu de travail peut favoriser des habitudes de sommeil optimales.

Durant le jour, vous faites de nombreuses activités qui peuvent avoir une incidence sur la qualité et la quantité de sommeil. Les activités que vous faites pendant la journée et avant l'heure du coucher font partie de ce qu'on appelle l'hygiène du sommeil. En remplissant le questionnaire ci-dessous, songez à l'impact de chacun de ces facteurs sur la qualité et la durée de votre sommeil.

| **Encerclez chaque réponse qui s'applique à vous** | **Colonne A** | **Colonne B** |
|---|---|---|
| | | |
| 1. Vous levez-vous et vous mettez-vous au lit à la même heure chaque jour, même la fin de semaine et durant vos congés? | Oui | Non |
| 2. Avez-vous l'habitude de vous détendre au moins une heure avant de vous coucher, p. ex., en prenant un bain chaud, en faisant de la lecture ou en écoutant de musique calmante? | Oui | Non |
| 3. Votre chambre est-elle sombre, paisible, fraîche et confortable? | Oui | Non |
| 4. Avez-vous un téléphone, un ordinateur ou une télévision dans votre chambre à coucher? | Non | Oui |
| 5. Êtes-vous actif physiquement durant le jour? | Oui | No |
| 6. Recevez-vous beaucoup de lumière vive le matin? | Oui | Non |
| 7. Buvez-vous des boissons caféinées après midi? | Non | Oui |
| 8. Buvez-vous de l'alcool dans les deux heures précédant votre coucher? | Non | Oui |
| 9. Regardez-vous la télévision ou utilisez-vous votre cellulaire, ordinateur ou tablette dans l'heure précédant votre coucher? | Non | Oui |
| 10. Faites-vous une sieste durant le jour? | Non | Oui |
| 11. Mangez-vous un gros repas avant de vous coucher? | Non | Yes |
| 12. Mangez-vous une collation avant de vous coucher? | Oui | Non |
| 13. Réservez-vous du temps pour gérer le stress, p. ex., en dressant la liste des tâches du lendemain? | Oui | Non |
| 14. Êtes-vous fatigué au moment de vous mettre au lit? | Oui | Non |
| 15. Prenez-vous un médicament sans ordonnance pour vous endormir? | Non | Oui |

Comptez le nombre de réponses encerclées dans la colonne A.

**De 13 à 15 réponses :** Fantastique! Vous avez des habitudes de sommeil saines. Continuez!

**De 10 à 12 réponses :** Excellent! Vous avez beaucoup d'habitudes de sommeil saines. Pour profiter de conditions encore plus optimales, choisissez 2 ou 3 de vos réponses dans la colonne B et efforcez-vous d'améliorer ces aspects au quotidien.

**De 7 à 9 réponses :** Certaines de vos habitudes de sommeil sont saines, mais vous pourriez les améliorer davantage en choisissant 2 ou 3 de vos réponses dans la colonne B et en travaillant chaque jour sur ces aspects.

**Moins de 7 réponses :** Vos habitudes nuisent peut-être à votre sommeil. Pour tenter d'améliorer vos habitudes de sommeil, choisissez 2 ou 3 de vos réponses dans la colonne B et efforcez-vous d'améliorer ces aspects au quotidien.

# Stratégies pour travailleurs de quart

En moyenne, les travailleurs de quart de nuit dorment presqu'une heure et demie de moins que les travailleurs de quart de jour. Les travailleurs de nuit sont obligés de dormir durant le jour, lorsque le système circadien est à son plus fort et de travailler quand ce dernier est à son plus faible, d'où de fréquents problèmes de sommeil. Avec les années, un manque de sommeil chronique peut mener à l'apparition de problèmes de santé.

**Conséquences du manque de sommeil**

- Système immunitaire affaibli
- Activité cérébrale perturbée
- Gain de poids
- Maladie cardiaque
- Blessures au travail

1. Faites du sommeil une priorité.
2. Faites votre possible pour maintenir un horaire de sommeil régulier, même pendant vos congés.
3. Si possible, prévoyez une période de sommeil fixe (p. ex., de 9 h à 11 h) qui sera toujours réservée à votre sommeil, les jours où vous travaillez et les jours où vous êtes en congé.
4. Contrôlez votre environnement. Une chambre à coucher qui est sombre, tranquille, confortable et fraîche peut aider à favoriser un sommeil réparateur. Envisagez l'utilisation de rideaux d'obscurcissement pour bien cacher la lumière du jour. Vous pouvez aussi utiliser un climatiseur pour garder votre chambre fraîche et atténuer les bruits provenant de votre maison ou de l'extérieur.
5. Partagez votre sommeil en deux périodes. Dormez quelques heures de retour à la maison, après votre quart de nuit, puis quelques heures avant votre prochain quart.
6. Ne consommez de boissons caféinées qu'au début de votre quart de travail.
7. Limitez la consommation d'alcool ou d'aliments difficiles à digérer dans les heures précédant votre coucher. L'alcool peut vous aider à vous détendre, cependant, votre sommeil sera moins profond et vous pourriez vous réveiller plus souvent. Contentez-vous d'une petite collation avant d'aller au lit (comme des céréales à grains entiers avec du lait, ou des fruits et du yogourt) et évitez tout repas lourd.
8. Évitez les lumières vives sur votre retour à la maison si vous effectuez des quarts de nuit. Portez des verres fumés foncés qui couvrent bien votre champ de vision et un grand chapeau pour vous protéger contre la lumière du jour.
9. Gardez la même routine du coucher, peu importe l'heure à laquelle vous vous couchez. Par exemple, vous brosser les dents, mettre votre pyjama, lire. Cette routine indique à votre corps et à votre cerveau qu'il est l'heure d'aller dormir.

Pour obtenir plus de conseils sur la façon de vous ajuster au travail par quarts, visitez la Société canadienne du sommeil à www.css-scs.ca.

Les travailleurs bien reposés sont plus productifs et heureux et ils moins sujets à s'absenter et à subir des blessures au travail.

**Quelles solutions peuvent être apportées au milieu de travail?**

- Fournir des ressources/séances éducatives sur le sommeil sain
- Déconseiller les échanges de courriels après les heures de travail
- Reconnaître que le stress est un facteur qui nuit au sommeil
- Dans la mesure du possible, garder l'employé sur le même quart de travail
- Dans le cas de quarts effectués par rotation, respecter le sens horaire (passage du matin à l'après-midi, au soir, à la nuit)
- Éviter d'attribuer des quarts consécutifs
- Fournir un espace tranquille pour les pauses/siestes
- Encourager l'activité physique durant les quarts de travail
- Remplacer les quarts de 12 heures par des quarts de 8 heures

Créer des lieux de travail sains, c'est à l'avantage de tous!

# Ressources et références


Santé publique Sudbury et districts www.phsd.ca

Société canadienne du sommeil www.css-scs.ca

National Sleep Foundation www.sleepfoundation.org

Chaput, J-P., Wong, S.L., Michaud, I. (2017). Durée et qualité du sommeil chez les Canadiens âgés de 18 à 79 ans. Rapports sur la santé, 28(9), 28-33.

Lucke, J. et Partridge, B. (2013). Toward a smart population: A public health framework for cognitive enhancement. Neuroethics, 6, 419-427.



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workplacet@phsd.ca

Espanola : 705.222.9202
Chapleau : 705.860.9200
Manitoulin : 705.370.9200
Sudbury Est : 705.222.9201
Sans frais : 1.866.522.9200


Public Health
Santé publique
SUDBURY & DISTRICTS

alPHa

Association of Local PUBLIC HEALTH Agencies

# Information Break

July 24, 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.*

## 2018 Annual Conference Wrap Up

alPHa wrapped up another successful annual conference, The Changing Face of Public Health, last month in Toronto. More than 100 members from across the province heard a variety of presentations on local public health system sustainability, Indigenous engagement and government relations. Highlights included a pre-conference guided walking tour of the downtown St. Lawrence neighbourhood, a fireside chat with Ontario's Chief Medical Officer of Health and the perennial alPHa Distinguished Service Award presentation. Many thanks goes to the conference planning committee members, speakers, sponsors and exhibitors, and attendees who helped make this a memorable and informative event. alPHa has drafted full conference proceedings which contain links to the slide presentations. The document may be downloaded from the alPHa website at the link below.
View alPHa's 2018 conference proceedings here (login and password required)

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## 2018-2019 alPHa Executive Committee & Board of Directors

At the June annual general meeting, a new slate of officers of the 2018-2019 alPHa Executive were appointed as follows:

President: **Dr. Robert Kyle** (COMOH, Durham)
Past President: **Carmen McGregor** (BOH, Chatham-Kent)
Vice President: **Wess Garrod** (BOH, KFL&A)
Treasurer: **Dr. Howard Shapiro** (COMOH, Toronto)
BOH Section Chair: **Trudy Sachowski** (BOH, Northwestern)
COMOH Chair: **Dr. Chris Mackie** (COMOH, Middlesex-London)
Affiliate Representative: **Paul Sharma** (OAPHD, Peel)

For a full list of the 2018-2019 Board of Directors, click here

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## June 12 Boards of Health Section Meeting

Representatives from 22 boards of health met during the annual conference in Toronto and heard presentations on the tobacco endgame, cannabis, and public health advocacy, among other topics. A link to those presentations is below. Trudy Sachowski was elected to the North West regional seat on the 2018-2019 Boards of Health Section Executive Committee of the alPHa Board of Directors. Acclaimed were David Pickles (Central East) and Gilles Chartrand (North East). The next scheduled BOH Section meeting will take place on February 22, 2019 in Toronto. *Please note there will not be a meeting in the fall of 2018 due to the October 22 municipal election.*
View presentations from the June 12 BOH Section meeting (login and password required)

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## Resolutions Passed at 2018 Annual Conference

At this year's annual conference alPHa's membership endorsed five resolutions on a number of province-wide issues, ranging from infection control to public health system sustainability. alPHa will be following up on the resolutions and sending them to various government contacts for their consideration and action. Responses are posted on the alPHa website as they become available and are organized by topic.
View the 2018 alPHa Resolutions here

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## Municipal Election Policy Priorities

Similar to the provincial policy priorities released last fall, alPHa will be developing policy priorities for the October 22 municipal election. A working group has been struck to review and discuss the public health priorities that will be delivered to municipal candidates during the weeks leading up to October 22. Look for further in this space and by email.

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## alPHa Website Feature: Consultations

From time to time members of the public, including health unit staff and board of health members, are invited to provide input into consultations on matters of health and public health. alPHa keeps a list of these consultations on its website. Click the link below for more information.
View the Current Consultations web page here

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## Upcoming Events - Mark your calendars!

**October 30, 2018** - COMOH General Meeting, Toronto, Ontario.

*Note: There will no Boards of Health Section Meeting held in Fall 2018 due to the municipal election.*

**February 21 & 22, 2019** - Winter Symposium, Toronto, Ontario. Includes COMOH Meeting (Feb. 22) and BOH Section Meeting (Feb. 22)

**March 27, 28 & 29, 2019** - TOPHC 2019, Toronto, Ontario.

**June 9, 10 & 11, 2019** - Annual General Meeting & Conference, Kingston, Ontario. Co-hosted with KFL&A Public Health.

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

alPHa
Association of Local PUBLIC HEALTH Agencies

# Information Break

August 31, 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.*

## Municipal Election Policy Priorities

Similar to the provincial policy priorities released last fall, alPHa has developed seven key public health policy priorities for consideration by candidates in the October 22 municipal election. Topics include Alcohol, Cannabis, Food Insecurity, Mental Health, Opioids, Oral Health, and Tobacco. Customizable templates on each priority have been sent to boards of health to assist them in raising these issues with local candidates for awareness and influence on healthy local policy development. Many thanks to the alPHa's Municipal Election Task Force members for their assistance in the development of the priorities and their templates.
View alPHa's 2018 municipal election policy priorities here

## alPHa Annual Report

Check out alPHa's 2017-2018 Annual Report covering the association's activities and achievements over the past year. Thank you to the alPHa Board of Directors, members and staff for their efforts in advancing the public health agenda.
View the 2017-2018 alPHa annual report here
View previous years' annual reports here

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## Government News Round Up

Canada announces tracking system to monitor movement of legal cannabis -2018/8/29

PM releases federal ministerial mandate letters -2018/8/28

Federal government approves roadside drug screening equipment -2018/8/27

Canada launches first Poverty Reduction Strategy - 2018/8/21

Ontario announces cannabis retail model - 2018/8/13

Province pauses overdose prevention/safe injection sites yet to be approved - 2018/8/11

Ontario cancels Basic Income research project - 2018/7/31

Province introduces legislation to end cap-and-trade carbon tax - 2018/7/25

Ontario to review safe injection/overdose prevention sites - 2018/7/24

Province pauses changes to Smoke-Free Ontario Act - 2018/7/4

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alPHa
Association of Local PUBLIC HEALTH Agencies

**THE CHANGING FACE OF PUBLIC HEALTH: CONFERENCE PROCEEDINGS**

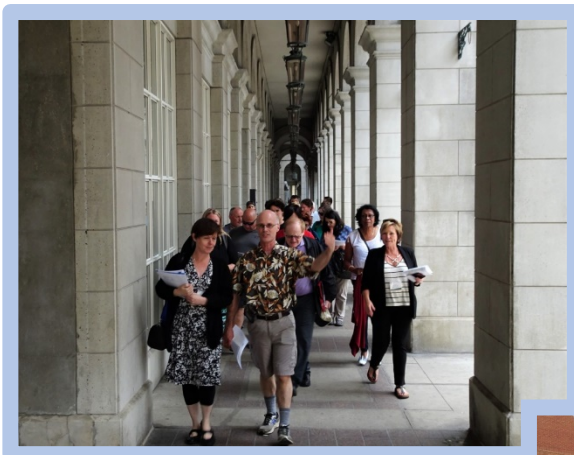
2018 alPHa Annual General Meeting & Conference - June 10, 11 & 12
Novotel Toronto Centre Hotel, 45 The Esplanade, Toronto, ON

## SUNDAY, JUNE 10, 2018

### Final Meeting of 2017-18 alPHa Board of Directors

Minutes of this meeting will be distributed to members of the Board.

### Guided Walking Tour of St. Lawrence Neighbourhood



Over two dozen delegates enjoyed a special pre-conference guided walking tour of downtown Toronto's St. Lawrence neighbourhood led by former chief planner for the city, Robert Millward, and Dr. Charles Gardner, MOH, Simcoe Muskoka District Health Unit. The focus was on the built form and how it intersects with public health with its influence on physical activity, social inclusion, and a host of other determinants of health. Assisted by Daniel Nicholson and Henry Tang from the City of Toronto and Loretta Ryan from alPHa.


Highlights included seeing and hearing about St. Lawrence Market, David Crombie Park and its adjacent mixed-income housing, the 1831 "porcupine drain" that was unearthed by the demolition of St. Lawrence Market North building, the 1887 Toronto Street Railway Company Stables (now home to Young People's Theatre), and the re-developed Berczy Park with its famous dog fountain.

### Opening Reception

Delegates were welcomed to a reception to share refreshments and conversation to prepare for a full schedule of Association business, education and further networking.

## MONDAY, JUNE 11, 2018


**Welcoming Remarks – Councillor Joe Cressy**

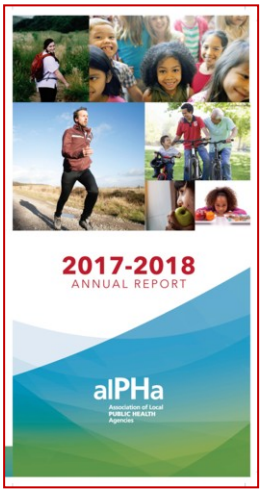
alPHa President Carmen McGregor welcomed delegates to alPHa's 32nd annual conference *The Changing Face of Public Health,* and acknowledged the Ancestral Traditional Territories of the Ojibway, the Anishnabe and the Mississaugas of the New Credit on whose territory we gathered.

She then introduced City of Toronto Councillor Joe Cressy to bring greetings on behalf of the city. Councillor Cressy noted that he came from a background in public health, most notably as a volunteer for a Ghanaian LGBT organization, for whom he provided materials that were intended to prevent HIV through safe-sex practices.

He then recited a list of accolades that have been accorded to the city in recent years to bring into stark relief its growing inequities. For all of the great things Toronto has going on, child poverty, homelessness and income gaps are serious issues, and he suggested that the city is failing the true test of how we care for our most vulnerable.


He cited the opioid crisis as one of the best indicators of this failure, noting that more than 1,200 people in Ontario died last year and this number is sure to rise. This crisis has expanded to the point that it is no longer limited to marginalized communities and is therefore going mainstream. As a result, it is being reframed as a public health issue and there is more acceptance of harm reduction approaches such as safe injection sites.

He closed with an encouragement to delegates to keep up their work on framing social issues such as housing, community design, poverty and human rights as public health issues, using sound and reasoned arguments for healthy living, and being the conscience of our cities.




**Combined Annual Business Meeting & Resolutions Session**

The agenda and reports for the Annual Business Meeting were circulated to members in advance and the draft minutes will be circulated separately. The alPHa Annual Report was also distributed and can be viewed here.

Outgoing alPHa Board members were recognized at this time, with thanks for their hard work on and support for moving alPHa's priorities forward over the 2017-18 term. Many thanks to Tracy-Allan Koester (ODPH), Miriam Klassen (COMOH), Valerie Jaeger (COMOH), Andrea Feller (COMOH), David Pickles (BOH), Gilles Chartrand (BOH), Patricia Hewitt (AOPHBA). Outgoing alPHa President Carmen McGregor and Section Chairs Dr. Penny Sutcliffe (COMOH) and Trudy Sachowski (Boards of Health) were also recognized for their service over the past term.

TOP: David Pickles, Trudy Sachowski, Patricia Hewitt
MIDDLE: Andrea Feller, Penny Sutcliffe
BOTTOM: Miriam Klassen, Gilles Chartrand, Carmen McGregor (with alPHa ED Loretta Ryan)

The 2018 Fitness Challenge Winners and Runners Up were also announced and presented plaques and certificates of recognition. Congratulations to this year's winner, the Porcupine Health Unit!

**Resolutions Session:** Five resolutions were passed at the 2018 AGM:

A18-1 Sustainable Funding for Local Public Health in Ontario
A18-2 Public Health Support for a Minimum Wage that is a Living Wage
A18-3 Public Health's Role in Food Affordability Surveillance
A18-4 Extending the Ontario Pregnancy and Breastfeeding Nutritional Allowance to 24 Months
A18-5 A Comprehensive Approach to Infection Prevention and Control (IPAC) in Regulated Health Professional Settings

These resolutions have been added to alPHa's online Resolutions pages where related correspondence, actions and other developments can be monitored.

**PLENARY: Local Public Health - System Sustainability**

This panel was assembled to explore key priorities for the public health sector and system sustainability from a variety of perspectives, including local public health approaches to working with Local Health Integration Networks (LHINs). Learning objectives were to anticipate, identify and evaluate current and key future priorities for the sector; determine challenges and assess potential actions to address future public health priorities; identify and explain the challenges and success factors in working with LHINs; and apply the concepts learned and experiences of others to working with a LHIN in local context.


Cynthia St. John kicked things off with a presentation on the recent merger of the Oxford and Elgin-St.Thomas health units. She provided an overview of the nine-month process that led to the creation of Southwestern Public Health and gave an outline of the motivations for doing so (chiefly the realization that meeting the requirements of the new *Ontario Public Health Standards--or OPHS*--would be a challenge for Oxford and Elgin-St. Thomas on their own).

She also provided some background on other factors that drove the decision to merge, including shared demographic characteristics, timing, and political will (both local and provincial). Ongoing challenges were also highlighted, including consolidating different board structures (i.e. an autonomous and a regional board of health that had to be divested from the regional structure), harmonizing information technology, and fostering a new organizational culture.

Next steps were also outlined, with an emphasis that while the merger is complete in name, the true integration of the two entities will take time. Success to date has been dependent upon clear and repeated statements of vision, relationship building, long-term commitment and celebration of milestones.

During the ensuing discussion, it was noted that this merger serves as a great example of how local public health can chart its own course and meet emerging challenges without relying on the kind of top-down approach that was embodied in the Expert Panel report. Ms. St. John acknowledged that the Expert Panel report was another important impetus to proceed, as it brought the idea of mergers in general back to the forefront of the public health capacity conversation.


Dr. Vera Etches then turned to the increasing ties between local public health and the health care system as another potential avenue to sustainability. She did so by presenting the initial findings of the Report Back on Public Health – LHIN Engagement Locally Driven Collaborative Project (LCDP).

She reminded the assembly that this engagement originated as a mandate for a more formal relationship in the *Patients First Act*, the nature of which was spelled out in the Board of Health and Local Health Integration Network Engagement Guideline, 2018. The purpose of this is to support the integration of a population health approach into the broader health system by bringing public health's expertise to health services planning.

The key question of the LDCP was, what are the key elements for successful collaboration? To find an answer, focus groups were struck and key informants were surveyed. This resulted in a list of actions to foster collaboration, another

on processes to promote role clarity, and a third one of ideas to overcome the difficulties presented by the misalignment of LHIN and PHU geographic boundaries.

Building relationships by working on specific projects, clarifying expectations, ensuring capacity, and identifying mutually useful data sets were identified as key mechanisms for effective collaboration.

The idea of local leadership in charting the path forward was raised again during this part of the discussion, especially where fostering a clear understanding of what public health is and does is at issue. This will be an important cornerstone to further developing the nature and purpose of collaborating with LHINs, as it will serve to leverage the partnerships and complementary aspects of the differing mandates to achieve the aims of doing so.

**PLENARY: Fireside Chat with the Chief Medical Officer of Health (CMOH)**

Dr. David Williams opened the chat by speaking about his earliest experiences working with vulnerable and remote populations, which influenced his approach to public health at several levels and several areas in the Provincial system. Working in these disparate areas also gave him a full view of the complexity of Ontario's public health system, which he acknowledged may seem chaotic to the untrained eye, but he prefers the term "dynamic", as the skills and structures that exist throughout the province enable the system to respond reasonably well to almost anything.

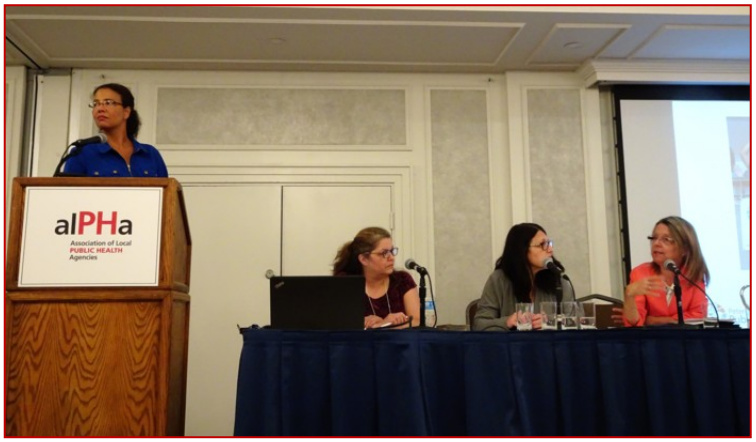
Dr. Penny Sutcliffe then invited him to talk about his most recent Annual Report, *Improving the Odds Championing Health Equity in Ontario*, and to outline some of the challenges and opportunities. He acknowledged that the biggest challenge is always the effort required to address the large societal issues that promote inequities, and noted that despite progress in some areas, disparities continue to increase. While public health does not have the power to change this trend on its own, it has tools at its disposal to address certain aspects of the problem and perhaps more importantly, the voice to speak authoritatively on the health impacts.

Dr. Sutcliffe then asked him to share what a day in the life of a CMOH looks like and how it has evolved over time. He outlined his experience in the field, his recurring role as an Acting CMOH and his opportunity to interact with previous Ontario CMOHs as well as CMOHs working in other jurisdictions and indicated that this has given him insights about possible models. He agreed that the role has changed over the past decade, beginning with the separation of the ADM role and culminating in the creation of the Office of the CMOH. He observed that this is a new situation wherein the CMOH has become a quasi-officer of the legislature (akin to the Environment Commissioner). There is still work to be done to determine what this model is going to look like and how the legislated autonomy and authority of the CMOH is to be used in practice.

Returning to the subject of his previous work with Indigenous communities, Dr. Sutcliffe asked for his perspective on the new OPHS health equity requirements as outlined in the Relationship with Indigenous Communities Guideline. His advice was that we need to acknowledge and understand the complexity of these communities by listening to them and involving them in the decision-making processes that lead to effective and helpful actions to improve health within indigenous populations. He noted that there has been lots of progress, and we need to maintain the momentum.

He was then asked for his perspective on return-on-investment and what steps public health might take to clearly measure and present the positive health outcomes of its various activities. He agreed that this will become an increasingly important frame in the near future, observing that while it isn't public health's job to rescue the health care system, there is much to be said about its enormous contributions to its sustainability.

The final topic was the opioid crisis, which he noted didn't start yesterday and won't be disappearing tomorrow. The current approach is one of emergency response, which is not sustainable in the long-term. Cultural attitudes need to continue to change and the multifaceted nature of the problem will require a concerted and coordinated effort.




**PLENARY: Indigenous Engagement**

This panel was convened to discuss various local public health approaches to indigenous engagement, describe the challenges and successes, and provide suggestions to inform others' activities and maintain the momentum.

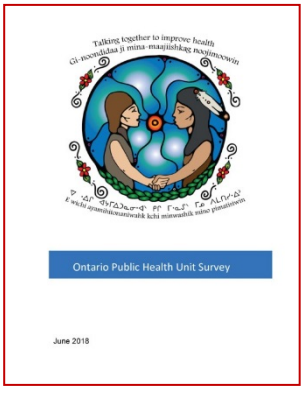
Dr. Rosemarie Ramsingh, a public health physician with Health Canada's First Nations and Inuit Health Branch (Ontario Region), kicked off the discussion by noting that lots of positive change is happening, citing the Federal Minister's commitment to giving indigenous groups more control over their own health and the new OPHS obligations for indigenous engagement as significant examples. She added that the Truth and Reconciliation Commission's 94 recommendations are having a measurable impact on how organizations are interacting with indigenous clients and communities.

She then invited Dr. Angela Mashford-Pringle, Associate Director of the Waakebiness-Bryce Institute for Indigenous Health, to draw on her expertise in the intersection of Indigenous health and education to provide some words of advice on engagement. Her first recommendation was to make sure that messages aimed at Indigenous people are developed by Indigenous people, while ensuring that the emphasis in so doing is in fact on the people rather than simply interacting with the organizations that represent them. She underscored the importance of this by reminding us that 57% of Indigenous people in Canada live off-reserve.

She also emphasized the importance of being cognizant of what she called the "ceremonial determinants of health" and their importance in reinforcing cultural identity and belonging. The smudging ceremony is an especially important one, but because it involves tobacco, can become contentious even though there are specific provisions in the Human Rights code and other pieces of legislation (e.g. the Smoke-Free Ontario Act) that protect it.

She argued that the cultural safety and competency training is an extremely important foundation for fostering the kind of understanding that needs to be in place before specific issues can be appropriately tackled. Traditional behavior-modification approaches to health will surely fail if underlying factors such as poverty, racism, and social exclusion are ignored. She suggested that public health has an important health promotion role to play as advocates for Indigenous health by maintaining focus on those factors.

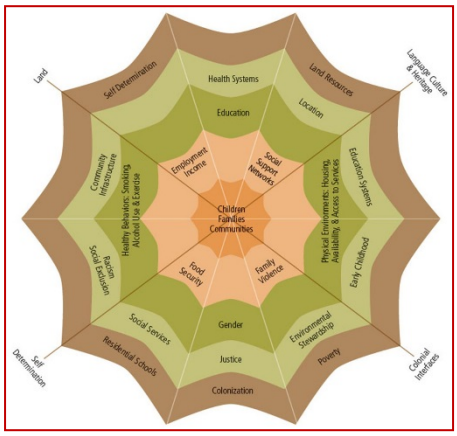
She also urged us to remove the "western biomedical lens" and to think about the importance of the land and water, socialization, belonging and identity as critical determinants of health.




The following panelist was Sandra Laclé, who referred her presentation to share the journey of the Public Health Sudbury and District's (PHSD) Indigenous Engagement Strategy. She outlined the approach, vision, functions, how staff will be utilized, and activities to identify principles for further direction. She also noted the PHSD decision to purchase public-health-themed Indigenous art for display in health unit properties, which conveys a welcoming environment for Indigenous people. She also pointed out that challenges are learning opportunities and that there is no preordained path. Collaboration and iteration point the way forward.

Finally, she referred to the just-released *Talking Together to Improve Health* report that was the outcome of a LDCP research project that was undertaken to determine "what mutually beneficial, respectful and effective principles and practices of engagement between First Nations communities and public health units in Northeastern Ontario can be identified, as an important step in working toward improved opportunities for health for all?"

Dr. Rosana Salvaterra then provided insights from the experience in Peterborough, opening with an observation that getting to the truth was hard, but getting to reconciliation will be harder. It will require a new vision based on a commitment to respect, and the Truth and Reconciliation Commission has given us a path in the form of its Calls to Action.




Her presentation outlined the bridge-building between Peterborough Public Health and the Hiawatha and Curve Lake First Nations, which began with agreements under Section 50 of the *Health Protection and Promotion Act* that allows for the provision of public health programs and services in return for the First Nations taking on the equivalent responsibility of a municipal partner.

Since that time, the First Nations have been incorporated into the strategic plan, and work has evolved to include learning to be an ally, establishing engagement principles, exploring meaningful and culturally appropriate ways of working together and developing a specific Indigenous Health Strategy for the Peterborough area.

She reiterated that this work is important and can be very challenging due to the extant systemic racism and social exclusion that continue to have huge impacts on the health of Indigenous people. She referred to the Web of Being as a useful placemat for looking at the various determinants of health with a focus on the Indigenous experience.


**PLENARY**: **alPHa Strategic Plan**

alPHa President Carmen McGregor provided members with an update on the ongoing renewal of alPHa's Strategic Plan, which hasn't had a substantive update since 2014. This time of change is particularly good timing to re-examine our purpose and priorities and identify strategies that will advance alPHa's mission, goals and objectives.

The process will be inclusive of all members, and the end product will serve as a tool for staff and the alPHa Board to guide day-to-day decisions, determine priorities and evaluate progress towards measurable goals.

The current Strategic Plan review began with a day-long alPHa Board retreat on April 12th, during which Board members examined and gave feedback on the current mission statement, strategic objectives and key priorities, followed by a SWOT analysis. A summary of the initial feedback from this session was shared with assembled delegates, who were then invited to provide any immediate input on paper that was provided at each table or to contact alPHa staff with their thoughts. She assured members that this is just the beginning of the process and that they can look forward to more formal opportunities for input and updates on next steps in the near future.

In closing, she noted that the alPHa logo and banner have been refreshed to reflect the efforts to revitalize alPHa's guiding statements of purpose.

**PLENARY: You Only Get One Chance – Factoring Values into Government Relations Speaker: Leonard Domino, Leonard Domino & Associates**


**Len Domino** referred to his presentation, opening with the observation that the new government is going to be very different from what we have grown used to, and our relationship with it is going to depend on an informed understanding of its values.

These values will set the parameters of political discourse over the next four years and will be the foundation of every policy decision and every related conversation and consultation. The rules of engagement will be defined by these values and as such must be incorporated into our own approaches to advocacy and government relations. Disdain for waste, the "sovereignty of the little guy" and minimal government interference in the daily lives of the people were given as three important examples of the Ford government's values.

Although truly defining the values of a government (which at the end of the day is made up of people whose values are not necessarily congruent) can be difficult and may even change over time, getting things accomplished depends on an understanding of what is important to government and demonstrating how a policy "ask" is likely to serve it.

A coherent and identifiable values system usually emerges from a reading of the various communications (campaign brochures, platforms, news releases etc.) of a given party. It is especially important to understand that the elected officials of any governing party truly believe in what they're doing, and it is therefore ill-advised to challenge motives.

He then reminded the audience that they are the greatest resource the province has on matters of public health, and they will be receptive to the knowledge and expertise as long as the advice is framed in alignment with the values and stated political priorities. Developing interpersonal relationships (for example between local board members and MPPs) can be valuable avenues for this.

*continued*

**2018 alPHa DSA Award Winners: Paul Ryan (BOH), Ralph Stanley (ASPHIO), Sandra Laclé (HPO), Ian Gemmill (COMOH).**


**Click on the images for full-size photos and on the graphic above for the dinner programme!**

**8:00 AM – 12:00 PM**: **Concurrent Business Meetings for alPHa's Council of Ontario Medical Officers of Health and Boards of Health Sections**

Minutes of these meetings and any related materials will be distributed to members of these Sections directly.

**Lunch Speaker: Dr. Theresa Tam**

The conference concluded with a lunch that included a special address from **Dr. Theresa Tam**, Chief Public Health Officer of Canada, which outlined her key priorities for the public health sector in the future, with a primary focus on health equity. Dr. Tam thanked delegates for the opportunity to talk to people on the ground, as she does not get that chance very often.

She turned to her presentation and shared the decision that she made at the beginning of her 5-year mandate to set strategic priorities to reduce health disparities in Canada, with a focus on the determinants of health and vulnerable populations. Her goal is to help level the playing field so that all Canadians can have optimal health, and she observed that Ontario has an enviable public health system in which health equity concepts are already embedded.

During the ensuing discussion, she expressed her desire to translate the kinds of multi-sectoral approaches to health promotion and disease prevention that are successful at the local level to the national and even international stages. Many non-health agencies at the federal level have given her the space to extend her reach beyond PHAC, which gives her access to and influence on important policy levers without relying too much on additional resources and supports.

She also encouraged members to read her annual reports and statements of priorities.

*Please note that Dr. Tam's presentation includes very detailed presenters' notes and is available to members for download here.*

**1:15 – 2:15 PM Inaugural Meeting of 2018-19 alPHa Board of Directors**

This meeting was to confirm the officers and executive committee members for the coming cycle:

| | |
|---|---|
| **President** / COMOH Representative, Central East Region | **Dr. Robert Kyle** |
| **Past President** / BOH Representative, South West Region | **Carmen McGregor** |
| **Vice President** / BOH Representative, East Region | **Wess Garrod** |
| **Treasurer** / COMOH Representative, Toronto | **Dr. Howard Shapiro** |
| **BOH Section Chair** / BOH Representative, North West Region | **Trudy Sachowski** |
| **COMOH Section Chair** / COMOH Rep, South West Region | **Dr. Chris Mackie** |
| **Affiliate Executive Representative** / OAPHD | **Paul Sharma** |

A complete list of alPHa's Board of Directors can be viewed here.

**This event was supported in part by an educational grant from the following:**

**PLATINUM SPONSOR**

Public Health Ontario | Santé publique Ontario

PARTNERS FOR HEALTH | PARTENAIRES POUR LA SANTÉ

**BRONZE SPONSOR**

SANOFI PASTEUR

**LUNCH SPONSOR**

Mosey&Mosey

**Thank you to the following Exhibitors:**

Ontario Chiropractic Association
The Ottawa Hospital mHealth Lab
Health Canada
BORN Ontario
Canadian Mental Health Association
Green Communities Canada

**SPEAKER BIOGRAPHIES**

**Sunday, June 10 – Walking Tour**

WALKING TOUR LEADERS

**CHARLES GARDNER** has been the Medical Officer of Health (MOH) for the Simcoe Muskoka District Health Unit since 2005, after having served as MOH with the Leeds, Grenville and Lanark District Health Unit for seven years. Prior to that, he worked in general medical practice in Newfoundland, New Brunswick, and Zimbabwe. In the past Dr. Gardner has been the chair of the Council of Ontario Medical Officers of Health, president of the Association for Local Public Health Agencies, president of the Ontario Council for Community Health Accreditation, member of the Ontario Public Health Leadership Council, and co-chair of the Healthy Environments Both Natural and Built Table for the Ontario Public Health Sector Strategic Plan. Most recently Dr. Gardner was a member of the Ontario Tobacco Control System Committee and of the Modernization of the Smoke Free Ontario Strategy Executive Steering Committee. He is also a member of the Smoke-Free Ontario Scientific Advisory Group and the Ontario Tobacco Research Network. Dr. Gardner is active personally and professionally on the promotion of health through green, compact, complete, walkable and cyclable communities.

**ROBERT (Bob) MILLWARD** is the president of R.E. Millward & Associates Ltd., where he has acted as the Lead Planning Consultant and Project Manager for a variety of master planning processes, large scale consultations and land use development projects. Bob founded R.E. Millward & Associates in 1997, after a distinguished career working as a municipal planning official for the City of Toronto, and before that with the New York City Planning Department. While at the City of Toronto, Bob served as the Commissioner of Planning and Development from 1987 to 1996, where he was

actively involved in all aspects of policy formulation, project management and economic development. Prior to this, Bob served as the Planning Director for the Central Core and Waterfront Division, and as the Director of Planning for the City of Toronto Housing Department (now Toronto Community Housing). He has been Chair of the Toronto Board of Trade's Planning Committee, coordinating various Board positions such as quality urban design, development approvals reform and Planning Act reform. He was also a member of the Waterfront Task Force, and the Board's Infrastructure Committee.

**Monday, June 11 - Plenary**

WELCOMING REMARKS

**JOE CRESSY** Before being elected, Councillor Cressy served as a Director of Campaigns and Outreach at the Stephen Lewis Foundation. In his various appointments, including to the Board of Health, Toronto Community Housing Corporation Board of Directors, Sub-committee on Climate Change and Adaptation, and in his role as Toronto's Youth Equity Advocate, he is committed to making life better in Toronto. Councillor Cressy works tirelessly to build better neighbourhoods, expand and improve public green spaces, and make life in downtown Toronto more equitable.

LOCAL PUBLIC HEALTH: SYSTEM SUSTAINABILITY (INCL LHIN ENGAGEMENT):

**DENIS DOYLE** studied at Carleton University and York University. After a long career at Xerox Canada, Denis spent six years in Information Technology management at CIBC. Warden Doyle began serving on Township Council in 2006 and was elected as Mayor of Frontenac Islands in 2010. At the County, Warden Doyle serves on the Sustainability Advisory Committee and the Trails Advisory Committee. Denis was County Warden in 2014 – 2015 and has served on the Kingston, Frontenac, Lennox and Addington Board of Health since 2014 and has been Chair since January 2017.

**VERA ETCHES** is the Medical Officer of Health for Ottawa Public Health (OPH). From a small town in northern British Columbia, her specialty training in public health and preventive medicine brought her to Toronto. Prior to joining OPH in 2009, she served as Associate Medical Officer of Health, Acting Medical Officer of Health, and Director of Clinical Services at the Sudbury & District Health Unit. As Associate Medical Officer of Health at OPH, she led and supported work across the breadth of public health practice–from clinical services and outbreak management, health promotion and disease prevention to surveillance, program evaluation, and evidence generation and dissemination. Appointed Medical Officer of Health in May 2018, Dr. Etches remains committed to addressing rural, Indigenous, and urban health issues, and is passionate about building bridges between government, business, community and academic sectors to promote and protect health.

**CYNTHIA ST. JOHN** is the Chief Executive Officer of Southwestern Public Health, a newly merged organization bringing together the former Oxford County Public Health and Elgin-St. Thomas Public Health that serves over 200,000 people in southwestern Ontario. Prior to the merger, Cynthia presided as the Executive Director of the Elgin-St. Thomas Public Health for 18 years. She began her career in the charitable sector by working with exceptional organizations such as the YWCA, the Anne Johnston Community Health Centre, and Dying with Dignity Canada. Currently, she is a Board member with the South West Local Health Integration Network and the YWCA of St. Thomas Elgin. Cynthia is the recipient of the Queen's Diamond Jubilee Medal for volunteerism and the Association of Local Public Health Agencies' Distinguished Service Award for public health leadership work at the provincial level. She holds a Masters of Business Administration with a specialization in Leadership.

INDIGENOUS ENGAGEMENT:

**SANDRA LACLÉ** is the Director, Health Promotion Division and Chief Nursing Officer at the Sudbury and District Health Unit. Sandra's professional passions include: health promotion, population health, health equity, chronic

disease prevention and healthy growth and development. She represents Health Promotion Ontario on alPHa's Board of Directors and is also a member of the Board of Public Health Ontario.

**ANGELA MASHFORD-PRINGLE** is the Associate Director of the Waakebiness-Bryce Institute for Indigenous Health, Dalla Lana School of Public Health (DLSPH), University of Toronto, where she earned a PhD in Aboriginal and Public Health. She is also Assistant Professor of Social and Behavioural Health Sciences at the DLSPH, where she has lectured in Indigenous Studies since 2010. An urban Algonquin woman from Timiskaming First Nation in northern Quebec, Dr. Mashford-Pringle undertakes research that is the intersection of Indigenous health and education. She has held research and administrative leadership roles at the Peel District School Board, St. Michael's Hospital's Well Living House and at the Public Health Agency of Canada where she managed the Aboriginal Head Start Urban and Northern Communities Program. She helped launched Centennial College's Aboriginal Business Diploma and has taught Indigenous Studies at Sheridan College.

**ROSEMARIE RAMSINGH** is a public health physician, specialized in public health and preventive medicine, who has been practicing in this field since 1998. She has spent the bulk of her career serving in organizations focussed on First Nations Health but has also worked as Medical Officer of Health in Northern Ontario and Southern Saskatchewan. She has also does international work on HIV/AIDS with the World Health Organization.

**ROSANA SALVATERRA** has served as the Medical Officer of Health for Peterborough Public Health since 2008. Prior to Peterborough, she worked in both Toronto and Stratford in similar positions. Dr. Salvaterra currently holds an academic appointment with Queen's University, and has worked both internationally, and in First Nations communities in Canada. She has also been a health columnist for the Toronto Star in the past and co-host of a daily TV health show. As a family physician, Dr. Salvaterra specialized in the care of immigrant, refugee and HIV-infected populations. She continues to practice clinical medicine in Public Health's Sexual Health Clinic. In November 2013, the Ontario College of Family Physicians (OCFP) bestowed an Award of Excellence to Dr. Salvaterra in recognition of her outstanding service as a member of the OCFP Board of Directors and her contributions to several OCFP Committees (Poverty, Environmental Health and Planning and Policy Development).

FIRESIDE CHAT WITH CMOH:

**PENNY SUTCLIFFE** was appointed as the Medical Officer of Health for the Sudbury & District Health Unit in August 2000. Before coming to Sudbury, she was the Medical Officer of Health for Yellowknife, Northwest Territories. Her first position as Medical Officer of Health was with the Burntwood Regional Health Authority in northern Manitoba. A specialist in Community Medicine, Dr. Sutcliffe has a longstanding interest in socioeconomic inequalities in health and is a strong advocate for incorporating broader determinants of health into core public health programming. She is particularly interested in pursuing opportunities for healthy public policy development at the local and regional level and to this end is engaged with local healthy community initiatives and with critically examining and modifying local public health practice.

**DAVID WILLIAMS** has been Ontario's Chief Medical Officer of Health since February 2016. He was previously the Interim Chief Medical Officer of Health for the province after serving as Medical Officer of Health for the Thunder Bay District Board of Health from October 2011 to June 2015. Prior to that, Dr. Williams held the position of Associate Chief Medical Officer of Health, Infectious Disease and Environmental Health Branch Director at the Ministry of Health and Long-Term Care from 2005 to 2011. During this time, he was also the Acting Chief Medical Officer of Health for Ontario from November 2007 to June 2009. Before working at the province, Dr. Williams was the Medical Officer of Health and CEO for the Thunder Bay District Health Unit from 1991 to 2005. He is a four-time graduate of the University of Toronto receiving his BSc., MD, Masters in Community Health and Epidemiology, and Fellowships in Community Medicine/Public Health and Preventive Medicine. Prior to entering public health, Dr. Williams worked in hospital based clinical practice as a General

Practitioner (GP) and GP Anaesthetist at the Sioux Lookout Zone Hospital and also in International Health at the United Mission to Nepal Hospital, Tansen, Nepal.

GOVERNMENT RELATIONS:

**LEONARD (Len) DOMINO** is a Government Relations specialist who for over two decades has been helping non-profit and corporate clients achieve their organization's goals by bringing their interests to provincial governments. He has served as Chief of Staff and Senior Policy Advisor to the Ontario ministers of Health and Natural Resources. Before that, he was an elected member of the Manitoba Legislative Assembly. Len specializes in training and coaching in government relations, communications, stakeholder relations and issues management.

**Monday, June 11 – Awards Dinner**

**PETER DONNELLY** is an accomplished leader with extensive experience in government and public health policy and program development and delivery at the local, national and international levels. As President and Chief Executive Officer, he leads Public Health Ontario (PHO), which provides evidence for policy formulation and undertakes public health capacity building, as well as provides integrated public health laboratory and surveillance systems. Prior to joining PHO, Dr. Donnelly was the Professor of Public Health Medicine at the University of St. Andrews in Scotland, where he established and led public health medicine research and teaching. From 2004 to 2008 he was the Deputy Chief Medical Officer to the Scottish Government, providing senior leadership and coordination at a national level. As the Director of Public Health in two jurisdictions, he was responsible for the delivery of local public health services and programs. Dr. Donnelly is an active researcher and lecturer in many areas of public health, with a focus on health systems governance and on violence reduction.

**Tuesday, June 12 – Lunch Plenary**

**THERESA TAM** was named Canada's Chief Public Health Officer in June 2017. She is a physician with expertise in immunization, infectious disease, emergency preparedness and global health security. Dr. Tam has held several senior leadership positions at the Public Health Agency of Canada, including as the Deputy Chief Public Health Officer and the Assistant Deputy Minister for Infectious Disease Prevention and Control. During her 20 years in public health, she provided technical expertise and leadership on new initiatives to improve communicable disease surveillance, enhance immunization programs, strengthen health emergency management and laboratory biosafety and biosecurity. She has played a leadership role in Canada's response to public health emergencies including severe acute respiratory syndrome (SARS), pandemic influenza H1N1 and Ebola. Dr. Tam has served as an international expert on a number of World Health Organization committees and has participated in multiple international missions related to SARS, pandemic influenza and polio eradication.

*For our Medical and Associate Medical Officers of Health, we are pleased to inform you that the Office of Continuing Professional Development has designated the Monday portion of the program with University of Toronto Accreditation status and has awarded it with the following credits: The College of Family Physicians of Canada – 4.5 Mainpro+ credits; Royal College of Physicians & Surgeons of Canada – 4.5 Section 1 hours;*

Globe and Mail Article, published September 4, 2018

OPINION

# Delving into the health data shows that Canadian kids aren't all right

ANDRÉ PICARD ›

PUBLISHED SEPTEMBER 4, 2018

As the school year begins, it makes for some fairly grim reading.

Children First Canada and the O'Brien Institute for Public Health have just published a new report examining the mental and physical health of the 7.9 million young people under the age of 19. "Many Canadians think this is one of the best countries in the world to raise a child, but the statistics prove otherwise," says Sara Austin, founder and lead director of Children First Canada.

She notes that Canada ranks a middling 25th out of 41 countries in UNICEF ranking of well-being of children and youth.

Canada is a safe country for kids – free of the ravages of war, largely free of deadly childhood diseases and prosperous. But the data from comparable countries remind us we can do better. Very few children and youth die in developed countries – just over 3,000 a year in Canada, and half of those are in the first year of life. Our infant mortality rate, 4.5 per 1,000 live births, is one of the worst in the developed world. Iceland, by comparison, has 0.7 deaths per 1,000 live births.

Worse yet, Canada's poor showing overall masks the disparities within the country, ranging from 3.4 per 1,000 in B.C. to 17.7 per 1,000 in Nunavut.

School-age children are remarkably safe.

But as parents load their kids into cars and on buses, or send them off on foot or bikes for the daily round trip to school or daycare, it is worth underscoring that the single biggest danger in a Canadian child's life is the car.

Speeding, gunning through a red light, rolling through a stop sign, texting at the wheel, taking a sharp right turn without looking for pedestrians or cyclists – all these common behaviours can have lethal consequences, especially in school zones.

Unintentional injuries – almost all of them preventable – are the No. 1 killer of children and youth, with motor vehicles posing the greatest risk, followed by falls and drowning.

Number two is suicide. In 2016, 35 children under the age of 14 took their own lives, as did another 203 aged 15-19.

In the past decade, mental health visits to the emergency room have jumped 66 per cent, and hospitalizations for conditions such as depression, anxiety and eating disorders are up 55 per cent. Meanwhile, the waits for psychological and psychiatric care are months and even years.

Clearly, we could be doing a lot better caring for their mental health.

Young people themselves know this is a priority: A survey of youth conducted by Children First Canada found that their three top concerns are mental health, bullying and poverty. About one in five Canadian children and youth live in poverty. In Indigenous communities, the situation is even worse: About 38 per cent of First Nations children, 20 per cent of Inuit children and 21 per cent of Métis children live in poverty.

Poverty invariably means living in substandard housing and wrestling with food insecurity.

As many as one in five children go to school hungry; one in two in Indigenous communities.

According to the new report, one in three adults have suffered from physical or sexual abuse before the age of 16. Two-thirds of them never told anyone.

Abuse remains a risk for children and youth today, as we are reminded by the all-too-common stories of abuse by clergy, sports coaches, teachers and family members. Children and youth need to be armed with tools to protect themselves, which means education about consent and reporting mechanisms where they are taken seriously.

Then there are the comparatively banal health issues, like one in four children being overweight or obese, and only one in three school-age children meeting minimum physical activity guidelines.

Becoming overwhelmed by all these data is easy.

We can't wrap our children in cocoons, protecting them from all risks and dangers, but we can adopt smart public policies that create welcoming, healthy environments.

Children First Canada, for example, calls for the establishment of an independent national commission for children and youth and for the implementation of a Canadian Children's Charter.

The goal, ultimately, is that every child reach her or his potential. We shouldn't lose sight of the fact that children and youth are healthier and safer than they have ever been.

In trying to improve their lot, we need to let kids be kids, to play and live and love.

*A version of this op-ed ran in the Huffington Post on September 12, 2018*

## Public health must become a priority

**By Dr. Trevor Hancock and Senator Art Eggleton**

In 2010 Canada's Ministers of Health stated in a Declaration on Prevention and Promotion that "the promotion of health and the prevention of disease, disability and injury are a priority and necessary to the sustainability of the health system". So you would think that public health would be a clear priority in Canada's health care system. However, Canada's governments have not acted in accordance with those fine words.

Public health is the only part of the health care system that is wholly concerned with preventing death, disease and injury. While most apparent in infectious disease control, it plays a leading role in the fight against tobacco, chronic diseases, obesity, injury, substance abuse, addictions and mental disorders. Not only does public health improve the health of the population, it is one of the best ways to sustain our publicly-funded health care system.

On average in 2015 the health care system consumed 37 percent of provincial program expenditures, a proportion that all provinces are struggling to contain. Because as health care funding's share of the budget increases, it squeezes other sectors whose contributions to health and wellbeing are just as important: Housing, education, social services and others.

There is only so much the provinces can do to reduce the cost of health care through efficiencies before they have to reduce services and access. But there is a better way: Reduce the burden of disease, which is the work of public health. In addition, there are significant economic benefits from prevention, not only from avoided health care costs but in avoided loss of production, income, and tax revenue.

But public health is being weakened across Canada. As it is, it receives only 3 - 4 percent of health care funding, and in some provinces and health authorities much less; public health funding in Nova Scotia is among the lowest in the country, at 1.5% of health care spending in 2010/11. Quebec's regional public health units were hit by severe budget cuts of 33% in 2015, while the BC Auditor General reported last year that while all the care sectors within the system had increases in funding between 2012/13 and 2015/16, public health funding actually decreased.

It is not only a matter of funding. Recent editorials and commentaries in the Canadian Journal of Public Health have pointed to other problems, including downgrading the status of public health within governments and health authorities, eroding the independence of Medical Officers of Health and limiting the scope of public health.

For example, the New Brunswick government recently dismantled the Office of the Chief Medical Officer of Health, moving some 70 of the 110 staff out of the Ministry of Health and spreading them across three different ministries. This prompted a former CMOH for New Brunswick to label these changes "a recipe for disaster", but despite this and other strong expressions of concern from public health leaders across Canada, the New Brunswick government has gone ahead with its changes.

Meanwhile, nationally, the Chief Public Health Officer for Canada was downgraded by the Harper government from leading the Public Health Agency of Canada to being little more than an advisor to the President. Inexplicably the Liberal government - which established the Agency in 2004 - has failed to reverse this change in status and authority.

So significant is the crisis facing public health that last year Canada's Chief Medical Officers of Health – who rarely speak out publicly against the provincial and territorial governments for whom they work - wrote in the Canadian Medical Association Journal imploring (their word) "health ministers to reaffirm commitment to the principles outlined in the declaration".

Public health cannot fulfill its vitally important role with one hand tied behind its back. Our health care system and the health of our population depend upon a strong public health sector. Canada's governments need to make public health a priority.

**********

*Dr. Hancock is a retired Professor of Public Health at the University of Victoria. Senator Eggleton is Chair of the Senate Standing Committee on Social Affairs, Science, and Technology.*

**APPROVAL OF CONSENT AGENDA**

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

# 2018 Annual Service Plan and Budget Submission

## MOHLTC Overview and Feedback

Population and Public Health Division

August 2018

Ontario

# Background

**November 20, 2017**

- 2018 Annual Service Plan and Budget Submission (Annual Service Plan) Template and instructions released publicly to public health units.

**December 11, 2017 and December 13, 2017**

- MOHLTC hosted two (2) training sessions (via webinar) with public health unit business administrators and financial staff regarding the 2018 Annual Service Plan Template.

**March 1, 2018 – May 8, 2018 (Phase 1)**

- 2018 Annual Service Plans submitted to the MOHLTC.
- MOHLTC immediate review of requests for base and one-time funding to inform preparation of the 2018 funding package.
- MOHLTC grant approvals announced.

**May 2018 – July 2018 (Phase 2)**


- MOHLTC conducted a more detailed review of the Annual Service Plans to assess alignment with the Ontario Public Health Standards (Standards), inform improvements required for 2019, and program specific reporting requirements.

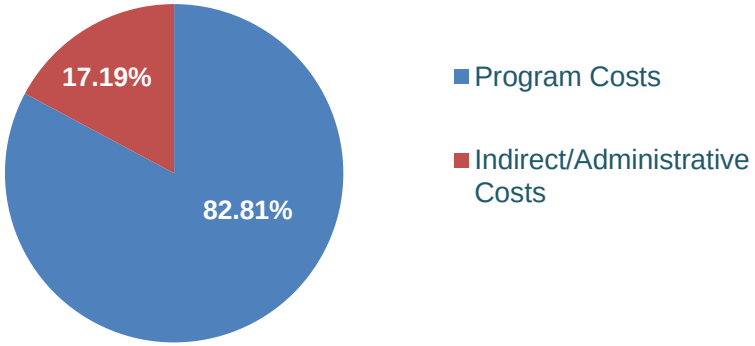
# Context

The 2018 Annual Service Plan is the first time that the MOHLTC has required public health units to describe the complete picture of programs and services being delivered, demonstrate that programs align with community priorities, and demonstrate the use of funding per program and service.

- There was substantial variation in how public health units submitted content in the 2018 Annual Service Plans including: type and degree of content provided, naming conventions of programs/interventions, which programs were included under each Standard, and funding sources for programs.
- Due to the variation noted above, 2018 content and data provided in the Annual Service Plans was reviewed in depth in order to inform improvements for 2019 and future years. Some gaps, challenges, and improvements have also been identified.
- The following overview slides include a summary of content and budget data submitted by public health units as part of the 2018 Annual Service Plans.

# 2018 Annual Service Plans At-A-Glance*

Total budgeted costs of approx. **$952.5M**
(100% costs; provincial and municipal portions)




Staffing includes a total of **7,731 FTEs**

6,885
Program Related Staff

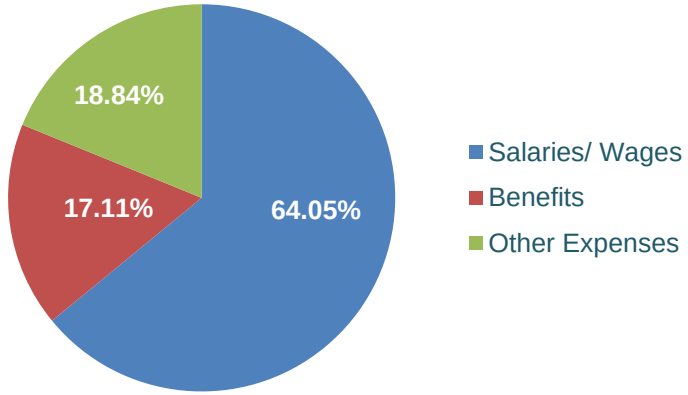
846
Office of the MOH/ Administrative Staff

*As submitted by public health units.

Organized according to the 4 Foundational Standards and 9 Program Standards

- Over **1,800 Program Plans** submitted (range of 31 to 85 per public health unit)
- Over **5,000 Interventions** identified (range of 65 to 417 per public health unit)

Key cost drivers/budget items include: salaries/wages, benefits, and other expenditures (e.g., travel, professional services, program expenses, offset revenues)

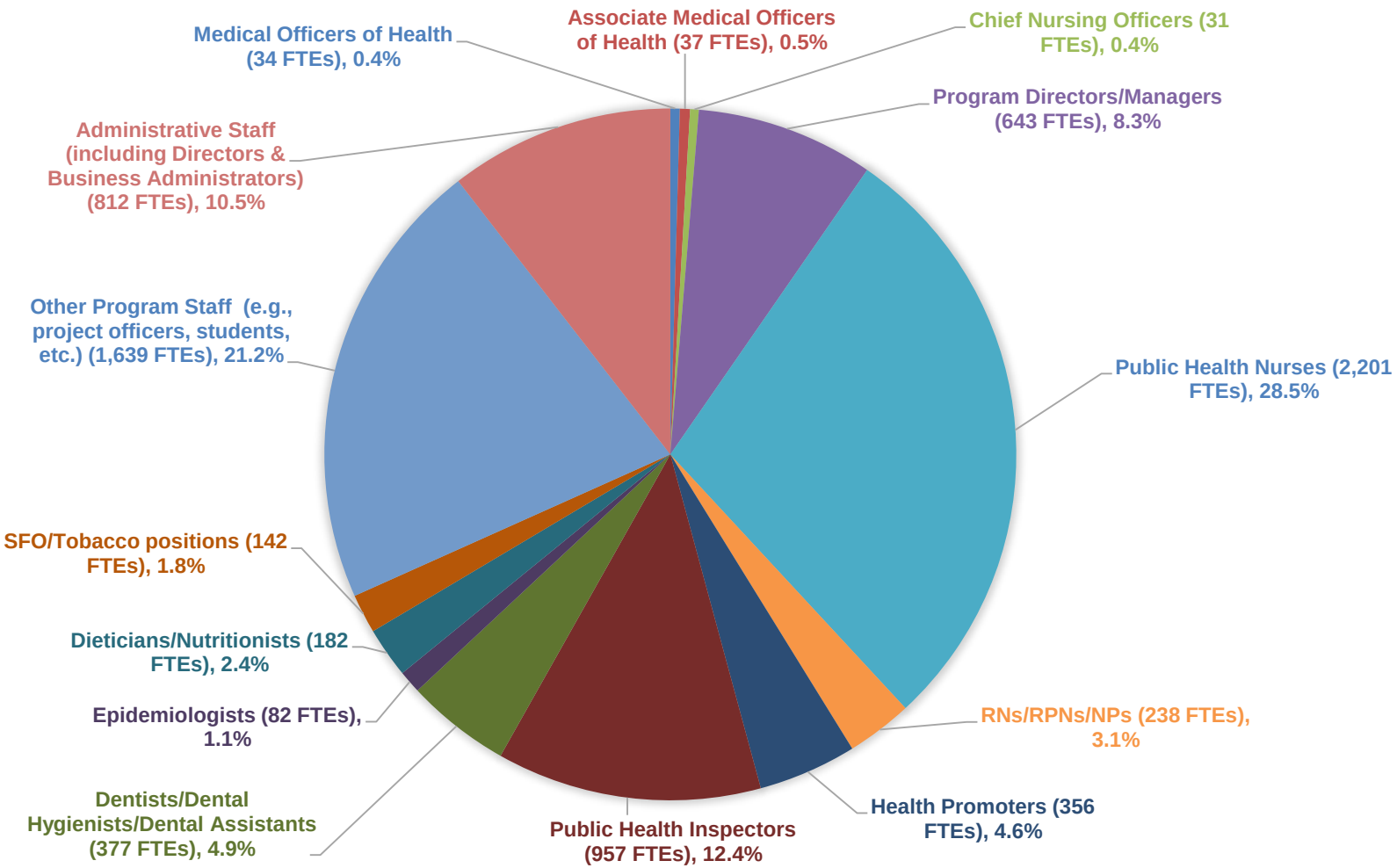


# 2018 Annual Service Plans Overview: Total Budget and FTEs by Standard*

| Standard | Total Budget by Standard (at 100%) | % of Total Budget | Total FTEs by Standard | % of Total FTEs |
|---|---|---|---|---|
| Foundational Standards | $74,418,241 | 7.81% | 774 | 10.01% |
| Chronic Disease Prevention and Well-Being | $85,018,923 | 8.93% | 612 | 7.91% |
| Food Safety | $53,190,929 | 5.58% | 468 | 6.05% |
| Healthy Environments | $22,684,916 | 2.38% | 203 | 2.63% |
| Healthy Growth and Development | $105,249,939 | 11.05% | 934 | 12.09% |
| Immunization | $48,416,921 | 5.08% | 513 | 6.63% |
| Infectious and Communicable Diseases Prevention and Control | $171,446,531 | 18.00% | 1378 | 17.82% |
| Safe Water | $22,847,438 | 2.40% | 205 | 2.65% |
| School Health | $133,086,890 | 13.97% | 1191 | 15.40% |
| Substance Use and Injury Prevention | $72,406,508 | 7.60% | 608 | 7.87% |
| Indirect Costs (Administration & Office of the MOH) | $163,685,930 | 17.19% | 846 | 10.94% |
| **TOTAL** | **$952,453,165** | **100.00%** | **7,731** | **100.00%** |

*As submitted by public health units.

# 2018 Annual Service Plans Overview: Total FTEs by Job Category*




*As submitted by public health units.

# 2018 Annual Service Plans Overview: Community Assessments

**Many public health units identified the following in their Community Assessments:**

Overview of public health unit populations, including unique challenges and risks with population size and density, geography, demographics, socio-economic factors, Indigenous populations, etc.

Health issues/priorities, including obesity, tobacco and cannabis use, alcohol use, healthy eating, physical inactivity, diabetes, infectious diseases, chronic diseases, mental health, oral health, etc.

Data to support priorities (e.g., rates of falls, prevalence of asthma).

Priority populations, including Indigenous peoples, low income, seniors, visible minorities, etc.

Demonstrated linkages to community partners, local municipalities, and stakeholders.

# 2018 Annual Service Plans Overview: Foundational Standards

**Many public health units identified the following under each Foundational Standard:**

## Population Health Assessment

Public health surveillance and evaluation activities.

Use data to measure, monitor, and report on health issues, including social determinants of health and health inequities.

Collaborating with key partners, in particular the LHINs.

## Health Equity

Decreasing health inequities, identifying priority populations, collaborating with community partners and members of marginalized communities.

Consideration of a health equity lens in priorities, programs, and evaluation.

Advocacy and promotion of health equity, internally and externally.

## Effective Public Health Practice

Building capacity in program planning processes, evaluation, and evidence-informed decision making.

Professional development opportunities, knowledge exchange, and quality public health nursing practice.

Quality and transparency; continuous quality improvement.

## Emergency Management

Emergency preparedness and response activities, business continuity planning.

Training and awareness of the organizations emergency response plan, as well as continuous updates to the plan in collaboration with key partners.

Identification of health hazards and risks.

# 2018 Annual Service Plans Overview: Standards and Program Plans*

| Standard | Program Plans (Samples) |
|---|---|
| **Chronic Disease Prevention and Well-Being** | • Active Living<br>• Built Environment<br>• Diabetes Prevention<br>• Menu Labelling<br>• Skin Cancer Prevention |
| **Food Safety** | • Food Safety<br>• Enhanced Food Safety – Haines |
| **Healthy Environments** | • Climate Change<br>• Health Hazards<br>• Healthy Built and Natural Environments |
| **Healthy Growth and Development** | • Breastfeeding/Infant Feeding<br>• Family and Reproductive Health<br>• Healthy Families<br>• Healthy Child Development<br>• Prenatal Health |
| **Immunization** | • Adverse Events Following Immunization<br>• Vaccine Preventable Diseases<br>• Vaccine Storage and Handling |

| Standard | Program Plans (Samples) |
|---|---|
| **Infectious and Communicable Diseases Prevention and Control** | • Infection Prevention and Control<br>• Infectious and Communicable Diseases Prevention and Control<br>• Rabies Prevention and Control<br>• Tuberculosis Prevention and Control |
| **Safe Water** | • Drinking Water Program<br>• Enhanced Safe Water<br>• Recreational Water<br>• Small Drinking Water Systems |
| **School Health** | • Healthy Smiles Ontario<br>• Healthy Schools<br>• Immunization<br>• Mental Health<br>• Vision Health |
| **Substance Use and Injury Prevention** | • Alcohol and Substance Use Prevention<br>• Harm Reduction (including Harm Reduction Program Enhancement)<br>• Falls or Injury Prevention<br>• Road and Off-Road Safety<br>• Tobacco Control/Smoke-Free Ontario Strategy programs |
| | |

*As submitted by public health units.

# 2018 Annual Service Plans MOHLTC Feedback: Community Assessments

## ✓ Overall Strengths:

- Generally good community assessments; provided sufficient data and information to understand the communities and populations in public health unit areas.
- Many public health units demonstrated that the information is used to inform program and service delivery, and that programs and interventions align with the Standards.

## ✓ Overall Areas of Improvement:

- Require more detail on key health priorities (including new and emerging priorities), unique risks, and priority populations (including Indigenous populations and populations relevant to tobacco control), including supporting data.
- Demonstrate linkage of the community assessments to program and service delivery decisions, and how programming addresses priorities and needs.
- Require more consistent data and narrative content, including how information is organized.

## ✓ Supports for 2019:

- Updates/changes to the Annual Service Plan Template to facilitate areas where improvement is required (i.e., more structured community assessment worksheet).
- Provide public health units with some constructive examples of completed community assessments.

# 2018 Annual Service Plans MOHLTC Feedback: Program Plans

- ✓ **Overall Strengths:**
  - ❖ Enabled the MOHLTC to better understand the complete picture of programs and services public health units are delivering in the context of the Standards, better monitor the amount of resources public health units are investing against the outcomes of those programs, and make more informed/equitable funding decisions.
  - ❖ Generally good program plans; provided sufficient level of detail to understand the community needs and priorities under each Standard, and collaboration with key partners.
  - ❖ Many public health units demonstrated alignment with the requirements of the Standards.

- ✓ **Overall Areas of Improvement:**
  - ❖ Require consistency of program names and interventions, including ensuring program names are not more suitable as interventions (and vice versa).
  - ❖ Require identification of specific key partners instead of high level sector partners (i.e., “X specific” family health clinic versus health care providers), and more details on program plans (i.e., descriptions, objectives, interventions) and priority populations, including linkages to priorities in the community assessments.
  - ❖ Ensure to include program plans for each program you plan to deliver as well as a health equity lens across all programs in the Annual Service Plan.
  - ❖ Ensure programming is implemented according to the requirements of the Standards and Protocols (e.g., School Health – Vision) and inadmissible expenditures are not reflected in budgeted expenditures (e.g., Healthy Babies Healthy Children Program, programming related to advocacy activities).

- ✓ **Supports for 2019:**
  - ❖ Updates/changes to the Annual Service Plan Template to facilitate areas where improvement is required (i.e., streamlined worksheets, expanded instructions).
  - ❖ Standardization of some program names and interventions to improve consistency.
  - ❖ Provide each public health unit with specific feedback/comments on their 2018 Annual Service Plans to assist with improvements for 2019.
  - ❖ Provide public health units with some constructive examples of completed program plans.

# Next Steps

**August / September**

- MOHLTC feedback to be provided to each public health unit on their specific 2018 Annual Service Plan.
- MOHLTC to solicit feedback from public health units on potential updates to the 2019 Annual Service Plan Template.

**September / October**

- MOHLTC to release the 2019 Annual Service Plan Template (due March 1, 2019).

**November / December**

- MOHLTC to host training session(s) with public health units on the 2019 Annual Service Plan Template and process.

**ADDENDUM**

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

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: _____**